MENTAL HEALTH COP

A VENN DIAGRAM OF POLICING, MENTAL HEALTH AND CRIMINAL JUSTICE

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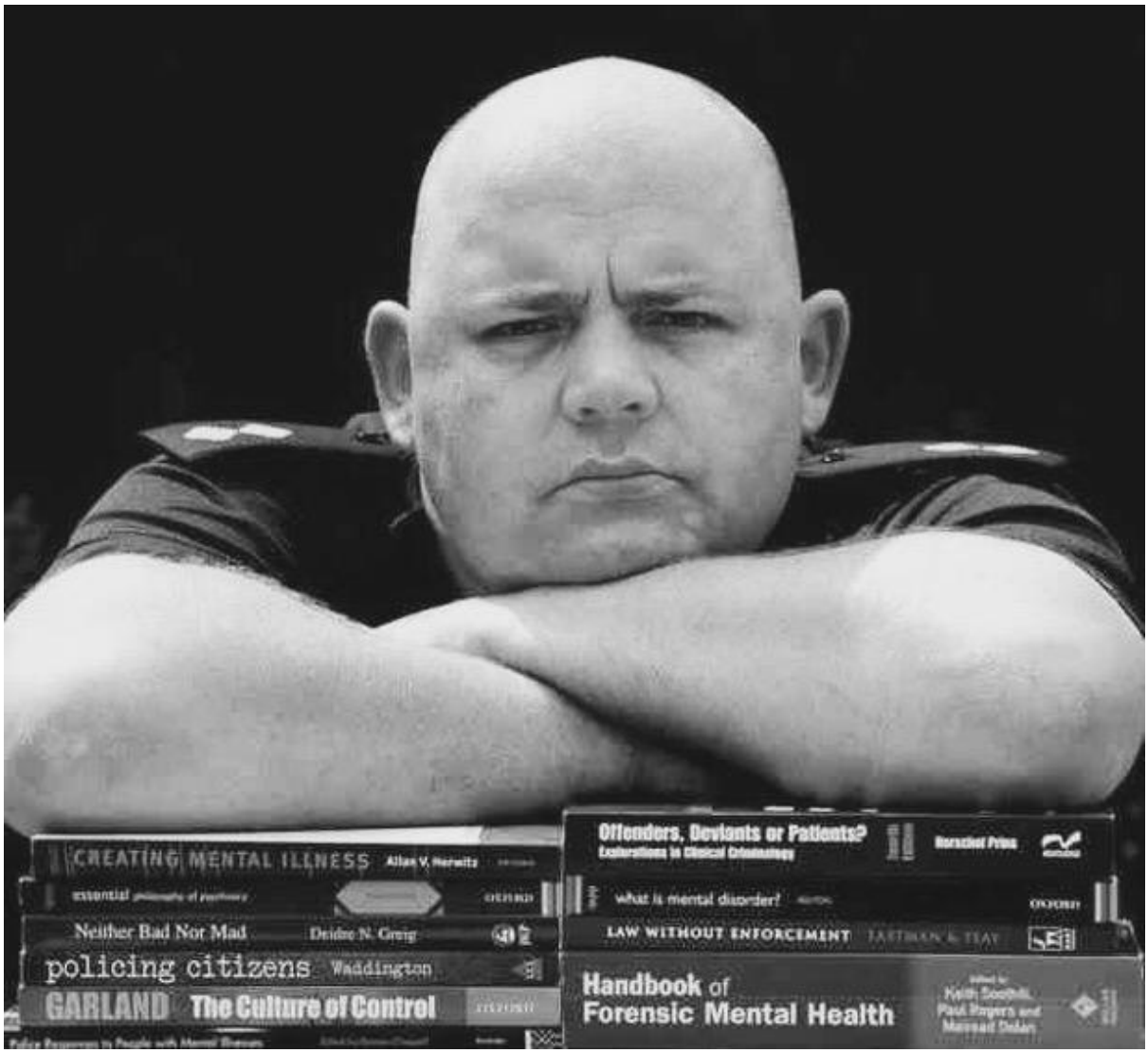
*Winner of the **President's Medal** from* the Royal College of Psychiatrists.

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



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JANUARY 2017

7th January 2017

Three Months … and Counting! –

***Update**: since writing this post, the Bill has become and Act and it is still thought commencement will occur in May 2017. I have written an in-depth series of posts on these matters, for more in depth thoughts about what this will all mean.*

This year, the Mental Health Act 1983 will change. It will be amended (during April, we think) by the Policing and Crime Act 2017* and by the time we sit here early next year, we will know far more about how we've coped with it all, but there are plenty of indicators around that we are not at all prepared for or sighted on these changes. So with three months to go 'til this all kicks in, it seems timely to loudly re-bang the drum lest we risk seeing police forces and mental health services having some really difficult conversations at 0337hrs on some Tuesday morning in early May. I'm nervous about all of this, quite frankly. Some areas are struggling under current laws and these amendments only make things far harder for the organisations involved. However, they should make things much better for the public and that, of course, is *exactly* the point – we're talking about the liberty of vulnerable people here!

For the avoidance of doubt, the amendments to the Mental Health Act are almost *exactly* as they were originally introduced to the House of Commons in 2016 – little has changed during the Parliamentary process so it's fair to point out that we've all had a year already to start preparing for this. I have emailed forces with considerably more detail than I am going to put in this post around three months ago, to point out we were six months out and needed to start partnership discussions if we hadn't already. I know some forces have done exactly this and have written plans they are working towards completing in adequate time. I know others are nowhere on this – sometimes because they've tried to raise the point, but haven't been heard.

Some forces are still detaining hundreds of people a year in police custody as a Place of Safety, so are struggling under the current legal frameworks to achieve what is needed – often because of problems way beyond their control. If this stuff isn't going to fall flat on its face, it's about senior managers in health, local authorities and police forces who need to be sighted on things. I would urgently recommend some senior managers in

A&E get interested in making the points I'm making in this post, because I strongly suspect that if adequate preparation for the changes are not made, they will be asked more frequently than ever before to support vulnerable people in the care of the police. And we all know what a quiet time A&E are having at the moment!

READY, STEADY, GO!

So set your timers for three months and start counting –

- In three months' time, it will be *completely unlawful* for police officers to take any child to a police station if they are detained under s136 MHA – yet only this week, I know for a fact that the police have had to email chief executives in mental health and acute trusts they work alongside, reminding them of the law and rebutting suggestions that they should just bang kids up in concrete rooms because that's how the NHS would prefer it.

- In three months' time, AMHPs will have just 24hrs in which to coordinate an assessment at a Place of Safety – if they decide it is necessary to make an application for that person's admission, they will not be able to extend the 24hrs up to 36hrs where that extension is only necessary to identify a hospital with an available bed. Commissioners need to think about bed capacity and their ability to admit over 3,000 people a year within this timescale.

- In three months' time, the police will have to ring a mental health professional, where practicable, before deciding to remove someone to a Place of Safety. So we need to know fairly soon, which phone number do the police ring in order to comply with this requirement. It needs to be available 24hrs a day, 7 days a week so even where areas have street triage schemes or liaison and diversion schemes, how will it work when they are not operating?

- In three months' time, adults will only be able to be taken to police cells in 'exceptional circumstances' – although this is not yet fully defined, the original idea behind this was around the detention of vulnerable people exhibiting 'behaviours so extreme it cannot otherwise be safely managed'. We need to see whether that remains the definition, but then understand what it means and how we should interpret that in light of existing medical guidelines.

There is more to the impending amendments, but those are the main things that will require planning and partnership discussions. If we haven't started thinking about this stuff already, we need to be ringing people next week to start talking about it, because in April 2017, this will be the law of the

country and failure to comply with it will amount to serious problems we won't be able to defend.

Wider questions: the Code of Practice to the Mental Health Act was updated in England in 2015 and in Wales in 2016 (it has been in operation only for three months!). We don't yet know whether those Codes will be updated in 2017 to take account of these changes, so the statutory guidance about how s135/6 operates (chapters 16 of each Code) may become less relevant and less able to be relied upon to hold each other to account. I think it's vital an updated Code is issued, or at least some transitional equivalent document until such time as the next full revision occurs – they normally occur about every 9yrs or so … next one due around 2024/5-ish!

Oh, and the power itself will be able to be used in private places (except private dwellings) so all other things being equal use of this power will still be destined to rise. You're welcome.

That's probably enough to be getting on with! – we've got three months and we really can't say we didn't know what was coming.

** The Policing and Crime Bill 2016 is yet to receive Royal Assent and become an Act of Parliament; it is anticipated the Queen will give her Assent to the Bill in late January and that the MHA amendments will take effect approximately three months later. These are estimates, subject to confirmation by the Government!*

15th January 2017

Regulation 28 Reports –

In December, I spent a very enjoyable afternoon absorbed in reading the detail of a twenty-odd page judgment from a Coroner's Court. It followed a situation where a man walked out of an ED Department and ended his life on a railway line not too far away from the hospital. The Coroner had no concerns about the police response to the report that he had left the ED, because there was no real way of knowing where he had headed towards and it is known he had died by suicide so soon after leaving that it would have taken quite unlikely luck for officers to have stumbled across him. The real interest in the judgment was the way in which the Coroner looked at the nursing and medical staff in ED – how did they triage the suicidal risk the man posed, how did they communicate and react; what more could have been done?

I've just read a newspaper article from Exeter following another recent Coroner's finding. A patient who was admitted to a medical ward after an acute asthma attack was assessed for mental health problems whilst on the ward and decisions were taken first of all, to transfer her to a mental health unit. Later, that decision was reversed and she was to be discharged home for community support. Somewhere in there, s5 (2) of the Mental Health Act was used to detain her but confusion appeared to reign about when that power came to an end. Following this, the patient left the ward claiming she was 'informal' – and therefore, allowed to leave. She subsequently took a paracetamol overdose and died five days later.

In these cases, and plenty of others besides, Coroners can issue what are known as a Regulation 28 'Preventing Future Deaths' (PFD) report. The intention here, is to demand responses and development by organisations where Coroners reasonably believe the learning from that particular death needs to be more widely absorbed – either by the other professionals working for that organisation; or by all professionals undertaking those roles across the country. The relevant agencies are obliged to provide a response to the Coroner to outline what they intend to do. You can see individual PFD reports (they can take a few months to be uploaded after findings) and learn more about the work of HM Coroners on the website of the Chief Coroner, including an annual report on their work.

ACUTE TRUST HOSPITALS

These are just two recent cases – there are more where similar issues are raised. I remember some years ago, other EDs being criticised by Coroners after vulnerable people walked out. If you ask any of the many police officers active on social media around mental health, you will see that many of us really do believe the EDs think they're covered if they just make sure they call the police quickly once someone leaves. This is not necessarily true! – As the first case I'm alluding to makes clear, even a diligent, quick response is not always enough to ensure that someone is found. So calls for the police to 'bring someone back' might be an intervention too far down the line.

It really might be necessary to stop people leaving in the first place. Also of relevance, it would seem, are the human rights implications from cases like *Ramone and another v Pennie Care NHS Foundation Trust (2012)* – a case where a vulnerable patient left a mental health unit and where it was found that even though a patient may have been admitted an a voluntary basis, available risk information may mean it's necessary to take steps to prevent that person from leaving. Melanie Ramone's family won a challenge that her Article 2 right (to life) had been violated where this did not occur.

So all professionals in acute hospital trusts need to understand the legal frameworks that apply – and the Exeter Coroner raised the next obvious point: **training**. Staff need knowledge of mental health, including mental health law, to discharge their duties correctly and as the news article made clear: there was no obvious reason why Wendy Telfer could not have been prevented from leaving under s5 (2) MHA. It is only fair to Royal Devon and Exeter Hospital staff to point out that there was a Devon Partnership Trust nurse on duty in that ward, as part of MHS Telfer's care (which may have meant that s5(4) could have been used by him. Either way – there were shortcomings perceived by the Coroner!

WHAT ARE THE OPTIONS?

As ever, there are only three broad options we need NHS staff to know about, either in ED or on medical / surgical wards –

- **The Mental Health Act 1983** – what powers do nurses and doctors have on the wards or departments where they work, under the MHA? In summary, ED nurses and doctors have none, but may consider asking the police to apply s136; medical / surgical ward doctors can use s5(2) MHA; mental health and learning disabilities nurses can use s5(4), if they are present; nurses and doctors working

where s5 MHA powers may be used, should not be calling the police to use s136, according to paragraph 16.20 of the 2015 *Code of Practice MHA (England);* according to paragraph 16.25 of the 2016 *Code of Practice MHA (Wales).*

- **The Mental Capacity Act 2005** – what authority would this afford a decision-maker? It will depend upon the particular medical circumstances and the risk someone poses to themselves; it may also depend on whether or not any existing framework is already in place under the MCA, like Deprivation of Liberty Safeguards. But certainly, the Mental Capacity Act affords NHS staff some scope to take urgent decisions in someone's best interests, where they lack capacity to do so for themselves because of an "impairment of disturbance of the mind or brain". Such decisions can include restraint or an urgent deprivation of liberty, where the criteria are satisfied for doing so.

- **Common Law** – regardless of those two frameworks, Lady Hale reminded us "the common law doctrine of necessity has two aspects, there is a general power to take such a steps as a reasonable and proportionate to protect others from the immediate risk of significant harm. This applies whether or not the patient lacks capacity to make decisions for himself." *Muja v Ashworth Hospital Authority (2003)*.

Obviously, the police have further powers under criminal law and to prevent a Breach of the Peace, but the main point I'm making in this post is that Coroner's are telling us we need to know more about how to stop being absenting themselves where there is an obvious risk. Those are one-sentence summaries of things and there is obviously a further level of detail to be absorbed and various practical implications that result; but these are the things on which it seems Coroner's are wanting NHS staff to have training. You can find more detailed explanations of these laws elsewhere on the BLOG – use the 'Blog' page to help you, if you're interested in learning more.

SAFETY ISSUES

It is obviously fair and not at all unreasonable for NHS Staff to ask the question about their own safety: most nurses and doctors did not train in their profession to end up rolling around the floor with someone making a concerted and aggressive attempt to leave. So what do we think about the important point of staff safety? It comes back to discharging duties and responsibilities under the Health & Safety Act 1974. All of the organisations for whole nurses and doctors work, have statutory responsibilities around creating safe systems of work, planning to mitigate foreseeable risks and providing training. The legal duties owed under the Act are owed by hospital managers not only to their staff, but also to patients and to anyone

else who may enter their premises, including police officers or paramedics, amongst others.

In other words, in considering the type of health service that they are endeavoring to provide, managers should be considering the likelihood of these issues. How likely is it that ED may see someone walk out after triage where MH or suicidal risk is known? How likely is it that a medical or surgical ward may have someone admitted who also has MH problems and may try to leave? If either of those things occur, what is the requirement on staff, what training do they have around MH law to make their decisions; on what support can they draw to help them, given that we all understand concerns around safety given the type of role that those staff are performing? What role would hospital security play – how are they trained and briefed to support? What role do the police play and do staff of all kinds understand when / how to engage them in these matters – let's be clear: their role should be limited, but officers have to realise they have a role.

The Coroner's Regulation PFDs keep on coming – one accusation which can be placed at the feet of NHS and Police services, an observation that is made by the charity Inquest, is that lessons are inadequately learned across the country, where avoidable deaths occurred elsewhere. How do we ensure that all EDs learn lessons from each other; that police forces learn lessons from each other – and that partnerships *between* services learn lessons from other partnerships! One way we can start to do that, as individual professionals, is to get interested in looking at care and risk from a *legal*, and not just a *clinical* point of view.

22nd January 2017

Training and Collaboration –

If we look around the world at policing and mental health issues, it doesn't matter whether we are looking at the incident-specific tragedies we read about or the wider issues raised by taking a broader overview: we only ever hear of two solutions in response to whatever we think problem is —

- **Training** – the idea that *if only* police officers were better trained, outcomes and encounters would be very different. They need more 'awareness' training about various mental health conditions, de-escalation techniques and alternatives to detention that may be available locally.

- **Collaboration** – the idea that *if only* the police and mental health services only work more closely together. And in real time, then we would also see improved outcomes and encounters because more appropriate people are then dealing with people in crisis, with police support to their decision-making.

I'm unconvinced, quite honestly. There is some obvious, intuitive merit to these ideas – my point is not to dismiss how important they are – but I wonder if you can also see the obvious problems here?! … There are several.

Even where there is evidence that these two solutions improve things – and there is some evidence they may help – it is all predicated on improving encounters people have with the police. It doesn't even begin to touch on why people have encounters with the police in the first place; and what we could do to avoid that. I suspect there is much more than we can and should do.

POLITICS AND HISTORY

Look back over the last fifty to sixty years and you can see a series of political decisions (big 'P' and small 'p') about how we deliver mental health services which have significantly increased the likelihood of contact with the police. This, in turn, increases the likelihood that some people, following that contact, will experience detention, the use of force or criminal

proceedings. This remains true notwithstanding efforts we may make to 'divert' people from the justice system. We regularly hear complaints about the prevalence of individuals suffering from a mental disorders in death-in-custody reports, fatal shootings and prisons statistics all over the world: this is what happens regardless of national Politics (big P), governments or wealth … although the extent varies, obviously.

This is not just true in the United Kingdom – look at the USA where police officers are frequently criticised for their actions: why are so few people asking the question about why US citizens have so little access to mental health services and why they are coming in to contact with the police? It's not that it's illegitimate to wonder about the police's use of force OR to think that anyone is putting an argument that officers should not be held to account. This doesn't preclude the support of ideas like Crisis Intervention Training but the idea that these things are solutions, is to assume that contact with the police was unavoidable, inevitable and the first possible point where society could intervene to support the vulnerable. We know this isn't true – and if we could reduce the over-policing and criminalisation of people with mental illness, we have less of a policing problem to fix.

Look at some developing countries where there are often very few mental health services – the criminal justice system absorbs people where social capacity, tolerance or patience for their distress has evaporated. I saw this whilst working in Namibia just over a year ago. This doesn't mean efforts by Namibia's prison system to improve training for correctional officers was pointless, just that a junior prison officer can't do that much to ensure support for someone two years before they are jailed. In Pure Madness (2003), award-winning journalist Jeremy LAURENCE reminded us that we don't know whether or community care for mental health works, because we've never really tried to do it – at least not properly. We don't resource mental health or community mental health services, anywhere, then when as a direct result of that decision, the criminal justice system becomes involved in responding to things that occur – from crisis incidents and minor crimes through to occasional high-profile incidents – we wonder about the nature or quality of the response and forget about the main problem here.

CRISIS RESPONSES

Only this month, we read of yet another inquest where the 'crisis' advice to someone who is already receiving care from a mental health trust is to 'ring 999', despite the fact that the police would inevitably be drawn in to a situation where they had no legal powers whatsoever and where no-one really knows whether fluorescent, paramilitary uniforms are going to be a positive addition to the situation or not. If you want to improve the experience of vulnerable people when they are in need of unscheduled care,

they actually have to have unscheduled care options that are able to meet their needs.

There police are not always going to get it 'right', when it comes to mental health – look around the news and you'll see examples of health services and professionals getting things wrong on mental health and they come pre-loaded with a three or five-year university degree plus years of post-qualification experience. There was a recent complaint on Twitter that police officers don't have the skills of a consultants psychiatrist – it's probably a good thing they don't, given we don't really want police officers prescribing meds and I've never seen a consultant psychiatrist rolling around the floor attempting to restrain someone. Policing and psychiatry are different jobs: we don't want the skills to match!

There are many reasons why all of this is vital: we can't always control the circumstances in which the police come in to contact with vulnerable people. A call may come from a person seeking support for themselves which they cannot otherwise get; or from a third-party because of concerns they have. That could be a family member, a neighbour or unknown members of the public who feel the police should be informed in order they can "do something!" However, some incidents are what I usually call deflected demands – calls that were made to health services for a health care response to someone who is unwell, but which are then directed to the police. We need to know more about whether this is about the urgent management of risk and an inherent need for the police, or because we are demand managing.

By the time of police involvement in anything, the tools they have available to them, irrespective of their training and irrespective of their collaboration arrangements, are potentially very blunt. Whether they are appropriate to the situation in ensuring we don't make people feel stigmatised and criminalised … who knows! By the time a police officer and mental health nurse turn up to private premises where most incidents occur, even the best trained police officer on the planet and the best mental health nurse co-pilot will still have just three options: do nothing; hope that talking achieves a different outcome; leave and hope you can persuade an Approved Mental Health Professional to obtain a warrant under the MHA.

TRAINING & COLLABORATION

So these two responses to problems may be helpful – this post is not arguing that they aren't. If someone has come to police attention, a nurse sharing information, offering an assessment or an alternative way of dealing with a situation may well be helpful. Police officers better recognising the need for that can only support a diversionary approach is vital. It just isn't the major problem to address here – unless we start

talking about why and how those of us with mental health problems and in distress increasingly come to police attention and are less able to access established pathways of help and support when in distress, I fear we may just keep on trying to do thing wrong thing righter.

26th January 2017

The Restraint Document –

Since September 2014, when I started at the College of Policing, we have been working on the development of a document about those situations where the police are called to a mental health or learning disability unit and asked to do something coercive. I've been on mental health wards many times, as an operational police officer: calls to investigate and potentially prosecute patients for alleged assaults or damage; requests to assist in restraining patients so nursing staff can administer medication; requests to assist in moving a person from one part of a mental health unit to another … or even to move them to an entirely different unit. As a probationary PC, my colleagues and I were regularly called in to the old All Saints' Hospital in Winson Green in Birmingham to a range of things where disorder and distress were manifest and the police were being asked to help.

These issues are as important as they are sensitive: we know that we don't want to over-police anyone, least of all vulnerable people already detained in hospital at a difficult time in their lives, nor do we want those places to be dangerous and beyond the reach or scope of the law, where that is necessary. We know that care in clinical settings is primarily a matter for healthcare professionals and it's for their organisations to ensure they address their own health and safety obligations; however, we also know that some things happen on mental health wards that may need the police. For a start, around 67% of the 70,000 assaults on NHS staff take place in the mental health sector and whilst most of that is not reported as crime, some of those matters are very serious. Recently, a murder inquiry was launched after a patient was killed on a mental health ward; in 2016 a mental health nurse was killed on a ward in Croydon and in 2014, a healthcare assistant in Gloucestershire. No-one can seriously argue that where such incidents breakout, that the police don't have a role to get in there and try to stop things from becoming any worse to prevent these kinds of outcomes. But it needs to be carefully considered and controlled, not least to mitigate against extremely untoward outcomes that raise difficult questions.

There are two problems this document aims to address –

1. Police being over-relied upon to enter clinical settings and undertake restrictive practices which fall within the scope of what we would all agree are predictable risks associated with being a mental healthcare provider.

2. Police not recognising the need to support healthcare professionals in addressing unexpected risks that are beyond their ability to cope, where control is lost and safety is compromised.

SO WHAT DOES IT SAY?

This is the three-point summary of this document –

- The provision of healthcare and the undertaking of restrictive practices associated with healthcare is the legal responsibility of the healthcare provider who must ensure compliance with health & safety legislation as well as human rights laws in the way they undertake this difficult work. Specifically, this includes the requirement to mitigate foreseeable risks.

- It is the role of the police to investigate allegations of crime; and to assist in restoring safety where unpredictable risks have seriously compromised the safety of staff and patients. The officers' role is to restore the circumstances of safety that allow staff to retake control at the earliest point and to then determine whether a criminal inquiry is required.

- Where it is alleged that safety is seriously compromised, for whatever reason, the restoration of safety is the key priority – if there are any discussions to be had about whether the call for the police is appropriate OR whether the police response was appropriate, these are discussions for *after* the safety of all has been ensured.

The Restraint Document, as we kept calling it, is a multi-agency *Memorandum of Understanding*. The College of Policing has coordinated its production and it is agreed between the National Police Chiefs' Council, mental health charity Mind, the Royal College of Nursing, the Royal College of Psychiatrists and the Faculty of Forensic and Legal Medicine. In the course of its production, independent legal advice was secured from a QC and junior counsel with experience in the legal matters around police powers and mental health law. In addition, it has been supported and welcomed by Amber Rudd, the Home Secretary; by Lord Adebowale, the chair of the 2013 Commission in to Mental Health and Policing in London; the charity Inquest and several others. I'll let you find details of what they've said, if you're interested, by going to their social media feeds or to the College of Policing website.

FREQUENTLY ASKED QUESTIONS

Already, some questions have emerged a few times, so let me address them –

- **Have all forces agreed to this?** – no, they haven't.
- It is not something they were asked to agree or disagree because it is an expression of standards by professional bodies and by Mind, on behalf of the public. Many police forces, healthcare organisations in the NHS, including CCGs, MH trusts and others were involved in and consulted as part of this work; but to get formal agreement of the five major signatories was hard enough!

- **What changes from before?** – absolutely nothing, strictly speaking. This document doesn't oblige us to do anything that wasn't already possible or desirable; it doesn't ban or discourage us from doing anything in the future that wasn't already banned or

discouraged. This document merely summarises the law and the relevant medical and other professional standards and guidelines, for organisations and individual professionals.

- **Can I disseminate this?** – yes, that's why it was published on the internet. There may well be partnership implications here, but only if areas or organisations have drifted in their understanding of what the law demands of us all. Even frontline professionals reading this and improving their understanding of the legal, medical and practical implications will improve the experience of patients.

- **So can officers restrain for medication or not?!** – there has been a rumour for many years that officers have 'no power to restrain for medication'. This is true, to the extent that the Mental Health Act (or Mental Capacity Act) does not expressly authorise any specific professional. Obviously, it is primarily a matter for healthcare professionals and police involvement should be extremely rare where thought unavoidable. There is a detailed example below, as to when / why.

- **So what happens now?** – the document needs to be taken by forces and healthcare providers, through their local Crisis Care Concordat action plans and local procedures developed around the principles outlined. This may mean forces need to consider how their control rooms handle calls to MH units, it may mean mental health and learning disabilities units need to think about staffing, contingency plans for events and how we interface and cooperate.

REAL EXAMPLES

Remember the two problems we're trying to fix, above? Here are some real examples which emerged in discussions of the working group. They came from professionals in policing, nursing and psychiatry.

- **Over-policing?** – an adult man, a s3 patient on an acute admission ward has had a difficult morning on the ward, has seemed unusually agitated and there are some raised concerns about whether he may hurt himself. Nurses have tried closer nursing support, but this has left concerns. They have decided, and it has been appropriately authorised, that he will be secluded for a short period with more intensive nursing around him. At the point where he is told this, he is sat on the floor of the ward corridor and refuses to move. He is not actively harming himself or others and there is nothing about his background that suggests it is anything other than a nursing responsibility to move him to seclusion. The police were called to assist, however a senior nurse who learned this had occurred, over-

ruled the decision, cancelled the police and directed the incident. The use of the police here was not necessary or relevant.

- **Under-policing?** – an adult man, s3 patient on a low-secure ward is reported to be "smashing the place up" and the police are urgently requested on 999. Upon arrival, there is some damage to posters from the notice boards but there is little more and the police are told that one nurse in the office, has been assaulted. The man is agitated, pacing around the ward whilst shouting about his delusions and making non-specific threats. The police contain him, *without* restraint, by having a few officers standing on either side, giving him freedom to move in that limited area without anyone in his personal space. This continues until a nurse explains what has happened and what they are asking for. An officer uses humour to de-escalate everything and it leads to the patient become less distressed. Nurses want to seclude him and provide medication so the police escort him 10m down the corridor, without restraint, and in the room he agrees to receive an injection. The police then speak to the victim and record an assault which is investigated later.

- **Too casual?** – a s3 patient on a ward grabs a nurse unexpectedly and starts attacking her. It quickly emerges that he has improvised a weapon out of something plastic and later, it is found to be a plastic biro-style pen. Having grabbed the nurse from behind, he uses the weapon to inflict several puncture wounds to the nurse's torso and colleagues immediately ring 999 for help. Without officers attending the ward, the police control room feel entitled to say that this is something the hospital should be able to handle and refuse to attend. A further 999 call is handled similarly. Thankfully, staff on the ward do manage to contain the patient, but not before another of them is assaulted. The injured nurse requires A&E treatment to her injuries, which amount to grievous bodily harm, for the purposes of crime recording standards.

- **Inappropriate?** – officers were called on 999 to a female patient assaulting staff and causing damage. Upon arrival, the staff have forced the patient in to some kind of side-room, off the main ward. There is damage to doors and a door frame, but those staff who were assaulted are uninsured and still involved in leaning on the door of the side room to contain the patient in there. Three male officers arrive and the doctor, after some vague discussion that had to get precise using closed questions(!), requests the officers to restrain the patient on floor so that nurses can give her an injection. What do we think about three male police officers being involved in the restraint of a young woman, so her trousers can be partially pulled down against her will? I think, if police officers did that in anything other than a life-threatening situation, they could expect to be disciplined

and sacked. So as the young woman was at immediate risk, despite ongoing agitation and distress, the decision was to ask the doctor to summon whatever he thought were the appropriate resources to do this. Police merely monitored the situation until that had occurred and withdrew from the area, remaining nearby.

- ***In extremis*** – five nurses on a ward have come together to administer medication to a patient after all efforts to persuade him to receive it have failed. They are appropriately trained to do this and have done it before, including with this patient. As the nurses take hold of the man's arm, he begins to struggle. Attempts to secure him are not successful and as he pulls his arms away from control, he manages to completely pull away from the grip of that nurse on that arm. As his arm suddenly breaks free, the back of his hand hits the face of another nurse with such force that is causes a serious injury, fracturing his jaw. He disengages in agony, a second nurse intuitively disengages to check on him and then to summon help, leaving the other three attempting to contain the man whose agitation is escalating. 999 is called for an ambulance and police and officers arrive within 9 minutes of the call. By this time, the remaining three nurses are struggling on the floor with this man, obviously exhausted and screaming for help. Two of them have been further assaulted, albeit without significant injury. The officers take control of the man to help and the nurses move away, obviously 'spent'. The nurse who rang 999 is the only one left who is neither exhausted nor serious injured and she asks the officers to keep the man restrained whilst they administer medication. There are no other nurses available. After this, one of the three nurses gets re-involved and the four of them – two nurses, two officers – move the man to a seclusion room on the ward.

LESSONS LEARNED

So what is going on here, in terms of the thinking? Whatever was behind the nurse in the first example calling the police, we can probably agree it's not appropriate – no current disturbance or violence, nothing that links to crime or serious risks to staff. Even if there were certain risks, as long as he's sat on the floor in the corridor, there should be contingency for bring staff together to undertake this task. In the second example, we can see that it is necessary for the police to attend to assess things, but upon arrival, they haven't done a huge amount because it's not quite as serious as first reported. We can debate all day long whether it was 'right' to call the police, but that's the judgement staff made – why not attend and assess things? Doesn't mean the police automatically *will* do anything or will do very much, but at least we can say we've assisted in assessing what's

required and that any decision not to act is taken after a proper understanding of the circumstances.

We obviously can't do that in the third situation because the police didn't go! … it doesn't need much explanation, does it?! – if nurses are being stabbed, we should be going! It's a real shame that even needs saying and thankfully, such examples were very rare but in those sorts of things, if there *is* anything to discuss about it, that's for later, not for now.

In the final example, it gets most controversial: the assessment the officers made at the time was that it was more dangerous to disengage and argue a point, than to help. One nurse and already suffered GBH injuries, two others were assaulted and three were, put frankly, completely knackered. There was one nurse left to actually administer the medication and no others available from nearby wards (for whatever reason – right here, right now, there were none available). If the police had not continued to assist, there could have been further serious assaults. Remember, when medication is authorised by nurses or doctors under Part IV of the MHA, nothing expressly prevents the police assisting – but we should obviously only be doing so in circumstances like this where there is no other option, at all. We should also remember s139 MHA, which provides that –

"No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, unless the act was done in bad faith or without reasonable care."

I hope the document helps you out!

FEBRUARY 2017

8th February 2017

Need an Appropriate Adult? –

Several discussions and questions recently about Appropriate Adults (AA) in police custody for vulnerable people that I want to quickly cover. In case you're not aware, an Appropriate Adult is someone who, according to the Codes of Practice to the Police and Criminal Evidence Act 1984 must be called to police custody for anyone under the age of 18yrs or anyone who is 'mentally disordered or otherwise mentally vulnerable'. They must be present for legal rights being administered, police interviews about the allegations and various other things. Al sounds straight-forward enough, doesn't it?! You can just imagine the booking in procedure where the custody sergeant tells the arresting officer, "He's only 17yrs old, get an appropriate adult on the phone and ask them to come down here." Usually this will be the person's parent or guardian and if there is no-one available, you can ring children's social services as there is a statutory duty to act as an AA for someone who cannot otherwise be supported.

There are two major problems when we turn this conversation to the circumstances of a vulnerable adult – 1) what does 'mentally disordered or otherwise mentally vulnerable' mean? … and 2) how do we handle things if we, the police, can't secure a volunteer? Absolutely no-one, anywhere has any comparable statutory duty to support that person whilst under arrest! Neither social services as a whole, nor any health or mental health service to which that person may be connected is obliged to fulfill this role in the absence of a relative, friend or neighbour. Recently, I was at a meeting with Chris Bath from the National Appropriate Adult Network who I've heard more than once saying, "If you can't even find someone from the banana aisle at Waitrose" given that most adults could fulfil this role … it's merely the case that no-one employed by the police can undertake it.

WOULD YOU CALL?

Would you call an Appropriate Adult for [name a famous, intelligent celebrity with a mental health condition here]? Imagine that person was arrested for something at a point when their mental health is pretty good. Imagine that they are in regular contact with the services who are supporting them; potentially taking medication and / or undergoing other forms of treatment and that to all intents and purposes they appear 'well'.

Would you still ask for an appropriate adult to support them during the process of investigation and interview by the police?

Well first of all, anyone in police custody under arrest would be examined by an approved healthcare professional – usually a doctor or nurse from a contracted organisation who advise on police custody healthcare issues. Ultimately, the decision about whether to call an appropriate adult is one for the custody officer, but given that the need for an AA rests on confirming one way or the other whether or not someone is 'mentally disordered or otherwise mentally vulnerable' you can see why a medical or nursing opinion comes in handy on these matters. They have the skills and are more likely to have access to information to help make this decision – but it remains with the custody sergeant to resolve any doubts and disagreements.

There have been examples of custody healthcare staff assessing someone and establishing that they have, for example, a diagnosis of depression. Because the person is receiving care from the NHS, taking medication and to all intents 'well', the advice to the custody sergeant is that they don't 'need' an AA ... and this is where things start to get difficult. PACE (Codes) don't talk about whether someone is thought to need the support of an AA or not – merely that the person either is or isn't 'mentally disordered or otherwise mentally vulnerable'. So are they? … or not?!

LEGAL NOT MEDICAL

The question of whether someone should have an AA is a legal one, not a medical one. Of course, we are going to defer to professional opinion about healthcare issues – but it is a legal assessment that follows and it remains the decision of the police. If someone with depression who takes anti-depressants is arrested they may well be thrown in to one hell of a situation – because actually, *anybody* who is arrested is thrown in to one hell of a situation! This could be all the more pronounced if the particular investigation has more far-reaching consequences for that person, be that loss of employment, public reputation or any number of other things including marital or key-relationship breakdown. The fact that until arrest that person was working for living, raising their kids and living a life doesn't alter what arrest can mean and can it do to some people. The safeguard was designed, it would seem, to ensure that people more likely to be vulnerable are supported whether that is because of a long-term health problem like schizophrenia or situationally specific circumstances.

So what does 'otherwise mentally vulnerable' mean?! – could this not also extend to someone who has no history of mental health problems whatsoever but who has been arrested for an alleged offence that could be, literally, life-destroying? Imagine a school teacher arrested for possessing

indecent images of children – I've arrested a man for exactly that and you could see the utter panic and terror behind his eyes. He was ultimately proved guilty of it all and rightly jailed, but you have to consider that whilst he's in custody, not entirely sure of the evidence against him, not sure of where this is all going, as he sat in the cell whilst we searched his house and seized a LOT of his possessions as part of the inquiry, that he must have been contemplating just how much his life was going to fall apart? I'm not suggesting everyone accused of a serious crime needs an appropriate adult, but some might, notwithstanding an absence of mental health problems. This is just one example of what 'otherwise mentally vulnerable' may mean.

And remember this: the PACE Codes make it clear that if there is doubt about whether someone is 'mentally disordered or otherwise mentally vulnerable' then you treat them in custody as if they are. So as you think through your examples of high-functioning people who you know has bipolar disorder or depression, keep in mind someone with any other kind of condition. If someone was receiving treatment now for cancer, you would regard them as having cancer notwithstanding how well they may be at the time. However, a decade later after receiving the all-clear and ceased treatment, you would no longer refer to them having cancer or being a cancer patient.

WHAT ABOUT HISTORY

So what about recovery? Many people recovery from mental illness – they lead meaningful lives, often free from medication or further support from secondary care mental health services. If someone is arrested who lived with a mental health condition years ago but has since recovered, would you regard them as requiring an AA? This is perhaps where there is more of a judgement call. Keep in the mind the cancer patient analogy: if the person regards themselves as recovered, they are no longer receiving treatment and there are no current indications that the fact of the arrest has caused any particular problems, especially if they've been medically screened in police custody by custody healthcare staff or by Liaison and Diversion services, then a history of something would not automatically mean you fail to acknowledge their recovery in the decision-taking.

I'm aware that some custody sergeants are debating this actively and that one force in the south of England has reinforced a policy that has the effect of increasing the need for AAs in custody. I am not without sympathy about the operational implications this sometimes have because I've been that duty inspector on a number of occasions where all efforts to secure a human being of any description to act as AA has been tried and failed – a number of times!

In particular, I recall one investigation of a poor bloke who had been arrested for reckless arson, endangering life in what had probably been a suicide attempt. He had been fully assessed in custody under the MHA because of his mental state and his long history of mental health problems. The investigating officers had spent over 22hrs of the PACE 'clock' dealing with the initial enquiries to be made, the MHA assessment and the repeated efforts to find a relative, friend, neighbour or any professional from any organisation anywhere who would be prepared to support him in custody. Nothing. We even left it a couple of hours and then tried them all again. Still nothing. So we interviewed him without an appropriate adult knowing full well this might end up meaning any evidence obtained would be excluded but we had to rely upon the fact that the requirements for an AA is in the Codes to PACE, not in PACE itself. Therefore, according to the relevant court ruling, it is something with which we should comply unless there are 'cogent reasons for departure'. The cogent reason being: no-one on planet earth except the police and his solicitor we're willing to try to help the guy and we're all banned from being his appropriate adult.

Would I seek an appropriate adult for [intelligent, famous celebrity receiving MH treatment]? — there is absolutely no doubt whatsoever in my mind. I would.

MARCH 2017

2nd March 2017

The PaCA Series –

If you're a police officer, a member of the public or a mental health professional and you just want to cut through all then faff, see this **operational summary for police officers** I've produced. It's just a dozen bullet points and although it's written for officers, it will make sense to others. If you want to read sections 135/6/8 Mental Health Act 1983 in their new format, see three links at the bottom of this post.

At some stage in the next few months, Part IV of the Policing and Crime Act 2017 (PaCA) will be subject to a commencement order in Parliament which brings in amendments to Part X of the Mental Health Act 1983 (MHA) – this part of the MHA relates, amongst other things, to police powers under the Act. The MHA itself has been amended and updated many times over recent years: by the Care Act 2014, by the Mental Health Act 2007, by the Mental Capacity Act 2005 and many other frameworks, but Part X has remained more-or-less untouched, certainly in terms of the substantive role and responsibilities of the police. Indeed, sections 135/6 of the Mental Health Act 1983 were carried over almost entirely untouched from the Mental Health Act 1959. So the commencement order we will see at some stage soon represents the first time in almost sixty years that police powers and responsibilities have been changed – since the decade where Buddy Holly was singing live music and where him doing so represented a serious threat to those who much preferred hearing of pink toothbrushes and blue toothbrushes (I refuse to provide a link to *that!*).

More seriously, think about how mental health care has developed since the late '50s – antipsychotics had only just been introduced to mental health care and had massive side effects, far greater even than those patients still live with today; we were yet to hear speeches from people like President Kennedy in the US or Enoch Powell MP in the UK which would start the political process of deinstitutionalising our approach to mental health care. We were yet to learn one indirect consequence of deinstitutionalisation: mass criminalisation of vulnerable people and incarceration in prison for many of us with serious health problems. Also consider how policing has changed: officers didn't have radios or many of the other modern accoutrements of policing, like tasers or access to the Police National Computer and other information sources – they were formally marched out of police stations each shift by sergeants and sent on foot patrols. They did this in a setting where human rights and health &

safety considerations were less at the forefront of our imagination. Indeed as they did this, attempted suicide was still a criminal offence and homosexual conduct was listed as a mental illness in major international medical textbooks.

I don't police the same society as my wife's grandfather – our jobs are notably different notwithstanding we operationally policed the same city, fifty years apart. So it's well overdue that police powers under the Mental Health Act were updated!

THE PaCA SERIES

This introduction just sets the scene for a series of BLOG posts over the coming weeks, each one of them focusing on an individual change being made to Part X of the MHA 1983. If you just want to cut to the chase, I have summarised the changes for **operational officers' ease of reference** in just a few hundred words – service users and other frontline staff might also find that post useful. However, if you want detail, you will remember the major aspects in the Policing and Crime Act 2017 affecting the MHA are –

Amendments

- No children may be taken to police stations as a Place of Safety (PoS) under ss135/6 MHA – ***post now published!***
- The police will now have a specific power of search for those detained under ss135/6 both at the point of detention and at arrival in a Place of Safety – ***post now published!***
- PoS detention under ss135/6 may only last 24hrs, unless authorisation extends this to 36hrs in specific situations – ***post now published!***
- Section 136 will be able to be instigated anywhere other than a home – bringing new opportunities and challenges – ***post now published!***
- There will be a requirement, where practicable, for officers to consult with a DR, nurse or AMHP prior to using s136 – ***post now published!***
- Adults may only be taken to police stations in 'exceptional circumstances' (yet to be defined) – ***this will appear once the Government have published the statutory Regulations.***

Implications

- Contradictions in the MHA Code of Practice – as soon as the PaCA kicks in, the Code is going to contradict and confuse so what happens next? – ***coming soon!***

- The PaCA and police custody: the new s136 and diversion from justice.

- A Summary of Rights – for detainees or their families to challenge and question.

This should set out how the law is changing and highlight some practical considerations for what this may mean in operational practice for officers and mental health services. If you want to read it for yourself, see the UK Government legislation website or the links at the bottom of this post. The final bullet on the amendments, as above, will come last in the series only because the Government are yet to publish the statutory Regulations which will precisely define these 'exceptional circumstances'. Whilst I've got a good clue what it's going to say, we'll have to wait and see how it's finalised before we can weigh it up properly.

There are some major debates that needs stringing when we consider this legislation and must remember, this is not guidance or opinion: it is the law being changed and compliance with it is not optional. I'm doing the series, quite frankly, because there are many standard questions coming through about what the law will say and what it will mean in practice but also because I'm hearing opinion from mental health professionals and police officers alike that they believe their area is not prepared for the changes and will not be ready. So we need to support senior managers getting in the same room at the same time and start talking this through, based on what the line does actually say.

And to save those of you who are looking at the detail of this from flicking back and forth between the PaCA itself and the current, soon-to-be-old sections 135/6 MHA, I have produced the 'new' versions of each provision in some new posts –

- **The 'New' Section 135 MHA**

- **The 'New' Section 136 MHA** – including sections 136A, 136B and 136C.

- **The 'New' Section 138 MHA**

Good luck!

2nd March 2017

PaCA: No Children in Police Stations –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest early May – but this is subject to a number of factors and may change.

One specific amendment to the Mental Health Act 1983 which will be with us shortly: it will no longer be lawful to hold children in police stations as a Place of Safety under the Act – **ever!** The legal amendment in s81 PaCA on this is a simple one: the MHA will read, *"A child may not, in the exercise of a power to which this section applies, be removed to, kept at or taken to a place of safety that is a police station." (Section 136A MHA, as it will be amended.)*

Here are two particular points on this amendment –

- **A child is anyone under the age of 18yrs** – someone who is 17yrs and 364 days old **is a child –** *see section 136A(5)(a) MHA*.
- The size, strength and presentation of the child are completely irrelevant – if they are under 18yrs of age it means they must be removed to a non-police station location.
- *End of debate! – at least as far as age is concerned.*

- **The amendment is a ban on the use of *police stations*** – any child detained under ss135/6 *cannot* be accommodated in *any part* of a police station. It's not just a ban on the use of police custody.
- Therefore, front office interview rooms, the more comfortable interview rooms sometimes used for vulnerable or serious crime victims … all of them will be out-of-bounds for children where they form a part of a police station.

IMPLICATIONS

There are few issues arising from all of this, some of which I hadn't expected to see, quite honestly. Others were fairly predictable —

Resistance and aggression – it doesn't matter if your 17yr old is "a 2m tall rugby player" who is really resisting detention for whatever reason. The person simply *cannot* be lawfully detained in a police station if the officers have only detained them under s135/6 of the Mental Health Act. It therefore means, all CCGs and LHBs need to think about their Place of Safety provision and ensure it matches up to the *Royal College of Psychiatry Standards on s136 MHA* (2011). This document makes it quite clear (p8) that PoS provision should be able to handle those of us who are detained for assessment and exhibiting challenging behaviour. Although it's not true of most people detained under these provisions, the management of resistance and aggression is a quite predictable part of the s136 pathway for just some people. Infrastructure in future will need to cater for that. Local policy may dictate whether or when the police may have to remain in the PoS to support that assessment process, although p8 says it shouldn't normally be required.

Arrest for crime – something that did surprise me in social media discussion about these changes, was the idea that officers should therefore consider arrests for other legal reasons where significant resistance or aggression is encountered. As Baroness Hale observed in her 2010 textbook on mental health law, it is usually possible to consider another legal basis for intervening, such as public order law or preventing a breach of the peace. But I keep coming back to this: the whole *point* of s136 is about offering the ability to intervene without resort to criminal law where the main concern within an incident is someone's welfare and wellbeing – and in this context we're talking about children, where diversion from the criminal justice system is even more of a bedrock principle. How is it going to help by detaining them in police cells whilst in distress and implying they are a criminal by a spurious arrest for a public order offence?! Indeed the whole *point* of the PaCA amendments is to reduce reliance upon police custody and avoid criminalising young, vulnerable people. Suggestions by some (who should know better) that the police get 'round this by using other laws are highly disingenuous and a clear affront to the will of Parliament. << I'm trying not to sit on the fence so I hope I made myself clear on that one!

Commissioning – prior to Christmas, a Chief Constable sought some advice after officers had detained a child and removed them to an Emergency Department under s136. This was mainly because their local NHS PoS did not and would not accept anyone under the age of 18. Preferring the idea of ED to police custody and backed by the Code of

Practice to the MHA which clearly states (para 16.38) that police stations are the last resort after other options are considered, the officers asked ED to support the child. A discussion broke out which led to escalations and emails flying back and forth. Notwithstanding those historical arguments documented elsewhere on the BLOG, the point is this: the argument, that the child should be taken to custody, is an argument that will be calling for unlawful action, once the amendment takes effect. So CCGs and LHBs need to be looking from a commissioning point of view what will be necessary.

There you go! – that should be enough to get thinking about on PoS provision for children. CCGs and MH Trusts need a clearly identified PoS for u18s, whether or not that is the same place as they will take adults (bearing in mind, most areas only need provision for one or two s136 detainees at a time – there is scope to think about how to use existing PoS facilities for u18s without those children coming in to contact with anyone other than the vetted professionals supporting them whilst detained, and possibly their parents or guardians.). The obvious warning to sound here, is to wonder what police officers would do if there is no available pathway for a child, or that pathway is temporarily unavailable? If the arresting officer cannot access the identified place and cannot lawfully use a police station, they will be forced to improvise. In reality, EDs are going to be high on the list of places to try and they are far from ideal. So EDs need to think about this and get in on their local commissioners' conversations about this.

We need to think about this amendment and ensure we grasp its implications in each of areas – because this one is black and white. **It will become unlawful to use police stations.**

The next post in the series will focus on new powers of search under s135/6.

3rd March 2017

The 'New' Section 135 –

What follows is the full, amended text of section 136 Mental Health Act 1983, as it will be following a commencement order for the Policing and Crime Act 2017 which will bring it in to effect. See related posts for the 'new' section 136 MHA, including sections 136A, 136B and 136C, as well as section 138.

***NB!** – this is NOT the current law as of 03rd March 2017 – this is the law as it will become, following a commencement order yet to be laid before Parliament. The full **Mental Health Act 1983**, as it stands today and which will be kept updated once the commencement order takes effect, can be found on the UK Government legislation website.*

Section 135 – Warrant to search for and remove patients.

(1) If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder—

> (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or
>
> (b) being unable to care for himself, is living alone in any such place, the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

(1A) If the premises specified in the warrant are a place of safety, the constable executing the warrant may, instead of removing the person to another place of safety, keep the person at those premises for the purpose mentioned in subsection (1).

(2) If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act or under article 8 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (Consequential Provisions) Order 2005 to take a patient to any place, or to take into custody or retake a patient who is liable under this Act or under the said article to be so taken or retaken—

> (a) that there is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice; and
>
> (b) that admission to the premises has been refused or that a refusal of such admission is apprehended, the justice may issue a warrant authorising any constable to enter the premises, if need be by force, and remove the patient.

(3) A patient who is removed to a place of safety in the execution of a warrant issued under subsection (1) or kept at the premises specified in the warrant under subsection (1A), may be detained there for a period not exceeding the permitted period of detention.

(3ZA) In subsection (3), "the permitted period of detention" means—

> (a) the period of 24 hours beginning with—
>
> > (i) in a case where the person is removed to a place of safety, the time when the person arrives at that place;
> >
> > (ii) in a case where the person is kept at the premises specified in the warrant, the time when the constable first entered the premises to execute the warrant; or
>
> (b) where an authorisation is given in relation to the person under section 136B, that period of 24 hours and such further period as is specified in the authorisation.

(3A) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the permitted period of detention mentioned in subsection (3) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(3B) A person taken to a place of safety under subsection (3A) above may be detained there for a period ending no later than the end of the permitted period of detention mentioned in subsection (3) above.

(4) In the execution of a warrant issued under subsection (1) above, a constable shall be accompanied by an approved mental health professional

and by a registered medical practitioner, and in the execution of a warrant issued under subsection (2) above a constable may be accompanied—

(a) by a registered medical practitioner;

(b) by any person authorised by or under this Act or under article 8 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (Consequential Provisions) Order 2005 to take or retake the patient.

(5) It shall not be necessary in any information or warrant under subsection (1) above to name the patient concerned.

(6) In this section "place of safety" means residential accommodation provided by a local social services authority under Part 1 of the Care Act 2014 or Part 4 of the Social Services and Well-being (Wales) Act 2014 a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place.

(7) For the purpose of subsection (6)—

(a) a house, flat or room where a person is living may not be regarded as a suitable place unless—

(i) if the person believed to be suffering from a mental disorder is the sole occupier of the place, that person agrees to the use of the place as a place of safety;

(ii) if the person believed to be suffering from a mental disorder is an occupier of the place but not the sole occupier, both that person and one of the other occupiers agree to the use of the place as a place of safety;

(iii) if the person believed to be suffering from a mental disorder is not an occupier of the place, both that person and the occupier (or, if more than one, one of the occupiers) agree to the use of the place as a place of safety;

(b) a place other than one mentioned in paragraph (a) may not be regarded as a suitable place unless a person who appears to the constable exercising powers under this section to be responsible for the management of the place agrees to its use as a place of safety.

(8) This section is subject to section 136A which makes provision about the removal and taking of persons to a police station under this section.

The full Mental Health Act 1983, which will be updated once the commencement order takes effect, can be found here.

3rd March 2017

The 'New' Section 136 –

What follows is the full, amended text of section 136 Mental Health Act 1983, as it will be following a commencement order for the Policing and Crime Act 2017 which will bring it in to effect. It also includes the new sections 136A, 136B and 136C. See related posts for the 'new' section 135 and section 138 MHA.

***NB**! – this is NOT the current law as of 03rd March 2017 – this is the law as it will become, following a commencement order yet to be laid before Parliament. The full **Mental Health Act 1983**, as it stands today and which will be kept updated once the commencement order takes effect, can be found on the UK Government legislation website.*

Section 136 – removal of mentally disordered persons without warrant.

(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.

(1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, 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.

(1B) For the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force.

(1C) Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult—

(a) a registered medical practitioner,

(b) a registered nurse,

(c) an approved mental health professional, or

(d) a person of a description specified in regulations made by the Secretary of State.

(2) A person removed to or kept at a place of safety under this section may be detained there for a period not exceeding the permitted period of detention for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

(2A) In subsection (2), "the permitted period of detention" means—

(a) the period of 24 hours beginning with—

(i) in a case where the person is removed to a place of safety, the time when the person arrives at that place;

(ii) in a case where the person is kept at a place of safety, the time when the constable decides to keep the person at that place; or

(b) where an authorisation is given in relation to the person under section 136B, that period of 24 hours and such further period as is specified in the authorisation.

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the permitted period of detention mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a

period ending no later than the end of the permitted period of detention mentioned in that subsection.

(5) This section is subject to section 136A which makes provision about the removal and taking of persons to a police station, and the keeping of persons at a police station, under this section.

Section 136A – use of police stations as places of safety.

(1) A child may not, in the exercise of a power to which this section applies, be removed to, kept at or taken to a place of safety that is a police station.

(2) The Secretary of State may by regulations—

(a) provide that an adult may be removed to, kept at or taken to a place of safety that is a police station, in the exercise of a power to which this section applies, only in circumstances specified in the regulations;

(b) make provision about how adults removed to, kept at or taken to a police station, in the exercise of a power to which this section applies, are to be treated while at the police station, including provision for review of their detention.

(3) Regulations under this section—

(a) may make different provision for different cases;

(b) may make provision that applies subject to specified exceptions;

(c) may include incidental, supplementary or consequential provision or transitional, transitory or saving provision.

(4) The powers to which this section applies are—

(a) the power to remove a person to a place of safety under a warrant issued under section 135(1);

(b) the power to take a person to a place of safety under section 135(3A);

(c) the power to remove a person to, or to keep a person at, a place of safety under section 136(1);

(d) the power to take a person to a place of safety under section 136(3).

(5) In this section—

(a) "child" means a person aged under 18;

(b) "adult" means a person aged 18 or over.

Section 136B – extension of detention

(1) The registered medical practitioner who is responsible for the examination of a person detained under section 135 or 136 may, at any time before the expiry of the period of 24 hours mentioned in section 135(3ZA) or (as the case may be) 136(2A), authorise the detention of the person for a further period not exceeding 12 hours (beginning immediately at the end of the period of 24 hours).

(2) An authorisation under subsection (1) may be given only if the registered medical practitioner considers that the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment of the person for the purpose of section 135 or (as the case may be) section 136 to be carried out before the end of the period of 24 hours (or, if the assessment began within that period, for it to be completed before the end).

(3) If the person is detained at a police station, and the assessment would be carried out or completed at the station, the registered medical practitioner may give an authorisation under subsection (1) only if an officer of the rank of superintendent or above approves it.

Section 136C – protective searches

(1) Where a warrant is issued under section 135(1) or (2), a constable may search the person to whom the warrant relates if the constable has reasonable grounds for believing that the person—

(a) may present a danger to himself or herself or to others, and

(b) is concealing on his or her person an item that could be used to cause physical injury to himself or herself or to others.

(2) The power to search conferred by subsection (1) may be exercised—

(a) in a case where a warrant is issued under section 135(1), at any time during the period beginning with the time when a constable enters the premises specified in the warrant and ending when the person ceases to be detained under section 135;

(b) in a case where a warrant is issued under section 135(2), at any time while the person is being removed under the authority of the warrant.

(3) Where a person is detained under section 136(2) or (4), a constable may search the person, at any time while the person is so detained, if the constable has reasonable grounds for believing that the person—

(a) may present a danger to himself or herself or to others, and

(b)is concealing on his or her person an item that could be used to cause physical injury to himself or herself or to others.

(4) The power to search conferred by subsection (1) or (3) is only a power to search to the extent that is reasonably required for the purpose of discovering the item that the constable believes the person to be concealing.

(5) The power to search conferred by subsection (1) or (3)—

(a) does not authorise a constable to require a person to remove any of his or her clothing other than an outer coat, jacket or gloves, but

(b) does authorise a search of a person's mouth.

(6) A constable searching a person in the exercise of the power to search conferred by subsection (1) or (3) may seize and retain anything found, if he or she has reasonable grounds for believing that the person searched might use it to cause physical injury to himself or herself or to others.

(7) The power to search a person conferred by subsection (1) or (3) does not affect any other power to search the person.

The full Mental Health Act 1983, which will be updated once the commencement order takes effect, can be found here.

3rd March 2017

The 'New' Section 138 –

What follows is the full, amended text of section 136 Mental Health Act 1983, as it will be following a commencement order for the Policing and Crime Act 2017 which will bring it in to effect. See related posts for the 'new' section 135 and section 136 MHA, including sections 136A, 1336B and 136C.

***NB!** – this is NOT the current law as of 03rd March 2017 – this is the law as it will become, following a commencement order yet to be laid before Parliament. The full **Mental Health Act 1983**, as it stands today and which will be kept updated once the commencement order takes effect, can be found on the UK Government legislation website.*

Section 138 – retaking of patients escaping from custody

(1) If any person who is in legal custody by virtue of section 137 above escapes, he may, subject to the provisions of this section, be retaken—

> (a) in any case, by the person who had his custody immediately before the escape, or by any constable or approved mental health professional;
>
> (b) if at the time of the escape he was liable to be detained in a hospital within the meaning of Part II of this Act, or subject to guardianship under this Act, [F2or a community patient who was recalled to hospital under section 17E above,] by any other person who could take him into custody under section 18 above if he had absented himself without leave.

(2) A person to whom paragraph (b) of subsection (1) above applies shall not be retaken under this section after the expiration of the period within which he could be retaken under section 18 above if he had absented himself without leave on the day of his escape unless he is subject to a restriction order under Part III of this Act or an order or direction having the same effect as such an order; and subsection (4) of the said section 18 shall apply with the necessary modifications accordingly.

(3) A person who escapes while being taken to or detained in a place of safety under section 135 or 136 above shall not be retaken under this section —

> (a) in a case where the person escapes while being removed to a place of safety in the execution of a warrant under section 135(1) or under section 136(1), after the end of the period of 24 hours beginning with the escape;
>
> (b) in a case where the person escapes after the beginning of the period that is the permitted period of detention in relation to the person under section 135(3ZA) or 136(2A), after the end of that period (taking into account any authorisation under section 136B(1) that was given before the person escaped).”

(4) This section, so far as it relates to the escape of a person liable to be detained in a hospital within the meaning of Part II of this Act, shall apply in relation to a person who escapes—

> (a) while being taken to or from such a hospital in pursuance of regulations under section 19 above, or of any order, direction or authorisation under Part III or VI of this Act (other than under section 35, 36, 38, 53, 83 or 85); or
>
> (b) while being taken to or detained in a place of safety in pursuance of an order under Part III of this Act (other than under section 35, 36 or 38 above) pending his admission to such a hospital,as if he were liable to be detained in that hospital and, if he had not previously been received in that hospital, as if he had been so received.

(5) In computing for the purposes of the power to give directions under section 37(4) above and for the purposes of sections 37(5) and 40(1) above the period of 28 days mentioned in those sections, no account shall be taken of any time during which the patient is at large and liable to be retaken by virtue of this section.

(6) Section 21 above shall, with any necessary modifications, apply in relation to a patient who is at large and liable to be retaken by virtue of this section as it applies in relation to a patient who is absent without leave and references in that section to section 18 above shall be construed accordingly.

4th March 2017

PaCA: Powers of Search –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest early May – but this is subject to a number of factors and may change.

When the police refer to powers of search, we are referring typically two types of power and there are examples of each in the Policing and Crime Act (PaCA). Firstly, it refers to powers to search premises; secondly a power to search people. For the first time ever, the Mental Health Act (MHA) will have a power for the police to enter and search premises without the need for obtaining a warrant from a Magistrates Court (see section 135, for examples of warrants being required). And there will now be explicit powers of search relating to people who are detained under the MHA by the police, whether that is as part of a s135 warrant or under the police power of section 136. A small personal note here: there was originally no plan to clarify powers of search around people and I asked the Home Office as the Bill was being developed whether it could be looked at? Lawyers first suggested that existing powers of search would apply to ss135/6 and didn't think it was necessary but a few emails back and forth demonstrated this was not the case and that officers were facing difficulties. So s83 PaCA is a little personal victory where I managed to get the law changed, or at least clarified; and to ensure that officers can easily see what their powers are to keep people safe whilst detained.

SEARCHING PREMISES

Dealing with premises searches is fairly straight forward. The PaCA will amend the places in which s136 MHA can be used. I will cover details on the ins and outs of all of that in a future post but to over-simplify things, it

will be able to be used anywhere other than private homes. The police will therefore have a power to force entry –

> *"S136(1B) – for the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force."*

So this will be a power to enter premises to use s136 including situations where s17(1)(e) PACE does not always apply. Section 17 of the Police and Criminal Evidence Act (PACE) includes powers to force entry to various premises in a range of different situations, but subsection (1)(e) relates to protecting 'life and limb or preventing serious damage to property' and can be exercised to enter any kind of premises. The combined effect of this existing law and the new amendments will therefore be, if the police have reasonable grounds to believe that a person is on the premises and that there is a risk to life or limb. Where concerns for someone's welfare are not quite that serious, but there is a suggestion that someone is in immediate need of care or control because of a mental disorder, the police can force entry to private premises, other than dwellings, in order to exercise powers under s136. If the police have entered a dwelling under s17 PACE, they cannot usually exercise powers under s136 MHA. (I will flesh out details around where the power can be used in a future post.)

SEARCHING PEOPLE

Section 136 MHA is an arrest, in law. It's not an arrest for an offence! – but it is an arrest. We know this because of s26 and schedule 2 of PACE. The importance of this legal pedantry, is that powers to 'search upon arrest' exists under s32 PACE and therefore, there has always been a power to search someone if there are reasonable grounds to believe they may present a danger to themselves or others and are in possession of something which may be used to escape from lawful custody.

However, s83 PaCA now introduces particular powers of search for ss135/6 and the scope is broadened. Whereas s32 PACE is a power to 'search upon arrest', s83 introduces powers which allow for other searches or further searches. The constable may search the person –

- **Section 135(1)** – at any time after the warrant is used until such time as the person is no longer held under s135 — the power is s136C(1).

- **Section 135(2)** – at any time whilst removing the person under the warrant — the power is s136C(1).

- **Section 136(2)** – at any time whilst they are held *at* a Place of Safety following use of s136 — the power is s136C(3)

- **Section 136(4)** – at any time *after* they have been transferred from one Place of Safety to another — the power is s136C(3).

So, for s136 MHA any initial search upon first being detained must be justified under s32 PACE and once the person has arrived at a PoS, they can be searched under the MHA, s136C(3). For section 135 MHA, initial and any subsequent searches must all be justified under s136C(1). **This is not a blanket power of search:** for any of those new MHA searches, the officer must have reasonable grounds to believe the person –

> *"(a) may present a danger to himself or herself or to others, and (b) is concealing on his or her person an item that could be used to cause physical injury to himself or herself or to others."*

Finally, there are limits to the extent of any search. The person detained may only be searched to the extent that is necessary to uncover the item the officer believes the person has and in any event, this cannot extend to requiring removal of anything other than someone's outer coat, jacket or gloves. You cannot request a person to remove their hat or shoes, notwithstanding any suspicion they may have concealed an item to which this section would otherwise apply in that part of clothing. There can be **no request** for would be termed a 'strip search', in police custody – despite the name, a 'strip search' is just any search that goes beyond the kind we are referring to here, which is limited to outer coat, jacket and gloves.

The next post in the series will focus on the new time limits on Place of Safety detention.

6th March 2017

PaCA: Twenty Four Hours! –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest early May – but this is subject to a number of factors and may change.

Following commencement, the limit for holding someone in any location as a Place of Safety will reduce from 72 to 24 hours. – *see s136(2A) MHA*. This will bring England and Wales in to line with Scotland who capped Place of Safety detention at 24 hours almost fifteen years ago. I will admit, this is the amendment I'm most worried about in the whole programme: we know there are various reasons why assessment under s136 exceeds 24hrs on a fairly frequent basis; indeed there are not-entirely-rare examples of 72hrs proving insufficient because of difficulties finding beds for admission.

So here are the main potential problems that will put pressure on the ambition that most cases are resolved within 24hrs. The more of these you have in your area, the more difficulty you are going to face, I would suggest! –

- **AMHPs** – there is a problem with staff retention in AMHP services. I'm aware from emails recently that in some areas they have not been able to ensure even one AMHP over the 24/7 cycle. One force said they'd detained someone under s136 at 9pm and were aware by 10pm that they would not see an AMHP until around 9am the following day because there would be none on duty at all. In fairness to some local authorities, they are finding it difficult to recruit and some have fewer than half of the full-time equivalent AMHPs for their core statutory functions. In fairness, I'm full of admiration for those undertaking the role – I wouldn't be prepared to do it. Big kudos to those who do!

-

- **DRs** – meanwhile in some areas, AMHPs say that they are more-or-less surviving but they struggle to secure a s12 DR to undertake the s135/6 assessment. On social media only a day or two ago, one AMHP was asking what happens in other areas of secure a doctor after they had made twenty-five phone calls to twenty-five different doctors!! … all of whom, declined to turn out. Any Registered Medical Practitioner can undertake a s135/6 assessment so perhaps we'll find the 'non-s12 approved' doctors having to be used to avoid running out of time? It may come to a point where AMHPs have to choose between using a s12 DR or getting it sorted within 24hrs because they can't have both.

- **Beds** – various indicators are telling us that admitting patients to hospital is challenging. We've seen media coverage of difficulties, including where admitting people from police custody after they were originally arrested for whatever reason. Admission after section 136 MHA assessment was always easier because staff could take whatever remained of the 72hrs to find a bed – now they will have whatever remains from 24hrs to do so. It begs *obvious questions* – that only CCGs / LHBs can answer – but meanwhile, police forces have threatened legal action to defend their officers where this happens and one force is facing legal action after someone spent four days in custody.

EXTENSION OF DETENTION

Just occasionally, the 24hrs time limit can be extended up to the real maximum of 36hrs – but this cannot occur every time just because complying with the normal limit is proving difficult. Section 136B relates to the extension and states –

"S136B(2) – an authorisation may be given only if the registered medical practitioner considers that the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment of the person for the purpose of section 135 or 136 to be carried out before the end of the period of 24 hours."

So there are four points to emphasise –

- The DR who is conducting the s136 assessment must authorise the extension before the 24hrs is complete.

- The DR can only extend detention where there is difficulty in arranging the assessment '*because of the condition of the person'* – they CANNOT extend detention because there is difficulty, for example, in finding a bed.

- If the person is detained in a police station as a PoS, the DR may give this authorisation only if a police officer at the rank of **superintendent** approves it – there is no contingency for an inspector to authorise this where no superintendent is available, although nothing prevents the superintendent authorising this verbally by telephone. It is not in any way related to superintendents' extensions under s41 PACE.

- Where an extension is authorised, the DR (and superintendent) must specify how long they are authorising beyond 24hrs. It's not an automatic entitlement to a further twelve hours every time – *see s136(2A)(b)*.

So where someone is intoxicated and assessment is delayed; OR where it is necessary to take someone to an Emergency Department for urgent medical treatment before assessment: these situations would allow the DR to extend detention – although how that happens if one problem is a delay due to not being able to secure a s12 Doctor, I'm not quite sure! What is clear, is that a lack of beds for admission will not allow an extension of the 24hrs up to 36hrs and a delay in finding an AMHP or DR is not sufficient either. Police officers should watch out for deliberate delays in undertaking assessments, so as to create conditions within which the authorisation appears possible. Forces should ensure that where they remain involved in detaining someone under s135/6 at a PoS, they have been clearly told the reasons for the delay in assessment, document it and satisfy themselves to the extent that they can it was appropriate. It would not be sufficient to simply say, "The DR authorised it", especially if it seems possible that there wasn't a legitimate reason for delay, such as finding professionals to do it.

PRACTICAL IMPLICATIONS

Things which have occasionally been done a touch casually now need to be done with some discipline: police officers need to ensure that AMHPs are told of s136 detentions as soon as someone has arrived at the first Place of Safety to which they are removed, including where an Emergency

Department has been used. **We must NOT burn up precious parts of the 24hrs clock by stalling on this point.** It may be the case that someone is not immediately able to be assessed and it could be there is a delay in the AMHP or DR becoming available, but the duty on the police is to inform the AMHP *as soon as possible*.

There was an inquest in Reading a few years ago whereby officers delayed informing the AMHP, mainly because the man detained needed treatment in an Emergency Department for physical injuries. Who amongst us hasn't done that with someone detained under s136?! – what are we expecting the AMHP to do if we know the person is within a queue of unspecified length with an uncertain amount of delay to be treated?! The Coroner took a clear position that it did not matter and that the AMHP should have still been informed. If nothing else, it put the fact of the s136 detention on record, might have led to some early information exchange that could have proved useful but it also allowed the AMHP to start planning their competing demands to be available for that assessment, having jacked up a DR, *as soon as possible* after ED had finished treating him.

This will become even more important, post-commencement. AMHPs are in shortly supply in many areas; s12 DRs are in short-supply in many areas. The earlier an AMHP knows of the detention, the more time they have to think about what may be required and to either roll with any problems, or at least to flag them up to the police or Place of Safety so they can manage everyone's expectations — **call the AMHP as soon as you get to the first place** to which you go and in to which you are accepted – whether that's an Emergency Department or *anywhere else at all!*

BEDS!

I've briefly mentioned this as a problem, above but I'm now going to labour the point. In fairness, this is the problem which seems to be most concerning to AMHPs who are going to be undertaking assessments and then very much being left at the mercy of NHS Bed Managers should there be any difficulty at all in securing an admission. Many people argue there is a national shortage of inpatient psychiatric beds, including for adults but especially for children and others with specialist needs requiring a learning disability or psychiatric intensive care unit bed. We still see stories around the country of people being moved hundreds of miles away and work I'm doing about admission from police custody shows us clearly there is an over-reliance upon the police to 'house' people, in not-altogether legal circumstances pending beds being managed or found. This doesn't look like being sorted any time soon and the new timescales for Place of Safety assessment aren't going to make this any easier so old arguments seem

worth revisiting as the inevitably become more in the future relevant in the future.

When I first started formally working on mental health I didn't really know where to start so I sat down and read the Mental Health Act – actually several times. I did the same with the Code of Practice to the MHA. I noticed section 140 of the Act and was interested in it after incidents in my own force where beds had been hard to come by. I also noticed that section 140 MHA was simply not mentioned in the (1999) Code of Practice, nor was it mentioned when the Code was updated in 2008. So I've banged on for a decade at every chance I've had about this often ignored provision of the Act. I can say 'often ignored' because over the years I have made Freedom of Information applications to over fifty Clinical Commissioning Groups (previously known as Primary Care Trusts) about what they have done with the legal duties arising from this section. I will let you read my post on section 140 MHA if you want more detail – the punchline is CCGs and LHBs must specify hospitals which are in a position to receive urgent admissions. Although the section doesn't say very much more the clear and obvious implication of the provision is that those hospitals should usually have at least a fighting chance of being able to admit people urgently, where their health and safety, or that of others is jeopardised. Almost no CCGs can fully answer the FoIs I have sent them over the years – many admit they weren't aware of the provision and don't understand what I'm asking.

So – when AMHPs and DRs have made their assessments within 12hrs and have only another 12hrs to find a bed for any admission that is indicated, whether or not the CCGs or LHBs has complied with this legal duty and actually commissioned services in such a way as to mean they have contingency. The police and Place of Safety services will be less of a contingency in the future, so compliance with this section and its implications are going to be vital. Wherever we see delays in admission and especially where it is assumed the police will just endlessly hang on to people pending these arrangements being identified, it arguably represents an article 5 violation and by virtue of s6(1) of the Human Rights Act 1998, no public authority may act in this way – **ever**.

If you are a mental health professional reading this: please ask your managers or CCG / LHB about section 140 MHA.

The next post in the series will focus on the places where s136 can now be initiated.

7th March 2017

PaCA: Anywhere Other Than a Home –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest early May – but this is subject to a number of factors and may change.

The time for debate about whether or not the police should have powers under the Mental Health Act (MHA) in someone's home are over: the Bill became an Act and the law is now framed, beyond discussion. Whilst the extent of s136 MHA has been widened, the summary of it is "you can use section 136 anywhere except a home where someone lives". This post covers the detail of what that means and will get in to that whole debate about gardens and garages, etc.. But you can forever ditch that tortuous phrase "place to which the public has access" and any notion about where the constable 'finds' the person to which s136 relates. The power may now be applied in all places except homes, but 'home' is not the word used by the legislation, so it takes a touch of explanation but I think, overall, it makes it much easier to understand. You can have your view about whether you agree with what they've done here, but I suspect we'll agree it's easier to consider its application.

YOUR HOME IS YOUR CASTLE

Section 136 MHA itself now reads as if it applies everywhere and this is the definition officers will need to consider –

> *"(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."*

However, officers then need to consider a newly inserted sub-section, s136(1A) –

> *"(1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, 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."*

So section 136 cannot be used where those of us with mental health problems are encountered in their own home OR within someone else's home, assuming they are there with permission and not trespassing. Nor can detention occur in someone's own garden unless it is a communal space shared with other people who live in other dwellings, for example in a block of flats. Garages, outhouses and yards are treated the same as gardens for this purpose.

I've already had queries on social media about people who live in what I might term 'non-traditional' housing: tents, canal barges, caravans, etc. – does the new s136 apply to those? The legislation doesn't specify anything more than I have cited, above, so therefore it is a matter for professionals to interpret that wording in light of circumstances. Those who raised the question tried to draw comparison between the purpose of the canal barge or caravan for that individual with the purpose I have for my house. I live in a house, a friend of mine from university lives on a (very lovely) canal boat on the Thames. Am I afforded legal protection from the application of s136 whilst she is not? – and if I am, why is she unfairly discriminated against for her lifestyle choice? All that I can do is encourage you to ask the legal questions: is this a house? – no. Is it a flat? – no. Is it a room? – in the sense that any space surrounded by wood, metal or canvass, whether it is on wheels, floating on water or pitched in the woods, is a 'room', yes, but the normal English understanding of that word suggests that such places are not rooms. If anyone has legal opinion or cases to the contrary, I'd be interested to hear them!

Finally, hotel rooms! – clearly they are a 'room' so can s136 apply in such a place? … do people 'live' there?! When you pay for a hotel room, you gain a right of occupancy over that room, subject to general terms and conditions in the hotel. We know from caselaw, warrants are required to enter hotel rooms and that hotel managers cannot over-ride that right of occupancy during the paid duration of someone's stay. Therefore, no – you

cannot use the new s136 in a hotel room, because the person is regarded as 'living' there, even if just staying for one night and day.

NON-DOMESTIC PRIVATE PREMISES

The extension of s136 therefore mainly relates to those private premises not open to the public which are not 'houses, flats or rooms'. It has been an anomaly for years that British Transport Police cannot use s136 on railway lines because the tracks are not public places. Of course in practice, they do 'use' section 136 but technically this occurs after they have used other legal powers to remove the person from the tracks and this is quite lawful – there is caselaw about police officers being entitled to consider someone 'found' when they have, in reality, placed them there after removing a trespasser. However, the new version of s136 just gets around all of that faff and makes it much clearer to apply and understand.

There are a range of other places which have historically generated debate about that old phrase 'Place to which the public has access' – and this discussion is now consigned to history. Wherever you previously sat on the use of s136 in an Emergency Department, cinema or police custody: we can all now easily agree that none of these places are 'houses, flats or rooms where that person is living'. Easy peasy, isn't it?! Of course, *whether* you instigate section 136 in those locations remains a matter of judgement and proportionality, but it is certainly possible to do so … and because the word 'finds' has been removed from s136(1), it doesn't actually matter where the person was originally encountered as long as the mechanism by which they have arrived in the subsequent place is a lawful one. Someone *lawfully* arrested in their own home who is then released from police custody, for example, may be subject to s136 MHA as long as the arrest was, in itself, done for legitimate policing purposes and not a manufactured 'stepping-stone' to create conditions in which to justify the use of s136. Custody sergeants in particular might want to bear that in mind, when deciding how to handle the detention of those arrested for minor crimes who are then deemed to require assessment under the MHA. << This one is, in my view, one of the biggest unintended consequences of how the law has been re-framed.

So all ambiguity about Emergency Departments is now removed – I don't think there was any confusion to begin with but I do know officers and ED staff have had some frank discussions about this point over the years. The police *may* (not must!) use s136 in ED, where it is justified on its own terms – and therefore *nothing* prevents ED staff from asking the police to consider the necessity, bearing in mind they do not have powers of their own in that environment under the Mental Health Act. Yet again, you may have a view about whether this is right or wrong, but that is the law as it stands.

PRIVATE HOMES

So what is the solution where officers are, inevitably called to private homes for a mental health crisis call? … they inevitably will be! The first choice should be to try to resolve the matter in a unrestrictive way, ie., referral to a relevant service. The service may require the person to consent to attend somewhere (like ED) or it may be able to come to the person (like a CrisisTeam or triage team). If that fails or is not appropriate, then the legal options are to consider the powers available. In no order of importance, they are –

- **Powers of criminal arrest** – if there is an offence or attempted offence – but this has to be because there is a *genuine* intention to investigate the allegation with reference to use of these powers!

- **Common law powers** – Breach of the Peace or the *doctrine of necessity*: but they are not as applicable as many of us think! Breach of the Peace is legally defined, the doctrine of necessity applies where the MCA does not, roughly.

- **The Mental Capacity Act 2005** – where there is an urgent, serious medical issue and someone lacks capacity. You cannot just remove someone to hospital because in some general sense, the lack capacity.

- **The Mental Health Act 1983** – consider referral to an AMHP (via whatever local process you have) to son insider a MHA assessment under s4 MHA or a s135(1) warrant. << The basis for suggesting this is the Sessay case (2010) – it's what the judge reminded us should have happened instead of officers misapplying the MCA.

So what this newly framed legislation does not do, is remove the need for senior managers to work out how 999 services and mental health services can work together in real-time to keep people safe. This needs to include AMHPs and the ability convene urgent MHA assessments, where necessary!

EVER-RISING USE OF SECTION 136

So if you haven't worked it out already: the use of section 136 MHA is about to start rising even faster than it already was! Remember: the last time figures were published, use of s136 had risen to over 28,000 detentions per year and this is up 10,000 in 10yrs, notwithstanding initiatives like street triage to try to reduce use of the power. If police officers can soon rely upon the power in wider circumstances, it is unlikely that they will use

the power less than they previously have. That's more s136 and MHA assessments for AMHPs to undertake; therefore more need for s12 Doctors as a part of that and more capacity required in NHS facilities to ensure those assessments can almost always occur in non-police settings. (The post in this series about restricting the use of custody as a PoS will appear later because the Government have not yet published the statutory Regulations which will define it.)

So as areas try to think about the implications of the PaCA amendments on their areas, they need to understand how the power is used by their local police, what factors may be brought to bear to affect that such as training or street triage, etc.. (It should be noted: street triage doesn't *always* reduce use of s136!) Whatever understanding they reach, they then need to ensure there is sufficient capacity and contingency in local facilities to be able to manage the number of detentions being made by the local police – this may include areas needing to consider their ability to handle multiple detentions at the same time, where previously they may have operated a facility which could handle only one detainee at a time.

Lots to think about, on this one!

The next post in the series will focus on the new 'pre-136 consultation'.

7th March 2017

PaCA: Operational Officers –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest early May – but this is subject to a number of factors and may change.

These are the Mental Health Act amendments, stripped to the absolute bone for ease of digestion by operational police officers. It may also be a useful summary for service users / carers or other front line professionals, but it's written for officers who need to read it!

Click on the 'more detail' links to take you to the main posts I've written on the amendments I'm briefly summarising here! –

Section 136 MHA –

- You can now use s136 in any public or private place, unless it is a "house, flat or room" where someone lives, or any non-communal "yard, garden, garage or outhouse" connected to such a place. Includes workplaces, railway lines, police custody or A&E departments. ***More detail.***
- However, you must consult, *where practicable*, with a DR, nurse or AMHP *before* utilising s136 – find out from your force who you are expected to ring! Document what they say to you – they cannot instruct you, only advise. Any decision to detain is yours, not theirs.
- When considering if it is practicable to consult, remember the person is free to walk away until such time as you decide to detain them – have you informed them of this; do they have the capacity to consent to remain pending consultation?
- Section 136 can only occur if a person is in *immediate need* of care or control – how immediate is that need if you have time to make phone calls? If you delay making a detention how do you justify later

on that there was an *immediate* need to act? **You must strike a balance!**

Place of Safety –

- You cannot, ***ever***, take a child to a police station as a Place of Safety – this means no-one under 18yrs. **NB:** this is not a ban on using custody; it is a ban on police stations. ***More detail***.
- An adult can *only* be detained in a police station in 'exceptional circumstances' – this is not defined because the Government haven't published the statutory Regulations: ***I'll update this page as soon as I know what they are!***
- A person can only be detained in a Place of Safety for 24hrs – unless a Doctor authorises an extension up to 36rs. They can *only* extend things if there was a delaying in undertaking the assessment **because of the condition of the person**: the DR *cannot* authorise extension because they're struggling to find a bed! ***More detail***.
- **Everytime you use this power**: call an ambulance, anyone with RED FLAGS to A&E, everyone else should go to whichever PoS is locally identified, unless you can identify another solution – police stations are only for adults only in exceptional circumstances.

Searches –

- Where someone is detained under s136 MHA, they are able to be searched on arrest subject to the criteria of s32 PACE – you can also now search under s136C once you have arrived at a Place of Safety for anything that may be used to cause harm or escape if you have reasonable grounds to believe they possess such a thing.
- This authority to search is ongoing whilst the person remains detained but each and every search must be justified, on its own terms, especially for any second or subsequent search since being originally detained.
- You can also now search someone at any point after you have executed a search warrant under s135(1) or s135(2) MHA – *the power to do so is s136C(1)* – this 135 search authority lasts until the end of detention under s135(1) OR until the person you have detained under s135(2) has arrived back at the place you were taking them.
- You are authorised to retain possession of anything you find during that search which could be used for causing harm and retain it until the end of the period of assessment. Anything found which is prohibited by an offence can be retained indefinitely after being seized under s19 PACE. ***More detail***.

8th March 2017

PaCA: The Consultation Requirement –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest early May – but this is subject to a number of factors and may change.

If you look at the so-called Street Triage schemes, most of them are predicated on the idea of police officers contacting a mental health profession, usually a nurse, and seeking information or advice about a person they have met at an incident. The nurse may opt to turn up to the job and do a face-to-face assessment or the may advise from wherever they are, by telephone. Many areas claim that since the introduction of street triage their use of s136 has reduced, in some cases quite considerably. This idea lies behind the new legal provision for police officers to consult, *wherever practicable*, with a professional before deciding to instigate s136 MHA – that's what we'll cover in this post.

This pre-136 consultation is a **legal requirement**, *where practicable* – you either must do it, or be able to justify why you have not done it. It's the one, or the other – you cannot simply use s136 and not explain why you had to crack on. This justification will need to be documented in pocket books for future reference because you can anticipate the legality of s136 usage being questioned if an officer has made no effort to consult and also provided no justification for why they didn't. In areas of the country where services are also under pressure for their Place of Safety (PoS) capacity, I also anticipate some NHS staff will feel entitled to question the officers about the consultation requirement – especially if they disagree with the necessity of it! – and will become interested if the police cannot clearly say *why* they had to act. OR – why did they act by detaining if the advice was not to do so?! – that's a can of worms explored below.

So you either document –

- *Who* you spoke to, along with *what* information they shared with you and what opinion they offered about your actions, if any; OR
- You document *why* you felt it was not practicable to consult before having to make the decision to detain.

The law says –

> *"Section 136(1C) Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult — (a) a registered medical practitioner, (b) a registered nurse, (c) an approved mental health professional, or (d) a person of a description specified in regulations made by the Secretary of State."*

- So this is a requirement to consult **before** you detain – if you have to detain someone to ensure their safety and there is no time to consult, there is no legal requirement to consult after the detention so proceed to the relevant Place of Safety.
- The law specifies three kinds of professional who could satisfy this requirement: a DR, a nurse or an AMHP. It doesn't say anything about specific individuals specified locally – any DR, any nurse or AMHP will do, but your local policy should outline the preferred option.
- You'll have to ask you line manager what telephone number you must ring to fulfill this obligation.

WHAT ARE WE DISCUSSING?

The section, above, makes no effort to explain the purpose of this consultation. Are we sharing information, are we seeking that professional's opinion about detention; or wanting to understand which PoS to go to if detention is the outcome? Are we asking for risk information which may be known to the MH trust but not the police; or asking about clinical issues like whether the person is thought, or not, to be concordant with any medication they take? The last question sounds like something a bit clinical and nothing to do with the police, doesn't it? – yet I could tell you the street triage story about the nurse who didn't ask a patient about medication and then gave officers an under-inflated risk assessment that led to them not detaining the person. Hindsight indicated very clearly that knowledge of medication issues would have led the nurse to give a different view. (You can guess the outcome of. It detaining the person.) So how detailed do we want to make this stuff?!

Is this enough? –

> *"Hi, this is Inspector Brown – I'm at an incident with young man who seems to have mental health problems and I want to consult, as per s136(1C) because of the potential that I may detain him."*

I admit if I'm ringing up, I have more questions and I'd be asking them!

> *"So, in addition to you telling me whatever you think I need to know and any opinion you might want to offer about whether detention might be appropriate. I'd like to know a) any information you have relating to risks to either him or me, including whether or not you have information that he may possess items which could be used to harm himself or me; b) whether he is prescribed psychiatric medication and whether you have any grounds to believe he's not taking it; and c) what mental health condition you believe he has."*

And this is interesting moral territory for mental health professionals, isn't it? – what if they are aware that a person habitually carries a bladed item, either for harming themselves or, as I was once told about patient who carried a knife, "It's his comfort blanket – it's just something he carries." Is a nurse going to tell the police that there is risk information which may then lead to that person being searched and arrested for a criminal offence when the officer finds them in possession of something they're not legally allowed to have?

THE LEGAL POSITION

Most importantly, officers in this situation need to focus on the legal situation **during consultation**. This is a point I've repeatedly raised throughout the progress of this legislation and have discussed with street triage schemes and their managers. Section 136 can *only* be used if the officer thinks there is *an immediate need* for care or control, in that person's interests or the protection of others.

- How immediate can that need *really* be, if we have time to delay and make a phone call to the NHS?
- If we make that phone call because we're not detaining someone as there is no immediate need and we learn nothing new, how can we then argue 10 or 15 minutes later there *was* an immediate need to act?

Rights and civil liberties are important here. You only need to watch the BBC news or get involved on social media to see frontline officers creating what I'm going to call 'considerable ambiguity' about what is occurring legally where they are involved in 'triage' encounters. Some service users on social media report having been held, unable to leave for non-negligible periods of time (measured in hours) whilst waiting for triage to get

involved. If consultation can happen quickly and easily, we can agree that information sharing within a few minutes which prevents someone needing to be detained is welcome. But I admit that I wouldn't be prepared to stretch that point beyond a few minutes before I would feel uncomfortable in not letting someone leave who wanted to. Remember, in the *ZH v Commissioner* (2013) case, the Court Appeal ruled someone had been deprived of their liberty by being held, unable to leave, for just 10 minutes. Even if someone is not objecting to remaining with the officers, are officers undertaking a capacity assessment of that decision to remain?

Parliament, having just amended our laws, could have inserted something in to s136 which said, "If following the application of s136 by a police officer, a registered nurse offers information or alternatives to detention which negate the original need for the officer's use of the power, the person may be released from detention" or similar. But they didn't. Parliament do not want nurses on the street ending detention unilaterally, otherwise they would have said so. Any decision to detain remains that of the officer(s) involved in the incident and this remains true after an officer has been told by a nurse that detention isn't appropriate.

IN PRACTICE

Ask yourself this: in what circumstances, precisely, would you ignore the advice you're given not to detain someone and proceed to detain them anyway? If you can't answer that question, you're effectively going to be doing as you're told and yet the decision to detain belongs to the police officer – it **never** belongs to the nurse. I can think of various situations in which I'd be prepared to detain anyway – I don't intend to do a disservice to the many excellent mental health nurses who have made great efforts to get their heads around mental health law but I know how little training they get on the legal issues relevant to police detention decisions. As such, examples I've come across over the last few years cause me to think some of the advice we'll receive will be duff, predicated on misunderstanding relevant legal issues and that I won't know in any given situation whether this was the case.

So my own operational approach is likely to be this –

- If I'm satisfied that the grounds for detention under s136 are met, I'm likely to argue it is not practicable to consult because I am admitting I have to act *immediately* to keep someone safe.
- If I'm satisfied it's appropriate to consult, I'm unlikely to be using s136 after the discussion unless they tell me some new information that alters my risk assessment.

Remember, the Code of Practice to the Mental Health Act makes it clear (in para 16.21 (Eng); in para 16.27/8 (Wal) – that s136 should not be used as a route to access mental health services – patients should go via their GP or their community mental health team, where appropriate. So if I'm prepared to put in a phone call because grounds for immediate detention are not met, s136 can't be the answer after the phone call if that is just about the convenience of a service to have someone brought to them. But what capacity will they have to follow-up the person at home?

Services should be available to people who need them, notwithstanding the legal framework that the police may or may not have applied. So I find this consultation requirement the most interesting of all the new amendments because I think I can see what it's getting at, but I admit to wondering how that will actually work in practice. And I worry in particular that people may be subject to *de facto* detention by frontline officers or schemes because somewhere in our recent history somebody unilaterally decided that less s136 is a good thing and that we'll measure the success of these programmes with reference to their ability to reduce the use of a power which is simply not relevant to most of the referrals they receive. (Most street triage doesn't happen in the street; and most of what they do isn't triage! – apart from that, it's well named.)

Areas need to be clear: how are we consulting; why are we consulting; what are we consulting about, precisely – when should officers do as they're told and how will incidents be handled if they took a view that is at odds with the advice they'd received?

The last post in the series will focus on the 'exceptional circumstances' in which police custody may still be used as a Place of Safety for adults – this will not be written until the statutory Regulations are published by the Government.

14th March 2017

Thomas Orchard –

Today, a police custody sergeant and two detention officers have been cleared of manslaughter following a hearing at Bristol Crown Court. This retrial follows the death, in 2012, of Thomas Orchard – a 32-year-old man from Exeter who lived with schizophrenia who had been arrested and removed to a police station whilst in crisis. For a short news piece which sets out the background very well, see Channel Four News. In terms of me covering these events on here, I want to put on record that I have had no involvement in any way with any process that followed the incident or any contact with any parties involved. What follows are only my own thoughts after following the investigation and trial process over the last five years via the media. It touches on those most difficult of issues: the criminal prosecution of police officers following the death of a vulnerable man.

The police received a call from a member of the public to the place where Mr Orchard was arrested under the Public Order Act. He was restrained upon arrest and removed to a police custody suite. Upon entering custody, it was contended by the police officers who were cleared that he was attempting to spit and bite. They resorted to use of an emergency restraint belt (ERB) which had been issued to them by Devon and Cornwall Police, in order to protect themselves whilst placing him in a cell. Having then removed the ERB and themselves from the cell, Thomas was alone for twelve minutes before concern for his welfare led them to re-enter and an ambulance was called. It was said in court that he died from a hypoxic brain injury and the effects of restraint, his brain having been starved of oxygen.

This is a tragedy on several levels, the obvious human cost and suffering to Mr Orchard's family being first amongst them. Devon and Cornwall Police have stated in their press release the officers involved have suffered a toll as they go through a four-and-a-half year process to get to this point. They stood trial for this once before, in January 2016, and this is not over: there are ongoing disciplinary considerations because the Independent Police Complaints Commission recommended that a total of seven police officers be considered for gross misconduct hearings. This includes the three defendants and four others involved in his original arrest. Regardless of those proceedings, the Devon and Cornwall Chief Constable remains under corporate investigation by the Health & Safety Executive to consider breaches of health & safety law. And of course, there is still to be an inquest in to his death which I doubt will happen this year. History in other cases

suggests it may not happen next year either. This is far from over and the Orchard Family's campaign continues, quite understandably.

QUESTIONS ARISING

As you may imagine, I've been interested in this case since first hearing of it. Early on, my interest was particularly sparked when it became known that the IPCC had written to all Chief Constables about the use of ERBs as an improvised 'spit guard'. This topic remains controversial now, as several forces consider whether or not to introduce equipment, very different to this ERB, which is aimed at protecting officers. This case then also raises that question about the ability of officers to discern a mental health crisis from behaviour on first presentation in a short timescale: in this particular case, Mr Orchard was reported to the police by a member of the public amidst an ongoing argument. No-one was offering pre-known information about his mental health so the ability to identify crisis concerns rested on the officers who attended the dispute or disturbance which had occurred. So how possible is it to train officers so that mental health concerns are raised as early as possible and how might this effect whether a person who is detained is arrested under public order law, as in this case, or detained for their welfare under the Mental Health Act? We know that Doctors can get this wrong, so officers are not always going to get it 'right' – but could we get this better?

And even if someone is detained under the Mental Health Act, there is then the question about whether they should be removed to police custody because of any challenging behaviour; or taken to an A&E department or a mental health trust Place of Safety (PoS) because of the difficulty in officers establishing in a few minutes whether someone's presentation has an underlying medical cause? Additionally, is any ostensibly necessary restraint in fact, placing someone at even greater risk?! This dilemma, from a case in 2012, is more apposite than ever as police and mental health services are currently waiting to hear how Government will define the future circumstances in which police custody may still be used as a PoS under the MHA. These questions more-or-less directly attend to the view offered by Mr Orchard's family that if he'd been detained under the MHA and taken to somewhere set up for reception of those in crisis, he'd still be alive today. The Inquest will no doubt attend to those issues and all I am going to do here, is address them in terms of what has been said in the past in other, not-always-identical cases.

ANSWERS RESULTING

- **Grounds for arrest / detention** – it has always been my view that we cannot always guarantee police officers will identify someone is mentally unwell. History shows us that psychiatrists can get this wrong, so it should be surprising if police officers do. That said, we have improved police training around mental health since this case, to reduce such instances where we can. I've professional experience of detaining many people who simply appear 'angry' upon first encounter only to have concluded by the time we get to the custody sergeant, that they are actually far more likely just to be 'fearful' – mainly of me. Understanding the difference between fear and anger is important, even if that realisation occurs slightly after the point where a detention decision has been made. Officers also have to make that call in light of how serious an offence may be – in this case, an alleged public order offence is quite a minor matter in the overall scheme. But other cases have shown officers must occasionally take these decisions where the distressed person has a knife but hasn't hurt anyone – in some cases where they have. At what point should officers be arresting for alleged offences, irregardless of information about someone's mental health problem, but ensuring that mental health support and assessment is an early and key part of detention after arrest? You may remember I highlighted two contrasting cases last year which were slightly more serious in terms of alleged offending.

- **Removal to a suitable place** – Mr Orchard's family have made public representations about removal to a more suitable environment, presumably a safe mental health unit. So if the attending officers detained someone under s136 MHA and then follow the Devon Place of Safety policy, would this lead to the avoidance of police custody for those who are frightened and resistant? It's not automatically clear that it would, unless officers were arguing the need for removal to an A&E department. It's not clear that officers did think this was needed, because A&E remains an option directly following arrest and they didn't take it. So what does all of that mean? Mr Orchard's tragic case is far from being the first to raise the question "Where should police officers take mentally distressed people who exhibit challenging or resistant behaviour after detention / arrest?" In the cases of Sean Rigg, Leon Briggs, Michael Powell, Toni Speck, James Herbert and others, this same question arose. However, even the current Place of Safety policy for Devon Partnership Trust clearly envisages that some detainees (para 6.5) will be transferred to police custody because of 'violence'. The policy doesn't give us detail about this stuff so we can't know for certain

that Mr Orchard would have been excluded but it's obviously possible. I won't go in to further detail here, but suffice to say when a local 136 policy shows the author-signatories don't know what 'AMHP' means (para 6.8), I tend not to hold out hope for its ability to address the kinds of questions Mr Orchard's family might reasonably want answered. Had a draft of that document been shared by Devon and Cornwall Police with a request for advice, I would have stated it needs *a lot* more work before they should sign it.

- **'Exceptional Circumstances'** – The Policing and Crime Act 2017 (PaCA) will shortly amend the Mental Health Act 1983 and will authorise Regulations (yet to be published) about those situations in which police custody may still be used. I watched with some disquiet the CCTV films that emerged during this trial or Mr Orchard being arrested in Exeter and then detained in custody, but having been involved in the process as the PaCA came in to being, it strikes me that even after the commencement of this law, cases such as Mr Orchard's may not be materially affected in terms of where someone ends up after detention. Obviously, it was an option to just completely remove police custody as a Place of Safety under the Mental Health Act for all age groups. Indeed, one Peer did table this as a proposed amendment as the Bill made its way through the Lords, but it failed. The Government consultation document (December 2014) suggested that police custody for adults should still be an option for any "behaviour so extreme it cannot otherwise be safely managed." Bear that definition in mind as you reflect on how the partnership trust may have considered paragraph 6.5 of their Place of Safety policy. If the statutory Regulations we will soon see contain something broadly similar, it would raise questions about whether future cases, similar to Mr Orchard's, could *in fact* lead to removal to a healthcare setting. Indeed, will it make it more likely than before, if PoS services can cite these Regulations as a reason to refuse admittance?

- **Emergency Mental Health** – so for me, this is about a more fundamental change of approach. Since 2012, we've seen numerous documents emerge which lend weight to the points many of us have been making for years. Ongoing, high-intensity restraint of someone whose resistant behaviour does not reduce should be causing officers to *think about under-lying medical causes*. They need to be calling ambulances to the point of arrest, especially but not only where they have employed s136 MHA. We need to have greater consideration at the point of detention about Clinical needs: either because of suspected underlying mechanisms AND / OR because of the impact of high-intensity restraint. NHS England published a Patient Safety Alert in December 2015 about the need for medical monitoring after restraint: it's not the kind of 'observation' that a police officer can do.

> We've also seen the publication of guidance from the Royal College of Emergency Medicine and the Faculty of Forensic and Legal Medicine about so-called '*Acute Behavioural Disturbance*' and NICE Guidelines about *Violence and Aggression: short-term management in health, mental health and community settings* (2015). We've also seen cases where the police have detained resistant and no doubt very fearful vulnerable people who have turned out to have conditions as varied as serotonin syndrome, meningitis and encephalitis. We can probably agree, this stuff is way above the pay grade of a junior police officer with a first-aid certificate and as Alison Orchard, Thomas's mother, has made clear today: we need to create just a few seconds of pause in the minds of frontline officers to think 'what if' and to remember Thomas.

Whilst the criminal trial has occurred in Bristol, other proceedings are underway in south London for the inquest in to the death of Olaseni Lewis in 2010. Families are waiting years, only to feel, as Alison Orchard said today outside the Crown Court, "no sense of justice". My own view is that the families are right to campaign for improvements to policing and I hope the work I've done has gone some way towards helping achieve that (I do know there is much more to do). That said, this is not just about policing: as few deaths in custody ever are. This is also about having the correct support infrastructure for officers to access emergency health or mental health pathways, even if it is just for assurances that people are not at risk if they do end up in police custody.

This is about police training, yes – recognition of mental health, understanding the impact of restraint, knowing to seek clinically signposting from paramedics, etc.; but it is also about Place of Safety services which operate to Royal College of Psychiatrists' *Standards on the use of section 136* (2011); it is about the availability and the willingness of ambulance and emergency medical services to support officers' decision-making. Unfortunately, there have been several incidents where officers have made detentions in situations like this under s136 MHA and still found themselves excluded from anywhere other than police custody and legal reform is protecting that likelihood going forward, despite argument to the contrary. There will still be lessons to learn here and more facts will emerge from ongoing processes, but as Lord Adebowale said in his 2013 report in to policing and mental health in London, "The police cannot do this alone."

MEDIA

- BBC News
- An extended piece by Channel Four News (inc video).
- Guardian coverage
- Guardian article on the Orchard family's perspective

- Devon and Cornwall Police Press Release
- Independent Police Complaints Commission press release
- Devon Partnership Trust s136 Policy (Nov ’15).
- Memorandum of Understanding on Restraint – contains all the medical guidelines referred to, above.

16th March 2017

PaCA: Section 140 MHA –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017. This post is one of several which relates not the amendments themselves, but to the implications arising from them.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest early May – but this is subject to a number of factors and may change.

It's now a dozen years since I first read section 140 of the Mental Health Act 1983 – and I recently met some senior mental health professionals who never ever read it or heard of it. When I first read the provision, in 2005, section 140 MHA was not mentioned once in the accompanying Code of Practice (1999), or the Reference Guide form the Department of Health. It still wasn't mentioned when the Code was updated (2008) or in the revised Reference Guide. If you read the formidable Mental Health Act Manual by Professor Richard Jones, you'll see this book provides the full text of the Act and Code as well as a commentary on the sections of the Act, so of course it was covered in there. However, the commentary was limited in comparison to that for other provisions.

I'm not going to repeat my first post on section 140, so you can go back to that original post if you wish. This blog argues just two things –

- We still aren't really talking about this provision – what it says, what it means and how we actually acknowledge its existence in law by **action in the real world**; AND
- It's now become more important than *ever* before – it will become *more important still* in just a few months' time; and **this raises the importance of point one!**

When public consultation occurred for the latest Code of Practice (for England) in 2014, the draft didn't mention section 140. I replied to that consultation asking why not, given it was missing form the two previous

editions and from the Reference Guides, so it consequently seemed that no-one had heard of it. Its implications may be widely ignored and I came to increasingly see that as a problem, not only for the police. I was delighted to find, when the Code of Practice was published in 2015, this provision finally received a brief mention (see the section commencing at paragraph 14.77).

PARLIAMENT'S INTENTIONS

When legal discussion occurs about Acts of Parliament, we often hear people wondering about parliament's intentions, too help interpret the text of an Act. Of course, intentions is one thing, the actual wording of the Act might be something else instead, depending on the quality of how the law was drafted. Section 140 of our current Act is, in fact, just a direct transfer to the '83 Act of section 132 of the preceding 1959 Mental Health Act. It's a provision that has almost sixty years of history but that, I haven't been able to find out much about that history, despite efforts. All I can say, is I've made Freedom of Information requests to well over 50 different Clinical Commissioning Groups (or their Primary Care Trust predecessors) and I don't find myself satisfied by a single, solitary answer I've received. I most recently did this in 2016 at which point several CCGs just replied to say they'd never heard of the provision and didn't understand my question. **And this is the law of our country we're talking about!**

The section itself says –

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

So what does this all mean? … actually?! –

The 1959 Act was written at time where mental health units were not expected to considered themselves 'full'. A local, county asylum would continue to accept and accommodate patients thought to need admission where applications to them were made under the Act or by the courts, notwithstanding such modern niceties like capacity or conditions. Indeed, earlier in my career, when I sought legal advice on MHA admissions, the barrister concerned advised that hospitals were actually not *legally*

permitted to refuse admission made to them. I haven't heard this repeated by anyone else since(!) – and indeed I've heard it repeatedly contradicted – but it attends to this point: where detention or admission is required, for safety reasons, it needs to be able to happen.

MORE THAN BUREAUCRACY

Legal considerations about the need to admit someone *urgently* under the Act include more fundamentally important things than niceties and bureaucracy in our particular domestic law. It could also amount – and it often *does* amount – to a human rights consideration. We know that prolonged detention in police custody (pending admission) can contravene Article 3; we know that protracted detention in custodial settings for no other reason than mental health problems can amount to an Article 5 violation; we know duties owed to patients who are known to be suicidal can give rise to Article 2 considerations, whether the patient is detained or voluntary. And we know that no state may defend these things by arguing they don't have the money to prevent them. As such, dependent upon the precise circumstances, the need to ensure an urgent admission may be something which triggers one or more of these various duties? – remember: **no public authority** may act in a way that is contrary to a person's European Convention rights, by virtue of s6(1) Human Rights Act 1998.

It must surely have been the intention of Parliament when writing and updating the Mental Health Act over the last sixty years that wherever AMHPs and DRs encounter people in urgent need of admission, that occurs just as it would if someone had any other serious, potentially life-threatening condition? I struggle to read section 140 without thinking about these implications: I know the section does not overtly oblige hospitals specified to receive patients where they have good reasons for needing to resist an admission because of the pressure they are under. But this, for me, is where the intentions come in to it – presumably, Parliament are asking CCGs to *ensure* that there are contingencies available to ensure that at least one of those hospitals is in with a fighting chance of *actually receiving the person* for urgent care. Whether CCGs commission things in such a way as to ensure hospitals run, as the Royal College of Psychiatrists recommends, at 85% capacity; or whether there are other mechanisms provided for around an increased availability of staff and space, to be triggered by managers in relevant situations – either way, it would amount to a plan.

The conversation inevitably comes back to money: the NHS mental health system is under pressure and NHS commissioners can't afford to do anything other than cut, the argument goes. But only yesterday we saw that NHS managers at national level have taken choices to use money ring-

fenced for mental health in order to clear the deficits of acute trusts. There are choices being made here. I remember reading the legal documents for the *MS v UK* case which related to a challenge against the NHS in Birmingham over protracted detention in custody. The lawyers representing the applicant, in their submission to the European Court mentioned a case from Ukraine, which I'll be damned if I can name or find when searching for it! – I will update this page if my queries bring it to light. But the case essentially said that no state can defend a violation of the ECHR by claiming 'economic necessity': you **can't** argue, "we can't afford to it in any other way" if your approach amounts to human rights violations. It's just not (legally) sufficient.

POLICE CUSTODY

These issues are *live* problems that your police service often see – it's over ten years since a police force first felt that they were in such an invidious position because of the inability of mental health services to get someone in to a bed that they referred the case voluntarily to the Independent Police Complaints Commission. The IPCC found the force and its officers *had* broken the law, but that there was just no way they could have done otherwise because the only alternative course of action they had available to them was to release the person from custody, whereby they would have failed on other obligations. It was one of the genuinely rare "damned if you do, damned if you don't" situations. Only a couple of years later, I remember a murder investigation in the West Midlands that risked going off the rails because a suspect needed to be admitted to hospital under the MHA and the argument broke out about no (secure) beds being available. As with the IPCC investigation in to GMP, it took threats of legal action by the force to eventually cause a bed to be found. More recently, we saw the case in Devon of a sixteen year old girl being detained for two days which led to a senior officer tweeting about the situation to draw attention to the problem and media reaction forced an outcome that was otherwise not likely.

Those examples all relate to police custody after arrest for an alleged offence but there have been difficulties relating to section 136 detention and admission from police custody. The *MS v UK* (2012) case involved a 72hr time limit within which to conclude arrangements for treatment but this was not adhered to, again because of arguments about accessing a bed in a secure mental health unit. In that case, the European Court ruled there had been an Article 3 violation because of the patient's "dire need" of psychiatric treatment. If we are about to see the timescale for s136 MHA assessment reduced from 72hrs to 24hrs, it seems only likely that there will be more cases in the future where we cannot arrange a patient's admission within the timescales afforded by domestic law.

I've been repeatedly asked in the last few weeks what should happen if the 24hrs limit is reached and no application has been made? – that answer is really, really easy: you have to decide whether to release a person in to the street, knowing they are so unwell they require compulsory admission to hospital; OR you unlawfully detain them pending the identification of a bed. There is no easy, ideal and lawful option available to you. You must decide between the two things, whilst escalating to senior officers and senior health managers, citing the legal problems and demanding resolution as soon as possible. But this all comes back to he question of whether section 140 means what I think it means: that CCGs and LHBs should be specifying those hospitals which have arrangements for urgent admissions AND then ensuring they are operating in such a way that if an AMHP needs to make an application for admission in a hurry, they are not prevented from doing so whilst exhaustive and protracted searches occur for beds. Whatever it is that section 140 means, the way in which it and all the other sections of the MHA are given effect, MUST then ensure that the human rights of patients are protected. No public authority may act otherwise and they cannot defend the situation by arguing that they don't really have the money to do it any differently.

APRIL 2017

8th April 2017

The Two Solutions –

No matter what you think the problem is, there are only ever two solutions in policing and mental health —

- The police need more training; AND / OR
- The police need to work in partnership with mental health services.

All the emphasis is on the police here, isn't it?! It's almost as if the only thing we need to talk about going wrong or being in need of improvement, is policing. It's a part of a subtle narrative that is far more widespread than we realise, if we actually just look for it consciously – and it works because it's highly intuitive: the police are not mental health experts and we've seen incidents where things go badly wrong when they come in to contact with vulnerable people … ergo, some expertise (achieved through training) would be good, but better still would be actual expertise (achieved through collaboration).

You can see the flaw with this, though, I'm sure – whilst the police are not perfect and no-one is pretending they are, whilst the police would undoubtedly benefit from real, good quality training on mental health (and on mental health law!); whilst the ability to call upon mental health professionals in real situations may well be of help – it's just simply not enough to explain what we know because it's not JUST the police who are cause the problems.

Let me pick you a real, high-profile example: the death in police custody of Sean Rigg.

MORE THAN MINIMALLY

Primarily cited in more recent years as evidence of need to improve things in policing, the tragic death of Sean Rigg is most usually thought of as a death in police custody – and of course it was. It's not often thought of as a case which highlights lessons for mental health services or for the training and responses of mental health professionals. This is highly curious, in my own view, because whilst the events following Sean's contact with the police bothered me enormously and raised obvious questions, I was

fundamentally at least as interested in why the Metropolitan Police needed to be called in the first place – and so was Her Majesty's Coroner. The inquest jury returned a narrative verdict which outlined two things 'more than minimally' contributing to Sean's death. Yes, one of those findings concerned the police response, their use of restraint and officers' reaction to him collapsing, but the first thing the jury highlighted was an earlier lack of care and reaction by mental health services. This included administering inadequate quantities of medication, a lack of care and crisis planning, a ten-day period in which concerns were not escalated after signs of relapse and to call a Mental Health Act assessment. Both systematic and individual problems.

Subsequent to those omissions, the Metropolitan Police were called and yes, various things went badly wrong. Some of them were systematic issues for the police as a whole, others were individual matters for the officers involved – just like those for the trust. It was one of those police encounters where you might wonder why Sean was arrested rather than being detained under the Mental Health Act and removed to hospital. Notwithstanding that point, once the police detain someone and restrain them on the ground, a certain set of considerations need to follow to ensure the welfare of any detainee who has been subjected to such a high-intensity restraint event and in no world where I work does that involve removal to police custody without reference to NHS expertise about clinical welfare. The jury found that these issues also 'more than minimally' contributed to his tragic death.

But here's the thing I can't stop wondering: had the first set of short-comings by the South London and Maudsley NHS trust simply not occurred, we have to wonder whether Sean would have encountered the Metropolitan Police at all? — so is the 'problem' we need to face *just* about police training and police collaboration? Absolutely not – it is also about how our mental health services and / or our mental health professionals operate. It is for others to get in to specifics of that but it's hardly unfair to point out this narrative when all we now hear, years later, is how this was a failure in policing that means we need far more training and more collaboration for the police. We do – but we need more than that.

POPULATION

The death of Sean Rigg was an individual incident, but it wasn't entirely isolated – I could have used any number of examples to make this point. And we can also look at certain things best viewed at the population level to make the same observation.:

We need to reduce s136 MHA, we are told – that is the publicly stated objective of many street triage schemes and indeed, most evaluations

we've seen for these initiatives have as their sole metric of interest, the impact of triage upon the use of this legal power. More than once, I've had to protest on social media about mental health trusts describing street triage as necessary to stop 'inappropriate' use of s136 MHA; and more than once, I've protested against the over-focus on s136. (Most street triage doesn't occur in the street and most of it isn't triage, so s136 is irrelevant to the majority of incidents being examined.) Again, it's the "police don't know what they're doing" narrative seeping out which is actually contradicted by data from within the NHS itself. It often suggests the opposite and it should be making us wonder about those same things raised by the London Coroner after Sean Rigg's inquest.

Within s136 data and street triage encounters from some areas, the proportion of people who are currently open to specialist mental health services in their area is a clear majority. In one example, 50% of people detained in a large city under s136 MHA were known MH trust patients in that same city and we'd have to assume that at least some of the others are known patients in adjacent areas, because c20% of detainees were people who lived outside the policing and mental health trust area where they were detained. In another example, one area was concerned at high rates of usage by the local police and kept telling me that detentions included high numbers of tourists from outside the force area who came on holiday and were inappropriately detained for drunkenness and other shenanigans. A short ramble through the management board papers on the trust website revealed an internal report on s136 which included the nugget of information that c75% of those detained by the local police were local residents AND known to mental health services.

So how wrong are they getting it, these ill-informed police officers?!

Finally, in a recent discussion with one force about their control room triage scheme, which is still quite new, they sought a couple of us from the College of Policing to do a quick and dirty review of their first internal report looking at their scheme. One statistic they uncovered was that half of all the people at the centre of the 'triage' calls were known patients with the local mental health trust and a further third of patients were recently discharged or disengaged patients with that trust. In total, as few 12% of those encountered were entirely unknown to the local trust, but who knows how many of those were patients known to surrounding areas? Now all those people in these last three paragraphs were patients who had a crisis care plan and in theory, had access to a care coordinator and / or the trust crisis team. Why was that not sufficient or why did it not work for them?

My own 20yrs of experience, police contact with known mental health patients includes a mix of things, both entirely unavoidable and completely preventable. I do wonder about how routinely forces and trusts are working together, sharing information and reviewing practice to work out how much

of each they have? – and how do they use that stuff to improve the police responses to the unavoidable stuff and to reduce the need for the police in the preventable stuff?! There is not only a risk to vulnerable people from inadequately trained police or police working in isolation; there is a risk to vulnerable people in criminalising them by over-normalising the police and this is where I think we need to look much more closely.

MISSING SOLUTION

We need to work out why so many people, with care plans and theoretical access to services are coming to police attention in ever-greater numbers – and why, the mental health system is evolving in ways which actively encourage this. Quite frankly, it often relies on it – as when it is expected the police will unlawfully hang on to people for days whilst we frantically bed manages resources to ensure admissions. We don't hear too much about the community mental health teams who say their workload has increased by 100% in 12 months; the CrisisTeams whose staffing is now 1/3rd the level it was about 10yrs ago; the fact that inpatient mental health beds have been reduced by 25% over the last few years, at a time when the number of people under the care of our mental health services is up nearly half a million patients. I could go on – abolition of early intervention psychosis services, reduction in the number of assertive outreach teams, etc., etc..

No-one doubts that the police need more training for the role they play and no-one, anywhere, is arguing that the police should play no role. However, accepting that there is a role, that we need more training to do it better, is not to agree the police should be staffing mental health units for those detained under s136 or that reaction to crisis incidents is sufficient. It is accepting things like, the need to improve the way the officers respond to and investigate allegations of crime, to ensure that victims of crime with mental health problems are not discriminated against within the criminal justice system. It is about ensuring that police expertise in criminal investigation and offender management is brought to bear on mentally unwell suspects, including through a model of liaison and diversion that actually thinks beyond health outcomes and addresses the question of when it is appropriate to prosecute a mentally disordered offender.

Policing has largely been motivated to look at mental health and improve its responses because of the legal fallout from serious untoward events. There aren't many of them that don't raise questions at least some questions about how partnership organisations operated at the point where policing went badly wrong. It's frequent quip of mine when presenting on this topic to joke that I still have just a few hours of training and that half of it was wrong. But I also remark that the other half of my training didn't work in the real world because the real world doesn't always look like the

Mental Health Act or its Code of Practice. In 2014 we published a Crisis Care Concordat and this document merely reflected a load of problems that were well-known and reflected in other reports and inquiries. Three years later, the police have completed all its actions from the national action plan – but has the NHS?!

And yet somehow it's still all about police training and police collaboration. This simply doesn't add up, does it?!

21st April 2017

Missing the Point –

Yesterday, Her Majesty's Chief Inspector of Constabulary, Sir Tom Winsor said something extremely important in his annual review, known as the "State of Policing" report. The main headline from the document was his argument that the police are now filling gaps in mental health services and that this represents a drain on resources which are being diverted from other policing responsibilities. It was his clear view that "the provision of mental healthcare has reached such a state of severity that police are often being used to fill the gaps." He makes the point that the police "have often been used as the service of last resort. In some areas, particular where people with mental health problems need urgent help, the police are increasingly being used as the service of first resort." He goes on, "We are still finding cases of mentally ill people – who have not committed any crime – spending the night in a police cell. This is because they are too vulnerable to be left alone but there is no bed for them in a healthcare facility. The provision of mental healthcare has reached such a state of severity that the police are being used to fill the gaps that other agencies cannot. This is an unacceptable drain on police resources and it is a profoundly improper way to treat vulnerable people who need care and help, not incarceration among criminals."

He makes a comparison for mental health care with the police approach to crime prevention, "It is far cheaper to prevent a crime than it is to investigate and arrest the offender after the event. The same is true of mental ill-health, which is not a crime. It is an old adage that an ounce of prevention is better than a pound of cure and this is particularly true when the cure fails and an emergency intervention is required to protect the safety of an individual in distress and, often, people nearby. By the time depression or some other mental disorder has been allowed to advance to the point that someone is contemplating suicide, or engaging in very hazardous behaviour, many opportunities to intervene will have been missed by many organisations. When that intervention takes place on a motorway bridge or railway line, or when someone is holding a weapon in a state of high distress, the expense to all concerned is far higher than it should be. The principal sufferer is the person who is ill, especially when it is realised that his or her suffering could have been much less or even avoided altogether."

I'm sorry to keep going, but his words are well worth reading, "There is the economic cost in terms of the expenditure of time and effort by the police and other public services, as well as the expense and trauma sustained by those adversely affected by the crisis at the time. The economic arguments for earlier intervention intensify the health and moral ones ready in play. Furthermore, research, carried by Ipsos MORI for HMIC, shows that only two percent of people think that the police has the greatest for responsibility for the safety of people with mental ill-health or learning difficulties. With an estimate one in ten young people having a mental health problem, this is not a matter for the police alone. The inadequacy of mental health provision and the lack of parity with physical health provision in this country should disturb everyone. It should never be the case that someone who requires treatment, for any condition, should become the responsibility of the police simply because other agencies do not have the resources to act."

FIFTEEN YEARS

I did not know this report was coming out until it was published and I started to receive media enquiries about whether the College of Policing would allow me to be interviewed (listen from 19:55). Having downloaded the report, abandoned a colleague I was having lunch with to read it on a Tube on the way to a BBC studio, I couldn't help but smile and shout "Yes!" to myself as I travelled down the Victoria Line in London. After tweeting the report, my reaction was to add, "I've been saying this for fifteen years – glad to see everyone's catching up!" And this links to the way I've been recently summarising where we are with things now. We can talk all day and night about various things that have gone wrong in policing and mental health, up to and including controversial deaths in custody following restraint. When we do, we tend to find people saying "the police need more mental health training" and "the police need to work in real time collaboration with mental health services".

Well, Sir Tom's intervention doesn't address either of those things, specifically – it goes far more directly to the real heart of the problem, to his credit: a problem I've flagged for many years now. Neither intervention even begins to address *why* we now rely so heavily on the police as part of our model of healthcare – what is driving people towards the police in the first place?! Professor Louis Appleby (former government tsar on mental health and criminal justice) was quite quick to dismiss the HMCIC's assessment, tweeting –

Again, this misses the point being made. Positive collaboration isn't addressing the reason *why* the police are being called in the first place and evaluations on these collaborations are known to be poor so we don't know whether it's decreasing police contact for vulnerable people, regardless of whether it's improving it. Helping the police respond better is the second of the two solutions and it's not necessarily *preventing* the deployment. Some so-called 'street triage' schemes will claim that they have identified calls coming in which don't need the police and the triage nurses have handled callers directly, without officers deploying. But we also know that some healthcare professionals have started diverting more demand to policing because "the police have nurses now!" and the triage nurses have complained like hell but be unable to avoid deploying to situations police officers aren't required at. I've seen that with my own eyes several times whilst shadowing.

And no, we don't have data – those who designed these things didn't appreciate the need for it. They were told, but they didn't listen. Can only say that I tried! … the blog posts are there to prove it!

ACADEMIC EVALUATION

We're simply not sure whether demand because of triage is rising or falling, because it's not being evaluated properly and in fairness to Mr Winsor, it's not HMIC's job to do research! — whereas it is Professor Appleby's. Research funding for policing and mental health projects seems to be hard to come by. Professor John Baker mentioned on Twitter recently that his attempt to secure funding hadn't been successful but that he'd be interested in doing it. I'm aware of two other academic bids for funding to take a more thorough and critical look at these collaborations which have been turned down by health funding agencies. What more can you do that try?! It's not HMIC's fault that 'positive collaborations' are collecting very limited data sets, that academics are choosing not to really look at this stuff and that research funding bodies are turning down applications. Until then, you might just have to make do with people blogging, and offering their opinions.

Of course, HMCIC's views are not just opinions – this is the professional judgement of Her Majesty's appointed adjudicator: he has a formal position in our society and a statutory duty to call it as he sees it, even if there are some remaining questions of detail. I hope his intervention prompts research to prove him right or wrong, then at least we'll know, won't we?! But however, you look at it, Sir Tom's views will no doubt be predicated on impressive quantities of information and opinion that HMIC collect from forces in their various routine inspections around custody and around general effectiveness, amongst others. The CQC are involved in advising on some of those inspections because of the obvious overlap with health issues in custody and CQC is an organisation on whose board Professor Appleby sits and for the record, their opinions and reports don't always survive contact with reality, either! … but I can't just dismiss the statutory regulator for healthcare and the Mental Health Act out of hand, can I?!

Meanwhile, my good friend Nathan Constable has blogged very well and very quickly on this new report. I'd encourage you to read his views. He's also busy working his way through a Master's degree looking more deeply at the issues around the role of the police and his early work has uncovered much that supports HMIC's position: that mental health professionals thirty odd years ago could see where community care was going, where the use of s136 MHA was going (up) and where the role of the police was going. You only have to look at other countries with non-public healthcare systems to see how the criminal justice agencies end up playing a massive role, because there are inadequate social justice mechanisms to stop it from

becoming necessary. If some people have a problem with uneducated police officers with 4hrs of training trying to fathom out what the hell is going on and making some kind of in-roads in to handling the rapidly increasing demand faced by British policing, they should feel free to step up: do some quality research that I can't climb through and I'll stop blogging and go an arrest someone for something. Until then, it seems a valid use of police time to try and understand how we address some of these issues, firstly and foremostly by actually understanding them and then do what the police are charged with as their primary duty: prevention.

25th April 2017

Medicalising and Criminalising –

So, we're still discussing the fallout of Sir Tom Winsor's comments almost one week after they were made. A few of us have blogged our thoughts on this and many of you have commented on those posts and social media more generally. We all share a view that there is a problem, but I'm not sure we share what it is, never mind a shared sense of what we should do about it. Some people have spent the week arguing that we are criminalising mental health and mental illness by relying upon the police to the extent that we do, but what I think has been interesting this week is the number of representations that we've got this the wrong way 'round: we're not criminalising illness, we're medicalising human behaviours.

Look at the literature on this stuff and you'll see both positions well represented. The US academic Professor Linda Teplin did a lot of work in the 90s arguing about criminalisation; another US professor, Allan Horwitz wrote a book called 'creating mental illness' which argued we over-medicalise behaviour. Australian academic Deidre Grieg devoted a whole book to the discussion of one man and his journey through the mental health–criminal justice interface: Garry David from Melbourne ended up having a whole Act of Parliament targeted at him and him alone, given that politicians were unable reconcile the public safety issues that arose from their perception that neither system was able to keep citizens safe from obvious risks. Less academically, we see a public narrative about the relationship between mental health and crime that seems all too often to assume that if someone with a mental health problem has offended, they must have offended *because* they have a mental health problem.

Then we need to remember we're not always discussing things fully: acuity of someone's condition is rarely discussed – not everyone who is mentally ill is psychotic and unable to lead a full and meaningful life full of employment, family and personal responsibility. But a few are. When you compare a range of issues for those who are often unable to function because of serious mental illness you see differences in approach by mental health services and by the police and prisons, compared to where we see the police called to a person with a non-acute illness that neither affects their personal responsibility for actions undertaken or means they should necessarily be treated any differently by the police.

CRIMINALISATION

This word is used in a couple of different ways, so as ever, we need to be careful with this kind of terminology – apart from anything else, some people just don't like it. I've been told to remove this word from reports I've written on a couple of occasions, because it's a bit opaque unless you spend time explaining it. Do we mean a) whether a person's attempts to secure care occurred via the police or criminal justice system when they were prevented from just accessing it directly? Or do we mean b) the extent to which the police and criminal justice agencies take different types of decisions when in contact with someone who is thought to have a mental health condition than they otherwise would – and of course this could be to a greater or to a lesser extent than they otherwise would.

It's certainly true to argue that we have some set-ups which now mean patients and mental health professionals think it's easier to access care via the police than otherwise. Street Triage schemes have often reported that they feel other parts of the health system, from GPs to Community and Crisis Teams, are occasionally pushing demand towards the police for someone who is not what you might think of as someone needing policing services. This 'normalises' the involvement of the police in healthcare, about which many patients have things to say, if you ask them!

However, if you have a situation in which 100 people are alleged to have committed an offence, you'll see the range of responses from the police from arrest, to warnings to cautions or criminal charges, as though appropriate. However, if those situations involved individuals suspected to be mentally ill, we are less likely to see arrest and / or prosecution outcomes because of diversion or referral to health services. Does this mean we ARE criminalising illness because care access was via the police or NOT criminalising because the officers took punitive CJ decisions less often? Depends on your politics (small p).

MEDICALISATION

The other perspective is to look at whether we're medicalising behaviour. I will admit, I'm less aware of any research that has been done on this issue so if anyone reading this knows of any, please leave a comment below and let me know. But yet again, this could mean one of a couple of things. Are we a) arguing that there may only be a limited and indirect relationship between behaviour and the panoply of health conditions which can be aggravated by social factors, but that social, non-punitive responses can be better than traditional criminalisation and punishment-rehabilitation? Or are we b) assuming a causal relationship between

someone's condition and their behaviour and arguing that if you address the underlying condition, you affect future behaviour – there is some evidence that this is true, however, certainly not for all types of mental health condition, all of the time.

Human beings will suffer very bad events in their lives which are entirely predictable and awful: bereavement is one that will affect most of us at some stage. Other people suffer from traumatic accidents and injuries, redundancy, abuse or divorce to list just some examples. All of us will struggle to some degree to cope with such matters when they happen, but this does not automatically mean they are ill. A few of us may need additional, sometimes professional support to handle our live experiences and some may become ill, usually for more than one reason as people are complicated things. But the difficult issue is where you draw the line between looking at someone's behaviour and choosing whether to see it as 'crime' or 'illness'. Indeed, there may be a need to see it simultaneously as both: the dichotomy between 'mad' and 'bad' is false one, both medically AND criminally! But however interesting this is, however philosophical you want to get about it and however much academics have written, if you're a front line police officer and you're going to have 43 seconds to take a decision as profound as this, we may have to accept here people are going to get it 'wrong' from at least some people's subjective perspective.

THE 9 AM JURY

It's quite easy to walk in as the morning hindsight squad and have a view about what some frontline cop should have done last night, in the dark, but always fascinating when you ask people to put themselves in the officers position. What the reaction this week has shown me, categorically and beyond doubt, is that there are a wide range of passionately held, solid views that officers are over-medicalising behaviour AND that they are over-criminalising the vulnerable; AND they are making these calls in situations most of us aren't prepared to place ourselves. The person in the high street who is waving a knife around, you have a minute to think about it: should they be arrested for possession of the knife or detained under the Mental Health Act. No, you can't have any more information, you have to decide and you have thirty seconds left. Have you decided yet? … not easy, is it?!

In other words, this touches upon my very favourite question in all of policing and mental health and the very thing that could be profoundly interested in this stuff when I was custody sergeant fifteen years ago: when is it "right" to prosecute someone for a criminal offence if we know they have a mental health problem? The public policy answer (in Home Office circulars 66/90 and 12/95 as well as the DPP's Code for Crown Prosecutors) is "the more serious the offence, the less relevant a person's mental health issues are to the police / CPS decision to prosecute." This is my attempt to

summarise pages and pages of stuff in to one sentence, so please forgive the deliberate over-simplification! Where someone is stealing food whilst psychotically unwell and living rough in crisis, we probably don't want them prosecuted for being hungry and very poorly. However, if they stabbed a supermarket security guard whilst doing so, it becomes a different assessment to make. If that assessment were influenced by a history of non-engagement with mental health services, absconding from hospital and / or a background which showed they posed a serious risk to the public as a whole, it becomes easier still to start taking these decisions. But make that a less serious but non-trivial offence, mix in social distress and substance use? How easy is it now?! … you have thirty seconds to decide.

Remember, only the criminal courts can issue certain kinds of protective orders under our mental health legislation which balance an individual's right to treatment with the need to protect the public, where necessary – that's true in most jurisdictions around the world. But given how far apart the views were this week – we need decide what we want our police to do and back them because whatever they get right or wrong, I know this: frontline officers only have blunt tools to take decisions that require sophistication and finesse. Have you ever tried playing a musical instrument gloves?

MAY 2017

9th May 2017

Surviving or Thriving? –

I've been trying to think about the question posed by the Mental Health Foundation for this year's mental health awareness week in the context of policing and our involvement in responding to mental health related demand: surviving or thriving?

I'm all too aware of comments realised in recent weeks by frontline officers on social media that demands and responsibility connected to mental health are rising and it's getting harder and harder to manage this demand across response and neighbourhood teams which are under pressure around how they spend their time. We have also seen senior figures like Sir Tom Winsor, HM Chief Inspector of Constabulary, voicing concern about the extent and the nature of the role the police are now playing in our wider mental health system and the effect this is having on frontline policing. I can't be the only police duty inspector who has stood in the middle of the night making the decision to order two police officers out of a Place of Safety where NHS staff had asked them to stay because it was the lesser of the various things I must police and for which I did not have enough resources because of a quick succession of serious crimes.

Are things not just getting worse?

Indeed, if you look, you will find plenty of information which can help you build an argument that the police are, at best, surviving – and I'm sure some police officers would add "and only just". You could point to the rise in our use of s136 of the Mental Health Act, it's up 10,000 in 10yrs since 2007, which means more officer hours spend removing people to various settings and often, remaining there with them for many hours until assessments can take place. We could add that mental health professionals are struggling sometimes to arrange assessments in a timely fashion – national guidelines state s136 assessments should occur within three hours and we know it's often double that and more. We have heard in the media recently that police coding of mental health incidents shows we have experienced a rise of around 26% in three years in the overall number of incidents which are classified as mental health related.

In his 'State of Policing' report, HM Chief Inspector of Constabulary reported that the police are all too often a first-resort contingency plan for our mental health system and that the extent of this problem is forcing Chief

Constables and duty inspectors to make frequent decisions about what they will prioritise; and how. Only over the weekend, a mother who lost her son in one of London's latest knife-attacks has stated that the police are not doing enough on knife crime. We could do more about knife crime and various other things if officers weren't remaining in health-based Places of Safety routinely, because NHS commissioning decisions have ensured the facility they opened for assessment wasn't fully staffed. You can only spend your pound or your police officer, once.

Could we look at this another way?

Since that report in 2007 on police use of s136, the proportion of people detained under s136 taken to police custody as a Place of Safety has massively reduced: from 66% in 2007 to 7.5% in 2016. That's a drop in numbers from 12,000 a year to jail for being ill down the just 2,100 – I strongly anticipate this figure will reduce again when the next figures are published in a few months. I was beyond chuffed to learn, for example, that my own force in the West Midlands has had the first ever year where no-one was taken to police custody as a Place of Safety, thus demonstrating a total turnaround in the position from ten years ago where everyone went to jail.

I also get a sense that we know more about this stuff now: we find examples of police officers delivering training about policing and mental health to mental health professionals, not just the other way 'round. We see that partnership relationships on mental health have improved beyond measure: not just around the development of initiatives like street triage, although they are very positive examples of innovation in many cases, notwithstanding the longer-term questions. In the West Midlands, a senior police officer is seconded to the Mental Health Commission chaired by Norman Lamb MP as part of the overall revision and delivery of a wide-range of mental health services, not just those connected to policing or criminal justice. And although, I'm nervous about offering this next view, I'm starting to wonder whether we're seeing a reduction in either the number or the controversy of some policing and mental health incidents. In the last IPCC report, the only s136 related 'death in custody' was, in fact, a death which occurred in a health setting after the police involvement in the s136 process had ended.

Should we look at this more positively?

Mental health demand isn't going to go away: the police service have been credited by many senior figures in mental health and in politics for driving the mental health agenda to a degree: it was a police officer, Commander Christine Jones QPM, who caused the creation of the Crisis Care Concordat. It was the police who drove the reduction in the use of police cells as a Place of Safety and convinced the Home Secretary that wicked problems

could be solved, something which has since become enshrined in law. It was police forces who sought out the opportunity to create street triage schemes in many of the areas we see them and in many instances, it is 'the police' via Police and Crime Commissioners who are directly paying for that, not our NHS. It is the police service which came out better in the eyes of the public, better than many NHS organisations, for the positive impact of our attitude and response when dealing with mental health crisis incidents. We're not perfect, but we're more often valued by the people who call us for help.

So it all comes back to your perspective: we know the police have a role to play in our mental health system – we always have had and always will do because not everything is predictable or preventable. Of course, there needs to be limits on the extent of the role – we don't want police officers on mental health wards handing out medication – but we need to understand and accept that we have a perspective on mental health issues in society that even some mental health providers don't have and a key role to play in tough decisions about criminal justice issues. We are positioned to drive the agenda to a degree and are doing so. Indeed, history shows that if we don't, we will be pushed in directions that are neither in the interests of police services nor the public we are here to serve. It also shows that if we are active in this arena, we can and will impact upon it.

In that sense, despite demand rising and things getting tougher, is this not a form of thriving we can be proud of? I think it is.

10th May 2017

Seni Lewis –

The Metropolitan Police and the South London and Maudsley NHS Foundation Trust were subject to a damning verdict in the south London Coroner's court earlier today – each of them facing criticism for contributing to the death of a vulnerable man. The death of Olaseni Lewis in September 2010 is one the most sensitive, controversial and difficult of all the death in police custody cases I've known connected to mental health issues. I had the opportunity to hear Mrs Lewis speaking in Brixton last year about her family's ongoing ordeal: it was nothing short of absolutely heartbreaking to listen to the experience of someone who'd already waited six years to learn how her son died, and to hear firsthand how the post-incident system had exacerbated the distress of what must have already been a devastating incident.

Various resources relevant to this post –

- The Record of Inquest – a narrative verdict, which explains what occurred and how Seni Lewis died.
- Press release from Inquest, the charity who have supported the Lewis family since 2010.
- Press release from the Metropolitan Police.
- Press release from the South London and Maudsley NHS Foundation Trust.
- Channel Four coverage of the case, including a 5 minute video with interviews.
- The Guardian's coverage.
- The Independent's coverage.

BACKGROUND

Seni, as he was known, was detained by the Metropolitan Police under s136 of the MHA and removed to a Place of Safety for assessment. After absconding from the unit, he was located and returned before being admitted on a voluntary basis to the Bethlam Hospital in south London, part of the South London and Maudsley trust. Following a disturbance on the ward which involved him trying to leave and damaging a door in the unit, the police were called. As officers were seeking a briefing about what was

going on and what they were being asked to do, a nurse beckoned them on the ward itself because things were becoming very difficult. Seni was restrained in handcuffs by the police and staff asked the officers to remove him to a seclusion room within the same hospital. The officers engaged in a 10 minute restraint as they placed him in to the room. After failing to close the door properly, it was thought necessary to re-take control of him using restraint and attempt against to place him within the seclusion facility, this time involving a 20 minute restraint which involved officers striking him using a police baton and other mechanical restraints. He collapsed under the strain of all of this and a DR examined him, finding a very slow heart rate. Little was done at that stage and when Seni fully collapsed, there was an inadequate response with failures in first-aid and CPR.

This is all reflected in the narrative verdict published today.

THE VERDICT

The jury stated that five things had a cumulative effect in creating conditions in which police restraint of a patient on a mental health ward would be thought necessary:

1. The admission process was substandard: lacking a full Doctor's assessment, adequate risk assessment and the influence of family members to help.
2. Ineffective use of medication to treat escalating agitation.
3. The NHS trust failed to meet their own target for trained mental health staff to adequately ensure care.
4. A lack of communication throughout between the police and the medical staff contributed to inadequate responses to Seni's medical needs.
5. A lack of trained and physically able staff to move Seni from the ward to a seclusion room, which led to them asking the police to do this, having already used handcuffs.

"These five cumulative factors led directly to the police restraints within the seclusion room."

Five issues: all of them omissions, conscious or otherwise, on the part of an NHS Trust, indirectly creating conditions within which calls for police support / restraint become more likely than they would otherwise have been. This is *exactly* what the 2017 Memorandum of Understanding (MoU) on police restraint in mental health settings was designed to address. If you are an operational police officer, please read this document from *cover to cover*, ***twice***.

The narrative verdict lists three things which, on the balance of probabilities, contributed to Seni's death at the hospital.

1. The two periods of restraint were each described as 'prolonged', the first being 'unnecessary and unreasonable due to the length of time Mr Lewis was in a prone position. The second restraint involved 'excessive force, pain compliance techniques and multiple mechanical restraints' which were 'disproportionate and unreasonable'.
2. During the second period of restraint, a doctor examined Seni after he became unresponsive and recorded a pulse of 45-50 beats per minute but failed to respond to this medical emergency.
3. The police failed to follow their training, which requires them to place an unresponsive person into the recovery position and, if necessary, administered basic life support.

WHAT DOES THIS ALL MEAN?

This means, that police officers can be drawn in to situations in NHS trusts where factors way beyond the officers' control, influenced by decisions taken hours and even days before by healthcare managers, may create conditions in which nursing and / or medical staff want the police to do things they should be extremely careful about doing, if they agree at all. I'm afraid to say this, but in the real world I police and given what we know about the accountability mechanisms and how they work, officers need to realise they are NOT there just to do as they're told or to agree to everything that's asked of them. It could be OK – in fact, it could be critically necessary – to say 'No!' and do something else, whilst escalating to the duty inspector to take control of the wider issues. I also accept this can create conflict with mental health staff on wards and I regret that, but only to a degree: conflict is not always a bad thing – it forces greater consideration of intuitive ideas and a counter-intuitive truth is a truth nonetheless.

The verdict tells us, in this case as in others, a failure to communicate throughout the incident created the problems which contributed to a death. The 2017 MoU tells us, the police should remain as uninvolved as possible until we're clear what's being asked or attempted. In Seni's case, agitated behaviour led to him damage a door on the unit. We can all agree, I'm sure: that's nothing worth risking his life over because we can always repair or replace a door. What prevents officers containing a situation, preventing a patient from approaching others or damaging things further but leaving them more-or-less untouched? This could involve something like a small, moving cordon on the ward whilst we think about how best to achieve the objective. Of course, professionals make the point that no-one thought life was being placed at risk: but *no period* of high-intensity or prolonged restraint is inherently safe.

Any period of prone restraint is inherently unsafe – and it's less safe the longer it goes on. This is all the more precarious when we refer to those of us with mental health issues.

OTHER IDEAS

This is more than hypothetical – but I want to stress ahead of the example that follows: all situations turn on their individual circumstances and involve subjective judgements. What follows doesn't imply it could have 'worked' in any other situation. It's offered only in the hope that nurses and police officers may take just a second or two, if at all possible, to think whether it offers ideas that may help.

Some years ago I attended a medium secure mental health unit to a similar report of a disturbance. We also met a large, physically strong man at 5am who had, apparently, "smashed up the ward" when they were understaffed. We were being asked to move him to a seclusion room … does this sound familiar? Of course, all circumstances are different and officers vary in their judgement of what's needed but more than once in such cases, we've been able to put a few officers between the patient and the other people present and then just allow time in which he can see the officers are not going to use a high-intensity restraint. We tried to strike up a conversation, in fairness to a bloody cheeky PC on my response team, they somehow managed to get jokes going at my expense about how the boss is bald(!) … the patient laughed for the first time. He then joked at my expense and we laughed again. We spent about 20 minutes moving in a small area of the ward corridor and didn't touch him during that period whilst nurses made various arrangements, moving other patients and so on. In fairness, I did touch the mental health nurse who entered the 'cordon', walking in to the patients personal space and shouting at him(!), because that really wasn't helping.

At the end of building a some degree rapport based on giving him time and space to be safely in distress and for the situation to defuse, he moved to a seclusion room without being touched or even 'ordered' to do so. Ultimately, some patient discussion by officers caused him to agree to receive medication and no-one was restrained. The only adverse outcome was for the cheeky PC had to get himself back to the nick sharpish to have coffee on my desk by the time we'd returned – but he's one of those cops who can influence others, he knows how to influence with words. He did his job well. For the record: this doesn't always work despite best efforts and my telling this tale is about suggesting there are other ways which are far less controversial to *contain, not restrain*. Worst case scenario, it doesn't work – but by that time, the bosses should be involved.

WHAT HAPPENS NOW?

It seems highly likely the Coroner in this case will issue a Regulation 28, Preventing Future Deaths notice which normally comes out a short while after the announcement of a verdict and is normally uploaded to the website of the Chief Coroner. We will have to wait to see what that says, but it seems it will have implications beyond London, because other forces have experience of being called in to mental health units in similar circumstances. Of course, both South London and Maudsley NHS Trust and the Metropolitan Police made reference in their press responses to the Memorandum of Understanding between five major national bodies, which I was involved in drawing together over the last two years. It's fair to say some officers on social media, want to know what they are expected to do if called in similar circumstances. Some officers are still of the view that there should never be a role for the police on mental health wards and that NHS organisations need to ensure staffing, training and so on which ensure the capacity, capability and training to handle incidents.

There will be more to say on this case in due course, once we see the PFD report but in the meanwhile, I encourage all operational police officers to read the MoU mentioned above, ***twice***. Your role on mental health wards is finite and limited – and it does NOT extend to doing everything you're asked to do by others, just because they are struggling. Doing 'something' might be the worst thing you could do; doing 'nothing' can often be best, containing a situation from getting worse, whilst pausing to escalate to some very senior people, getting them out of bed, if we need to do so. And if operational police officers do have concerns about the background conditions in any healthcare facilities creating conditions around this sort of thing, the MoU makes it absolutely explicit that things should be escalated and reviewed.

The worst news for Mrs Lewis and her family, is that this is far from over. They have called for the CPS to review the decision not to bring criminal charges against the officers involved, the IPCC have directed Gross Misconduct and Misconduct hearings against the officers involved, there is an outstanding Health and Safety Executive investigation in to the South London and Maudsley NHS Trust and the potential for civil or human rights challenges to be brought, if thought necessary. Based on history, it could be several years yet before those processes conclude and when you remember that we're almost seven years beyond Seni's death, you can't help but wonder why things have to take this long.

16th May 2017

Dear #RCN17 –

Earlier today, the Royal College Nursing voted at their National Congress in Liverpool "to lobby to ensure that Emergency Departments are no longer designated places of safety for the purposes of mental health legislation". So, I'll cut straight to the chase: that's not a really thing – in the sense that the word 'designated' does not appear in the Mental Health Act, and only appears four times in the whole Code of Practice to the MHA, never in relation to sections 135 and 136 which relate to police powers and places of safety. It's just not a thing around which to have a meaningful debate because, as a police officer, I simply don't need to care whether somewhere is designated or not. Those who urgently need ED care because of the nature of their medical needs are going to go there under s135/6 regardless of designation; and those who are detained and don't require ED in the strict medical sense but where no alternatives exist, may also end up there, especially after the Policing and Crime Act amends the Mental Health Act later in the year. If nurses, doctors or the NHS wants it otherwise, they are at liberty to commission sufficient capacity elsewhere to give real options in the real world and work with their police services to ensure use of section 136 is appropriate.

So, for the record: none of what I've written here means there isn't still work to do by police forces on how individual officers take their decisions about what is the 'right' thing do, where more than one option exists.

Whether or not a place is 'designated' or 'identified' in a local protocol relating to section 135/6 doesn't prevent decisions being taken about attempting to rely on a particular location, because at the time, in the particular circumstances, it appears the best way to proceed. Indeed, the whole point behind the 2017 amendments to the MHA, which will come in to effect soon, is to get beyond rigid determinations by managers in offices via protocols about which location or kind of location should be used and on which occasion. In my career, I've frequently exercised my legal right as a police officer to determine the place we will seek help for someone who is detained by officers because they are thought to be unwell – and this does include asking ED departments to support someone where the only alternative was police custody. If someone actually needs a MH unit place of safety that doesn't exist or is unavailable / unwilling to offer support, should that person be in ED or custody? They don't need ED, strictly speaking, but is ED the least worst option of the two? Who knows!

– it probably depends whether you're asking a police custody sergeant or a ED nurse or doctor, or the person who needs help. What I know is, I'm quite happy to take time to see if we can keep octogenarian dementia patients out of the cells by improvising and I see no legal barrier to ED choosing to help. Indeed, history shows they probably will. Less likely that they will if the person detained is a 26yr old bipolar patient, but that may just be my experience.

CASE STUDY

About a decade ago, one interesting case involved my officers being asked to locate a lady who had run from a maternity unit whilst mentally unwell, very shortly after giving birth. Officers found her and shared the concerns for her welfare expressed by nursing staff at the hospital but she refused all attempts to help her to be safe. They ended up detaining her under s136 and removing her back to the maternity unit. Was this 'designated'? … should the RCN have a discussion about the appropriateness of using maternity units because, on of the face of such an idea, it sounds quite ridiculous? Of course, the action taken was to use that hospital as a Place of Safety and arrange assessment there because it represented the best decision in those circumstances – designation didn't come in to it because it is lawful for a police officer to remove a person to the location that they think is the appropriate choice in the circumstances and ask that location to provide help and care. Whether that location chooses to agree to that request, is absolutely a matter for them but that decision will subsequently be seen in its context: if the officer at that time, for that patient, in that place had no other alternative or if they or anything else supporting or advising them thinks it is the 'right' thing to do, ED or whoever sought out remain accountable for any decision to help or turn the person away. Sometimes, it may be quite right to turn people away – just remember, the custody officer at the police station retains that right, too!

Difficulties ED's and / or the RCN have with the implications of NHS commissioning are things that could and should be raised with NHS commissioning managers, some of whose have been decommissioning MH unit Places of Safety over the last year or two. What #RCN17 seem to be trying to raise, is the lack of alternative options for police officers to support someone outside the ED setting. Their debate, reflected on social media, seemed to broaden out to other issues that were not about the operation of these powers under the MHA.

These points are important to bear in mind –

- Most people who are legally detained by the police are not detained under s136, but arrested following crisis incidents which mostly occur in private premises.

- The whole 'place of safety' and 'designation' debate is irrelevant to them, given that they are being detained under the MHA.
- Most people who attend Emergency Departments are not taken there by the police: they either self-present at ED or are taken there by family, friends or other agencies like the ambulance service.
- This debate will not touch that cohort of people because the ED's status as a 'Place of Safety' or otherwise is irrelevant to anyone who is not detained under the Mental Health Act by the police.
- You cannot get away from the fact that ED is a part of a hospital and hospitals are Places of Safety, designated or otherwise, under the Mental Health Act.

THE REAL PROBLEM

I can agree with what (I think) RCN are getting at here: they seem to be wanting sufficient health-based Places of Safety that are not in ED settings, but which are either adjacent to them, run by the mental health trust, OR which are located in mental health trust premises. Fine – why not just say so?! Focusing the debate on the legally illiterate point about designation (which, I can only remind you, isn't a legal thing but a proxy term for internal NHS arguments about inadequate commissioning!) is a way of indirectly focusing frustration on perhaps the most vulnerable group of all: those of us who are so unwell that an uniformed police officer has taken our liberty away because we seem to lack agency to make safe decisions for ourselves.

So, the RCN weren't discussing mental health in ED, or even mental health more broadly: any attempt to debate or change issues around designation is purely an attempt to discriminate between those who are in police custody under the MHA, and those who are detained for other legal reasons, and those who are not detained at all. Bearing in mind the point above: most people with mental health issues detained by the police are not detained under the MHA; most people with MH problems in ED are not detained by the police. This debate is targeting a very narrow group of people who are already stigmatised by virtue of their legal circumstances.

For the record: no-one is saying ED is a good option for those of us who are mentally ill or in distress, or therefore saying that those of us with mentally health issues who are detained by the police under s136. But whether you're 'designated' or 'not designated' locally will make not the slightly bit of difference to whether or not the CCG or LHB commissioners are going to ensure adequate alternatives for those patients who do not, per se, require what we traditionally think of as ED care – the broken bones, lacerations, head injuries, chest pains, breathing problems, overdose

attempts, etc. Under the laws coming through in just a matter of months, if I detain a 17yr old under the MHA and there is no locally identified pathway, I'll be heading your way to ED – designated or not, and not withstanding whether there is a 'need' for ED care. Likewise if I detain an 86yr old dementia patient when the local PoS facility is full. To do so may be the only lawful option I have available to me – to a location which is recognised by law as Place of Safety under the MHA, which is defined in s135(6) without reference to the use of the word 'designated' or to what a local protocol may say.

There is absolutely no legal obligation on any organisation to provide a Place of Safety – let's just have a think about that. And whilst we do, remember that debates caused by component parts of 'the system' pushing against each other cause those of us with mental health problems to think they're just not welcome in ED – something reflected in the CQC inspection on crisis care pathways last year – and I'm worried that nursing has reinforced this perception by supporting this motion without properly defining the problem they are actually trying to fix. Many service users have contacted me on social media today to say this is precisely what they've been made to feel – and perception is reality for people.

24th May 2017

Fifteen Minutes –

This is a written version of a talk I gave last night, where I had fifteen minutes to summarise my thoughts on the overall topic of policing and mental health. It's a while since I had such a short period in which to condense my thoughts and it was a useful exercise in rooting out the extraneous junk from my mind!

Michael./

If you look around the world at adverse incidents that cause us to discuss the police roll in mental health issues, you see a range of problems:

- The extent to which the police are relied upon as first- responders
- Problems in the use of force:
- Restraint related deaths
- Fatal police shootings
- Controversial use of things like Taser
- Normalisation of the police as a *de facto* crisis service
- Criminalisation of vulnerable people:
- Prosecution almost entirely for the purposes of accessing clinical services
- Incarceration in prison where upstream interventions would have prevented the need.

From that lot and much more besides, you can start to form your own view about whatever it is that you think the fundamental problem might be. Whatever conclusion you come up with, you will find that there are only ever two real kinds of response to that problem, if people have bothered to define it all –

1. The police need more training: mental health awareness, de-escalation and legal education.
2. The police need to work in closer collaboration, preferably in real-time, with experts from mental health services.

Do you spot the problem with this? – there is a fundamental difficulty at the heart of how we understand the problem and how we design solutions in response to it. The police are not *all* of the problem here – so they cannot be *all* of the solution.

REPORTS AND MORE REPORTS

Look at the Adebowale Report (2013), the Crisis Care Concordat (2014), the Home Affairs Committee report (2015) on policing and mental health – they ALL began as conversations and pieces of work to examine what is going wrong in policing and mental health and they ALL ended up concluding that this is not *just* about policing. In fact, it's not even *mostly* about policing! Lord Adebowale was asked by the (then) Metropolitan Police Commissioner to report on what the Met needed to do to improve: twenty-eight separate recommendations, fewer than half of which were exclusively about policing. Many of the recommendations were aimed directly and solely at non-police organisations and Lord Adebowale made it crystal clear in the report that the police could not be expected to sort the problems on their own.

The Crisis Care Concordat is a national structure by which to promote cooperation between police and non-police agencies on all issues affecting 24/7 crisis care. In a national action plan containing sixty separate actions about what we must do to make the world a better place, the police are named on five of them. You could also look at the amendments to the Mental Health Act 1983 which are on hold whilst we have a General Election and will be introduced later in the year: all of the amendments bar one is legislating to push for what some areas have been able to do for many years now, with the pressure falling mainly on non-police agencies to improve access to services, provide alternatives to detention, undertake both assessment and admission much faster than we currently see. The Home Affairs Committee report made very few police-specific recommendations in the twenty-nine observations made: they were mostly concerned with the lack of commissioning and provision which made police responses necessary.

These reports are more besides make it clear that we have problems in NHS commissioning, provision and education, this is not just about poor, untrained and ignorant police officers making poor decisions because, bless them, they don't really understand these matters. Actually, there are plenty of mental health professionals around who argue without being prompted by me or anyone else, that officers are usually not bad at all at spotting that "something's not quite right here." Of course there are issues with mental health presentations that are sometimes less obvious or where mental health problems co-represent with other issues from substance

abuse to comorbid physical illness, but then that's also a problem on occasion for Doctors so what standard are we holding the police to here?

FIX THE PROBLEM

Many will and do make the political (small p) point that the expanding role of the police is inevitable around mental health: they argue that cuts and politics (large p) mean that all that can be done is being done and if that's not enough it's because of under-investment in mental health. No-one anywhere, is arguing that politics (small or large P) is irrelevant: but the narrative that it's all about the politics of things just doesn't fit the history we've seen or the facts available to us now.

The real problem here is: we haven't defined the actual problem … we're still in the "Do Something!" phase of developing our police responses and as long as we keep thinking it's just about police training or police partnerships, we'll keep missing that 2/3rds of stuff from those reports which tell us it's much more complicated and that actually, on occasion, it's the health service taking its own decisions about the services it provides which is important. No amount of training for front line officers or those like me who work around policies and partnerships is going to ensure that a CCG complies with s140 of the Mental Health Act – it wouldn't cost CCGs *anything* to start doing so, but they'd need to be aware of the provision first! I can't ensure before every 999 is made to the police about difficulties on mental health wards that they are adequately staffed so that response police don't walk in to 'Seni Lewis' style vacuum against which backdrop they are then being asked to undertake various tasks they are inappropriate for police officers. No Chief Constable can *make* an NHS provider have a Crisis Team that is equipped to operate beyond the telephone or to stop them from reducing the size of that crisis or community team because of the apparent 'success' of their street triage scheme. All of these things (and much more besides) are, ultimately, a matter for the NHS to determine.

So one of the problems in policing is how to prepare officers so they don't become too far involved in things after inappropriate requests to plug gaps. In a recent example, "Inspector, can you transport this distressed and agitated patient who requires a psychiatric intensive care unit 300 miles away, in a police van without us being able to administer sedation that they require for the journey because of other medical reasons." Oddly enough, the answer to that will be "No!" – it's just far too bloody dangerous for a start, but it would be an entirely undefendable course of conduct if it came under scrutiny from those who hold the police to account! And, actually, the patient themselves has certain legal rights that are not protected by the police agreeing to do this … so the answer is "No!". To think any officer *would* agree to that is quite worrying but whether the officers know how to

say "No!" constructively … who knows?! The answer to that situation is not 'better partnership working', it's clear and effective commissioning by the NHS of methods of conveyance and the patient will have to remain where they are, with static police support if there's a risk, until you sort it. And if you don't sort it soon, we'll have to start speaking to lawyers to start extricating officers from a situation that is rapidly becoming illegal, if it isn't already. Sometimes the most necessary partnership is the one between the police and *the public*.

THE ROLE OF THE POLICE

I personally think the real problem IS the over-reliance upon the police and our inability so far to define the role of the police in our wider mental health system. Not all of that is about politics and / or resources: it is, as often, about the choices we make whereby legal knowledge and a greater understanding of individuals' rights are absent from our assessment of what must be done, what may be done and what might be done. That world wide experience does show, if you don't provide alternatives, the police and the criminal justice system will end up using blunt tools to fix complex health and social problems crudely. The role of the police should be –

- To remain as uninvolved in our crisis mental health system as possible, consistent with safety – this is not arguing there is no role; it is arguing against the 'normalisation' of policing in crisis mental health care. Quite frankly, many patients simply don't want the police involved in their healthcare, and it always comes at a cost of one kind or another.

- To thoroughly investigate all allegations of crime received where someone involved is vulnerable because of a mental health problem or learning disability – and to bring to justice those offenders who may have unmet health needs, but where the public interest is served by doing so, for the individuals own benefit in long-term as well as that of the public.

- To work in partnership with health, mental health and social care services, mainly in the sharing of information and joint problem solving and prevention, rather than ever-improved ways of responding to crisis that is all too often an example of merely 'doing the wrong thing righter' and the very opposite of early intervention.

We can have as many or as few alternative to policing and criminal justice as we like: we'll either pay for them directly, or through increases in the need for secure mental health care after the police inevitably find themselves having to prosecute some people for more serious offences, something which is a phenomenally expensive in each and every case

where it happens and our secure mental health system is currently more than full --- that’s the choice to be made here.

31st May 2017

Sections 23 and 25 –

Imagine you're the front line police officer called in to a mental health ward. Reports have been received from a patient's family that the patient is being held on the ward without authority and they want the police to assist in extricating the patient from their hold, alleged to be unlawful. The control room sergeant has spoken to the caller who said, "The patient is my brother, his mother is with me and she is his nearest relative. Four days ago she gave written notice under s23 of the Mental Health Act that she was ordering the discharge of her son from hospital and as the hospital authorities have not issued a barring notice within 72hrs, they are obliged to release my brother – they are refusing to do so and he's being held against his will, unlawfully."

A few questions, then! –

- Is this actually any responsibility of the police?!
- Can the man's mother actually order her son's release against the wishes of the hospital?
- What's a barring notice and how does it work?!

There are other, obvious questions, but let's start with these just for today!

Yes – this can be the role of the police to referee this sort of thing, if it really comes to it. Firstly, there are questions of law at stake and one could imagine some situations in which the active debate or dispute could give rise for the police to mediate or even prevent a breach of the peace in some situations. Also, don't forget, there is the issue of someone's liberty with an allegation here someone is being unlawfully deprived of it. We would become involved to some degree in other situations where allegations are being made of people being held by others without legal authority, so why not this? You would intervene if your police colleagues unlawfully arrested someone (or at least escalate to more senior officers), so why not if the allegation is against NHS staff? It may or may not be something to get actively involved in, but you'd at least examine it.

Yes – the man's mother *can* order his discharge from hospital, assuming that she is his Nearest Relative under the Mental Health Act. I've written about Nearest Relatives' rights before – they have quite a number of weird and wonderful powers and privileges and one of them is section 23 of the

Act: the right to order the discharge from hospital of a patient who is detained for assessment (section 2), treatment (section 3) or guardianship (section 7). Once this notice in writing is given to the hospital concerned, the person *must* be released unless the Responsible Clinician in charge of the patient's care issues a 'barring notice' under section 25 of the Act. This is more than a relative's opinion or agitation, it is a legal right that must be respected, subject to the specifics of section 23 and 25.

Section 25 itself allows the discharge to be prevented: however, it requires the Doctor concerned to certify for the record factors which are above and beyond those required to be 'sectioned' in the first place. In order to be admitted to hospital, the AMHP and DRs are saying the patient is 'suffering from a mental disorder of a nature or degree which warrants the detention of the patient in hospital for …" assessment or treatment. In order to issue a barring notice under s25, a Responsible Clinician must confirm their view that "the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself." 'Dangerous' is not further defined, so it needs to be given its everyday meaning. What we do know, is that the word 'danger' does not appear in the criteria for admission under sections 2 or 3, so it has to mean something 'extra'. Not all sectioned patients are 'dangerous' (something we are repeatedly reminded) so it's clear that not all notices under s23 should be blocked. In any event, the barring notice must be issued within 72hrs of the Nearest Relative's instruction to discharge.

IMPLICATIONS

Ideally and of course, this is not a police situation at all – apart from the obvious point that very few officers will ever have heard of s23 or s25 or be able to offer a view on it all(!), there's the issue that hospital staff should understand, respect and apply the law. This BLOG post comes from a discussion on social media about a situation in which an NR was asking for advice about their notice being served on a Friday and come Tuesday, no barring notice had been issued and yet the hospital concerned had not released the patient and was reluctant to do so. Of course, there are other ways to see the dispute resolved – there are on-call senior clinicians and hospital managers, including Directors with access to legal support, to help trusts understand the situation. I can therefore understand the argument some officers put forward when I posed this question on social media, asking what they'd do. Many were reluctant to become involved, for the reasons given – but I have also known situations which centre on the lawfulness of detention and have involved requests by families or patients for their concerns to be escalated beyond NHS ward staff to be declined, for one reason or another. The police are therefore called as the 'someone should do something!' agency. That's actually why we have a police service:

"something's happening that ought not to be to happening about which somebody ought to do something now!"

There are wider considerations in my view: the police become involved in refereeing disputes between individuals and other agents who carry coercive authorities in several, civil law situations. We become involved in disputes involving bailiffs, debt recovery grants and so on; we take a position on how to temporarily resolve conflicts on a range of family law matters where civil court judgements are in place, pending the ability to get the appropriate people, solicitors or courts involved. But I also like the argument that all public authorities – including the police – are state agencies who have a *positive* obligation to ensure the human rights of the public. Section 6(1) of the HRA 1998 makes it clear that no public authority (which includes the police or mental health trusts) shall behave in a way that is contrary to someone's Convention Rights and the Act makes the proactive duty a clear, statutory one. Detaining someone in a hospital for more than 72hrs after a section 23 notice has been served by a Nearest Relative is to continue to detain someone outside processes prescribed by law, potentially an Article 5 violation – and as more than one mental health professional pointed out: it takes a Doctor around 10 minutes to fill out a barring notice and they have 72hrs to do it. The law clearly implies organisations need systems in place and the law generously affords them three days within which to operate.

Remember, when considering issues of false imprisonment, the burden rests with the person or authority undertaking the detention to demonstrate there is a lawful basis to it. So in the absence of any ongoing arguments or disorder, this is one that could be handled from afar. I could imagine asking, "If you agree you're preventing the patient from leaving and that you received a section 23 notice more than 72hrs ago, I'm wondering what possible legal authority you have for preventing his release. I suggest you urgently escalate this to your senior managers before complaints are made of false imprisonment and they take urgent legal advice to satisfy themselves of the situation." I could also agree that if a professional is fully acknowledging that they are deliberately detaining people without a clear and obvious legal authority by which to do so, that situation is something that does become legitimate police business. It's another example of situations where the necessary partnership to focus on, is the one between the public and the police.

JUNE 2017

11th June 2017

Already Liable –

Can a police officer detain a person under s136 MHA if that person is already affected by mental health law in some way?

Imagine a police encounter where the officers are told by someone the person they have concerns about is on leave from hospital, with permission — or maybe living in the community under one form of restriction or condition? Can they use section 136 if they feel the grounds for it are satisfied?! Yes, absolutely they can – there is **no doubt whatsoever** about this but the post will explore why a straightforward-enough question can get complicated and will thrash out a bit of detail that may help to win any argument if officers encounter problems. Oddly enough, the inspiration for this was an officer who contacted me having encountered problems!

I can think of a couple of situations where very similar legal questions arise, in addition to the one highlighted by the officer, so it's worth considering a few situations –

- A person has been granted s17 leave from hospital and is at liberty for a few hours or a few days, with the express permission of their psychiatrist – what if an officer encountered them and felt grounds for using s136 were met?

- A person has absconded from a mental health unit and become immediately AWOL under the MHA. What if the officer was less certain about their legal powers or just unsure of the accuracy of the information they were given – does anything prevent s136?

- Some patients discharged from hospital are subject to a community treatment order (CTO) or to 'conditional discharge' (under Part III which relates to forensic patients) – what if officers felt the grounds were met in these cases?

Nothing in law prevents police officers using s136 MHA if they think the grounds for doing so are satisfied and this remains true regardless of anything else. In each of the above scenarios, the law does provide a clear mechanism to allow the Responsible Clinician to instruct the return of a patient where concerns emerge. (Responsible Clinician, or RC, is the legal term under the MHA for the person, usually a psychiatrist, in charge of a

patient's care). So for example, leave granted by a psychiatrist under s17 MHA may be revoked by notice in writing and the person must then return to hospital or they will become AWOL under the Act. If concerns emerge about a CTO patient or perhaps where conditions of the CTO are breached, the RC may issue a recall notice – again, a bit like leave being revoked, this obliges the CTO patient to return to hospital at a specified time and failure to adhere to this requirement renders the patient AWOL. Where conditionally discharged patients are living in the community, the Ministry of Justice can issue a warrant under s42 MHA for their compulsory return to hospital. And of course, anyone who has absconded from hospital whilst detained under the MHA may be taken in custody and returned either to hospital or to court, depending from which section they are AWOL.

IMMEDIATE NEED

The obvious point to make about these things is: they all take a certain amount of time to disentangle and in their own right can become complicated. With 168 hours in a week there is a less than 1-in-4 chance that any RC will be available for an immediate decision. These methods of recall may be used where concerns are flagged by family members, by community mental health professionals who are worried about relapse or deterioration where it is thought best to return the person before their condition becomes so acute that someone's safety is compromised. In principle, any officers dealing with an incident who think legal frameworks are in operation could just urgently contact mental health services for confirmation and push for them to be the decision-makers of what may need to happen under recall or revocation laws. But this bumps up against the most obvious practical reality of all – the need to act ***now***.

Of course, a police officer's use of section 136 is subject to the officer believing the need for the power is *immediate* – it may be known the patient is on a CTO, it may even be known attempts are being made to ask the responsible clinician to issue a recall notice. But where officers are called to a situation in a public place and feel they need to act immediately to keep someone safe, nothing should prevent them from taking necessary steps – and nothing does. Actually, in the case of CTO patients, use of s136 merely affords decision-makers the same amount of time in which to make the right decision about what to do next. CTO patients, when recalled to hospital, are there for 72hrs, just like s136 detainees under current law. And of course, if RCs want to take their own decisions about a patient, they obviously welcome to respond to 999 calls to the police about people in distress.

It's therefore important to emphasise: nothing prevents a Place of Safety receiving someone detained by the police under s136 who is subject to these other frameworks. It may well mean that the AMHP who is then

contacted about the detention starts other conversations with existing care teams rather than conducting an entirely fresh-assessment, but that's a matter for them to untangle. In the case of patients who are AWOL having left without authorised leave, it may appear more obvious that s18 MHA should be used to return the person – but even then, it can be complicated. Which section were they absent from? – on which day does the s18 power of re-detention expire?! Unless you know the answer to both questions, we can't be certain someone is, in fact, still AWOL.

GETTING PRACTICAL

Do you remember the nightmare scenario I wrote about last year – the Scottish CTO patient who had travelled to Nottingham and been encountered by local police whilst unwell and in distress? In order to quickly resolve the incredibly complicated, impenetrable legal quandary about whether English officers could detain a Scottish CTO patient encountered in England under the well-known(!) Consequential Provisions Order that I'm sure you're all familiar with … the answer was to use s136 because it was becoming too silly for words. It can be difficult at operational incidents to achieve certainty about MHA legalities – the Nottingham incident showed that Doctors were unavailable at short notice and themselves unclear as to legalities. It *forced* the police to make their own decision using laws available to them.

History shows – and I'm sorry to have to say this – police officers would be wise to question what they are told by word of mouth when it comes to legal situations. More than once in my career I've been told by mental health professionals that I or my officers have powers which, in reality, we didn't have. As an aside, I'm not the only one who was surprised to learn how little legal training mental health nurses and psychiatrists receive in their training – in some cases it's almost none! So from my own point of view, verbal information from anyone about someone's current status under mental health law is just uncorroborated information that I may bear in mind, until otherwise proven. If there's time to check it out and let more appropriate people take decisions about patient welfare, then that's obviously the preference.

But what we shouldn't have, is a system which, to the extent that it does, relies upon the police as a *de facto* crisis service, only to prevent the officers from taking good faith decisions to keep someone safe or to make things more difficult for them and the patient where they do. The reason for this post is not just one example raised in a question by an officer, it's a situation I've been asked about a few times and I've personally encountered it a couple of times. Detention under s136 of patients already subject to the Act should still lead to removal to a Place of Safety and the necessary legal untangling. If we remember what s136(2) MHA tells us about the

purpose of this power, it is to allow "examination by a registered medical practitioner and to be interviewed by an Approved Mental Health Professional **and of making any necessary arrangements for his treatment or care**." This can include the untangling of legalities around known patients who got in to distress or difficulty whilst in the community, liable to certain aspects of the Mental Health Act.

21st June 2017

Dear Scotland –

Dear Scotland,

Your Mental Welfare Commission has recently published a snapshot report about Police Scotland's use of 'place of safety orders' under the Mental Health (Treatment and Care) Act (Scotland) 2003 – the MHA(S), if you prefer. Section 297 MHA(S) is the equivalent power to section 136 of the Mental Health Act 1983, the MHA(EW), if we're being consistent. The report is just a three-month snap shot but it raises several questions which the Commission themselves are openly asking. It is precisely because they have made a direct comparison and reference to the use of Place of Safety orders under English and Welsh law that I thought a short blog may be helpful, flagging some learning we've gone through in England, but also contrasting certain parts of England to help think through how culture and evolved practice affect the police's use of powers.

It's worth reading the report – it's only 13 pages long and that includes the cover and a blank page as well as plenty of tables and white space!

BACKGROUND

Unlike English and Welsh forces, Police Scotland has a statutory responsibility to inform the Mental Welfare Commission of any occasion these powers are used. Notwithstanding that requirement, over the last five or so years, it seems likely that reports haven't always been made accurately – either that, or there has been a very steep and highly unusual rise in the use of the orders. The report tells us that s297 was used on 130 occasions in 2006/7 – but that rose to 795 occasions in 2015/16. The Commission themselves put some of that rise down to better recording and reporting which is fair enough: we know recording quality improved south of the border, too. In the snapshot report over a three-month period, the number was 295, which might imply a further rise – something to keep an eye on.

That said, what struck me most about Scottish figures when I happened to look them up a few months ago, was how LOW those figures are. Let me explain *why* this was my instinct:

Scotland is a country of over 5 million people – and let's round things off by saying they use this power 800 or even 900 times a year. Contrast this with Northumbria Police or with Leicestershire Police – they are areas with around 1 to 1.5 million people and yet each of those forces was using section 136 MHA(EW) before either of them introduced a street triage scheme. That's a significant variation when you remember that Glasgow itself is a larger city than either Newcastle or Leicester and – so is Edinburgh! This is very low by crude comparison, so what's going on.

REGIONS OF ENGLAND

Use of s136 in England, however is not consistent and it's obvious there are local variations not easily explained by differing need amongst populations. Prior to street triage, for example, West Midlands Police and Nottinghamshire Police used s136 roughly the same amount. This is interesting because one force is three times the size of the other, based on officer numbers and resident population. So is one force over-using s136 and the other under-using it?! It's probably a bit of both, but there are certainly differences here that need unpicking. After these forces introduced street triage, Nottinghamshire's use fell to around 500 from 1100, whereas the West Midlands initiate reduced by approximately 250 and gradually returned to normal levels. This attests to something about the appropriateness of usage that probably needs some more unpicking – what does it tell us about s136 that in some areas street triage reduces s136 significantly and that sustained; elsewhere it has a temporary effect on usage and regresses to the mean; in other areas, like Lancashire, it has no effect on the usage and the rate continued to climb, unaffected.

Try comparing Nottinghamshire to Humberside – these forces are not identical in terms of size but are similar in terms of officer numbers and population … and yet one is using the power *ten times* more than the other. These places *are* different! … but are they really **that** different?! I sincerely doubt it; and so it immediately begs questions about how individual police officers take their decisions around mental health calls and the extent to which evolved cultures and practices in given police force areas affect those decisions. We've had to get in to some detail about this England because discussions about the provision of health-based Places of Safety often do demand that we address the question of whether s136 MHA(EW) is being over-used? Remember, when street triage was introduced in England, it first appeared in Cleveland and was a direct response by the local trust to what they considered to be 'inappropriate 136' (see a screenshot of their website, left). Elsewhere, during discussions about 'inappropriate 136', it turned out this was a perverse assessment by health professionals about what 'appropriate' actually means. Some psychiatrists have been known to say that unless someone is 'sectioned' after the assessment, then the use of the power was wrong!

But it's not enough to look at s136 usage and think about whether it is over-used or under-used – in all areas, it will be simultaneously involve both of those things – and more besides. What about encounters where officers arrest for a criminal offence or a Breach of the Peace, which centre on someone who is suspected to in mental distress and where mental health law might have been the better option. What about encounters which don't end in the use of any kind of detention but which arguably should have done. It is a common complaint, I'm afraid, that A&E staff see the police turning up in their departments with vulnerable people who are under a form of restraint, sometimes in handcuffs and the officers then attempt to explain that the person is there on a voluntary basis. An AMHP recently queried the number of people detained under s136 who turn up in Places of Safety in pyjamas, wondering how many were in fact, encountered in their own homes which are off limits for s297 / s136.

GETTING IN TO DETAIL

So the things you're probably going to need to look at are numerous –

- How many uses of s297 MHA(S) are objectively *wrong* – for example, people removed from private premises under some subterfuge or other, only to be detained under s297 once outside. There is caselaw on various versions of this in England and Wales and all of those practices were regarded as unlawful.

- How many people detained under s297 were, in reality, just drunk and doing 'odd' things or verbalising non-specific threats of some kind? – without some objective evidence of any background of mental illness, behaviour by drunk people is usually best explained by alcohol. So safeguard them in whichever other way and once sobriety returns, they can still be assessed, where concerns permit.

- How many people arrested for a Breach of the Peace in Scotland are people in distress encountered in a public place where s297 probably was the way it should have gone? – some people refer to this as a 'proxy' arrest. Of course, in private premises where s297 does not apply, this may be needed and justified. But in public, this might need looking at.

- How many people arrested for a substantive crime, like assault or criminal damage and thought to be mentally ill? – this one is a touch tricky because public policy tends to demand that people who are seriously mentally ill and diverted from the justice system and s297 is a way of doing this at first contact if the crime is minor. But how serious do we allow the crime to get before we should prioritise the arrest?

It's complicated stuff: my only point is, there are things that England and Wales have discussed and learned from, which suggest at least some answers and ideas for the questions posed in the Mental Welfare Commission's report. And if you use social media, especially Twitter, you will see the most important answers of all: the Scottish public have their experiences of police contact when they are unwell and several have said they've found themselves in police cells for a Breach of the Peace after a mental health crisis in public. Sometimes, they have been told by officers involved that it's easier and less time-consuming to deal this way, which raises important questions about the s297 process, if that's true.

What does seem possible, is that there is scope to look at whether or not mentally vulnerable people are being criminalised unnecessarily and whether there is scope to issue guidelines or training that would re-dress any problems you may uncover.

We hope this helps!

Love from,

England and Wales.

23rd June 2017

Updating the Blog –

I'm after your views on something! The blog is now approaching 675 posts, as well as various other pages and resources and when the Policing and Crime Act 2017 eventually takes effect, it will render many posts instantly out of date. On previous occasions when I've attempted to go through the blog updating every single post on something or changing appearance to make it fit a new 'theme' that I've used on WordPress, it has taken me a week of effort – and that was when the BLOG was nowhere near as large as it now is.

The BLOG always was intended to help police officers navigate their way through incidents and I'm still getting feedback that it continues to be valued for this. I therefore feel I have to make it clear that pre-PaCA stuff is now potentially out of date so that no-one attempting to use the posts as information falls foul of the update. I've been thinking of a few options and I thought it was probably better to ask those of you who are good enough to read, use and circulate this how you'd prefer me to do this from a few ideas I've had … and if you've got an idea that is better than any of these, I'm all ears so please feel free to leave a comment below. I'm not the one using this BLOG, so you're probably better placed to advise what you'd want!

There are three potential options as I see it –

- Work my way through the old posts and put a colourful disclaimer at the top of anything potentially affected by changes – this will take considerable time but if it's the preferred way of doing it, I'll make the effort over the Summer!

- Put a massive disclaimer-caveat on the front page of the blog pointing out that anything published prior to PaCA could be out of date and to check carefully before relying on anything.

- Archive the whole blog so it's there on the internet to be read as it currently is, but closed to comments and start an entirely new BLOG from the point of the PaCA amendments and transfer material across that remains relevant.

For what it's worth, I'm leaning towards option 3, not least because I've been thinking for a while of getting around to doing something different, based on requests – vLogs, or short videos on YouTube and uploaded to the BLOG which allows an audio-visual versions of the Quick Guides and other stuff like the PaCA amendments themselves. Some officers have asked for this, especially as smartphones have proliferated, as an easier way of consuming this stuff. Such a change of style in the way of presenting material might mean a new website, with links to the old that means nothing is lost or unavailable, is the best way to go?

As I say, I'm struggling to think what's best to do and in all fairness, option 3 came from someone else I happened to discuss this with (thanks Dan!). It may be you can think of something even better! … thoughts welcome.

Thanks,

Michael./

25th June 2017

Treatment and Care –

Six years ago, Nicola Edgington attacked Kerry Clark and Sally Hodkin in south London, seriously injuring Kerry, a 22yr old woman and killing Sally, a 58yr old mother and grandmother. She was prosecuted for murder and attempted murder, convicted in March 2013 and sentenced to life in prison with a minimum recommendation she serves 37yrs. She appealed against this outcome, but it failed. Four hours before the attacks, the Metropolitan Police had contact with Nicola, having been called to a taxi rank in Greenwich and they assisted her to the Emergency Department at Woolwich Hospital where she was seen by a mental health nurse and admitted on a voluntary basis to a nearby mental health unit. She absconded from the unit thirty minutes or so later, and attacked the two victims shortly afterwards as they made their way to work. If you prefer not to read a pile of material, there is a simple, but useful audio / visual summary of this on the BBC news website.

This week, a report has been published by NHS England in to the care and treatment Nicola was receiving from Oxleas Mental Health Trust and this follows publication on the day of her conviction of an IPCC report in to the police contact. That same week, I wrote a blog which summarises my main observations and concerns from a police point of view and having just re-read it, I now want to provide an update, having seen the NHS England Report. What is interesting about the report, is that its conclusions have been swiftly and robustly rejected by Sally Hodkin's family who issued a statement via the charity Hundred Families. I also have my own concerns about this report and I noticed that it was leaked to a journalist ahead of publication, who got straight in with the 'Met Police tried to suppress this report' and 'police failures led to killing' angle ahead of any possible response by any of the parties involved. He didn't even begin to mention the catalogue of errors by the NHS until much further down his report.

For all these reasons, this post ended up being much longer than the average. It is precisely to allow you to consider things that went unmentioned and to see some things that went uncontextualised to allow you to form your own views about what you think might have gone on leading up to the publication of this report. It may assist in you forming your view to know Sally Hodkin's family pursued damages in the civil court following what they believe to have been her preventable death – from the

NHS, not from the police. I'm not a detective, as you know, but the dots here seem quite easy to join.

SUMMARY

For me, there are three problems I want to highlight – there are loads more problems, but this is what I'm going to focus on because it's Saturday night, I'm not trying to fix the whole world here and a comprehensive analysis of all this would take weeks! This is a blog about how two junior police officers have effectively been blamed in a confused report for a decision they took which authors say was a 'root cause' of Sally Hodkin's death, when even her family can see that this wasn't the case at all. —

- **The Mandate** – this is a report by the NHS in to NHS treatment and care. We already have an established process by which to hold the police to account and it's Chief police officers, the Independent Police Complaints Commission and the Courts. Of course, where agencies come together over an incident, there are overlaps but the role of an NHS report is surely to examine how effectively the NHS performed its task in whatever context it was asked to do so? That's what the IPCC do – they took account of NHS issues in the deaths of Sean Rigg and Seni Lewis but did not purport to investigate them.

- **The Conclusion** – the NHS report acknowledges the panel's lack of expertise in policing (see third paragraph, p7) and suggests for the future that a policing perspective should be included. If it occurred to them whilst writing the report, especially in light of the problem they face about the 'mandate', then why not ask during the inquiry? The police would have probably come up with someone independent. Notwithstanding, they insist on drawing conclusions which are at best, debatable and at worst, appear disingenuous and obfuscatory.

- **The Leak** – this report was leaked to the Press, albeit we don't seem to know who leaked it. That having been acknowledged, I'm way beyond interested that the journalism which resulted from it led with the 'police failure' angle, taking the report at face value and made the policing issues the primary focus notwithstanding the rest of its findings. It also emphasised the dispute and potential legal action between the Metropolitan Police and Oxleas Mental Health Trust as if the Met should just let an unqualified, inexperienced panel say whatever they like, however questionable or potentially unlawful.

JUDGEMENT CALL

The IPCC and the NHS reports focus heavily on the period of time 0431-0434 on 10th October 2011, the point where Nicola had looked to leave the ED for a second time and where it is correctly argued section 136 *could* have been applied. Two Metropolitan Police officers had arrived at Woowich ED and waited with Nicola whilst she was booked in to the system. Having then spoken with her in the waiting area and explained their decision they could not stay with her, they made to leave the department. Nicola initially followed the officers out of the department saying she did not want to stay on her own and officers returned her to the waiting room, re-explained that they could not stay and sought her assurance she would remain there until called. She gave that assurance, they felt able to believe her and subsequently left the department. Notwithstanding her distress, no-one can contest that this story includes Nicola remaining, being assessed and being admitted to Oxleas House.

When we look at police decision-making, some things are objectively right or wrong – if the officers who found Nicola after the attacks had not arrested her for murder, this would have been objectively wrong despite the fact that nothing in law says, "when someone is suspected of murder they MUST be arrested for it". However, a failure to arrest would prevent officers having full powers of search and seizure to secure evidence and it would prevent the ability to consider the need for interview and a host of other implications – in other words, it would have compromised the investigation and further endangered public safety, which we can agree is objectively wrong. The same is true for some mental health crisis calls: if someone is actively harming themselves or trying to hurt others, lacking capacity and unwilling to engage, then a decision not to invoke s136 would be objectively wrong (unless another legal mechanism achieved the same purpose and was to be preferred.) However, in this case the report is arguing that MHA powers *should* have been used for reasons which no frontline response officer could reasonably be expected to understand – the reports points out how the assessment could have taken a different look at the fact that Nicola was a conditionally discharged patient, presumably with a view to recall. You'd be amazed how many mental health nurses don't know what conditional discharge is or what difference it might make. As far as frontline police officers are concerned, an assessment is an assessment and if the nurse in ED wanted a full MHA, they could have called one.

A quick point on the fact officers did not undertake a PNC check and were not aware of Nicola's previous offending history as they escorted her to hospital. I'll tell you now and for free: not all police officers conduct PNC checks on people they assist to access mental health care. Not all street triage advice or encounters involve a PNC check on the person at the centre of it and I remember the day after the publication of the IPCC report

starting a shift with my response team and I asked that room of twenty-five officers this question: no-one in the room said that they would *always* conduct such a check. This may be alarming, but judgement of conduct at work is partly around measuring that against the standards of competent peers.

LEAST RESTRICTIVE PRINCIPLE

So are we saying here that everyone who asks for help must be forced to receive it, notwithstanding their willingness? Bearing the 'least restrictive principle' – which goes entirely unmentioned in the report, incidentally! – what are we saying if we're not saying that? You'll notice more broadly, as street triage services have developed around the country, many areas are pushing for much less use of s136 MHA – only yesterday I was at a legal seminar where this imperative was being pressed and you only need to get on the internet to see MH trusts berating the police for 'inappropriate' use of s136 MHA. None of this stuff is ever really defined, at least not so precisely so that I could stand up in a training event and actually tell front-line cops what is expected of them.

- If the officers **had** used s136, it may or may not have still led to admission to a unit from which Nicola could abscond.

- If officers do **not** use s136, it does not prevent the triage nurse asking for a full Mental Health Act assessment which could have still taken further time to consider Nicola's situation.

- *In other words* — the report authors see s136 as a gateway to something certain – and as the *only* gateway to that. This is just demonstrably false and so it cannot, in all logic, be a root cause factor in this attack. It assumes that things always work as planned, which is almost ironic given what they're engaged in reviewing in this document.

- The report is at pains to make it clear this is what the authors think should have happened, but they also say it's a judgement call that reasonable professionals in good faith can disagree about. This is at best confused and at worst a weak conclusion – it's the one, or it's the other.

Look at p76 of the report, which seems a touch disingenuous to me – it is the point where the authors discuss the police decision to escort Nicola to ED on a voluntary basis. They quote from the (14th edition) of the *Richard Jones Mental Health Act Manual* about the ability to use compulsion on someone who is willing to undertake voluntary admission. What the report does NOT make clear, is that Jones is referring here to voluntary admission

to hospital as an inpatient, not to voluntary access to an ED for assessment of whether hospital admission is required. The fact that this quote from Jones is irrelevant to the point they're making should have been clear from its open reference to Section 5 of the Mental Health Act: this section contains two holding powers, one for Doctors and one for registered mental health or learning disabilities nurses. *Neither* power can be invoked in an ED … he's writing about section 131 of the Mental Health Act – voluntary hospital admission.

The report goes out of its way to selectively represent certain issues. They tell us (on p77) that officers were in breach of the Metropolitan Police's Standard Operating Procedure by not involving a paramedic in the conveyance. What they don't say, is that when this was explored by the IPCC (paragraph 189 of their report), the officers gave an account for why they *deliberately* took this decision: the presence of the ambulance crew was agitating Nicola, Woolwich ED was only a short distance away and they felt it was better to proceed alone. The IPCC fully accepted this – SOPs are not **rules**, they are **guidelines**. I'm going to stop getting picky, although I have list on my notepad several other things I'd want to get picky about if time and space permitted – the post will simply end up being too long, if it isn't already.

ROOT CAUSE

The number one root cause of this murder, according to the report (see p13) is the police decision not to use s136. Like the IPCC, the panel concludes this was a judgement call reached in good faith. It even says, "Given this set of circumstances some Police officers may have applied Section 136 of the Mental Health Act whilst others may not have. The Police Officers involved reached their decision in good faith and were satisfied that Ms A did not meet the relevant test." But they go on, somewhat illogically, "However, the Panel believes that Ms A could have been placed on a section 136." So was this a judgement call, or not?! If by 'judgement call' we mean something where two perfectly competent professionals might quite honestly reach different decisions based on their perception of the same circumstances, then how can it be objectively wrong? The panel stops short of accusing the officers of negligence and we can note they are saying the officers 'could' have used s136, not that they 'should' have done so. But they point out what *could* have happened so many times their implication is clear: they're judging the officers.

The officers *could* have done any number of other things, in all fairness: they *could* have stayed with Nicola, in ED, throughout the assessment, without invoking s136 – many police officers across the country do that every day, for various reasons. They *could* have used s136, of course – but they also could have taken a decision that their discussions with Nicola and

with ED staff were sufficient for them to be satisfied that it was appropriate to leave and that they had encouraged ED staff and security to ring if they perceived problems. Indeed, when Nicola was making 999 calls from ED, the Metropolitan Police did ask if things were OK and they were told by the hospital themselves there was no need for the police to return. So if the officers were wrong, were they objectively or subjectively wrong?! … were they actually *wrong* at all, bearing in mind the IPCC and the NHS report point out it was a judgement call and not certain?!

But here's the real nub of it for me: three things —

- If the Metropolitan Police *had* used s136 there is absolutely no certainty whatsoever that Nicola would have been 'sectioned'. History is littered with examples of people being detained by the police under this provision and being released for reasons that aren't immediately obvious to the officers, only for them to end their lives soon after, or to come to 999 attention again almost immediately and be further detained … and THEN sectioned, after a second assessment. The report seems to take for granted that an MHA assessment would have reached a particular conclusion, which is ironic, given how much else went wrong in this case. Despite the Metropolitan Police *not* using s136, nothing prevented the mental health nurse in ED seeking to convene a full, statutory assessment and nothing prevented it being conducted. They could have chosen to section Nicola and admit her either to Oxleas House OR to whichever other unit they wished. And if it were thought that the absence of s136 were crucial, why did no-one anywhere ask the police to return or escalate that decision to police supervisors. **The police were specifically told at 0512 that there was no need for them to return, after specifically asking if support for Nicola was needed**.

- Secondly, if a trained mental health nurse from the liaison team is going to proceed on a voluntary basis by also misunderstanding that mental health law allows compulsion of the willing, what standard are we holding the police to?! This nurse had a three year degree and who knows how many years of experience of doing nothing other than stuff like this … and they were two frontline police with a few hours training. The paragraph, mentioned above, from the Richard Jones Mental Health Act Manual relates to the very scenario facing the MHLN nurse in ED, and not to the one facing the police in ED or elsewhere – the nurse could have requested a full Mental Health Act Assessment and they could have asked the police to return. Ultimately, it could be argued that the officers' judgement was borne out by the fact that Nicola made it to Oxleas House for admission and absconded after the point where any s136 officers would have left anyway. If we're arguing that the s136 assessment would have arranged admission to a different kind of unit then it's just as easy to

point out that voluntary admission could have been to another kind of unit.

- Finally, Nicola was admitted to Oxleas House from ED, arriving at 0637 and remaining unsupervised until she absconded around 29 minutes later. The report details that she was left unsupervised in an assessment area, albeit one where the patient could control the door and choose to leave, if they wished. Nicola did this and spent time in the reception area. She also left reception and went outside during this 29 minutes. The report seems really careful to avoid being precise about what status Nicola had during this time: was she now an voluntary patient of the trust, or not? On the one hand, the ED staff and security had left her with MH trust staff with agreement; but on the other hand, MH trust staff did not engage with her and take her up to the ward where a bed was available for her. The report mentions the absconding policy, which implies she was considered to be a patient of the trust, otherwise she's just a person at risk. Since the time of this incident, trust policies and procedures have changed around all aspects of these issues and two nurses have been sacked in connection with the period which led to the absconding. In particular, **the front door of Oxleas House now has a lock on it!** So … it turns out, the murder would have been prevented regardless of what the Metropolitan Police did or didn't do, if only the trust had a basic security feature that most people would imagine they would already have if they are in the business of admitting people there who have previously killed someone.

Is it possible, we're over-thinking the complexity of all this? The major things that went wrong in this case had already occurred way before the Metropolitan Police met this woman on October 10th – and that's not my opinion, that's the view of Sally Hodkin's family who are living with the impact of all this, years after the event and forever more. They are probably the most important people of all.

* ***Disclaimer*** *— I am not and never have been a Metropolitan Police officer. I was aware of, but not involved in, discussions between the Metropolitan Police and NHS England about the draft report's contents and conclusions and, in the absence of her own MH staff officer who was on annual leave, I once compiled a summary timeline of events on 10th October, based on the IPCC report. This was for the benefit of the force mental health lead, Commander Christine Jones QPM, ahead of her attending a meeting about the report, at which I was not present. Beyond that, I had no involvement in any other aspect of this.*

26th June 2017

The Important Partnership –

We hear a lot about partnerships in public services, the need for various agencies to do them, to have them or the need to improve them. Simplifying horrifically, the narrative seems to be that there are gaps and overlaps between different public agencies and if only managers could bridge the gaps and cooperate on the overlaps, all would be well. Indeed, you could argue that this is what sits behind the Crisis Care Concordat, one of the most significant 'partnership' documents we've seen on the issue of mental health crisis care. Don't forget: the Concordat came from discussions specifically about policing and mental health, following the tragic case of Olaseni Lewis in south London in 2010. The concern was that it was a failure of the police and mental health services to work in partnership that caused the death of this young man.

Of course, we now know that's only a part of the story and legal processes rumble on regarding the various parts. What this and several other cases have recently caused me to wonder is whether this simplistic idea of 'partnerships' between agencies misses out some very important people AND puts the focus in the wrong place, on occasion?

What about the partnership between the police and the public?! – those of us who like the Peelian Principles know a part of the seventh principle very well: "the police are the public and the public are the police" and this is etched in stone, literally, at the new headquarters of the Metropolitan Police in London, New Scotland Yard. What we see many times over is police officers, usually junior and frontline officers and staff, effectively advocating for the rights and welfare of vulnerable people: to access support which might otherwise be denied, or resisting requests by mental health services to undertake tasks which should not be for the police because we risk making the outcome worse for that person.

A RECENT EXAMPLE

A duty inspector from a police force rang me a few weeks ago on a weekend evening. He had a young woman in police custody under a s135(1) warrant, officers having attended the lady's home two days earlier with an AMHP and a Doctor to assess her under the Mental Health Act 1983. Her clinical

history and presentation on the day indicated it would be necessary to remove her to a Place of Safety for assessment and they took her to local a mental health unit. Whilst waiting for the second doctor to arrive for a full MHA assessment, the lady, in her distressed state, proceeded to cause damage to the PoS unit and the decision was then taken to transfer her to police custody. Following assessment, it was decided admission under the MHA would be required and the usual hunt began for a bed – this time, a psychiatric intensive care unit bed. Around two days after the warrant was first executed the bed emerged and the application was potentially able to be completed.

The logistical problem which caused a delay to the AMHP completing the application was how to move the patient almost 300 miles to the hospital where the bed was identified?! – nowhere any nearer could accept the patient as she was still exhibiting challenging behaviour whilst acutely unwell. The journey would obviously take a long time to complete, there was the question about food, drink and access to toilet facilities along the way and the issue of medical or nursing supervision. Officers were told that a 999 ambulance was not appropriate, the patient would ideally need to be sedated but that this couldn't happen in her case because of other medical factors beyond everyone's control. A private, specialist ambulance contractor had been contacted but the police were told this could not be sourced for well over 24hrs – so could the police undertake the transportation on behalf of the AMHP?! … and unfortunately, no medical or nursing support could be provided either in custody or during that journey.

This shouldn't really be a hard decision, should it?!

The answer is just a plain and simple, straight-forward refusal: point blank. There's all manner of danger and illegality within that request … but shouldn't we be working in partnership with each other?! My colleague stated openly he felt under significant pressure to agree to this and could feel in the pit of his stomach that it was the wrong thing to do but he was reluctant to say, "No!" in a way that didn't expose the patient to further risks or delay in custody. But this is where my point comes in about the important partnership: that which needs to exist between the police and the public, around how we handle these specific and sensitive requests. If the request had been something which roughly met the police half-way in terms of resources, risk and safety, then it there could be a discussion about things. But not otherwise, because it puts people are legal and clinical risk.

SCRUTINY

You can imagine what would happen if that had been agreed to and reviewed, either by the IPCC, a civil court or heaven forbid a Coroner's Court after an adverse development? Why were officers moving someone three hundred miles on their own, when it was known they needed medical or nursing supervision because they ultimately needed intensive NHS care not readily available in the back of a police van or on the hard shoulder of a motorway?! … what role here does the law play, in terms of mental health services? Well one of the first ones is it's up to the NHS to commission healthcare services; it is up to AMHPs to make legal applications under the Act, once the grounds are met; and to detain and convey people to hospital as a result of all that. All of this MUST, by law, be able to occur in a way which survives contact with health & safety legislation and with human rights frameworks, such as Article 3 which prevents inhumane and degrading treatment, and so on.

The role of the police, where these things are being compromised because of pressure on the overall mental health system is to weigh up whether they should provide assistance that may not necessarily make things any worse, indeed it might assist in not aggravating things – or to resist doing so because they absolutely think it will. For example, the Code of Practice indicates (Paragraph 17.14 in England; 17.18 in Wales) that the police may be called upon assist in ensuring safety during admission where someone is 'violent or dangerous' – but this doesn't mean that where such an assessment may reasonably be formed, the police should be doing this entirely alone! Indeed, it is one of many factors that should be considered and both Codes refer to the need to preserve people's rights and their dignity, in conveyance. Not sure how that's achieved if officers end up frog-marching a distressed patient in handcuffs in to motorway services to use the facilities.

The issue here between the organisations is not about partnerships and how we work together: it's about each organisation ensuring we don't make unreasonable requests of each other, causing undue and intolerable pressure, beyond their ability to cope. It's about ensuring the legal rights of the patient and the legal duties owed by the non-police organisations in the particular example – of course, there are other examples where the police need to be careful they're not doing that to AMHPs and NHS staff. Officers could, in theory, have said, "Go on, then!" and tried their best, but we can all imagine what would have been said if a clinical emergency developed *en route* and / or restraint was used and / or a predictable set of degrading circumstances emerged? We would be back to the sorts of things we saw in the Seni Lewis, Sean Rigg and other cases where scrutiny

would be on those using force and not on those who created the conditions within which it became more likely to be used.

WIDER DISCUSSION

In the operational police work I've done, I've often found that the important partnership that needs to be forged is actually between the police and those of us with mental health problems – or their families and friends. It is genuinely gratifying to become involved in something and find that the police have been able to help the public directly and where this is consistent with good partnership working with the NHS, that's all very well. It should always be borne in mind, however, that the police are not on anyone's side, that they have a duty to the law, first and foremost and that we cannot always be expected to act a certain way when we are invited in some way, shape or form, in a conflict that exists between NHS resources and patients' rights.

It should always depend on specifics as to how any situation like that is resolved because, I repeat: as police officers, we are not on anyone's side during a legal conflict. But enabling the police to do the right thing so they may professional acquit themselves is usually the same thing as ensuring the rights and dignity of patients – unless something gets in the way.

29th June 2017

AMHPs and AMHPing –

I've got to know a fair number of AMHPs in my time. In fact, I'm going to come clean on this occasion – some of my friends are AMHPs and I've been known to take refreshments with them on a clear evening. Tony now owes me at least one beer for writing this for #AMHP17! … incidentally, it's pronounced 'amp', before we get much further in to all this. I've been known over the last few years to go out of my way when they ask for inputs on CPD events because a clear understanding of who these people are, what they do and the circumstances in which the operate is crucial for operational police officers. I also think the opposite is true: they need to know more about the police and the learning we've gone through over the last ten or fifteen years. I've had some of my most interesting professional disagreements with some AMHPs(!) but in all fairness, it was usually based on things I'd learned from other AMHPs who had been kind enough to help me get my head around things when I first started working properly on this stuff.

I will forever treasure the disagreement about the grounds for s135(1) warrants which became necessary in February 2014 … my favourite, ever s135 story and I got to be the duty inspector for it! AMHPs helped me win that debate with another AMHP and it meant resolution of a siege that had gone on for 9hrs without anyone being seriously injured when there was a point we thought someone may get killed. AMHPs are the mental health professionals who get the decent legal education – and they are the non-medical people, to protect the rights of those who could become embroiled in coercive mental health care. They are ***vital*** to the system – in many respects they ***are*** the system.

Yet we have a problem – when I ask in a room full of police officers or paramedics "Does everyone know what an 'AMHP' is?", a good number of people will have no idea. Some of those who do won't necessarily know what the acronym 'AMHP' stands for – it is **Approved Mental Health Professional**. Not '*Accredited*' mental health professional, no, No!! … not approved mental health '*Practitioner*' … no, No, NO!!! – these won't do at all. In fact, it is getting the acronym badly wrong that usually winds them up a complete treat. It's not quite as funny as the reaction from our dear friends in green being referred to as 'ambulance drivers', but you get the general idea! "Accredited Mental Health Practitioner", usually works best – just in case you ever need to know ……

STEREOTYPING

AMHPs are easy enough to identify as a breed: they will not be some walking stereotype wearing brown sandals or bearing leather elbow patches on a checked tweed jacket – there's no need here for poor stereotypes about social workers, involving bean bags or joss sticks. A better stereotype, however, might be the one fully-loaded with the standard-issue AMHP kit: a lanyard of some kind, possibly with an IT security dongle and a pen hanging from it; a well-thumbed copy of Richard Jones's Mental Health Act manual, replete with coloured post-it notes or pages marked with highlighter pen; and a hardback A5 diary, page-per-view, stuffed with folded pages of A4 and elastic bands wrapped around it. If you were to search the boot of their private vehicles, you'd probably find emergency food and drink and an extra jacket, jumper or a blanket. These things are the cuffs, baton and CS of AMHPing, it would seem – the basic tools of the trade.

More seriously, I couldn't be clearer about this: these people are **absolutely crucial** to the operation of the mental health system and as I usually tell them, I wouldn't do their job for all the money in the world. They are put at the centre of so many aspects of how our system operates at key points of crisis and whilst enjoying almost all the responsibility for things, they usually have absolutely none of the authority whatsoever to direct organisations and resources around the outcomes they must ensure. They are completely reliant upon the NHS, the police and the ambulance service to know their roles and pull their weight. Some AMHPs spend their days working as mental health social workers in community mental health teams, not specifically undertaking the AMHP role until they need to pull on their capes (or blankets) as their CMHT has a need for it. In addition, they may perform a 'duty AMHP' role for the area for a few days each month. Elsewhere, there are permanent 'AMHP hubs', where a certain number of AMHPs are AMHPs every day and do little else beyond this important statutory role. Ideally, there should be an AMHP available 24/7 for urgent MHA assessments and assessments under s136 – it is the latter where officers are perhaps most likely to meet an AMHP.

I've mentioned they are the ones with the formal, examined legal knowledge: they must do this to qualify and many of them are quite formidable legal eagles, it must be said – I've been grateful over the years to several of them who've let me buy them coffee and helped me get my head around the legal issues. They undertake a certain amount of CPD each year to ensure they remain up to date with developments in the law, some of this being run by specialist solicitors firms or university law departments. It was thanks to AMHPs that I learned a lot when I first worked in this area around mental health law – it was an AMHP who first properly explained the Mental Capacity Act 2005 to me (thanks, Matt!) and who introduced me

to Richard Jones's *Mental Health Act manual*. This is a major publication, usually updated each year to keep current, and is often regarded as the last word on how to interpret mental health law. Most AMHPs are given a copy by their employer each time a new edition is published. One claim to fame on the manual: Professor Jones once emailed to say my blog had made him change his mind on a couple of police-related issues on s135 MHA and he amended his manual accordingly!

QUICK FACT CHECK

On the role played by our AMHP friends, did you know, for example –

- It's not the Doctors who 'section' patients under the Mental Health Act 1983 – it's the AMHP?
- An AMHP can decline to make an application, even if each Doctor thinks it vital – that's how important and legally significant they are.
- They act *independently* when it comes to making statutory decisions – regardless of who their employer is. Like police officers cannot be directed to arrest someone if the officer honestly believes the grounds are not satisfied, they cannot be directed to 'section' someone.

- 95% of AMHPs are mental health social workers.
- Most of the other 5% are mental health nurses.
- AMHPs carry a warrant card and have legal powers that the rest of us don't have – it's a criminal offence to obstruct an AMHP in the course of their duty – see s129 Mental Health Act 1983 – and this includes failing to follow any instructions to withdraw from a Mental Health Act assessment.

- Contrary to popular policing myth: AMHPs do not request police support in the majority of the MHA assessments they undertake – it varies by area, but roughly 1 in 3 MHA assessments in the community involve the police.
- AMHPs are NOT responsible for finding 'beds' for patients! – such duties fall to the lead Doctor in the MHA assessment.
- Blaming an AMHP for a lack of beds is like blaming the police for a lack of AMHPs – it's pointless, and it just won't help. All they can do, is pass the police's frustrated message to the DR or bed manager.

- There are similar roles in Northern Ireland and Scotland to the English and Welsh 'AMHP':
- Northern Ireland still use term previously used in England and Wales until 2008, Approved Social Worker – and only social workers may do the role in NI.
- Scotland has Mental Health Officers who play an analogous role to the AMHP under Scottish mental health law.

- AMHPs have powers to enter premises to check on anyone thought to be mentally disordered, under s115 MHA – however, they can't force entry in order to do so.
- They also undertake a whole host of MHA work that the police or paramedics rarely see – this includes attending hospitals to consider other types of legal decision.
- Perhaps a s2 patient in hospital needs reassessment for detention under s3 MHA; or perhaps a s3 patient needs consideration of a Community Treatment Order ahead of discharge? – AMHPs get involved in all of this and much more besides.

AWARENESS DAY

The 29th June is #AMHP17 day, promoted by the *Adult Principal Social Workers Network* as an awareness raising day for this most important of roles – I'm often not a fan of 'awareness days' but I'm right behind this one. If you get the chance to discuss things with AMHPs whilst you're at jobs requiring police support, try to take the time to learn a bit about their role, its highlights and its frustrations. I always encourage 999 staff to understand: whilst the police and ambulance service are busy arguing about who will attend an MHA assessment to assist in conveying a patient, there is an AMHP, recently abandoned by the two Doctors, who is still with the patient and the family, trying to keep things safe whilst #Team999 are busy working out whether the ambulance will come before the police arrive or whether the police will dispatch officers before the ambulance is available.

We often create a catch-22 in which the AMHP and patient are trapped where we refuse to dispatch one emergency service until the other confirms they are *en route*! << This is the single-biggest frustration AMHPs voice in my direction, in the hope I can encourage officers in particular to help break the deadlock. If you're a control room sergeant or an operational cop and you can help do this, please do – AMHPs who favour the police's support are AMHPs who may go that extra mile for us in other circumstances, so build trust and relationships where you can because we also need them to help us.

So this is why experienced AMHPs have emergency food and clothing in their boot, in addition to their basic AMHP-kit! – it's not uncommon to hear tales from AMHPs that they started an assessment at 3pm, had concluded the decision-making by 5pm after a difficult assessment and were still there at midnight trying to get #Team999 to break the catch-22 deadlock, all the while conscious that the longer the delay, the more likelihood that the

hospital may have to give away the bed to someone who needs it and who can actually get there this side of Christmas.

NEAREST RELATIVES

But if you want to get to know an AMHP well, you could ask them to explain to you something about their very favourite topic: who is the Nearest Relative under the Mental Health Act? In order to undertake their legal decision-making, AMHPs have to identify and engage in discussion with patients' Nearest Relatives for various purposes under the Act. Nearest Relatives have a host of weird and wonderful rights and authorities under the Act and working out who this is for a particular person can be very simple – so my wife is my NR and I am hers, but I am also my mother's NR (she is widowed and lives alone) and I'm also my son's NR (because I am older than my wife).

But sometimes it is a nightmare and AMHPs are obliged to obsess a little over this important safeguard of patient's rights. Failure to get this correct can invalidate someone's legal admission to hospital and occasionally AMHPs have to go to County Courts to displace Nearest Relatives who exercise unreasonable objections to MHA decisions. So when AMHPs get going on social media with their nightmarish situations involving a patient with one parent they never see and who cannot be traced plus six siblings, some of whom live abroad, and some of which are step-siblings and half-siblings and where the patients non-intimate flat-mate is providing some level of 'care' to the person … you'll need popcorn, quite honestly. So if you want to a distraction from increasingly poor quality television, go and read section 26 of the Mental Health Act which outlines how to determine who the NR is, work out your own and those for your immediate family and your best friend and then ask yourself: who is Harry Potter's Nearest Relative?!

Many AMHPs are working in LA or NHS organisations which have fewer than half the AMHPs they actually need, attrition is high and pressure immense on a group of people who are invariably spinning plates all the time they're at work. Some areas have fewer than half the full-time equivalent AMHPs they need to cover 24/7 – their system is wobbling, to say the least and they really aren't just there filling in forms for the Doctors: they are *the key legal officer* in our mental health system and I, for one, am immensely impressed by anyone who is both willing and able to do the job they do.

Look after the AMHPs you meet – even if you do find the odd one here or there who *is* wearing sandals.

30th June 2017

Stepping on Toes –

Over the last few years, we've seen a massive extension to 'liaison' work in mental health services. 'Liaison psychiatry' is now a sub-specialism for those psychiatrists who work in acute and other medical settings, giving specialist mental health support to those doctors in Emergency Departments, medical and surgical wards, for patients with co-morbid mental health problems. We see this in mental health nursing too. We've known for decades that many of us would like to see more mental health nurses based in police custody and as time has gone on it has increased and 70% of the population of England is now covered by Liaison and Diversion schemes. In just the last few years, we've seen this accelerate significantly:

- We have mental health nurses in police cars doing 'street triage'.
- We have mental health nurses in ambulance vehicles working with paramedics doing 'street triage' without the police.
- MH nurses are in police control rooms.
- They are also in ambulance control rooms – indeed, they are in ambulance control rooms which cover forces where they are also in police control rooms; AND out doing street triage in police cars … or ambulance cars. Or both.
- We see mental health nurses working in 111 call centres to give clinical advice to non-clinical call handlers and talking to patients.
- In addition, of course, we still have crisis teams operating in each mental health trust, albeit many are much smaller than they were before – which probably won't come as a shock after reading all that lot.

Just to emphasise how far the overlaps between agencies has gone, we also see police cooperation with ambulance services – and this adds to the mental health mix!

- Some street triage initiatives are a three-person endeavour – a police officer, a mental health nurse *and* a paramedic.
- In some areas, we have joint police-paramedic patrols, not specific to mental health, but involving such 999 calls.
- We see paramedics in some forces in police control rooms, including forces where there are attempts to get MH nurses in the police control rooms.

- If you look around you will see that paramedics are now able to apply to some private medical companies to work as healthcare professionals in police custody, alongside the MH nurses doing liaison and diversion.
- They are also appearing occasionally in Emergency Departments.

CONFUSED LANDSCAPE

It begs even more questions, doesn't it?! I had enough unresolved, unanswered questions about street triage before areas who swear by it also brought about the introduction of ambulance-flavoured street triage. It immediately made me wonder: if a 999 call came in about an agitated, distressed mental health patient who had taken an overdose and was threatening to harm himself with a weapon, would we send the police and the ambulance-triage car; or the police-triage car and a first-responder ambulance; or something else? And who decides? – the 999 operator?! They normally ask which service you need so would the answer be police or ambulance … or both?!

I also had questions about efficiency – if we have mental health nurses in call centres, whether that be 111, police control room or ambulance control room, do we really need them *all* when they're broadly doing similar things, often at the same time. Advising non-specialist staff, sharing information from relevant health records and talking directly to prior to people. Do we need three nurses spread across this function or could #Team999 not just access the 111 nurse(s) for support and information? When calls come in which involve co-morbid mental health and physical healthcare issues, does the Force Control Room sergeant call upon the paramedic, the mental health nurse or both?!

The landscape here is getting increasingly cluttered – we're stepping on each other's toes a bit. It's not that any of these initiatives is an appalling idea, but these various things are often being done in isolation, no doubt for genuine reasons, but in such an overlapping and confused way that it prompts to ask my favourite question of all: "What problem are we trying to solve" and my second- favourite, "Why is this the solution to that?" As an old superintendent of mine used to regularly say: form follows function – you work out what you're trying to do, having understood your demand, and then you design a system to meet that demand. I can't help but think that these initiatives are reactions to circumstances that were themselves unintended consequences of other decisions in the wider health system.

I'll leave you to contemplate my point – I'm off to enjoy two weeks of annual leave in France. And my point is essentially an old one; and I've

made it before – this is not a health *system*, in many important respects, it's just a coincidence.

JULY 2017

13th July 2017

The MHA Changes –

I'm being absolutely **inundated** at the moment, via email, phone and social media, with questions about when those changes to the Mental Health Act 1983, contained within the Policing and Crime Act 2017, will be brought in to effect. The amendments will alter quite considerably the 1983 powers relating to the police and to the operation of Places of Safety.

Such is the relentless volume of enquiry, I decided to text the Home Office from holiday(!) and want to share an update with their permission: I begged them to do this to help spare me the pain of relentless enquiry and so that I may focus my efforts on fromage français et vin blanc, etc! –

> *"We can clarify that the changes to s135/136 Mental Health Act 1983 (ss 80-83 of the Policing and Crime Act 2017 and related regulations) will come into force no sooner than September 2017. When the exact commencement date is known (ie, at least three weeks in advance, when those regulations are laid in parliament) this will be communicated to national partners for dissemination to local agencies. In the meantime, local health, policing and social care and other agencies can continue to necessary implementation planning."*

So, it will happen no sooner than September 2017 and therefore, it may be later than that for all anyone currently knows. Whilst I'm keen to keep you all updated! … I now suggest we all get on with enjoying the summer and I shall be starting this by continuing my holiday in the painfully beautiful Loire valley, in central France. Today, I enjoyed cycling around the place and endured un grande eclair café, bière 1664, cidre et fromage aux Château de Chambord (above).

If you will insist on these updates whilst I'm on holiday, you will see very short blogs that also boast of time off – it's only fair!

I hope this helps … au revoir!

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Michael./

16th July 2017

The Law of the Land –

Did I mention I'd been to France?! … see above! We arrived home late last night and now have a recovery day before the harsh reality of work, first thing in the morning! I had a very interesting experience once I'd arrived at Calais until disembarkment because of a discussion on social media which I found too interesting to ignore and which arose from the lack of beds to allow for an urgent admission to hospital. An AMHP found themselves in an invidious, albeit increasingly common position over the weekend following a Mental Health Act assessment after the police use of section 136. The lead doctor in the assessment was unable to provide a PICU bed to allow the AMHP to complete their legal application to a psychiatric intensive care unit so, after various escalations to NHS

managers and no doubt a considerable amount of frustration by all involved, the man was released, his 72hrs assessment period having expired. This happened notwithstanding the AMHP describing the man as a "high risk to others" … and that there were "concerns for safety of the public".

As if that's not enough to pique my interest, what really drew my attention, despite my having promised myself I'd spend the journey drinking coffee ahead of my 7th, 8th and 9th hour of driving, was the observation that the "Police can't do anything, despite concerns".

Let me cut to the chase – this is nothing whatsoever to do with the police and entirely the wrong problem to highlight. The police had already encountered and safeguarded then man to the extent they are able by law and brought him in to contact with all the correct people: an AMHP and a Doctor. Following assessment by the NHS and local authority they couldn't arrange any bed placement within 72hrs. It was their decision to release the man when they had a legal duty not to do so. I'm struggling to see that as any kind of policing issue, if I'm honest.

THE LAW OF THE LAND

Where a Mental Health Act assessment has taken place and admission is the indicated outcome, it falls to the lead, s12 doctor in the assessment to ensure a bed is identified to the AMHP for admission to occur as swiftly as required. In practice, the doctor will usually contact the NHS bed manager, often a senior mental health nurse, to identify the appropriate unit. That shouldn't take more than an hour or two, assuming that the area is working in a way, as per Royal College of Psychiatrists' advice, that wards are at an average occupancy level of around 85%. This allows slack in the overall system for just these kinds of situations: to ensure this man can be urgently admitted. However, Mental Health Act assessments and compulsory hospital admission are, amongst other things, legal processes and they are governed by more than one kind of law.

Section 13 MHA governs the AMHPs *legal duty* to make an application under the Act –

> ***s13(1)*** *If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf.*
>
> ***s13(1A)*** *If that professional is — (a)satisfied that such an application ought to be made in respect of the patient; and (b)of the opinion,*

> *having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him,* ***s/he shall make the application****.*

The old Mental Health Act Commission (predecessor organisation to the Care Quality Commission) published guidance on this very point, in their 8th and 9th Biennal Reports on the operation of the Act, around the turn of the century. Old though it is, and abolished though they are(!), it represents the last point of guidance I can see from either MHAC or CQC on how this part of the Act should be applied. If anyone knows of something more recent, please let me know!

Para 4.45 of the 08th Biennial Report –

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

Para 2.49 of the 09th Biennial Report –

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

For clarity – all bold emphasis above is mine, not that of the MHAC.

There are problems with this advice: but there are problems with ignoring it, too. Who is policing compliance with the Mental Health Act itself; who is looking, if anyone's looking at all, at section 140 MHA? It remains my recent experience that most CCGs and mental health trusts haven't heard of this provision, never mind have any meaningful policy on how they are interpreting its implications. (I've done dozens and dozens of FOI applications in the last few years, asking different CCGs about this.)

INTERNATIONAL LAW

This situation probably triggers various kinds of human rights considerations, depending on the specific patient and their circumstances at the time. Firstly, failure to admit someone to hospital when they are in dire need of psychiatric care can amount to an Article 3 violation – see the *MS v UK* case (2012), as an example of that. Other versions of this kind of story see patients held beyond 72hrs and without obvious legal authority and pending the identification of a bed – that would amount to an Article 5 violation of the ECHR. Finally, imagine that a patient who was released from detention in these circumstances killed themselves or seriously hurt someone else – you can imagine a view being taken that Article 2 considerations may apply to any patient suicide.

But in a very real sense, they do – s13 imposes a legal duty to make the application when certain grounds are met and none of those involve beds and / or willingness on the part of the NHS. By not making the application when the act says that you "shall" make it, the AMHP is brought in to question. The old Mental Health Act Commission (predecessor of the CQC) even went so far as to issue guidance on this particular point, reminding everyone that they have a duty to comply with the Act and this advice was obviously subject to legal advice before being put out there. It advised that the AMHP should go to the s140 list and make their application to the relevant hospital. They should then detain / convey the person to that place and resolve the issues at the hospital with hospital managers. I'm aware Professor Jones argues in his books that this approach is 'of doubtful legality', but then so is not doing this in the circumstances you've described.

The United Kingdom is a signatory nation to the United Nations *Convention on the Rights of Persons with Disabilities*. Given other points I'd prefer to make, I'll just leave that comment there, because we can imagine what that might say about all this.

PRESSURE ON AMHPS

This kind of situation is just one of the many I referred to in a recent post on AMHPs as to why I wouldn't do their job for all the money in the world – but I worry about them in this particular situation. Having delivered CPD to AMHPs on a large number of occasions, I tend to find it almost always the case that AMHPs believe that they CANNOT make a legal application to a hospital unless it has been identified in advance as willing and able to receive the patient. And yet I've also met AMHPs who have done so, *in extremis*, in order to bring pressure to bear on a system that was asking them to absorb intolerable professional responsibility for risk management, way beyond their ability. I've also met solicitors and barristers who have given a different to that expressed in Professor Jones's Mental Health Act manual that the MHAC advice (above) is 'of doubtful legality'; or at least have gone further to recognise that acting against the advice is similarly precarious.

Firstly, the MHAC advice was issued after taking legal advice – so already, we have a difference of opinion between lawyers which shouldn't shock many of us. Secondly, not complying with this advice is also of doubtful legality! You either end up with unlawfully detained patients because professionals are too frightened to release someone, knowing the obvious risks involved; OR you end up with a person being released when they should have remained detained and all the obvious legal issues that can or do flow from that.

Secondly, why should the AMHP be the person who has to take responsibility for not complying with their legal duty (s13) when the situation is not of their making?! I just don't see that as fair. If I attend a 999 emergency as a police officer and find a man has killed his friend or partner, he's getting arrested for murder, whether or not the custody sergeant has a cell!! The problems that flow from my decision are simply not for me to absorb – it's for the sergeant, duty inspector and chief constable to sort out! If need be, police officers can sit with him in the holding area of a cell block for as many hours as it takes whilst they get it sorted. Not arresting him is NOT an option – and nor would that be expected of me, which is perhaps the most important point. I'm not expected to duck my legal responsibilities because of any problems in the system. In reality, were this ever to happen, we'd find the nearest non-violent, non-vulnerable prisoner and kick him out – we can sort out the shoplifting case later. I cannot even begin to imagine any officer of any rank criticising my decision – they'd just be working flat out to support it, by creating the capacity and resilience required by doing something.

HOSPITAL ADMISSION

Of course, it's always pointed out that hospitals aren't legally obliged to accept a patient, even where an AMHP has made an application. Fair enough – imagine for a moment it was done, the police and AMHP turn up at an acute admissions unit which also has a PICU unit and the AMHP explains the situation to the ward manager, asking them to escalate to the on-call manager. I wonder how prepared they would all be, when they see a human being in distress, flanked no doubt by the police, and an AMHP pointing out why they felt they had no other choice but to do what they've done to somewhat force the issue and remain lawful. Imagine the AMHP and police saying they'd remain at the hospital to help with whatever transitional arrangements were attempted until a solution could be found. Would that manager delude themselves in to thinking that any decision they took not admit the person or in some way make arrangements is entirely neutral for them in terms of any liability for anything that may follow, knowing full well that the AMHP and police will document that person's name for the benefit of any Coroner or criminal inquiry if the person is not admitted? … or will they start improvising alternatives and perhaps escalating it to their Chief Executive and / or the CCG on-call director?!

This is more than hypothetical: it's not hard to provide evidence of suicide following non-admission; it's also possible to show evidence of serious offences being committed by acutely unwell patients whose MHA assessment or admission was delayed when powers under s135(1) were available to AMHPs with warrants. And as other AMHPs were themselves pointing out, there are some temporary solutions which could be considered –

1. Call in additional staff and admit the patient to the PICU anyway but with 3:1 nursing support.
2. Also consider the most well patient on the PICU and transfer them to an acute ward with additional support, whilst considering whether someone in the acute ward could be safely granted leave. Again, we know this happens on occasion.
3. 'Admit' the person to the Place of Safety and secure extra staffing or even, some police support, to keeping the situation safe until a bed is found. Before anyone thinks of reasons why this can't happen, it's happening 2/3 times a month in just one MH trust I know of – it's a regular tactic to manage demand, alas.

There will be others …

So we all need to be aware: we have reached a point where perceptions amongst some professionals are that things have become so very difficult

we just release people who everyone agrees need detention on public safety grounds and we do this notwithstanding the obvious legal issues, arising. To make things worse, the AMHP made it clear that a second patient in police custody also required a PICU and that bed search wasn't going well either. My final point is this: don't fall in to the trap of thinking this is austerity politics (small or big P, as you prefer) or any kind of recent development: these kinds of difficulty in admitting patients promptly have been going on for years and *years* and **years** but the pressure is all too often absorbed by AMHPs and the police. I submit we should operate professionally within the law in such a way as to ensure the pressure is on the professionals in commissioning and management to resolve the invidious positions that frontline staff didn't create. I feel entitled to say that because if one more senior psychiatrist or CCG commissioning manager asks me, "Sorry, what's s140 MHA – I've never even heard of that!" … I may just have to do a small scream.

Perhaps it's with me being a policeman that I tend to take that question very badly – because, whether it was part of your professional training or not, the public have an inviolable right to expect that public organisations will comply with the legal duties and wider legal frameworks that govern them because **it's the law of the land** and as we all know: ignorance is no excuse.

22nd July 2017

Please, Just Stop! –

There is a commonly occurring scenario amongst our 999 colleagues in green and blue where they unwittingly conspire together to cause a nightmare! – and it needs to stop before someone is disciplined or even worse, hurt. I wouldn't BLOG on this unless it had happened a large number of times and I'll prepare you: I'm unapologetically *banging on at length* in this one to set it all out *again*(!) because it really grinds my gears how often I hear of it! If you just want to skip to the punchline, there is a Quick Guide on responding to mental health crisis in private premises.

The scenario usually goes something like this –

Paramedics attend a 999 call reporting a mental health crisis on private premises. When they arrive they discover a non-compliant patient in distress and after talking to them, they form a view the person has potentially serious mental health problems and appears to lack capacity around their immediate decision-making. They are concerned the person would be at risk if they were left at home so paramedics call for police support and when the officers arrive they point out that potentially serious mental health problems, indicate the person needs to go to hospital for urgent assessment and that they have been assessed to lack capacity. The officers take that at face value, after all, NHS staff typically know more about mental health and appropriate assessment or care than police officers, so they decide to remove the person to hospital, most usually to an Emergency Department. Upon arrival of the patient, who by now may well be in handcuffs or under at least some form of restraint if they continue to object, there is inter-agency confusion and conflict. What is the legal basis of the person now they're here; if the person is still non-compliant with what is occurring, whose responsibility is it to stay with the person to prevent them from leaving; can the police handcuff someone if they are relying on the MCA to intervene; … and many more confusions and conflicts besides.

Where a version of this has occurred, it will usually have gone awry long before the conflict at ED! From everything I hear in discussion on social media, the MCA is blatantly overused and sometimes straight-forwardly abused in many of these circumstances. This BLOG is a direct result of a discussion raging right now on a mental health nursing forum on Facebook!

THE MENTAL CAPACITY ACT

Of course, the MCA does offer some protection to people who act in accordance with the principles of the Act where they do the least restrictive thing in someone's best interests. But there are real difficulties and extra legal criteria to be satisfied before any of this allows someone to rely on the MCA to restrain someone or deprive them of their liberty. I've written about the MCA elsewhere in terms of the principles and the assessment of capacity, so refresh your memory about all that if you need to. For here, I need only say that if you're going to restrain someone, that must be a proportionate intervention, relative to the likelihood and seriousness of harm the person would otherwise face (section 6 MCA). If restraint occurs in such a way as to deprive the person of their liberty, then it can only occur in order to provide a life-sustaining intervention or to undertake vital act to prevent a serious deterioration in their condition (section 4B MCA). I usually explain that this means someone's condition, without urgent removal to hospital, must already be more or less life-altering or life-threatening.

The so-called 'acid test' as to whether you have deprived someone of their liberty is to ask yourself whether the person under "constant supervision, control and unable to leave". In the incident which is often referred to as the 'Acton Swimming Pool case', the judge ruled that a detention in handcuffs amounted to a deprivation of liberty in around 10 minutes. So removing someone by force to hospital in a journey that probably takes much longer than that and with the intention of holding them in ED until further assessment is undertaken, it will almost certainly amount to a deprivation. Accordingly, don't forget to read the first sentence of s4B MCA –

"If the following conditions are met, D is authorised to deprive P of his liberty while a decision as respects any relevant issue is sought from the court …"

This means the Court of Protection, which can be accessed 24hrs a day for urgent issues, but it's never going to be the police's job in a medical emergency to start doing this – just remember to outline the fact of removal under the MCA to the paramedics / triage nurse at ED and tell them to get advice on their responsibilities if they wish the police to remain there, ensuring any ongoing deprivation of liberty.

SO WHAT WENT WRONG?

Do you remember the Sessay case, from 2011? If not, re-read the first paragraph of this BLOG and imagine a scenario similar to that one but

where paramedics were not involved at all and where the police officers took the patient to a health-based Place of Safety rather than an Emergency Department – then you'll have the gist of it. Ms Sessay was held in that PoS for several hours and then sectioned under the MHA having been removed from her own home 'under the MCA' when it was neither immediately life-altering nor life-threatening. She successfully sued the police and the mental health trust for removing her from where she lived whilst purporting to rely on the MCA as the legal basis for intervening. Her situation was difficult and she was clearly a vulnerable adult, but it wasn't – *there and then* – any kind of life-altering or life-threatening incident. In the ruling on that case the judge made it clear that he saw "no lacuna in the law" … in other words, the statutory framework for intervening in private premises to assess in their own home or to or remove them for assessment, is the Mental Health Act 1983 – where the person is thought to be suffering a mental disorder.

The reason things tends to go wrong, in my own view, is that paramedics and police officers misunderstand the relevance of the Mental Capacity Act and massive overstate its utility. For all the examples of this kind of thing, I'm not aware of many of them being fully challenged, either by the patient in a complaint or civil claim, OR by supervisors in the services (who will have had similar training to the frontline staff, in all fairness to them.) The *Sessay* case is the exception.

And for the police officers reading this, one particular thing that goes awry is that you believe you are obligated because paramedics had declared the person to lack capacity. I've been there – in all fairness the person may lack capacity, but here are two crucial questions you need to ask the paramedic who claims this to ensure you're acting lawfully –

- **What does the person lack capacity for, precisely? –** people don't just have capacity or lack it; there has to be a decision somewhere in the incident in respect of which they lack capacity.

- **What are the medical risks if we do not remove them to hospital? –** this is where an assessment of whether someone right here and right now, is likely to suffer a life-altering or life-threatening consequence because of their condition.

So where our friends in green say, "This man's taken an overdose of 100 tablets that will probably prove fatal and he lacks the capacity to understand he may die", then it's job done – all the MCA boxes are ticked and we can act to safeguard him, including by using a level of restraint proportionate to that risk and take him to an Emergency Department. Where someone has injured themselves and the injuries are superficial cuts which require some cleaning and dressing, it's much more difficult to justify because no-one is likely to die from that. You may be justified in restraining

someone to remove a bladed article from their possession so they cannot injure themselves further, but once that has been done, the restraint should probably end. If you want to reflect on the legal wording of things, look at sections 5 (the general defence to acts done), section 6 (additional criteria for restraint) and then sections 4, 4A and 4B (which all relate to depriving people of their liberty).

SO WHAT'S THE DRILL?!

Upon arrival of emergency services in someone's home, the first consideration may well be an urgent assessment of whether crews have walked in to a life-altering or life-threatening situation which requires immediate action because someone lacks capacity. If it does, crack on – no problem. Tell the hospital on arrival that you've acted under the MCA because of the circumstances, that urgent consideration needs to be given to their treatment and also to any need for the involvement of the Court of Protection.

Most usually, however, the matters will not be so urgently life-threatening as to justify this highly restrictive approach. If we find a person who is believed to be vulnerable because of a mental health problem that requires assessment you have to work out a way of helping the person access a relevant service by taking them to it or by getting the service to the them – and you must proceed on the basis of doing 'least restrictive thing'. This is a term used in both the Mental Health Act world AND the Mental Capacity Act world and for the benefit of police officers, it's not entirely dissimilar to the idea of reasonable force. You can only become as restrictive as you absolutely need to be – anything more and the intervention is disproportionate and therefore unlawful.

- So, would the person agree to attend any kind of walk-in service for those of us with mental health problems? This might include ED who have psychiatric liaison services, but there could be other places like a Sanctuary, or a walk-in service specifically for mental health, like the Birmingham Psychiatric Decisions Unit.

- If the person is not willing to agree, irrespective of whether they lack capacity, then your standard options remain: contact their out-of-hours GP; if the person is known to MH services, contact the community or crisis team, depending on the time; if you have any kind of street triage service or a mental health nurse based in the police control room, they are an option. You are may have further options locally.

- And, of course, if officers are thinking, "this is a section 136 type scenario, albeit in a house", then officers and / or paramedics would

be quite entitled to ask the local authority to consider the need for a Mental Health Act assessment, via an AMHP and a DR. Remember this judge's views in the *Sessay* case.

- The route to assessment may vary, the ability of those services to respond in a timely way may vary, and in some areas AMHP services will not accept a referral directly from the ambulance service or the police. That is a policy decision by them, not a legal barrier they must respect. Escalate to your bosses and theirs, make the case and ask for help. It remains for others in all the services I've listed above to explain why they did not or couldn't help.

Please don't think I'm being naïve in suggesting these options, because I am aware of how likely some of those attempts are to fail – I've been that duty inspector countless times! But what I do know, is that where I try, I can stand in a Coroner's court, should I ever need to do so, and explain to a vulnerable person's family that I did everything I lawfully could. And if it does fail at the first attempt in respect of a person who lacks capacity but who is not suffering an immediately life-altering or life-threatening condition, then the MCA may allow officers or paramedics to remain on the premises even where there are objections whilst they or their supervisors escalate matters to ensure that less-restrictive outcome.

DEAR COLLEAGUES

Those final points are really important for first-responders in blue or green, however: the fact that you think attempting to do the right thing will be unlikely to succeed is NOT a justification for failing to try. It is also important to know this is far from hypothetical! In my role at the College I have been required to assist forces, the IPCC and Courts in reviewing several of these kinds of incidents, some of which have involved tragically adverse outcomes where vulnerable people have died. I can assure you the focus is always going to be on those officers or 999 crews to ask if they did all they could, *irrespective* of whether they had any legal powers.

But non-999 colleagues should remember remember this: the law is currently framed in a way that was originally set in the 1950s. I'm sure we can all agree: society, mental health care, practical interpretations of human and legal rights were different. Stated cases show that the days of the police being very casual about those rights are over: police forces have been sued and challenged in a range of ways for a variety improvised solutions to the sorts of scenarios we're considering here. They lost them all. The law is that police services have no powers whatsoever under the MHA to remove people from their own homes, even where that person IS reasonably considered 'to be in immediate need of care or control', as per section 136 of the Act. They can only rely instead upon the MCA where this

high-threshold of 'life-altering' or life-threatening' consequences are looming large.

To bring things right back to 2017, our Government and Parliament are now bound in to this arrangement: the UK Government reviewed police powers under the MHA in 2014 and this led, in turn, to the Policing and Crime Bill 2016. During consultation on the Bill there was specific consideration of whether the legal situation in private premises needed altering, *either* by amending police powers OR, in preference, by *ensuring* the ability of the police to call upon appropriate professionals from health services to assist. The Bill was introduced in February 2016 and contained no proposed change to the law. Despite the tabling of amendments during the passage of the Bill, Royal Assent was given in January 2017 without those amendments succeeding. So this legal scenario is exactly how we, as a country, have decided we want it to be. We cannot in all conscience then blame 999 services for failing to sort what we decided they can't.

WORKING TOGETHER

All public services professionals working in emergency mental health care must accept this means that paramedics and police officers *must* rely and must be *able to rely* upon some form of support from other agencies when faced with these challenges. Those agencies and professionals must remember, once they're engaged, they have a duty to ensure the human rights of patients; not only their right to life, but also their right not to have the state over-interfere in their right to a private life. This means, accepting all difficulties about resources and so on, that we must be able to work together, including at short-notice, without *any* expectation that we leave 999 crews powerless and responsible for things they simply cannot resolve. It is simply not fair to expect them to shoulder responsibilities for something they had no power to fix.

Senior managers need to ensure effective joint protocols around this and finally, the answer to this is not always going to be 'Street triage'. Mental health nurses, brilliant thought they are, offer no legal powers to these situations and some of the examples of private premises problems also involve nurses being on scene, supporting 999 crews and it making no difference because the nurse agrees a patient needs formal assessment under the Act or removal to a Place of safety – a legal solution is sometimes required.

23rd July 2017

Admissions on Admissions –

You may have noticed the Care Quality Commission published a report this week on the State of Mental Health Care. Or maybe you were getting on with your life or your job, but I've given it as much time as I have spare and was very interested in what I read. The CQC run an ongoing programme of inspections across the mental health trusts of England (there is a separate inspectorate for Wales) and they are also the statutory regulator for the use of the Mental Health Act 1983. This week's report seems, to me at least, to be an overview of the individual reports they produced in their last inspection round, peppered with a sprinkling of MHA insights. I hope I understood it correctly.

As ever these days, with so many reports to read and keep an eye on, I tend to sometimes use my iPad just to search for terms within the report that will be relevant to my work. Things as obvious as 'police' often through up little nuggets and so it proved with the CQC report.

Page 38, worth quoting a block of the text, if you have a spare moment! –

"There is national concern about the difficulty of finding a bed when a young person requires inpatient care. When a bed is found, it is often a long way from the young person's home. We do not always detect this unmet need because our assessment focuses on the quality of the care provided to patients who are already on the ward, and not to those that require or are awaiting admission. However, we have received reports of the impact of the unavailability of inpatient care. This includes a letter from an assistant chief constable about a 17-year old who was kept in a police cell for 78 hours because no bed was available. The assistant chief constable commented that "the majority of this time in police custody was unlawful and it amounts to a human rights violation, given that Article 5 of the European Convention on Human Rights prevents detention by the state except in accordance with processes outlined by domestic law".

Three things from me, on this –

- We now have it plainly laid out that the CQC doesn't appear to look at the admissions process – they look at the care provided once people are admitted. This makes sense of various things which have confused me for years. I have wondered why the process never

seems to be mentioned in any detail as there are obviously legal issues surrounding it.

- We can see here that senior police officers are putting it in writing to inspectorate-regulators that they believe they are being asked to inflict or endure human rights violations of vulnerable people in police custody because of delays and difficulties in securing timely admission. This mention of 78hrs is just the tip of the iceberg, I can assure you.

- Nowhere in this report in section 140 MHA mentioned – this is the legal duty on CCGs to ensure hospitals are designated in connection with urgent admissions. It is something that was unmentioned in CQC reports for the first few years of their existence and has only recently appeared. I simply don't know what the CQC think about any of this.

Oh, no, four things – at no place in the **entire report** about the state of mental health care does the report mention Approved Mental Health Professionals, the AMHPs. Simply staggering!

ADMISSIONS PROCESS

I would love to see this looked at every time an AMHP fills in an application for a patient's admission under either s2, 3 or 4 of the Act, they fill in a statutory form – they also complete an AMHP report. This means that somebody, somewhere is sitting on a goldmine of information because the two, taken together will outline when an AMHP was notified of the request for an assessment, when they secured the DR(s) to assist them in undertaking it and when the assessment took place. It will note the conclusion they reached, what the outcome needed to be and when a bed was notified to the AMHP after any assessment indicated admission. It's all there to be reviewed – and of course, the location of the MHA assessment is recorded, so we could even examine whether any difficulties vary across Emergency Departments, police stations or community based assessments, for example in patient's homes.

If we have Assistant Chief Constables writing to regulators with a 78hr example, does it occur to wonder how often such examples are occurring? I have recently done work on this which has formally been reported via Chief Constables to the Home Office and Department of Health. 78hrs, or just over three days detained, is just one of the lesser examples – another was 97hrs, which is an interesting number because that's 1hr longer than the police in England and Wales may detain a criminal without charging them with something and remanding them to appear at court. And some of the examples are measured in three figures, if we're still counting in hours, not days. If these situations do amount to an Article 5 violation – detained

by the state without an obvious authority in domestic law – then how many of these situations do we have nationally in a given month or year?

Section 6(1) of the Human Rights Act 1998 prohibits public authorities including the mental health trust, the CCG, the local authority and the police from failing to ensure the Convention Rights of vulnerable people in these situations. I've said before and I will say again, there are two issues in domestic law that are conveniently forgotten in the creation of these situations. CCGs have a duty to ensure the health needs of their populations are met and section 140 MHA in particular imposes a clear duty to designate hospitals which can receive patients in circumstances of special urgency. How many CCGs comply with this in any meaningful way? My Freedom of Information requests suggest, most don't comply – some don't even know what the question means. This, in turn, creates a situation where Approved Mental Health Professionals can't comply with their duties under s13 of the Act – the duty to make applications where the grounds for doing so are met.

We've had police forces threatening and starting legal action against the NHS over this, we've had Assistant Chief Constables tweeting publicly to pressurise managers to resolve ongoing situations, we've now got them writing to regulators and escalating to senior officials in the Government. I'm merely suggesting it's way beyond time we dusted off those MHA applications and those AMHP reports and see what they reveal.

29th July 2017

Body Worn Video and Mental Health –

The police have been rolling out body worn video (BWV) for many years now. You will notice, if you look at 999 response officers on patrol, many of them have two devices hanging from the upper portion of their protective vests: one of them is usually their police radio, the other, slightly smaller device is usually one of several types of camera. This gives a fish-eye view, with audio, of what is in front of that officer at that time and offers considerable insight in to the incidents they police. I remember when I first joined, most police custody suites did not routinely have comprehensive CCTV throughout and that when this was first introduced there was an amount of disquiet about the surveillance and scrutiny officers would be subjected to both whilst attending to their duties and whilst in between. However, once rolled out, most custody sergeants – and I was one of them! – took the view that it merely assisted in showing some of the outrageous things people do to the police, the support staff (including healthcare staff) and to themselves whilst detained and that we were, in the main, working hard to ensure we handled people professionally. Recordings from police custody have been used to assist in convicting people of murder and been used to acquit officers of wrongdoing when accused of misconduct or assault, perhaps far more quickly than they otherwise would have been. Of course, a few managed to show the opposite, but it greatly assisted in holding the officers to account.

When I was posted as an intelligence & offender manager inspector in 2007, I was given the responsibility for trialing some BWV equipment that had been secured for the area. The devices weren't especially reliable, there was all manner of problems from actually downloading the captured images to IT systems, issues around data storage as well as keeping clear audit trails for evidential purposes that would allow their use in court or complaints processes. In particular, it was especially difficult to present the material in a way that keep the audit trail of how 'edited' the footage had been. Some may say, "Why edit the footage at all?!" … well, an officer may have attended an incident and been there for half an hour, but only 90 seconds of it recorded anything of evidential value. Even allowing another 90 seconds either side of that segment, you'd need five or six minutes of footage, not the full thirty minutes, so should the CPS and Courts just be given unedited footage and told to work it out for themselves? That would cost a lot of time. Officers also occasionally use the toilet during their working hours and none of wants to see that!

The basics of this are that devices record when the officer turns them on and starts recording, the device will store the last X-minutes of footage before starting record over itself – ie, 30 minutes held on camera and when it starts to record minute 31, you lose minute 1 unless you've instructed the device to preserve it. Officers could press the button early on to preserve an extended period and if they don't, you'll lose minute one of the footage as soon as you've started recording minute 31, for example. Upon completion of their shift they download that content to a secure IT system and if they do wish to edit the footage to highlight the two five-minute clips of value, they can create the smaller, shorter files without losing the longer ones. On my iPhone – I've been on holiday in France, filming my son jumping in to a swimming pool and when I trimmed the clips to upload for his grandparents' delight, Apple gave me the option of trimming the old clip and making it shorter, or creating a new shorter clip in addition to retaining the old one. The police software for BWV doesn't give the option of trimming the original: it only creates a new file of the shorter version so that all can be subsequently seen by courts, Professional Standards Departments or the IPCC. You can see the College of Policing's interim guidance on BWV, subsequently incorporated in to all guidance for the service – this still represents a decent summary of all the issues, should you want detail.

MENTAL HEALTH

And inevitably, we've started to see BWV issues in the context of mental health incidents … and it's causing discussion. The College's guidance document doesn't mention mental health and, of course, officers responding to 999 calls or other situations may well turn on their cameras *en route* to an incident without knowing what the incident is and, having dealt with it, may instruct the device to preserve that evidence of the interaction for a range of reasons. For spontaneous incidents, I think we all understand that some filming of vulnerable people is inevitable and indeed, some may think it helpful in terms of being able to see how officers handled things, should there be a complaint or dispute – it preserves the rights of people to ensure accountability.

But what happens in other, more sensitive and pre-planned situations? The three I've recently received questions about are –

1. BWV whilst executing a warrant under s135(1) MHA – an intervention in someone's private home that may involved a Mental Health Act assessment taking place there.
2. Continued use of BWV in a health based Place of Safety where NHS staff requested officers turn off the video and a conflict occurred when the officers refused.

3. Police attendance at an inpatient mental health unit, following a request by NHS staff that they help with a patient who had become violent towards staff and other patients.

One objective of BWV is to record the actions of officers when they are using police powers and especially when they are potentially coercing other people under those powers. Accordingly, force policies often stipulate that any entry to a building that is conducted under the terms of a court warrant, where entry is, by its very definition, opposed by the occupants, should be recorded. In one police force, I read a policy that made it absolutely clear: this was mandatory and not up for debate. The filming should not only extend to the entry by force, but also to the time spent on the premises as trespassers right through to point of leaving. Granted, the authors of the policy may well have been considering drugs raids, searches for firearms of stolen property and if they had missed out mental health act warrants in their considerations, they wouldn't be the first or last police officers to do so.

That said, are Mental Health Act warrants any different from the perspective of what we're asking BWV to capture? – did officers make reasonable attempts to enter without smashing the door off; did they use proportionate force in gaining entry; did they use proportionate and dignified methods to search the premises for the person sought and secure the premises? What discussion took place by the officers about their decision-making – for example about whether to remove the person to a health-based Place of Safety for assessment under the Act, or for the AMHP and DR(s) to undertake that assessment in the premises? In many respects, it's little different: although some may argue there are different things at stake given the nature of the warrant, this pre-supposed that crime warrants are not especially sensitive, capable of intruding on third-parties who live at the same address, etc., etc..

DOING DETAIL

It gives rise to an important question, doesn't it?! … **can an AMHP, the patient or anyone else (like NHS ward staff) demand that the camera be turned off?**

No, they can't.

- The operation of BWV is something which is for the officer to justify and the legal advice is that they have a common law power to do so where they judge it reasonable and proportionate.
- The guidance is generally that BWV should not be used in private dwellings but that this can be done where justified, but not just as a routine record of proceedings.

- It should be considered only where officers reasonably believe they will be making written records of events, because of the use or potential use of police powers.
- Although it is unmentioned in the guidance, one can imagine this would extend to NHS premises – nothing prevents staff asking for videos to be turned off, but where officers feel this cannot be done they should explain the reasons why.
- Of course, depending on the legal situation in hand, nothing prevents the AMHP or NHS staff preferring that officers leave a situation rather than it be recorded, if the officers are not prepared to turn it off.
- Finally, principle 3 of the document outlines how 'common sense' should prevail – hence the point officers should be considering BWV only where they anticipate making written records for legal reasons.
- If a section 136 detention on camera had led to someone being removed to a Place of Safety and any resistance, fear or volatility at the point of detention had abated and everyone is just sitting around waiting for assessment, what would the point be?
- If the wait involved continued circumstances which justified the use of it, then it can continue for as long as officers remain.

Nothing prevents mental health trusts and their police forces sitting down to discuss BWV and agreeing to refine any joint operating protocols – indeed, there is a duty on the police (principle 7 in the College's guidance document) to consult about the use of BWV. Accepting that officers retain the right to use the equipment notwithstanding views that it should not be deployed, they are required to justify their use of it, by outlining what they thought they'd be gaining, against that which they were risking. So we need to be talking to people if we're asked about it and not just saying, "No – it's my decision." Of course it's also worth remembering, any footage in any incident which is not required for a criminal investigation or prosecution will remain securely stored in a police data warehouse until data protection policies see it deleted – this stuff isn't going to end up on YouTube without a specific reason for putting it there!

Body Worn Video is part of the new normal. It must be borne in mind that some of the most controversial incidents in all of policing's history have been deaths in custody involving vulnerable people in mental health crisis. We can see all around us campaigns from families and friends demanding justice and accountability for the death of their loved one – something I sure we can all empathise with were it ever to happen to our loved ones. BWV will go some distance to ensuring that where officers have stuffed up, they are able to be held to account. That said, I'm perhaps bound to observe that where officers are dealing with the complexities and sensitivities I write about on this blog, they're getting it right in difficult circumstances more often that not, and body-worn video is potentially crucial in showing the difficulties we face to those who hold us to account.

AUGUST 2017

3rd August 2017

Re X (a child) No 3 (2017) –

Today, the head of the Family Division has handed down a judgment containing some of the most extraordinary language I've ever known a senior judge to use, questioning whether the issues before him mean we can lay claim to being a civilized society and warning that we may soon "have blood on our hands.

WOW! …. just WOW!!!

It concerns the case of a 17yr old young woman, currently detained under criminal law after being sentenced by a Youth Court and who is due to be released from that secure custody location 11 days from now – the 14th August. It is agreed by prison staff, mental health and social care professionals that she requires admission to an inpatient mental health unit for further assessment and treatment, one estimate being that she may need to be there for as much as two years in the opinion of the Consultant Child and Adolescent Psychiatrist who wrote a report. It is further agreed that she poses and real and imminent risk of suicide if released, staff fearful that she wouldn't be alive more than 24hrs or so. I'd encourage you to open the ruling and read it: it's quite remarkable, not least because Annex A to outlines the current lengths the custodial staff are having to go to, to keep her safe. Highlights of this include, constant 2:1 observations at no more than arm's length at all times, 8 staff on standby to restrain her and it outlines various risks and issues which give rise to the need for this level of intrusion. Trust me: the previous sentence you've just read **doesn't even get close** to outlining to scale and depth of challenge for staff attempting to keep this vulnerable young woman alive.

X, as she is known in the legal rulings, requires a low-secure adolescent psychiatric bed that is not available. There are six of these facilities in the country and all are currently full. None anticipate a bed becoming available in the next few months and the clock on that sentence is ticking down with just 11 days remaining. In today's judgement, Justice Munby refers to his own second ruling from June in which he states that unless some progress is made, he "we should be left with little but the hope that the police would have had occasion to take X into custody before she was able to cause herself irreparable harm. Is that really the best the care system and the family justice system can achieve?" (in paragraph 8 of today's ruling). The

judge has directed a copy of the judgment be copied to the Secretaries of State for Health, Justice and Education in addition to the Home Secretary.

But my main area of focus is obviously "we should be left with little but the hope the police …" I can see why he says it, but let's take that to its logical conclusion, shall we?!

WHAT COULD THE POLICE DO?

Well, we could help kick the can down the road for a bit … if that helped?!

Of course, if X were released the police could get involved in responding to her, but it's already at least doubtful that decision would survive contact with Article 2 ECHR given the risks. There is a statutory mechanism available today to transfer someone from the 'prison' estate to the mental health system: it's section 47 or 48 of the MHA. Not doing that then releasing an obviously suicidal person begs its own legal questions because the prison service cannot act in a way that fails to ensure convention rights – the right to life being more important than the others in the most immediate sense. Obviously, they're all important. I digress …

So, you could call the police on 999 … "I need officers now to detain someone outside under s136 MHA who is about to be released." This has happened before around the country and it's usually exceptionally difficult stuff because we invite the police with no planning or knowledge to do as they're told when they're highly confused about what's occurring and why and in the certain knowledge that they're not appropriate professionals to be caring for people, certainly not people as complex and vulnerable as X. But first things first, let's hope the officers get there quickly enough and actually do encounter her, otherwise we've immediately got a high risk missing person inquiry on our hands. Assuming they do, they will inevitably consider section 136 MHA, to remove the young woman to a Place of Safety for assessment. She can be held there for 72hrs, for necessary arrangements to be made. The legal pedant in me wonders whether using section 136 is right when we don't need any assessment of that person's needs. Section 136 is for the purposes of allowing the individual to be 'examined … and the making of necessary arrangements'. We already know the assessment: it's already been done; we also know the arrangements should have been earlier and weren't.

However, no police officer in the country will be arguing that, they will be wanting to keep X safe but given the judge has spent over a month pressurising the system to no avail and has quite appropriately issued a rocket in today's ruling, I do admit to wondering whether an extra three days will help us achieve in fourteen days what he's already worried about achieving in 11 days and which hasn't been achieved over the last 40 or 50

days. It seems likely that if we get to the point of s136 being used, it will probably expire again without a bed becoming available. We already know from the ruling that the low-secure CAMHS bed is unlikely to become available for several months, according to today's ruling.

So eventually the poor old custody officer will face the decision that the prison system will face in 11 days' time: do we release an obviously suicidal person from custody, quite probably in violation of Article 2, or risk violating Articles 3, 5 and 8 to keep her alive? I must admit, I have some of my own views about just kicking this further down the road to the police instead of considering now those arguments the police will have to consider after 72hrs of s136 when they will be less well placed to do so. It would be an abrogation of an obvious kind. If the objective here is to pursue admission to a mental health unit and that this could happen today under s47 if a bed existed, why not just continue to hold the young person under the current arrangements until that bed emerges? Would section 139 not apply to the prison's actions?! To be fair to them, it's not clear that it would as I'm not aware of that argument being tested in court and lawyers seem to disagree. In fairness, though – don't they always?! Whether prison or police, we could always ask that question, would the organisation rather be sued for trying to keep someone safe and alive, rather than questioned about why they took deliberate decisions which endangered the person because other organisations were unable to deliver on their part of the deal. If things were going swimmingly for this young woman's transfer to an appropriate care facility, she would not be released at all, but transferred. There is an argument for saying, "Keep her detained and alive, then!" and whilst this is a moral, not a legal argument, I'd be interested to know the reasons why a court would condemn professionals who took this view.

But then it all comes back to the original point: this situation is complex beyond words and if you chose not to do so when I first mentioned it, go and read Annex A of the ruling and ask yourself: are the police the correct organisation to be running in to that unwarned whilst being implored to 'Do Something!' … that's all it amounts to. I suspect the police service towards whom this tragic case seems to be heading will know absolutely nothing about it whatsoever and it would seem a contingency plan of some kind is needed in case it comes to that, as the judge seems to fear it might.

Complex beyond words and even more tragic. I repeat: I've never known judge's remarks of this kind in a case like this and I can't say that I disagree with any of them.

Update (4/8/17) *– a bed was found just over 24hrs after the publication of the judge's remarks.*

Update (7/8/17) *– the ongoing difficulties in making this happen are reflected in a further High Court ruling, "No 4".*

7th August 2017

Endemic Abuse –

DAILY NEWSPAPER OF THE YEAR

THE TIMES

Monday August 7 2017 | thetimes.co.uk | No 72295

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Chelsea blow it at Wembley

Henry Winter Sport, pages 62-63

NHS abuse of mental patients 'endemic'

Warning over use of force amid record violence

Peter Yeung

Record levels of violence and abuse against vulnerable patients at mental health trusts were reported last year amid accusations of "endemic" use of force in the NHS.

More than 5,000 serious incidents involving both children and adults were investigated, including hundreds of suicides, dozens of killings, more than 2,000 cases of self-harm and even deaths of children.

The figures, obtained by The Times through freedom of information requests, have shocked a sector reeling from accusations of flawed care after the High Court judge Sir James Munby lambasted the "disgraceful lack of provision" last week for a teenage girl at acute risk of taking her own life.

Most of the serious incidents relate to quality of treatment and patient safety, and showed:

- More than a thousand complaints relating to care, including delays and use of medications.
- 2,170 incidents of self-harm.
- 371 suicides.
- 198 confidential information leaks.
- 199 cases of abuse of patients.

The Times has categorised each serious incident report and found that the number involving abuse of patients rose from 106 in 2013-14 to 199 last year. Investigations carried out into abuse of child patients rose from 9 to 39 in a single year. NHS figures show that 103,027 people spent time in specialist mental health treatment in 2015-16.

Norman Lamb, the former Liberal Democrat health minister, said that force was used "far too much" in mental health treatment.

He added: "It's just intolerable — the trusts need to be accountable. The use of physical force is endemic in the system. Abuse of patients, on the face of it, can be characterised as gross misconduct. The system is under an impossible strain and it shows that we're not providing enough resources to good, preventive care."

Approximately a quarter of people in Britain will experience a mental health problem every year, according to the mental health charity Sane. In the first official estimate of its kind, the children's commissioner for England has said that more than 800,000 children have mental health problems.

Anne Longfield, the commissioner, said that the experience of child patients in mental health services is of "rattling around a system that feels completely incoherent".

Expressing particular concern over the number of child deaths, of which there were more than 100 since 2011-12, she added: "One of the ways that these children are being let down is that as professionals we are not demonstrating the right levels of curiosity and determination about their treatment.

"I don't think the government is moving fast enough on this, showing enough determination on this or indeed putting enough money into this."

The figures from NHS England in 2015-16 met the serious incident guidance, meaning that they are significant enough to warrant an investigation, outlined by the health

Continued on page 2, col 5

Worth the wait Jessica Ennis-Hill received the heptathlon gold medal in London that she was denied by a Russian drugs cheat at the 2011 World Championships

Jihadist cell 'musketeers' spread hate on YouTube

Fiona Hamilton Crime and Security Editor
Duncan Gardham

The terrorists who plotted a deadly pipe-bomb and meat-cleaver attack shared scores of extremist videos hosted by YouTube that featured Islamist propaganda.

The terrorist cell known as the Musketeers exchanged videos from fanatics, some linked to the extremist preacher Anjem Choudary, who used dead fighters and bloodshed in the Middle East to reinforce their message of "martyrdom", the Old Bailey was told.

The Musketeers are the latest in a long line of jihadists who have used social media to spread their message of hate and to encourage attacks. One of the group sent material to a younger male relative to try to radicalise him. The court was told during the trial of their YouTube use.

The revelation comes as technology companies face increasing pressure over the accessibility of extremist content online. Last week Amber Rudd, the home secretary, visited senior industry figures in California and called on them to do more to stop extremists using their forums.

Khobaib Hussain, 25, Naweed Ali, 29, both from Birmingham, and Mohibur Rahman, 33, from Stoke-on-Trent, who all had previous terrorism convictions, were each jailed for life last week with a minimum of 20 years. Tahir Aziz, 38, from Stoke, a late recruit and the only one to attend sentencing, was told that he would have to serve at least 15 years. All four were convicted of preparing terrorist acts.

The group's plot was uncovered in an elaborate sting by police and MI5 in which Hussain and Ali were employed by a fake courier company last August. Undercover officers discovered a pipe bomb, imitation handgun and large cleaver carved with *kafir*, meaning unbeliever, in Ali's car.

Their four-month trial was told how they shared videos hosted by YouTube as they made their plans. The jury was told about 28 videos, most of which contained extremist material.

The four men moved the videos between themselves on the encrypted application Telegram. Some of them

Continued on page 2, col 3

This morning's headline in The Times is a complete stunner – *NHS abuse of mental patients 'endemic'* (£). Already, early on the day of publication, we have various commentators running off down various routes, from

Professor Louis Appleby bemoaning a 'harmful media bandwagon', to individual mental health professionals pointing out that the words 'mental patients' are outdated at best and stigmatising at worst. Then we've already seen objections to the implied journalistic conclusions whereby *The Times* is mistaking every serious untoward incident review for 'abuse', which conflates distinct issues, apparently. I'm sure we'll see more of this as the day goes on – for example, I'm waiting to hear the 'bad apple' theory which we often hear about when it comes to excesses and abuses of police powers. This is the idea the majority of officers are good people who get up every day to put themselves in harm's way in order to protect the public and the stories we hear of abuse are isolated examples by individuals who joined and served for the wrong reasons – just 'bad apples'. I'm sure that's true of the majority of frontline mental health professionals, too – most of them are working hard in a struggling system, doing unpaid overtime amidst under-staffed services and they often do so at great cost to their own health and wellbeing as they routinely plug the holes in the dam. But that's not the point being made, is it?!

And you'll notice what didn't get mentioned in all of that – any abuse of mental health patients. Choose different words to 'abuse' if you prefer, but something that benotes the idea of patient's rights not being respected, physical coercion in the administration of care being excessive or disproportionate and, probably much less often, conduct amounting to wilful neglect or assault. This is a really difficult topic to raise, isn't it? – it makes us ask the most profoundly awkward and sensitive questions and no matter how someone goes about doing that, it will probably give rise to suspicions of there being an underlying agenda. We've seen this in today's coverage: *The Times* are helping to undermine the NHS so that it helps prepare the way for privatisation, according to just one that I saw; so-called 'anti-psychiatry' views are underlying this according to another … and bear in mind, we're only a few hours beyond the public waking up on this Monday morning to this headline so there is probably to more come.

But you'll notice what didn't get mentioned in all of that – any abuse of mental health patients. I'm acutely aware of the need for effective partnerships between the police and mental health services, so I tread lightly here and, I hope and suspect, with a heightened level of awareness about the difficulties staff face in providing their services. It's also true the police service has a role to play in preventing and investigating crime and abuses and that our first loyalties are to the public we serve and the law of the land. It is with those things in mind that I wonder if we can agree on just a basic set of shared facts and use them in discussions about these most difficult issues? It should be noted: some patients have already responded privately to tweets on this story that they will not engage in this discussion because they anticipate being shut-down in light of the responses they've already seen to it. Perhaps that is because we have other journalists, less likely to question? In today's *Financial Times*, David Tang

somewhat solipsisticly threatens, he "will howl and hunt down anyone who dares to question the NHS."

WHAT WE KNOW

- Many members of the public have had excellent care from NHS mental health services, who literally saved their lives.
- This is not everyone's experience of NHS mental health care.
- The numbers reported here are very small relative to the overall number of patients receiving care from NHS MH services, albeit they appear to be rising.
- The numbers published by state organisations are not always accurate – history shows some things can go unreported and misreported.
- Police forces do receive criminal allegations of abuse of patients in institutional settings – not all of which are proven.
- Some investigations have led to successful criminal prosecution of NHS staff – see Winterbourne View as just one high-profile example.
- Some of those investigations have been individual crimes, flagged by NHS staff and managers to the police and reflect individual's misconduct, not those of the organisations they were employed and trusted by.
- Coercive activities in NHS data, show more coercion in some trusts than others and answers as to why this is the case are not always obvious.
- If just one patient abused by an individual or amidst any culture that allowed it, that is one too many.
- No discussion is off-limits, as long as it is respectfully conducted and based on everyone's honest perspectives, experiences and a shared set of facts.

My own view, having read the article, was far less animated than some of the things we've seen on Twitter this morning. I wondered why we were surprised that a system under significant pressure to do more with less, is apparently seeing a rise in its reliance upon coercion and is less safe than it was before? If we are going to operate a system of mental health care which, in part and only some of the time, allows and indeed relies upon the exercise of state powers under the Mental Health Act to coerce people, then there will, from time to time, be viewpoints about the exercise of those powers which are irreconcilable, some of which may involve allegations of excess or abuse. This shouldn't be surprising, because we see it in all areas of state activity where coercive powers are used over other human beings. We see police officers, prison officers and mental health professionals have been convicted of individual abuses; we also see certain locations focused upon: institutions or organisations where the overall levels of coercion sit outside the norms we'd expect and see elsewhere.

My concern here is about whether patients who wish to flag their allegations or their perceptions of abuse can do so freely and in such a way as to mean they are taken seriously and examined, either by health service investigators or by the police? In my own operational experience, I've known situations where patients are alleging their rights have not been respected and upon arrival, you have to conclude they are correct. Voluntary patients being prevented from leaving wards without staff applying legal powers to keep them there, being a common example. What should be noted in response to this article is the number of patients or carers / families on social media pointing out they feel vindicated, because this story reflects something from their own experience. Whether that objectively amounts to any form of assault or neglect is another point altogether but if trust and confidence is important, ensuring reporting mechanisms and scrutiny of coercive practices is crucial but this post was motivated by no-one appearing to focus on the point *The Times* are making and debating that, directly.

I'll leave this final point here: I recently did a training input for police officers in Lancashire, one of whom asked a question to seek advice about how to handle reports by unwell, detained mental health patients that are 'obviously' associated with that person's paranoid delusions. The officer chose an entirely hypothetical example of something he thought was 'obviously' ridiculous allegation of criminal abuse but very much wanting to know how to professionally respond: he wondered aloud about staff poisoning the patients on the ward. I began to smile as he finished his example because it immediately made me think of an operational job my response team dealt with one Friday night about three years ago. Guess what, a member of staff at a residential care setting for vulnerable and elderly adults was poisoning the residents. One of them was hospitalised in intensive care and nearly died; many more were quite poorly for days. The defendant was not only a care worker, but a special constable with West Midlands Police! But the report made came from other care staff managers and notwithstanding her keenness to volunteer for unpaid policing activities, we arrested her within a couple of hours of the first report. She was charged with three attempted murders and sentenced to life in prison, albeit firstly with detention in a mental health hospital for treatment.

The fact that abuse is rare and highly unlikely, doesn't mean it isn't there, it doesn't mean it shouldn't be discussed and that it doesn't mean it isn't rising in a system under strain. The fact a national newspaper used a bad headline whilst making this point and that this is further pressure on a struggling system, doesn't mean we only get to discuss the headline and politics of mental health funding. No-one can say that abuse doesn't occur and that this is sometimes individual and sometimes about systemic cultures: history simply does not support such an interpretation of the shared and available facts.

11th August 2017

The Coroner's Courtroom –

For the first time in my career, I gave so-called 'expert' evidence to a Coroner's Court around a mental health incident. It all centred on the response to a vulnerable man in his own home and I will blog more specifically on that once the court has published its documents. Suffice to say here, I became quite concerned by the difficulty 999 crews seemed to face justifying their actions and inactions; as well as the extent to which other organisations tried to focus on those difficulties.

So leaving those specifics for later, here is a checklist for how to approach these issues so that as a paramedics or police officers you can't be the one accused of doing too little or failing in your legal duties towards vulnerable people. This is what I want you to know, having read hundreds of pages of documents and given over 5hrs of evidence overall, just in case you end up there connected to an operational incident.

PRIMARY ASSESSMENT

Imagine you enter a private premises and realise you are answering a mental health crisis call. You make that initial assessment of the person, the location and grab on to any information which is available. Here's the quick checklist for what I will call the primary assessment – this means the assessment of whether the police can take action now, without referrence to others, almost immediately ensuring the safety and wellbeing of the person they've just met, pending assessment –

- **Mental Capacity Act 2005** – this appears first on the list *purely* so you ask yourself whether you have walked in to a situation which is already, more-or-less, **life-altering or life-threatening?** It's obviously vital that we don't miss this!

- If so and you are responding to someone you think is over 16yrs old and who lacks capacity about a specific decision, then you may have a duty to ensure their welfare and you would be able on rely upon the MCA if challenged about what you did. Call an ambulance if you're a cop; call the police if you're a paramedic who is going to need help to restrain the person and remove them to hospital and whichever

you are: have a think of this problem from the other 999 crew's perspective as to why they will want your support. Scratch each other's backs, as it were! #team999

- Try to engage the patient in agreeing to attend hospital for assessment and care. If they decline and police or paramedics think the medical issues are *already* life-altering or life-threatening, you may consider removing them to hospital under the MCA. Your legal justification will be around section 5, 6 and 4B of the Act because even if your actions amount to depriving the person of the liberty, s4B outlines how this can be justified if you are provide a 'life-sustaining intervention' or doing a 'vital act to prevent a serious deterioration in someone's condition'.

- **Unrestrictive options** – in the absence of needing to act immediately to save a life, is there any ability to call upon other professionals to take over the clinical assessment of someone you think is mentally unwell? Whether that is the Ambulance service, an out of hours GP, a community or crisis mental health team will depend on your area and the circumstances you face: **make sure you know what your local options are!** In the absence of that being possible (for whatever reason), document what you did, what you may have tried to do or what you considered and ruled out, with reasons.

- **Criminal Law** – if there is any evidence of a criminal offence, attempted or substantive, then you may have powers to arrest in respect of that offence in order to ensure the safety of the person. It may still be necessary to get clinical advice about risk if the intervention is still predicated upon concerns for someone's mental health, because conditions that officers may think of as 'just' mental health issues can often be other maladies, from meningitis, serotonin syndrome, Addison's disease, brain tumors or diabetes … other examples are also available! Call an ambulance if you're detaining and restraining someone who you think is mentally ill.

- **Common Law** – history shows officers have often relied upon common law powers, usually to prevent a Breach of the Peace or its continuance, to intervene in private premises. It's almost been a proxy for the absence of powers under the Mental Health Act 1983 (MHA). Where a breach of the peace is actually occurring(!), this is perfectly legitimate but officers need to be satisfied that the legal basis is sound otherwise the risk is a custody officer will decline to authorise detention. The same concerns apply to detention and restraint under Common Law as criminal law: medical matters are not identified or managed in any way because of the chosen legal framework to be applied.

- **Mental Health Act 1983** – the police service have no powers in private premises under the MHA, except where someone is already liable to detention under the Act, for example an AWOL patient. You may not arrest for criminal or common law matters and remove a person from the property only then to detain someone under s136. The exception to this point, is where someone has been removed from a building or land where they are not allowed to be: trespassers who are evicted on behalf of property owners may be regarded as 'found' in the place to which they are removed, for the purposes of other laws. If you have got this far thought your primary assessment, you've just ruled out your use of legal powers.

SECONDARY ASSESSMENT

So if you've quickly checked off that list and you find that you're still stood in a private premises with someone who you think is experiencing a mental health crisis. Next part … and *this* is the bit that's crucial, based on what I went through in the Coroner's Court two weeks ago.

- Tell YOUR supervisor – get them engaged in this to take on some responsibility for this minefield you're now navigating!

- The *Sessay* case (2011) tells us that where there are concerns for someone's mental wellbeing in a private premises and no legal ability for the police to intervene, the route to assessment is via an Approved Mental Health Professional.

  Section 13 of the Mental Health Act states –

  "If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf."

- Ask yourself (or ask the officer, if you're wearing green) whether using section 136 MHA would have been an option if the person were to have been encountered in a public place? If yes, **do not leave the incident** without referring this to someone who takes on responsibility for what happened next. This could include responsibility for doing nothing next, as we'll see below.

- However, regardless of local policies and preferences in local authorities, mental health trusts or GP services **there is nothing in**

law that prevents paramedics or police wanting to draw the local authority's attention to the potential that s13 contacting the AMHP service for their area to discuss the matter.

SUMMARY

So to sum that all up! –

Primary assessment

- MCA – life-threatening or life altering?
- Any unrestrictive options: GP / street triage / other?
- Criminal or common law – any offences / breach of the peace?
- MHA – is the person in that location lawfully?
- MCA – is it proportionate to remain pending secondary assessment?

Secondary assessment

- MCA – consider s5 and s6 MCA as the basis to keep the person safe.
- Inform your supervisor – request support.
- Remember the *Sessay* / Seal cases – no legal 'improvising'!
- Consider whether you'd use s136 if found in public.
- Can you or supervisor refer the whole thing to a duty AMHP / EDT / CrisisTeam / GP or whoever gate-keeps?

At this stage, you need to be clear about what you're communicating:

"We've been called to a MH crisis incident where I'd be using s136 MHA if we met this person in public. I'm concerned for their immediate welfare and in the absence of legal powers of my own to remove the person and safeguard them, I'm seeking your support to consider the need for a Mental Health Act assessment."

Document everything, including names and their verbal reactions – formal or informal. If you should *ever* have to stand in Coroner's Court, you will want and you will need to be able to show your 'working out' for all of this, accepting you won't be an expert in these areas of law. I would encourage you to refer to the *Sessay* judgement in your statements and if you're really feeling confident, refer to paragraphs 33-38 to reinforce your understanding of MH issues in private premises is that the MCA cannot be relied upon (unless it's life-threatening / life-altering) and that the MHA is the route to take, via an AMHP and a DR.

And on behalf of AMHPs everywhere, who will probably feel somewhat stitched up by what I've written above, please be prepared to help them with this if they ask for help. The above has been known to lead to an

AMHP turning out to premises with a doctor within 45mins (yes, really) and detaining someone under s4 MHA. They will face exceptional challenges however, if doctors are in short supply, if they need warrants from the court or if there are no beds. Help to the extent you can because any decision to walk away will also be questioned. And trust me – it will be questioned!

Finally: whoever may complain about this approach about resources or local policy, just keep coming back to this point: "Nothing I am asking for breaks the law and this approach reflects my assessment of the risks in these circumstances and I am legally entitled to draw to the local authority's attention that s13 MHA may apply to this situation. Your responsibility is to decide what your response going to be, bearing in mind it will be documented for the record and referenced in legal proceedings if necessary. This is the way Parliament have deliberately chosen to structure the law and I'm operating within it."

This is about partnerships, but not just professional partnerships between the police and the other public services, it's about balancing those against the partnerships police must maintain and develop with the public, because they are the ones we serve and who have legal rights which should be respected.

15th August 2017

Mental Health Expert –

Today, I was invited to do something because I've been identified as "an expert in emergency mental health care." I did wonder whether this was one of those mistakes made by someone who wasn't reading closely enough, as when a medical recruitment company recently invited me apply for "vacant consultant psychiatrists' positions in Birmingham, Manchester or London". Apparently my CV had impressed them – my LinkedIn page, actually. It was obviously somehow beyond-impressive as it managed to distract their attention away from my utter lack of a medical degree or any professional registration as a medical practitioner. In fairness, I do have a first-aid certificate … but actually, even that's expired if I'm being completely honest because I'm not currently in an operational role. I'm an associate member of the College of Paramedics, if that helps, but in fairness they don't let me anywhere near the drugs or the cannulas. So nothing makes me an expert in emergency mental health care … I'm a policeman.

I can probably claim to have read certain medical or clinical guidelines from NICE and various Royal Colleges like Psychiatrists or Emergency Medicine that some doctors and nurses haven't read (or heard of), but I'll admit there were some large words in there based on Greek and Latin and I didn't entirely understand them – I certainly couldn't try to spell them in order to make this post look more impressive. So no, I don't feel like an expert in anything, quite honestly. Me and my 4hrs of training (half of it was wrong, the other half was irrelevant in the real world) are still making this stuff up as I go along – sometimes literally. I'm trying to do that conscientiously, of course, and I want to understand things and make progress but nevertheless, that's what this all amounts to – improvising. Most of this blog, is just me trying to put thoughts in order so it sounds vaguely coherent by the time I have to talk about it in meetings.

MENTAL HEALTH LAW

I realised early on that one key perspective missing from this emergency mental health care stuff, is the legal one and as a police officer, I can do something about that. Whilst I'm not legally qualified, I've done my legal exams for promotions and am used to making operational policing decisions based on my understanding of criminal and other laws. As a lot of the things

I've been asked do to in my operational service and in policy work on mental health have been to consider the implementation of police powers or support for the administration of the Mental Health Act. It has always been true the majority of questions raised when I was the force MH lead for West Midlands Police and since being at the College of Policing these last three years were legal questions. "Have I got power to force entry?" … "Can I not rely on the Mental Capacity Act to do that?" and my favourite one, "Can English police detain an eastern European man who is missing from a CTO under Scottish mental health law if we found him near the wheelie bins behind Marks and Spencer's in Nottingham?!" … err, just use s136, officer!

Even in my attempts to bring that perspective nearer the front of the considerations about how the police interface with health services of all kinds, I'm all too conscious that I have no qualified expertise. I was especially conscious of this when I spent several recent hours in the witness box of a Coroner's Court … seven barristers lined up, none of them on my 'side' because I was an independent witness to the Court. I stood there before the questions started, just thinking to myself "this is where I'm probably going to be badly exposed" – for making it up and misunderstanding things! What I've noticed over the years is that when police officers ask police in-house lawyers for legal advice on mental health law, they often direct officers to me, so how solid our legal advice is, I'm not entirely sure! I even once raised a question with an in-house lawyer and he sent me a link to my own BLOG … you couldn't make it up!

So it was with some relief to find that the only really challenging legal questions in court about the police guidance produced by the College of Policing in 2016 came from one barrister who merely insisted that we, the College, were wrong about how to interpret the some of the stated cases relevant to the issues before the jury; and wrong about whether the Mental Capacity Act could be relied upon to take someone from their own home to an Emergency Department. In fact, "precisely wrong" was the phrase used to describe it … I could only escape by insisting that we'd taken great care in producing this stuff, listened to many professional and individual perspectives from all over the place, including AMHPs, solicitors and other professionals who train the MCA to care staff and, of course, the we'd taken legal advice on it all. If I'm wrong, I'm wrong with a lot of people stood metaphorically behind me, helping me get this wrong.

A friend of mine recently posted a meme on Facebook, "The older I get the more I realise no one has a ******* clue what they're doing. Everyone's just winging it." Be honest with yourself and disagree if you need to … but I certainly am and I couldn't help but notice that whilst she was telling me I was wrong, she wasn't telling me *why* I was wrong … and I'm still none the wiser today. Maybe she was making it up as she went along?! … it's easy to accuse an unqualified policeman of talking rubbish without

explaining yourself and then just move on to the next question after hearing his answer.

PARAMILITARY NURSING

I've worried for some time about police officers crossing the floor with mental health matters because they perceive themselves as gaining in expertise when they're working so closely with their partners in NHS mental health services. And just to show I'm not the only one thinking about this sort of thing, I've had a few conversation with Claire Andre, the police liaison nurse at Northumberland, Tyne and Wear mental health NHS trust. She's been asked if she's actually a police officer and has had to explain she's a nurse, just as I've been asked if I was a mental health nurse before joining the police – she like me, couldn't work out whether to be flattered, offended or both! But we're both alive to the idea the idea that police officers and nurses working closely at this interface can end up thinking of themselves as some kind of hybrid professional, rather than just a better informed cop, or nurse.

This kind of thing reached peak nightmare for my version of this concern when I happened to walk in to a street triage office somewhere in England last year to overhear one of the PCs on the telephone to a person I had to assume was a member of the public who'd rung the police in connection with MH issues. As I entered the room I heard, "Yeah, uh huh … you probably need to up your meds!" in an encouraging voice.

WHAT?! ……

Turns out it was a known mental health patient who'd rung the CrisisTeam and been told to ring the police, but presumably not to get medication advice from an officer?! … **we need to get a grip!** What if that person now takes more than they were prescribed to take, already on a high dosage or are self-medicating, using other substances and they end up developing serotonin syndrome?! That sort of thing can prove fatal if properly qualified people aren't advising patients what to put in to their bodies and you should alter medication only under clinical guidance or supervision, for various reasons …. and all because some PC over-reached their expertise, if they actually had any to start with. And just to back up the very point I'm making here about my lack of expertise in these matters, I can only protest about the consequences of ill-advised police advice about SSRIs because I asked a couple of clinically qualified people, including Claire how to construct this paragraph! Why would I know, beyond me knowing it's a BAD THING?! …

I'm a policeman.

STRIKING A BALANCE

You have to work for three years at university to qualify as a mental health nurse so what chance we can pick this stuff up in police car by doing a few shifts with street triage?! … whilst there's no university course for policing, you take prosecution decisions in the police at the rank of sergeant, so it usually takes even longer than an undergraduate degree and involves those legal examinations I mentioned earlier, in addition to years of experience of investigating crime, preparing court evidence and handling custody detainees. So this stuff works both ways round: I've had numerous MH care professionals telling me what they think the law is only to get it so badly wrong that it was genuinely difficult not to laugh and just pat them on the head. My point is: nurses nurse, the police police – we just have to learn how to better manage that interface without being unable to ask questions or even challenge on occasion. But we haven't go this balance right yet and we must put the public and vulnerable people first in all that we do.

So, some kind of mental health expert? … no. And this isn't faux modesty or an attempt to be humble: it's actually a real insistence that you've very badly understood what I'm trying to do here! I'm not trying to fix the world, I'm trying to police it and that means ensuring rights and protections for vulnerable people as well as taking the most difficult decision of all: when those responsibilities mean I should use force on a vulnerable people to protect them and when, if at all, I should place them even further in to the criminal justice system than their contact with me.

That isn't mental health care: it's policing.

SEPTEMBER 2017

1st September 2017

Mark and the Mental Capacity Act –

I didn't watch the second episode of #Ambulance last night – I won't bore you with the reasons why, but my iPad was flashing at me towards the end with people tagging me in conversations they were tweeting as they went – all questions about the story of "Mark and the Mental Capacity Act". So I got it up on iPlayer and watched the final 15 minutes to see what the chat was all about, not least because the tweet I saw first read, "Watching #Ambulance on BBC1 and witness West Midlands Police refuse to attend to assist with Capacity Act … awful." – and we're back to the police again! But first things first: I've worked alongside West Midlands Ambulance Service for my whole career and I give freely of my own time to help train student paramedics at several universities – my respect for them is limitless. I thought this crew came across really well and it's obvious that Maya in particular was trying to go the extra mile for this guy. Nothing that follows detracts from my respect for their humanity: it's just me on my hobby-horse about how blue and green need to work together when legal issues arise about mental capacity in operational situations.

Give the programme a go for yourself, but if you want to focus on what I'm covering here: the story of Mark doesn't begin until 35 minutes in to the programme, so don't just watch the last 15 minutes as I did last night! … fortunately for me, the first part of Mark's story that I missed before tweeting about it, only adds to the points I want to make:

Essentially, two paramedics are called to my old patch in south Birmingham where a forty-year old man has fallen in his house and hurt his back and shoulder. It becomes clear quite quickly that Mark is an alcoholic and he has already consumed six cans of cider before the crew arrives. After a few minutes summarising a 30 minute interaction, Mark refuses to attend hospital and the programme cuts to another story. At 45 minutes in to the episode, we're back with Mark and the ambulance service are asking for the police. "Can we have police rolling on this one, man lacks capacity and is refusing to be conveyed to hospital." This is where it gets interesting for me because there is nothing like enough information in that request on which to make a good decision about coercing someone to hospital.

I'd encourage everyone in blue / green to read sections 1-6 of the Mental Capacity Act 2005 – at least twice!

So, using the **ID a CURE** mnemonic, let's go through the legalities of all this —

DIAGNOSTIC & FUNCTIONAL TESTS

ID – has the patient got an impairment of disturbance of the mind or brain? << This is the diagnostic test.

- Unless someone does suffer an impairment or disturbance of the mind or brain, an intervention under the MCA doesn't get off the ground.
- Well, the ambulance service were first called by Mark's partner for physical injuries connected to a fall.
- When they are exploring the matter of alcohol consumption, it's made known he has consumed six cans of cider and that 'normal' for him is as much as twenty. His speech seems slurred and there is mention of him having four seizures a day, albeit there is no seizure during the part of the film we see. The narrative from paramedic Maya focusses on Mark's addiction and her concern for him is predicated upon that, rather than on physical injuries.
- So what is the impairment of disturbance that is vital to there being an ability to get the MCA intervention off the ground? – it's not clear, but seems loosely based on alcohol and addiction.
- Obviously, we weren't there and the programme was edited so it maybe something off camera happened that was relevant or which wasn't broadcast for confidentiality reasons. So let's run with the crews assessment for now, albeit social media shows I'm not the only one questioning whether he had an impairment or disturbance of the mind.

AND! –

CURE – is the patient unable to communicate his decision; or to understand, retain or evaluate information, relevant to his decision? << This is the functional test.

- Mark was communicating clearly throughout this clip, albeit with slightly slurred speech. He was absolutely crystal clear in his refusal to attend hospital, making this clear several times.
- What was it that he failed to understand? Paramedics made it clear that they wanted to let the hospital give him "a full MOT" and that they wanted to get him help with his addiction. "They can only beat it when they're ready" which raises an interesting question about forcing him to hospital in connection with his drinking issues if he's not ready, as was obviously the case.
- I didn't hear anything being said to Mark about the risks of not attending, beyond the potential that a seizure could be very problematic if it went on too long. It wasn't explained to him (unless off camera) how likely this

seemed to be. So there was no evidence he failed to understand anything relevant to his decision.

- Paramedics were on scene for over three hours: no doubt, having been in situations like that, they tried way more than once to explain, persuade, etc.. Was there any evidence in that time that Mark failed to understand anything or that was unable to evaluate any information he was given? Even when the paramedics outlined the risk of a long seizure preventing him breathing, it's not at all obvious that he failed to use that information in his continued decision to stay where he was.

Everyone over the age of 16 is presumed by law to have the capacity to take their own decisions about issues like medical care, alcohol consumption and so on. The law makes it absolutely clear that no-one can be deemed to lack capacity simply by virtue of having made an unwise decision. So to be confident that we should be ringing the police in the first place, we have to be confident, on the balance of probabilities, that Mark has an impairment OR disturbance of the mind or brain and that as a result of that, in respect of a specific decision, he cannot communicate his decision or that he fails to understand, retain or evaluate information relative to making it. This programme caused a lot of social medica debate: suffice to summarise, there were a number of paramedics questioning the decision to declare a lack of capacity and amongst the AMHP community of their Facebook group, there was a thread running within the duration of the programme and not one of them was arguing for an MCA intervention.

INVOLVING THE POLICE

But again for the record: we weren't there, so let's run with the judgement made. How awful was it that West Midlands Police refused to attend? Well, based on the information given by the ambulance service controller who first rang through, not that appalling at all – nothing like enough information was supplied to enable West Midlands Police to form a proper view and my own opinion was, having two controllers discussing the finer points of the MCA when it seemed likely neither of them was massively familiar with it was probably not the best way to proceed. Might have been better for someone at the job to discuss the matter with a control room supervisor.

What is clear is that both controllers were wrong about the law, based on things they said. It is simply not true that paramedics or ambulance service crews more generally have "no powers under the Capacity Act". The Mental Capacity Act 2005 doesn't have 'powers' – it provides a framework for acting in someone's best interests after an assessment that they lack capacity and provides that people will be protected from legal liabilities for what they have done, as long as they've acted in accordance with the act. To put it bluntly: if you kidnap someone to hospital, you can't be prosecuted

or sued for that, if you've done it because they've just had a heart attack and can't make decisions for themselves, etc..

Legally speaking, paramedics have exactly similar scope to act under the MCA as a police officer – they are no more empowered or restricted and before any paramedics say "It's not our job to coerce people", it absolutely is. I lecture on this very topic on paramedic training across the West Midlands (ironically enough!) and every session I ask the students, many of whose are experienced technicians making the step up to paramedic whether they see it as their role to coerce people – most of them shake their heads. I then ask whether they've ever thrown a blanket around a confused elderly person who is frightened and given them a 'tactical cuddle' or engaged in some 'therapeutic blanketing' to restrict their arm movements, whilst strapping them in to a chair? Just one example of low-level coercion: but coercion nonetheless and often done because patients lack capacity and the paramedics are doing a sterling job acting in people's best interests.

PROPORTIONALITY

Of course, Mark was an adult man and it may well have been thought beyond the ability of our heroes in green, which is fair enough – because nothing I'm arguing here suggests paramedics should be rolling around the floor trying to restrain people (albeit a paramedic and I did exactly that in the early hours of Christmas Day 2012, trying to stop some bloke bleeding to death). Once you've done the diagnostic and functional tests, you can declare someone to lack capacity: but this doesn't then tell you anything about what you can do next. It certainly doesn't mean that anyone can just take them to hospital when they don't want to go. We need to consider more things first.

- Will waiting change the situation – perhaps capacity might return, for example because alcohol wears off? Seems unlikely in Mark's case, given his alcoholism, but it needs to be considered when weighing up how to proceed.
- Is removal to hospital to only way to meet his needs? – the journey to hospital seemed predicated on a precautionary "full MOT" and the need to get help for alcohol dependency. Forced removal to A&E wouldn't be justified for a precautionary medical and alcohol services can be access in a number of less restrictive way,s through someone's GP, for example.
- What is the consequence to Mark of not acting – it's fair enough to say he lacks capacity but so what? "So what" isn't a flippant phrase: it's about assessing the proportionality of forced intervention. If a patient is likely to die without acting now, then crack on officer – you can use most of the tools in your legal kitbag from manual handling, to handcuffs or leg

restraints. There have even been incidents where Taser has been used to stop people who lack capacity from killing themselves.

The law on this stuff is sections 5 and 6 of the Mental Capacity Act 2005 – section 5 provides that there is general defence to anything done under the Act as long as it is consistent with the principles of the Act: that everyone is assumed to have capacity unless assessed otherwise, that an unwise decision doesn't amount to a lack of capacity, etc., etc.. But where coercion comes in, we also need to consider section 6. This states that any restraint must be proportionate to likelihood and seriousness of the harm that would otherwise be suffered – this section specifically makes it clear that restraint is the "actual or threatened use of force", so when the West Midlands Police officers turn up and tell Mark that staying at home is 'not an option' and start taking his cider off him, we're straight in to s6 territory, (which means we must also be satisfied of section 5). West Midlands Ambulance Service tweeted during the show that 'after some convincing', Mark finally agreed to go to hospital. If he agreed to go, why did he need a police escort all the way there?!

In reality, Mark was forced to go, because his choice was 'agree or be taken' – that's not really a free choice, is it?! I'll end with this observation: when asked by anyone else to act coercively in respect of someone who lacks capacity, I tend to want answers to the following questions –

- What is the impairment or disturbance here?
- What is the decision you say they can't make?
- Why do they lack capacity?
- What happens if to this person is we don't act now?

And using that information, I have to be satisfied that my restraint of another human being represents a proportionate response to the risks and threats outlined: the police are NOT there just to do as they're told and they are not just entitled, they are obliged by law to satisfy themselves that the action they are taking seems legally justified and is the 'least restrictive thing' in that person's best interests. I repeat these points: the paramedics were obviously diligent, caring professionals and my admiration for West Midlands Ambulance Service is limitless – but the blue/green interface of the Mental Capacity Act needs more work, in my opinion. From what was broadcast, everyone in the handling of that job, from the paramedics to the controllers to the cops who turned up, needed to be much more in to the detail of things and communicating much more.

Update *– following publication of this post, Maya has undertaken further work on social media pointing out there was more to this job than was made clear in the programme. She wasn't willing to outline what that was, so it could well have been confidential things, unable to be broadcast. This adds weight to the point already made – we only have a part of the picture,*

here. That said, I admit to thinking it would have been advisable to make that known in the programme itself rather than aftewards because we now have police and paramedics guessing without relevant facts as to whether this murky area of law was correctly applied or not.

21st September 2017

Six Missed Chances –

I want to ask you to put all your preconceptions to one side for the five minutes it will take to read this and for a short while afterwards. If you use the links below and read the Six Missed Chances report from the IPCC, which is published today and follows the death of James Herbert in Somerset in 2010, your instinct may be that some of it is not practical. I fully and freely admit, that was my instinct when I read a draft copy of it last year and I've had to really think about this because it's challenging us to think again about whether we can think differently. I suspect and do understand some officers may wonder whether the IPCC actually understand police work at all or live in the real world – social media shows these questions are emerging as people read the media coverage that is coming out. I would suggest they read the report instead, because it's not the longest thing of this type you'll ever see.

A man died here – the report merely asks the service to think again about whether we could think or act differently: in how we respond to crisis incidents and consider or undertake restraint as a tactic. I admit I don't think it's a big ask and would argue we all owe it to James and all those who have been affected by his death to think again about whether it's *possible* for us to think differently about the use of force in handling a mental health crisis.

THINKING DIFFERENTLY

Tony Herbert, James's father, spoke earlier this month at the NPCC / College of Policing conference on mental health. I admit to sitting there, watching this man speak for his dead son to an audience of people doing the same job as those who were with him in the hour or so prior to his death. I sat there thinking about Harrison, my "nearly-13" year old son, simply unable to conceive of any situation where he has already lived more than half of his life and not with us in another 13 years – I admit I dream some non-specific dreams about the life he may be able to lead. And there was Tony, having lived that nightmare, saying out loud that he doesn't think officers acted maliciously and that he is absolutely confident no officer came to work that day aiming to hurt anyone. But regardless, James died in police custody and it appears there were lots of complicated reasons as to why he did. These issues are not just about frontline police officers: it is about senior police officers and their responsibilities around policies, joint

protocols and effective training; it's also about healthcare partners who must be able to deliver on their side of the deal: the ambulance service, the emergency departments and the mental health system.

The report is about trying to help the police understand how those various factors combine and need to be addressed in their totality – unless I've entirely missed the point. It's about asking whether the police – at all levels – can think differently, given that James's death is not the most recent death in police custody involving someone in mental health crisis and the lessons it offers are not unique to James's circumstances. You can look at the death of Thomas Orchard in Devon in 2012, Sean Rigg in London in 2010 and many, many others and see similar issues: this is about frontline police officers, but it's not JUST about them – it's about creating a context in which they stand a chance of thinking that the ideas in this report are possible.

- As long as they believe it's unlikely an ambulance can turn up at all, the more likely they are to think we should "get on with it" by conveying people in police vans.
- As long as they are told by joint protocols that people who are resistant, challenging or even violent should be detained in custody, they are more likely to go to custody.
- As long as they hear that "A&E is not a place of safety", the more likely they are not to take someone there who needs it for emergency psychiatric reasons to which published medical guidelines relate.

We could go on. Last night, I did some Google searching of MH trust websites, in an area of England where I know the ambulance service will not agree to comply with the Crisis Care Concordat requirements for ambulance services, where Place of Safety services still insist that anyone who is intoxicated, aggressive or under 18yrs old still cannot access the NHS Place of Safety and where A&E are openly resistant to the idea of anyone going there purely in preference to custody. So the toxic circumstances that existed in Somerset in 2010, still exist in some parts of England in September 2017. Just imagine if there was another death in custody where officers had used a police vehicle to convey someone to custody?!

WHAT IT DOESN'T SAY

The report itself says what it says: it doesn't necessarily say what the media are purporting to have it say. Read it for yourself, if you're going to get in to the discussion: it's less than 40 pages so anyone with a specific interest in this won't have to spend too much of their time – and if you do just you want a summary, read the IPCC press release, because it covers the salient points. But what this report does NOT say, contrary to the BBC News

headline, is that "the police should not restrain people in custody with mental health problems".

No, no … the report **simply did not say that**!

It acknowledges in various places that the police have difficult judgements to make and that restraint when it is used, merely needs to be proportionate to the situation. All over social media this morning, officers are putting up hypotheticals about scenarios they've dealt with, then reflecting on the (inaccurate) BBC headline that restraint should not be used as if to ask, "So what do they want us to do here, then?!" This is why it's important to take time to read this and reflect: the IPCC are not saying officers should never restrain: but to justify inflicting a fatal restraint on someone, you need to be managing a pretty serious level of risk and threat to justify that as proportionate.

We need to remember this: a man died here and a family's life is still in turmoil as processes connected to this concluded only this month, more than seven years down the line. My own view is we owe it to James's parents and family to take a small amount of time to think again about whether we can think differently. We absolutely need to accept, if nothing else, that the strategic and partnership context in which the operational decisions were taken, was inadequate. I was formally commissioned by the IPCC a few years ago to review the multi-agency s136 policy in play at that time. It is correct to say, as mentioned in the report, that if any police force had asked my advice about the policy, I would have advised against signing it.

No-one is saying that the ideas in this report will make a difference in every case, because this is complex stuff with fast-moving factors and no-one is saying it is never relevant for officers to use force and we know, when we do, that is sometimes on people who are medically very unwell. But we do need to show we've not just defensively rejected the ideas amidst an immediate sense that it's not practical and then, this *may* make a difference to just one or two families who will not have to experience the utter trauma of losing a son and perhaps that can afford Tony and Barbara a small measure of peace.

I just think we owe all them at least a small amount of our time to think on it.

WHAT IT DOES SAY

And what is there to disagree about?! —

- Prioritise safety and wellbeing.

- Try to de-escalate things to prevent or reduce the use of force.
- Aim to contain, rather than restrain, wherever possible.
- Ensure robust, effective local protocols across police / NHS so we know what to do and when.
- Proactively share and better disseminate information about vulnerable people to influence all of the above.

I'm not sure we're allowed to disagree with this, are we?! Most of it is the just law of the land in operation and it always has been but it will be really easy to look at this report and say, as Avon and Somerset Police has: much has changed since 2010. New national guidelines for the police on mental health, new training packages, new national standards; a Crisis Care Concordat, some street triage and liaison and diversion; nurses in control rooms, nurses in police cars, nurses in A&E departments, greater collaboration – LOTS of meetings. My biggest fear is that most of those things don't actually address the key issues which emerge during incidents which can lead to deaths in police custody (or suicide following contact) incidents: if a police officer believes they must get 'hands on' with a vulnerable person, how do we bring everyone together in quick time and what are the pathways we're choosing from?

This is what was missing in 2010 (and in 1998, when I joined), this is what is still missing in too many areas today – this is what street triage won't touch because, frankly, they will almost usually not be there to take a view on what is necessary. And faintly, whether or not an NHS service provider does or does not agree or aspire to what the Crisis Care Condcordat sets out, the legal responsibilities for police officers remain. Where s136 of the Mental Health Act, assuming all attempts to de-escalate have been tried, someone presenting like James needs to be removed only to an A&E department because his presentation to the police was such that any number of things could have been going on, medically, and as a police healthcare doctor once said, "Officers seem too keen to try and medically manage challenging patients in custody that no junior doctor would go anywhere near without bleeping for a consultants."

We have a first aid-certificate – we are police officers – we have limits. It's not illegal to call for an ambulance – it's not illegal to take someone to A&E if that's genuinely where you believe they need to be. Seek help – both for the patient you've detained and yourself because you will usually lack the skills needed to know what's right. And if the worst does happen, you can look Mr Herbert in the eye and promise him you did nothing less than your very best.

25th September 2017

OK, Let's Try This Again! …

Around nine months ago I started writing **a series of BLOG posts**, in the three-month build up to the introduction of the amendments to the Mental Health Act 1983, contained within the Policing and Crime Act 2017. The original idea was that the changes would kick in during May 2017 but you may remember a snap General Election got in the way of that and an outcome that probably wasn't the expected outcome got in the way of a suggestion that the commencement order – a necessary Parliamentary process to bring the changes in to effect – might get concluded before the Summer recess for MPs. Parliament only reconvened in early September and we've already broken again for the political party conference season, so it's now going to be October before the order can be introduced to the Commons. The jokes have started on social media about whether this will emerge during 2017!

The estimate I'm hearing at the moment is: the amendments will take effect in late November or early December.

So, despite everything and way more than half a year down the line from the posts, we are **still** in a position where we probably have three months to go until the changes take effect! If you are an frontline police officer, this **operational summary** is aimed **directly at you**. Twelve bullet points that put the amendments in a shortened form, with links to the fuller posts. Might I recommend you click the link from a smartphone, save the page and bury it somewhere at the back of your phone for reference when this stuff takes effect?! The full posts I'm referring to, written earlier this year are here –

- **Amendments**
- No child may be taken to police stations as a Place of Safety (PoS) under ss135/6 MHA – **full post**.

- The police will now have a specific power of search for those detained under ss135/6 both at the point of detention and at arrival in a Place of Safety – **full post**.

- PoS detention under ss135/6 may only last 24hrs, unless authorisation extends this to 36hrs in specific situations – **full post**.

- Section 136 will be able to be instigated anywhere other than a home – bringing new opportunities and challenges – **full post**.

- There will be a requirement, where practicable, for officers to consult with a DR, nurse or AMHP prior to using s136 – **full post**.

- Adults may only be taken to police stations in 'exceptional circumstances' (yet to be defined) – **this post will appear once the Regulations are published**.

Finally, if you want to read the new laws for yourself, there are three further posts, one each for the three sections of the MHA which will be amended soon –

- **Section 135**

- **Section 136**

- **Section 138**

EMERGING MYTHS

Certain things have emerged as myths over the Summer and forces have been contacting the College to seek clarification as they've continued work to prepare for this. A short list of the main myths I can recall, just to shoot them down in flames in case they've taken hold or risk doing so! –

- The consultation requirement means officers **must** consult – no, it doesn't. It means the officers must consult, *where practicable* – those words show the law doesn't make this strict requirement and if officers simply must act to detain and keep someone safe, the lack of consultation doesn't render this unlawful. Fine judgements will have to be made here!
- Officers **must** search all patients upon arrival at the Place of Safety – it's not a routine power of search. The law demands that the officer (not the staff) must have "reasonable grounds to believe" the search to be necessary. 'Belief', in law, is a much higher threshold than 'suspicion' so you can't just go on a fishing expedition to see what you find!
- Children **can** still be taken to police stations as a Place of Safety as long as they're not in the custody office or the cells – this is not correct. The ban in the Act is on the use of police stations as a whole and not just on the use of police custody. You can't use the front office or the more comfortable interview room used for vulnerable victims of crime, etc..
- The extension to 24hrs of detention can be used if there is difficulty finding an AMHP or Doctor to undertake the assessment – if only this were true! Extension can only occur in connection with the condition of the person, not

because of a lack of professionals or because of a lack of beds for any admission required.

- The debate is running about *where* the new version of s136 can be used – the law says it cannot be used in any "house, flat or room" where that person or another lives; or any "garden, garage, yard or outhouse" connected to it, unless it is communal. So individual homes made from buildings and its land and outbuildings are (still) out-of-bounds.

FINAL COUNTDOWN

Finally, over the coming weeks, I will try to add a couple of posts which are half-baking in my head after conversations over the Summer about unintended consequences. I suspect not everywhere will be fully prepared, notwithstanding the extra time this delay has afforded; and I also think it will be quite lawful to act in ways that weren't necessary considered as these laws were progressing through Parliament and granted Assent. The major one will be around police custody, I suspect. It will be lawful to use s136 in police custody and I see this having two impacts: pre-release risk assessment; use after a Force Medical Examiner calls for a statutory assessment in custody, but *prior* to the MHA assessment being conducted. This latter point is the thing I don't think has been fully considered yet.

After all that, we now seem to be back at the point where we have three months, but perhaps a bit less, until this stuff will become law. Time to think again about whether we're ready and for individual front line staff to get their heads around their version of the obligations that will follow and how we will handle the problems that are bound to emerge in due course.

OCTOBER 2017

1st October 2017

Tenants and Lodgers –

A man lives in his brothers home as a lodger, paying rent. He has a bedroom of his own, but shares other facilities in the house with his brother's family, including the bathroom, kitchen and lounge, etc., etc.. Because of concerns for his mental health, the landlord-brother invites mental health services in to his home to consider how to help his lodger-brother. Resistant to the idea of it, the man retreats to the safety of his own room and makes it clear he doesn't want anyone to enter his bedroom and wants mental health services and the police to leave. Now, for the purposes of this blog, it doesn't matter which of the two scenarios you want to consider this happening in –

- No Mental Health Act assessment (MHAA) has occured so we're wondering if a s135(1) warrant required to enter the room?
- A MHAA has occured so it's a question of whether a s135(2) warrant required to enter the room to remove the patient to hospital after the application is made?

I'm no kind of expert in housing law, as you might imagine! … I'm aware of the R v Rosso case (2003) which involved a patient who had been 'sectioned' resisting the entry of police officers to a hotel room. He was charged under criminal law with assaulting the officers and convicted but he appealed against his conviction by arguing the officers needed a warrant under s135(2) to enter the hotel room and were therefore not acting in the execution of his duties. The case is much misunderstood because the Court of Appeal rejected his appeal and ruled officers did not need a warrant. Many people forget this was a for a very particular reason: the room he was in at the time was NOT the room he'd paid to stay in. The television in his own room was broken, so the hotel agree he could use another room purely for the purposes of watching TV. He had no right of occupancy over the room he was in, hence he had no right to deny the officers access after they had secured the hotel manager's permission. If he'd been in his own hotel room, it seems likely the court would have ruled a warrant was necessary – but he wasn't, so it isn't!

DOMESTIC COMPLEXITY

Things become more complicated when we leave hotels or hostels behind and start thinking about various types of domestic dwelling. A few spring to mind –

1. A house is completely rented out to a couple with some kids as a family home – the landlord lives elsewhere.
2. A house is rented out to some students or young professionals where they each have their own bedroom, but share communal facilities like bathroom, kitchen, lounge, etc.. – the landlord lives elsewhere.
3. A landlord rents out a room to a lodger, who has their own bedroom in a house which the landlord and their family also use – they share the kitchen, bathroom and lounge, etc..
4. A landlord rents out a room or rooms to lodgers, but lives distinctly and separately within the same building, for example, in a self-contained attic flat – the lodger's do NOT share a kitchen, bathroom or lounge with the landlord, but they do share with each other.

Scenarios 1 and 2, above – these are straight-forward enough: the family, the students and the young professionals have a tenancy which affords them rights of course sole occupancy which mean they are allowed to take decisions about access. In scenario 2 the only difference is, that student A can grant access to communal areas and to student A's own room, but not to student B or student C's room. In any shared dwelling, one person granting access to a part of the building they are allowed to grant access to is sufficient to overcome the objection of others. So, my wife may grant access to our house and that person would not be trespassing even if I had objections to them being there. Finally, tenancy's usually give landlords rights of access with notice in order to inspect and maintain the property but that should normally be agreed with the tenants in advance, wherever possible, and terms around it specified in the contract.

Scenarios 3 and 4 are a touch more complicated – and my thanks go to Leicestershire Police's Street triage team for the Sunday morning headache after they had a version-3 type situation. My instinct was that a warrant would probably be needed as the lodger is paying rent for the provision of the room and is entitled to privacy, etc., etc.. Turns out, I was wrong! … so every day's a skool day. The UK Government and the Citizen's Advice Bureau both have information pages on their websites and they unequivocally state a lodger, renting a room in a house where they share facilities with their landlord, has no exclusive right of occupancy and a landlord would be entitled to enter the room or grant access, albeit subject to reasonableness and some level of affording privacy to the person, given what kinds of things people get up to in their own bedrooms! It therefore

follows, if the landlord has a right of access, they have a right to grant access to others – no warrant required, in either of the scenarios under section 135 MHA.

So the way to assess things is to ask whether the person has a right to deny others access to the room? Lodger's don't, if they're sharing communal facilities with their landlord. Lodger's who don't share with their landlord and tenants whose landlord lives elsewhere, do have that right. So the need for warrants should be construed accordingly, but if there is doubt about the lawfulness, a warrant can be considered to ensure the rights of those of us with mental health problems is protected.

5th October 2017

The Wessely Review –

Yesterday, Prime Minister Theresa May announced she has asked Professor Sir Simon Wessely to lead a review of the Mental Health Act 1983 and to report back by Autumn 2018 on what a new Mental Health Act may look like. Sir Simon is a psychiatrist by background, professor of psychological medicine (especially working with our military) at the Institute of Psychiatry and Psychology, King's College, London and he is the previous President of the Royal College of Psychiatrists. He is now the President of the Royal Society of Medicine, the first psychiatrist to hold that position and you can follow him on Twitter (see image, above) if you want to keep up to date with the MHA review and his cycling holidays! You can also read his own views about this work.

One or two comments on Twitter yesterday about the wisdom of appointing a doctor as the lead of a review of our laws: it hadn't occurred to me to worry because having known Professor Wessely a few years, it seemed obvious to me one of the first things he'll probably do is surround himself with the best people he can find to offering necessary perspectives, from mental health and capacity lawyers of various sorts, to patients and their families as well as the professionals of all kinds who operate the Mental Health Act in everyday life. I hope I'm right!

TERMS OF REFERENCE

The UK Government have set out terms of reference for Sir Simon's review and by way of some background to all of this, I was reminded of a blog post by Andy Bell, deputy chief executive of the Centre for Mental Health which explains a lot of the current issues and problems as our laws and our public service realities come in to tension and conflict.

Anyone who has read my BLOG before will know there are many pieces on this site which highlight operational problems connected to the police and I already know that Sir Simon has asked to speak to Chief Constable Mark Collins, the NPCC lead on mental health, so I'm guessing that's the start of a conversation about how the police interface with the MHA in our various circumstances.

This thing will have a different impact in Wales to that in England, because the review relates to England and to those matters not devolved in Wales. The health system and its legislation is devolved in Wales, but not everything in the Mental Health Act relates to the health system: apart from the obvious police powers, all of Part III of the MHA relates to the operation of the courts and criminal justice system and policing and justice matters are not devolved – as if this wasn't complicated enough!

JUST SOME THOUGHTS

This post will be short: it's just to set out what's going on and provide some links if you're interested in reading them. But I also want to post some questions, whether you are a police officer a member of the public with whatever perspective on the issues or whether you're another kind of professional. Ask yourself, what problems do you encounter with the Act, especially where it relates to the police and what would you want Sir Simon's review to take account of when forming opinions for recommendations in a year's time? Please feel free to leave a comment below – don't do it on Twitter or Facebook, as the comments will inevitably be hard to gather – if they're all below, they're in one place and NPCC can then make sure when we're asked for any opinion, we can represent the views of police officers in our response. A few of my own thoughts, having had 12hrs to think about this, most of which was spent asleep!

- **The country's response to mental health crisis in private premises is not safe –** the recent inquest in to the death of Michael Thompson showed this again and without wanting to argue for expanded police powers, it's fair to say that we still risk people attempting to blame police or paramedics for not keeping people safe because they neither have powers to use nor the ability to call on the support of those who do. This could be addressed in a number of ways and the review should look at them.
- **We have massive problems in securing admission to hospital –** whether this is too few beds, too few alternatives or anything else besides, the fact remains that there are thousands of cases a year (based on estimates) of where patients rights are violated or their safety compromised whilst delays in accessing beds thought needed are resolved. This will only become more difficult when timescales for assessment in Places of Safety are reduced in a few weeks. Whether we need a new 'section 140', whether we need legislation to compel minimum standards of out of hospital alternatives, etc., is for Sir Simon to resolve but the problem needs grasping, in my view!
- **Greater clarity about invasions of privacy and property for inpatients –** the MHA was (essentially) drafted in 1959 and much was taken to be implied. Where we get in to frequent discussions about

searching, restriction, seclusion, seizure of property (like mobile phones), do patients need greater clarity about their rights whilst detained?

- **Should we aim to have capacity based mental health legislation? –** the MHA allows interference with autonomy even where patients have capacity to take certain decisions. Is it time we moved away from this and had capacity-based legislation? The Mental Capacity Act 2005 (MCA) has been criticised and formally reviewed by the Law Commission with various problems in that part of our 'mental health' world, too. Should the pair of Acts be scrapped and modernised?

I've actually got a much longer list than this, but that will do just to give some examples. Mental health campaigner Mark Brown wrote a very interesting opinion piece in the Guardian yesterday, encouraging a bolder, more positive vision and that's also worth a read. Have a think: leave a comment. If you don't, we can't consider what to say to Sir Simon if / when he comes knocking on the door for a police perspective on the issues and challenges ahead.

Regardless of anything else: this is quite a task ahead and I can only wish Sir Simon the very best of luck with it! Attempts have been made in the UK to review and replace the Mental Health Act and they failed miserably amidst big debates about what the purpose of our mental health laws should be. The Mental Health Act 2007, which largely just manned and updated our two main legal frameworks (the 1983 MHA; and the 2005 MCA) and that was a compromise after the Mental health Bill 2004 failed to make its way through Parliament. That legislation incidentally, included scope for a s136 type power in private premises, which I note purely as an historical curiosity.

The task is huge and important – very best of luck Simon!

7th October 2017

Mental Health Act Review –

We learned this week of Professor Sir Simon Wessely's appointment by the Prime Minister to review the Mental Health Act 1983 and since then, he has spoken to my boss, Chief Constable Mark Collins, to ensure the police contribute to the debate about the realities of our work, the problems and issues we face from a legal point of view. The boss asked me to start thinking of points to raise for discussion – not because we have any fixed view or are being asked to write any kind of Christmas list, but because there are probably certain debates we would hope Sir Simon's review might address that affect policing and the broader emergency and mental health systems of which we form a small but important part.

So these are not final thoughts, proposals or demands! – it's just a list of things I've recommended to Mr Collins that we ask Sir Simon's team to consider finalising, one way or the other, amidst the much broader work that such a review must get in to. Police stuff is a growing and important, but nonetheless small part of the overall working of our mental health laws in the United Kingdom.

Here goes! –

- A **total ban** on the use of police custody as a place of safety for ss135/6 powers – this is called for by the Angiolini Review (2017) in to deaths in police custody and by the time of any new MHA, the country should be routinely seeing only a few dozen cases per year. This could be the final step to eliminate the practice of goaling the vulnerable.
- There needs to be a settlement – entirely absent in 2014 review of police powers which led to the Policing and Crime Act 2017 amendments of the MHA – on the powers, obligations where mental health crisis incidents are happening in private premises: do we empower the police or obligate others to support? Our mental health care system is very different to how it looked in 1959, with much more community care and a far greater role for the police: yet we're still using 1950s legislation to keep people safe in crisis.
- This becomes relevant after the Michael Thompson inquest (Lewisham, 2016; heard at Southwark Crown Court, 2017) – 999 services powerless, GPs and AMHPs too slow to react, deceased mental health patient as a result of fire.
- We could amend the s135-type power: obligate AMHPs/DRs to support 999 crews (and resource them accordingly); create a MH nurse's power similar

to s5(4); allow a police power for 6hrs pending an AMHP decision about a s135(1) warrant … there are a number of options which could be explored and this could include an inspector's authority to act if we needed safeguards on anything the police could do.

- The UK and New Zealand are the only countries NPCC are aware of where their police officers cannot ensure the safety of vulnerable people in private premises. Street Triage schemes show that most police 999 calls to MH matters are in private premises and our nearest neighbours, allow police one legal power, applicable everywhere.
- Street triage often sees situations where officers have, in reality, held people against their will pending the advice or attendance of a ST nurse. Examples include situations lasting over an hour. Should we allow a registered mental health or LD nurse to discharge s136 if it is agreed an alternative not known to the officers when they had to take their decision, is available?
- Abolish the distinction between 'AWOL' and 'absconded' patients – create one category of being 'absent' from the place someone is legally required to go or to be. This would mean merging the s18 and 138 powers in to one power of re-detention for those who are liable to the operation of the Act when they are 'absent'.
- Simply the timescales within which officers can act after someone goes AWOL or absconding: there are well over two dozen different timescales which could apply to various situations of AWOL / absconded: this could be simplified in to far fewer timescales.
- For example, Part II patients of any description could be retaken for up to 7days or 28 days, Part III patients retaken without limit of time. If s135/136 police powers under the MHA were adequate, as outlined above, then any absent patient encountered after the 7 or 28 days limit could be dealt with under s135/136 equivalent powers.
- Amend Part III of the MHA to allow a Magistrates Court under ss35/36 to remand directly to a hospital on a defendant's first appearance, based on two doctors' recommendations: follow various serious crime inquiries where patients are seriously ill but require admission to the secure system. << This would prevent unnecessary remands to prison in order to then seek a transfer to the secure hospital system.
- Consider the creation of a s136 type holding power in A&E which could be used by ED staff (or their security representatives) until such time as the police arrived to any emergency. << There have been Coroner's inquests about ED staff 'allowing' patients who are suicidal to leave and relying on police to find them. Without this, the law is very opaque about ED powers to keep people safe, even briefly.
- In various Australian states, s136 type powers are also available to paramedics, registered mental health nurses and all doctors: do we need to consider that here? There have been instances of Doctors seeking police to use s136 and officers refusing. Sometimes this was correct refusal; but not always. << What are we trying to achieve?

- Take s35(7), 36(8) and 38(10) absconders, which require the patient to be returned not to hospital, but the criminal court which imposed the order; and allow patients to be returned to hospital for care, with presentation to a court ASAP afterwards: would prevent a very ill, secure care patient being held in police custody overnight or over a weekend, pending appearance. It was also remove confusion by police officers of where to take people.
- Ensure that processes for recall of conditionally restricted patients under s42 MHA includes clarity on the re-call warrants about whether the s42 warrant is, of itself, a power of entry to-retake the patient, or whether an additional s135(2) warrants is required to execute the s42 warrant of recall? Why not just attach a power of entry as part of the MoJ recall process?!
- Consider allowing a power of entry without warrant in order to re-detain someone who is absent, even if that authority required an inspector's authorisation to be used. The matters at stake in recovering a patient safely are often far graver than in other common policing situations where officers can enter of their own volition without an inspector's authority – like arresting a shoplifter.
- Clarify in the Act, those interventions and procedures which allow the use of reasonable force – police powers, nursing holding powers, AMHP powers, delegated powers.
- Specific, not implied, powers, in the Act around patient autonomy when detained on wards: powers to search, powers to seize and retain items (whether it would be lawful or not lawful to possess them otherwise).
- Clarify the position where applications for admission are required but AMHPs are delaying the application for the want of an inpatient bed. Do we need to create a legal state of 'limbo' so that people whose bed is not easily identifiable can be held in a Place of Safety until it is available? This occurs thousands of times a year and is likely to occur more frequently once amendments to the MHA take effect.
- Clarify cross-borders powers of detention within the UK: it is beyond complicated and needs simplifying!
- Do we need a separate Mental Health Act and Mental Capacity Act? – the MCA 2005 has been subject to considerable criticism and this could be an opportunity to harmonise things and clarify 999 powers of intervention for those who lack capacity.

These were first instincts, I already see debates, issues and problems with some of it, but I was asked to list some topics as mere ideas and so I threw in some that I'm against or undecided about! Please don't think this is me or 'the police' *lobbying* for anything: they are debating points, only!

But let me know your thoughts, in comments below rather than on Twitter or Facebook.

Michael./

8th October 2017

A Difficult and Complex Week –

There will be a number of families and a number of police officers across the UK who have had a very difficult weekend of reflection – this has been a complicated and busy week in policing and mental health. Firstly, three West Midlands Police officers were cleared on Wednesday of perjury and perverting the course of justice in a criminal court trial which lasted a month, over six years after the death of Kingsley Burrell; then on Friday, six Metropolitan Police officers were cleared of gross misconduct in a disciplinary hearing chaired by an independent legal official and a non-Metropolitan Police chief officer; and finally on Friday afternoon, an inquest concluded in to the death of Joseph Phuong in south-west London after police officers used section 136 of the Mental Health Act and struggled to find any NHS building that would allow access for assessment of his condition. We're still waiting on details to emerge on this last case and I'll update once I know more.

Three men died in the care and control of the state: so the stakes could hardly be higher or the issues more sensitive. It's important the consideration of what happened is serious and humble. But it's obvious why there will be many people angry and confused this weekend, trying to take this all in because in all three cases, the trial, hearing or inquest that concluded was just one part of an overall process in the aftermath of a tragedy that has several parts. Some deaths in state custody see a lengthy investigation, a criminal trial, an inquest, a disciplinary hearing; and in recent years we've seen examples with ancillary and adjacent complaints and investigations associated with the conduct of the substantive process.

All of this stuff takes **far too long** to unfold: but that's something on which everyone seems agreed – it's a separate point and one for a different day.

COGNITIVE DISSONANCE

Whenever there is a death in police custody or following contact, you are always going to see these multiple investigations and inquiries. They run from different perspectives and involve different 'standards of proof' which make understanding the multiple outcomes in a single case somewhat difficult and potentially confusing. For example, if there is a criminal inquiry

or trial (as there was in the Kingsley Burrell case), the investigators and then any jury who hear the evidence are trying to decide whether the offences alleged can be proved *beyond all reasonable doubt*. Any inquest (as there was in all three cases mentioned above) are trying to determine who died, when, where and why – they attempt to reach their conclusions *on the balance on probabilities*, but if they are inclined to think that someone died by unlawful killing or suicide, they must be satisfied of this *beyond all reasonable doubt*. Where police officers face disciplinary charges, (as we saw today in the Seni Lewis case), the panel assembled to consider whether the officers breached the police conduct regulations are reaching their conclusion *on the balance of probabilities*.

But even that is not enough to fully explain: a criminal investigation is seeking to establish what happened and any trial to determine the guilt or innocence of the defendant's charged, not the contributory roles of any professionals who were not charged, or the organisations that anyone worked for (unless there has been a corporate prosecution). A Coroner's inquest is seeking to determine the questions above and it can consider the roles of any individuals or organisations considered relevant to determining those questions. A police disciplinary hearing is focussed on the officers who have been brought before it and whether they conducted themselves according to the standards established in police conduct regulations – it has no remit to look at outside factors. So we see these various legal theatres are constituted differently, working to different standards of proof and the background of the decision-makers varies. I'm really sympathetic to arguments these things don't cohere very well overall and that incidents where people have lost their lives leave a situation where it seems no-one is being held accountable at all for the death of a vulnerable person.

It seems our legal system, taken as a whole, is guilty of cognitive dissonance: it is *repeatedly* found to produce conflicting findings where officers are cleared of disciplinary wrong doing despite a Coroner's jury having found that the force used by the officers was 'excessive and disproportionate'. Misconduct hearings and inquests work to the same standard of proof most of the time, so it doesn't appear to make any sense, does it?! … and if officers have used disproportionate and excessive force according to an inquest jury, why will the Crown Prosecution Service not automatically charge officers with criminal offences and place them before a criminal jury to account for themselves?! These things are hard to reconcile no matter what angle you look at this from – families must wonder how misconduct hearings can find that officers "did nothing wrong" when inquest juries said they did; and officers vindicated in a hearing must wonder how the inquest jury could have found they went so badly awry. The best I can do, for what it's worth and having followed this stuff for years, is to wonder whether it's just that we have different human beings making these assessments? Just like two criminal trial juries can reach different decisions based on the same evidence; and just as two groups of

police officers can make different decisions about the same professional matter – in many of these cases two different groups of people (often with different perspectives) have reached different views.

COLLECTIVE MEMORIES

Discussion this week has involved people asking what I think of these various outcomes. In a sense, that's impossible to answer because I haven't sat through all of the evidence in any of these cases. And even if I had, it's not for me to determine any of the outcomes and whether the conclusion was 'right' or 'wrong'. It is what it is and we all have to work out how to get better from here, amidst the confusion, the contradiction and the complexity. My slightly wider concern is something else: I've spent the week watching reactions to these cases and my heart goes out again to the families involved – how could it not? But I admit to wondering whether we've forgotten that in none of these cases were the police acting in isolation. I admit to wondering why we're not talking any more about the role of our NHS in these cases? The officers in each incident and many more besides were working in environments where NHS staff also made bad mistakes which contributed the position and the context where they took the decisions they did. Wider NHS policies and practices were far from irrelevant as they have been in other cases over the years.

To use a different example: the death of Sean Rigg in south London in 2010:

This is primarily and correctly cited as one of the most high-profile and contentious deaths in police custody we've seen in the United Kingdom. This was another case where Sean's family have been through all the frustration of multiple investigations, inquiries and inquests. But I can't remember how long it's been since I heard the public narrative around his case remember the jury's finding that NHS neglect contributed to his death, *as well as* police actions following that neglect. << This is not an argument that one aspect is more important than the other; OR an argument that the police don't need to look at themselves because things should not be reaching us in the first place. As I have repeatedly said over the years: not everything is predictable and preventable, so we need to know what we're doing. But some things are preventable; and that's not irrelevant, unimportant or something to ignore. We could have more than one problem here.

My point is this: if we think that asking the police to address the problems they have and which contribute to our society's reaction to those of us who are in acute distress because of mental ill-health, we're missing at least half of the point. Report after report which has been commissioned to look at policing has found this, by ending up saying more about our health and

social care systems than it had to say about the police. This was what Lord Adebowale found in 2013 when he was commissioned by the Metropolitan Police commissioner to review 55 incidents of death and serious injury in London – 28 recommendations, 9 of them about policing. We are awaiting publication of the Angiolini Report later in the year. Leaks to the media of this report – commissioned by the last Home Secretary to look at policing and the post-policing processes – seems to have plenty of things to say about our healthcare system even though it wasn't commissioned by the Department of Health or focussed on concerns about healthcare provision. It turns out: it's just an unavoidable part of any debate about a policing response to a healthcare crisis. *And it couldn't possibly be otherwise!*

FORK IN THE ROAD

In case of any there being **any doubt whatsoever** here: I'm not saying the police are perfect and having nothing to learn and no way to improve. I absolutely think there is still plenty that we need to do which is just about us and nothing to do with other professionals, other organisations. In particular, we would do well to start listening more to the public we are actually here to serve – we need to be more aware of our impact upon vulnerable people, both before during and after we've even thought about restraint. Where we find we can't avoid restrictive practices, we need to be more aware of its risk and our responsibilities. But what I am doing here is what Lord Adebowale has done and what I'm guessing Dame Elish will do: push back at the overly-simplistic notion that this is *just* about policing and police officers. In a final example of an tragic incident where the NHS were operationally uninvolved, we still see reasons to think we need to look more widely than policing:

Thomas Orchard's family are in the middle of all of this – there has been a criminal investigation in to Devon and Cornwall Police officers which led to two different criminal trials. In one, the judge abandoned the trial for reasons I'm not aware of and in the re-trial that followed, all three defendants were cleared. Still to come will be an inquest and potentially, misconduct proceedings against seven officers which the IPCC have indicated are required. In thinking about how better we might handle an incident of this kind we could wonder whether the officers should have recognised Thomas was experiencing a mental health crisis and detained him instead under s136 of the Mental health Act before removing him to hospital. Read paragraph 6.5 of the (current!) Devon Partnership NHS Trust policy on the use of s136 in the Exeter area and tell me whether you agree a man who had been restrained in handcuffs and leg restraints was likely to be granted access? Read the comment of a former Exeter police officer on a previous post to see what they thought of that idea. It may be that detention under s136 may have made no different to where Thomas was taken.

It is possible that we have more than one problem at the same time – and that they are inextricably inter-connected: our police forces are not perfect – they need more training and greater awareness, etc., etc.,; but we do continue to see problems in our healthcare system and these two systems don't integrate and collaborate as fully as we need them to. In each of the three cases which have part-concluded this week, there were problems with our healthcare system that are now relatively unmentioned; and I suspect many of them continue to exist in many areas. Police officers are still at risk of being drawn in to things they shouldn't go near or which desperately need NHS support for vulnerable people they've encountered where they've happened. If we only want to talk about policing and police accountability, we are missing an opportunity and often ignoring the overall outcome from these disparate and dissonant proceedings.

9th October 2017

PaCA – Place of Safety Options –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017. This post is one of several which relates not the amendments themselves, but to the implications arising from them.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. Current Home Office estimations of timescales suggest late November / early December – but this is subject to a number of factors and may change.

Under current law, a Place of Safety is "a hospital, a police station or anywhere else temporarily willing …" to receive the person. The definition has always allowed "anywhere" to qualify as a PoS, subject to the 'temporarily willing' part, but the grammar of this sentence has caused confusion. More than one A&E department has argued 'temporarily willing' also applies to hospitals acting as a Place of Safety. In other words:, the argument went that hospitals are not a Place of Safety unless they are temporarily willing. Of course, if we are going to torture the English language to make that argument, then it would also apply to police stations, but that point gets ignored whenever you raise it! And whatever the merits of the argument or my own views on that: within weeks it will be consigned to history.

But history has allowed anywhere to used as a MHA Place of Safety: the teenage girl who was just taken home, because the detaining officer was keen to avoid taking her to a noisy custody office – his only other choice at that time; the kindly GP in a rural area who was asked by an officer on foot patrol who'd detained a man, if he could just give them somewhere warm to sit until he arrange transport that was indefinitely unavailable – the GP went further and asked the AMHP to come to them, where they sorted it without further travel; and finally, the young girl ran off from school as they were trying to call her parents and arrange mental health services to help her in crisis – the officers found her and took her back to school to ask "what now?" and ended up staying there as MH services were already on the way.

So the Act always has allowed for flexibility and improvisation, notwithstanding that local policies have often denied this or made no mention of it. The re-wording of the Act aims to make this all much clearer and in my opinion alters only a few things, but makes it more complicated to navigate through difficult detentions –

DWELLINGS

It's section 135(6) that contained the old definition and that has all been reworded – you will also need to read the newly-inserted s135(7) MHA. You'll notice that no use is made in the law of the word 'dwelling' or 'non-dwelling' but these are the words I'm going to use in the rest of this post to distinguish between the "house, flat or room" stuff, from any other option that may be considered. Of course, dwelling has different connotations and only recently, one person made the point that their narrow-boat was their home and their only dwelling. But is it a "house, flat or room"? Almost certainly not, I'd guess … any views?!

The new law –

(6) In this section "place of safety" means residential accommodation provided by a local social services authority under Part 1 of the Care Act 2014 or Part 4 of the Social Services and Well-being (Wales) Act 2014 a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place.

(7) For the purpose of subsection (6)—

(a) a house, flat or room where a person is living may not be regarded as a suitable place unless—

(i) if the person believed to be suffering from a mental disorder is the sole occupier of the place, that person agrees to the use of the place as a place of safety;

(ii) if the person believed to be suffering from a mental disorder is an occupier of the place but not the sole occupier, both that person and one of the other occupiers agree to the use of the place as a place of safety;

(iii) if the person believed to be suffering from a mental disorder is not an occupier of the place, both that person and the occupier (or, if more than one, one of the occupiers) agree to the use of the place as a place of safety;

(b) a place other than one mentioned in paragraph (a) may not be regarded as a suitable place unless a person who appears to the constable exercising

powers under this section to be responsible for the management of the place agrees to its use as a place of safety.

The proposal to explicitly allow removal of someone to a "house, flat or room" etc., has caused some consternation. The new law attempts to put the person detained in the driving seat of this, in the sense that they **must**, first of all, *agree* to any of the possibilities. Officers could take the person to a place where they live alone, to a place where they live with someone else, or to a place where they do not live, but are likely to receive support from those who do. In each case: the patient must agree, before you even consider whether anyone else's permission is required. If the person lives alone, only their agreement is required to take them home; if they do not live alone or if you not taking them home, agreement is also required from one person who lives at that location.

A few things on this point –

- The requirement for *agreement*, seems to be different to the issue of *consent* which implies the person would have to have capacity – if someone agrees they'd like to go home, does an obvious lack of capacity to make that decision mean we should definitely think of another, more 'traditional' option?
- There could be certain issues connected to taking someone home: many people with serious mental health problems have experienced trauma or abuse, to one extent or another, and it would be the worst thing imaginable if an officer detained someone and then took them back to a place where an abuser was, whether that be a parent or a partner, etc..
- So background thought about the option being pursued may be needed: the officer I referred to above who took a teenage girl home did diligent background checks before going there. He checked PNC; spoke to Children's Social Services and tried to speak to MH services, who were not contactable – but at least he tried. Nothing suggested a problem.
- Also consider the AMHPs – the AMHP has a duty when convening assessments to ensure the person is interviewed in a suitable manner, and issues around dwellings and families may affect this. It may be known the person's family member will cause problems in an assessment; it may be the dwelling is known to be unsuitable for various reasons.

Keep the person detained at the centre of decisions – seek to discuss it with the AMHP, if you can, potentially via street triage or other partnership schemes: if trying to put this stuff in place is going to take hours or involve professional conflict and disagreement, perhaps we should rethink the position before sitting around for ages. **AMHPs do actually win**, when it comes to disagreements, by the way! – they have to take responsibility for the conduct of their assessment.

NON-DWELLINGS

This is where things may get difficult, because this is where the disagreements have occurred before and may yet again, under apparently different rules. It has always been my argument that Emergency Departments could act as a Place of Safety under the MHA and they always did have the right to say 'No', if they felt that was the appropriate thing to do. I'm not at all convinced that much of this has changed: it's just that s135(7) makes it more explicit that those controlling non-dwellings have to give their approval to their location being used. And contrary to certain arguments I've heard, it seems clear that s135(7) does apply to hospitals. (Use of police stations will be subject to individual statutory regulations, due for publication in the next few weeks.)

So crucially — I'm aware some EDs think the rules are changing here. I don't think they are, notwithstanding how the law has been reworded. It was always lawful for officers to ask ED to act as a PoS, whether or not the person's presentation indicated ED as being required and this remains the case. I recall asking ED to allow my officers access with a lady detained under s136 who was in her 60s and probably had dementia. She didn't have an obvious reason for being in ED, but our only other option was custody, so it seemed right that we try to keep her out of there, if at all possible. ED agreed to let us keep her detained there. This kind of thing doesn't change when the Act is updated in December: it will still be possible to ask, it will still be possible for ED to say no, if that's what they wish to do. And they can still choose to say yes.

Doctors in ED may well be reading s135(7) and thinking this is now the power they need to insist that officers remove someone to a more appropriate setting. My point has always been, that people do tend to go directly to those more appropriate settings where they exist with capacity to receive patients; we tend to start thinking about ED and other options where all we've got left is police custody. The difference in the future is that police custody will not be an option in all but the most limited of circumstances, and certainly not available in the case of my lady with dementia, above, who we helped when I was a sergeant about fifteen years ago. One fear I've had amidst all of this work to amend Part X of the Mental Health Act (the part containing police powers) is that areas who have relied heavily in the past on police custody and / or who don't have sufficient capacity for their anticipated, and potentially rising demand from s136 detentions, may end up in a perfect storm.

THE PERFECT STORM

I recently did an email survey of force mental health leads to see where they felt they were with this. There are forces in England who are nervous they still don't know where they will take under 18s; some worried about overall PoS capacity – most are worried about whether the NHS has enough beds to conclude admissions within 24hrs. And of course, some NHS Trusts still don't know what the statutory regulations will say about the use of custody so their managers will be unclear how many times detainees can be deflected to custody. If I were them, I'd aim for very low volumes being lawfully allowed to custody. Take that as a hint, if you wish.

So imagine –

- You've detained someone, you call an ambulance and there's no agreed reason why someone would need to attend ED.
- You contact the Place of Safety designated in your area for s136 and they are unable to accept the person.
- The legal grounds for suing police custody, as outlined in the Regulations, are not satisfied.
- Do we ask ED to act as a Place of Safety and / or start considering other the other options involving dwellings?
- What do we do if ED quotes s135(7) and / or the dwelling options are discounted as possible because the person lives 100 miles away.

What I'm worried about, is the possibility that someone could be held in a police vehicle or ambulance outside an ED department for a significant period of time – if you think I'm worrying unnecessarily, see episode 7 of #Ambulance from BBC1 last week, where it happened for real. Areas need to get talking to each other, if they're not already – and it was pleasing to see, in the replies to my email, that some forces do think they're ready to stroll through this.

I hope they're right!

12th October 2017

Still Too Many Questions –

I wrote last week about three separate process which had concluded after adverse events involving the police and their response to mental health calls. I mentioned the conclusion of the inquest in to the sad death of Joseph Phuong and couldn't say much about it as details weren't covered in the media. I heard about this case shortly after it happened, when discussing policing and mental health matters with the Metropolitan Police and had awaited the inquest, interested in the view that would be taken of how events had unfolded – but I was aware I didn't know anything like the full picture and I still don't. I don't know whether the Coroner will issue a 'Regulation 28' Preventing Future Deaths report, but I would imagine, if it's coming, it will be worth reading. The IPCC have also suggested they'd review whether or not they can publish their report in to the conduct of Metropolitan Police officers and I await that decision with equal interest because there seems more to reflect on in this case.

Last week's post was essentially bemoaning the fact that adverse outcomes resulting from a combined NHS and police response to a mental health emergency often reach a point where all we focus upon are problems with policing. I do understand why that is and the post was in no way an attempt to insist there are no problems in policing – there are perfectly understandable instincts to ensure that people are held to account following someone's unexpected death and a genuinely held view that this doesn't occur in cases where it should (that's argued to be a problem in policing and in healthcare, incidentally). Last week, the gross misconduct hearing after the death of Seni Lewis led to his family calling for a meeting with the Commissioner and if that had been my son who died, I'd want that, too. I have no issue with it as there are things to discuss with the police and it never does harm for officers at any level to take time to listen. I just also hope there is a request to meet with the Chief Executive of the relevant mental health trust, because there are issues and listening lessons there, too.

Today, the first media coverage emerged after the Inquest in to Joseph Phuong's death – a Guardian interview which straight away proved my point from last week's post. See the header image, above: it is a screenshot from the Guardian which begins, "The sister of a man with schizophrenia who died in police custody" … I had to stop reading there, initially but then quickly noticed the headline writers had better understood the incident and

made no mention of the police. Joseph Phuong died in Springfield Hospital in south-west London whilst detained under the MHA by the NHS and after they had restrained him, forced him to received medication and removed him to a seclusion room. He wasn't in police custody in either sense: he was not in a cell block, he was not under arrest or detained by the police in any other building, like a Place of Safety. Yes, his admission to hospital occurred via a route that involved the police, yes the police had also used restraint during that process – yes, that all needs looking at if someone died. Ultimately, the article manages to get it right: it's clearly states towards the end of the article Mr Phuong arrived at Springfield Hospital 'in the early hours' (just after midnight, according to other public reports) and was restrained by NHS staff shortly after 2am. He was secluded and medicated against his will during that process and 2hrs later he was found collapsed (despite being on constant observations) and afterwards pronounced dead at A&E.

YET ANOTHER TRAGEDY

The Independent Police Complaints Commission launched an independent inquiry in to Mr Phuong's death. They have not published their report or their findings, except to say that no officers will face no misconduct proceedings, arising from this tragic incident. The Guardian reports Mr Phuong was first of all taken to A&E by ambulance with a police escort (presumably on a voluntary basis?) and left that location after arrival. So my first question would be to wonder about whether the grounds for using s136 were met during this first encounter and that's obviously a question for the police – it will be interesting to learn whether the inquest record or the IPCC report says anything on this point and it's the only question I've got for the police in my understanding of this incident. But if the Guardian had done just a little more digging, they would have discovered suggestions already in the public domain that go beyond what they have reported in their article on other parts of the narrative —

The London Evening Standard, reporting shortly after the tragedy, stated that there was then a second reason for the police to become involved and that Mr Phuong was detained under s136. It is inferred there was a delay for an ambulance – knowing some of the issues in London around ambulance conveyance after use of s136, I admit to wondering if they did arrive at all? The Standard mentions something else the Guardian doesn't – an attempt was made to take him directly to a mental health unit (MHA Place of Safety, presumably). Only after that was he taken to St George's A&E department. Did he access the Place of Safety or was he turned away? – no mention was made at the start of any additional medical factor indicating A&E would be necessary. Whilst there, it is alleged Mr Phuong assaulted a police officer and he was arrested and taken to custody, where he know he remained for many hours after his Mental Health Act

assessment indicating he required admission. I'm guessing there was a bed problem which meant it remained necessary for him to stay in police custody until that was resolved, still under frequent restraint by officers. In all fairness, an eight-hour delay for a bed isn't a big delay these days, but it's still a delay that means police custody and more restraint.

Eventually, Mr Phuong was admitted to hospital, almost twenty-four hours after the police first encountered him, during which time he has experienced five separate period of restraint, according to the reporting. A sixth episode of restraint by NHS staff occurs two hours prior to him being found collapsed, during which time he was also given medication against his will. How do we untangle all for this, for necessary accountability and for the organisational learning that needs to occur?! First, we need to start by accepting that in any circumstances where the police and the NHS are struggling to come together quickly and effectively, it needs to be a joint review. I admit to wondering how that is reinforced if following a death there are questions about ambulance responses, place of safety access, timeliness of Mental Health Act assessments and the availability of inpatient beds?

ORGANISATIONAL LEARNING

The Standard reports the IPCC will now consider whether they can publish the report of their investigation given the inquest has concluded – I've also asked them to consider doing so and look forward to learning their decision. One thing we should bear in mind: there have been recent examples of the IPCC using their legal powers to direct forces to hold gross misconduct hearings for officers, even where the original decision by the force was not to do so because grounds weren't met. Notwithstanding suggestions in the public discussion about the IPCC being the 'same thing' as the police, I can assure you many officers take a different view, based on certain cases they have seen where the independent panel appointed to hear a gross misconduct case has dismissed charged amidst suggests that there never was a case to answer. Regardless of that reality / perception debate about police / IPCC relations, I mention it because it does seem likely if the IPCC thought there was any suggestion officers had misconducted themselves, they would have pushed for a hearing because of the amount of criticism they face for not holding the police to account. Yet here is a case where officers were not investigated on any basis of misconduct at all, the officers were not placed on restricted duties or suspended during the investigation.

The police and the NHS owe it to the people we exist to serve and the families of those who have died in state 'care', to discuss how we work effectively together, prevent further such outcomes wherever possible and the media owe it families and to the frontline staff who have to do this work, to fairly represent what actually happened to the public so we can

avoid a simplistic perception of what went wrong. Joseph Phuong died tragically and there are probably lessons to be learned by all: there always are. But did he didn't die in police custody and the inquest criticism of the Metropolitan Police doesn't seem, so far, to suggest the main operational decisions they took were in any way wrong. Nor was police restraint specifically linked to the conclusion of why Mr Phuong died. Ultimately, and perhaps unbearably for his poor family, that was recorded as 'unascertained', which is not a verdict we hear very often.

This all comes back to real basics, doesn't it? – do we have a well understood s136 process in a local area which has capacity to absorb predictable levels of demand and allows the frontline staff from these agencies to come together quickly over important issues, minimising the need for restraint and maximising the clinical oversight of people who are to unwell to be left in the care of police officers with first-aid certificate? I genuinely hope this less-reported case is given a higher profile than it has had so far, because it strikes me putting a sharper focus on common problems that some would say are only becoming more frequent issues in many areas and which will become more acute once the law changes in December – but only if those who report on it and going to take time understand the issues and research the events involved before they confuse and distort anything further. I always hope in these matters that families at least feel they've had answers as to what happened and why. Can only hope that's the case.

22nd October 2017

Be Kind, Be Patient –

You may have seen that internet meme bouncing around on social media, above? This post is essentially about how this advice may be more important than other things we spend much longer talking and worrying about. I've been caused over the years to read a lot of books that have been pushed in my direction, in lieu of any proper training on what I do – professionals wanting me to know more about the 'medical model' and 'psychological approaches', even sociology and philosophy. I also catch snippets of CPD designed for AMHPs and mental health nurses, when I've been waiting to give presentations to them, or when I've been hanging around afterwards. In the course of doing my job, I've received hundreds if not thousands of emails and social media contacts over the years from patients, their families or carers about police training on mental health related matters.

"The police need more training on [insert diagnostic label of your choice]" is common. Calls for training seem to be the number one recommendation of various reports and complaints which examine where things have gone awry and training, I do agree, is important. This stuff is an area of policing which touches up against complex intellectual disciplines with many diagnostic criteria, psychopharmacology other words we can't spell as well as awkward legal structures. I can agree we need at least some training on this, without any pretence at all that we could or should build half a mental health nurse in uniform. But at the core of this feedback is something rather simpler and much more easy to contemplate. And quite beautifully, it tends to come from those of us who have actually lived through some of this stuff or are still doing so.

There are lots of conflicts and tensions in policing and in the demands we face: some people have called for condition-specific training on certain mental disorders or groups of disorders. Given we couldn't realistically give specific training on all discrete disorders or even categories of disorders, are some mental health conditions more important than others? – should that decision on where to focus the training be based on the frequency of encounters we have or upon the extent of difference the condition makes to how we should police? Do we target the more common conditions or understand the more complex issues, however rarely encountered? Are peri-natal mental health issues more or less important that obsessive compulsive disorder; is autism more or less important than schizophrenia

where these issues are competing for time amidst a training schedule? If all four of these must go 'in', what remains 'out'?!

Perhaps we had better ask people who are 'policed' what they actually want from their police?! –

DOES IT MATTER?

No matter the books I read, the people I talk to, the research I hear about at conferences, all things point to the same conclusion, in my view: the public just want the police to be as kind and patient as possible, even in the face of various kinds of frustrations. I don't get emails saying that the custody officer had correctly identified someone as having bipolar disorder; but I do get them where we just knew that something wasn't quite right and the custody officer was extremely kind and took time to explain things and reassure a person. I don't hear stories of officers showing a depth of insight in to these issues but I get plenty praising their patience, the decency and their humanity.

When we were putting together the College of Policing APP on mental health, numerous people asked us about training to accompany it and worried out loud that by training, or even over-training, police officers on the multitude of different mental health conditions, we would strip away that which was most essential, from a service-user's point of view: simple caring humanity. People don't want diagnosticians in uniform or someone who can necessarily 'fix' them; they want to be treated with courtesy and respect, as an individual who can help them in the short-term. Help might not even necessarily mean helping achieve immediate access to NHS professionals; it might just been giving time to stay with someone whilst a crisis subsides.

A patient at a Crisis Care Concordat event once sought me out after a talk to make sure we didn't over-train the police out of their lay-person, decent-human-being backgrounds and make them think they've become quasi-clinicians. She feared this would remove everything she wanted and needed from a police response. One of her experiences had been officers meeting her in acute distress and sitting on the kerb with her for over half an hour or so whilst another police officer was just along from them, talking on the radio, trying to get information, support and then eventually, an ambulance to attend. It all took so long that by the time the officer rejoined them, the patient felt relatively fine – the crisis had blown over – and she trusted them enough to let them know of a friend she'd be able to talk to and stay with. Officers who were thinking of whether to take her to A&E or use s136 were then reassured enough via the friend's willingness to help, to do neither of these things. Each were 'pathways' the person was keen to avoid and MH services followed her up the following day.

RISK ASSESSMENT SCALES

This week, whilst waiting to deliver a talk to a group of AMHPs, I heard a presentation by an academic about the use of risk assessment scales for people who have hurt themselves deliberately. Read the papers about this for yourself, if you wish, but it turns out these things have been thoroughly tested and are not as reliable as simply asking the person themselves; and not as reliable as the instinctive opinion of the clinician caring for that person. They are often used to determine whether patients should be considered low, medium or high risk and that grading influences other issues on everything form whether to ensure a higher intensity of support in the community or to call for a Mental Health Act assessment. That's a lot of resource to expend if the tools used to form the risk-rating are wrong more often than they're right!

Also referenced within the presentation was the number of psycho-social assessments that are undertaken on patients who presented in EDs after self-harm – it has been in the NICE Guidelines for sometime that good clinical practice is to ensure such assessment on all patients and the last time I heard the percentage figure, it was around 40%. It's apparently now risen to just over a half of all patients, but this is thought to have more of a positive, protective value than structures wrapped around patients after the use of risk assessments scales (which are wrong more often that they're right).

Of course, despite the clinical sounding term 'psychosocial assessment', this is mainly a matter of listening to people and taking them seriously around their difficulties and helping identify ways of supporting them on their own terms (as it has been explained to me). The presentation just kept coming back to that point: be nice to people, be patient with them and listen to their stories.

FIGHTING A BATTLE

Most police officers, when they encounter someone in distress, are meeting someone they haven't met before. Many police areas have a small number of individuals who are known to have complex mental health and social problems who repeatedly present to the police and other emergency services; most police forces examine 'repeat' s136 detentions or those well-known to police, mental health and social services, but in the main, those we encounter are not individually known to each officer. So firstly, this raises the importance of ensuring officers have timely access to relevant information from both the police service (other officers may have encountered this person before) and from partner organisations (most

people the police encounter are known, currently or recently, to mental health services).

Academics have written about the relationship between trauma, abuse and experiences of serious and enduring mental health problems in adults . Seventy-five percent of all mental health problems begin during childhood so when meeting someone in acute mental distress in circumstances where there is considerable risk to that person, officers are potentially walking in to years or even decades worth of difficulty that may have already proven challenging to even the most qualified of mental health and social care professionals. The likelihood that officers can 'fix' the person is limited and fortunately, that's not what patients I've spoken to actually want. They have a very limited set of requirements that bodes well across all policing encounters we ever have, whether related to mental health crisis or not.

Couldn't we all do this?! –

- **Be kind** – you've got no idea what I went through to get here and meet you.
- **Be patient** – don't rush me because you need to get to the next job.
- I was probably scared before you turned up and I don't know you as a person any more than you know me – you are initially a person in uniform and that can be frightening until I can get a sense of the person behind that uniform.
- **Tell me your name** – the "#hellomynameis Michael" bit, not the "I'm Inspector Brown!" bit.
- **Listen to what I'm saying** – it might give you good clues as to how you can help me best and all people are different.
- Try to accommodate any requirements I seem to have, if you can – the gender of the officer(s) might be important to me; who gets contacted about me; how I'm transported or to where …
- **Don't use jargon** – section 136 and AWOL, etc..
- Don't assume mental health services are the answer – you don't know me and that might be a problematic part of my history.
- **Problems with the system are not my fault** – some police officers leak their frustrations and it can make people feel like they're being blamed because a CrisisTeam didn't help, for example.
- **Turn down the radios, turn off the blue lights**, if you can – and if you can't, just trying explaining that to me.
- **Only bring as many officers as you need** – I don't want too many people staring at me unnecessarily.
- **Don't shout at me** – you don't know how many voices are already screaming at me or how shouting can overload my sensory system.
- **Ensure my dignity**, as far as you can – that will mean an awful lot.
- **Try not to restrain me**, even if that means we have to spend a bit more time for me to trust you – if you can make me think you are actually seeing me as a person and trying to help, I may be able to trust you.

- **Don't lie to me** – ruins everything and the short-term gain may mean I never, ever trust the police again and you make it harder for your colleagues if there is a 'next time'.
- If I was stood on a high-building, you'd do all of this *without question* – what difference does it make if I'm just in the park, on a bench?

Nothing exceptional here, is there?! – it's what I'd want from the police no matter what job they went to. I know most of us do this anyway – I haven't written this post because I sense that we usually get this wrong! A reminder of what the public say isn't going to do any harm and there may be some officers (or for that matter, paramedics, mental health professionals or other NHS staff who hadn't thought of some of these things) who might think of doing some things differently in future.

Policing is not about us: it's about the people we meet and some of them are fighting battles you know nothing about and have been for years. **Be kind, be patient** – and let them be in charge as much as you possibly can.

23rd October 2017

Mental Health v Criminal Justice –

It's all too often a contest, of sorts – or perhaps a stand-off?! … two massive paradigms of state intervention, constituted and resourced for a certain set of separate public purposes, governed by separate laws that were (substantively) written around the same time, in the early 80s; and yet in so many important respects, they overlap and expose each other's problems and shortcomings in a "mental health is from mars and criminal justice from venus" kind of way. If only the main purposes of each weren't focussed on people from earth! – the public we're all here to serve.

If you want to read something exceptional on this, try Professor Jill Peay's book, shown in the image above. This post is borne of a thread on the Masked AMHP Facebook group – an AMHP asking about a scenario where a man is in custody for GBH. The 'mental health triage' nurse in custody called for a Mental Health Act assessment and the doctors he contacted suggested they should not even assess the person, because the only recourse they would have afterwards would be to use s2 or s3 of the MHA, which "would not be appppropriate". I will admit, I was aghast to read that without there also being further information that helps you understand. My instinct was, "well what if, as in many cases in years gone by, there simply isn't the evidence to charge the person; and what if an assessment under the MHA were to conclude the person was detainable?!"

My only point is this: we'd need to know more before one of these state paradigms wipes its hands of the situation – they'd certainly need to know what the other is thinking and what they are capable of doing instead. This re-opens debates I've tried to address on this blog before and really, it's about whether AMHPs and DRs understand the criminal justice system and how it makes prosecutions decisions, as well as whether police officers understand Mental Health Act assessments. If no other message is taken away from this post, then it's a plea that no matter what professional role you undertake, you pledge to learn enough about prosecution or MHA assessments, to begin to understand how this stuff dovetails, if required.

THE MAIN PUNCHLINES

There are certain things that are non-negotiable legal requirements in MH and CJ. We all need to know them ALL —

In *CriminalJusticeLand* —

- Prosecution can only occur where it is considered that there is sufficient evidence to charge the person and it is in the public interest to do so.
- If either of those aspects if missing – you cannot legally prosecute someone.

In *MentalHealthLand* —

- Someone may be detained under the MHA if they have a "mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment or treatement", under s2 or s3 of the Act.
- If that aspect cannot be satisfied – you cannot legally admit someone against their will.

It logically follows from there, we could have various scenarios in police custody where a person thought to be unwell is also suspected of offending. There either will or won't be sufficient evidence to charge in the opinion of the investigating and custody officers; there either will or won't be sufficient grounds to make an application under the MHA in the opinion of the AMHP (assuming the two DRs have given medical recommendations). So Leaving aside the public interest test for just one moment, you have four possibilities –

1. Sufficient evidence to charge; detainable under the MHA.
2. Sufficient evidence to charge; not detainable under the MHA.
3. Insufficient evidence to charge; detainable under the MHA.
4. Insufficient evidence to charge; not detainable under the MHA.

The public interest test only becomes relevant where there is evidence to charge a person with an offence and that is most often argued over in scenario 1, in my experience. The other three situations are quite straight forward, so let me deal with them to get rid of them quickly: 2) you're going to use a CJ outcome, because the MHA is not an option for you; 3) vice versa! … and 4) the person just get released because neither prosecution nor admission is required. In all three of these scenarios any ongoing healthcare matters are for the NHS to follow up via a GP, a community or crisis mental health team or in whatever other way thought appropriate.

SCENARIO ONE

It is where the MHA system could admit someone and the CJ system could prosecute someone that these two paradigms interface most often and most contentiously – when, precisely, do we still prosecute someone for an offence committed whilst so ill that they require hospital admission? It's a remarkably difficult question, most of the time; but it's been made even harder in recent years because the 'bar' for how acutely ill someone must be to be 'sectioned' has gone up as beds reduced.

Scenario 1 is now a harder judgement to make, involving only the most unwell in our society. We usually agree where suspects are accused of stabbing people or stealing small amounts of low value goods when they've never been in trouble before. Stabbing someone is rarely going to be something the CJ system doesn't take an interest in, but we also usually agree we don't want vulnerable people criminalised for stealing some food whilst living rough in crisis. But people are often more complicated than that, aren't they?! … we're frequently referring to people who are neither straight-forwardly "ill" and who may have some history of previous offending and / or previous history of failing to engage with MH services and failing to show up to court, whilst on bail. It opens up that awful "mad versus bad" dichotomy that I hate so much. << It simply isn't a thing – it is perfectly possible both legally and ethically to be 'mad' and 'bad', if people are going to insist on using those simplistic terms or any synonyms along similar lines.

The MHA itself contains provisions relevant to the overall operation of our criminal justice system. Part III MHA – all the sections between 35 and 55 – relates to a whole suite of remand, assessment, and disposal options, which are available to the *criminal courts only*. No doctor, no police officer and no AMHP in this country can do what the criminal courts can do under Part III MHA. So if those provisions are ever thought relevant, they can only be accessed after criminal prosecution. Criminal prosecution can only be launched where there is evidence of a crime – this is a fundamental tenet of criminal law and we would expect and demand nothing else. Prosecution without evidence is beneath us all.

THE CRIMINALISATION CONTINGENCY

I've written about this before: the idea that someone is prosecuted mainly or purely to allow them to access a kind of clinical care that is usually reserved for patients who have come through the criminal justice system and Part III MHA. Many medium secure units and high secure units will only accept patients from the criminal justice system or where there has been

referral from units with lower levels of therapeutic security making referrals 'upwards'. Some years ago, I became involved in a case, supporting a Senior Investigating Officer, after he hit up against *scenario 3*, above. The man arrested for murder was assessed in police custody and found to need admission under the MHA. By that time, there was insufficient evidence to charge, because the suspect had been arrested in a house where a body was found – and that's not an offence. It was still not possible to prove that he killed the victim because he was too ill to be interviewed, there were no witnesses to the killing and recovery of forensic evidence was still in it's early days with the location still being searched by the police.

This is where today's Masked AMHP Facebook group began: a situation where someone has been arrested for GBH, where a clinician calls for an MHA assessment – we don't know from the circumstances what the legal position was with the investigation. The AMHP contacted Doctors to undertake the assessment and it was eventually decided that they would not assess the person because they would only have s2 and s3 to rely upon, in the event that admission was required. Because of the seriousness of the offence and the perceived "risk" (whatever that means), it was being argued that the person should be prosecuted and then handled via Part III MHA. << I'll come back to Part III in a moment, but there's are other reasons to outline why prosecutions can't always occur.

In the MS v UK human rights case (2012), we saw the police detain a man under s136 MHA after finding him in a car that was likely to have been stolen. When they made enquiries with the registered keeper of the vehicle, they met a woman who had been extremely badly assaulted. As the story unfolded for the officers, the injured lady turned out to be the man's maternal aunt and she was just extremely glad he was now in police custody as a Place of Safety (there were no NHS options in Birmingham in 2004) and the police were getting help for him. It was almost beyond doubt he'd taken his aunt's car without her consent (an offence) and caused her GBH injuries, whilst psychotic. She required extensive surgery to repair that damage, however she simply refused to make any kind of criminal complaint against her nephew, arguing she knew he was really unwell and that all he needed was help. The human rights challenge was against the NHS for failing to get him out of police custody and subjecting him to inhumane and degrading treatment whilst he was in 'dire need of psychiatric care' – worth bearing in mind for AMHPs and doctors who are refusing to do assessments without necessarily understanding the criminal justice position.

PART THREE

There are some misunderstandings about Part III that may influence some of the things I have concerns about —

Firstly, even if there is sufficient evidence to charge (*scenario 1*), this doesn't mean the criminal courts have powers to 'divert to hospital'. The provisions for remanding defendants to hospital are sections 35 and 36 MHA – neither of them are available to the Magistrates' Courts at the point where a defendant first appears before them. In fact, s36 MHA is not available to them at all; section 35 only applies to someone who has been found guilty or who has been found 'responsible' for the act or omission charged, OR if they consent to the court exercising these powers. So it cannot be known for certain in a police station, that someone being charged with an offence would certainly be remanded to hospital by the Magistrates – it's extremely unlikely and I'm not aware of it ever happening. Apart from anything else, s35 requires information from the 'Approved Clinician' from the relevant hospital, and if everyone has refused to undertake an MHA that will not be lined up ready for the court.

Also, if someone is charged with an offence indicating higher levels of 'risk', we can assume it is more likely than not going to be a more serious offence, like GBH in the example which promoted this post; or in the MS v UK case; or murder, as outlined in my own example, above. Where an offence is indictable only, the defendant is not asked to enter a plea until they reach the Crown Court, which means the Magistrates can either remand the person to prison or release them on bail pending the CJ process. What do we think they're likely to do for a serious crime defendant who is thought to be seriously mentally ill?! How OK is it to send a vulnerable person needing hospital treatment to hospital, because NHS prefers not to admit them to a relevant kind of secure facility? … would we even be having this discussion about cancer patients and linking their potential for hospital treatment to whether or not the police have prosecuted them for something?!

My final point is this: we know from history that patients who require certain regimes of 'therapeutic security' like high or medium secure units, can access them where necessary. Preferred NHS policy that this should not happen directly from police stations is just that: NHS policy. It is not in the MHA and nothing prevents someone being 'sectioned' under the civil provisions like s2 and s3. This may, in the real world, be necessary from time to time, because it is simply not always the case that a criminal prosecution is immediately possible, as we saw in the murder case, as we saw in the MS v UK case and in others that haven't gone anywhere near the news or the human rights courts. If someone is in 'dire need' of psychiatric care, then that remains the case regardless of the state of any

criminal investigation that may be occurring and it remains incumbent upon the state to be able to ensure their fundamental rights.

Unfortunately for everyone, saying "secure beds take days to organise" and "NHS policy says they must be charged" is irrelevant and not a matter for the police. History also shows those arguments fail, for the reasons given, so we need to be accordingly prepared of these situations when they emerge.

***NB** — if you're not a police officer and want to read more about how the Police and Criminal Evidence Act 1984 operates, there is a PACE for Beginners series of posts, for your consumption.*

NOVEMBER 2017

2nd November 2017

Half-Hour Checks –

Well, it's all now official: the Mental Health Act 1983 will be amended by the provisions in the Policing and Crime Act 2017 with effect from midnight on 11th December 2017. The regulations were laid in Parliament today for a) commencement of the change; and b) the use of Police Stations as a Place of Safety and we can now stare straight down the barrel of what we know has been coming for around three years.

The big surprise in these developments has been the extent to which it will become very difficult to use police custody as a Place of Safety, *at all*. We knew the amendments would ban such use for children, but we always understood that police stations could continue to be used for adults in exceptional circumstances. Whilst there were various hints in the consultation document from 2014 and various other clues during the informal discussions which occurred between the Home Office and the NPCC / College of Policing, we obviously couldn't be certain of anything until such time as the Regulations were published – and that happened today.

We now know it will be a strict requirement whilst police stations are being used for this purpose that detainees' health is *checked by a healthcare professional* **every half-hour** and necessary advice given to custody staff to enable them to ensure the health and wellbeing of the person. This is the amendment which seems to have caused the most shock whilst discussion occurred but I want to be absolutely clear about what I think on this: I wouldn't want it any other way and I don't actually think it's strict enough. Since you're now wondering, I would have preferred to see a total ban on the use of custody as a Place of Safety and that if there were to be any circumstances in which it occurred, it would be with a constant healthcare presence 1-to-1 for that detainee.

HIGH RISK DETAINEES

We saw on Monday, publication of the Independent Report into Deaths and Serious Injuries in Police custody (the Angiolini Report) – 110 recommendations to make the world a better place and amongst them was recommendation number 25 which calls for an end to the use of police custody as a Place of Safety. My understanding of the reason why this wasn't done during the Policing and Crime Act amendments is the ongoing belief that it may still be necessary to hold some people in police custody

because they are exhibiting such a serious level of resistance or aggression that an NHS facility would be unable to ensure the safety of staff or other patients; and that the physical infrastructure is not built to police or prison cell standards. In fairness, I'm aware of a few cases where NHS facilities have been damaged by people who were unwell and frightened whilst detained pending assessment – so, does this mean we should be using custody or improving healthcare infrastructure?!

The statutory regulations published today outline the criteria for removal to a police station as a Place of Safety and I published a specific post on that earlier. In case of any doubt at all, for someone to meet these criteria they have to be posing a massive risk – serious injury or death – to themselves or other people. Even then, a police inspector would have to authorise a police station to be used and foremost in that officer's mind should be the safety of the person. You only need to look to the recent IPCC Report *Six Missed Chances* or to yesterday's Angiolini Report to see how the police are repeatedly implored, quite rightly, to encourage to adopt a 'safety first' approach to those they detain.

If someone is so unwell because of mental disorder that an officer has intervened by detaining them, there will be at least some level of restraint ongoing and where we start to think that the person's behaviour could pose "an imminent risk of serious injury or death" we need to be asking proper questions about what might be driving this. We don't need certainty on it – we need suspicion about what might be driving someone to appear so unwell and pose such risks. We only need to look at history to see various potential reasons: head injuries, encephalitis, acute behavioural disorder, serotonin syndrome, meningitis, strokes, epilepsy and I could go on and on … and, of course, someone could just be so seriously mentally ill that they are quite unable to escape the beliefs, their voices they're experiencing and detention by anyone could be terrifying: so much so, we could just see a basic, human 'fight or flight' instinct kicking in, for reasons that don't make obvious sense to those of us trying to keep that person safe, but which make perfect sense to the person detained.

CUSTODIAL HEALTHCARE

Have you ever been responsible, legally and literally, for the safety of a psychotically unwell, extremely frightened person who is obviously seeing things and hearing things that are way beyond my realm of perception and who has been jailed up in a cell for days because of a lack of alternative options? I have – and I was absolutely bloody terrified, frankly. I started a night-shift a discovered there was a lady in our cells under s136 because the Place of Safety had refused to receive her. She was one of the most unwell people I've ever met in my life and looking at the custody record it was absolutely obvious that no-one had done basic medical checks despite

the fact that she'd been detained under s136 MHA. Long story made short, I made it clear that unless someone could tell me that basic medical checks had been done on her, to rule out the need for her to be in A&E, she'd be transferred to A&E to ensure her welfare.

If we are serious about putting patient safety first, we can't cry that it's becoming all too difficult where people exhibit challenging behaviours. We wouldn't do this with a violent person who'd struck their head on a windscreen in a car crash – I've even seen convicted drug dealers, who had their heads caved in with metal bars by rival drug dealers over debts and turf get care for their injuries when they were no more or less poorly than some of the people I've seen being pushed towards police custody when experiencing a psychiatric emergency. Parity of esteem, if it's to mean anything at all, has to reach in to the difficult places, too. So if the Mental Health Act (Police Stations as a Place of Safety) Regulations 2017 are highlighting that the only people can should ever be detained in custody are those at most risk then it strikes me that a few considerations should *always* apply –

- We only do this where we have no other option at all!
- If we really are going to think about this(!), we *maximise* the clinical screening of the person *before making a final decision.*
- Once the person arrives there, we ensure close clinical oversight of them – to ensure they fit to be detained in police custody.

CONFLICTS OF LAWS

Remember, the use of police custody for any purpose is subject to a well-established body of laws – **the Police and Criminal Evidence Act 1984** (PACE), plus the associated Codes of Practice to PACE, especially Code C on detention in custody. (If you're a healthcare professional who is less familiar with this territory, I wrote a few small guides for a non-police audience.) Those frameworks already oblige the custody officer to have regard to someone's medical welfare and it is already the case that where someone arrives in police custody, either under arrest for an offence or detained under the MHA via these new Regulations, the custody officer must decide whether the person requires clinical attention and they must either, call an Approved Healthcare Professional (a specific term for custody healthcare, and NOT the same thing as an AMHP); or they must call an ambulance or transfer the person to hospital. Depending on specifics, it is quite feasible that decisions (or preferences!) to use custody after detention hit up against the solid brick wall of a confident, knowledgeable custody sergeant who genuinely believes that PACE frameworks mean they must, *in all conscience*, transfer that person to hospital.

Here was my own personal reaction to the Regulations when I saw them in their final form, bearing in mind I've been the duty inspector who was involved in overseeing and directing the early decisions after someone is first detained; I've been that custody sergeant to whom the vulnerable were carried because (at that time) officers had nowhere else to go; and I've been the police constable detaining people under this Act and being nervous for days on end that the decisions I was forced to take through the want of properly established pathways weren't going to backfire for reasons beyond my control and I'd find myself investigated (or worse) for manslaughter.

As a police inspector and bearing in mind what I've learned doing all the work I have on policing and mental health, **I cannot think now of a single, solitary situation in which I would authorise removal directly to a police station from the point of arrest**. I'd question the ability of any healthcare professional to tell me, in a street, during a restraint that someone presenting in the way the Regulations describe didn't need careful screening in a medical setting, prior to it being considered 'safe' to proceed to custody and hold them in a small concrete room, *healthcare checks or not*! So, for me, if no paramedic has come to the scene when officers are thinking about these Regulations: to an Emergency Department we will go! Even if a paramedic attends, I'd have questions for them if they were saying it's OK to go to custody with anyone who poses "an imminent risk of serious injury or death" to themselves or others. Same would apply to any suggestion in ED that someone should be taken to custody. It would be whether the professional's judgement was maintaining nothing in these documents indicated the person needed to remain in that or any other kind of healthcare setting –

- NICE Guidelines (2015) – Violence and Aggression: Short-Term Management
- Royal College of Emergency Medicine – Guidelines on Acute Behavioural Disturbance
- Faculty of Forensic and Legal Medicine – ABD: guidelines on management in Police Custody.
- NHS England PSA (Dec '15) – vital signs during and after restrictive interventions / manual restraint.

There are some big words and complicated ideas in that lot – probably best that cops aren't trying to disentangle this stuff and sort it out, until we know people are going to be safe. My thinking is unable to take me very much further than that, quite honestly, which may be my bad but you only need to pay attention to the news to see why.

4th November 2017

Timing Is Everything –

In 2016, the Welsh Assembly Government published a new Code of Practice to the Mental Health Act 1983. This followed on the update England had received the previous year. In many respects, there is now far greater concordance between the policing aspects of these two documents which certainly made it easier than it would have been to write the College of Policing's guidance during 2015/16. We're going to have to update that guidance shortly, to take account of the new provisions and I have a question to answer which seems literally impossible to answer, as things stand.

Politically speaking, all health issues are a devolved responsibility in Wales, whereas policing is not. This creates some difficulties when it comes to issues which affect both. The Mental Health Act is an example of this – it's primarily health legislation but it contains policing and criminal justice provisions, like Part III of the MHA and the powers being amended like ss135/6 and s138. The specific example emerges in the guidance document which has been published ahead of the changes to the MHA introduced by the Policing and Crime Act 2017. Forces and mental health trusts are now in to that frantic period of work before the changes take effect on the 11th December and one of the main pressures that we will face as we move in to next year, is that we will only have 24hrs to get someone 'sorted' when they are detained under s135/6. It's sometimes problematic to do so where we have 72hrs, so every minute of the 24hrs will be crucial.

So when, precisely, does the Place of Safety clock start ticking?!

THE LONG ARGUMENT

- **The English Code of Practice (2015) states, in paragraph 16.26** – the maximum period a person's may be detained under s136 is 72hrs. In practice, detentions should not need to be this long. The imposition of consecutive periods of detention under s136 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).

- **<u>The Welsh Code of Practice (2016)</u> 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.

Make of that lot what you will! It begs certain subordinate questions before you can get properly in to it. Before the 2017 guidance document emerged – more on that, below! – people would argue that "A&E is not a place of safety!" and simply hope that ended the argument about a) whether the obligations which kick in upon arrival at such a place began on arrival at ED; and b) whether that meant more officers would be turning up with anyone and everyone, arguing, "because you are a Place of Safety, you have to accept this person!"

In reality, it was only ever about the first aspect, but I do accept the history of this stuff means ED also feel, a bit like the police, that some vulnerable people are somewhat treated like a can to be kicked further down the road and that their (busy and often chaotic environment) wasn't ideally suited for those of us in distress because of a mental health crisis. I don't think anyone massively disagrees with that – I'm only making the point that in any area of each country, some people detained under s136 will also urgently require the kind of medical care that can only be provided in an ED. And that if you're detained under s136, we need to know what to do upon arrival at ED – do we start the clock, must we contact the AMHP, etc., etc.?

<u>ENGLAND v WALES</u>

Since nothing in the 2015 English code specifically stated whether 16.26 applied to arrival at ED (for whatever reason you went there) or whether it just meant arrival the s0-called 'designated Place of Safety', we weren't entirely certain what to make of it. I say 'so-called' because neither the Act nor the Codes talked about a 'designated Place of Safety' – this is a phrase in common usage and which is given a certain rarified, quasi-legal status, but which isn't actually found in a legal document of any standing. I think it just means a place of safety that has been agreed or specified in the local protocol about the operation of s136 MHA. Whilst it is, of course, important to outline what the most commonly used locations may be, nothing agreed locally prevents any improvisation because the Act has always said that

anywhere can be a Place of Safety under the Act – including my mother's house, if the need arose.

My favourite point on ED was always , "A&E is part of a hospital and hospitals are a place of safety, according to s135(6). If they are also agreeing the person detained needs to be in their department for assessment and treatment that only they can offer, then how are they NOT acting as a Place of Safety for the purposes of the Mental Health Act when a) they are a hospital; and b) they have agreed to receive the person. The distinction between being 'injured or ill' and requiring assessment for 'mental health' may not be possible and for various legal reasons, these issues may need to be considered together. And at the risk of making the most obvious point of all: this argument is usually breaking out when the only person who has yet put their professional name to the pathway the person is experiencing is a police officer with a first-aid certificate – and they may be wrong!

The publication of the current Welsh Code complicated things unnecessarily, in my view. Firstly, it started from that premise: that 'treatment of illness or injury' is separate to 'mental health'. So many cases over the years show that some people – not all! – who go to EDs often stay there for urgent MHA assessment and then for admission to the acute hospital for treatment without consent. It is not always known at the point where someone enters ED whether they will be able to leave again – like the lady detained under s136 who was 'bounced' to ED by the Place of Safety nurse and found to have meningitis – didn't leave ED, MHA things considered and concluded in the acute hospital.

ADVICE

So, when does the clock start ticking?! – well, we do know that the English and Welsh Codes can't both be right! And if you're a British Transport Police officer and you operate both sides of the border, you might wonder which rules you should be following – does time spent in A&E 'count' or does it 'not count'?! Bearing in mind this disagreement is a disagreement in the Codes of Practice, which is not the law, but statutory guidance, I specifically asked the Home Office to ensure this question was addressed as they produced their guidance. This is what they came up with —

The recent guidance document states, in paragraph 4.4 – if a person detained under s135 or 136 is taken first to the Emergency Department of a hospital, for treatment of an illness or injury (before being removed to another place of safety) the detention period begins at the point the person arrived at the Emergency Department (hospitals being a place of safety).

For me, whilst accepting this isn't a court ruling so we do not definitely know, this more-or-less settles the matter. The document has been produced but the Department of Health and the Home Office, in full consultation with the Welsh Assembly Government and the Police Liaison Office of the Welsh Assembly. It specifically points out that each country has its own Code of Practice but that compliance with it may have to change, where substantive laws have changed. Well, overall timescales for detention under s135/6 have changed, considerably; and what I also know, is that following this guidance means you'll never accidentally drift in to the territory of unlawfully detaining someone.

Remember, you can extend the detention of someone under s136B from 24hrs to 36hrs if the condition of the person prevents their assessment under the Mental Health Act. A delay because of treatment in A&E for injuries or illness would be one of the particular examples in the minds of the legislators – "if there is a hold up because of intoxication or injury, they may need more time, so we'll give them s136B" or similar, so they've catered for the possibility that delay may mean we need slightly more time.

ERRING ON THE SIDE

Of course, there may be opinion out there that this interpretation is wrong – I'm aware of some advice given that suggests it is. It just seems the obvious point to make that the DH/HO also had legal advice on this when it was produced so what we're left with is a disagreement amongst lawyers who have advised in Wales versus those who have advised in England. What a shock … said absolutely no-one. Having discussed this thing informally with many lawyers over the years, including this week, most don't understand why the Welsh Code says what it says and agree there are concerns about taking it at face value.

Back in the real world, police officers, place of safety staff and far less occasionally, Emergency Department staff may have to make real decisions about when the 24hrs or 36hrs is 'up' and whether they can or should continue to coerce other human beings. All I know is this: if you count it from arrival at ED, you'll never end up accidentally detaining someone unlawfully. If you do ignore the time spent in ED, you're awarding yourself extra hours with which to detain someone pending a final decision about them. How many hours is OK? – can we can ignore a 4hr wait; and then still help ourselves to a further 36hrs; what about. a 12hr wait meaning we end up holding someone for 48hrs overall? How lawful would it be to take that 12hrs for ED treatment, then also use the s136B extension to effective take double what parliament intended? … where does it stop?!

Parliament seem quite clear: they want things done and dusted in 24hrs maximum as a standard, 36hrs *in extremis* – they no longer want people

detained for longer than 36hrs under *any* circumstances. It has always been my view that time spent in ED has to 'count', for the reasons given – Parliament has now reflected the idea of delays for urgent illness or injury with a specific provision giving more time where this has been necessary. In the absence of a court ruling on this particular point, I admit I'm at a loss to understand why we just don't get on with things within this framework and stop arguing about it.

It could just be me …

6th November 2017

Inspector to Inspector –

I've been a police inspector for most of my service – about fifteen of my twenty years so far. Regardless of what happens to me in the future, I will retire from the service having spent more time at this rank than any other. And what a position it is! – it's an operational enough rank to mean you can still do real police work and see the raw humanity in to which policing offers the most amazing and privileged insight. And it is the most Romantic rank of all – most of the policing heroes we idolise from television and literature, like Frost, Rebus, Gently and Morse were inspectors. Actually Morse was a Chief Inspector, but you'll notice he didn't always tell people about that. He knew …

The Inspectors' Central Committee (as it was then called) of the Police Federation of England and Wales were kind enough in 2014 to recognise efforts I've made over the years to try to help around policing and mental health: of the various recognitions I've had for banging on, that one's just a bit special because it's from those I've served alongside and who do what I've done night after night, weekend after weekend and Christmas after Christmas. We're usually the sole operational police leader for large areas, sometimes overseeing hundreds of officers and likely to take many of the early big decisions for the largest or most sensitive events in all operational policing. And so this post is written specifically for the inspectors and the inspectors alone – to help you navigate what will soon become one of the gravest responsibilities carried by our rank and on which much political attention has been focussed.

We've been invested with sole responsibility for what I consider to be the single most contentious decision of all, in the Mental Health Act amendments: we will be the sole guardians of the decision about whether police stations should be used as a Place of Safety under the Act and only for those most in need and potentially at the gravest risk. This is the stuff of seminal reports for years gone by: the Equality and Human Rights Commission, the Angiolini Report, the Adebowale Report, the Bradley Review, the Home Affairs Committee report, multiple CQC, HMIC and IPCC reports as well as Coroner's Inquests and Regulation 28 'Preventing Future Deaths' reports … ALL have touched on this point and it has been the stuff of debate at the very highest levels for the last five years or more. We – the Police Inspectors of England and Wales – are the safeguard against human rights abuses under the MHA and deaths in police custody in the

most time critical circumstances. This could appear a somewhat daunting responsibility(!) but it's also an immense privilege which I know we can discharge with common sense and compassion to lead police officers and the public. This post doesn't highlight much that's new: it just brings existing guidelines together in the context of this new legal authority for our rank and I admit I don't see this as needing a four-hour training package: we already know most of what will follow in this post.

POLICE STATIONS

Once the Act is amended on 11th December, any decision to use a police station as a Place of Safety requires an inspector's authority and I think it will be fair to predict that when this call is required, there could well be objections and concerns no matter what we do or why. The decision itself will only be the beginning of our involvement in an incident that may absorb us in to subsequent discussions, concerns or even complaints. I suspect our partner organisations are going to want to speak to us to challenge some of our decisions not to authorise removal to a police station; we may also find custody sergeants fancy a 'quick word' with the boss where authority has been given, but where the custody sergeant disagree with it. I suspect a few of us will also find a statement to resolve, where we are not content to authorise the use of a police station but where mental health partners are also struggling to agree to allow an NHS facility to be used.

There is a lot invested in this decision: the IPCC will be very interested, I suspect, in the rationale for a police station being used or not used, in the event of an adverse incident; partners will question the insight the inspector has to the consequences of their decision where they have declined to authorise it and want to persuade some of us to change our minds. And if we don't, it may well beg immediate questions for how much we are going to ensure the safety of the patient, the NHS staff and the detaining officers by ensuring sufficient resources are made available for the consequences of the decision.

Firstly, a quick reminder about the decision we have to take: under the Mental Health Act (Place of Safety) Regulations 2017, a police station may only be used as a Place of Safety in exceptional circumstances. This means –

- The detaining officer reasonably considers that the person's behaviour poses an imminent risk of serious injury or death, to themselves or another
- No NHS place of safety in the force area could reasonable handle the risk posed by the detainee
- YOU have authorised the use of custody, against those criteria.

So you need to be satisfied that the detaining officer is giving you information that says the person poses such a risk. You must then ask yourself what that risk could signify – it will not just be risk of assault to the officers or the wider public, it may also be a presentation that is because of an underlying medical issue or a presentation which gives rise for the need for restraint, which in itself can prove fatal.

URGENT CHECKLIST

- Your first considerations must be – have we called an ambulance to this. If not, why not? – do it.
- Does the detaining officers have enough support from colleagues to manage that scene? If not, can we get more officers up there?
- I'd be directing a sergeant get involved very closely, if there isn't one already – this incident could go to anywhere yet, I want a first-line supervisor all over it like a rash whilst focusing on nothing else, if at all possible.
- What is the 'clinical assessment' of RED FLAGS – best done by the paramedic, of course; but if they're not coming or will take too long, it will have to be the cops present to make that call on the basis of their first-aid certificate and personal safety training.

If we have someone whose behaviour is giving rise to the need for a high-intensity or protracted restraint and de-escalation has failed before restraint and following it, we need to think about whether this is a **medical emergency**. Some highly resistant, agitated presentations can be attributable to underlying medical problems, to the use or abuse of drugs or alcohol and in some cases latent risks can be exacerbated by the use of restrictive practices like restraint. This stuff is documented in many of the inquiry reports mentioned above. This has been repeated most recently in the Angiolini Report and there are medical guidelines and documents which pertain to this, also.

For what it's worth, this is what I'd be thinking: **no-one goes to police custody unless someone in the NHS has confirmed to me or my officers that the person concerned does NOT require medical assessment in an ED.** If they want to put their professional registration to that decision based on watching the police detain someone at a scene or outside an ED, then fair enough. Then – and *only* then! – will I begin to think about it.

RESOURCES YOU NEED

I'd recommend saving this post on a device you carry with you at work, just in case you get in to real difficulties with discussions and you need to pull out the references for why you're arguing what you're arguing —

- NICE Guidelines (2015) – Violence and Aggression: Short-Term Management
- Royal College of Emergency Medicine – Guidelines on Acute Behavioural Disturbance
- Faculty of Forensic and Legal Medicine – ABD: guidelines on management in Police Custody.
- NHS England PSA (Dec '15) – vital signs during and after restrictive interventions / manual restraint.

There are some big words and complicated ideas in that lot – probably best that cops aren't trying to disentangle this stuff and sort it out, until we know people are going to be safe. My thinking is unable to take me very much further than this: high intensity or protracted restraint = Emergency department unless some paramedic is putting their name to a decision that this course of action isn't necessary. They should batting in accordance with all of the above guidance so if they're trying to argue it: ask them. "The NICE Guidelines on Violence, the NHS England stuff on post-restraint obs: you're saying this person doesn't need attention in an Emergency Department and are safe without clinical supervision from now on?!"

And remember this: *your* decision to authorise the use of a police station is not the same thing as the custody sergeant's decision to authorise detention in custody. All that stuff in PACE Code C stuff that we remember from when we were custody sergeants and which we consider when acting as Review Officer then kicks in: does this person require clinical attention? – if so, can they receive it from the custody healthcare staff and if not, call an ambulance or transfer them to hospital. We are trying to ensure the person may be removed to the police station, both legal and medical grounds; the custody sergeant must ensure the person may remain there, on both legal and medical grounds. These two things are quite different, because people can deteriorate in custody, especially after restraint – see the NHS England PSA, above.

So, ask yourself this – how can we tell in the street that someone who is busy resisting or even fighting the police whilst in an acute mental health crisis is **not** suffering from ABD or any of the various underlying medical problems we've known in the past, like *serotonin syndrome*? Answer honestly: do you even know what that is? – and if you'd heard of it, did you know it's a rapid on-set potentially fatal condition that requires urgent

treatment in ED?! I didn't until a couple of years ago – and had to look it all up after reading the outcome of a death-in-police custody inquest. And obviously: brief your officers on all of this, so they know what your reaction is likely to be – share the resources with them, if that helps.

Thanks to @NathanConstable for reading this one and ensuring what I'm trying to say lands cleanly!

13th November 2017

PaCA: The 'What If' Questions –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017. This post is one of several which relates not the amendments themselves, but to the implications arising from them.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. We now know the changes will take place on **11th December 2017**.

We now know we are staring down the barrel of the Policing and Crime Act amendments to the Mental Health Act 1983 – they are just *four weeks away*, as of today. In the last week, I've had numerous phone calls from forces and emails from officers asking 'what if' type questions … basically, asking what the operational answers will be to situations we all hope won't emerge, but which history suggests are quite likely. Not all of these problems will emerge in every area, so I'm not predicting that everything will grind to a halt, but I would suggest most of these problems are likely to occur in at least one part of the country OR are likely to occur as an occasional problem in areas where things usually work well.

This post can be added to in the future, because I've started off with just those questions I've received so far and a few I've thought of just during a train journey to London! There may well be others and no doubt some I haven't thought of at all … fire them and we can all get thinking. This post is just to get us to start that process of us thinking about a potential Plan B, for those occasions where Plan A just isn't possible, for whatever reason —

- **What if there is no-one to consult with prior to using s136 MHA?**
- Then it is not practicable, so you crack on without doing so. You are not obliged to scour the NHS for any old Doctor or nurse, AMHP or paramedic, to run a scenario past them which will likely lead to them wondering why you're boring them with the story at all! If you areas has a so-called 'street triage' service, or an established method by

which to consult, fine – you must use it where practicable. If not, just crack on officer.

- **What if the person consulted believes s136 MHA should not be used?**
- The legal power under s136 is for constables and for no-one else – this point is emphasised not to dismiss the views of others, who may have information and valid reasons for advising a particular course of action. However, that is just one piece of information or opinion the officer must take in to account when forming a view to detain. Nothing prevents a police officer listening to any view offered, from the consulted professional or from any family members present, and then taking the action they think they must.
- **What happens if our area has nowhere identified for under 18s to go as a Place of Safety or if the identified location is unwilling or unable to receive a particular child?**
- The only remaining option which will definitely exist in every area is the Emergency Department in the acute hospital. Nothing in law prevents an officer asking ED to act as a Place of Safety for a child, where no other provision exists or where that provision is un
- The only other alternative is to 'improvise' – and this will need careful thought.
- You cannot use a police station at all for someone under s18yrs of age – this is not just a ban on the use of custody, it is a ban on police stations, including front office interview rooms, the rooms some stations have for vulnerable victims or the TV / rest room. All banned because they form part of the police station.
- **What if the Place of Safety is full and the person detained does not require treatment in the Emergency Department?**
- Historically, police custody was used for many people who did not require ED treatment where the NHS Place of Safety was full with others detained under s136. This is now not lawful, because of the restrictions imposed on these use of Police Stations as a Place of Safety.
- If the so-called 'designated' Place of Safety is unable, unwilling to receive the person and the grounds for using the police station are not met, then you have to find another solution. Nothing in law prevents a police officer asking ED to consider allowing the person to be assessed in the ED. It's not ideal – but nor is it unlawful, as long as ED agree to this action.
- Should they choose not to do so (there is no obligation upon them to do so), then officers must consider improvising, as outlined in the previous answer: could that person be taken home or to a family member's or friend's home? If all avenues are exhausted, it may be a case of making it known to the MH PoS and / or ED, that there are no viable options and the person will have to remain in a police vehicle until such time as they can be received.

- **What if the NHS disagree with the inspector not authorising the use of a police station and are refusing to allow access for someone they think should be taken to custody?**
- The inspector's authority is required, by law – no authority given, no using police stations for that person.
- Of course, the police and NHS should be discussing things, communicating and exchanging information and concerns to allow a swift pathway to be identified that all are happy with. Things to consider, include –
- Are the NHS pushing for a police station because they have genuine fears about their ability to manage challenging behaviour in someone who is agitated and distressed? – perhaps the inspector or sergeant having a word and committing to police officers remaining in the NHS Place of Safety would suffice to overcome that fear?
- **What if the grounds for searching someone are not met but the Place of Safety insist upon a search?**
- It is worth explaining that under s32 PACE (search upon arrest) and the new s136C MHA (search after detention under ss135/6) that it is not a blanket power of search, that each search must be justified and that the grounds for doing it are far higher than speculation or suspicion someone is carrying an item.
- All searches under either provision require 'reasonable grounds to believe' the person is carrying an item for one of the purposes specified – this means you need to be 7 or 8 out of 10 certain you'll find whatever you think you're looking for.
- **What if the 24hrs runs out whilst the NHS are still looking for a bed?**
- The person must, by law, by released from detention if no MHA application has been made which allows further detention. As most of these situation will occur in an NHS Place of Safety, I would make sure I was telling the sergeant or inspector when we hit these milestones: 12hrs, 18hrs, 21hrs, 22hrs, 23hrs, 24hrs and seeking their support for a contingency plan!
- Sergeant / Inspectors: I'd be escalating to NHS managers from 18hrs onwards and making sure they realise they cannot rely upon the police to be involved in ongoing detention after 24hrs; that the situation of 'no beds' shouldn't emerge; they should look at s140 MHA and s13 MHA in this context and remember that detention beyond 24hrs could violate Article 5 of the ECHR. Press for urgent resolution and escalation by them to CCG on-call directors around beds, etc..
- This is all subject to the 24hrs limit unless it was extended up to 36hrs under s136B – if an extension has been authorised, then detention may continue until then, when the same considerations will apply.

These are just some of the 'what if' questions: if you have others, *please leave them in a comment*, below and I'll answer them if I can by adding to

this post. It's clear just from paying attention on social media that all areas are not going to get this right all of the time from 11th December. Some areas have particular issues (like where to take children) and others may just have occasional capacity problems. Given the restrictions under the 'old' system will almost completely vanish, identification of a Plan B and the knowledge required to activate and navigate through it, will be crucial.

This stuff isn't going to be hard in theory: it's going to be hard in practice so take the time in advanced of December 11th to get your head round both Plans!

16th November 2017

Seni's Law –

Earlier this month, Steve Reed MP, introduced a private member's bill to the House of Commons which is being informally referred to as Seni's Law – the Mental Health Units (Use of Force) Bill 2017. This follows the death in 2010, of Olaseni Lewis in a hospital in south London – an incident to which the police were called and which involved restraint. Mr Reed is the local MP for Seni Lewis's parents who have campaigned for justice since this tragic incident and the publication of a PMB in Parliament brings the possibility of legal changes which may assist in protecting individuals whilst they are detained in hospitals under the Mental Health Act 1983.

The Bill has received support in principle across the political spectrum so it's extremely likely that a version of this Bill will become law in England at some point next year. (It will not affect the other three countries of the UK because health issues are devolved in those jurisdictions).

NHS ACCOUNTABILITY

The Bill is largely not about the police, I am very pleased to say. It is mostly about the NHS having proper systems in place to govern the use of restrictive practices, esp physically restrictive practices like restraint, and that such matters are properly recorded, reported and analysed at both local and national level. For example, there would be a requirement for the Secretary of State to produce a report in connection with the data that would be gathered by law. This for me represents the multi-factorial explanation that the Inquest jury returned in connection with Seni's death: see my post from the time of the inquest for more detail on that.

My own view is that this law is largely welcome: at various times over the last few years, it has become obvious to me that the scrutiny of our NHS around use of physical force and coercion is at odds with how we hold police, prisons and other arenas of detention to account. The Bill would also call for an independent investigation of certain types of death in the NHS and this is something I've suggested should occur for some while. I fully understand that many of the deaths which occur in our NHS where patients are detained against their will are largely deaths caused by natural causes – for example, an elderly patient with dementia who dies primarily as a result of conditions associated with old age and which are nothing to do with the detention of the state. But when a teenager dies in NHS care,

unexpectedly and in unexplained circumstances, the approach needs to reflect modern standards we impose upon other agencies who detain and coerce people.

I recently attended the book launch in London for Sara Ryan's absorbing book which outlines her compelling campaign to secure justice for her son, Connor Sparrowhawk. Connor died in an Oxfordshire learning disabilities unit, contributed to by neglect and at the book launch I was also most fascinated to hear from the family's barrister, Caoilfhionn Gallagher QC, who argued that were it not for Sara and her family, there would probably not have been any kind of investigation. Part of the 'Justice for Laughing Boy' campaign was to highlight how much difference there is in the state's response to unexplained or unexpected deaths in NHS care, when compared to what occurs in police or prison custody. We may have concerns and questions about the IPCC, but at least they exist to be criticised and challenged. The police weren't even called to Connor's death, not withstanding that it was initially unexplained and unexpected.

BODY WORN VIDEO

The main 'police' element of this Bill bears some explaining because I want to gather views around it – especially from those with experience of being detained in mental health units. One clause creates a strict requirement that any officer called to a mental health unit for any reason should be wearing body worn video from the point they are called to attend. This is obviously about accountability where the police are called and things have gone awry and presumably is about giving effect to the theory that officer behaviour is modified where the officers know they're on camera, but for me it raises some further, more interesting questions.

Inpatient settings are supposedly places of sanctuary for those of us with mental health issues when we are at our most vulnerable – we don't, to my knowledge, routinely have CCTV cameras giving full coverage on MH wards because of the argument that it violates patient privacy principles, but by arguing for body-worn-video on officers, we seem to want such cameras brought in when the police attend. So —

- How do patients feel about the idea that they or other patients would be filmed in incidents when the police attend?
- How much consultation has there been with service users about this new law?
- Why does the Bill only seek to hold the police to account by ensuring their actions are videod? – it doesn't seek to hold NHS staff to account around whatever may have occurred before the police turn up.

Surely an independent investigation in to a death in NHS care (whether or not the police were involved) would only benefit from CCTV? – I've been wondering why the Bill wants the police videod but not NHS nurses who restrain patients. Think about the cases of Rocky Bennett (1998) or more recently Joseph Phuong (2016) to consider NHS restraint related deaths that would not have been caught on body worn video because the police were not involved at the point where clinical staff were restraining patients. Is it any more or less controversial or in need of close scrutiny that someone who died in the custody of the state died following restraint by nurses or by police officers? I admit to not understanding the difference – at all.

Let me know any thoughts you have, in the comments below – there's more to it than I've covered here, but my time is limited at the moment. Apart from anything else, the NPCC are being asked questions about practical matters of implementation so your views could be represented in the replies given by the Boss if you let us know what they are!

RESOURCES

- The UK Parliamentary website to track the Bill's progress.
- The Mental Health Units (Use of Force) Bill 2017.
- The parliamentary briefing paper.
- The College of Policing 'restraint' MoU for inpatient MH / LD settings.

25th November

PaCA: What is a Place of Safety? –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017. This post is one of several which relates not the amendments themselves, but to the implications arising from them.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. We now know the changes will take place on **11th December 2017**.

This week has been full of phone calls, emails and questions – mainly about how officers should consider the choice they have to make about which Place of Safety to use after they've initiated someone's detention under s136 MHA. In particular, many of this week's questions have been connected to the role Emergency Departments have to play, not least because one ED in England, whilst in discussion on these matters with their local police force, asked that I be made to stop tweeting things(!) they disagreed with about the legalities of s136 and choices about Places of Safety – yes, really!

The irony being, I had done nothing more than tweet a screenshot of the Government guidance on the Mental Health Act amendments, jointly issued by the Department of Health and the Home Office, with which they happen to disagree. Paragraph 4.4 of the guidance states, "If a person subject to section 135 or 136 is taken first to an Emergency Department of a hospital for treatment of an illness or injury (before being removed to another place of safety) the detention period begins at the point when the person arrived at the Emergency Department **(because a hospital is a place of safety)**." The bold is my emphasis, because this message doesn't seem to be getting through! I didn't write this stuff or make it up … I'm only hoping to explain it so police officers know how to discharge their duty of care and so that patients know their rights whilst detained by the police.

It seems the disagreements about these points comes from different bits of legal advice that people have sought from trust solicitors, etc., etc.. I'm not sure we need to inform the press that multiple lawyers representing

different people Andy organisations with different vested interests at stake don't always agree with each other. It's hardly a shock to anyone, is it?!

WHAT IS A PLACE OF SAFETY?

Let's revisit the very basics, but in the context of these new laws. The definition of a Place of Safety under the MHA is contained in s135(6) and it has not been radically overhauled for December. As with the previous definition, **absolutely anywhere can function as a place of safety** under the MHA, subject to some criteria, but the traditional three options have always been and will no doubt remain –

1. An Emergency Department in an acute hospital.
2. A mental health unit with a Place of Safety room or suite.
3. A police station.

NB *– I have always listed them in this order, not because ED should be the main choice for most people – it should not. But it should be the first question police officers ask themselves after detention: "Does this person, now they are in my care, require urgent ED treatment or assessment for any reason? if so, go thee; if not, go to your locally identified PoS facility, probably in a mental health unit."*

The Act itself, continues to list "residential accommodation provided by the local social services authority" as a Place of Safety: I'm not aware of that ever being a preferred option in any area, or of it being used at all. The three traditional options tend to be those which are specified in the local Place of Safety protocol, but the Act has also always said something that allows improvisation through problematic situations: what used to be "anywhere temporarily willing to receive the person" is now "any other suitable place". We now have a whole new sub-section to help us understand the rules for using another 'suitable place'. History has seen private homes, GP surgeries, third-sector organisations and even a maternity unit(!) being used as a Place of Safety, all for specific and particular reasons.

Section 135(7) now explains that what must be considered if we are to rely upon "any other suitable place'". If it is proposed to use a "house, flat or room" as a Place of Safety, it must involve the agreement of the person detained and they live with others or are being taken to someone else's home, it must also involve the agreement of another person who lives there. If the non-hospital, non-police station option is being pursued and it is not a "house, flat or room", permission must be secured from the controller of the premises that it can be used for that purpose. It should be noted though, especially by anyone who is entering discussions about Emergency Departments, s135(7) is a discussion about 'any other suitable

place' *only* – it is not a discussion about residential accommodation, hospitals or police stations. At the risk of being a stuck record, paragraph 4.4 of the guidance reminds us "a hospital is a place of safety".

LOCAL POLICIES

All areas should update their local s136 policy to reflect the legal changes and agree how pathways will operate after 11th December. Particular care and attention may need to be given to the circumstances in which officers consider the 'any other suitable place' option. The extent to which this may need to be considered in the real world may depend upon the capacity of local arrangements and the extent of preparation areas have gone through.

Recently, an area contacted me for advice because with three weeks to go, their NHS did not have an answer for where children should be taken under the section 136. Another contact this week to say they were making more detentions than their NHS can cope with and relying on custody – what was the drill for 11th December if the MH unit are unable to accept someone because they are full and ED are insisting that they "are not a Place of Safety". Well first piece of advice, is not to enter in to pointless legal arguments with EDs about whether they are or are not … there is no definitive way to resolve that, an arguing legalities with Doctors and NHS managers is as pointless as arguing pharmacology with lawyers. It doesn't actually matter whether they are or whether they're not, it doesn't actually matter what they think they are in law. This is quite an arrogant statement, isn't it?! Bear with me …

What I mean by this is – as anywhere can be a Place of Safety, nothing at all in any situation whatsoever prevents a police officer removing someone to an ED and asking for help. Whether this is because the person has taken an overdose or whether it's because there is simply no other open, accessible place for them, is neither here nor there: the request by the police for help is lawful. How ED respond is a matter for them, but it is a decision taken on the record and capable of review in subsequent inquiries, Coronial or otherwise. If an officer in area X has detained a man from area Y which is hundreds of miles away, and the MH PoS is full and the (new) legal criteria for using a police station are nowhere near satisfied, it may be there is no other way to try to get him somewhere safe and warm pending decisions about his welfare. Nothing would prevent the police asking the MH Unit or ED to improvise to help in that situation: the MH could agree to allow the man on to a ward and temporarily use an other area of the hospital as PoS (dayroom, unoccupied office, etc.) or ED could agree to help. As long as they realise that refusal means the person will be sitting in a police car outside because there is literally nowhere else left to go that is lawful, the decision is theirs to take.

DOMESTIC DWELLINGS

For the avoidance of doubt, s135(7) as it applies to dwellings (defined as a "house, flat or room") and non-dwellings, means the following agreement(s) must be secured. Note that agreement implies something slightly different to 'consent', and this point is much discussed amongst the AMHPs on social media, for example in terms of whether someone, especially the person detained, may have the capacity to 'agree' or 'consent'. Either way, if it were me contemplating this approach, I'd be doing PNC, intelligence and other checks, if possible; I'd also be liaising where possible with the NHS liaison about the person / location and if possible with the AMHP who will have to undertake the assessment, to establish whether anything is know that would prevent that option being sensible. Remember, the AMHP has to be satisfied that they have interviewed the person in reasonably manner and the location of the interview may affect whether they are happy to proceed in that context.

Agreements required —

- A person may only be removed to their own home if they agree; and if they live with others, one other person at the location must also agree.
- So where P is a married man who lives with his wife and young children, he may only be removed to the premises if both he and his wife agrees to their home being used for that purpose.
- Where P is a young person who lives with their mother and step-father, agreement would be required from P and one of the adults who own or control the property.
- Where P is an adult man who suggests his best friend would be willing to help, agreement is required from P and the friend or anyone else the friend lives with.
- Where officers are consider removing a person to 'any other suitable place' that is not a "house, flat or room" consent would be required, under s135(7)(b) from the person who is a controller of that premises. So a GP surgery could be used if one of the GPs agrees to its use for that purpose.

Remember this: nothing in the law prevents you doing what you think might be the best thing for someone in those particular circumstances and local policies are guides, not rules. They certainly do NOT trump the law of the land, to which we're ultimately accountable.

DECEMBER 2017

1st December

PaCA: Summary Videos –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017. This post is one of several which relates not the amendments themselves, but to the implications arising from them.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. We now know the changes will take place on **11th December 2017**.

With every conceivable expense spared and filmed whilst *on location* at the exclusive Travelodge, Sale … here are two short videos which explain the main changes to the MHA which take effect on Monday 11th December.

Should take about 15mins to watch them both —

2nd December 2017

PaCA: Brace For Impact –

This blog is part of the series which will cover, in detail, the amendments to the Mental Health Act 1983 within the Policing and Crime Act 2017. This post is one of several which relates not the amendments themselves, but to the implications arising from them.

For background to the series, see the introductory post which outlines why I'm doing this and what other specific issues will be covered concerning laws that will come in to effect in the next few months. We now know the changes will take place on **11th December 2017**.

In just over one week, we will have much less time to ensure those of us detained under s136 MHA are assessed in a Place of Safety and it will be more complicated than it was before at a time when use of this power appears to be rising*. Earlier in the year, I cut and paste sections 135 and 136 MHA on to a word document, and then went through the Policing and Crime Act, adding all the amendments so I could have a copy of the law as it will appear once implemented on 11th December. Originally just a reference tool for myself, I published it on a blog and it seems to have been quite frequently used, according to the WordPress stats dashboard I have access to. What I couldn't help but notice when I carried out that exercise, was the word count: these pieces of legislation have considerably expanded in size – we've added two sub-sections to s135 as well as more than that to s136 and three whole new sections to the MHA itself – s136A, s136B and s136C.

Police officers will now need to *know much more* and to *think much more* when using s136 because the law is more complicated than it was. They will also need to be aware that in many areas of England and Wales, the NHS will find it harder to operate within the legal framework, for a variety of complicated reasons: officers will not only need to know the law and what the Plan A should be; they will also need, I suggest, a Plan B for how they will discharge their responsibilities as well as they can amidst difficulties and uncertainties – how will we handle operational incidents where the Plan A is just not possible?

I am trying really hard here not to scaremonger and it is a careful balance between that and ensuring I help prepare my operational colleagues for the reality I am seeing. A force mental health lead told me only this week, that they have been written to by one of their mental health trusts, insisting the police detain people in custody in circumstances where the law simply doesn't allow for it. So what will their constables, sergeants and inspectors need to know on Monday 11th December? They won't just need to know the new laws well enough to discuss and debate; they also need to know their Plan B for how they are actually going to act if those arguments fall on deaf ears. I'm guessing if senior NHS managers are writing to insist on certain things, their frontline staff will be under orders to refuse to act contrary to those instructions.

RECENT EXPERIENCES

In what may appear to be a diversion from this introduction, I wanted to highlight that I've been asked during this year to undertake work on policing and mental health of a kind I haven't really had to do before. I mention this because it has afforded me new insights in to this territory which I thought would be likely to re-affirm in my mind the difficult position operational officers can find themselves in; OR it would cause me to think afresh about old ideas which have somewhat cemented in my mind over the last ten years.

I've been asked four times this year to act as a so-called 'expert' witness in legal proceedings – in one of those matters, I have written a report and given evidence in a Coroner's Inquest, in the other three I am in the process of writing reports and legal proceedings of various kinds will happen next year (and possible beyond). By seeing the specific detail of matters which have been independently investigated by the IPCC and reached the legal stage, I've had to challenge myself about how I theorise the appropriate way to respond to some of the most challenging incidents officers face. I'm glad to say, this work has merely served to reinforce what I already thought and given me new grounds and new evidence to assert the ideas which I first developed when setting up Place of Safety services in the West Midlands between 2006-11. I can't say more than that at this stage, but I'm quite able to repeat something I've said before many times in training, conferences and guidelines or policies that I've authored or reviewed –

The police cannot simply do as they are expected to do by the NHS because of their preferences, structures or funding and then hope to survive contact with all the accountability mechanisms – police officers must know what is the 'right' thing to do and pursue that, getting as close as they may, even if it involves managing some expectations or conflict along the way.

BRACE FOR IMPACT

So, do you already know the answers to the following questions? –

- Do I have the time an ability to consult with someone before deciding whether to detain this person?
- To which Place of Safety will I remove this person? – what are my options?!
- Is this an urgent, medical emergency that requires attendance at A&E because nowhere else can manage the illness / injury issues this person is presenting with?
- How do I get them there? – it should be by ambulance if at all possible, but what if they can't or won't come?!
- Do I have relevant permissions for my preferred choice? …
- I need the person's consent for some options; that of a person they live with for others or who controls the property I'm proposing to go to; and I need active consent by A&E, the MH unit or the duty inspector for the rest of it.
- Does the person in control of that location consent to their building being used for this purpose?!
- If I am even thinking about police custody am I able to confirm to the duty inspector that "the person's behaviour poses an imminent risk of serious injury or harm, either to themselves or another?"
- Even if that were the case, am I able to manage that person's challenging behaviour in an NHS setting if I remain there to help the nurses and other staff who become involved?
- Once I have managed to get access to some kind of building, I have to inform an AMHP and DR and it should start to get a bit easier!

Then, of course, we have to process the person and all of the above questions are a part of Plan A where everyone knows the law and the NHS have the capacity, capability and willingness to support that decision-making. Upon arrival at the first location the person is accepted in to, the new 24hrs clock starts ticking, we need to inform the AMHP whose responsibility it is to conduct the assessment. The Code of Practice MHA states the AMHP should do this with a s12 DR, whilst the MHA itself merely requires a 'registered medical practitioner'. We know AMHPs sometimes have difficulty securing a s12 DR, but with 72hrs to play with, it's always been possible to work through that.

PLAN B?!

What if Plan A doesn't work? For example, what if the Place of Safety is full and if ED refuse to admit someone because they continue to insist (contrary to the Government guidance on these amendments) that they are "not a Place of Safety"? What if you work in an area which has unilaterally declared

that "all violent detainees must go to custody"? Apart from the fact that the law now demands much more than someone simply being 'violent' (incidentally, not a word used in the Mental Health Act (Place of Safety) Regulations 2017) – even if the grounds for using police stations are met, it doesn't mean it will be medically safe for that person to be taken there. The NHS have guidelines on these matters, but they won't have to explain why they didn't implement them if the police can simply be told in a local policy or by writing a letter that "anyone who is violent will be turned away".

What's the Plan B?! – it's about ensuring, as the Metropolitan Police did in the Joseph Phuong case: make sure you **always** –

- Call an ambulance to **every single detention** under s136
- Remove anyone thought to be exhibiting a **RED FLAG** to an Emergency Department, regardless of challenging behaviour – simply ensure enough officers to manage its impact.
- Remove anyone not exhibiting a **RED FLAG** to the identified Place of Safety, notwithstanding any challenging behaviour – again, ensure enough officers to manage impact.
- Police station are no longer the last resort, in law – because there are specific criteria for accessing it for adults, children cannot access it (as a Place of Safety).
- A last resort option, should ED or a MH PoS be unable or unwilling to receive, will be to improvise through the 'any other suitable place' stuff – perhaps via the person's home or any family or friends?!
- Without this, you really are at the mercy of either the MH PoS or ED being willing to help you improvise.

The most dangerous thinking of all – assuming it's not worth trying something because you predict it will fail.

- **Ask for an ambulance whether or not you think it may come** – seek an ETA and if it is too long to remain where you are with the person you have detained, get practical and crack on. No-one, anywhere will be able to accuse you of not trying – and hat may be important later.
- **Contact the ED or PoS whether or not you think they will accept the person** – ask for help, point out your limited options and offer to remain on site, if that helps turn 'no' in to 'yes'. No-one, anywhere will be able to accuse of not trying – and that may be important later.
- **Escalate problems to your duty sergeants or inspector; also to NHS managers if appropriate** – ask for those decisions to be discussed and reviewed by others. No-one, anywhere will then be able to accuse you of not trying – and that may be important later.

MOST CRUCIALLY

If you don't try to do the right thing, the right outcome won't happen – if you do try to do the right thing, it may happen and even if it doesn't, no-one, anywhere will be able to say you didn't try. Based on my recent work, I would suggest these points may make the difference between whether or not officers are treated during death in custody investigations as witnesses, or suspects.

To those who may argue things like this go wrong so very rarely, this kind of warning is pure hyperbole, I say this: firstly, it's not you that will be in this position and police officers are entitled to ensure they can account for their use of coercive powers on vulnerable people; and secondly, yes, 'only' 14 deaths in police custody per year, and 'only' 1 or 2 of those involving people detained under s136 MHA – everytime the detention of someone with mental health problems goes very badly awry, we end up talking about the same things, over and over again.

What I'm outlining here is *nothing more* than ensuring operational officers can't be accused of failing to learn the lessons of the last twenty years, where things went awry for their colleagues, some of whom ended up in a criminal court before then ending up in a Coroner's court. And this is about the lives of vulnerable people in the care of the state – does it get more important than that when we know the system isn't always there to support officers' decision-making?!

***NB**: you don't just 'brace for impact' because you think you'll crash and burn; you do it to maximise the chance you will emerge unscathed.*

** Yes, I know the data for 2016/17 showed a small reduction (of 2%), but that data omits a return from Devon and Cornwall Police who have historically used the power about as much as the touted reduction. There are also reasons to doubt the figures that have been published – I was contacted by several forces in the days following publication saying their figures were wrong. I suspect a small rise, of perhaps 2-3%, but I can't prove that.*

5th December 2017

PaCA: The Integrity Test –

It's getting really close now, isn't it?! – just six days until the amendments to the Mental Health Act kick in and my phone is ringing red-hot with questions and queries about various scenarios that are occurring to people. Social media and emails are also going twenty-to-the-dozen. If I may say so, I'd encourage everyone to actually read the legislation, if they haven't already – many of the answers are directly in there, to be fair and I'm not a High Court judge, so whatever opinion I give you, it's just my opinion. I'm not entirely sure whether a tent on private land, used as a semi-permanent dwelling could be considered a room. And what if that private land belongs to someone else who doesn't know the person is there with their tent; and what if, upon learning of it, they don't object, because they are sympathetic to the person's predicament? When I go camping in Cornwall with my family, I tend not to think of myself as being a "room", but I'm not sure if there is case law on non-traditional or non-permanent dwellings and what difference it makes where they are situated.

Many of the questions that arise would, I suspect, be answerable if we just read the new law. It's all I tend to be doing, quite honestly. For those who were not aware, the new laws can be found here –

- **The 'New' Section 135 MHA**
- **The 'New' Section 136 MHA** – including the new sections 136A, 136B and 136C.
- **The 'New' Section 138 MHA**

This post emerges from a chance remark on social media discussing the changes. I'm in the process of re-posting the blogs I wrote earlier in the year, as reminders each day of the various changes leading up to Monday. Having re-posted yesterday about the imminent ban on using police custody as a Place of Safety for children, someone replied, "Standby for arrests for minor offences to rise." It suddenly struck me, on Monday, we are all facing and integrity test of sorts, and we have some very serious ethical decisions to make, when professionals are under pressure.

PARLIAMENT'S INTENTIONS

During 2014, the Home Office and Department of Health ran a year-long consultation about how these laws should be amended. 2015 was spent drafting the Bill which was introduced to Parliament in early 2016 and granted Royal Assent in early 2017. We've since had almost a year to consider the finalised specifics, ahead of commencement next week. What interested me as the Bill progressed to Assent, was that it had changed very little after its introduction to the House of Commons. Various MPs and Lords brought various amendments, but one by one they were either defeated or withdrawn. So first thing to say is that we've had this stuff telegraphed over three years in advance – the result of the 2014 consultation came out in early December of that year. We knew, for example, that children would not be able to be taken to a police station as a Place of Safety, so why we are still in the position in some areas of not knowing where someone will go, I'm not certain. Bear in mind that this dilemma only applied to 20 children in the last set of figures, it should be beyond the wit of our National Health and Police services to work out how to keep 20 kids safe, without using a police station.

But for me, the idea that we 'get around' the legislation and its intent is perverse. Yesterday's was not the first time someone called for or predicted that difficulties delivering the infrastructure necessary to ensure these changes work, would lead to decision to get around it by other lawful means. If a child can't go to custody as a Place of Safety, it may be an option to think about whether the child is also committing a Breach of the Peace or a criminal offence like public order or assault. But at the risk of pointing out the obvious —

This isn't about criminalising kids even more – it's about keeping out of traumatising environments that stand every chance of making their predicament worse!!

We shouldn't be trying to get around the difficulties caused by this new legislation: we should be understanding the intent that sits behind it and aiming to ensure that this is put in to practice in the real world. Custody and criminal justice processes are known to be pathologising, for those of use with mental health problems – it increases the likelihood that someone will harm themselves or try to end their life; it feels inherently stigmatising and criminalising, if you listen to those of us who have had to experience this whilst in distress and unwell. The point here is, Parliament don't want kids in police stations when they're believed to be ill – they want them in healthcare settings receiving assessment and care from people who are not police officers. The police budget in the UK, even after the cuts of recent years is still over £12bn but the NHS budget is in excess of £105bn – surely there is scope within that

INTEGRITY TEST

So Monday is an integrity test of us all – will we look to 'get around' these new frameworks for our own convenience or will we rely on the obvious and unambiguous intentions of Parliament to push for outcomes for vulnerable people of all ages, to ensure they receive the right support from the right people at the right time? If you are a police officer, remember this: every time you 'fudge' an issue by making a criminal justice choice where a mental health choice would be initially better, you prevent the NHS from understanding the demand that exists for crisis mental health care. Every time we do this, it decreases the likelihood that we will evolve responses to demand that actually are capable of matching it; and this goes way beyond the issue of children and police stations as a Place of Safety.

Some estimates suggest that in around 80% of cases where s136 is used, the police could have legitimately made another choice – either to use criminal or common law, or not to invoke a restrictive option at all. As we've covered before on this BLOG, it begs the question of how police officers should make choices where they are faced with competing options. It remains my belief that we should ensure police use their substantive powers under criminal or common law, unless –

- The incident is trivial or victimless
- The victim in an incident is not really reporting a crime, but seeking help for someone in need.
- That the person's behaviour appears more likely to be a consequence of their condition, than anything else.
- **NB:** remember, after 11/12, if you subsequently have reason to believe your decision is wrong, you will be able to reverse it.

So, you could face this dilemma where officers encounter an adult how is presenting in distress with significant levels of violence. Arrest for public order and remove them to custody and you 'get around' these new, awkward Mental Health Act (Place of Safety) Regulations 2017 which require inspector's authorities, etc., etc.. This again, is an integrity test for all of us: if we believe that someone in such distress that these Regulations may apply to them, then we could well be dealing with someone whose life is at risk because of their condition AND / OR because of the impact of any restraint upon their person. Use criminal or common law to arrest them and you don't ensure that NHS partners have to get involved in helping ensure that person's welfare. Detain the person under s136 if you believe them to be 'mentally disordered' and the opposite is true. The kinds of situations envisaged within those Regulations are the stuff of death-in-custody inquiries for the last twenty years, so 'getting around' them by making other apparently justifiable choices and you put your career on the line, if not your liberty.

Custody sergeants and Review Officers will be key to checking against this tendency, because nothing obliges them to authorise detention where serious medical risks are apparent – PACE Code C obliges considerations of whether people need a transfer to hospital and someone may be released without further action, under investigation or on bail, as appropriate, if that assists in prioritising assessment of potentially unmet health needs.

INVISIBLE DISCRETION

Police officers often work alone or in pairs – although supervised in theory by the sergeants, officers are often at incidents on their own, making low-visibility choices. Monday sees the opportunity to use Parliament's intentions to ensure the safety, integrity and dignity of some of the most vulnerable people in our society and adherance to these new frameworks will ensure officers can insist on support from others to keep people safe. Getting around the issues that you actually think you are handling has several kinds of effects that are all important –

1. It will further stigmatise and criminalise those of us who live with mental health conditions of all kinds;
2. It will fail to ensure local NHS services are obliged to help us in our quest to keep people safe;
3. It will expose you if things go awry, which they're more likely to do without clinical support, to the kinds scrutiny you've never imagined in your wildest nightmares – you only need to have been through a contact death investigation to see this.

So the message is nothing more complicated than this: **do the right thing to help keep people safe**.

If you really believe you're dealing with a violent man on drugs, feel free to make public order or other arrest decisions that you think are appropriate – we shouldn't be using the Mental Health Act as a place to dump awkward people we do not believe to be ill. But where we are responding to a mental health crisis call, the new frameworks are there to ensure we raise our game. All the decisions we take from Monday will be tests of our integrity and tests of our ability to ensure that our local partnership processes evolve to meet this challenge. We can assist in hastening that, starting on Monday.

14th December 2017

The Same But Different –

Norman Lamb MP wrote to his local police force recently, asking about those kinds of cases I've been banging on for years now: people being held in custody for hours and hours, if not days and days, following their arrest for an alleged offence but whilst awaiting admission to hospital under the Mental Health Act 1983. The BBC covered this sort of thing last week, following the release of data by the National Police Chiefs' Council and Mr Lamb's contact with Norfolk Police led to some data for his local area.

Two things struck me —

1. 68hrs is quite a short period of time compared to some of the examples we've seen in recent weeks. The NPCC data made reference to a child being detained for 5 days and to an adult being detained for 6 days, so less than 3 days makes me think some people got off quite lightly!
2. The Medical Director of the Norfolk and Suffolk NHS Foundation Trust gave a response to the media that made me wonder whether a) someone else who didn't understand the problem wrote a press release that went out in the MD's name without being properly checked; b) the MD doesn't understand the Mental Health Act or c) the MD did a distraction technique because there isn't actually a defence to a human rights violation.

Detaining people against their will without an obvious authority in domestic law is an Article 5 violation; other case law outlines that protracted delays getting someone in to hospital from police custody when they are in 'dire need or urgent psychiatric care' can violate Article 3, also. So here's why the MD's response to Normal Lamb's findings is at least confused and at worst, quite deeply disingenuous.

"THESE DETENTIONS"

The mistake that appears to have been made in the Norfolk situation is not dissimilar to the one made by Radio Four journalists on the Today programme when they interviewed Chief Constable Mark Collins about this last week: detention in police custody after arrest, pending identification of an MHA bed for an inpatient admission is **entirely separate** and **entirely**

unrelated to issues around the use of or the reduction of s136 of the Mental Health Act. These two things are not 'these detentions' because they are two kinds of thing.

In respect of people being detained in police custody under arrest pending the identification of a bed, the Medical Director claimed in local media coverage, "Through our close partnership working with the police, we are doing a lot to avoid the need for these detentions. In Norfolk alone we estimate that we have avoided over 150 detentions under the mental health act, in the past year." It's slightly ambiguous, but I'll bet 50p or a pound that this refers to the close working in street triage to avoid use of s136 MHA – admission to hospital is 'detention under the Mental Health Act' so the comment simply can't relate to an admission to hospital scenario, which is what Mr Lamb is enquiring about. Detention by the police under s136 – avoided or otherwise – is not 'these detentions': 'these detentions' are, being under arrest for an offence in custody, not detention under s136.

They are two different things.

And it strikes me as a real shame that a senior member of a mental health trust's executive team would either badly misunderstand the difference between these problems OR attempt to present them as being the same thing, when they demonstrably aren't, for whatever reason that happened. Of course the crucial difference between avoiding a s136 detention and avoiding a protracted delay to identify a mental health bed for admission is that one of these 'avoidances' involves no laws being broken, whereas the other one involves at least three or four laws being broken, including PACE, the MHA and human rights frameworks: this is an important distinction to understand lest we find ourselves accused of playing fast and loose with the fundamental rights of vulnerable people.

Oh, and finally: finding beds is a job for the NHS – I do wonder what the CCGs in Norfolk have done about their duty under s140 MHA and what policy the provider trust operates around that legal provision … as quoted in the BBC coverage of Mr Lamb's discovery, to argue that "We're doing our best" isn't quite good enough when we know the NHS have been spending funding for mental health services on clearing acute trust debts rather than ensuring that fundamental human rights are protected. Legally speaking, it's no defence to a violation of fundamental rights to point out the system stretched and money is in short supply. That's why they are 'fundamental' rights – they are more important than everything else!

19th December 2017

Place of Safety Stuff –

We've been playing with the newly amended police powers under the Mental Health Act for over a week now – I say 'playing' because it seems there are various kinds of games going on from the early feedback I've received! This post aims to just highlight those kinds of problems that have been drawn to my attention, so those of you reading may reflect on them and how things have been working in your area. It's nothing major and new legislation always takes a while to settle – for example, we're now more than 58yrs on from a Place of Safety being defined as 'social services accommodation, a hospital and police station or anywhere temporarily willing to receive the person' and we've still enjoyed a healthy dose of A&E departments insisting that they are NOT a Place of Safety under the Act. Fifty-eight years … are A&E departments not part of hospitals, then?!

The Royal College of Emergency Medicine has published a new guidance document about the changes which came in, to assist staff in EDs to navigate the new requirements. It carefully avoids addressing the 'Place of Safety' question head-on, but in fairness to them, it does outline various things that appear to reflect the new Government guidance on the amendments: that hospitals are a place of safety (see paragraph 4.4). RCEM point out that the place of safety 'clock' starts from the point where someone first arrives in ED after detention. Why would a Place of Safety 'clock' start, unless it was being accepted that the place was being used as a Place of Safety, even if just whilst initial assessment and care of injuries or other illnesses are undertaken? It points out that referral for MHA assessment should occur as soon as possible after the person arrives. << Police officers should always inform the local AMHP as soon as possible – even if the assessment will need to be delayed for a few hours, it puts the need for it on the AMHP's radar and may allow them to plan more appropriately to be available when they are, in fact, required. It also allows them opportunity to conduct background research, if required.

REVISITING BASICS

There are some basics around s136 and Places of Safety which have not changed in the amendments, but which seem to feature in last week's highlights. For example, if someone is to be transferred from one place of safety to another, it has always been a requirement of the Code of Practice

that this transfer be authorised by a doctor or an AMHP and that before moving the patient, it is confirmed that the other location can receive the person on arrival. There's no point removing someone from an A&E department after treatment for injuries to a mental health unit PoS if it is already fully occupied and unable to physically accommodate the person. Yet that's what happened in one area last week and we had a poor guy in a police vehicle bouncing around a system that wouldn't allow him in. This simple shouldn't have happened – he should not have been removed from ED until we knew the MH PoS was in a position to allow him in!

We've been aiming to get the police to ring for an ambulance in connection with s136 for some whilst now – apart from anything else, it is a requirement of chapter 17 of the Code of Practice to the MHA (in England and in Wales) that non-police vehicles be used for conveyance and following use of s136 this is most usually only possible in an NHS ambulance. But we also want our hero colleagues in green to help us out with clinical stuff: remember, what YOU think as an officer may be a mental health problem could be any number of other medical maladies: meningitis, diabetes, encephalitis, brain tumour, serotonin syndrome, Addison's Disease (you'll probably have to look that one up!), etc., etc., … you can see my point? I chose each of those conditions because they have happened in the real world after police contact with someone thought to be mentally ill. Paramedics can help with identification of this stuff! But paramedics also now have a statutory role to play, because they are named in the Mental Health Act (Place of Safety) Regulations 2017 as being one of the professionals with whom to have a pre-s136 conversation. Without accessing to MH records, I'm not necessarily what they'll be able to say to the police, but they are listed as an option so we should be trying to get them involved, for all of these reasons.

The choice about a Place of Safety is broadly similar as it was before:

- First consideration: does this person present with a RED FLAG that means they require urgent removal to ED? – if so, go there.
- If not, can we access a health-based Place of Safety where this person may be assessed? – if so, go there.
- If not, can we improvise a location that is appropriate and suitable (person's home, that of any family or friends who may be willing to help? – if so, try that but remember the caveats in s135(7) which apply to this.
- Finally, no child may be taken to a police station, EVER; adults may only be taken in exceptional circumstances – ensure this doesn't occur without an inspector's authority and unless there has been at least some clinical assessment to ensure it would be safe, especially if ongoing restraint is required.

- Nothing in law prevents a police officer asking ED to consider helping, if they genuinely find themselves without other options which exists in the real world.

NEW DEVELOPMENTS

The pre-detention consultation requirement has proved interesting in some areas! – several officers have attempted to contact a crisis team or triage team only be told it wasn't clear why they were ringing and any decision to detain was theirs to take! – this caused confusion at both ends of the phone. In fairness to my nurse colleagues in community or crisis teams, no-one specified the purpose or nature of this consultation, so it may be some haven't had to think through what information may be useful to the officer and what they can or can't share. In fairness to some police officers, what

One duty inspector contacted me about an incident where it had been drawn to his attention officers were physically detaining and handcuffing a person, pending the outcome of an attempt to consult with healthcare professionals. Again, in all fairness, brief detention and the use of force are not only permitted where officers have arrested someone or detained them under the Act, but the more restrictive that brief intervention, the easier and faster it will start to amount to a deprivation of liberty and how brief can that be before a court would think it unlawful? Is 1 minute OK, if the consultation then gives us a better plan than detention? It 1 is ok, is 2 or 5 … or 10?! In the particular situation the inspector formed the view the officers had no rationale for the detention except that they were waiting on information from the NHS, so he suggested that perhaps the detention decision was already, in fact, taken and it would be better resolved at a Place of Safety.

Finally, there is the whole 'crime' thing. What if someone is arrested for a fairly minor crime, even possibly arrested for it in private premises; and the FME in police custody calls for a Mental Health Act assessment because they think someone is fairly poorly and may require admission? Already this week, we've had a situation where the police were called to a hospital where a teenage child was on an open paediatric ward voluntarily, because of mental health problems. After some kind of disturbance officers were requested to arrest and remove them because of risks to others. Once in custody it quickly became clear that there was little evidence of offending, limited public interest in criminalising a young person and that they were going to have to be detained under the MHA. Therefore the custody took the decision to release the child under investigation, to allow for MHA processes to occur. The arresting-investigating officers were asked to liaise with the AMHP to arrange the MHA assessment and if the child been at liberty was thought unsafe, to consider the use of s136. That is ultimately what occurred, but the Place of Safety did question the use of s136 in police

custody. Remember, s136 no longer requires officers to 'find' a person in any particular kind of place, it merely says s136 cannot be used in "house, flat or room where that person, or another person is living".

These are just a few early thoughts and anecdotes about it all – I'm sure we'll hear more over the coming weeks!

26th December 2017

I'm a Mental Health Professional –

I'm a mental health professional – but I didn't realise this when I first joined the police.

When I retire, the operational incidents that will live with me beyond my career are almost exclusively those which have involved very vulnerable people. The poor guy who set himself on fire; the man who killed his mum and neighbour; the young woman who inflicted more harm or herself than I've seen when people have been brutally attacked by others; the guy who was so profoundly and utterly terrified of us purely because he thought the police were there to kill him; the middle-aged woman who was so psychotic in police custody that she spent days and nights screaming without sleep; the man who barricaded himself in to his bedroom with a knife for his own protection in his own home and we spent hours attempting to resolve that without using force and even more hours disagreeing about police powers and the grounds for getting a warrant under s135(1) MHA. I could go on and list more … as could most police officers. There have been so many vulnerable people who were surprised to find we were compassionate and caring a point where they really needed us to be – we were there when others weren't.

I'm a mental health professional – but you may not realise it.

I am entrusted with my own legal powers under the Mental Health Act that no doctors or nurses are allowed to exercise – so we need to see that as a privilege and a responsibility. In addition to an urgent power of detention for those in crisis, I am also empowered to ensure that patients concerned in criminal proceedings are brought back to court where they abscond from assessment or care. Only I can execute warrants issued by the courts in connection with assessment or re-detention of those already subject to the use of the Act. I am routinely relied upon by other professionals, even where they have their own legal powers, to be the professional who ensures someone is receiving care under the Mental Health Act, by ensuring safe detention, conveyance and repatriation. There is a long list of things about our mental health system that only I can do; with some extras that frequently come my way where others would prefer we acted rather than them. It may be you didn't realise because no-one asked you either: I'm often disappointed by how little evidence I see of the public being asked about the role they want to see the police playing and I'm all to aware of

the look of fear and shock on the faces of people who have had the police called upon them by other services.

I'm a mental health professional – but the system doesn't want what I know.

I have a whole host of information about mental health issues that the NHS doesn't know: details about the use and re-use of s136 MHA, how many calls received out of hours for people in crisis struggling to access other forms of care, how many suspects arrested for alleged offences are then assessed under the Mental Health Act; I know which mental health units see the highest number of AWOL patients, including which of them have problems with environmental security issues and which of them call the police to involve officers in restrictive practices; and finally, I know where some of the gaps are: those places where patients struggle to access care directly or bounce between different parts of the NHS. I've always wondered why this information isn't more sought after – it's as much a part of the public' experience as what happens when they ring a CrisisTeam or go to A&E. I know much of the learning that has come from mental health related deaths following police contact which often seems unknown to our NHS and I'm all too aware that many of the major reports we've commissioned in to what goes wrong in policing ends up saying more about the NHS than it does about the police. This insight is often absent from much of our dialogue about partnerships and where it is present, it seems not everyone is reading the reports and learning the lessons.

I'm a mental health professional – but no-one asked me if I wanted to be:

The history of this business is that the police were not consulted – we are, frequently, *still* not consulted – about the role we play in the wider mental health system. Over the last twenty to thirty years, decisions taken by others to change the role of the police have not involved us in those discussions and this has two implications: there is uncertainty in the minds of officers about what their role actually is; no-one structured those policies to take account of our views when we would increasingly be dealing with things. It wasn't the police who decided to push a position where we were the agency who exercised legal powers that are available not only to Constables, but also to AMHPs or others authorised by the NHS. It wasn't the police who failed to show up at local, regional and national discussions about areas of mental health care that quite obviously involve them – things like the prosecution of inpatients who are alleged to have offended on wards; the role of the police in undertaking 'safe and well' checks; the extent to which the police are relied upon to undertake restrictive practices on under-staffed inpatient wards. We need to be careful about this, too: if we don't involve the police in helping fashion the role they play, we risk

ignoring their particular perspective and then end up over-policing people, which can be as dangerous as under-caring in the first place.

I'm a mental health professional – but I have quite limited training.

The nature and extent of my training is seen as key to all of this by many – everyone agrees, I need more of it. I need a four-hour training input on autism, three days on personality disorder, a two-day mental health first-aid course, awareness of schizophrenia and bipolar disorder, learning disabilities, learning difficulties, acquired brain injury, perinatal mental health issues, other conditions that can present as mental health problems from diabetes to epilepsy, even Addision's disease. Of course, whilst improved training is important and whilst we'd all hope it enables the police to respond more effectively to those situations they face, how that addresses the fundamentally far more important question of why an increasing numbers of responses is becoming necessary, I'm not quite sure. We seem to be living in a time when very deliberate public policy decisions are being taken to push mental health demand further down the line, until police involvement becomes inevitable. Whilst we need awareness, we also need detailed and comprehensive legal training because I'm rarely deployed to a condition-specific incident. I sometimes don't even know someone's name.

I'm a mental health professional and I probably always will be: it came as quite a shock, I can tell you – and I'm still adjusting now.

26th December 2017

OBE –

I wrote this post in June 2016 and simply forgot to publish it. Having had a bit of a BLOG clear-out over Christmas where I've binned about thirty part-written blogs where I found myself just banging on again and again about the same old thing. However there were a couple I decided to keep and this is one of them, just for personal reasons.

I was thrilled to receive a letter in May, indicating that the Prime Minister wished to put forward my name to Her Majesty the Queen, recommending

that I be appointed an Officer of the Order of the British Empire (OBE) for services to policing and mental health. Since the announcement, I have been smiling broadly and have laughed out loud a few times, overwhelmed by messages of support from frontline police officers as well as mental health professionals and members of the public. I was delighted but surprised to receive three very lovely letters from Chief Constables Phil GORMLEY and Simon COLE as well as Commander Christine JONES – the last three national policing leads on mental health. It has all been truly humbling but most of all because of those remarks received from people with experience of the police and our mental health system whilst in crisis – those have meant the most. Thank you to everyone who offered congratulations.

I have been told many times that I must be very proud and I've repeatedly replied that wasn't the overwhelming emotion – I mainly just feel *vindicated* and *relieved*; and that I hoped this would allow us to push on with getting some things done in the real world. My own view is that we are still talking too much and doing too little on policing and mental health; that real work needs to start soon or momentum will be lost as it slips from the list of priorities. The College of Policing publishing new APP (guidelines) on mental health in October and we have held events across the UK for police forces to learn how the APP and its supporting training packages will need to be delivered in challenging partnership circumstances. In the second half of 2016 and throughout 2017, police forces should be reviewing their local arrangements and training provision to ensure that they are fit for purpose against the new standards; ensuring they can survive contact with accountability mechanisms like the IPCC and HMIC.

But College APP and training will, of themselves, achieve little – it all needs 'operationalising' by police forces and their officers and staff in imperfect situations whilst dealing with vulnerable and often complicated people with many complex, unmet needs in an evolving, challenging partnership environment. My time working on this agenda is coming to a conclusion and I will probably be back in West Midlands Police during 2017, so if I can abuse the opportunity of being honoured to say just two things –

- Some areas of the country still maintain partnership arrangements which prevent all agencies from fully discharging the duties and obligations placed upon them, in various situations of mental health crisis to which they are invited – they are too often obliged to choose between complying with local pathways or complying with the law or relevant professionals guidelines. (Examples available on request, but many of them documented on this blog).
- Some police forces are reluctant to challenge this or find it difficult to make progress, despite history telling us it could lead to a disastrous outcome – like a death in police custody – and families affected will never understand why more wasn't done. I'm still trying to work out whether the police are

disinclined to push back against what we too-often see as *experts*, but I know we need to do more of it if we are to do our best for vulnerable people.

I worry at the moment that the progress we are seeing claimed is not necessarily progress at all – there are still things to learn about how we *normalise* and over-expose the police to mental health crisis situations where they make things worse, despite their best efforts. That ethical debate hasn't really begun because we're still focussed on learning the laws, building basic professional relationships and developing pathways to mental healthcare. To what extent does it criminalise vulnerable people that pathways to crisis care are *all too often* via the police or with their unnecessary involvement; to what extent does it affect psychological safety and wellbeing of those of us in crisis to be in the 'care' of the police for hours or even days, potentially whilst restrained in a cell? We seem to be trying to operate together, but ever-later in the crisis that are under massive strain, as often as possible – we've publicly said this is the opposite of what we really need to be doing.

Success in this area should be judged by the improvements seen for those of us who live with mental health problems and when front line officers report that they find this aspect of their job far less difficult to deal with and much less time consuming. So we need to establish whether what we're now doing works from the patient's point of view – not from the perspective of organisations.

End of Volume:
278 Pages
102,700 Words

Total to date:
2,518 pages
880,500 words