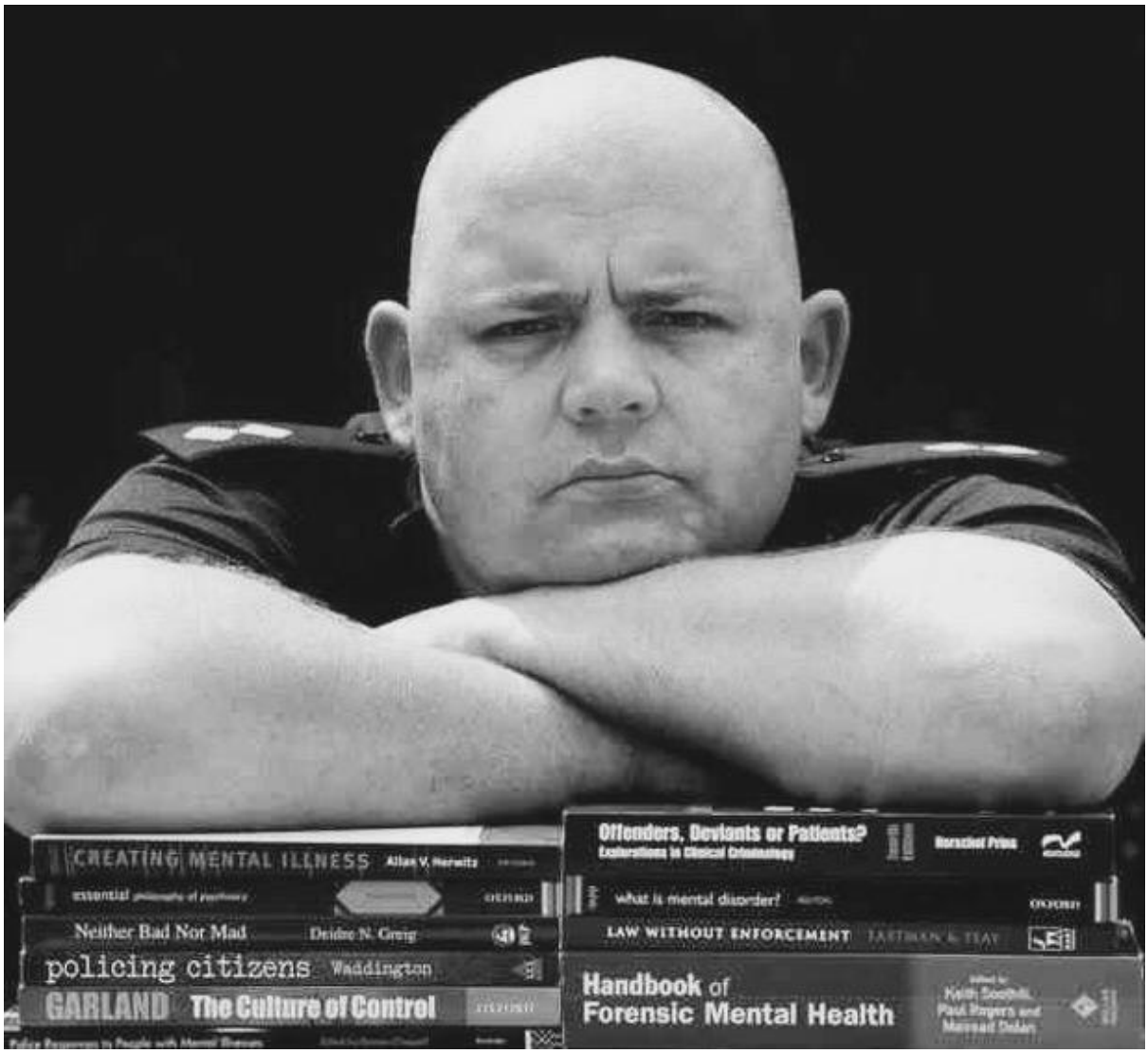
MENTAL HEALTH COP

A VENN DIAGRAM OF POLICING, MENTAL HEALTH AND CRIMINAL JUSTICE

Volume Eight – 2018

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

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



Michael BROWN OBE BMus MA MSc

JANUARY 2018

3rd January 2018

And / Or

Compare and contrast the following two pieces of law –

- Section 136(2) says someone removed to a Place of Safety may be taken there to be examined by a registered medical practitioner and interviewed by an Approved Mental Health Professional; **and** of making any necessary arrangements for his treatment or care.
- When you read section 135(1), it says someone may be removed to a Place of Safety with a view to the making of an application under the Act, **or** of making other arrangements for his treatment or care.

The **bold** is my emphasis – does it matter that the apparent purpose of one of these Place of Safety orders is interview **AND** arrangements, whereas the other is interview **OR** arrangements? … is this a distinction without a difference, or could it be crucial to something?! Both seem to represent the purpose of removing someone to a Place of Safety and we often think of 135(1) as being "like s136 but after a court warrant in someone's own home", but does this pedantry amount to any kind of distinction that has a real effect?

Since the MHA amendments took effect at the end of last year, it has become possible to use s136 MHA in police custody. For example, if officers have arrested someone for shoplifting and it only becomes apparent that the person may have serious mental health problems after they are detained in custody, the custody sergeant could now take a view on whether to bring the criminal investigation to a halt (temporarily or otherwise), and use s136 in the custody area before removing someone to a Place of Safety. The question has arisen about whether this is lawful IF the person in custody has already been assessed under the MHA is, for example, simply waiting a bed. Does the detaining officer have to have it in their mind at the time of using s136 that both parts of the 'purpose', as outlined in s136(2), are required?

THOUGHT THINGS

Imagine a situation in someone's home where services had assessed them under the MHA and decided that admission was required. If they had

entered the premises under a s135(1) warrant, made their decision and then hit a problem that no bed was available, the warrant would allow removal of the person to a Place of Safety, whilst that bed search is carried out – this is "with a view to making an application". That phrase not being a part of s136 does this change anything?! Maybe … this linguistic precision (or pedantry – depends on your view!) has certainly been deployed before to suggest that once an MHA assessment has occurred, police officers cannot then use s136. I'm not sure it's as simple as that; so let me show why.

Imagine our assessment in private premises had not involved a s135(1) warrant or the police … an AMHP, two DRs and a CPN had attended a patient's home without the police where either they have been allowed to enter and an MHA assessment has occurred. The view has been formed that an application will be made and they bump up against the 'lack of beds' problem. Let's imagine an all-too-real development, which I've experienced several times: the patient becomes concerned at the prospect of admission and leaves their home, implying or even openly stating they will harm themselves. We then see a 999 call to the police, to report an immediate high risk missing person. Are we seriously saying that if police officers find him, no bed having yet been found or MHA application made, they cannot use s136 MHA to immediately safeguard someone who is at immediate risk because they happen to know an MHA assessment has already occurred?!

Of course, not. Apart from anything else, enough may have changed because of that missing person event to change the necessary outcome from the assessment – it could have been the intention to admit the patient on a voluntary basis, but now it may be necessary to admit them on a compulsory basis.

I realise, obviously, there are differences between my almost-hypothetical missing person and someone in police custody who has been assessed and is awaiting a bed, but each gives rise to the same legal question: is it unlawful to use the power outlined in s136(1) because of the supposed purpose of the section, as outlined in s136(2). If the answer to that is yes, then it is also yes for our hypothetical missing person; if not, then it is still no in custody – **it's the one, or the other**.

PACE DETENTION

The difference in reality tends to be, that in the missing person situation, everyone is agreed on the urgency of acting and that takes priority over supposed legal pedantry; in the custody scenario, the person is safely under arrest – so what's the urgency?

Remember this: there is no power under the Police and Criminal Evidence Act 1984 – and there never, ever has been – to detain someone in police custody pending a Mental Health Act assessment OR pending the identification of a bed, to which a Mental Health Act application may be made. This may well have been what we did for decades, since PACE was created, in fact – but it's not what the law says, nor has it ever. Whilst someone who is mentally unwell is in custody, s34(2) and s37(7) of PACE continue to apply and once we reach a decision that the original grounds for detention no longer apply, we must make that decision about whether to release a person (pending further enquiries or without further action) OR to charge them with an offence. To the extent that MHA processes may be relevant to determining whether there is sufficient evidence to charge someone, you may countenance all that happening in parallel with an ongoing investigation.

But it has always been true, that if someone in custody who is thought to be unwell reaches the legal positions outlined in s34(2) PACE or s37(7) PACE, then it applies to them and their liberty, notwithstanding their health issues. If this point is reached before MHA assessment has occurred, people seem quite comfortable that the newly amended version of s136 can apply in police custody and I already know this has happened many times around the country since 11th December last year. But discussion about this happened in the north of England this week, after an MHA assessment had occurred and a view was given to the police that they could not, legally, use s136 MHA because the MHA assessment had occurred.

Can that be right? – I'm not sure it is. The grounds for using s136 are those contained within s136(1), subject to the qualification now contained in the new s136(1A). Because apart from anything else, nothing actually prevents a person who has already been assessed being assessed again after being safely detained. You might question the point of that, because it may seem fairly ridiculous to suggest it, but we know that many patients are assessed twice during their admission process, for a variety of reasons and sometimes it's as simple as the passage of time since the original assessment.

URGENCY ISSUES

But go back to the urgency stuff: where a custody sergeant has quite properly concluded on the basis of evidence and public interest that a person should be released from PACE detention, if they are thought to be very unwell and even a serious risk to themselves, if released, then this just creates a new legal problem: it doesn't justify excessively or even unlawfully depriving someone of their liberty under PACE when we accept the grounds are exhausted.

Section 136 may be used "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" remove that person to a Place of Safety, etc.. Nothing in here at all, or in subsequent sub-sections, which qualifies this, except that s136(1A) provides the power under s136(1) can only be used in any place which is not a "house, flat or room where the person, or another person, is living; or any yard, garden, garage or outhouse" connected to it.

I think we'll learn more about how this new aspect of s136 is going to be relied upon increasingly to get mentally unwell people out of police custody, even though they may not have been brought in under s136 in the first place. This will create problems some people haven't thought much about yet and whether the NHS has capacity to handle this, we're still not clear. But we should remember, if we check Hansard, that the purpose of the amendments overall is to reduce the number of people going to or staying in police custody when they are mentally ill. What appears to be an unintended consequence of the reform, helps take us further down that route than ever before, but we'll need the understanding, the infrastructure and so on to cope with it.

4th January 2018

MUCH LESS BLOGGING

You guys seemed to use the BLOG a lot last year, way more than any other single year since I started in 2011 and that was really encouraging on one level. However, I couldn't help but notice the vast majority of the increased use was down to two things —

- The series of posts which related to the Policing and Crime Act amendments of the Mental Health Act 1983, introduced in to law last December.
- A series of posts in which I just said again the same things I've said for years, only in light of new events, seeking to ram home the same point as before.

There are now well over 700 posts on here – many of them saying the same thing over and over again and I don't under-estimate that dripping like a tap is actually a necessary part of drilling home a message, particularly one that doesn't always sit easily or appear straight-forward, but the essential messages in this blog are simple:

THIS BLOG – KEY ISSUES

1. We need to take responsibility for understanding the law of the country as it actually is, rather than as it's rumoured to be.
2. We certainly need to know medical risks associated with any work which involves the compulsion of those of us living with mental health problems.
3. We need to get on with our work knowing that organisations and their partnerships are not perfect, that we haven't had enough training – we never, ever will have enough for the range and the complexity of *stuff*.
4. We need to know how to police amidst uncertainty and contradiction, in light of all of the above.
5. We must learn the lessons of history and, where necessary, teach them to others – one situation at a time, if we must.
6. Police officers need to know how to police: regardless of context, training and partnerships. In fact, history shows the latter may confuse you and get you in trouble – you need to get your own head around this stuff from source material.

I'm going to be doing much less blogging this year: a very deliberate decision because a) I've actually run out of things to say, really and b) I actually do have other things I want to do with personal my time and I owe it my family – stuff mainly focussed on my own health and wellbeing, to be fair. Although I work on this now as a full-time job, most of the blogging remained exactly what it is right now as I type these words: personal effort in my own time after my family are in bed with the dog next to me on the sofa, listening to music as I do … my 'Top Songs 2017" from Spotify, if you must know – the Verve, if you want to be precise.

BORING MYSELF WITLESS

There simply isn't much more to say for now – there is only the issue of whether we are going to stop talking about things as much and start doing things some more; examine whether we're doing the right things and actually bringing solutions to problems – or not. That's not something I can directly influence by blogging the same material over and over again and something as informal as blogging loses impact with repetition, making the same point again and again – so, feeling that I've done my bit, I'm going to try a bit less before I bore myself to tears.

I was told today that it looks likely my secondment to the National Police Chiefs' Council and the College of Policing will be extended again so what I will be able to commit to doing is working my socks off *at work*, as I always have and on here, I will do something I briefly tried before a few years ago: **a monthly update blog**. Apart from that, I will probably restrict myself to particularly interesting developments or cases, any new legal issues that emerge and some stuff around the Wessely Review of the Mental Health Act 1983 as it unfolds during 2018.

I suppose you can sum up where I am with this stuff by the flippant sounding truism: "I can explain this to you but I cannot understand it for you." I think that's where my head is, although without any problems flippancy. There's not much I'm ever asked to explain that isn't covered on here already – so fill your boots with what I've already done.

Best wishes,

Michael./

11th January 2018

Condition Orange

On Monday in the House of Commons, questions to the Home Office occupied some of the afternoon. Mental health questions came up and I've re-produced two brief exchanges from Hansard for that day. The purpose of doing so is to document the lack of specific understanding that exists on these topics. The question and the Government response is incoherent – none of the three responses below actually address the public policy question implied by the preceeding question, but the question is poorly framed. I'll let you read the exchange and will then outline some of the issues –

Preet Kaur Gill (*Birmingham, Edgbaston)*

How many people have been unlawfully detained for more than 24 hours while awaiting a mental health assessment in each of the last three years.

The Parliamentary Under-Secretary of State for the Home Department (*Victoria Atkins*).

Provisions in the Policing and Crime Act 2017 ban the use of police cells as places of safety for under-18s, restrict their use for adults and reduce the maximum period of detention to 24 hours. Information on the length of time for which people are detained under the Mental Health Act 1983 pending an assessment is not held by the Home Office, but we are seeking to ascertain the scale and nature of this issue and we are reviewing the available information that we were provided with last month by the College of Policing.

Preet Kaur Gill

Under the Police and Criminal Evidence Act 1984, the police have just 24 hours to hold someone with a mental illness. The College of Policing shared with the BBC last December the fact that 264 people were held for longer than this, including a mentally ill child who was held for five days. Is the Home Secretary aware of this report, and what steps have been taken to remedy the situation?

Victoria Atkins

Very much so, and I thank the hon. Lady for raising this important issue. We know that there is an issue in this area, and she will be pleased to know that her constabulary—the West Midlands—in fact does very well on this. It did not use police cells at all for such detentions last year; indeed, since 2013 it has used them on only 14 occasions. Of course, however, any such occasion is one occasion too many. She will I am sure join me in being pleased that the use of police stations as places of safety nearly halved last year, but we need to do more.

Mike Wood (*Dudley South*)

Does the Minister agree that a police cell or a police station is not a suitable place for an innocent person suffering from mental health problems, and will she support initiatives such as the mental health triage projects in the West Midlands to make sure that people with mental health problems get the medical support they need when they need it?

Victoria Atkins

Very much so. My hon. Friend will be pleased to know that health places were used as places of safety in more than 26,000 cases last year, compared with 1,029 cases of using cells, but we are determined to try to sort this out.

CONDITION ORANGE

For all the use it was, the minister may as well just have said 'condition orange' to all three questions because her replies are answers to different questions, that simply weren't asked.

- Firstly, how many times were people unlawfully detained? – the answer to that question is a number. It either happened zero times, or ten times or a thousands times, etc. We need an integer. In fairness to the Minister, we don't accurately know because police forces don't know this figure accurately. But the point here is, no matter how few or how many people are taken to police custody as a Place of Safety under the Mental Health Act 1983, such people are NOT people detained unlawfully for more than 24hrs – condition orange.
- Secondly, the College of Policing data referred to and quoted by the BBC came from some work I did in 2016 – it related to people brought in to custody under arrest for offences who are then subsequently 'sectioned' and diverted from the justice system, albeit after many

days in some cases. The 'zero' figure being referred to is the number of people detained by West Midlands Police under s136 MHA which is nothing whatsoever to do with how many criminal suspects were diverted from arrest under the MHA – "How many people were unlawfully held?" – condition orange.

- Finally, street triage isn't an inherent way to reduce the use of police custody for 'innocent' people suffering mental health problems. Some forces had managed to eradicate the use of custody or reduce it to truly exceptional levels before street triage was ever invented and in some areas where they had street triage, use of s136 (and its potential to lead to custody) continued to rise. "We don't want vulnerable people with mental health problems in custody unless they're accused of offending so how shall we do it?!" – condition orange.

(Interesting use of the word "innocent", there – because all people under arrest are innocent until they're proven guilty, even where they are arrested for murder, so 'innocent' means literally everybody.)

It doesn't matter how few people are taken to police stations under the MHA as a Place of Safety, there will continue to be a large number of people taken to custody under arrest – and that is partly the delivery result of the Government's decision to re-affirm that the police service in the UK should not have powers that almost all other police services have got: a s136 type power in private premises. So where offending behaviours are involved and where risks of further harm exists, officers who cannot lawfully use s136 MHA will resort to other lawful powers to keep people safe – that is only human instinct kicking. As a consequence, we need to understand the different dynamics that exist for the MHA-Place of Safety cohort (who are encountered in places which are not dwellings) versus how things work differently where people are arrested for offences and still taken to custody.

As Hansard shows, we obviously don't know the difference.

27th January 2018

Keep Your Eye on the Ball

You may remember, I've been banging on for a number of years now about the problem of people being in police custody for many hours or even for many days, waiting for Mental Health Act assessment, or more usually waiting for a mental health bed in to which they can be admitted after assessment. This noise I've been making is now well in to its second decade, in all fairness and I'm bored of hearing myself talk about it. However, we're starting to get somewhere in the sense that this matter has been raised with the Department of Health and the NHS at national level, who accept the premise that there is a problem. It has also been discussed with Government ministers and questions have been raised in the House of Commons. The BBC even did a news piece about it, just prior to Christmas 2017. So we may be getting somewhere, however slowly.

This post argues that custody sergeants and duty inspectors or superintendents are now much more in the driving seat of some of these issues that they've ever been before, because a) we actually understand this problem much more keenly; and b) the MHA amendments on 11th December have now settled a legal issue in a way which helps: **section 136 of the MHA can now be used in police custody**, where necessary. But first of all, a reminder from the Police and Criminal Evidence Act 1984 and a plea from me that where someone is in custody under PACE (or for any non-MHA related reason), we need to think much more carefully about the actual grounds for their detention in a police station. Remember this at all times –

- There is **no power** under PACE to detain someone in a police station for the purposes of a Mental Health Act assessment.
- There is **no power** under PACE to detain someone in a police station for the purposes of finding an inpatient bed.

So detention in custody MUST be justified under PACE itself, to allow detention to continue – and if it is no longer justified, PACE insists that the person be released.

There are broadly three situations where release must occur.

SECTIONS 34 AND 37

It's worth re-reading these two sections of PACE in full and the bail amendments in the Policing and Crime Act 2017 have complicated things. But essentially, there are three circumstances where the detention of criminal suspects must end –

- Where there is not yet sufficient evidence to charge someone with an offence, where enquiries will need to continue but detention in police custody is not required for those enquiries to occur.
- Where an investigation has concluded, in evidential terms, but where the police and / or the CPS must consider whether charges should be brought in the public interest and it is not necessary to keep the person ins custody whilst they do so; OR
- Where an investigation is complete, there is insufficient evidence to charge anyone with an offence OR where it has been decided already that it is not in the public interest to charge someone.

Any PACE detention of someone who is mentally unwell can reach any of these points because even serious mental illness does not preclude investigation or prosecution; and the fact someone is considered or known to be mentally unwell doesn't alter the imperatives in PACE to release someone from detention under criminal law – the person must still be released, either with or without bail if still under investigation (bullet point 1); pending a decision about whether to charge them with an offence (bullet point 2) or released with a written notice of no further action, if that was the decision reached (bullet point 3).

Now, this is absolutely crucial to understand why the preceding points make any kind of sense: if release then gives rise to issues of safety because of mental health issues, that is an *entirely distinct* legal issue, which cannot be addressed by prolonging detention in custody unlawfully under the PACE.

This is where the Mental Health Act needs to take over, in some way, shape or form.

MENTAL HEALTH ACT DETENTION

It would depend what stage we have reached of assessing someone's health as to how the MHA might take over from PACE, once the person has been released. Firstly, nothing prevents MHA processes beginning whilst someone is detained, as long as that detention is justifiable on its own terms under PACE. Is the person's detention in police custody without charge necessary in order to secure and preserve evidence or obtain

evidence by questioning, as per s37 PACE? If so, because officers are still taking statements, securing CCTV or forensic evidence, etc., then nothing prevents the convening of a Mental Health Act assessment. And if the assessment occurs and admissions is indicated, the person can be 'sectioned' from police custody without any significant problem about the legal basis for detention.

But should the custody officer reach those pinch-points where evidential assessments occur about the 'necessity' of detention, the person must be released and PACE replaced by something else, if there are concerns about a vulnerable person's safety and immediate wellbeing. So, if the FME has ordered an MHA assessment and a pinch-point is reached, nothing prevents the release of the person from police detention and their removal to a Place of Safety under s136 as long as it was genuinely felt that the criteria in s136 were satisfied.

- A person suffering from a mental disorder
- Immediate need of care or control
- In their own interests or for the protection of others
- Necessary, in the opinion of the detaining officer.

I am arguing, after listening to other views on this, s136 may be used at any stage after a MHA is called for; and indeed, it could be applied where someone remains under arrest because it is perfectly conceivable someone accused of an offence for which they must remain under arrest is "a person suffering from a mental disorder who is in immediate need of care in their own interests" and that removal of that person from a police custodial setting is considered preferable. I can't be the only police officer in the country who has known Doctors to say, "This person being in here is doing them no favours at all and you need to get them out as soon as possible, because it's traumatising." You should also bear in mind the argument from the *MS v UK* (2012) human rights case: it can be inhumane and degrading to unnecessarily protract detention in police custody.

THE COUNTER ARGUMENTS

Now, as discussions have occurred about these points over recent months, there are always very quick objections! Let me try to despatch them one at at time.

- ***You can't use s136 if a MHA assessment for someone in custody has already occurred and the outcome is known:***The argument goes that the purpose of s136 is to arrange an assessment by an AMHP and DR and that's already occurred, so it's not possible to use the power.

- There are several things to point out why this doesn't fly and I've written on this previously – my punchline was, the grounds for using s136 MHA are only those contained in sub-section (1), subject to the new sub-section 1A.
- The other major point is: nothing in the law prevents a second, further assessment! … stupid though that may sound, there are many instances where admission to hospital does involve more than one.
- Furthermore, there are other types of situation where an AMHP and DR would not do a full assessment after use of s136, regardless of what is said in s136(2) about the purpose of s136.
- Discovery after the use of s136 that a patient is already AWOL under the Act and simply needs returning to hospital under s18 MHA would be one; a patient who is subject to a Community Treatment Order, etc..
- ***You can't use s136 in custody because the person is safe there and not in immediate need of 'care or control'.***
- It may be true that someone is not in immediate need of control whilst detained under PACE, because being under arrest by the police means you are 'controlled'.
- However, it is perfectly possible that someone is in immediate need of *care*, whether or not they remain in police custody – and if this all arises as PACE is ordering someone's release, control is also lost, should it be considered necessary.
- As outlined above, I'm putting the argument here that we previously held people in custody because of custom and practice when PACE didn't allow for it, strictly speaking.
- As I acknowledged, above, if PACE grounds for detention exist, MHA assessments can still occur in custody whilst someone is under arrest – this post is only suggesting that such grounds didn't always exist in the past, if we're really honest with ourselves and we should start refreshing our approach.
- Finally, there was always uncertainty about using s136 prior to last year's amendments, because questions would arise about whether someone was 'found' in 'a place to which the public have access'. That's now just a relic of legal history and no longer relevant at all.

In thinking through these issues and whilst discussing them with AMHPs, solicitors and other police officers and mental health professionals, I've re-imagined myself in the position of being the custody sergeant or the duty inspector in an operational role.

What would I do when discharging legal responsibilities now the law has changed?

BENEFITS TO CONSIDER

I would be using the new opportunity to get those of us who live with potentially serious mental health problems out of police custody wherever I thought they did not need to remain there *for criminal investigation purposes*. I would familiarise myself with section 34 and 37 of PACE and combine the new 2017 bail provisions with the new 2017 MHA provisions, in order to ensure this could always occur safely.

The final point to make here is that this is happening in police forces already and on Thursday I did a short input to a senior meeting in Lancashire Police arguing that this new approach has various benefits which include anticipating the situation where someone in police custody has been assessed as requiring admission to hospital under the MHA but is languishing in the cells pending a bed being found. Of course, it means they may be languishing instead a Place of Safety under the Mental Health Act but that in itself has benefits. They may well be more proximate to NHS staff and I would history shows, in my experience, the NHS will be more keen to resolve an unlawful detention in their own building than one in police custody, especially if the police are not actively objecting to the legalities.

Of course, such an approach may also mean that use of s136 rises, potentially sharply in areas where a lot of criminal suspects are assessed under the MHA. It may mean that NHS areas who were struggling, comparatively, have increased pressure upon them for access to a Place of Safety. That may mean, if NHS mental health trusts can't match that demand, there is consequential pressure on A&E departments and on police officers having to remain in A&E or elsewhere whilst places of safety are found and assessments improvised. Difficult though we all know that is, it has one over-riding attraction that everyone – in the police and the NHS need to focus on: at least it means things are handled **legally**! We all have a positive, not a reactive, duty to ensure the Convention Rights of those who are detained in these circumstances, including Articles 3 and 5, amongst the others that could become relevant … and at least, if things go awry with someone's health, as they all too unexpectedly can, the person is in some kind of healthcare setting where they may stand a better chance of rapid care, when compared to being held by the police in a small concrete room.

As I've said many times before: *I didn't write this stuff!* – I'm just trying to explain it.

FEBRUARY 2018

8th February 2018

Liable To Be Detained

An AMHP and two doctors, one of whom is s12 approved, attend a patient's home following concerns about their mental health deteriorating. They conclude the patient will require admission to hospital and that admission under s2 of the Mental Health Act will be required – the application is duly made under the Act so the patient is now 'liable to be detained', the precursor step to being detained in hospital. The patient is unwilling to travel and for a range of reasons, neither police nor ambulance crews are available to attempt to persuade, influence or effect the admission of the patient to hospital. A decision is taken to leave the patient at home with their family and try again the following day but by then, the bed in to which the patient was to be admitted is no longer available, it having been given to someone else overnight.

The MHA application appears to lie in tatters, but then a bed becomes available at the original hospital to which the application had been made and the 'exam question' arises –

How long does someone remain 'liable to be detained' once a Mental Health Act application has been made?

In other words, for how long could the AMHP rely upon the original application they made before the bed vanished to still justify taking the patient to the original hospital, now that a second bed has become available there? It's a relatively easy answer: **fourteen days**. After that time, the patient would need to be re-assessed under the Mental Health Act and a fresh MHA application, with new medical recommendations made. But why do the police need to know this?! … it's fairly obscure AMHP stuff, isn't it?! Maybe … but not always!

Late last year, two officers were asked to remove a patient from their home to hospital, in exactly this kind of situation: a bed was available so an application was made, the patient wouldn't agree to go and no resources were available to ensure that happened and eventually the bed was lost, but then another found. On the fifteenth day after the MHA application was made, a bed becomes available and the request is made of police officers could they execute a warrant under s135(2) and remove the person to hospital? It was an example of something I spoke about in Leeds yesterday whilst doing AMHP CPD, that police officers need to know the law for

themselves. Because the warrant should not have been issued: the patient was no longer liable to be detained an no authority remained in place to take them to hospital.

SECTION 6 OF THE ACT

Many officers are now familiar with the power used to ensure someone's safe admission where they cannot or do not consent to go to hospital. Once the AMHP has filled in that pink form with the name of the hospital, supported by two medical recommendations by two doctors, one of whom must be s12 approved, the person is then "sectioned". This is an informal, non-legal term: the correct explanation of the person's status is that they are now 'liable to be detained' under the Act and may be conveyed to hospital for admission and detention to take effect. Normally, such conveyance occurs as soon as possible after the application is made and this timescale scenario doesn't arise.

However, the recent example brought it to the forefront. So we need to re-read s6(1) MHA to understand this –

Section 6(1) –

An application for the admission of a patient to a hospital under this Part of this Act, duly completed in accordance with the provisions of this Part of this Act, shall be sufficient authority for the applicant, or any person authorised by the applicant, to take the patient and convey him to the hospital at any time within the following period, that is to say—

(a) in the case of an application other than an emergency application, the period of 14 days beginning with the date on which the patient was last examined by a registered medical practitioner before giving a medical recommendation for the purposes of the application;

(b) in the case of an emergency application, the period of 24 hours beginning at the time when the patient was examined by the practitioner giving the medical recommendation which is referred to in section 4(3) above, or at the time when the application is made, whichever is the earlier.

So if the application is made on a Tuesday, that counts as day one, whether the application was made at 1am or 11pm, Wednesday is then day two and so on. As the clock turns midnight to turn the second Monday after the application in to Tuesday, the 'liable to be detained' status ends.

ABSCONDING WHILST LIABLE

However, do things change if the person didn't just refuse to move, but if they absconded? – does the effect of s6(1) mean that the person cannot be retaken and detained, if they are encountered on or after the fifteenth day?

No, it doesn't – things are different where someone has 'escaped' whilst liable to be detained. If someone has escaped from legal custody in those circumstances, they may be retaken (by a police constable, an AMHP or anyone who had custody of him immediately prior to his escape) at any time during the period that would have applied if he had become absent without leave under the Act. In other words –

- If a s2 patient escapes whilst liable to be detained, they should be treated as a s2 patient who had become AWOL from hospital on that day.
- Such patients can be returned to hospital any time up to 28 days after they arrived, so you have 28 days to find them.
- If a s3 patient escapes whilst liable to be detained, they should be treated as a s3 patient who had become AWOL from hospital on that day.
- Such patients can be returned to hospital any time up to 6 months after their absence starts, so you have 6 months to find them.

So it's not a major point being made here, in the sense that the answer to the exam question is 'fourteen days', counting the day on which an application is made as day one. The larger point, though, yet again, is that we need to know the law on this stuff because two officers may have been persuaded to force entry to a premises and force someone to hospital where no authority to do so existed. And this also taps in to some of the stuff I've been stacking up for Professor Sir Simon Wessely in his Review of the Mental Health Act – we need to simplify this stuff, because this scenario is a not-even-once-a-career type nightmare and who has the headspace to store legislative detritus like this just in case it might be needed once at some stage during the 2020s?!

19th February 2018

Twenty Years and Counting

I recently passed a professional and personal milestone, having joined the police service twenty years ago and I hope to receive an email soon outlining I've qualified for a Long Service, Good Conduct medal. All things being as they were supposed to be, this would mean I've got just ten years left to do before I retire from the service but it will probably end up being about eleven and a half because of pension changes forced upon me and I've long since started questioning whether we'll actually get to the position I want us to be in by the time I do retire. So this post just puts those thoughts down and I'll look again in a decade as I start to wrap this all up and get on with what's left of my life.

I started properly piling in to policing and mental health about fifteen years ago, when a Chief Superintendent in West Midlands Police was seeking officers from Birmingham who were interested in doing some extra work to improve policies and procedures across the city, following the merger of two mental health trusts. I'd been questioning things informally, started studying things and wondering about the inherent madness of it all from the moment I hit the streets in 1998, but here was a chance, in 2003, to actually do something about it. The work continued in the aftermath of the death of Michael Powell, in September 2003, which saw the criminal prosecution of ten of my West Midlands Police colleagues. Their legal defence in their trial in 2006 was, essentially, that they did what they were trained to do and removed Mr Powell to the place which local policy said they should take him – police custody. It is certainly true that in 2003, there was no health-based Place of Safety in an NHS setting and we were very much losing the argument at the time that in some mental health emergencies, vulnerable people should be removed to healthcare settings. (In fairness, that argument still persists fifteen years later, with NHS trust writing to police forces telling them about the 'exclusion criteria' they will apply to any police decision following the use of s136 of the Mental Health Act, notwithstanding that the argument

Fast-forward those fifteen years and Birmingham and the West Midlands force area, are now in a position where no-one is removed to custody, regardless of how challenging their presentation may be. This is quite an achievement and I hope it's at least some consolation to Mr Powell's family to think that today, things would be handled differently. But we still have problems in areas of the country that can't achieve this – and let's be clear:

the last data shows that only West Midlands Police and Merseyside Police achieved this. The other 41 police force areas were still relying on custody to at least some degree and it has been necessary for the Government to legislate in order to push progress in other areas. This lends verisimilitude to my own theory that some of this stuff is not going to get solved unless they NHS are obligated and unless those obligations are policed. It's just a conclusion I've been unable to avoid drawing, over the years.

SO WHERE ARE WE NOW?

Over the last year, I've found myself being asked to undertake bits of work which I've not previously had to do: providing so-called 'expert' reports for various inquiries where the police have been called to a mental health emergency of one kind or another. Here are some other conclusions I'm unable to avoid drawing, from the sum total of this work –

- Regardless of organisational failings, police officers and the police will still be blamed when things go wrong – it seems to suit a narrative that we hear all over the world of police officers 'killing' vulnerable people; it doesn't fit our ingrained narrative about the selfless NHS.
- Those who author operational protocols and policies between the NHS and the police often manage to publish policies that were either not legally checked or not properly legally checked. What is the point of legal checking and sign-off, if untrained cops can pick up the damned things and spot holes the size of cannonballs?!
- Accountability mechanisms don't compare, for policing and for healthcare: for *every* death following police custody or contact there is an independent decision about the kind of scrutiny that is required and fully independent investigations are the norm. Even *unexplained* and *unexpected* deaths in the NHS don't need reporting to the police! << **Yes, really**.
- We still haven't worked out what we're trying to establish when we investigate things where NHS and policing decisions, strategic and tactical, potentially contributed to an adverse outcome: is it about individual accountability, corporate accountability or something to do with a culture of learning? … or all of the above and more besides?!

Let me exemplify this, with my current, favourite example of all time, involving a death following police contact and custody that isn't as high on the radar as some other cases, perhaps for an interesting reason –

Just prior to Christmas 2017, a Coroner's Court in London returned a verdict in the inquest in to the death of Mr Joseph Phoung. Mr Phoung had been detained by the Metropolitan Police in 2016 under s136 after a report of a break-in near his home. Recognising he was a vulnerable man, they detained him and called for an ambulance – this is a requirement of the

Code of Practice to the MHA, a feature of the Metropolitan Police's policy on mental health and something which is supported as appropriate by the pan-London commissioning standards on s136 in the capital. The London Ambulance Service were unable to resource this request and no ambulance arrived before officers felt it was necessary to make their own attempts to remove Mr Phoung to a place of safety.

Having removed him to the local health-based place of safety, they were turned away and efforts to find somewhere suitable in neighbouring areas also failed, even though they had space available. So the mental health system across a quarter of the capital was unable to provide a small, ligature-proof room in which Mr Phoung could be reassured and kept safe for a few hours. Officers removed him to A&E as an alternative setting – of course, this wasn't ideal, but the Code of Practice to the MHA (paragraph 16.38) outlines they should try alternatives before settling on a police station as a *last resort*. After a difficult time in A&E during which Mr Phoung exhibited some very challenging behaviour and assaulted a police officer, he was removed to police custody. A long delay occurred before he could be formally assessed and having been deemed to need admission to hospital, a longer wait ensued before a bed could be identified. There were problems with *every single stage* of attempts by the police to secure NHS support for this vulnerable man.

PUBLIC PERCEPTION

Approximately 24hrs after he was detained, Mr Phuong was admitted to an NHS hospital under s2 MHA. Officers left him there, in the care of NHS staff and a few hours later, NHS staff restrained him, forced him to received medication and secluded him on the ward. A further two hours later, Joseph collapsed and was rushed to A&E where he died shortly afterwards. And what was the first sentence in the Guardian the following week? – "The sister of a man with schizophrenia who died in police custody in south London …". It assumes of all which preceded Mr Phuong's tragic death, it was detention by the police that mattered most. We know this isn't true as most of the criticism in the jury's verdict was reserved for the NHS, but in public perception terms, this is just another vulnerable man from an ethnic minority community who died because of the police and haven't we all heard that before?! … slow hand clap.

You'll notice if you click the link for this article and read it now, the Guardian altered the wording, changing 'in' to 'following'. I screenshot the original article at the time and I've used it as the header image for this post, for comparison purposes. The Coroner did consider the actions of the police in examining Mr Phuong's death, of course she must; however, the immediately preceding actions involving NHS restraint, medication and seclusion, which was at least as relevant go almost entirely unmentioned

in the first few paragraphs of the piece. We don't like to think of vulnerable people being restrained in hospitals and drying there, do we? But we do know such actions can be problematic, too – it's not only twenty years since I joined the police; it's also twenty years since the NHS restraint of Rocky Bennett, which led to an independent review of mental healthcare practices involving restraint.

The Rocky Bennett report was, to an extent, the 'Stephen Lawrence' report for mental health services, as it touched upon the issue of institutional racism in mental health care, something which is still a hot topic today and being examined by Professor Sir Simon Wessely as part of his review of the Mental Health Act 1983.

SO WHERE ARE WE HEADED?

I find it really hard to avoid this awful conclusion: we are unable to focus on *the actual problems* at the centre of some of these matters. The *Angiolini Report* (2017), highlighted to us all, *again* – as if it should need saying, *again* – that any attempt to look at problems in policing after serious, untoward outcomes cannot be done with confidence and credibility unless we also look at the context in which policing occurs – it doesn't occur in a partnership vacuum and it doesn't occur where we only detain distressed people who are physically well, uninfluenced by drugs or alcohol and who are not so frightened and unwell that they think officers are a direct threat to them. One of the Coroner's cases I've had to give evidence in was a concern or question about policing *under*-action, rather than *over*-reaction: it still gives rise to questions about whether junior cops should be accountable for things they were potentially powerless to prevent – "damned if you do, damned if you don't", as the cliche goes.

Early next month, I have to give evidence at an inquest in to the death of a man who was detained under s136 of the Mental Health Act, following a request by the ambulance service for support at a mental health emergency. I was requested by HM Coroner to prepare a report which necessitated me examining the joint operating policy between the local MH trust and the local police force – the sort of thing I have done many times in the past for other death in custody cases; and I've been asked by forces who are thankfully not reacting to adverse events to help them check or update their local policy. Almost invariably, we find problems: and they are not secret problems people couldn't be expected to know about – they are problems which were dealt with in the 2010 guidance from the NPIA (the College of Policing's predecessor organisation) and again in the 2016 updated guidance from the College which was produced as part of the Crisis Care Concordat.

Deborah Coles, the CEO of Inquest, has made the point again and again and mentioned this when I was interviewed for the Angiolini Report: the lessons we see emerging from recent cases, only some of which are mentioned above, are largely the same lessons we learned after the death of Roger Sylvester which occurred in 1999 – the previous century! And the big lesson, in my own opinion, is this: as long as we keep over-focussing on policing, we miss the obvious learning point that emerged from the death of Michael Powell and many others.

This is not just about policing – this is also about healthcare.

STRATEGIC PARTNERSHIP WORKING

Let me be really clear, in case of any doubt about this whatsoever: I don't put this argument to deflect attention away from policing – not for one moment. In various cases we could list, the police have got things badly wrong. But we must remember the Angiolini Report made 110 individual recommendations and when we set-aside those which related to improving investigations, procedures and transparency *after* tragic events have occurred, we find that the police service could not – on its own – deliver on the majority of them. This is not just my opinion, either – Lord Adebowale wrote in his 2013 report in to policing and mental health in London that the Metropolitan Police "cannot do this on their own" and his recommendations were not mainly about the police, but the strategic partnerships and support the police will require right across the health and social care systems.

So, if it will take a combined effort of policing services and healthcare services working together to ensure that the 'right' options are available for operational police officers and healthcare staff, what will it take to ensure that the lessons of history are learned in both policing and healthcare?! A feature of various IPCC and Coronial investigations is that the officers' general argument is that they were adhering to local policy in place at the time – so what does this tell CCG commissioners across mental health, ambulance and emergency healthcare pathways? – do they even know the names I've listed in this post and perhaps, more importantly, the more recent names that I could have given?! Does a CCG commissioner in the north of England see any relevance for them where a death in police custody occurred in the south of England four or five years ago?! As long as we keep seeing inquiries, inquests or investigations which reveal problems in how the healthcare systems are set up to support urgent decision-making about the welfare of vulnerable people, we risk seeing more police officers trying to defend themselves by arguing they were selecting from inadequate options that risked setting them up to fail. "Damned if you do, damned if you don't" because they're obliged to choose between breaching national guidelines and breaching local guidelines – how

do you choose which breach you'd rather try to defend, especially when you know you'll face resistance in your real world if you go against locally agreed procedures?!

In November, shortly after Leon Briggs died in custody in Bedfordshire, I wrote a blog – and it warned "another death in police custody or following contact **could happen tomorrow** in any area where procedure is not built to mitigate against unlikely but highly significant risk." And it did, didn't it? – Terry Smith died in Surrey eight days after Mr Briggs died in Bedfordshire – we'll learn much more about these two cases and others like Thomas Orchard during 2018/19 which will probably see me writing more posts which simply hark back towards what we already know to be necessary. Why weren't these issues addressed after the national guidance to the police in 2010 or after the Crisis Care Concordat in 2014? … and if partnership issues were not addressed at those points, why should we imagine they will be addressed after the Angiolini Report in 2017?! It's hard to avoid a conclusion that we seem to have agreed we're simply not going to sort this and I'm struggling to wonder why not because it seems eminently sortable. My best guess is because for all the talk about ever greater accountability, it's accountability that focusses on frontline police and not on strategic leaders across both policing and health and all our accountability mechanisms (the IOPC, CQC, HMIC, HCIB) don't fully cooperate to ensure the necessary joint up working. And if we have solicitors signing off joint operating policies that get the law wrong, what chance do front line cops and vulnerable people really stand or consistently surviving contact with legally complicated medical emergencies? You can decide for yourself whether it's "little" or "none".

26th February 2018

Somewhere, Out There

Chief Superintendent John Sutherland is a leader – we know this, because people follow him and listen keenly to what he has to say. That's all you can judge it on, at the end of the day. He inspires people – he certainly inspired me. No doubt he will continue to do so for many years to come. Who was it that said, "A leader without followers is just somebody else out for a walk"?! I've seen plenty of senior people out for a walk on their own, over the years. Mr Sutherland is not one of them and this week, his final days in police service, I want to pay my own small tribute using the medium we've both found key to expressing ourselves – the blog!

It's been my privilege to spend time in John's company over the last few years and I've enjoyed that immensely. We co-presented at the Superintendent's Association on policing and mental health – my own perspective on some of the external challenges we face followed by him cautioning his peers on the internal conflicts we face in policing as we try to rise to them. He's consistently encouraged me to keep chipping away at this agenda and to draw enthusiasm that we are having a discernible impact on the national debate about mental health – but he's not infrequently reminded me to look after myself, conscious of pressures he knows we all have. Ours is an important role to play, but we also need to understand the impact on ourselves and our families to protect against an experience like his own.

And this is what has often been missing in policing, for me – leadership in recognising the impact upon police officers of policing and the police organisation. Human beings are individuals and have finite capacity, they can caused to break. Perhaps those of us who didn't quite break but got bloody close can still recognise that we've taken many mental knocks along the way, as we no doubt took the physical ones. Resilience is such a misunderstood concept; it's not about what may have ground you to a halt – it's also about having the courage to stand up again and find a new way to contribute. Mr Sutherland stood up again and inspired in new ways, on a broader platform, than he had done running some of London's busiest boroughs.

Please watch this, if you haven't already –

So, somewhere out there a man who used to be a boy in blue and became a police commander will enter a new phase of a life well lived, following service well served. And because we know he 'bleeds blue', like so many of us, we can only imagine this must feel full of daunting uncertainty. Given John's reputation as a leader and a spokesman who has helped raise awareness of how mental health issues can affect any of us, I suspect he won't be too far away from it all. Like all those men and women who 'enter the hurting places', who have been there and done it, who didn't stand by, but gave of themselves, he will always be a part of that wider police family because he's one of us.

And regardless of everything that will soon be history, he can proudly retire from the Metropolitan Police and rest assured that every contact does leave a trace – and his was nothing but positive, enduring and inspiring.

Sir, it was a privilege, thank you. Stand down: we've got this.

MARCH 2018

7th March 2018

Pre-Identifying 135 "Beds"

A little lack of knowledge can be a dangerous thing –

A couple of years ago, I learned of a perculiar incident in a police force area that would have made a great blog to emphasise a point, but it was so specific, I withheld from doing it, in case it self-identified those involved. I have since learned of two other cases under review where a similarly distinct legal point was at heart of what occurred. I've also heard this from AMHPs recently and I'm at a loss as to where it comes from: hence this post.

It concerns the police execution of warrants issued under s135(1) of the Mental Health Act 1983 and whether we must, by law, work out in advance where the person may be removed to. So the exam question is this:

Is it lawful to execute a s135(1) warrant and take the decision to remove someone to a Place of Safety even if nowhere has been pre-identified to act as a PoS under the Act and / or where no bed has been pre-identified for the patient's admission?

And the answer is: YES, it is lawful.

LAW v POLICY

The cases I'm alluding to but not describing in detail involved situations where an AMHP or a local policy has ended up creating the impression that a lack of PoS space or admission bed is a legal barrier to the execution of a warrant and removal from the premises. This needs to be knocked on the head because it's **wrong** and police officers need to know what one of the sergeants in these incidents did, when dealing with an AMHP who insisted that an admissions bed **must** be available.

Ultimately, the police cannot apply for s135(1) warrants or execute them without an AMHP and DR present, so AMHPs are absolutely key to the decisions about the application and execution of warrants. Nothing can happen without their consent and cooperation. So imagine a scenario: everything is jacked up for the execution of the warrant, the AMHP does a last minute check that the 'bed' is still available and learns that it's not. They state the execution of the warrant will have to be

delayed but they've already been emphasising the risk to the patient or others if they are not assessed in circumstances where they are highly likely to be admitted to hospital under the Act.

In one of the cases prior to the MHA changes in December 2017, the sergeant in charge said something along these lines, "A warrant under the Act doesn't need a bed and given the risks you've highlighted leading to us all being here, why don't we just execute the warrant anyway and remove him to a Custody if nowhere else, so he's safe, supervised and secured? You can then resolve your bed problem in the time available …" This occurred before the 2017 amendments to the use of custody but the underlying point remains valid. It's a good job he wrote that down along with the AMHPs decision not to execute the warrant – it meant no accountability for the untowards event that occurred before a bed was found and the patient detained.

A SUMMARY OF 135 STUFF

For your reflection and general smoking –

- It well may be considered *good practice* to pre-identify a bed in case the whole 135 process leads to the need for an MHA admission; and
- It may be in the Code of Practice that *where possible* a Place of Safety is pre-identified in case the execution of the warrant leads to a need for removal from the premises to a place of safety, for whatever reason.
- **But ultimately, good practice and statutory guidance is not the law.**
- Section 135(1) simply states that officers "can force entry if thought fit … and … remove to a place of safety, if need be."
- Where there is a need to do so, nothing prevents the execution of a 135(1) warrant and removal to a Place of Safety just as if the officers had encountered that person and detained them using 136.
- They would call an ambulance, they would consider whether anything means the patient needs removing to A&E and they would either take them there or remove them to the local health-based place of safety under s135(1).
- The police station is there if the statutory regulations criteria are met and nothing prevents improvisation if things are proving difficult.
- Of course, your local Place of Safety protocol should outline what the options and contingencies are, arguably including how situations are handled and escalated where these operational problems occur.

Of course, what no-one wants is someone detained under a warrant and have nowhere obvious to go – there are already far too many cases like that under section 136. But I do know this: if someone is held in such a predicament, they're not out getting themselves seriously hurt or worse.

And finally, whilst we're here discussing s135, a quick reminder of some other stuff we do get wrong or do badly –

- AMHPs do report police officers stating that they are refusing to execute warrants until a 'bed' is pre-identified. Just bear in mind how you'll explain the decision not to act now if before you can act, someone has been seriously hurt or worse, despite the AMHPs best efforts – this isn't just about AMHPs, it's about all of us and the policies we agree to work to!
- Also bear in mind there have been Coroner's outcomes which criticise police forces for failing to give the execution of s135 warrants due priority – remember, our AMHP colleagues, when they're busy AMHPing are trying to organise one or two doctors, possibly navigating a distressed family, possibly having queued in Magistrates Courts for a warrant, plus the police and their requests for written risk assessments – they are ring-mastering a circus and in charge of no-one.
- How do you know you'll need an inpatient bed until you've completed the assessment that flows from the execution of the warrant?!
- And finally remember this: **it is NOT the AMHPs responsibility to find a bed anyway!** … it's the doctors, once an application for admission is required.
- Blaming AMHPs for no beds or no Place of Safety is like blaming the police for the same things – legally ignorant and utterly pointless!

A little knowledge can be a dangerous thing – but so can a little lack of it. Get knowledge: then go do stuff.

19th March 2018

Live-Tweeting

All of us who use Twitter are probably guilty on occasion of wanting to shout up about a job to highlight something we see as important – a success story where someone was helped, a criminal caught, officers who've acted bravely, etc.. We want to highlight our work, the pressures on us, the successes we have and help explain to the public the reality of our work and what we're contending with as we wrestle with it – sometimes literally. In that context I want to write here about something I've done as much as anyone and to caution against it: therefore to the extent that this might look like a telling off – and I *really* hope it doesn't – it's one that applies to me at least as much as anyone else. It's something (I think) I've stopped doing after listening to others on Twitter who live with mental health problems: **live-tweeting mental health or suicide related jobs**. And I mean this both in the sense of an organised live-tweetathon, for example of a kind that was once set-up and then cancelled at the last moment by a police force street-triage team; as well as the occasional live-tweet by an officer in a shift, but which is put out in real time as just one job of many they're dealing with that day.

What harm could this cause, you may ask? We normally anonymise tweets about all the things we deal with and mental health issues are, we keep insisting, a part of our "core business", so why shouldn't the public learn of someone's life we've saved or the hours we do spend sitting about in mental health units when all the laws and guidelines say we shouldn't? After all, we could be at the next 999 call helping other people by then, couldn't we?! It all comes back to the identifiability of individuals within the tweets – not that the public at large will identify the person being referred to, but *the person themselves* may recognise the person being referred to and we quite simply don't know what impact that will have. Would you want one of your most desperate moments of all, broadcast without your express permission, even if the officers did take steps to minimise how likely it would be for a third-party to read it and identify you? Potentially not.

But we also know that third-party identification has occurred, despite those attempts to 'anonymise' things so this is not just a hypothetical risk.

DIFFICULTIES LIVE-TWEETING

It's remarkably straight-forward: even if you tweet something without using someone's name or age, by simply stating their gender after they have been detained, located or arrested, we're also telling 50% of people reading, "this is not about you". If my local police did that in my home town (Bromsgrove, Worcestershire – population c29,500), then we're certainly narrowing down on just over 14,000 people if we're trying to think who it may be. Although that's still a lot of people and whilst there is the possibility Bromsgrove police have detained someone in Bromsgrove who is not from Bromsgrove, that only narrows it down further because the police do mostly detain people in their own home area, when using s136 MHA or criminal powers of arrest.

We also find other clues that narrow things down –

- General indicators of age – elderly man, young woman or teenager. We're narrowing this number down even further:
- Of the c14,000 men in my home town, how many of those will be teenagers or pensioners – well, at any given time, most will be neither; so that excludes most men and we've now narrowed things down to a few thousand.
- How many times would my local force use s136 in a given day? – well, they used it 786 times in the whole of the previous year, that's twice a day, force wide and I live in a small town in one of the three counties they cover.

If a tweet goes out about detaining an adult male in Bromsgrove under s136 and I know that I was detained on that day, it's almost certainly me, without further information. And because I'm an individual in a tweet, not a police officer conducting a criminal inquiry, I only need to believe the tweet *could* be about me, for potential damage to be done.

If you scan social media on this point, you can meet people who now know that they were at the centre of a police-tweet some hours or days earlier. This has included examples of police helicopters tweeting pictures from heat-seeking equipment of their search for someone in a wooded area – the picture including that human being, just located. It has included a tweet from a small town by a twitter account connected to that town and making reference to enough vague identifiers to narrow things down quite considerably whilst telling the person just how many officers and resourced were expended on finding them – just in case they didn't feel bad enough! << of course, we all *know* that wouldn't be the intention of the officers. Police officers join and go to work every day to help people, even where there may be a view that someone has fallen between the cracks or could

have been helped earlier by others. But it always *risks* looking like we may be describing the burdens we carry.

SUBLIMINAL IDENTIFICATION

Other inherent qualities of a tweet narrow things down even further: if we know the timing or rough timing, the identity of the officer who responded and tweeted or anything specific about the incident. Officers may withhold all information about the patient they think is identifiable, but they themselves may be identifiable – if I've been helped by PC Smith at 9pm and remembered his name because of how supportive they were; and then by 10pm PC Smith is tweeting about an incident as they book off-duty, that may make me realise it's about me, even though there's nothing identifiable in the tweet. If police were searching for me whilst I'm missing and they find my in a difficult or unusual place and refer to it, even non-precisely, that may make me realise the tweet was about me.

And finally, there's descriptive wording: recently a police force twitter account described a specific person who was detained as 'volatile'. The force concerned is large, they use s136 a lot, but given it came from one of their local accounts, it narrowed things down massively and they also used the gender of the person concerned, thus ruling out half of the population. I wonder how many people of that gender were detained by that force, in that area of that force, under the MHA that evening? << Note: they even narrowed down the shift on which this took place, thus ruling out those shifts in the day when the detention did not occur.

And this is the big message that bears repeating: the risk isn't mainly that a third-party may read something and think, "Oh, I bet that's Billy from down the road", but that Billy himself may read it and think, "Not sure I wanted my healthcare issues broadcast across twitter, even if they do think they've anonymised it. And I'm not sure I'm happy to be described as 'volatile' or for any inference to be out there that I've consumed resources apparently 'better' spent elsewhere on 'real' crime. I already felt worthless and I certainly do now every knows!"

WHAT I AM NOT SAYING

And let me repeat this point so it's not un-said and so no-one accuses me of throwing stones from my greenhouse: **I have actually done this**, *many* times. I've done this more times than care to admit and it took a *long* while and some very real examples for the points that were made to me to sink in. When you've actually sat down at reasonable length with someone over a cuppa, someone who was the unwitting focus of a tweet and you've listened to them explain the reasons why they'd have preferred to have the

option and, even then, may well have said "No, thanks" despite recognising virtuous motives, then you can say you've got an insight in to these kinds of issues. If you haven't done that, you may struggle to get it. I certainly did now I've actually had the chance to do this more than a few times, it made me realise people on the opposite end of the police-person encounter have questions and concerns I hadn't even thought about. Unless, I'm misjudging myself very badly, I would venture to suggest some of those things may well have escaped most police officers.

No-one, anywhere, is saying the police shouldn't use Twitter to highlight the kind of work we do, including on mental health and this point includes highlighting difficulties, human stories and officers' bravery on occasion – it's all just about the *way* we go about this, and when. Using single incidents as the basis for a tweet, risks the kind of thing I've heard about a lot from people who've had police contact. As do single incidents at the centre of a BLOG and several years ago, I had that experience, too. I've got a blog in draft form, entirely finished and ready for publication, but I'm all too aware it relates to a particular case and even though that case has been heard in a Coroner's Court where all details were made public, it wasn't a high profile case covered in the media and I am not prepared to publish it without the family's permission because it relates to the death of their loved one.

If you're concerned about mental health, suicide prevention and offering support to people, nothing prevents you from tweeting to say so – you could do so because of news articles, new research or simply to signpost people to services by offering helplines or other sources of online information, etc.. I couldn't help but notice one recent reaction which told us such concerns are unfounded because things are anonymised where names and precise details are withheld and that this is an important topic and it "needs talking about". Even a cursory scan of that person's social media feed shows us see they have not tweeted about or discussed the importance of these issues once during 2018. The topic is *so* important, they haven't mentioned it. << If you are this person and you've ended up reading this BLOG post wondering if I meant you, ask yourself whether I've sufficiently anonymised this final paragraph so that you couldn't tell this remark was about you? Your yardstick was: if no names were used, it has been anonymised. I used no names, I didn't even raise the matter of gender or rough age, so you tell me: can you spot yourself?!

Exactly.

Post-script: *just after I finished this post and whilst I was busy sorting the paragraphing, spell-checking and so on, I was tagged on Twitter in another example of people raising concerns after an official police account tweeted something, just as outlined above. The rudeness and lack of professionalism from what appear to be police officers responding to*

objections on private accounts was nothing short of breathtaking, to be honest. Various levels of "WOW!"

APRIL 2018

2nd April 2018

Making the Same Mistakes

I woke up this morning to a tag on Twitter from Australia drawing my attention to questions being asked following an encounter between Victoria Police in Melbourne and a mentally vulnerable man referred to as 'John'. Police officers had been requested to undertake a 'welfare check' by a psychologist who was concerned about John's mental health. In the link that follows, there are various short video clips and extended footage from security cameras at the front of John's property which show a use of force incident. It involves some footage that may prove difficult to watch, so please consider whether or not you open the link. The debate obviously focusses on the use of force by the officers, as well as the fact they have hosed down a handcuffed man whilst filming it. Accepting that there appears to have been an investigation launched, that no CCTV footage of any incident shows all that one would want to know to form a judgement about how things were handled, it does seem fair to say, even at this early stage, that it would be difficult to conceive of additional factors, currently unknown to the journalist or the public which would allow the footage to be seen in a light where concerns were completely negated. It is reported John has sought legal advice over the matter.

I'm becoming more familiar with the debates on policing and mental health in Australia in recent times: several years ago, I became aware of work done in Queensland and New South Wales to improve police responses and training to policing and mental health incidents and looked at them from afar via the internet, some Skype discussions and I met a few Australian officers at conferences I was attending or when they visited the UK on fellowships. More recently, this has expanded further: a week or so ago, I gave evidence (via a live-link) to an inquest in Sydney where a Coroner's Court is examining the police response to incident which ended with the fatal shooting of a young woman called Courtney Topic in 2015. It was the kind of incident to which the UK police would be very unlikely to send armed officers and therefore the court was considering whether different tactics and considerations may legitimately have been expected to prevent a fatal outcome. Difficult stuff indeed and the outcome of that inquest is still awaited. In August of this year, I've been invited to attend a conference in Adelaide to talk about policing and mental health issues and as I've learned more and more, it's obvious that we have far more in common than the issues which distinguish us from each as countries or police services –

- **We're making the same mistakes** – and this is not a specific point about Australia and the UK: to the extent that I've understood problems in other countries, they are largely the same everywhere with a few distinctions about local issues which alter the order you'd prioritise the problems.
- **We're seeking the same solutions** – no matter the differences, we see everywhere reaching for co-responder models where mental health nurses are deployed with the police; and we hear much talk about the need for more and better training for officers: this begs as many questions as it answers, in my experience.

Let me tell you why this is simply "doing the wrong thing righter" and that we need to remember what we say we ask our police service to do.

OVER-RELIANCE

The incident of John in Melbourne could have happened in Manchester – in the sense that UK and Australian police are asked by mental health professionals to check on the mental health of vulnerable people for reasons that I still don't always understand. I've written before about this: how on *earth* would a police officer be expected to do this? It's just not possible to achieve, if we actually THINK about it! No police officer can assure anyone else as they walk away that someone is OK and this is about much more than whether or not officers are trained –

- Where the police turn up at someone's home, even two of the friendliest officers on the planet with the best training going, it could still be problematic – we know that some patients have an intuitive fear of the police because of their clinical condition, we know some automatically think the police means they're being criminalised or stigmatised as violent;
- We also know that the power dynamics between officers and the public are not equal and some people may fear the encounter will end in coercion of one kind or another – and coercion doesn't always mean being physically coerced.
- Police officers have all the accoutrements and authority of the state to coerce people and in Australia their reach does extend to your private home and front garden, unlike in the UK. (What happened to John, assuming it was a detention under mental health law, could not lawfully have happened in the UK because he was in his own house and then his own garden.)
- So where officers turn up and say, "John, your psychologist has asked us to check on your mental health – how are you? Do you need our help?!" … what do we think this may mean for John himself?

- If John says or does anything that implies his mental health is difficult for him, or that he may be at risk from himself, what do we think the officers will then be contemplating? – can they ring back the psychologist and say, "Look, he says he's not at all well and we can sense that, too – you'd best get yourself or a colleague 'round here sharpish to help him?" Invariably, we can't.
- And if John says he's fine and doesn't need police help, should we believe him where there is no obvious reason to disbelieve him? – we know there are reasons why some people lie to the police about their mental health: because the public tell us this when we ask about how we can improve our responses. Telling the police the truth is to risk being coerced, one way or another.
- We are then cops on someone's threshold carrying a professional responsibility for ensuring someone's immediate safety, so what will we do if someone is unwilling or unable to seek help on their own or via their support services, where they have some? It's got 'detention under the Mental Health Act' written all over it.

So before we get anywhere close to the questions that emerge about how these officers on this day decided to discharge their responsibilities – and I have loads! – we need to be asking the question most forgotten: **why do we rely upon the police to the extent that we do and task them with things they couldn't possibly do, even if they wanted to help?** Remember, officers can't be expected to reliably rate likelihood of self-harm; advise on anything to do with medication; they can't always force a person to another location for an assessment by qualified staff and what many co-responder models demonstrate is that the person probably just needed access to healthcare services anyway. Did John actually need something from the police? – there could be more to know about this incident, but as things stand it seems unlikely.

MAKING MISTAKES

This the original mistake: to assume that demand faced by the police is unavoidable, unpredictable and unpreventable demand and that the task is merely to ensure that the police are trained and equipped via partnerships to handle it better. Frankly, this is complete rubbish. Of course, there *are* incidents coming to police attention which were completely unavoidable, unpredictable and unpreventable but many (or most?) of them are not; and where they are not unavoidable, unpredictable and unpreventable, that doesn't mean it requires a police officer to respond. Whether we examine some particularly high-profile untoward events like deaths in police custody, or whether we take a broader view over population level data, like s136 detentions or 'triage' encounters in UK police forces: we come to learn that much of this demand involved people needing and often wanting a healthcare service and being unable to access it or for whatever other

reason not receiving it. Thereby, we create conditions in which police (and for that matter ambulance services and emergency departments) become more likely to be relied upon as a blunt tool to provide some kind of 'care'. Remember, two things 'more than minimally contributed' to the death of Sean Rigg in London 2008 and the first of them was neglect by mental health services. Had that not occurred, it's quite doubtful the Metropolitan Police would ever have met him. In Sydney earlier this year, a a young man called Jack Kokaua walked out of an emergency department where he had been detained under mental health law and when re-detained by New South Wales police, died following restraint. Of course, we may yet learn that officers could have handled that situation better, but it will still leave a question unaddressed: why was a detained mental health patient, previous sedated by the ambulance service and removed to an emergency department, able to walk out more-or-less unchallenged?

Most crucially though, this is not an argument against better training and leadership in policing; or against efforts to cooperate with mental health services – those things are very necessary for those occasions where we *are* responding to unavoidable, unpredictable and unpreventable demands. But like all the best medicine, prevention is better than cure. If we can ensure that those who simply need timely access to relevant services get it, we might reasonably expect to see the police responding less often to people in crisis and where they do, making a more positive difference because they're better trained and supported – the real partnership issues to be address between policing and mental health services is not the day to day efforts between frontline cops and front line nurses; but the strategic relationship, the population data sharing, the proactive addressing of repeated and more difficult problems which is best done in meetings by knowledgable senior managers and analysts. We do this for domestic abuse and child sexual exploitation – we'll start doing it more systematically on mental health eventually.

Other mistakes –

- We give the police tasks they can't *actually* do – like making suicide or self-harm risks assessments of vulnerable people during welfare checks. I can tell you whether someone is alive or dead, whether they're conscious and breathing, but whether they're likely to hurt themselves in the next 6hrs is something my psychiatric training didn't touch, I'm afraid. You want to know that someone's OK – you'll have to come and check that yourself.
- We give them tasks they can't *legally* do – police services don't always have legal powers to ensure a contact occurs between a vulnerable person and a mental health professional: the UK limits its police powers under mental health law and prevents their use inside private dwellings but even in countries like Australia where this is not

the case, there is a threshold for using police powers. By definition, thresholds are not always met.

- We give them tasks they can't *morally* do – calling officers to psychiatric units to undertake tasks normally expected of mental health professionals gives rise to ethical questions: I can't be the only police officer asked to undertake tasks in a hospital where gender of staff wouldn't matter but where analogous tasks in police stations, gender of officers would be controlled by law. I'm not forcibly removing a woman's clothing for medication unless her life is quite literally at risk (and it wasn't)!

THE ROLE OF THE POLICE

I'm not going to defend for one moment what I saw watching footage of a man wearing the word 'POLICE' on his back hosing down a beaten, mentally ill pensioner kneeling in handcuffs in his own front garden whilst one of his colleagues smiled and filmed it. Feel free to try and convince us, gentlemen, that this was reasonable, proportionate and necessary, but you're going to have work damned hard and show me a detailed argument that negates suggestions this amounts to torture or inhumane and degrading treatment. But I do insist that whatever investigation gets going in to this, it should also ask the forgotten question: what the hell were the police doing there in the first place; and if it were thought unavoidable necessary because of urgent circumstances, where was the back up for the officers to address the questions that will necessarily arise for the psychologist after the officers have said, "Yes, he's here: alive, breathing and conscious. What do you want to do next given we cannot assure you of anything else?"

Police uniforms, power dynamics and implied threats and coercion from even deploying the police can be a game changer: it is not benign and this is all too conveniently forgotten by those who over-rely upon the police to ensure adequate coverage of crisis 'care'. If you doubt these subtle implications, ask yourself whether a police car suddenly pulling behind you at speed with lights activated makes you instantly check your speed? – whether an officer knocking your door unexpectedly makes you worry what they're about to tell you that you might really not want to hear? Now imagine that whilst you're struggling with your mental health, whilst you're frightened or where you worry about being touched or coerced by people you know have limited training on mental health, even if they are attempting to communicate effectively and compassionately. Policing in mental health 'care' is, by default, an implied use of force – because it carries the implied 'or else' of the entire state right behind everything it does and that can be frightening to any of us. Some have looked at this footage and said it was all a police reaction to the officer being assaulted: all I saw was a vulnerable man pull away from being grabbed, which we can probably agree, is just human instinct.

We’re not going to see the elimination of adverse incidents until we stop tasking the police inappropriate with stuff they cannot do: so whilst no-one is defending anything on the footage relating to John or any other incident where police actions are rightly questioned, society needs to ask itself more keenly how it wants its police service to spend its time and then train officers properly for the tasks that are legitimately within their competence and capacity. ANything else is doing the wrong thing righter and making the mistakes history has already told us not to make.

03rd April 2018

135/6: Authorising Officers

Short post mainly for those ranking officers who have statutory roles to play under the revised Mental Health Act 1983 (MHA) provisions which focus on those rare occasions where custody is still used as a Place of Safety under the Act. This is just bringing together a few of the issues which have emerged during the few months since December. It might be worth the custody officers in particular saving this link to your desktops in custody: it is the Mental Health Act (Place of Safety) Regulations 2017, issued under the MHA.

The **big thing** to be wary of before we even get to ongoing supervision and care in custody which is something for both the duty inspector *and* the custody sergeant to think about: whether the presentation the detaining officers are describing has been sufficiently triaged by NHS staff to rule out the need for A&E assessment or treatment shortly after detention. It's all very well those criteria in Regulation 2 being satisfied to allow the use of a police station, but what if that presentation is also consistent with a medical emergency that is somehow being slightly forgotten about whilst we think through whether or not the law allows us to do something and whilst we're focussed on managing a more difficult restraint incident:

My general rule of thumb since the new law was set out for us has been and this is what I'd do if I were operational again tomorrow:

No-one goes to custody unless they've been seen by a member of NHS staff who is putting their professional registration to the decision that the person does **not** need A&E care. We know that 'imminent risk of serious injury or death' presentations will probably mean restraint of at least some kind has been applied not least because we're also saying that 'no place of safety in the force area' can manage that presentation … well, history shows that could be ABD, meningitis, post-ictal psychosis, Addison's disease, brain tumours, diabetes, etc.. No triage: no custody, in my opinion. No police officer in this country could confidently use their first-aid certificate to state there is not something potentially life-altering or life-threatening going on there. The emergency NHS is wheels have roles to play here and if not, I'd be removing people to A&E and then explaining why I wouldn't have done so if only an ambulance had turned up.

Please don't think that such debates and deliberations are hypothetical: these things have been key features in determining police officers' liabilities during death in custody inquiries. I can think of three examples without trying hard.

USING CUSTODY

So, let's now assume that custody has been authorised after the inspector is satisfied of suitable triage. The person has been booked in by the custody officer and risk assessed and we're now settled in to the rhythm of supervision until the s136 assessment is arranged or the person transferred elsewhere.

Three main things under the Regulations:

1. Half-hour healthcare checks by a healthcare professional – this is in **Regulation 4**.
2. Hourly reviews by the custody officer – this is in **Regulation 5**.
3. Remove anyone from the police station if the original grounds under *Regulation 2* for holding them there no longer to apply – this is in **Regulation 5**.

- **First big issue:** there MUST be half-hour healthcare checks by a healthcare professional whilst someone is detained in police custody and if this is not possible, or ceases to be possible, the person **must** be removed from there and taken elsewhere. Again, it is a **legal obligation**.
- **Second big issue:** police custody, even where it is properly authorised against the criteria can only be used for as long as those criteria remain valid. If someone's presentation alters to a point where the inspector could not have authorised custody to be used, the person must be removed from there and taken elsewhere. This is not an option: it is a **legal obligation**.
- **Third big issue:** no extension to the 24hrs of detention may be given in a police station unless the superintendent gives it *in addition* to the doctor who forms part of the assessment. The superintendent is not obliged to agree with the doctor and must form their own view that the criteria under s136B are met and this means there has been a delay in convening the assessment *because of the condition of the person*. A lack of doctors, AMHPs or beds is no basis for an extension.

CHECKLIST

So, this is your handy checklist, if you like —

- Get the healthcare of the person checked (as you will have done every half-hour since their arrival in custody) and discuss the matter with the nurse or doctor concerned.
- **Ask the healthcare professional:** "is this person medically fit to remain in police custody, having given due consideration to Code C of the PACE Codes of Practice, particularly to paragraph 9.5 and Annex of that Code?"
- **Ask the healthcare professional:** "Does this person require assessment or treatment in A&E for any medical reason?" – you'll need a confident "No" to that to go any further!
- **Conduct your own review of them** – this is required hourly and you're reviewing the inspector's original grounds for authorising a police station under Regulation 2. Note: the custody officer reviews this, not the duty inspector and this is not a PACE duty, so the custody officer's decision is final and not subject to review under s39 PACE.
- **Ask yourself**: are the original reasons for requiring the use of police custody still valid? – if so, continue; if not, you **must** transfer the person to another Place of Safety.

This is all subject to one caveat in terms of an obligation to remove because of inability to comply with Regulation 4 or because a review under Regulation 5 determines the original grounds are no longer met: the removal to the other location should not occur if arrangements to have them assessed under the MHA have already been made and transfer would unnecessarily delay this or cause the person significant distress. This is **Regulation 7**.

Other Notes of Potential Interest –

- The Code of Practice to the MHA (Chapter 16 in England, 2015; and Wales, 2016) states that transfer to another place of safety must be authorised by a doctor or an AMHP; however, a statutory Regulation outranks a Code of Practice so where no authorisation is possible, officers should proceed to remove the person in accordance with this framework.

- The Code of Practice also states that officers should ensure that a subsequent Place of Safety has confirmed they will be able to receive the person before they are moved; again, Regulations ordering removal outrank the Code and if no confirmation can be secured, it may be necessary to remove the person to A&E or to "any other suitable place" as defined by s136(7).

For more detail on the 2017 amendments to the MHA, including on the topics covered in this post, see a series of posts on the various changes.

5th April 2018

The 136 in Custody Thing

I said about eighteen months ago, that once the Mental Health Act was amended to unambiguously allow the use of s136 of the Act in any place that was not someone's home, we'd see police officers considering its application in police custody areas, for a range of reasons. This post is mainly for police officers and mental health professionals working in or around police custody during criminal investigation. If others want to understand some of the legal issues within the post, see some of the other resources on the BLOG to understand the Police and Criminal Evidence Act 1984 (PACE) or the amendments to the Mental Health Act 1983.

This post is about when, if ever, a criminal suspect should be released from detention whilst under investigation, in order to be diverted to the mental health system. There are two scenarios I have in mind, broadly speaking –

- A way of safeguarding someone who suddenly and unexpectedly indicates an intention to end their life just as they are being released from custody as part of an ongoing investigation.
- It could be used where PACE grounds to hold someone have expired (see s34 and s37) but where there is an ongoing need for some form of MHA process – either an MHA assessment by an AMHP and DR; or where someone is awaiting admission.

There are a few version of this second idea, varying by way of timing – at which point should a decision be taken to suspend PACE and implement s136, but for the ease of initial explanation, let's just take the broad idea.

For what it's worth, I think there is merit in giving the consideration to these things, because they do have the potential to offer a form of solution to certain historic problems, even if it is a short-term solution. But that's not what this post is actually about! – this is about the problems opened up, especially where officers are too quick to push for this; and especially where the grounds for doing so are actually not met.

BACKGROUND

The majority of people who are taken to police custody who are then identified (on whatever basis) as having some kind of mental health condition are not then assessed under the MHA for potential admission to hospital. So first things, first: the fact that someone is thought to have some kind of mental health condition **should not mean** we suddenly start issuing urgent bail from custody, suspending criminal investigations and shouting for a Place of Safety. Apart from anything else: the grounds for using s136 in these circumstances would usually not be met; and for most people, it would be a complete waste of time anyway: they'd soon be discharged with little more than a letter to the GP.

The number of people assessed under s136 who are then identified as requiring specialist mental health services (which would include any admission to hospital), is a usually less than half. Most people assessed under the MHA are not admitted to hospital and any mental health care they require can be organised by Liaison and Diversion Services (LaDS) in custody – 85% of the population of England is covered by a LaDS. So for those who are arrested and taken to police custody and may be lawfully detained there under PACE, a good LaDS can ensure the healthcare needs of people under arrest are met unless the person needs to be 'sectioned', in which case they would need to call upon an AMHP and Doctors to undertake the statutory MHA assessment,

There is also a practical reality here: if the police start shouting for s136 for any arrest where the suspect says they have depression, the Place of Safety system will soon grind to a halt, because in some areas it isn't exactly free-flowing to start with! Areas usually have a finite capacity in their PoS system and police forces do need to be aware that the history of s136 is a perception by many that the power is over-used already, this could potentially make that even worse. Section 136 isn't about getting complicated suspects out of custody, not least because that suspect may indeed be criminally responsible for the offence they are alleged to have committed and natural justice may demand there still be the kind of CJ disposal that anyone else would receive for similar conduct.

THE DECISION TO 136

First obvious point: if you are going to even think about an approach that means someone is released from police custody and detained under s136, you need to ensure a couple of fairly obvious things.

1. **Are there ongoing grounds under PACE to keep the person detained?** – where PACE grounds continue to exist, nothing prevents

an FME assessment, a LaDS assessment or even a statutory MHA assessment occurring in police custody, as it always has. So if we are still securing and preserving evidence and / or seeking to obtain evidence by questioning and where we have not yet reached a view about whether immediate prosecution will be required, why would we think of ending detention unless someone's health was so bad that they were unfit for detention in custody? Nothing prevents the two processes running alongside.

2. **Are the grounds for use of s136 actually satisfied?!** – this should be beyond obvious and barely in need of being stated, shouldn't it?! But does that person appear to a constable to be suffering from mental disorder and to be in immediate need of care or control, in their best interests or for the protection of others? If the actual grounds for detention under s136 are not met, then this whole debate is a non-starter. If the kind of care that someone needs is available in custody whilst someone remains lawfully under arrest, what's the point?

Putting these things together, you will usually need a collision of the two circumstances: a genuine difficulty in further justifying detention under PACE; along with a healthcare situation believed to be sufficiently serious in its own right to justify the use of s136. The exception to this, of course, is where someone is so ill, it is a medical emergency, they are unfit for detention in police custody and need to be urgently transferred to A&E.

Otherwise, absent one or both of these factors: we shouldn't, by law, be thinking of it. And what useful purpose would it serve, even if it were lawful?!

UTILITY

There is no easy dividing line between mental health and crime: not because they are the same thing, obviously not. But because the boundaries each are not easy to define and some behaviours at the edge of each are overlapping: simultaneously demonstrative of a serious mental health condition and a contravention of a country's criminal code. Public policy tends to suggest we should approach the overlaps and in the UK this is by arguing that we should only criminalise people for more serious offences or where broader public safety is at stake.

So the police have an important role to ensure balance in the application of public policy:

- We don't want the police to fail to bring to justice those who have offended where a mild or moderate mental health condition has in no significant way affected their liability for their conduct.

- We don't want the police to criminalise seriously unwell and other vulnerable people for minor crimes that were situationally related to their condition and the context of an incident.
- We do want the police to protect the public from those who pose a much more significant risk to the public in order to allow the criminal courts to make thorough assessment of how we balance that patient's right to treatment with legal frameworks to ensure public protection.

Does it get more interesting or more complicated than this in ANY area of public policy?! << I have to admit, I don't think it does. As Professor Jill Peay says, professionals operating at the interface of mental health and criminal justice are undertaking some of the most complicated work of any individuals in those professions. But this also means is vitally important stuff: these decisions can be the sorts of things, in extremis, that contribute to suicide and homicide, so they should always focus the mind carefully and be subject to sober judgement.

We need to think REALLY carefully about the potential for us to take premature decisions: if we're shutting someone out of immediate access to the mental health system because they are alleged to have offended, is that a proportionate response to the alleged offence and how detrimental may this be to their health? If we're shutting someone of the criminal justice system because they have a mental health condition, is it one which is sufficiently serious to require urgent assessment ahead of any other consideration about an offence they may have committed and this risk this poses?

All cases on their individual merits.

6th April 2018

Beds and Stuff

It was being asked again last night, in the AMHP social media world as to whether Britain had run out of inpatient psychiatric beds. Obviously a difficult night to go out AMHPing, at least in some parts of the country. Over the last two weeks, I think I've been asked about four different scenarios where a massive bed hunt was going nowhere fast, three of them related to the detention of children. In some of those cases, detention by the police under s136 led to a fairly quick assessment of the person detained and for a decision to admit to be easily reached: only for it to then be made known that the relevant kind of bed for that patient is at least six days away. There have been other examples prior to this recent flurry, of course: it does tend to suggest we've got proper problems.

Where things get really difficult, there has been an increasing practice for mental health services to use the place of safety room itself as an improvised 'bed'. ANd before I go any further at all, I want to point out this is not an example of me choosing to put things in the public domain that aren't all ready there – just see social media for details! So for example, a person is detained by the police under s136 and taken to the place of safety for assessment which concludes that detention under the Act is required. However, because of there being no bed, the application is made to the hospital where the MHA Place of Safety is and the patient moves nowhere, but metamorphoses from a s136 detainee, to a s2 MHA patient without moving an inch.

Other versions of this practice have occurred where a person is originally arrested for an offence and taken to police custody, but then 'diverted' from justice under the MHA to a Place of Safety facility, not under s136, but under s2 itself as a detained patient. There the patient remains under quite unique circumstances until a 'bed' becomes available at whatever point and they are transferred (s19 MHA). In one example last year, a young person admitted under s2 to a PoS remained there for several days until a proper inpatient bed became available and, of course, during that time all s136 detentions of subsequently vulnerable people had to go elsewhere.

LAWFUL OPTIONS

One thing to say about this upfront: at least it's all lawful! Pressure to admit patients, especially from police custody, often arises because timescales to secure a bed exceed those allow by law for doing so. If someone is detained under s136 MHA, the AMHP and DRs have just 24hrs to make the necessary arrangements for that person's care, including admission, if required. If no application has been made for someone's admission to hospital under the Mental Health Act, they are free to go after the 24hrs expires. This is also true if someone was arrested initially and assessed under the MHA in custody.

Finding a bed in a timely way, is vital in order to prevent the situation becoming a human rights violation. Holding someone without a legal authority is an Article 5 violation (the right to liberty); releasing a suicidal person when you are under a legal obligation to detain them could well amount to an Article 2 violation (the right to life). There are other violations that may apply, for example where protracted detention before admission could amount to an Article 3 violation (inhumane and degrading treatment). This was actually a finding in the *MS v UK* ruling in the European Court in 2012.

In order to avoid such a mess, forcing through an admission by using a Place of Safety on an improvised basis is an option that some areas are resorting to, sometimes with police support. As I said: at least it's a lawful way to progress! … it's progress of a kind. But it's not always seen as a choice a between a lawful or an unlawful option: these kinds of improvised solutions to bed problems are, obviously, unsatisfactory. No-one would want a patient detained in a place of safety where better options existed; but police forces are right to consider asking whether these solutions could be considered. Why not improvise a lawful solution that protects the patient's fundamental rights and get closer to what we'd all want for them that ongoing detention in custody?

UNLAWFUL OPTIONS

So the problems emerge if it is thought unconscionable to release someone where they are known, for example, to be actively suicidal or a risk to others and where no-one is able or prepared to improvise. Requests have been made in some cases for the police should either keep someone in custody (if they were originally arrested for an offence at we ran out of time to 'divert' under the MHA) or that the police should help to keep someone at the Place of Safety even though the 24hrs to make arrangements has run out. Where there are no other options at all, then it may come to that

invidious decision – do we unlawfully detain to keep someone safe or do we release them and follow them up later when a bed is found?

This should be an absolute *last resort* decision, borne of some desperation.

It's not really last resort territory if we're looking at things through the 'ideal' versus 'non-ideal' lens. Last resort is whether we choose the 'lawful' or the 'unlawful' option when we've only got these two left to choose from. Remember, all public authorities have a positive duty (s6 of the Human Rights Act 1998) to ensure the European Convention Rights of those to whom they owe a duty. The 'unlawful' choice to breach someone's fundamental human rights should not be the decision, unless it is unavoidably forced upon us. Anything else is better and this shouldn't really need to be said, should it?!

My final point here is: every time this happens, it creates a knock-on difficulty and just shifts the pinch-point around the overall system. It will continue to do so unless we alleviate the need to improvise in this way. And ultimately, it all comes back to factors way outside the control of the police but whilst leaving them responsible for decisions that were taken in strategic healthcare meetings months prior to the pressure. What is perhaps most interesting to me is the apparent assumption that the police always can and always will to expend resources remaining with patients for days on end whilst beds are found. Not only can the legal issues outlined above be compelling, managing overall demand at a given time may mean the ongoing detention of someone who should, by then and by law, have been safely detained in NHS care is not the biggest priority they face.

It's again time to decide what the police are for and whether we value fundamental human rights in practice as well as in theory.

8th April 2018

Draft Mental Health Strategy

This is an opportunity to comment upon a draft strategy for policing and mental health, which is being put together by Chief Constable Mark Collins, the National Police Chiefs Council lead on mental health.

Please feel free to distribute this public document around as you see fit, including on social media or within any organisation to which you are connected if they may have an interest.

In addition to circulating this formally to partners and encouraging even further circulation by them, we are putting this out on social media as the quickest way of securing broader public feedback and in order to distribute it as widely as possible to frontline professionals in policing and other public sector agencies who might not see it through official channels.

A few explanations of the document which is linked below –

- It is just a plain text format word document – the final edition will be a colour document that looks much more professional than this. Feedback is requested on the actual content.
- Consultation within the police service brings us to this penultimate draft – we are not aiming to highlighted every issue that could be mentioned; but to focus on some key issues whilst laying down some important principles and objectives.
- The purpose here is look longer term and to shape the role of the police service in our wider system of public service – **did we get this right?**

For various reasons, I'm afraid the turnaround for any feedback is regrettably tight, should you wish to offer your view. If someone would like the document in a different format, please contact me on the email below.

You can either leave a comment below, as I will take them all in to account, or leave feedback more formally via my College of Policing email address –

Please click here –

Draft National Strategy on Policing and Mental Health.

23rd April 2018

Policing is Not The Problem Here

Policing is not the problem here: the extent to which we rely upon policing – *that's* the problem. This doesn't not mean the police have no role to play, that the police are perfect and that we should never rely on them to act as society's safety net. Sometimes it is inevitable the police will be the first point of contact for someone in mental health crisis and we are right to expect officers and their organisations to be competent in ensuring immediate safety and appropriate referral to relevant forms of assessment and support.

Nor does my argument mean that what the police know about mental health issues in our society is irrelevant and uninformed: the police see things that are outside the norm and we know like no others what it's like to be that safety net. This gives us an insight in to how mental health issues operate in society that is different. If you doubt this: imagine what it's like to be a police officer at 3am on a Thursday trying to use s136 of the Mental Health Act and finding, for all intents and purposes, that our NHS is closed and that when things go wrong, you may find you're being asked questions under criminal caution even though your actions complied with the policies that were set down in your area.

Here are some thoughts, in summary: the detail that sits behind this little off-load is elsewhere on this BLOG, spread across countless posts –

- Almost all of the major untoward events in policing and mental health, reveal failures or omissions in health, as well as in policing.
- This might be about the days and weeks preceding the police contact or it may reflect the difficulty our healthcare system faces in offering real-time support to our officers when they must act as that safety net.
- How soon can we involve other agencies and have them take responsibility for the slower-time decisions which follow the intervention of the police? – that time span is often measure in hours or days, when the theory and the agreements suggest it's there within minutes.
- More than a few police officers who have found themselves in criminal courts of gross misconduct hearings accused of wrong doing have had to point out that their actions, largely or entirely represented compliance with local policy and procedure, often set down by the

NHS and endorsed by senior officers who didn't necessarily realise what was wrong.

- In fairness to our bosses: why would they realise?! – they thought joint policies were about adopting practice based on NHS expertise. Turns out, there was a deliberate and fairly subliminal strategy to push risk, liability and often cost towards policing against the direction outlined in national guidelines.
- Major reports on policing mental health make far more recommendations about the health and social care systems and their interface with policing than they do about policing itself – see the *Adebowale Report* and *Angiolini Report* as just two recent examples.
- I'm yet to learn the detail of a death in police custody where I did not end up being just as concerned with healthcare provision or policy, if not more so, than I was with the policing response.
- Any focus which is *just* on policing and a need to improve it, is missing the point – almost *entirely* missing the point!
- We seem to have fallen for the seductive trap in thinking that what we must focus on is improving police responses through training and partnerships – I think this is merely 'doing the wrong thing righter'.
- You can have as much early intervention as you're prepared to pay for – and if you don't pay for it, you'll just end up paying more anyway, ensuring ever-later intervention with blunt tools which are far more likely to go awry.
- We can make a choice to do things properly, or not – it would probably end up being cheaper, if we did.
- And we all too often choose 'not' because the lessons of things gone awry are learned the hard way in policing, if they're learned at all; but they are rarely learned in 'health'.

To entirely misquote and misconstrue Carl von Clausewitz's aphorism, "Policing is a continuation of healthcare, by other means." Just like war can represent a failure of politics, policing mental illness can represent a failure of social justice when it comes to ensuring timely access to relevant care and support. If *all* we are going to do is focus on what is wrong with policing when it responds and improve *that*, we might as well pack up and admit we don't care – policing is not the problem here: the extent to which we over-rely upon policing is the problem here. We must rely upon it less as a *de facto* mental health service, without pretending that there is no role for officers to play – and if we don't, it will cost us more and lead to poorer outcomes. The police service cannot, on their own, make that happen – the choice is for others to make and they do make it, even if just be default of the *status quo*.

Earlier this week, I had to listen to a phone call made to a mental health crisis team and whilst the content of that call is not my story to share, I was nothing other than stunned to hear for myself the reaction of a mental health professional to a request for some support: "ring 999!" Absolutely

nothing within the incident suggested this was even vaguely necessary … indeed, it would have just set up the police or paramedics to fail. So let me put this another way: there is *plenty* that is visibly wrong with policing responses we could spend our time fixing – and we probably will because it needs fixing regardless of what else we don't do. But when we've finished doing all of that, it will have had, at best, a marginal effect but it won't be able to affect all the outcomes we don't like where we've over-relied upon the police as a *de facto* mental health service.

Policing is not the problem here – the extent to which we rely upon policing: THAT's the problem here; and I worry that we will continue to make deliberate choices by default, as we have for decades, to make this problem worse, not better by focussing on the more obvious, but secondary problem we face. And then we'll wonder why all the guidelines and all the training for policing made little or no difference, whilst failing to realising we didn't do anything about the *fundamental* problem.

28th April 2018

AMHP Emergencies

My esteemed blogging colleague the Masked AMHP has, in his latest post, addressed the question of whether AMHPs are an emergency service, rightly pointing out that a range of situations lead to demands that AMHPs suddenly jump in to action with their A5 hardback diaries, lanyards and well-thumbed copies of Jones to detain the vulnerable. I've enjoyed learning from many AMHPs over the years, our Masked blogger included, but I want to disagree with certain things in his latest post, in the spirit of inter-agency debate. I recommend you read the post first and that you become a regular reader of the Masked AMHP blog as it shines light on a role that many of us still don't fully understand, including other mental health professionals, on occasion. At least we, in the police, have some better excuses for any ignorance we may display!

The point is correctly made that AMHPs are not, in fact, an emergency service. Whenever an AMHP is called upon to act in that capacity, they can rarely do so alone and without reference to context. AMHPs may apply to detain patients under the Mental Health Act 1983, but they may not do so without a supporting recommendation from at least one doctor; and it will usually require two doctors, one of whom must be "s12 approved". We know that certain parts of the England and Wales have shortages of s12 doctors and that AMHPs can make as many as 25 phone calls to secure one, taking hours of time that would preclude any kind of rapid response to anything, frankly! I've also heard many AMHPs complain about the scenario referenced at the end of the post: hospitals shouting up on day 28 of a s2 detention asking for assessment for potential detention under s3 of the Act when it's rarely the case that such assessment was not predicted to be necessary a week earlier.

So I sympathise about the general point: AMHPs are not an emergency service, not least because they cannot simply dash out, replete with their AMHP kit and act. They are dependent upon others and in this day an age, they feel constricted by the general lack of beds which are available when MHA applications become required. I get it: and I've said publicly many times how much I admire the work AMHPs have to do, how I think they're underpaid for what they do and that I would not and could not do their role for even triple the salary. It would drive me to distraction and I'd end up losing my rag with people – frankly! But here is my point: the fact they are not an emergency service does not prevent the fact that AMHPs are key to

acting urgently in some emergencies and some of the arguments my esteemed colleague puts forward for his argument are the product of deliberate policy decisions that services have made over the last fifty to sixty years and not an inherent part of the Mental Health Act itself. Let me explain:

BEDS

It is pointed out that one factor affecting AMHPs from acting quickly and negating their ability to be relied upon as an emergency solution is the need for an inpatient bed in a relevant hospital, to which an application can be made. In fact, the MHA says nothing at all about beds and does not countenance the AMHP delaying their application at all, once the AMHP has decided that it is necessary to make it – this is contained in s13 of the Act. Of course, after a MHA assessment, an AMHP does not have to apply for admission just because they could apply for admission: application may be delayed where it is thought trying an alternative course of action is more appropriate for that patient. However, where an alternative is not appropriate and the AMHP has decided the application is required, s13 outlines that they "shall make the application". No mention of beds, or delays. They 'shall' act.

So relying upon the modern difficulty with beds, which is something entirely unmentioned in the Act itself, is nothing to do with whether or the MHA 'intends'. (NB: the intention of legislation isn't necessarily important unless the wording is ambiguous: where the law is not ambiguous but has been carelessly drafted to allow for interpretation beyond what was intended, it is the wording that counts – see the ruling in Cheshire West, for an example of this.). As reports have made clear, the key to ensuring beds are almost always available when required is having the proper balance of inpatient and outpatient services. Some areas, like Northumberland, Tyne and Wear MH Trust, have relatively few problems in this area. Meanwhile in other areas, there's a white board on the bed manager's office wall with a list of thirty names of patients who are waiting for a bed.

SECTION 4

Section 4 of the MHA is also mentioned in the context of AMHP emergencies: this is the lesser used of the civil admission mechanisms and our long-practising colleague has relied upon s4 MHA in only 3% of his applications. I've heard AMHPs say that it is their local policy not to use s4 MHA because it's not best practice but again, this is fallacious. Section 4 is on the statute book, its criteria for use are clearly defined and a situation either meets these criteria or it doesn't. I would argue that by not using s4 when a situation involves its criteria being satisfied is bordering on outrageous if it's purely because of a local policy preference to use s2 or s3

when the delay for a second doctor puts people at risk. That's hardly best practice and only last week I heard of s4 MHA being relied upon by an AMHP towards the end of a s136 detention because no s12 was available.

And be under no illusions: some people have unpreventably died amidst all the waiting whilst these discussions occur in the night about whether AMHPs are an emergency service; whilst others have been safeguarded by rapid use of s4 in the real world within one of hour some officer shouting up to argue for it. I'm really not clear why a junior police officer or paramedic should care one jot that partners would prefer not to use s4 MHA. I'd prefer not to use s136 MHA, but that's just my hard lines too, isn't it?! – it's part of the law and society may have a realistic expectation that I know about it and use it where the grounds are met.

EMERGENCIES

There are some emergency situations to which AMHPs are key. I've been at them. I've made the phone calls having to have the argument. I have had to cite s13 MHA to try to motivate the AMHP to remember there is a legal responsibility on the local authority to ensure an AMHP 'considers the need for an assessment'. This doesn't mean the AMHP must actually do an MHA assessment, but the local authority is obliged to ensure an AMHP can consider it. Obviously the answer has to be "Yes – an assessment is needed" or "no – an assessment is not needed." A reply that says, "We're not an emergency service" is not an answer to the question of whether an assessment is needed and is not a response to the duty in s13.

Some situations will simply not be resolved without AMHPs, notwithstanding that this will also be dependent upon finding a doctor and the resolution of the NHS's preference to operate in a way which prevents AMHPs complying with the law when they need to. There is nothing one way or the other in the Act which prevents AMHPs or their services setting themselves up in such a way as to be able to provide urgent follow-up to requests for assessments. There may be things in the real world that prevent this, such as AMHP recruitment and retention which is a real problem, but that could also be fixed without reference to the MHA by improving pay, conditions, and by resolving the non-legal matters that frustrate the hell out of AMHPs as much as they do the rest of us.

SOCIAL CONTEXT

We know that section 4 applications have happened after police attendance at crisis incidents and we know that this has sometimes been possible within one hour of contacting an AMHP for support. It can and it does happen, albeit rarely – and nothing in law prevents this. As with policing

and other professions: it is not just AMHPs who get to determine what AMHPs do. The law guides that, expressly or implicitly; the models of care we operate drive that because no-one would seriously argue the only thing to have changed in AMHPing since 1959 is the name we given that professional and the number of assessments undertaken. As policing has been obliged to get more involved in this territory, we've seen how the under-funded mental health system often attempts to make 999 services responsible for resolving things they couldn't resolve even if they wanted to. This includes some situations where the real solution is AMHP-centred – like providing an efficient and adequate follow up to mental health emergencies in private premises.

I've dealt with countless cases over the years, some of them extremely high-risk, high stakes events involving extremely vulnerable people, some of them barricaded in their own bedroom with knives in circumstances where they post an obvious risk to themselves and others; as well as having given evidence in Coroner's Court about a case where 999 crews were entirely powerless in law to safeguard a man who everyone involved believed needed *urgent* safeguarding the legal answer came back to the need for AMHPs, a DR and potentially a s135(1) warrant. Accepting the view that these things can take time: I also know that by me throwing resources to assist the AMHP (a fast response car and qualified driver!) we've gone from '"completely struggling" to "sorted" with AMHP on premises with doctor and warrant in less than an hour.

Despite what everyone thinks, the ambulance service are not an emergency service either (as defined) – neither are gas companies or water utilities but they obviously do deal with emergencies and they recognise they must plan and prepare for that reality in their work.

MAY 2018

1st May 2018

Interim Report: MHA Review

At 10am on 01st May, the interim report of Professor Sir Simon Wessely's review of the Mental Health ACt 1983, commissioned by the Prime Minister in late 2017, will be published.

If you check the UK Government website after 10am on 01st May, you will be able to access a copy of the report. I had a copy of this report last week and for what it's worth, I think it's as good as I hoped it could be for an interim update and I'm pleased to see the police role in our mental health system highlighted as it is, especially given the review's observations about how that role has become what it is.

This very short post is just to provide the link to it – I will blog on this later once the report is public and I'm freer to say more.

7th May 2018

Interim Report: MHA Review

Last week, Professor Sir Simon Wessely published his interim report after being asked in 2017 by the Prime Minister to look at the Mental Health Act 1983. A lot of people have been interested in this since the moment it was announced – a lot of people have a vested interested in this, full stop. It's important stuff and I don't think I under-estimate things when I say that the state of our mental health law partly characterises us as a country, because it speaks to how we see ourselves looking after some of the most complex and most vulnerable people, at their most difficult time. By Christmas we'll have absorbed what Sir Simon is putting forward as his final recommendations.

A review of what we've got raises some of the most fundamental questions: when, if ever, should the state take away someone's autonomy and, potentially their feelings of dignity and self-respect? When, if ever, should we force people to receive treatments against their will – including treatments where even psychiatrists themselves are unable to agree on long versus short-term benefits? Should our law be 'capacity' led legislation: that you should be allowed to take any decision as long as you have capacity to do so? – plenty of patients and mental health professionals of various stripes will say some people are subsequently thankful that someone took control of their welfare and wellbeing when they were at their darkest point and that pure 'capacity' based legislation will cause some people with certain kinds of mental health conditions to die.

For me, I was just really glad to see that the police were included in this review early. We have remained involved throughout and you'll notice in the interim review, that the police and policing will be one of several special interest groups in the second half of the review. My boss, Chief Constable Mark Collins is the policing lead for the National Police Chiefs' Council and he's submitted various ideas to Sir Simon for consideration, as well as various problems we'd like to see him address in some way, and been an active member of the Advisory Group referred to in the report. So, we're in there trying to help people understand what an important role the police can play, but how we are probably over-relied upon already.

POLICING

The report isn't that long, as these things go – barely 60 pages by the time you strip out the standard guff that all reports have! Policing is covered in section 7.4, page 24, but you'll have to excuse me copying it all here as I'd like you to read it all –

"The police recognise that helping people with mental health issues is a part of their core business. The police are key partners in the community-based model of mental health care. This is particularly true in cases of immediate responses to people in mental health crisis, where the police have specific powers under the MHA to section people for short periods of time under sections 135 and 136. The use of these powers has remained at a high level over the last decade. This underlines the importance of the police role, but also challenges the NHS to ensure that services are available and ready to take over responsibility at the most appropriate time.

The contribution of police officers to crisis care has been praised by the CQC, but nevertheless should not have to make up for gaps in health care provision. This is especially so because for many people, interactions with the police can be upsetting and stigmatising, and at the very least not therapeutic. This is particularly the case for certain BAME [Black and Minority Ethnic] communities, such as African and Caribbean individuals. There has been a significant reduction of the use of police custody for people held under section 136 but not yet enough to end this practice entirely.

Another emerging issue is that people who are arrested under criminal law stay in police cells for too long after an approved mental health professional (AMHP) has decided that they should be admitted to hospital. It should be a matter of principle that those who are unwell should be treated within the NHS rather than a police cell. This principle should extend to the transportation of service users under the MHA which should under most circumstances be conducted by NHS ambulance services.

We believe that the care of people in cells is as much an issue for health and social care as it is for police. We will consider whether NHS England should take over the commissioning of police custody health care services, or otherwise create a plan so that people in police custody get better care, and faster transfers out to NHS and social care services.

Finally, but crucially, equality issues are of the utmost importance when it comes to all police work, and we will consider how new approaches and innovations from forces have helped to address the experience of people from BAME communities who come to the attention of the police when needing mental health support.

We will consider further:

- *How recent legislative changes to sections 135 and 136 are changing service approaches and whether it is right to bring an end to having a police cell designated as a place of safety. If so, what safeguards and resources are needed to do this safely?*
- *Why people who are arrested under the criminal law are staying in police cells for too long after an approved mental health professional has decided that the person needs to be admitted to hospital, and what can be done to address this.*
- *Why police vehicles rather than ambulances are still transporting the majority of people under these sections, and what can be done to address this.*
- *The practicalities and benefits of NHS England taking over the commissioning of health services in police custody, as has been recommended in both the Angiolini and Bradley reports.*
- *Equality issues, particularly police interactions with people from BAME communities under the MHA.*

This covers the main issues that police forces and police officers raise with me, when they are asking questions that come down to the problems with our mental health law. Others might include addressing, in some way, shape or form, the very real problem that the UK currently cannot ensure the right kinds of professionals respond in a timely way to someone in a house when they are in crisis – do we also need to look at how we safeguard people in their own homes when they are at risk?

IF I MAY?

If I were to offer an observation as someone reading the report and trying to think from the outside, as if I hadn't been to the meetings or discussed this at all, I think I'd wonder aloud, as I am constantly doing at the moment, about whether the problem to be fixed in policing is the issue of NHS support, delays in achieving that support (for beds, for conveyance, for place of safety spaces, etc.) or whether the real problem is the extent to which we appear to over-rely upon the police as a de facto mental health care provider. The fact that the police are praised for their contribution and that patients themselves report the police as displaying a better attitude towards them and their needs whilst they are in crisis, is welcome, but not relevant to me. My decorator is nicer than my plumber, but when the heating goes in my house, I'm not ring the guy with the brushes and roller.

One thing that's been obvious throughout this review process, including the various comments I've seen from those of us with mental health problems on social media, is that many of the things that people 'want' are not, directly, issues with legislation. They are issues with resources: ahead of

going to one of the first Advisory Group meetings, I asked on social media what people and police officers would like to see. Often, the answers were things like, "Crisis Teams that can actually respond in a timely way when there's a crisis incident" or "more inpatient beds", etc.. Of course, you could have both of those now, without changing the Mental Health Act itself – the NHS just needs to take the necessary action to increase staffing on crisis teams and to open up more beds. (Before anyone attacks my use of the word 'just', I am aware of the nurse recruitment problems, funding cuts, etc., etc.. – I use the term to distinguish between choices that could already, in theory, be taken and choices which require amendments of primary legislation.)

So I'm fairly happy enough so far, because a special interest topic group in Phase 2 of the review is bound to get in to the detail of these things and for what it's worth: I know Sir Simon, who took some flak on social media for even being appointed to lead this review, is trying hard to do the impossible. From whatever perspective you want to look at this, it's a near-impossible job because when I sit and listen to those parts of the discussions and debates that don't professionally concern me, I can see there are many people passionately arguing their case for things which are equally passionately opposed by others just across the room. It doesn't matter what he does or what he recommends here, he is going to disappoint plenty of people for daring to even suggest certain things and for not daring to do so. And whoever was chairing this review, they could be accused of vested interests as well. All I can say is this: it looks to me from the parts I am seeing as if this is being done as fairly and openly as possible and that the various conspiracy theories I hear are ill-founded.

Let's now see what the second phase brings.

20th May 2018

My Health and Yours

My healthcare, and that of my family and friends, is absolutely none of your business. None whatsoever, with all due respect! Yours is none of mine and I'm only professionally interested in a very limited and particular way.

I've been asked a few times whether I'm interested in this area of policing because I have personal experience of mental health problems, or perhaps via a good friend or relative? That's none of your business, as I've said. This reply should not be used to construe that the answer is 'Yes' and that I'm trotting out privacy rights in order to avoid revealing things. To be honest, I'm trotting out my privacy rights (and those of my friends and relatives) just because I can and because it's up to me whether I reveal things about my or their health. I'm afraid, I'm a bit like that – private, contrarian and rather fond of my rights as well as being very content with the attendant obligations that always accompany rights. It's my decision what I choose to reveal about my healthcare and it's not for me to reveal things about the health of my friends or relatives without their consent or another damned good reason.

If you're asking, last year, I did have a small health problem and it was my wife who pointed out something I hadn't realised: that this was part of an emerging pattern which could be a greater cause for concern. Seemed like wise advice from her, so off I trotted and the Doctor gave me some malady-specific advice and medication in addition to one of those fat-man-over 40 MOTs which I'd managed to avoid for three years and it all helped in the short-term whilst putting my mind at rest about a range of other things you start thinking about when you're a bloke over 40 who rarely goes to the doctor. But when it was more recently suggested I might go to a doctor for another reason, I exercised the right of every sentient person to laugh at the very idea of it, munch on some painkillers and crack on. I have been known to make doctor-related decisions without prompting from anyone else, to take complete responsibility on my own, too – to decide to go to the Doctor without any outside support or encouragement from anyone.

That's enough of my medical history and it was my decision to share that much of it with you – as was it my decision to keep details about particular maladies private! It's none of your business, obviously! … I'm sure you're getting the hang of this already! This is the thing about healthcare, and other aspects of our personal lives: it's private stuff and we can all choose

from where we take advice, whether we act upon that advice or whether we reject it all and do our own thing; and whether we tell the world. Ultimately, it's up to individuals to make decisions about their health and their healthcare – most of the time. It's almost never going to be your responsibility.

CAPACITY AND CULPABILITY

Obviously, there are circumstances where these important principles are compromised. Children have far fewer individual rights in these situations and their parents or guardians routinely act on their behalf. Some adults can't take decisions about their own health, because of injury or illness – if you've just been knocked over and knocked out as a pedestrian in a traffic collision, you'll probably want your friends and relatives, or helpful police and paramedics to start making decisions about what they think is in your best interests and act accordingly.

You can also imagine that if your healthcare issues are driving your behaviour to a point where it affects others, we may expect the police to step in and then work with healthcare professionals to determine what must be done. Do we prosecute the drug addicted burglar or robber, if they are offending to fuel their chemical dependency? – of course, we most usually do. We also do this in some cases where a person has experienced psychosis, but most usually in those rarer cases where they've hurt someone else or been found in unlawful possession of items which could be used to cause harm. History shows we do incarcerate people in prisons and in mental health units who pose a risk to others because of their health and addiction issues.

So you could summarise all of this, more or less, as follows –

Decisions about the healthcare of sober, conscious, non-vulnerable adults who have not broken the law is ultimately a matter for them and not for anyone else.

ADVICE AND GUIDANCE

Most of us reject healthcare guidance to one extent or another, whether that is because we eat too much, drink too much or exercise too little. I'd be genuinely interested to know how many adults of working age could say they moderate alcohol within Government guidelines, whilst taking the relevant amount of exercise, eating their Five-a-Day portions of fruit and vegetables within the recommended calorie limit, etc., etc.. We recognise that our autonomy allows us to reject advice because most of us do on at

least one of those areas, even where the advice is based on the best available medical and scientific evidence.

So what's different in policing or medicine, where someone's healthcare decision isn't perhaps what we, as professionals advising and guiding, would hope they do? How many police officers and paramedics attend a mental health incident where things are not so serious as to justify restrictive and coercive interventions but where we find it difficult to accept the decisions of people who are nonetheless vulnerable, even if just in our view, if they are rejecting advice. I've recently heard a few police officers talking about how they still have to 'do something' in a situation where they've (correctly!) established they have no legal powers to override someone's autonomous and, no doubt, unwise decision.

But here's the legal nugget of this post: an unwise, even stupid decision can still be lawful – a person does not lack capacity by virtue of wanting to behave in a reckless or dangerous manner with regard to their own health. You want to stop taking medication, or walk out of A&E before treatment is completed; you want to decline an ambulance trip to hospital after you fell – all of this is a matter for you, not me … subject to those caveats of whether you have capacity to take your decision; and whether your behaviour amounts to an offence which is impacting upon the rights and safety of others. (And by 'rights', I mean the actual legal rights of others, not the ones we make up to justify a moral intervention that has little basis in law.)

GOOD REASONS

Final point: some people have reasons for healthcare decisions which are profoundly important to them and which are morally and intellectually sound, from their perspective. The fact that any professional may disagree and even think the reasons risible, is neither here nor there. If you doubt this, look at the kidney dialysis / paracetamol overdose case where a lady refused treatment because she didn't want a live of relative poverty and loneliness 'in a council flat' getting old. Doctors at the hospital argued that she lacked capacity to take decisions for herself and the Court of Protection rejected this, citing an earlier case –

"An adult patient who… suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered," … "This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."

There are lots of examples in policing where we assume that the right thing to do is to take healthcare choices away from people where we would, perhaps, be better advised to help people make choices for themselves. Once someone is under arrest or detained under the Mental Health Act, things are different, but prior to that or where such thresholds are not met, it's actually none of our business, beyond ensuring people have been advised or sign-posted to options they may not have been aware of, which they may or may not find helpful.

Your healthcare choices are a matter for you – and that means public professionals should respect your right to make your own choices, even if they can't respect the choices themselves.

JUNE 2018

3rd June 2018

Attention to Detail

Last year, the National Institute for Health and Care Excellence (NICE) published their Standards on the Mental Health of Adults in the Criminal Justice System. This involved NICE reviewing the best available evidence and practice around the contact that vulnerable adults have with the criminal justice system. Subsequently, NICE published what they call a '*quality standard*' – this is the subject of a comment piece in the recently published issue of *Progress in Neurology and Psychiatry (volume 22, 2018).*

I've just spent a whole week in Cornwall (picture above), trying really hard to step away from work – it's been quite a busy few months during which I've had to do things which are quite new to all the work I've ever done on policing and mental health. I've also been consumed in the recent months that the net effect of what we've ended up doing to make the world a better place is merely making it worse. Not just slowing down how much worse it's getting – but actually accelerating things in the wrong direction. I know it's not a view that many people share; I'm very aware of all the mantras that come out when these kinds of views are articulated – that the only way to do things is in partnership, etc., etc.. So upon return from annual leave, I read the comment piece about the NICE Quality Standard and found, yet again, reason to question those kind of underlying assumptions and – like the reports I've had to write in recent months for various legal processes after deaths in police custody – I found myself wondering about attention to detail.

I need to repeat one more thing, about which I'm at risk of becoming really boring whilst I drip like a tap: if you think that the work to be done here is improving policing and criminal justice responses to the mental health demand that we face, you're fundamentally mis-identifying the problem. The problem here is not the police: it is the extent to which we deliberately rely upon the police to triage and gate-keep mental health demand that we increasingly decide should be criminalised. We rely too much and we need to work out how to stop because having just spent the last fifty or sixty years gradually and subliminally shifting institutionalised mental health demand from health to prisons and then regretting it; we need to make no mistake we are now seeing a similar shifting of crisis and community care from health to police and probation. And this Quality Standard and the arising expectations in comment pieces are just helping us reinforce this, in my own strictly personal opinion.

110 RECOMMENDATIONS

The comment piece claims that the Angiolini Report (2017) contains *"110 recommendations for improving the way that the police manage vulnerable people at the point of arrest".*

No, it didn't – did the authors of the piece actually read the Angiolini report?! It contains 110 recommendations (see page 235 of the report – they're all laid out, one by open) and you'll notice the majority of them do not relate to the management of vulnerable people at the point of arrest or contact. Those which do relate to that, barely relate to the police – they relate to the National Health Service and its need to improve accessibility and its interface with policing. Around 70 of the recommendations relate to processes *after* a death in police custody has occurred; processes connected to investigations carried out by the Independent Office for Police Conduct, to the whole coronial court process and certain specifics, such as a call for families who are bereaved after a death in custody to have access to Legal Aid.

If you look at the roughly 40 recommendations which do relate to how vulnerable people are managed, you'll see that fewer than 10 relate to matters over which the police have *sole* control. In other words, most of the 'Angiolini recommendations' are about improvements in post-death procedures; less of it is about preventing deaths from happening in the first place and those which do have that bearing are about how accessible our NHS is.

POLICE CELLS

The comment piece correctly states that Angiolini claims *"Police cells should not be used to hold those detained under mental health powers."* This is correct – it does call for that. But it goes on, *"The NICE Quality Standard seems to accept that this sort of change will be a lengthy process"* and *"that procedures can be put in place in the interim, to keep people in custody safe and minimise any potential unnecessary harm."*

No, no, and again, no – history and evidence shows it cannot and it shows that moving to a position where areas do not rely upon police cells as a Place of Safety can occur in a relatively short period of time, given the will to achieve it. Areas without any Place of Safety provision at all have shown it is possible to get from nothing to working in a matter of weeks. I've been part of making this happen and these services still exist in the real world, where no-one is taken to police custody whilst detained under the MHA, **ever**. Yes, it will take careful multi-agency working and a commitment by Chief Constables to perhaps take more than a fair share of the resourcing

in the interim transition period, but it's possible. See West Midlands Police, for details.

In the comment piece, little mention is made of prevention, yet this is the bedrock of most crime reduction and public health strategies: so how do we prevent vulnerable people from getting to police contact in the first place? You could be forgiven for thinking that the authors have assumed all CJ contact is unpredictable, unpreventable and unavoidable demand where the task, as outlined in the Quality Standard, is merely to better respond to what is happening, primarily through the medium of improved policing largely dependent upon improved training and competence. These are the standard traps to fall in to – look at s136 data, look at street triage data, look at Liaison and Diversion or arrest data: those I've analysed show that most of the people in contact with the police are non-offending, known patients with requirements best satisfied by the NHS and which do not, for the main part, need the police at all. And of course, the fact that policing and criminal justice can be an anxiety aggravating, even pathologising process is left more or less untouched.

And as for 'accepting' lengthy process: the Code of Practice to the MHA has called for the use of custody to be 'exceptional' or a 'last resort' since at least 1999 – is two decades enough to ensure that every area of England has a ligature proof room? Just think of how many far more complicated things we've managed to sort in much less than two decades and then ask yourself whether the urgency of tectonic plate shift is inevitable.

THE QUALITY STANDARD

There are four planks to this thing: my own view is that it reinforces that responsibility mainly rests with the police and it relies heavily on this mantra we repeatedly here in the UK and elsewhere: that the most important thing we can do is give the police more training. It's as if policing is all that's gone wrong here. "Training for police officers to use non-contact and appropriate communication styles with disturbed individuals is clear available, but like the introduction of body-worn cameras, is probably not consistent or mandatory." I'll again be honest: the irony of NHS professionals highlighting inconsistency in policing is not lost on me after I learned that there are 27 different training courses *in London alone,* for restraint in mental health nursing. And of course, none of them are operating to a validated standard. Then add to that the 57 mental health trusts being commissioned by over 210 Clinical Commissioning Groups so that even one mentla helath care provider trust is not providing a consistent service across two different CCG areas and that this is because *the NHS want it that way*.

In policing, despite 43 different territorial police forces and a few other specialist ones, we have one personal safety training manual and all police forces operate to it. They may run their officer safety training in different ways, combine their OST with other things like first-aid in some forces, but not in others: but it's one national standard around the use of force and for all of my twenty years in policing, it has emphasised verbal communication and de-escalation.

A quick word on Liaison and Diversion teams, seen by Lord Bradley as key to whole diversion / criminalisation thing. Around 85% of the population of England is now served by a LaD scheme. Many of them operate on the basis of referrals made by the police to the nurses on duty in custody. I've known areas look for ways to improve the number of referrals made by the police, because of an ongoing suspicion that the police are 'missing' some vulnerable people in custody. Of course they are! – they always were and they always will. Doctors with access to medical records get this stuff wrong when they have hours to assess someone, so I'm not sure what standard the police are being held to, if I'm honest, when they often have minutes to make decisions about who is vulnerable.

THE WIDER PICTURE

"The true challenge is not knowing what to do". I couldn't possibly disagree any more profoundly with this. I meet people regularly who do not know what to do – have no idea of what is possible and think their problems insurmountable. But one thing I can agree with, is the comment's view that *none of this stuff is new*: they mention the *Reed Report* from 1992, and the *Bradley Report* from 2009. We've since had the *Adebowale Report* (2013), the *Home Affairs Committee report* (2015) and then the *Angiolini Report* (2017). In between all of those, we've seen countless individual Coroner's inquiries, human rights cases, IOPC death in custody investigations, which all raise similar issues … over and over and over, again and again and again.

This would almost be boring if it weren't for the loss of dignity, safety and humanity – the extent to which the learning is there to be had, but ignored. Instead, a preference of pushing an agenda that may help at the margins but doesn't address the core issue of why were are increasingly seeking to criminalise vulnerable people as a gateway to healthcare? We did it to prisons and probation and we're now doing it to the police. Until we stop just looking at the police, calling for ever greater levels of training and start looking at why vulnerable people come in to contact with the police in the first place, we're going to keep getting our analysis of this wrong. And of course, I would suggest we have for far too long.

So, we're off to a flying start to my return from leave! – the mission for us all is to combat the covert criminalisation of vulnerable people which

emerges from the unintended consequences of public policy being disaggregated, yet run on the pretence that we need to improve policing and police training which ultimately, at its best, is just an overly attractive half-truth. If you think otherwise, then I suspect we're trying to fix different problems.

10th June 2018

The Forensic Route

When we hear mental health professionals talking about someone going 'down the forensic route', they mean a patient with healthcare needs being managed under Part III of the Mental Health Act 1983. This Part of the Act includes all those sections from 35 to 55 and it covers a range of provisions for the criminal courts and the Ministry of Justice to manage those offenders who are thought to be seriously mentally ill and in need of treatment, whilst their case progresses through the criminal justice system.

So, if you don't mind, we need to get rid of one really important issue very quickly, before talking about issues around forensic options: if the police or CPS are yet to prosecute someone for any alleged offence, Part III is of no application whatsoever to that patient, no matter what their 'risk status'. There are plenty of people walking around in society today that I think are dangerous criminals and I'd prefer they were behind bars for my family's and your safety, but until I can get evidence to prosecute them for something, it's a risk we all have to bear as the general principle of our justice system is that we would rather have guilty people at liberty than innocent people in prison.

THE CRIMINALISATION CONTINGENCY

First things first: when someone has gone down 'the forensic route', they will most usually be managed initially within a secure hospital, often categorised as low, medium or high secure. There are four high secure hospitals in the United Kingdom: Broadmoor in Berkshire; Rampton in Nottinghamshire; Ashworth in Merseyside and Carstairs in Scotland. Typically there are several 'medium' secure hospitals in every region of the UK, some specifically for women, some for children, most for men as male patients make up the bulk of the secure patient population – just like men make up the bulk of the prison population. Many of the people in these hospitals are their during their transition through the criminal justice process, on 'remand' for psychiatric reports or for treatment pending trial (sections 35/36) or they are there as a consequence of sentencing under various kinds of 'hospital order' (sections 37, 38, 41 and 45A). Secure hospitals are also the place to which remanded or convicted prisons are transferred if someone is identified in prison has having become sufficiently ill to require inpatient mental health care. So Part III MHA contains

provision to transfer remanded or convicted prisons (sections 47/48) and to transfer them back again, if necessary (s50).

Now, there is nothing in the Mental Health Act itself which demands that secure hospitals can only be used if the patient is in the criminal justice system. Nothing in the law prevents a 'civil' of Part II detention in a secure unit. This would be someone who is detained under section 2, section 3 or section 4 of the Act but who is deemed to need to kind of 'therapeutic security' that can only be delivered by our secure hospitals. So to give you a real example to hang your hat on, Ian Huntley (who murdered Holly Wells and Jessica Chapman) was taken under s2 MHA to Rampton hospital from the police station he'd been taken to after arrest. Whilst at Rampton he was prosecuted for murder and the trial process took its place.

The argument that secure hospitals can only take forensic patients is one I hear a lot and I'm blogging on this today because an AMHP asked my view on all of this during the AMHP Leads event in London on Friday. A murder investigation had begun and because of concerns about the suspect's mental health, a mental health act assessment had concluded and formed the view that the patient required admission. However, the NHS had stated that the man would need to be prosecuted and 'go down the forensic route' because he was accused of murder and, to quote the AMHP, "no hospital in the country will take someone accused of murder unless they've been charged." I've referred to this before as 'the criminalisation contingency' – the suggestion that you can only access certain kinds of healthcare if you've been prosecuted and that unless you've been prosecuted you will be denied access to this care even if you needed it.

PARITY OF ESTEEM

Meanwhile, criminal investigations involving vulnerable suspects are occurring. In many cases less high profile than Ian Huntley's, the suspect is 'sectioned' under the civil provisions to a secure hospital and the police investigation then concludes at some stage. Where necessary and once authorised by the CPS, the police then charge the person and they appear in court. At that stage, if necessary, the defendant is then remanded under Part III of the Act. A good example of this in case that did make national headlines at the time, was the murder of Christina Elkins in March 2013. In that case, Philip Simelane was arrested on the Thursday Christina died and on Friday afternoon he was 'sectioned' to Reaside Clinic, the main medium secure unit for men in south Birmingham. The following week, once there was evidence to charge him, West Midlands Police went there to complete the formalities and in due course, this s2 MHA patient was 'produced' to the city's Crown Court for his first appearance.

Interestingly in this case, they had made a special arrangement that Mr Simelane's first day at court would involved two hearings, one straight after the other: a Magistrate first handled his initial appearance, sitting in the Crown Court room; then judge heard his first Crown Court appearance. All the while, Mr Simelane was still in Reaside Clinic, appearing by video link. The reason for this is to do with technicalities of the Mental Health Act. Magistrates cannot remand patients to hospital under s35 MHA until the defendant's guilty has been admitted or proved; Crown Court judges can remand after someone's first appearance. By having successive hearings, it prevented a situation in which the Magistrates may well have ended up remanding the seriously unwell defendant to prison where he would then be subject to normal delays to be transferred from prison back to Reaside under s48 MHA. (If you want to understand the extent of the problem of seriously unwell people in prison, read *Insane* by Alisa Roth (2018) or just look at the image in the header from the Economist article on moving the institutionalisation of the serious mentally unwell from health to (US) prisons over the last fifty years – Britain is doing similar things!)

All clear so far?! … good! (It sinks in eventually, you might just need to read it a few times!)

Of course, in other cases, the problem is the one I hinted at nearer the start: that serious unwell, potentially very dangerous patients are arrested for offences and assessed under the Act, but there is not enough evidence to charge them with any offence by the time they've been deemed to need admissions.

A real example will probably make the point clearer:

THE BODY UNDER THE FLOOR

Stephen Devesey was convicted in 2012 of murdering his ex-girlfriend, Nicole Cartmell in 2011. He was arrested at a premises after officers undertaking routine enquiries in to her being missing attended the address in Birmingham and discovered her body. Twenty-four hours or so later, he had been deemed to need admission to hospital under the MHA and by that stage, all the Senior Investigating Officer could prove was that Stephen had been in the house at the time the body was found. There was no direct evidence linking him at that stage to her murder; various forensic enquiries were still ongoing and he could not be interviewed because of his health. It was going to be necessary to bail him for further enquiries, let his health improve so he could be interviewed and question him once all the relevant background information and evidence was gathered.

That's when it happened: "Sorry, sarge – we can't section him because he needs a secure bed and he can't have one unless you charge him with murder". That's when the SIO rang me at home for advice. At that time, and still today: some MSU's or forensic psychiatrists argue that secure beds cannot be accessed by people who are under arrest in police stations, that they are reserved for patients who are in the criminal justice system already. And it does beg the question: what do we do with someone like Stephen? … the working theory is he's probably killed someone and the clinical risk assessment is he needs secure care: but there simply is no evidence (yet) that he is guilty of an offence. The evidence may be likely in due course; but it doesn't exist today. So, by law, he cannot be charged. But he could be 'sectioned' and it's only trust policy or forensic policy that he cannot have a secure bed.

Since 2011 and that case, West Midlands secure services, police and CPS have sat down together many times to discuss this an other issues, which is why when Mr Simelane was prosecuted a year or so later, a process existed by which to ensure he accessed secure care without being charged and was then brought to justice once the evidence was there. This demonstrates very clearly that this was nothing whatsoever to do with the law and everything to do with cultural practice in the NHS, which probably evolved for good reason, but which was too rigid for the reality of the world. Very pleased to say that when I gave these kinds of examples at a study day yesterday where Professor Nigel Eastman was present (unarguably one of UK's foremost forensic psychiatrists), he totally agreed that denying access to secure services for Part II patients with relevant risk histories was bizarre.

The forensic route is fine for people who are charged with offences – what about those who need that care but can't be charged?

13th June 2018

Capacity for What?!

It's rearing its head again: whether or not somebody has the 'capacity' to be a victim or 'capacity' to be a suspect. One thing that promotes a blog post is a conversation with someone who is noticing a particular problem and today's post is an example of that: an inspector who has been reviewing crime reports and crime recording standards, wondering if sometimes the police are too quick to try to latch on to misunderstood ideas of 'capacity', as a quick proxy for whether to record or investigate a crime. I think he's on to something here, as we've seen high-profile examples of this. It also flicks that switch of mine that 'capacity' is a legal concept to be discussed when referring to the Mental Capacity Act 2005 and someone's ability to take a particular decision for themselves when they be putting themselves at risk. But it's not really the thing to do when you're investigating a crime allegation to ask, "Does he have capacity?"

Let's just be really clear: it's a stupid question that tells you nothing because it doesn't mean anything in the context of crime; and whenever we're asking about capacity it has to be about capacity *for* something specific. Does the person have capacity to decline medical treatment for a head injury, for example – there is a legal way to work this out. But if someone with dementia, who doesn't know what day of the week it is and who doesn't recognise their daughter's face when she visits them, says they've been assaulted and hurt by care staff, it doesn't mean they're wrong and that it didn't happen just because aspects of their allegation or testimony may be questionable. Maybe the assault upon them was witness by someone else or caught on CCTV?! … perhaps there is other evidence that corroborates enough of the allegation for us to know the kernel of it is true, even if certain details are found to be untrue?

ASPECTS OF FACT AND TRUTH

Just because somebody in a care home says they've been poisoned, doesn't mean it isn't true – I know this because I dealt with such a report and the quick action we took on the night of the first report, including an arrest which allowed us to preserve evidence early on that may otherwise have been lost, meant someone was convicted of attempted murder and various related offences and jailed for life. If you remember the scandal a few years back at Winterbourne View, Bristol – we learned that care staff were

assaulting and neglecting patients and thankfully, eventually, they were brought before a court and sentenced for criminal acts.

But what we learned afterwards was, perhaps more important to the point I'm making in this post. When the whole matter had been reviewed, is that residents were calling the police to report being victims and they were less likely to be taken seriously because they were residents in a care home for people with learning disabilities who had all been assessed, by virtue of the fact that they were living there, as lacking the capacity to take certain decisions about their lives. In reality, when those people asked their police service for help, we ended up asking the offenders whether or not that request was something we needed to take seriously, and, oddly enough! – the offenders said, "No – it's just [insert name of resident], you know what they're like! Leave it with us officer."

Just because someone has cognitive problems doesn't mean that everything they say is in some way wrong or fabricated because of some feature of their condition. It may be the only empirically correct thing they've said all day, but if examined it may well be there is evidence to support that allegation and it's the police's role to treat all cases on their merits, make reasonable adjustments for disabled people – including victims and witnesses – and to try to go that extra mile to see if there is corroborative evidence that helps.

VICTIM SUPPORT

Several years ago, Victim Support published a report which taught us, if we didn't already know, that people with mental health problems and / or learning disabilities and other developmental conditions were more likely than most to be a victim of crime. Three times more likely, in all fairness. However, where those victims came to the criminal justice system for help, they were less likely to be believed by the police, when false notions of 'capacity' would creep in to assumptions about their 'reliability'.

This was then compounded further by our other criminal justice partners: CPS would be less likely to take a case forward even where the police did believe it should do so and courts were less likely to convict defendants whose victim was vulnerable because of assumptions about reliability of someone's testimony. Some may say, for example, that if a person whose grasp on the realities of their own life is such, that they cannot currently comprehend enough about events around them for their evidence to be compelling – and where a criminal prosecution rests on one person's word against another person's, there may be problems in proving an offence beyond all reasonable doubt.

However, what the victim support report also made clear is that insufficient use is made of best evidence procedures; and examples were given of where dogged pursuit of truth by some investigators of lawyers meant that corroborative evidence, even just corroborative circumstantial evidence, might make the difference between a case succeeding or not because the victim's allegation is buttressed by something that shows the allegation is not borne of something resulting from their condition.

PRESUMPTIONS AND ASSUMPTIONS

Ask yourself, to what extent does a victim's poor mental health or their learning disability cause you write-off reports prematurely? How many call handlers have had conversations with victims or their families or carers where they've heard the allegation of theft and then asked a professional, "Does he have capacity?" How may officers record a crime where an allegation has been made that cannot be quickly disproved and then written it up for filing on the basis that the victim 'doesn't have capacity'?

Well, a chance discussion with an inspector for HMICFRS today, caused me to think about this – he wants us all to ask more questions about this: how often do we make presumptions about someone's competence as a victim or witness based on knowing they have.a particular condition? And what do we know about people with the same condition? … they're ALL very different. As the National Autistic Society say, "If you've met someone with autism then you've met just one person with autism." Some people with autism are doing world-class, ground-breaking work in science and mathematics or running companies; others are unable to live their lives outside fairly restrictive institutions. Saying that someone has autism doesn't, of itself, tell you a damned thing about their agency as victims.

You could repeat all of that for every other condition: some people live with depression and they get up every day, take an anti-depressant and then go quietly about the business of living a life, raising a family and going to work. Others are trying to get through the day curled up in bed, unable to face the world and others are hospitalised. Saying that someone has depression doesn't, of itself, tell you a damned thing about their agency as victims or witnesses.

VICTIMS, WITNESS and SUSPECTS

And this is not a question just about those on the receiving end of crime: the same problems emerge for witnesses and a slightly different, but nonetheless related set of problems for vulnerable suspects. How often do you hear the question raised about whether a suspect 'has capacity'? I've covered these issues for suspects a number of times, but the point remains:

we can and sometimes do prosecute patients for offences who 'lack capacity' – so asking a capacity question at the start of an investigation is a quick route to missing an opportunity to protect the public from crime.

92% of people who offend whilst living with a mental health or learning disability problem, do so not because of their health or development, because despite it. This figure was mentioned in the 2017 NICE Guidelines on the Mental Health of Adults in the Criminal Justice System. Fair enough: we have to work out very carefully who are the 8% are! But even with that small group, there will be a minority of people who have offending so seriously or persistently, no doubt because of their illness, but who are such a risk to the public that prosecution is necessary to ensure a response that does afford them that right to access care,

So, a request from me: please stop talking about 'capacity' in criminal justice contexts – what we need to know is

- What is the allegation made?
- Does the allegation amount to a criminal offence, if true?
- Whether there is any evidence to corroborate it – could I get any evidence of that kind?
- Whether there is any evidence to support it – could I get any evidence of that kind?
- Then listen to what the victim is asking for.
- Weigh up the potential for arrest and prosecution, based on the evidence.

And challenge other police officers, too: 'capacity' has a specific legal meaning and it's not usually what we mean when we're talking about action taken to safeguard someone who is a risk their own health, for example.

17th June 2018

Let's Do The Maths

Look back to when I joined the police are you'll see that crime levels, measured either by police recorded crime or by the British Crime Survey, were much higher – but if you look at statistics on use of s136 of the Mental Health Act, the quality of them has not always been great, but what we do know, is they've mainly just increased year on year, from the first proper attempt at detailed stats in 2007, by the IPCC (as they were then called).

- **2007** = 18,500 detentions under s136, of which 65% were removed to custody.
- **2017** = 28,271 detentions* under s136, of which 3.5% were removed to custody.

** we know this figure was too low: Devon and Cornwall Police were unable to submit a return and they have historically reported approximately 1,400 to 1,500 uses of the power per year; and we know some forces under-reported their figures, so it's likely to be at least 30,000.*

It will be the autumn of 2018 before we learn the new figures for 2017/18, but it strikes me we're due to see another rise, potentially this time a touch steeper than before. And remember: these figures are rising despite the fact that in some areas, street triage has been attributed as reducing the use of s136 quite significantly. In Leicestershire and Northumbria Police areas, for example, they each used to use the power over 800 times a year and now are seeing just high double figures or low triple figures pre year (see image, above) with almost no-one going to custody. Between those two forces alone, they've reduced the use of s136 by almost 1,500 but we're still seeing an overall national increase. If you've checked Twitter today, you'll see, in just one division of Lancashire Police, they currently have police officers in A&E departments with three separate people detained under s136 and they have been there for fourteen hours, according to their Assistant Chief Constable who has tweeted about this. Just as I responded to him on social media, he mentioned that a fourth person has now been detained and there is still no available Place of Safety in a mental health unit. So that is another person heading to A&E, without specifically needing the services of an A&E department who, no doubt, are fairly stretched themselves with other demand. This is one police division only: Lancashire have three and there are other s136 detentions in the other divisions at the same time as this.

Now, to make a point that will be uncomfortable, but which I can't avoid making: we've been pushing for years to ensure that we don't take people to police custody, other than exceptionally. This is right for all manner of reasons which are well rehearsed elsewhere, including by me. But one thing we shouldn't forget, is that by not removing people to police stations we will **increase** the amount of police resource necessary to facilitate the process, *unless* the NHS sets up its place of safety process to comply with nationally agreed standards. And being frank: they often don't. I recently reviewed a s136 policy in a force area and it stated "it's best practice for officers to remain". This is actually the opposite of best practice, according to the senior signatories of every relevant organisation in the country. A vested interest, perhaps? – well, if your Chief Constable can be persuaded to do this for you, you don't really have to staff your place of safety at all, do you?! You can the revenue funding it would take to employ a number of nurses or nursing assistants.

IN CASE OF DOUBT

When I first joined, someone removed to police custody as a Place of Safety could often be handed over to the staff in the custody office and my partner and I would be back out on the street within an hour, maximum. Occasionally, one of us would have to remain in custody to do 'constant obs' or a camera watch and the other would be back out on the street, single-crewed for other work. Those enhanced level of observations may be necessary just until the doctor arrived to authorise a different approach, or it may last until the end of the s136 process, which would last ten and a half hours, on average.

If you open an NHS alternative, the assessment time is often reported as being a five or six hour process and unless the officers are able to leave within one hour – as agreed to be the national standard on s136 in the 2011 RCPsych publication – then that means two officers remaining there. Ten to twelve hours of resource every time, just to get to the assessment. For those 20% of people who would require hospital care, which then means finding a bed and finalising admission arrangements, it would be longer still.

So you can do the maths –

- **Police custody** = 10.5hrs per detainee and many of those would not require detaining officers to remain involved; those which do would only require one officer.
- **NHS PoS** = 5hrs per detainee, sometimes 6hrs per detainee and then further time for 20% of those and this time two officers would be required.

- If a force had 500 detentions per year, that might roughly mean* around 2,800hrs per year to handle people via custody and 5,800hrs a year to handle people via the NHS process.

** The mathematics on this is rough and for illustrative purposes only: forces don't always keep statistics, but it's predicated on timescales suggested above and where 25% of those detained would require enhanced obs throughout; 25% would require nothing after booking in; and 50% enhanced obs for just the first 4hrs only. In the NHS setting the maths is done on 5hrs to assessment and 20% of those detained for a further 4hrs beyond that for bed search and conveyance. In reality, it's often way more than that.*

Another way of saying all this is: a Chief Constable with 500 detentions per year, who has most of those detentions managed in an NHS Place of Safety which does not or cannot allow the officers to leave after an hour, is putting (roughly and almost) *twice as much resource* in to that same demand as they were before. It equates to more than one full-time equivalent police officer spent to 'improve' things. It may improve the s136 process that someone was not removed to custody, but what does it cost in terms of 999 response, attention to detail in pre-trial disclosure; youth crime prevention work, etc.? The answer is that it costs *something* – it's *not* cost-free.

SO WHAT ABOUT TRIAGE

Given the success, mentioned above, of street triage in some areas, why don't forces just do that to help alleviate at least some of this problem? It's a fair question, but again you probably need to do some maths to understand what's going on and, again, I've covered this before on here. But in summary, depending on which model of street triage you adopt, the Chief Constable could be expending more resource via triage to manage the same demand as before, whilst also encouraging new demand. This argument will not be true of all schemes because there are thee or four 'models' of things that we now refer to as street triage, but some schemes are more resource intensive for the police than others – indeed some don't involve police resources.

If a police area's Place of Safety process for those detained under s136 involves a 5hr assessment period, followed by further time for those c20% who require admission, we can again work out the hours spent managing that demand. 500 detentions per year means 5,800hrs if we assume that those admitted to hospital will require a further 8hrs of resource after assessment – two officers for 4hrs. If you avoid 90% of those detentions because of street triage, you are now spending roughly 1,300hrs on the 10% and and managing that 90% in a new way. It will still take at least

some time to do this and you'll have to work out what they do instead – suffice to say it may take an hour or so, which seems to be preferable to the 10hrs in the Place of Safety. if we suggest it will still take 1hrs per job after street triage arrive, that's 450hrs: 1,750hrs spend managing the demand that used to take 5,800 – seems like a saving, doesn't it?! Used to spend 5,800hrs, now spending 1,750 so roughly a saving of 4,000hrs which is, more or less, two full-time equivalent police officers. Happy days!

But in order to make that possible, you have to maintain a team of police officers: some forces have four, others have six, in order to make the street triage process possible. Those officers work for 2,000hrs a year each – you can then see your 4,000hrs of saving per 500 detentions in that light. If you've reduced by 700 detentions per year you may well have saved 5,600hrs, but if it cost you over 8,000hrs to do that, you can't legitimately claim to have saved two full-time equivalent police officers because you've actually spent one, not saved two. But remember: not all street triage schemes are quite as resource intensive but claim success, albeit perhaps not quite so spectacular and not all areas who've tried triage in the same way have the same impact. And what this post is not going to explore at all, is the very real phenomenon that the existence of street triage causes dysfunctional behaviour in both policing and in the NHS. << **Not just my opinion**: this has been said to me *again and again and again* by both nurses and officers who work on it. That's a post for another time.

WARNINGS AND CAVEATS

You can't put a cost on human dignity and the quality of someone's experience; these figures are back of the envelope numbers to suggest that somebody who can really do maths and good quality research looks at this more closely. HMIC reported in their PEEL Inspections that evaluations of street triage are limited, which follows on from NICE stating that evaluations were 'poor' or 'very poor'. You can argue with my maths if you want, but please don't write in because I'm not trying to make a precise assessment: just a illustrative point that the 'solutions' we keep coming up with to the problems we think we've got might be more resource intensive for the police, not less.

And remember, whether or not you like Theresa May or agree with her: the original idea behind making sure that people could access NHS facilities and services for assessment without being detained by the police or without being detained in police custody was about **saving police time**. We all know, in the real world, it is about more than that – it is about the public we serve: their dignity and wellbeing, their safety and security. But what I'm arguing that we cannot ignore is now a broader discussion about how delivery of the things intended to *save time* are actually **costing us**.

There is a resourcing and economic reality to what we do: if Lancashire police currently have eight police officers off the road in A&E departments – two officers for each of the four people detained under s136 – it shouldn't be much of a surprise if someone who reports anti-social behaviour, or volume crimes in progress finds there is, at best, a delay or at worst, a complete inability to respond. We all want what's best but I've said it before: I've been the duty inspector who had to decide whether to order officers out of A&E department and take a risk OR resource some incoming 999 calls which all involved the words 'shooting', 'gun' or 'rape'. Quite an invidious position to be placed in, if anything goes wrong with any of those jobs.

I know this risks 'perpetuating tensions' and I was reluctant to write this and bang on about it. But if this tension is not highlighted and discussed, then it merely means a different tension sits with my frontline police officer colleagues who I know have their ongoing versions of the 'shooting', 'gun' and 'rape' dilemmas that I've had in the past. It's only because this goes *precisely* against what we all agreed we'd do in 2011 that I feel obliged and entitled to raise it, even if it does 'perpetuate tensions'. The tension is already there and it's not worsening because solutions are more resource intensive than problems and that has to be wrong if it's because nationally agreed standards aren't being applied.

26th June 2018

Twenty Four Hours in Police Custody

Last night's episode was a belter wasn't it? … see Channel 4 'catch up' on the internet, if you missed it: 10pm on 25th June. It was right up my alley – Nyaar St Juste rang the police telling them to come with shovels because there was a body in a garden. Upon arrival officers arrested him because he had failed to turn up to Luton Crown Court the day before for unrelated matters involving a 'taser' type device and whilst he was in custody pending court he was interviewed. This was not a suspect interview; it concerned the call he made regarding the idea of body parts in the garden. The police were making enquiries in to it all of that, which started to suggest he may have been the one to dig the hole – nothing was quickly found to suggest a crime so he was taken to court, released by the judge on bail and proceeded to stab his mother, causing his brother to ring the police and report the whole thing.

Thus an attempted murder investigation began. Because of the way he was presenting with limited communication, whispers and unusual demeanour, the custody nurse quite rightly sought a mental health assessment, for which he had to be taken to A&E. This would have otherwise caused delays in custody that would start to affect the investigative "PACE clock" governing the amount of time the police have to hold someone under investigation without charging them with any offence. The mental health assessment – implied to have been a Mental Health Act assessment for potential admission to hospital, but this wasn't precisely clear – concluded, according to the officers that he wasn't unwell but that in any event, if he were, that they didn't have any secure beds anyway, which would have been the type required.

MENTAL HEALTH v CRIMINAL JUSTICE

By this point, we now have the mental health and criminal justice systems bumping up against each other: the inability of Bedfordshire Police to secure assessment within timescales which fit the investigative framework and I was now also starting to wonder about the mental health response. At the risk of appearing to jump to the end of this story, Nyaar does ends up 'sectioned' (in the words of the programme) by a criminal court after being found not guilty by reason of insanity. Precisely, this means he was given a *restricted hospital order*, known sometimes as a "section 37/41" order – detention in hospital for treatment and unable to be released,

granted leave or transferred between mental health hospitals without the authorisation of the Secretary of State for Justice because he poses "a risk of serious harm to the public". And his 'insanity' relates to his mental state *at the time of the offence*, not his mental state at the time of trial. He was in custody immediately after the incident, so it seems likely to me he would have been 'sectionable' at that point. But what do I know?!

What I do know is, it wouldn't be the first time we see mental health services assessing someone who could be admitted to hospital under the MHA and concluding that they can't be. And this episode shows an example of what I call the *criminalisation contingency* – you need X kind of mental health care but you can't have it unless the police prosecute you. Think parity of esteem: imagine the police response to a drink driver who crashed his car in to a brick wall, breaking his legs and smashing his head off the interior, causing a serious head injury. Imagine if either ambulance or police said, "Well, he obviously needs A&E, orthopaedic operations and a head injury assessment but he can't have any of that until the police prosecute him." We'd all be up in arms and the police and paramedics sacked for gross negligence. Different in mental health, though – isn't it?!

And the episode shows what can go wrong, if this is what happened … because the initial CPS assessment was, "there is insufficient evidence to charge." Which means he should be released. So what if it were true, as seems possible, if not likely – that he could have been sectioned but they chose not to do so because it was assumed the police will be able to prosecute him and then the police couldn't gather sufficient evidence?! You could hear the anxiety in the words of the officers as they contemplated all of this – it got so worrying that we even heard an Assistant Chief Constable asking if the police couldn't just "emergency charge him", which they can't. That's not a thing once you've taken CPS advice. No doubt, all due to the horror of releasing someone.

HEARSAY

A brief word on hearsay evidence, for those who don't know what that means. Charlie, Dave and Steve are in a pub one evening: Steve asserts that the football World Cup is beneath his contempt, full of cheats who are diving all over the pitch making any attempt to watch it entirely unbearable and that rugby is a far superior game. Ardent football fan Dave punches Steve to reinforce a stereotype and teach him a lesson for his candid insights. Charlie then rings the police and says, "Dave just punched Steve". Whether Dave is still on hand to hear this and react or challenge the assertion, as he sees fit, will determine whether or not the call tape and the call handler's evidence is admissible evidence against him – Charlie himself is an eyewitness but the call handler is not: he or she can only say, "A man rang up and said …" and that's hearsay. Same applies when the

police or paramedics turn up to treat Steve: if he comes round and says, "Dave punched me after failing to understand how rugby is a far superior game", the evidence of the police or paramedics will not be directly admissible against Dave if he had already left the scene.

So in this case, Nyaar is alleged to have stabbed his mother, his brother makes the call to the police (hearsay) and the victim and brother repeat the allegation to paramedics (hearsay) – you can see how it starts to become problematic as direct evidence. It's useful information, but not direct evidence. Then they find a knife in the property that has blood and DNA on it – well, if you DNA tested all the knives in my kitchen, you'd find two or three traces of DNA on there, albeit hopefully no human blood. Doesn't prove anything, of itself, though. If you found my DNA on one of my knives and human blood, it doesn't mean that I stabbed anyone – it could have been my wife or son who did it and you'd still expect to find my DNA.

So we have police hoping MH services might be able to 'section' Nyaar; and mental health services potentially assuming the police will be able to charge him – if the latter is not true, MH services having said he's not sectionable and in any event they didn't have a bed, creates something of a problem doesn't it?!

Imagine if the police had NOT won their appeal against the CPS's original decision not to prosecute?! Release …

EVERY DAY THING

This kind of case is not isolated – we hear all the time of serious crime allegations where MH services really want the person prosecuted immediately, regardless of mental state or any care needs identified during a mental health (Act) assessment. I wrote about this only recently after some questions arose following a talk I did to Approved Mental Health Professionals about MHA assessments in police custody. The punchline being —

- You can only prosecute someone if you have evidence of guilt and determine it's in the public interests to prosecute.
- You can admit a patient under Part II of the MHA (sections 2, 3 or 4) to a secure mental health unit for assessment – it's what happened to Ian Huntley, amongst many other examples.
- Resistance to admission because NHS trusts would prefer people to go 'via the criminal justice route' is fine if there is actually evidence of guilty, but we know there are cases where their either is no evidence of guilt OR it is only forthcoming after weeks of enquiries and forensic examinations of physical evidence.

What I didn't see on **#TwentyFourHoursInPoliceCustody** was evidence of close communication between whoever it was that did the mental health assessment at hospital and investigators and in any event, why would police investigators challenge and how could police investigators challenge any decision made, if they weren't there to discuss matters? They may not be able to work out whether it is a genuine clinical view that thresholds for admission are not satisfied, or whether assumptions are being made about 'going down the forensic route'.

So, some brief advice for investigators and custody sergeants who are faced with the potential situation that MH services may be implicitly relying upon the idea that the police will prosecute someone for something —

- Make it clear at the start of MH assessment that a criminal investigation is ongoing, that we do not yet know whether it will be legally possible to prosecute the suspect.
- We need to understand more about the suspect's mental health and mental state, to know how the investigation proceeds and / or whether there are any clinical barriers to any aspect of it, like an interview.
- That following MH assessment or MHA assessment, we'll need to discuss things and may need to do so again once the investigation reaches a conclusion or a barrier.

And then just bear in mind, and I'm not sorry for repeating this as police officers are told this very routinely —

- There is no legal barrier to the admission of a patient to a secure unit directly from a police station under s2 or s3 MHA, if secure care is the kind of care they require.
- Indeed, delay and obfuscation around this issue could amount to a human rights violation – see *MS v UK* [2012].
- Any insistence by the NHS that prosecution must occur is not grounded in any law at all, it is NHS policy which does not bind the police, CPS or Courts in any way whatsoever.
- If these points are disputed by any AMHP or DR, just say the words, "Ian Huntley" over and over again, until the point is conceded. He not only went straight to secure care from a police station, but it was a High Secure care, even harder still. Merely makes the point: this is possible and sometimes necessary. There are many other examples.

All comes back down to three things —

1. The police need to understand the legalities of the mental health system (not their policies, which are different);

2. Mental health professionals need to understand the criminal justice process, including the investigative stage.
3. **WE ALL NEED TO COMMUNICATE ACCURATELY AND CLEARLY! … after gaining knowledge.**

28th June 2018

CarePlan: Call the Police!

We are hearing stories on social media at the moment, of patients who claim they were told to 'call the police' when they have contacted their community or crisis team for support as they recognise they are becoming unwell or at a difficult point. We also know, on some occasions, a patient's formal CarePlan for crisis is to 'call the police' as the first resort. I fully understand, as pointed out by a mental health nurse on Twitter last night, that we have no way of knowing whether patients who claim to have called the police were, in fact, told to do so; and we don't necessarily have evidence that all the CarePlans which purport to list this, actually do so.

What we do know is this: at least *some* of these examples are verified and we do know that *some* of the time that 'call the police' is put in to practice, it has involved a CrisisTeam or CommunityTeam themselves making that call on 999, not the patient. In other words, the 'call the police' phenomenon is real, even if some maintain it may be exaggerated on occasion. I don't really want to get too far in to the obvious point raised by the nurse's skepticism; that an early thought after hearing the anecdote was to assume the patient was lying – that won't really get very far without getting quite shouty, will it?!

I particularly enjoyed hearing a recording recently of a call to a CrisisTeam by a patient who chose to record their own call 'for training and monitoring purposes' and it involved a person asking for someone to talk to as they recognised their own relapse and having tried various distraction techniques of their own, before ringing. To say my gast was entirely flabbered as the nurse sought to quickly get rid of the call and ring 999 is to dramatically understate things: there was just NOTHING there to justify ringing the police. A person wanted to talk: it was bluntly (and rudely) refused and the actual words used by the patient seemingly ignored, the phone went down and the local police received a 999 call.

So this stuff happens – doubt your patients and accuse them of exaggerating if you wish, I have stuff to say about when it does occur –

SELF-HARM & SUICIDE

Firstly, a quick point about 'suicidal patients' – if a nurse who is unable to deal with a patient thought to be harming themselves or threatening to do so is in urgent need of a policing or wider 999 response: don't tell THEM to make the call and assume it will happen. There are lots of things that shouldn't need explaining about why that could go badly awry – some people don't want the police to come in and coerce them to 'safety', they want to die or hurt themselves and if you're taking that risk seriously, leaving the reporting of it to the patient is not enough: put the 999 call in and the help the controller by sharing information relevant to the case and be prepared to advise and take things further. Remember your probably sending the cops to something they can't deal with so don't just hang up and get on with the next thing on your list having ticked this one off because the police are *en route*.

This ongoing help is needed for (at least) three reasons –

- Most of these kinds of calls received by the police are in private homes where they have no powers – officers may need to engage you about how to safeguard the person if they turn up and find themselves powerless.
- Officers cannot tell you whether or not your patient is 'safe and well' and it is not their job to do so – they may merely confirm whether the patient is dead or alive and offer the obvious helps if the person is alive but injured or obvious ill.
- Safety in mental health is not something that is visible to the police and the officers attending will have a first-aid certificate only so they will need back up from mental health professionals to fully resolve the situation.

Secondly – a point I've made before: if a visual assessment by the police and support for that from the CrisisTeam or CommunityTeam is not enough, the police will need support to access or navigate the AMHP process. Because we know some AMHP services are inaccessible to the police, they will need your help and are quite entitled to ask for help, given they were put in the position by the NHS. So if the officers were to say something like, "I'd be using s136 on this person if they were not in their own home, but because they are I can't do that – you either need to come out or arrange an AMHP / DR because it strikes me that s13 MHA is engaged here."

What's your response plan?

PARTNERSHIP WORKING

If we are serious about partnership working and we are going to write in to someone's CarePlan 'call the police', we should be giving serious consideration to the proactive, advanced disclosure of relevant information to the police service concerned. CarePlans of this kind should be drawn up with patients themselves, obviously at a time when they are well enough to make decisions about their care. If agreement is reached that it may be necessary and appropriate to ring the police, then the patient should be asked to consent to disclosure of information to the local force which will help them get it right.

You could imagine any number of things could be relevant from, "Don't send male officers, if possible" to "patient has spare key at neighbour's (no 11) should entry need to be gained and consents to the key being sought and used by the police". It could also include more safety information, "Patient uses blades to self-harm" or "patient asks that officers be patient and afford him time and space – don't rush decisions" or "Would be helpful if officers called patient's cousin Sue to help as patient likes her help when unwell – her number is 07770 770770, etc..". I'm sure we can all think of even more useful nuggets to have on the system.

If each Community MH team manager contacted their local neighbourhood policing sergeant or inspector (details available on force internet websites), they could easily agree a way to share this agreed disclosure with consent and the police then use it to improve the quality of their response if they are called. This, in turn, makes it feel like much less of a 'bat' from MH services who are, often, sending officers in to situations where they have no background, no context, no powers, no training, no abilities to achieve the task implicitly set by their despatch.

I'm sure it can be understood how difficult a position this creates for them and it has been the stuff of deaths following contact in our history.

MY EXPERIENCE

In case of doubt, I end with my own tale: the last time I went out to such a call –

The CrisisTeam rang 999 to say, "Patient has rung up saying unwell, asking for voluntary admission to hospital and we've had to say no as we've got no beds. She's then threatened to kill herself and put the phone down. Can you send officers to do a safe and well check." This was a Friday evening, just before handover to the night shift, so I was just sitting at my desk to start writing up all the stuff for the nights inspector and all the constables

and sergeants were committed with 999 jobs on a busy shift. So I slugged my coffee and went to it on my own, not least because the call was just around the back of the police station.

When I arrived and knocked on the lady's door, she did open it, but kept the door on the small chain lock so the door could only open about 2inches. She seems surprised to see me, not just a little bit anxious and I explained why I'd attended asking if she was OK? I couldn't see all of her so it was not possible to tell if she was physically injured in any way, but I could tell that she was Alive, Breathing and Conscious. It also seemed likely she wasn't Ill, Injured or Intoxicated, but I couldn't be certain of that, given how little of her I could see. In this situation, I had absolutely no legal powers at all, because she'd answered the door and remained in her own house and the conversation would not have given me cause to think she met the criteria for use of s136 even if she had been outside her house.

SAFE AND WELL

So I rang the CrisisTeam –

"We're here – she's alive, breathing and conscious and although I can't really see her properly though the gap in the door, I don't have grounds to force my way in. What do you want to do now?"

"Well, as long as you're saying she's are and well, that's OK."

"Well I'm not saying that – that's not my job. I'm saying she's alive, breathing and conscious and that I have no powers to act. That's all I'm saying. For all I know, she could be actively plotting to hurt herself as soon as she shuts the door because you're the people to whom she made the suicide remark."

"But she is safe and well, isn't she?"

"I've got no idea! Is she? – how do you know?!"

Suffice to say this ended by me saying, "I've got a horrible feeling you're going to write in your notes that Inspector Brown said this lady was safe and well, so let me just make clear, I'm about to write this up to say that I specifically did not and that all I'm assuring you of is that right now, she's alive, breathing and conscious. If you need to satisfy yourself of more than that, you'll need to come out. If you choose not to do so, you may not say I didn't alert you to the fact that your apparently suicidal patient could still be at risk. Can I have your name please?"

All of this stuff is way more complicated that 'call the police' – and calling the police can make things worse. Unless we think this stuff through, share information and work in a genuine partnership, it's often little more than trying to deflect demand to cover someone's backside. Officers should remember the limits of their legal powers and clinical assessment skills – they CANNOT assure anyone that a mental health patient is 'safe and well', even if they're trying to help. Confirm alive or dead and whether there are any immediate emergency medical needs, then refer back to whoever sent you and tell them to now deal in slower time. Escalate to supervisors and if no satisfactory response from whoever sent you, ask for the AMHP / DR response suggested by the judge in the Sessay case. Document everyone's names in the record – history shows they may be relevant to cite in a Coroner's Court or IOPC investigation.

30th June 2018

Exacerbating Tensions

I've had to ask myself recently whether I'm guilty of potentially exacerbating tensions or conflict between the police and mental health services, after a number of suggestions on social media and elsewhere that this is the effect of what I am doing. It didn't take long to work out that this is *precisely* what I am deliberately doing, on *just some occasions.* I would argue this is of necessity, other options being unavailable or unacceptable. In addition to thinking that the management of mental health demand cannot just be about what the mental health system thinks the police should do, I have also come to believe very profoundly, the key to determining the role of the police lies in the rights, protections and views of those of us who live with mental health problems. And somewhere in there, even without us considering the roles and realities of policing, lies tension.

I have always listened very keenly to a number of mental health professionals who have helped me over the years, people to whom I will be indebted for all the coffees and beers shared and the books loaned and read; and incidentally, it's clear that front-line mental health professionals also see difficulties, tensions and conflicts on a daily basis, whether or not it's something that involves the police. But I am really clear that most of what I've learned about mental health and policing I got from talking, often at length, to those of us who have lived the system – that and actually reading the Mental Health Act 1983, the Mental Capacity Act 2005 and the Human Rights Act 1998.

It makes you realise there is conflict there already and it needs resolving, if possible – or managing, if not. When conflict borne of disagreement or ambiguity exists between two different professionals or organisations, you have just two choices about your reaction. You can stand your ground and hold your position, or you can compromise. But here's the rub for me and for the police: we *cannot compromise* on certain things – and THIS is where suggestions arise that I have 'exacerbated tensions'. I would and will here argue, that it is my legal **duty** to do so and that I have always thought this because of the Oath of Office swore when attested in 1998. And this is why we sometimes see other police officers, including very senior police officers, doing the same thing.

Let me tell you why, for those who are worried about my approach –

CONFLICT ZONE

Early on in my career and repeatedly since then, it was obvious to me that by doing as told or by 'the system', I could on *just some occasions* risk jail, the sack or be killed. This all sounds *very* dramatic, doesn't it? – it's not intended to be falsely so – like several others, I have had the experience of being under criminal and gross misconduct investigation, overseen by the Independent Police Complaints Commission (now the IOPC), for doing my job as well as I could after a man died following my contact with him. And like those other officers, I believe my officers and I were just trying our damnedest to get him out of the situation alive. Our efforts didn't prevail, albeit not just for reasons to do with us and I will remember his screams until the day I die when he set himself on fire right in front of us.

This is intended to convey the reality of what we deal with and how I see *some* (but I stress again, *not all*) operational police work to which we often send junior police constables with a few years' service at most. The examples of this kind of stuff are included all over this BLOG and are in the news for all to see. There are yet more cases under investigation and within the Coroner's Courts of the country as I type this, highlighting this again and again. One of the most precious bits of feedback I ever had from a frontline police officer followed me interrupting his willingness to do what an AMHP wanted them to do. The officer, a really keen young lad, admitted to me that he had told his partner that night, "The fucking boss has gone off on one AGAIN about fucking warrants and mental health – let's just get in there and get this sorted!!" Suffice to say at the end of the shift when he was kind enough to admit this because he wanted to add, "But if you'd let me, I'd probably be dead now. So cheers."

There is conflict and tension inherent in this business – it was there before I joined the police and it continues to this day. It needs addressing in some way because ignoring it is not an option, but here's the thing: when there is a disagreement between two people or two organisations and you cannot find a way to compromise that is acceptable to all, you are forced to a decision. Do you set aside your concerns and queries and do as the other party would wish, or do you …. not do that? I know that in the last twelve months I have been called to appear in Coroner's Court four times as an expert witness (and there are other legal proceedings pending for other cases), where these issues are at the forefront: why did the police just do as locally expected, why didn't they push back in accordance with national standards?

CONFLICT RESOLUTION

A difference of position or opinion between professionals or their organisations may have various things underpinning it. But in my experience it is most usually a clinical or legal issue – if I wanted you to do something which breaks the law or puts someone's safety at serious risk, you are obliged to decide: will you be doing as expected or are you going to resist? You may well wonder about the context and the risks versus benefits: if this request were me telling you to drive the wrong way up a motorway entry slip because I had established a controlled way doing this to help you escape a massive queue caused by a serious collision that will close the road for most of the day, you're going to set aside the law prohibiting this manoeuvre because a police officer told you to do it. If I ask you to unlawfully and inappropriately sedate patient who won't "calm down" or 'section' someone because "it would be better that way" you're going to say "No way!" or something similarly blunt.

Real example, presently apposite if you use Twitter to follow what's going on: if someone needs to be 'sectioned' but there's no bed available and the timescales have run out so detention is now unlawful under domestic and international law. Do the police just continue to sit there, unlawfully holding people, saying nothing and getting on with doing as they're told? Or do they start potentially exacerbating these tensions by escalating to senior managers, agitating for a solution, or even considering legal action, which has been known? We know that some senior officers have gone public about these matters and one can only imagine what senior NHS managers thought of it but no one should doubt that such situations are at least one kind of human rights violation, if not more than one. Senior police officers are bound by s6 of the Human Rights Act 1998 – as are all police and mental health professionals.

What we do know from history is, if the police don't escalate, agitate and consider all their options, delays can continue for days and days; and if they choose to start pushing back against the assumption they should just help out by acting unlawfully, solutions are often found shortly after the escalations are assertive enough. No-one wants to work like this, do they?! – I'm sure we'd all say we want to work in partnership and work collaboratively and jointly make the world a better place. But the opposite of a world where the police service now know nearly-enough about the clinical risks, legal threats and other risks because of a decade of to understand reality is not a world where things are naturally collaborative and tension free.

CONFLICT MANAGEMENT

There was conflict in this entire agenda before I joined the police. I merely walked in to it in 1998 wondering how it can be police officers can find themselves under criminal investigation because they tried their best to handle a situation where the over-arching infrastructure and policy framework, not to mentioning the legal and other training, was woefully inadequate? I could also see tensions within the NHS from the start: are there many NHS professionals who don't think that they could do with more staffing, more services and facilities and that the absence of them doesn't, on at least some occasions, lead to requests for police support that should not be necessary and they'd prefer not to ask for?

Here's the reason my approach could quite reasonably be accused of being conflict based: I don't look at mental demand on the police from a *clinical* point of view. I take the view that people's health is a matter for them up until the point where the state must intervene to keep them safe or until they break the law. That's my threshold for getting directly involved. More than happy, following any contacts I have where someone may have health or social issues that have not put them at direct risk or on the wrong side of the law, to suggest things that may help them and signpost or refer accordingly. But how people live their lives is a matter for them.

My own view over the last decade is, that the we're trying to fix the wrong problems and in so doing, the solutions we've come up with to the problems we *think* we have are more resource intensive on the police than the real problems we should have been trying to fix. So as things stand, I see my role at least in part, to slow down the acceleration of the problems we're perpetuating because we mis-focussed in the first place. So conflict *management* is necessary, because conflict *resolution* doesn't seem possible for as long as all services are doing more with less and in objective agreement that all our systems are under significant pressure.

CONFLICT MINIMISATION

You can't ask me to break the law or risk people's safety and then object that any resistance is exacerbating tensions, because I'm just going to point you to s6 of the Human Rights Act and remind you I'm a police officer. I'm not on anyone's side. You can't object that I'm planning for how best to handle those situations either, by raising difficult discussions about things that should not and cannot be compromised because such discussion is about effecting change demanded by law. That's about seeking conflict *resolution* and, if that's not possible, conflict *minimisation*. And in any event, "we were told to do it like this" just doesn't wash in Coroner's Courts.

I'm very motivated around this stuff and have spent the best part of fifteen years trying to understand all perspectives on this – I remain willing to learn: but having deliberately driven my career in a certain direction to be able to focus on it, I am actually fighting for something here – and this should only represent any kind of challenge to those who would over-use the police in a way that makes things worse or have them assist in undermining the law. It's outlined in something like 750 posts on this BLOG written over the last seven years: I couldn't have been clearer about what that is – the right of the public to take their own healthcare and wellbeing decisions; and the protection of front-line police officers from risks and liabilities that may cost them their jobs, or more.

I look at this from a legal point view, not least because it's what I largely think is missing in our approach to mental health matters. So I'll end this, by re-affirming that Oath I took over twenty years ago, by way of illustrating precisely where I'm coming from. (The bold emphasis is mine.) –

"I do solemnly and sincerely declare and affirm that I will well and truly serve the Queen in the office of constable, with fairness, integrity, diligence and impartiality, ***upholding fundamental human rights*** *and according equal respect to all people; and that I will, to the best of my power, cause the peace to be kept and preserved and prevent all offences against people and property; and that while I continue to hold the said office I will to the best of my skill and knowledge discharge all the duties thereof faithfully* ***according to law****."*

JULY 2018

5th July 2018

Accountable to the Law, not the NHS

On 12th November 2013, I wrote a blog entitled 'Here We Go Again', following the death of a vulnerable man in Bedfordshire who we now know was called Leon Briggs. His death is subject of an ongoing criminal inquiry, more than four and half years later and that means, regardless of what happens criminally, there is still a potential disciplinary process to come, certainly followed by a Coronial hearing to establish all the issues around Mr Briggs's unexplained and unexpected death on 4th November 2013. The full circumstances around that incident are yet to emerge and be tested and my best guess is, the legal process for that will run well in to 2019, if not the next decade.

But on 12th November 2013, I sat down in the evening to write that very general post, trying *again* to point out to police officers the various factors that can combine together to create conditions in which a death in police custody is more like than otherwise. The idea was to sound a reminder alarm through social media and that might prick officers' attention. Little could I have possibly known, that on *that very evening*, Terry Smith came in to contact with Surrey Police and died after being detained under s136 of the Mental Health Act, restrained and removed by police vehicle to police custody. This is very broadly what we already know from news reports happened to Mr Briggs. Having written that post, it shocked me to think, only a few days later when learning of the incident in Surrey, that I'd written this so confidently –

"Let us be clear about this, yet again — another death in police custody or following contact could happen tomorrow in any area where the procedure followed by the police is not built to mitigate against unlikely but highly significant risks. Some police forces work in areas where their MH trusts work very closely in developing proper procedures, other police forces don't. But the duty of care owed by every officer and by every police force, is the same irrespective of where in the country they are."

– MentalHealthCop Blog, 12th November 2013.

And it did happen again, didn't it? – not 'tomorrow', but that very evening! As I wrote the prediction it was busy happening. The death of Terry Smith, we now know, was contributed to by the neglect of Surrey Police after prolonged and excessive restraint and a serious failure in the duty of care owed. This is very sobering judgment to take in and it needs to be taken

seriously by every police force in the country: without taking *anything* away from that verdict, it is also about a few other things that were discussed in the inquest itself that I want to highlight.

HERE WE GO AGAIN

The most tragic thing of all, is that the deaths of Terry Smith and Leon Briggs echoed other cases: Thomas Orchard died in Devon and Cornwall custody in October 2012; Toni Speck in North Yorkshire police custody in July 2011; James Herbert died in Avon and Somerset custody in June 2010; Sean Rigg died in Metropolitan Police custody in August 2008 and Michael Powell in West Midlands in 2003. Not all of these cases were legal detentions under the Mental Health Act, but they were detentions of people known or thought to be suffering mental health problems, who were then resistant to detention (probably due to fear rather than anger) and removed by a police vehicle to police custody.

And it's an obvious point: the decision a police officer about which law they will rely upon to justify their intervention is in no way, shape or form related to the clinical needs of someone detained or how those needs are exacerbated by any restraint applied. The charity Inquest who support the families of those who die in the care of the state have repeatedly said that the accusation of which the police stand accused is not failing to learn lessons, but of repeatedly failing to learn repeated lessons – and here we go again. Since the deaths referred to so far, we have since seen others which are still at the early stages of being investigated.

In December 2017, the law on s136 changed around the use of police custody: Regulations were introduced which now define the 'exceptional circumstances that we've seen police, mental health and emergency departments as well as ambulance services arguing over for so many years. And on one viewpoint, they don't help! – the regulations state that only people who pose "an imminent risk of serious injury of death to themselves or another" may be removed to custody; and only where no NHS facility can manage that risk and when authorised by an inspector. Which inspector in their right mind is going to authorise the use of a police station for someone "at imminent risk or serious injury or death" because of a suspected mental illness?!

Hopefully none – ever! … but guess what?!

I'm wrong about that. It *still* happens.

INQUEST EVIDENCE

It is a matter of public record that I gave evidence at the Inquest for Terry Smith, having written a report for the Coroner who had requested a non-Surrey police expert view of the various issues. So I've read the various statements and other documents. There's nothing I need to say here that you can't glean for yourselves by reading a few things:

- Inquest has produced a press release, including a statement from Terry's family, which is heart wrenching to read.
- Surrey Police has publicly responded to the verdict on their own website.
- There is also a useful four-minute video piece from Channel Four which includes an interview with Terry's father, Leslie.

There has been little mention of the local s136 protocol in the coverage: although I faced questions about this for almost half of the time that I gave evidence, several barristers, including the family barrister focussing upon it. The joint operating protocol that was in existence between Surrey and Borders Partnership Trust and Surrey (and Hampshire) Police in November 2013 was, in my own professional opinion, awful. And I said so in court – had Surrey Police sent a final draft copy to me for an opinion, I would have advised against signing it because it was legally, clinically and procedurally deficient – in my view. I admit to being surprised that it got through Governance in an NHS trust, not least because it managed to get the Mental Health Act wrong (on a legal point unrelated to the inquest, but suggestive of a casual level of checking).

Secondly, there is the issue about national guidance in policing, versus local policy: obviously no police should ever really have to ask themselves "In my handling of this case, should I comply with local or national guidance, given that they're do not say the same thing?" Police forces need to ensure their procedures are compliant with national standards on s136, the Code of Practice and all the lessons which need to be learned again from cases like Terry's.

THIS COULD HAPPEN AGAIN

So let me be completely clear about my position now that we're in July 2018: **this could happen again tomorrow because the learning is usually just done by the force affected**. One can imagine Surrey Police will have had a Gold Group running on this matter and it will continue to meet to handle the fallout from the verdict. I already know that Surrey have made strides in their approach since 2013 and continue to do so – but I went on the internet an hour ago and the joint protocol on s136 between

the police and the MH trust still talks about people who are 'violent or unmanageably disruptive' or where they are suspected to have consumed drugs or alcohol or been subject to CS spray being taken to custody. << Some of this stuff has no basis in law at all! It's almost as if Terry didn't die in custody at all.

Despite the law being changed last December on the use of custody, I've had passing conversations with middle ranking officers who head up custody for forces who have remarked about the changes, things like, "We've only had a few coming through, but I'm satisfied that was right because they were really violent." But were they violent or frightened? – and on whose judgement?! If no-one has given consideration to the fact that a 'violent' or agitated presentation can be attributable to any number of serious medical maladies, how do we know this person is safe and fit to be detained?

It was only very recently that I got to hear again from Dr Tony Bleetman, an emergency department consultant and from Rob Cole, consultant paramedic from West Midlands Ambulance Service. The three of us present on an Advanced Paramedic Master's course at Warwick on policing, mental health and ABD. I was sitting there again listening to Tony list the very serious medical conditions that can threaten life that are often associated with symptoms that could be ABD and just reminding myself afresh: **no police officer, anywhere, is going to be able to sort this or make the clinical judgements.** You need to get ABD candidates to ED, allow for rapid triage and then potentially quite severe clinical management. What that looks like is up to ED and if the do wish to turn you away, don't move, escalate to your and their supervisors, expressing your concerns in the strongest terms. Let the bosses row it out and don't back down from asserting this is a medical emergency until formally declared otherwise. And that person's name goes in the record!

STRATEGIC CONTEXT

As with *all* NHS or healthcare professional opinion offered in the context of your *legal* duties should be considered as 'intelligence'. It may need further developing or corroboration, it may be as sound as a pound. Forces obviously carry a huge responsibility here to ensure that whatever local procedures they are signing up to, are checked. I don't know whether Surrey Police legal services signed off the s136 protocol that got the MHA wrong, but I'm hoping they didn't, because by missing that very basic legal error, it would cast doubt on what else they may have missed.

We know today, that some NHS organisations still dispute and argue about the term 'acute behavioural disturbance' and 'excited delirium'. No – those terms are NOT in the medical manuals classifying mental disorder –

manuals like ICD-10 from the World Health Organisation; and DSM5 from the American Psychiatric Association. That said, there are a number of legal rulings, of which Terry Smith's is just the latest, where Coroner's, having heard medical evidence including the disputes, have ruled caused death. Add to that three documents **all duty supervisors need to know about** if we must police alongside organisations who may not provide care in a way that complements the legal reality of our work –

- The Royal College of Emergency Medicine – Guidelines on ABD (2016).
- The NICE Guidelines – Violence and Aggression (2015)
- The NHS England patient safety alert – post-restraint observations (2015).

All of these publications have come out since various deaths mentioned here and represent serious authority for the proposition that ABD is a thing or a cluster of things that amount to a life-threatening medical emergency. I know, because I've tested this theory, that not all ambulance service or ED staff know about these documents. You may have to explain it to them.

GET IT RIGHT

Following use of s136 MHA where someone is presenting challenging behaviour, probably because they're already half frightened to death by an experience that even before the police has turned up has got them in a compromised medical state, you do this and you do it every, single time regardless of advice to the contrary –

- **Arrest** – make your 'arrest' under s136 (or your re-detention under s18 or anything that commences a detention of a person thought to be mentally ill.
- **Ambulance** – call an ambulance every single time. Whether they come and how quickly is up to them, you then make your conveyance decision based on their response.
- **Assessment** – make an assessment of any critical conditions, sometimes known as 'RED FLAGS' which may require ED care before anything else: this will include ABD or anything involving highly agitated, challenging behaviour, especially where prolonged or where restraint is required and ongoing.
- **RED FLAG = ED** – remove anyone presenting with a 'RED FLAG' to the nearest Emergency Department, preferably by ambulance but if they can't or won't play: do it yourself ASAP.
- **NO FLAGS = MH** – remove anyone not presenting a 'RED FLAG' to the identified Place of Safety for MHA detentions in your area.
- **Escalate** – to your sergeant or inspector if you experienced any problems in proceeding through those five steps. Let the bosses take

up the dispute and you focus on de-escalating, restraint reduction and the person you're caring for.

Therefore, if I may end with something of a rallying cry: **I couldn't give a toss what a particular ambulance service or any Emergency Department thinks** about the concept of ABD; what they do or don't recognise as a medical term or whether they believe they are a place of safety under the Mental Health Act. They don't have to be legally accountable for your decisions and it's easy to deflect officers with limited training in other directions. **People have died** because these debates and individual professionals' or organisations' opinions have been allowed to influence local policies away from national standards; creating an entirely unjustifiable ambiguity about what is required. In actual fact, this stuff has been *crystal clear* since the NPIA guidance on mental health in 2010 which made it clear that ABD or excited delirium was a medical emergency and it should be remembered: that guidance document was overtly badged and supported by the Department of Health – it wasn't *just* police guidance, it was formally declared consistent with DH guidance and I personally flogged around the country in late 2010/2011 running seminars for all police forces on those new guidelines and they have only since been strengthened in College of Policing APP, partly because of the obvious immediate learning from these cases and because of those three clinical documents, above.

We have no absolutely excuse – and this is will happen again if only Surrey Police learn from this. We all need to learn from this and that doesn't just mean the police.

This is at least partly about why NHS organisations write and put forward policies which contradict their own national standards. I'm afraid this is widespread, having seen meetings where I've watched some NHS managers scream down senior police officers for daring to suggest that we need to remember the whatever we do: it must comply with the law. Remember the narrative we normally hear on the news whenever they're describing initiatives like street triage or liaison and diversion is "Here are the *highly trained experts* to help the [poorly trained] officers". I've never been sure how it 'helps' when local NHS preference or practice deviates from national clinical and legal standards. Irrespective, the final point is this –

As police officers we are accountable to the law, not to the NHS.

6th July 2018

Acute Intoxication is a Mental Disorder

The longer I work on policing and mental health, the less frequently I experience certain things which used to hit me square in the face every time I went near the topic as a PC: a new piece of knowledge that leaves you entirely confused and thoroughly re-examining the paradigm you're trying to get your head around. Having done a fair few talks over the years to professionals in policing and in mental health, I thought I had it fairly squared away in my head how to answer the questions that arise when discussing intoxication by drugs or alcohol, relative to police decisions about things like section 136 of the Mental Health Act. And then, Wiltshire Police rang for an opinion on a psychiatric report they'd received ahead of an inquest. I'm still thinking this through, several weeks later, because it's almost entirely beyond comprehension this hasn't come up before.

In February 2017, the police were called to an incident in Salisbury where they found a very drunk individual who had involuntarily expelled urine and could seemingly not stand or talk. Officers spent considerable time with him, calling an ambulance and whilst the paramedics did undertake some level of assessment, no records exist to show exactly what that entailed. Having made a decision the man did not require conveyance to or treatment in an Emergency Department, they left decisions about his safeguarding to the police. For reasons I'm still unclear about, the officers left him in situ on a winter's evening and he died of acute alcohol intoxication and hypothermia. The Coroner's verdict ruled this was an accidental death contributed to by the neglect of both paramedics and police officers. You might be wondering on the basis of that summary what this has to do with mental health?

The Coroner in this case commissioned an independent psychiatric opinion, seeking answers to certain questions. The pertinent ones for this post are –

1. At the time of police and paramedics contact, was this man suffering from a mental disorder?
2. If so, *could* section 136 of the Mental Health Act have been used.
3. And if so, *should* s136 MHA have been used?!

I'll let you have the punchline before making the points I want to make: the answer to all three questions was 'Yes' – he was mentally disordered (acute alcohol intoxication); 'Yes', section 136 can be applied to any mental

disorder that is not a disorder related to dependence upon alcohol (abuse / misuse being different to dependence and addiction); and 'Yes', in preference to leaving the man in a public toilet, the officers should have used section 136 to safeguard him, notwithstanding the paramedics' opinion.

WHERE DO I START?!

I decided I would write a post on this inquest when I had time, but I've been motivated to make the time, based upon a conversation on social media only this morning: the AMHP forum on Facebook are currently discussing whether there has been a real and steep rise in the use of s136 MHA since the legal changes last December. Several contributors to that discussion are lamenting perceived over-use of the power by police officers when people are 'not mentally ill, they are just drunk and disorderly'. Haven't we always been told that drunkenness is not a mental illness and that the Mental Health Act can't be used on someone who is intoxicated?

I have spent fifteen years doing policy related work and I will be honest: I've had psychiatrists, mental health nurses and others shout at me(!) when discussing issues around s136 and Places of Safety because of their no-doubt genuine belief that drunkenness should be dealt with in a different way. I've heard argument that where s136 is used on drunk people where there is no known background of mental health problems and no context on first contact that showed any evidence of self-harm or suicide, that most people are assessed as having no extant medical needs. They might need a bacon sandwich and a cup of tea to sort their hangover, but no referral to a GP or community mental health team.

And let's not forget this: the much-lauded concept of street triage started in the Cleveland Police are in 2012 and that began after frustration in mental health services that their local officers were using s136 too frequently on drunk people who had no ongoing care needs at all once they'd sobered up. Having approached local senior officers to offer training, they found themselves rebuffed and street triage, to quote an AMHP from Middlesbrough, "is all about stopping the police from getting it wrong." They found that over 95% of drunk people just sobered up and went home; the other 5% were those drunk people known to have a background of serious mental illness or who were found hurting themselves or in a precariously suicidal position. So, we're now spending millions of pounds of public money on triage schemes which, amongst other things, aims to stop an over-medicalised response to the social issue of alcohol abuse.

NATIONAL POLICY

For all of these reasons, national guidelines in policing advise officers away from using s136 on drunk people unless there is that known background or context, because it plays the percentages in a realistic way if people are either conveyed to A&E for potentially toxic levels of alcohol consumption and, if people need legally detaining, arresting someone for being drunk in a public place or drunk and incapable does not preclude a MHA assessment for anyone who sobers up and who is still thought to be exhibiting unusual behavioural signs that may mean an underlying disorder. Remember the story of the bloke in Walsall who bought over-the-counter products to help him stop smoking and then drank a load of red wine? – he ended up sectioned under the MHA in hospital because after sobering up, there was a lingering effect of the alcohol and the medication that took three days to wear off.

But, it turns out it really is true that acute intoxication (by either drugs or by alcohol) is listed in the International Classification of Disease, 10th edition, published by the World Health Organisation as a mental disorder. The MHA can be applied to any mental disorder that is not a disorder related to dependence; therefore s136 is 'in play' for drunk people or those experiencing a drug-induced psychosis. I should imagine any mental health professionals reading this are starting to panic at the potential their local police officers may start scooping up nighttime economy punters and pouring them in to Places of Safety and Emergency Departments! …

Well, in his oral evidence to the Coroner's Court, the expert psychiatrist did say that he was not arguing the police should be detaining all very drunk people under s136. What I left the Courtroom without, however, was a clear understanding from him of how a police officer could or should tell the difference between the very drunk person who *should* be detained under s136, from the very drunk person who **should not.** Maybe that detail will follow later. But what did become clear is that the reason for suggesting the use of s136 was merely as an alternative to leaving someone where they were. In reality, of course, those were not the only two options available – the officers could have removed the person to A&E under the Mental Capacity Act, they could have arrested for at least two criminal offences and in other incidents involving very drunk people there may be other offences committed or friends / family on hand to help that person without the police needing to act.

DECISIONS, DECISIONS

My final point is to ask what standard we are holding the police to in these matters? Having seen a copy of the psychiatrist's report, I rang a few

mental health professionals. "Did you know that acute intoxication (drugs or alcohol) is a mental disorder in ICD-10?" I also asked this on Twitter: literally no-one knew! I must have canvassed over a century's worth of experience and none of them knew this. When that was explored in the Coroner's Court, the psychiatrist also admitted that he'd shown his expert report to a Professor of Psychiatry who had apparently exclaimed, "Ooooh, I didn't know that!" The expert went on, after that admission, to say he thought the fact Wiltshire Police officers didn't know this as a 'serious concern'.

I'm just going to say that one more time: two frontline police officers not knowing something was a mental disorder when a Professor of Psychiatry and a raft of mental health professionals with over a century of experience between them also did not know this is, apparently, a 'serious concern' … *seriously?!* What standard are we holding the police to here?! It is – *quite frankly* – completely ridiculous!

But let's imagine these officers did know something that a whole mental health system (almost) full of professionals with postgraduate degrees appears to not know: how does that change any real-world decision-making?! What do we think a place of safety nurse or AMHP may say when we ring them up and explain, "We've detained this guy whose name we don't yet know: he was lying drunk in a puddle of his own urine, unable to walk or talk and there was no background known or context of self-harm or suicide and we've brought him in under s136." One professional admitted, perhaps because they know me well they felt they could speak freely, that they'd probably just say, "Michael, you're taking the p*ss mate, you can f*ck off with that!" Seems fair enough, to me.

MEANWHILE IN THE REAL WORLD

I just can't my head around any of this – it's simply too weird for words. But if you are a police reader, you can have some fun with this: next time someone mentions the police should not be using s136 MHA on drunk people just say, "The ICD-10 lists acute intoxication as a mental disorder and as abuse of alcohol is not the same thing as dependence, the MHA can apply to it." And then just watch their face – you're welcome.

My opinion remains the same: we should stay well clear of s136 with drunk people unless we know from their background or the context we're responding to that we need to have concerns about their mental health. This means (amongst other things) where someone is known to mental health services, currently or recently; where parties connected to the incident are telling you they have a history of mental health problems or where you find them hurting themselves or in suicidal state. Otherwise,

safeguard that person in a different way that does not involve leaving them in a public place to freeze overnight.

Choose from letting family or friends help them; let another agency help them, if willing; use the MCA to remove them to A&E, or you could even arrest them for being drunk and incapable in a public place – just don't leave them where you found them face down in a puddle of their own waste in the middle of winter. It's a real shame that needs saying, isn't it? – whether that's to the police or to paramedics.

25th July 2018

Telephone Triage

A curious thing appeared on the internet recently: a preventing future deaths report from the Warwickshire Coroner, which has been sent to the Chief Executive of Birmingham and Solihull's Mental Health Trust (BSMHfT). It follows the death of a man by suicide, thirteen days after the BSMHfT street triage (ST) scheme had contacted with a man who ended his own life in a hotel. No details were given about why the contact with ST occured in the first place, but we know from the PFD report that it was contact by telephone. Amongst other concerns the Coroner had about record keeping by ST (there was none), point 5 on the PFD leapt off the page at me when I first read this.

- **5) The purpose of the telephone triage was unclear** – it was described as not being a mental health assessment … **so what was it, then?!**

And if it wasn't a mental health assessment, what does it mean, if anything, for police officers who have ST schemes across the country where they become involved in police incidents because they believe the person needs MH assessment, often as an alternative to the use of s136 MHA? If I believe someone may be unsafe because of mental health problems and requires a level of assessment beyond my capability, are we saying that no telephone discussion can ever be a mental health assessment or that this telephone exchange wasn't? … it's not clear, is it?!

This fits in to the narrative unfolded by Her Majesty's Inspectorate of Constabulary earlier in the year: that 'street triage' schemes needed clearer strategic objectives; as well as evidence of evaluations being 'poor' or 'very poor', according to the NICE Guidelines on the Mental Health of Adults in the Criminal Justice System (2017). We still don't understand these things as well as we need to – I remain of the view they were set up too casually and some of the problems we're seeing emerge were predictable and forewarned by some of us!

THE FIRST RULE

Over many years, I've heard a number of clinical mental health professionals say that the first thing you do when you undertake a mental

health (Act) assessment is a physical health check, if for no other reason than to ensure there aren't obvious concerns about other medical issues or alcohol or drug intoxication. I've seen the importance of this myself: how many times have paramedics turned up at s136 detentions made in good faith by officers, only for the good people in green to say, "Err … A&E: this is not a mental health matter." Diabetes, brain tumours, encephalitis, meningitis, etc., etc., – all because a decent physical of basic observations was done by an experienced healthcare professional.

There was also that job when I was shadowing a street triage team … we walked in to a man's house one evening after a GP, who had not attended his patient's house to examine him prior to ringing 999 for the ambulance to serve to 'send triage and section him'; and it was obvious to me and all my clinical qualifications (expired first-aid certificate) that the *only* thing needed was for this bloke was for him to be taken as soon as possible to A&E by ambulance. His head, stomach and foot were heavily swollen and largely purple: something the GP and his medical degree would have noticed himself if he'd bothered to turn up and examine the man before reaching for the 999 bat-phone In fairness to him, though, it was end of office hours on the Friday before Christmas and he probably had a family or a party to get to.

So as we've seen the expansion telephone based approaches to mental health, it's important to understand what these phone calls are, starting as they do at a massive disadvantage that the clinician can't see the patient. Is it really possible to fully,and properly assess someone's mental health? There seem to be varying views on this; but it's importance because of one simple fact: in most areas where ST operates, **the nurses do not actually see the majority of patients face to face**. There are some exceptions and ironically enough: West Midlands Police's triage scheme with Birmingham and Solihull Mental Health Trust claims to see a small majority of all the people at the centre of calls, but they are the exception. In some areas, ST actually sees 15%-25% of people and the rest are supported by the provision of telephone discussion and information sharing. So it's unfortunate that this PFD from the Warwickshire Coroner ironically relates to a job in the area who perhaps see most. And of course, in other areas, all of the 'triage scheme' is telephone based, with the nurse in the police control, acting in remote support and sometimes speaking to patients by phone.

NOT AN ASSESSMENT

So this question of whether telephone discussion is or can ever be mental health assessment is actually important to the vast majority of ST schemes and I would urge those involved in them, whether police or NHS, to have the discussion for the record: is telephone discussion never, ever or always

or a mental health assessment? … and if not never or always, when is it ever?! Whatever actually was going on in the phone discussion to which the Coroner refers it was definitely thought to relate to someone thought by the police (or ambulance service) to be at risk because of mental health problems. But all we really know at this stage is that when after hearing the evidence in the inquest, it has caused the Coroner to be concerned enough to raise the question about what the purpose of it was, if it was 'not a mental health assessment' and the trust definitely stated it wasn't.

Did the police or paramedics know this? … or did they think it was and therefore feel able to walk away reassured on the basis that an assessment had occurred?! Communication was and is always vital to joint agency working and police officers need to be careful to understand what has actually happened in an incident. There have been a few other Coroner's incidents recently where officers have made assumptions about the nature and quality of healthcare assessments and then felt reassured to walk away, only to learn the very hard way (gross misconduct investigation) that healthcare professional hadn't clearly communicated and in some instances, including this one, hadn't made any professional notes about what happened.

The original point of ST, as outlined by the Prime Minister when she was Home Secretary and by various senior officers since, is to ensure more appropriate assessment of vulnerable people and this should lead, it was hoped, to a reduction in the use of s136 MHA and in the use of police cells as a Place of Safety under the MHA. It was further hoped this would, in turn safe police time and resources and I've written elsewhere about why I think in some cases, the opposite has occurred – I won't repeat that hear, but Chiefs should think about it more!

PRACTICAL PURPOSES

Where my brain is completely seizing up is this – so all comments from mental health nurses welcome: is non-face-to-face discussion of someone *ever* a MH assessment? – or not?!

One-word, closed question.

Whilst I'm at it, I'm going to outline a related concern raised to my attention recently by an AMHP. In that AMHP's area where he regular conducted a number of s136 assessments each month before the invention of triage, he would personally expect 'at least a handful' of people detained under s136 whilst so intoxicated by drugs or alcohol that they would be allowed 4-6hrs by him to sober up before his assessment – his colleagues would see other people each month and allow sobriety periods, also. He wasn't complaining about the use of s136 on intoxicated people, except in the odd case here

and there because the individuals were often found at risk on bridges, on high buildings or in positions where suicide was imminently accessible, if the choice were made. He also accepted a large proportion were found to be known to mental health services currently, or previously. His point was this, after discussion with his colleagues: they, as AMHPs, were *never* seeing people in such circumstances any more, or maybe 1 or 2 per month across the whole AMHP rota. Street triage were seeing them instead and his question was this –

Are mental health nurses in his local triage scheme assessing drunk / drugged on their own, whilst still intoxicated, in positions where they were previously being detained under s136 in order to allow them to sober up and be assessed? A section 136 is always at least two-professionals undertaking assessment in controlled conditions – sometimes three professional. Street triage is one MH nurse, usually operating alone (clinically speaking).

We still haven't fully discussed all that we need to, in order to understand the new dynamics of these processes and on the day that publication is made of the IOPC deaths in and after police custody and contact report where, yet again, no specific mention is made of street triage despite the fact that s136 related deaths in or after custody have risen as have deaths after contact without custody, I think we need to start talking just to make sure we understand what's going on here.

AUGUST 2018

3rd August 2018

A Safeguarding Call

The recent conclusion of an inquest in to the death in 2016 of Mr Luke Leggatt in Canterbury has given rise to a social media debate amongst police officers about the East Kent Hospitals NHS Foundation Trust's reaction to Coroner's process. Mr Leggatt had been taken to the hospital by his brother after taking cocaine and having resisted assessment or any treatment for this, had left the hospital. The police were not called when he walked out and he tragically died of a heart attack, caused by a fatal level of cocaine toxicity. Faced with an obvious degree of criticism, the East Kent Hospitals spokesperson announced that they have changed their policy on patients who walk out of A&E to make sure that every such patient is subject to a 'safeguarding call' to the police irrespective of any assessment of ongoing risk to that person.

Job done – over to the police. Settles everything, doesn't it? I have at least few dozen questions and observations about this, not least because of how it appears to have been done.

Whilst missing patient / missing person investigations can often be frustrating to officers, the potential seriousness of each case is widely understood and most officers are told that one of the easiest routes to disciplinary procedures, is to be casual about them. What is more likely to promote casualness than a number of investigations in to people who are not at risk, reporting, it would obviously seem, to create the impression that another organisation has 'done something' to cover it's back after a tragic, adverse event?

MISSING REPORTS

Here is *just some* of what a police officer would want to know from an A&E Department or any hospital reporting a patient absent, absconded or missing. Even if a person is at immediate and obvious risk where you start with crews looking for people nearby and making the urgent and obvious enquiries like "Did they go straight home" or "are they nearby to the A&E?", the force would still try to have one officer gathering this information whilst a search begins, to maximise information and lines of enquiry if searches have to widen and investigations deepen. This stuff can be critical in the 'golden hour' of a vulnerable person being missing.

What has the reporting organisation done prior to ringing the police? – if nothing, why not?! … missing patients are still a hospital's responsibility to a degree, certainly until the police are sufficiently briefed to take over the matter as a missing person's investigation. It should always be borne in mind that missing patients and missing people are NOT the same thing, for what should be obvious reasons. The starting point is that hospitals owes a duty of care and that this cannot be entirely passed to the police with one phone call which says, "Michael Brown walked out: here's his date of birth and address". This is also about not duplicating effort, especially in more urgent cases.

- Name of the person who is being reported missing
- DOB / address / phone number / description
- Details of anyone known to them – Next of Kin; person who brought them in.
- Circumstances in which they went missing – this means more than "walked out of A&E":
- Why were they thought to have come to A&E?
- What condition were they complaining of?
- How long did they remain there?
- Is there **any reason at all** to question in law their mental capacity to take their own decision to leave? – who did that capacity assessment, when and why?
- What are thought to be the medical risks to this individual? – not just on this presentation, but from any hospital records, is anything else relevant to the investigation or risk assessment?
- If no assessment of capacity, because there was no reason to question their capacity; why is the report being made to the police, given that people are entitled to leave if they wish and, although it's rude and inconvenient, they're not obliged to ask permission or tell the hospital.
- What are thought to be the medical risks to that individual of having left?
- Given that there are some limited situations in which A&E departments and hospitals can hold people, why was this not done in this case? – again, this is not a criticism: it is about the police understanding whether it is because the hospital themselves believe that no legal grounds existed … that, in turn, may influence how the police make their legal decisions.
- Precise circumstances of leaving: did they tell staff they were leaving and leave against advice; did they slip out unobserved? – because this begs further questions.
- What direction did they go? – are they known to have left hospital grounds or could they still be on hospital grounds?
- Extent of any search of hospital undertaken by hospital staff / security – if we can't rule out the patient leaving the hospital, I'd be asking

security and staff to search it (because we have had patients turning up dead four days later in toilets that weren't searched).
- Any available CCTV of what the person last looked like when they went missing.
- Bearing in mind that the police will often be entirely unable to make an assessment of whether or not a person is 'safe and well' (medically speaking), and given an obvious lack of legal powers over people in a lot of circumstances, what exactly are the police being asked to *do*, strictly speaking?
- This question is about way more than pedantry: it goes to clinical leadership of a clinical situation that the police cannot fully absorb. If the answer is "once found, call an ambulance", fair enough – but any request the person be 'brought back' to hospital will invite questions about what legal powers are open to the police in that medical situation, especially if a person has not been assessed as lacking capacity.

CAPACITY & UNWISE DECISIONS

This list is not exhaustive – I can think of other questions and issues that would be relevant in some cases. I wonder if the hospital, described in the press article, as "under extreme pressure due to staff shortages" actually has the organisational capacity to sit down with officers and answer these questions for everyone who walks out who is not thought to be at specific risk?!<

And it invites this obvious question:

Are we saying that this process will be what the hospital attempts to initiate if a sober adult man attends on a Friday night because of a cut to his hand from a DIY accident but becomes bored of waiting whilst appreciating that A&E are struggling to see him in four hours because of all the critical, trauma and alcohol related cases coming in like heart attacks, car crashes and assault injuries? Surely, once it's noticed he's not there, you get reception to ring him on his mobile number (which you took during booking in) to wonder where he is and he'll say something like, "Just appreciated you're really busy on a Friday night – I'll bear with it tonight and come back in the morning when you're less busy." Are we seriously saying that this means the hospital will phone the police to make a 'safeguarding call'?!

Frankly and bluntly, what on EARTH for?!!? … a capacitous adult, exercising a lawful choice – even if it's unwise, it's still lawful. What would the police do on arrival that a phone call couldn't try to do? Nothing – it's this aspect of this sudden change of policy by East Kent Hospitals that risks being labelled 'back-covering exercise' … and it is being labelled as such on social media by officers reading the article. It also invites the other question, was

this policy change discussed with an agreed with Kent Police so that the kinds of questions I'm raising here were raised with hospital managers? – and if not, why not?! It is my current understanding this wasn't discussed with them and it amazes me to contemplate that because of the number times in my work the NHS stress that consultation is everything and working in partnership is key.

TRIAGE

There is also one question that arises for me here that has niggled at me all my service. I have dealt with reports like this, during all of my operational roles. What is always missing in those reports from the various NHS hospitals I've worked near, is two things –

- Any obvious consider at the triage stage of mental capacity to take decisions, including that to walk out, for whatever reason – it strikes me that where there is no reason to question capacity (and bearing in mind that capacity in adults must be assumed unless there is reason to question it), this should influence how hospitals respond to adults making choices.
- Any contingency planning for those who might leave, whether indicated or not – this article does not cover what the hospital thought the risks to Mr Leggatt would be if he left and on the one hand they called security but on the other hand didn't stop him leaving.

As a hospital manager, I'd be interested in why staff were reporting people 'missing' to the police – another public organisation that I would also know by watching the news are "under extreme pressure", unless there was an obvious reason to do so. But in fairness, Mr Leggatt presented whilst acutely intoxicated by cocaine and we know that consumption of cocaine can affect mental capacity to take decisions – it is, for example, listed as a mental disorder in the medical manuals and no attempt appears to have been made to keep him there prior, or to call the police at all. It's all very well comments being made to say that hospitals can't force people to things, but actually the law provides a framework for that, *in extremis*. Whether or not those frameworks apply in a given situation is a far finer judgement, but if you read the Kent OnLine article for yourself, you may form the view that I did: that there are a lot of things going on between the lines that are important and not being made plain.

There reasons to suppose a cocaine intoxicated, distressed adult man may be vulnerable on various grounds and that the police should have been called when he left – it strikes me *that* is the problem here: risks and vulnerability were under-estimated and a call that probably should have been made, wasn't made .. one can only imagine why. I'd be interested to see what the Coroner's verdict was or what any Preventing Future Deaths

report may say (if there is one), but this stuff doesn't stack up to a unilateral amendment that everyone who gets bored waiting in a busy A&E and makes a capacitous decision to leave should be subject to a 'safeguarding call' to the police.

5th August 2018

Justice Delayed, not Denied

On August 3rd 2018, Kaylsey Smithen was convicted of the manslaughter of his 46yr old mother, Janice, which took place in Birmingham more than six years earlier. This short post is a little bit of speculation on my part, based only on media reports of the legal process, but which seeks to outline why such a delay can occur and challenge again assumptions that professionals might make about serious mental illness being a barrier to criminal prosecution.

You may remember this case if you follow me on Twitter: at the start of 2018, Birmingham and Solihull Mental Health Trust apologised to Mrs Smithen's family for the standard of care he received prior to her killing. There was some debate arising from the Safeguarding Adults Review about whether the police should have been called to a Mental Health Act assessment and / or whether the police were at fault.

Following his arrest for murder in 2012, shortly after his mother's body was discovered by the police, he was detained under the Mental Health Act (MHA), having been diagnosed with paranoid schizophrenia. He was assessed as being unfit to stand trial – meaning he would be unable to follow legal proceedings or to instruct his solicitor. One report from the Birmingham Evening Mail implies he was given a restricted hospital order in 2013 after being found responsible for fatally beating his mother. This implies a legal process which found him unfit to stand trial but guilty of going the act during a 'trial of the facts'. Whether or not I'm inferring correctly there, he remained in hospital under one provision or other of the MHA.

FORWARD TO 2018

Fast-forward to recent events and his health has obviously been deemed to have improved, at least sufficiently to allow him to instruct a solicitor and understand legal proceedings despite remaining in hospital under the MHA. **Remember:** this is one of my key messages across this whole blog?! –

The fact that you are mentally ill enough to be in hospital, detained under the MHA does ***not automatically mean*** *you are not criminally responsible for your actions and* ***it does not mean*** *you cannot be made to go through*

the criminal justice process. All individual cases are taken on their individual merits – ***no presumption either way.***

Kaysley Smithen stood trial at Birmingham Crown Court for murder in recent days and he put forward a defence of 'insanity' – this means he argued that *"he did not know what he was doing and / or did not know what he was doing was wrong"*, by virtue of his mental health condition. Yesterday, he was found not guilty or murder but was convicted instead of manslaughter on the grounds of diminished responsibility, his insanity defence having been rejected by the jury. This reinforces the importance of this panel of twelve peers: notwithstanding that there would have been significant psychiatric evidence in this case, it all amounts to opinion only – important opinion, no doubt – but opinion nonetheless. It remains necessary for juries to form their own view about things.

Important things to remember –

- Any 'fit to stand trial' considerations, is about whether someone is fit to stand trial at the time of the trial: it is nothing to do with the mental state of the person at the time of the offence. Lord Janner would have been fit to stand trial had he been prosecuted in the 1990s, but he had degenerative dementia when he was eventually prosecuted in the 2010s and was, predictably, found unfit to stand trial.
- Kaysley Smithen's case has worked other way: he was initially 'sectioned' and too ill to stand trial – several years later, his condition has improved and regardless of his mental state in 2012, he was prosecuted because he was not fit to understand the process to which he was central.
- Insanity and diminished responsibility defences are all about the mental state of the defendant at the time of the offence – so in any case like Mr Smithen's where his health has sufficiently improved over time to allow for a trial, it remains open to him to argue and / or for the court to find, that his offending was explained (insanity) or partially explained (diminished responsibility) by his mental state.

PUBLIC INTEREST

You might wonder what difference all this makes, especially if Mr Smithen was given a restricted hospital order in 2013 after being found unfit to plead; only for his recent manslaughter conviction to give him a … restricted hospital order?! There are a couple of things to say: the first being that there is an obvious difference between the following two types of patient –

- A person with serious mental health problems who hurts another person when they were very unwell and *did not know* what they were doing.

- A person with serious mental health problems who hurt another person when they were very unwell, but who **did** know what they were doing.

When it comes to the point where Mr Smithen is being considered for discharge from hospital, or any other patient who has been through this process in a similar way, the Mental Health Unit at the Ministry of Justice, as well as the psychiatrist in charge of their care, will have to give consideration to the risk to the public of release. This is the purpose of s41 Mental health Act: to protect the public from the risk of serious harm and it is what distinguishes a hospital order under s37 from a *restricted* hospital order under s37/41.

So it's easy to see why a finding of guilt for manslaughter matters to the overall assessment of risk to the public, especially given it implies very strongly the relationship between his offending and his illness – it was NOT found to be directly causal. If you open up my blog and enter any of the legal terms for which I've given hyperlinks in this post, you will find other posts with particular examples that have occurred over the years. And if you want to read an excellent book on all this, get yourself a copy of the book in the header image, above – Mental Health and Crime by (LSE Professor) Jill Peay. My favourite book on all this MH-CJ stuff.

And so the familiar saying that "justice delayed is just denied" is not always true! – where an offender has serious mental health problems, some delay may mean that necessary to support and care can be given to a suspect or defendant and that this allows for a trial to occur which subsequently assist in protecting the public from serious harm.

SEPTEMBER 2018

22nd September 2018

ABD and the Ambulance Service

I haven't blogged for almost two months! Various reasons – busy, on holiday, bored of saying the same thing over and over again … there are a few in the pipeline but I decided to put them all to one side to write this one, because the story animated me. It concerns the concept of Acute Behavioural Disturbance, or ABD – it's sometimes referred to as 'acute behavioural disorder', but the 'disorder' word tends to send certain doctors in to an intractable debate because of the lack of research around the concept and the fact that ABD is not recognised in the main medical manuals as a 'disorder', implying a greater level of medical certainty about cause and effect. All this has led the ambulance service to be in a bit of a state about it where some refuse to recognise the term and others are all over this issue like a rash.

The wider debate around ABD has been going on for years, albeit conducted under another name. Some of you may be more familiar with the term 'excited delirium' and any distinction between these phrases only further complicates things – whether ABD is a generic term for a range of things and excited delirium is only one form of ABD; or whether ABD is the new name for what we used to call excited delirium … who the hell knows. But there are a few things I know about this ABD / excited delirium discussion which are more about the law and our legal system than they are about medicine and science. And it's really quite simple –

- **Coroner's cite these things as a cause of death in inquests** – so until medicine and science sort the issues out more clearly, that's the end of the debate as far as I'm concerned.
- **This is (at least a part of) the explanation for why some people died in the most controversial deaths in custody in the last 20yrs** – we can't keep hanging out the police to dry when we know it's about more.

This blog is prompted by a Coroner but not *after* a difficult and sensitive inquest: rather a Coroner is raising this debate *before a full inquest* in to a death and suggesting that she may take the very rare, if not unprecedented decision to issue a 'Preventing Future Deaths' report over ABD, prior to the full inquest in to the death in 2017 of Douglas Oak, in Dorset.

DOUGLAS OAK

In April of 2017, Mr Oak was reported to be acting erratically in Branksome, Poole – he was said to be walking in and out of traffic and the police were called. Upon arrival, officers located him and formed the view that he was exhibiting signs of ABD – in accordance with national guidelines in policing which have existed for at least eight years now, they called for medical help. Since at least 2010, national guidelines for the police service state that excited delirium (now known as ABD) should be treated as a medical emergency until otherwise declared by more qualified professionals. This means an ambulance should always be called where these concerns exist and someone will probably need to be removed to an Emergency Department. In fairness to this police position and the healthcare issues that I'm about to outline, there are various documents in existence to support this approach. Indeed, it was consultants in emergency medicine in Birmingham and senior paramedics in West Midlands Ambulance Service who, to their eternal credit, helped me and West Midlands Police understand the risks and threats around this stuff as we were trying to improve our responses to such incidents following the death of Michael Powell in Birmingham in 2003.

The National Institute for Health and Care Excellence (NICE) published a Guideline in 2004 (no longer available on the internet) on the short-term management of violence in psychiatric settings and emergency departments. Within, there is clear contemplation of a necessity whereby we look at 'disturbed' or 'violent' behaviour and recognise that there could be various medical explanations behind such presentations. This document has since been updated and the original replaced: NICE published Guideline NG10 in 2015 which takes these arguments further. It helps us in the police and elsewhere understand various long words which are difficult to spell: all medical conditions that may need assessment and treatment in ED as an emergency. The obvious implication here is: don't take these people to custody and restrain them, because that could end very badly indeed and everyone will wonder afterwards why you did that.

But isn't this a story we're familiar with? – police removing vulnerable people to custody after restraint, sometimes whilst continuing restraint and people collapse and die?! Sean Rigg, James Herbert, Seni Lewis, Toni Speck, Rafael Delezeuch, Kingsley Burrell, and many others. We know that investigations in to the deaths of Leon Briggs, and Kevin Clarke are ongoing, in addition to the death of Douglas Oak and in the earlier of those cases the precise problem was that the police absorbed responsibility for the whole incident, without attempting to call on medical help and without thinking clinically, and people died. More recently, we're seeing this trend change: the police ARE thinking medically and clinically but when they call upon or work alongside healthcare staff, those professionals either don't

respond in a timely way, are themselves unsighted upon ABD as a problem. Obviously in the case of Mr Oak, as with the case of Kevin Clarke, it is known from press coverage or press releases that police officers called an ambulance.

POLICIES AND PROCEDURES

This is not necessarily about, or not just about, individual ambulance clinicians or their staff. No doubt, from my experience, there are some clinically qualified staff who could do with clicking on the link for NICE Guideline NG10 and reading it, or perhaps some other material I will link at the bottom of this post. However, a bigger problem is whether organisation recognise the risks an issues. For example, a number of ambulance services across the UK have told their police forces that they don't recognise the term 'ABD' and that officers need to stop using it, instead providing descriptions of behaviour which work better with ambulance triage systems. Of course, just what we want and need when handling an emergency as a long and complicated discussion of descriptive features rather than the ability of police officers to just say (or shout!) "ABD!" to then allow a shared sense of what we're referring to.

And this is not just about ambulance services: we have seen in recent years and in some of those Coroner's proceedings problems of this type with locally agreed policies on the operation of s136 of the Mental Health Act. You might remember the case of Terry Smith in Surrey, where local policy expressly stated (and still states!) that officers who have detained someone who is 'violent' or 'unmanageably disruptive' are more likely to require removal to custody as well as those who are known to the under the influence of drugs. So where Mr Smith had contact with the ambulance service initially but where the police were called because of agitated behaviours, the use of s136 lead to his removal to the police station and local policy said nothing to even countenance that may not always be safe. It did contain a vague paragraph stating the obvious: that if someone required urgent medical attention they should be taken to an Emergency Department but the document made no attempt to reconcile the contradiction that can occur between the need for urgent medical attention and the imperative to take 'unmanageably disruptive' people to custody. And just to be fair to Surrey, their policy isn't isolated: similar problems existed in the policy in place at the time of the deaths of James Herbert and of Leon Briggs – all three cases occurring in different parts of the United Kingdom, so we can infer this is about something more deeply ingrained in our health system's approach to these matters.

And in all fairness to the point I'm making here: there are guidelines out there in the real world about ABD – some of them more recent, but others are older. The Royal College of Emergency Medicine and, separately, the

Faulty of Forensic and Legal Medicine have published guidelines on these matters. The RCEM guidelines from 2016 are linked within the Guardian article covering this Coroner's request for clarification about ABD after the death of Mr Oak. And yet the ambulance service have been known in some areas to say, "Those guidelines don't apply to us". Well, no they don't – strictly speaking. But on what basis does the ambulance service reject the clinical guidance of the United Kingdom's specialist Royal College for Emergency Medicine?! These guidelines don't 'apply', strictly speaking' to the police service either, but I'm not sure where we'd start in any rejection of them, unless that objection were a legal one, where we can claim at least some competence. But if the RCEM guidance isn't sufficient, then we also need to know where the ambulance service stands on –

- Nice Guidelines on Violence, NG10 – published in 2015
- NHS England Patient Safety Alert on post-restraint observations – published in 2015.

ADVICE TO POLICE OFFICERS

Firstly, if any officers or paramedics wish to know more detail than I'm covering in this post, there is a three-part series on ABD elsewhere on this BLOG, written by a consultant in emergency medicine. Part One of the series contains the links to the other two.

All frontline police officers can do whilst people like me are sent in to rooms with senior health and ambulance leaders to work with them as they get their heads around this, is –

- Call an ambulance to **every** detention you make under the MHA or in any other arrest / detention you make where ABD is a concern.
- Remove that person to ED for assessment and treatment whilst bearing in mind that paramedics will be unlikely to be able to rule out ABD at the scene.
- If the ambulance service can't / won't / don't come, then get that person to ED without further delay, once you know you're not getting an eight minute response.

Also bear in mind the reverse imperative to support: in the deaths of Leon Briggs and Terry Smith, the 999 calls and initial incident handling were ambulance service incidents. In each case the police were called to assist and it led to detention under s136. However in neither case did the paramedics on scene travel to the chosen location with the patient – if these people are on scene when you're busy helping them with the incident, make sure they continue to help you after you've helped them! It's only fair. We don't want people collapsing in the back of police vehicles; and if people do collapse we'd prefer that a paramedic with a grab bag was right on hand.

Whether people travel in the ambulance with police support or in the police vehicle with paramedic support – I don't mind. Make a sensible decision based on a risk assessment but whatever you do, make sure as far as you can, that both professions travel with the person. Document everything afterwards, about whether they showed up, whether they helped, whether they travelled. The Coroner may well be interested.

Our ambulance service is strapped and paramedic education around mental health and mental health law is not where the College of Paramedics would like it to be – they are currently working on that. But their service being strapped means there will continue to be cases, beyond the control of operational paramedics and front line officers, where they are unable or unwilling to attend, perhaps because the 'ABD' term isn't pressing buttons for them.

You can only do your best and once you realise they're not coming: Emergency Department as soon as you possibly can – it's a medical emergency until otherwise declared and you have all the documents available today (linked above) to support this position.

23rd September 2018

Not Enough of Something …

We don't have enough inpatient mental health beds in this country – but I might be very wrong about this, though! It is my opinion, that when we take account of the capacity and capability of the community, crisis and social care which is currently available, we don't have enough beds. Solve that by increasing the community and crisis care by all means, so that there are alternative services for people who don't inherently need admission, but who need more or different support as an alternative to admission; increase social care by all means so that people currently in hospital who are medically fit for discharge from hospital can actually be discharged in circumstances where their housing, substance use, education or employment needs have adequate support to help them lead independent lives in the community.

But my underlying point is: the balance is not right and it is perhaps we, in the police service, who see this most obviously when patients need beds after a statutory Mental Health Act assessment. Although AMHPs are often the ones left wrestling the bed management system (despite it not being the AMHP's job to find the bed), it is the police who are all too often expected to go above and beyond to keep people safe whilst all that plays out, even where the law has run out of options by which we may do so. There will be an inquest later this year, where this will all be played out in light of a death and so far, the debate in that area seems to ignore the reality of our laws.

Three problems –

1. MHA assessments in the community, no bed available – police asked to attend someone's house or A&E to 'wait' with them until such time as a bed is found.
2. MHA assessments in a 'Place of Safety' after use of section 135 or 136 – police expected to remain through the entire assessment period and until a bed is found.
3. MHA assessments in police custody (after an arrest) – officers expected to keep the person detained in police custody until the bed is found.

The problem with all of the above, is that laws apply to this situation to ensure that in some versions of each, it would be unlawful for the police to do this. Unlawful in the sense that the Mental Health Act itself is arguably

breached (I'm familiar with the counter arguments, hence the word 'arguably' – don't write in); and in the sense of whether or not the MHA is breached, the way it was adhered to still failed to protect even more fundamental rights.

SECTION 13 MENTAL HEALTH ACT

A number of times over the last fifteen years, the police service has sought legal advice around MHA application processes and a number of solicitors and barristers have come back with opinions which fly in the face of established practice in most areas I've known. Specifically, when I first read s13 MHA – which covers an AMHPs duty to make applications – I remember reading the criteria that must apply before the AMHP "shall make the application" and noticing it said nothing at all about 'beds'. It talks about hospitals. Now, of course: a hospital with no available bed in it is quite likely to say, "No, we can't admit that patient" because there is no available space. Such considerations as safety, staff patient ratios to ensure effective care and supervision will all play in to this. We know that mental health wards are often difficult places and

But this doesn't alter the fact that the Act says the AMHP "shall make" the application once the criteria are met. They are –

- That the AMHP believes that an application ought to be made
- Having regard to any wishes expressed by relatives or the relevant circumstances that it is necessary and proper for them to make an application
- (Assuming of course, that they have the necessary medical recommendation(s) for the section being considered);

Remember as well: whatever argument is put up about custom and practice of not applying until beds are found, or the interpretation of s13, etc.; that s6(1) of the Human Rights Act 1998 applies to these matters and no public authority (a HRA term which applies to both mental health trusts and local authorities) may act in a way which fails to uphold someone's fundamental rights under the European Convention. So, delays in making applications which compromise someone's right to life (Article 2), their right not to suffer inhumane and degrading treatment (Article 3) or their right to liberty (Article 5) are just some of the issues which could be engaged by delays.

So this bed stuff is not *just* about how we balance community and institutional care – it's about the fundamental rights of our most vulnerable friends and neighbours.

PREVIOUS ESTIMATES

We've always known these delays have gone on – in 2005, Greater Manchester Police had to threaten judicial review to end a three-day detention and it got as far as them having a Barrister outside the High Court, ready to go. In 2007, I remember having to advise in a murder investigation where such problems were emerging, helping the SIO to navigate through the MHA process and it was only the threat of legal action which led to a bed being found. In 2015, Devon and Cornwall's Assistant (now Deputy) Chief Constable, Paul Netherton, did a public tweet and we know Twitter has seen similar protests more recently. But what we were lacking for ages was a sense of scale: we know it happens, but how often does it happen?!

In 2016, the National Police Chief's Council did some work on this and ended up suggesting, based on some dip-sampling that this was a 2,000 times a year problem. Eventually, that was accepted as probably being near the mark, but more recent, more in-depth work has revealed that it probably wasn't even the half of it. We currently estimate it to be 4,000 to 4,500 times a year that the police are connected to people in scenario 3 (above) only – delays for people under arrest in custody. If you then looked at detention under s136, we know that some forces report that all of their s136 assessments are concluded within 24hrs, but the finding of a bed is not always within that timescale, as it should be. One force, who've looked more closely at all of this, argue that 30% of their section 136 detentions do not conclude within 24hrs, usually because of delays waiting for beds.

Even if that number were double the national average, if 15% of all s136 cases were unresolved 24hrs after they began, that would be another 4,500 to add to the pile – 9,000 so far in total. The police service have no way of knowing how many delays there are in community assessments because we're usually not involved in them, but I do know of some such assessments where the outcome whilst waiting for a bed was that the service user died before the bed could be found. In other cases, the patient has run from their home, been reported missing and then found and either detained under s136 or arrested.

WHERE DOES THIS LEAVE US?

We know that when AMHPs want to make applications under the MHA, they are prevented from doing so in a timely way many, many thousands of times a year. So much so, that the fundamental human rights of patients is compromised, sometimes in ways where their life has ended when we have to wonder if it would, had there been a timely application. We also know that where AMHPs and others get nervous about the risks associated

with those delays, they often look to the police to solve that problem, even though the police may not have been involved at all up to that point and where they may be legally powerless to do so, even if that were already involved.

The law sets out frameworks to be complied with: it seems astonishing to me that we don't take the time and trouble to measure how often we do and then review the commissioning and provision of services in the light of those findings. But one major problem is that the breach of s13 which is evidenced by the non-making of an application which the AMHP thinks is required, is not always regarded as the legal breach that it is – whether viewed as a breach of the MHA or a breach of the human rights implications of how the MHA operates. Pick you breach, by all means – but let's at least agree there is one!

This again comes back to things like s140 MHA: the provision which provides a duty on Clinical Commissioning Groups in England and Local Health Boards in Wales to specify hospitals in their area which can receive patients in circumstances of special urgency. There is a bit of work now going on about this widely ignored provision that some CCGs admit they don't know about, at all – despite it being mentioned in the Code of Practice to the Act and, perhaps crucially, in the Act itself. But regardless of your profession, do you know what the local s140 arrangements are to ensure that patients can be admitted in a timely way, without their fundamental rights being compromised? If not, why not?! … you might want to ask.

Either way – we don't have enough of something.

27th September 2018

The Thankless Task

Have you ever been given a piece of work to do or faced some decision in your life where no matter what you do, you'll be criticised? More than that: the vast majority of people will look at your decision and either criticise or comment that things could have been done differently?!

I've spent many hours this year, especially over the Summer, in various meetings associated with the Mental Health Act review. In particular, I was recently in the Advisory Group to the Review, chaired by Professor Sir Simon Wessely, past President of the Royal College of Psychiatrists and Regious Professor of Psychological Medicine at King's College, London. Whilst there, whilst listening to various people talking about the sensitive and important issues which may feature in the report the Professor must submit to the Prime Minister, two things ocurred to me:

- Because of my general effort to blog a bit less often during 2018 than I did in 2017, I have managed to say precisely nothing on here about the review – and I should correct that as soon as possible.
- Far more importantly, it occurred to me: no matter what this bloke recommends, many people, if not most people, are going to criticise him or comment that it could or should have been different.
- Some will politely and constructively criticise that he perhaps could have gone further in some areas whilst regretting that he didn't; and others may quite vehemently criticise that he hasn't been anywhere near radical enough; or hasn't been inclusive enough; or has listened too much to some vested interests, whilst not to others – you only have to be familiar with the many debates, arguments and amazing fallouts on social media to see how extremely dissatisfied some of us are with our mental health system and the laws within which it must operate. So how you come up with a series of legal recommendations that satisfy everyone in those disparate and dissociated groups, I've no idea … but come December 12th, when the final report is published, we'll see where we are.

WHERE ARE WE NOW

You may remember, back in April, the Review published its interim report and outlined what it thought the general issues were and the specific areas where more work was required. There were eighteen areas overall and each

issues has had a 'topic group' working over the Summer on the various issues within that topic. So for example, the police topic group, chaired by the PCC lead on mental health, Matthew Scott from Kent, has been looking at the five specific issues flagged by the Review leaders, as well as considering a few other issues which member of the topic group feel need considering. If you want to refresh your memory on those things, see my previous post from May 2018 on the policing implications of the interim review.

So, the police have been involved in various other topic groups because there are obvious overlaps with some of the other issues: there is a broader 'criminal justice' topic group and another on African-Caribbean mental health. We've chipped in briefly at the Advisory Group on some other topics which are not about policing, but which have the occasional overlap – such as the mind-blogging complexity for frontline officers of 'recalling' people from a Community Treatment Order. "What's a community treatment order" you might ask?! If you don't know – and why would you?! – then you probably don't know the three different ways in which people can be recalled from them AND the different timescales which apply to the effect that those methods has on the ability of the police, AMHPs or others to re-detain people and take them back hospital. I've known mental health professionals of all kinds get this stuff wrong, when they manage patients on these orders as a part of their day-to-day work. How often is the average police officer asked to return someone who has been recalled?! … not often enough to make it reasonable that they have free recall of the methods and timescales, that's for sure! That's just one example for you – we've asked for that to be looked at.

So the policing topic group has finished its meetings and reported back to the Review leadership: they now have the heavy duty of working through all of the competing priorities and vested interests at stake in order to decide what to recommend to the Prime Minister. There are still some public meetings in October, whereby those who still have an interest in how this pans out can make their views known but by December 12th, Professor Wessely must make recommendations to the Prime Minister about how the Mental Health Act should be changed.

MANAGING EXPECTATIONS

You might remember if you've followed the debate at all, that the problems being flagged to necessitate a review were –

1. Rising rates of detention in hospital, under the MHA –
2. Disproportionate representation within those figures of those from an African-Caribbean background.

I've learned a lot from being involved in this process, especially the African-Caribbean group chaired by the quite-inspiring force of nature that is Jacqui Dyer MBE. Jacqui was the vice-chair of NHS England's Five-Year Forward view and is an experienced and impressive campaigner around mental health generally and "the black experience" in particular (that's the term Jacqui's uses). It's obvious that if you just think about the policing stuff; or the African-Caribbean stuff; or the Criminal Justice stuff – what Simon is grappling with are multi-faceted, complex issues with irreconcilable vested interests at stake.

Some people think the MHA should be totally abolished and not replaced – did you know that some countries don't have a Mental Health Act or equivalent? … who knew?! Some think it should be *totally* replaced with a new Act that is predicated exclusively upon 'capacity' and people's decision-making – but did you know that some very vulnerable people with certain mental health conditions that could lead to their death, don't lose capacity until they are medically beyond hope of recovery – eating disorders was given as an example of this. Some have argued that as the British Government is a signatory to the United Nations Convention on the Rights of Person's With Disabilities (UN CRPD) and that the review recommendations should be fully compliant with that international treaty and the 'optional protocol' that we also adopted.

So be prepared, no matter what position you come from to find that all of this complex, competing stuff cannot be completely reconciled to the satisfaction of everyone.

POLITICS AND THE REAL WORLD

The political reality of this is: no matter what Sir Simon recommends, it means *nothing* at all in the real world unless the Government adopt it and get it through Parliament, in whole or in part. And we should all bear in mind it will take several years to do that, no matter the detail of the report. Those of us who remember the fate of the Mental Health Bill 2004, which was the initial product of the last review of the Act (The Richardson Review), will remember it was loaded with some controversial stuff insisted upon by the Labour Government and the opposition was such that the whole Bill fell which meant NOTHING got through.

The interim review report sets out an obvious desire to make a positive difference in a number of areas: whatever your view on the particular changes required, it's all just been a very interesting talking shop (with nice Royal College of Psychiatrists biscuits!), unless something from this report makes it to the House of Commons for a vote. I hope to see a few things in there which, based on this Summer's work, seem likely to feature

because I'm keen to see that lead to change in the real world – we have been talking about some of the things the Review may help change for *far too long*. And by 'far too long', I don't mean the review's timescales – the review has happened at pace. I'm referring to the *years* and *decades* for which some problems have existed in the real world because our Mental Health Act 1983 is, ultimately, just the Mental Health Act 1959 with some additions to safeguard rights.

We, the police service, are policing alongside a highly-deinstitutionalised model of mental health care, rightly replete with demands and concerns about autonomy and human rights, using legislation drafted at a time when those demands and concerns were taken less seriously and when the role of the police was very different. Our model of mental health care is unrecognisable compared to that when the Act was created and our expectations of our police officers has evolved. I use that word advisedly, because evolution doesn't imply design! Simon's job in reconciling all of this is quite a thankless task, in a way – that's just my opinion.

But his focus on making a positive difference in the real world has remained and I'd close with this observation, which I make willingly: I've seen criticism on social media and in email exchanges of how he's and the Review leadership have approached their duties here and having been in more meetings than I can count since the end of last year, I can honestly say I recognise none of it.

I wish him the best of luck squaring his circles!

OCTOBER 2018

5th October 2018

Even More on ABD

Today the College of Paramedics produced their position statement on Acute Behavioural Disturbance and it adds weigh to those tomes I've previously pushed as authorities or resources on the subject. ABD continues to be a subject of debate, arising recently in another post I did during a pre-inquest hearing in Bournemouth in to the death of Mr Douglas Oak who was 35yrs old. In that matter, Dorset Police called for support from South West Ambulance Service after believing Mr Oak was suffering from ABD and the subsequent issues with ambulance attendance have led to a comparatively rare direction from the Coroner who is inquiring in to Mr Oak's death at a young age.

Bearing in mind a full inquest is yet to occur and not scheduled to take place until 2019, the Coroner gave the ambulance service two weeks to produce more material on ABD and their policy or response to it, and suggested that unless she was satisfied she may issue a preventing future deaths report prior to the full inquest occurring. I'm not sure I've ever known that happen before, so it's not insignificant. I don't know whether we'll hear more about that publicly prior to the inquest, but it's one to watch.

And meanwhile, following the inquest in to the death of Terry Smith, which was listed as partly attributable to ABD but where a private ambulance crew acting on behalf of South Coast Ambulance Service called for police support and then remained uninvolved in taking clinical decisions about his welfare; and following the death of Leon Briggs which is subject to ongoing proceedings but where it is known the ambulance service called for police support and where the police ended up conveying him to police custody without paramedic support, there are ongoing questions all around the country about ABD.

COLLEGE OF PARAMEDICS

So today, I think it's welcome the College of Paramedics has weighed in to this with a very brief position statement, just two pages long and it will be worth police officers and paramedics reading this. It will now be added by me to my standard list of resources I mention when having to give reasons

to push past some of the junk we hear about ABD from all manner of healthcare sources, including some MH trusts, some acute trusts as well as some Ambulance trusts.

Anyone who has read up on this topic or followed this BLOG will know that ABD is not officially listed in medical manuals like the DSM5 or the ICD-11. We are all fully aware that the 'pathophysiology' (try spelling that after a few drinks) is not settled amongst clinicians or scientists and we know that the position various NHS trusts adopt on this issue can often be influence by one or two people with opinions which are nor more or less credible than the opinions of their peers in other similar organisations which are the polar opposite of theirs. We all get that this is difficult because we don't want to over-medicalise things, but concern that we may do that doesn't automatically trump the concern under that we might have been under-medicalising things.

So this is a fact: in the absence of certainty or a more clearly agreed position on the aetiology and epidemiology of ABD (we've all got dictionaries), **the police service are the ones in charge of refereeing this argument and we will resolve it for you.** This may seem like a controversial, indeed a very arrogant opinion to offer, but it's predicated one simple reality: **we are the ones left dealing with people if the NHS can't decide what to do.**

So in the absence of an agreed position across the UK, and in light of the these difficult cases being rare events that could happen anywhere in the country and where simple instructions are needed for officers who will deal with this kind of incident maybe once or twice a career, at most – the police service will be letting its most junior people and it's junior leaders sort out which consultant psychiatrist or emergency consultant gets ignored and which ones get listened to. You may ask yourself what could possibly go wrong with that approach?! – they do have first-aid at work certificates, after all so are not entirely unqualified to arbitrate on such lofty clinical matters involving multi-syllable words!

WHY NEW GUIDANCE?

The College of Paramedics made it clear in their social media coverage why they've produced a statement and you can see it in their tweet, in the header image, above –

This is a *direct response* to problems which have bearing on the ambulance service from deaths in police custody which have been aired in Coroner's Courts. So it's in the interests of ALL operational officers to know the College of Policing guidance on this, which reflects the documents I normally cite when ABD comes up –

- The RCEM guidelines (2016).
- Nice Guidelines on Violence (2015)
- NHS England Patient Safety Alert (2015).

The College of Policing, like NPIA before it, have guidance which says:

- ABD is a medical emergency until otherwise declared by a clinician in direct contact with the patient.
- So consider the need for an ambulance every time for urgent assessment and transfer to hospital.
- There may be rare cases where it would be faster to get someone to A&E by police vehicle than it would to get an ambulance to the person: this may amount to a 'cogent reason' for not calling an ambulance, but that should be a deliberate decision.
- Where ABD is suspected and any detention is under s136 MHA, by definition of the medical emergency there will be no time to consult with a professional who is not on scene and it should be borne in mind that a 'paramedic' is suitable professional for the purposes of s136B consultation.
- Where someone has been removed to an healthcare environment whilst exhibiting challenging behaviour, officers should support NHS staff to ensure the safety of all.

Today's publication isn't saying anything new: it just adds weight to what the police service have been saying for years, but please bear in mind if you are an officer: not all ambulance services have agreed positions, procedures or pathways so in order to give weight to the above, you may need to assert your position and take control of a clinical situation in the face of clinical staff who are not necessarily working with you. Having had to give evidence in Coroner's Courts in the last year or so, it's important you demonstrate you have discharged your responsibilities under the police services' national guidelines, notwithstanding what your local paramedics or ambulance service thinks. History shows the spotlight will be on you, not them, if things go wrong so you need to know your position and be ready to assert yourself for a safe outcome.

For other links to resources on ABD, including a three part series written by a Consultant in Emergency Medicine, see my most recent post on 'ABD and the Ambulance Service'.

13th October 2018

Minimum Standards

This one's longer than normal – sorry! Thoughts just kept coming, so it's probably best you put the kettle on first and ensure you have more than a few minutes! And treat yourself to a biscuit – non-chocolate hob nobs are best.

There are a lot of conversations occurring nationally at the moment, at operational levels of policing, about what I might call 'minimum standards' in partnership working. Everyone knows that both policing and health services are stretched, mental health services in particular being more negatively affected than non-mental health services, as ever. But I'm increasingly hearing from duty inspectors and sergeants that they are sometimes having to decide which 999 calls for urgent help they don't answer, because their officers are sitting calmly in healthcare settings with people detained under s136 MHA for periods of time that seem only to be lengthening: lengthening in how long it takes to secure an assessment; lengthening in how long any admission takes to organise, because of difficult in finding beds, for example. Having been that duty inspector, I know that I'm not the only one who has occasionally decided that I'm obliged to take a big risk by leaving someone with NHS staff who are not willing to take responsibility for that person, because those officers are more required elsewhere and that if I have to explain to the Chief why I had to stuff something up, I chose that rather than the armed robbery, the shooting or the child rape incident. << That sentence alludes to a *real* decision in my own career from 2013. Which of those things would *you* rather not resource at all because your officers are in ED guarding a man who is asleep with no sign in our future of an assessment?

Many times over the last decade we have seen police forces sitting down with their partners because of a variety of initiatives and reforms, to plot how the future will operate because of a new report, changes in the law, a new Code of Practice or whatever. Working backwards: we had legal change last December (2017), we had the Angiolini Report just before that; we had new Codes of Practice (Wales, 2016; England 2015) the NHS England Five-Year Forward View (2015) and a whole range of things coming out from the Crisis Care Concordat (2014). We might as well keep going: in 2013, we had new 'commissioning standards' from the Royal College of Psychiatrists' group on s136 MHA which came only two years after the last revision of their Standards on the Use of Section 136 (2011) and that was only the

year or so after the Bradley Review injected some focus in to policing and mental health in the review of all mental health / criminal justice stuff. So that (non-exhaustive) list takes us back only to the start of the decade – real historians of this agenda will know we could go back further, to the first decade and even back to the last century.

Here's the thing: whilst we can point to some areas where some progress has been made; anyone who wants to argue that it's all been progress is not paying enough attention to the detail of this OR they are not interested in it. It's really easy to make a 'political' (small p) argument about the vast progress we've seen: let me explain what I mean by that.

POLITICAL APPEARANCES

If a member of the public wanted to contact a senior official in healthcare or policing; for that matter, if they wanted to contact their MP, a Government Ministers or even the Prime Minister and argue that things were getting worse or not as they should be, it would be child's play to come out with a superficially convincing response that has the effect of dismissing the concerns and deflecting them away. "What do you mean things are getting worse – we've changed the law to reduce the use of police cells as a Place of Safety, there has been £15m of funding for extra Place of Safety services and more funding again for initiatives like 'street triage' and 'liaison and diversion' in addition to which the Crisis Care Concordat has proved vital in bringing organisations together to improve crisis care pathways to ensure people get the right treatment at the right time."

This is hard to argue with: firstly, because it's all true and has had some positive effects; secondly, because to argue that those positive effects need to be seen against any neutral or negative impacts. (Anyone who has ever tried to change large systems and cultures will know that nothing has unintended consequences that the impact of some very necessary and welcome change will be negative. It's how you weigh the relative values of those things which help determine the overall desirability of the thing.). But thirdly, you actually have to know your stuff to be able to analyse this: it's no good shouting at me (as has actually happened, more than once) that something is good when your own analysis shows you have failed to take account of very important things in reaching your conclusion; AND when your exposition of the benefits of your thing show that you lack the legal knowledge to realise that the thing you're shouting about breaks the law!

POLITICAL REALITY

It is my own view that we have made lots of progress in many areas since 2010 – there is no doubt in my mind at all. I'm always going to be particular pleased and proud that the use of police cells as a Place of Safety under the MEntal Health Act has reduced from 11,500 in 2008 to just 1,015 in the last set of figures. The next set of figures, it has been hinted, will see that reduce again by more than 50%. I have heard from more than one Political source (capital P!) that the work West Midlands Police did in 2005-2010 with partners after the death of Michael Powell is what convinced many that there could be a real and permanent reduction in the number of people we jail for their trauma and distress. But because this is my favourite example, I want to use it to demonstrate the claim I made in the previous paragraph that you also need to look at neutral and negative impacts of this 'progress'.

- It is **more resource-intensive** for the police to remove someone to a healthcare setting than to jail, *unless* that Place of Safety service is operating to the very high standards suggested in the Royal College of Psychiatrists' (2011) Standards on Section 136.
- Incidentally, 'street triage' is often more resource intensive than not having street triage. << Not (just) my view: that of a UK Chief Constable whose force has a very well regarded scheme which blazed a trail.

When we started with the Place of Safety work in 2005-2010, West Midlands Police had it is a red-line that we would not, could not and should not remain in any health-based Place of Safety that was set up with every single person who was removed there. Plenty of reasons for that: a) it's simply not necessary for vulnerable people to have the police hovering over them in all cases – to suggest it is to reinforce the assumption mental health services often campaign about that patients (most people detained under s136 are known MH patients) are violent; b) it's not the nationally agreed standard about what should happen – the 2011 standards had a 2007 predecessor which said the same thing on this point; c) the effect of a policy where officers remain with all people detained is that it would cost West Midlands Police double the resource (or more) to staff the MH unit in this way – at a point where we knew massive reductions in officer numbers was coming, that simply wasn't an option and the Chief Constable would have rightly asked why I had just cost him that resource, especially given that the national agreement is that it wouldn't be done this way.

I won't pretend it was easy to convince partners that this was a necessary red-line: I won't even pretend that in principle, some of them agreed and then in practice we had early bumps where operational staff would disagree with the very clear process we had set up to determine whether the police remain and an escalation process for disagreements. But I will say, that after the whole things settled down, it worked well enough to be tolerable for all, with occasional incidents reminding us all of the need to keep an eye on things. Overall, after the first period of operating, we actually found

that the force we saving resources, compared to the previous use of police custody – around 50 full-time-equivalent constables per year.

MAKING PROGRESS

We have more change-inspiring initiatives coming down the line: in less than two-months, Professor Sir Simon Wessely will have published his final report reviewing the Mental Health Act 1983. That will set off a process in Government of looking at his recommendations and decide whether or not, and when, to bring forward a Bill for consideration in Parliament. Being realistic and knowing how long it took for the Richardson Review in to the Act to lead to the Mental Health Act 2007, it will be a number of years yet before we see further legislative change. However, the overall point I'm making in this post is that we have LOTS of work to do before then in many areas. And the example I've chosen about resources and Places of Safety was a deliberate one for another reason, in addition to being my favourite.

The Wessely Review has asked the Policing Topic Group to look at and advise on whether the use of police custody as a Place of Safety for adults may be entirely banned, in the Act. The topic group advised that it could and should be done. Ultimately, of course, it is up to Professor Wessely to decide whether or not to make that recommendation in his final report; and up to the Government to decide whether to accept that and put it in to any Bill they produce in the future. But we also know that this will represent a different kind of challenge in different parts of England and Wales because of where things stand *today* – in October 2018.

Some areas use of police custody is negligible: West Midlands and Merseyside were down to zero-use of custody in the last figures; Hertfordshire were also there recently but along with Leicestershire, Northumbria and so on, had only a couple of people. I'll bet, if they're honest with themselves when reviewing those cases, that there probably wasn't a particularly problematic reason why those individuals couldn't have been managed in a non-police setting and for all those areas, things will be relatively easy in terms of reducing the use of custody to zero, if the law should change. However, will the officers from those forces have to remain in the Place of Safety every time, with every detained person, regardless of risk, in violation of the nationally agreed standards from 2011? Currently, in some of those areas, the answer is yes.

NEGATIVE AND NEUTRAL

If you have surveyed social media in recent weeks, you will see that there are problems in this sphere: this is what I mean with 'negative' and 'neutral'. It sounds great that we're reducing the use of custody, but what we do know, for definite, is that this does NOT mean people are easily accessing relevant MH unit Places of Safety where a consideration can be given to handover. Some areas of the country do not have sufficient Place of Safety provision for the numbers being detained and when officers find that they are unable to access such places, they default now to Emergency Departments because of the severe legal restrictions on being able to use custody. People can have their views on whether ED is, in fact, better than custody but most police and ED staff would probably agree with each other that neither is great unless the person is a) accused of a crime sufficiently serious to mean that has to be the priority; OR b) medically unwell or physically injured in such a way that ED has to be the priority – neither environment is designed to be the 'right' kind of place for a vulnerable person needing a quiet space to stay safe until they can be assessed.

But Twitter tells us(!), that in Lancashire a few months ago, there were seven – yes, seven! – detained people in one ED at the same time, purely because officers couldn't access a Place of Safety in a mental health unit. Most of the mental health trust's 136 suites were being used as temporary 'beds' for patients requiring inpatient admission under the Mental Health Act, thus denying access for anyone detained by the police under section 136. Of course, seven detained people means fourteen police officers in ED ensuring that people remain detained and this problem was compounded further because some of those 136 detentions remained detained way beyond the permissible 24hrs because patients needed inpatient beds that weren't available – which we knew, because that's the problem meaning they couldn't access the Place of Safety in the first place! This week on Twitter, a response inspector was also tweeting about 5 people being detained in ED with inordinate delays for assessments and difficulty securing beds with many police resources 'off the road'

So, even with the 2017 amendments to the police provisions of the MHA we know there are problems delivering upon them. Further amendment in the future will only compound this if, before then, we do not get to grips with the problems we already face. Later this month, the Government will publish the latest s136 figures which will be capable of a positive spin, because it seems highly likely the numbers going to custody will have more than halved from last year, continuing a downward trend from 2008; and we also know that most of the use of custody in the forthcoming figures will relate to that part of the reporting period before the law changed to restrict custody. One police force told me, they'd used custody more than 100 times up to December 10th 2017, but from 11th December they hadn't used it once. So I've every confidence that when we sit here in October

2019 looking at the first set of figures which cover a whole year of activity under the laws amended in 2017, we will see the use of police custody down to double-figures nationally. When I remember that 10yrs ago West Midlands Police accounted for over 1,000 uses of police custody, double-figures nationally would be quite an achievement.

UNINTENDED CONSEQUENCES

However! … has it come at various kinds of cost that are not sustainable? Have we got large queues of police vehicles in EDs purely because someone thought to need mental health assessment has been removed there, purely for a want of other options? Are police forces effectively staffing s136 suites because CCGs have commissioned a room in which to wait, but no staff to receive, assess and supervise the patient so the police can be release in appropriate cases, *as per national standards*. If these standards mean nothing, perhaps they should be ripped up? – because it creates an expectation on the part of the police and I still regularly hear stories that CCG MH commissioners don't know of these standards and dismiss the need to consider them because the police are still 'over-using' section 136. It leads to the argument 'why should we have to resource a unit to look after people who should never be detained in the first place?'. Those arguments have been addressed elsewhere and remain, largely, fallacious.

I'm yet to have such discussions with NHS staff, CCG commissioners or police officers for that matter, where it isn't obvious very quickly that their definition of 'over-use' is predicated on a less-than-full consideration of what 'appropriate' use is. Of course, you can point to examples of where s136 was used when we'd probably all agree it shouldn't have been. But I can also guarantee that if I walked in to custody or analysed street triage encounters, I could find you concrete examples of incidents that led to arrest or led to no detention at all, where s136 should have been used and wasn't. As Baroness Hale (President of the Supreme Court) said, in her textbook on mental health law (2017), section 136 is both over-used and under-used because officers will almost always have another power and my own view is that some police officers and mental health professionals push for the criminalisation of people who should be detained under s136 because in so many important respects it's simply easier and less resource intensive to arrest people.

The police service could unilaterally end the use of police custody as Place of Safety today, if we wished. Just lock people up for other legal reasons and then custody is not being used as a Place of Safety under the Act. But is that really what we want?! If it's not, we need to re-agree that our previous commitments to work together need to see police forces ensuring that they use s136 'appropriately' (see College of Policing guidance, for

what that actually means!) and then health services need to ensure sufficient capacity, including staffing, to ensure the experience of the patient looks a bit like what we all thought it should, when we last discussed it in 2011. And we need to do those things in the next year or two, to ensure that if custody is fully banned, we haven't just ensured that the police service are spending double or triple the resource per detention, compared to those times we'd hope to forget where the United Kingdom used to jail its most vulnerable subjects at their most desperate time.

25th October 2018

Strategic Problems

In a lot of the work I've done and still do, the subject frequently comes up public funding for services and, in the last eight years or so, of public sector cuts. We all understand how important money is and I don't think there's a public sector professional around who isn't keenly attuned to these kinds of debates because most of us are seeing how stretched things are. This post comes off the back of a financial bomb-shell to the police service that Chief Constables are, they claim suddenly, being required to fund a £457m hole in the police pension scheme and many of the bosses are warning of 'dire consequences'.

Today, we've also seen two publications which are not unimportant – the Home Affairs Committee have published their report in to the 'Future of Policing' after hearing evidence from across the service over the course of 2018. As a complete aside, you'll have to forgive me for briefly expressing my surprise and satisfaction that some of the more contrary things I said seem to have influenced the committee's conclusions, after I sounded some reticence about street triage schemes. More broadly, the report sounds a warning and calls for increased funding for the police after setting out various problems with the core business we deliver, whilst sounding alarms about the changing role of the police. On mental health the report points out the police are now 'the sole emergency service for mental health crisis in some areas' and it calls for NHS funding to be spent in such a way as to reduce this burden on policing.

Also, we saw the publication of the 2017/18 UK Government statistics on policing: of interest to me are those statistics on the use of s136 of the Mental Health Act 1983. We are now topping out at 29,662 uses of this power each year, of which 471 people were removed to custody which is a 5% rise in the use of this power (despite those efforts of street triage schemes to reduce its use), but the proportion of those remove to jail is now just 1.6% of all of us detained under this power in crisis. << If you remember when I got started and interested, West Midlands Police alone were taking over 1,000 a year to jail for being unwell: it's now less than half of that for the whole country and whilst this should be a success story, it comes at a cost which links to this context about funding, pressure and the expanding role of the police.

SOLUTIONS AND PROBLEMS

In my work, I have a growing number of particular phrases, questions or observations I find myself using again and again and again – like a dripping tap – to help ram home various important points I need to keep making, to be consistent. The one I need to pull out of my drawer on this occasion is my observation that "the solutions we've introduced to the problems we think we have are more resource intensive for the police than the problems were." Everyone wants to focus on helping people, reducing stigma and criminalisation and working in partnership with all of the other statutory and non-statutory agencies relevant to our country's wider system of mental health.

But at what cost? If you said to a Chief Constable, that for a few resources being spent we could massively improve a process which would then save resources overall – they're probably going to bite your arm off, especially now. If the resource cost would lead to no resource saving, but better outcomes for the public, they'd still be interested – Chiefs have encouraged greater reporting of under-reported stuff in the past and that doesn't save resources, it only increases work but because improved reporting of things like domestic abuse, hate crime and sexual offences. But that's a good thing.

Where the issues become complicated is when a development costs the police significant resources, where we all agreed in advance that it wouldn't and that position is forced upon the police at massive cost. For example, average detention time in police custody for s136 was 10.5hrs last time I checked. Most detentions which do occur in custody require both detaining officers only initially and then either, both are back on the street, or at least one of them is whilst the other does enhanced safety observations. Average. time in an NHS Place of Safety is around 5-6hrs – it's often as much as 9/10hrs in some places. If you have a force detaining 500 people a year and you work out the police resource implications, it is MUCH more resource intensive to take people to health buildings if the officers must remain there for 5/6hrs.

WHAT PROBLEM ARE WE FIXING?

I've just returned from a conference where it has been genuinely useful, as well as both inspiring and frustrating in equal measure to spend a some days talking and listening with other officers and academics about all this stuff. Britain is not massively different to the various other places, but of course we have our particular peculiarities. We stand out because a) we're not routinely armed – generally considered to be a good thing when it comes to de-escalating and safely resolving mental health calls; and b) we, along with New Zealand, have no legal powers in private premises –

Australia, Canada, the United States, etc., all allow their police officers to keep people safe when they are in crisis at home.

There has just been a two-day discussion about policing and mental health, reviewing the evidence for the various ideas and interventions that we see applied around the world. I will be blogging about that on another occasion, but suffice to say here that the evidence is limited, it's not great quality and to the extent that it tells us anything, it suggests that most things aren't having a massive impact. We looked at Mental Health First Aid, co-responder models of various kinds as well as the world-renowned CIT programmes which started in the US. Before the event began, I kept saying that all of these things suffer from the problem that nobody involved in them seems to have defined the problem they're trying to fix. This was acknowledged in the discussions.

So here's what I think is going on, behind the more obvious difficulties of public sector funding restrictions and the particular position of UK policing at the moment. I think we've just spent 60years de-institionalising mental health care, only to find that we've accidentally just re-institutionalised everyone to prison; now, because the funding of NHS community MH services has never been great, we're shifting associated costs of being unable to respond to everyone to other parts of the health system and to the police. Remember what the Home Affairs Committee said today, their words – "the police, are the sole emergency service for mental health in many areas" and the burden of this must be reduced.

DOING THE WRONG THING RIGHTER

For what it's worth – and it's probably not worth much – I think we're trying to fix the wrong problem. Looking at the s136 data, we see more use of this power by the police – and you should bear in mind the street triage schemes which have been associated with significant reductions in 136 are probably saving us several thousand detentions a year, so the 29,662 figure for 2017/18 is a suppressed number, compared to the 18,500 in 2007/08 that the IPCC researched.

- Police contacts leading to s136 or calls for triage appear to be going up, and rapidly.
- The amount of resources per s136 contact is greater, on average, than 10yrs ago because the police are effectively staffing MH unit places of safety.
- We are now in a position where around 4,000 to 4,500 people a year are being 'cared for' by the police in custody after their arrest, pending an inpatient bed emerging.

- We are seeing instances of a dozen or more police officers in a single Emergency Department because the MH trust has used the MH unit Place of Safety as a bed.

I am receiving emails from colleagues stating that so many resources are tied up with MH unit staff, ED beds watches because of MH unit closure, requests for care in custody taking days because of a lack of available inpatient beds.

In a very significant way, we appear to be aiming to transfer the cost of crisis and emergency mental health care from health to policing and believing that it would assist in forging partnerships which would provide a return on investment in the future, senior officers have gone for it. And now, eight years down the line when we have parliamentary reports warning of 'dire consequences' to policing as a whole, I feel I have to pose the question: if policing has been cut by 24% and MH services by 8%, for how long can we continue to see ever greater demands made of the police by the MH system to staff street triage, MH units and provide short-term pre-inpatient stays in custody?

PRIORITISING THINGS

One Chief Constable has already stated that it costs much more to run their street triage scheme than it would to not do so. If Chiefs are pushed for resources, they could genuinely re-coup a lot by thinking about whether this is an essential or a luxury they can't afford because it's not sustainable against other competing demands. None of this has to mean poorer service, because as we found in Toronto, the evidence sitting behind the solutions we've come up with is actually very far from great!

The real issue before us, **we've set about resolving the wrong problem**.

- We've decided to assume that demand faced by the police is largely unavoidable, unpredictable and unpreventable demand – that the problem is how to help the police manage it better.
- All the reports internationally tell us that policing is not the majority of the problem here: and yet the solutions always focus on policing, not on society OR health and social care organisations.
- **The real problem is what we're demanding of the police and the extent to which we're choosing to rely on them for things they can't do.**

I sat yesterday listening to an academic tell a familiar tale of a police encounter gone awry, involving a person with a traumatic brain injury. It inevitably led to a description of some training offered on TBI and some

more recent incidents better handled. It's all about training and partnerships, right?!

Wrong – it's about accepting the police have a limited role to play within our wider system of social responses to mental health emergencies and other incidents: anything involving time-critical responses, threats to life or crime, etc.. Beyond that, choosing to rely on the police is to make the strategic mistake.

It's then we start **Doing the Wrong Thing Righter**.

NOVEMBER 2018

22nd November 2018

Not Just Doing the Wrong Things Righter

This post was **first published by the N8 Policing Research Partnership***, subsequent to their event on policing and mental health, hosted by the University of Lancaster in November 2018.*

The profile of mental health issues as a thematic in policing has risen considerably over the last fifteen years. In addition to a number of high-profile reports (Adebowale, 2013; Angiolini, 2017) there have been a succession of untoward critical incidents which have been featured on the front pages and the evening news and inevitably lead to calls for greater police accountability, police training and awareness of mental health issues. Indeed, Prime Minister Theresa May has made mental health a priority theme, mentioning it during her first public speech after taking office, having introduced a range of initiatives in her previous role as Home Secretary.

The United Kingdom is not alone in placing focus on this theme: most countries have seen police controversies involving vulnerable people with mental health problems, although more often the focus is on fatal police shootings given the tendency of most countries to routinely arm their police service with firearms. Notwithstanding that crucial difference, political and social reaction has tended to be similar: calls for greater police accountability, greater training and awareness of mental health conditions and in particular, calls for the police to work in closer collaboration with mental health professionals and their organisations.

This all sounds highly intuitive: police officers have limited training around mental health, they are certainly not qualified in any clinical or meaningful sense as mental health professionals; introducing mental health nurses to such situations where they can access health records, share information and offer clinical opinions seems sensible. However, in practice this raises several further question which seem rarely asked, never mind answered, in the discourse and the evaluations of these new ways of working.

TRAINING AND COLLABORATION

Around the world, notwithstanding slight variations in laws, politics and culture, attempts to improve policing and mental health most usually focus on just types two initiatives –

- **Training** – Crisis Intervention Training; Mental Health First Aid; other bespoke training approaches.
- **Collaboration** – the placement of mental health nurses, or less often mental health social workers, in police vehicles, control rooms or custody areas.

Some areas have gone in for a blend of these solutions: by improving training and introducing qualified staff to more than one kind of environment. Whilst there is little doubt that we need better training for officers, these efforts focus upon the need to improve police responses, through improved knowledge and confidence of better training and closer clinical support.

This takes for granted something quite important about the problem we have decided to fix – we're concerned about the quality of police responses and determined to improve them. What this approach does little to address, is the problem of why the police, and by extension the criminal justice system, have become so relied upon in the first place.

LESSONS FROM HISTORY

If we apply a detailed eye to the thematic reports from Lord Adebowale and Dame Elish Angiolini, we learn that the problem is not just about policing. They both endorse training and collaboration ideas but point out that whilst this is necessary it is not sufficient: "While the [Metropolitan Police Service] has accountabilities in this area, the MPS cannot and should not replace the NHS and social care services who need to play their part in the delivery of safe services." (Adebowale, 2013, p5). This notion is perhaps best seen in the Coronial inquiry in to the death of Sean Rigg. Mr Rigg died in contact with the police in London in August 2008, having run from accommodation operated by mental health services. The jury's found that two things had 'more than minimally' contributed to Mr Rigg's death and the nature and handling of police contact was certainly one of them. However, the jury also found that neglect by mental health services in the days prior to this encounter also contributed significantly.
The Rigg case is not isolated in raising questions about healthcare contact or preparation prior to a police encounter. Furthermore, we know that in some cases individuals who have died by suicide have ended their lives within just a few moments of discharge from A&E, and that the police were

still responding on blue lights to secure initial details from NHS staff, without an opportunity to intervene. The reports cited reveal more recommendations aimed at health and social care organisations then those aimed exclusively at the police. Of course, many are pitched towards all organisations who have contact with vulnerable people in emergency situations involving mental health, encouraging the closer collaboration that is undoubtedly necessary.

What is obvious however, is that requirements to improve operational responses cannot just sit with policing; and that all organisations need to work preventatively. There are a great many questions which need to be addressed in the future regarding the ways in which we've chosen over the last few years to collaborate. In the United Kingdom, as elsewhere, the attraction of the co-responding model, known as 'street triage' schemes is obvious. Most police forces now operate at least one kind of scheme, where nurses are placed in police vehicles or control rooms, to improve inter-agency partnerships and real-time information sharing. And yet, despite their prevalence, the best we can say about the majority of the evaluations is that they are 'low quality'. This is not my choice of words: it is the rating system applied by the National Institute of Health and Care Excellence to studies used in the production of their guidelines; and it is the highest rating achieved by a triage study in the 2017 guidelines on the 'Mental Health of Adults in the Criminal Justice System'. This sentiment was also echoed by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services.

LOOKING TO THE FUTURE

What better research, including ethnography, would be able to determine is whether 46% of triage incidents are generated by the NHS when they are struggling to handle demand for their services which do not require the police; how many deaths in custody or following contact have there been and what do we need to learn from this; what training has been given to the nurses involved, given anecdotal reports from officers that they have been advised to do things which are unlawful, to resolve incidents?

In consultation work for the College of Policing on the production of guidelines and training for the police service, it was notable that the public want different things from their police service when it comes to mental health, than the National Health Service wants. Of course, one only has to follow the news and use social media to see there is often a disconnect between the public and the NHS about what vulnerable people? want from mental health services. It should therefore be no surprise that police officers are placed in to positions of conflict when responding to mental health related demand. They know they are often called upon because members of the public have been attempting to access services without

success, or to undertake functions on behalf of the NHS which may or may not belong to them (welfare checks, medicating patients, returning patients to hospital from their own homes).

If we are to negate the conflict and ambiguity created for operational officers, we need to reconcile the conflict we place them in; we need to determine what problem we're actually trying to fix and have better understanding of the reality of those efforts in order to evaluate whether or not we are successful in our endeavours. But it always needs to be borne in mind that policing is, inherently, a restrictive practice and is to be used sparingly, lest we further stigmatise and criminalise vulnerable people. If we don't address those problems in our efforts to collaborate, we are at risk of **just doing the wrong thing righter**.

DECEMBER 2018

20th December 2018

One Great Thing

I've just deleted about half a dozen draft blogs, none of them finished … I tried to write a few things over the last fortnight and just became interminably bored, quite honestly, for the fact that I was just saying the same thing, over and Over and OVER again.

This is what I was going to cover, as each post was centred on something new, if not hot off the press –

- Some more thoughts on the Wessely Review in to the Mental Health Act;
- Thoughts after the misconduct proceedings which saw a West Midlands Police officer dismissed after the death of Kingsley Burrell in 2011;
- Thoughts ahead of going to Manchester last Monday to discuss s140 MHA with the CQC;
- Thoughts about the progress of the Mental Capacity (Amendment) Bill 2018 which will alter the MCA 2005.
- Thoughts after the Inquest in to the death of David Stacey in Leicester in December 2017 which has just concluded a verdict involving neglect by mental health services.
- Thoughts after the Inquest in to the death of PC Sharon House MBE – one of my colleagues who suicide was contributed to by neglect by mental health services.

Half way through writing about each of those things, I'll be really honest – I lost all sense of making any point that felt new and I became wary of boring those who are kind enough to read this blog. I'm also wary, after some discussions this year, of appearing to harp on about negatives all of the time, especially where it is me highlighting negatives about mental health services. I've been accused many times over the years of being 'anti-mental health services', which is criticism I have to take very seriously. This has happened again in the latter part of the year and caused me to wonder how balanced and fair I'm being. I've resisted posting partly because I've been genuinely reflecting and discussing with people whether or not I am being as fair as you could expect a police officer to be.

I was asked by Leicestershire Police to prepare a report, potentially for use in the Coroner's Court, after the death of David Stacey. It ended up not being used in part because it was suggested the report was 'not independent'. Of course it wasn't! – I'm a serving police officer and I was asked by a police service to write a report which was, in part, a request to comment on a psychiatric report with which they already disagreed. Of course, I attempted to do this as fairly as I possibly could, evidencing the critique as much as I could – but it was never going to be independent, was it?! – I'm a police officer and I've never been, wanted to be a mental health professional. I do what I do because I have ideas about how things should be, and those ideas are fashioned by what I passionately believe is an under-appreciated and under-studied perspective that has a nasty habit of seeing things different to received wisdom in politics and in mental health services.

WORKING TOGETHER

So for me, conflict is the starting point: things are not as they should be and that needs to change – so says every thematic report ever written, including the recent MHA Review and the HMIC report, *Picking Up the Pieces*. Events don't unfold as they should – and some (NB: not all) of this stuff is **nothing whatsoever** to do with politics and funding, directly. Of course, politics, strategic leadership of public services and resources available to them are all very important issues, but they're not the only important things. We had problems at this interface when I first started working on policing and mental health, when we had – comparatively speaking – plenty of money as the government of the day pumped in the cash. Some of the problems we had in 2009 – 2010 have improved since the coalition government took office; others have worsened. But many things have remained constant issues, notwithstanding their frequency.

The biggest frustration I have had during 2018 is having to listen to people telling me that everything that is wrong is wrong because of government funding. I'm not naïve: I've seen the difference made to my police force over the last eight years, but I also know during that time, they have done things which have received acclaim for forging real progress – so have many other police forces like Merseyside, Northumbria and the Metropolitan Police (to name just three – don't write in). The particular frustration is not that I mind hearing the argument about funding and resources, I just don't want that to prevent us focussing on issues which are – right here, and right now – things we could do something about. We have some big problems with public services, no doubt – but that simply doesn't mean there is nothing we can do about things we see going wrong.

So what I decided to do instead of half-heartedly finish those posts, was delete the bloody lot of them, whilst reflecting in a new post what they

commonly shared. They all relate to what I've always considered to be the big issue that remains entirely unaddressed at this interface: a shared knowledge of, appreciation of the importance of, and implementation of *the law*. Professor Wessely's review of the Mental Health Act is all about legal reform, but as the report itself makes clear, some of the calls for reform arise from the law not being properly applied as it stands. Services have in some respects decided to operate outside the legal frameworks and the argument follows that the law is out of date. Form your own view, of course, but it could equally argued that services should be bent to the law until it's changed and not operating outside of them.

THE CENTRE OF THINGS

When Professor Wessely's review was launched, one of the vice-chairs, Sir Mark Hedley commented, "No Mental Health Act ever made ill people better – skilled care did that". But he pointed out that the law can set the framework and affect the culture of the way in which that is done – and so it should; not just the MHA itself along with the MCA, but also the Human Rights Act and all the health & safety, negligence and other laws that sit around and alongside our main mental health and capacity frameworks. Look at the other topics I nearly blogged about:

- **Misconduct proceedings** – officers called to a mental health unit because of a violent disturbance; fair enough so far. After weapons were removed and immediate safety restored, the NHS decided to direct a transfer to another mental health unit and the way in which this was done breached the MHA, the Code of Practice and contributed to the reasons why junior police officers would have found themselves in the most invidious position. I can tell you for free: had I been those officers, knowing what I know, I'd have simply refused to do it. The least that would have had to happen was the provision of a lot of clinical support and legal clarity. THEN and only then, might I have agreed to do more than simply contain the risk situation in to which I'd been suddenly invited.

- **Section 140 MHA** – this again is an area of activity which directly exposes that we don't have sufficient grasp of the law. Many CCGs don't comply with the duty to specific hospitals in to which patients can be admitted in circumstances of special urgency. Attempts to find examples of good practice around s140 didn't get very far – we only found one trust with a policy on it and my eyebrows went through my head when I read it.

- **The Mental Capacity Act** – this has always been considered problematic to understand and Parliament is currently trying to make

it better … or worse depending on your view! And whatever happens with that, Professor Wessely has suggested even further amendment and my best guess is that this will not make clear in the minds of all 999 and EMergency Department staff how the legal framework applies to their operational reality.

- **David Stacey** – this tragic inquest related to an accidental death contributed to by the neglect of mental health services. Police sought MH support and MHA assessment for a vulnerable suffering his first psychosis in his late sixties. Following MHA assessment, the professionals left a man in need of admission to hospital in his own home whilst they sought a bed and before it was found, he was involved a in vehicle collision. The inquest revealed real problems in legal understanding amongst mental health professionals (inc the outside 'expert') and legal compliance by services.

- **Sharon Houfe MBE** – another inquest finding of neglect, this time in respect of services being unable to support a serving police officer who had become suicidal. In that case, the officer presented to mental health services several times in the week prior to her tragic death and actively asked to be admitted to hospital. At least one nurse involved has been referred to the Nursing and Midwifery Council around professional conduct issues with decisions pending on whether two more nurses will be referred. The legal point here being that we seem to need a keener understanding of what amounts to 'neglect', in law.

MAKING PROGRESS

So it seems to me, if we are to enter 2019 with a determination to do better in the future and forge some progress, we need to do one thing in particular – improve legal literacy across the whole emergency mental health care system. It shouldn't need saying that this whole interface of policing and mental health involves high stakes, high risk business: not knowing the duties and obligations across this partnership risks practice which fails to take account of the rights of patients. That's the most important aspect of this for me: patients are people who have rights, organisations have obligations and duties in respect of them and this includes respecting and upholding the legal rights.

There have been reports published and inquiries held this year, which have had to point out that police officers, mental health nurses, psychiatrists and others do not know the legal frameworks in which they practice. And I'm not talking about obscure aspects of it, which might reasonable be the knowledge of people deeply versed in mental health law: I'm talking about police officers not knowing s136 MHA; mental health nurses who work on

wards not knowing their s5(4) powers; AMHPs telling me that they have no powers to return AWOL patients. Some of this stuff is about the blurring of organisational policy or inherited thinking, with the actual legal framework. And I can't stress this enough: the police are as guilty of this as any other organisation or group of professionals.

The One Great Thing we can all do to improve things next year that costs NOTHING – learn the law – and do this by just reading it. It's available for free, on the internet and there are various other places to help understand what's been read. It's the best free training you'd ever receive – as an inspector at the start of my service told me: "knowledge is confidence and confidence gives power". My addition to that advice is that power, wielded correctly, is really about protecting the public and respecting their rights. This is territory, when it comes to mental health, that patients and the public tell us all we need to be better at.

- **The Mental Health Act 1983**
- **The Code of Practice to the MHA** (2015, England)
- **The Code of Practice to the MHA** (2016, Wales)
- **The Mental Capacity Act 2005**
- **The Code of Practice to the MCA**
- **The Human Rights Act 1998**

27th December 2018

A Work In Progress

I took a fairly unplanned decision a few weeks ago, to change the 'theme' of this blog on WordPress, just to shake things up after a few years of this looking the same. I haven't done anything particularly radical, but I came across a new theme which I think just looks a touch fresher and I was immediately and unexpectedly quite happy with it. As with all such changes, it immediately threw the formatting of various things out of whack so I knew I'd treated myself to a fair few hours of going through every single post and page – around 800 of them – to put things back together and tidy up a few matters which have been hanging undone for months and years. So this short post just covers what I've done so far and what will be done in coming weeks.

I only hope it makes things better or easier to use for those of you kind enough to drop by here and indulge me –

- On the new front page, you'll notice the small icon, top right corner of three parallel lines in a box: as before, this opens up a side-panel which gives access to the various menus.
- You'll find a search box, as before – you can enter whichever term you want, a bit like a Google search of the site, and it will result any blog containing that term.
- At the bottom of the new menu section, there is now a drop down menu of 'categories' (see middle image, below):
- I'm adding categories to each post I've done – and by searching one of those categories, it will bring up all the posts I've done making reference to it.
- As you might expect, a lot of them related to sections of the Mental Health Act, like "Section 136" and this should make something of an index, whether to browse or use as a search tool (see index, right Finally, I've deleted some of the old pages which I hadn't updated in an eon and which I could tell weren't used very often, but I have updated an overhauled the main legal resources page, now entitled '**Mental Health and Capacity Law**' (see index, left image, above). This now contains the most up to date links to Acts of Parliament, Codes of Practice and other relevant Regulations. I've an idea to add to this page in future or even to make that page one which opens up a few others because I've also expanded the coverage

and explanations of case-law, providing links to the judgments for those who want to read much more detail.

It will probably take me a number of weeks to work through all of the remaining posts, to ensure they're properly formatted! I've done just over 10% of them and I'm working backwards from the most recent stuff so I'm now in a position to notice that completion of this by end of 2018 is fantasy land stuff! I'm revising the time it may take to complete this task to end of January 2019, whilst hoping for a fair wind in my general direction.

All feedback gratefully received if you have any thoughts or hit any problems,

Michael./

27th December 2018

The Big Reports

I've often referred to the stack of reports on my shelf at home which have been published over the years and touch upon my treasured Venn diagram of policing, mental health and criminal justice. Well, those thousands of pages all went for recycling recently and I decided to put links to them all on one post so they can be referred to electronically, as and when required.

This is mainly for my own benefit, to be fair(!) but I hope it's helpful to you, too!

THEMATIC / PARTNERSHIP REPORTS

- The National Partnership Agreement (for *Right Care, Right Person*): Home Office / Department of Health and Social Care (2023).
- IAPDC Preventing Deaths at the point of arrest, during and after police custody: Independent Advisory Panel on Deaths in Custoy (2022).
- Strategic Review of Policing: government commissioned review of policing, which touches upon policing and mental health, citing this blog, amongst other things (2022).
- Joint Thematic Inspection: various national inspectorates' inspection of mental health and criminal justice (2021).
- UN Human Rights Committee: human rights violations of African descent by law enforcement (2021).
- Health Equity in England: The Marmot Review Ten Years' On (2020).
- National Strategy on Policing and Mental Health: published by NPCC and the College of Policing (2020).
- CPS Prosecution Guidance: Victims with mental health conditions (2019) - DPP's guidance relating to vulnerable crime victims and witnesses.
- CPS Prosecution Guidance: Suspects with mental health conditions (2019) - DPP's guidance on relating to vulnerable suspects.
- CQC Review of the MHA Code of Practice (2019) - reports on how the Code is not well understood, used or disseminated; particular findings on s140 MHA.
- The NHS Long Term Plan (2019) - Strategy for the development of the NHS.
- The Wessely Report (2018) - Independent Review of the Mental Health Act 1983.

- Picking Up the Pieces (2018) - Her Majesty's Inspectorate of Constabulary report.
- The Future of Policing Report (2018) - Home Affairs Committee report.
- What Works? (2018) - Scottish Government report in to collaborative responses to mental health crisis.
- The Angiolini Report (2017) - Independent Review.
- Five Year Forward View (2016) - NHS England.
- Mental Health Crisis Care Concordat (Wales, 2015) - Cross-government and partner concordat in Wales.
- Right Here, Right Now (2015) - CQC Thematic Review of Crisis Care.
- Crisp Report (2015) - Independent Review in to inpatient mental health beds for adults.
- Preventing Deaths in Detention of Adults with Mental Health Problems (2015) - Equality and Human Rights Commission.
- Policing and Mental Health (2015) - Home Affairs Committee report.
- Mental Health Crisis Care Concordat (2015) - Cross-government concordat in Wales to improve mental health crisis care.
- Victim Support Report (2014) - At Risk, Yet Dismissed.
- Positive and Proactive Care (2014) - NHS document about the reduction of restraint interventions in mental health care.
- Crisis Care Concordat (2014) - Cross government concordat in England to improve mental health crisis care.
- A Safer Place to Be (2014) - CQC Report in to health-based Places of Safety.
- The Iacobucci Report (2014, Canada) - Independent Review.
- The Adebowale Report (2013) - Independent Review in to policing and mental health in London.
- A Criminal Use of Police Cells (2013) - HMIC / CQC / HMIP review of the use of police custody as a Place of Safety.
- Fair Society, Healthy Lives: The Marmot Review (2010).
- The Work of the Independent Police Complaints Commission (2010) - Home Affairs Committee Report.
- The Bradley Report (2009) - Independent Review in to mental health and criminal justice.
- Police Custody as Place of Safety (2008) - IPCC report on use of s136 MHA.
- The Police and Mental Health (2008) - briefing paper by the Centre for Mental Health.
- The Richardson Report (2000) - Independent Review of the Mental Health Act 1983.
- Caldicott Report (1997) - Independent report on patient confidentiality.

ACUTE BEHAVIOURAL DISTURBANCE

In addition to thematic reviews on stuff, there are also a number of guidelines which have been published which touch on these matters, to one extent or another. They are often the product of thematic reports.

- Guidelines on Acute Behavioural Disturbance (2022) - Royal College of Emergency Medicine. << *Replaces the 2016 guidance.*
- Position Statement on ABD / Excited Delirium (2022) - Royal College of Psychiatrists.
- Position Statement on Acute Behavioural Disturbance (2018) - College of Paramedics.
- Memorandum of Understanding (2017) - on Restraint in MH and & LD settings.
- Authorised Professional Practice on Mental Health (2016, updated 2017) - College of Policing guidelines.
- NICE Guidelines on Violence (2015).
- Guidelines on Management of ABD in Police Custody (2019) - Faculty of Forensic and Legal Medicine / Royal College of Emergency Medicine.
- NHS Patient Safety Alert on Restraint (2015).
- Home Office Circular 66/90 (1990).

INDEPENDENT OFFICE FOR POLICE CONDUCT

- Death after custody / contact, 2023
- Death after custody / contact, 2022
- Death after custody / contact, 2021
- Death after custody / contact, 2020
- Death after custody / contact, 2019
- Death after custody / contact, 2018
- Death after custody / contact, 2017
- Previous reports are available via the National Archive for the IPCC

THE MENTAL HEALTH ACT 1983

Finally, the Care Quality Commission (CQC) in England and Health Inspectorate Wales (HIW) publish annual reports about their oversight and monitoring of the Mental Health Act 1983. All the published reports I can find are here —

- **England (CQC) —**
- Monitoring the Mental Health Act, 2021/22
- Monitoring the MHA, 2020/21
- Monitoring the MHA, 2019/20
- Monitoring the MHA, 2018/19
- Monitoring the MHA, 2017/18
- Monitoring the MHA, 2016/17
- Monitoring the MHA, 2015/16
- Monitoring the MHA, 2014/15
- Monitoring the MHA, 2013/14
- Monitoring the MHA, 2012/13
- Monitoring the MHA, 2011/12
- Monitoring the MHA, 2010/11
- Monitoring the MHA, 2009/10

- **Wales (HIW) —**
- Monitoring the Mental Health Act, 2021/22
- Monitoring the MHA, 2020/21
- Monitoring the MHA, 2019/20
- Monitoring the MHA, 2018/19
- Monitoring the MHA, 2017/18
- Monitoring the MHA, 2016/17
- Monitoring the MHA, 2015/16
- Monitoring the MHA, 2014/15
- Monitoring the MHA, 2013/14
- Monitoring the MHA, 2011-13 **
- Monitoring the MHA, 2010/11
- Monitoring the MHA, 2009/10

*** For the avoidance of doubt, there is no report specific to either 2011/12 or 2012/13; merely the double year report linked above.*

What is not included on this page, but may be added as things go along, are Preventing Future Death reports from individual inquests or the case-law which is relevant to this area, which I have covered on another page. I may add to this page as others come to mind that I didn't print off at some stage and, inevitably, as others emerge in coming months and years!

You might remember I've argued on here that the challenge is to take those things we know from clinical guidelines, legal guidelines and judgments and come up with a 'theory of stuff' on policing and mental health. How do you we express ALL of the above in a few statements about the role of the police. Remember, policing is not the problem here: the extent to which we over-rely upon the police is the problem. In my view, these reports are the evidence for this way of looking at things.

27th December 2018

Refusing s135(1) Warrants

This brief post is just a complaint on behalf of AMHPs everywhere. In recent weeks and months, I have received queries from AMHP services and AMHPs who are at jobs, for my advice on how to handle a situation where they have sworn out a warrant from a Magistrate under s135(1) and, having organised a Doctor to attend, they ask for police support. It seems increasingly common that AMHPs complain of police forces refusing to supply officers to execute the warrant and this is causing problems. I've had yet another email about this again tonight, from an exasperated AMHP whose Christmas seems to be hanging in the balance over an incident they have been told to attend and "see how you get on" where the risks involved are considerable.

Accepting completely there will be an aspect to this situation that I don't know, it always strikes me intriguing how a risk assessment which would see me thinking of sending more than a double crewed car has somehow seen three attempts to secure police support have all failing with an instruction to 'crack on'. So with all that background, here's a list of relevant of stuff to bear in mind, if you are a control room call-handler, a front line cop or supervisor when a request comes in to support an AMHP by executing a s135(1) warrant –

- Most MHA assessments don't involve the police, so if an AMHP as not only requested the police, but gone to the trouble of queueing at court, you should assume that they really do believe police attendance is required to manage risk of some kind.
- Once the magistrate has issued the warrant, there is a statutory duty on the police service to execute the warrant within a reasonable time, based on whatever assessment of urgency prevails.
- AMHPs cannot execute warrants under s135(1) – or s135(2), for that matter.
- They only have "all the powers of a constable" over a patient once they have made an application for someone's hospital admission and the patient is being taken and conveyed under section 6 MHA.
- **It should never be forgotten** – patients and professionals have died and / or suffered serious injuries around the delayed execution of warrants or mis-informed.

- In particular, there was a case a couple of years ago in Sheffield where a Coroner insisted upon improved processes to be established after a delay in police resourcing of a s135(1) warrant, contributed to the creation of a situation where a patient was killed in an altercation.
- My most complex MHA assessment in private premises job was one which involved considerable arguments over s135(1), but one thing to bear in mind is that any warrant issued by a magistrate involves someone who presents a type of risk which may need managing by the application of reasonable force that only the police have the power to do unless and until the person is 'sectioned' by the AMHP.

DUTY TO ATTEND

I have spent many hours in recent years trying to insist that police forces are not adopting an approach where, they would basically refuse to attend an incident unless MH services had sworn out a warrant. If we are now in a position where we refuse to attend when there is a warrant, then things are worse than I feared. I think we all understand how demand on policing is rising, there may be occasions where officers are not available at the first time of asking, or there is a delay. But if large organisations like a police force simply cannot ensure the resourcing of a warrant that will most usually take no more than a double-crewed car, we have some problems.

Inability to resource a request should, in my opinion be escalated to duty sergeants or inspector, not least because it's difficult enough to bring together an AMHP, a Doctor, police officers and potentially an ambulance, so if agencies don't actively prioritise it, there will always be ways to obfuscate: "tell us when the ambulance gets there and we'll send officers", etc., etc.. If the ambulance service play the same game, it just becomes all kinds of difficult. Imagine being the AMHP?! … no wonder these people keep emergency food and blankets in the backs of their car.

Once an AMHP has obtained a warrant from a court and is asking for police attendance, there is a legal duty kicking in, right there. Fair enough: it may mean some juggling of resources and priorities and a delay; and this is why local protocols should specify – in detail – how all of this gets done. But what shouldn't ever be happening is that we tell AMHPs to crack on and 'see what happens'. If I were the AMHP, I'd hand in an envelope to the front office containing the warrant and a short note. It would invite the police to either ring on a number to arrange to attend the MHA or to endorse the warrant with reasons for it not being executed and returned to the Magistrate's Clerks for the area.

30th December 2018

Stress-Testing Contingencies

About a decade ago, I was pottering about as the duty inspector in south Birmingham when a full-scale police mobilisation of public order units was ordered. This involves having to get together a sergeant and seven constables on to van, all of them 'level two trained' in public order tactics – riot police, to you and me. For every three vans you put together, you need an inspector in overall charge and that group of twenty-five officers (x1 inspector, x3 sergeants, x21 constables) deploy as a 'police support unit', or PSU. Large scale events or disorder frequently have a number of PSUs under the leadership of one or more Bronze commanders; and the overall command of a Silver. This thing was ordered around 1pm on a weekday afternoon and the requirement was for us to be at a rendezvous point at Birmingham airport within 60 minutes of that mobilisation being ordered. My area had been obliged to send a sergeant and seven but also to supply the PSU Commander for a group of three vans from other south Birmingham policing areas and off we went to the airport.

On arrival, there were a number of other PSU Inspectors turning up, each of them with three vans under their direction and rumour was bouncing around as to what was going on – was there some dramatic event about to unfold at the airport; or were we just being bounced on a mobilisation exercise to test readiness?! … that was one of the possibilities we considered as we chatted en route to BHX because we were asking control and making phone calls to find out but nothing was coming back. But you never truly know and when we got there, we were all ordered off the vans with our public order bags for a kit inspection and somebody with clipboards emerged – just a mobilisation exercise! It was a much larger than any I've ever known before and I'm ashamed to say that I personally failed the kit inspection!! It being a hot summer day in an era where we all wore formal white shirts under our protective vests, I wasn't wearing a tie (summer rules permit this) and I didn't have one in my bag either!

EPIC FAIL – we all understand intuitively as children how badly one needs adequate neckwear if Air Force One is due to crash-land at the local airport, etc.!
Why am I boring you with this? – well recently, we were discussing section 140 at a Care Quality Commission event and the discussion came up about planning and preparedness for predictable events. Whether Air Force One

was due unexpectedly at Birmingham Airport or whether a riot had broken out in another city and we were being RVd and prepped to provide support – the point is, this test-exercise ensured that we were all assessed and given feedback on what needs to improve to ensure we're at a state of readiness for whatever level 2 public order officers are potentially sent to. So the question arose, where urgent admissions to hospital are required, do we have the systems in place to ensure that what needs to happen even can happen within timescales?

WORKING TO DEADLINE

Police forces tend to work to timescales by which they have to be able to do things – each force will know what its basic, 'primary mobilisation' requirement will be: how many PSU's have to be ready, dressed in riot gear to hit the streets within an hour or an hour and a half of being told to form up. How many PSUs must they be able to provide within a further period of 60 or 90 minutes, etc., and this is what you saw happening in 2011 when riots broke out in London and spread to Birmingham and Manchester – large numbers of officers in riot gear, deploying in groups of 25. We know it will occasionally be necessary, so we have to be prepared. We know that police officers might have to point a gun at someone and decide whether or not to end their life: so we spend a lot of time and money training firearms officers, buying expensive equipment of various sorts; ensuring they have advance first-aid training, etc.. Planning and preparedness for what we heavily predict we're going to have to deal with.

In the context of urgent hospital admissions, then – I got to wondering whether the NHS start from the perspective of thinking about what we know they may need to do, even if only rarely, and planning for how we ensure it will happen within the law. So here's a scenario for you –

> *A child is assessed in an Emergency Department after having been detained by the police under s136 and removed there because of serious self-inflicted injuries. They are assessed as requiring admission to a Tier 4 CAMHS beds and this conclusion is reached at 6pm on a Saturday evening. Consideration is given to how support could be provided at home over the weekend but it is ruled out as viable on the basis that the risks involved to the child are unconscionable.*
>
> *Let's be generous and assume it took just 6hrs to provide initial care for injuries and convene a Mental Health Act assessment on a Saturday: if this situation occurred a hundred times, in how many of them would we identify a CAMHS bed and fully conclude an application for admission to hospital by midday on the Sunday?*

My point would be, that inability to do this by that deadline means we start to drift in to difficult legal territory, many versions on which would involve violating fundamental human rights, even if it doesn't further endanger the patient from a medical point of view. Repeat the scenario, if you will – but this time, change ED to police station for an adult man who was arrested for GBH on a relative who steadfastly refuses to make any complaint of assault because they are more concerned about their relative's mental health. Assessment by 6pm in police custody is that the patient requires a PICU or even an MSU bed by midday on Sunday: how many times in a hundred would this occur by the deadline?

MS V UK, 2012

This latter version of this story was the situation in **the *MS v UK* human rights case**, a verdict from 2012 following an incident in Birmingham in 2004. In the case specifics, the patient had been assessed within 9hrs of being detained under s136. The fact that he had assaulted his aunt only became known after his arrival at the police station under s136 and in the absence of any admissible evidence from the victim in the case (his maternal aunt) there was no basis to charge him. By 9hrs in, the basic MHA assessment had concluded that admission to a forensic unit may be required and it was beyond the 24hrs of detention now permitted by law that a second, forensic assessment took place. So immediately in such a case, notwithstanding any questions about whether or not the patient could or should be prosecuted, if the NHS require a second assessment by forensic services for forensic admission, do we have capacity to do that within the 24hrs permitted? Or do we have that capacity for CAMHS Tier 4 admissions, bearing in mind I often hear that in some areas CAMHS don't work out of hours?

So how do more specialist assessments fit in to the bare and unchangeable legal fact that section 136 permits 24hrs to do everything that is required to facilitate any admission that is needed? Not only might you need the forensic or CAMHS assessments, if required, you'd also need to contact the bed managers and actually physically find a bed. We know this is problematic thousands of times a year – **Professor Wessely made reference to this** in his Mental Health Act review and the fact of bed management problems and no obvious solution.

So my argument is, we need to better understand the reality of the way in which patients present: I tend to think of it in essentially three ways, because I group the situations by the legal framework in play at the point of the Mental Health Act assessment –

- **Detained under s136** – all admission issues must be concluded within 24hrs of that patient's arrival at a Place of Safety, unless the

assessment was delayed for some reason which has led to a doctor authorising a 12hr extension.

- **Under arrest at a police station** – those who are arrested for an offence may be assessed in custody as long as their detention there is lawful because of ongoing investigations. Where it is not, some patients may be detained under s136 on release and remove to a Place of Safety, where 24hrs may be taken to conclude assessment and admission procedures not yet complete.
- **Unrestricted assessment** – for those patients in their own homes or who have self-presented at an Emergency Department or been taken there voluntarily by police, ambulance or other services.

STRESS TESTING

So what I'm suggesting is, from any of those situations we may need to admit someone and that may need to occur within a few hours or within less than a day in order to avoid a situation where someone's fundamental human rights are violated. This could be something around Article 2 if a predictable suicide is not prevented by detention; it could be an Article 3 violation (inhumane and degrading treatment) as we saw in the *MS v UK* case; or Article 5 where, because of the obvious lack of procedures by which to ensure rapid admission when needed, someone ends up in police custody, or a Place of Safety or even just 'held' in an Emergency Department without an obvious authority in domestic law by which to justify that *de facto* 'detention'.

Fully accepting that I see a particular slice of the admissions system and most usually only where it has come off the tracks, I do wonder if we ran the two scenarios above 100 times each in the real world or maybe asked every trust to do so as a table top exercise, how many times in 100 would the admission occur within the implicit or explicit legal timescales? This kind of exercise is also something the police service have done to learn from problems. Older readers will no doubt remember the shooting in Hungerford, Berkshire in 1987 where Michael Ryan killed sixteen members of the public and seriously injured fifteen more. The police service's capacity to quickly deploy authorised and equipped firearms officers was questioned in the aftermath of what was a prolonged delay in responding and police firearms capability found wanting. Part of stress-testing the system afterwards involved Her Majesty's Inspector of Constabulary requiring forces to examine how many armed, equipped and trained firearms officers were on duty at a certain time of day in the months preceding the attack. The results lead to a massive overhaul of how forces deploy, train and prepare firearms officers incidents of this kind.

This is what I'd love to hear of us doing around complex urgent admissions: table-top exercises or contingency planning based on real cases from which

we might reasonably be expected to have learned. If *MS v UK* happened in Birmingham, what plans do Birmingham and every other trust have to ensure it doesn't happen again and violate someone else's Article 3 rights? I'll help you out: we know that whatever happened afterwards it has happened again, because I've had to deal with worse as a duty inspector. And at the risk of this being taken as yet another example of me **whinging or complaining** about things and failing to take in to consideration "all of the good partnership work" going on around the country, the fact of these issues being problematic is being cited publicly by senior police officers, mentioned in Government reports and independent reviews of mental health services. This is not about policing resources or NHS bureaucracy: it's about *the protection of fundamental human rights*, which is something we're ALL proactively obliged to do, by virtue of s6(1) Human Rights Act 1998. And we're not allowed to justify violation of such rights by complaining that it was all too difficult, complicated or expensive. That's why their called **fundamental** rights.

31st December 2018

Twenty Nineteen

The forthcoming year is the sixtieth birthday of the first piece of modern mental health legislation – **the Mental Health Act 1959**. It's worth noting this milestone, in my opinion, because sixty years on we are still struggling to think about how we give effect in the real world to some of its requirements. Section 132 of the MHA '59 is the same legislative requirement as that which is currently imposed upon the National Health Service by section 140 MHA '83 – and yet earlier this month, as we approach the sixtieth anniversary of this legal requirement, meetings were taking place to discuss how this will be done.

That's just a part of where we've come from and in many respects we need to look forward, so this post is just a New Year's Eve run down of various things we will see in the next year on policing and mental health.

PUBLICATIONS AND EVENTS

- In January, the Misconduct Hearings are due to start after the death of Sean Rigg – whatever the rights and wrongs, it's not fair on Sean's family or the officers involved that it's taken almost 11 years to reach this stage.
- Also in January, we should learn the more detailed response from the UK Government after the publication of the Wessely Review in to the Mental Health Act 1983.
- We will see the conclusion of the parliamentary process for the Mental Capacity (Amendment) Bill 2018 which will change aspects of the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards.
- We will see Misconduct Hearings at some stage after the death of Thomas Orchard – not quite 11 years to reach this stage, but almost 6 years is also a considerable burden for everyone to bear.
- We will learn the order in which we may see any inquest or misconduct proceedings after the death of Leon Briggs in 2013, more than 5 years after his death.
- The National Police Chiefs Council and the College of Policing will publish a national strategy on policing and mental health.

- NPCC and the College of Policing will publish a new definition of a 'mental health related incident' in early 2019 – this arises from an HMIC requirement to define such things, so that forces are trying to be consistent about how they record and flag mental health related jobs to allow for more precise understanding of demand.
- Although not specific to policing, we should see publication of the NHS England 'long-term plan' for the health service. This is a 10yr vision of how health strategy will unfold across the coming decade and will involve details about the emphasis being placed (or not) on mental health services.
- The Crisis Care Concordat should reconvene after a meeting in December was cancelled to control how the necessary partnership working will be progress which is so vital to success in this area.

PROFESSIONAL TO DO LIST

On my own professional 'to do' list for 2019 is to complete certain pieces of written policy work and to further update and amend some things you're already familiar with.

- I have to write-up the details of the ABD Conference, held in December 2018 so that we begin production of a 'practice guideline' on ABD for the police service, hopefully endorsed by organisations like the (Royal) Colleges of Emergency Medicine, Nursing, Psychiatry and Paramedics, as well as the Faculty of Forensic and Legal Medicine.
- There will be a workshop in January 2019 on 'street triage' which will also lead to a publication – this will probably be some kind of 'assessment framework' which
- Work will continue with the Crown Prosecution Service and NHS England, to finalise guidelines, as already exist in Wales, about the investigation and prosecution of offenders with mental health problems, especially in relation to assaults on NHS staff.
- College of Policing Authorised Professional Practice will probably need updating because of several of these issues: legal changes, improvements to police practice around ABD or street triage and certainly around the criminal investigation and prosecution of offenders.
- In March 2019 the National Mental Health Forum chaired by Chief Constable Mark Collins will convene in Birmingham, I'm thrilled to say. This follows on the back of my own force, West Midlands Police, agreeing to co-host a two-day CPD event for police force mental health leads and partners they may wish to bring. It will allow for a formal 'launch' of some of this stuff, as well as 'learning the lessons' and partnership presentations.

- In September 2019, the 4th national conference on Policing and Mental Health will convene in Liverpool. One idea for this year's event (yet to be confirmed) is to focus one of the days on the theme of child and adolescent mental health – always amongst the more sensitive of these sensitive issue, CAMHS related policing demands always bring extra complexity.

PARTNERSHIP TO DO LIST

Of course, in the background of events and publications, there is an ongoing need to develop partnerships. This will be a constant theme on all years to come. Some areas of the UK are clearly getting on well and working well together; other areas are … err, not. One force mental health lead recently said to me, they find it hard to see their local partnership working as any kind of partnership, more an abusive relationship, but knowing some details from that area that aren't in the public domain, I can understand why such a view might be held. That said, there are problems in policing and their approach towards mental health. I'm not sure we can honestly say we're "there" with police attitudes towards mental health demands.

Can't see say this loudly enough: not all demand faced by the police, related to mental health crisis is preventable and predictable, even where it involves people who are 'well-known' to mental health services. Policing is **always** going to have at least some role to play, not least because its obvious we still have too many police officers who think that where someone with mental health problems has offended, they have offended *because* they have mental health problems. This is not true, *most* of the time; and even where it is true some of the time, that doesn't mean the police don't have a role. Remember this at all times: some powers under the Mental Health Act 1983 are only available to the criminal courts – as such, some situations involving very unwell patients who have offended, where there is a need to untangle the relationship between mental health and behaviour may need to go to a criminal court and it may be necessary for the judge to take certain decisions which assist in protecting the public.

The partnerships discussions which need to occur in 2019 are key: we are still in a state of conflict about what the roles and responsibilities of the various services are – both police and mental health leaders need to recognise that there is still considerable ambiguity playing out in practice about who does what, when and how. The law and policy often say two different things, if they say anything at all, about how certain situations will be handled and if we are to do justice to the learning from 2018 in the forthcoming year, we need to get managers at all levels to start discussing

these very difficult and complex areas in meetings and moving beyond the quite bland platitudes that arise when people are skirting complexity by talking in vague terms about the important of working together. If the law doesn't make all coercion under the MHA outside of hospital the job of the police, we need to start talking about who is going to do this in the various circumstances where the Codes of Practice state it is the role of non-police actors. And if we don't, we'll continue to see verdicts on neglect in Coroner's courts, as we have done as recently as this month.

A PERSONAL NOTE

There we go – a very short post without attempting to make any particular point. It's just a heads up of things you may see or hear more about in the coming twelve months which touch upon the natural venn diagram(!) of policing, mental health and criminal justice. But of course, and inevitably, there will be various things from the real world which also get in the way and tragically punctuate or experience during that time.

For my own part, I will click past two milestones next year which are of personal significance. In February, I will move beyond 21yrs of police service which probably means I do need to realise I'm definitely a grown up in policing terms! In September, I will click beyond the point where I only have 10yrs of police service left to do – very conscious that can sound like a long time but it doesn't seem 10yrs since my nearly-14yr old who thinks I'm a boring and grumpy old man looked at me through 4yr old eyes as if I were some kind of hero. So I hope next year to put arrangements in place to start doing a PhD so I can begin to think of what life may involve after policing, because there is so much more to do in this field and I'm already convinced this won't be finished by the time I retire in 2029, all being well.

Plenty to do – so enjoy your New Year, have a drink and dance and on Monday 7th when the hangovers have worn off and the tree is binned or packed away, let's get on with it and do it properly this time.

End of Volume:
191 pages
68,139 words

Total to end of volume 8:
2,703 pages
946,539 words