MENTAL HEALTH COP

A VENN DIAGRAM OF POLICING, MENTAL HEALTH AND CRIMINAL JUSTICE

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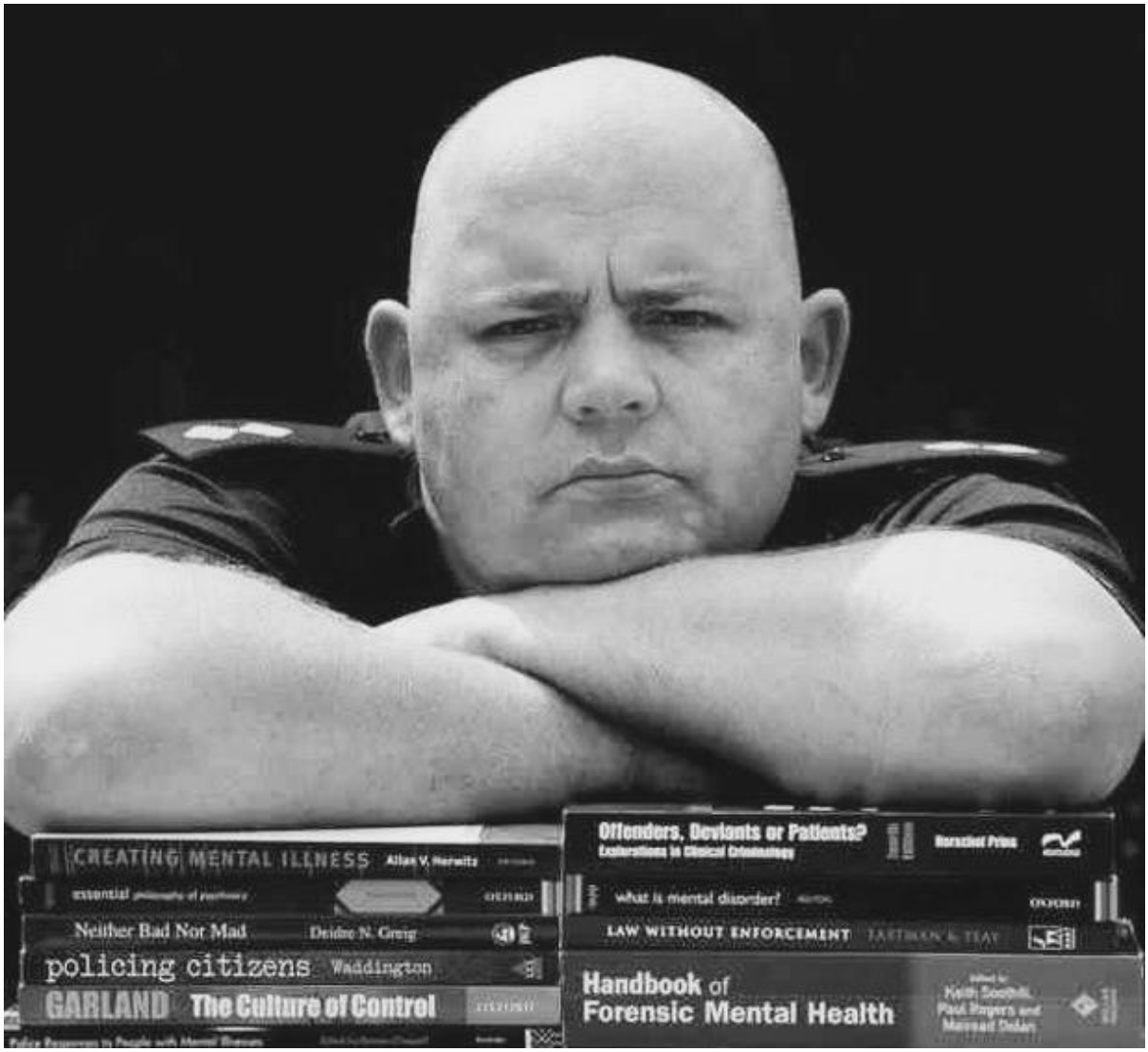
*Winner of the **President's Medal** from* the Royal College of Psychiatrists.

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



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10th January 2016

A Benign Presence –

Have you ever had an unexpected knock on your door from the police? I haven't, thankfully – and long may it remain to be so. I've actually been the unexpected knock on the door from the police on more occasions that I'm comfortable with and I'm not sure you ever forget the first one – I certainly haven't. We were asked to attend an address on my area in Winson Green in Birmingham to inform a woman who her elderly mother had unexpectedly died in hospital – and this task fell to me on the morning of Mother's Day. I could still take you to the address now, almost eighteen years after this responsibility and I'll never forget the look in her eyes when she first opened the door. That was actually worse than her reaction when I said the words, at least for me – it bordered on terror.

Far more frequently and more recently, I've had a different version of a similar thing – being an unexpected presence on the door step on a mental health service user. This has been in a few situations over the years: being asked by mental health professionals to accompany them to a Mental Health Act assessment because it is claimed that there are inherent risks that will require police support; being asked by mental health services or out-of-hours GPs to undertake an urgent welfare check on a patient, because of concerns – and both of those without the patient or service user having an idea at all that the police are being brought or sent. More recently, there is a third variation on a theme – street triage (ST). In a similar way that I could take you to that first address, I could take you to another where the police were told a service user was suicidal. The look on that young woman's face when she opened the door was, again, one of sheer terror. It's always been my experience that sending the police to an address is not without an emotional impact on those who are there, regardless of the reason. Let's remember what the police do: they often break terrible news; investigate criminal offences, occasionally by arresting people; and they are a 'just in case' service where it is predicted that risks may emerge that require the police to manage them in ways that only the police can: by the threat or the use of coercion, for example under the Mental Health Act. Officers, of course, try their best to be decent and humane and proportionate, but we all know the mere impact a uniform can have when it is unexpectedly introduced into our reality.

Of course, some service users have stated that they have good experiences of the police responding to a mental health crisis, either on their own or as

part of a MHA assessment or street triage intervention. So this post, whilst aiming to prompt a discussion about whether the unexpected involvement of the police in a mental health related incident is an entirely benign thing, is not assuming that we can reach a simplistic answer. Some people observe paradoxically that unnecessary policing is stigmatising but that they'd rather deal with officers when they're in crisis than mental health professionals – others vehemently disagree. Maybe we could do with proper research on service users properly about their experiences, not just about police attitudes; but about their involvement at all. And these questions have to sit within the overall public and political debate about what we want the police to spend their time doing – Chief Constables could choose to offer themselves up for all manner of tasks: the question is whether they should and what factors they should consider in reaching those decisions. This is about whether unnecessary involvement of the police in the provision of mental health care is entirely without impact on those in contact with mental health services.

INTER-AGENCY PERCEPTIONS

Earlier this week I took two police officers and a paramedic from a West Midlands Police street triage scheme to the South London and Maudsley NHS Trust to go through some training simulations on mental health. It's was a testing ground to see whether NHS simulation training for mental health professionals can useful apply to 999 emergency services. We were joined in that trial by the London Ambulance Service and the Metropolitan Police. The idea was that two members of the course were given a small background briefing on a situation and they then walk in to a room where a professional actor with relevant professional MH experience acted through a situation, responding to the professionals attempts to manage a situation. The first situation involved a man calling 999 for the ambulance service after he had a taken five paracetamol tablets whilst drinking and whilst becoming mentally unwell. His flat-mate had called the police about the situation also and we end up with one paramedic and one officer at the same location. As soon as the officer walked in to the room, which represented the patient's flat, he said, "What are the police doing here? I haven't done anything wrong! They shouldn't be here." and he become verbally agitated for a while.

In the debrief of the incident, we got in to the discussion about what the police were doing there. Obviously, they were called by the flatmate and it was unclear whether the police knew that paramedics were also at the scene or on the way – this mimics reality all too often. But on arrival, the officer found a paramedic already dealing with a patient and no-one has flagged any aspect of the incident involving anything that you would immediately think of as a police responsibility – no imminent or immediate threat to life; no crime by or against this member of the public; and no

Breach of the Queen's Peace. I wondered why the police wouldn't just make sure the paramedic was aware we were there, but remain outside the incident until asked to do something that required the police to prevent the possibility that the officer's mere presence aggravated an already difficult situation? Obviously, if the police had arrived at the incident first, this wouldn't have been possible – officers would have had to start establishing what was going on until the ambulance service had arrived. Mental health first aid, if you like.

This phrase parity of esteem is used a lot, to argue for equity in mental health care, comparable to that seen in physical health. If this situation had involved an accident or physical injury, we could expect the police to lead, only until such time as an ambulance arrived and then to take a back seat, or even leave the incident. If officers arrived and found the paramedics dealing, they would check whether or not there was anything in the incident requiring police support and if not, standby back or leave the incident. We also have to remember this reality about mental health care in particular: the police are possessed of coercive powers of arrest and detention under the Mental Health Act – the dynamics in play are just *not the same* as officers providing first aid to someone who has fallen and broken their arm.

AGGRAVATING FACTOR

A paramedic at the simulation training offered the view, based on her own experience, that police officers – more often than not – were professional at incidents where she had found herself dealing with mental health crisis incidents. However, on balance, she argued that the introduction of police officers without an obvious purpose was usually an aggravating factor, despite an officer's best efforts. I have heard similar things said by service users: that they don't want routine involvement of the police in their healthcare and this is often for a variety of reasons. There have been previous concerns that incident records end up influencing things like DBS checks for future employment; concern is often voiced that it makes people feel stigmatised or criminalised for have a mental, as opposed to a physical, condition; and finally, that it does affect the ability of the police to prioritise against their broader obligations.

Street triage schemes often turn up to support at incidents where the police were the agency called and they often make a better fist of things when they do. However, we are starting to see they are also sent to patients who merely require from by a mental health nurse what the NHS would call 'unscheduled care'. This is the case because CrisisTeams, community mental health teams and out of hours GPs often lack the capacity to provide this kind of response and have realised that triage exists so we see triage asked to undertake unscheduled visits to service users in their homes. (The reduced capacity of CrisisTeams and CMHTs of various sorts to provide

unscheduled care; and their increasingly frequent policy of only seeing patients out of hours in A&E is probably another BLOG altogether but suffice to say here, that in the last decade, the number of patients requiring secondary (ie, specialist) mental health care has risen by 60% according to the Royal College of Psychiatrists, and outpatient crisis care has reduce in many areas to a third of its previous level. Arguably, it's no wonder that demand upon our emergency system – police, ambulance and A&E – has risen and we have seen a development in support by mental health trusts to those processes. We now see MH nurses in ambulance control rooms, in A&E departments as part of psychiatric liaison services; and in policing – control rooms, custody and triage.)

I would like to see this examined more thoroughly in proper research, not just with reference to triage but evaluations of such schemes do seem one obvious place to consider this and it's often unmentioned (in the ones I've seen). How to service-users perceive the routine involvement of the police in their healthcare pathways where that is unconnected to statutory duties under the Mental Health Act or broader police responsibilities around crime, disorder and safety? Mental health *is* core police business and officers need to be better at it: I suspect this may also mean better at recognising when not to get involved as well as better at understanding how to get involved when it is appropriate.

Perhaps we should start simply: by asking each time the police are deployed on an unexpected basis, "What do you expect to be the reaction here? – have you considered this request in terms of its unintended but inevitable impact?"

12th January 2016

Sessay Situations –

I didn't get 'round to writing a blog on the SESSAY judgment from 2010 before I'd referred to it so many times in other posts, it didn't seem worthwhile. It's often regarded as an important ruling, because it relates to a situation in which police officers find themselves all too often: first responders in a mental health crisis incident on private premises. In this particular case, the Metropolitan Police was called to a person's private premises because neighbours had concerns about whether a young child was being properly looked after and found a mother in the premises with a youngster. Officers were ultimately right to have concerns about the mental health of Ms SESSAY – she was subsequently sectioned under s2 MHA and detained in a mental health unit. The civil claim was about the method by which officers arranged for assessment under the Act.

This post aims to give just a brief summary of the case, but more important it aims to highlight why this particular ruling doesn't apply to all situations of officers finding themselves in private premises and wondering about the Mental Capacity Act. It is precisely because of the number of times I hear this case referred to incorrectly, that I thought this post may help – so this is about understanding how to make a decision in private premises about whether the Mental Capacity Act 2005 will help support decisions; or on whether officers must attempt to allow the Mental Health Act 1983 to take its course, difficult thought that often is.

One final point of preamble: I can't be the only police officer or professional who read this judgment and laughed out loud at the very thought of its implications. Just remember as you read this, judges are not there to interpret the law in light of resourcing realities: but in light of what the law actually does permit when we're invading the civil liberties and lives of vulnerable people. I hope you get to the end of this without laughing, but if not, please remember that this is an argument for proper resourcing of mental health services; not an argument for bending or breaking the law.

SESSAY

So how do you ensure assessment for someone who is encountered in their own home where it is thought to be essential to their health and wellbeing?

The Metropolitan Police officers in this case are said to have been aware of s135 of the Mental Health Act as being the primary power to remove a person from their own home but were also aware they could not rely upon it because they did not have a warrant under subsection 1 and were not accompanied by an AMHP and a Doctor. The judgment itself says nothing about efforts they may have made to contact with duty AMHP for their area before they then took Ms SESSAY and her child from her home to the local police station where officers took the child into police protection (under s47 of the Children Act 1989) and they continued to their local mental health unit Place of Safety for those detained under ss135/6 of the MHA.

They sought to rely upon the Mental Capacity Act 2005 to justify their intervention, and you can understand their logic: without the ability to rely upon the MHA, officers honestly believed that Ms SESSAY lacked capacity to take decisions around her own health and that the least restrictive intervention in her best interests was fulfilled by taking her to the local MH assessment area for assessment. To an extent, they were vindicated – when assessed by an AMHP and two Doctors, an application for detention under s2 of the Act was made because it was argued that Ms SESSAY was legally incapacitated to make decisions and not able to look after her child.

The problem here is that the MCA has limits on what can be done when it comes to restraint and depriving someone of their liberty. That's what was challenged in the case and the Metropolitan Police commissioner settled the case and agreed with the argument. The judge outline the set of statutory provisions that relate to mental health crisis on private premises and this included a reminder of the various provisions of the Mental Health Act that could have applied. I'm not going to rehearse the ins and outs of the MCA because that is covered elsewhere on this BLOG – feel free to read that link to refresh your memory before reading on, if you need to. The points to be made now are –

- To what extent you still can rely upon the MCA in private premises to intervene.
- How you approach situations where it is the MHA which should be the basis to intervene.

WHERE THE MCA APPLIES

As I was getting my head around the MCA some years ago, I remember summarising to someone what I thought I had understood and I typed this on an email –

"So if I've understood this correctly, we're saying police officers should stay clear of relying upon the MCA unless they have to intervene to protect someone from serious harm or get urgent medical treatment?"

They just replied; "Yes!" It's a little bit crude, so let me elaborate briefly.

Imagine you have attended a situation similar to SESSAY – and every police officer in the country will have done – but consider that there are concerns about a paracetamol overdose. If there was evidence to suggest that someone had taken 50 paracetamol, could you use proportionate restraint to stop her taking even more? – if you have those preconditions that you reasonably believe the person to lack capacity and that you are acting in the least restrictive way, in their best interests, you potentially could. Where a situation allowed officers to take control of the medication rather than restrain the individual, that would be preferred and restraint would probably not be justified – but if medication was in the individual's possession and they started trying to empty the contents, personal restraint may then be justified to remove the medication and prevent further ingestion.

And would the MCA then allow removal of that person to hospital, bearing in mind the judge's comments in the original SESSAY case? **Yes, it almost certainly would.**

The difference between SESSAY and critical overdose situation is that people would potentially die without further action in the latter case. No-one was arguing that Ms SESSAY's life was at risk, without some further mechanism taking effect. Without any further action at all, someone who has taken a significant overdose may die. This is where officers must be aware of sections 6 and 4B of the Mental Capacity Act which covers restraint and urgently depriving people of their liberty. Restraint under the MCA can be effected where it is a proportionate response to harm, taking in to consideration the seriousness of that harm and its likelihood – hence, you could justify restraint to stop someone taking a potentially fatal overdose, or to stop them from self-harming in a way that would seriously injure them.

Of course, you'd call an ambulance for all of the above wherever possible, to offer advice and clinical intervention, but officers would be justified in unilaterally intervening if they had to take action to stop serious harm or prevent a serious deterioration in someone's condition.

WHERE THE MHA APPLIES

It's where none of this applies, that we're back to talking about the MHA. If you don't have "section 4B criteria", you need to think outside the MCA. Section 4B allows MCA based intervention (for people over 16yrs who lack capacity) if it is necessary "to provide a life-sustaining intervention or prevent a serious deterioration in their condition" without a further development in the situation.

The judge in SESSAY reminded us that the Mental Health Act provides a full suite of options to intervene in someone's supposed mental ill-health in private premises. An Approved Mental Health Professional (AMHP) and a Doctor could attend the address at assess Ms SESSAY for admission under section 4 of the Mental Health Act, if urgent assessment were needed and there was insufficient time to arrange for two Doctors and a full MHA assessment. The judge also reminded us that the AMHP could pop in to see a Magistrate on the way to the premises if a s135(1) warrant were needed.

Now this, precisely, is the part where I admit I laughed – out loud. The idea that officers attending such a call or any other spontaneous incident could get the control room to ring a duty AMHP and that they could turn up at an address with a Doctor in a reasonable timescale is just hilarious! AMHPs and the crisis or emergency duty teams in which they work are just not set up or staffed to provide this kind of response. I've asked for this several times in operational situations since the SESSAY judgement: I've only found a response was possible on one occasion and it took five hours. Even then, I'm convinced it only occurred at all because our presence outside the address to which the response had been made followed a report from the CrisisTeam that a patient had walked out of A&E mid-MHA assessment and was at serious risk. Of course, they turned up without the warrant that we told them they'd need, so who knows how long it would have taken to go via a Magistrate. Otherwise, it doesn't happen, in my own experience.

NINTEEN FIFTIES LAW

To understand the problems in actually realising the Mental Health Act, it's worth bearing in mind developments over the last sixty or so years. The bulk of the legal interventions in the 1983 Act were lifted more or less unaltered from the Mental Health Act 1959. So we are running about in the early twenty-first century in with a highly deinstitutionalised model of mental health care in a far more human rights and health & safety oriented society, using laws that were designed for Dixon of Dock Green and the asylum era. Our mental health care system has changed beyond all recognition since the 1950s and the role of our police service has changed accordingly.

So what could possibly go wrong?!

You also have to remember one other point: this legal stuff has been reviewed and debated several times, as recently as 2014 and the law is almost exactly as your elected Government want it to be. Sir Paul BERESFORD MP introduced a ten minute rule motion in 2014 to amend section 136 MHA because of his experience on patrol with the Metropolitan Police – it was set aside because of the ongoing Home Office and Department of Health review of s135/6 of the MHA occurring at that time.

Some amendments will be put forward in the Policing and Criminal Justice Bill to be brought before Parliament this year, although not the one Sir Paul wanted to see; and by 2017, we will have some the law develop, albeit not in way that will alter what I'm writing about here. Police powers in private premises was specifically discussed in the review and in light of Sir Paul's experience and despite this, there are no proposals for change. I was in a room at the Home Office in November 2014 with a range of people who had gathered to discuss the topic of how to ensure appropriate intervention in private premises, especially in situations where the emergency services are called and first on the scene of someone in crisis and the outcome of the review is the same as the SESSAY judgment: the law is adequate for the purpose and it is up to agencies to arrange themselves to deliver on the implications of the law.

This suggests – to me at least – it remains incumbent upon local authorities to ensure sufficient AMHPs on duty, with sufficient access to s12 Doctors and out-of-hours Magistrates, to be able to support 999 staff decision-making where faced with a SESSAY-type situation. Please don't say 'street triage' to me at this stage! … whilst such schemes will be able to identify situations where police or paramedics may be wrongly inclined to think 'Mental Health Act!' this post is about situations where the implementation of the Act or other legal intervention is exactly what is required, for an incapacitated patient. Mental health nurses on street triage carry no legal powers whatsoever and this post is not about situations which require no legal intervention. This post relates only to those situations where legal intervention is necessary.

Final point: there is little or no value in thinking 'Breach of the Peace', either. Since the ruling in HICKS *et al* v Commissioner of the Met (2014), we know that an arrest under this common law power should only occur where officers have an intention at the point of arrest to bring that person before a Magistrate. I presume we can agree, that no-one in the SESSAY or any other similar case was thinking that a court appearance would help. (HICKS is due to be appealed to the Supreme Court in 2016, so we'll have to see if that changes anything.)

So if you're a front-line police officer, this is the summary –

- **Get clinical and supervisory support for all of these situations** – paramedics and sergeants should be supporting you here!
- Think MCA for emergency, potentially life-saving intervention where things are already headed down a serious route
- Think MHA for urgent but not yet emergency intervention and contact an AMHP if you think you need to: give them a chance of supporting your decision-making.
- Whatever you then end up doing, at least you've tried to do the right thing first.

17th January 2016

Scots Law on Mental Health –

I'm off to Scotland on Monday and half hoping the weather warnings we're just hearing about might mean I get stuck there! I'm originally from the very north of England so a lot of my childhood memories involve holidays and short trips to Scotland – I've always loved the place and especially the people. At university I spent two summers playing bass in shows at the Edinburgh Fringe and have some great memories from that, as you might imagine! Living in the Midlands, I'm able to go there very rarely so I was thrilled to be invited to support work that Police Scotland are doing on early intervention, mental health and criminal justice and I'm looking forward to going again in March to do a presentation at the Royal College of Psychiatrists' Forensic Psychiatry conference in Glasgow.

So I've been spending a lot of time reading … mainly Scots Law on mental health and capacity; and I admit I have my eye on a book I will buy to learn much more if this work continues beyond next week. But this post is a fairly short one: aiming to provide a load of hyperlinks to various legal instruments and other mental health websites that people may find useful, including police officers in Scotland. I just kept a list of the ones I was looking up as I did my background prep and thought you may also make use of them?

LEGAL INSTRUMENTS & RESOURCES

A very good website for all things mental health in Scotland is that of the Mental Welfare Commission – the Commission is the statutory regulator for Scotland and ensures the law is being adhered to through visits, inspection and investigation. Their website includes easy-to-understand guides to the mental health system and mental health law as well as containing links to other resources and websites. In particular, I'd encourage those who want to know more to click '*the law*' on the top toolbar of the Commission's website which opens up links to the Mental Health Act 2003, the Adults with Incapacity Act 2000 and the Criminal Procedure Act 1995. Each of the links to those pieces of legislation has easy to understand summaries of the most important provisions.

It is also worth looking at the Scottish Asssociation for Mental Health, the leading mental health charity in Scotland – again, loads of resources on their website for all those interested in, affected by or working in connection with the mental health sector. There is a load of useful stuff on there and it's worth taking a look.

If you want to read the source material directly for yourself, go to the main legislative instruments for Scotland on mental health and capacity law, as well as the criminal justice system. They are –

- Mental Health (Care and Treatment) (Scotland) Act 2003
- Adults with Incapacity (Scotland) Act 2000
- Criminal Procedure (Scotland) Act 1995

- Volume 1 of the Code of Practice to the MHA(S) – General applicability
- Volume 2 of the Code of Practice to the MHA(S) – Civil compulsory powers.
- Volume 3 of the Code of Practice to the MHA(S) – Mentally Disordered Offenders.

POLICE POWERS

As always, there are various police powers under mental health law that police officers should know about and officers should also make sure they are aware of the **psychiatric emergency plan** for their area, which is issued under the MHA Code of Practice (vol 1). An example of a PEP from Dumfries and Galloway is a useful document to read – I'm assuming at this stage that such documents are supposed to exist across Scotland, but I'm struggling to find others at the moment. There is also the Scottish Government's mental health strategy, 2012-2015 which should keep me nicely occupied on the train tomorrow and prevent me getting in to trouble.

Amongst the legal powers of interest and relevance to police officers under the MHA, these are the most significant –

- Section 297 – urgent removal from a public place.
- Section 293 – removal order from private premises
- Section 294 – urgent removal order (private premises).
- Section 303 – redetention of individuals who have absconded
- Section 292 – warrant to enter premises

Some years ago, when I first starting writing the BLOG, I wrote some Quick Guides about English / Welsh mental health law. I later adapted them with the assistance of Scottish officers to create Quick Guides on Scots' mental health and capacity law and I've recently been contacted by a few operational officers to say that they find them useful and that they've

helped make a positive difference at incidents. I'm more than aware that not working with this legislation every day, I may be missing some of the subtleties that need to be considered so I'm more than happy to take feedback about how to improve these, if anyone has ideas? … just leave a comment below or use the email contact sheet on the front page of the BLOG.

I hope this helps as a starter for ten?! – there will be more to follow this, I'm sure.

20th January 2016

No Legal Duty –

You may remember at the end of last year there was an inquest in York into the death in a police station of Toni SPECK whilst detained under section 136 of the Mental Health Act? … the jury decided, on the balance of probabilities, that she died from serotonin syndrome whilst detained by North Yorkshire Police. This was one of two explanations given by the pathologists involved in the investigation, the other arguing that she died from excited delirium – the condition that many doctors argue does not exist. Coroner's have a right to consider any issues that they reasonably believe are relevant to the circumstances of someone's death and because Toni SPECK died in police custody, the inquest was what is known as a 'Middleton inquest' or an 'article 2 inquest'. Counsel for Ms SPECK's family argued that the Coroner should consider as directly relevant the issue of NHS services in York deciding or omitting to ensure that there was a health-based Place of Safety available for those who were detained by the police under the provisions of the Act. The Coroner declined to consider this as relevant and prevented evidence being heard about it in connection with Ms SPECK's death.

JUDICIAL REVIEW

We have recently seen the publication of a ruling where Ms SPECK's family sought to judicially review that particular decision. Continuing to argue that the Coroner should have considered health-based Place of Safety arguments, they asked for permission to bring a judicial review in the High Court, to overturn the omission of this consideration. I read this with interest, not least because I've spent a large part of my life arguing about the need for health-based Place of Safety provision in all areas and because I'm pretty sure I will look back on my work at the end of my career and think that the introduction of such a service in Birmingham was about as good as it got.

Having been the custody sergeant who had to detain people in police cells because there was, quite bluntly, no other option at all; I have often thought it may well have been nothing more than luck that meant I haven't been one of the officers who did exactly what local health arrangements wanted me to do, only to find myself suspended and investigated for

homicide and misconduct offences arising from obliging their preference. I now know that there are few situations in which I would ever authorise detention in police custody of anyone detained under the MHA who had not been clinically examined by a member of the NHS – if the arrangements in an area failed to offer up a member of the NHS that was accessible at the point of arrest or at a health-based Place of Safety, I'd remove that person to A&E. This is my own, strictly personal view.

- How do I know someone I've detained isn't suffering from serotonin syndrome? – **I don't … and I can't.**
- How do I know someone I've detained isn't suffering from a urinary tract infection that has altered their cognitive functioning? – **I don't … and I can't.**
- How do I know someone doesn't have a brain tumour? – **I don't … and I can't.**
- How do I know someone isn't experiencing one of over 40 kinds of epileptic seizure? – **I don't … and I can't.**
- How do I know someone isn't diabetic – **I don't …and I can't.**

- **These are all real examples, by the way!** – some of them potentially fatal, if unchecked.

So the provision of health-based Places of Safety is an important issue, along with appropriate conveyance arrangements: there are national guidelines on relevant s136 PoS standards, including conveyance; there has been adverse caselaw and IPCC inquiries arising from the detention of individuals in police custody; and, of course, there is an ongoing argument from the Royal College of Emergency medicine that Accident & Emergency departments are unsuitable places to take someone with a mental health problem.

SPECK JUDGMENT

So here's a peculiarly British kind of problem: there is **no legal obligation** *at all*, on anyone *at all*, to ensure suitable provision of a health-based Place of Safety service of the kind envisaged by the Royal College of Psychiatry standards on s136 (2011). No legal duty, whatsoever. Everyone agrees it's a good thing and that it should happen; that bad things are seen to occur when it doesn't happen … but no-one has a duty to ensure it actually happens!

You couldn't make this up!

For what it's worth: I was surprised the argument was put at all. Easy to say this after the ruling, but I think I'd have predicted this outcome, because ultimately, any medical issues that cannot or should not be

managed in police custody as a Place of Safety can lead to officers removing someone to A&E. Whilst there are many reasons to argue that a health-based Place of Safety is highly desirable, it's not ultimate critical to providing emergency patient care – that's what A&Es are for. I fully, fully appreciate that A&E will not like this argument, but it nevertheless remains (legally!) true.

This ruling is interesting for a couple of other points: the judge made passing reference to the 'designation' of local services as a Place of Safety, pointing out that the Chief Constable had agreed to designate police custody for use. It was therefore interesting that they did not mention the issue of designation when referring to the officers' legal right to remove someone to A&E as a hospital. This remains one of the points of confusion in some areas, about whether A&E is a Place of Safety at all. I've always argued that irrespective of whether or not it is 'designated' as such, officers remain entitled to take the decision to remove someone to such a location, especially where they have concerns about the immediate health of a patient.

This brings us back to the key issue in the death of Toni SPECK and others like James HERBERT, Michael POWELL, Sean RIGG as well as plenty who I won't name as investigations and / or legal cases are ongoing: to what extent should police officers be responsible for deciding without any clinical support whatsoever, the location to which someone should be removed under the Mental Health Act? We continue to learn of cases like that of Toni SPECK, where people detained were suffering from a serious underlying medical conditions that required urgent intervention but which would not always be obvious to non-clinical staff, even with an up-to-date first aid certificate! It must be heart-breaking to learn, as her family did, that if officers had removed her to A&E, it may well have been possible to identify and / or better react to those medical problems.

WHAT DOES THIS MEAN?

This is not a binding, stated case – although it potentially clarifies the situation for some: there is **no explicit legal duty** on any organisation in particular to ensure health-based Place of Safety provision. Does this mean that areas could simply choose not to provide these services? … everyone seems to agree they're a good idea! Well, that's what happened in many areas for most of the time since the 1959 Mental Health Act received Royal Assent and first introduced the modern s136 power. It was only around 2010 that we moved to a position where more people were detained in hospital under this provision than found themselves in police custody. We also know that some mental health trust areas have reduced their PoS provision over the last few years and that others are looking to do so.

But this ruling implicitly confirms a couple of things – and they are important. The whole thrust of the concern leading to the Coroner's decision seemed to be the understandable anguish that if faster access to clinically qualified staff had occurred, it may well have led to identification of Toni SPECK's condition and a life-saving intervention applied. I infer from the challenge brought and the judicial review sought that it was assumed a health-based Place of Safety would have delivered this? … I suspect it didn't make the crucial difference, but maybe I'm wrong about that.

Would a mental health nurse at a PoS mental health unit who was undertaking an initial and routine screening assessment of a detainee have identified concerns about their agitated, resistant presentation and / or serotonin syndrome and recommended removal to A&E? Almost certainly not, would be my experienced-based answer. Would a police officer or paramedic have been able to do so at the scene? It is certainly not reasonable to expect the police to do this – something the jury in the inquest made quite clear in Toni SPECK's case. So we're back to paramedics who are now usually called by the police to the scene of detentions under the MHA – is it reasonable to expect them to identify such issues and what about occasions where they are unable to respond?

As the High Court refusal to allow judicial review made clear: the police have got *every right* to remove people to an A&E department where they are unclear that someone would be safe in police custody and of course, this includes custody sergeants who have already detained people in custody, but where concerns develop about health and wellbeing. If NHS areas wish to do this by ensuring ambulance responses and health-based Place of Safety provision – notwithstanding a lack of clear legal duty to do so – then they increase the likelihood that police officers who are increasingly aware of what can go wrong as more and more evidence mounts amidst the tragedy of lives lost.

24th January 2016

Mental Health Act Admission –

This short post covers the main admission frameworks of the Mental Health Act 1983, in limited detail for the benefit of police officers and the public. Advance notice is hereby given(!) that AMHPs or psychiatrists will find this superficial. The purpose here is to make two wider points for police officers, after briefly reminding or explaining what these principal provisions actually mean.

VOLUNTARY ADMISSION

As with any other aspect of healthcare, any person can go in to hospital if it is suggested to be necessary and if they wish to do so. You can decline that offer if you have the capacity to do so. Although it may appear unnecessary to have a legal provision for admission that does not require compulsion or restriction of liberty, section 131 of the Mental Health Act covers this point and makes it explicit.

When I first joined the police, mental health services used to distinguish between 'voluntary admission' and 'informal admission' and to make a distinction between patients with the capacity to do so consenting to their own admission and those without that capacity who were merely not objecting. This distinction has ceased to have relevance since the Mental Capacity Act 2005. The new Code of Practice (2015) highlights that where patient under assessment lacks capacity to make decisions, or where their capacity is fluctuating, they should be detained under the Mental Health Act 1983 if they are to be admitted to hospital.

I'm going to make a point at the end of this post, about how this kind of principle should be considered by police officers when considering the application of s136 MHA.

DETAINED PATIENTS

There are three main provisions that lead to people being detained against their will under the Act. I can think of various situations where officers may benefit from knowing the difference, so as to understand how their own decisions may fit in to these frameworks, especially those where allegations of crime have been made –

- **Section 2** – detention in hospital under this section must be authorised by an AMHP and two Doctors, one of which must be 'section 12' approved. Detention allows for assessment of mental disorder, lasts for up to 28 days and *cannot* be extended. Patients detained under this provision have a right to appeal to a mental health tribunal, which is a part of HM Courts' Service.

- **Section 3** – detention in hospital must also be approved by an AMHP and two Doctors, one of them being 'section 12' approved. This type of detention allows for treatment of mental disorder, can last for up to six months and *can* be extended. The first extention lasts six months; subsequent extensions last for twelve months and there is no overall maximum period. Patients detained under this provision have a right to appeal to a mental health tribunal, which is a part of HM Courts' Service.

- **Section 4** – this is an emergency admission provision, requiring just one Doctor to support the AMHPs application. It can only be used where it is not practicable to wait for a second Doctor, lasts only for 72hrs and the patient has no right to appeal to a tribunal. Within the 72hrs, a decision must be made about a second medical recommendation for any further detention.

For those who are interested in the detail of this stuff, there seems to be an almost constant debate amongst AMHPs about whether it is ever right to use section 3 to admit a patient to hospital from the community. Where a patient is known to services and their diagnosis is clear from previous contacts, some argue there is no obvious reasons why a section 3 application can't be made, for example, after a MHA assessment in someone's own home. However, I had a really difficult experience as a custody sergeant that shows why attempting section 3 admission can prove problematic. It is at least partly for reasons such as these, other AMHPs argue initial admission to hospital, even for patients who are known, should be via section 2 of the Act.

NEAREST RELATIVE

A particular feature of section 3 MHA, is that a patient's Nearest Relative (NR) can legally object to admission. Unless the AMHP displaces the NR after a successful application in the county court, the NR's objection stands – and this displacement under section 25 MHA can only occur if the AMHP can show that an NR is acting *unreasonably*. In my case, a man had been arrested for an alleged robbery and he was very obviously unwell. The MHA assessment in custody led to a decision to admit him under s3 MHA and his NR objected – and that was the end of that! … I was stood there asking, "What do you mean 'we'll leave it with you, Sarge!' … he objects and that's that?!"

And it turns out it was – unless the NR is being unreasonable and in this case, the AMHP wasn't prepared to argue that he was, no MHA application can be made and the AMHP cannot then start arguing for a section 2 application. So we prosecuted him for robbery and he was remanded to prison by the courts, because that suddenly became the only legal way by which to prevent harm to him or to others. We unnecessarily criminalised him – which happens more than it should, for various reasons, including this one.

I have only one other example of NR objection in my eighteen years of policing: it interesting for different reasons and it occurred when I was a duty inspector. I started duty at 10pm to find a women in custody under s136 MHA who had been detained that afternoon but spent a few hours in A&E having various physical healthcare problems attended to. No AMHP seen her in A&E, in fact there was no evidence of an AMHP having been contacted at all, so when I started duty I rang the night duty AMHP and was told, that an earlier AMHP had been aware of her detention and he said, "The NR objects so the AMHP is going to court tomorrow to displace them and you have to hold her until then."

I was intrigued to know why an as-yet un-named AMHP had decided to attempt to legally displace a Nearest Relative who could have yet objected to admission because the s136 assessment had not yet occurred, never mind a full MHA assessment. (For those who don't know the difference, assessment under s136 requires just one doctor in addition to the AMHP; full MHA assessment requires two.) I wondered whether the answer of the court would not just be, "Come back when you have an assessment conclusion and an objection to that assessment conclusion – you're presuming and guessing, at this stage." So I rang the duty AMHP to query this and was told they weren't coming out and that I obviously didn't understand the process.

Can you guess what happened at court?! … I guess you can't qualify in common sense.

RELEVANCE

So there are three basic methods by which, under civil law and without the involvement of the criminal courts, you can find yourself detained in hospital against your will. That is unless you have the capacity to make your own decisions and take up a voluntary admission, were it to be offered to you. But why am I arguing that officers might need to know these three things, bearing in mind you will find section 4 MHA used very rarely indeed – so it's mainly down to the two normal provisions of section 2 and section 3.

Remember what they actually mean, in law –

- **Section 2 –** means detained for *assessment* of a mental disorder.
- **Section 3** – means detained for *treatment* of that condition.

Imagine a scenario with two alternative endings –

A young person is reported to be on the adverse side of a motorway bridge and appears to be about to jump. Motorway police officers make towards, their control room starts affecting traffic signs to get traffic to slow down and eventually, the motorway is closed in both directions. Meanwhile, local officers have made towards, the duty sergeant is on the bridge with an officer and they are talking to the person, the duty inspector is overseeing and gets a negotiator on standby to turn-out. They can't find out the person's name, form the view the person has been drinking and may have mental health issues because of the language they are using about hurting themselves and instructions they claim to be acting on.

It takes over two hours and the turnout of a negotiator to talk the person down and they are detained under s136 MHA. Calls to the police during the road closure make it obvious that there was at least some public frustration at the degree of inconvenience caused, one man claiming to have missed a job interview and another upset that his visit to a very ill close relative in hospital is delayed. The man was under the influence of alcohol, but because of concerns of his mental health, he is detained section 136 MHA. He is taken to police custody because nowhere else was available and when searched he is in possession of a something illegal – you can make your hypothetical incident involve drugs or weapons, as your prefer. He sobers up overnight and is seen by an AMHP and DR the next morning and they subsequently arrange for him to be 'sectioned' under the MHA.

ALTERNATIVE ENDINGS

Now, bearing in mind that bringing a motorway to such a halt is a criminal offence if you put yourself on or over a road (s22A Road Traffic Act 1988), that it's probably cost the UK economy about two million pounds whilst the closure was in place and that some members of the public have been put out and distressed by the actions, do the following two outcomes change how we see the incident?

- What if he was sectioned under s3 MHA because of a long-standing history of schizophrenia and previous inpatient admissions to hospital – upon examining his background, he has never done something like this before, has no history of using drugs or weapons for violence: it's thought he is extremely unwell after the recent and sudden death of his only surviving parent.

- What if he was sectioned under s2 MHA and it transpired three days later that he had no mental health issues whatsoever and had become somewhat disturbed in his cognitive functioning because he had consumed lawfully obtainable drugs as well as street drugs and then alcohol, creating a chemical cocktail that induced a temporary mental-illness like state than even convinced psychiatrist then next day?

Bearing in mind the original incident: do these outcomes make us reflect differently on the original incident and what the police should do? I would hope so! – there is no reason whatsoever why our second individual shouldn't be considered for prosecution, bearing in mind the various offences involved in that incident. But would any of us argue for that outcome in the first case?

So someone being 'sectioned' in police custody doesn't actually tell us very much, does it?! … and most people 'sectioned' from the police station are detained under section 2 of the Act. How often do we bail anyone if they were originally arrested for an offence in order to follow them up in case they were like our second case, above?

SECTION 136 AFTER-THOUGHT

And you'll remember I said these considerations around capacity could also be relevant to effective and correct use of section 136 MHA?

Officers are being encouraged at the moment to consider various actions which have the overall intention of reducing the use of this power to detain someone. It is probably wise to consider the question of capacity wherever thought is being given to offering a 'voluntary' alternative. Most of us will

have experience of encountering a person, either in public or in private, and finding that when officers offer either a referral via Accident & Emergency or more recently, via street triage schemes, that the person agrees.

Do they have the capacity to do so? – did we event explain the information relevant to that decision?! Offering A&E is one thing – what about A&E, knowing that the average turn-around time may be 4hrs; or 8hrs?! What about explaining the civil liberties things – like whether officers will be remaining there with them, to ensure they don't leave? If you are planning to go to A&E on a 'voluntary' basis and to remain there with the person to ensure they don't leave; haven't you effectively employed s136, especially if it relates to a person who very obviously lacks capacity around their decision-making? … all just food for thought.

27th January 2016

Subcontracting Responsibility –

It was several years ago that I first sat in a room listening to a mental health professional delivering legal training to the police about mental health and capacity law and found myself thinking, "But that's not right!" More than once I've had cause to review protocols between the police and mental health services which have been written by health or social care professionals and found myself thinking, "But that's not right!" … legally speaking. When I first had these thoughts, I usually scuttled off to do more reading or re-reading on different aspects of mental health and capacity law but as the years have progressed, I've become more confident in just saying so. In the last eighteen months of being at the College of Policing, forces have been kind enough to invite me to attend training events that they've run, where they have asked professionals of various kinds to deliver training to police officers. I have had several occasions to flag up to forces that they've been given duff information and was recently in a meeting where a training proposal was largely based around the idea of calling the local mental health trust and inviting them to deliver inputs to staff.

So I want to caution against subcontracting responsibility, whilst accepting that this probably comes about because of a lack of national training standards on mental health across policing – something I am actively working on correcting this very week!

In recent examples –

- One mental health trust asking officers to believe that they would have to use section 136 of the Mental Health Act 1983 (MHA) on inpatient wards in general hospitals because section 5(2) MHA can only be used on psychiatric wards. << *This is wrong* – it can be used in any inpatient situation by any registered medical practitioner and in fact, things go further. The Code of Practice (2015) to the MHA makes it clear in paragraph 16.20 that section 136 should not be used on wards, that staff should use powers under section 5 to 'hold' patients for assessment under the Act where this is required. We all know what can go wrong when the police are unnecessarily called in to inpatient settings in connection with mental health issues.

- Another force invited training on the Mental Capacity Act 2005 (MCA) for officers and a lead trainer, who was an AMHP by background, told

the assembled operational constables and sergeants that they are empowered to use force to remove a person to hospital and hold them there "if a paramedic tells you they need to go to hospital and that they lack capacity to refuse." << This *could* be correct, but it requires additional factors and considerations that were left entirely unmentioned. This advice, with further qualification, is wrong. We all know what can go wrong when the police start misapplying the MCA in private premises.

- I always love the debate about warrants under s135(1) MHA, something which I recently addressed in Liverpool at an AMHP event. I've more than once heard and seen AMHPs telling the police that warrants under this sub-section may *only* be obtained where access to the premises cannot be gained with permission. << *This is wrong* – it's also the misunderstanding that sat at the bottom of one of the most testing operational incidents I've ever dealt with! … an incident that would be have been as easy as pie if only the AMHP involved had known what this sub-section allows. We know what can happen when the police enter premises to mitigate risks without any legal powers to do so!

- Finally, there was the street triage training I saw – no wonder I've ended up concerned about civil liberties in this context. I am particular inclined to recall an email review of an incident where front line response officers disagreed with the advice of nurse who, in my view, seemed professionally affronted that their advice on a man in crisis was ignored. The escalation email betrayed a lack of knowledge by the nurse and the officers were quite right (as well as legally entitled) to take a different view – but how many street triage schemes are predicated on the basis of nurses being experts? They are on mental health issues, of course – just not necessarily on mental health law on which they receive surprisingly little training.

I could go on. The point here is not to denigrate mental health professionals, although I realise that's the a real risk here – there are many mental health nurses in particular who have impressive legal knowledge and of course formally study mental health law in order to qualify. I've learned an awful lot from such professionals and continue to do so. The point here is to caution against the notion of subcontracting responsibility for officers training requirements to another organisations without quality assuring that content.

VESTED INTERESTS

Only today, we saw publication of a Guardian article which claims that police incidents connected to mental ill-health have risen by 33% in three

years, based on Freedom of Information requests made by journalists to police forces. The College of Policing is quoted as stating that between 20-40% of police time is spent on mental health related matters. A few quick incidental points about this article, before returning to the point about training –

- It may be thought that's a very wide range to claim: 20-40% – these figures were the lower and higher numbers that we know some forces use, not our estimate overall.
- And the claim was not about the percentage of police time spent, but about the percentage of overall police demand connected to mental health.
- There will, undoubtedly, be an element in the rise of better data collection – the police have been learning more, recognising more and therefore recording more of our work as involving mental health.
- So not all of this 'rise' will be real – my personal view, for what that's worth, is that most of it is.

Returning to the original point: I've often wondered about the extent to which the legal arguments adopted by some mental health trusts or professionals is motivated – not maliciously – by their vested interests? An AMHP who can persuade an officer that a warrant cannot be secured doesn't have to undertake the considerable extra activity associated with doing so; a mental health trust who can persuade the police to come and use s136 on an inpatient ward will not have to work out how to apply section 5 and administer the implications of such a decision. And so on.

I really don't think this stuff is motivated by any kind of malice – not at all. I'm rarely, if ever, convinced these things are about deliberately misleading officers. It just becomes convenient for the police to absorb risk and responsibility and so received wisdom develops that this is the way it should be done – or maybe in some areas that is the way it has always been done? Of course the most common legal error heard in all of this stuff is the one about physical restraint and the use of force, in various situations: outside the example of restraint for seclusion or medication in an inpatient setting, I've heard countless times that "only the police have the power to restrain." You could apply this to situations where AMHPs have 'sectioned' someone; to situations where AWOL patients are located and need to be returned to hospital; or to situations where paramedics wish to remove someone to hospital for urgent or emergency intervention under the MCA. It may be true that only the police have training, but it's certainly not true that only they have a legal authority to do so. That subtle distinction becomes important when you get in to details.

Policing and mental health is usually all about the details!

QUALITY ASSURANCE

So where forces are contemplating training or informal briefings, it must be worth checking what's actually being delivered – and not just on legal issues. Many MH trusts still argue that those members of the public who are detained under section 136 of the Mental Health Act 1983 who exhibit aggressive or resistant behaviours should be taken to police custody as a Place of Safety purely on that basis. The examples continue to build, if they weren't already convincing, about officers making a perfectly reasonable assessment that someone may be suffering from a mental disorder only for it to emerge later that they were actually suffering from a serious undying medical problem. In due course, I'll tell a story about section 136 and meningitis that will make every officer in the country question whether it is *ever* right to take someone to custody unless they've first been medically cleared by the NHS.

It remains the case that some mental health trusts actually still want the police to do exactly that for which the IPCC would arrange to criminally investigate them if the worst happened after assumptions had been made about aggressive resistance on detention. So is that trust the best organisation to explain to local police how to discharge their legal duty of care? Perhaps we should accept on mental health, as we do on almost everything else in professional policing, that we work in partnership with many organisations but we are not blindly beholden to them where they advocate wrongdoing – however motivated – and we should be confident we're developing the expertise to make our own decisions about how we lead our staff and live up to our responsibilities.

29th January 2016

Normalisation –

This is a guest post by Em, or @DrEm_79 from Twitter – our various discussions on there made me realise she has a lot to say that is important and relevant for police officers responding to mental health crisis incidents. I think there's a lot going on here and much of it is contradictory: but that seems to me to be precisely the point Em is trying to make – the normalisation of the police as a ***de facto*** *mental health service is something to caution against and worry about*

I'm giving a ***trigger warning****, too: Em's post contains descriptions of suicide attempts and restraint that may disconcert some who read this —*

It takes eleven minutes to walk to the GP surgery, but I only made it halfway. I don't remember deciding to die. I don't know why I chose the wooded embankment, and I'd lost consciousness before the police search helicopter, the ambulance and resus. When you're unconscious in intensive care, as well as the life supporting interventions, they remove your contact lenses. Several days later, when I woke up, it was to a blur. There was a tube and ventilator supporting my breathing, fluorescent light and blurry hi-viz. The hi-viz turned out to be police, still waiting in the relatives chairs opposite my bed.

I have what are referred to as severe and enduring mental health conditions, and started hurting myself when I was five. Over the thirty years since, I've had a lot of contact with police because of my mental health. Police have saved my life more than once. They've listened to things no one else has, stepped into my flat when everyone else has walked away, seen me at my most terrified and vulnerable, and selflessly got themselves into trouble arguing for me to have mental health assessments when other services were trying to shift responsibility. They've also restrained me for hours, detained me in cells, vans, handcuffs and leg restraints, unwittingly contributed to the destruction of my career, and a hate attack by my neighbours. Police intervention when I've been unwell has left me at times too frightened to stay in my own home, with a front door that didn't close. It's fair to say our relationship is uneasy. The intersection of mental health and policing is complex, and there are as many experiences of mental health as there are people. I can only speak from my own perspective.

Changes to the way mental health care is provided and policed where I live over the last ten years have not helped me. In crisis I need help from clinicians who know me, can recognise I'm ill and respond early. But now early intervention is rare, and crises are left to escalate.

My mental health care plan stated that if I or others call mental health services because I'm unwell, mental health services are to advise calling police if I'm at risk. Sometimes it's the mental health staff, sensing risk and needing to do something with the sense of responsibility, who call. A "welfare check" by police is now seen as a health intervention. This normalisation of police as the first responders to mental health is stigmatising, distressing, and for people like me who are known to be unwell, just adds to the resource ultimately used in a crisis. I'm not sure police being the planned response to people who are looking for mental health help is a good thing in a sophisticated society. As someone on the receiving end of that shift from health holding responsibility for mental health response to police, it frightens me, and at times has made me more unwell.

Over all of the contact I've had with police when I've been unwell, there are some things that have helped, and there are others, both at the individual and systems level, that haven't.

Things that can help –

Beware short term thinking for long term problems –

Many mental health conditions, by definition, are not one-off events. Most people with mental ill health will have more than one mental health related crisis in their lifetime. In responding to mental health crisis there's a need to consider both immediate need and also the longer term implications of that response. My experience of police in mental health crisis is that they are good at thinking in immediate terms, especially when dealing with someone at risk to themselves, but that this short term thinking can sometimes take over, which can lead to consequentialist ethics – as long as the immediate crisis is resolved, it doesn't matter what you do to get there. Short term focus applied to a long term or recurring condition can create problems in future.

For example, last year the mental health team reported a concern for my welfare. I wasn't at home. A police sergeant called me and asked me to tell them where I was and for me to meet with them. They promised I wouldn't be made to go to the hospital, that all they wanted do was talk. On meeting them, I was immediately put into the police van and taken to hospital. I can see this may seem justifiable; a promise they were never going to keep achieved the short term outcome they were looking for, but longer term what that created was a person with severe and enduring mental health

problems, very likely to have further crises in future, who no longer believes the police will tell them the truth. In the long term it has made things harder for everyone. Many people with mental health conditions have experience of trauma and trust in others may be fragile. Expediting an outcome by not telling the whole truth may jeopardise the only opportunity for that person's trust.

Radios, the third person, and remembering I'm there –

When I'm experiencing hallucinations and delusions, routine aspects of police work can be menacing and frightening. Being aware of this and making even small allowances can help.

For example: radio use. When I'm hearing voices, and may be paranoid that people are talking about me and planning to hurt me, disembodied voices coming from radios or officers repeatedly leaving the room to talk into the radio, often only partially out of earshot, can add to the fear and beliefs I already have. You can't stop the voices I'm hearing or the delusional ideas I have when I'm unwell, but if you're able to, explaining what you're doing and why, as you're doing it, can help: "I'm just going to speak to my Sergeant on the radio, to let him know where we are.."

I often don't feel in control when I'm ill. That's part of what is frightening. You may not feel able to let me have control over what happens, but keeping me informed and talking to me rather than about me in my presence can help. Even if it doesn't seem like I'm taking in what you're saying please keep talking to me, acknowledging my presence, and telling me what's happening as much as is possible. Try not to talk in the third person about me when I'm there, it can worsen feelings of paranoia and threat. Many people's experience of voices is a commentary in third person. Even if someone isn't interacting, talking to them about what you're doing as you're doing it, letting them know and including them can prevent the situation from becoming worse.

Restraint –

Unless you've experienced hallucinations, flashbacks, or other perceptual disturbances, it can be difficult to imagine what it's like, but we all know what it is to feel afraid, or that you can't trust someone. When I'm unwell that fear can exist at another level, which is partly why I think restraints can often go so wrong. Whereas someone who isn't experiencing a disturbance to reality might observe they are being restrained, perhaps in a cell, and realise they aren't going anywhere, and eventually relax, the things I am frightened of in crisis often aren't proportional to what is being done to me. When I fear someone is trying to hurt me, that belief doesn't just go away if my movement is restricted. The fear will likely be escalated by restraint. It isn't 'acting up'; it's terror.

Some of the times I've been restrained by police were before anybody even tried alternatives such as talking to me. Restraints have lasted hours, with me becoming more and more frightened, but once restraint is started I become so much more afraid the only option to stop is chemical sedation or further restraint. Restraint while mentally unwell is confusing, terrifying, and traumatic. Where it is not essential, avoid it, or at least know what you are getting into, and have a plan as to how you'll get out of it.

Stigma; and leaving a life to go back to –

In mental health crisis the focus from police I've met has sometimes seemed to be to contain and transport me to the hospital as swiftly and by whatever means possible. This has often involved transport in police vans or cars, handcuffs, even though I've never been violent to another person and there has been no crime. Although I can guess some of the pressures that might make the quickest form of transport seem like the best, be aware of the effect very public police interventions for mental health can have at somebody's home.

For example, I live in a tenement building, when attending my flat, police have had discussions with bystanders including my neighbours where police have disclosed my history of mental health problems. More than once I've been filmed by people being put into a van for transport to hospital. There is a stigma to being with the police; people assume you are criminal, dangerous, disruptive, undesirable. I've lost professional status and career because of stigma that still exists about mental health. Police aren't responsible for my neighbours' intolerance of people with mental ill health, or their subsequent attack when I returned from hospital, but protecting me isn't just about containing me in a van and waiting with me at hospital until I'm detained, it's also about being aware of the impact you've had on my life and my community, and leaving me a life to go back to.

Think about language –

I don't expect police to be therapists, or have endless time and full knowledge of a situation, but thinking just a bit about the words you use and the way you ask questions can make a difference to the responses that you get when I'm unwell, and ultimately can make a difference to the amount and reliability of information you can gather to help decision making.

For example, when there has been a call with concern for my welfare and police want to ascertain whether I am at risk. Commonly, officers do this by asking: "Are you planning to do anything silly?"

This tells me a value judgement the officers are making about self-harm and suicide. It makes me less likely to think that person understands, wants

to help, or can be trusted. It also directly impacts the content of my answer. When I'm unwell often nuance and turn of phrase are lost and I interpret things quite literally, or ascribe them more meaning than I might on a day I am well. I also don't think suicide is silly, and at times I've been unwell I have felt it is the most sensible thing in the world, either because I've felt compelled to do it by external forces, or because I've felt so depressed it has seemed a rational choice. The answer you get can depend on how you ask.

Other ways to explore suicidal feelings are, if there is time, gradually in a stepwise way. Start by showing you are interested, there aren't set words, if it doesn't sound authentically from you that's easy to pick up, but things like: How have you been feeling today? … Have things ever been this bad before? … You said you can't cope, are you having any thoughts of ending your life? Ask explicitly about suicide. There's good evidence it doesn't put the idea in someone's head, and there is a lot of stigma, suicidal thoughts may not be volunteered if you don't ask directly.

If someone does say they are feeling suicidal be aware that's an incredibly difficult thing to say; it's taboo in society, and there are even more barriers to talking to police about it. So often if I have spoken about suicide to officers they don't even acknowledge it, as soon as they have that information their next movement is to press the button on their radio and start talking to their Sergeant "Yes, yes, admits is suicidal..". It would have taken a few seconds longer to acknowledge to me that they'd heard that and that they wanted to help. Those few words can make a massive difference. In crisis it is easy for the needs of the person who is unwell to become peripheral to service protocols and needs. Try to avoid this.

Say you want to help –

Professionals often implicitly and sometimes explicitly assume when a person is in crisis that the person will trust them because of who they are, and that the person will believe that the professional's motives are to help. This often could not be further from what the person believes. It isn't enough to assume that I think you want to help, you need to say that, and act in a way to back that up.

People without mental health training often feel uneasy talking to people who are mentally unwell. Often this comes from a place of concern – they don't want to make anything worse, but it has an isolating, dehumanising effect on people who are unwell, and in crisis can increase risk. In an acute crisis listening to someone who is ill is one of the best strategies to help them feel calmer and start to trust, and may be the difference in making it possible to help them.

Filling out a form does not make somebody safe –

Beware mistaking following process for mitigating risk. After being called out to me, police almost always have to fill out a form for their vulnerable person database. I'm seen as a vulnerable adult, and coming to my home they've often had concerns for my welfare – risk of harm to myself, lack of food and heating, lack of security, risk from others. There have also been many forms submitted to report adult Protection Concerns under the Adult Protection act with concerns about self-neglect and risk from others. These forms are sent to social services. Yet despite dozens of these forms, and hours of police time, not one of these concerns has resulted in changes to my treatment or care. There are complex reasons for that – uncertainty over which service, if any, holds responsibility for care and treatment and crisis response. Even when Adult Protection meetings have been held there has often been ambiguity, obstacles, or no outcome. Yet because it is procedure, still the forms are completed and sent.

It seems the process was followed and there was a partnership in place, but nobody had oversight as to what impact that process had on the risk it was trying to manage. Even the fact the forms contained the same concerns over and over didn't alert anyone that the situation hadn't been addressed. I don't know if there are other systems like this, where ticking a box or completing a form gives mistaken reassurance that risk has been managed? Protecting someone may involve a form, but the form alone does not help me.

Planning and prevention –

Although uncertain and frightening for me, and often portrayed by the media as unpredictable and dangerous, there is a predictability to mental ill health. If police are going to be part of the response to mental ill health, could planning and prevention have a bigger role?

For example: When unwell my awareness and perception of the world around me can change. This can lead to me travelling miles and finding myself somewhere, often with physical harm, sometimes unaware how I've got there. If police are alerted by somebody concerned where I am, I become a resource intense high risk missing person. Yet there is often a predictability to my travel. In the days or hours before I become unwell I have sometimes tried to seek help but not been able to access it. There are also patterns. I've been missing and unwell and hurt a number of times, but for years nobody sat down with me afterwards when I was more well to talk about what the triggers were, the types of places I found myself, or tried to ensure there are safeguards in place so the situation could be managed more safely if it recurred.

I don't think providing mental health care is the role of the police, but this is the sort of area where working with me has benefitted everyone. A few months ago a local Sergeant spent time talking with me, being reliable and

straightforward, and rebuilt some of the trust I had lost in police. He listened (a lot) and started to understand what was going wrong in responses to me, what helped and didn't. It's far from fixed, but that time has helped police start to develop a more informed, safer response. They understand more where I am likely to be when unwell and the safest ways to respond, and have saved resource in doing so. It isn't a high profile media lauded scheme, and that Sergeant has had no recognition; but by gaining my trust, getting to know me and what happens to me, and thinking with me about how police can help me to be safe, he's helped police to save my life more than once.

Don't give up hope –

I've been critical of police responses to mental health, but there is one way in which police response has been consistently more helpful than many other services, including mental health services. And just now, I'm worried this may soon be lost.

When someone has been ill for a long time, health services can sometimes develop something called therapeutic nihilism, a feeling that nothing is going to help the person. Unfortunately sometimes without realising they then stop trying to help. This is often seen at suicide inquests, when people report clinicians having said to the person who has now died that they could not help them, or other negative or very hopeless statements.

Hopelessness is associated with completed suicide, and this type of response can be immensely damaging. Clinicians also have a different view on responsibility of people who are unwell to the police, again we know from inquest evidence and service user experience that with some disorders in particular, professionals may say things such as: "it is up to you whether you die", "we can't stop you" (which may be true, but..), "if you wanted to do it you would have". Such negative statements may not be said with harmful intent, but that is often their effect.

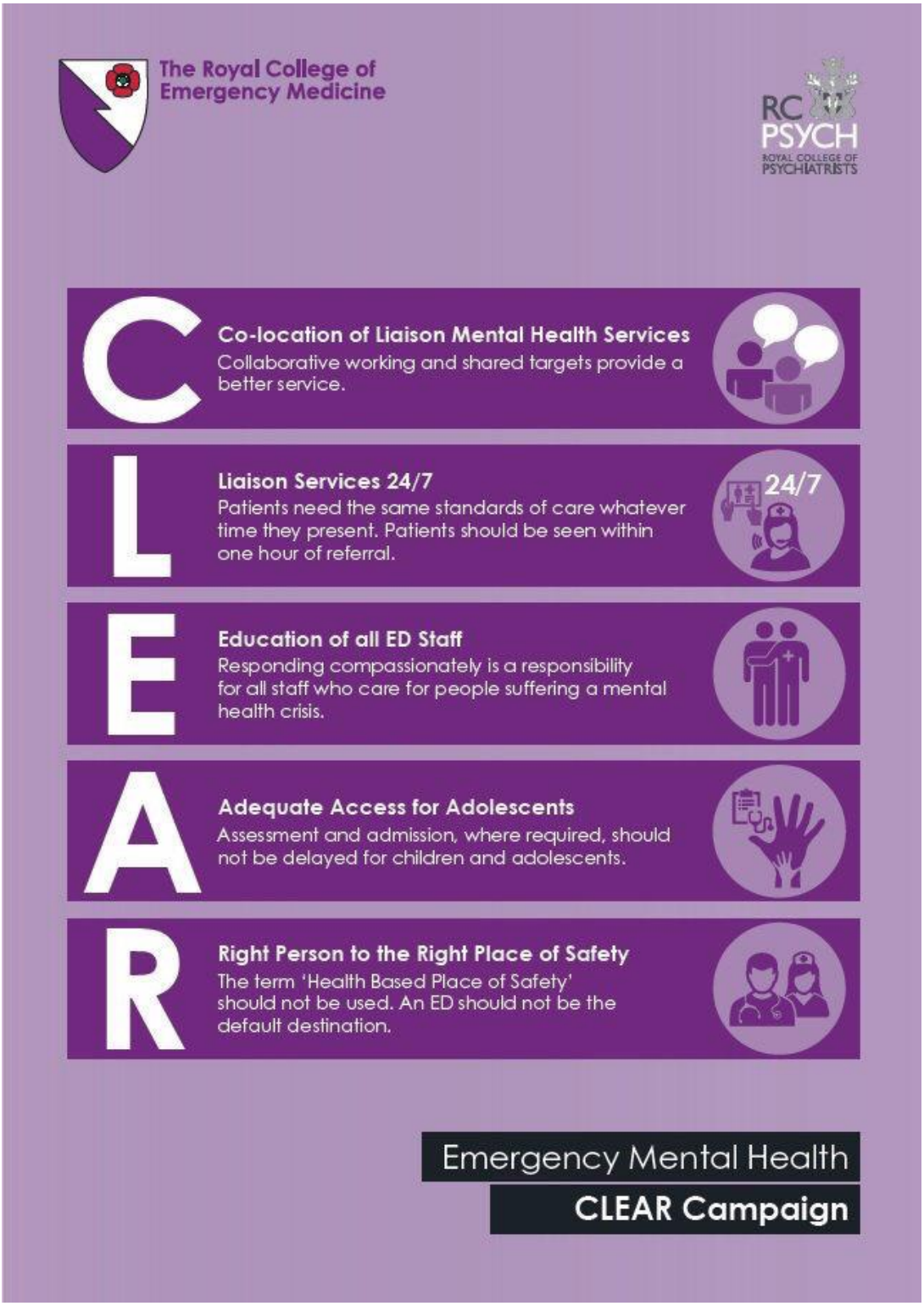
Yet the response of the police, perhaps because of their duty to protect life, seems more hopeful. They will keep trying to intervene, keep trying to help, and don't refuse to come to help people as health services may end up doing with some patients. This persistence can be lifesaving. When a person is totally without hope it can help, even fractionally, for someone else to believe they are helpable, and importantly that they are worth helping. People who are feeling suicidal often feel they don't deserve help. One of the best ways to challenge this is to show them you want to help and you aren't giving up on them. I wonder if this is one of the reasons service users report contact with police in crisis is often positive, in some cases beyond the time that the police are with them. Just acting as though there is never no hope at all sends a message that may make a crucial difference to somebody.

This is one of the reasons I'm not entirely convinced about some of the current co-response plans between services. I hope they won't lead to the nihilism some other services show to people with the most complex problems starting to affect police response. Police are good at not giving up in mental health crisis in a way that other services are sometimes not. It can be harder to give up on yourself when there is someone else not giving up on you. I hope that isn't lost.

Even when I'm most unwell, treat me like a human, talk to me and listen, and be as compassionate as you can to another person who is suffering. Even when unwell I can sense hostility and value judgements and they do not help. Be aware of the effects of stigma that exists around mental health, the assumptions people make about criminality when police are involved, and where you can, try not just to protect my immediate physical safety, but leave me some dignity and a life I can face again after the crisis is over.

30th January 2016

All CLEAR?



Last Friday the Royal College of Emergency Medicine, in conjunction with the Royal College of Psychiatrists, launched the 'CLEAR' campaign, concerning mental health emergencies – see the poster, above. It's the last of the five points that has seen a bit of discussion on Twitter today and of course: that's the one that affects the police –

- Co-location of liaison services
- Liaison services should be available 24/7 in ED
- Education for ED staff
- Adequate access for adolescents
- Right person to the right Place of Safety

I'm not sure anyone would put forward an argument that emergency mental health care is entirely adequate. Indeed, the CQC published a specific report on this last year, touching upon patients' experience of crisis services, A&E departments, the operation of s136 of the Mental Health Act, etc., etc.. So it has to be welcome that two medical Royal colleges want to do more and do better on emergency mental health care but we also know the rising pressure that ED is under at the moment as well as the rising pressure on MH services.

There are problems with 'R'; and if you read the whole poster it goes on to say that Emergency Departments should not be the default option as a Place of Safety –

- This implies the 'right' Place of Safety actually exists – we know this isn't always true.
- It implies that we actually know what the 'right' Place of Safety is for any given patient – we also know this isn't true.
- It says that an ED is not the default destination – is there actually any evidence that it ever was?!

The UK has detailed plans for various things in healthcare but one thing they've struggled with for decades is the question of where an intoxicated, suicidal mental health patient should be taken if they were detained under s136 by the police. We have no clear idea what would happen.

HISTORY

I'm one of those police officers guilty of having used an Emergency Department as a default option – in May 1998. You see, they trained me on s136 MHA in Pleece Skool and told me that a 'Place of Safety' under the Mental Health Act 1983 was 'a hospital, a police station or anywhere else temporarily willing to receive to the patient'. Having detained a man I had

concerns about on the Dudley Road in Birmingham, I was only 150 yards or so from the front door of A&E and not knowing of any other hospital in my area, we walked him up there. I'd already been in that Department various times, arresting drunks for threatening and assaulting staff and it seemed to be a place where people were keen to see the police. They often gave us a cuppa to keep us hanging about in the department when it was busy, it kept us acting as a deterrent against people causing problems in there.

But turn up with someone and say 'section 136 of the Mental Health Act' and it was a very different kettle of fish.

In 2008, the Independent Police Complaints Commission published one of the first truly national surveys of the use of this power. Based on 2007 data, it revealed that approximately 18,500 individuals were detained under this legal provision and that 11,500 of those were taken directly to custody. Of the remaining 7,000 people, many of them were taken to a Place of Safety in a mental health unit – London was more or less completely covered with PoS provision so that accounts for a further 3,500 of those. Of course, within the remaining 3,500 will be all those people who were presenting with conditions that made an Emergency Department the appropriate place: those patients who had potentially overdosed, who were physically injured by self-harm injuries or who had other medical problems. But this brings us to one problem: in what circumstances is ED the 'right' place? – even ED can't agree about that.

The idea that ED was a default option most of the time is just not borne out by what we know about how this power has been used – that distinction is claimed by police custody and we do know that this has contributed to deaths in custody. Since 2008, other data have emerged and as the use of police stations has reduced, I've no doubt that ED has copped for a proportion of that demand. Whilst I understand ED frustrations about this for cases other than where ED is specifically clinically required, there are legal reasons why officers might be inclined to chance their arm there – and there is nothing unlawful about them asking the question! But by the time we get to the end of this post, I hope to convince you that all of this debate is a red-herring and that the real problem no-one discusses is – proper alternatives to detention for people in contact with the police; and sufficient services to which those who are detained can be removed where it can't be avoided.

LEGAL PROBLEMS

There are further difficulties we cannot ignore: this initiative assumes that there is agreement about where various people detained by the power should go. Remember the case of Toni SPECK in York from 2011? – she

died from serotonin syndrome according to the Coroner and her inquest led to various legal arguments, both during and subsequently, about whether there was a legal duty to provide a specific Place of Safety in a hospital that isn't an ED. The High Court quite quickly dismissed an application for judicial review by stating that there was no such duty in law; and where police officers have immediate concerns about wellbeing, they could go to a hospital ED. Of course that Coroner's jury also ruled it was not reasonable or fair to expect police officers to pick up all those potential medical problems with which patients detained under the provision may present and it also heard evidence that if she had been taken to ED her life may well have been saved.

The police cannot do this alone, as Lord ADEBOWALE told us – several years ago!

So if officers work in a place where there is no specific mental health unit Place of Safety; where that location is unstaffed by anyone who works for the NHS; or where the ambulance service either will not or do not respond to a request after detention – where do the authors of the poster want the police to go? … what is the 'right' PoS in that situation?

And what about those pesky things like statutory guidelines and caselaw? – it's been a statutory guideline since at least 2008 that police stations should not be used as the automatic first or even second choice, but only as a *last* resort. Before giving in to that inevitability, officers should consider the alternatives – so is ED an alternative for someone who does not require it on clinical grounds, but where another health setting is unavailable? What about the police detaining an 87yr old woman with dementia and when you shout up to the control room, you learn the 136 suite is unavailable – do we lean towards police custody or ED – where do you want your elderly parent or grandparent taken? Does it matter if she's not 87yrs old, but 57 … or 27?!

IN THE REAL WORLD

It's all very well saying ED is not the default option, but that assumes we live in a world where the 'right' options are actually available to the officers who can then be expected to make the correct choice. What happens about acute behavioural disorder? – I refer you to another post for the ongoing debate about whether that's a 'thing' or 'not a thing', but I can completely assure you, ED departments take a very different view about these issues. Only this week I had a conversation with a force mental health lead who was contrasting the attitudes of two ED departments in his force area towards the police when dealing with people in crisis. One of them even formally wrote to the police to tell them that they 'weren't a Place of Safety under the Mental Health Act', helpfully quoting from the Act itself to

emphasise their point. The only problem was they omitted the word 'hospital' when they were cutting and pasting section 135(6) MHA.

I'm sure it was just an error.

I'm curious as to what the poster authors recommend the detaining officers should say to the custody sergeant when they arrive in custody and the sergeant quite rightly asks, "What alternatives have you considered and tried before coming here to satisfy the obligation on us all under paragraph 16.38 of the Code of Practice to the Mental Health Act?" In case of doubt, the UK's highest court ruled in 2005 that a Code of Practice is not mere advice, it is a statutory guideline "which should be followed unless there are cogent reasons for departure." So read paragraph 16.38 and ask yourself what you would do as a police officer.

IT'S GOOD TO TALK

Bearing in mind the CLEAR campaign is collaborative initiative between professional colleges, it seems unusual that the College of Policing weren't involved, bearing in mind that 20% of the headlines they're hoping to raise awareness about are connected to the use of a police power. (I also wonder whether patients could have been involved, bearing in mind Twitter didn't seem to have anyone popping up in discussion to say they thought it was a positive step.) It would be unlikely that a query to the College of this type wouldn't end up with me and Friday was the first I'd heard of it. Of course, it's not the first time the police (or patients!) have been left out of discussions on mental health that affect the police. It's traditionally been seen as our role to do as we're told and we quietly did that for many years, subcontracting our responsibilities for leadership and training to others.

But we're now in a time where the police have had to learn some hard lessons and push back against a system that inadequately integrates the commissioning of ambulance, emergency and mental health services to allow the lawful discharge of the duty of care which is owed by the state to those who are detained in crisis. The frustration about this is evidence within the NHS itself, especially in ED – patients told the CQC last year that attitudes towards them are often poorest in ED.

I saw a tweet today during the debate about the above where a Consultant in Emergency Medicine and clinical lecturer at a University told the world that he was "happy for ED [to be used] as a PoS if guaranteed 1hr to see an AMHP and psychiatrist + immediate transfer if admission required." No wonder service users were today wondering whether he makes similar protests to other medical specialists – that they MUST respond within a certain time and admit within a certain time, otherwise patients shouldn't come in. Let's be honest, that's the inference of the tweet.

So on this basis, I'm really looking forward to going to the Royal College of Emergency Medicine mental health day in late February to see if I can stop us talking about red-herrings and see if we can focus on the real problem together!

– The RCEM and the RCPsych have issued a clarification statement on this very point, in responds to concerns. I'm not sure it helps me, but all credit to them for responding.

FEBRUARY 2016

8th February 2016

Reforming the Mental Health Act –

A parliamentary bill containing proposals to amend the Mental Health Act 1983 has been introduced to the House of Commons by the Home Secretary and will progress through Parliament in the coming months. Specifically of interest to me, this bill will seek to amend sections 135 and 136 of the Mental Health Act and the proposals seem more or less in line with the recommendations from the consultation document that was published in December 2014. You can trace the progress of the Bill on the UK Parliament website and the initial draft of the Bill is now available to read in full.

The main proposals are –

- **The scope of s136 will be widened** – this will allow the power to be used anywhere 'other than a dwelling', thus bringing in to play private workplaces, railways lines and any other kind of private place.

- **Detention time will be reduced** – from 72hrs in a Place of Safety to 24hrs overall, thus matching the maximum time for similar detention in Scotland. We may need to look north!

- **The 'Place of Safety' definition will be restricted** – to prevent children (u18s) from being removed to police custody in any circumstances; and to prevent adults being removed to custody other than in 'exceptional circumstances'.

- **The 'Place of Safety' definition will be expanded** – there is mention of allowing other places to act as a Place of Safety. This proposal confuses me because s135(6) already allows for "anywhere that is temporarily willing" to act as a PoS under the Act. Not sure what this new proposal means!

- **Introducing a consultation requirement** – it is proposed that officers will be required to consult health professionals before instigating use of section 136 of the Act.

You can take your pick as to what you think this announcement means: it's either a milestone which heralds a new era of crisis intervention by the emergency services which will mean that far fewer people detained under these powers are removed to custody and criminalised when they have not

broken the law; or you could argue it's a a final acceptance that we must force the NHS to ensure basic crisis provision for those in need because there will be no back-up plan. Or will there?! … we know that the words 'police station' were removed from the Scottish definition of a Place of Safety in section 300 the Mental Health (Care and Treatment)(Scotland) Act 2003 – but just see s297(5) for the Scottish 'get *into* jail' card. Looks like England / Wales are going for 'exceptional circumstances' instead!

I'm inclined to think these are actually not mutually exclusive positions and I'm not too greatly troubled whether NHS services do this willingly, as they have in Birmingham for more than five years and to great impact; OR whether CCGs which have historically ignored this in the hope it will go away are now dragged to the table and compelled to get their heads around it. I'm sure my mental health colleagues in Birmingham will attest that either way, they are going to learn that this stuff isn't so problematic that it can't be overcome with decent partnership working that will actually enhance relationships across the whole interface of policing and mental health. Some areas of England achieved all of the above without the need for legislation and operate creatively – they must be wondering why other areas can't.

WHAT WE NEED TO KNOW

To fully understand these proposals and their potential impact, we will need to know more details so this post won't be long. The obvious point is wonder what 'exceptional circumstances' will mean. This is unaddressed at this stage and reference is made to Regulations being drawn up in the future. In the original consultation, it was defined as acceptable if a person's behaviour "is such that it cannot otherwise be safely contained." That is the story behind most of the controversial, restraint-related deaths in police custody over the last quarter of a century so we will need to be careful if we're defining police station PoS detentions based on resistant or aggressive presentation.

We know that resistant, aggressive behaviours can be caused by serious medical emergencies – recent examples include acute renal failure, meningitis and serotonin syndrome so before we exclude people to custody somewhat 'exceptionally' what clinical triage mechanisms will be there to support officers' decisions so these things don't get missed?

We will also need to know more about the availability of specialists to asses those who are detained, especially out of hours. I've often used the example under the current 72hrs law that if you are a 15yr old girl with a learning disability, detained at 6pm on Good Friday, your s136 detention will expire at 6pm on Easter Monday and during all of that time, many areas will be unable to resource that assessment using a CAMHS or Learning

Disabilities specialist, as recommended by the Code of Practice to the MHA. Whilst that is a point of good practice, rather than a binding requirement, there are some areas where non-CAMHS or non-LD specialist s12 DRs will not assess children or known learning disabilities patients. So with a 24hrs detention timescale, such situation is a potential problem in some areas not just on Easter weekend but *every* weekend and that will need to be borne in mind.

NHS CAPACITY

Tomorrow will see publication of the report of the Commission on Acute Adult Psychiatric Care – we already know from the interim report last July that it will highlight significant problems in the availability of inpatient admissions beds even for adults. CAMHS and LD beds have historically been even more difficult to find, as we have seen in high-profile news reports. Where an Approved Mental Health Professional decides to make an application for admission under the Act following the use of section 136, there will be a significantly reduced timescale in which to manage the process of finding a bed. In 24hrs, there may be a period spent in A&E receiving treatment for injuries; and / or a deliberate delay to allow sobriety to return to allow a meaningful assessment and that could easily take 6-12hrs. If 12-18hrs remains to find a bed, we know that will prove challenging unless CCGs see this amended legislation as a clear indicator to change how they commission services. It will also add weight to the importance of effective arrangements to manage the implications of section 140 MHA which I still maintain is massively ignored and misunderstood!

The thing that is not in the proposals that I know some were hoping to see address is a solution to the widely acknowledged problem of police responses to mental health crises on private premises. We know from street triage that most of these incidents occur in dwellings, not in public places and it remains true that police officers have no legal powers to intervene where somebody is in immediate need of care or control. This matter was considered in the 2014 consultation and no proposal is brought forward on this point. Sir Paul BERESFORD MP raised a Ten Minute Rule motion in the House of Commons in 2014 after his experience of shadowing two Metropolitan Police officers at an incident where they were powerless to deal with a situation of significant risk and unable to mobilise the professionals who were empowered to manage the situation. Unless someone brings forward a proposed amendment to the Bill during its parliamentary journey, officers will still find themselves in this position, from time to time.

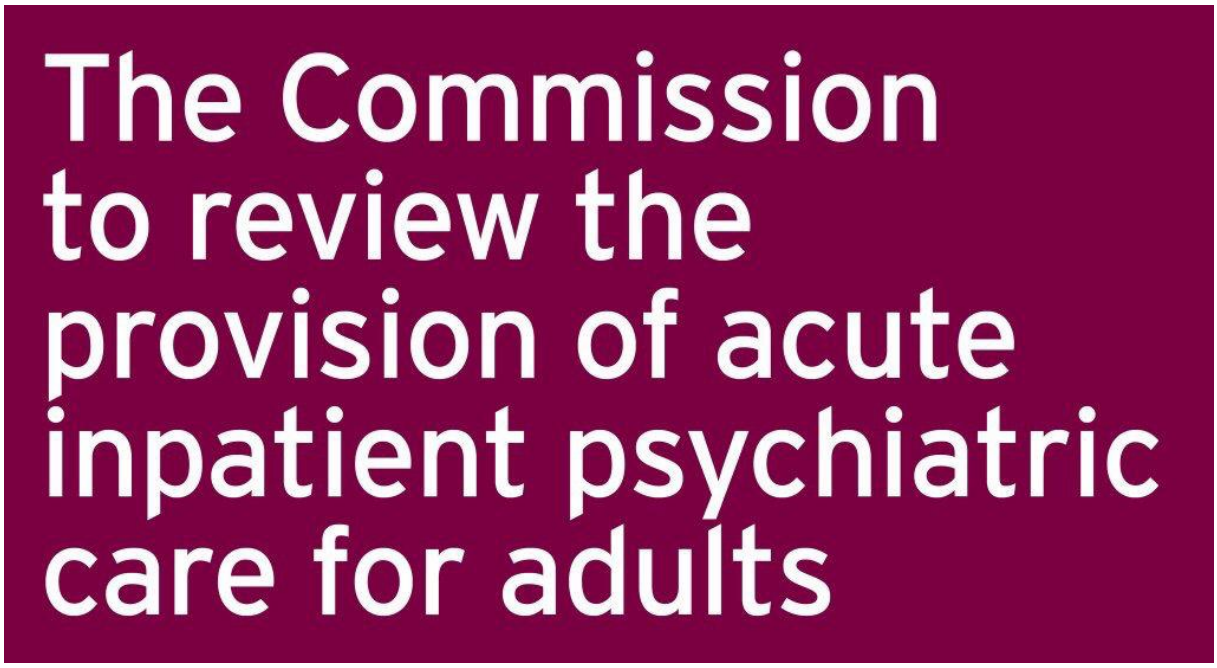
Finally, we will need to understand more about this consultation requirement – I can't be the only police officer in Britain whose experience of attempting to contact 24/7 crisis services is patchy because of their

capacity problems. Some cities with 250,000 population and 2,500 of those open to mental health care services are known to have one or two mental health nurses on duty out of hours. We know that the reduction in CrisisTeam staffing levels is not fully made up even by the introduction of street triage schemes and that it will be necessary to think creatively about how such consultation is to be achieved at 5am. (For what it's worth, I'd encourage areas to look at what Leicester do with street triage, liaison and diversion and psychiatric liaison services.) We also need to know what role of that health professional will be in the subsequent decision. What if the nurse suggests a course of action that the officer disagrees with – who 'wins'?!

Like a few other things implied by the announcement, we'll need to wait and see!

9th February 2016

Do We Have Enough Beds? –



The Commission on Acute Adult Psychiatric Care has published its final report! – and the publication was headline news on BBC Breakfast this morning with a range of people welcoming its findings. I have been very interested to be a Commissioner in this inquiry, not least because I've never done anything like that before but also because the subject matter is something that many would imagine is not immediately linked to policing or criminal justice. And yet at *every* stage of the Commission's work, I found myself with things to think about and say, relevant to policing, mental health and criminal justice. I have learned a lot, quite honestly!

So here are the resources –

- The full CAAPC report – 126 pages long!
- The summary report and recommendations – 2 pages.
- The Royal College of Psychiatrists press release.
- The interim report – published in July 2015.

- The RCPsych Background Briefing Paper.

This has been a major piece of work and I know the staff within the RCPsych policy unit who did a lot of research and running about at the whim of the various Commissioners have worked tirelessly to produce it. The risk with any such thing is that it becomes 'yet another report' that can be filed away – in my case, I print them off and put them on a shelf in my house.

DO WE HAVE ENOUGH BEDS?

The Commission's essential task was to address the question of whether England has sufficient inpatient psychiatric beds for adults. It was obvious to everybody at the first meeting of the Commissioners that the answer could not be a 'Yes' or 'No' and that is reflected in the final report. You can get talking if you want to about whether mental health care should be more balanced towards inpatient care or community models of care: it was really interesting for me listening to very senior and experienced people as well as service users all over the country talking about their views. But ultimately any local health economy is going to be a balance of inpatient and community provision – the issue is whether local areas have got their balance correct. The report concludes that there are enough examples of imbalance to suggest urgent action is necessary – not least on the long journeys some patients undertake when first admitted (see the recommendations, above)

Policing seemed throughout the inquiry to be connected to the issue of sufficiently minimising imbalance to prevent instability becoming too great, although even there we came across examples of where it could not do so (see example one on page seventeen of the full report) and therefore the final report highlights the need for a 'systems' approach to our mental health care – this means seeing various public functions as directly connected to achieving a balance. If 16% of patients don't need inpatient care but do need community care that doesn't exist, some will become hospitalised, some will become criminalised, others may develop informal coping strategies like drugs, alcohol or self-harm. If 16% of patients are in hospital having required admission but are now medically fit for discharge and have no housing or other vital social supports, it prevents discharge occurring and forces the system to rely on the most expensive resource of all: an acute inpatient bed.

So my concluding thought about all this, having spent a year working on the Commission is that you can have as many or as few alternatives to admission as you like, you can plan properly for that by understanding demand, or not – as you prefer. Either way, we will end up paying for it anyway with out of area and private sector admissions costs; with criminal justice interventions and imprisonment; or with a cost in human suffering

from unnecessary institutionalisation, predictable self-harm or avoidable suicide.

So we may as well just do this properly and accept it needs planning and paying for.

13th February 2016

Thinking of the Future –

I'm really conscious that there will come a point where the focus on policing and mental health will wane – my view would be, it has already peaked and we need to capitalize on the time we have until the sun sets. During that period, the College of Policing will publish its national guidelines and training, forces will have the chance to do something with them and by the time we get to the end of 2017/18, attention will begin to focus on other issues, both within policing and without.

I'm not necessarily sure we'll have sorted the relevant issues by then: but we'll have found some ways to make them seem less outrageous and attention will begin to fade as other priorities take hold. Within policing, the view may be taken that once we have national guidelines and training, reflecting on the former in local policing and delivering the latter, surely that will do?! Some police officers still think (or hope?!) mental health is something we can 'sort' as a project and then move on to real policing. If Lord ADEBOWALE's vision of *core police business* is to mean anything, it may rather be something to which we will need to pay ongoing attention just as we do with domestic abuse and youth justice issues, amongst others.

There are few problems we need to start watching for –

POLICIES

Towards the end of 2016, forces will have realised that the contents of College APP don't necessarily accord with their local practices and will be experiencing the cognitive dissonance that comes from trying to adhere to national guidelines as well as to local partnership practice. There will be combination of reasons for that, some within policing itself; others without. As APP focuses on the essential and non-negotiable aspects of this interface, forces will need to realise that where it doesn't easily fit, this will be connected to their internal policies and their partnership arrangements. Work will be required and some of that won't be easy.

Section 136 of the Mental Health Act and the whole 'Place of Safety' debate still exemplifies this: police forces point out that word games about the

meaning of 'PoS' are still rampant – despite it being very clear in the Act! – and exclusion criteria are still applied by MH service providers notwithstanding what the CQC say in their reports. The reality is that there remains work to do on conveyance arrangements for those detained under the Act with ambulance trusts arguing that they are not commissioned to undertake various functions and of course, we know that forces still approach the use of section 136 very differently. That all needs ironing out and it will be about partnership work, not policies.

TRAINING

You might imagine training is the silver bullet in all of this: it is mentioned with monotonous regularity whenever a report is written on this topic and partners in health seem fairly determined to make sure we realise the problem is with officers not sufficiently understanding mental health. Of course, it's quite likely that there are significant training needs amongst health professionals – especially legal education for them – as well as remembering that the bulk of police training requirements are around legal issues. I receive almost no queries at all about how to raise officers' awareness of conditions; ongoing relentless deluge of questions about legal duties, legal opportunities and legal difficulties. So the key thing about training may well be the way in which trained staffed are deployed and used, rather than anything else – we have some trial and error to work this out.

There is also the issue of information retention – police officers will encounter the situation of recalling a CTO patient perhaps once a career, if they're lucky … or unlucky, depending on your view! We need to be realistic about what we're asking officers to achieve after their training: I would expect them to know that whenever you detain or re-detain anyone under the Mental Health Act 1983, you transport without using a police vehicle wherever this is possible, you consider the health & welfare of the person detained at every stage. I wouldn't expect any front-line police officer to freely recall the three different ways in which to serve a recall notice under s17E MHA or the subsequent time at which they allow officers to remove the patient back to hospital. It's the job of mental health professionals to know what they're doing around recall and be able to explain that legal point where officers have the power to act. << That's why this is not just about policing!

INSPECTION

Of course, who knows what will take the focus of inspectorates or independent investigators? If history tells us anything, it is that there will

be one or two deaths and half a dozen or so 'near-misses' each year, following the use of section 136 of the Mental Health Act. Some of those will mean independent investigation of the circumstances by the IPCC who will use the College of Policing APP and training as a benchmark – did forces' policies adhere to the national guidelines; were officers properly trained; did officers adhere to the basic requirements of their training?

It wouldn't surprise me if mental health featured in future inspections by HMIC in conjunction with other partners. We've already seen focus on these issues in the *Core Business* reports, the *PEEL* inspections as well as other in thematic inspections around custody and vulnerability. I would add a word of caution to those who are going to start inspecting: make sure you understand the stuff you're looking at before judging it and remember that the main Act of Parliament for mental health law received Royal Assent in 1983, not in 2007!

FUTURE PROOFING

I repeat my point: I wonder whether we have reached or are just approaching the peak of interest in this subject? – we seem to think we've found the solutions in guidelines, training and street triage. I also suspect we can infer this from ongoing force rationalisations, some of which may see full-time positions as mental health coordinator vanish – and this is *despite* the net effect of ongoing pressures in the health and social care system is to deflect greater demand in crisis care to the whole emergency system (including A&E and the ambulance service) and initiatives like Liaison and Diversion and street triage raising newer questions and challenges. We also know that we haven't even begun to properly discuss the role we want the police to play – I think this is where we should have started to avoid the conclusion that we see activity at the expense of achievement in this arena.

The trap to fall in to – and I see evidence that it's proving to be an effective snare in the meetings I attend – is to think that 'improved' policing responses to ever greater demand, somehow represents early intervention. Yesterday we saw publication in the British Medical Journal of an article which evaluates street triage: the first such academic paper to arise, instead of local evaluation documents. It claims that street triage is more or less cost-neutral, bordering on cost-saving but it takes for granted the arrangements in Sussex as the baseline and it fails to consider the data that the street triage scheme did not gather.

The police service needs to make sure it does get lost in the smoke and mirrors that can surround these issues: the danger of not driving through national guidelines and training to have the necessary impact upon partnerships is that vulnerable people will continue to find themselves

criminalised and stigmatised by the impact of the justice system upon their crisis care. We need to make sure that as focus and resource may deplete, we maintain our ability to tell the difference between that which appears highly intuitive and that which will be highly impactive – to do so, we need to start that proper conversation about the role we are attempting to forge for the police in our broader mental health system whilst keeping a very close eye on the direction overall mental health provision is headed. We haven't really started to do so, distracted as we are on the minutiae of whether A&E is a Place of Safety and whether or not street triage and training are the silver bullet. We ignore history and context at our peril.

What are we actually trying to do here? – we don't have very much longer to decide.

16th February 2016

Shouting at the Rain –

Did you watch Spotlight on 15th February – this is the BBC regional news for south-west England … why would you, unless you live there?! There was interesting coverage of ongoing issues arising from the use of section 136 of the Mental Health Act 1983 by Devon and Cornwall Police. The debate about where should be used as a Place of Safety was front and centre and the point of the article appeared to be to highlight the 'tension' between Emergency Departments and the police – there was a spokesperson on either 'side', giving their view. This an example of a local tension that needs some historical context and which does directly link to national issues. (If you want to watch it, you have a matter of hours to do so! – but the key quotations are below so this continues to make sense.)

Only yesterday, I emailed the Department of Health and Home Office about an exactly similar argument in the south-east of England … anyway, we'll get to all that: but pause first of all … pop the kettle on and get yourself some biscuits, because I think this one is brilliant and enlightening about attitudes and it's also a complete waste of time spent shouting at the rain … in my opinion. I will explain! –

DEVON AND CORNWALL

Historically, Devon and Cornwall Police has always been a comparatively high user of this legal power, with a high proportion of people detained each year ending up in custody. When they did the first piece of modern research on s136 in 2008, the Independent Police Complaints Commission had Devon and Cornwall down as the second highest individual user of police cells as a Place of Safety. (Sussex was first, incidentally – and they've also been on the news this week for reducing it.) To put that in some kind of context, this means use of 136 on a par with or higher than many of the countries biggest, urban police forces and typically way above what would normally be considered to be the most-similar forces. Of course, this force area is not without its cities, its challenges and its deprivation: Plymouth, Exeter and Truro all lie within the vast expanse of these two (very different!) counties. (I admit I like my cream on top, the Cornish way!)

Various ideas have been suggested over the years, ranging from the influx of tourists boosting the actual number of people in the two counties without boosting its resident population and thus skewing the figures; parts of the south-west of England do rank above-average for many negative demographic indicators like poverty, unemployment, suicide levels, etc.. We also know that forces have different attitudes and approaches towards the use of section 136 (especially when compared to how they use other powers of intervention and detention involving mentally vulnerable people) and that this can be affected by the health infrastructure that supports those in crisis, as well as the police officers who are often first responders. All of these things and more besides could perfectly well combine to explain certain things but I repeat my constant mantra that I'd love to see this properly researched and subject to proper statistical analysis.

RECENT HISTORY

You may recall November 2014 as the month when Devon and Cornwall Police made national news headlines after a senior officer tweeted about the ongoing detention of a girl in police custody? She had originally been taken to police custody in crisis and the lack of an appropriate inpatient bed meant she spent far longer in the cells than was legally allowed. That incident along with the general work across England and Wales to reduce the use of police custody for those in crisis led the Chief Constable of Devon and Cornwall to write confidentially to partners in health stating their intention to significantly reduce reliance upon police stations as a Place of Safety under the MHA.

I haven't read that letter so don't know the specifics, but it seems obvious that the CCGs in the force area have either been unwilling or unable to ensure sufficient health-based Place of Safety provision in mental health units and hence we see this 'tension' between the police and Emergency Departments. The BBC article on Spotlight and its online news coverage did not mention mental health trusts or CCGs once in their coverage. Instead, they focused on whether the police are just 'passing the buck'? We know that most forces would probably benefit from looking at the training and direction officers receive about use of this legal power, there is potential for officers to simply use it less and hopefully College of Policing training later this year will help forces address that. In the meanwhile, we are where we are –

VIEWPOINTS

Dr Anne HICKS, Consultant in Emergency Medicine at Derriford Hospital in Devon and spokesperson for the Royal College of Emergency Medicine on mental health issues said was interviewed on BBC Spotlight and said –

"When we're crowded, we can have six patients on trolleys … we will have all of the cubicles around us full. You then bring an agitated mental health patient in here and we're trying to create the space and that creates real tension between us and the police because we don't feel we can deliver that safe, nurturing space that these patients need."

I think we all get that, don't we – at least apart from all those detained by the police being 'agitated' to any degree more than those in EDs are already after they've spent an evening drinking a gallon of sheep dip and fighting a kebab before falling down? None of us in policing are disagreeing that ED isn't ideal – not for a moment. But that quote probably wouldn't be said about agitated RTC victims even where it was their own poor driving that lead to their condition and their subsequent agitation. It also could have been said by the Chief Constable about custody … "six people queued up to be booked in; cells all full; unable to create a safe, nurturing space", etc., etc.. This should be the first clue that we're arguing about the wrong thing! More about that in a moment …

In response to these points, the Chief Constable Shaun SAWYER noted:

"For someone in mental health crisis, it should be the professional caring environment of mental health assessment. If that is not available and that individual is not a risk or a threat of harming others or themselves, then to me, A&E is the next place to strongly consider before it is a police cell."

TEXTBOOK

This reply is something of a text book summary of the legal framework: hospitals and police stations are Places of Safety under the MHA (see section 135(6) MHA); and all areas should agree a local protocol about which places are used in specific circumstances but local practice also needs to acknowledge various other imperatives such as the Code of Practice to the Mental Health Act and human rights law that wasn't as directly relevant when this law was first written in 1959! Remember, the Munjaz case (2005) saw the highest court in the UK tell us this document must be adhered to unless there are 'cogent reasons' for departure. A&E are absolutely entitled to turn the police away and refuse to help someone who has been detained – frankly, some of them do! But this is quite a different legal point to the

question of whether or not it is lawful for the police to ask whether they will try to help. You'll notice the Chief Constable's words: "A&E is the next place to strongly consider …"

So back to the Code of Practice: it says within –

"A police station should not be used as a place of safety except in exceptional circumstances, for example it may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or other users if the person were to be detained in a healthcare setting. A police station should not be used as the automatic second choice if there is no local health-based place of safety immediately available." – *paragraph 16.38 CoP MHA.*

So quite arguably, the Chief Constable's direction to his officers is an attempt to get close to what paragraph 16.38 is actually getting at, albeit in non-ideal circumstances – by not asking A&E whether they might be prepared to help that particular person in those particular circumstances and to dash off to custody is to violate spirit and the wording of this paragraph. In fairness to him, the police didn't write this stuff but they have a duty towards what the Secretary of State is trying to achieve by writing it! Just in case anyone reading this is tempted to question the officers' judgements and whether or not those detained a really mentally ill, a document from Devon Partnership shows that 75% of those detained by the police are currently open or previously were open to their local services – the hyperlink to this document will follow once I find it again, having read it two or three months ago!

It seems Devon do not have such a local agreement at the moment and I wonder whether that is because the CCG and the mental health trust have gone unmentioned in this coverage – I also wonder why they have gone unmentioned?! Strictly speaking, there is no legal obligation on the CCG to provide a mental health unit based Place of Safety but if a CCG decides not to do as others have done (and where they've reduced the use of custody to a handful of occasions a year or eliminated it entirely), then this kind of 'tension' seems inevitable. If you were the police officer who had detained someone and you knew both of this paragraph and the certainty the custody officer would ask you what else you'd considered before resorting to the cells as a third or fourth choice, what would you say? – and if you were a Chief Constable, how would you interpret it when giving direction to your officers?!

A WIDER PERSPECTIVE

I have often wondered whether the police, Emergency Departments and indeed the ambulance service wouldn't be better off just getting together

to try and jointly influence CCGs? As you take the wider view of these matters, you'll see examples of all organisations having room to improve how they deal with those of us in crisis because of mental health problems. They are all guilty of betraying their attitude that those in distress should 'go away' – manifested in far less direct language, but nevertheless amounting to the same thing. A&E can't provide the 'nurturing environment', neither can the ambulance service who have been known to have patients on the back of a truck for hours whilst debates occur as to which part of 'the system' should deal; the police are not faultless here and we know examples exist of officers just dropping off people in A&E and leaving without thought to the consequences and I know of at least one such case where it has led to the patient's death and another where it led to an A&E nurse being grievously assaulted.

These are all symptoms of a broader problem.

Here's a thing: not ONCE in all my work between 2005 and 2010 to get a properly integrated Place of Safety process set up in the West Midlands involving all these agencies playing their part where it's necessary to do so did I manage to get all of the relevant health agencies in the *same* room and the *same* time to discuss their various perspectives. **Not once!** The problems that arise are only going to be tackled *together* where we think how we may jointly address them. I ended up worked with a superb psychiatric nurse and we had to physically flog around various NHS organisations one at a time after they literally *refused* to sit down together, never mind work together. That issue – *right there* – is the problem: **not** the decision-making of those police in Devon who are caught in the operational reality of an integrated commissioning void.

To think otherwise is to spend your time shouting at the rain.

24th February 2016

Only Following Orders! –

I have had lots of conversations, emails and indeed tweets over the years with police officers about reliance upon the Mental Capacity Act to justify intervening where other professionals have declared someone to lack capacity about some medical matter or other. Most usually, it is connected with a decision by someone to decline medical care in situations where 999 services end up jointly addressing the question of whether to allow them to do so. On the one hand, some police officers have been scared witless about justifying their intervention under the MCA because of the Sessay case (2010) and on the other hand some seem only too keen to start coercing the vulnerable because a paramedic or a doctor has said they should. This BLOG post is about the latter situation (although the former position isn't right either!) … can you rely upon another professional's judgement where the Mental Capacity Act is being bandied about?

Yes – and no! – that's the answer. *But mainly, No!*

I once attended MCA training that had been provided by a police force to its frontline officers and amongst other points made, the AMHP who was delivering the training said, "If a paramedic tells you that someone lacks capacity and needs to go to hospital, then you can use reasonable force to take them there." I wrote this down at the time, hence I'm able to quote it directly many months later and I did so because it was the only way I could distract myself from the overwhelming urge to leap out of my chair and undermine the trainer in front of everybody. There was no further qualification to this statement and that is *precisely* the problem: no mention in the overall training about the difference between restraint and a urgent deprivation of liberty; no mention of s4B of the MCA which qualifies those circumstances in which an urgent deprivation of liberty may be inflicted upon someone – just the quotation as given as the first example of how to put in to practice the decision-making that the paramedic will have gone through leading up to requesting the police.

In other examples, there was the tweet by an officer who was keen to show the work of the police that they were taking someone to hospital under the MCA and when I enquired about circumstances because of my interest in this, the logic behind the coercion was that the paramedic said it needed to happen. Just today, I received an email from an officer with an exactly similar situation: and the same reaction – a paramedic has declared a lack

of capacity so "that's up to them", implying it bound the officer to act … it really, really doesn't!

You need to know much more.

NUREMBERG DEFENCE

This is the real problem: you can't just justify your actions after the fact by simply saying "I was only following orders". The AMHP trainer and the officers are wrong in these situations because whenever a professional is using physical force to coerce another human being, they have to be able to justify this on their own terms. A paramedic may well tell you about capacity, but they can only help inform your view about proportionately. Imagine the person who is coerced to hospital complains to the duty inspector that the officer involved assaulted them and imprisoned them against their will. On the face of it, the officers' actions will have amounted to this unless they have a legal justification for doing these things? Officers usually make detailed notes where force has been used, and the legal basis for doing it. If I saw their statement or their official notebook and it just said, "The paramedic said I had to!", I would be quite alarmed!

And here's why –

The paramedic, of course, is far better placed than any police officer to make a clinical assessment of someone's needs and to know the particular kind of clinical response that would be necessary. This is not what I'm questioning – not for a moment. What needs greater thought, is whether or not coercion to hospital is the least restrictive thing and / or a proportionate response to the situation? Examples might help – imagine a patient is in their own home and they have injured themselves but are declining hospital treatment: and let us further imagine that person has broken their finger whilst drunk – are we dragging them kicking and screaming to hospital if a paramedic declares them to lack capacity?

I hope you shouted, "No!" based on just those facts?! – without anything further, you're going to let them sober up and when they wake up and realise their hand hurts and it's partly pointing the wrong way, they can get treatment having recovered capacity. What's going to happen if someone doesn't get care for a broken finger? – there are some consequences and having suffered exactly this injury I can tell you it hurts more to have your finger reset hours after doing it than if it happens shortly after doing it, but there's nothing especially long-term to worry about. You are almost-certainly not going to die from that! But now imagine the person is experiencing suicidal ideation and has consumed enough tablets to end their life – *totally* different isn't it?! … apart from anything else, justifying

the use of reasonable force becomes much easier because the stakes are much higher.

If coercive intervention leads to handcuffs and leg restraints with four police officers carrying someone bodily in to the back of an ambulance or police vehicle, they can justify that if that person would otherwise die but would struggle if they had broken their finger! – the MCA requires officers (in section 6) to take account of both the seriousness and likelihood of risks particular being realised. And this is the point where we need to know the case *R (G) v Nottingham City Council* (2008) – the NHS removed a baby from its mother on the say so of a social worker, without satisfying itself that it was acting lawfully. It was unable to avoid liability by arguing that they were merely following the instructions of the other professional and another organisation.

LEGAL JUSTIFICATION

So where officers are engaging either in restraint or in urgent deprivations of liberty, *they* must be able to justify their actions unilaterally and I would suggest with reference to sections 6 and 4B of the Act. That means they must understand the other professional's view on the consequences of inaction. If the paramedic cannot articulate a consequence that renders coercive intervention a reasonable and proportionate response to the management of the identified risks, the officer should question further or potentially decline to act. Unless you start hearing something about life-threatening or life-altering consequences, it's reasonable to wonder whether your use of force would be lawful.

Don't forget, if this situation was against the backdrop of responding to a mental health crisis in in someone's home, the Mental Health Act provides the statutory framework for intervening and it involves services coming to the person, not the person being coerced to the services! I fully appreciate that many mental health crisis teams (where they still exist!) and AMHP services don't like the implications of the 1959 Mental Health Act or necessarily agree with the judge in the Sessay ruling, but that never the less is the law as it stands in 2016 and both the police and ambulance services have every right to expect support for those situations that cannot otherwise be safely managed, in accordance with that ruling. I would respectfully submit that if a local authority is not going to ensure sufficient AMHPs to provide that range of services envisaged by law they should probably do the public a favour by saying so, in order that such matters can be discussed by the Government and / or Parliamentary authorities which decided in a review of the MHA in 2014 that such matters did not need legislative amendment.

Meanwhile, back in the world of Mental Capacity Act interaction between 999 services, police officers need to remember this legal lesson: a paramedic can provide you with the capacity assessment, YOU remain responsible for the legal use of force applied and therefore YOU must be satisfied that it is reasonable in the circumstances.

MARCH 2016

4th March 2016

The Nineteen Fifties –

You remember Britain in the nineteen fifties … the Suez Crisis, the Korean War and the Queen actually having to make a major constitutional decision about the appointment of a Prime Minister following the resignation of Sir Anthony EDEN. Bearing in mind the Queen recently became the longest reigning monarch in British history, you have to go back to the 1950s to see a decade where we had any other monarch. This was a LONG time ago! – a time that finally saw an end to rationing following the restrictions imposed during World War II. And it was a very different time – during the 1950s, Britain was part of leading on the delivery of the United Nations universal declaration on human rights and towards the end of the decade, we modernised our mental health laws. This subsequently led to Enoch POWELL's second most well-known speech – the Water Tower speech. It is regarded by some as having precipitated the UK's move towards a more community oriented model of mental health care and to the deinstitutionalisation movement away from reliance on old Victorian asylums.

This is when our current mental health laws were written.

They were for *that* particular society and for *that* particular model of mental health care – highly reliant upon old county institutions often built in the nineteenth century. The 1950s was the decade in which the first anti-psychotic medication was developed – chlorpromazine – and it was a period where homosexual activity was covered both by psychiatric manuals and criminal law.

This was when our current mental health laws were written! – the Mental Health Act 1959.

MENTAL HEALTH ACT 1983

Although the 1983 Act appeared to be a significant update with a total overhaul and an entirely new Act, it wasn't a legal revolution – more of an evolution. In many respects the 1959 Act represented the revolution, sweeping aside nineteenth century laws about 'lunatics' in section 1 and modernising our approach. When the 1983 update occurred, police powers

under what are now sections 18, 135 and 136 of the '83 MHA were merely brought over almost unchanged from the '59 Act (sections 40, 135 and 136, respectively). The main compulsory admission provisions (sections 2, 3 and 4 of the '83 Act) were also brought across (from sections 25, 26 and 29). Along the way, we've just slightly altered terminology and the most specific example is probably the title and professional backgrounds of those who make applications for admission: those we have known as Approved Mental Health Professionals (AMHPs) since 2007 were original Mental Welfare Officers (MWOs) in 1959, changing to Approved Social Workers in 1983.

But look at this –

- Section 25: admission for assessment for up to 28 days – MWO and two doctors.
- Section 26: admission for treatment for up to six months – one MWO and two doctors.
- Section 29: emergency admission for up to 72hrs – one MWO and one doctor.
- Section 40: return of AWOL patients – MWOs, Constables or anyone else authorised by hospital.
- Section 132: even my pet subject s140 MHA had an equivalent duty in 1959!
- Section 135: warrant to enter and remove patients to a Place of Safety – Constable, MWO and DR.
- Section 136: power to remove someone from a place to which the public has access.

It all sounds so very, very familiar, doesn't it?! The 1983 Act replaced the '59 Act but replaced it with an exactly similar foundation, but merely altered some less fundamental details and introduced structures to ensure patients rights and autonomy. So this is the basis for the claim I often make about our law being 1950s legislation – the main planks of what goes on today was written when Buddy HOLLY was alive and well.

SOCIAL CHANGE

But just think about the change again: with a large number of patients detained in hospital for years, how often do we think the average MWO would attend an address to assess and 'section' someone? – how often would the average Constable use s136 MHA '59?! If an MWO did ask for police support at an assessment, do we think there would be as much focus on the legal minutae that we now see, following rulings in the Seal, Sessay and Hicks cases from early twenty-first century? – by definition, those rulings hadn't been made and as one of them relates to misuse of laws which only took effect in 2007 (the Mental Capacity Act 2005), it wasn't a

consideration. I certainly don't anticipate anything like as much discussion about warrants under s135(1) '59.

This could be a touch unfair to our historical colleagues but I'm guessing if a police officer manufactured a situation in which someone in a private premises went outside, there wouldn't have been much objection to misuse of the s136 provision? There certainly wouldn't have been a human rights based challenge as we saw in *Seal v Chief Constable of South Wales Police* case which was heard in Strasbourg in 2010.

But the main issue I want to highlight occurs in the shadow of some recent jobs I've been contacted about by mental health triage schemes. They are *precisely* the jobs which I said in a post two years ago would be almost totally unaffected by these new methods of partnership working and thus has proved to be the case. I'm even received an email from a police officer about a perception of pressure being placed to act unlawfully. But it's interesting to note before I describe these incidents, that triage schemes have been found to think in exactly the terms that police officers did in the 1960s – how can they lawfully fudge their way around the implications of our 1950s legislation?!

STREET TRIAGE

Imagine that someone rings 999 with a complaint about a potential offence. Police officers respond and find through independent evidence that the alleged offence has almost certainly not occurred and the victim who rang has potentially serious mental health problems. In accordance with new procedures, they ask for street triage to get involved to assess or advice in the circumstances. When triage arrive at the scene, the outcome of the background research and the nurse's assessment is that they have a mentally disordered person in their own home, under the influence of a decent amount of intoxicants, albeit not 'incapable'; and they are exhibiting non-specific suicidal ideation. The officer is of the view that if such a person had been encountered in a public place, they would have used s136 MHA '83 to detain them and ensure their safety. But the person is not in a public place. – they are in their own home and actually, they are asking the triage team to leave. The MH nurse has concerns about doing that and everyone is agreed they cannot rule out that the non-specific suicidal ideation may manifest itself in serious self-harm of a kind the patient has previously engaged in, although not in recent times.

What do you do?

- You cannot arrest this person for any criminal offence, they are not committing one.

- There is no imminent breach of the Peace and in any event, the Hicks case has said something about that from the perspective of human rights law.
- Can you rely upon the Mental Capacity Act because of the suicidal ideation? – this is where most debates end up, so let's look at it in far more detail.

You can only consider a potential lack of capacity in connection to a specific issue or decision in someone who is suffering from an impairment or disturbance of the mind or brain – so do they have one and what are you asking the person to decide? You need to know these two things so you may undertake some kind of capacity assessment to make the decision. In our hypothetical example above, the impairment or disturbance part will most likely be satisfied because the person has a serious mental illness, is open to mental health services and is intoxicated sufficiently to mean their capacity to take a particular decision may well be compromised. But what decision?! – and can they communicate their views in respect of it; do they understand the information relevant to it; can they retain information relevant to the decision and evaluate or employ information appropriately? That's your call, based on the circumstances you find but even if your thinking has got you to a point of declaring a lack of capacity, let's say about the decision to attend A&E on a voluntary basis, to remain safe with police officers and agree to a mental health assessment, what does that mean you can then *do*?!

- You can do the least restrictive thing in their best interests, stopping short of restraining the person or depriving them of their liberty – so this may include remaining on the premises in opposition to the direction to leave, pending the making of other arrangements to safeguard the person; or temporarily taking control of things which the person could use to cause themselves harm. **Section 5 of the MCA** covers this.

- If restraint is thought to be necessary, it will only be lawful where it is a proportionate response to the risk of harm and to the likelihood of that harm – so if the person is attempting to ingest medication in an apparent overdose or to self-harm using an implement, it may be justified. **Section 6 of the MCA** covers this.

- If it is thought to be necessary to remove the person to another location and hold them against their will, potentially for several hours, this urgent deprivation of liberty will only be justified where it is necessary to provide a life-sustaining intervention or to do a vital act to prevent a serious deterioration in their condition. This is the one we need to focus on further. **Section 4B of the MCA** covers this.

URGENT DEPRIVATION

So we hear of officers being asked by paramedics, street triage nurses or their supervisors to 'use the MCA'. Let's look at how that relates to our situation, above. There is no suggestion that Emergency Department treatment is required – no suspicion of an overdose, no underlying medical complication that risks the life of the person; no wound or injury that requires attention to save that person's life or prevent the serious deterioration. So what would happen at the Emergency Department? … in addition to a physical healthcare assessment that may be somewhat limited in its scope if the person continues to object and resist, what would you *do* when you get there? The actions seem to be focused on officers remaining proximate enough to the person to stop them from harming themselves, potentially with a view to a mental health assessment once sobriety returns. Do we need to be in ED for that?

If we've decided we have to 'do something!', would it not be less restrictive to wait with the person at their premises, pending sobriety returning and then re-address the issue of capacity at a later point? The MCA does suggest delaying action if it is thought that capacity will be regained – the decision to trespass would be defendable under section 5, as would any decision to temporarily restrict access to mechanisms that would cause harm; if restraint were briefly required, section 6 would cover this. All of this is less restrictive than the action of physically coercing someone to ED, especially if there is nothing specifically additional that ED can offer. Remember the risks involved in the restraint of mentally or medically vulnerable people. And if the person should meanwhile exercise a genuinely free decision to leave their home, they surrender protection from the use of s136.

It all takes us back to the Sessay case (2010) – the judge reminded us all that there is a statutory mechanism to deal with this hypothetical situation and "there is no lacuna in the law". You contact an AMHP and ask them to attend and assess the person under the Act, if need be with the assistance of powers afforded by a s135(1) warrant. But here's the issue that reflects back on our 1950s legislation. Had you had this situation in 1961 or 1971 (or 1991?), it strikes me as much more likely that the police would have resolved the situation another way. We still hear now about officers turning up in Emergency Departments with people who are obviously detained against their will but who were encountered in their own homes – this was the feedback I received about modern policing from the Royal College of Emergency Medicine at their mental health study day.

EATING CAKE AND HAVING IT TOO

Whatever we think of the above, and whatever mental health system we had in 1959 that influenced the thinking behind our current laws, the fact is that police powers under ss135/6 MHA were formally reviewed in 2014 and the Home Office recently published proposals to update aspects of the MHA which do not effect these considerations. So 1950s legislation or not, this is how your Government wants it to be – albeit they pointed out the duty on Local Authorities in the Code of Practice to the Act to have sufficient AMHPs available to undertake their statutory functions. What I submit we can't keep doing, is protest at police 'improvisations' around the kinds of incidents and then say we're going to refuse to help them do it properly – you can eat your cake, etc., etc..

In fairness to some AMHPs and some areas, it's not just the AMHP provision that affects things, it's also s12 DR availability and securing warrants out of hours, if required. But regardless of the problems around those issues, it remains right to say we can no longer expect the police to keep fudging the legalities of responding to mental health crisis incidents in private premises. Outside certain specific situations, it is simply a reflection of our current, modern laws that responses that require lawful detention to keep people safe when they are at risk in private premises rests with AMHPs as the only professionals who can coordinate assessments and swear out s135(1) warrants.

It is therefore vitally important that police, paramedics and triage cars who find themselves in these positions draw to the attention of duty AMHPs in their areas, situations where an AMHPs involvement may make a difference. It is up to AMHP's to justify their response to these requests, just as they feel entitled to ask for police support where they believe it is necessary when undertaking MHA assessments. The basis for asking, given that we have ruled out arrests for offences, Breach of the Peace or reliance upon the MCA will be to simply say '*Sessay*'. If we don't ask for help from each other that we think we'll need, we run the risk of misunderstanding the nature of the demand we face, we risk missing opportunities for professionals to support each other and most of all we risk the legal rights and potentially the welfare of vulnerable people.

6th March 2016

Legal Education –

In 2015 we've had the second year of our Concordat in England, the launch of a Welsh Crisis Care Concordat, yet more thematic reviews of various kinds and ever more inquiry reports to read through – and we're *still* seeing many of the same problems we've seen for some years. This post is about something I've raised a few times, but which has probably had less coverage than some of the other stuff – **a common legal education** for *all* professionals working at the emergency mental health care interface. The law is no different in England if you are an mental health or A&E nurse than if you are a police officer or paramedic. The law is the law, whether or not you realise it.

I spoke at an AMHP event this month and whilst making a remark about the general lack of legal education on mental health and capacity law for health and mental health professionals, I took the time to exempt AMHPs from my fairly indiscriminate and outrageous generalisation! … then an AMHP asked me about a scenario that just made me think, "You're an AMHP – why don't you know that?!" I always remind myself when I get questions from police officers, that we gave them very little training on this stuff and that whilst mental health is a background factor in many police incidents, the particular ins and outs of different sections of the Mental Health Act 1983 come up very rarely for individual Constables. So it is unsurprising that questions keep coming but as AMHPs themselves often point out, they have a postgraduate education on mental health and are formally examined at that standard on mental health law – they then *do* mental health and mental health law stuff (almost) every day. What chance the police will get it consistently right when the AMHPs can't?!

It reminded me of the complaint I once handled from a mother who was understandably upset that a police sergeant at my station had made an error in his understanding of recalling patients from Community Treatment Orders (CTO). The sergeant had never heard of these things before and had made a punt in good faith that happened to be wrong decision. As a result, the patient who could have been returned to hospital for treatment was not returned and it led to a delay in his readmission which meant his stay lasted longer than it needed to. We can all agree this is not great! – but before I attended the meeting with the mental health professionals and the man's family in connection with the complaint, a mental health nurse (from the same mental health team actually!) rang my station in connection

with another CTO patient, asking police to assist in a recall. When I asked her 'when and how the recall notice had been served', she asked, "What's a recall notice?!" What chance a police sergeant will always get this right when he's never heard of them or been trained on them if a mental health nurse who cares for such patients most days doesn't understand them either?!

CASTING A WIDE NET

Let me make the most obvious point: I actually claim no expertise on mental health law – I just picked up the Mental Health Act and read it (way more than once); I then did likewise with the Code of Practice and then repeated those processes with the Mental Capacity Act 2005 and its associated Codes. I'm still making this stuff up as I go along and still learning every day. But I wish to case some very wide assertions! – we just **don't seem to know enough law** to get this stuff right at the policy or at the operational levels. Some examples for you –

- **CCGs who admitted they do not know what s140 MHA means** – alarming bearing in mind that the section imposes a legal duty upon those organisations to ensure that Local Authorities are made aware of those hospitals in their areas which can receive patients in circumstances of special urgency. If you're not aware of it, how can you begin to think through its implications?!

- **Place of Safety services which still do not understand the implications of s136(2)** – three queries this week alone on that one, asking whether or not nurses in an NHS PoS can keep doors locked or attempt to prevent patients leaving and if so, under which laws.

- **Officers misunderstanding when warrants are required under the MHA** – if an AMHP undertakes a MHA assessment in someone's home, no warrant is required to remove that person from the premises if the AMHP has already 'sectioned' the patient. Section 6 MHA provides an authority to detain and convey and yet officers keep leaving AMHPs up the proverbial river without a paddle by responding to requests for supports with "You need a warrant!" They're laughing at us, folks! … we really don't need one. Not at all!

I could go on! … I did enjoy the one about the senior nurses in an acute hospital who fired off a snotty email about hospital security officers who declined to physically restrain and detain a patient purely on her say so. The hospital security officers asked perfectly relevant questions about section 5 MHA and the nurse couldn't satisfy them, so they declined to act. Turns out those security officers knew more than the nurses about section

5 and she ended up looking quite silly to her managers when the security manager pointed this out.

And of course, I'd have to finish with the front-line response officers who ignored the street triage nurse's advice about whether or not to implement section 136 MHA only to find another irritated reaction on email and for the officers to be vindicated. That all circled around issues of capacity that had been confused by the nurse and it's quite arguable that the confusion exhibited means the decision to use s136 was absolutely correct, notwithstanding the apparent consent of the patient who may or may not have lacked capacity.

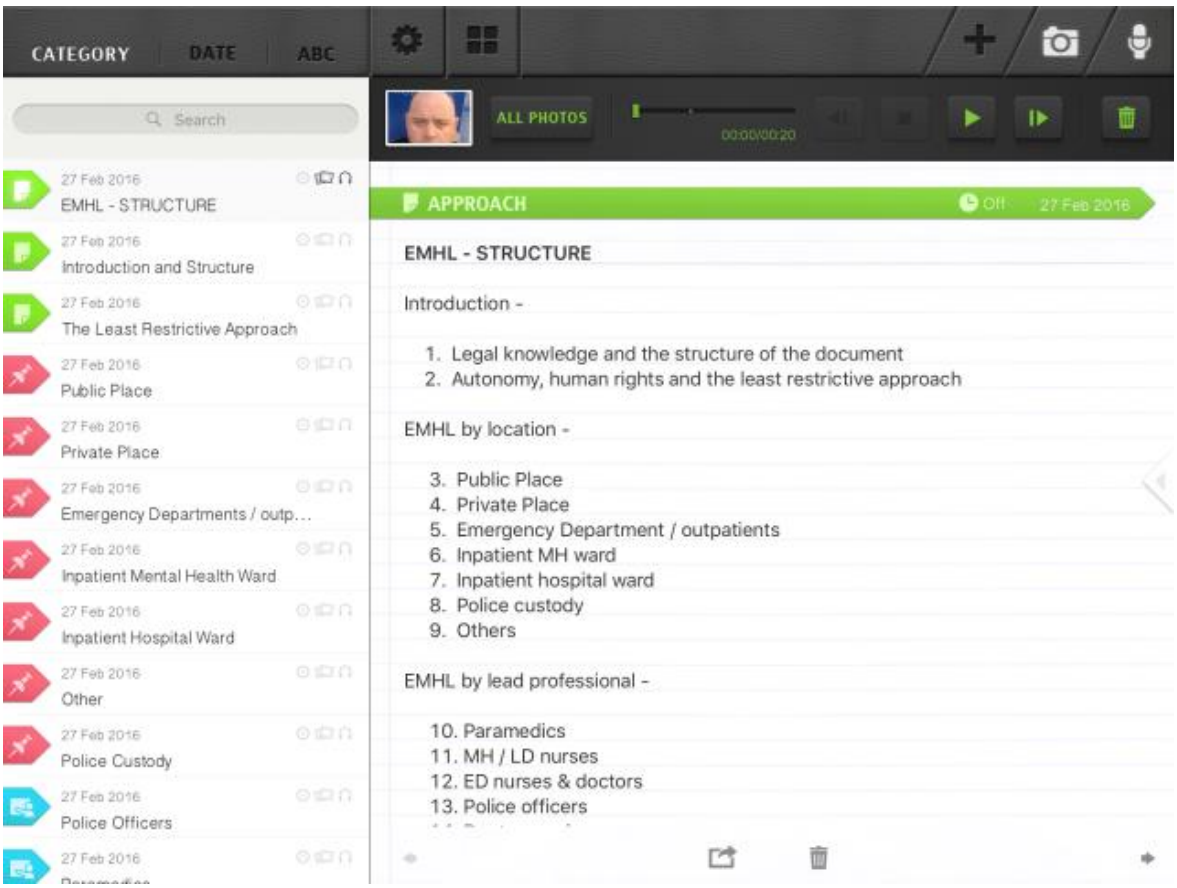
I hope I've made my point!

A NEW PROJECT

Having written those BLOGs a couple of years ago, I mentioned in a recent talk the idea of an 'Emergency Mental Health Law' syllabus that cut across those organisations who deal with mental health emergencies, especially where organisations have to interface with each other. It seemed to gain a positive reaction in a room full of NHS professionals and so I've resurrected the idea and decided to do something about it. My hope might be to get it badged by as many relevant professional bodies as possible in such a way that it would provide a common syllabus focused purely on those situations where professions come together in urgent or emergency situations with various kinds of learning materials to support it. I'm not suggesting an academic law book here: that's a bit beyond me and my music degree! – but I am suggesting there is scope for a practical document to assist front line professional improve their understanding, support their decision-making and seek further reading or information if they want it.

I suspect this will take some months, even just to write out the various sections, which I've outlined. I'm going to email this around a bit to drum up support and feedback but then attempt to flesh out the various legal considerations. My general idea is to have a couple of bits of introduction to emphasise human rights and least restriction principles, in both mental health and criminal law, before then highlighting the various laws that may apply to a situation depending on whether we look at it from the point of view of the location where it occurs or the lead professional involved. This then allows each professional to understand their limitations and their opportunities to call on another professional's support, respectively. Finally, to cover the legal frameworks themselves, including the MHA and MCA; the common and criminal law as well as human rights and health & safety.

Let's see how it goes! A couple of screenshots from my outline notes –


CATEGORY
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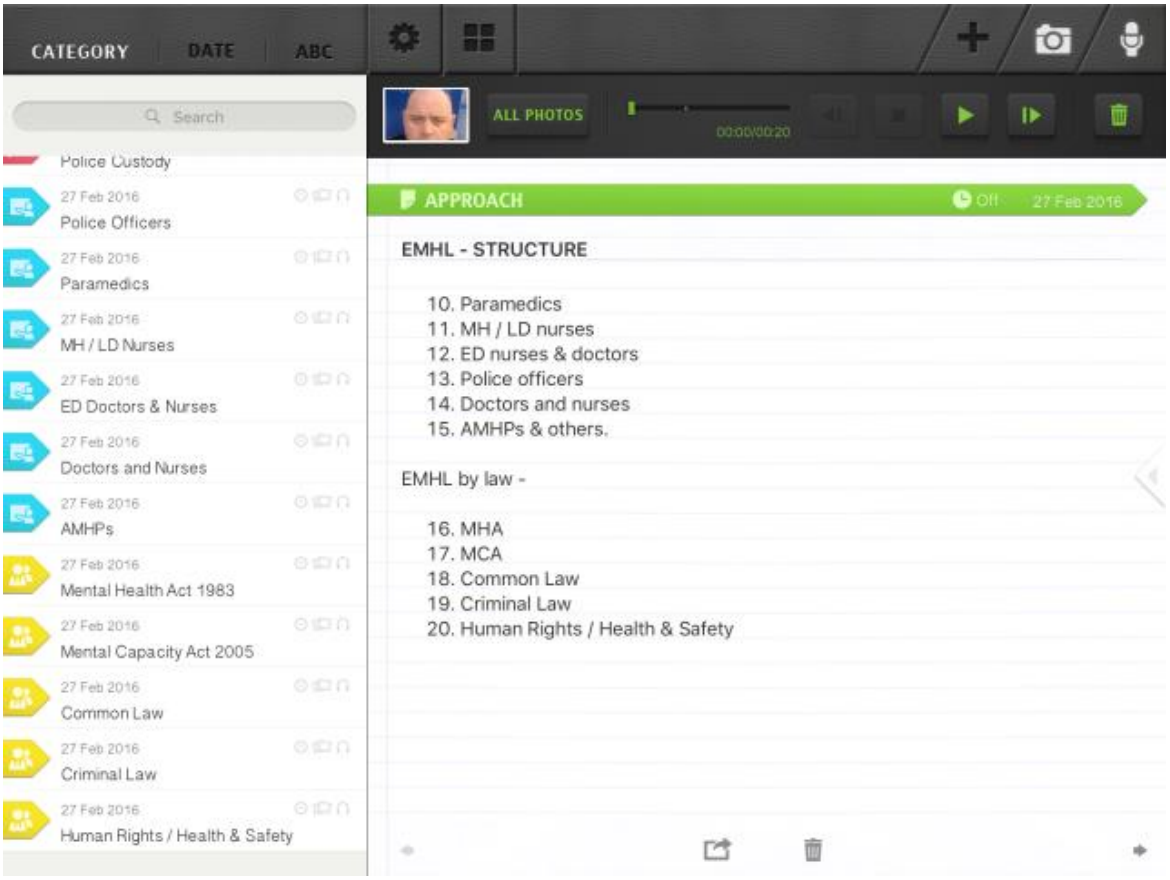
27 Feb 2016
EMHL - STRUCTURE
Introduction and Structure
The Least Restrictive Approach
Public Place
Private Place
Emergency Departments / outp...
Inpatient Mental Health Ward
Inpatient Hospital Ward
Other
Police Custody
Police Officers
APPROACH
Off
27 Feb 2016
EMHL - STRUCTURE
Introduction -
1. Legal knowledge and the structure of the document
2. Autonomy, human rights and the least restrictive approach
EMHL by location -
3. Public Place
4. Private Place
5. Emergency Department / outpatients
6. Inpatient MH ward
7. Inpatient hospital ward
8. Police custody
9. Others
EMHL by lead professional -
10. Paramedics
11. MH / LD nurses
12. ED nurses & doctors
13. Police officers


CATEGORY
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Police Custody
Police Officers
Paramedics
MH / LD Nurses
ED Doctors & Nurses
Doctors and Nurses
AMHPs
Mental Health Act 1983
Mental Capacity Act 2005
Common Law
Criminal Law
Human Rights / Health & Safety
APPROACH
Off
27 Feb 2016
EMHL - STRUCTURE
10. Paramedics
11. MH / LD nurses
12. ED nurses & doctors
13. Police officers
14. Doctors and nurses
15. AMHPs & others.
EMHL by law -
16. MHA
17. MCA
18. Common Law
19. Criminal Law
20. Human Rights / Health & Safety

8th March 2016

Police Use of Force –

The Independent Police Complaints Commission has today published its report on the Police Use of Force. As always with any discussion about the most sensitive and complicated areas of policing, mental health features heavily within in it and there are some quite revealing findings. This is just a short post to cover it, you can read the full report and its own executive summary on the IPCC website. If you want the whistle-stop tour of that document, read the summary near the start and then leap to page 55 for the section on mental health.

My first concern with all of this is the same concern I have about other approaches: talking about mental illness or mental disorder immediate invites us to believe in a clear division between those concepts and mental wellbeing and mental order,

But the headlines are –

- 20% of all use of force incidents involve someone known or suspected to have a mental disorder.
- Those of us with mental disorders are four times more likely to die after a police use of force compared to those not known to have a mental disorder.
- In fifty percent of incidents where the police use force in connection with someone who is mentally unwell, that individual was in possession of a weapon.
- Those with mental health problems were more likely to be under the influence of drugs or alcohol and to represent a risk to themselves or others.
- And nice to see a call from the IPCC for far greater investment in mental health services to reduce police contacts with mentally vulnerable people.
- **Finally, and all credit to @NathanConstable on Twitter for spotting this one –**
- The IPCC were far less likely to have concerns about the appropriateness of the force used when it was used in mental health related situations, because of the above factors.

EARLY THOUGHTS

These are quite small samples, so standard caution to small samples applies. In almost three quarters of the incidents which led to complaints or investigations, the police had been called to encounter the vulnerable person by a third-party because of a concern for welfare. This for me, links back to the broader point about the extent to which we have come to rely upon and see the police as a *de facto* psychiatric emergency service. Indeed, the IPCC calls for greater investment in mental health services precisely because of this point.

Final point, the definition used by the IPCC for 'mental health' or 'mental illness' is limited and narrow and relates "to someone detained under the Mental Health Act or if they were a patient at a psychiatric hospital. It was also relevant if the person had previously attempted suicide, was suffering from depression, or had current or historical mental health concerns." … in other words, it relies upon the current systems in policing to identify people, only some of which are supported by NHS or other screening approaches. So this report will have under-identified people who featured in complaints who match these definitions, made a choice not disclose and were not flagged by the police to third parties.

MENTAL HEALTH RECOMMENDATIONS

- R3 – Risk assessment processes should prompt special considerations around vulnerability where mental health is known to be involved.
- R4 – Training in communication and de-escalation to resolve incidents without using force.
- R15 – Forces should review their policies for attendances at hospitals, mental health units and other medical settings to minimise police involvement.

- R19 – College of Policing to devise a plan to address the recommendations from their perspective.
- R20 – HMIC to ensure that forces responses to this report feature in PEEL inspections.

Oh, and as a postscript: regarding the explanation of the legal basis for the use of force on page 1 – there are *many* more legal justifications and defences to the use of force than s3 of the Criminal Law Act 1967 and they are especially relevant to mental health and vulnerability. They include s117 of the Police and Criminal Evidence Act 1984, the Mental Health 1983, the Mental Capacity Act 2005 as well as some others. And the Human

Rights Act did not receive Royal Assent in 2000. I'll just leave those thoughts there – you're welcome.

17th March 2016

PFD Report –

Where a Coroner concludes an inquest they are entitled to issue a 'Preventing Future Deaths' order making recommendations to relevant agencies where they feel that minimises the likelihood of similar, future tragedies. The agenices are obliged to provide a response and it seems there is one heading my way at the College of Policing, following the very sad conclusion of the inquest into the death of Martine BRANDON in Hampshire in November 2014. You can see. PFD reports and learn more about the work of HM Coroners on the website of the Chief Coroner, including an annual report on their work.

Media reports have covered the background story. To Mrs BRANDON's death and the various failings by Hampshire Police for which the force have apologised and in connection with which various officers face disciplinary proceedings. The bulk of the story concerns Mrs BRANDON's detention and treatment in custody – but there is one particular aspect of the case which appears to be heading to the College of Policing and which I'm suspecting will land on my desk at some stage soon. It is in connection with the specific issue of the original grounds for Mrs BRANDON's detention at the point of arrest, shortly after she first encountered the police.

Media coverage tells us the senior Coroner criticised the decision of police officers to arrest Mrs BRANDON for possession of a knife, rather than detain her under the Mental Health Act because "Mrs BRANDON was clearly mentally unstable" and should have been taken to "a safe place".

So how do you frame guidance to help officers understand when to prioritise detention under the Mental Health Act from arresting someone for a criminal offence?

GUIDANCE

What follows in the remainder of this post is not about the particular case, because such decisions by police officers cover a whole host of situations and circumstances, often involving other considerations to those raised by Mrs BRANDON's arrest. But one of the biggest problems is that all such decisions MUST, by definition, be taken in circumstances of ambiguity and

uncertainty. No police officer knows very much for certain when making such a call and I'm starting from a premise on which I have to assume we all agree: that in some situations, police officers will be quite right to arrest a mentally unwell person for a criminal offence and manage their healthcare needs whilst under arrest. Even if such occasions are rare, we still need to be able to articulate how to distinguish them so officers know what is expected. The most obvious example is where the alleged offence gives rise to the need to exercise police powers of search and seizure after arrest for an offence: if someone has allegedly committed an offence where there would be forensic evidence, for example.

So how does one frame the kind of guidance the Coroner is calling for: where is the line between those situations where s136 MHA would be the appropriate authority and those situations where other powers should be used? – indeed, what do we need to think about as the 'normal' response to such a dilemma: do we assume such situations should be handled via the "Mental Health Act unless …" or "Arrest for the offence unless …"? I've always thought this is profoundly difficult and I addressed this very question during the early months of writing this BLOG. The media coverage of the Coroner's comments caused me to reflect on my thinking because the very example I used in that early post was very similar to this tragic incident and I argued for an arrest, not the use of the MHA.

My main reason, was about the management of risks. Most of the people that the police detain under the MHA will not, subsequently, be 'sectioned' – if the person is detained under s136 and then discharged from detention after assessment, there needs to be proper management of risks. In some incidents where threats are made, the police have a positive legal duty under human rights law to ensure risks are mitigated, including drawing such threats to the attention of those affected, if they were not already aware – so called '*Osman*' warnings. Of course one way to mitigate risk if serious threats are made, is to arrest the person for the offence and consider their mental health needs as part of the broader criminal investigation. If someone is assessed and not 'sectioned' under the MHA, which is the case for most people, then they remain in custody for investigation of the allegation.

It may ultimately be a judgement call based on the nature of the threats, the background of those involved and a whole host of other variables but I've known Approved Mental Health Professional raise concerns that officers are *too quick* to use s136 where criminal offences are involved, including an example where someone was waving a knife around. It was that example which I had in mind when writing the 2012 post after an AMHP complained about the inaction.

There is a major practical problem when guiding police attendance at mental health crisis incidents where detention or arrest is necessary –

PRACTICAL PROBLEM

Criticism of a decision not to use s136 MHA implies that officers knew or ought to have known that someone was mentally ill and still took a deliberate decision to arrest for an offence rather than the MHA. That may be the case in this example and it is not the only tragic incident where the point has been raised.

We should learn the verdict next week in a criminal trial of police custody staff following the death of Thomas ORCHARD in 2012. He was also originally arrested for an alleged offence rather than detained under the MHA and his sister Jo is quoted as believing this decision was ultimately critical. "My brother's case should have been treated as a medical crisis rather than a criminal one. He should have been sectioned rather than arrested. If this call was made correctly my brother would still be alive today." This is difficult and important stuff – but DRs don't always get this right when they have an hour or so to undertake an assessment: in some incidents, police decisions are taken far faster and without the benefit of knowing someone's background. Indeed in this case, it was observed Mrs BRANDON had no recorded history of mental illness.

So one practical thing is obvious: whatever guidance can be produced on this kind of decision, it can only be implemented where the officers involved do, in fact, suspect the person has a mental disorder. There are any number of problems with ensuring this, as I have been reminded during my last eighteen months of helping draft guidance on policing and mental health. It sometimes takes Doctors with a decade of post-qualification, post-graduate education several days or weeks to establish whether someone has a mental disorder – it can take days after certain presentations to work out that someone is actually just under the effects of drugs. Any number of other factors can influence perceptions around mental-wellbeing, including false positives from legal highs and other medications as well as false negatives such as alcohol.

We know that there have been several cases over the last few years where mental health professionals have assessed someone at a dynamically unfolding police incident and got it wrong, even with the benefit of paramedics to assist in assessment by ruling out obvious physical health indicators. We also know that this has on at least one occasion led to someone's death.

The reality that police officers, especially where they are acting independently of other agencies in time critical incidents, are not *always* going to get this right.

SOME OTHER THOUGHTS

I'm also convinced that these issues raise bigger questions about our public policy on so-called 'mentally disordered offenders' and touch on the subject of parity of esteem. Research indicates that most people who offend whilst mentally unwell are not offending *because* of their condition. Indeed, NICE guidelines on Violence and Aggression contain the statistic that this is true of only 7% of MDOs – and that statistic assumes we can, in reality, determine the difference between mentally 'disordered' and mentally 'ordered' people or offenders. So if you wanted to play the odds, you'd be better off assuming that any offence should be regarded as separate to anyone's health needs until more fully understood as being related. Legally speaking, all offenders are assume to be sane and responsible for their actions but public policy (in Home Office circular 66/90 as well as others that followed and updated it) encourages diversion from justice where this is consistent with the management of risks to the public. Without knowing too much about someone's mental health, their history of offending, how can officers weigh this decision at the point of detention? – section 136 is, in itself, a diversionary mechanism so nothing prevents this approach but it is more confidently taken the less serious the alleged offence and the less complex a person's background.

I also admit to wondering whether detaining someone under mental health law would have made the difference some have hoped for? – I accept fully, that national guidelines on the use of s136 imply there should be 'safe places' set up by the NHS for the reception and safe detention of anyone who is detained by the police and that custody should be used as a Place of Safety only on an *exceptional* basis. Reality is often *very* different. You may remember only two months prior to the death of Mrs BRANDON, the BBC's Panorama programme covered a week in Southampton police station – the very custody area where this tragedy unfolded. We saw people detained under s136 MHA during that programme who should never have been there according to these guidelines and nationally, we are still nowhere near achieving a situation where police custody is used only exceptionally. Indeed, the CQC published their report on Crisis Care (2015) which followed up on their report on Places of Safety (2014) – both of these remarked on the exclusion criteria which are all too often in place within NHS Place of Safety services, notwithstanding what is said on p8 of the Royal College of Psychiatry Standards on s136 (2011). It is often worth

remembering these things following any death in police custody of a mentally vulnerable person.

Finally, the most obvious point for me is this: regardless of the legal reason that governs someone's detention, the police have every right and arguably a duty to call an ambulance for someone they think requires it and to remove someone to A&E if that is thought to be necessary. This applies in respect of both physical and mental health and we know the volume of evidence that already exists, and guidance which already supports the notion that until otherwise declared by someone who works for the NHS:

The ongoing restraint of a mentally vulnerable person is a medical emergency.

CONCLUSION

I'm therefore left wondering whether it's the wrong way to look at things to be focused on different standards of health-screening procedures or separate pathways, as the NHS calls them, for those in one kind of legal detention compared to another? – your unmet clinical need is your unmet clinical need regardless of whether the police arrest you for an offence or detain you under the MHA; indeed that is also true of if you have been removed you from your own home in a life-threatening emergency under the Mental Capacity Act or not detained at all. Police officers would have the same duties and obligations towards anyone they think is vulnerable and the NHS is available in one way or another for anyone who needs it. The precise legal framework is potentially irrelevant, unless local NHS procedure makes it difficult to navigate – which they still all too often do and maybe that's the main point here?

APRIL 2016

1st April 2016

Mental Health and Policing Conference –

A short, functional post, to announce the national conference on Mental Health and Policing, being hosted by the National Police Chiefs Council and the College of Policing in Warwickshire on 24th May 2016.

There will be a range of speakers and as I publish this post they are confirmed to include Simon COLE, Chief Constable of Leicestershire and the NPCC Business Area lead on disability and local policing; and Christina MARRIOTT, Chief Executive of Revolving Doors. We couldn't not include Commander Christine JONES, the NPCC and Metropolitan Police lead on mental health or a joint presentation from Northumbria Police and the Northumberland, Tyne and Wear NHS Foundation trust – they are the only MH trust in the UK to have a clinical police liaison nurse, Claire ANDRE.

There will be more announcements of people I'll be excited to tell you about, just as soon as they are confirmed, in the next couple of weeks!

The conference will also include a series of workshops on the future of street triage: by the time of the event in May, University College London should have published their evaluation of the original nine pilot sites of street triage and we've drawn together three forces who have different perspectives to offer, selected to represent particular issues worthy of wider consideration and learning. As we see associated schemes in liaison and diversion developing alongside triage; as we learn more about the overlapping 999 role with the ambulance service and the challenge of providing 'triage' in rural areas, the workshops should help areas

understand the learning that various areas have gone through, to integrate emergency mental health care.

We'll also be close to the launch of college of Policing APP and training products.

That's it for now! – see the website **www.mhanp.uk** for registration and for more details as things emerge. And there is no truth at all in the rumour that the conference is in Warwickshire because it's just a short-ish drive from my house!

2nd April 2016

Trying Not To Offend –

Terminology in mental health can be an extremely sensitive business, we see a lot of discussion about it, including from Time to Change. I will admit, I do keep tripping over myself. In fact, such is the complexity of this, I don't think I've addressed the subject specifically in almost 600 posts despite this being important stuff. Language has the potential to discriminate, to disenfranchise and to demoralise so it's often sad that we often see counter-protest from time to time about perceptions of excessive political correctness with suggestions 'the world's gone mad!' – see what I did there, to make the point?! – when those of us affected by mental health problems make representations about how we describe people, conditions or responses, whether they be medical or otherwise.

I remember one of my favourite comedians, Dara O'BRIAIN, being heckled in a show by some bloke about political correctness and Dara replied, "Yes, that f*cking politically correct brigade with their … good manners and courtesy!" This rather sums up where I try to spend my linguistic time – in the territory where people affected by the language in question would prefer us to be. That having been said, it's not always easy to work out – when I first began in this area of work I remember being surprised about the extent to which terminology is carefully questioned and whilst I've not got used to it, I admit to still tripping over myself. Whilst drafting a recent document I'd used the term 'restrictive practices' several times in a paragraph and for nothing more than the sake of variety I used the term 'coercive practices', but this received a big veto from mental health professionals party to that work.

TERMINOLOGY MATTERS

So some patients doesn't see themselves as patients, some service-users object to that particular term and prefer 'patients' – once upon a time, a mental health professional commented on a draft policy document about criminal investigation and prosecution by suggesting that the term 'suspect' should read 'those accused of or at risk of offending'. That caused one hell of debate because anyone who is at risk of offending is not necessarily, yet, a suspect – that only occurs once there are reasonable grounds in law to suspect that the person has committed an offence. This 'suspicion' may not

amount to grounds to prosecute the person but if a criminal inquiry has started and is continuing, then the person may no longer be at risk of offending because they've completed what they were previously at risk of doing – but they've now become a suspect.

Is this all making sense?!

The post however, is about my exception to my norm: where I feel there is a need to insist upon certain terminology even though it is uncomfortable and down-right objectionable. I'm the first to admit there is much within our Mental Health Act to object to, being essentially 1950s legislation as I've previously shown. I have a particular dislike for phrase used in s135(1) as one of the grounds upon which a warrant under that section may be sought to search a premises and potentially remove someone to a Place of Safety: it sub-section refers to someone 'kept otherwise than under proper control'. I know what it's getting at, but we must be able to come up with a more appropriate way of describing a vulnerable person at risk?! Whether or not anyone is trying to do so, that's the phrase AMHPs and police officers currently have to work with and understand, because that's what it is in the Mental Health Act.

Paraphrase that at your peril, especially if you're also doing the six or seven other individual, component parts of the sub-section and trying to piece together what it all means. Re-phrasing or paraphrasing things risks a change to the precise meaning of words that can affect decisions. It is only where this risk is present that I think I change my approach about terminology.

EXAMPLES

Two real examples for you –

- Where the police have detained someone under s136 of the MHA – or for that matter under ss18, 35, 36 , 38 or 138 MHA – that person has been **arrested**, in law. Not arrested for an offence, obviously – but arrested nevertheless. This is precise legal terminology and it then affects other matters, like the powers available to search someone after arrest in order to keep the situation safe. We need police officers to understand these sections of the MHA are preserved powers of arrest under s26 and Schedule 2 of PACE because it helps officers understand what rights and protections are then afforded to the people they've arrested and it informs officers' decisions about managing safety, post-arrest. You cannot search someone for implements that may cause you harm if you haven't arrested someone – telling officers that "section 136 is not an arrest!", as some mental health professionals have, risks causing confusion on

rights and authorities, post-arrest. Of course, none of this means the police run up to vulnerable people in crisis and say "Hands up – you're under arrest!" – language used should fit the circumstances and be sufficient to allow someone to understand without frightening or antagonising them. But officers need to know the legalities in their head, so they properly handle the fact that detention, arrest or whatever you'd prefer to call it is fundamentally a legal process that removes someone's liberty and affords further opportunities as well as responsibilities.

- There was discussion on Twitter today about autism and in particular whether the terminology 'mental disorder' or 'mental health' applies to it. Of course, I'm aware that autism and Asperger's are more usually described as neuro-developmental spectrum conditions and that the terms *mental health* and *learning disabilities* are objected to from the point of view of classifying conditions. But from a **legal** point of view, it is important than police officers, lawyers and courts understand that autism is a condition that comes within the definition of mental disorder that we see in s1(1) MHA, not least because autistic victims and suspects are entitled to certain safeguards if they come in to contact with the criminal justice system. Someone with autism or Asperger's would be considered for vulnerable or intimidated witness provisions, potentially removing the need for them to give evidence in chief in court, if they were robbed or assaulted, for example. In custody, someone with autism would be entitled to an appropriate adult to support them whilst in the cells and in interview – you're not entitled to this under PACE because you are recognised as having a neuro-developmental condition in medical terms, but because such a condition means that someone is 'mentally disordered or otherwise mentally vulnerable', in legal terms. Again, the language is far from ideal – I get it! But we need to keep in mind the difference between medical / scientific terminology and legal terminology and why professional terminology is often important.

Does that make sense?!

SO WHAT'S THE POINT HERE?!

Somewhere in today's debate I was firmly told, based on things I'd said, that I really didn't understand autism. I admit to being rather surprised that this came as a shock or was considered a major criticism – I am a policeman! I don't particularly understand lots of things and I will never, ever have much more than a lay person's understanding of the variety of conditions and disorders that the police encounter and only to the extent that it helps me understand how to do my job. Like most police officers, I've got my examples of where consultant psychiatrists with twenty years

of post-qualification experience and education get things wrong around responding to someone experiencing an acute psychotic episode – given that we know this will happen, to what extent is it reasonable to think police officers can get bombproof around a particular condition that even advocates describe as 'invisible'. Mistakes and oversights made in good faith are somewhat inevitable.

But the legal terminology exists precisely because the language on mental health or mental disorder is very, very far from settled. Over the years, I've been told that dementia is not really a mental health problem, but an organic brain disease. Anyone who has suffered a brain injury, in a car crash for example, is not 'mentally ill' in the sense usually meant when we reference to someone with schizophrenia but even that is a condition that once led a Professor of Psychiatry at Cambridge (no less) tell me in a lunch queue, "Schizophrenia isn't really a disease, you know?" So there is a sense in which the police being fairly practical people who have to keep policing whilst all this erudite debate continues to evolve, need to keep it simple.

When they meet a person with any of the conditions or injuries, syndromes or disorders that I've named in this post, they need to be able to say whether that means someone is 'IN' or 'OUT' for the purposes of whether they can use section 136 of the Mental Health Act to keep that person safe when they otherwise wouldn't be. If that approach doesn't sit easily with the medical / scientific system then perhaps we just need to remind ourselves that police officers are usually making legal decisions of one kind or another because outside those situations, interaction with the public cannot be presumed to sit astride a guarantee that someone's medical background is known or knowable – the best you might be able to expect is that officers are attempted to de-escalate situations and to communicate, clearly and professionally with whoever they've encountered, regardless of whether they're vulnerable or not. So nobody here is trying to offend anyone else, but merely to be legalistic and realistic about can be achieve – and why we need to be clear about the language we use when playing with the rights of vulnerable people.

7th April 2016

Section 136 in Private Premises –

You'll remember that the Home Office introduced a Bill to Parliament in February 2015 to make various reforms to policing itself and to laws affecting the police and I did a short BLOG post on the topic? Amongst other things, the Policing and Crime Bill 2015 will amend police powers under the Mental Health Act 1983 in various ways and the Home Office summarised them in a press release when the Bill was first introduced. Consistent with the 2014 joint Home Office / Department of Health review of the operation of ss135/6 of the Act, the press release told us the Bill proposes to widen the use of s136 by "extending police officers' powers to act quickly to detain and remove people experiencing a mental health crisis from any place **other than a private dwelling** [my emphasis] (for which a warrant would still be required)."

Well, I eventually got around to reading the Bill itself in far more detail than I previously have and I'm not quite so sure that's what it says! Please help me think this through …

THE FUTURE ONE, THREE, SIX

If you read the words proposed to substitute the current arrangements, s136 of the Mental Health Act 1983 in the future will seem somewhat different. This is all contained within clause 59 of the Bill, (on page 75 of the PDF when you open it) –

"**Section 136(1)** – *if a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—*

(a) remove the person to a place of safety within the meaning of section 135, or

(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety."

So where does that say anything about dwellings, whether they be houses, flats or rooms? This new version just doesn't mention anything about where this power may be exercised, implying it can be used anywhere. Location is not mentioned in the newly proposed s136(1A), if that's what you ended up looking at because that sub-section will relate to powers of entry *only;* the question of where or whether a power can be used is separate to whether or not officers have a right to force entry to a premises *in order* to use that power –

"**Section 136(1A)** – *the purpose of exercising the power conferred by subsection (1), the constable may, if need be by force, enter any place where he or she believes the mentally disordered person to be, other than—*

(a) any house, flat or room where that person, or any other person, is living, or

(b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms."

The new section 136(1B) relates to the proposed requirement that officers consult a mental health professional before using s136 (raising questions about the meaning of the words 'immediate' and 'necessary', but that's a separate matter!); and clauses 60-62 relate to amendments other than to the detention power itself: those relate to things like what is a Place of Safety in law; who may detained in which PoS and the timescales for overall detention. Nowhere else in clauses 59-62 does it discuss dwellings: whether they be a house, flat or room.

WHAT DOES THIS MEAN?

This appears to mean, if a police officer is already lawfully in a house, flat or room or if they have another legal basis to enter it (like s17(1)(e) of PACE to save life and limb), **they will be able to use s136 to detain someone**. If you read this stuff and then believe I'm wrong about this, please say so in the comments below – but *please tell me why* I'm wrong. I can't see anything in these clauses to suggest I am.

The use of section 136 could *more than double* after this Bill takes effect in its current form. Even more difficult still, that increase would occur just as the other amendments in the Bill mean police stations can be relied upon far less than they are at the moment. We currently see 20% of people detained under this power taken to custody so we're *already* (or still?) struggling to make the use of custody 'exceptional' when we have 25,000 vulnerable people detained per year. If there were 50,000 or more detained, the NHS would need significantly more capacity in their Place of

Safety of provision and they'd need to be looking at that **now** if it is to be ready for the Bill to potentially receive Royal Assent in 2017.

We can imagine other implications: forces will want to think about their own policies and their joint operating protocols because they could then, in theory, be proactively asked to attend a private home in order to utilise these powers. What I've seen happening with street triage initiatives makes me believe this is a very real risk. I wonder whether CrisisTeams, who've seen an uplift in their referrals whilst experiencing a cut in their resources, might think such an expanded power is a new way to shortcut the MHA assessment process, assuming officers could gain lawful entry without a warrant? We know they can view triage as an extension of their own service, to be tasked with crisis care work without reference to whether there is a policing purpose within the referral – why wouldn't they do it, if they're struggling for resources or unable to cave AMHPs for assessments?!

I hope I'm not wrong or confused about what I've read – but we could do with finding out if I am and whether the apparent change between the press release and the Bill itself is a change of approach or a drafting error. Otherwise, we risk some *very* unexpected things in 2017 for which we haven't planned and prepared at all.

Update 08/04 *– I have contacted the Home Office about this: they have referred this observation back to their lawyers and those who draft legislation because it is their intention to ensure s136(1) is restricted to private places but* ***not*** *including a house, flat or room where that person lives.*

12th April 2016

The Namibian –

The following opinion piece appeared in the Namibian newspaper on 12th April 2016. It follows the Namibian Correctional Service re-running training on mental health for their staff after the pilot programme I ran in Namibia during 2015. It was slightly edited by the newspaper as these things are, here is the full version –

THE NAMIBIAN OPINIONS TUESDAY 12 APRIL 2016 7

No Health Without Mental Health

• MICHAEL BROWN

THE first step towards solving a problem is recognising that you have a problem in the first place, it is said. Mental illness can still be a taboo subject in some parts of the world, and those living with mental illnesses, neuro-psychological disorders and intellectual disabilities still find themselves stigmatised, marginalised and criminalised because of their problem. We know that people with mental health problems all over the world are disproportionately represented at all stages of the criminal justice system (CJS), and that this problem is not just about the availability of healthcare.

The United Kingdom may well be a G8, so-called first world economy, but a high proportion of those who are imprisoned there – well over three-quarters – are diagnosed with one or more mental disorders, and most criminal justice professionals will remark on the difficulty of ensuring support for them by mental health agencies.

All countries need to appreciate the extent to which vulnerable people, already marginalised by their disability, are then doubly stigmatised by police and prison systems. But where they are, criminal justice system agencies need to avoid compounding that, and are well-placed to do so.

It was the highlight of my career so far to visit Namibia in November 2015, and to train correctional service and police officers. I learned more than anyone else, and it kept striking me again and again: we're all struggling with the same issues – how do we improve the identification of vulnerable people amongst all those we meet? When we do, how do we improve the quality of the response by making reasonable adjustments for disabilities? How can we work best in partnership with whatever mental health and social care services we have available to minimise the negative impact upon mentally-ill suspects and prisoners, and to maximise the chance of rehabilitation and recovery?

We need to break down some myths:

• Most people with a mental health condition in conflict with the law have not offended as a direct result of their condition. Research suggests fewer than 10% of mentally disordered offenders (MDOs) would be found insane – this is a legal, not a medical term: it differentiates MDOs who did not know what they were doing from those who did. That said, it may well be in the broader interest of the public that vulnerable people are not unnecessarily criminalised, except where this protects the public.

• The second myth is that the ideal response to mentally disordered offenders is hospitalisation for mental health treatment. Psychiatrists and psychologists sometimes talk about 'therapeutic jurisprudence' and the importance of social boundaries on acceptable behaviour. In other words, it may be the right response to punish and deter through sentencing, and then focus on rehabilitation and recovery, as with every other convicted criminal.

What does this mean for Namibia's police and correctional services? Firstly, those police officers working hard 24/7 to keep us safe should not view vulnerable people with mental health problems as an inconvenient problem who are solely the responsibility of mental health services.

These issues are 'core police business', to quote Lord Adebowale's major UK report (2013) on policing and mental health. There are vulnerable people all over the world alive today because a police officer handled a difficult situation appropriately when someone in crisis was threatening to harm themselves, or less often, others.

It means that police and correctional service officers have a role to play in keeping people safe on remand and after sentencing, even where they are SPD (sensory processing disorder) prisoners intended to be cared for in a hospital. They can still make a positive difference to safety and well-being from the way in which they assess risk, monitor and react to individuals as professionals – senior leaders across the criminal justice system have a responsibility to ensure their organisations are ready for this: a point Namibia has already reached, putting them well-ahead of the game in Africa.

Both Namibia and the UK are signatories to the United Nations Convention on the Rights of Persons with Disabilities, and one area where mental health and criminal justice agencies share common ground is that they have a lot of contact with vulnerable people and a shared interest in keeping people and society safe.

There must be a shared approach to the overlapping areas of responsibility, but there is no reason why improving partnerships in the local context can't be led by the criminal justice system.

The Namibian Correctional Service has done exactly that by reusing the training materials we developed last year to roll out further training to staff in 2016 on this most important of topics: there's no health at all without mental health.

• Inspector Michael Brown is the mental health coordinator at the UK College of Policing and a serving officer with West Midlands Police.

Michael Brown

The first step towards solving a problem is recognising that you have a problem in the first place, it is said. Many societies don't see open discussion about mental health issues or understand the extent to which people with disabilities are affected by their criminal justice systems. Mental illness can still be a taboo subject in some parts of the world and those of us living with mental illnesses, neuro-psychological disorders and intellectual disabilities still find themselves stigmatised, marginalised and

criminalised because of their problems. We know that people with mental health problems all over the world are disproportionately represented at all stages of the criminal justice system (CJS) and that this problem is not just about the availability of healthcare.

The United Kingdom may well be a G8, so-called first-world economy but a high proportion of those who are imprisoned there – well over three quarters – are diagnosed with one or more mental disorders and most CJ professionals will remark on the difficulty of ensuring support for them by mental health agencies. All countries need to appreciate the extent to which vulnerable people, already marginalised by their disability, are then doubly stigmatised by police and prison systems. But where they are, CJS agencies need to avoid compounding that and are well placed to do so.

It was the highlight of my career so far to visit Namibia in November 2015 and to train Corrections and Police officers. I learned more than anyone else and it kept striking me again and again: we're all struggling with the same issues – how do we improve identification of vulnerable people amongst all those we meet? When we do, how do we improve the quality of the response by making reasonable adjustments for disabilities? How can we work best in partnership with whatever mental health and social care services we have available minimise the negative impacts upon mentally ill suspects and prisoners to maximise the chance of rehabilitation and recovery?

We need to breakdown some myths –

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- The second myth is that the ideal response to mentally disordered offenders is hospitalisation for mental health treatment. Psychiatrists and psychologists sometimes talk about 'therapeutic jurisprudence' and the importance of social boundaries on acceptable behaviour. In other words, it may be the right response to punish and deter through sentencing and then focus is then on rehabilitation and recovery as with every other convicted criminal.

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"core police business" to quote Lord ADEBOWALE's major UK report (2013) on policing and mental health. There are vulnerable people all over the world alive today because a police officer handled a difficult situation appropriately when someone in crisis was threatening to harm themselves, or less often, others. It means that Police and Corrections officers have a role to play in keeping people safe on remand and after sentencing even where they are SPD prisoners intended to be cared for in a hospital. They can still make a positive difference to safety and wellbeing from the way in which they risk assess, monitor and react to individuals as professionals – senior leaders across the CJS have a responsibility to ensure their organisations are ready for this: a point Namibia has already reached, putting them well ahead of the game in Africa.

Both Namibia and the UK are signatories to the United Nations Convention on the Rights of Persons with Disabilities and one area where mental health and criminal justice agencies share common ground is that they have a lot of contact with vulnerable people and a shared interested in keeping people and society safe. There must be a shared approach to the overlapping areas of responsibility, but there is no reason why improving partnerships in the local context can't be led by the CJS and the Namibian Correctional Service has done exactly that by reusing the training materials we developed last year to roll out further training to staff in 2016 on this most important of topics: there's no health at all without mental health.

13th April 2016

Medical Factors –

For as long as I've worked in this area, the issue most often highlighted to me as being the one where the police, probably need to improve has been that of criminal investigation of hospital inpatients where they have allegedly assaulted NHS staff. There has been some recent activity on this issue and those of you attending the College of Policing's conference on 24th May in Warwickshire will have the chance to hear more about it from NHS Protect, the organisation who oversee many of the security and assault issues in the NHS. NHS Protect have released annual statistics on assaults in the NHS for many years, the most current detailed format of them having been around for about five years, thus their recent five year summary document.

One thing that has long interested me in the format of data recording is the requirement over the last five years or so that following an incident of alleged assault in the NHS, there should be an indication given of whether or not it was believed to be an assault 'involving medical factors'. First of all, I'm interested in what this means: if a drunk man is being treated in A&E for a suspected broken arm after falling down following a gallon of something invigorating, does it involve medical factors if the lashing out was a direct result of staff manipulating his injured arm during the process of assessment, accidentally causing pain to him that he wasn't expecting? Repeat that story with a dementia patient who is not intoxicated and doesn't it change anything?

The NHS Protect's definition of 'medical factors' is more or less the legal definition of insanity, "That the person did not know what they were doing or did not know what they were doing is wrong owing to illness, injury or mental disorder." So let's see what the NHS Trusts themselves say about their assaults, because it's extremely interesting and it has the potential to affect investigations. If you haven't already worked it out, you'll see by the end that I'm arguing the definition of medical factors isn't one that helps the interface with the police and it isn't one that's gets NHS staff to where the NHS seems to want to be, when thinking about what to report.

NHS MH TRUST DATA

West London Mental Health Trust and Cheshire and Wirral Partnership Trust each reported in the latest statistics that *all* of their assaults involve medical factors: that none of their patients knew what they were doing when they assaulted staff – or if they did, they did not know it was wrong because of their condition. Meanwhile in other news, Nottinghamshire Healthcare and Oxleas NHS Foundation Trust believe that *none* of their alleged assaults involved medical factors – all of their patients knew what they were doing. How likely is it, in major mental health trusts, that all of these returns to NHS Protect are correct?! … what is the major difference between the service users of Ealing and Greenwich that puts them poles apart?! I don't believe it, quite frankly. When the latest data came out, I mentioned some of this on Twitter and to their credit, Nottinghamshire Healthcare responded to being tagged and invited me to email them. Suffice to say, they deliberately don't answer the question at all – they didn't say why – and this shows up in the return as a 100%, 'no medical factors' report. I didn't get a response from the others.

So the next time a West London mental health nurse is punched and as part of the inquiry the investigating officer asks the question about medical factors and how that will be recorded in SIRS (NHS Protect incident reporting IT), it could – potentially – undermine efforts to prosecute. It also means that if investigations are being conducted by the same Metropolitan Police detective in Ealing and Greenwich, he or she will be about as confused as they ever hoped to be about what on earth is going on! As part of the investigation, is it not relevant to overall considerations that someone with clinical qualifications in the organisation the victim works for is saying that the accused person did or did not know what they were doing or did not know what they were doing was wrong? … how could it not be relevant?!

Meanwhile in the other trusts, are we potentially opening up the possibility of criminalising people who have been recorded as not having a relevant medical factor, when in fact, they do? … where is the middle ground and the likely reality? The NICE Guidelines on Violence suggest that less than 10% of mentally disordered offenders have offended as a *direct* consequence of their mental disorder. One of the Oxford Pocket Handbook series for doctors says that "most people who are violent need a policeman [sic] not a doctor" – of course, a different way of saying the same thing is that some people who are violent need a doctor not a police officer, but that determination is where the heart of this stuff is presumed to be. It strikes me that trusts like Birmingham & Solihull NHS foundation trust may have it right: their data more or less reflect this idea that in 10% of cases, the suspect may have offended as a direct result of their condition.

PRESUMPTION

Of course, if we're getting into the more interesting and high-hanging fruit of this debate, whether or not someone knew what they were doing is not always the crucial factor. If a s2 patient in an acute admission unit stabs a member of staff with a weapon, we can safely say they'll be going to court soon – if they were legally insane, this is something for them to raise in court as a defence and it then still allows the court to consider disposals under Part III of the Mental Health Act and to secure reports from forensic psychiatrists and to impose remands or interim orders ahead of deciding the final outcome. Whereas if they'd pushed a nurse without causing any injury, whilst being secluded and still acutely unwell, if they did not know what they were doing was wrong, we're far less likely to see charges brought.

I often wonder whether we're over-simplifying things: I also wonder whether we're over complicating it – as has always been the case with any criminal investigation into the alleged culpability of a suspect who is detained in a hospital, we're attempting to establish whether a fist hit a face and whether or not we can prove the person who did it was intending to hurt or injure the person they've struck. (For the pedants, that last sentence was intended to paraphrase and generalise about the mens rea for *all* assaults – I understand it's more specific than that, depending on the precise allegation!). The insanity concept is helpful to pre-emit issues of *public interest* but only where *public protection* is not at risk.

This stuff matters because the police do, in my opinion, need to get better at investigating criminal offences involving those of use who live with mental health conditions but we know they need background information and opinion from the NHS to help that along. We know that the attrition rate in the criminal justice system for victims with mental health problems is worse than for victims generally: and yet we also know that those of us with mental health problems are more likely to be victim of crime in the first place. But the suspect stuff is – in my own opinion – the most interesting sub-topic in all of policing and mental health:

When is it appropriate to criminalise a person for an action that was committed whilst they were mentally disordered to such an extent that they were liable to detention in hospital under the Mental Health Act?

14th April 2016

High Hanging Fruit –

This is really difficult post – and it's necessary because I've often thought in policing and mental health we spend a lot of time avoiding the really difficult conversations and picking the low hanging fruit. I would argue that much of the time spent discussing Place of Safety provision, street triage schemes and liaison and diversion services: they are all examples of the low hanging fruit. I recently watched a person in a meeting have s moment of clarity that some fruit hangs higher and brings in to view a whole host of debates – I want to highlight some of them. The one I'm not going to mention here, because I intend to cover it soon, is that all those low hanging initiatives are ways of avoiding the discussion about how the will or capacity to intervene early has been lost and that this is measured most keenly in the extent to which people are criminalised. More on that next week.

I heard recently that one area has more or less abandoned its Crisis Care Concordat (CCC) plan, just over two years after the Concordat was published and made subject to an overview process via the mental health charity, Mind. We recently saw publication of the final evaluation report of the CCC, and I think it's fair to describe it is 'mixed'. I don't think many people seriously doubt that the whole agenda has been a positive step in bringing together organisations who, in some areas, didn't have an effective relationship. But getting together to chat about stuff and write it down, doesn't make it happen and I think that summarises my view of the problem with it. My son has got a massive Christmas list on standby for December 2016 and we already know that no amount of careful handwriting is going to see him own those items come Christmas!

I remember asking police forces about the CCC when I first arrived at the College of Policing and received various emails saying, "They won't talk to us – they're not interested" and so on. The number of those replies have dissipated over time but the police seem reassured that the lower hanging fruit is being gathered. I hear many mental health trusts and many forces highlighting what a good relationship they have and how important it is to work in partnership. Indeed, it has long since been my experience that where you start a conversation about the details of particular aspects of partnership work, in an effort to ensure that it works *properly*, you are often reminded of the importance of partnerships if the police part of that discussion is not willing to accept a status quo where they are committing

more resources than they should be, because of NHS choices not to do what we all agreed they would.

I'm sure an example would help! –

POLICE POWERS AND DUTIES

Recent work on calls for police responses to inpatient mental health wards have led to discussions about staffing levels in the NHS – you may remember that NICE have stopped work that Government originally asked for on what constitutes safe staffing levels. Some mental health inpatient wards are occasionally not staffed in such a way as to ensure they could take care of those predictable aspects of being a mental health service provider. The RCN point out it is often not unusual to find 3 nurses during the day and 2 at night for a ward of 15 patients. (I do understand that not all available staff are nurses, there may be others available, too). But given that restraint can involve five staff, how do you do it? In some areas, anything that is known to be necessary occurs at shift change when double staff are available.

Accepting that not all wards involve similar levels of 'therapeutic security', these restrictive functions are usually understood to be –

- preventing people who are legally detained from leaving,
- being able to administer medication under Part IV of the Mental Health Act;
- secluding a patient or transferring them between wards and units.

It is an inherent risk of running an organisation that detains other people against their will and occasionally forces medication and location transfers upon them, that some patients will object and resist – I'm genuinely unable to see it any other way. I remember the occasion as a duty inspector running a 999 response team where we were contacted around 6pm to be asked if officers could attend a ward at 8pm to restrain a patient for medication because they were insufficient staff. The answer was, of course, that we couldn't and the caller was advised to start ringing their managers to escalate any staffing problem they had. No current disorder or disturbance, no immediacy required – not something that needs to involve the police, assuming the organisation has the right plans in place around those functions listed above.

But this is really awkward isn't it, as it starts to edge in to difficult ethical and legal territory? … in recent work, which has involved the College of Policing asking an independent QC to give legal advice on police powers and duties in these contexts, one question in particular arises about whether the NHS should be calling the police to wards to assist in

preventing an assault if a patient is becoming disruptive; or is likely to be resistant and aggressive where staff must attempt to seclude, transfer or medicate a patient. It's hard to resist the fallacious lure to answer the question that has been posed to me several times recently, "Does a nurse have to be assaulted before you'll come, then?!" … it sounds like a relevant question, doesn't it? If you say "Yes", you'll be slaughtered for appearing to countenance NHS staff being attacked during their work – which we all agree is an outrage – and if you say "No", you open up the police to attending incidents that the NHS should be handling with sufficient staff who are trained and, if necessary, equipped. Obviously, I'm referring here to those functions that are obvious implications of the work these trusts do in circumstances where they have greater powers to handle the situation than the police (if the police have any at all).

It is slightly clearer where there has already been an unforeseeable incident that involves significantly raised threats and / or an obvious criminal offence: if that patient were in possession of a weapon or something that could be used as one upon return from authorized leave, the risks are higher and it's more obviously a police responsibility to become involved – that would be the case in any hospital or location. It is a challenge to draw any kind of distinction between what is a foreseeable NHS responsibility and what could occur within a hospital that amounts to a police responsibility – but it can be done. It seems to be when we get in to the territory of attempting to define* these thing, we often hear that legend rolled out that we have to keep making sure we work in partnership, like the CCC says. I admit to feeling that this is often a euphemism for "can you please make sure you keep doing certain things that we know are not your responsibility?" I can't help but wonder whether this is because of the cost of ensuring safe staffing levels – I admit I'd love to know why NICE stopped this work where it relates to mental health.

PERCEPTION

More than once I've known NHS managers describe their partnerships and relationships with the police as extremely positive: you only need to look around various social media platforms to see evidence of this. I admit to wondering on occasion, whether the closeness can create a blindness? One NHS manager recently told me that their relationship with their police force on s136 and Places of Safety was 'perfect' – they have meetings, they're on first name terms, they have each other's mobile numbers and can ring at any time to discuss problems and solutions to problems: it's just perfect. That person looked stunned when I said that I doubted it.

I'm sure the relationship is courteous, good-humoured and professional and it can't be a bad thing that there are open channels of communication between senior operational managers, but if the Chief Constable is still

staffing unstaffed NHS Places of Safety and frontline officers are moaning about being bounced around the county looking for an PoS premises that will accept them and have to remain there with low risk patients for almost 24hrs (real example), it seems we need better insight in to what is going on. Things seem far from 'perfect'. I do wonder whether there is a CCC plan that has moved an area forward on this particular issue, or on inpatient ward staffing levels to reduce calls on the police to coerce patients? Is there a CCC plan that means police officers or paramedics attending crisis incidents in private premises that can only be realistically solved by an AMHP pitching up rather quickly with a s135(1) warrant and a DR can access those people and those mechanisms in a timescale that isn't edging towards the geological?

This is some of the high-hanging fruit which the CCC agenda may highlight or document, but which it often doesn't address. If CCGs don't commission services in a way which allows for sufficient NHS staffing to detain or restrain and medicate or transfer patients on wards, to what extent is it a role for the Chief Constable to undertake bearing in mind he or she will usually have no legal duty whatsoever to do so? The answer to the question "Do we have to wait until …" is that NHS organisations have legal responsibilities to patients, staff and anyone else who enter their premises (including to police officers and paramedics!) to ensure safety by mitigating foreseeable risks. And 'foreseeable' in this context doesn't mean that the risks we're talking about are only those which will be frequently occurring.

THOUGHT THINGS

So here's the challenge, in a thought experiment –

An incident occurs on a ward where an assault is threatened by a patient who is acutely unwell, unless staff allow him to leave. When this is refused during an attempt to de-escalate the situation, he attempts to force open the doors of the ward and leave. Staff manage to get him away from the door and ring 999 for the police. Upon arrival, they are not raising a criminal allegation around the man's behaviour or conduct because it is recognised that he remains psychotic after a recent admission under the MHA. The unit is staffed by too few nurses to undertake these functions and in any event only one of them is trained in restraint to a level that is beyond their basic, 'breakaway' training (to maintain their own safety).

The request of the police could be to restrain the patient for medication or to help move him to another ward or unit where there is an available seclusion room. Either way –

The police arrive and contain the situation by surrounding the man on the ward, attempting to engage him in discussion thereby preventing any

Breach of the Peace or criminal offence – order restored without any ongoing need to actively restrain him. The senior nurse or doctor makes the request (to restrain and / or transfer) and the senior officer declines to do so, arguing it is an NHS responsibility to administer the Mental Health Act but they will remain to prevent control being re-lost whilst NHS arrangements are made. The lead clinician states they do not have staff available to them and the police suggest contact with their on-call senior manager to make the necessary decisions around these responsibilities.

What is that police officer doing wrong, *legally* speaking, bearing in mind they don't work for the NHS? It could be argued – and just to be clear, I am arguing it – that the police re-taking control of a situation and containing it whilst affording time for NHS arrangements to be marshalled is as far as legal duties upon the police extend. (Subject to any duty that arises to criminally investigate any alleged offence, which most usually will not necessitate an *immediate* arrest and which returns us to the main dilemma.) Any interruption of this principle should only be where the action is literally time-critical and cannot otherwise occur. In such situations, the police can refer the situation after the fact, including to the CQC who carry oversight responsibility for Health & Safety issues in the NHS. Happy to hear why I'm *legally* wrong, in the comments below.

Difficult stuff, isn't it?! – that's why proper partnerships need to be about the difficult discussions that I think we're busy not really having and which are based on organisations' *legal* responsibilities, not evolved custom and practice which we know has gone badly awry in the past, costing real lives.

** I was once accused by an AMHP of **re**defining policy on police attendance at MHA assessments with regard to situations where s135(1) warrants are required. Notwithstanding that my supposed views had been mis-represented, I made the point that this wasn't an attempt to re-define a policy, but merely to create one in the first place. There were no national guidelines on MHA assessments and s135(1) warrants until 2010, the same is true of the topics covered in this post.*

We've evolved our practice based on unagreed assumptions about roles and powers – enough people have been injured or worse to mean we now need to correct all conditions and that's what I thought the CCC was all about.

16th April 2016

What Cost Progress? –

One of the main reasons the Home Secretary emphasised that we need to make progress on policing and mental health is to free up police time to concentrate on other issues – mainly around the broader crime prevention agenda. I don't think she is trying to imply that police time so the most important thing in the world or that there is no overlap at all between mental health issues and core police functions. She just seems to be making the point that the police time committed to this overlap is considerable and could very obviously be reduced. So various things have been happening to deliver progress on this under the overall banner of the Crisis Care Concordat agenda. It certainly can lay a highly intuitive claim to some impressive results –

- reliance upon police stations as a Place of Safety massively down since 2010, from over 11,000 to the cells down to about 4,000;
- the overall use of s136 MHA in street triage areas massively down, typically by 25-33%; and
- overall satisfaction of those professionals and members of the public who have experience of this stuff seems to be up.

What's not to like?!

One of the main problems is that we need to fully analyse this to understand whether or not the 'progress' we claim is actually just making this problem worse, from the point of view of police time. If it is, it raises some interesting public policy questions for us all.

Before I get in to details, I want to make one thing clear: progress at the interface of mental health and policing is not and should not just be about saving police time. The service benefit to the public is obviously more important and nothing is free of cost or unintended consequences. Improving the experience of vulnerable people who come in to contact with the police is about far more than the amount of time the police will expend and I will highlight some examples where it will quite rightly involve greater time and effort. But what follows are mainly examples of where, in an effort to *save* time and resources, we've managed instead to *spend* time and resources. It begs the question: if we have also improved the experience of those vulnerable people for whom the police have had to provide a response, to what extent should a Chief Constable be paying – quite literally

– to improve that crisis pathway to assessment and care for vulnerable people? My final caveat on this post, is that we still don't have proper data on this stuff – people saw fit not to collect it, notwithstanding that they were advised, so I'll try to bear that in mind as I am inevitably forced to generalise and over-simplify!

PLACE OF SAFETY

In an ideal world, your local police officers will use s136 responsibly and correctly, leading to the removal of vulnerable people to a Place of Safety only where necessary and that person will be handed over to the NHS within half an hour for assessment and the police will leave. Such a process doesn't happen anywhere in the United Kingdom, to my knowledge, but it's what we all agreed to in the Royal College of Psychiatry standards on s136 which were published in 2011 and were slightly updated in a guide to NHS commissioners in 2013. Always amazes me that our NHS can transplant human organs and knows what will happen tomorrow if there is an Ebola patient, but we don't know how to staff a building to accommodate a vulnerable person in crisis for an assessment of their needs and we certainly don't know where they will go tomorrow afternoon if they've also consumed half a bottle of vodka to quieten the voices in their head.

Less than a decade ago, 66% of the 18,500 people detained under this power were taken to police custody; and none of the 33% who were spared this indignity benefited from a service that worked according to the national standards, referred to above. Since then, 'progress' means we now see only 20% of 24,500 people taken to custody – we can agree this is a good from the point of view of more timely, dignified assessment for the person concerned (albeit someone should be examining why the use of the power has gone up by around a third in a decade).

- The average assessment time in police custody is still around 10hrs, where the cells are still used.
- The average assessment time in an NHS PoS is around five hours.

If the police remove someone to custody, they don't always have to leave an officer there to undertake one-to-one or camera observations of someone. Custody staff can often do it, and if camera observation is required, one member of staff or police officer can watch multiple cameras at the same time. Where someone is taken to an NHS PoS, it is still usually necessary for two officers to remain there until the assessment is completed; and if an inpatient bed is required after admission, it will take longer again. Do the maths on this at your leisure, but you'll find it means more police time is invested in staffing unstaffed NHS Places of Safety than if we used the cells as often as we did a decade ago. Many NHS areas will simply say they don't have the funds to properly staff their Place of Safety

in such a way as to ensure it complies with those RCPsych standards so the police will have to remain.

In other words, the 'progress' we've made is now costing the police more than it was before, because NHS trusts often don't staff their Places of Safety.

STREET TRIAGE

Meanwhile, of course, in an effort to reduce the use of s136 and avoid the use of custody, we have seen street triage schemes emerge. I won't repeat here what I've already covered but we know that from the point of view of s136 reduction, many ST schemes now mean the police have tripled their resource commitment to managing the workload. And we know that the very existence of triage schemes is resulting in existing NHS structures like out of hours GPs, crisis teams and community teams, asking street triage to pick up work that the police would not have previously been involved in, because nothing in the referrals is anything that you might recognise as a core police responsibility? (Yes, I'm aware of the other, non-s136 related workload in private premises but someone in the street triage world forgot to record that, never mind analyse it.)

It must be right that I acknowledge the impact of particular triage schemes varies depending on the model operated by the force you look at; and depending upon the number of days and hours that are covered. The resulting mathematics therefore varies and I'm more than satisfied that some models of triage *are* saving police time, but for me this only reinforces the importance of understanding not only the demands we face, but also the reasons why we face them – it's about the overall flow of patient demand right through the mental health crisis and police system. We do nowhere near enough of this mapping, currently.

So I ask –

To what extent is it appropriate that a Chief Constable pays – both literally and in resources – to improve NHS Place of Safety and other crisis care pathways when it is also involves more demand being deflected to 999 than was previously the case?

The amount of police time spent is not the most important thing in the world – but it's not irrelevant either and it only becomes a discussion in the first place as a result of choices some areas have made about the accessibility of the unscheduled care services they offer. When I have mental health nurses and AMHPs themselves telling me that there are conversations going on in rooms to which the police are not invited which involve explicit discussion about how much more crisis care demand can be

deflected to 999 (including to A&E), then it means we cannot totally ignore the impact on police resourcing where it is connected to deliberate decisions by NHS managers*.

** If anyone is tempted to point out something political about cuts – 1) I'm a policeman, so I'm not going to do anything party political; 2) police budgets increased by less than the NHS MH budget in real terms 2001-2011; and have since decreased by more since 2011.*

21st April 2016

Police Crisis Care Responses: part 1 –

Following various discussions on Twitter about crisis care responses and policing, @DrEm_79 has undertaken a short study to gauge the views of the most important people of all: those who rely on public services when things become very difficult. This is the first of two posts resulting from that research survey and I hope you will agree it demonstrates much that should give us pause and thought. I'm therefore delighted to host Em's write-up of her findings about which you will hear more if you're attending the above conference in Warwickshire on 24th May —

If you or a loved one were unwell at home or in a public place, who could you call for help?

For people with mental ill health, the reality is that often police are involved in responses to health crisis. Services talk about keeping people safe in crisis, and the police are seen to have a role in this in a variety of mental health situations, but this only usually encompasses physical safety. Few studies have looked at the psychological impact of police involvement on people who are unwell.There's ongoing debate about police involvement in mental health, much of it framed in economic terms, or measured by numbers of detentions under section 136 of the Mental Health Act (Heslin et al., 2016, Irvine et al., 2016). As someone personally impacted by mental ill health, and with much more experience of police response to crisis than I'd like, those outcomes aren't the ones that matter to me. Yet reading the various reports and papers about policing and mental health crisis, service user voices seem to be almost unheard, some evaluations consulting only with professionals not service users, and where there is service user feedback, it being collected and filtered by those delivering services.

Two million pounds has been spent on pilot studies looking at Street Triage schemes (Reveruzzi and Pilling, 2016) – where police and health services respond together to mental health crisis incidents – they have received media attention, claim wide ranging successes, and there have been recommendations to extend the pilots (Reveruzzi and Pilling, 2016). There is an assumption that attempts to reduce detentions in cells and reduce the use of s136 will decrease harm to service users, but no studies have

examined in depth potential harm to services users from police involvement in first line responses to mental health crisis, and no Street Triage studies have looked at who service users want to respond to them in crisis

To better understand the experiences people with lived experience of mental ill health have had with police response to crisis, I conducted an online pilot survey. The study was not funded, and independent of services. It was a short survey, just five questions long to enable people in lots of different situations, including people who might be unwell currently and find it difficult to concentrate, to be able to take part. The survey can be found here – http://www.surveymonkey.co.uk/r/VDPNSLJ

WHAT DID THE STUDY LOOK AT?

The aim of the study was to explore experiences of police responses to mental health crisis from the perspective of those with lived experience of mental ill health, either themselves or as a carer.

The study questions looked to answer three research questions:

1. Do police responses to mental health crisis have a helpful or harmful impact on people who are unwell? Are these impacts different in the short and longer term after the event?

2. What are people's experiences of police responses to mental ill health?

3. Which services do people with lived experience of mental ill health want to respond to them when they are in crisis?

HOW WAS THE STUDY CONDUCTED?

The survey was online only and cross sectional in design. No incentives were offered for participation. A small pilot was conducted to ensure the questions did not cause distress.

Study recruitment was completed by sharing the link to the online survey on Twitter and Facebook. Within two days of the survey link being shared, 100 people had responded.

The five questions in the survey looked at whether people had experienced a police response to themselves, or to someone they cared about; whether people had experienced helpful or harmful short and long term effects from police responses to crisis; and who people wanted to respond to them in

crisis. There was also a question where people could talk about what had happened to them and the impact of police responses in more detail.

WHAT CAN 100 PEOPLE TELL US ABOUT POLICE RESPONSES TO CRISIS?

Who took part?

94 of 100 people who completed the study said that they had experienced a mental health crisis which had involved a police response, either themselves or to someone they care about. Four people said they had not experienced this, and two people did not answer this question.

Of the 94, 70% had experienced the crisis themselves and 30% as a carer.

What impact did police involvement in crisis have? – Short term impacts of police response to mental ill health:

When asked what impact police involvement in the crisis had in the short term, 95 people answered the question.

- Of these 95, 5 people (5%) said the police involvement had no impact.
- 44 people (46%) said the police involvement had either been helpful or very helpful.
- 46 people (48%) said police involvement had been either harmful or very harmful.

Eight people added comments to the question. One of these said the question was not applicable to them, and another contained factual information about the outcome. One response was very positive about the impact the police response had:

"They couldn't have done more to find my friend (they had gone missing with fears for their safety) and they couldn't have been more caring & helpful when they found them."

The other six comments described negative impacts from police involvement. These included feelings of criminalisation, increased mental health stigma, loss of trust in police, worsening of distress, and worsening of suicidal thoughts. One comment described a 14 year old being kept in a police cell for 26 hours.

"They made sure I was physically "safe" and alive but they made my suicidal feelings and distress worse. After they left I went from feeling suicidal to determined and making plans to end my life."

"Scary. Felt criminalised afterwards lost all trust in police and stigma from people who'd seen me out in the van."

Longer term impacts of police responses to mental ill health:

Participants were also asked what impact police having been involved had in the longer term, 97 people answered this question.

- Of these 97, 27 people (28%) said the police having been involved had no impact in the longer term.
- 17 people (18%) said the police having been involved was helpful or very helpful.
- 47 people (48%) said the police having been involved was harmful or very harmful.

The question also had an option for people to not answer harmful or helpful but add their own comment instead. 6 people (6%) did this. Of these one person felt the question didn't apply, one was positive about the involvement of the police:

"[…] the brilliant way they dealt with the incident gives us great confidence."

Four of these comments from people who had not completed the scale of helpful to harmful indicated the response had been harmful:

"Very detrimental"

"Long term trauma from being locked up"

"An increase in medication. leading to excessive amounts of prescribed drugs. suicidal thoughts. fear and anxiety. PTSD."

"Scared of police. Don't tell anyone and try to hide when am in crisis, scared it will happen with police again"

WHICH SERVICES DO PEOPLE WITH EXPERIENCE OF MENTAL ILL HEALTH WANT TO RESPOND TO THEM?

This question asked: If you or someone you care about were mentally unwell in a public place or in your home and needed help because of your/their mental health, which of the following services would you most like to come to help?

100 people answered this question, cross referencing this with the first question this means that four of those responding did not have lived

experience of police responses to crisis either themselves or as a carer, and a further two people may not have.

The question asked people to pick the service they would most like to respond. The options were: mental health services, general health services, social work, police, a combination of police AND health or social work (similar to a Street Triage team), a combination of health and social work but NOT police (similar to high fidelity models of some mental health crisis teams), or other.

Participants indicated the following preferences for response:

- Mental health services, e.g. mental health nurses or doctors – 31%
- General health services, e.g. ambulance or GP – 7%
- Social work, e.g. AMHP or MHO – 4%
- Police – 6%
- Combination of police AND health/social work – 16%
- Combination of health/social work, but NOT police – 27%
- Other – 9%

Of the nine people who wanted a response other than those services listed:

- One person said they were now reluctant to engage with any service.
- One person suggested an Independent Mental Health Advocate.
- Four people suggested family, along with Samaritans (two people), staff already paid to look after the person (one person), and the early intervention mental health team (one person).
- One person differentiated between locations, saying police should respond in public places and mental health professionals should respond to incidents at home.
- One person said police and ambulance.
- One person said health professionals only, and suggested a mental health paramedic service made up of mental health nurses and social workers, and a mental health A&E equivalent,

WHAT ARE PEOPLE'S EXPERIENCES OF POLICE RESPONSES TO MENTAL ILL HEALTH?

Participants were asked if they would like to say more about the impact of police involvement. 61 people answered this question using free text with no word limit. These answers have been analysed thematically. Themes emerging included: loss of trust in police or in health services, impact on health behaviours – disinclination to seek help again in future and trying to conceal symptoms to avoid a further police response, feeling let down or betrayed by health services, criminalisation including impacts on work and volunteering, worsening of symptoms, associations with trauma both with

the police response as a source of trauma, and as a trigger to previous trauma, detention in cells, stigma, physical restraint and containment and physical injury, short and long term distress, and shame. These will be discussed in a follow up blog looking at the qualitative analysis in more detail.

WHAT DO THESE RESULTS MEAN?

Only 16% of participants, given a choice, would choose police and health/social workers to attend together to a mental health crisis, and only 6% would choose police. This means that given a choice 78% of people would not choose for the police to be involved in a response to them in a mental health crisis. Mental health services were the most popular choice to respond with 31% of participants preferring this. The second most popular option was a combination of health and social work but not police with 27%. These findings have implications for those who commission services for mental health crisis, and those involved in frontline services making decisions about how best to respond to incidents. There is a disconnect between what service users want and current trends in service provision.

Many people (46%) rated the impact of police response as helpful in the short term. This is reflected in the comments people made describing kindness and compassion of individual officers. However in the short term, more people (48%) found police involvement to be harmful than helpful. When this question was extended to the longer term impact of police involvement, the results are striking, only 18% of people finding police involvement in the crisis response to have had a helpful impact in the longer term, and 49% of people considering it to be harmful. This matters because almost half of people say they have been harmed by the police response, yet little work has been done looking at what aspects of response cause this harm. Also feedback with service users rarely looks at longer term impacts of contact with services, so these longer term harms may be missed by some service evaluations. It also raises questions about the types of harms people are experiencing, and how these can be prevented.

The qualitative analysis of the free text question provides some initial answers to these questions about the types and causes of harm, and will feature in a follow up blog. The comments left on the questions analysed here also provide insight into this, with descriptions of longer term traumatic effects of police involvement, and in the short term, worsening of suicidal thoughts. These suggest that despite an emphasis on safety in police responses to mental health crisis, paradoxically responses in some cases cause harm, and the psychological safety of people in mental health crisis needs to be better understood. Impacts on health behaviours and

criminalisation of service users are also concerning, and are discussed more fully in the follow up blog.

WHAT ARE THE LIMITATIONS OF THIS STUDY?

This was a small study without funding, and it has some limitations. Sharing the study on social media only will have limited the range of people who could take part and may have introduced bias, although question answers did indicate that people in a range of situations, including people currently detained in hospital under the Mental Health Act had participated.

As a service user who has my own experience of police responses to mental health I may also introduce bias into the design and analysis of the study, and positioning it as service user led research may also have limited or influenced who took part. However the responses describe a range of positive and negative experiences and some participants were keen to praise police responses. The independence of service user led research could also be seen to attract responses from people who might not take part in research conducted by services. If the study was extended and funded these biases could be addressed more fully.

HOW WERE ETHICAL CONSIDERATIONS ADDRESSED?

As a small service user led study this study was independently conducted and not approved by an institutional ethics committee, however ethical considerations were important to this study, and the study was conducted according to ethical good practice. No service user data were collected so participants are not identifiable. The survey was piloted with a small group of people with lived experience of mental ill health to ensure the questions did not cause distress. It was designed to be short and easy to complete and the Samaritans number was given at the start of the survey so even people who did not complete it would have a route to get help if thinking about the issues caused them distress. The introduction to the study also explained who was collecting the data (a service user) and why, and offered an opportunity to ask questions.

Following the survey being shared several service users tweeted me and said it had been interesting or easy to complete. No questions were compulsory so people could take part in the study even if they did not want to answer particular question,

CONCLUSION

Despite investment in Street Triage schemes, 84% of those with lived experience of police responses to mental health crisis would prefer other services respond to them if they had a choice. The study suggests some individual police officers are having positive impacts on individuals, and 46% of people find police response to crisis helpful in the short term, however this impact changes, and only 18% of people found police responses helped in the longer term. People also described longer term traumatic effects of police involvement, and worsening of distress and suicidal thoughts in the short term. .This study points to the need for better understanding of the impact of police responses on people in mental health crisis, including both short and longer term effects. It also highlights the importance of service user involvement in service design and research.

Coming up – Qualitative analysis of participants' experience of the impact of police involvement in mental health crisis

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24th April 2016

Police Crisis Care Responses: part 2 –

This post follows a short piece of service-user survey work by @DrEm_79 (from Twitter) – the nature of this is it produces a longer piece than normal BLOG post, but I can assure you it's worth reading all the way through. Alongside the first post, it offers important insights in to crisis care responses involving the police.

Now this is complete, I just to thank @DrEM_79 for doing it: I think what she's uncovered is very far from unimportant and given how easily social media can be deployed begs questions about why we don't see more of this.

Incidents involving mental health issues account for 20—40% of UK police time (College of Policing, 2016). Despite this there has been little research looking at how police responses to mental health crises impact service users. Some evaluations of police mental health schemes have not consulted with service users at all, speaking only to professionals.

Despite investment in Street Triage schemes where police and health professionals co-respond to mental health crisis, part one of this peer research study found that 84% of those with lived experience of police responses to mental health crisis would prefer not to have a co-response with police if they had a choice. It also found that almost half of people with lived experience of police responses to mental health found them to be harmful (48% in the short term and 49% in the longer term). Little work has been done looking at impacts of police response on service users. It is not known what aspects of response contribute most to harm, or the types of harms individuals experience. Work is also scarce looking at what it is about police responses that service users find helpful.

This peer research study of service users looked at which services people wanted to respond to them in crisis and whether they had been helped or harmed in the short and longer term by police responses to mental health crisis. It also aimed to explore people's experiences of police responses to mental ill health in more depth and look at impacts of police response on individuals.

Part one of the study can be found here. 100 people participated in the study within two days of study recruitment commencing. As well as the questions discussed in part one, participants were asked if they would like to say more about the impact of police involvement. 61 people answered this question using free text with no word limit. These answers were analysed thematically.

RESULTS

1. Reasons for police involvement

Thirty participants discussed the reasons police became involved in the mental health crisis. Police involvement was associated with self-harm or suicidal behaviour for many. Only two people had contacted the police direct for help. The most common reason for police involvement was because the person or their carer had called mental health services (hospital, CMHT, or crisis team) requesting help with suicidal thoughts, self harm, distress, or worsening symptoms, and health services had called the police. Participants described feelings of punishment and loss of trust:

"I phoned the crisis line suicidal and they sent the police. The crisis line refused to help and no one would come to assess me. The police stopped me from leaving and tried to force me to go from my house to the hospital trying to trick me outside but I refused. Mental health services passing the buck and punishing people for being ill sending police" – *Participant 1*

"My relative has been detained s136 around 30 times in last 5 years. Police intervention has kept her alive, but has also been hugely traumatising. Services work on the basis that you shouldn't need admission to hospital, which means people are left at home when they are suicidal." – *Participant 2*

Other reasons for police involvement included missing persons, concerns for welfare from other agencies, police called to attend self-harm on inpatient mental health units, and people absconding from mental health units and from A&E. Nine people described being sectioned under the Mental Health Act, eight of these with section 136. Four people described arrest for Breach of the Peace connected with suicidal behaviour.

Some described the actions of the police in positive terms:

"My nephew was 4 at the time (has Downs Syndrome and Autism) and escaped from home, missing for half an hour, police sympathetic and understood the vulnerability and his being unable to know his own name

and address – found safe and well – very supportive throughout ordeal – *Participant 3*

Others described more harmful impacts from police involvement. A number of participants made comments sympathising with police but feeling let down by health services:

"The ambulance crew phoned the out of hours doctors who refused to attend and they tried to tell the police to arrest an elderly man with dementia because he was confused in his own house, the police and ambulance did all they could but were let down by the doctor." – *Participant 4*

2. Loss of trust and feeling let down

Loss of trust and feeling let down was the biggest theme in the study, and was raised by more than half of those who commented. Participants described a number of different aspects to this. Feeling let down by health services was the most common impact discussed, followed by loss of trust in the police. Some people described a loss of trust in all services after police involvement in the crisis response and said that police involvement had caused them to disengage from help:

"Since then I've lost trust in police and the crisis line who called the police. I don't call anyone when I need help and suffer alone as what they did made a bad situation worse and humiliated and hurt me deeply" – *Participant 5*

Participants described impacts of police involvement on health behaviours, with police involvement leaving them less likely to seek help in future, or altering suicidal behaviour so that there was less chance they would be found when attempting suicide in future:

"I'm […] more wary of speaking honestly to, or dealing with mental health services, in case the police get involved again." – *Participant 6*

"I felt intimidated & humiliated by police. I was told to stop being "silly" (this even though I have C-PTSD & was going through a rape trial at the time. There was a complete lack of understanding, compassion or empathy. I felt totally degraded. My experience served to ensure that if/when I attempt suicide again to ensure I do it in a place I cannot be found." – *Participant 7*

Participants also reported that police involvement in the crisis had made them less likely to report crime in future. People also reported fear and

avoidance of the police. This is concerning as people with mental ill health are more likely to be victims of crime than the general population:

"Afterwards I had my phone stolen and was too scared to report it to police as every time in crisis they keep me trapped in my house and I couldn't bear going through that again" – *Participant 8*

"Seeing police now cross street to avoid, won't go out if police cars in the road. I don't trust police now" – *Participant 9*

"After they left I was alone and in a worse state than before their arrival. I feel frightened of the police now. I doubt I'd feel able to call them if something happened to me (ie a crime, or my abuser finding me)." – *Participant 6*

Some participants expressed regret at having asked for help because police had been involved:

"I wanted someone to help me when I was ill not to make things worse by sending police. I wish I never asked for help" – *Participant 10*

Participants also highlighted inequalities or assumptions in their treatment, some contrasting this with physical health conditions, or feeling their behaviour had been wrongly labelled as due to illness:

"Damaged my trust I was ill not a criminal why do people with mental health problems get police when people with physical health problems don't? I am scared of police now after being kept in a cell waiting for assessment. Sectioned but no rights in reality" – *Participant 11*

"I was arrested by police under s 136MHA but was not told this by police only by staff at hospital. I was in fact trying to leave my husband but because I had had mental illness I feel the default position was assumed. Ended with me having to return to a very difficult household. 4 years later and I still feel very raw. Just because you have had a mental illness does not mean that every unusual behaviour is down to that." – *Participant 12*

People also described a lack of communication during the incident, and feeling that they did not know what was going on:

"Was a very terrifying experience. Didn't have anything explained to me and they were already in my home when I returned home, having broken my door. Then two wrestled me and handcuffed me, again nothing was explained. I thought I was being arrested for a crime though had no idea what. Only told when got to 136 suite where I was and that I had been sectioned." – *Participant 13*

Others described a lack of follow up, feeling that although there had been a response, the crisis was not resolved, and feeling the police were only interested in their wellbeing at that moment, not in the longer term:

"After police closed involvement mental health services often did not continue to offer much or any support." – *Participant 14*

"But after they left I felt worse than before they arrived, less safe, like I never would be safe anywhere (I had escaped my abuser to try and find safety), and frightened that they might come back with a warrant or show up to check on me or try to intercept me when I next went out to section me. I know that sounds paranoid, but their response to my refusal to attend the hospital frightened me and I didn't know how far they'd go. It was also upsetting having them arrive telling me they wanted to help me, but the fact was, after they left there was no referral to mental health services or follow up or anything. I was just abandoned to carry on struggling alone. It felt like a case of "make sure she's still alive tonight, but after that we don't care what happens to her, she's on her own"." – *Participant 6*

3. Criminalisation

The second most common theme in this study was criminalisation, and was raised by around a quarter of respondents. A number of different aspects of criminalisation were discussed. For some it was a feeling:

"I don't trust police anymore or ask for help in crisis I try to hide it. Hospital called police when I called them for help and I felt like a criminal" – *Participant 16*

"The police were lovely, every time, however I'd still not like to see the boys in blue for a MH crisis, I'd feel better if it was entirely managed by NHS staff- let the police catch criminals! Even though you've done nothing wrong in terms of the law, you feel like a criminal for being with the police." – *Participant 17*

"Scared, betrayed, society felt I was criminal and didn't belong" – *Participant 18*

Others described concerns about police involvement impacting criminal record disclosures:

"I was being held under section 136 to take me to a place of safety. As I was already going in, it seemed ridiculous and I told them that. When inside the hospital, I was upset because I was worried about it showing up on an enhanced CRB." – *Participant 19*

"I was arrested for breach of the peace when I attempted suicide. Criminal record so then not allowed to do volunteer work with children." – *Participant 20*

Stigma was a major factor and people felt judged or shamed by police involvement:

"I felt guilty by association, 'mad' by association, and degraded by having been involved in the situation." – *Participant 21*

"Humiliated. Degraded. Lost confidence. Ashamed to go out. Attempted suicide soon after. Definitely made self-harm worse" – *Participant 22*

Several people also described marked police vans being used for transport which contributed to distress:

"Crisis team called police when I told them I was suicidal. Damaged my trust in people who should be helping. Passed me off to police instead who handcuffed me and pushed me into a marked van with spectators thinking I was a criminal" – *Participant 23*

Participants also described Taser use, one person described the interaction of the threats of coercion with their mental health:

"My son was sectioned. The police had been called a few times before this. It's a shame the mental health services didn't listen to us as parents. My son ended up going manic and getting sectioned for several weeks. The police had to point a taser at him" – *Participant 24*

"I was threatened with a taser. It was very frightening. I already believed people were trying to hurt me and my family and police were part of that, it made the paranoia a lot worse. – *Participant 25*

Two participants talked about the impact of being a police officer themselves and needing help:

"I was a serving police officer, suffering from PTSD and in crisis , I was detained by colleagues I knew, placed in the same unmarked police vehicle I had placed arrested people in previously. I didn't want to see officers I knew when I was in crisis. – *Participant 26*

"Because I am a police officer myself it was very awkward and distressing but the officers who helped were lovely. It only went downhill once the MH team became involved. – *Participant 27*

The public nature of police involvement was a concern shared by several participants:

"After hours and lots of conversations outside my house which neighbours were cross about and two police cars parked on my drive all night they left with no help not seeing anyone. Useless upsetting stigmatising." – *Participant 28*

"Being held on S136 means the local police (small town) now know me and I am often stop checked while perfectly fine and just getting some shopping. It's embarrassing" – *Participant 29*

Four people described having been arrested for breach of the peace:

"I was arrested for "breach of the peace" after my psychiatric hospital refused to assess me out of hours as they had assessed me previously. I appreciate (now) they were getting to keep me she and felt their options were limited by being kept in a cell overnight was not ideal." – *Participant 30*

"Police unlawfully arrested me for breach of peace (there was no breach of peace at all. I didn't even say one word to police) to get me out of my flat and into public place. Then they kept me in a cell for 8hrs telling me to 'get a grip' and 'stop attention seeking.' Solicitor got me unarrested and despite getting compensation for unlawful arrest and false imprisonment, the mental scars from this remain 5 years on. I panic at sight of any police officer or police car. Really harmed me." – *Participant 31*

"Was arrested for breach of the peace and kept in a cell for 18 hours […]." – *Participant 22*

Others described threat of arrest:

"Have been sometimes threatened with criminal charges which makes me scared of police involvement and also section 136 lead to a long stay in a police cell Other times I've felt the police were the only people who cared" – *Participant 33*

People described impacts of detention in police cells under arrest or as a Place of Safety as frightening and distressing. Some of these were for prolonged periods:

"15yr daughter held for 43hrs in custody cell – no MH beds." – *Participant 34*

"Detained under S136, as I had been reported as missing person & self-harmed in public place. PoS was Police cell, I was scared & frightened." – *Participant 35*

"I get locked up in a cell overnight. This has happened countless times and just adds to my distress" – *Participant 36*

Other participants described effects of damage to their property as a result of police involvement:

"Many, many 'safe and well ' checks where door kicked in whether there or not. Am physically disabled and cannot reach the door quickly plus there is a keybox and police have code yet still kick door in." – *Participant 37*

"Rental agency unhappy with door being forced (although I paid for repair)" – *Participant 13*

Blame and accusatory language was also raised as an issue:

"For me the initial focus was quite a checklist – did I need medical attention (yes), had the terms of a restraining order been breached (yes), had I caused or collaborated with that (no, but the questioning had a repetition about it that suggested that I must have been partly to blame because a mess of that size doesn't just appear out of nowhere), was I officially able to make a statement (yes). Then, as the 'sectioning' process took over the checklist changed but the tone of the questioning seemed accusatory still, as if we had wasted their time and they had to start all over again with a new set of questions. I felt bewildered, and I really didn't understand what was going on, what to expect or how my answers would be used. It was like being held responsible for something without knowing what the consequences would be." – *Participant 38*

"I was not arrested but despite no legal basis I was handcuffed and stopped from leaving my living room not even allowed to go to the toilet without male police watching me. Since then I've lost trust in police and the crisis line who called the police. I don't call anyone when I need help and suffer alone as what they did made a bad situation worse and humiliated and hurt me deeply." – *Participant 39*

4. Trauma

Trauma emerged in the analysis in a number of ways. This was partly participants talking about the police response triggering memories of previous trauma:

"16 year old daughter pinned down by police which gave flashbacks to previous sexual assault." – *Participant 40*

"They searched me which retriggered trauma and two men held onto me and in handcuffs in my own home but I'm not violent. Not necessary." – *Participant 41*

"They asked me if I would go to the hospital voluntarily and when I said no told me they might have to look at forcing me. It left me feeling violated and unsafe in my new home (some of the things they did were things my abuser did – they were aware of the background and I did specifically tell them)." – *Participant 6*

Other respondents described the police response itself as a source of trauma:

"First involvement with police and still traumatised now (this was Dec 2015) & have moved house as was having flashbacks etc" – *Participant 13*

"Police are not adequately trained to deal with mental health crisis, and being left in their care at home for over 8 hours waiting for a MHA Dr to arrive was a traumatic experience." – *Participant 43*

"My relative has been detained s136 around 30 times in last 5 years. Police intervention has kept her alive, but has also been hugely traumatising. Services work on the basis that you shouldn't need admission to hospital, which means people are left at home when they are suicidal. Could go on and on about this" – *Participant 44*

Trauma from the police response was described as persisting long time after the event:

"5 years on. I panic at sight of any police officer or police car. Really harmed me." – *Participant 31*

5. Physical impacts

Police responses had physical impacts on participants, which were discussed in terms of restraint, physical containment to a place they did not want to be, and also physical harms. One person described a case where the person had died by suicide detained in police custody in a cell at a police station. Others described heavy handed responses contributing to problems, and physical injuries sustained:

"Erroneous claim of violence from crisis team led to heavy-handed police response. Attending officers clearly had no specialist training in mental health. Police and crisis team augmented a crisis needlessly!" – *Participant 46*

Four described physical harms:

"The hospital wanted to lock me in the mental health room in A&E (it's basically a cell-sized room with high windows and a concrete bed/bench covered in a plastic-coated foam cushion). I didn't want to be locked in (they often don't even let you out to go to the toilet) so I tried to resist. The police and security picked me up by the arms and legs and tried to get me into the room. Once I was on the floor they repeatedly tried to shut the door with my leg in. I ended up with bruising. I've had some poor treatment in hospital but I never expected it from the police in a public place. I am much less trusting of the police now." – *Participant 47*

"[…] All clothes taken left naked then given padded clothes couldn't rip tried to ligature with bandages custody officer came in pulled arms back banging head on floor and called me a stupid bitch." – *Participant 22*

"After Self-harming in a Psychiatric Inpatient unit, the Police were called, why? Don't know, was assaulted by 2 Male Police officers, gave me a good kicking. Yet I had already let 2 Police women handcuff me. So I wasn't dangerous, I wasn't aggressive and couldn't defend myself. The Police had a bad attitude from the first moment they came face to face with me." – *Participant 48*

Limits to freedom while in presence of police were described by several people, including having to wait many hours in the presence of the police before a MHA assessment:

"I was not arrested but despite no legal basis I was handcuffed and stopped from leaving my living room not even allowed to go to the toilet without male police watching me." – *Participant 49*

6. Helping

As well as the negative impacts described, people also talked about positive effects of police involvement. These included being a calming presence:

"[…] One of the youngest PCs present (I think, but don't know for sure, she was on probation or training placement) was absolutely brilliant. A cup of tea, a smile, a reassuring comment when she said 'it's ok, they have it under control, just take a moment to calm down' and offering to help call someone to be with me. She really de-escalated my fear in the moment." – *Participant 38*

"Police totally calmed a very volatile situation down. Listened and talked to individual and didn't judge." – *Participant 50*

Participants also described police helping with practical arrangements:

"They took care of my pets feeding and making sure they had water while paramedics dealt with me. Other times they've wanted to take me to hospital but I refused." – *Participant 51*

Others explained how police involvement had helped to ensure their physical safety and protect them from harm:

"During a period of mania I was extremely vulnerable during the night alone in my underwear in a notoriously dangerous park. Police brought a blanket in and encouraged me to their car where I was taken to a MH ward." – *Participant 52*

"I was very depressed & suicidal, my husband (now ex) called them. They spoke to us both separately & thankfully could see through him that because I was so desperate was because of continued domestic abuse. They spoke to me & gave me contact numbers & advice & also arranged an emergency appointment with my GP." – *Participant 53*

Some participants also described police involved in the response as being empathetic, kind and compassionate:

"I was taken to hospital semi-conscious following an overdose, when I came to there was a policeman standing next to my door. I asked him why he was there and he said was to make sure I was ok, he contacted the detective in charge of my abuse case which was soon to go to court and he came to see me to see if was ok. When I was detained in psych hospital both previously and after this, same detective came to see me to see how I was doing and to remind me none of the traumatic events had been my fault. Initially the police outside my door in A&E frightened me, but they were lovely." – *Participant 54*

"The 2 officers that attended were really good, they stayed out of the way and when they did need to interact they were really calm, polite and empathic, couldn't have wished for better response." – *Participant 55*

Participants also talked about how they felt police had been let down by other services:

"15yr daughter held for 43hrs in custody cell – no MH beds. […] Generally police good, having to fill gap of inadequate MH Adult Services" – *Participant 22*

"Police have always treated me with immense kindness. They have spoken of their frustrations due to MH cuts." – *Participant 56*

"Police often called by private company who have contract for his care on CTO if my son goes missing or there is a problem. They always appear to be helpful but often not their job. What is needed is more support from company who are paid massive fee." – *Participant 57*

Some people who had experienced harm from the police involvement in the crisis response also described kindness from police. Compassionate and traumatic responses were not always distinct. This raises questions for those involved in collating feedback from crisis incidents, and in evaluating services. Although someone may describe individuals as kind and compassionate, that does not mean the overall impact will be helpful.

"Have been sometimes threatened with criminal charges which makes me scared of police involvement and also sctn 136 lead to a long stay in a police cell Other times I've felt the police were the only people who cared." – *Participant 58*

Others had a different response with one respondent simply saying:

"They completely lacked compassion." – *Participant 59*

7. Impact on mental health

Participants also discussed ways that police involvement in the response had impacted on their mental health. Impacts were unanimously negative, with police involvement worsening distress:

"Humiliated. Degraded. Lost confidence. Ashamed to go out. Attempted suicide soon after. Definitely made self-harm worse" – *Participant 34*

"At an already stressful time this was unhelpful and made my recovery all the more difficult." – *Participant 60*

SUMMARY

Participants described a number of short and longer term harms from police involvement in the response to their mental health crisis. These have implications for mental health services, police, and those commissioning services and developing policy. Participants often felt let down that they had wanted mental health service support and help, but instead it was police that were sent to them. This diversion of health need to the police caused distress, and in many cases seems at odds with efforts and policy to divert mental health need away from the criminal justice system.

Paradoxically, although police responses in crisis are often focused on ensuring physical safety, survey responses suggest that involvement of police leads to behavioural and attitudinal change for some individuals which may increase risk, whether by withdrawal from services, not seeking help for health crisis in future, concealing symptoms because of fears police will become involved again, or escalation of risk in suicidal behaviour. Fear and mistrust of police is also concerning. People with mental ill health are more likely to be victims of crime than the general population, yet because of police responses to mental health crisis, participants stated they would be reluctant to report crimes against them to the police.

Criminalisation and mental health stigma are also important, causing distress and lasting impacts on individuals. Some of the examples of practices such as marked police vans being used for transport to hospital, people in private premises being tricked outside so they could be detained under s136, and people being held without apparent legal basis, also suggest policy and practice guidance (for example House of Commons Home Affairs Select Committee, 2015) are not being adhered to in all cases.

Traumatic impacts of police involvement in mental health crisis response also need further attention. Trauma is associated with a range of mental health conditions, yet this study suggests involvement with the police in crisis is retriggering and in itself can be further traumatising.

The extent of the harms described by participants in this small peer study suggests further research is urgently needed into impact of police involvement in responses to mental health. It also highlights that future evaluations of schemes designed to meet need in mental health crisis, such as Street Triage, must prioritise service user participation in evaluation if the true outcomes of the scheme or intervention are to be measured and understood. That schemes are described as successful without whilst harm is being caused to service users is concerning. People experiencing mental health crisis deserve protection, not just protection of their immediate physical safety, but also ensuring that where possible further harm is prevented, and that responses to crisis do not make things worse for the person.

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25th April 2016

The Police as Contingency –

Many times in my career, along with every other police officer in the country, I've been called upon to do something as part of someone else's contingency plan – can the police support paramedics in attending an address, because it's flagged as being connected to violence; can the police attend an address on their own to undertake a 'safe and well' check, also known as a 'welfare check' on a patient who has rung the crisis team. We know that many patients, or parents of younger patients, have been told to ring the police if things become difficult at certain times – usually connected to the non-operating hours of the service giving that advice; and we know that many patients have had 'ring the police' written in to their crisis plans without their knowledge.

There are a few things to say to this, that I thought were worth focusing on –

RISKS ASSESSMENT

Firstly and most importantly, I've never known these plans be put in to any kind of action with anything like an adequate amount of information being relayed. "Can you back up an ambo crew, patient with a history of violence."

Well, frankly, what on EARTH does that mean? – did this guy shout at the previous crew and threaten to hurt them, did he try to hurt them; did he succeed in hurting them, but fortunately not too seriously; or did he cave in a paramedics head using a wooden fence post and then stamp on and break their hand (real example)?! And when, did this happen – if it was in 1997, should we review the approach? – if he was only ever a bit shouty, and we've been there a dozen times since without problems, maybe we should review it when it's so historic; if it was in 2015 and we haven't been there since, it seems fair enough that the police are involved. If he did brutally attack a paramedic, then the age of the incident may not matter at all because of its seriousness.

Secondly, the control room or the duty sergeant is going to have to make a decision about police resources: do we send one, single-crewed officer or

a double-crewed car? – maybe a Taser officer would be a good idea if the previous incident involved wooden fence poles? Maybe the nature of the ambulance job also effects this decision – if this incident involves a person who is experience a mental health crisis, we might want to send a sergeant or a street triage resource (if available). I once received a call like this and initially took a sergeant and six Constables; once there I ordered another sergeant and another seven Constables in a van with riot gear, releasing one of the double-crewed cars. Understanding risks is not about just curiosity, it's directly relevant to decisions that are ultimately **legal** decisions about Health & Safety law – we are still under a duty to risk-assess jobs to ensure safety to the maximum degree: yours and ours!

LEGAL CONTINGENCIES

Finally, where the police have been structured as the individual crisis response by a mental health organisation, we can occasionally create this 999 exchange in reverse. I remember an incident where a family were struggling to meet the needs of their 14yr old son at home and he had been 'sectioned' one evening by an AMHP and two DRs. However, the bed wasn't available until the following morning and the family had been asked to convey the lad there at 9am with someone saying as they left the address, "Any problems between now and then, just ring the police." All of points one and two, above, remain relevant here but there is an additional reason to be frustrated: what are the legalities here? Assuming this incident was ongoing in private premises when the police arrived, they have no legal powers at all unless there is a criminal offence going on! Do the parents realise this? – or have assumed or been told the police will be able to resolve whatever is happening in a way that seems logical, caring and appropriate?!

The eagle-eyed amongst you will have noticed I've been deliberately ambiguous in the sentence that talked about legalities: if there is no bed available, I usually get really pedantic in asking whether or not the AMHP has completed their application for admission or not – because the answer alters the legalities for the police. If they have completed it, and the police attend a crisis incident, then we can start having a think about s6 MHA by ringing the out-of-hours AMHP and discussing things. If they haven't, then it will have to be a different discussion. Of course, either way, the police will be waking in blind to a situation that involves laws that I've known MH nurses and AMHPs misunderstand so my final point is that putting the police in to this unprepared and un-briefed is just bloody unfair on the officers who have no legal powers to ensure that can come across as being logical, caring and acting appropriately!

WHAT THE POLICE DO

Remember what the police can do: we can talk to people or use force – I'm guessing that if talking to people we're going to be successful, the police wouldn't have been called! If we are going to be called, we need the chance to do a good job by being given the right information and where it is known that the police are going to be the back-up plan at some stage in the future, why not ring the police in advance and let them know they've just become part of a plan? "Hi, this is the CAMHS CMHT – I just want to let you know that we've advised two parents to ring you tonight if things become difficult. Their 14yr old son James has autism and a learning disability and will be going in to hospital at 9am tomorrow. If the parents call you, you should be aware that James occasionally has a form of meltdown and can be aggressive towards his parents and others but the best way to deal with it, would be for officers to just contain a situation to stop it getting worse, make the situation as calm as possible by turning off blue lights, sirens or radios and try to give him time. You can ring this number when you get there and speak to [name] about what's going on and they can talk the officers through the options. An MHA application for admission has been made so s6 MHA will apply in the situation, but you will need to think about whether that is the appropriate way because the hospital are not expecting him until 9am tomorrow."

Now – whether or not I agree that this is an appropriate role for the police – at least I stand half a chance with that information calmly explained by a control room operator. "This is what CAMHS told us this afternoon" … imagine if officers arrived and were having to be told this by a distraught father whilst they were already in to some form of restrictive intervention because they worried James would hurt himself or someone else?

28th April 2016

We Need To Talk …

I suspect forces and their mental health partners are going to need to have some properly serious discussions later in the year about the role of police services on psychiatric wards: it's one of those discussion I alluded to in a previous post that we often dance around or try not to have but incidents connected to it keep coming quick and fast. You'll remember that the Policing and Crime Bill is making its way through Parliament at the moment and obviously, MPs from all parties are entitled to suggest amendments to the Bill during it's passage. Yesterday, the those amendments so far received were published on the Parliamentary website and two MPs – Charles WALKER and Norman LAMB – have tabled proposals which mean this discussion really needs to happen. What is the extent and the role of police officers on inpatient mental health wards, should *ever* Taser be used and if so, what degree of scrutiny should it receive – these are all questions that arise for discussion within the amendments. And let's not forget, this is the most serious, sensitive business: people have died in police and NHS contact on wards; NHS staff have died during disorder and disruption on wards – all of it is affected by staffing levels, approaches to Health & Safety risk assessment.

The College of Policing has been working on this for over eighteen months with professionals from other organisations, professional bodies and Government departments. I find it exceptionally interesting, so we need to start discussing what we've found out, accepting that data – as ever – is not adequate to allow a proper understanding.

Mr Charles WALKER MP has proposed that the Home Office should mandate the collection of data about every instance of police being deployed to wards; he further proposes that every use of Taser should be reported to the Chief Officer of police and reviewed after the fact for the appropriateness of the deployment and the use of Taser. Mr Norman LAMB MP goes further: he has proposed that no police officer should ever be allowed to use a Taser on a psychiatric ward. So there are two issues here –

1. The deployment of officers to wards in the first place
2. How officers who are deployed to wards then undertake tasks in connection with that 999 call.

WHAT WE'VE LEARNED

I'm going to simplify what I think I've learned in this process in to four key sentences, summarising

1. Mental health wards are often not able to draw upon sufficient staff to undertake the restrictive practices that most people would imagine fall under the purview of NHS responsibilities to administer the Mental Health Act – the police are called to NHS wards hundreds of times a month across the country in connection with what I will call 'disorder or disruption' linked to 'therapeutic security'. In other words, situations which have become difficult or impossible for NHS staff to manage but which are not obviously incidents of offending that require arrest or even investigation.
2. In most of the situations where the NHS call upon the police, they are not calling in connection with what they are regarding as criminal activity because in the majority of incidents where a crime has occurred, the NHS's own data shows they take the view that the patient's actions were caused by or contributed to by their condition. That's a whole other debate in itself, which I've covered elsewhere.
3. Therefore what the NHS are usually asking for, is police 'muscle' to help them attend to legal responsibilities that most of us would understand to be theirs: the restraint, seclusion or medication of patients under the MHA – obviously, if you are in the business of providing mental health care that involves detaining other humans against their will and preventing them from leaving your building and taking medication you think is necessary whether or not they want it, there will be few people who would suggest this will be without.
4. No-one is saying here, that there aren't situations in which police support for this 'MHA stuff' won't be necessary – if a patient becomes agitated because they are told medication will be given to them despite their objection and they damage furniture and fashion and improvised weapon from a chair leg or broken piece of glass, then the risks are such that the police will be required. No problem.
5. But the police legal responsibility is to mitigate that unforeseen risk NHS organisations would not be expected to manage – and where officers attend and contain a situation, then remove a weapon or barricade in whatever way, the situation should revert as soon as possible to being one for the NHS; to make decisions about restraint, seclusion or medication, as they see fit and both health & safety law and human rights law would potentially have things to say about their inability to do so.

THIS WEEK AT WORK

Only this week, I have had five different queries from police forces about this topic of the police on MH wards and it's only Thursday morning. Both of my meetings when I get to London this morning are about this topic – I'm not sure whether it feels like the issue is getting more frequent because I'm doing particular work on it at the moment, or because forces are experiencing more requests and queries. Anyway, North Wales Police, South Yorkshire Police, West Midlands Police and the Metropolitan Police have all raised queries this week alone – asking "what are our legal duties; our legal powers and those of the NHS?"

In one case, officers were called to a psychiatric intensive care unit in the afternoon, at shift change over time. NHS wards often plan to undertake restrictive practices at change over time because they have more staff available to do it. On the particular occasion, twelve members of staff were reported to be tasked with giving medication to one patient, albeit someone with a significant risk history. The police were asked to be on standby on the ward, but out of sight, in case their efforts to administer medication went awry – it was agreed that they would and seven officers attended. Nineteen professionals to give medication to one person. When the man was told he would have to receive medication, he stormed off to his room making verbal threats and all twelve staff were reported by the sergeant in charge to back off and refuse to act because of the risks involved. The police were asked to restrain the man for medication and then transfer him to a seclusion room.

Now, let's deconstruct this: a man on a PICU (for patients who require intensive support because of their condition and the way in which it manifests) required medication and made verbal threats. Even if they amounted to an offence of threatening behaviour under s4 of the Public Order Act 1986 of Threats to Kill under the Offences Against the Person Act 1861, those offences weren't the main point behind police support being requested: it was about police 'muscle'. And final point about deploying the police to that incident from a legal point of view: the hospital's legal duty of care under Health & Safety law is owed as equally to the police officers who attend as it is to the NHS staff who work there. Nothing in law particular prevents the police from doing this. However, it should be recognised that nothing obliges them to do so either, especially where they have contained a situation that only they can manage and / or where no offences are being committed or threats to life being made out.

This creates the potential of a stand-off and it is *that*, right there, which we need to discuss – *properly*.

WHAT AM I NOT SAYING?

Is this a point about mental health staff? – no! It's a point about how organisations approach the management of this kind of risk. Actually, a man in his room verbalising threats in circumstances where we are never going to consider immediate arrest and removal to police custody for the offence, is never going to be a legal responsibility of the police service. It remains an NHS legal responsibility to administer the MHA and until the situation becomes so serious because of raised risks, the response to these kinds of operational problems needs to be reflected in mental health trusts' risk assessments and contingency plans.

Is this to say there is never a role for the police? – no! It's about everyone understanding that the police do not have legal responsibilities to patients on wards, or staff, until situations are sufficiently serious to trigger what we expect the police to do in society as a whole. I'm often told that mental health staff have the same right to protection in law as members of the public who are shopping in Waitrose and if someone thought they were about to be assaulted whilst picking up their quinoa and pomegranates, they would be able to call the police. Unfortunately, this is not as simple a comparison as you might think: Waitrose also have to risk-assess the situations in their shops which are foreseeable: their staff and customers are owed a duty of care in that same regard. But somewhat obviously, Waitrose are not obliged to consider how to coerce a vulnerable individual as part of their foreseeable business – it's just not what they do.

Now, as a society we could all take a view, that we don't want mental health professionals undertaking this – we could, as a country, legislate to make coercive practices in hospitals the responsibility of the police, when directed to do so by the NHS. If an MP wishes, they could table such an amendment to the Policing and Crime Bill and it could be considered. It strikes me, based on their amendments, that neither Charles WALKER nor Norman LAMB think that is the way to go forward and their views could yet, be reflected in law depending on the debate that emerges around the Bill in the House of Commons next month.

IN THE REAL WORLD

Some final points: some times these debates lead to the discussion about cuts, funding and resources. Well, I've never believed that this argument is the right one to have, but if you insist: between 2001-2011 the NHS's own data shows a real-terms increase in funding of 59%; over the same period, the police received 31% increase. Since 2011, the NHS have cut mental health services by 8%, whilst the police have been cut by around 20% – some would say it's nearer 25%. So if you do want to have the discussion based on resources and cuts – the police are having to

rationalise far harder. This is probably why in one of the other incidents I've discussed with a force this week, part of it involved an NHS manager reacting with incredulity that 'only' two officers were provided after a request for assistance. Again, a request that didn't trigger any legal duty on the police, incidentally. When the manager protested to the duty inspector asking specifically for another 'three or four officers, the duty inspector said, "How Many officers do you think I have at the moment?!" Pressed for an answer the manager said, "Twenty?!"

"No – nine, you've got two; another two are at A&E with a s136 detention we've been told you can't assess until morning and of the other five, two have prisoners and there are three officers left dealing with all the 999 calls – crack on!"

We need to talk … and more importantly still, we need to talk to patients themselves, which is exactly what I'm spending this afternoon doing.

MAY 2016

1st May 2016

Locked Up –

A man was arrested recently for an alleged offence after he went in to a large store brandishing some weapons that he'd improvised from household items and this included several razor blades. Quite naturally, it led to a 999 call for the police to attended and contain the situation before any got hurt. The man was arrested and taken to the police station. After being seen by the Force Medical Examiner (FME) a full Mental Health Act (MHA) assessment was requested and after this was conducted the custody officer was informed that it was the intention to admit the man on a voluntary basis to the local mental health hospital. There was then some professional conflict between the custody sergeant and the professionals about how to resolve the incident, the sergeant feeling that the man shouldn't be going anywhere on a voluntary basis, given what he felt were the risks of absconding or of the patient just changing his mind whilst travelling or upon arrival.

So a discussion broke out, can you 'section' someone so they are detained under the MHA itself, if they are consenting to admission, with capacity to make that choice? Well, it's clear that you could, legally speaking – see chapter fourteen of the Code of Practice to the Mental Health Act 1983. It therefore raises the question of when you should? The Code outlines –

14.14 – When a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to give or to refuse consent is consenting to admission. (See chapter 19 for guidance on when parents might consent to admission on behalf of children and young people.)

14.15 – This should not be regarded as an absolute rule, especially if the reason for considering admission is that the patient presents a clear risk to themselves or others because of their mental disorder.

14.16 – Compulsory admission should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people.

14.17 The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent).

COMPELLING THE WILLING

The police officers asked for consideration of the man being 'sectioned' despite his willingness, given that the crisis incident which gave rise to his arrest and assessment involved homemade weapons being brandished towards members of the public. There was a sense that only good fortune had avoided injury being caused. The AMHP and DRs were not satisfied: after initially indicating that the man could NOT be 'sectioned' where he was consenting with capacity to admission, they admitted being unaware of the above provisions which had been shown to them by the duty inspector involved. They stood their ground and requested that the police assist services to convey the man on a voluntary basis to hospital which then raises further questions, both for them and for the police: if the man is willing, why does he need a police escort; and do the police have a duty to become involved in the conveyance of a man who is not legally detained and who could not be prevented from leaving the vehicle or refusing to enter the hospital building?

I admit that I'm not sure I would want to be involved in it, if I'm honest – and I suspect I could argue no obligation to do so. Why would I want my decision-making intensively scrutinised by the IPCC for failing to prevent a situation unfolding that I had no power to prevent until the man attempted to commit a criminal offence? … it's not a criminal offence to change your mind about admission to hospital on a voluntary basis. When the question arose about what would be expected if problems did emerge *en route*, mental health professionals suggested the man could be "arrested by the police" to prevent him 'absconding' … precisely what he would be arrested for, remained unspecified and unclear but perhaps more importantly, this seemed to betray a belief on the part of those who assessed him that the situation should not be allowed to develop in such a way as to allow him to exercise his legal right to liberty. Perhaps this was because of the risks, involved?! Either way, it would be a *de facto* detention; in addition to putting the police into a predicament.

TRANSFERRING RISKS AND LIABILITIES

This all raises an important debate: does it demonstrate a tendency to prefer risks to be borne, tolerated and absorbed by police officers who have been somewhat cajoled in to a situation they cannot control? Legal responsibility for the consequences of decisions arising in the MHA

assessment sit with the AMHP and DRs involved, not the officers who originally arrested the man. If it is legally possible and occasionally necessary to 'section' someone who is willing to attend hospital and has capacity to decide, then what *are* those situations if they are not those related to ensuring a legal framework is wrapped around people who, because of their illness, represent a risk to themselves and also to others if they do not remain?! I'm struggling to think of one.

When I discussed this incident, it reminded me of an interview given by the medical director of Southern Health NHS Trust about repeated escapes from hospital premises of people who *are* in fact detained under the MHA. Dr Lesley STEVENS said of patients in mental health units, "We don't lock people up." Even allowing for her deliberate choice of language to which any of us could take exception when referring to people who are unwell, it does remain true that our mental health system is responsible for detaining people against their will and stated cases make it clear that this duty extends to keeping people detained in circumstances where the risk of them leaving is too great to tolerate. Pick another term that 'locked up' by all means, but let's not pretend that services for those made subject to the MHA should be a revolving door where people can come and go as they please. The flip side of this is, where patients like the man with the homemade weapons is, in fact, detained; he should be afforded the courtesy of this being formalised so that he has legal rights within the system that is detaining him, he can have those decisions reviewed and can challenge them if he feels the need.

Learning points here – those who consent with capacity to MHA admission can be sectioned if there is a reason to do so; the police have no obvious legal duties to convey voluntary patients and we create risks and liabilities for the public and the officers if we insist upon doing this in circumstances where the AMHP / DR would expect the police to keep the person against their will until admission is achieved.

11th May 2016

Obligations, Opportunities and Options –

This debate about police *legal duties* in mental health wards continues: I'm on a train to London as I type for further meetings to discuss the legal advice the College of Policing have received from a QC on this topic. We fed in a range of questions and concerns about the legal *duties* of police forces in a variety of contexts where incidents on wards may involve disorder or disruption. Some of these hypothetical questions involved weapons and crimes, others did not. We asked about the relevance of NHS intentions: are they ringing the police to report a crime, ask for assistance in restoring safety when control is lost; or both. It's proving to be extremely interesting stuff, from my point of view.

In case of any doubt, legal *duties* means those things the police are obliged to undertake and where there could be criminal, civil or disciplinary liabilities for the officers or the Chief Constable if they did not attend to them. This should be distinguished from what we might (badly) describe as a *moral* duty – those things that some may argue is an obligation falling to the police bearing in mind the various ways in which to approach ethical issues. The advice is twenty-four pages long and this is what I think it says in a few bullet points –

- **The police have a legal duty to investigate allegations of crime brought** – this does not amount to creating a duty to attend a particular location or to attend it immediately. Any decision to give an emergency response would be as a result of other factors within the incident.

- **The police have a legal duty to protect life and the right to life** – where this is at risk, they have a duty to respond and this could include, for example, that the crime is in progress; someone is seriously injured or could be as a the result of the incident involving a weapon. (This list is not exhaustive.)

- **The police have very few legal authorities which are exclusively theirs** – powers under the Police and Criminal Evidence Act 1984 around arrest, search and seizure are reserved to police but s3 of the Criminal Law Act as well as all those opportunities under the

Mental Health or Mental Capacity Acts are available also to healthcare professionals.

- **The NHS have legal responsibilities of their own** – to their patients, their staff and to anyone else who walks on to their property to create a safe environment; to have health & safety procedures and risk assessments to mitigate foreseeable risks and those risks must be assessed in the context of the kinds of services mental health trusts provide.

This raises important questions: essentially the message is one that I've pushed on this BLOG for several years – in that regard, I was quite pleased to read the advice because I'm very far from being a QC and the main learning for me was the specific stated cases which amplify the arguments I've put for some while –

If you are in the professional business of detaining other human beings against their will and then forcing them to remain in a particular place you have to prepared for the need to prevent them from leaving. This will occasionally involve forcing people to receive medication they may not want and where that involves restraint or transfers to other wards or units, then you should plan and prepare for the reality of what it will take to achieve that. It will mean you may have to physically take hold of people and will give rise to other questions about things like the training to be required for NHS staff and the transportation to be used, etc..

OVERDUE DISCUSSION

What I will put out there for discussion – because we are going to need to discuss this, folks! – is that some mental health professionals who are following the debate have said that it's really important that police services continue to support and work closely with mental health trusts. I need to address this directly: firstly, it's such a generalised, bland statement that no-one could reasonably object to it! … but nor does it tell us anything. Remember, whilst the police service is a partner organisation in a meeting room, the 999 operational officers who attend incidents aware independently attested legal officials who exercise a considerable discretion in the execution of their duties. There is a limit to what a police inspector in the BLOGosphere or a Chief Constable in a policy document can *direct* and commit officers to do where they are inclined to choose another, less restrictive and perfectly lawful option.

But secondly, it often seems to me to be a highly euphemistic hint that we don't disrupt the apple cart – perhaps because this is difficult, sensitive stuff? I know some have wondered whether this whole affair is the police

saying "We're not coming!" Indeed, I received an email from a psychiatrist who demanded to know the authority that the College of Policing have to undertake this work and asking whether we are arguing someone has to be hurt before the police will attend a ward? … it is often pointed out that police officers come equipped with stab-proof vests, incapacitant sprays and Tasers, as well as personal safety training so we should attend where there are risks being reported.

There are just a few things to say about this –

1. Except where the police are exercising their legal powers around criminal investigations or where they are managing serious risks to life, which would usually (but not always) involve some kind of criminal offence; they have no legal powers beyond that which mental health professionals have available to them already.

2. Otherwise, those equipment would be considered anathema to mental health professionals for incidents which are about the treatment and care of patients. So if mechanical restraints are a bad thing and NHS trusts don't supply them and train staff in their use, why would staff call for them to be used by others in connection with treatment and care?

3. The only extra dimension the police bring to a restrictive treatment situation is personal safety training – but we know that the NHS can chose to give such training to their staff and to a very large extent, if it chooses not do so, this is a matter for the trust and CCG concerned, as well as the CQC. It doesn't automatically trigger a legal *duty* for police officers.

Finally, let us remember *why* the apple cart **needs** disrupting and why this discussion must occur: there have been several inquiries in just the last couple of years that require the police service to get in to this. The ADEBOWALE Report (2013), the Home Affairs Select Committee report (2015) are just two I could list. You'll see concerns about police officers on mental health wards within the suggested amendments to the Mental Health Act 1983 because MPs who are high profile campaigners on mental health have tabled it directly. Organisations like Black Mental Health UK are right to raise concerns about the deployment of officers with very different equipment and approaches to what are essentially *clinical* incidents. You'll also remember that there have been two high-profile deaths of mental health inpatients in contact with the police whilst detained under the MHA and in each case both the police officers and NHS staff faced criminal investigation because of the mess that the whole thing represented. We shouldn't also forget the homicide of a mental health professional after a

patient returned from authorised MHA leave with a large knife and fatally attacked her – so we need to ensure the police attend what they must, but that they don't become inappropriately engaged without a way to hand back responsibility for clinical care to the healthcare provider.

The stakes on this could hardly be higher than the need to ensure people stay alive, hence the need to make sure we get this right and it would be foolhardy to keep doing what we've done before knowing it is predicated on false understandings of duties and obligations and has led to the consequences we've already seen. If we want to create an environment in which the police recognise where their role does extend to attending wards to support NHS staff, we also need to do this by ensuring the NHS don't unwittingly create conditions in which the police is taken for granted by routine requests to undertake tasks that the NHS is legally obliged to prepare for and which the police service has neither a legal *nor* a moral duty to undertake. There is a line to be struck here and a need for everyone to look at their understanding of things: but we cannot avoid the reality that we must do so within the framework of the laws that govern us all.

13th May 2016

Crime Recording Rules –

It is a criminal offence in the United Kingdom to abscond or escape from lawful custody – two separate ways of phrasing the same common law offence. Most typically, we think of this where someone has been arrested by the police and after arrest, they have found a way to escape; or perhaps someone who has absconded from a prison or a prison service vehicle. When you stand as a criminal defendant in a courtroom, you are also considered to be in the lawful custody of the court and if you leap the dock and then run, you are also liable for the offence. I remember about fifteen years ago a defendant did that at Birmingham Crown Court, which is a modern three-story building of courtrooms: to make good his escape from the building, he jumped all three floors of the atrium in one go, smashing his ankles upon landing and still trying to get away … security had little problem taking a leisurely stroll down the road to catch up with him as he attempted to hobble! Jailed, obviously.

But how does this all relate to the Mental Health Act (MHA) *detention*, which we don't traditionally think of as 'absconding lawful custody' – we don't usually think of it as 'custody' at all and as Dr Lesley STEVENS of Southern Health reminded us, "We don't lock people up!". As with all crimes, the Home Office issues guidance to when offences should be officially recorded in the crime statistics and the rules were updated in April 2016 – the overall guidelines are known as the Home Office Crime Recording Rules. I emailed all force mental health leads about this a few months ago, ahead of the change, but it didn't occur to me to write a post about it until a recent case in London.

REECE DAVIS

Mr DAVIS is a 23yr old man who was a patient at the Bethlem Hospital in Beckenham, south London. He was detained there under s37/41 MHA, which means he has already had contact with the criminal justice system after an alleged offence whilst mentally ill. The court obviously found it necessary to authorise a hospital order under s37 MHA because of mental health problems but they also imposed a restriction order under s41 having been satisfied that Mr DAVIS posed "a significant risk of harm to the public". He was recently taken from the Bethlem Hospital to Croydon

University Hospital from where it is alleged he escaped through a window. He was later arrested for attempted murder after a man claimed to have been stabbed whilst jogging.

From a criminal offence point of view, the question then arises, do we record an offence of escaping from lawful custody? These are the new and current rules –

1. If someone is detained in hospital under Part II of the Mental Health Act 1983, no offence is recorded if that person absconds from hospital – this will cover sections 2, 3, 4, 5, 6, and 7.
2. If someone who was detained under Part II has already absconded and then been re-detained by the police, an offence is recorded if that person escapes from police custody whilst being taken back to hospital – this would include patients who are AWOL under s18 and those who are re-detained under s138 MHA.
3. Where someone has been detained under s37/41 of the MHA, the offence is recorded as soon as possible after they escape from hospital or from escorted leave, as in Mr DAVIS's case – I'm having to infer that this would also cover patients who are transferred to hospital from prison under sections 47 or 48 *and* are then also 'restricted' under s49. The MHA requires such patients to be treated 'as if' they were restricted under s41.

What the Home Office were not clear upon, is those who abscond from sections 35, 36, 37 (without restriction), 38 or 45A – these are all Part III detention provisions and it seems sensible to me to record them for the same reasons but take advice from your crime recording registrar because this is not what the HOCR say, but neither do they say what should be done!

This gives the effect of meaning that absconding from civil detention under the MHA, where admission was not connected to criminal offending that was taken to court, should not lead to patients being criminalised if they absenting themselves from hospital or fail to return. However, where hospital admission is at the direction of the criminal justice system, the offence of escaping is recorded and in need of investigation straight away. Makes sense, if we think about it.

17th May 2016

Bullying and Intimidation –

Did you see the recent piece by an anonymous NHS bed manager in the Guardian about being scapegoated on behalf of the NHS for the 'beds crisis'? – if not, it's worth pausing already to read the link before going any further. It really did set me thinking because of the various references to the police bullying and intimidating the writer, in the context of various difficulties ensuring the efficient admission of a patient to hospital. Then I had that horrible period of reflection, wondering whether I've bullied and intimidated NHS professionals, too? – I couldn't help but conclude that I probably had been perceived in that way; and that I had once received direct feedback to that effect from an NHS CrisisTeam nurse who said they felt pressurised.

My job is, at the end of the day, about conflict management and conflict resolution, set against the backdrop of having various legal responsibilities. Police officers use a range of tactics to go about their business and it can look and feel unpleasant: we use coercive force, we threaten the use of it; we arrest and prosecute people – sometimes we threaten such a course of action to promote compliance with less restrictive outcomes such as drunk people going home quietly and so on. I can't truthfully say that in the course of my work I have never raised my voice to a member of the public as a tactic in making my communication understood and impactive. Within the arena of mental health, I can't say I've never done this either.

Maybe this makes me an intimidating bully in the minds of some?

ANONYMOUS HIT AND RUN

I can almost understand why a bed manager wishing to write such a piece as this would do so anonymously. Those castigated within it have no ability to reply and the piece itself raises questions about legal compliance of individual professionals, mental health trusts, CCGs and local authorities. Whilst it doesn't tell us anything we don't already know, it re-emphasises the pressure in the acute mental health system, which is something we know is also far worse in the CAMHS and LD systems. But I got to the end of this piece and wondered whether or not the author had escalated these concerns via the appropriate channels to the Trust management, the CCG

and the CQC. Maybe they did – writing this piece under the cover of anonymity did make me wonder whether this was their preferred way of doing so.

I want to start by focusing on that nugget of misunderstanding in the third paragraph of the piece which makes me think they author doesn't understand the implications of the points they raise and why their protest is mis-directed.

"I'm often faced with harried community mental health professionals, struggling to manage a newly-detained unwell individual while surrounded by exasperated police and ambulance workers, collectively waiting for the private sector to decide whether they'll provide a bed halfway up the M1."

So here's the major problem that might let us see this bullying and intimidation in a new light: if the harried professionals in the community haven't yet been supplied with a bed by our scapegoated author, then the person is **not** 'newly-detained'! AMHPs never cease to remind us all that you cannot make an MHA application without knowing where the bed is and will most likely refuse to do so until the bed manager has identified it on behalf of the first-assessing DR. It's far from unusual that AMHPs who are struggling in that context would have requested police support, otherwise I've known scenarios where they remain unharried at the premises until the bed is found.

MURDER

In my favourite example of this kind of problem, I had been contacted at home by a Detective Inspector who was the Senior Investigating Officer for a murder inquiry. His suspect had been in custody for 27hrs after a superintendent's extension of detention and it was now 5pm. A recent assessment of evidence had revealed that they did not have sufficient evidence to charge a young man with any offence and he had been assessed by professionals as requiring admission to hospital under s2 of the MHA. One of those discussions began where the medium secure unit refused to admit him unless the police charged him with a crime and the psychiatric intensive care unit refused because he was too risky, having probably killed someone.

That impasse had run its course for a few hours at the point where I was called. The DRs involved had told the custody officer at 5pm that they would be back the following morning at 9am to re-start their search for a bed and looked fairly blank about what the sergeant should do at 2am when his 'PACE clock' ran out! I remember getting out my laptop at home and writing a letter for the DI. I advised him to whack it on a job letter-head and give a copy to the DR and the AMHP going through all the standard explanations

and requests for this kind of situation and meanwhile, I took advantage of knowing a senior person in the MH trust who helped resolve the impasse. Bed found within an hour – murder inquiry derailment resolved.

I've absolutely no doubt that those involved in the MHA assessment felt pressured – that was absolutely the intention of it. I suspect that ACC Paul NETHERTON also intended that when he took to Twitter and made national headlines in November 2015 in respect of the 16yr old girl from Devon who had been languishing in police custody for two days. Making views firmly known, issuing threats of non-passive reaction to unlawful situations and warning of consequences is absolutely a part of making headway in some situations and I'd want the police doing all of this if it were my relative whose rights were being denied to them, whilst holed up in some police custody area.

TACTICAL COMMUNICATIONS

In the case where I was firmly informed that I was pressurising and intimidating, I had been caught out by a CrisisTeam nurse 'interfering' in the processes of admission for a patient who had been in police custody after arrest for a minor offence in excess of 30hrs. I had decided I should probably start 'interfering' and 'initimidating' people having commenced work at 2200hrs that day as the duty inspector and found an undoubtedly illegal detention in my cell block. An AMHP was unable to comply with s13 MHA because of there being no bed from the trust and so they had become an unwitting party, along with the CCG and the NHS trust concerned, to an Article 5 ECHR violation – they were insisting that the police do not release the patient despite having been told by the custody sergeant that he had run out of lawful grounds on which to detain them.

The conversation was an awkward one: I re-hashed that old stuff about the Mental Health Act Commission's guidance about section 140 MHA and applications in circumstances where there is no bed available; I pointed out that I would be recommending to the early shift that they asked police legal services to consider High Court action to expedite the onward discharge from police custody; I asked for a mental health nurse to be deployed to police custody overnight, to ensure the wellbeing of the patient, bearing in mind the distress they were in and our concerns for their welfare after more than a day in dark concrete cell. I will be honest: I didn't expect any of this to go down terribly well! That wasn't the point – but it did appear to result in progress and a bed found within two hours.

We all understand that MH trusts say they are struggling: I know from colleagues and friends in those professions that budgets have been cut in some trusts by 20% despite the overall protection of the NHS budget in the last parliament and I've seen for myself how both NHS England and

individual CCGs have cut providers' budgets. I'm not unsympathetic to that. But when a police officer is aware that laws are being violated in respect of a vulnerable person in custody or at risk in the community and especially where the police service are being expected to suck up the consequences of that in vacuum of legal powers to ensure safety, it's not unreasonable that concerns are raised, that threats are made about counter-reaction to those unacceptable circumstances. It's less then a handful of times I've ever told an NHS professional that I was going to contact a solicitor with a view to considering legal action to protect a vulnerable person and the custody staff caring for them and on each occasion, it has brought a solution to the impasse.

UNPROFESSIONALISM

Policing is about conflict management and conflict resolution: various tactics are deployed to manage and resolve the various conflicts in which we become engaged and whilst no-one is going to defend bad manners, aggression or unprofessionalism, it has to be accepted that assertiveness, exhibiting frustration and declining to accept that which should not be tolerated are quite different things.

It was the US police chief Charles RAMSEY who recently said that when you stop viewing police work as law enforcement and start viewing it as the maintenance of constitutional and human rights, that you start to understand how the police can be on the same side of the community in the various struggles that it faces. Sometimes, public service organisations will find themselves in conflict with each other and I'm aware of situations which reverse this principle, where the police get things wrong. However – and without wanting to over-egg the pudding here – our scapegoated author is referring to various situations that can and have been found to amount to human rights violations.

I'm not quite sure why they thought the police would keep quiet about that or do nothing?

19th May 2016

New ABD Guidelines –

The Royal College of Emergency Medicine and the Faculty of Forensic and Legal Medicine have today published a new best practice guideline on the topic of *Acute Behavioural Disturbance*.

All 999 response officers, first-responders and street triage police officers need to know about them bearing in mind the number of deaths following police custody or contact that are still linked by Coroners to 'restraint related' or 'cocaine related' excited delirium, now more often termed *acute behavioural disturbance*.

The whole classification and conceptualisation of these ideas remains subject to debate within the medical professions, and the document alludes to this by stopping short of regarding these phenomena as a 'disorder'. My point has always been: regardless of medical taxonomy, Courts and organisations like Inquest tell the police service that people die from whatever it is that's going on and that alternative approaches are needed to learn lessons from history because we can control or reactions and responses, even if we cannot control the background or underlying issues.

It's only sixteen pages long and when you strip out references, intros and covers, it's perfectly consumable and the medical language is not impenetrable to those of us with a first-aid certificate as our highest clinical qualification! It essentially says –

- Suspected ED / ABD is a medical emergency until otherwise proved.
- Restraint and restrictive interventions need to be seen as a last resort, although they may be unavoidable.
- Urgent action to end restraint as soon as possible will be necessary.
- Emergency Departments have a role to play – by definition then, so do the ambulance service!
- It highlights the police as the inevitable first-responders because clinical presentation is associated with highly unusual, bizarre and often aggressive behaviours.
- There is NO minimum safe period of restraint.
- Treatment with benzodiazapenes, antipsychotics or ketamine may be required.
- It could be safer to consider the application of Taser to allow for medication, rather than manual restraint, because the impact upon

the person concerned may well be less, given the risks of acidosis in ED / ABD cases.

LEGAL ISSUES

What the document doesn't massively touch on but which will be relevant for any police or paramedics who become connected to such incidents, is the legal basis for acting – that will also be relevant for EDs. The detention of a person by the police may have already occurred before the involvement of healthcare professionals and it could either be for a suspected criminal offence or under the Mental Health Act 1983. Neither of those things matter massively, because neither of them allows for the treatment of the person in the way suggested by this guideline. The Mental Capacity Act will be of relevance to those considering treatment options and where a case of ED / ABD is honestly assessed, there will be few limits to what is urgently justifiable under ss 5/6/4B of the MCA because these situations will be regarded as life-threatening until otherwise assessed and that may well take an ED consultant to do so.

But this revisits that old debate about violence and aggression. Only this week, as part of #MHAW16, I've seen police forces proudly telling their public how much they've reduced the use of cells for those detained under s136 MHA and that the examples which remain are only those where detainees are 'unmanageably violent'. Always makes me wonder whose skill base has been able to say, "This is not clinically significant". The RCEM / FFLM document tells us that fatal outcomes can be expected in 10% of cases, so the odds are difficult ones to ignore if we are talking about potentially fatal outcomes. In reality, it seems we still have officers taking unmanageably violent detainees to cells and detaining them there, without that person having been seen by paramedics, without them having been seen by a DR in ED and with knowledge that the FME may be 90minutes or more away from the police station.

One of the Oxford University Press handbooks for Emergency Medicine says, "Most people who are violent need a policeman [sic] not a doctor." Exactly the same intellectual proposition can be said in different way, "Some people who are violent need a doctor, not a police officer." In reality, some situations are going to need both: because I'm fairly confident you don't really want me taking decisions about your medical welfare when you lack capacity to do so for yourself and when 10% of the time, the outcome could be fatal for you.

JUNE 2016

9th June 2016

Spit Hoods and Child H –

That was quite an unexpected day! The IPCC published a summary of one of their investigations along with the recommendations they have made to Sussex Police following a series of serious incidents in which a young person was arrested or detained. Sussex Police have accepted that a total of 12 police officers misconducted themselves and have instigated either disciplinary procedures or have given management advice to those still in service – two have since retired. The media coverage has been considerable, raising more questions for me than it answered.

It's clear things went wrong: the Deputy Chief Constable of Sussex Police admitted as much on early morning radio and that has been repeated throughout the day. In addition to undertaking disciplinary procedures and giving advice where thought necessary, Sussex has stated they have reviewed policies and procedures, including around so-called spit hoods or spit guards, suggesting that there needs to be a debate with the College of Policing about these devices. That's when my phone began to ring and I found myself in a small room at BBC Birmingham talking to Radio FiveLive (1:12:50). Of course, despite the fact that the College Press Office made it clear before the interview that we couldn't talk about the specific case – after all, we'd read the news that morning but the College isn't an automatic party to IPCC investigations and we hadn't known of it previously! – the second question of the interview took us straight to it, "But she was ELEVEN!?"

These detentions clearly involved a difficult and challenging sets of circumstances and give rise to very sensitive issues. Perhaps the gravity of how Child H's family are looking at this can be seen from the opinion of their solicitor who described this as the most "inhumane and degrading" case of a child being detained in police cells. I can't stress this enough: stuff went wrong here, although the reasons behind those failures aren't clear from public media coverage and I know no more about the particular case than you do. I want to read the IPCC investigation report, quite honestly!

SPIT HOODS

The controversy at the centre of these detentions was the use of a so-called 'spit-hood' or 'spit-guard' and many people will be unaware that a few police forces issue this equipment. For those who are not familiar with them, such devices are designed to protect professionals from those who may spit or bite during restraint and there are various versions – one involves a more-or-less transparent mesh which means breathing is not restricted but bodily fluids wouldn't easily penetrate the mesh. In another, an emergency restraint belt mainly intended to be used for restraining people's legs is also claimed by the manufacturer as being something that can be used as an 'improvised' spit guard. Such a device is alleged to have been significant in the case of Thomas ORCHARD which involved a custody sergeant and two detention officers standing trial for manslaughter – and they are due to face re-trial in early 2017.

So we know these devices are and approaches are not without controversy and difficulty.

I'm aware in mental health services of a spit guard which involves applying the device to the professional, not the detainee. It is basically a visor that covers the face and ears and leaves the patient or detainee unrestricted. Each of these devices has different risks and benefits and – obviously, if worn by the professional, the visor can become covered in bodily fluids and restrict the professionals' view; and there are probably more on the market from specialist companies that I haven't come across because I haven't taken extra time to research this stuff. But for all the various risks and benefits, one other point remains true: not using them at all *also* has risks and benefits. It opens up the reality of what would happen in forces where such devices are not available: manual handling of the head and neck and I'll be honest, I've been forced to do that, because I am not going to let myself be spat at during my work.

Most police forces do not issue a spit-guard of any kind to their officers, but I'm aware that many forces and groups of frontline officers, have discussed these issues, because spitting and / or biting – whether by an 11yr old or a 21yr old with a neurological disability or from a 31yr old who has been arrested for burglary – is particular challenging behaviour to accept and manage, despite allowances that are made where officers know the person has a disability. Some officers who have been spat at have subsequently contracted diseases like **hepatitis** and **meningitis** and despite all the discussion today about the rights of those detained, especially children, it also remains true that police officers are *absolutely entitled in law* to take reasonable steps to ensure they are not assaulted at work – they do not have to tolerate the very real risk of being assaulted in *any* way. I have experience of my own of a detainee wanting to spit at me and I freely

admit, in the absence of any other way of keeping myself safe, clean and unexposed to the unknown risks, I used physical force with my hands to ensure the face was pointed away from me. This business is not edifying and I'm sure it carries dangers in terms of placing pressure on the head and neck. Such risks are obviated with the use of an effective spit-guard, but it's about how you trade off the various kinds of risk involved.

DIFFERENT APPROACHES

Of course, discussion on social media today has seen the police heavily criticised for 'spit-hooding' a child and Miss H, her mother, has called for the practice to be immediately banned. We can all understand why and when I listened to Miss H's description of the shock and horror of seeing her daughter in custody, you couldn't fail to wonder how it must have felt. I am the parent of an eleven year old and the very idea of this happening to him is extremely distressing to contemplate. But it raises broader questions than any individual incident can help us understand: how do we want the police to keep people safe within the laws we ask them to operate? We cannot demand the police remove children under arrest for offences to specialist CAMHS facilities because –

- They often don't exist! – and we see the Government having to legislate to motivate the NHS to ensure adequate provision for children detained by the police under the Mental Health Act;
- PACE says people under arrest should be taken to custody unless they require A&E treatment;
- A&E have traditionally had their own views about the appropriateness of taking mental health patients of any age to a busy department, but especially so when they are distressed and exhibiting challenging behaviours – but we also know there are dangers in not doing so!

But this also gets us in to a topic in which I'm increasingly interested and to which Child H's mother directly referred: by appearing to defend the general principles that sit behind police actions on the grounds that these are difficult situations and that ultimately, the police often keep people safe until situations have stabilised and formal assessment can take place, we see the restriction of a child using three separate pieces of police safety equipment as one where we define safety *in purely physical terms*. We thereby implicitly disregard this young person's *psychological safety* and well-being. What do we think will be her anticipation of future encounters with police officers if she should become unwell in the future? – for some patients with mental health problems, physical harm is less concerning than psychological harm.

OTHER CUSTODY PROBLEMS

For those who have wondered about why no appropriate adult was provided during the various detentions, I would like to say a few things although we'd probably need to read the IPCC report to know why. All I can say that may go some way to explaining why a child's mother would not be permitted in custody on all occasions is that in three of the four detentions concerned, Child H was arrested for alleged offences, not detained by the police under the MHA. Perhaps this was a result of police being called to private premises where powers under the Mental Health Act for police officers are not available? … I don't know.

But I do know that a person who is a victim or a witness in an incident subject to criminal investigation cannot act as the appropriate for the person under arrest. I also know that when Code C to the Codes of Practice to PACE was amended in 2012, the requirement for an appropriate adult where a person is detained under s136 of the Mental Health Act was amended – it now states (para 3.16 to Code C) that there was no role in the assessment process for the appropriate adult. Whilst I've always interpreted that to mean an appropriate adult should still be called for children and adults when they are first booked in to custody and their rights and grounds for detention are explained, there are varying opinions about this.

I've mentioned a lot over the last eighteen months, various people are confusing the proposals the Government are bringing forward about banning the detention of children in police cells. The proposed ban in the Policing and Crime Bill 2016 is purely a ban on the detention of children who are detained by the police *under the Mental Health Act*. **Nothing** will legally prevent the detention of children with mental health problems in custody where they have been arrested for offences and as more people are encountered in private premises than public places, it follows that where detention is necessary to keep someone safe, it will more usually be for offences than under the MHA and that's what we see in the 'Child H' case: three arrests for offences, one detention under the MHA.

WORK TO DO

And of course the discussion that no-one has had here is about the broader health system: why was no health-based Place of Safety available to this 11yr old on the occasion where she was, in fact, detained under the Mental Health Act – a police cell shouldn't have been necessary on that occasion according to nationally agreed standards on the operation of s136 that were in place in 2012. The media report from the IPCC is very clear that there

were broader failings in capacity and capability not just from the police but also from others that could *and should* have been involved here. Therefore this raises questions about the IPCC itself: its authority is over the police forces and officers where misconduct is alleged or suspected so what happens to the reports of the non-police shortcomings?

So the big questions: do all areas of the UK have in place the infrastructure and mechanisms to ensure that a young person exhibiting very challenging behaviour can be safely cared for, with dignity, irrespective of whether they were arrested for alleged minor offences or detained under mental health law and can we say this kind of thing would never happen again? If you look at the background reasons why this happened at all and then examine areas for their Place of Safety provision as they prepared to deal with the implications of the Policing and Crime Bill, there are some who think it is not possible to achieve and are lobbying for the proposals not to go ahead.

If you remember that there will be *no change* to the way in which the NHS can distance itself from the immediate or urgent need to provide sanctuary to children arrested for minor offences following a breakdown in their homes where parents are struggling to keep them safe, you are forced to conclude that officers may – yet again – be faced with little or. no option but to start deciding whether they use or improvise a spit-guard or whether they manually handle the head and neck of a vulnerable person to protect themselves from assault whilst trying to keep someone safe who probably needs urgent medical care.

19th June 2016

Brazilian Money Laundering –

This week there was a very high-profile killing and within just a few hours, we heard that the offender had a history of mental health problems and sought help only the day before. Since that time and despite the fact that there are other obvious points of interest and lines of enquiry to establish a motive or reason for the attack which has destroyed a family and reached to the very top of government, the internet and social media have been replete with comments which show that little else needs to be known: the mental health history explains the crime.

I want to show talk you through a far less high-profile case which also hit the news this week after the conclusion of a trial to show how potentially complicated the relationship is between mental health and criminal offending. It concerned a robbery in Dudley, West Midlands in February 2015 and the defendant's trial was concluded at Wolverhampton Crown Court on Friday. The various twists in the investigation and trial process show how complex things can potentially be but ultimately how these things are determined. Needless to say, it is not the sort of thing that gets sorted out in police custody in the hours or even days following arrest.

In February 2015 Tommy SMITH attempted to steal a Range Rover that was on a driveway but was interrupted by the victim, Peter CHURM. In a sustained attack using an 8inch knife which snapped during the attack, Mr CHURM was stabbed to the back of the head and neck and SMITH fled the scene. He later attempted to flee an address where officers had traced him during arrest enquiries and was detained by a police dog handler. SMITH was charged with offences including attempted murder and appeared at the Crown Court.

SECTIONED, UNFITNESS AND INSANITY

I want to distinguish between these three separate issues, which can come up during criminal proceedings –

- 'Sectioned' – sometimes in police custody, suspects are 'sectioned' under the Mental Health Act 1983 before they are charged and an assessment undertaken about whether it is in the public interest to

prosecute them. We still conflate the issue of being 'sectioned' with the possibility of being prosecuted – yes, you can found guilty of a crime even though you were 'sectionable' throughout the whole investigation and trial process.

- 'Unfitness' – we hear of unfitness to stand trial and unfitness to plead at the court stage, but also of unfitness to be interviewed in police custody. These concepts are all different to being 'sectioned', even where mental ill-health is involved and many suspects who require inpatient hospital care are capable of following criminal proceedings, partaking in their own trial and instructing their lawyer. Broadly speaking, that's what we mean by unfitness.

- 'Insanity' – this is a legal concept in criminal law, not a medical one so it should come as no surprise that insanity and the clinical criteria for compulsory detention in hospital are overlapping, but ultimately unrelated concepts. Everyone is assumed to be sane and capable of being held responsible for their actions unless they prove otherwise to the satisfaction of a jury.

Tommy SMITH, who was 17yrs old at the time of the attack, was charged with the attempted murder of Mr CHURM as well as other offences including burglary. In the first instance, the trial took over a year to start so that Mr SMITH was well enough to participate in his trial – unfitness is something that is determined by the mental condition of the defendant at the point of trial, not the point of the offence. This is in contrast to insanity, which is based upon the condition of the defendant at the time of the offence. Thus, someone who may have been incredibly unwell during an incident, could be perfectly fit to stand trial and yet put forward a defence of insanity.

That is what happened here: the defence put forward that he was legally insane and therefore not guilty of the offences and the whole question was put before a jury. They had to make the ultimate determination of the issues, not least because two psychiatrists giving expert opinion in court, disagreed with each other. They ultimately found, on the balance of probabilities, that SMITH was not insane – in other words, the requirement to show that "he did not know what he was doing or did not know what he was doing was wrong" was not satisfied in this case. However, they also found that he was not guilty of attempted murder, finding him guilty instead of the still serious offence of unlawful wounding with intent to cause grievous bodily harm and burglary.

So this means he is now a convicted criminal, held fully responsible in law for his unlawful actions towards Mr CHURM. The court must then move to the matter of sentencing him in connection with those offences.

SENTENCING

None of this so far means that Tommy SMITH wasn't mentally ill: it just means that the particular nature of his particular condition means that he did not convince the court that he qualified for a defence to the charges because of insanity. It is quite a high threshold to reach, that of insanity – hence there are comparatively few findings each year of criminal defendants being not guilty by reason of insanity. A much lower threshold in connection with someone's mental illness is that required for compulsory inpatient care under the Mental Health Act 1983 and this is the direction the judge turned after the jury's verdict.

He was first of all remanded in to secure psychiatric care pending pre-sentence reports and this could have been under a number of provisions, the media coverage I have seen doesn't specify it. Section 35 MHA allows the Crown Court to remand for treatment and psychiatric reports – I'm guessing this wasn't used, because reports were already available and used in the trial itself. Section 36 MHA allows the court to remand for treatment, during which time the Probation Service would be able to prepare the PSR; section 38 MHA allows the court to instigate an interim hospital order, which is something of a trial run for twelve weeks in hospital, to allow the court to understand whether or not a hospital order is the correct sentence, based on further advice from forensic psychiatrists. In sentencing this week, Tommy SMITH, now 18yrs old, was given a restricted hospital order under s37/41 MHA. This means he will be detained indefinitely and until such time as a review tribunal, authorised by the Ministry of Justice grants him conditional discharge from hospital.

Most importantly for anyone who might ask, why not just 'section' him anyway? – this process also means, having been convicted of serious offences and given such a sentence, that he will be subject to the public protection frameworks of MAPPA … Multi Agency Public Protection Arrangements. Alongside the conditional discharge framework in s42 of the Mental Health Act, this means there is considerable opportunity to manage any problems that occur once he is discharged from hospital, although that will probably be many years from now.

MENTAL HEALTH AND CRIME

I hope this disentangles various concepts that can come up during criminal investigation and trial where the suspect or defendant is thought to be mentally ill. It's not often that they all come up during one case, which is why I decided to do this post. We should keep in mind, most people who live with a mental health problem are still capable, in theory, of being held responsible for their actions in a criminal court. Whether we chose to do so, is quite a different matter! Generally speaking, the less serious the alleged

crime and the more serious someone's illness, the less public interest there will be in a prosecution. The more serious the offence or the more risk there is to the public at large, the less relevant someone's condition becomes to the police or CPS charging decision and the more important it is to let the courts make the necessary decisions against being able to fully weigh-up the relevant factors about fitness, insanity or sentencing.

Ironically enough, where someone is found unfit to plead, where they are found insane or where they are fully convicted of the offence, it remains open to the court to consider imposing a hospital order (s37 MHA) supported by a restriction order (s41), where necessary. So a restricted hospital order can be diversionary mechanism for someone who cannot participate in the trial process, it can be a diversionary mechanism for someone who is found legally insane and is therefore not guilty; or it can be a sentence in its own right after a full finding of guilt. It is therefore really important not to conclude anything about the relationship between mental disorder and crime just because a particular defendant has a mental health problem, was prosecuted or received a hospital order – those are just broad legal concepts and frameworks: each case needs to be treated on its individual merits.

What has all of this got to do with Brazilian Money Laundering, you may ask?! – Detective Constable Pete MILLER from West Midlands Police, the investigating officer in this case, knows only too well. This tweed-wearing, criminal hunter's devastatingly thorough professional skills we're brought to true detective-readiness only when one of his former uniformed inspectors made him learn the importance of going the extra mile in the matter of 'the Brazilian Money Laundering job' that had started to appear doomed to collapse … and has never let him forget it since.

JULY 2016

16th July 2016

Correct Use of Section 136 –

You may have been following the progress of the Policing and Crime Bill 2016 through the parliamentary process – this is the Bill which will amend various bits of legislation on various issues in policing, but for our purposes, it is most notable that it will amend police powers under the Mental Health Act 1983. The Government undertook a consultation in 2014 about what such amendments should look like and there have been various debates in the House of Commons as the Bill completed its journey through the lower house. It will shortly commence it's passage through the Lords and various topics are still up for debate.

Members of Parliament like Normal LAMB, Charles WALKER and Kevan JONES have introduced proposals to further amend the Act in ways the Government hadn't originally planned – on topics like, the use of Taser by the police on inpatient mental health wards; training for police officers on mental health and seeking to define in the Act itself what the exceptional circumstances would be where An adult can still be detained in police cells. This latter amendment was thought necessary by Norman LAMB because the government proposal was that the definition would be issued in Regulations published by the Home Secretary.

MENTAL HEALTH IN PRIVATE PREMISES

This post concerns one of the recent debates on the Bill: on 14th July, Sir Paul BERESFORD spoke about the difficulties of effective police responses in private premises to mental health emergencies. The keen-eyed amongst you may remember Sir Paul's name – he is the MP who introduced a ten-minute rule motion in 2014 suggesting that section 136 of the Mental Health Act be amended to allow officers to take protective action in private premises. This was set aside after the Home Office made it known that the issue was being considered in the 2014 review.

I can only assume that in the absence of that topic being overtly addressed and in light of there being no other obvious solution to the very real problem these situations represent, Sir Paul has raised the point again. But it's one of the Government responses to his point that particularly caught my attention, from the (then) policing minister Mike PENNING. This is what I

want to raise *again*, quite frankly because it infuriates me to distraction how undefined these various accusations and observations are.

As quoted in Hansard, Mike PENNING said –

Before we consider changing section 136, we need to ask whether it is being used correctly. We are concerned about the number of section 136 orders that are being used, and the data that I asked for show that forces in some parts of the country almost never use section 136, while others use it extensively.

So, what is 'correct' usage? – I don't understand what that means. I also don't understand why the Home Office are concerned about the usage – let us not forget, the Deputy President of the Supreme Court Baroness HALE, argued in the fifth edition of her textbook on mental health law (2010) that the power was potentially very *under*-used. Of course, it's true that forces use the power differently – before either force had introduced street triage schemes, Nottinghamshire and West Midlands Police were using the provision as often as each other. The problem being: West Midlands Police is almost three times the size of Nottinghamshire in terms of their officer numbers and the resident population. Humberside Police only use section 136 MHA about 400 times a year, whereas Sussex use the provision around 1,500 times. So what does 'correct' mean? … I know what I think, but I suspect Mike PENNING doesn't agree with me!

VARIABLES

And there is far more to it all than s136 numbers. As Baroness HALE pointed out, one reason for inferring the power is *under*-used is that there are many situations in which someone with a mental illness encounters the police and where the MHA power would not be the only one available. Very often it may be possible to arrest for a criminal offence or detain the person to prevent a Breach of the Peace. As such, to understand police decision-making in arrest encounters, you need to understand how a police force's use of the MHA fits in to their other detention and non-detention decisions. This is something that is not massively researched: how many people in a police area who are arrested for offences are subsequently assessed under the MHA because of serious concerns about their mental health? – and of those, how many were arrested in public places where s136 would have been an available option; how many were in situations where it should have been obvious the person was potentially suffering from a mental disorder?!

But the other reason Mike PENNING's answer is interesting, is because of an example he gives from his own experience –

When I was out on patrol with the Metropolitan police in Camden, we went to what the neighbours described as a "domestic situation"; in other words, someone had allegedly been assaulted. When we arrived at and eventually got into the flat, the one thing that the person who had been assaulted desperately did not want was for their loved one to be arrested and taken to a prison cell, because they were ill. They were ill in a similar way to someone who had broken their leg or who had a medical illness. They were ill and they needed to go to a suitable place of safety.

All too often over the years, that person would have been arrested and ended up in a police cell. If they were not subject to section 136, they would not necessarily have the safeguard of being seen by a medical or psychiatric specialist. That is one of the reasons why the amount of time that someone with a mental illness can be kept in a police cell is massively restricted by legislation.

Is this not precisely what Sir Paul BERESFORD is getting at?! – Mr PENNING witnessed police attendance in private premises at a reported assault which involved a family member seeking help for their loved one who was ill. Yet the Metropolitan Police could not detain the man under the Mental Health Act and quickly access specialist support. Instead they could either arrest him for the alleged offence or not detain him at all and risk a further escalation of the situation which had already resulted in one person being hurt. On which health service could they call for an alternative response, that is available in timely way, 24/7?

WICKED PROBLEMS

This is why I find this whole debate quite infuriating, if I'm honest – everyone seems to accept that there is a legitimate and quite wicked public policy problem ensuring effective responses to vulnerable people who are unwell in private premises. We know that street triage type initiatives can address just some, and by no means all, of those situations and that leaves the others. As Sir Paul makes clear from the fatal incident he refers to, the stakes are quite high. So you can either have a health and / or social care-led response to safeguarding people in distress; or you can enable the police to take protective action, like in most other countries, accepting that this brings a lot of unintended risks and consequences.

We know that it will lead to reliance by the health system upon the police as a resilience or contingency option, when crisis or community mental health teams are unable to cope with demand – we've seen that happen to some street triage schemes. We also know that it carries risks as far as patients are concerned – apart from the obvious point of making people

feel criminalised by over-exposure to the police, there is also recent research about how suicide risks can be raised by contact with the criminal justice system, even after allowing for other factors.

I'm not a fan of the idea that we extend police powers and understand why Mike PENNING is nervous about it: but it's pointless just having half a debate. If this is not the answer to the problem that we agree is very real and not getting better, it is incumbent upon those who are saying "No!" to actually solve the problem. If they don't, it seems nothing other than totally predictable that some officers, acting in accordance with the law of England, will refer their concerns about the immediately vulnerability of patients to mental health services, invoke as much informal safeguarding as family, neighbours or the community can give and hope it is enough.

We know it won't always be.

17th July 2016

Answer the Question! –

You may have noticed in the BLOG published yesterday, I didn't really address the question of what 'correct' use of s136 actually is, despite criticising throughout the lack of precision by others who raise the topic of correct use, or over-use of this provision. This was deliberate – I've covered the topic elsewhere on this BLOG for many years and I was forced to think really hard about it earlier in 2016 when a Coroner wrote to the College of Policing following an incident in Hampshire where officers arrested a vulnerable woman for an offence, rather than detain her under s136. It gave rise to the debate I've had many times, about when should officer detain under the Mental Health Act 1983 (MHA) and when should they arrest for an offence, if both options are available?

In yesterday's BLOG, I argued that it would be necessary to look at data from police forces that is generally not available, when trying to reach any kind of assessment about 'correct' usage of section 136 – especially if various figures in mental health services and in Government are intuitively prepared to argue against the instinct of Baroness HALE, that s136 MHA is *under*-used. If an apparently suicidal person on a motorway bridge is threatening to jump, when – if ever – should they be arrested for the public nuisance offence or Road Traffic Act 1988 offence? We do know that some people who have mental health problems have been criminally prosecuted and that others have been diverted under the MHA: what variables influence this?

But I decided to re-address the question, for clarity's sake and because someone on social media accused me of ducking it, just as I was accusing others of doing! So here's what I've previously said, amplified in light of where we now find ourselves in 2016 with things like street triage and legal reform –

ARREST OR DETENTION?

Well, this has been my standard answer for years, about how to make the decision between mental health criminal detention: I'll get explicit about 'correct' usage, immediately afterwards –

You arrest for the criminal offence, UNLESS: >>>

- The offence is trivial, especially if it is 'victimless'; or
- The victim reporting the incident is not seeking a justice response, but is seeking help for someone they know to be suffering from mental-ill health.
- That in the circumstances, the conduct is more likely than not attributable to mental health problems which should in the circumstances be prioritised.

The idea here, is that police officers will prioritise the health of people who may have offended in a minor way and only criminalise those where the offence is more serious and where greater consideration may need to be given in light of more information as to whether diversion is the right approach. It often will be, but it's hard to judge such things on a bridge over the M42 at 10pm on a Tuesday.

So what is 'correct' usage of s136 MHA? – in addition to thinking about any offences that may be involved, we also need to think about whether detention is actually necessary at all and we need to respect the limits of the powers that Parliament have afforded to various health and social care agencies.

ALTERNATIVES TO DETENTION

Avoiding detention of any description is connected to the ability to avail other options: and this shouldn't come as a shock. Policing research from fifty years ago by Egon BITTNER, and then developed by Melissa MORABITO around 10 years ago showed that arrest decisions in mental health encounters are clearly linked to police officers' knowledge of and ability to access alternatives. Common sense, isn't it?! … but it means that alternatives need to exist, police officers need to know that they exist and they need to know how to access them. This is why I've often smiled at the feedback we hear about street triage schemes claiming that they are reducing 'inappropriate' use of s136.

I'm not saying that some use of this power isn't inappropriate – it always has been and it probably always will be. But there are two points to make about this supposed, 'inappropriate' use: firstly, some triage nurses have been known to suggest 'inappropriate' use when working with the police as they find themselves jointly responsible for situations they cannot otherwise resolve in private premises! Secondly, a police officer using the power to take a patient (most people made subject to the use of s136 are known to mental health services) to services isn't an example of 'inappropriate' use if that officer cannot otherwise facilitate an encounter in circumstances where they believe it is urgently necessary to safeguard

someone. In fact, there's actually a third reason that no-one seems to want to talk about, which is there is reason to question how appropriate it is to be making decisions about suicidal people during ten or fifteen minute interviews on cliff tops and in the backs of vehicles. Most police officers can tell you, that putting time and space between people and difficult circumstances can be a very effective way to alter mindset and diffuse emotionally charged situations.

So it seems to follow that 'correct' use of section 136 MHA is —

- **Proportionate** – detention reflecting the potential seriousness of any inaction.

- **Lawful** – hardly seems worth emphasising, does it? … but so many professionals – *not just police officers* – still seem to struggle with the idea that it is unlawful to manufacture someone's presence in a public place so as to 'allow' use of s136.

- **Appropriate** – in terms of an inability at that time to access alternatives to detention; *and* in circumstances where it is not necessary to arrest someone for any offence.

- **Necessary** – in the opinion of the officer whose responsibility the exercise of the power is.

FOR THE AVOIDANCE OF DOUBT

The debate we hear on all this is still remarkably and surprisingly ill-informed: over the last two years I've challenged a lot of mental health trusts, professionals as well as political and journalistic commentators – without except, suggestions of 'correct' usage or allegations of 'inappropriate' use fold, as soon as you start challenging. We *still* hear people using the *conversion rate* argument about s136 – the idea that unless any detention by the police 'converts' in to someone being sectioned by an AMHP and two doctors it was 'inappropriate'.

That sort of claim always makes me drag out my story about the bloke detained after being persuaded back over an M6 motorway bridge who was then detained s136 MHA and then sectioned by an AMHP and two Doctors under s2 MHA. Three days after being admitted for assessment, he suddenly became lucid as the temporary effects of pharmacy drugs and celebratory alcohol wore off. Was the use of s2 MHA 'inappropriate' just because it didn't lead to a confirmed diagnosis? – of course not.

But as ever, as research has shown for years: whilst the trick to reducing s136 does lie partly in effective police training and more importantly in leadership, it lies more usually in timely access to appropriate crisis services both for patients and police officers in contact with them. The less of them you have, the more likely your local constables will be inclined to use this mechanism to bring together patients and professionals where urgent safeguarding needs indicate this is necessary and otherwise impossible to achieve.

So some of the variables you'll need to understand if you're going to look at the use of s136 across police forces, is the percentage spend by CCGs on mental health; the configuration and exclusion criteria of crisis mental health services; and the degree of integration that exists in that area across the health and social care organisations to prioritise mental health. We know that this varies across England – why wouldn't it affect the decisions of police officers working alongside such dysfunctional systems given what research tells us about detention decision-making?

19th July 2016

Taser and Torture –

This BLOG post is a direct response to a piece that appeared in the Guardian, entitled *Tasers have no place in mental health care* by Matilda MacATTRAM, Director of Black Mental Health UK. Before going further, I'd encourage you to read the whole piece for yourself. The debate in the House of Commons did include two amendments by MPs about Taser: Charles WALKER MP called for greater scrutiny through improved reporting; Normal LAMB MP (former minister of state for mental health) called for an outright ban on the use of 'electro-conductive devices' on psychiatric wards. I think the (then) policing minister, Mike PENNING MP, more or less summed up my own position: that we would all like to live in a world where the police are not called to inpatient psychiatric wards and that even if they were, that it would not be necessary to use a device like taser. But I don't police the world I want to live in; I police the world I do live in and mental health wards can be extremely violent and dangerous places that patients and staff alike will often say feel unsafe.

A couple of months ago, a mental health nurse was murdered by a patient in a Croydon mental health unit. In 2014, a mental health nursing assistant was murdered by a patient in Gloucester after he returned from authorised leave with a ten-inch kitchen knife. The last time the NHS published their assault figures, we learned that around 70% of the 67,000+ assaults which were reported occurred within the mental health sector – we know that many of those were assaults occasioning actual or grievous bodily harm. So the first thing we need to do is – *yet again* – debunk the myths that surround the nature of the relationship between mental ill-health and crime.

MENTAL HEALTH AND CRIME

MacATTRAM writes —

What we seeing [sic] is a health service relying on a forensic solution to meet clinical need, and yet policing really has no place in mental healthcare.

WOW! – I hardly know where to start at the naivety of this statement. It is *explicitly* written in to our laws that policing has a place in mental health

care … the Mental Health Act 1983 affords various powers to the police and mental health professionals but we expressly afford the police some powers of their own that even psychiatrists and mental health nurses cannot exercise – section 136 MHA. The criminal justice system is the only route to some patients being detained under certain kinds of orders of the Mental Health Act and guess who makes decisions to send people in to the criminal justice system? That will be the police. So it is neither true, nor realistic to make this claim.

The 'forensic solution / clinical need' statement needs pulling apart too before we can get on to any role that Taser should or should not play. I admit tor remaining unclear as to what this means, precisely. But if we are saying that all interventions on mental health wards around aggressive or resistant behaviours are *clinical* interventions, then this is also far from the accurate. Many patients who have offended even whilst detained under the MHA in hospital are found, in law, fully responsible for their actions and convicted. For example, when Ryan MATTHEWS appeared in court in December 2014 accused of the murder of healthcare assistant Sharon WALL, he pleaded guilty and was imprisoned – there was nothing 'clinical' about his attack. Imagine – hypothetically – that a police officer was standing there, in possession of a Taser: justified to use it?

More widely on crime and mental health, research referred to in the NICE Guidelines (NG10) on Violence (2015) refers to the figure above 90% for the proportion of people mental health problems who offend whose behaviour does *not* directly emerge *because* of their mental health condition. So where any deployment of Taser is being considered by a police officer in the context of a serious offence in progress or serious risk to life, it would remain true that most people could – at least in theory – be held responsible in law for their actions and that this is not a 'clinical' intervention, but a crime prevention intervention.

TORTURE

I've heard the claim before about Taser amounting torture so I decided this time to actually look it up. We need to refer to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and then to the 39th session of the UN's Commit Against Torture, which met in 2007. The document of the 39th session is 325 pages long and I've done my best to read it all: I can only see one reference to Taser and it comes on p40. It is important to understand the context of the following comment: it is a specific reaction to the Committee learning that Taser has been issued to certain members of the various Portuguese police services –

The Committee is deeply concerned about the recent purchase by the State Party of electric "Taser X26" weapons for distribution to [the Portuguese Police]. The committee is concerned that these weapons cause severe pain constituting a form of torture, and that in some cases it may even cause death, as recent developments have shown.

The State party should consider relinquishing the use of electric "Taser X26" weapons, the impact of which on the physical or mental state of targeted persons would appear to violate articles 1 and 16 of the Convention.

I will give advance notice of what may appear to some to be imminent pedantry in what I'm about to say, but I think these are important points to make –

- **What does the UN Convention on the Prohibition of Torture Actually say?** – the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.
- **What did the UN actually say about Taser?** – it didn't say "Use of Taser amounts to torture" in a general proclamation. They said they are 'concerned' … so is it, or isn't it?! Well, there are clues elsewhere because they revisited this in 2013 when the Dutch Police were considering a pilot of these devices whereby they would issue them to all police officers in a certain area.
- **The Netherlands, 2013** – whilst expressing their reservations again, the Committee did not call for total relinquishment, but merely to refrain from 'flat distribution' to all police officers. They hoped that special protocols would be agreed for those who did carry the devices and that they would only be used as an alternative to lethal weapons. But torture is torture, right? – there can be no exceptions to that rule and there is no defence under the Convention.

UNITED KINGDOM LAW

Section 134 of the Criminal Justice Act 1988 is our domestic law and creates a criminal offence of torture, punishable by imprisonment. During one CAT document on UK progress against torture, the Committee does express regret. That UK law affords a defence to any allegation of torture, something the UN says should be removed. UK law states that –

A public official or person acting in an official capacity, whatever his nationality, commits the offence of torture if in the United Kingdom or elsewhere he intentionally inflicts severe pain or suffering on another in the performance or purported performance of his official duties.

There is another offence under sub-section 2 of someone doing so if they inflict severe pain or suffering an another at the instigation of a public official. The defence I referred to is in sub-section 4 – and this is where I breathed a sigh of relief because it "shall be a defence for a person charged with an offence under this section in respect of any conduct of his to prove that he had lawful authority, justification or excuse for that conduct. For the purposes of this section 'lawful authority, justification or excuse' means … lawful authority, justification or excuse under the law of the part of the United Kingdom where it was inflicted."

My sigh of relief was because I have inflicted severe pain or suffering on others in the course of my duties: I have repeatedly struck people with batons; I have restrained people for hours on end in hospitals to stop them hurting themselves; and used public order shields to strike people repeatedly and pin them against walls – thus allowing my colleague to repeatedly baton a large knife from the grasp of a man who seemed hell-bent on killing us. But in those contexts I was acting lawfully, tasked as I had been with arresting or detaining people under other laws, like the Police and Criminal Evidence Act or the Mental Health Act. I have also been in charge of several operations where Taser has been deployed against extremely violent and sometimes very vulnerable people.

A SHORT HISTORY OF TASER

Matilda MacATTRAM is quite to highlight that Taser was first introduced in the UK for authorised firearms officers, in order to give them a 'less lethal alternative' to guns. The wider distribution of the device is attributable to subsequent decisions to issue Taser to officers who do not routinely carry firearms and this is where it gets controversial for some. Is Taser the

second-highest use of force, ranking just below firearms and above the use of batons or incapacitant spray? – no, it's not. In terms of the impact and after effects, Taser can be less injurious to those targeted than a baton; it can also be effectively operated from a greater distance and at less risk to the officer and third-parties.

So Taser equipped officers are often deployed, for example, to incidents where people are reported to be carrying or threatening the use of knives and most of the time, those officers do not draw their Taser – it happened only very rarely. Both of the homicides of mental health professionals, referred to above, were committed with large knives. To effectively use a police baton on someone with a knife, you have to get close enough to allow yourself to be stabbed: with Taser that is not the case. It is also worth bearing in mind, that in terms of self-defence, none of us have to take *any risks whatsoever with our own safety* before being legally allowed to defend ourselves, pre-emptively, if necessary. As the greatest threats to the safety of police officers arises not from guns but from knives, it seems inevitable that Taser would be considered as having a role a wider role than those situations where the police would be thinking of pointing a gun at someone. Unless, of course, someone has a better idea for how we stop someone opening up their own neck with a bread knife, without getting close enough to be stabbed?!

What went unmentioned in Matilda's article is that the vast majority of time that Taser is 'used', this merely means it is removed from the holster and / or pointed – it is *not* normally discharged at the subject. And let's be clear, the UN appears to have stopped just short of saying, "Use of Taser is torture", because of the remarks they subsequently made about the Dutch pilot in 2013. These later remarks indicate that comments made in 2007 appear to have been modified and updated – quite rightly given the majority of its 'use' sees no pain or suffering whatsoever inflicted on the target.

I can only summarise: mental health wards can be places of extremely serious violence, including the use and threatened use of weapons and including the deaths and serious injury of mental health professionals – in the majority of those cases, there will be no legal barrier to the full investigation and prosecution of those who have injured NHS staff, even whilst unwell. As such, parity of esteem has to work both ways: if we accept that the police may be running in to an A&E department – where assault rates are actually far lower – why would we suggest that colleagues working in mental health services are entitled to any less protection from their police service and why would we seek to totally prohibit officers from using equipment that will limit injury and better ensure their own safety?

I admit – I don't even begin to understand.

29th July 2016

Mental Health & International Law –

When I woke up this morning, I was greeted with a familiar message on Twitter from a duty inspector: "We have a male who has been sectioned under 2 MHA but they say there's no bed. He's been here all night and no word of any bed today. Can they do this and just expect us to lock him up?" I sent back the hyperlink to a BLOG I wrote three years ago and sent some advice on escalating the incident to senior police officers and trying to do so to senior health managers. The duty inspector then added that he'd been told there were "no mental health beds in England" and that they were having to try and ensure this guy's wellbeing whilst knowing perfectly well he should be in hospital. A lot of NHS telephones seemed to be turned off during office hours, from what he reported back and he was told by one nurse during the process that "the other inspectors turn a blind eye." That's almost an incitement to corruption and false imprisonment – right there, folks!

So off we go again: this kind of situation is the single most common kind of problem incident I am contacted about at the College of Policing. It occurs way more often than weekly, on average two or three times a week; and of course, those are only the examples which people flag up or where they seek advice in resolving the problem. Who knows how many people are just cracking on and trying their best without telling me – most of them, I'd imagine. Of course the first thing is to recognise that there is a problem to face: in the scenario, as flagged up this morning, the person in police custody will usually not be 'sectioned' under the Act. It's a common myth that when a Mental Health Act assessment concludes with the news "He needs admission under s2 MHA" that the legalities kick in from that point. In fact, a person becomes 'sectioned' at the point where an Approved Mental Health Professional makes a written application for admission to a specified mental health unit and if there is no obviously available bed, then the application won't have been made.

That means the person in custody remains there, subject to whatever legal framework brought them in originally. If that was an arrest following an allegation of a criminal offence, then PACE governs detention and it's a case of either prosecute the person or release them from custody, with or without bail depending on whether the investigation will continue whilst that person is in hospital. There is a police force in England being sued in connection with exactly this kind of problem, so where does the liability sit

if the police were doing their best to ensure the safety of someone whilst the AMHP, CCG and / or MH trust were – between themselves and for whatever reasons – unable to comply with the obvious legal duties that rest upon them?

BEDS CRISIS

In 2015, the Royal College of Psychiatrists launched an independent commission of inquiry chaired by former Chief Executive of the NHS, Lord CRISP. I was privileged to be one of the commissioners supporting that work and we looked at the question of whether there were sufficient acute inpatient beds for adults in England. It was obvious from just the first meeting of the commissioners that the answer was not going to be a simple 'Yes' or 'No' – whether or not a particular area has sufficient supply of inpatient provision was often connected to whether or not they had the correct balance of alternatives to hospital admission. There were many mental health trusts where they rarely, if ever, sent patients out of their trust's area to another mental health trust and never used inpatient provision in the private sector. Other trusts did one or both of these things with varying degrees of frequency and often believed that they didn't have enough beds.

So the commission found that in addition to 16% of patients in hospital not needing to be there in the first place; they also found 16% who were medically fit for discharge but could not yet leave because there were shortcomings in post-hospital support. That may have been something to do with housing, benefits or drug and alcohol support, but it prevented discharge. But whatever the reason, if a patient has become acute unwell enough to require admission and no bed is available, then you don't have enough beds *at that time*, irregardless of whether the real problem is difficulties in community or crisis provision, alternatives to hospital or problems discharging others once medically fit.

So do we have a beds problem? – depends on whether you think there is still scope to deinstitutionalise our mental health system to community provision, or whether that balance has been reached. For what it's worth, I think there is still room to deinsititionalise but that the real reason 'care in the community' hasn't worked, is because it hasn't been properly tried yet. And I suspect we'd find if we looked at it, we've disinvested in community mental health services about as much as we've cut inpatient mental health beds over the last few years.

SECTION 140 MHA

Connected to all of this, I recently bashed off a number of Freedom of Information requests to Clinical Commissioning Groups in England, asking about section 140 MHA. I've done this before. This section imposes a **legal duty** – *ie*, it is compulsory – on CCGs to specify those hospitals in their area which are in a position to receive patients in circumstances of special urgency; and those which are specified to receive patients under the age of 18yrs. In total, I did another two dozen FoIs – that's in addition to the three dozen I did about two years ago. I asked again for the names of the hospitals that had been specified for the 'urgent admissions' purpose; and whether or not anything was done in commissioning to ensure those hospitals were run in such a way as to ensure available capacity for urgent admissions, for example, operating at the 85% threshold recommended by the Royal College of Psychiatrists. One difference between my first and second batch of FoIs is that during the intervening period, the Code of Practice to the Mental Health Act has been updated and republished, now making specific mention (para 14.74) of the duties on CCGs under section 140.

The replies made for very depressing reading: over half of the respondents said, "We do not hold this information – please contact the Mental Health Trust." Why would a mental health trust hold information about how a CCG had discharged a legal duty that rests not with them, but with the CCG itself? Even if the MH trust did know the answer, you would imagine the CCG would have to retain a record of it in case of things like … Freedom of Information requests – or NHS England inquiries. It's seemed to me a bit like someone writing to the Chief Constable to ask something to do with the use of police powers under the Children Act 1989 and the reply saying nothing more than, "Contact social services." I'm therefore forced to conclude again, that CCGs aren't complying with their legal obligations under the Act to even know about this section or what it means, never mind to actually commission services in such a way as to give effect to its intentions.

Finally, even those CCGs who could send me the name of a hospital, there was nothing happening to ensure the hospital operated in such a way to mean it actually did stand a chance of consistently being able to ensure the admission of a patient in urgent need, as per the ruling in the MS v UK case (2012). So I have to conclude that the deliberate decisions being made about the commissioning of public mental health services are being taken by people who often don't know about the obligations that international law inflicts upon how the services need to be able to operate.

INTERNATIONAL LAW

So this gets us back to the broader, positive duties on public authorities including CCGs and mental health trusts, to ensure the European Convention rights of those in contact with the UK's state agencies. The caselaw of the European Court tells us that failing to expedite the admission to hospital of people detained lawfully in police custody can amount to an article 3 violation; it tells us that detaining people in settings not intended for the purpose that sits behind their detention can amount to an article 5 violation and we already knew that there is a more obvious article 5 problem if someone is detained somewhere in circumstances where domestic law does not allow for it.

Imagine if the police had arrested a man for an offence and were found out that he was acutely I'll with a physical health condition: let's say he was found to have serious cardiac problems. Imagine if the Force Medical Examiner attended custody and said, "this man needs to be admitted to hospital for care!" He wouldn't stay in police custody until that admission could be organised – he'd be transferred to A&E to begin to ensure his wellbeing and more appropriate monitoring of his condition. It may be that A&E isn't appropriate for someone with a mental health condition, but why not transfer someone to a health-based Place of Safety, for example? All of this hits the buffers of capacity and provision, obviously – but we should have some idea of what we're trying to do here, especially if the current arrangements are so unacceptable. And unlawful.

From just a bit of dip-sampling that was far from being anything I'd pretend to call research, it is a massive under-estimate to suggest that these kinds of problems occur about *ten times a day* in England – that's over three and a half thousand times a year we're subjecting people to the indignity of custody when we've already determined they are so unwell as to need inpatient admission. If almost all of them did amount to a human rights violation, as well as to a personal tragedy for those affected, it needs urgently examining, at the most senior levels of the health service because this stuff is not just a bad thing, it's almost certainly *unlawful*.

I'd hate to think about how the expectations of the UN Convention on the Rights of Persons with Disabilities hits these scenarios – I could easily imagine some senior figures would probably faint.

31st July 2016

A Comedy of Errors? –

Imagine a patient taken to A&E by ambulance after taking an overdose who is then admitted to the poison's unit of the acute, general hospital. A mental health assessment is requested as routine, because of the overdose, but is scheduled to take place tomorrow once the patient is anticipated to be medically well enough to undergo that assessment. Later on the day of admission, he becomes distressed on the ward and attempts to leave but the junior doctor on-call places him under a s5(2) Mental Health Act order. Still distressed, he patient lashes out at staff and verbally threatens them, so they desist in attempts to prevent them from leaving and call security to stop him getting out of the hospital. For whatever reason, security cannot locate the patient and he is presumed to have absconded.

The crux of this little anecdote is to get at the legal powers that are now in play. The ambulance service were requested to attend the patient's home address and return him to hospital – an interesting decision, given that he had lashed out at hospital staff and threatened them. What powers would a paramedic or technician have in this situation?! – the answer will be revealed towards the end!

Enquiring with the ward staff about the missing man, they are told by nursing staff that the Mental Capacity Act allows them to bring the person back – someone who has taken an overdose must be suicidal and that means they lack capacity, right?! – the answer is towards the end but the paramedics are unconvinced and given a stand-off, because the patient would not return, the ambulance service seeks the support of the police. A section 5(2) MHA patient is refusing to return, can the officers help them out?! – answer towards the end, but the police claim to lack powers in this situation, can therefore add nothing to it and decline to attend.

ABSENT WITHOUT LEAVE

We're still not getting very far, are we?! – an overdose patient, not yet medically fit and potentially suicidal according to ward staff and we can't work out whether they can be returned and / or whether anyone has a legal power to do this. So far, we have various ward staff – including those who instigated the power! – two paramedics who could be elsewhere answering

999 calls and the police who have probably interrupted perfectly good coffee and doughnuts(!) to turn down the chance to help; and despite their collective training, we're still unsure about this.

Welcome to the health and criminal justice systems of the fifth largest economy in the world! – inspiring, isn't it?!

So far, the only people who are right in summing up the predicament they are in, are the ambulance service: they have no powers *of their own* to rectify this situation and yet they are the people stood near the patient's house with the responsibility for them. The advice they've had from the ward is wrong; the support they've not been given by the police is wrong and there is a clear and easy answer to this situation! … that does not rest with the paramedics only.

This patient is absent without leave, missing from section 5(2) MHA – he may be retaken by a constable, an AMHP or anyone else authorised by the managers of the hospital, in the 72hrs after the section was implemented. As all of this happened in the first day of absence, there was well over two days in which to get it sorted. As with all other powers for AWOL patients, there is no power of entry in order to return the patient, so a warrant under s135(2) MHA would be required. Of course, what I don't know, is how the communication occurred between the various parties. Did the ambulance control room tell the police it was a section 5 patient? – we know that some problems of this kind is actually just about communication.

BECOMING JADED

If this post sounds slightly cynical or jaded(!), I fully accept the rebuke! – I've noticed myself recently becoming quite impatient with these sorts of things. I unintentionally woke up the dog shouting at the tellybox this week when I saw #999whatsyouremergency on Channel 4 and I suspect it's because there is a human limit to the amount of times a person can keep saying the same things, over and Over and OVER, again and Again and AGAIN … and that I'm towards that limit after another two years of working on nothing but this stuff, bringing me to a total a five full years over the last twelve and ongoing attention in between those jobs. I may need to go and be a policeman again!?

All that said, I did then immediately have a sharp word with myself: this AWOL situation is one of almost forty different scenarios where people who are not where they are meant to be under the MHA, need to be considered for return.

The law allows for people to become AWOL under the following twenty sections of the MHA –

- 2
- 3
- 4
- 5(2)
- 5(4)
- 7
- 17A
- 35
- 36
- 37
- 38
- 37/41
- 42
- 45A
- 47
- 47/49
- 48
- 48/49
- 135(1)
- 135(2)
- 136(1)

And in addition to the above sections allowing for some people to be 'absent', some of them also allow for people to have absconded. These AWOL situations have various timescales that apply to the period within which people can be re-detained and returned, ranging from a few hours to indefinitely; and they don't allow that same group of professionals from the above scenario to act. Some of these things are police-only powers. In the police-only powers – 35(10), 36(8) and 38(7) – the person should not be returned to the hospital from which they're missing, but to a courtroom. One of these things requires a warrant from the Ministry of Justice before the legal power can be invoked.

All clear for you?! … no wonder people less involved in this are confused! I asked a question on Twitter as part of writing this blog, seeking to understand what people thought the answers were and there are other professionals, including mental health professionals, getting this wrong. Why wouldn't they?! – we don't actually provide legal education of any reasonable standard for our professionals – I make an exception for the Approved Mental Health Professionals who are trained and examined on this stuff; but certainly MH nurses get next to nothing.

So for what it's worth, here are some links to other posts I have done with reference materials and other ideas to use smartphones to access material quickly. We can all imagine what would be said if this patient had come to harm whilst everyone was busy not knowing what they were doing, yet we

didn't really give any of these people the chance to get it right by training them properly —

- What do all the sections mean?
- AWOL timescales
- Quick Guides

Finally, if you want this stuff easily accessible, do what I've done and create a reference section of BLOGs on your phone's homescreen. Instant access to this stuff which I know various police and paramedics have resolved situations for them in seconds – at least in terms of knowing what they have to do!

I can explain most of this stuff, but I can't understand it for you or look it up for you when you need it most! … but good luck with it.

AUGUST 2016

1st August 2016

Leytonstone Sentencing –

Muhiddin MIRE was today sentenced by a criminal court following the attack at Leytonstone Underground station last December that made prominent national headlines. I admit, I had a bit of a job initially piecing together what exactly the court had done, following vague media reports that appeared somewhat to contradict themselves! One simply claimed the man had been sentenced to 'life in jail' whilst another that he would 'begin his sentence at Broadmoor'. This made me wonder whether, in fact, the court had sentenced him to what's known as a *hybrid order* – this turns out to be exactly what they'd done; so I thought I'd quickly explain it, in case of any doubt as to what this means!

Before I do, I'd observe that somewhere between being charged with attempted murder by the police and his sentencing today, he has been transferred between the criminal justice and mental health systems. When he first appeared at court, there would be no power for Magistrates to remand the defendant to hospital under the Mental Health Act. At or after his first appearance at the Crown Court, he could be transferred and that has obviously occurred and facilitated a period of assessment by the psychiatrists who have given professional opinion to the sentencing judge. The defendant has pleaded guilty to the offence, notwithstanding that his mental illness is serious enough to mean he reaches the threshold for admission to hospital under the MHA.

So this is yet another example to prove the point that serious mental illness does not always equate to a lack of criminal responsibility for serious crimes. Indeed, as previously pointed out, attempted murder is the most difficult kind of assault to prove – because a charge of murder succeeds if it can be proved that the defendant intended to kill or seriously injure the victim; attempted murder requires proof of intent to kill. A notably higher threshold to satisfy.

HYBRID ORDERS

A hybrid order means that the court can issue a 'normal' criminal sentence of imprisonment to any defendant over the age of twenty-one, but they will first be admitted to hospital under the Mental Health Act for treatment. It

then depends how long the patient's treatment lasts as to whether they are discharged from hospital or transferred to prison to complete that original sentence. All of this is done under s45A of the Mental Health Act 1983.

So in Muhiddin MIRE's case, he was sentenced to 'life imprisonment with a recommendation that he serve a minimum of 8.5yrs in jail', commencing with the treatment aspect of the hybrid order. Let's imagine he remains in hospital for 6yrs receiving treatment, he will then be transferred to prison for a minimum period of 2.5yrs before the Parole Board would be able to take any decision about his release from prison. Were his hospital treatment to last 9yrs, then release would be *considered* – but not necessarily granted! – as soon as the clinician in charge of his care recommended discharge from hospital. If the Parole Board did not grant immediate discharge, he would be transferred to prison to serve further time in jail until his case for release is reconsidered.

Finally, anyone made subject to a hybrid order after conviction for any offence specified in Schedule 1 of the Criminal Justice Act 2003, will be subject to the provisions of Multi-Agency Public Protection Arrangements, or MAPPA. These are arrangements which aim to ensure, amongst other things, post-release mechanisms through which public authorities cooperate to share information, to ensure risks are properly managed in the community, if or when a patient is discharged or prisoner released.

So this is the only form of sentence which combines two periods of detention: first in hospital and then in prison. These orders seem to becoming more popular amongst judges, the point being that they prevent people with serious mental illnesses who are convicted by the courts of being subject to a far shorter period of detention under a (restricted) hospital order than they would have done if they had been sentenced only to a period in prison.

And we could debate the ethics that sit behind that approach, all day long … on another day!

24th August 2016

Tasers on Psychiatric Wards –

If you have been following the progress of the Policing and Crime Bill 2015, you will have seen it has recently started its journey through the House of Lords. Accordingly, noble peers have had an opportunity to table amendments to the original Bill, for consideration and debate during the committee stage and on the floor of the House.

The main aspects which affect mental health are –

- A proposal to remove the words 'police station' from the definition of a Place of Safety under s135(6) MHA – this would mean police stations could never, *ever* be used.
- A proposal to ensure the right to an appropriate adult for anyone detained in a PoS under s135 or s136 MHA – the amendment fails to specify who would have to provide this adult or who funds it.
- Finally, it is re-suggested that Tasers or 'electro-conductive devices' should be banned from use on psychiatric wards – this is a second attempt by the Liberal Democrats to introduce such a ban. It was previously introduced by Norman LAMB MP and defeated in the House of Commons.

DEFINITIONS

There is a great BLOG on this topic by @NathanConstable from Twitter which gets in to the whole debate about tactical options and asks the obvious questions about what will be expected by those who are proposing and supporting this ban? Will they, ultimately, back police officers who shoot an armed patient if a Taser would have sufficed were it not banned by them? Remember, the 'use' of Taser in around 78% of incidents simply means it was drawn from a holster and threatened: no-one was touched, at all. Yet we are having a second argument to suggest that police officers should, instead, hit people with metal poles or fire baton rounds or bullets at them. (Assuming in all instances that attempts to de-escalate without resort to force have been tried and failed.)

I want to address another question and it causes me to ask "So what is a 'psychiatric ward'?!" There are many kinds of environment in which patients

may be detained under the Mental Health Act 1983 that I would never describe with those two words. What about the patient who is living in semi-supervised accommodation as a 'step-down' from low secure forensic care, prior to being conditionally discharged? – if there were an incident at the location and officers attended, Taser would be permissible because it's definitely NOT a psychiatric ward … it's not a ward of any kind! What about a dementia patient, living in a nursing or residential care home, detained under the MHA? – the same argument applies. But surely someone's vulnerability is their vulnerability; the risk of these devices (all equipment carries risks; as. Does doing nothing) is still the risk whether the Taser is discharged on a ward or not. Are we also going to ban Tasers during the execution of warrants under the MHA – if not, why not?! Such events are often the immediately preceding step in admission to a psychiatric ward so the sensitivity and / or medical risks will be broadly similar. I've directed Taser officers to undertake such tasks and would happily do so again, unless legally prohibited from doing so.

What happens where a person who is detained in a psychiatric ward under the MHA is transferred to another kind of location – that could be to A&E for urgent medical treatment or to an acute inpatient setting for whatever purpose. We know that some patients are detained under the MHA to general hospital wards because they require surgery or other treatment for conditions that are associated to their mental disorder. If there were a serious incident – and can think of several, I've known – then would the officer be able to use a Taser? What about a learning disabilities hospital or unit – they're not traditionally referred to or thought of as 'psychiatric wards'. What about a health-based Place of Safety – I once knew a patient pull a knife an officers in an NHS PoS. They drew a Taser and threatened to use it – gaining compliance without touching the person and causing no injury whatsoever. Thankfully, that seems unaffected by this proposal but if that had been patient who returned to a 'psychiatric ward' after a period of s17 leave, Taser wouldn't be an option.

I can't help but think: we either issue this kit, accepting its risks; or we don't. Restricting its use in such an arbitary way really just tells us that those proposing the amendment don't trust officers to make the appropriate judgement about its suitability.

THE OTHER MATTERS

The reason I'm looking forward to the debate occurring, is that the proposal around police stations will mean there *must* be discussion about the kinds of circumstance in which opponents to the proposal think stations should be used. Here's a predication: we'll hear about people whose behaviour is 'so extreme it cannot otherwise be safely managed' – we'll hear about the capacity and capability deficit that prevents safe management of vulnerable

people who exhibit challenging behaviours – as if that somehow *obliges* the police to put people at risk by incarceration and ongoing restraint – and we *won't* hear how the deliberate decision to remove people to custody is indifferent to whether or not resistant behaviour could be indicative of underlying medical problems or something that puts them at raised risk because of the need for restraint.

I doubt whether it will be acknowledge by those who oppose a ban that most of the circumstances in which it is still argued police stations are acceptable places to *gaol* the vulnerable are actually just deaths-in-custody waiting to happen. We'd know that if we just listened to families whose relatives have died. I obviously hope that police stations are removed from the list of Place of Safety locations, but I genuinely fear that the amendment won't succeed, not least because the Government could have chosen this reform to begin with and someone will probably point out the impact on NHS services, including A&E which would have to act as the overspill if mental health trust PoS were full and police stations unable to be relied upon. I fear that will be prioritised over more important things.

Finally, I'll be intrigued to see whether the Appropriate Adult proposal succeeds. This one slightly surprised me, because the role of the Appropriate Adult role is currently one for police custody, for those taken there against their will. That is usually because they have been arrested for an offence and may well need to be interviewed after having their rights explained. The AA role is to ensure people understand the process, assist with communication, see that the person's rights are being respected and challenge or advocate, as necessary. Where someone has been detained under s136, Code C to PACE makes it clear (para 3.16) that the AA has no role during the formal interview by the AMHP and Doctor, presumably meaning their role is restricted to just the booking in procedure for the administration of rights and to ensure a general understanding of things.

Some people argue that this is broadly the role of the AMHP when they are undertaking an assessment under s136 so this just duplicates things. It also would create the highly unusual situation in which the right to an Appropriate Adult is a statutory right for those detained under ss135/6 whereas it stops short of that for those under arrest at police stations, detained under PACE. And it does raise that question – who is going to do it and pay for it, given the amendment doesn't specify?

28th August 2016

For The Want of a Nail –

Guest BLOG from Chief Constable Simon COLE, former lead on mental health for the National Police Chiefs' Council.

For the want of a nail the shoe was lost
For the want of a shoe the horse was lost
For the want of a horse the rider was lost
For the want of a rider the battle was lost
For the want of a battle the kingdom was lost
And all for the want of a horseshoe nail

I must confess that I had always thought (and still do think) that this was about Richard III's defeat at Bosworth Field, Leicestershire, but then, as the chief constable of the city in which he is laid to rest, for me Richard is the most alive and omnipresent of medieval monarchs in day to day life! However, my researcher (well Wikipedia) tells me that this quote is attributed to Benjamin Franklin, Founding Father of the United States of America.

I am always interested in how such basics impact on policing. For every positive impact of grand strategies or complex delivery plans it does seem that commonsense, compassion and attention to detail have a place too. They are the nails that hold things in place.

There are often stories in the national press about bed shortages in the world of health, and about logjams of patients waiting to move out into social care. What does that have to do with policing? Because policing is part of a huge, complicated, system that supports people we are absolutely at the heart of these issues. The lack of beds for mental health patients, accompanied often by problems accessing appropriate transport, sees police officers and staff spending time hunting for those crucial nails. A cursory look across social media quickly reveals officers and staff having to transport people who are ill in police vehicles, often after lengthy waits. This is not what is described in the Mental Health Crisis Care Concordat.

The concordat focuses on four areas;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well

That should be supported by local agreements, and overseen by a partnership group that includes a combination of police, PCCs, partnership trusts, ambulance trusts, health commissioners, and local authorities amongst others. They are the people who decide how many 'nails' there are: how many bed spaces, how many vehicles for transportation, how many actual places in the Place of Safety. If there aren't enough of those nails, or there are too many, then they need to know that is the case. It is also the place where some dynamic, innovative partnership based systems thinking can take place to drive progress.

Escalation of what is going well, and what isn't going well, is really important. That is both as things are happening through control rooms and duty teams, and then slower time through the provision of data and information. That will enable those who are doing the commissioning of health services to see that they have got enough nails, enough horses and enough riders. Because of course the kingdom that we are fighting for is one where people who are ill receive timely, compassionate and appropriate support. For want of a nail that Kingdom can be lost….if you doubt that then please just pop to Leicester and ask Richard III.

Simon Cole QPM is Chief Constable of Leicestershire Police.

SEPTEMBER 2016

1st September 2016

ABD: a Medical Perspective –

This is the first of a three-part series by a UK Consultant in Emergency Medicine, Dr RS. The topic of ABD keeps coming up again and again, I was grateful for an offer to get in to some of the detail of all this – debate and discussion is welcome in the comments below. Parts 2 and 3 in this series will emerge in the next few weeks.

INTRODUCTION

Acute Behavioural Disturbance/Disorder (ABD), formerly referred to as "excited delirium' is increasingly being recognised within the UK, with concerns raised by police forces, HMP institutions and the media; due to the difficulties in establishing the true rate of occurrence (see later), the unfettered availability of novel psychoactive substances ('legal highs') prior to the introduction of specific legislation undoubtedly precipitated a spike in presentations. Arguably the medical response to this rising trend has been sluggish; the Royal College of Emergency Medicine published a guideline on the recognition and treatment of ABD this year (2016).

As with any death in custody (or following police contact), the spotlight focuses on the actions of the officers involved; considerable scrutiny is paid to any use of force employed in an attempt to respond to an individual who is displaying often extremely violent and aggressive behaviour. Controversy exists due to the perception that death is as a result of excessive use of force, and the often negative findings at post mortem to definitively answer why a person suddenly died, leaving relatives with unanswered questions, and police officers subjected to often lengthy investigations, with emphasis on their decision making in the most challenging of circumstances.

The purpose of this BLOG is to increase awareness of the condition, attempt to explain the underlying physiology (limiting medical jargon), treatment options, and necessity of a multi-agency response to individuals exhibiting this life threatening condition, to relevant sources will be made.

Finally, it may be worth explaining my own interest in this subject: I am a medical practitioner working in Emergency Medicine within the UK, with a specialist interest in clinical forensic medicine, psychiatry, and toxicology;

I volunteer as a special constable and have prior experience as a Forensic Medical Examiner (police doctor). Over the years, I have personally treated cases of ABD, and seek to increase knowledge dissemination to improve outcomes, but also to recognise the high-risk of mortality associated with the condition.

BACKGROUND – THE HISTORY OF ABD

ABD whilst often described as a relatively new phenomenon, was first reported in a case series by an American psychiatrist in 1849 as "exhaustive mania." He described a cohort of hospitalised patients exhibiting signs of fever, with extreme agitation, lasting anywhere between hours up to 22 days; death occurred in 75% of cases, with no physical cause found at autopsy.

In 1985, American pathologist Wetli coined the term "excited delirium;" in the Miami region of the USA he noted a pattern that police officers were called to an individual acting strangely, and unresponsive to police instruction. Upon attempting to restrain the person, their behaviour became increasingly violent and aggressive for a short period, followed by sudden collapse and cardiac arrest; resuscitation attempts proved futile. Post mortem findings were limited to injuries of the extremities associated with handcuffs or "hogtie" restraints; toxicological studies were either negative, or levels of cocaine were lower than those found in recreational use. As a consequence of these at-the-time unexplained deaths, civil rights campaigners raised concerns over excessive use of force by the police.

Since Wetli's publication, there have been further reports of ABD in the medical literature. A variety of recreational drugs have been implicated as the precipitant for the condition, in addition to a limited number of psychiatric illnesses. Theories as to how persons suddenly succumb to the illness, along with postulations relating to the police use of force have been put forward, often with limited evidence or appreciation of the extreme physiology associated; perhaps even more concerning, evidence for suitable treatment options has only recently been published, with clinicians utilising therapies based upon the treatment and care of patients in psychiatric institutions, and 'what worked in the past.'

In 2009, the American College Of Emergency Physicians published a white paper to formally recognise the diagnosis of Excited Delirium, with suggestions on the management of such patients presenting to the emergency department; in the UK, The Royal College of Emergency Medicine published updated clinical guidelines on Acute Behavioural Disorder in 2016; formal recognition and treatment options are not currently part of a recognised medical curriculum.

UK police force training on ABD (still referred in some areas as excited delirium) is highly varied, ranging from acknowledging its existence in the mandatory officer safety training, to formalised instruction on the disorder.

LIMITATIONS OF MEDICAL EVIDENCE

The role of evidence-based medicine is firmly established with the UK; evidence-based policing whilst in its infancy, is gathering momentum. Critical appraisal of the medical literature reveals the paucity of reliable data available; as an example, a simple search for "diabetes mellitus" in Pubmed will reveal just over 401,500 hits. A similar search for "excited delirium" and "acute behavioural disturbance" will result in under 200 hits. The 'level' of evidence as a guide to the quality of publications is limited to case reports/series, with very few prospective evidential data collection; formal randomised controlled trials for the treatment of ABD have been published this year.

A substantial proportion of the literature is published within the forensic pathology field, reflecting the high mortality rate of ABD; the often inconclusive or negative findings at autopsy highlight the lack of a distinct physical terminal event (see part 2). Hampering searches of the literature are the multiple synonyms used to describe ABD: excited delirium, acute exhaustive mania, lethal catatonia, agitated delirium are to name but a few, perhaps indicative of the dispute of what constitutes a diagnosis of ABD.

The collection of robust, statistical evidence to identify the incidence, severity, expected outcome, and success (or failure) of proposed treatment for ABD is notoriously difficult. There are several contributory factors responsible for the impediment of data collection on ABD; not least a specific diagnostic coding for NHS does not exist, police incidents with suspect cases (non-fatal) are hard to discern from the usual 'angry man,' and fatal occurrences are investigated by the coroner (England & Wales) or procurator fiscal (Scotland) with limited access to, and data-sharing between, agencies. Further complicating matters, the Independent Police Complaints Commission (IPCC, England and Wales), and Police Investigation and Review Commission (PIRC, Scotland) limit any information until after an investigation has concluded, which may be years from the incident.

The true incidence of the extreme presentation of ABD that is life-threatening is (fortunately) relatively rare; a search of incidents reported to the press that are consistent with death secondary to the condition, reveals any one UK police force has only been subject to at most, one readily identifiable case, (with the exclusion of the Met and Police Scotland, secondary to population and geographical statistics). Given that multiple Emergency Departments are located within such areas, the chance that an

individual Emergency Medicine doctor to have experience in the recognition and treatment of the presentation is likely to be extremely low.

DEFINITION OF ACUTE BEHAVIOURAL DISTURBANCE

The diagnosis of ABD has now been accepted as incorporating three core features:

1. Delirium
2. Autonomic disturbance
3. Violence/aggressive behaviour

Delirium

Delirium is characterised as an acute confusional state; features consistent with delirium include: inattentiveness, lack of orientation to time/place/person, often coupled with delusional beliefs (extreme paranoia in the context of ABD) and hallucinations (auditory and/or visual). Whilst delirium may result in lower levels of activity, with ABD the person always exhibit agitation, and constant motor activity. This state is responsible for the lack of recognition of emergency services personnel/family members or believing that such people are false or imposters.

Autonomic Disturbance

This feature of ABD refers to the state of the body being a hyper-stimulated state i.e. flight or fight mode, but escalated, and sustained beyond what would normally be experienced. Physiological changes associated with this state include a rapid pulse, elevated blood pressure, elevated body temperature, dilated pupils, flushed skin, and rapid breathing.

Violent Behaviour

As to the behaviour exhibited by individuals in a state of ABD, what is predominantly reported is a sustained aggression towards emergency services personnel, and family members attempting to assist.
The destruction of glass/mirrors has been reported as feature of ABD; however rather than acts of vandalism, this is most likely a result of the altered perception associated with a delirious state. Seeing distorted reflections, such as demons and the like may trigger an attack resulting in the destruction of the reflective surface. It can be incredibly difficult for emergency services personnel to discern the difference between the statistically more probable ‘angry man’ from an individual exhibiting signs of an ABD.

There is no diagnostic test for ABD; identification is made clinically, from an assessment made observing the patterns of behaviour, a basic assessment of cognitive function, and associated abnormal physiology. What is has become clear, is that ABD is a spectrum of a condition rather than an 'all or nothing phenomenon' – appreciation of this is critical to understanding the necessity for early intervention, and the high rate of mortality associated with the extreme presentations faced by police officers.

Part 2 of this blog will examine the known triggers for ABD, with an exploration of the underlying physiology associated with the condition.

7th September 2016

Leicestershire Police CIT –

Some hyperlinks to various BLOGS and resources that will be of benefit –

- What Do All The Sections Mean?
- The Quick Guides
- The Mental Capacity Act

Reference materials –

1. The Mental Health Act 1983
2. The Mental Capacity Act 2005
3. Code of Practice MHA (2015)
4. Code of Practice MCA (2008)

Golden Nuggets of Knowledge! –

- A Dozen Little Details
- Top ten pieces of case law

Getting practical –

- Not quite an App!

10th September 2016

ABD: part 2 –

This is the second in a three-part series on Acute Behavioural Disturbance written by Dr RS, a UK consultant in emergency medicine.

The first instalment of this series has been widely read and you may wish to begin there if you missed it originally.

In the previous edition, the history and clinical features of acute behavioural disturbance/disorder (ABD) were described; the triggers for the condition will be described, along with the underlying physiological changes associated with the condition below.

CAUSES/TRIGGERS FOR ABD

Delirium – one of the key diagnostic features of ABD is described as an acute confusional state; theoretically any cause of delirium can trigger an ABD, however the overwhelming precipitant of ABD is related to drug use. Most of the medical literature relates to cocaine however since Wetli's initial case series, a variety of substances have been implicated. The underlying pathology of delirium relates to a disturbance in the *function* of the brain, as opposed to anatomical changes. Brain cells (neurones) constantly signal to each other through chemical messengers (neurotransmitters) to change the processes within the cell itself; several neurotransmitters have been identified, namely serotonin, dopamine, nor-adrenaline, GABA and others. Whilst the type of neurotransmitters is relatively limited, the receptors to which they bind are numerous; for example serotonin receptors have 14 subtypes alone. For the purposes of simplicity, delirium can be characterised as an imbalance of the closely regulated processes governing the balance between excitatory, and inhibitory neurotransmitters, resulting in an 'overstimulated' brain, predominantly in the areas of the brain relating to perception (interpretation of sensory input), cognition (thinking), and wakefulness.

Drugs – drugs used for recreational purposes are the most frequently reported cause of ABD, especially within the domain of forensic pathology. Drugs exert their psychoactive effects acting within the brain to alter neurotransmitter release, reuptake or breakdown; some drugs act as direct

receptor stimulants. Cocaine, the first substance reported to trigger ABD continues to be responsible for such presentations; similarly, amphetamines (including met-amphetamine 'crystal meth' or ice), feature frequently. Within the UK, deaths secondary to ABD as a result of cannabis intoxication and various novel psychoactive substances have been reported. GHB (liquid ecstasy) intoxication may induce an ABD; acute withdrawal from GHB in users who consume the drug daily may rapidly manifest an ABD.

Mental illness – incidents relating purely to mental illness are rare, with substance use often compounding presentations; in the very first descriptions of acute behavioural disturbance in the mid 1800s, mental illness was the sole determinant. The mechanisms by which mental health conditions may lead rise to ABD are complex and beyond the scope of this article; case reports featuring predominantly manic states, and to a less extent schizophrenia exist. Postulations as to the underlying brain chemistry responsible for such episodes again lend to alterations in neurotransmitters.

Physical health – isolated case reports relating to ABD are rare, but a physical cause for such events should be excluded. Recognised causes for delirium secondary to physical illness include head injury, brain tumours, stroke, prescribed medications, low blood sugar, and alcohol withdrawal. Such cases often present in a more advanced age group (excluding alcohol withdrawal, or delirium tremens which is found in all ages), however their role in the cause of ABD should be considered by clinicians.

UNDERLYING PHYSIOLOGY OF ABD

Due to the nature of persons exhibiting ABD, measurement of the underlying physiological changes has proved problematic; advances in medical technology, has led to a greater understanding of the dynamic processes involved. For persons exhibiting ABD the physiology is akin to the "fight or flight" response, albeit elevated beyond the body's tolerance. As a consequence of grossly elevated circulating catecholamine levels (adrenaline, nor-adrenaline, and dopamine) a state of autonomic disturbance arises; put simply the autonomic system is responsible for regulating processes such as heart rate, blood pressure, and blood flow to organs.

Characteristic of ABD, the individual will constantly be moving as a result of the underlying agitated state; when responders attend and attempt to administer aid, this is met with intense fear and often violence (secondary to delirium and misinterpretation of the offer of assistance). This constant physical activity results in a rise in body temperature (hyperthermia);

sustained activity levels, with escalation in resisting efforts of help overwhelm the ability of the body to compensate for this heat generation.

The third aspect of physiological changes resulting from ABD is referred to as metabolic acidosis. The body strives to maintain the blood pH in a constant range – neither too acid, nor too alkaline. Complex systems interplay to achieve this neutrality (far beyond the scope of this article); suffice to say in ABD these adaptive systems are overwhelmed and a state of acidosis exists. One of the compensatory mechanisms to temporarily achieve this is to increase the respiratory rate to 'blow off' carbon dioxide, hence why suffers of ABD will hyperventilate, and prior to sudden death often exhibit panting patterns of respiration.

WHY DO PEOPLE DIE OF ABD?

Not everyone who exhibits features of ABD will die; it must be appreciated that survival outcome is related to the duration of the state. When police are asked to respond to a person (usually male) who is behaving aggressively or in a bizarre manner, it is impossible for officers to determine how long such a person has been suffering such a state without direct observation.

Non-fatal cases – this is often as a result of early recognition of agitation, without the extreme physiological response and is the most common conclusion to the milder forms of ABD.

Sudden cardiac arrest – an unexpected cardiac arrest, often after intervention by police officers, is by far the most controversial event associated with ABD. Sadly resuscitation is rarely successful, even if cardiac arrest occurs when the person is being transported in an ambulance to hospital, reflecting the extreme physiological stress and irreversible changes leading to cardiovascular collapse. The effect of metabolic acidosis reduces the strength of contraction of the heart; this acidosis also affects the transmission of the electrical activity within the heart, increasing the susceptibility to abnormal rhythms. When first responders attend such a person, the sudden burst of catecholamines released when struggling may result in 'stunning' of the heart and sudden cessation of contractions.

Multi-organ failure – as a consequence of sustained hyperthermia (with body temperatures persistently elevated above 41 degrees), multiorgan failure ensues. The heat stress upon the body activated the blood clotting systems with the generation of microclots, which almost immediately are dissolved, consuming the clotting factors, resulting in spontaneous bleeding in various body systems. This coupled with dehydration, and a reduction in blood pressure will result in low perfusion of vital organ systems, namely the liver, kidneys and brain. Intensive care may support the patient for a

period to assist recovery, however death may ensue within 48 hours to 2 weeks due a variety of complications.

POST-MORTEM EVIDENCE

As discussed in part 1, autopsies often prove inconclusive to provide a definitive cause of death. Minor injuries associated with use of force, or toxicological studies positive for drugs may be the only positive findings – given a lack of information and understanding of the physiological processes responsible for death, it is natural to conclude death is related to use of force.

Measurement of blood catecholamines after death is not a viable option as they degrade within minutes; measurement of the metabolic stress the body is under (referred to as 'blood gas') is reflective of the state of the person at the time of the test, and again is invalid once a person is deceased.

Ultimately determining the cause of death requires as much information as possible, but a critical understanding of the extreme physiological state underlying ABD which is only measurable during life, rather than at post mortem.

Part 3 of the series will explore treatment options for persons with ABD, and the limited options available to first responders (predominantly the police) in attempting to respond to such events.

11th September 2016

New Section 136 Data –

Anyone fancy doing a PhD?! – we're badly in need of some proper research to be done on section 136 data so we stand a chance of knowing what on earth is going on! Friday saw publication by the National Police Chiefs Council of the latest data on the use of this power and we can see various ways of looking at this stuff if we wanted to provide a tabloid-style headline. So depending on whether your glass is half full or half empty –

"Use of police cells as a Place of Safety reduces by over 50%!"

"Police use the Mental Health Act more than ever before!"

In then bears *much* further scrutiny and begs *many* more questions –

1. Why are some police forces of similar size using s136 very differently?
2. Why are some forces using this power to a very similar extent when they are so obviously different from each?
3. Why have some forces with street triage schemes reduced their use of s136 and sustained that, whilst others reduced it but it has returned to normal levels?
4. Why have other forces not reduced it at all, despite street triage?
5. Why are some forces still relying upon police custody for almost half of their Place of Safety provision, but some haven't used the cells at all?!
6. Where s136 has been used in the street, how long does it take to sort out where someone will be removed to and how long are officers sitting in queues for hours until they can even get in to those locations?

Here is the Press Release from the National Police Chief's Council (containing links to the last two year's worth of detailed data). The image below, broken down by force area, is for 2015/16 and at the bottom, in yellow, are the total figures for the last three years. During reaction to the release of this data, I raised caution about the accuracy of the numbers involved: not only are simple year or year comparisons sometimes unhelpful, but we know there are *still* problems with this data despite the effort of NPCC to collate it.

Comparing this year with last year, use of s136 is up by almost 5,000 to 28,271. However, we know there was an incomplete data last year! To point out one big example of that, in 2014/15, the Metropolitan Police reported incomplete data (for whatever reason) which put their annual numbers at 829. This year it was 3,693 – up by almost 3,000 and back to where you'd roughly expect it to be (albeit rising). Factoring that in along with other data omissions, we can see the 2014/15 data needs a lot of salt! –

- **28,271** (15/16) – inc 2,100 to custody.
- **23,602** (14/15) – inc 4,537 to custody.
- **26,137** (13/14) – inc 6,667 to custody.

Here is the detailed breakdown, across England and Wales.

Use of Section 136 of the Mental Health Act 1983 in 2015-16 (England and Wales)

Police Force Area	Total s136 to police cells*	Total s136 to police cells (aged under 18)	Total s136 to health-based places of safety**	Total s136 to health based-places of safety (aged under 18)	Total use of s136	Total use of s136 (aged under 18)
Avon and Somerset	242	0	1020	50	1262	50
Bedfordshire	5	1	328	9	333	10
British Transport Police	28	1	1453	74	1481	75
Cambridgeshire	7	0	293	17	300	17
Cheshire	12	1	203	18	215	19
City of London	2	0	123	2	125	2
Cleveland	27	2	153	8	180	10
Cumbria	38	0	211	12	249	12
Derbyshire	16	1	209	9	225	10
Devon and Cornwall	100	3	*1364*	*38*	*1464*	*41*
Dorset	10	0	419	29	429	29
Dyfed-Powys	53	1	173	3	226	4
Durham	23	0	113	3	136	3
Essex	110	3	689	29	799	32
Gloucestershire	46	1	439	26	485	27
Greater Manchester	18	2	1310	77	1328	79
Gwent	81	4	185	20	266	24
Hampshire	27	0	665	30	692	30
Hertfordshire	0	0	642	22	642	22
Humberside	6	0	75	5	81	5
Kent	75	1	951	34	1026	35
Lancashire	5	0	659	22	664	22
Leicestershire	2	0	86	1	88	1
Lincolnshire	173	8	195	8	368	16
Merseyside	0	0	320	22	320	22
Metropolitan	17	1	3676	62	3693	63
Norfolk	8	0	323	16	331	16
Northamptonshire	20	0	406	16	426	16
Northumbria	2	0	220	14	222	14
North Wales	10	0	313	9	323	9
North Yorkshire	51	0	259	16	310	16
Nottinghamshire	20	0	480	24	500	24
South Wales	192	3	518	31	710	34
South Yorkshire	96	0	695	16	791	16
Staffordshire	30	2	486	24	516	26
Suffolk	3	0	355	12	358	12
Surrey	25	0	743	37	768	37
Sussex	151	0	850	45	1001	45
Thames Valley	39	1	1042	50	1081	51
Warwickshire	11	0	239	14	250	14
West Mercia	15	1	896	44	911	45
West Midlands	2	0	1019	29	1021	29
West Yorkshire	269	4	1072	38	1341	42
Wiltshire	33	2	301	16	334	18
Totals 2015/16	**2100**	**43**	**26171**	**1081**	**28271**	**1124**
Totals 2014/15	4537	161	19065	786	23602	947
Totals 2013/14	6667	256	19470	596	26137	852

* How many s136 detentions did your force have from 1st April 2015 to 31st March 2016 that went directly to a police station?
** How many s136 detentions did your force have from 1st April 2015 to 31st March 2016 that went directly to a health-based place of safety?

Source: National Police Chiefs' Council Lead for Mental Health. Data provided individually by police forces.

The header image of my next post, below, is the (inaccurately!) recorded use of s136 going back over a decade.

WHAT'S GOING ON?!

Who knows what's really happening?! In reality and based on what we know there are a large number of significant factors influencing all of this and understanding the relevance of them to different areas is fairly important. It is quite beyond me to understand it all without a great deal of work in each area that I don't have the time to do! So I would encourage people reading this in various areas to try to ensure the conversation starts and perhaps engage some decent academics to look at it?

I still receive enquiries at the College of Policing about mental health street triage with people asking, "What's the best model to operate?!" and I always reply, it depends what your problems are and what you're trying to achieve. And of course, none of this even begins to discuss the issue of the 'conversion' rate, which is a major piece of information used by some professionals to argue the police are over-using this power. Previously, just 17% of people detained under s136 would be admitted to hospital under the MHA but we know two things that put this figure in context –

1. **The threshold for admission is not a constant factor** – many MH professionals have been arguing it has risen over time as the number of available inpatient beds has significantly reduced. Is it any wonder that with fewer beds, fewer patients become inpatients?!

2. **How many 'successful' outcomes do not involve admission under the MHA** – how many patients were admitted informally, referred or re-referred to a community mental health or other health service? If a cop spots a vulnerable person who is subsequently cared for by a community MH team who transforms their life, isn't that a success?!

I would argue, for a few reasons, there are forces in represented in the above data who are *under*-using this power and need to think about how to use it **more**. I argue this because section 136 is just one legal power from a whole range of legal authorities that can be applied by the police in various situations. To fully understand section 136 usage, you also need to understand how it fits in to those overall options. How many people arrested for criminal offences or to prevent a Breach of the Peace were subsequently and rightly assessed in police custody under the MHA because of concerns for their health? How are interactions between the police and people with potential mental health problems handled and what factors

influence an officer's decision to a) detain; and b) chose the framework for detention?

In other words: are some forces more likely than others to find their officers are using public order laws, drunkenness laws or other provisions where a further moment's pause and interaction may make it clear that detention under the Mental Health Act is a more appropriate route – and how do forces encourage officers to make decisions where substantive offences are involved like possession of a knife or an assault? Only this week, we saw concern raised by a judge about a prosecution being dropped where a man was waving a knife around in a public place whilst mentally ill; this comes just a few months after a coroner raised concern that the police arrested someone with mental health problems for possession of a knife and didn't detain her under the Mental Health Act.

LOOKING FORWARD

This is the last set of data to be published ahead of the law being changed in 2017 and it's obvious that some areas have far more work to do than others to prepared for the likely implications. If police stations are banned (one amendment to be discussed in the Lords next week will seek a total ban), there are seven police forces who need to be thinking of their contingency plan for over 100 people a year – will that mean unless there is provision, each of them is taken to A&E?! I fully accept colleagues in A&E may have a view about this but if the law literally bans the use of custody and there is no health-based Place of Safety, what are the other options?!

We are obviously still waiting to learn what '*exceptional circumstances*' will mean if that Lords amendment is defeated and the original proposal in the Bill is enacted. A further problem that is not reflected in these figures is the ability to access a bed for those who are to be admitted to hospital following the police's use of s136 MHA. Only this week, I was called at 9:30pm by a triage car from one force who told me their duty inspector was putting pressure on them to sort a situation where someone had been in detention in a health-based PoS for around 30hrs and the MH trust were having a right old job finding a bed in either the public or private mental health sector. In eight months' time, that situation will either be unlawful and a violation of European Convention Rights; or just a couple of hours away from becoming so.

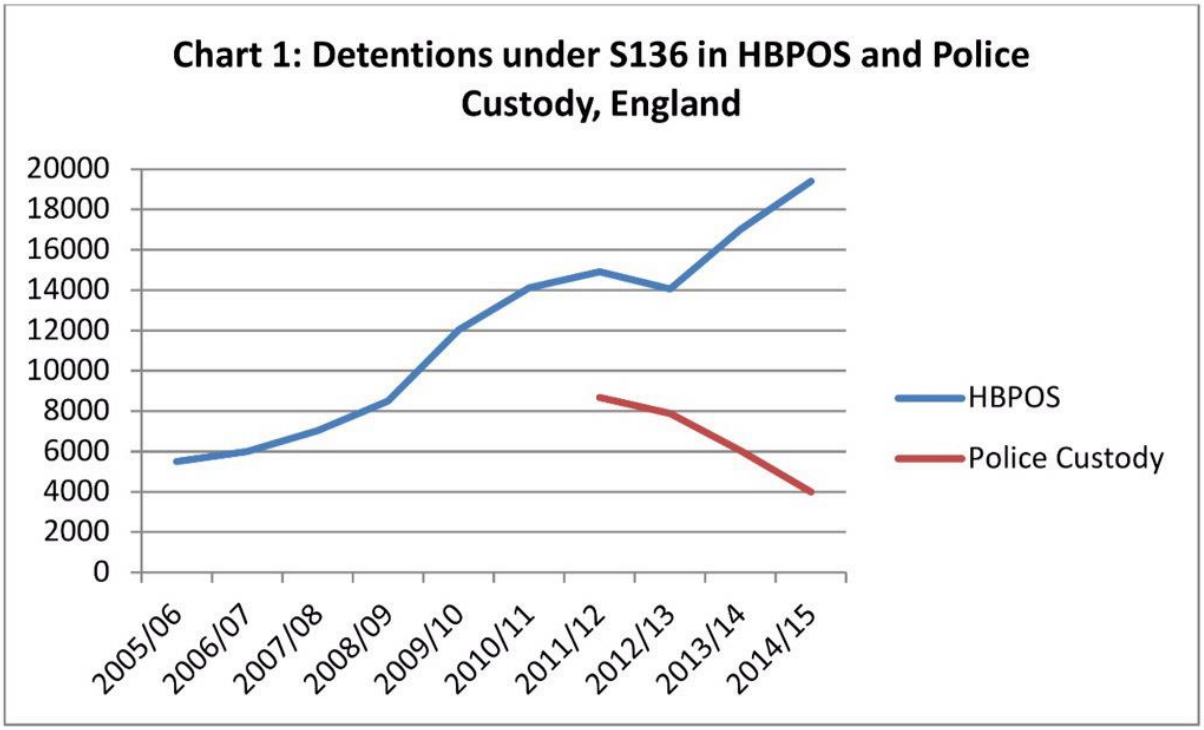
Section 136 MHA and everything that flows from it and is associated with it needs to be better understood. In all fairness, there are PhDs being done as right now on the use of the power, on street triage and other aspects of policing and mental health. However, what access those research students have to some of the data, I don't know. How many forces or MH trusts will

be free with data that supports the notion that they are breaching the law or Codes of Practice to the Act because of the overall pressure on our mental health system. How much of this research will reflect operational practice where police officers are sometimes required to become involved in or responsible for highly un-desirable situations that should never have occurred in the first place?

We have ***a lot*** still to do – and first of all: what is section 136 actually *for*?!

18th September 2016

Police Liaison –



I woke upon one day last week and whilst boiling the kettle checked Twitter to find an article entitled 'police liaison' in the British Journal of Psychiatry (no less) about street triage. Consumed with interest, I opened the PDF to find it granted free-access (I don't subscribe) and I started reading. In paragraph one, I admit to putting the phone down on the kitchen surface and breathing deeply whilst I got the milk out of the fridge. I read on, caffeinated!

The article sets an evaluation of street triage against the background of section 136 usage – more on that premise, later – and tells us that "it **requires** *[my emphasis]* the input of an Approved Mental Health Profession (AMHP) and two doctors for the assessment." Except that it doesn't! …. it *requires* just one registered medical practitioner, which is made clear by subsection 2 of the section itself, which states, "A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by **a registered medical practitioner** (RMP) and to be interviewed by an

AMHP and of making any necessary arrangements for his treatment or care." It doesn't even demand that the RMP is 'section 12 approved', although this is highly recommended by the Mental Health Act Code of Practice.

So what occured to me after reading it –

- The whole article about police liaison is about usage of s136 – yet we know most street triage encounters occur in places where s136 can't be used. There is therefore no analysis of the majority of its work!
- We also know that s136 is only a very small, and in some areas a relatively unimportant, part of 'police liaison'.
- It is predicated on not fully understanding what s136 requires – although many MH trusts and AMHPs prefer to have two doctors for assessment, this does not arise from the law, but from local policy. It makes me wonder how we justify any greater, longer restriction whilst we look for that second, no doubt helpful but legally unnecessary doctor?
- It fails to ask some really obvious questions about the approach of triage to encounters, where reductions in s136 have been observed – how do you delay the instigation of powers that are, by their drafting and definition, *immediately* necessary whilst officers 'phone a friend'?
- It starts from the premise that s136 is *over*-used, when we don't know that it is – there are some commentators, including the Deputy President of the Supreme Court, who argue it's probably *under*-used. In reality, forces use the thing so differently that it's probably a bit of both and depends which area you're looking at.
- None of the problems associated with non-use of s136 following triage contact are mentioned, at all – we know there are some issues with it, not least because there have been Coroner's inquiries following contact with these schemes. Have these things happened in that area?

TWITTER REACTION

I want deal with the reaction on Twitter from a few nurses and AMHPs, that two doctors for assessment is 'good practice' and standard procedure in many areas. Fine: the law can set a minimum standard and areas can choose to exceed it, but we know that this will also not be without difficulties and consequences. As s136 is currently framed, detention can last for up to 72hrs. This does not mean that all of 72hrs can be taken just because it's convenient – surely if the principle of 'least restriction' (which I remember reading about once upon a time) is to mean anything, it means we don't detain people for longer than is necessary.

If the law demands one doctor and there is no particular and obvious reason to include a second doctor from the outset, any delay in their attendance would need to be justified as proportionate to the delay it caused. If an AMHP had one (s12) Doctor available 3hrs after somebody's detention under s136 but a second doctor wasn't available until 9hrs after that, how do we justify the extra 9hrs of detention when the law could have been complied with at 3hrs? Indeed, during this morning's Twitter exchanges, more than one police officer was explaining that they've known cases of long delay to secure that second doctor so this is not hypothetical. I've also known it as recently as yesterday where a Mental Health Act assessment is requested for someone in custody (which would require two doctors) and the AMHP has turned up with just one, because they apparently pre-determined that the man's history would preclude him being sectioned under section 2 of the Act because admission to an acute admission ward would be inappropriate; he would require prosecution for the alleged offence to be admitted to a medium secure unit. Fair enough: but these decisions were made without anyone knowing or asking whether there actually was sufficient evidence to charge the person!

And this 'two doctors' approach for section 136 doesn't play the odds – most people detained are not subsequently admitted to hospital. Accepting some cases will be borderline, I'm not suggesting that none of those cases will always just need one doctor because an AMHP and the first doctor may know enough upon receipt of the referral to know a full MHA assessment is necessary; and the 72hrs is there to be used. I'm just imagining a situation where one of my family members is jailed in police custody as a Place of Safety for 3hrs when the first Doctor becomes available, but is then kept there for a further 9hrs for a second-opinion without any sense that it's necessary and everyone pitches up at 12hrs to do what could have been done earlier and my relative is sent home. Indeed, if a common complaint about police decision-making, also voiced this morning, is that it's "obvious" some people – or even *many* people – detained under s136 shouldn't have been detained at all and that police officers are too risk averse in their approach. It makes a bit of a mockery of that feedback that we're always using two doctors to do what one doctor could do in the vast majority (83%) of all cases and this approach has been normalised to such an extent that we're publishing articles on the false premise of what the provision involves.

POLICE VOICE

During discussion about potential research on things like s136 and street triage, it was mentioned this week on Twitter that 'clinical' people should be doing it. Conscious that this tends to mean doctors and nurses, I was most curious because a) look at the above; and b) there is an obvious role played by non-clinical professionals in a mental health crisis care: police officers, paramedics (who someone recently insisted to me are 'healthcare'

not clinical staff!?) and – of course – AMHPs (usually mental health social workers). I do try really hard not to be too picky with this kind of stuff (believe it or not!) – but one reason I keep banging away via a BLOG is: if we're happy to exclude the police from and others from research and discussion about a process that flows from a police decision and which requires ongoing police involvement then what else is being missed by professionals who often have too little legal training around the issues they purport to evaluate?! This is just one example: there is no ambiguity at all in s136(2) about what is *required* – it's written in everyday English language and is hardly the most technical or complicated of our laws.

But that gets me to a wider point: I worry about the exclusion of the police from various discussions that are going on in this country about the police role in our wider mental health system. In the same way that many patients have rightly demanded, "Nothing about me, without me", the same should be true across organisations and their partnerships. The College of Policing has worked for *two years* on Guidelines for situations where calls are received asking the police to undertake restrictive practices (ie, restraint) in mental health or learning disabilities settings. It took this long purely because of the large number of health, NHS, third sector and other organisations who needed to be involved and consulted. Collating that feedback was a mind-consuming nightmare which I will never full tell you about because of the volume of it, the considerable contradiction within it and so on. But imagine if we hadn't consulted and the College produced guidelines on matters affecting inpatient wards without speaking to staff who work there or more importantly with the patients who are detained there without liberty or autonomy?!

Yet in that time, I can think of at least three of four programmes of work or guidelines in health that directly affect the police where it seems highly likely that no effort was made *whatsoever* to consult with the police. I won't embarrass those involved, but I could back this up, if required to do so. I suspect there are plenty of conversations going on in rooms to which the police are not invited about how responsibility, risk and liability can be transferred to the criminal justice system and we see this in police-mental health processes. New data on the use of section 136 MHA has been celebrated as progress because the number of people being removed to police custody as a Place of Safety has halved over the last year, whilst the use of the power is still rising over time. On how many of those massively increased number of cases are two officers now being required (despite national guidelines to the contrary) to remain at the PoS for assessment? "Most of them, in many areas", is the answer and in some cases this means even more resource being expended by Chief Constables than was the case when cells were being heavily relied upon as Places of Safety under the MHA. Do the Chiefs realise this? – why would they unless they turned over the stone themselves. No data is being gathered on it and it gets buried

beneath the argument, "We agree that cells are the wrong place and we don't have enough staff."

LOOKING WIDER

Any premise that section 136 tells us very much at all is fairly flaky. We saw the 2015/16 data published last week and immediate comparisons were being made with the previous year's. Yet we know that the 2014/15 data was incomplete and that the data to is, at best, partial. I still can't tell you how many patients were admitted to hospital on a voluntary basis following assessment under s136. But there is so much more to triage and to police liaison as a whole –

- What about criminal suspects who are mentally ill – the whole liaison and diversion debate? When and at what point do we prosecute someone for an offence and when do we divert them from justice? – this group is about four or five times the size of the cohort detained by the police under s136 but we hear far less and know far less about them. What is the re-offending rate of individuals arrested for offences who are 'diverted' from justice at the point of arrest? We don't know.
- What about those in contact with the police who are not detained under s136 and don't need to be – whether that is street triage encounters; welfare checks on vulnerable people, etc.. Police forces around the country are asked to undertake tens of thousands of welfare checks every month, most of the time where the person is not 'missing' and where there is no other urgent issue that justifies risking the psychological wellbeing of someone by 'calling the police' on them.
- What about matters pertaining to the administration and application of the MHA – things like AWOL patients and those who have otherwise absconded; calls for the police to attend wards to undertake restrictive practices on behalf of ward staff, etc.? We know that there is still too much reliance upon the police to undertake these functions where they have no legal duty to do so and, again; where it risks having a very negative impact on the public.
- What about allegations of crime on mental health wards – whether those allegations are made by patients or staff? We know that there is dissatisfaction with the consistency of the police in their investigations and that improvement in this area could bring many benefits to all. However, the NHS needs to understand how much damage their own approach around the recording of 'medical factors' could do in this arena.

So I worry that we really are still making this stuff up as we go along; and that without a greater effort to gather data, we always will be. But first, we

have to open our eyes to the questions and problems and an informed police view point is vital to that.

21st September 2016

Restriction, Restraint or Removal? –

I recently delivered some training in Leicestershire which involved explaining the Mental Capacity Act 2005 to emergency services personnel. Quite unintendedly, I ended up explaining it in a way I previously hadn't which struck me as a more helpful approach than my previous efforts! So, I thought I'd outline it here in case it helps others.

As quick reminder, the MCA allows others to take decisions about a person who is reasonably believed, on the balance of probabilities to lack capacity. A person lacks capacity about a specific issue if they have an impairment or disturbance of the mind or brain and cannot communicate, understand, retain or employ / evaluate information relevant to that decision. For those who like mnemonics, you may remember the "ID a CURE" approach –

- Impairment; or
- Disturbance

- and cannot …

- Communicate,
- Understand,
- Retain; or
- Employ / Evaluate

One from the top two and one from the bottom four and, on the balance of probabilities, you can declare a lack of capacity. But what does that allow or obliged you to then do? This is the new explanation I employed with 999 personnel they suggested sounded useful.

LEVELS OF INTERVENTION

My new contention is that there are now three levels of intervention that need to be considered: listed in the title of the post – restriction, restraint or removal. I also want to re-emphasise, that this is about 999 responding to situations that were often unpredictable and unknowable – this is not about slower-time interventions involving Best Interests Assessors and long-term decisions.

- **Restriction** – undertaking actions which may restrict a person's rights and liberties, but only to a very small degree to mitigate a risk / threat;
- **Restraint** – actions which physically restrict someone quite briefly, proportionate to a greater level of risk.
- **Removal** – the process of taking someone against their will to another location for medical assessment / treatment, on the basis that the situation is especially serious.

Let me use one scenario which I can then add to, to escalate through the three types of intervention as a proportionate response to a vulnerable person who lacks capacity.

CASE EXAMPLE

Imagine a 999 service is called to a private address in response to a mother (in her fifties) asking for help for her adult daughter (in her twenties) with serious mental health problems. Her daughter has become unwell over the last few days and they are awaiting a response from mental health services, but this evening, her daughter has been openly threatening to take her own life unless she is admitted to hospital is threatening to overdose on medication she has gathered. The exact nature of the medication is unknown and mum is able to outline she has previously been admitted to hospital after a serious overdose and she has previously self-harmed.

999 responders arrive at the address and can quickly agree, they think this young woman seems extremely unwell and may need urgent assessment under the Mental Health Act. Her mother has been told in the last hour that assessment cannot occur that evening and she should call 999 or take her daughter to A&E if there are problems. A non-descript bottle of what appears to be various tablets is on the coffee table along with a razor blade and mum is confident she hasn't yet taken any of them. The young woman is declining all offers to going to A&E for assessment of her mental health, saying she just wants to be 'sectioned' and in terms of efforts to explain that A&E is the route to assessment and potential admission.

In efforts to offer a more urgent pathway to assessment and potential admission or care, it seems likely that the young woman lacks capacity to take decisions because her psychosis is affecting her ability to understand what the first-responders are offering. It is decided on this basis that they will have to do 'the least restrictive thing in her best interests.'

So what does this actually mean?!

Restriction –

The main risk at this stage, is that whilst the 999 crew is attempting to identify a route through, that the young woman will pick up the tablets or razor blade and use them to harm herself. Can you justify interfering with her property (the tablets and blade) bearing in mind that no-one has a legal right to walk in to someone else's house and interfere with their possessions? Yes – those items are potentially very linked to the situation being managed; she's threatened to use at least one of them in connection with the frustrations around accessing unscheduled care / assessment; and it is reasonably believed that she lacks capacity to take the decision about the solution being offered to travel to an ED for urgent assessment by psychiatric liaison services.

Could the 999 crews remove her to the ED against her will? Probably not yet – the Sessay case outlines the reasons why. The judge ruled that in such circumstances that an urgent MHA should be attempted so contact should be made with an AMHP who should be told of the mother's belief that she needs urgent assessment is supported by those attending and that in the circumstances there is no legal mechanism available to remove the patient from the address. Unless the situation changes, the MCA would probably afford a defence to the professionals under s5 MCA, for interfering with the patient's property to keep her safe, but it wouldn't go beyond that.

Restraint –

Imagine that scenario with one difference: upon arrival, the young woman is holding the medication and threatening to take it consume it unless the 999 crew takes her to a mental health unit. Bearing in mind all the other circumstances and a belief that she lacks capacity, would the crew be justified in removing the medication from her possession, by restraining her in order to do so? Probably – assuming that there was a reasonable belief by the professionals that this action was a proportionate response to the seriousness of the harm the person would suffer and proportionate to the likelihood of that harm, the MCA would provide a defence under sections 5 and 6 for taking steps to protect her from the potential that she will consume the medication and cause herself irreversible harm.

Another example might include: the RTC victim who was struck by a vehicle whilst crossing the road who now has a head-injury, is intoxicated and who is hoping to leave the scene of the collision without assessment by paramedics. Whilst being unsteady on their feet and somewhat confused, it is reasonable believed that the head injury could be significant and that they lack the capacity to take the decision to decline treatment. In the first instance, they could potentially be restrained by police officers to prevent

them leaving until paramedics can advise on whether there are grounds for removal to hospital without consent.

Removal –

Imagine another difference: upon arrival, the bottle of tablets is about 1/4 full and her mother informs you that she believes her daughter has consumed 3/4 of the bottle which was full only an hour beforehand. Although it can't yet be known what precisely is in the bottle, it seems probable that such quantities of certain things could prove life altering or life threatening. It seems necessary to ensure the young woman does not ingest any more of the tablets and that she will need assessment and treatment in A&E to mitigate the effects of the overdose. The MCA does make clear, in s4A of the Act, that no-one can be deprived of their liberty under the MCA unless the criteria in s4B are satisfied – these state that someone who lacks capacity may be subject to an urgent deprivation of liberty where this is necessary to provide a life-sustaining intervention or do a vital act to prevent a serious deterioration in someone's condition.

Our RTC victim, above, might be removed to hospital if paramedics were saying that the head-injury appeared so serious that without urgent hospital treatment, the person might – on the balance of probabilities – deteriorate and suffer a life-altering or life-threatening consequence.

EXTENDING THE MODEL

So! – we can extend the model to explain the MCA. First of all, established whether you can "ID a CURE" and where you can, you have three options and must undertake the least restrictive of them, depending upon the level of risk to the individual. If you can mitigate the risk by *restriction*, you will be unable to justify *restraint* or *removal*. If restriction is not possible or not appropriate, you should consider *restraint* first and only start to consider but not *removal unless restraint is insufficient* to ensure that person's best interests and keep them safe.

Happy to take feedback on this – please leave a comment below. It ended up being an improvised explanation to a group of 999 professionals in a particular context, so keen to know whether it helps simplify what can be a complex area of law.

23rd September 2016

Threatening Patients –

When I was a young boy, I can vaguely remember my dear Godmother once saying something about calling the police if I was naughty, saying the police would "take you away". Without missing a beat, I remember my mother responding quickly and firmly, "Don't say that to him!" She went on to explain that the police do not, in fact, take kids away for being naughty; that she needed me to understand that a police officer is somebody I can go to for help if I was ever stuck or in trouble; and that she should *never, ever* say that to me again. WOW!

It is probably this incident that accounts for my hatred of hearing adults say similar things to their kids. I've been known to be the policeman who kneels down next to kids and says, "What you've just been told isn't true – we don't take young children away from their parents for being naughty because police officers are there to help you and protect you if you're in trouble." I then usually explain my reasons to the parents and ask them not to do it in future, because they would probably agree that if I saw their child in danger, they would want them to ask me for help and they would expect me to give it. Hard to do that if the kids are running away, frightened of me.

So there's a version of this in policing & mental health land and it's occurred enough times this week, in various scenarios, that you will have to let me get this off my chest!

WASTING POLICE TIME

A Twitter conversation this evening has revealed that @MindourMinds has documented six recent examples across England of patients being threatened with arrest for wasting police time, following apparent suicidality. This is not the first time I've heard of this and just to be crystal clear: it's not the police threatening to arrest and prosecute patients – it's apparently mental health professionals. I regret to confirm I have heard of one example of such a case being brought but, quite rightly (I've seen many of the legal papers) it was dropped at court for being fairly ridiculous.

Wasting police time is a criminal offence, of course: but it is highly unlikely that any incident of suicidality, including any attempt, would be considered an example of it. The legal definition is within s5(2) of the Criminal Law Act 1967, "Where a person causes any wasteful employment of the police by knowingly making to any person a false report tending to show that an offence has been committed, or to give rise to apprehension for the safety of any persons or property, or tending to show that he has information material to any police inquiry, he shall be liable."

"Wasteful" … and "knowingly making a false report". I admit I'm struggling to understand how a patient ringing mental health services and claiming to be suicidal is a waste of police time? Even if the CrisisTeam felt obliged to then seek an urgent 'safe and well' check because of concerns for that person's immediate safety; how do you prove that this was 'wasteful'?! But of course, finally: even if the patient actually had told a blatant pack of lies to encourage MH services to provide some kind of service or to facilitate admission to hospital – even then: it wasn't the patient that rang the police and caused their 'employment', wasteful or otherwise.

INHERENT CONTRADICTION

So it's highly doubtful that there would be sufficient evidence to charge someone in these circumstances and I've only known it happen that once – it was dropped at court. How do you prove beyond all reasonable doubt that a person with mental health problems who claims to be suicidal, actually isn't?! … you can't prove a negative, as they say. Even then, there's the requirement to show that person caused wasteful employment *of the police* by making a false statement if concerns by healthcare staff were serious enough that they rang the police to check on someone's welfare?!

That's the inherent contradiction here: the person ringing mental health services is either making a false claim in which case there's no need to ring the police; OR they are not, in which case any deployment of the police by other services is not 'wasteful' because the concerns have been taken sufficiently seriously to warrant the police!

So: if you are a mental health professional wrestling with these issues, do consider what would need to be proved in a court in order to go down this legal route. Otherwise, if you make these kinds of threats, you risk looking silly if it turns out the police won't take the action you were hoping for. Of course, CrisisTeams can call the police for any reasons they think legitimate. Whether or not the police then actually do as they're asked, is quite another matter. It has been a feature of policing research for years (see *Policing Citizens* by PAJ WADDINGTON) to note that police officers do not have an inherent service-provider relationship with those who call

them. They may assess a situation and take the view that the caller is in the wrong and the 'accused' is acting perfectly properly.

The police are NOT on anybody's side – all circumstances turn on their individual merits.

THREATENING THE POLICE

Meanwhile, in another incident a service-user who has given permission for me to refer to this, was asked to attend a meeting without a clearly defined purpose. Suspecting it would be a Mental Health Act assessment for potential admission, they exercised their right not to attend, for various reasons that are important to them. When they failed to show up, a phone call followed in which the assessment was rescheduled and they were told that if they failed to attend on the next occasion the police would be called. This is not the first example of such a story I've heard over the years and I admit it also makes me feel very uneasy.

The problem with this is several-fold: firstly, what are they hoping the police will do? The obvious point to make is that any agreement by the police to attend the person's home address means creating a situation in which the officers have no legal powers. So unless the request was being described as an urgent welfare check, necessary because of fears for someone's life, the police could only ever knock the door and see what happens. Secondly, if there's no reply, the officers would walk away; and if there is a reply, they can only convey the message that has already been conveyed. Thirdly, it is not a criminal offence to fail to attend an appointment with mental health services, even if it is a statutory assessment under the Mental Health Act; and officers would have no MHA powers because the person is in private premises. So why wouldn't mental health services arrange to attend the address themselves whilst armed with a warrant to enable entry and an assessment that the police are then obliged to cooperate with?

Either way: it's the implicit assumption that the police are a coercive arm of mental health services, to be threatened and deployed at their whim that bothers me here. It is fair enough to comment that a mental health professional may feel obliged to report a situation to the police in certain circumstances, even with their recommendation or request: but it's ultimately for the police to decide whether the police get involved and on what legal terms. This is especially true where there are issues around criminal investigation and prosecution.

CARE AMIDST COERCION

There are various circumstances in which threatened coercion is inappropriate and this is made clear in the Code of Practice to the Mental Health Act. When it comes to the issue of patients being admitted to hospital, the Code specifies (para 14.17) that no-one should be told that if they do not agree to voluntary admission, they will be sectioned. The same applies (para 27.38) to voluntary patients who are already admitted: they should not be denied their right to leave a mental health ward under threat of being 'sectioned'. The Care Quality Commission has referred to these kinds of situation as *de facto* detention – and they caution against such situations on both ethical *and* legal grounds.

Attempting to promote patient cooperation with a statutory assessment by threatening to call the police also creates a similar, but in my view, slightly the more sinister situation. No-one is obliged to cooperate with mental health services, unless the requisite legal frameworks are put in place, either to assess or treat their condition. If I, as a police officer, am to respect patient's autonomy and liberty, I don't really want to personify a threat made that I may disagree in which I'm refusing to play any part. It's also not for mental health professionals to determine that a situation certainly amounts to an offence that could be prosecuted. I can't help but recall the incident I encountered about a decade ago where a mental health nurse rang the police to complain of criminal damage by a patient only for my investigation to reveal unlawful detention by the nurse and the mental health services she worked for.

If the police are to be the guardians that many want to see them be, it means standing up for the rights and autonomy of patients as well as *appropriately* supporting mental health services. But as I said: the police are not actually on anybody's side here!

24th September 2016

Para 16.16 to the Code of Practice –

It turns out I didn't read the new (2015) Code of Practice to the Mental Health Act 1983 as closely as I thought I had! The @LovelyClaireyA from Twitter said something recently about the execution of warrants under section 135(1) that didn't sound right to me and I was grateful to learn something new after she pointed me to the Code of Practice – paragraph 16.16. This paragraph has no equivalent in the preceding Code, hence it gives rise to a few new questions; and so having made a mental note to consider this a topic for the future, I got on with my weekend. Within 36hrs of speaking to Claire, I received an email from a police control room inspector seeking clarification on the execution of s135(1) warrants after an operational incident in his force area. The job had caused a disagreement with the AMHP who was accompanying the officers in executing the warrant and I therefore thought I'd prioritise getting this done, since my general rule is that two or more things new to me in the same week means it's probably occurring a lot more frequently and worth covering.

It all surrounds the question of conveyance from an address where a s135(1) warrant has been executed, in order to remove someone to a Place of Safety (PoS) for assessment under the Act or for arrangements to be made for that person's treatment or care. The warrant, which can only be executed by the police, contains two legal powers: one to force entry to the premises, if need be; the other to remove that person to the PoS, if thought fit. Once inside the premises, the Code requires the AMHP and Doctor to consider (para 16.8) whether any assessment can occur there with the consent of the patient or whether removal is necessary. Historically, removal to the PoS has been best done in a non-police vehicle wherever possible and practicable; but police officers would normally remain involved until arrival at the PoS by physically accompanying the patient in the ambulance, or in whichever vehicle is used if no ambulance is available.

So what does this new paragraph in the Code actually say? –

"When taking the person to a place of safety on a section 135 warrant, the AMHP, hospital managers or the local authority (as appropriate) should ensure that an ambulance or other transport is available to take the person to the place of safety or to the place where they ought to be, in accordance with a locally agreed policy on the transport of patients under the Act (see

chapter 17). It may be helpful for the AMHP to escort the person or meet them on arrival at the place of safety, in order to ensure continuity of care and to provide information for the hand-over. The police should not normally be needed to transport the person or to escort them for a section 135 warrant."

GETTING PRACTICAL

This is saying – if Claire and I have read it correctly! – that upon entry to the building and following any decision to remove the person to a PoS, the police "should not normally be needed to transport **or escort them**" [my emphasis]. So, the AMHP (and paramedics) can lawfully do this, according to the new Code. Presumably, this also amounts to a legal process whereby, the AMHP and others could use reasonable force, consistent with keeping themselves safe, if the need arose during conveyance. I can hear the objections already and I understand them! – but this will come down to a distinction between what the law and the Code say (the law and the Code, not being the same thing!) and the reality of AMHPing and paramedicine, and their professional views about what they should be contributing to these situations.

I will come back to this question: if the MHA allows restriction of people made subject to the Act by professionals other than police officers, in what circumstances do professionals other than police officers use this powers, other than in situations which occur involving detained patients on hospital wards?

- **Meanwhile, in reality** – there is nothing unusual about discussions about what role the police should play in administering the implications of Mental Health Act when it comes to conveyance or restriction upon those who are subject to it. If an AMHP had conducted an assessment in the house and 'sectioned' the person, there is a common debate about how to convey the person under s6 MHA to hospital. The same rules apply: it should not normally be done in a police vehicle and, in reality, the AMHP should be able to arrange an ambulance but the police still find they are all too often connected to admission conveyance because no ambulance is available or because someone is resistant to admission. Remember: the Code of Practice does NOT demand police involvement purely because someone is resistant. Only where they are 'violent or dangerous'. This situation is little different, in many respects.

- **Drafting of the Code** – having thrown this topic about on social media after discussion with Claire, some suggested there is confusion and contradiction in the drafting of the Code itself. Paragraph 16.3 informs us what the purpose of the s135(1) warrant actually is: it is

to provide "**police officers** with a power of entry to private premises, for the purposes of removing the person to a place of safety for a mental health assessment or for other arrangements to be made for their treatment or care." So if the legal power belongs to a police officer, can someone else discharge it if the police also disengage from the process? Some think not; however there are other, similar examples available where others have acted on behalf of a police officer, even though they've disengaged (see below). If you look at paragraph 16.14 of the Code, it also creates a touch of confusion about who should be doing what, in this context.

WIDER IMPLICATIONS

So if something is 'not normal', in terms of frequency, what does *that* mean?! We can surely start by agreeing it probably means, 'not most of the time'? Could we go even further and agree it should happen on a minority of occasions, perhaps only where certain criteria are met? The overall idea from Chapter 17 of the Code (which covers conveyance) is the police should be involved in the conveyance of a person only where they are 'violent or dangerous'. This is where my inspector colleague on email found that he had done what the Code suggests only to bump up against an AMHP who would have preferred the Code be disregarded in the circumstances. Having entered the building and a decision having been taken to remove the person to the PoS, the police withdrew from the incident and suggested the AMHP should make the necessary arrangements to convey the person.

So that brings us back to what a Code of Practice actually *is* – I remarked many years ago that we all too often see the Code as some kind of vital document that *cannot* be breached. Yet when it is convenient to argue so; it is something that is quickly set aside – many examples are available to highlight the contradiction this represents and this situation is just another example of the latter. Conveyance of resistant individuals all too often involves the police where they are neither violent nor dangerous because, quite simply, there is no other arrangement by which to do so. No planning takes place (that I am aware of) to ensure that AMHPs can call upon the necessary, non-police support in these situations. There are still long delays for ambulances; there are usually no other conveyance mechanisms and there are certainly no other staff who could assist in supporting a resistant, frightened patient without potentially terrifying them by calling the police. Why? – do commissioners and managers not ask themselves "If the Act or Code says this, what does that mean in the real world and how would we actually get it done?"

This kind of discussion emerged in Hampshire a year or so back when the MH Trust and the police commissioned a service to ensure that officers who

had used s136 of the Mental Health Act could handover the care of someone at the point of arrest – whilst still in the street – to trained staff who would then remove the person to the Place of Safety (on behalf of the Chief Constable) and remain there (on behalf of the MH Trust) to ensure the wellbeing of the person pending assessment. Then, as now, some questioned whether or not the first part of this would be lawful given the same argument: it is a police power to remove the person to the PoS, so can it be delegated where the Act itself does not explicitly say so? Well, there are various other situations in which police powers are delegated to others, so why not s136 MHA? – why not s135(1) MHA, especially as the Code seems to be encouraging it. The relevant services in Hampshire are certainly satisfied, on legal advice, that it can.

Let me conclude with this remark: I didn't write the Code and as far as I'm aware, the police didn't offer a contribution in the consultation for the Code that something like this paragraph be included! Nevertheless, it seems we now need to start talking about it because the Munjaz case (2005) reminds us that we should only be breaching the Code of Practice if there are "cogent reasons for departure". The poor AMHP in my colleague's situation probably thought, "How on earth do I get this done, if the police don't or won't help?!" That probably amounts to a cogent reason for them as an individual professional but back everything comes to strategic planning and joint operating protocols: has every area updated their local protocols on MHA assessments in private premises and / or conveyance since 2015 to specify how this stuff gets done along with commissioning managers making the necessary policy changes to ensure that AMHPs aren't in that position in the first place? … and if not, why not?!

27th September 2016

Pushing the Envelope –

I'm going to start with a disclaimer! – this post is thrown together to prompt discussion. I am not (yet!) putting this forward as a position or suggestion; I'm not even saying I've finished thinking this stuff through or that I believe every point made below. This stuff is not settled in my mind and is written purely to prompt discussion of a couple of things we seem to be taking for granted. All views very welcome in the comments section below.

On Monday of this week, I was asked to present to the PACE Strategy Board at the Home Office – this is a regular gathering of interested parties who oversee and discuss the issues that arise from the administration and application of the Police and Criminal Evidence Act 1984the Police and Criminal Evidence Act 1984. It is attended by the Police Chief's lead on Custody, Chief Constable Nick EPHGRAVE (Surrey Police); Emeritus Professor Michael ZANDER, the UK's top legal guru on PACE; and other representatives of bodies like the Crown Prosecution Service, the Law Society, and so on. The problem I presented on is one that will be familiar to regular readers of the BLOG: a person in custody for an alleged offence has been assessed by professionals under the Mental Health Act and is deemed to need admission to hospital but no bed is available and question arise about the legal governance of their detention.

There have been some high-profile examples of this –

- You may remember a Tweet by Assistant Chief Constable Paul NETHERTON which made national news headlines in October 2014 after a 16yr old girl was in custody for almost two days.
- An application for Judicial Review was made by Greater Manchester Police in 2005 and they referred themselves to the IPCC after a man was in custody for over three days.
- In 2012, a West Midlands Police case involving use of s136 of the Mental Health Act led to detention exceeding the 72hr permitted maximum in a case which was subsequently ruled by the European Court of Human Rights to have violated the Article 3 rights of the man involved.

Well, this morning I woke up to find a tweet had been sent to me and many others, highlighting yet another situation where a child was being held in custody pending the identification of a bed that didn't appear to exist; and in a great piece of work by journalist Andy McNICOLL we seem to have information confirming what most of us working in this area already know: problems with timely admission to hospital are getting worse. That being the case, it seems highly likely that the number of police related problems will be rising too. That's certainly what my emails tell me!

LEGAL REMINDER

In case you haven't seen the previous posts I've done or want a summary reminder, the legal problem is essentially this –

- When someone is in police custody under PACE for an alleged offence, they can only be detained to charge them with the offence for which they have been arrested; OR detained because it is necessary to allow for efforts to secure such evidence.
- Until an Approved Mental Health Professional (AMHP) makes a written application for someone's admission to hospital under the Mental Health Act, PACE continues to govern the detention of the person detained.

These two provisions of PACE are absolutely crucial to this situation –

- Section 34 of PACE – **general limitations on police detention**: in particular, you should look at s34(2) –

"If at any time a custody officer (a) becomes aware, in relation to any person in police detention, that the grounds for the detention of that person have ceased to apply; and (b) is not aware of any other grounds on which the continued detention of that person could be justified under the provision of this part of this Act."

- Section 37 of PACE – **the duties of a custody officer before charge**: look at s37(7).

"Subject to section 41(7) below, if the custody officer determines that he has before him sufficient evidence to charge the person arrested with the offence for which he was arrested, the person arrested shall be (a) (i) released without charge and on bail, OR (ii) kept in police detention for the purpose of enabling the Director of Public Prosecutions to make a decision under section 37B below, (b) shall be released without charge and on bail but not for that purpose, (c) shall be released without charge and without bail, or (d) shall be charged."

PUSHING THE ENVELOPE

In previous posts on the 'no beds' problem, I've alluded to the fact that worry about the legalities of detention on the part of the police only kick in when the PACE 'clock' reaches the 24hr mark. This is not strictly correct, though – as two provisions of PACE show us and they follow on from the custody officer's duty to keep grounds for detention under constant review –

- If the person was originally detained because there was *insufficient* evidence to charge the person and the custody officer reaches a view that there is now *sufficient* evidence to charge the person, they must charge them or release them on bail (for CPS advice or other reasons, as they see fit) – *this is in s37(7) of PACE.*

- If the person was originally detained because there was *insufficient* evidence to charge the person and the person is held because it is necessary to secure evidence, then the custody officer must release the person (either with or without bail) once that necessity ceases to apply – *this is in s34(2) of PACE.*

Nothing in PACE itself provides grounds to detain someone for a Mental Health Act assessment – so a vital question is 'does conduct of that assessment contribute to the gathering of evidence, relevant to determining whether someone should be charged? Unless the answer is that it does, it returns us to our quandary!

MEDICAL NEEDS

Obviously, PACE Code C covers the detention and treatment of someone whilst they are held in custody and it has various things to say about those detained whilst suffering a mental disorder. It covers the need for appropriate adults, amongst other things. However, in keeping with the legal issues for physical healthcare problems, there are a range of options for the custody officer to secure assessment from an Approved Healthcare Professional – an AHP is usually a doctor or nurse working for a contracted healthcare provider to assist the police with medical opinion about those in custody and shouldn't be confused with AMHPs mentioned above! AHPs are generic healthcare staff who do fitness to detain / fitness to interview assessments in custody; AMHPs are (usually) mental health social workers who coordinate Mental Health Act assessments.

If someone in custody was arrested and then discovered after detention in the cells to have an injury, the police must either call for an AHP to attend

custody and assess that person; or transfer the person to hospital (by ambulance if need be) should the situation not be something that can wait for the attendance of an AHP. So if the guy in the pub fight has possibly broken a finger whilst punching people, the AHP would assess that and may give him the option of waiting until release to attend hospital, having some painkillers whilst in custody or the arresting officers being asked to run him to the Emergency Department for an assessment / x-ray or whatever he requires.

If, following the call to the AHP or whilst that person was at ED, the grounds for detention change or no longer apply, the custody officer would act accordingly by ending or changing the grounds for detention. I've been the PC at the hospital who had taken someone there from custody and was told whilst waiting for treatment that the person was to be released from arrest for various legal reasons. Maybe the person arrested for assault is detained pending enquiries, statements and CCTV recovery and whilst waiting in ED, it is established that the victim of the offence does not with to complain of any assault and there is no other evidence? … the person is released from custody and he can then take his own decisions about his broken finger and whether to go to or remain in the ED.

PARITY OF ESTEEM

So is mental health any different, because of the potential that a person arrested may lack capacity to take their own decisions if released? We start from the position of presuming someone has capacity but we know the police encounter and arrest people in crisis and bear an obvious duty of care to ensure that person's welfare *to the extent that they lawfully can*. But the PACE point remains: if the grounds for detention cease or change, the custody sergeant is obliged to act accordingly and then any subsequent questions about the welfare of a mentally vulnerable person become something that should be subject to other decision-making. So it is potentially quite possible that someone detained without charge for enquiries to be completed, could be released from custody if the grounds cease to apply notwithstanding that they are mentally unwell to an as-yet unassessed degree.

Imagine, for example, a young adult who lives with a relative: the police are called to a crisis incident in the home they share and upon arrival it is obvious the person is unwell and has assaulted the relative, quite seriously. They are also in immediate need of care and because officers in private premises have no powers under the Mental Health Act itself, they arrest the person for the assault and take them to custody. MHA assessment is requested by the AHP because of the concerns about their health and the relative is giving information that supports the need. However, the relative is merely grateful for the police turning up and

safeguarding the person, refusing to make any complaint of criminal conduct because they believe this has only happened because the person is ill and in need of help.

What are the grounds for detention now? – on what basis is the person detained for MHA assessment?! Assuming there are no further enquiries which could realistically be done to ensure there is evidence for an offence, s34(2) applies and the person should be released, either with or without bail. What happens around mental health assessment will depend on circumstances and goes back to the same kinds of considerations as officers would apply if the first encountered the person where there is no criminal allegation.

IMPLICATIONS

I re-stress the point: this is a thought-piece and I'm still thinking this stuff through after two very separate conversations following the PACE Strategy Board forced me to think about some stuff that I realised I'd assumed or taken for granted. But all this begs a lot of interesting and potentially complicated questions for me, I must admit – and it does appear to have rather major implications, I'm afraid! – if PACE obliges the custody sergeant to release someone (under either s34 or s37, for whatever reason), should the officers then consider the need to rely upon s136 MHA after release?!

I can already hear objections to this: and I've acknowledged them myself in the discussions I've had before writing this BLOG with an AMHP friend of mine, some force mental health leads, etc. The objection is normally, "How would you regard that person has having been 'found in a place to which the public has access' if they are only in that place because the police released them from custody. There are two points to immediately make here –

- If this is a problem at all, it will only be a problem for about six months or so – the Policing and Crime Bill will change s136 to ensure it can be used in any private place that is not a dwelling. So it will be able to be used in police custody in the near future and the person can then be removed to a Place of Safety for the assessment, assuming other aspects of the definition for the use of s136 are satisfied.

- But it may not be a problem! – some argue police custody is a place to which the public have access because it is expressly set up for receiving the public and lots of other locations are still such places despite access being controlled or restricted – like the 'airside' in airports. And even if it's not, the circumstances of someone being in the police station front office or road outside are not because of any

subterfuge by the police to create the situation – they were obliged to release the person from arrest!

And if this point is right: what would that mean for the use of s136 MHA, especially when the law changes next year? But then what this does do – if it's even vaguely right! – is ensure that people in police custody thought to be mentally unwell are not detained in police custody, where that is not necessary in terms of the criminal justice process. So this is an argument about de-criminalising the process of ensuring the health and wellbeing of people who do not need to remain in police custody, for reasons around investigation and prosecution.

FINAL THOUGHT

Of course, there will be some situations in which conducting a Mental Health Act assessment is a part of the overall criminal investigation and relevant to issues around securing evidence and potentially interviewing the suspect. I would suggest these will tend to be the more serious cases where there may be a need to prosecute someone in the public interest notwithstanding how unwell they may be. It is occasionally the right thing to do.

As said: this is a discussion piece – all views welcome, below.

29th September 2016

ABD: part 3 –

This is the third and final part of what I hope you will agree has been a fascinating short series of BLOGs by Dr RS, a UK Consultant in Emergency Medicine. My final vote of thanks to him for taking the time to do this. If you haven't seen the first two parts, you may want to consider reading them before launching into the final chapter –

- *Part One*
- *Part Two*

In parts 1 and 2 the history, causes and underlying physiology were discussed. In the final piece, the treatment options available will be described, according to the current best medical evidence available, along with personal experience of treating patients presenting at various aspects of the Acute Behavioural Disturbance spectrum.

GENERAL CONSIDERATIONS

Established medical evidence for the specific treatment of this condition is extremely limited; recently the results of trials into the management of severe agitation, and observed prehospital care have been published building the evidence base (albeit in different healthcare models to the UK). Prior to this, most treatment has been transposed from the management of agitated patients as a result of psychiatric illness. As indicated by the prior two articles in this series, pertinent to the management of ABD is the recognition that this is a MEDICAL emergency, as opposed to a psychiatric one. The prehospital management of such cases would necessitate a separate article (which I am happy to provide if requested).

Initial Assessment –

The initial assessment of a patient presenting with suspect ABD is challenging, and poses risks to medical, paramedical and police staff. By definition the patient is in a delirious state, and as such unable to understand efforts to try and provide medical assistance; attempts to

verbally de-escalate are ineffective, and delay urgent medical intervention. The patient is in a state of fear, and believes persons are attempting to inflict harm; this can result in resistance to the most basic of medical care (for example measuring vital signs), to intense violent outbursts resulting in injury to themselves and care providers. If brought to the Emergency Department by police, the use of handcuffs and fast straps is often necessary to facilitate transport to definitive care.

Rapid SENIOR clinical assessment, based on observations is required to establish the diagnosis (raised body temperature, rapid pulse, delirium); it is rarely of immediate practical use to obtain blood tests (a finger-stick blood glucose can be measured to exclude a low blood sugar).

Initial Management –

The primary goals of resuscitation (for this is a life-threatening condition) are to administer rapid sedation, cooling, and fluids. The practicalities of delivering these interventions can be challenging; to obtain intravenous access in a patient that is combative can be incredibly difficult due to limb movement, collapse of the veins (from dehydration), lack of veins from intravenous drug use, and the very real risk of a needlestick injury to staff. Injuries to staff, and the number of staff required to physically restrain a patient who is often incredibly strong pose additional issues.

SEDATION

The aim of sedation is to reduce the extreme agitation as a result of the chemical disturbance within the brain; this is NOT simply to make the patient "easy to manage" nor used as a punishment. Without sedation, agitation will continue to escalate to the point of cardiovascular collapse. Sedation of a patient with ABD is not without risk; consideration of loss of protective airway reflexes, and suppression of the respiratory drive leading to hypoxia (low blood oxygen levels) are the primary complications, as is a sudden loss of blood pressure (hypotension).

The choice of sedation agent has been the subject of recent research; the time of peak action, method of administration, and complications from the drugs themselves necessitates consideration. Established management of agitation for psychiatric practise utilises lorazepam (a benzodiazepine), and haloperidol (an 'antipsychotic' or neuroleptic) injected into the muscle. The time of onset to peak effect is usually in the region of 20 minutes; for life-threatening ABD this is time-to-effect is to protracted to have a meaningful application. Within the Emergency Department, the use of intravenous benzodiazepine medications (diazepam, lorazepam, midazolam) offer one solution, however the doses required may be considerably higher to achieve effect. The use of neuroleptic medications, may have an adjunctive role but

are probably best avoided in patients with ECG changes secondary to acidosis (which may be difficult to establish).

If intravenous access is impossible to establish (or poses too great a risk to staff), the possibility of intra-osseous access can be considered (but again risks to staff, displacement of the needle, and lack of access to a suitable site can obviate its use). In such situations, the threat to life of the patient due to the need for restraint, hyperthermia (increased body temperature), and continuing acidosis may necessitate the use of intra-muscular ketamine; ketamine is an anaesthetic drug that has a rapid onset of action when given into the muscle (within 5 minutes), however a doctor must possess the necessary skills to manage a patient's airway once administered.

The administration of emergency anaesthesia in extreme cases is often the only option to provide life-saving treatment; this is a complex task, and necessitates care from clinicians who possess the appropriate skill set. Emergency anaesthesia enables formal airway control, the administration of powerful sedation, and ventilatory support to a patient who is imminently at risk of cardiac arrest, or whose aggression and agitation is such that risk to staff and themselves is of such a severity no other options exist.

INTRAVENOUS FLUIDS

Once sedation has been achieved, it is imperative to obtain intravenous access. At this point, blood samples for the measurement of acidosis, blood electrolytes, kidney and liver function tests, and creatine kinase (to measure muscle breakdown), clotting studies, and full blood count (measuring platelets, white cells and red blood cells) should be taken. An ECG to establish any abnormal rhythm or electrical conduction abnormalities is necessary.

The administration of cooled fluids (usually saline) aids in supporting the circulation (due to fluid loss from dehydration and sweating), promoting the excretion of muscle proteins released, and cooling of the body core temperature. Usually 1 to 2 litres of fluid are required to restore fluid losses, and aid in recovery from acidosis.

The role of administering bicarbonate as a fluid in acidotic states is often advised against by the medical literature; however in cases of severe acidosis with ECG changes and low pressure unresponsive to fluid resuscitation, a dose of bicarbonate may reverse the negative effects on the heart, and this decision is usually reserved on a case-by-case basis.

COOLING

Cooling is the third aspect of the resuscitation of the patient with ABD; this is achieved by stripping the clothes, the use of ice, and cooled fluids. Paracetamol and ibuprofen will not lower the body temperature; by the reduction of agitation through sedation, the process of heat generation from muscle activity is negated.

AFTERCARE

Once past the initial resuscitation phase, the cause for the ABD requires consideration; overwhelmingly drugs of abuse are responsible and time for the body to metabolise these agents and excrete them is the only treatment necessary. On-going sedation and fluid therapy may be required to support the patient for the next 24-48 hours. In a select group of cases, severe disturbance of thought process may continue, and necessitate specialist psychiatric assessment and treatment.

To conclude, the incidence of acute behavioural disturbance within the UK is increasing. Whilst controversial, and some clinicians may refute the existence of the condition, I am a firm believer that ABD is a distinct clinical entity that proves challenging to the police and medical personnel. With greater knowledge of the condition, and increased recognition by Emergency clinicians the fatal outcomes may be reduced, but not entirely eliminated. Should anyone have further questions, or request input I am more than happy to assist.

OCTOBER 2016

5th October 2016

LEPH – Harm Reduction -

The third Law Enforcement in Public Health conference is being held in Amsterdam in the first half of this week and it was a massive privilege to be invited to attend and address the main conference on Monday morning. Professor Nick CROFTS from the University of Melbourne is the main driver behind this and having 'met' him over the internet and by email, it was great to finally meet him in person. He made an important point at a pre-conference meeting, "There is only one Master's degree in Public Health that touches on the role of Law Enforcement: at the University of Melbourne" … oddly enough! And this links to the issue about whether police organisations are sufficiently tapped in to the public health agenda and whether or not health and other social services see the police as an important partner?

As a police officer: I know stuff health professionals don't know, about health issues – everything from the percentage of people presenting under arrest who are seriously mentally ill, to the location and nature of mental health crisis presentations. Police data could amplify metrics owned and controlled by health: how many people encounter the police whilst in crisis are known mental health service users? – what does that tell us about mental health care, discharge from hospital or revolving doors of crisis >> admission >> recovery >> discharge >> relapse?! The police are also in control of factors which directly affect health and wellbeing: from the right to use reasonable and proportionate force which includes mechanisms which seriously damage physical and psychological health; through to the right to initiate prosecution proceedings on behalf of the sate which can themselves prove pathologising.

WHAT IS THE ROLE OF THE POLICE?

There things to argue about here: I've really enjoyed this conference, it's been amazingly intellectually stimulating not just because it is attended by academics, health professionals of various kinds and enough police officers to make our presence felt in the debate. I've been *massively* influenced by various people here and even just reflecting on the police officers present, they hail from the Netherlands, the UK, the US, Australia, Ghana, Zambia, South Africa, India and Vietnam – and I'm sure I'll have missed some in

that list. Obviously public health professionals are interested in improving health outcomes at the population level, reducing and minimising harm to people, especially in vulnerable populations. That immediately gets us in to the discussion about what we mean by 'harm' and what we mean by 'vulnerable'. I'm told the United Nations use the phrase 'key populations' as euphemism for vulnerable – that, in itself, opens up a whole new perspective on things. The conference isn't focused specifically on mental health so other health issues under focus include things like, alcohol abuse, obesity, drug use, sex work, violence reduction, etc.. And so I've found myself asking out loud and on social media: "what is the role of the police, then?" to understand where our public health colleagues are coming from.

It gets us immediately in to difficult territory, both legally, politically and ethically. If you accept the evidence that the 'war on drugs' approach over the last forty years has been a spectacular failure in terms of the fact that it had cost trillions of pounds or dollars, incarcerated millions of people across the world and we're no better off in terms of health outcomes, to what extent should the police take decisions about non-enforcement of drugs laws because that improves health outcomes when Parliaments have deliberately chosen prohibition? We know the police in a lot of countries enjoy considerable discretion in their enforcement decisions and that policing is more often characterised in low-level, day-to-day situations by non-enforcement of the law. But to what extent should that lead to a deliberate city or country-wide decision not to enforce possession offences because health services want to set up supervised drug use clinics as part of improving health and safety and reducing the use of hard drugs? We heard from Allan ROCK, former Attorney General of Canada about exactly such an approach in Vancouver which massively reduced overdose deaths in the city – he authorised the police to support a drug use programme by ensuring there was a legal exemption from criminal liability for those involved in it. Officers didn't have to feel ethically compromised by referring people to services that were predicated upon violation of Canadian drug laws – those laws had been set aside by politicians, for those particular circumstances.

This raises those difficult questions, however, for police officers not working in such an environment: to what extent can officers turn a blind eye to offending behaviours even where they suspect it is 'for the greater good'? – and does it matter whether that is an individual, situationally-specific decision by a patrol officer or something more amounting to a policy approach by a far more senior officer, as we saw in some years back in Brixton under Commander Brian PADDICK? One point that I've made at LEPH – and which has been made or supported by others in their presentations – is to look at the extent to which police services become involved in responding to incidents and ongoing problems which are predicated upon health issues because the wider design or absence of public services means there is a deliberate reliance upon the police? This is

true in most of the work I do: I've argued for years that we rely too much on the police as an agency that creates a buffer between the public and mental health services, thereby creating time and space to make it easier – and let's be frank, cheaper – for mental health services to respond. I see evidence for this all over the place and it's obvious from this event my thoughts are not restricted to the UK.

WHAT DO YOU WANT US TO *DO*?

There are some disagreements still to be had: everyone here seems to agree we should all be focused on harm reduction but in a pre-conference meeting where attempts were being made to agree some principles which should influence a policing approach to public health, it struck me there were two problems: firstly, the principles were mainly about what the police should do better or do more – training, awareness and collaboration, etc., etc.. The first principle for discussion was borrowed from Hippocrates: first, do no harm.

The problem with this, however, is we do ask our police services to undertake activities which cause harm: we even require them to lawfully kill people, on very specific occasions and that can, very controversially, be the case with a someone in a key population group. But more routinely, we ask them to undertake tasks which affect health and wellbeing at the population level: we ask them enforce various kinds of drug and other 'lifestyle' laws, we ask them to enforce laws on sex work and immigration; in addition to volume offences like assault and theft (including their aggravated variations) which can lead to imprisonment. We know that these activities disproportionately affect key populations for a variety of complex reasons. Disentangling all of that will probably require far more than senior, informed police leadership – these are both political and Political issues, very directly.

And finally, it struck me that this further leads us to another two equally important points, alluded to above: firstly, the police know things and can do things that contribute to this agenda but are often conflicted by the legal responsibilities entrusted to them by elected governments. Mental health – and after LEPH, most public health issues around addiction, sex work and poverty – are issues about which police officers have various things to say and various data to offer … whether they yet realise or not. Secondly, the police cannot do this alone and for as long as we don't include the police in the discussions, health and social care professionals, as well as politicians and societies will miss out on understanding the very unique viewpoint that police officers of all ranks have on policing and public health.

There is a lot to think about following this conference – the police need to get much, *much* more interested in this and others need to let us get far

more *involved* in it. A great conference – I look forward to following the next one in two years' time! Hopefully they've be able to livestream it by then, too?!

7th October 2016

Bed Management –

There was considerable interest last night in a news story I tweeted – it generated way more than the expected number of replies, it was retweeted more widely than most news stories I circulate. It related to an apparent 'threat' by the Chief Constable of Devon and Cornwall Police to 'take the NHS to court' around mental health bed shortages. From the 5th September, the Chief ordered a new process to apply to those situations in police custody where people are detained after arrest whilst awaiting an inpatient mental health bed. This usually relates to situations where there is difficulty for mental health services in identifying where a particular bed is available. Less often, I've known the problem to be disagreement about what kind of mental health setting is the appropriate one or disputes between areas where patients were assessed after arrest in area 1 when they are residents of area 2 – which may or may be nearby.

Either way, the problem is: Mental Health Act assessments of vulnerable people which conclude with a decision to admit someone but where the Approved Mental Health Professional (usually a mental health social worker, who is legally warranted to 'section' people) cannot complete their application for admission within the timescales which are available to the police. And even then, there is frequent misunderstanding about what those timescales actually are! … but that's for another day.

SECTION 136 MHA

First, we need to clear up some confusion, shown both in the article and in the response it has received in social media land. More concerningly, this confusion is also seen in the media response by healthcare managers to the Chief Constable's action becoming known. Most of the incidents to which the letter relates will NOT be use of section 136 of the Mental Health Act 1983. Even when police custody was more widely used as a Place of Safety under the Act, there were very few incidents of bed searches taking more than the 72hr permitted maximum. The *MS v UK* (2012) human rights case was such an example, but they are very rare. It is far more frequently the case that bed searches are problematic for patients who were originally arrested for alleged offences where the subsequent decision is taken to divert them away from the criminal justice system. So talking about the

reduction in the use of police cells as a place of safety is the straw man fallacy exemplified: it's just not what this is all about, except very rarely.

Some social media respondents have also suggested this is the result of austerity and political decisions. It's not for me to get party political about this, but I would point out that I've been banging on about this for well over ten years. There is an example from 2005 of a police force threatening and then preparing to commence legal action about this kind of situation. It involved a vulnerable man spending over three days in custody because of NHS arguments about beds. In that example, the force concerned referred themselves to the IPCC because they were so concerned they were acting unlawfully having taken a decision they would rather keep the man safe when it was obvious he was a serious risk to himself than release him because of an inability by the NHS to comply with our country's legal frameworks.

So this is not just about politics, either – this was happening when the NHS was at its peak level of funding for the last few decades it's not *just* a political point. It's more probably linked by to the ongoing attempt to ensure that resourcing and obligation around mental health crisis care is transferred from health to policing; just as we transferred responsibility around institutionalisation from health to prisons – the project has been operating under the radar for fifty years or more. Even to the extent that the last two Governments have taken decisions about health funding, it also remains true that NHS England and Clinical Commissioning groups across England have often taken decisions of their own to disadvantage mental health. You may remember about five years ago, NHS England applied a lower level of uplift to funding of mental health services when compared to other services; you may be aware that in the last month, it has emerged that more than half of CCGs plan to cut the proportion of their budgets given over to mental health services. I could go on!

BREAKING THE LAW

Last week I received an email from a police force Chief Inspector who had become embroiled in just such one of these situations and was seeking advice. I saw emails yesterday that show the discussion that was prompted by an attempt to review why a situation had occurred in police custody that was almost certainly unlawful. What was most interesting about it, is that the senior health managers in that case made it clear that they did not see the situation as being unlawful at all. They didn't say why the analysis being applied by the police was wrong, of course. Just that they were wrong. I've seen that done many times before.

So here's the reminder –

- A person under arrest at a police station is detained there subject to the laws contained within the Police and Criminal Evidence Act 1984.
- A person who has been assessed for admission under the Mental Health Act is not 'liable to be detained' until an AMHP makes a written application for that patient's admission to hospital.
- Whether these two things work in effective conjunction will depend on the circumstances in each case, but they certainly weren't designed to do so: PACE makes no mentioned of 'diversion' from justice; the MHA makes no special reference to circumstances where assessments occur in police custody.
- Be default: no mental health services or professionals should rely upon the provisions of PACE to enable the detention in custody of someone who is thought to be mentally ill: that's why we actually have a Mental Health Act, somewhat obviously!
- The MHA contains provisions to enable the urgent admission to hospital of people who are in need of that; AND provisions to ensure that CCGs and Local Health Boards (in Wales) provide for it, where required.
- It's a question of how services are commissioned and delivered.
- Detention of anyone outside these frameworks is – very straightforwardly – a violation of Article 5 of the European Convention on Human Rights. Ergo, it's unlawful!

Just from my own perspective, I do admit to wondering why people are surprised a police officer is wanting to see the law upheld, especially where failing to do so could bring very real legal liabilities for individual police officers and, indeed, for him as a Chief Constable? He was to be able to explain to courts the legal basis for detaining people against their will and where such explanations are difficult-to-impossible because of decisions by other organisations over which he does not assert control, it strikes me that he has every right to secure his own position. We know the NHS does likewise, in lots of other situations!

WORKING IN PARTNERSHIP

Is this kind of thing a threat to partnerships and partnership working? – maybe. But what kind of partnership expects one party to take on board the risks, costs and liabilities associated with the other being unable to comply with legal frameworks that apply to them?! Imagine if the police decided they don't have the resources to deploy officers to mental health units when disorders occur which threaten the safety and wellbeing of staff; imagine if the police failed to investigate allegations of criminal offending by patients against staff?! Of course, both of those things *have* occurred, in the real world, haven't they? Did the NHS say, "that's OK, we appreciate

resources in the police have been cut by 20% and that this is very difficult so we don't mind and we'll accept it whilst talking reassuringly about partnership working"?

No – they didn't!

Partnership working is about *far more* than 'getting on' and / or appearing to get on. It is also about challenging each other to improve – challenge can, and does, take many forms in partnership land but the worst news for those who take a dim view of the Chief Constable's decision to force the situation is this: in all my years of trying to highlight this particular problem, I genuinely regret to conclude that agitation towards ensuring compliance with legal frameworks; and threats or commencement of legal action are the *only* things that have secured the onward release from custody of vulnerable people who would otherwise have spent many more hours or *days* in custody than they did. Power to change that rests with CCG managers who could ensure the legal responsibilities they have under s140 MHA (which I would argue 95% of them either don't know about or aren't complying with, even if they do) are adhered to. I don't understand why they shouldn't be accountable for any decision they've taken to disagree with those frameworks.

When our system of hospital admission was introduced in the 1959 Mental Health Act, Parliament did not have in mind the highly deinstitutionalised model of community mental health care that we currently see. But yesterday, the University of Manchester National Confidential Inquiry on Suicide and Homicide revealed again what the Royal College of Psychiatrists Commission on Acute Adult Psychiatric Care already told us earlier this year: the balance between community mental health provision and inpatient care is not right; too many beds have been cut; and there are consequentially risks being managed in the community that shouldn't be. The police may be a legitimate part of handling the outfall of that, but there is a limit to what they can do – we should agree they have a right to raise their concerns formally if they are being directly invited to absorb the impact of those policy decisions by breaking the law. I will freely admit I do struggle to see it any other way.

11th October 2016

Individual Experience –

What value do we place on personal experience, especially where it comes down to individual opinion? I've been struck recently by the number of attempts we make to infer from individual opinions and experiences, lessons which might influence our overall approach to things. Last night, I was interviewed by the BBC about policing and mental health issues to coincide with the College of Policing publishing new APP (guidelines) and training packages. North-West Tonight are running a two-part feature about the story of Neville, a young guy from Manchester who has mental health problems and who, we learned, was imprisoned for assaulting a police officer whilst they were dealing with him whilst in distress. Understandably, having been detained by the police, subjected to a use of force and taken to police custody, his recall of events was fairly negative overall. The line of questioning from the BBC was along the lines of "Don't the police and criminal justice system fail people like Neville with mental health problems?" … "aren't we unnecessarily criminalising people here?" … "isn't there an institutionally ingrained problem with officers' attitudes towards mental health?"

All from one story! Fair enough: many other people have got negative stories too, so I'm not suggesting this is an isolated example but it has to be seen against the background of incidents where the police have been found to be quite exceptional, in variety of ways. More realistically, the majority of encounters will be somewhere in between – officers ensuring a professionally acceptable response to situations where the option of doing the right thing may not always exist and where the time for an earlier, less stigmatising intervention by anyone is days or weeks behind the encounter.

The irony here is: this is just my opinion – which I fully accept needs broadening out with some theoretical frames of reference and some proper research! In the next life and / or after I win the lottery, I'm going to do research on this stuff because it's quite badly needed and long overdue.

CRIMINALISATION

I've written about 'criminalisation' elsewhere: there are two general theories around what it means –

- Processes which have the effect of making people feel criminalised around healthcare issues – if the police, custody blocks and the courts become involved in what are, in essence, responses to healthcare difficulties, are we not *criminalising* people?!
- The nature of decisions when CJ professionals know they are dealing with someone who is mentally ill – are these decisions different to the decisions those professionals would take if mental vulnerability were not thought to be a factor within the incident?
- So, if you like, it's the different between the *subjective* and *objective* experience – small consolation to individuals, but relevant to looking at the impact of public policy. Of course, this is a false dichotomy: any sophisticated society would blend the two to understand the dynamics at play.

So, it probably depends on your perspective, your politics (small p) and the context of it all – if you have a health problems, have not offended in any way and can only access mental health services via the criminal justice system, then yes: you're going to feel criminalised when compared to those with other kinds of health problems. If you have come to the attention of the police after members of the public saw you in the High Street in possession of a knife, then we need to think differently. People in public with knives are usually arrested and then quite frequently prosecuted or cautioned for the offence. If the outcomes for people with mental health problems are different, then we can take another view about whether they are more or less 'criminalised' than the norm.

In reality, once officers suspect or know you have mental health problems, you are less likely to be arrested and prosecuted for possession of a knife and more likely to be detained initially under the Mental Health Act or entirely diverted from justice. You could argue, as various academics have, that this amounts to people being less criminalised than would otherwise be the case – research over fifty years in various countries show that if diversionary mechanisms are made available to the police who are properly trained in how and when to access them, they will use them. So even by this yardstick, the extent to which we criminalise people is within our control.

ATTITUDES

This idea that police attitudes are culturally ingrained and in bad need of a sort out requires a few responses. Nobody doubts that there are attitudes in society around mental health that need challenging: we draw the police from society and then subject them to a very perverse perspective on mental health issues, so I think it would be genuinely stunning if we didn't see examples in policing of poor attitudes. We see it everywhere else, including in mental health services, on the news and in politics – so why would the police be any different?! But look at last year's CQC report on mental health crisis care: your police service were thought by patients who have experienced a crisis in their mental health crisis to rank second only to the ambulance service in exhibiting positive, patient and compassionate attitudes towards those in distress.

This is not that bad when you think the others who were rated by patients included mental health teams, GPs and A&E. The police has work to do, no doubt, but it's hard to land a claim of 'poor attitude' when this recent research suggests patients themselves value their attitude more than most and despite the overall crisis care system often forcing officers to take decisions they'd rather not – like removing people to police custody as a Place of Safety, which still happens too far often.

Extrapolating conclusions about attitudes from individual actions is also fraught with worry. I've been known on occasion to authorise a 'serial' of officers in heavily protective equipment (riot gear), armed with tasers, batons and shields to detain a man under the Mental Health Act. This no more reflects my general attitude towards mental health issues than the colour of my car says anything about it but it would be stretching things to expect the extremely unwell man who was thereby safely removed to hospital to see it that way when he was no doubt, very frightened and unwell. I can't rule out that if I was being spat at or bitten by someone with mental health problems, that I wouldn't use force in order to protect myself from assault. The allowance that is often made for mental health problems

is in the criminal justice outcome, rather than the immediate actions in ensuring everyone's safety – which includes police officers' safety.

FAILING PEOPLE?

One thing I've heard repeatedly throughout my decade of work in this field, is that people value the fact that they police are always there for them. Even where people can see that officers haven't always been at their best, haven't always done the right thing (for whatever reason), they have often valued the fact that they are, at least, there. Of course, the police have got improvements to make, lessons to learn and I hope that the new APP and training packages go some way towards ingraining those learned lessons. Of course, there are many examples of people's we would probably all agree people were 'failed'.

Your police service is responding to *millions* of mental health related events every year: using Mental Health Act powers over 28,000 times in England alone, over 50% more than they were a decade ago; encountering *hundreds of thousands* of crisis incidents every year. It's easy to keep bringing out that half of people who died in police custody had mental health problems without remembering that many of those had other complications and complexities, like substance abuse and / or other underlying health problems. It's a shame we don't have a mandatory duty to refer incidents somewhere every time officers saved somebody's life, often by risking theirs – I suspect the second number would dwarf the first; and I don't say that to diminish to in *any way* the importance of ensuring all police forces learn the lessons from each death in custody. It's vital that they do.

But credit where it's due – and as national guidelines and training are yet to have effect, it's mainly due to the tens of thousands of frontline, *un*trained operational police officers who police with common sense and compassion the vast majority of the time. If we want to talk about whether people are 'failed', we should look at the overall system within which those officers are required to make black and white decision, arising from endless shades of grey about what the 'right' thing actually is. And if we ever want to check their attitude, we need as a society to look at our own.

And this is just my individual experience and opinion – it probably does need triangulating with far better research!

18th October 2016

Compulsory Treatment Orders: Scotland –

There I was, enjoying a short break from almost two days of siege managing hundreds of emails like a real street cop and due to drive to a meeting when Nottinghamshire Police rang up with the question I have already declared to be the winner of the "most difficult legal question on policing and mental health – 2016". The bookies have now suspended all other bets despite there being almost a quarter of a year left to go!

"We've got a bloke in Notts who is apparently missing from s113 of the Scottish Mental Health Act and we need to know whether there is a cross-border power to redetain him!?" Thanking you kindly, Sergeant HORSNALL (the Notts MH coordinator)! … *what the hell* is s113 of the Mental Health (Treatment and Care) Act (Scotland) 2003?! – I couldn't freely recall it, if I'm brutally frank with you! I've read up on various parts of the Scottish MHA but for obvious reasons have far less knowledge around it than English / Welsh law. I once did commit to memory the provisions in Article 8 of the Mental Health (Treatment & Care) Act (Scotland) 2003 (Consequential Provisions) Order 2005 – it all just trips off the tongue, doesn't it?! … this order allows for the police in England, Wales or Northern Ireland to detain a Scottish patient when found elsewhere in the UK. This mainly relates to patients who have absconded from mental health units where they were inpatients and obviously, that's not what Nottinghamshire were ringing about! You know when you feel you've got your head 'round stuff and someone throws a curve ball?!

First things first: the Mental Welfare Commission for Scotland is a great source of advice on all things around Scottish mental health and capacity law. This includes short guides and summaries in accessible language – worth checking out if you're in Scotland or dealing with any issue involving Scots' law.

My interim advice was – whilst I tried to look up the answer! – to consider whether or not the grounds exist for detaining the man under s136 of the English Mental Health Act; and if so, that would allow removal to a Place of Safety where people who know more about this stuff can unravel it all! It also has the advantage, being quite honest, that the person can be removed to a local health facility pending that unravelling and any decision about whether or how the person will be returned to Scotland. If we could latch quickly on to a specific and obscure legal power that we think allows

re-detention, then a) we're are operating amidst uncertainty; and b) Nottinghamshire Police have the problem that repatriation has to be negotiated directly with Scotland and local mental health services could resist becoming involved. Use of s136 obliges them to get involved sooner and may mean the patient doesn't end up sitting in a police station for hours whilst things are sorted out. Let's keep our eye on the ball!

SCOTTISH CTOs

In Scotland – as in England / Wales – they have a legal mechanism known as a Compulsory Treatment Order, covered by ss63-66 of the MHA(s). Whilst it has obvious similarities to the CTOs south of the border, they are different in other respects and legally distinct entities. They allow for an application to be made to a Tribunal in Scotland, based upon medical opinions and a report from a Mental Health Officer (Scottish equivalent, roughly speaking, of an Approved Mental Health Professional) to determine whether someone should be subject to legal conditions and restrictions to ensure their mental health and wellbeing. One of the main differences in Scotland, is that it can lead to hospital admission but the Tribunal can move straight to a CTO whilst the patient remains in the community. In England / Wales the person must have been a s3 or s37 MHA inpatient first.

The question that arose somewhere in Nottinghamshire early today, is whether a Scottish CTO patient who has travelled to England can be detained by English Police and returned to Scotland? Obviously, this could mean a patient who has not been an inpatient at any stage and who could be subject to any number or variety of conditions and restrictions on their CTO, detail of which might not be available at the point of decision making. It may not be as simple as whether they have or have not 'absconded'.

Under Scots' law, a Mental Health Officer may apply (s63) to a Tribunal for a CTO. The Tribunal then have the power to grant a CTO or an interim CTO, with various conditions. Those may include, detention in hospital or certain conditions connected to ongoing residence in the community to ensure the wellbeing of the person. The conditions could include a residence requirement, an attendance requirement (e.g., to an outpatient clinic for treatment) or other conditions as thought necessary. Under s112(3) and s113(4) of the Scottish Act, the 'responsible medical officer' (RMO) for the patient can authorise them to be taken to a hospital, for treatment if the attendance requirement or any other measure is not complied with and it is thought necessary to ensure that person's health.

APPLICATION IN ENGLAND

So if we're all now getting really interested in this(!) we can start wondering whether the conditions are considered breached and whether the RMO has given an authorisation under s112 (if there is an attendance requirement) or s113 (if there is a breach of any other measure applied as a condition). Of course, depending on the detail of the CTO, it may be that the person isn't breaching any of that and has simply travelled to England when there are concerns, for whatever reason, about their health. Unless the police can access the RMO or someone who can communicate information on their behalf, we can't be certain that s112 or s113 will apply. In any event, does that authorisation extend to English police officers?!

Well, if the person has breached a residence or attendance requirement on their CTO, they may be taken in to custody by a Scottish police officer. As such, they may be taken in to custody by an English, Welsh or Northern Irish police officer under Article 8 of the 2005 Consequential Provisions Order. So it therefore depends on whether we know that a CTO condition was breached. Without being able to contact anyone, we can't know for certain, even if we had been confident of the law! – comes back to that old thing of information sharing across mental health and criminal justice and the legal knowledge of those who are communicating with the police. Nottinghamshire Police were emphatically told that Article 8 covered the situation, but no-one could confirm that the CTO had been breached – so that information may not have been correct and there could easily have been a false detention or a deliberate decision not to detain someone who could have been safeguarded. I could have flipped a coin at this stage – instead, I spent the money on ibuprofen to help my headache.

In the end – and *this*, **right here**, is my point! – there is a lot to be said for just dealing expediently with common sense with what is right in front of you and cutting through all of the garbage, above. Whilst I'm enough of a nerd about this stuff that I had to keep reading and researching until I understood the answer, guess what?! – my instinct was the right one based on what we could confirm and that even if I'd been wrong, the action recommended as interim advice sufficed to handle the policing dimension of the call and it would allow others who are better qualified to untangle it all! We're not mental health nurses, lawyers or psychiatrists and we don't need to be: we're police officers and we have particular responsibilities – prevent crime, bring offenders to justice, protect life and property and maintain the Queen's Peace – the end. He was detained under s136 of the English Mental Health Act 1983 – and quite rightly, too. Any criticism of not using appropriate powers under Scottish law comes back to mental health services being unable to clearly communicate the precise situation they were reporting.

Here is a document from the Scottish Mental Welfare Commission – ten pages of stuff about various kinds of cross-border transfers and absconders involving Scotland and other UK jurisdictions: it just shows how silly things can get, legally speaking!

19th October 2016

Conflating Beds –

We hear this word 'Beds' a lot when we hear discussion of mental health services and it can get very confusing because the word is used to mean different things, not all of them literal. It happened earlier today during Prime Minister's Question time in the House of Commons so I thought I'd again stress the detail of certain distinctions that become confused and conflated when we hear discussions of various kinds of 'beds' that are not the same thing!

- **Version One** of what we mean by 'bed' is a place in hospital for someone who is admitted as an inpatient, either voluntarily or whilst detained under the Mental Health Act 1983 – this often will involve an actual bed! … with pillows and sheets where you can get your PJs on and hopefully get a good night's sleep. In this sense, it's like a bed on a medical or surgical ward, although in modern mental health units, patients often have their own room.

- **Version Two** is where we hear the word 'bed' used after a person has been detained by the police under either s135 or s136 of the Mental Health Act and removed to a Place of Safety. If the NHS cannot make a Place of Safety available for that person's assessment under these provisions we sometimes hear that "the NHS have no beds". This is completely different to Version One where someone might have been arrested for an offence, taken to police custody and then assessed as needing admission to hospital.

Strictly speaking, the Place of Safety Version Two thing is usually nothing to do with beds in any literal sense – it is more probably appropriate to talk about 'capacity' or 'space' affecting the ability of the NHS to accommodate someone until their assessment can occur. I've seen many such services and most of them have no sleeping facility at all because the vast majority of people are dealt with in under 6hrs. (This is an average – please don't write in: I am aware that some areas take much longer and individual circumstances can go way beyond 6hrs!) One or two PoS services which do have a room which doubles as a seclusion style area for those exhibiting challenging behaviours and a mattress can be brought in if people really do need to sleep overnight. Otherwise it chairs or sofas in the assessment room(s) if someone wants to sleep until assessment things happen. It's not

about beds: it's about the ability to undertake an assessment during which someone is unlikely to need to sleep or lie down for any length of time.

PRIME MINISTER'S QUESTIONS

So today, the Leader of the Opposition asked a question about beds (version one) following which the Prime Minister answered by saying something about beds (version two):

From Hansard 19/10/16 –

JC: "I received a letter from Colin, who has a family member with a chronic mental health condition. Many others, like him, have relatives going through a mental health crisis. He says that the "NHS is so dramatically underfunded" that too often it is left to the underfunded police forces to deal with the consequences of this crisis. Indeed, the chief constable of Devon and Cornwall has this month threatened legal action against the NHS because he is forced to hold people with mental conditions in police cells because there are not enough NHS beds. I simply ask the Prime Minister this: if the Government are truly committed to parity of esteem, why is this trust and so many others facing an acute financial crisis at the present time?

TM: "May I first of all say to Colin that I think all of us in this House recognise the difficulties people have when coping with mental health problems? I commend those in this House who have been prepared to stand up and refer to their own mental health problems. I think that has sent a very important signal to people with mental health issues across the country. The right hon. Gentleman raises the whole question of the interaction between the NHS and police forces. I am very proud of the fact that when I was Home Secretary I actually worked with the Department of Health to bring a change to the way in which police forces dealt with people in mental health crisis. That is why we see those triage pilots out on the streets and better NHS support being given to police forces, so that the number of people who have to be taken to a police cell as a place of safety has come down. Overall, I think it has more than halved, and in some areas it has come down by even more than that. This is a result of the action that this Government have taken.

JC: "The reality is that no one with a mental health condition should ever be taken to a police cell. Such people should be supported in the proper way, and I commend the police and crime commissioners who have managed to end the practice in their areas. The reality is, however, that it is not just Devon and Cornwall that are suffering cuts; the Norfolk and Suffolk mental health trust has been cut in every one of the last three years."

PEDANTRY

Why does this matter? – well, I'm not offering particular criticism of our political leaders on this, because it's commonly misunderstood and other politicians very active on mental health matters have made this mistake. Frontline officers often talk about 'beds' when they mean capacity in a PoS for an assessment; I've heard NHS Commissioning Managers make the same mistake recently. If we think that reducing the use of police stations as a Place of Safety is going to have an impact on the kinds of problems that were recently highlighted by the Chief Constable of Devon and Cornwall, to which the Leader of the Opposition referred, then we are mistaken.

It has always been the case, despite our focus on the police use of their powers under the Mental Health Act, that we arrest far, far more people for alleged offences who are then assessed in police custody under the Act. On Twitter today, the Leader of the Opposition followed up his PMQ with a tweet that said "No-one with a mental health problem should ever be taken to a police cell". I presume he also means "whilst in crisis and detained only under the MHA" because if his tweet is taken literally, then we need to think urgently about those hundreds of thousands of arrests every year of people who have mental health problems and are accused of breaking the law – it's going to require a whole new solution and a pile of legislation.

Nothing at all prevents the arrest and detention in police custody of someone who is seriously mentally ill, especially if they are accused of stabbing, raping or killing someone. Rare though this is, it happens enough to mean we need to acknowledge that if we are to effectively investigate offences and make appropriate decisions about whether people are prosecuted, they may need to spend at least some time in custody where forensic evidence can be recovered, where assessments can occur and where decisions can be taken about how best to proceed.

We don't have great statistics on this point, but when I looked at it some years ago, the 'arrested and then assessed MHA' figure was five times bigger than the use of s136, although that was in a force which had relatively low use of s136. Another force mental health lead looked at this in a higher-use-per-capita force and found that they had three times as many MHA assessments for people under arrest in custody as they had uses of s136 MHA. So focus on beds version two is missing most of the problem.

UNDERSTANDING THE PROBLEM

Sort out further reductions in the use of police custody by all means – who wouldn't welcome that?! … but don't imagine for a moment that it will address the problem that appears to be getting greater all the time – the protracted detention in police custody of someone who is due to be diverted from justice under the MHA but where a timely admission to hospital cannot be achieved because of the want of an acute admissions beds somewhere within mental health services, and preferably within 25miles of wherever that person calls home.

If cops, NHS managers and staff don't understand the difference: it's no wonder Prime Ministers and Leaders of the Opposition don't either – and that's why we heard someone today asking about apples and hearing about pears.

20th October 2016

Authorised Professional Practice –

The College of Policing has now completed the production of new guidelines on mental health for the police service in England and Wales and this blog is a part of the College's efforts to communicate this publication to the public as a whole, as well as the police service and partner organisations. These new guidelines are known as Authorised Professional Practice (APP) and they are supplemented by the first national training products on mental health for policing. These are the College's main contribution to the 2014 Crisis Care Concordat which aims to improve the country's response to vulnerable people right across the mental health and criminal justice systems.

APP and training materials have been available to police forces for several months and work has begun to prepare for the impact they should have because mental health issues effect every area of policing and are believed to be connected to a third of all demand: this is core police business and all officers, at all ranks, need to understand how it affects their role and responsibilities. It was being publically launched to coincide with World Mental Health Day on 10th October 2016 – on the theme of psychological first aid. The College of Policing held several events around the country in July 2016 to introduce forces to these materials and to help them understand the preparatory work that they will need to do, to prepare for the implications they have.

Mental health issues inherently demand a partnership approach: the police service *cannot* do this alone; and forces should use the publication of APP and national training standards to influence and improve their local arrangements. We know that challenges across the country do vary, with different challenges in urban versus rural areas; we know that mental health funding and commissioning varies across the country. That is what forces must address and what operational police officers must assist in identifying and handling.

IMPLICATIONS FOR THE POLICE

APP represents the standards which must be met in all areas of the country and in any analysis of local arrangements, forces and officers must bear in

mind that any difference between the two means something needs to change in local arrangements – this is what local Crisis Care Concordat actions plans should have already identified and every area has made a commitment to address those things. APP is based on statutory requirements, relevant Codes of Practice to those instruments and case law – as well as on lessons that need to be learned from IPCC inquiries, Coroner's inquests and from medical and healthcare guidelines.

The aim here is to ensure that vulnerable people access crisis care without being unnecessarily criminalised by the police and that vulnerable victims and suspects are identified as early as possible and supported within the criminal justice system, where appropriate. For example we know that people with mental health problems are three times as likely to be victims of crime as people without; we also know that people with mental health problems are heavily represented within the criminal justice system.

It will be important to the success of this programme that Chief Constables ensure sufficient resources are allocated to understanding what this programme means for their organisation and their local partnerships. There local Crisis Care Concordat forum in each area is the arena in which any particular issues can be raised which are crucial to the success of the programme. It is also important that individual police officers take the time to read the guidance: they will often be far better placed to understand any particular challenges and difficulties in making the APP happen in the real world.

IMPLICATIONS FOR THE PUBLIC AND PARNTERS

The public can expect to see much closer cooperation between their police service and the relevant partners in the NHS and other public bodies: this should be reflected in better access to crisis care and a greater range of options to resolve situations where the police become involved. Partner organisations from ambulance services, mental health trusts and acute care providers should expect to see their police services reviewing their overall approach as they move towards ensuring the way in which they deliver their service complies with APP. Ultimately, this is the standard against which the Independent Police Complaints Commission will hold police officers and forces to account.

The College doesn't under-estimate the difficulties in some areas of ensuring that policing / mental health partnerships work in a way that reflects the statutory framework, the Codes of Practice and so on. However, we know that many of the most high-profile and difficult incidents which have often arise against a background of the police service being unable to operate in the way they have been expected. It is vital that the national

partnership working envisaged by the Concordat ensures that operational officers have every chance to do the right thing.

APP on all police topics is available publicly on the College of policing website – www.app.college.police.uk

This is not the end: merely the end of the beginning – we already know that there will be further changes to come and that many challenges remain: In October 2016 a new Code of Practice for Wales was introduced; by Spring 2017 the Policing and Crime Bill will have received Royal Assent and that will amend the Mental Health Act 1983. We also know that other organisations are continuing their own work to delivery on their obligations under the Concordat and that forces still face important decisions about street triage and / or Liaison and Diversion schemes in their areas. For that reason, the College will continue to support nationally by engaging with other national bodies and supporting police services and their partnerships.

21st October 2016

AWOL from Scotland –

It seems that it's been the week for Scottish mental health patients to journey to England, in a variety of legal situations that have subsequently confused the life out of police and mental health professionals alike. So we had the incident the other day about a Compulsory Treatment Order patient who turned up in the Midlands and today I've had a call about a Short-Term Detention patient who turned up on the south coast. The first confused the life out of the local police; the second confused the life out of the A&E department. These things being as they are: I'm expecting the third incident any time now to complete the set and I'll just bet it has a twist or angle that I'm not about to cover here!

OK … two incidents is not that many, but it's not the first time I've had a batch of 'Scottish AWOL' queries so I thought I'd best cover the topic in one post. First things first: abbreviations to make this easier to both write and read! —

1. MHA(S) = The Mental Health (Treatment and Care) (Scotland) Act 2003.
2. MHA(E) = the Mental Health Act 1983 in England / Wales.

Your legislative resources —

1. The Mental Health (Treatment and Care) (Scotland) Act 2003.
2. The MH (T&C)(S) Act 2003 Consequential Provisions Order 2005.

MAIN DETENTION PROVISIONS – SCOTLAND

Here is a list of the three main detention 'civil' provisions under the MHA(S) —

- **Emergency detention certificate**, under s36 MHA(S) – this provision allows one DR, preferably with involvement of a Mental Health officer (MHO) – a professional who is roughly the equivalent of an Approved Mental Health Professional – to detain someone in hospital for up to 3 days. The DR may act alone, if they cannot

reasonably consult an MHO. Broadly, this is the equivalent of s4 MHA(E).

- **Short-term detention certificate**, under s44 MHA(S) – this provision allows a DR, where supported by a MHO, to authorise detention in hospital of someone for up to 28 days. Broadly equivalent to s2 MHA(E).

- **Compulsory Treatment Order**, under ss64/5 MHA(S) – this provision allows an MHO to make an application for a CTO where two DRs submit reports for consideration. This can involve admission to hospital, for up to 6 months, broadly equivalent to s3 MHA. However, it may also allow for the imposition of restrictions upon patients who live in the community, including a residence requirement and / or an attendance requirement (to attend somewhere for treatment). When considering an application for CTO, the Tribunal may decide to grant the application but only on an interim basis, allow for detention or restriction for a 28 day period.

AWOL FROM SCOTLAND

Firstly, AWOL is the English and Welsh term, under the MHA(E) – in Scotland they refer in law to 'absconders'. Sections 301-303 cover the powers to re-detain Scottish mental health patients who have absconded from the above provisions and *are still in Scotland*.

- **Section 301** – covers those patients who have absconded from a Compulsory Treatment Order. As you'll recall, above: there are two kinds of CTO – the sort where you are detained in hospital, the sort where you are subject to restriction in the community. If a patient has absconded from any hospital in which they are detained by CTO or if they have breached a residence requirement of any 'community' CTO, then s303 MHA(S) applies to them.

- **Section 302** – covers 'other patients', including emergency detention certificates, short-term detention certificates and CTOs, but also includes those detained under a nurse's holding power under s299 MHA(S) and those who are subject to certain particular provisions of the MHA(S) that I'll let you research for yourself, should you need to! If someone subject to any of these frameworks absconds OR if a Responsible Medical Officer (RMO) issues a certificate under s114 or s115 MHA(S), then s303 applies to them. (Sections 114 and 115 relate to breaches of CTOs which don't automatically qualify as 'absconded' but which require the RMO to authorise their qualification as 'absconded'. Those who were paying close attention to a BLOG earlier in the week about Scotland will remember that even if an RMO

has authorised detention under s113(4) MHA(S) for a breach of other, general conditions of a 'community' CTO, this does *not* qualify as 'absconded' … as Nottingham city centre police now know!)

- **Section 303** – covers the ability of various professionals to take anyone to whom sections 301/302 applies and return them to the relevant hospital. This includes, a Scottish police officer, a Mental Health Officer or anyone on the staff of a relevant hospital or authorised by the patient's RMO.

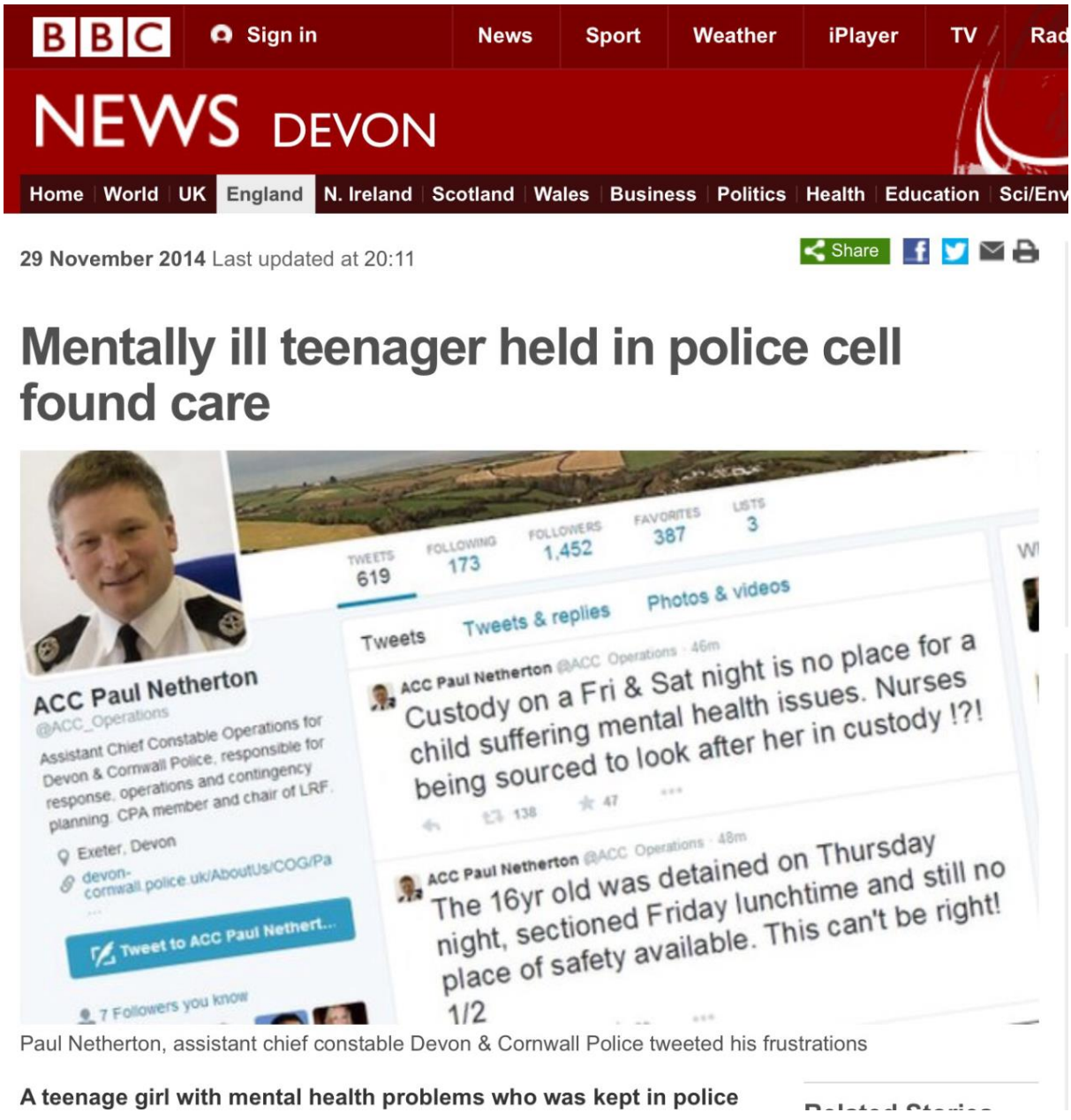
Still following?! … not long to go now!! – once you've confirmed that the person has absconded from one of those provisions (ss36, 44, 64 or 65), or that an RMO has authorised detention of a CTO patient under ss114 or s115, then s303 would apply if they'd been encountered in Scotland so any police officer in England, Wales or Northern Ireland may take that person in to custody and return them to Scotland. This is made clear in Article 8 of the MHA(S) Consequential Provisions Order 2005. Such patients may also be taken in to custody by an AMHP in England / Wales or an ASW in Northern Ireland. To conclude this all with a little known fact: it is expressly into s135(2) of the MHA(E) and in to a129(2) MHO(NI) that a warrant may be granted by a Magistrate in connection with the need to exercise detention under Article 8 for a Scottish patient who has absconded to any other part of the UK. If you *ever* have that situation in the real world, I advise you to take a written copy of the MHA(E) / MHO(NI) to place under the nose of the court clerk or Justice of the Peace because I'm guessing they might say, "Eh?!" or simply not believe it's a *thing*!

There you go! – all done. How's your headache?!

Next up in the Scottish series – Absconding *to* Scotland, based on the Mental Health (Absconding Patients from Other Jurisdictions) (Scotland) Regulations 2008.

25th October 2016

Police Leadership –



I heard the Health Secretary Jeremy HUNT deliver a speech at today's *Crisis Care Concordat* Summit in London, the first major speech he's delivered on mental health, we were told. Almost the first thing he did was praise the

police service for the leadership shown on the subject of mental health crisis care, driving much of the debate that led to the creation of the *Crisis Care Concordat* itself. I might be wrong, but my sense was the comment did not land well with everyone! One service user tweeted about this, wondering whether it should be the police driving certain aspects of healthcare provision – and of course, I don't think there was a police officer in that room who wouldn't happily see the issues we face being confronted head-on by senior health leaders and commissioners.

History shows another approach became necessary, for a range of reasons perhaps uniquely understood by the police.

BACK SEAT DRIVERS

Following his speech, the Q&A session saw Commander Christine JONES from the Metropolitan Police, the lead for the National Police Chiefs Council asking, "Mental health services are underfunded: at what point will parity of esteem be matched by parity of funding?" Almost immediately, we saw reaction about how senior health leaders were unlikely to challenge as directly as this. Again: the police driving the debate, literally, with the Secretary of State for Health on the general topic of mental health, not a question specifically about policing! Would Commander JONES be asking that question if a senior health leader were doing it or likely to do it? … I doubt it.

After I woke this morning, my attention was drawn on Twitter to an article by Lord BLAIR in today's Guardian, a former Commissioner of the Metropolitan Police. This article was bouncing around the conference room at the Oval, in hardcopy … "have you seen this?!" and so it was handed from person to person. It quite obviously divided opinion amongst the non-police professionals present (and on Twitter). It ranged from 'flabby opinion' that was 'not offering any solutions' to some who thought it was imprecisely making perfectly valid points about the outcomes we see from our current arrangements. It's obviously not for the police, serving *or* retired, to tell the health system how or when to ensure upstream intervention in mental health care anymore than it is for health professionals to get specific about how the police should discharge their responsibilities under criminal law. However, it is perfectly fair comment for NHS staff at all levels to flag up problems in policing and say, "What are you going to do about it, Copper?!" Or similar.

The main agenda at the CCC today was all about health – a couple of the workshops focused on policing and legal issues but the main room was all about health. Quite right, too! – the police should be much less of a voice in this, ideally. That they aren't does lead to certain observations which I make very reluctantly after today's events. We need to see *achievement*

and *progress* in this area: not just **activity** – and this means we also need to describe what we're actually trying to achieve. The *Concordat* obliged local areas to produce an action plan, uploaded to the Mind website in 2015 – I'm told this plan should be refreshed and updated by all areas in early 2017. In addition, we heard today about the *Five Year Forward View* plans that are required, in order to deliver on the NHS England strategy for mental health during the remainder of this Parliament. Of course, those following developments in health will know that various areas have grouped together to produce Sustainability and Transformation Plans (STPs), in order to make the NHS as a whole sustainable in coming years.

PLANS ABOUT PLANS

So what about those 2015 Action Plans – how many areas have ensured delivery of the majority of their contents? If you remember the mapping process set down by Mind: areas were to go from Red to Amber when they'd agreed to some principles to work in partnership; and then Green once uploaded to the Mind website. I remember commenting at the time there should be another colour for *completion* of the plan, even if just 80% complete. However, one police officer today described his local CCC leadership group as a talking shop where "nothing gets done". It's not the first time this month I've heard that said, quite honestly. So in addition to those plans, which now need revising, we see then need for more plans after the Five Year report and all of that has to fit in to STPs concerning overall NHS efficiency – the plan of plans!

We know from recent media coverage, that more than half of CCGs are cutting the funding they give to mental health as a proportion of their overall budget, despite suggestions from Government that the proportion should increase. That is the context within which any plan needs to be seen and we know that the trend in terms of crisis care is an upward one – barely a week goes by without coverage on increases in crisis related issues: whether systemic or individual. No-one who follows current affairs in any detail could fail to understand that there are dynamics at play in society that effect mental health which do go beyond the health service but none of that explains decisions we see to situations ever more towards the social justice safety net that is policing and criminal justice.

I also prepared a question for Jeremy HUNT, in case no other police officer put their hand up. I was going to ask, "What should we conclude about mental health and crisis care if more people than ever before are being detained under s136 MHA, more people are going missing whilst mentally ill, more people are being arrested for offences and then being assessed under the MHA in custody?" There was a sense today amongst (at least some of) the police officers that whatever progress is being made on CrisisCare – and there is lots of it! – it seems to be *at the expense* of

upstream interventions. Those of you who follow along on social media know I'm all too fond of quoting Archbishop Desmond TUTU: "There comes a point you have to stop pulling people out of the river, get upstream and find out why they're falling in."

POLICING IN MENTAL HEALTH

When I first got involved in working on the policing interface with our mental health and wider health system, I remember specifically saying to myself that I wasn't ever going to get myself in to the position of being caught telling healthcare professionals how to run their health service or how to deliver on their professional obligations. This was partly a question of manners: I'd be prepared to listen to anyone about the impact of the way we police on them, but it is ultimately for the police to square away competing demands and priorities in how police services are run, held accountable as they are through various processes. I took the view that that the reverse courtesy should be applied in how I worked on mental health.

But if I've learned *anything* in the last twelve years on this topic, it is a conclusion very reluctantly reached and best summed up in a metaphor from my other area of professional interest: public order policing. Progress on mental health has come when police officers or police services form a cordon, take ground and hold the line. History shows that problems in health-based Place of Safety provision actually came not from the Concordat – no doubt it helped – but from some forces saying, "Enough is enough: this will have to change and it will change with or without the consent of the health system". We've heard recently about problems in partnerships where the police are being routinely expected to handle the fallout, often unlawfully, of a health system that has decommissioned too many inpatient and specialist beds whilst apparently disregarding s140 MHA and other obligations. History shows that resolution of those operational problems has come from senior officers tweeting to publicly shame the system in to gear and from actual or threatened legal action.

So the lesson appears to be this: the police are bungling around in this arena, still – not always getting it right and we sometimes miss the subtleties or complexities. We are not experts, we are not clinicians and we're not trying to be. We just have a unique perspective on some of these important issues and one that is all too misunderstood and disregarded. History shows that unless we shout loud and / or agitate on behalf of vulnerable people, we don't make progress. I'm far from alone in wishing this were not so. As a natural introvert *and* an experienced public order commander I can tell you that shouting and agitation is occasionally a tactic in taking ground and making progress: it is to be used *sparingly*, recognised as a restrictive or coercive practice and it is not without collateral intrusion.

However, it does remain a legitimate tactic and leadership is recognising when it is required, when the collateral intrusion may be worth the risk and involves not over-playing it. If we want that voice to quieten down, I suspect we need to see fewer, clearer plans about what the destination is and how we get from here to there without violating the rights and expectations of vulnerable people who are all too often caught up in it.

Notice the above didn't really focus on the public we serve? – neither did today.

NOVEMBER 2016

16th November 2016

What *Are* You Doing?! –

Imagine this: someone rings the police to express concern for a friend or relative's mental wellbeing, asking the police to 'check on them' to see that they're OK. The officers attempt to do so, ringing a phone number that the friend provided and knocking on the person's front door. No reply and no response. There was no information to suggest the person was suicidal or self-harming, just that the friend or relative had non-specific concerns. Phone calls are put in by the police control room several times, including in to the early hours of the night and a note with a reference number is posted through the person's front door.

What is going on here, precisely? It all falls back to that whole discussion about 'welfare checks', sometimes known as 'safe and well' checks and I've written about them before. Whether or not the police realise it, they are going to struggle to do them even if they do locate the person concerned; so let's remind ourselves of the problems where the safe and well check is connected to mental health issues.

- **Ability** – on what basis will the police make their decision about whether someone is, in fact, safe and well? Will they do a mini-mental state examination or use some form of risk assessment tool, perhaps using their psychiatry or nursing skills? – of course not. We know from history, that trained mental health professionals have massively mis-identified risk issues connected to mental health problems and suicide has followed contact with trained, experienced mental health nurses. It's no sillier to expect the police to always get this right than to argue that because nurses are trained in restraint and personal safety, that they should deal with patients on wards who threaten them with knives. There are some things that are just way beyond the skill set of the people involved and it needs different professionals to handle a situation they are specifically trained for.

- **Location** – even if the police find a person and can tell that person has obvious and serious mental health problems, they may be quite powerless to do anything about it. Remember, the police service in the United Kingdom has no legal powers in private premises, which is precisely how your Government want it, having reviewed police-MHA powers in the last two years. We should also remember, if we believe the data that street triage teams produce, that private premises is *precisely* where most of the mental health crisis incidents occur. Therefore, does it matter whether the police see someone in person or speak to them on the phone? – to an extent, it might. Police officers may see things during a personal encounter that may influence whether they detain someone or not – but if the person is in a place where they cannot lawfully be detained, does that matter or add anything?

- **Power dynamics** – when a uniformed police officer asks you if you're OK, do we think we get consistently accurate answers which assist in assessing the level of distress someone is in, or the risk they may pose to themselves? This isn't a point about telling lies to the police – it's a point about vulnerable people having often had difficult experiences before, being detained in police custody, for example and we've seen more media about that today. Many people are perfectly aware that if police officers have serious concerns about someone's wellbeing, they may find themselves removed to police station or NHS facility for assessment by someone who has access to background records and does actually have the professional skills and responsibilities to assess. So knowing concerns on the part of an officer may mean removal to a police cells or Place of Safety and possibly being strip searched or constantly monitored, do we think people are always upfront about their mental state?!

The problems go beyond this, however: they also need considering and a recent experience highlights a few of them –

- **Feeling stigmatised** – some people just don't want to have contact with the police when they are unwell, for various legitimate reasons. It may be previous experiences of contact made things worse; it may be that being in contact with officers makes someone feel criminalised; and it obviously raises the potential question, "Are they going to detain me?!" with everything that involves. Remember, even where people find that officers were as kind, patient, compassionate as they could be, it is often factors beyond the control of the police that mean the whole thing, overall, was seen as a negative experience. I've lost count of the times service users are quoted as saying, "The officers were great, they made a bad situation much more bearable for how kind they were, but at the end of the day, they had to lock me in a cell because there was nowhere else to go" … or similar.

- **The police as a 'stick'** – the police are, on occasion, used by mental health professionals or services as the 'stick' with which to threaten patients with coercion unless they comply with professionals wishes. You only need to look at Twitter to see how many people have had this experience. "If you don't come to be assessed under the MHA at 10am, we'll call the police!" To do *what*, precisely?! … it all goes back to the above: call the police to find someone and conduct a 'safe and well' check and you might find the police stuff that up, despite their best efforts. Let's imagine that the call results in a missing person inquiry and the person is found at 8pm that night: will the MH service who called now turn out to support the officers, especially where the officers find themselves powerless in the circumstances?

- **Adding to distress** – and how does all of this affect the mental wellbeing of someone who may be unwell, whether acutely or otherwise? – is it *actually* helping?! I worry that the intuitive need to 'do something' means police officers and services sometimes start down a path without understanding the difficulties they unleash for themselves and for the person concerned later down the line. What are you going to actually *do* once you find the person – what *can* you actually do to help that person? Is the process of attempting to find or meet them, making the situation worse, potentially to the extent that you decrease the likelihood of finding them at all, whilst simultaneously raising the risks to that person by increasing their distress?

Obviously, where the police receive information that a vulnerable person may be self-harming, suicidal and or a serious risk to themselves, they

have a clear duty to protect life – but not all situations are like this. Also important to acknowledge that an accurate risk picture may not be known when a member of the public or a mental health professional chooses to report a concern. But it seems to me a legitimate public policy question about whether the police can actually do what is asked of them; and whether the police themselves realise their limitations? I've seen more than one report investigating an untoward outcome – including reading another one just yesterday! – where the decision of police officers to fully absorb responsibility for asserting someone else's wellbeing, without calling upon others and amidst a lack of ability to do anything other than refer the matter to others, has taken them in to **gross misconduct** territory.

This post doesn't say anything I haven't already said but the message bears repeating: police officers are NOT mental health professionals and cannot always do what mental health professionals can do, or what various people think they can do. This is not about a lack of training – it is about unreasonable expectations being placed on officers which do not always seem unreasonable. If we are going to rely upon the police in terms of searching for or checking on people, officers and police services need to feel entitled to say, "OK, we've found this person – others now need to support us in making sure we get this right."

23rd November 2016

I'm Really Sorry, but! …

I'm not trying to get on anyone's nerves here, I'm really not. I just feel really passionately about this and we can probably agree that it is actually my job to keep chipping away at all aspects of policing and mental health issues. So with considerable regret, I must again raise the topic of street triage, something which I'll admit I often go out of my way to avoid discussing, not least because it tends to go down like the proverbial balloon. So I'm really sorry and not I'm trying to bore anybody here, or to undermine hard-working professionals who no-one doubts are trying to make the world a better place by supporting vulnerable people. I have to just hope it can be understood, I've been given a job that is around the application of the law and newly developed guidelines which needs to sit within a culture of robust evaluation. I am also subject to the police service's Code of Ethics, which makes it clear we have a duty to challenge, question and discuss. I do again, because I know from discussions yesterday that I'm not the only person with questions and with concerns. Others who said so yesterday, include psychiatrists, AMHPs and police officers.

An academic article was published yesterday in the BMJ-Open (**NB**: *not* in the BMJ itself!) about street triage in the North-East of England, operating in the Northumbria Police area alongside Northumberland, Tyne and Wear NHS Trust, undertaken by Newcastle University, a Russell group institution (no less). There have subsequently been several media pieces covering the highlights from this publication, most of them within professional online articles rather than in the mainstream and through the magic of social media further discussion by people who know of such collaborative approaches elsewhere in the country. On this occasion, the main highlight seems to be that 'street triage' cuts the use of police powers in half; it has brought about significant cost savings (estimated at around £1m for a large mental health trust like NTW) and improved outcomes for vulnerable people who now often experience a far less restrictive approach to their crisis care.

So far, so good, right – who could possibly object? My objection is not to street triage, *per se*, my whole point is we don't know enough about it to know whether we should be objecting to it or not! My objection is to extremely partial evaluation that fails to even acknowledge, never mind address, very obvious issues that should influence any assessment of the risks versus the benefits. I keep hearing that street triage 'works', but no-

one can tell me what it's trying to do. I also hear some say, 'it works for us', to quickly sidestep the whole discussion about what's for and what it's doing.

I've suggested that this article would be a good thing to give to university MSc students looking at research methods: it would allow them considerable scope to think about what this article is NOT saying and what the authors have NOT considered as relevant to an evaluation of the scheme as a whole or the use of s136, for therein lies the interest for me. I note (from what I can tell by looking them up), that none of the authors of the article appear to be police officers or lawyers – yet the primary aim of their focus is an analysis of the use of particular legal power and it's mainly the legal perspective that's missing, for me. Although that's not all that's missing.

OFF THE TOP OF MY HEAD

So here's a list of thoughts in no particular order –

- Are we really surprised to discover that if the police can now take mental health services to vulnerable people, they have to take vulnerable people to mental health services far less often than they previously did?! I'm not sure we needed a two-year research study to tell us that would happen. I'm infinitely more interested in why the police are involved at all, accepting that they will always play just some role in our wider mental health system. I worry this is inappropriately expanding the role, increasing risk and stigma – see below.

- As early as the second paragraph, I had to pause when it was claimed that "three broad outcomes" result from use of s136 – involuntary admission, voluntary admission or referral to community services. Of course, it fails to mention the fourth outcome which is 'absolutely no follow-up whatsoever' and which can occur for a variety of reasons. This is reflected to a degree, in NHS Digital data on the use of s136.

- But what are the unintended consequences in terms of how this service fits in to the wider health economy? – we know from observing street triage teams more ethnographically, there are several unintended consequences and I've written about them before. They go unmentioned here but can include even more MH related demand being deflected to the emergency system via the police by GPs, community mental health services, etc.; and sometimes, it leads to later, not earlier, intervention for people seeking support. We don't know the extent of this, precisely because no-one's looking at it in the evaluations! That's why I've spent about

many nights in the back of street triage vehicles, watching what they do and it's a mixed bag, in my limited experience.

- We know that street triage does not mostly occur in the street: this is yet another academic article where the main focus of evaluation is the use of police powers under the MHA which can only occur in the public sphere – what is going on in the 50-odd *plus* percent of ST incidents which occur in places where use of s136 is not lawful? It's barely mentioned, as UCL barely mentioned it in their evaluation of the nine so-called pilot schemes (that weren't actually pilots at all – triage had been up and running in three police forces for quite a while by the time those nine began). Whilst we're on the subject, co-responding by police and mental health services didn't begin in the USA in the 1980s: "car 87" has been operating in Vancouver since the 1984 and co-responding with health in Canada goes back to the 1970s.

- There is no reference to what we know about the use of other police powers – you can easily reduce the use of s136 by simply using other powers instead: did they? We know that police forces have different cultures around the use of powers, for a variety of reasons to do with training, history and partnerships. This is why Nottinghamshire Police and West Midlands Police were using s136 MHA about the same amount prior to instigating street triage schemes in 2013 despite the fact that West Midlands Police is three times the size, with three times the population.

- What is the follow-up rate for all of the referrals that are being made – community mental health services in that part of the world told the Crisp Commission that they had seen a 100% increase in workload in the year to May 2015 with an attendant reduction in staff. We know from some triage teams that they put in referrals at 10pm when someone is in crisis, and they're not followed up by CMHTs the following day. I have no idea whether this is a rare or a frequent occurrence, because no-one's recording and evaluating it.

- "ST teams typically comprise a Police Officer and Mental Health clinician working together to attend incidents" – except that they don't, do they?! Several schemes involve putting the mental health professional in the police control room (*Norfolk, Devon and Cornwall*) and others involve the clinician responding alone to support front line officers attending incidents (*Hampshire, Cleveland*), but even in the Northumbria scheme and those like it which have a multi-agency vehicle, they report *not physically attending* most of the incidents they were contacted about. This was also true in Leicestershire and elsewhere. So any analysis of a particular scheme, especially where it is getting in to cost-benefit analysis, needs to acknowledge they

have an expensive resource, in the form of a police officer, who is not physically attending incidents because other officers are there and a nurse is giving remote advice and information that could be given from anywhere. I would suggest that is important to understanding the whatever dynamics of inter-agency working you want to understand; and to any health economics that are being attempted as a result.

- On my night out with street triage in this area, *all* of the incidents we attended were generated by the NHS which was unable to cope with a kind of demand that did not need the police: it needed mental health professionals who didn't have the capacity to help. *None of those calls* were from members of the public asking the police for urgent help in a context you would recognise as a policing incident. Across my nights out with ST as a whole, just under a half of all incidents were like this and several were explicitly referred to triage where they would not have been if it hadn't existed. Make your own mind up about what that means about the role of the police in mental health crisis care but one research question I'm interested in would be "To what extent does the existence of street triage cause the system to refer incidents relating only to health issues to the police service, because of the ability to deploy a mental health nurse who would otherwise be unavailable?" We know that the answer to this question is not "To no extent at all" so we need to know more what the answer is, far more precisely.

- I have been a regular presenter at CPD for AMHPs in the North-East of England over the last few years and the last time I did this, they expressed concerns about ST-type approaches that are not reflected in the evaluation. It is AMHPs who become excluded from the public contact where s136 usage reduces, because the AMHP plays a formal role in the assessment. So what do this crucial professional group think – I suspect many don't know what to think because they, like me, can't find any full evaluations to read.

- Why so little mention of other schemes who have NOT found these outcomes? – I know of three police forces who have started doing the kind of street triage being evaluated here, but have pulled away from it completely or substantially because notwithstanding an impact on the use of the s136 legal power they found other reasons to think it not worthwhile. In one case, that was because of a view by the police that they were being expected to burden excessive costs for benefits the health system welcomed but for which they were not prepared to pay. The authors in this example haven't touched upon these matters so I'm wondering if they considered them, or knew?

- The paper notes the research evaluation of Dr Margaret HESLIN *et al* from the Institute of Psychiatry in London who evaluated the Sussex street triage scheme. From a health economics point of view, they note that street triage was cost neutral but that it involved a significant transfer of cost around public service provision from health to policing. So a public policy question for you: "To what extent is it the responsibility of Chief Constables to pay for efficient healthcare pathways?" We know the answer to this is not, "Completely!"

- What is the understanding of s136 MHA, on which so much of the analysis rests: it refers (without a footnote) to 'inappropriate' use of s136 – what does that actually mean in the minds of the authors?! … we don't know.

- Leading on from that point, we also see no overt consideration of what is happening legally whilst these incidents are being handled in a new way. Section 136 is a power whose need must be immediate, in order to be lawfully used – given that street triage in south of the Tyne is moving around in an unmarked van, without lights and sirens and can take up to 45mins to reach an incident, what is the status of vulnerable people encountered by the first-responders who call for triage?

- Do the attending police officers point out to the encountered person that they are not detained and not obliged to remain with the officers? … or are they, in reality, detained pending triage's arrival to make the decision?! From other schemes, on just some occasions, we know they are and this can be both ethically and legally dubious – informing people that they are not detained and free to leave is common and legally required during other kinds of police encounters in order to remove ambiguity. It should be here, too; not least because of the questions around vulnerability and mental capacity that aren't always features of those other kinds of policing situations.

- And the title of the piece: "Too much detention" – I presume the authors are unaware that Baroness HALE, the deputy President of the Supreme Court who often gives the lead judgment on mental health and capacity law rulings like *Cheshire West* (2014), argued in her 2010 textbook on mental health law that s136 is, quite probably, *under*-used overall. Paradoxical though this may sound, it is quite possible to reduce the use of something that was already under-used: it's a logical fallacy to assume that because something can be reduced, it must have been over-used to start with. The police could arrest innumerable people for offences or Breach of the Peace instead of using s136 in order to reduce the use of the power: any decision to do so tells us nothing at all about use of s136 before or after that

change of approach because it could be true that arrest powers were already over-used prior to their increase!

- Finally, the costs savings of £1m or so – even allowing for acknowledgements of estimates being made and so on, the thing that seems to be missing from the economics of it all, is the issue around cost to policing. I've already mentioned the piece by HESLIN which is referenced in this article, and that showed a transfer of cost for less restrictive healthcare pathways shifting from the NHS to the police. In order to run this kind of street triage team, forces are contributing between four and seven police officers.

- This amounts to between 8,000 and 14,000 hours of police time and between £200,000 and £350,000 a year of cost, which needs to be offset against all the other calculations of time and money whilst remembering that any comparison to what was previously occurring in an area needs to remember that it was a s136 pathway already over-reliant upon the police because of an under-commissioned PoS service where the police were, in effect, asked to staff the mental health unit, requiring 10hrs of resources per detention. This doesn't happen everywhere and amounts to a different partnership context against which to evaluate the impact of an ST scheme.

- I also can't omit to mention the reference in the penultimate paragraph about the use of police custody "when clinically indicated" – I notice that's left hanging in the air, entirely undefined, as are the current proposals to define 'exceptional circumstances' for reliance upon police custody in the forthcoming revision of Mental Health Act. I've got no idea what it means and suspect that health guidelines suggest it will more or less *never* be 'clinically indicated'.

AND BREATHE!

I could go on … and on. It remains my view that street triage is *very* under-evaluated, that nothing we've seen so far gets us close to having a clear under-standing of risks versus benefits and that this week's publication is encouraging but an extremely partial view. And you'll have to forgive me repeating this point: my objection is not to street triage – it is to limited evaluation of these new ways of working! We didn't even mention deaths following contact with triage assessment, have we? … they need looking at, too.

That's why when I see things like this and find that people claim it's an obvious success that needs to happen everywhere on a 24/7 basis, it does get me fairly exercised because it's put across as a self-evident truth, beyond discussion. In reality there are many professionals and services

who say otherwise but then again, they haven't fully analysed it either! I'm far from alone in having unanswered questions, although it sometimes feels that way – I actively want someone to come and show me I needn't worry, because I'd love to be convinced about all this, given the obvious upsides to a collaborative approach.

But I want loads of data, quantitative AND qualitative. So whilst we're on the subject: where are the patient's and public's voices in all of this? Exactly.

Other posts touching on street triage and those aspects of s136 MHA referred to above –

- Street Triage
- Eight dimensions of street triage
- Flavours of street triage
- New section 136 data
- Correct use of section 136
- Answer the Question!

DECEMBER 2016

14th December 2016

When Time Stands Still –

When does the 'clock' start ticking, after someone is detained under s136 or s135(1) of the Mental Health Act? Straight-forward enough type of question: under the Police and Criminal Evidence Act 1984, the 'relevant time' is subject to considerable explanation, for the avoidance of any doubt. When you are arrested for an offence the police may detain you for 24hrs before deciding whether to charge you or not and this is calculated as 24hrs after you arrive at the first police station you are taken in the force where the offence is under investigation; or 24hrs after your arrest, whichever is sooner.

What about s136 and s135(1) MHA? – nobody seems to know!

This hasn't massively mattered in the past, because each of these two provisions allows for someone to be detained for up to 72hrs in order to ensure they are assessed by a DR and an AMHP and for the making of any arrangements for that person's treatment or care. It is rare, although not unknown, for someone to spend as much as 72hrs in a Place of Safety for these purposes. But in (roughly) April of next year, the Policing and Crime Bill will have become an Act of Parliament and this 72hr figure will be changed to 24hrs. There will be just 24hrs to arrange an assessment by an AMHP and a DR and to then arrange for inpatient admission in many of those cases.

Over the last years and decades we've seen the number of inpatient psychiatric beds in England and Wales diminish significantly during a time when the overall number of detentions under the MHA has been rising significantly. Recent figures from NHS Digital outline for the first time, the number of MHA admissions has exceeded 60,000 – I remember only three years ago, when massive concern was voiced the figure had initially exceeded 50,000! So whilst MH services are somehow having to figure out how to fit ever more admissions in to ever fewer beds, the use of s136 is rising significantly: to over 28,000 this year, compared to around 18,000 a decade ago. We also know it can be difficult to find inpatient beds in a timely way – especially specialist beds for children, those requiring intensive care or secure services. This will only get more difficult if there is less time, legally speaking, in which to find them.

So this issue of the 'clock' becomes important, because we need to know exactly how restricted we are, if someone needs admission after being detained by the police under the Mental Health Act.

THE PoS 'CLOCK'

It's fairly easy to work out when the 72hrs begins if someone is taken to a mental health unit Place of Safety or a police station – it is calculated from the time of arrival, because s136(2) MHA makes it clear "they may be detained *there* for up to 72hrs". It usually gets confusing when Emergency Departments become involved and this is made manifest in the two views expressed in the English and Welsh Codes of Practice to the Mental Health Act 1983. Because Wales has devolved political responsibility for health matters to the Welsh Assembly Government, they issue their own Code of Practice for Wales and separate Codes were first issued in 2008. The English updated theirs in 2015 and a new Code for Wales was published in October 2016. From a policing point of view, the most recent Codes simplified things for policing as there are now far more similarities between the two documents than there were after the 2008 updates.

However, on this point of the 'clock', they appear to just flatly contradict each other! In the English Code of Practice (2015), it states (in paragraph 16.26) –

"The maximum period a person may be detained under section 136 is 72 hours. In practice, detentions should not need to be this long. The imposition of consecutive periods of detention under section 136 is unlawful. **The maximum 72-hour period begins at the time of arrival at the first place of safety** (including if the person needs to be transferred between places of safety)."

In the Code of Practice for Wales (2016) it states (in paragraph 16.46) –

"If, in exceptional circumstances, a police officer needs to take a person to an emergency department after detaining that person under section 136, for the emergency medical assessment or treatment of their physical health this should not be treated as an admission to a place of safety. ***Detention under section 136 will begin when the person is taken to the appropriate place of safety*** *for the assessment of their mental health."*

There are various things to get picky about and I usually find it can be helpful to get picky. You may already be thinking that my bold emphasis in the Welsh Code is wrong: detention begins when someone gets detained! – you can't have a situation where you are detained in a street but are somehow not yet detained, until the detention you have experienced takes you to a particular mental health unit, via an ED department. I've

deliberately complicated that explanation to highlight how ridiculous it is – detention is not a legal phrase in this context, it is just a word that has an ordinary English (or Welsh!) meaning. You can either walk away from that officer, or you can't because they've detained you; and none of this is relevant to the 'clock', because s136(2) makes it obvious that the time from detention to arrival at a PoS is not counted.

If you still want to be picky, you'll may ask yourself, "Is ED a Place of Safety?" … the English Code is saying that the 'clock' begins when the person arrives at a PoS … so is ED a PoS; or not?! Well, there are a few arguments about that, too – the police power, once used, is to remove someone to a PoS and s135(6) defines hospitals as a Place of Safety under the Act. It makes no distinction between EDs and other kinds of hospital, it makes no reference to that status as a PoS being subject to any designation or to any agreement on the part of the hospital. By way of analogy, only certain police stations would be used as a PoS, usually those designated for receiving detainees and holding them for 24hrs (or more in certain circumstances). But if a rural officer did remove someone to a local police station and use the front office interview room as a temporary place to hold someone, they have been removed to a police station, which is also in s135(6), so s136(2) kicks in, arguably.

THE LAW IS THE LAW

Of course, one point broader legal point is: it's not for Codes of Practice to define the law itself, that is already done in the Act of Parliament. As one notable mental health lawyer once said to me, "Nothing in a Code of Practice will make lawful something that is unlawful under the Act – and vice versa," So a Code of Practice can say what it likes: it won't alter the law of England or Wales if the Act makes the point clear.

So what does the Mental Health Act 1983 actually say?! –

It says that police officers who are satisfied the criteria are met in s136(1) may detain the person "and remove them to a Place of Safety". In s136(2) it makes it clear that where somebody has been removed to a PoS, "they may be detained there for up to 72hrs" etc.; this will reduce to 24hrs next year. Place of Safety is defined in s135(6) and includes "hospital" in the definition and most importantly: it is often the case that when someone enters the ED department, no-one can say with any confidence whatsoever whether that person will leave ED during the time that s136 remains in play. If we cannot be certain what function the ED will play, how can we confidently say at the point of arrival that it is only acting as a place to receive assessment or treatment of their *physical* health. What if the patient being detained there lacks the capacity to take decisions about their physical healthcare treatment and what if those problems are associated

with mental health problems to the extent that treatment could be given under the MHA?

I can think of at least a few scenarios –

- A person is thought by officers to have a mental disorder, is detained under s136 but paramedics advise that something else appears to be wrong and assessment in ED is required. If assessment requires a more prolonged stay in ED or even admission to the acute hospital, what does this mean for the 'clock'? – examples have included patients who turned out to have meningitis, brain tumours or patients who attempted to overdose where it took 12hrs or more to run blood test and ensure treatment.

- Someone was removed to ED under s136 but the legal process concluded before they were able to leave that hospital; or the 72hrs even ran out! – this has been known to happen with overdose cases where assessment and treatment can lead to admission lasting several days.

- There are problems with accessing any other kind of PoS after initial removal to ED – sometimes, MH unit PoS facilities are full at the point where you might hope to transfer the person and occasionally, police custody sergeants may decline to accept a s136 transfer from hospital; and they are legally quite entitled to do so. It may simply not be possible to move the person.

What the Welsh Code of Practice seems to be saying, is that someone who is detained by the police in Cardiff, having taken an overdose, can be taken to ED and spend 24hrs or more detained against their will whilst doctors assess their condition and offer treatment, only then to be taken to a health-based Place of Safety where a further three-day detention period can be relied upon. It means, in theory, the overall maximum period of detention is limitless because no amount of time in ED for physical care counts. Do we presume four days of detention would be OK? … or five, or six?!

YOU CAN'T BOTH BE RIGHT

Of course the most obvious point is, these two things can't both be right, unless you accept the argument that ED departments, despite being 'hospitals' and despite no-one being certain about how and to what extent ED will be used in any given situation, can divorce itself from the notion that it can act as a Place of Safety under the Mental Health Act and that in most areas it occasionally will need to do so. The English Code gives one answer; the Welsh Code gives another – the answer is actually in s136(2)

itself, which makes it clear that the time commences when someone arrives at the Place of Safety they are taken to. Hospitals are a PoS under the Act and no-one can truly know what will happen to any particular patient's journey at the point where they first arrive at an ED.

Finally, there's the practical point that if you adhere to the viewpoint given in the English Code, you are never going to found wanting, legally speaking. If you follow the advice in the Welsh Code, you could end up finding it difficult to defend a detention that exceeded the maximum time permitted. It's all the more likely the maximum will be exceeded after April of next year as AMHPs struggle to secure beds for admissions after use of s136. (Not connected to my main point: but there will be provision to extend the new 24hrs maximum up to 36hrs in some circumstances, but it still represents a halving of the available time!)

I'm guessing and hoping the Department of Health and Welsh Assembly Government will be issuing new Codes of Practice in 2017, less than a year or two after having updating the 2008 editions – the Policing and Crime Act 2017, as I suspect it will be called, will change several aspects of the police's powers under the MHA. It would be great if they could clear this up for us all so we actually know what the law is and what is expected of us when we subject the public to the operation of these powers!

21st December 2016

A Theory of Stuff –

I had a recent conversation about a policing and mental health issue, relating to the role the police may play on inpatient psychiatric wards where nursing staff are seeking support for some restrictive intervention under the MHA. In passing summary of the relevant legal issues at play during such requests, I said, "It's the responsibility of healthcare providers to plan and prepare to mitigate foreseeable risks connected with their activities; and it is the role of the officers to investigate allegations of crime and to respond to serious risks which arise from unforeseen circumstances which have gone awry to the point where safety is seriously compromised."

This has become more or less my standard summary of the work we've been doing under the chairmanship of Lord CARLILE CBE QC, which should emerge early next year. I usually add one further point: "Where the police do attend because of unforeseen or more serious risks, it is their role to create safe conditions within which healthcare staff can re-take control of the restrictive intervention unless it needs to become a criminal justice intervention, for example by arresting someone." In other words, because MH staff may want to administer medication, this does not mean it is the role of the police to assist in that process just because a ward is not able to do so. If it were a matter of life and death, then the law would probably would allow for the police to support this process, but it often isn't quite so serious.

The recent conversation revealed disquiet at this statement. Surely if a patient needs medication and the ward cannot muster enough staff to administer it, it falls to the police to help, right? No. Let me give a real example to show why.

CAN YOU IMAGINE?

Imagine a 999 call where a patient is 'smashing up the ward', with demands for urgent help. The police arrive to find a group of nurses and a doctor holding a patient in a small room off the ward, physically leaning on the door to stop the person from leaving. There is shouting coming from within and through a small observation panel, it is obvious the patient is highly agitated and distressed. The first police officer to arrive is the duty sergeant

– concerned he is on his own, the staff immediately shout, "You need more officers, get more officers!" and the sergeant explains that two constables are just arriving and will be here within a minute. The doctor explains that staff have attempted to persuade the patient to receive medication over a long period and it has all failed. She is a s2 MHA patient and they have taken the decision to administer medication without the patient's consent. They ask the three male police officers to enter the room, take hold of her and place her in a prone position so her trousers and underwear can be pulled down and an injection given.

Meanwhile, the patient is pacing around room and hitting the walls, but not causing any damage. Prior to police arrival, some damage has been caused on the ward, but that cannot now be undamaged by anything the police do or don't do and nothing more is at risk as the patient is contained in a side room.

Can you imagine the furore if three male police officers forced a vulnerable woman to the ground and pulled down her underwear in any other context? – imagine if we learned that had taken place in police custody, even at the direction of an FME for some medical reason or other?! If it didn't make the mainstream media as an outrage, it would probably still make the Professional Standards Department and / or the IPCC as a complaint and police officers have been disciplined for less. Why such urgency to have three male officers, partially strip a female patient? – she's now in a room, contained and not causing herself any further harm in the short-term. The damage is now history, it needs repairing and there can be a criminal investigation in to that if anyone is alleging it should be considered for a prosecution. But in terms of the immediacy of entering the room to undertake a restrictive intervention to administer medication – there is no obvious immediacy (or at least, none was being made clear) such that the dignity of the patient needed to be compromised in this way.

THE ROLE OF THE POLICE

This is what we're getting at when we discuss the role of the police, not just within inpatient settings, but more generally – how do we frame some broad principles which would allow officers to understand how to judge their role in any mental health related incident; how do whole police forces understand how to judge their role when framing policies and procedures? I've recently spent a lot of time around the country, talking to forces in order to help their learning and development staff understand the legal material within the College of Policing's Authorised Professional Practice (APP – guidelines, to you and me) and to prepare for the reality of standing in front of a room full of operational officers to deliver the training. Of course, the complexity and difficulty of this topic is reflected in the almost-700 posts on this BLOG and in outlining how the College of Policing are

asking forces to approach this topic, I have outlined what I would say is a theory of policing and mental health.

This is not an attempt to sound grandiose, but to use the word 'theory' in its scientific sense: the explanation we offer to what we (think we) know from the world around us. Scientists throughout history have observed the world around them and sought to explain it with reference to theories that take account of those observations and the results from their work. If you find a persistently troubling fact that disturbs your theory, you have to refine the theory by changing the explanation, not insist that the troubling information can be dismissed. So the theory used to be that the sun and moon revolved around the earth and various people including Copernicus suggested otherwise. This alternative was eventually proved, in the sense that the best explanations for what we know is that the original theory was only half right: the moon does revolve around the earth, but the earth around the sun.

So in policing and mental health, how do we explain the role of the police? Well, you take all of what we (think we) know and provide an overall explanation that fits. Things like —

- We know, legally speaking, the police have no Mental Health Act powers in patients' homes, yet we also know that most of the crisis incidents the police attend are in exactly those locations. Many such incidents can be professionally resolved without resort to legal powers but where they do become necessary to keep people safe, this cannot be for the police alone, because we don't have powers that others do possess. To suggest that it can always rely on the police, is to miss both the legal thing and the policy thing we know or to fail to take them in to account.

- We know mental health crisis presentations where patients are so distressed and frightened that they exhibit very resistant and aggressive behaviours, can be attributable to underlying medical emergencies. We know that any restraint thought necessary can exacerbate that situation and medical guidelines exist in relation to this: so any suggestion that people presenting in such must be taken to police custody and until they 'calm down' or specialist inpatient beds are available is to miss that thing we know about medical and restraint risks.

- We know that 30 cases of assault on NHS staff have been privately prosecuted in the criminal courts by NHS Protect after the police and / or CPS declined to do so – this is why officers who say, "We can't prosecute a s3 patient who punches a nurse" is not explaining that professional issue in a way that survives contact with what we know, because NHS Protect won all thirty of their cases. To suggest that

inpatients in mental health units cannot be prosecuted is to miss that thing we know, about the history of criminal allegations from inpatient mental health settings.

- We know the mere fact of police involvement in a mental health or crisis response can be criminalising and frightening for some patients involved. That may even be because caring, empathetic officers had limited options available and had to do something regrettable, like detaining someone. To think the police can always be a reassuring presence when someone is in crisis, is to miss that thing we know about human beings all being unique, sometimes frightened and with different needs; and police officers being police officers, they don't always have the skills or the options.

A THEORY OF STUFF

So look around you: see the legal frameworks we have in this country and the international frameworks we've brought in to our domestic law; see the various judgments of the courts in civil, criminal and human rights cases; look at the medical, nursing and care guidelines; read the books that academics and professionals have written; look at the way the police fit in to that wider system of 999 and of emergency mental health care; but most importantly – listen to what patients say about their needs and about the role of the police; read what they say on social media about how the world revolves for them.

Then, you can start working out how to structure a wider social response to those of us with mental health problems which must involved the police to some degree – mental health is core police business. But by better understanding those things, you'll see where the police fit in to that wider response … and where they don't.

For what it's worth, about twelve years in to my efforts to do so, this is where my head is: if you disagree, please do so in the comments below as I'd enjoy discussing it –

- **The police should be as uninvolved as possible in providing responses to mental health crisis care incidents** – this is not to argue there is no role for the police: mental health is *core police business*, but not all crisis events are predictable or preventable and some will require the skills and legal powers that only police officers possess. This is about wanting to minimise the potential that police officers will unwittingly criminalise people; and inadvertently provide the wrong response to the circumstances, despite their best efforts.

- **The police should ensure a more consistent response to crime involving those of us with mental health problems** – living with mental health problems means we are more likely to be victims of crime; we are more likely to suffer criminal justice 'attrition' with our cases not being taken forward; and we need much greater consistency of whether we prosecute a vulnerable suspect or divert them from the justice system, especially where the offence is alleged to have occurred against healthcare staff in a clinical environment.

Whatever specifics I've learned over the last twelve years – legal material, medical guidelines, Coroner's outcomes, IPCC inquiries, etc., etc.; – all of that feeds in to those two conclusions. Every time I read a new case, study a new report or think about the various lessons that we've been told we must learn, I re-test whether these two things stand up to what we know about how the courts and lawyers say we can act; and to how healthcare professionals say we best serve those of us in distress. Every time I hear of initiatives that go against these ideas, I wonder whether that means we end up going in to conflict with things we know about the real world: and I invariably find we do.

We need to remain open minded about how we make the world a better place; and we need to ensure we ask questions when new information arises – does this information reinforce this working theory or do we need to re-think our overall approach in light of this new information? Then, in the end, it comes down to what we're trying to achieve. I suspect that's where some of next year's conversation needs to focus but we need to find the best explanation for now about what we know whilst acknowledging we always need to know more.

27th December 2016

Twenty Seventeen –

Some thoughts ahead of the New Year, after sitting recently and wondering where on earth we'll be with things by Christmas 2017! —

THE BOSS

Firstly, Commander Christine JONES QPM, the National Police Chief's Council lead on mental health will be retiring in early 2017 after a distinguished career. She has been the NPCC lead on mental health for the last four years and was a driving force behind the creation of the Crisis Care Concordat which was published in 2014. A fierce supporter of the operational officers who face and take tough decisions every day, often whilst finding themselves in far-from-ideal contexts, I know that she has challenged partner organisations around the extent to which commissioning and fragmentation in health contributes to the extent to which the police service is called upon. What some perhaps haven't seen is how challenging she is *within* the service to improve the leadership, oversight and knowledge of the detail around this area.

I remember in 2013 being asked to assist Kent Police with their early work around mental health and they asked me to speak in their lecture theatre to a group of senior and operational officers as well as partners. At the last moment they told me that Commander JONES was attending to listen and it's one of those rare occasions I suddenly became very nervous indeed! Those who know me well know I just keep my mouth shut rather than say stuff I don't believe: I think Commander JONES has led us exceptionally well – she's been a passionate advocate for vulnerable people and for frontline police officers, often saying the things I know many people were only thinking and I've watched her standing up to senior healthcare professionals and politicians alike, challenging assumptions and saying things they didn't always enjoy hearing.

I'm especially grateful for the support she's afforded me personally, in terms of arguing for my secondment to the College of Policing and in encouraging and supporting me to keep chipping away at issues when she knew I was taking flak. I'll always be grateful for that, because when you

feel like you're one of the few in a room saying certain things, it's helpful to have such backing from someone who really understands these agenda.

I wish the Boss nothing but the very best for the future – it's genuinely been a proper privilege.

NEW LEADERSHIP

Therefore secondly, you should be aware that the NPCC lead on mental health transfers in late January to Chief Constable Mark COLLINS, of Dyfed-Powys Police. Mr COLLINS has already met Commander JONES to start the process of handing over and I've already sent him a couple of pages of A4 outlining some headlines that I would recommend he looks at. Top amongst them are the initiatives which fall under the name 'liaison and diversion' and 'street triage' – there is still more to be understood on both of those issues; from better understanding and defining the concepts through to more thorough research and evaluation of things that go beyond the supposed benefits to the health system.

Mr COLLINS takes over the national lead at a point where forces will be starting to deliver training to officers based on the College of Policing packages that we've spent two years developing; he takes over as demand on the police connected to mental health is rising quite sharply but at a point where we still know the overall data we have to understanding that demand and the particular problems is not as comprehensive as it needs to be.

I think it's great that the lead will transfer to Wales – land of my grandfather(!) and where I studied criminology – because there is plenty of work to do there and the devolved political system for health in Wales, but not for policing, provides a slightly different dynamic to things. Wales published a Crisis Care Concordat at the end of 2015 and are just adjusting to introduction of a new Code of Practice for Wales, which took effect in October 2016. Obviously, Mr COLLINS's responsibilities for NPCC will cover both England and Wales and as he's worked at senior level in both countries and overseen various developments around mental health in his last force – he seems ideally placed to lead on this and very keen to become involved.

FORTHCOMING HIGHLIGHTS

Keep your eyes open next year: we're going to see various things worth watching! This will include –

- **The Angiolini Report** – a review ordered by the Prime Minister in to deaths in police custody will be published early next year. We know that mental health will be one of several important areas of focus and I'm keen to read it, having met with the review team to discuss these matters.

- **The Policing and Crime Bill** – once this becomes an Act of Parliament, it will be introduced in the Spring and will reduce the use of police cells as a Place of Safety, limiting the time someone can be detained. I know some areas of the country are worried about their ability to work within these new frameworks, but laws being what they are, they're going to have to find a way.

- **New Regulations** – the Policing and Crime Bill does not make explicit the 'exceptional circumstances' in which police cells can be used as Place of Safety under the MHA: these will emerge in the first quarter of next year and discussion can start about how to give effect to those regulations, given that there doesn't seem to be a settled, agreed answer about when the use of police cells is acceptable.

- **Health Guidelines** – the National Collaboration Centre for Mental Health and the National Institute of Health and Care Excellence (NICE) will each publish new documents about commissioning standards for emergency and crisis mental health care; and mental health in the criminal justice system.

- **Restraint Guidelines** – the Expert Reference Group chaired by Lord CARLILE will publish its first Memorandum of Understanding on police-related restraint in mental health settings in early 2017. It will essentially remind us of the obvious: restrictive healthcare interventions are a matter for the NHS; crime and mitigating unforseeable serious risks can involve the police. Everything else is about managing the gaps and overlaps.

- **Coroners' Inquests** – at least two high-profile deaths in custody related to mental health matters. I suspect we'll be told again to learn lessons that have already been highlighted in previous high-profile tragedies.

- **IPCC Inquiries** – at least another two high-profile inquiries relating to mental health that should be finalised.

- **Criminal Trials** – there are two trials due where police officers are accused criminal offences connected to deaths following custody or contact. This is as serious as it gets and the justice system take its

course – regardless of outcomes, there will be things we can learn here. It's important that we do.

MOVE THINGS FORWARD

Finally, some news affecting me amidst all of this! – I am *totally* chuffed to have been invited by Mr COLLINS to work as his mental health coordinator on his NPCC portfolio for the next couple of years. My secondment at the College of Policing was due up at the end of March anyway and I had started discussions with West Midlands Police about an operational posting for April 2017. Whilst I do intend to end my career in an operational police role I still have at least twelve years left to serve so I'm delighted to be given a chance to keep chipping away at this agenda around mental health when there is still so much left to do.

In fairness, evidence shows that demand on policing connected to mental health is rising – up at least 26% over the last three years – and I'm grateful to West Midlands Police for still affording me the opportunity to push this agenda. So from April 2017, I will be seconded to NPCC via Dyfed-Powys Police working directly to Mr COLLINS, albeit 25% funded by the College of Policing so I can continue to support the work they will need to undertake to keep APP and training materials up to date, in light of all of the above.

I hope you all had a Merry Christmas, that those emergency and health services workers who worked didn't take too much of a bending and that you all have some chance to enjoy some time with family or friends – Happy New Year!

31st December 2016

More Assaults on NHS Staff –

A short post, because it's just updated data on topics I've written about before, where the same issues prevail. NHS Protect issued its 2015/16 data for assaults on NHS staff and the headlines are –

Name of Health Body	Total Assaults (1)	Assaults Involving Medical Factors (2)	Assaults NOT Involving Medical Factors (3)	Total Staff (4)	Assaults per 1,000 Staff (5)	Reported Criminal Sanctions (6)	Reported Civil and Administrative Sanctions (7)
Sector Total	**46,107**	**35,440**	**10,667**	**241,490**	**191**	**769**	**392**
2gether NHS Foundation Trust	354	170	184	2,321	153	0	1
5 Boroughs Partnership NHS Foundation Trust	946	932	14	3,700	256	19	0
Avon and Wiltshire Mental Health Partnership NHS Trust	1003	422	581	4,560	220	1	0
Barnet, Enfield and Haringey Mental Health NHS Trust	583	362	221	2,900	201	5	0
Berkshire Healthcare NHS Foundation Trust	563	425	138	4,500	125	4	9
Birmingham and Solihull Mental Health NHS Foundation Trust	1,283	289	994	4,808	267	10	2
Black Country Partnership NHS Foundation Trust	742	629	113	2,621	283	7	0
Bradford District Care Trust	684	239	445	2,919	234	0	0
Calderstones Partnership NHS Foundation Trust	1,597	1,597	0	1,017	1570	17	7
Cambridgeshire and Peterborough NHS Foundation Trust	764	693	71	4,173	183	0	0
Camden and Islington NHS Foundation Trust	362	362	0	1,716	211	0	0
Central and North West London NHS Foundation Trust	1,194	1,183	11	8,145	147	10	4
Cheshire and Wirral Partnership NHS Foundation Trust	668	186	482	3,600	186	0	1
Cornwall Partnership NHS Foundation Trust	459	384	75	2,057	223	3	1
Coventry and Warwickshire Partnership NHS Trust	3,075	3,072	3	4,016	766	3	0
Cumbria Partnership NHS Foundation Trust	460	446	14	5,172	89	2	1
Derbyshire Healthcare NHS Foundation Trust	233	233	0	2,468	94	4	1
Devon Partnership NHS Trust	550	537	13	2,518	218	0	4
Dorset Healthcare University NHS Foundation Trust	401	94	307	6,240	64	0	0
Dudley and Walsall Mental Health Partnership NHS Trust	199	133	66	1,157	172	0	0
East London NHS Foundation Trust	873	873	0	6,001	145	66	0
Greater Manchester West Mental Health NHS Foundation Trust	818	531	287	3,317	247	63	75
Hertfordshire Partnership University NHS Foundation Trust	967	967	0	4,949	195	0	0
Humber NHS Foundation Trust	161	161	0	3,384	48	0	57
Isle of Wight NHS Trust	82	80	2	3,685	22	1	0
Kent and Medway NHS and Social Care Partnership Trust	924	617	307	3,751	246	0	0
Lancashire Care NHS Foundation Trust	1,420	1,109	311	8,212	173	30	55
Leeds and York Partnership NHS Foundation Trust	905	706	199	3,155	287	0	0
Leicestershire Partnership NHS Trust	815	769	46	7,083	115	3	0
Lincolnshire Partnership NHS Foundation Trust	582	556	26	2,015	289	12	3
Liverpool Women's NHS Foundation Trust	2	0	2	1,375	1	0	0
Manchester Mental Health and Social Care Trust	335	312	23	1,600	209	15	24
Mersey Care NHS Trust	281	127	154	4,209	67	105	0
NAViGO Health and Social Care CIC	94	32	62	600	157	0	0
Norfolk and Suffolk NHS Foundation Trust	1273	933	340	4,046	315	20	0
North East London NHS Foundation Trust	372	369	3	9,757	38	2	0
North Essex Partnership University NHS Foundation Trust	312	221	91	2,515	124	48	78
North Staffordshire Combined Healthcare NHS Trust	269	256	13	2,108	128	3	5
Northamptonshire Healthcare NHS Foundation Trust	454	434	20	4,447	102	9	0
Northumberland, Tyne and Wear NHS Foundation Trust	3,583	3,401	182	6,666	538	55	0
Nottinghamshire Healthcare NHS Trust	1554	0	1554	9,835	158	52	5
Oxford Health NHS Foundation Trust	317	315	2	6,054	52	4	3
Oxleas NHS Foundation Trust	416	0	416	3,663	114	3	0
Pennine Care NHS Foundation Trust	687	671	16	6,788	101	5	6
Rotherham, Doncaster and South Humber NHS Foundation Trust	939	926	13	3,992	235	4	0
Sheffield Health and Social Care NHS Foundation Trust	898	660	238	3,095	290	0	1
Solent NHS Trust	240	226	14	3,101	77	1	12
Somerset Partnership NHS Foundation Trust	373	258	115	4,550	82	9	9
South Essex Partnership University NHS Foundation Trust	841	772	69	5,324	158	9	1
South London and Maudsley NHS Foundation Trust	1342	268	1074	4,734	283	32	0
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	753	736	17	3,769	200	3	1
South West London and St George's Mental Health NHS Trust	509	210	299	3,201	159	48	18
South West Yorkshire Partnership NHS Foundation Trust	1,004	211	793	4,923	204	0	0
Southern Health NHS Foundation Trust	2818	2814	4	7,080	398	19	3
Surrey and Borders Partnership NHS Foundation Trust	468	299	169	2,186	214	2	5
Sussex Partnership NHS Foundation Trust	439	431	8	4,323	102	14	0
Tavistock and Portman NHS Foundation Trust	32	32	0	650	49	1	0

- **Assaults are up by over 2,500 to 70,555 in the last full year.**

- That covers the whole NHS: the figures further break down to –
- **52,704** assaults involved what NHS Protect calls 'medical factors' – see below.
- **17,851** assaults did not involve medical factors.

- MH professionals are two, three or four times more likely to be assaulted at work than the 'average' for the NHS as a whole.
- I'm not sure we know how many NHS patients were assaulted, whether by other patients or by NHS staff (yes, it does happen). NHS Protect don't record (or at least don't appear to publish) those data.

Within the various sectors of the NHS –

- **46,107** assaults occurred within the mental health sector of the NHS – 35,440 of those involving 'medical factors'.
- **2,300** assaults occurred within the ambulance sector – 712 involving 'medical factors'.
- **20,018** assaults within the acute sector – 14,780 involving 'medical factors'.

MEDICAL FACTORS

I've written about this elsewhere and for detail, I'd encourage you to read the previous post. Suffice to say here, that medical factors are defined as relevant to an offence if "the person did not know what they were doing or did not know what they were doing was wrong, because of injury, illness or treatment." This is, more or less, the legal definition of insanity, so it is quite a high threshold to meet. There are very few insanity findings in criminal courts in any given year, yet the NHS records that more than 5 in every 7 of the assaults on their staff were at the hands of patients who meet that description. This seems unlikely to me – it strikes me as a massive over-representation given what we know from other sources that insanity pleas are few and far between. We also know from research for NICE Guidelines that fewer than 10% of people who offend whilst mentally ill are offending *because* they were mentally ill. There is little direct, causal relationship between illnesses and offending, it seems.

Little appears to have changed in terms of certain inconsistencies that needed pointing out in my previous post – we need to debate what they mean. Nottinghamshire Healthcare Trust and OXLEAS NHS Foundation Trust (south-east London) both recorded that none of their assaults involved medical factors. No-one at all in those areas – not even one person – was so unwell because of illness or injury that they lacked all insight in to their actions. And yet just down the road from those two, in Derbyshire Healthcare NHS Foundation Trust and in West London Mental Health Trust, ALL of the patients were so unwell they were, essentially, insane. I've

worked as an operational police inspector in both Birmingham and in the Black Country: look at the figures for BSMHfT and the BCPT, above: one thinks that just over 20% of assaults *were* due to medical factors; the other thinks that just under 20% *weren't*. I know Birmingham and the Black Country fiercely defend their cultural and various other differences but take it from me as a neutral (a Geordie) who has lived and worked in both places for over twenty years overall: I can assure there is not *that* much difference!

It strikes me again and again, neither of these extremes is likely to reflect the medical or legal realities in those areas. Just for completeness, there are two MH trusts data missing from the header image because of the page layout so I've highlighted them below because they also tell another story: why do MH trusts with a 1:2 ratio of staffing when compared to each other have roughly similar levels of assaults? You are twice as likely to be assaulted at work if you're a mental health nurse in Ealing than if you work in Middlesbrough.

Name of Health Body	Total Assaults (1)	Assaults Involving Medical Factors (2)	Assaults NOT Involving Medical Factors (3)	Total Staff (4)	Assaults per 1,000 Staff (5)	Reported Criminal Sanctions (6)	Reported Civil and Administrative Sanctions (7)
Tees, Esk and Wear Valleys NHS Foundation Trust	953	887	66	7,400	129	3	0
West London Mental Health NHS Trust	882	882	0	3,339	264	43	0

Of course, trusts differ in the services they provide – only some provide medium secure services; only some run learning disabilities or children's mental health services; and only three trusts in England provide High Secure services and (West London is one of them) … but this all needs untangling if we are to make sense of data that is superficially confusing because it doesn't compare apples with apples.

RISING LEVELS OF CRIME

What's missing are the reporting levels to local police services. One MH trust told me that they report around 15% or 1-in-8 assaults on the staff to the police, because of their assessment of 'medical factors' and their consideration of victim's views plus a guess at the public interest test for prosecution. So they determine that a report is not needed 7 times out of 8. Yet in a recently developed MoU between NHS Protect and the police service, NHS are requesting trusts to report 100% of incidents recorded in these data to the police. With what purpose in mind? – of course, anyone who is assaulted is entitled to report that to the police, but I'm wondering what the motivation would be for doing so if the suspect was an 89yr old degenerative dementia patient who has pushed a nurse causing no injury during the provision of personal care?

This approach should be even more interesting in those trusts which report 100% 'medical factors' – because they are asking the police to criminal investigate the liability of someone that professionals themselves are already assessing as unlikely to be convicted, ever. That having been said, in those thankfully rarer cases of more serious crime, the potential that someone is unfit to stand trial or likely to be found not guilty by reason of insanity is not sufficient reason, in itself, not to prosecute. The criminal courts in this country have powers under the MHA that no doctors have to balance off the issues where treatment needs to be considered alongside public protection. So we do need that debate about when it is right to prosecute a very vulnerable person who has offended. We know the answer is not 'never', so it begs the question, 'when?'

Does a rise of 2,500 reported assaults comes from greater recording of incidents previously not reported because of a lack of time to do so or a belief that nothing worthwhile would result; or from a genuine rise in the levels of crime? … we don't know! I've heard anecdote recently for each of those explanations and from professionals I know well and would trust; but it should be borne in mind the violent crime in society generally is rising and demand on the NHS is rising at a time when resources are being rationalised. It would not be unexpected if we saw numbers rising even just allowing for rising levels of offending. We need more data … *much* more data. We also need a clearer understanding of what 'medical factors' should mean and how this is being interpreted across the NHS. We need much more analysis and discussion of yet more data.

We don't know what we're doing so we don't know whether what we're doing is wrong.

This should be on our to-do list for 2017 — Happy New Year!

End of Volume:
301 Pages
105,000 Words

Total to date:
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