MENTAL HEALTH COP

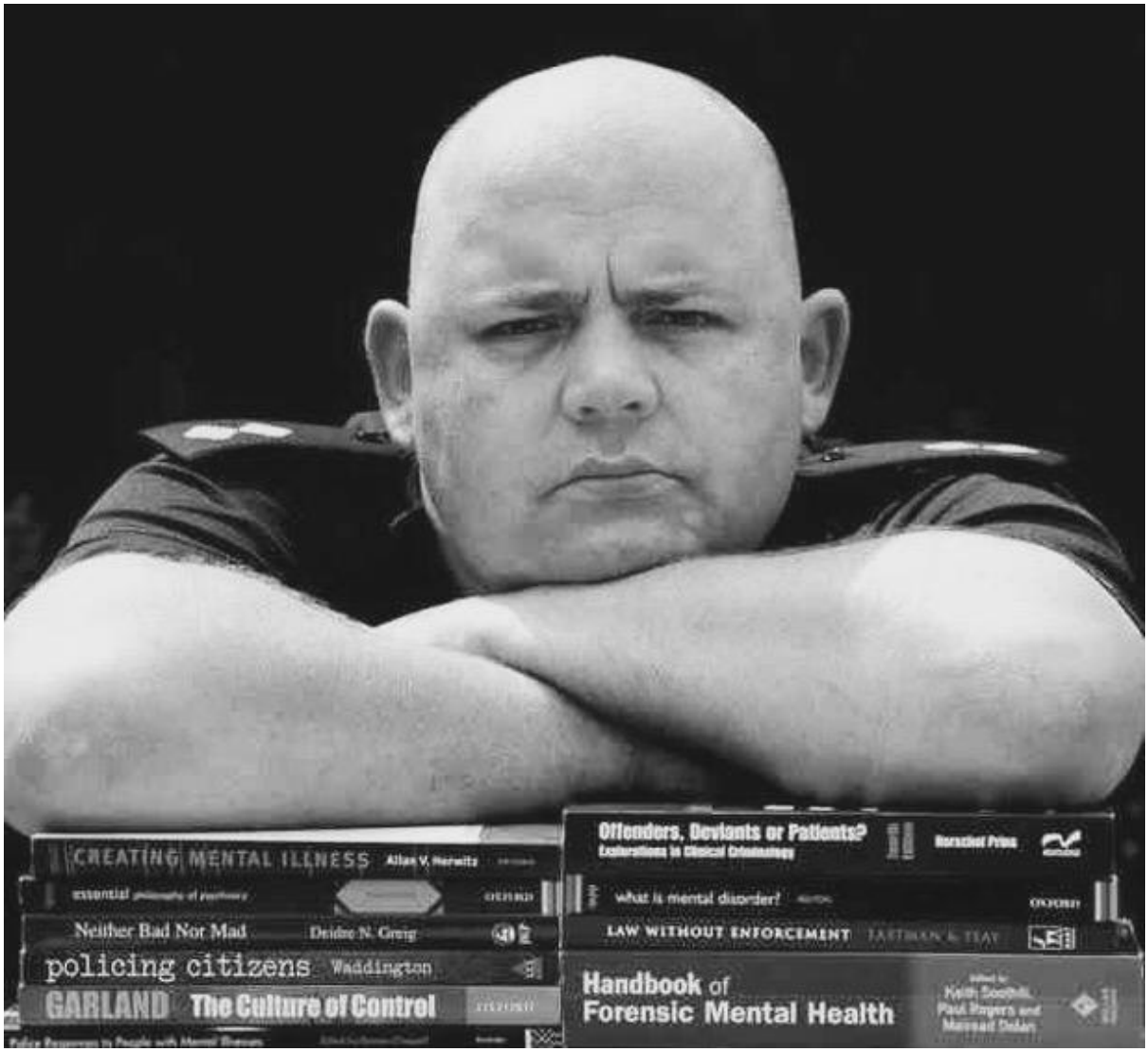
A VENN DIAGRAM OF POLICING, MENTAL HEALTH AND CRIMINAL JUSTICE

Volume One – 2011

& Miscellaneous

*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

PREFACE

Covering Essay

About –

I'm a serving 24/7 police inspector blogging in a *personal* capacity. I've had more than my fair share of policing & mental health incidents and **I continue to get them daily** on the frontline of British policing.

It was the overwhelming feeling when I joined of not knowing what on earth I was doing, that got me asking questions about this stuff. I asked them of other police officers, including supervisors, but it emerged they often knew little of use. I have made it my business to ask psychiatrists, forensic psychiatrists, A&E doctors, paramedics as well as psychiatric nurses and AMHPs (or ASWs as they were) how we should operate in this area of policing. Anyone who would stand still long enough and talk to me, frankly.

I eventually found out that there are no simple answers and no-one was particularly working on policing and mental health. I had triangulate a multitude of opinions and form my own, accepting from the start that once I felt confident enough to begin expressing views, I would meet just some people who were prepared to *die in a ditch* before they would *ever* agree with me – *even though* I was trying my best to understand laws or guidelines and was representing back opinions from people who do their job. When you point this out – that other people who do their job disagree with them about the issue in hand – and that they are contradicted by their own guidance, you'll be patronised and talked down to: what do the police know about mental health?!

You'll then *start* to understand the kind of paradigm we've constructed.

It's when you then meet other quite amazing health and social care professionals who will tell you that you were quite correct in what you thought you'd read or heard – you start to wonder what on *earth* has been going on?

I'm not seeking any form of anonymity and am open about my views on this stuff, but nor am I attempting to represent the police service's views officially. You'll need to speak to Chief Constable Simon COLE of Leicestershire Police for that – he leads for the service on this issue and a lot of policy positions are represented in national guidance to the police service, which I was involved in producing. I'm making this blog as close to that document as I possibly can, bearing in mind it is not perfect and news and legal cases develop this stuff all the time.

I am not attempting to be subversive at all, but to represent the uncertain and ongoing debate about the role of the police, the legal structures within which we must operate and this will involve outlining considerations and thoughts that will not always go down well with everyone. But I'm

interested the criminalisation of mental health issues and I'm interested in ensuring that operational cops with their 8hrs of mental health training, can survive legal contact with this extremely complex business and do their best for patients and vulnerable people.

Through this blog, I want to try and get police officers and health / social care staff talking to each other. It is years of me doing just this in my own area that has brought me to a position where I feel confident in knowing what to do, along with reading a lot of law and guidance.

Regards,

Michael./

Biography –

I was born in Newcastle-upon-Tyne and brought up in Northumberland. After leaving school I read music at the **University of Birmingham** (BMus 1996; MA 1998) and joined West Midlands Police. I served for four years as constable in Winson Green, Birmingham – both in uniform and in CID; and was promoted to sergeant in Moseley / Sparkhill in 2002. It was as a sergeant that I began studying for an MSc in Criminology and Criminal Justice at **Cardiff University** (MSc 2004), within which I wrote my final dissertation on "police decision making on criminal suspects who are mentally ill".

Having taken an active interest in mental health issues affecting policing, I was promoted to inspector in 2003 and in 2005 was posted as the force lead on mental health at West Midlands Police headquarters. I was awarded a **Bramshill Fellowship** in 2007 and then posted to an operational inspector's role in Birmingham where I policed an area with the largest mental health related demands in the force. In 2009, I again was posted to West Midlands Police headquarters, this time to work for the ACPO Lead on Mental Health & Disability as well as establishing health-based places of safety in every borough of the West Midlands. Seven Place of Safety services were completed by 2011 and more or less eliminated the use of police cells as a Place of Safety in one of the country's largest forces. These services have resulted in tens of thousands of vulnerable people avoiding the indignity of detention in police cells whilst in crisis and this practice was commented on by Her Majesty's Inspectorate of Constabulary and the Care Quality Commision as **national best practice**. It was subsequently highlighted in the UK Parliament.

In 2010, I began lecturing on the **MSc in Forensic Mental Health** at the **University of Birmingham** and continue to do so. I have since done guest lectures at a variety of academic institutions including the world-renowned **Institute of Psychiatry**, University of London and the **University of Manchester**. I am also a guest lecturer on initial paramedic training at the **University of Worcester** and have delivered CPD training to Approved Mental Health Professionals across England and Wales and have presented widely at various national and international conferences in the UK and South Africa.

In 2011, I was again posted operationally and these 'frontline' positions have allowed me the opportunity to command several highly demanding, critical incidents involving vulnerable people. This has notably included many crisis events where people indicated an intention to take their own lives by jumping from heights or by fire. I have also successfully overseen the response to a double homicide and several other incidents of serious violence; an incident where a man experiencing an acute psychosis was

pointing a firearm at members of the public and supporting health colleagues with entering premises in opposition to armed individuals to detain them under mental health law. These operational postings continue to impress upon me the extent of the work that we have yet to do to improve the way we police and the role of the police in our broader mental health system.

I started writing the "**MentalHealthCop**" blog in 2011 to reflect these ongoing questions and concerns and became active on social media to promote awareness of the role officers all too often play. Along with my previous experience, this led to my being seconded to the College of Policing in 2014 as their new mental health coordinator and this now allows me to work nationally and internationally on mental health policy and practice in policing. In 2012, I won the **Mark Hanson Digital Media Award** from the leading mental health charity **Mind** in 2012, presented by Stephen Fry on London's South Bank; and in 2015 I was awarded **the President's Medal** by **the Royal College of Psychiatrists** for "a significant contribution to the lives of people living with mental illness", presented by Professor Sir Simon WESSELY at their International Congress in Birmingham.

I am married to Lucy and we have a son, Harrison. I occasionally play in bass in various bands and less occasionally find time to play squash. I am an RFU-qualified rugby coach and referee and I help run my son's junior rugby team – an absolute highlight in any week!

MEDIA

Four pieces of journalism which appeared in UK national press.

The Guardian: Beyond the Call of Duty

by Mary O'HARA, 18th December 2012.

When Michael Brown's name was called out at the Mind Media awards and he made his way to the stage to pick up the award from Stephen Fry, the audience cheer was distinctly louder than for any of the evening's other winners. That Brown was stunned to win, never mind be given such a rapturous response, was patently evident. Reflecting a few weeks later on the accolade for his popular blog, written under the moniker Mental Health Cop, the shock is still evident.

"I didn't in the least bit think that I'd win at all," Brown says, an expression of disbelief still on his face. "To subsequently learn that actually the judges felt it was a clear winner astounded me, to be perfectly honest."

The blog was initially conceived a year ago as an attempt to provide an online space where police officers could access clear, informed advice on how to deal with incidents involving people with mental health difficulties. Brown describes it as "by a cop interested in mental health issues, for cops who have to deal with mental health incidents".

"It might be people who maybe present a risk to themselves or [are] expressing suicidal ideas. Or [a situation] where some kind of emergency intervention is needed," Brown says of the kind of incident a police officer might encounter.

EQUIPPED TO COPE

He refers to officers as "street-corner psychiatrists", who are often first at a scene when a person might need expert medical attention from mental health professionals. Brown says it is "essential" that police officers are equipped to cope. Providing an online resource that officers feel happy to consult is, he suggests, one way of helping that happen. With this in mind, the blog is packed with more than 200 articles touching on issues ranging from the use of physical force by officers to the prevalence of mental health problems within the force itself. Alongside these are practical tools such as an FAQs section and digested guides to complex aspects of mental health legislation.

The fact that mental health problems can be extremely complex and that symptoms might not be obvious to an officer arriving at the scene makes it a confounding area, Brown argues. Add to this that mental health legislation seems opaque and perplexing to many officers, and it is understandable that some feel out of their depth.

"A police officer who hasn't had time to get their head around [the law] is going to be incredibly confused. It's quite awkward legislation," he says.

Brown says a particularly pleasing aspect of writing the blog is the positive feedback he gets. He volunteers a story by way of example of a female officer in Wales who was called to an incident where she needed to find a "place of safety" for someone with mental health problems, and ended up in a dispute with the local A&E as to whether they would fulfil that role. The Mental Health Act requires that a place of safety, such as a hospital environment, be found for people who are to be detained. The officer contacted Brown to tell him that she used the blog to remind staff at the hospital that if someone is displaying a "Red Flag" – for example, is physically harmed or exhibiting signs of mental distress such as mania, then they can legally be sent to the emergency room.

"She said that she pulled the blog up on the iPhone, pointed it towards the nurse and said 'Can you read that, please?'", he says.

Mental Health Cop now has thousands of followers, including health and social care professionals, lawyers, campaigners and service users. It also has guest bloggers, and solicits input from anyone interested in the subject of mental health and criminal justice.

"I thought when I started doing this that it would be worthwhile doing it if we could get a niche following, and that might include people from outside the police service," Brown says. "I didn't envisage in a million years it would have 7,000 followers. It's [now] a broad network of people. I know that psychiatrists read it. A lot of mental health nurses read it. There [are] a lot of service users who read it, I'm pleased to say." Brown, 38, had always wanted to be a police officer, despite studying music and a short spell as a music teacher. His personal curiosity in mental health issues was sparked, he says, after realising that more than half of his first arrests had involved "someone in mental distress".

But it developed into a "genuine" interest when he was a custody sergeant and observed that many people experiencing mental health difficulties were being brought to the station. He began to wonder if it was really an appropriate place for them.

"I found myself working on a cellblock and therefore far more of my day was spent dealing with people who had mental health problems," he says.

The blog's genesis came out of work he was doing on mental health-related projects with the Association of Chief Police Officers (Acpo) aimed at improving the force's response to incidents when someone presented with a mental health problem.

Feedback from the "frontline" included requests for an online resource that officers could turn to for answers to critical questions in an emergency. This, combined with encouragement from some Twitter followers – Brown had been tweeting under the name Mental Health Cop for a while – galvanised him to write a blog that would be "accessible to everybody".

He speaks at length and with great earnestness about why he believes the blog is a valuable aid to policing and something that fosters respect among officers for people who are in distress. When it comes to the more controversial areas of policing and mental illness, such as using unnecessary force on people in custody, Brown is less forthcoming, but he doesn't shy away from the concerns that shroud the police force's reputation on the issue. He is aware that media attention tends to focus on when something has gone terribly wrong, such as when someone dies in custody.

Brown mentions, unprompted, Sean Rigg, perhaps the most high-profile recent incident of a death in custody. The 40-year-old musician, who had schizophrenia, died in August 2008 after Metropolitan police officers held him in a "prone" position for eight minutes. An inquest in August concluded that police had used unsuitable and unnecessary force.

IMPROVING LIAISON

Brown stresses that Acpo's work on mental illness and training is a positive move towards a much-improved system for officers interacting with people in mental distress. Concerted efforts to improve liaison with key agencies, such as ambulance services, to make sure detained people are dealt with appropriately is a key factor in preventing mistreatment, he suggests.

When asked how his bosses have reacted to the blog, which he writes in his spare time, usually at night, he says their support has been "overwhelming". But he acknowledges that there are limits to what he can write, mainly to do with being a serving police inspector. He cannot comment, for example, on "ongoing cases".

"I do sit and check myself constantly. Do I know what I know because I am a police officer?" he wonders.

So what are his ambitions for the blog? More guest bloggers, including service users, and he says he wants to add more thorny topics to his

repertoire. "I've kind of touched on and hinted at things like mental health restraint … but there's something to be said about how we can improve what we do around that."

Curriculum vitae

Age 38.

Family Married with one son.

Home Worcestershire.

Education Ashington high school, Northumberland; University of Birmingham, music degree and MA; Cardiff University, MSc in criminology and criminal justice.

Career 2010-present: visiting lecturer on MSc in forensic mental health course, University of Birmingham; 2009-present: guest lecturer University of Wolverhampton on policing degree courses; 2010-11: part-time secondment to the National Policing Improvement Agency; 1998-present: police officer, West Midlands police; 1997-98: peripatetic music teacher, Northumberland county council music service.

Awards Mind digital media; chief constable's award (2012) for outstanding contribution to mental health; Bramshill Fellowship (2007) to study policing and mental health.

Interests Watching rugby and coaching his son's team, playing bass in several bands, reading non-fiction.

The Guardian: Why we need the online presence of MentalHealthCop

by Mary O'HARA, 18th February 2014.

Last Friday West Midlands Police (WMP) suddenly suspended the Twitter account of @MentalHealthCop, the enormously popular, award-winning feed from police officer Michael Brown. The same day, Brown's equally admired personal blog which, like the Twitter account, had become a "go to" destination for people interested in the intersection of policing and mental health services, shifted from "public" to "private" access only.

The abrupt change to MentalHealthCop's online status met with an instant and incandescent reaction from his legions of followers, who demanded an explanation from the force.

MentalHealthCop stands out among police officers on social media. Mental illness and policing is an extremely sensitive area, not least because some of the most controversial deaths in police custody where restraint has been used have involved people with mental health conditions, while over half of all deaths in custody involve someone with a mental health problem.

The police are frequently the first emergency service personnel to come into contact with people in crisis. How officers react and how they interact with health services in the detention and care of people can mean the difference between exacerbating someone's difficulties and making sure they get access to appropriate care. This is the stuff MentalHealthCop has been writing about for the past few years and for which he has won considerable praise. In his blog, which won the mental health charity Mind's 2012 digital media award, he writes fluently about the complexities of frontline policing and the law, and offers advice and insights into how collaboration between the health service and police forces can make a positive difference. On Twitter he has been popular for engaging with tough questions and alerting the public to new developments and research.

His 16,000 followers, who include other officers, psychiatrists, social workers, health professionals, lawyers and mental health service users are demanding to know what WMP is doing. When I asked on Twitter for people's views I was inundated. (Brown himself has remained silent.) Among the comments made about how "invaluable" and "rare" MentalHealthCop was, many people questioned the suspension for being "counterproductive" and an "own goal", at a time when the police's reputation is arguably at an all time low.

Reflecting the sentiments of many, human rights lawyer Peter Edwards tweeted: "Very sad day when police silence an informed voice about mental health and policing." Psychiatrist Alex Langford told me: "Michael Brown's impartiality, open-mindedness and willingness to teach have been a valuable lesson to many of us."

The WMP assistant chief constable, Garry Forsyth, took to Twitter to explain that the account had been suspended while an alleged "breach" of WMP's social and digital media policy by the officer was investigated. The police would not confirm what the alleged breach was, but there have been suggestions that it was for tweeting about the extent of mental illness among police officers.

An official statement said: "Certain aspects of the officer's communication is currently being investigated for alleged misuse." If WMP fails to provide a full explanation for its action or decides to close the Twitter account for good, we can expect further outrage. The episode raises fundamental questions about the police's use of social media and throws doubt on claims about transparency.

The Spectator: Why The Police Silenced One of the Best Officers in Britain

by Nick COHEN, 18th February 2014.

West Midlands Police's announcement that it had ordered the closure of the blog and Twitter account of Inspector Michael Brown – 'the mental health cop' – has caused astonishment and anger in equal measure.

Thousands of grateful patients, police officers and doctors have followed Brown online ever since he realised that he had had only two hours of mental health training. He decided to remedy his ignorance in 2011. He went about finding ways to cut deaths in custody by 'providing officers with information about how to handle mental health calls and to manage clinical risks'.

Numerous prizes, including the Mind Digital Media award, followed. Everyone loved him apart from the Corporate Communications Department at the West Midlands Police. Assistant Chief Constable Garry Forsyth, who is responsible for 'customer services', said last week that he was investigating Brown for 'misuse of a force [Twitter] account'. Breaches of police rules on officers' talking to the public would, he continued, be 'taken extremely seriously'. What crime could have the apparently altruistic Brown have committed?

The Mail, Guardian and Mirror ran the story, but could not say why the brass had sent in the heavy squad.

Here is a sequence of events no one has noticed. On 4 February, West Midland Police's corporate PRs had a publicity coup. The BBC's *One Show* filled prime time television with a puff piece about its 'street triage' scheme, in which a nurse accompanies officers on patrol and decides whether to send a mentally ill person home, to hospital or to the cells.

The BBC's reporter, the poet Benjamin Zephaniah, was impressed. His mentally ill cousin had died in police custody 10 years ago. 'At long last I'm glad to see something has been done,' he said.

Inspector Brown was not so sure. On his now banned blog, he wrote that 'a nurse in a car with a cop' may not be the best solution. (The police may have closed it down but you can read a lifted extract here) Mentally ill and handicapped people in trouble needed pathways to 'available, accessible and responsive health services', which could provide places of safety. As the *One Show* was broadcasting, he tweeted on his now banned Twitter

account that street triage could not be the answer if the 'police's place of safety pathways aren't working properly'. (If you google 'mentalhealthcop and triage' you can see some of them)

This was hardly a vicious critique, but if it was too much for the West Midlands Police to bear its subsequent behaviour would be scandalous. Because as things stands it looks as if his officious superiors could not tolerate intelligent argument about a PR campaign. Rather than allowing a good man, who has helped thousands of people, openly debate a matter of public health and public importance, they shut him up, closed him down and threatened him with disciplinary proceedings.

Private Eye: Knacker is a Twitter

by Ian HISLOP, 20th March 2014.

Panic swept the West Midlands Police after senior staff committed a major PR gaffe by closing the Twitter account of Inspector Michael Brown, better known as the "Mental Health Cop", whose advice on how the police should treat mentally ill suspects had made him one of the most admired officers in Britain.

The top brass was furious that Brown, who has won awards from the mental health charity Mind, had suggested on Twitter that the force's policy of sending nurses out on patrol to decide if suspects needed treatment, rather than a police cell, would not work if the NHS did not have the resources to care for the sick. No one else had even noticed that Brown had mildly criticised his superiors' policy – but the force's faintly sinister corporate communications department did.

Assistant Chief Constable Garry FORSYTH duly reached for the 11-page social media agreement that West Midlands officers have to sign, which bans all information that "conflicts with the corporate message". Guessing that his superiors would mine his published writings for evidence against him, Brown disabled his "Mental Health Cop" blog. At a stroke, said David Allen Green, an authority on social media and the law, "thousands of valuable links to reliable information had been lost".

Other officers became understandably nervous. Detective Constable Richard Horton of Lancashire Police, whose revelatory accounts of police work in his NightJack blog won the Orwell Prize, closed his Twitter account too. When the suspension of Brown's Twitter attracted the attention of the national press, Forsyth tried to calm the outrage with a press statement – but he failed to tell the public the real reason for investigating Brown, instead implying that the inspector had committed a grave breach of police rules, which was being "taken extremely seriously".

Realising that line could not hold, the force executed a reverse ferret and reinstated the Twitter account. But it could not leave it there. It said in a second press release that a "professional standards investigation has established that the officer accepted there had been some inappropriate use and informal advice was given". This was nonsense. Brown did not accept the advice and the press release has now vanished from the web.

As it licks its self-inflicted wounds, perhaps it is time West Midlands Police concentrated on catching criminals rather than on corporate communications.

QUICK REFERENCE GUIDES

The 'Quick Reference Guide' Blogs –

UPDATE >>> *You will now find the series of blogs I am referring to on their **own page** at the top of the blog. There is a scroll down menu for the different legal jurisdictions within the UK.*

I have had feedback coming through on email and Twitter for a while, that officers are finding the blogs very useful – in terms of providing 'training' on mental health which has been badly wanted for years and also in terms of being used as a reference tool at incidents. In particular, it has validated the hours of time spent writing these materials in the evenings. Because people have asked(!) I tend to park myself in front of the TV with a favourite film on after my family are in bed and get typing.

Tonight I sat down with the intention of writing several very short, very punchy blogs and I've just published six. The intention is not to tell a story, give a view or waffle on about my view of the world – the intention was to write "DO THIS, THINK ABOUT THIS, BALANCE THESE ISSUES TO REACH A DECISION" type blogs. I will then be able to arrange the blog and these pages in a way that makes the blog more useable.

So the six blogs I've published are each under 300 words, on:

1. s136 and Places of Safety
2. s135 and Assessments on Private Premises
3. AWOLs
4. Conveyance
5. Offenders
6. Red Flags

I also intend to also cover "MH Crisis in Private Premises" and "RAVE risks" as well as doing versions of the first three for Scotland and Northern Ireland – although I'll probably postpone that for another evening! I'll publish a page that has all these links on there, with a link to the blog's FAQ page which will shortly get updated.

All taken together, it should make the blog more 'useable' by frontline cops, who are the primary audience. It should also mean that officers could link to these pages via a SmartPhone icon and at the touch of a button have materials which are consumable at police jobs, to help with decisions.

- *This quick guide is an attempt to "operationalise" some complex issues but you should refer to your own force policy and your supervisors for specific local requirements.*

Quick Reference Guide –

RAVE Risks –

- This is a mnemonic to assist in establishing whether a non-criminal incident, involving the adminsitration of health and / or social care processes should involve the police.
- It is a starting point for discussions, not an end point.
- And it relates to the heightened potential for risks which are legitimately beyond the ability of NHS or Local Authority staff to manage *after* employing their normal procedures.

  - **RESISTANCE**
  - **AGGRESSION**
  - **VIOLENCE**
  - **ESCAPE**

- These are the grounds upon which it could be argued that the police should be involved in support NHS processes to implement mental health law.
- Where there are NO '**RAVE risks**', it could be argued that there is no statutory responsibility for the police to undertake health or social care functions;
- ***Whether*** the police then choose to do so, will be case by case, in light of other demands and in line with the Chief Constable's views on how to deploy their officers.

- **MORE DETAILED INFORMATION ON RAVE RISKS**.

Quick Reference Guide –

RED FLAGS –

Dangerous Mechanisms

- Blows to the body
- Falls > 4 Feet
- Injury from edged weapon or projectile
- Throttling / strangulation
- Hit by vehicle
- Occupant of vehicle in a collision
- Ejected from a moving vehicle
- Evidence of drug ingestion or overdose (inc alcohol)

Serious Physical Injuries

- Noisy Breathing
- Not rousable to verbal command
- Head Injuries
- Loss of consciousness at any time
- Facial swelling
- Bleeding from nose or ears
- Deep cuts
- Suspected broken bones

Attempting Self-Harm (persistent except when under restraint)

- Head banging
- Use of edged weapon (to self-harm)
- Ligatures
- Especially where above accompanied by a history of overdose or poisoning

Psychiatric Crisis

- Delusions / Hallucinations / Mania

Possible Excited Delirium – two or more from

- Serious physical resistance / abnormal strength
- High body temperature
- Removal of clothing
- Profuse sweating or hot skin
- Behavioural confusion / coherence
- Bizarre behaviour

- **MORE DETAILED ARTICLE ON RED FLAGS**

Quick Reference Guides –

Mental Health Crisis in Private Premises –

- In private dwellings, the police service in the UK have **no powers** to utilise mental health law to resolve a mental health crisis.
- They obviously do retain powers to arrest for criminal offences or for a breach of the peace and to force entry in order to do so.
- There is no power to force entry *per se* without a warrant in order to manage a mental health crisis, unless there is a criminal offence or a breach of the peace.
- Obviously there are powers to force entry "to save life or limb".
- The Mental Capacity Act 2005 (England / Wales) and the Adults with Incapacity (Scotland) Act 2000 are of only limited capacity in private dwellings – where there are imminent risks involving people who lack capacity.

INITIAL ACTION

- Take immediate action, if deemed necessary under criminal law, (incapacity law) or common law (BoP) to ensure immediate safety and security.
- Once done or should that not be appropriate, call an ambulance to the scene.
- Consider sources of information, including the patient themselves, to establish professionals connected to ongoing care, if any;
- Consider relatives or friends who could be called to assist and support the person.
- Consider a capacity assessment – like **the CURE test** – but defer this to any health and social care professional who is made available / accessible to the incident.

SUBSEQUENT ACTION

- Make a decision of whether it is possible or necessary to effect a coercive intervention
- Having called an ambulance, consider calling one or more of the following sources of intervention, support if it is felt that follow up mental health care is necessary:

- Mental Health Crisis Team
- General Practitioner
- Duty AMHP from the local authority or via the Crisis Team.
- Ensure referral for safeguarding to the appropriate authority.

LEGAL REMINDERS

- There are no powers for police officers to act under the Mental Health Act in private premises.
- There is no ability to stop people moving around their own home, accessing rooms or locking them, leaving the premises or picking up items within the premises which could be potentially harmful to them or others: **UNLESS** –
- It constitutes a criminal offence or a breach of the peace.
- Article 8 of the European Convention is of application to people's right to peaceful enjoyment of their possessions.
- Parliament intended the coercive response to mental health crisis in private – *except* where there are imminent, life-threatening risks – to be an AMHP and DR (or MHO and DR) undertaking assessment for urgent admission under law.

- **MORE INFORMATION ABOUT MENTAL HEALTH ON PRIVATE PREMISES.**

Quick Reference Guides –

Conveyance –

- *This quick guide is an attempt to "operationalise" some complex issues but you should refer to your own force policy and your supervisors for specific local requirements.*

INTIAL ACTION

- It is a core responsibility of the NHS to convey mental health patients – it *may* be a police responsibility to support if **RAVE risks** are involved.
- This includes conveyance after s136, after s135 or someone being sectioned; after someone being recovered AWOL or between mental health facilities.
- If **RAVE risks** are involved, discuss things – even if briefly – before wading in.
- **Always** request an ambulance if agreeing to support conveyance.
- If patient's have been sedated by medical staff before conveyance **ABSOLUTELY INSIST** upon **medical** supervision >>> this means a nurse or doctor, not just a paramedic.
- Discuss restraint that involves handcuffs or leg restraints: if the police are being asked to take responsibility for safety, it is ultimately a police decision whether such PPE is used.
- Is the place to which the patient is being removed aware of this and willing to accept?
- Refer disputes around ANY aspect of conveyance to your **DUTY SERGEANT** wherever time allows.

SUBSEQUENT ACTION

- **Constantly** re-assess for **RED FLAGS** whilst the person is conveyed,
- Remove to A&E if any **RED FLAG** emerges at any stage.

LEGAL REMINDERS

- It is a police decision whether to become involved in conveyance in all of the above circumstances apart from s136.
- They are only obliged to do so where there are statutory responsibilities to prevent crime or protect life – **RAVE risks**
- If s136 is instigated and no NHS conveyance is available, then the police must remove that person to a place of safety.
- Whether handcuffs, leg restraints or other PPE / use of force is utilised is ultimately a police decision.

Quick Reference Guide –

Should I Stay or Should I Go? –

- *This quick guide is an attempt to "operationalise" some complex issues but you should refer to your own force policy and your supervisors for specific local requirements.*

INITIAL ACTION – A&E

- Unless A&E is set up and *designated* as the main NHS Place of Safety, only remove to A&E if the person presents with a RED FLAG.
- Remain with the patient in A&E – they are not set up to manage the *legal* detention of the person.
- They provide physical, urgent healthcare connected to RED FLAGS.

INITIAL ACTION – Place of Safety

- Arrive at an NHS PoS – do PNC / Intelligence checks to understand risk.
- Share that risk information where it is relevant to the NHS keeping themselves safe.
- Require risk information known to the NHS be shared with you.
- Jointly rate each detainee as LOW, MEDIUM or HIGH risk.

SUBSEQUENT ACTION

- Patients who are **LOW RISK** – should be left with NHS staff for assessment.
- Patients who are **HIGH RISK** – should be supported to protect NHS staff and the individual.
- Patients who are **MEDIUM RISK** – should be subject to agreement between staff over whether the police are needed.
- Some medium risk patients will require police security; others may be known to staff and be safe without police security.
- If in dispute about **MEDIUM RISK** patients – remain *in situ* and refer the matter to your supervisors and subsequently to your inspector.
- If the NHS demand that the police remain with **LOW RISK** patients because they are short-staffed, email your inspector.
- This should be taken up with the MH trust and MH commissioners – it is not right for a range of reasons.

LEGAL REMINDER

- There is **no** legal obligation *per se*, for the police to remain in an NHS place of safety.
- There **is** a legal obligation on the police to prevent crime / protect life.
- Police leaving an NHS Place of Safety once the patient has arrived:
- It arises from the **Royal College of Psychiatrists Standards on s136** (p8).
- Remaining in an NHS PoS may be necessary to prevent crime against NHS staff.
- **68% of all assaults** on NHS staff are against mental health professionals.

- **MORE DETAILED GUIDANCE ON THIS SUBJECT**

Quick Reference Guide –

Offenders –

- *This quick guide is an attempt to "operationalise" some complex issues but you should refer to your own force policy and your supervisors for specific local requirements.*

INITIAL ACTION

- This guidance applies to both "inpatient" offences AND offences committed in the community.
- Preserve evidence for offences in the normal way – witnesses, CCTV, forensic, etc..
- Do not immediately assume that it is not in the public interest to invesitgate or prosecute
- Gather as much background information about mental ill health as possible, especially if it is possible to contact a mental health professional with knowledge of the suspect
- Get medical opinion about whether the suspect can be interviewed.
- **Inpatient offences** – formally request background information listed here:

SUBSEQUENT ACTION

- Once decided whether to interview / section:
- **Fit to be interviewed** – appropriate adult, interview, weigh evidence: disposal decision.
- **NOT fit to be interviewed** – Mental Health Act assessment, await outcome.
- Once decided whether to 'section' under the MHA:
- **No section** – appropriate adult, interview, weigh evidence: disposal decision.
- **Section (minor offence)** – consider 'diversion' without charge; and / or caution, warning or local resolution of the offence.
- **Section (serious offence / risk)** – take background information to CPS for consideration of charge and Part III MHA application to court.

LEGAL REMINDERS

- Insanity is a defence, for the defendant to raise:
- "Every man is presumed to be sane and possess a sufficient degree of reason to be held responsible for his actions."
- It **IS** legally possible to arrest someone who is already sectioned under the MHA
- It is sometimes necessary to prosecute people who are mentally ill in order to secure opportunities available under Part III MHA.

- **MORE INFORMATION ON THE PROSECUTION OF OFFENDERS**
- Specific, more detailed guidance on inpatient offences.

ENGLAND / WALES

Quick Reference Guides –

Knowledge Check –

Are you a front-line police officer? What is it you **need** to know about policing and mental health without having to look it up?

I would argue that it is not that very much at all – here are 500 words to summarise the important operational parts of this whole blog – with links to more comprehensive explanations and other material. And don't forget the Quick Guides which are individual guides, with legal references to the situations below which I've reduced to their absolute minimum.

Place of Safety Detentions

- Section 136 MHA cannot be used in private dwellings
- Once it is used, call an ambulance to *every* arrest – **RED FLAGS to A&E** – No RED FLAGS to psych PoS: when all else fails and you can't improvise around it, police station only as a last resort.
- Anywhere can be a place of safety, if they temporarily agree to receive the person detained. Just make sure you're certain of why you're acting, against the decision-making model.

Planned Assessment on Private Premises

- Attendance only if there are demonstrated **RAVE risks** – **request a warrant** if it the risks come from the patient to be assessed; attend whether a warrant is forthcoming or not.
- Consider PoS Detentions (above) if it is decided to remove to a Place of Safety and Conveyance of Patients (below) if removed from the address to a PoS or following 'sectioning'.

Sponteneous Attendance to a Private Premises

- No power of detention under the MHA at all.
- You can arrest for an attempted / substantive offence or for a Breach of the Peace if there is fear of "an immiment risk of violence."
- The Mental Capacity Act should be considered and instigated by healthcare professionals not by the police, unless use of it is necessary to mitigate an immediate, serious risk by someone who lacks capacity.

Conveyance of Patients

- Request a non-police conveyance for all transportation or transfers, unless urgency or risk / violence prevents this being realistic.
- If police conveyance is used for those reasons – ensure clinical supervision from a paramedic, nurse or doctor (depending on the clinical issues.)
- Sedated patients should be nurse / doctor.
- If at any stage there are **RED FLAGS** during conveyance, divert to the nearest A&E.

AWOL Patients

- No power to do anything except detain s136 if you find an **informal / voluntary MH patient**.
- A power of re-detention under s18 if the patient is **formally declared AWOL** under the MHA
- No power of entry to detain AWOL patients under s18 – you need **a warrant under s135(2)** which you can obtain yourself or with involvement of MH services.

Prosecution of Offenders

- Gather the evidence as normal (witnesses, CCTV, etc.)
- Request as much background information on MH as possible in circumstances.
- Assume a diversionary approach to low-level offending; assume a prosecution approach to serious offences;
- Nothing prevents arrest / prosecution where this is necessary because of threat and risk.
- Prosecution sometimes is necessary to ensure Part III of the MHA is used to manage threats and risks.

National Decision Making Model

- Where doubt prevails, or amidst conflicting advice – weigh up the legal options, with the relevant policies and procedures with the need to prevent crime, bring offenders to justice, protect life / property and maintain the Queen's Peace.
- Decisions will be defendable if they are taken in good faith, with these intentions in mind.
-

- **Don't assume that trying to do the right thing is a waste of time** because you anticipate some resistance, either from individual professionals or the agencies they work for – attempting to the right thing before settling for the least worst option might be thing that makes actions legally defendable, especially following any serious untoward event.
- **The last thing you need to know**, is where to find the answers to the stuff you don't know – that's why you should bookmark the blog or save a link on the home page of your smart phone. The **Quick Guides** and the **FAQs** might the first reference tools; but don't forget the **full index** of over 450 articles on different aspects and the search facility on the top right hand corner of the main blog page.

Quick Reference Guides –

s136 and Places of Safety –

INITIAL ACTION

- Call an ambulance to EVERY arrest made
- Remove anyone displaying a **RED FLAG** to the nearest A&E department
- Remove everyone else to the NHS place of safety in your area.
- Use a police station only as a last resort, if you cannot improvise any other alternative solution.
- Alternative solutions could include a domestic address – their's, a relative's or friend's – if it were assessed as a safe / appropriate setting.

SUBSEQUENT ACTION

- Call the Approved Mental Health Professional yourself and take their name
- Call the Registered Medical Practioner if the person you detained did end up in the cell block.
- **Constantly** re-assess for **RED FLAGS** whilst the person remains detained under s136 and in contact with the police.
- Remove to A&E if any **RED FLAG** emerges at any stage.
- Once the patient is received, consider whether You Should Stay or You Should Go

LEGAL REMINDERS

- Where the police remove someone to after arrest is, *ultimately*, a matter for the police.
- Local protocols are important, but only binding if they actually deliver **legal** outcomes.
- **Paragraph 10.22 MHA CoP states**, "A police station should not be assumed to be the automatic second choice if the first choice is not available. Other options should also be considered."
- **Paragraph 10.39 MHA CoP states**, "a person should never be moved from one place of safety to another unless it has been confirmed that the new place of safety is willing and able to accept them."

- NHS preferences not to deliver upon their own guidelines and Codes of Practice ARE NOT sufficient grounds to ignore legal frameworks.
- Ensuring that you have attempted to secure the right kind of assessment and care; or the nearest available thing, is important to demonstrating a discharged duty of care.
- Doing what we all know to be the wrong thing, will not be defendable with "But the NHS would not / could not …"

- **MORE MATERIALS ON ALL ASPECTS OF S136 AND PLACES OF SAFETY**
- More **detailed guidance** on how to act before / during / after s136 detention.

Quick Reference Guides –

s135 or Assessments on Private Premises –

INTIAL ACTION

- Decide whether the police are going to attend the assessment:
- There is a legal duty only where the AMHP has a warrant OR where there are predicted **RAVE risks**
- Otherwise – it is discretionary.
- If there are **RAVE risks** from the patient, ask for a s135(1) warrant to be obtained – document any refusal / inability.
- Yes, the AMHP absolutely CAN apply for a warrant even if they know they can obtain access.
- The point of doing so, is the warrant allows the management of risk once inside, by removing for assessment in a place of safety, if need be.
- If there are **RAVE risks** from a third party, familiarise yourself with:
- s115 MHA – AMHPs right of inspection to premises – no power of entry to do so;
- s129 MHA – criminal offence of obstructing an AMHP in the course of their duty
- Ensure the quick guide for conveyance is your next read.

LEGAL REMINDERS

- Whether to apply for a warrant is a decision for the AMHP
- Whether to ask for a warrant, is the right of the police.
- **Without** a warrant under s135(1) of the Mental Health Act, the police have NO powers to use force until: –
- the AMHP has 'sectioned' the patient or unless a criminal offence is attempted or a breach of the peace apprehended.
- With a warrant under s135(1) , the police can force entry if need be, and remove to a place of safety if thought fit.
- Whether to remove to a place of safety is a decision for the police.
- If you do so, follow the same procedure as if for s136 MHA.

- **A MORE DETAILED EXPLANATION ON s135 MENTAL HEALTH ACT**
- More articles on various aspects of assessments on private premises.

Quick Reference Guides –

Mental Capacity Act –

- *This quick guide is an attempt to "operationalise" some complex issues but you should refer to your own force policy and your supervisors for specific local requirements.*

INITIAL ACTION

- To determine whether or not someone lacks capacity the "**ID A CURE" Test** can be applied –
- **Impairment** – is there an impairment (temporary or permanent) which prevents the person from being able to 'CURE', as below; OR
- **Disturbance** – is there a disturbance of the mind (temporary or permanent) which prevents the person from being able to 'CURE', as below;

- **AND** – *just one* of the follow factors then need be **absent** for the person to lack capacity

- **Communicate** – can the person communicate their decision to you (even if not verbally)?
- **Understand** – can the person understand the information that would enable them to make the decision?
- **Retain** – can the person retain the information in order to make the decision?
- **Employ** – can the person employ the information to make the decision effectively?

SUBSEQUENT ACTION

- If action involves removal to a healthcare facility, either a psychiatric unit or an Accident & Emergency department, ensure that NHS staff are made aware that the Mental Capacity Act has been applied.
- Inform your sergeant that this action has been taken so they can support your actions / decisions.

LEGAL REMINDERS

- Determine capacity with reference to the test in s2 MCA – not a scientific assessment, just a considered decision.
- Whether someone can take a decision is determined by the approach in s3 MCA.
- Undertake proportionate acts to safeguard someone's best interests (understood from s4 MCA), in accordance with the principles in s1 MCA.
- According to s4A MCA no-one is authorised to deprive another person of their liberty, unless it is a s4B MCA response to the need for life-sustaining treatment or to prevent a serious deterioration in their condition.
- Officers are then protected from liabilities by virtue of s5 MCA, as long as they acted in the best interests of someone they believed lacked capacity.
- Any 'restraint' must be done in accordance with s6 MCA.

- See a more comprehensive post on the **Mental Capacity Act for the police.**
- See a link the fully explains the **urgent deprivation of liberty / urgent restraint** laws.

Quick Reference Guides –

AWOLs –

- *This quick guide is an attempt to "operationalise" some complex issues but you should refer to your own force policy and your supervisors for specific local requirements.*

INTIAL ACTION

- There is a legal duty to report all AWOL patients to the police who are "Dangerous, especially vulnerable or subject to Part III MHA".
- "Part III MHA" means patients who entered the mental health system via the criminal courts, often described as "s37" or "s37/41" patients.
- Otherwise, reporting missing persons is *discretionary* to the mental health trust.
- **Detained MHA patients** – there is a power to redetain under s18 MHA
- **Voluntary / Informal patients** – there is no power to redetain. They must be assessed afresh under the MHA.
- If the whereabouts of the patient are **known** to the MH trust from which they are missing, it is the duty of the MH trust to repatriate them or go to assess them.
- It is the responsibility of the NHS to commission conveyance arrangements to do this.
- If support is sought from the police, this should be because there are **RAVE risks** and it is the role of the police to support, not *replace* the NHS.

SUBSEQUENT ACTION

- There is no power to hold people in police cells after detaining someone as AWOL under the MHA.
- It is the legal duty to return the patient to the hospital from which they are missing or to which they have been recalled.
- Bed management issues arising from the re-detention are then a matter for the NHS, through their contigency arrangements and duty managers, if needed.
- These should be sorted out at the hospital concerned, with ongoing police support if there are **RAVE risks**.

LEGAL REMINDERS

- The power of arrest under s18 does **not** have a power of entry attached.
- If entry needs to be forced in order to exercise it, a warrant under s135(2) is required.
- Police officers may apply on their own for a s135(2) warrant, if they need to.
- It would be better if the application or execution of the warrant were accompanied by a mental health professional.
- **Paragraph 28.14 MHA CoP** – "If the patient's location is known, the role of the police should … be only to assist a suitably qualified professionals."

- **MORE INFORMATION ON AWOL PATIENTS**

Quick Reference Guides –

Absent / Absconded –

- *This lists various sections of patient who are absent or who have absconded and the timescales within which they may be re-detained by the police.*

ABSENT (without leave)

- Patients who are AWOL from hospital under these sections –
- **2** – up until 28 days after their original admission to hospital
- **3** – up to six months after the date on which they become AWOL
- **4** – up to 72hrs after their original admission to hospital
- **5(2)** – up to 72hrs after their original detention under this power
- **5(4)** – up to 6hrs after their original detention under this power.
- **7** – up to six months after the date on which they become AWOL
- **17A** – up to six months after the date on which they were recalled.
- **37** – up to six months after the date on which they become AWOL
- **37/41** – any time after they become AWOL.

LEGAL REMINDERS –

- All of these re-detentions are made under s18 of the Mental Health Act
- There is **no power to force entry:**
- Should forced entry be required – apply for a warrant under s135(2) from a Magistrate.

PART II ABSCONDERS (from legal custody)

- Liable to be detained means an application for admission to hospital under the following sections has been made, but the patient has absconded before arrival there.
- **2** – up to 28 days from the date they abscond
- **3** – up to six months from the date they abscond
- **4** – up to 72hrs from the time they abscond
-

- Patients can also abscond before being received into guardianship under section –
- **7** – up to six months from the date they abscond
- **37*** – up to six months from the date they abscond
- **37/41*** – at any time after they abscond
- * *These sections are under Part III, but by virtue of s40 MHA and for the purposes of absconding and absence they are treated "as if" under Part II.*

PLACE OF SAFETY ABSCONDERS

- **135(1)** – if absconded *before* arriving at the PoS, up to 72hrs after absconding.
- **135(1)** – if absconded *after* arriving at the PoS, up to 72hrs after arriving.
- **136** – if absconded *before* arriving at the PoS, up to 72hrs after absconding.
- **136** – if absconded *after* arriving at the PoS, up to 72hrs after arriving.
- **LEGAL REMINDERS –**
- All of these re-detentions for Part II and Place of Safety absconders are made under s138 of the Mental Health Act
- There is **no power to force entry:**
- Should forced entry be required – apply for a warrant under s135(2) from a Magistrate.

- **PART III ABSCONDERS** (from lawful custody)
- There are three sections where particular powers apply if the patient abscond from hospital whilst involved in criminal proceedings –
- **35** – remanded to hospital for reports: re-detain under s35(10)
- **36** – remanded to hospital for treatment: re-detain under s36(8)
- **38** – an interim hospital order after conviction: re-detain under s38(7)
- **Only the police** can re-detain these three categories of patient
- The police **must return the patient to the court** which remanded them.
- There is no power of entry under the MHA to exercise these powers, but! –
- Escaping from lawful custody is a criminal offence and a power of entry may be exercised to effect and arrest for it, OR
- Obtain a warrant under s135(2).

- TO READ MORE DETAIL SEE THIS POST ON ABSCONDING OR ABSENT?

Quick Reference Guides –

Recalls / Revocations –

This guide was written after an attempt by MH services to recall a CTO patient who had history of resistance and aggression. The police said, "Sorry, we don't have any powers to do that." This is wrong, although the police are not the only ones who do.

The recall / revocation of CTO patients is very similar to the re-detention of s42 conditional restricted release patients despite them being for very different categories of patient.

COMMUNITY TREATMENT ORDERS (CTOs) – INITIAL ACTION

- Any patient on a CTO under s17A MHA can be recalled to hospital for up to 72hrs by their Responsible Clinician, a psychiatrist.
- Ensure that a "recall notice" has been served upon the patient concerned – ask to see / have a copy.
- **This is important:** examples exist where recall notices have not been served or served correctly and the police have still been requested to detain / convey.
- The notice can be served personally or delivered by hand or by first class post – see below for when it takes effect because it is not necessarily immediate.
- Request confirmation of the "RAVE Risk" information to influence the approach.

CONDITIONAL RESTRICTED RELEASE – INITIAL ACTION

- Any patient previously detained under s37/41 MHA can be conditionally discharged by the Ministry of Justice under s42 MHA.
- They may be recalled to hospital if the MoJ issues a warrant for their recall and return to hospital.
- Ensure that a "s42 MHA warrant" has been issued for the patient concerned – ask to see / have a copy.
- **This is important:** examples exist where recall notices have not been served or served correctly and the police have still been requested to detain / convey.

- Request confirmation of the "RAVE Risk" information << There will usually be loads of it, because s37/41 patients by definition have been deemed to post "a significant risk of harm to the public."

SUBSEQUENT ACTION – FOR EITHER CATEGORY OF PATIENT

- Once detained, regard the patient as in legal custody and act as per any other MHA
- Ensure an ambulance is called to convey the patient.
- Assess and constantly re-assess for **RED FLAGS** whilst the person is conveyed.
- Remove to A&E if any **RED FLAG** emerges at any stage.
- Detain / restrain in the least restrictive way, with due regard to the person's status as a patient.
- Ensure you understand issues around the conveyance of MH patients.

LEGAL REMINDERS

- If CTO recall notice served by hand – effective immediately
- If CTO recall served by personal deliver – effective the next day
- If CTO recall served by first class post – effective two working days later, ie: exclude weekends / bank holidays.
- The CTO recall notice taking effect renders the patient AWOL for the purposes of s18 MHA.
- There is no power of entry to detain someone under any circumstances of s18, unless s17 PACE or breach of the peace powers apply.
- To force entry, a warrant under s135(2) is required.

Quick Reference Guides –

Guardianship –

INITIAL ACTION

- First of all – be clear what the action the police are being required to take.
- **Usually one of three things:**
- 1) Re-detain someone who is AWOL from Guardianship; OR
- 2) Assist in the transfer of someone from one guardian to another.
- It may be necessary to execute a warrant under s135(2) in order to do either of those things.
- Confirm that the police are being required to do something for which there IS a power – do not assume that mental health professionals understand what "AWOL from Guardianship" means.

SUBSEQUENT ACTION

- Call an ambulance to EVERY detention made where you intend to re-detain or transfer someone under Guardianship.
- Involve police supervisors in discussion about any future safeguarding.
- Guardianship is not about having full coercive authority over patients.
- Patients retain legal autonomy about many things and Guardianship fails as soon as patients start to object to it and withdraw consent.
- Once a patient who is returned or transferred is delivered to the Guardian – nothing in law stops them leaving the premises again.
- Repeated AWOLs may indicate the placement is breaking down and / or that a different kind of legal order is appropriate, for example a DoLS order.

LEGAL REMINDERS

- Guardians have three powers under s8 whilst someone is resident:
- **1** – to require the patient to reside at a specified place; << "reside", not "remain."
- **2** – to require the patient to attend at specified places at specified times for the purpose of medical treatment, occupation, education or training;
-

- **3** – to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, Approved Mental Health Professional or other person so specified.
- **NB:** "AWOL" cannot just be that patients have left the place of residence – they are allowed to do so.
- It must *either* include that they left in a way which is clearly indicates permanent absence will follow, *OR*
- They left earlier that day or the previous day and have not returned to "reside" there.

More **detailed guidance** on Guardianship and the legal authority of MHA Guardians.

Quick Reference Guides –

What Do All The Sections Mean?! –

It has only just occurred to me to write a post like this, but now that it has, it seems one that was obviously needed months ago! … what do the different sections of the Mental Health Act 1983 mean, especially in relation to policing?

Incidentally, if you're a cop with a SmartPhone why don't you save this page on your homescreen – start a little folder with MH reference stuff like this and the **Quick Guides**? I know some officers have done so and started using it at jobs and **showing it to mental health professionals** to influence outcomes! <<< *Not the original intention of the blog, but if it helps …*

Here is a very quick run down, necessarily a snap-shot, so I'm not going to explain all the ins and outs of every section listed – mental health law books are **thousands of pages long**! You could argue about detail on this if you really wanted to but instead, I'd encourage you to read **Mental Health Law Online**, a website and goldmine of resources, if you want something more specific:

Part I

- **Section 1** – the definition of mental disorder: "'mental disorder' means any disorder or disability of the mind; and 'mentally disordered' shall be construed accordingly".

Part II – this is the terminology you will hear AMHPs and MH professionals using:

- **Section 2** – the power to detain someone believed to be suffering mental disorder for assessment (and treatment). The order lasts for up to 28 days and cannot be extended or renewed. It is imposed after application by an AMHP and two DRs one of whom must be "section 12 approved". <<< *You see? … paradoxically, you need this guide just to understand it!?>!* The patient has a right of appeal against detention to a Mental Health Review Tribunal.
- **Section 3** – the power to detain someone for treatment of mental disorder. This order lasts for six months and can be renewed. It is imposed after application by an AMHP and two DRs one of whom must

be "section 12 approved". Right of appeal against detention to a Mental Health Review Tribunal.

- **Section 4** – the emergency power to detain someone for assessment for up to 72hrs. This is in effect a s2 detention, but is imposed where an AMHP and only one s12 Doctor believe it is needed and delay for a 2nd doctor is impracticable. No right of appeal.
- **Section 5(2)** – a 'holding power' for DRs to detain an inpatient in hospital for up to 72hrs for assessment under the Act. Cannot be used in A&E because the patients there are not (yet) "inpatients". Can be used by non-psychiatric doctors on inpatients with psychiatric problems who are on 'general' medical wards in a non-psychiatric hospital.
- **Section 5(4)** – a 'holding power' for a nurse *of the prescribed class* – usually a more senior psychiatric nurse – to detain someone for up to 6hrs: either for consideration by a DR of whether to use their 5(2) holding power; or to arrange an MHA assessment. Again, this holding power can only be used on patients already admitted.
- **Section 6** – the AMHPs authority to detain and convey someone to hospital for admission under the Act.
- **Section 7** – this allows patients to be received into "Guardianship", which obliges them to reside in a particular place, but still allows them a level of personal autonomy.
- **Section 12(2)** – Various things in the MHA can only be done by or must include a "section 12 approved doctor". Such DRs are those "having special experience in the diagnosis or treatment of mental disorder."
- **Section 13** – the AMHPs duty to undertake MHA assessments and make applications for admission.
- **Section 17** – the right of hospitals to grant leave as part of rehabilitation and recovery. Such leave might be very brief when first granted – an hour or so – and it may be supervised by a staff member. However, as patients near release it may be for a weekend, for several days or longer. It is a **very necessary** part of rehabilitation and recovery for patients.
- **Section 17A** – the right of hospitals to release a patient from detention subject to Supervised Community Treatment (SCT), otherwise known as a Community Treatment Order (CTO). Excuse the comparison, (but this page is being mainly written for police officers!) – it is effectively like "bail conditions". If the conditions are not complied with, a person can be recalled and failure to return makes them 'AWOL' under the Act.
- **Section 18** – the power to (re-)detain AWOL patients and return them to hospital. There is NO power of entry in order to do so. Can only be exercised in a public place or where legal permission to enter a private building or dwelling has been obtained.
- **Section 19** – the authority of hospitals to transfer patients between different MH facilities.

<u>Part III</u> – these are sections relevant to decisions by criminal courts and prisons

- **Section 35** – power for a criminal court to remand an accused person to hospital for psychiatric reports. Lasts for twelve weeks but can be renewed for further twelve week periods.
- **Section 36** – power for a criminal court to remand an accused person to hospital for treatment pending trial. Also lasts for twelve weeks and can be renewed.
- **Section 37** – power for a Crown Court to impose a **hospital order** upon a person convicted of or found responsible for an offence. This order can be imposed after a full conviction or following conviction for manslaughter on the grounds of diminished responsibility; it can also be used following a successful insanity defence or after a finding of unfitness to stand trial. The order lasts until such time as the Responsible Clinician believes it needs to be discharged but patients retain a right of appeal (under different rules) to a Mental Health Review Tribunal.
- **Section 38** – an interim hospital order: can be imposed on a convicted or responsible person to undertake assessment and treatment as to whether a full hospital order is the right outcome.
- **Section 41** – **a restriction order**, sometimes known as a '37/41 order'. The Crown Court can 'restrict' an order made under s37 which subsequently prevents the DR from taking decisions to released the patient, transfer the patient to a different (kind of) mental health hospital or to allowing them periods of s17 leave from hospital. It obliges the DR to have such decisions authorised by the Ministry of Justice Mental Health Unit. Such restriction orders can only be imposed if the original court was satisfied that the patient posed a "significant risk of harm to the public."
- **Section 42** – anyone detained under a restricted hospital order is never just 'released'. They are always released under this section, in what is known as **conditional restricted release**. Again, pleased excuse the comparison, but with my police audience in mind, it amounts to being released on licence, again with some potential restrictions or conditions. If those restrictions or conditions are breached, the Secretary of State for Justice, through the MoJ Mental Health Unit, can issue a warrant for the return of that patient to a named hospital. They then assume the status of a s37/41 restricted patient.
- **Section 47** – a **"transfer direction"** authorises the moving of a convicted prisoner to a hospital, if they develop a need for mental health treatment whilst serving their sentence. By virtue of s47(3) MHA, such a patient is then treated in hospital 'as if' they had been sentenced to a s37 hospital order by a court. This is sometimes referred to a 'Notional s37' and I have written a <u>specific post about this</u>.

- **Section 48** – same power as per s47, but for remand and other prisoners (such as immigration detainees) in contrast to s47 for convicted prisoners.
- **Section 49** – a **"restricted transfer direction"** imposes restrictions upon leave, discharge or transfer without Ministry of Justice permission, as per s41 MHA. Sometimes, this is known as a '47/49 order', but it for our purposes the same as '37/41 order'.
- **Section 50** – is a **"remission direction"** to remove a s47 MHA patient back to prison if their detention in hospital for mental health treatment is no longer required but their sentence of imprisonment is not yet up.

<u>Parts IX and X</u> – offences and police powers

- **Section 126** – criminal offence of forgery (with respect to MHA documents) or possession of forged items.
- **Section 127** – criminal offence of wilful neglect of an inpatient.
- **Section 128** – criminal offence of assisting a person to absent themselves without leave from hospital; or harbouring such patients after absenting themselves.
- **Section 129** – criminal offence of obstruction of an AMHP or refusing to withdraw from an AMHP.
- **Section 132** – the rights which must be explained to someone when detained in hospital, including where detained under s135(1) or s136 as a place of safety.
- **Section 135** – warrants under the Act for (1) assessments on private premises; and (2) recovering patients who are absent without leave.
- **Section 135(6)** – legal definition of a place of safety.
- **Section 136** – police power to detain someone in immediate need of care or control and remove them to a place of safety. Power to detain lasts for 72hrs.
- **Section 137** – authority to regard someone subject to an application for admission under the Act as being 'in legal custody'.
- **Section 138** – power to do two things: a) recover someone who has absented themselves from detention under s135(1) or s136 and return them to a place of safety. Power lasts for 72hrs after they went missing or after arrival at the place of safety; whichever is sooner; and b) power to take someone into custody who has absconded whilst liable to being detained under Part II of the MHA.
- **Section 139** – protection from legal liability for individuals who aim *in good faith* to do things in pursuance of objectives under the MHA. The law requires permission from the High Court or Director of Public Prosecutions to be obtained ahead of any proposed legal action, either civil or criminal.
- **Section 140** – a *requirement* upon Clinical Commissioning Groups and Local Health Boards to stipulate those hospitals in their areas which are able to receive patients 'in circumstances of special urgency' and those which are suitable for patients under the age of 18.

SCOTLAND

Quick Reference Guides (Scotland) –

s293 and Assessments on Private Premises –

INTIAL ACTION

- Decide whether the police are going to attend the assessment:
- There is a legal duty only where the Mental Health Officer has secured a removal order OR where there are predicted **RAVE risks**
- Otherwise – it is discretionary.
- If there are **RAVE Risks** from the patient, ask for a s293 removal order to be obtained – document any refusal / inability.
- Yes, the MHO absolutely CAN apply for a warrant even if they know they can obtain access.
- The point of doing so, is the warrant allows the management of risk once inside, by removing for assessment in a place of safety, if need be.
- If there are **RAVE risks** from a third party, familiarise yourself with:
- s317 MHA(S) – criminal offence of obstructing an MHO in the course of their duty
- Ensure the quick guide for conveyance is your next read.

LEGAL REMINDERS

- Whether to apply for a warrant is a decision for the MHO
- Whether to ask for a warrant, is the right of the police.
- **Without** a removal order under s293 of the Mental Health (Care and Treatment) Act, the police have NO powers to use force until: –
- the MHO has 'sectioned' the patient or unless a criminal offence is attempted or a breach of the peace apprehended.
- With a removal order under s293, the police can force entry if need be, and remove to a place of safety if necessary.
- Whether to remove to a place of safety is a decision for the police.
- If you do so, follow the same procedure as if for s136 MHA.

- **A MORE DETAILED EXPLANATION ON s135 MENTAL HEALTH ACT**
- More articles on various aspects of assessments on private premises.

Quick Reference Guides (Scotland) –

s297 and Places of Safety –

INITIAL ACTION

- Call an ambulance to EVERY detention made
- Remove anyone displaying a **RED FLAG** to the nearest A&E department
- Remove everyone else to the NHS place of safety in your area.
- Use a police station only as a last resort – it is not a place of safety – and only if you cannot improvise any other alternative, acceptable solution.
- Alternative solutions could include a domestic address – their's, a relative's or friend's – if it were assessed as a safe and appropriate setting.

SUBSEQUENT ACTION

- Call the Mental Health Officer yourself and take their name.
- Call the Registered Medical Practitioner if the person you detained did end up in the cell block.
- **Constantly** re-assess for **RED FLAGS** whilst the person remains detained under s297 and in contact with the police and remove to A&E.
- Once the patient is received, consider whether You Should Stay or You Should Go

LEGAL REMINDERS

- Where the police remove someone to after detention is, *ultimately*, a matter for the police.
- Local protocols are important, but only binding if they actually deliver **legal** outcomes.
- Although police stations are not defined as a Place of Safety under Scot's Law, they may be used in lieu of the existence or availability of such a place.

- NHS preferences not to deliver upon their own guidelines and Codes of Practice ARE NOT sufficient grounds to ignore legal frameworks.
- Ensuring that you have attempted to secure the right kind of assessment and care; or the nearest available thing, is important to demonstrating a discharged duty of care.
- Doing what we all know to be the wrong thing, will not be defendable with "But the NHS would not / could not …"

- **MORE MATERIALS ON ALL ASPECTS OF s297 AND PLACES OF SAFETY**
- More **detailed guidance** on how to act before / during / after s297 detention.

Quick Reference Guides (Scotland) –

AWOLs –

INTIAL ACTION

- Reporting missing persons to the police is *discretionary* to the mental health trust.
- In practice, patients who are dangerous, especially vulnerable and subject to criminal proceedings will always be reported to the police
- **Detained MH patients** – there is a power to redetain under s301 MH(C&T)(S)A
- **Voluntary / Informal patients** – there is no power to redetain. They must be assessed afresh under the Act.
- If the whereabouts of the patient are **known** to the MH trust from which they are missing, it is the duty of the MH trust to repatriate them or go to assess them.
- It is the responsibility of the NHS to ensure conveyance arrangements to do this.
- If support is sought from the police, this should be because there are **RAVE risks** and it is the role of the police to support, not *replace* the NHS.

SUBSEQUENT ACTION

- There is no power to hold people in police cells after detaining someone who has absconded under the Mental Health (Care & Treatment) (Scotland) Act.
- It is the legal duty to return the patient to the hospital from which they are missing or to which they have been recalled.
- Bed management issues arising from the re-detention are then a matter for the NHS, through their contigency arrangements and duty managers, if needed.
- These should be sorted out at the hospital concerned, with ongoing police support if there are **RAVE risks**.

LEGAL REMINDERS

- The power of detention under s303 MH(C&T)(S)A does **not** have a power of entry attached.
- If entry needs to be forced in order to exercise it, a warrant under s292 is required.
- Police officers may apply on their own for a s292 warrant, if they need to.
- It would be better if the application and / or execution of the warrant were accompanied by a mental health professional.

- **MORE INFORMATION ON ABSCONDED PATIENTS**

NORTHERN IRELAND

Quick Reference Guides (Northern Ireland) –

A129 Mental Health Order 1986 –

INTIAL ACTION

- Decide whether the police are going to attend the assessment:
- There is a legal duty only where the AMHP has a warrant OR where there are predicted **RAVE risks**
- Otherwise – it is discretionary.
- If there are **RAVE risks** from the patient, ask for an a129(1) warrant to be obtained – document any refusal / inability.
- Yes, the ASW absolutely CAN apply for a warrant even if they know they can obtain access.
- The point of doing so, is the warrant allows the management of risk once inside, by removing for assessment in a place of safety, if need be.
- If there are **RAVE risks** from a third party, familiarise yourself with:
- a125 MH(NI)O – criminal offence of obstructing an ASW in the course of their duty
- Ensure the quick guide for conveyance is your next read.

LEGAL REMINDERS

- Whether to apply for a warrant is a decision for the ASW
- Whether to ask for a warrant, is the right of the police.
- **Without** a warrant under a129(1) of the Mental Health Order, the police have NO powers to use force until: –
- the ASW has 'sectioned' the patient or unless a criminal offence is attempted or a breach of the peace apprehended.
- With a warrant under a129(1) , the police can force entry if need be, and remove to a place of safety if thought fit.
- Whether to remove to a place of safety is a decision for the police.
- If you do so, follow the same procedure as if for a130 MH(NI)O.

- **A MORE DETAILED EXPLANATION ON a129 MENTAL HEALTH ACT**
- More articles on various aspects of assessments on private premises.

Quick Reference Guides (Northern Ireland) –

A130 Mental Health Order 1986 –

INITIAL ACTION

- Call an ambulance to EVERY arrest made
- Remove anyone displaying a **RED FLAG** to the nearest A&E department
- Remove everyone else to the NHS place of safety in your area.
- Use a police station only as a last resort, if you cannot improvise any other alternative solution.
- Alternative solutions could include a domestic address – their's, a relative's or friend's – if it were assessed as a safe and appropriate setting.

SUBSEQUENT ACTION

- Call the Approved Social Worker yourself and take their name
- Call the Registered Medical Practioner if the person if you detained did end up in the cell block.
- **Constantly** re-assess for **RED FLAGS** whilst the person remains detained under s136 and in contact with the police.
- Remove to A&E if any **RED FLAG** emerges at any stage.
- Once the patient is received, consider whe
- ther You Should Stay or You Should Go

LEGAL REMINDERS

- Where the police remove someon to after arrest is, *ultimately*, a matter for the police.
- Local protocols are important, but only binding if they actually deliver **legal** outcomes.

- NHS preferences not to deliver upon their own guidelines and Codes of Practice ARE NOT sufficient grounds to ignore legal frameworks.
- Ensuring that you have attempted to secure the right kind of assessment and care; or the nearest available thing, is important to demonstrating a discharged duty of care.
- Doing what we all know to be the wrong thing, will not be defendable with "But the NHS would not / could not …"

- **MORE MATERIALS ON ALL ASPECTS OF A130 AND PLACES OF SAFETY**
- More **detailed guidance** on how to act before / during / after a130 detention.

Quick Reference Guides (Northern Ireland) –

AWOLs –

INTIAL ACTION

- There is a legal duty to report all AWOL patients to the police who are "Dangerous, especially vulnerable or subject to Part III MHA".
- "Part III MHA" means patients who entered the mental health system via the criminal courts, often described as "a44" or "a44/47" patients; or as a "hosptial order" or "restricted hospital order".
- Otherwise, reporting missing persons is *discretionary* to the mental health trust.
- **Detained MHA patients** – there is a power to redetain under a29 MHO
- **Voluntary / Informal patients** – there is no power to redetain. THey must be assessed afresh under the MHA.
- If the whereabouts of the patient are **known** to the MH trust from which they are missing, it is the duty of the MH trust to repatriate them or go to assess them.
- It is the responsibility of the NHS to commission conveyance arrangements to do this.
- If support is sought from the police, this should be because there are **RAVE risks** and it is the role of the police to support, not *replace* the NHS.

SUBSEQUENT ACTION

- There is no power to hold people in police cells after detaining someone as AWOL under the MHO.
- It is the legal duty to return the patient to the hospital from which they are missing or to which they have been recalled.
- Bed management issues arising from the re-detention are then a matter for the NHS, through their contigency arrangements and duty managers, if needed.
- These should be sorted out at the hospital concerned, with ongoing police support if there are **RAVE risks**.

LEGAL REMINDERS

- The power of arrest under s18 does **not** have a power of entry attached.
- If entry needs to be forced in order to exercise it, a warrant under a129(2) is required.
- Police officers may apply on their own for a s129(2) warrant, if they need to.
- It would be better if the application or execution of the warrant were accompanied by a mental health professional.

- **MORE INFORMATION ON AWOL PATIENTS**

THE PARAMEDIC SERIES

THE PARAMEDIC SERIES

Introduction –

To see any of the other **paramedic series** blogs, refer to the index:

There was a recent suggestion by a Police and Crime Commissioner of physically situating police and fire services in the same buildings to facilitate greater inter-operability and overlap in the use of equipment / resources. My first reaction to this was, "why Fire? – surely there are greater overlaps between the police and the ambulance services?"

I can't tell you how many jobs we go to with West Midlands Ambulance Service, it is far too numerous to count, but when we get there we are often working hand in glove. I have never, ever stood in a building with a fire officer making sure our joint decision-making stacks up to an effective intervention involving staff from each organisation – I've either been asking questions relevant to my criminal investigation of arson or taking direction about the extent of cordons or evacuations they need put in place when dealing with a fire which threatens public safety.

In contrast, my response team sees the ambulance service almost every day, sometimes several times a day; and the nature of the interaction is that someone needs an element of both healthcare and security and we have to work very closely together. 999 operators often despatch both services together.

It would be remiss of me not to mention the success West Midlands Ambulance Service have had in recent years. They are currently Ambulance Service of the Year 2012 and when I talk to police officers who work outside my region, they are often surprised at the response WMAS provide to this area, in terms of mental health. I know why and I'm proud to work alongside them all.

A "PARAMEDIC SERIES" OF BLOGS

I've taken some advice from paramedics I know about what would be of use and / or of interest about the role police when it comes to mental health related incidents. After their advice, I have written a number of blogs, to address several types of situation –

1. The one where **you are going to call the police** into a situation you are already dealing with; and
2. The one where **the police are calling you** into a situation they are already dealing with.
3. The one where **we're both called to a Mental Health Act assessment** being coordinated by an Approved Mental Health Professional; or to a situation where we start wondering about **the application of the Mental Capacity Act 2005**.
4. 4. The one where the legal detail of the MCA is covered, when thinking about whether it allows detention and restraint of someone who lacks capacity.
5. The one where we cover the different kinds of assessments that can occur involving mental ill-health
6. The one where we cover some legal issues about the use of force – both in terms of self-defence and the safe detention and conveyance of patients detained under the MHA.
7. The one where we explain what an AMHP is?

I have been advised to do this whilst presuming no legal knowledge at all, and limited mental health training because it can then be read and used by trainees at all stages of their career. If you think these posts are useful, I'd be grateful to you if you could raise awareness of them via social media or your professional networks. It will be done over a few posts, to keep each of them short-ish and consumable – but they're all listed below.

Treat this post as a general introduction or an index to them – I may add to it if you give feedback on the posts or we think of more ideas to cover in a "Paramedics' series." The posts are, by necessity, summaries pitched at Paramedics – they contain links to the longer, substantive posts I have written which fully explain various issues and which are replete with legal technicality and links to specific stated cases, guidelines, etc.. At the bottom of each post are links to the full index of this blog and to the "Quick Guide" series I wrote for police officers which you may also find useful.

If after wading through these you want to think about the knowledge I'm aiming for police officers to achieve, please see this "Knowledge Check" post << *everything you need to know about policing and mental health in 500 words*. I also once wrote a post about what the police would like the

NHS to know and it has been widely read and circulated within the NHS. Actually, it is in the top 5 of my 'most read' blogs ever.

Posts that may be of general interest on policing / mental health issues –

- "RAVE Risks" – this is a mnemonic meaning **Resistance, Aggression, Violence or Escape**. It is my way of attempting to summarise how we judge a situation involving mental ill health where it may appropriate or very necessary to involve the police.
- Biology, Psychology or Sociology – a post which skims over the different **approaches to mental illness**. I found this fascinating to learn and it goes some way to understanding from a 999 point of view why you sometimes feel you are banging your head on a wall.
- What If Richard Bentall Is Right? – some thoughts about our system of mental health care and the criticisms it often receives.
- Autonomy and Mental Capacity – some thoughts about **respecting people's right to make decisions**. Absolutely key to our 999 work is considering when it may be right to let someone take an unwise decision.
- Care in the Community – many people wonder whether **community care is responsible for tragic events**. Some thoughts on this, as well as the the history and the alternatives.

NB: I'm using the word "paramedic" generically – I'm aware of the differences between technicians and paramedics and that we see third-sector ambulances which contain first-responders who are neither of the above.

LAWS AND ROLES

Firstly, you'll see that there are different ranks and roles of police officer. I have previously written a detailed explanation of them all, but you'll probably just need to know three on the frontline:

- **POLICE**
- Police constables – they wear numbers on their shoulder and actually do the work!
- The sergeants – they wear collar numbers and three stripes. They supervise, oversee and direct where necessary. You are quite entitled to ask to speak to one, if you think it's needed.
- The duty inspector – my 'proper' day and night job – is the senior operational police officer and every area has one, 24/7 – they are the final decision-maker, they oversee the critical and serious incidents and they handle complaints issues.

- The duty inspector may also referee some of the politics which I regret creeps into our attempts to make this work – especially when resources are tight or many agencies are struggling to cohere.

- **NON-POLICE**
- Approved Mental Health Professionals, known as AMHPs (pronounced "amps") – usually a social worker, occasionally a psychiatric nurse or another mental health professionals.
- AMHPs are legally warranted and at the centre of MH assessments which occur in a different few situations mentioned below. It is a criminal offence to obstruct an AMHP in the course of their duty, under s129 of the Mental Health Act 1983.

- **LAWS**
- I previously wrote a "Quick Guide" to the Mental Health Act – this lists all of the relevant section numbers from the MHA and gives a sentence's worth of explanation for each.

If you want more detail on these subjects or any others, please email me on mentalhealthcop@live.co.uk and I'll happily add more posts and link them within this page. Some police officers have saved the blog itself, the Quick Guides or specific posts to their homepage on their iPhones as a reference – I add that just as a thought you may find useful. There should be an App available during 2013.

FURTHER READING

Don't forget three methods of using this blog to find out more:

- There is a full index of almost 700 posts on all manner of topics.
- There is a series of "Quick Guides" originally intended for police officers, but some will be of interest to paramedics.
- There is a "search" facility in the top right hand corner: by entering any keywords on policing / mental health will bring up the relevant posts, including entering sections of the MHA like "s136".

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

The Paramedics' Series -

You Call Us –

To see any of the other **paramedic series** blogs, refer to the index:

A PARAMEDIC LEAD INCIDENT

Crime – at the risk of stating the bleeding obvious and in order to get it out of the way, anything that involves criminal offences, attempted criminal offences or causing the immediate apprehension of violence – what we call a Breach of the Peace – is *core police business*.

Specifically, however, you should always bear in mind that it is a criminal offence to obstruct or hinder a paramedic / technician in the course of their work, contrary to s1 of the Emergency Workers (Obstruction) Act 2006. It is also an offence under section 2 of that legislation to obstruct or hinder someone assisting an emergency worker and I have previously mentioned the offence of obstructing an Approved Mental Health Professional – you could find yourself in the position of witnessing an AMHP being obstructed and you should consider on their behalf the ability of the police to help resolve that.

If you and your colleagues are being unlawfully obstructed, you can quite legitimately call for police support. This would include for example, that you've attended an address where one person is injured or ill and is seeking your help whilst a third-party is attempting to prevent you from gaining access to them. It is sufficient for your access to be lawful, that one person at that location who is legally entitled to grant access, has done so. It would be worth bearing this in mind at domestic abuse incidents, for example, where a potential offender is attempting to deny you access to a victim who has sought help. Call the police because that person is committing an offence by obstructing / hindering you and we can only imagine that they'll be keen to help with police enquiries into the original incident, too.

Anything that involves a substantive criminal offence or an attempt to commit one and the police can then use force against the offender to prevent it from happening, or arrest them for it.

General police powers – the police have an authority under s17 of the Police and Criminal Evidence Act, to enter a property by force in order to "save life or limb or prevent serious damage to property." This authority carries quite a high threshold – it is not sufficient to say, "we have concerns for welfare." Where you're struggling to get into a house after a 999 call about serious injury or threats to life, you can call the police.

RESPONDING TO MENTAL ILL HEALTH

Mental ill-health in public – you attend an incident where you are attempting to secure care for someone who you think may have a mental disorder who is a public place. If they consent to your recommendation and agree then all is well and I know the ambulance service deal with plenty of such calls. It's always interested me that you're only referral option is to take such patients to A&E and you cannot access MH services directly, in the way that you access certain specialist units for other kinds of medical conditions. Hey ho …

But what can the police bring to this, if the person you're attempting to help does not consent? If the person is found upon the arrival of the police to be **in a public place**, to be **suffering mental disorder** and to be **in immediate need of care or control** – either **in their own interests** or **for the protection of other people** – then the officer can detain them under s136 of the Mental Health Act and remove them to a place of safety. I'll mention PoS services a bit more, slightly later but there are dozens of articles about different issues within s136 in the blog index.

Mental ill-health in private – if you have concerns around someone declining the treatment or assessment that you believe to be necessary and they are in a *private place*, then the police are much more limited in how they can help. There is either a gap in the law or a gap in the response of mental health services, depending on which way you view the problem:

The UK is amongst only a few developed countries that does **not** empower its police to use mental health legislation in someone's private dwelling – if you're really interested, compare it with the Republic of Ireland. As such, our powers in someone's house are restricted to situations where someone is committing a criminal offence or is breaching the peace. To "breach the peace" the person must be behaving in such a way as to cause others to fear an "imminent risk of violence." So a slightly vague sense that someone may "do something" later or after you've left, does not amount to a BoP. << This doesn't mean don't call the police, if you think it may help: it is a word of caution that we may not be as much help as you'd hope if the person persists in refusing treatment when we get there.

A few years ago, the Metropolitan Police "used" the Mental Capacity Act 2005 to defend the removal of a patient from their own home for mental health assessment and the courts ruled that this was illegal. The judge reminded us that if assessment was required under the MHA, it could potentially be done at the premises by an AMHP and a DR attending the location and that this approach was Parliament's intention when they drafted the Act. They even ensured that AMHPs could apply for a warrant from a Magistrate to ensure they could get entry to a premises and control the assessment properly and police officers have to execute this warrant on the AMHPs behalf. The court reminded us that Local Social Services authorities are obliged to have sufficient AMHPs available to meet foreseeable demand for assessments.

And so the worst news is: if you attend a private dwelling and find a mental health related situation which something less than demanding *urgent* intervention to prevent suffering death or serious injury, the proper response is to engage MH services. This will probably mean the crisis team – and request their involvement, potentially to include an AMHP and a DR if MHA assessment for admission is thought necessary. << *Don't worry(!)* – I do live and work in the real world and know that this has *almost never occurred* when paramedics or police officers have sought it, but it is important to try to secure this response when we know it's right, for reasons I'll explain below when we discuss the actually using Mental Capacity Act. I'm also aware that some CrisisTeams do not open themselves up to direct referral from the ambulance service and / or only respond to calls for known patients.

By all means call for police support at such incidents if there are offences being committed and risks apprehended, but I'm sure the police would like me to point out, that we're somewhat restricted – like you are – in what we can do when we get there, other than arrest people for crimes to prevent them happening or continuing.

In the next blog, I'm going to cover what will be going through the minds of police officers if they call you into a situation they are already dealing with.

FURTHER READING

Don't forget three methods of using this blog to find out more:

- There is a full index of over 700 posts on all manner of topics.
- There is a series of "Quick Guides" originally intended for police officers, but some will be of interest to paramedics.
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The Paramedics' Series -

We Call You –

To see any of the other **paramedic series** blogs, refer to the index:

A POLICE-LEAD INCIDENT

In many important respects, the police are still wrestling with the nature and extent of their role around managing issues involving mental ill-health. Whilst a few officers stick to the view that it is "not police work", more officers recognise that it is daily police business for a range of valid reasons. Given that mental ill-health is connected to at least twenty percent of police demand, police forces and individual officers should be taking it seriously and looking to improve their knowledge and understanding.

Section 136 MHA – This is the police power to detain someone in a place to which the public have access who is in immediate need of care or control, in their own interests or for the protection of others and to remove them to a place of safety. This enables an assessment by an Approved Mental Health Professional and a Registered Medical Practitioner. Where police officers detain a person under s136, they either *will* be thinking or they *should* be thinking about ambulance. Let me explain why:

Police officers have faced enormous criticism where they have failed to recognise clinically significant features in patients they have detained; this has also included officers misunderstanding the nature of clinical issues, like mistaking diabetes for mental illness. There have been several high-profile deaths in custody and other serious events, where officers were criticised and in some rare cases, criminally prosecuted, arising from these mistakes and misunderstandings. For those reasons, the police service have started to assert the requirements within the Code of Practice to the Mental Health Act, which stipulates non-police methods of conveyance for those who are detained – para 10.17 and Chapter 11 refers to it being about the dignity of the patient in ensuring that they are conveyed in the most humane way.

However, the main reason the police want to see paramedics at s136 jobs, is your clinical skills. It is not only around the potential that we could

misunderstand something, although that is vital – it is also around the bone of contention that arises when police officers take people to **Accident & Emergency under s136**. A&E traditionally have not seen themselves as "a place of safety" (see below) and this is simply not a tenable position – because anywhere, including my mother's house, can be a place of safety if they are temporarily willing to receive a patient. It is more about police officers (and now paramedics) understanding what would make A&E the appropriate place to take someone who had been detained because some people quite simply *need* to be in A&E and it's impossible to physical have the patient without also legally having the patient . It is also far 'easier' to convince an A&E triage nurse that you're not just "trying it on" if a paramedic is there, talking the medical talk, about why it's appropriate.

In the West Midlands, we asked the NHS to specify what kinds of clinical conditions should trigger removal to A&E because of an acute need. An A&E consultant put together a list of what became known as RED FLAGS and all 11 A&Es agreed them as the basis upon which to go to A&E before anywhere else. Paramedics have proven key to ensuring that RED FLAGS are properly identified after use of s136 and we can cite at least three examples of lives having been saved that may otherwise have become deaths in police custody.

Finally – where a police officer has detained someone s136, they cannot hand the patient over to you and leave it with you: they should accompany the person to whichever place of safety is deemed most appropriate as the person remains in police custody until they are delivered into the detention of someone who is willing to take ongoing responsibility for detention and arrangement appropriate assessment – this will **never** be paramedics and will only be A&E is some very limited circumstances.

A Place of Safety – the legal decision about where someone is removed to after detention under s136 (or s135, which is covered in the next blog) rests with the police officer who detained the person, although it's going to be a brave cop who goes against the advice of a paramedic or any other medical professional who may have been involved. A PoS is defined in s135(6) MHA as being "residential accommodation provided by the Local Social Services Authority, a hospital, a police station or any other place temporarily willing to receive the person." So *anywhere can be a place of safety*, in theory – whether they get used as such in practice will depend upon your local s136 or PoS protocol.

It is worth knowing about Para 10.22 of the Code of Practice to the MHA when wrestling with the moralities of where officers might be thinking about taking someone. This paragraph imposes a duty not to automatically consider the police station to be the first or even the second choice location for a PoS: "other options should be considered before using the police station as last resort". So it has been known that if accessing a PoS is proving difficult, attempts could be made to 'improvise' through the

situation by taking someone to their own home or to a relative's. It might not be in the local s136 protocol, but it's not illegal either.

OTHER DETENTION AND CONVEYANCE

Section 18 MHA – this is the authority afforded to police officers (and AMHPs) to re-detain someone who is Absent WithOut Leave (AWOL) from hospital under the MHA. Many of the issues that officers should consider upon re-detaining someone who is AWOL, will be similar to those for s136, mentioned above. Taking someone (back) into custody means an assessment of risks and medical need will be necessary and again, officers have been prosecuted for alleged neglect where they have failed to call for an ambulance or react to the clinical risks in play when they find patients.

Patients can become AWOL in a range of circumstances but most the common situations involve patients who were detained under the MHA in hospital and have either left without permission or have failed to return from a period of agreed leave. It can also involved situations where patients on Community Treatment Orders, have been recalled to hospital. In all of these situations, and more besides, officers may want to seek your support to identify whether A&E is required and to convey the patient. I'm going to write about the 'politics' of this in another "Paramedic Series" blog, because it is well understood by the police that there are debates about whether this is an appropriate use of a 999 ambulance and that views of Ambulance Service managers are not consistent on these issues.

Section 6(1) – When a patient is 'sectioned' by an AMHP, the patients becomes "in legal custody" and the AMHP may then "detain and convey" that patient to hospital – against their will, if need be. Most usually, especially if force will be required, the AMHP will look to the police to undertake that task and the police will say, "Call an ambulance." The AMHPs authority under s6(1) may be delegated to others, including police officers and paramedics, to convey the patient and keep them detained – they simply need to authorise those other professionals to act. If you become involved in a situation where, along with police officers, you are conveying a patient to hospital who has been 'sectioned', then the officers certainly and potentially the paramedics, will be authorised to "detain and convey".

Urgent Transfers – In some areas, it is commonly assumed that if an urgent transfer is required of a patient from one psychiatric unit to another, that the police can be used, especially where the patient to be moved is aggressive or resistant. Police forces are increasingly resisting this approach, not only by citing the Code of Practice issues mentioned above, but also by pointing out the difficulties that can be unwittingly

encountered. In particular, where transfers are sought because patients have become aggressive, it raises the question of how patient safety will be managed in the journey – does the request to transfer people mean implicitly that a patient should be restrained? – we all know the risks associated with protracted restraint. What about transferring patients who may have been forcibly medicated by a psychiatrist before the transfer? – well one issue that has arisen several times, is the question of whether the psychiatrist or a nurse will be travelling with the patient to the new location in order to ensure that any ongoing need for medication is attended to. Obviously as a paramedics you are not licensed to administer some of the medication that psychiatrists would use to sedate a patient and I'm reliably informed by paramedics that when a patient is sedated during transfer and the Code of Practice demands that they be supervised by an appropriate professional, this does not include paramedics / technicians. **Police officers are extremely unlikely to know this!** – please give them a nudge and help them make appropriate representations if transfers in which we become jointly involved start to look like this!

In the next blog, I'm going to cover issues around the Mental Capacity Act and the undertaking of pre-planned Mental Health Act assessments in someone's home.

FURTHER READING

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The Paramedics' Series -

The Mental Health and Capacity Acts -

To see any of the other **paramedic series** blogs, refer to the index:

MENTAL HEALTH ACT ASSESSMENTS

There is a difficult catch-22 situation for Approved Mental Health Professionals when they are trying to arrange to assess a patient in their own home, for potential admission under the Act. The police will often say "Let us know when the ambulance service arrive" and you will say the opposite! For all the reasons in the previous posts, officers will be reluctant to convey a detained patient in a police vehicle without some kind of clinical support; and paramedics may be reluctant to convey patients who may pose a risk to themselves or others. All of that having been said, most MHAAs occur without police support.

An AMHP who wants to coordinate an assessment will require a "section 12 doctor" – this means a doctor "having special experience in the diagnosis or treatment of mental disorder." Most MHAAs involve an AMHP and two Doctors so that they may make an admission application under section 2 of the Act or under section 3; but where there is a difficulty getting a second doctor, s4 may be considered –

- **Section 2** – detention for up to 28days of someone believed suffering from mental disorder, in order to assess them. Once the nature of the disorder is understood, a patient can be transferred onto section 3, if necessary.
- **Section 3** – detention for up to six months of someone for treatment of a mental disorder. This order can be renewed if necessary – some patients can be detained for several years.
- **Section 4** – detention for up to 72 hours of someone believed suffering from mental disorder. If a second doctor subsequently agrees, patient can become a s2 patient.

One of the main debates for the police in the lead up to these assessments, is whether or not the AMHP has secured a warrant under s135(1). The warrant will determine what authority the police have within that address to manage the risks which have caused them to be called – you'll remember

from a previous post in this series, that the police have no legal powers under the MHA in a private dwelling. So they can only act by force to prevent crime or prevent a breach of the peace.

This issue about a s135(1) is also relevant to paramedics where you have jobs involving people ordering you out of their house. Imagine that you were told to do so by someone you believe is in need of assessment and / or admission? – unless you can find lawful authority to remain there, you must comply with the instruction and the same applies to the police. If you have ongoing concerns about mental ill-health that means you think the person should be compulsorily assessed or detained, then you'll need to think about an AMHP obtaining a s135(1) warrant and attending with the police. Obviously, if you believe you can remain in the premises because of an assessment of Mental Capacity which leads you to conclude that the patient lacks the capacity to take the decision, then you could consider remaining, but in those circumstances police support may be needed to ensure your safety and prevent an escalation of problems.

Where an AMHP has attended an address and made a written application for a patient's admission to hospital, then the police and / or paramedics may detain and convey, if authorised by the AMHP to do so.

THE MENTAL CAPACITY ACT

This legislation is very challenging for paramedics and police officers, not least because none of us get very much training on it. Although it has application to a large number of health and social care situations, it's relevance to emergency services' work is comparatively limited. I have written other posts and a "Quick Guide" to the MCA elsewhere on the blog: suffice to say here that it usually emerges between the police and the ambulance service in the following situation –

You are called to an address where a patient is threatening to harm themselves and / or take an overdose, but they are doing so in circumstances where it is not a criminal offence and it is not a Breach of the Peace. << *This situation is quite common:* a lot of police and paramedics I know are reporting that CrisisTeams and other MH services are starting to say "Ring the police" or "Ring an ambulance" when patients identify themselves as being in crisis and in need of support. So whether police or paramedics were called to the incident, by the time we're both standing there in that house, we have an issue of what kind of intervention can apply if we believe one is needed.

Firstly, if the situation revolves around whether someone needs admission under the MHA to hospital, then an attempt to arrange that should be made – via the CrisisTeam and / or an AMHP.

If you get to the point of feeling that you need to assess Mental Capacity Act to consider use of the MCA, then –

- **Everyone is presumed to have the capacity to take their own decisions.**
- To reach a position where a lack of capacity has been established and there is a lawful basis to doing something proportionate in the best interests of a patient, a capacity assessment should be undertaken.
- There are various tools for assessing capacity, but one that I put together after two bits of advice from a paramedic and a mental capacity trainer and former AMHP, is the "IDaCURE test".

The police have been criticised by the courts for removing a person from their home "using the MCA" and taking them to a place of safety for assessment under the MHA.

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The Paramedics' Series -

The Mental Capacity Act –

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When I get asked about the Mental Capacity Act and what it may allow the police and / or the ambulance service to do, I generally say this in order to summarise it all: "Stay clear of the Mental Capacity Act as something that allows you to do anything unless you are faced with an imminently life-threatening or serious risk situation. And if you are a police officer, get the NHS into the situation as fast as you can, probably by calling a paramedic!"

It's a simplification, but it is intended to circumnavigate all of the legal discussion that can sometimes follow. This addition to the Paramedics' Series emerges from a spontaneous discussion on Twitter yesterday between @NathanConstable and me, which was joined by various others from the medical and paramedical professions. He has documented his specific queries and concerns in a blog, to which this is a reply. But this post also follows on from certain questions posed to me during the College of Paramedics' #PatientSafety2013 Conference in Birmingham.

From that discussion, it was clear that questions persist, including about the specific detail of what the law says and it focussed quite quickly on the potential of the Mental Capacity Act to offer a legal solution to the "non-compliant incapacitated patient" problem, especially if that situation is encountered in a private dwelling where the Mental Health Act cannot be used by the police. And indeed it does, in some very limited circumstances.

SO WHAT DOES THE LAW ACTUALLY SAY?

Firstly, if you're unfamiliar with the general thrust of the MCA, read my original post it which covers the general principles of the Act and the potential defences it affords to decision-makers, as covered in sections 1 to 5.

Section 4A of the Mental Capacity Act is key to a baseline understanding of what can and cannot be done in detention / restraint:

- "This Act does not authorise any person ("D") to deprive any other person ("P") of his liberty. But that is subject to; (a) the following provisions of this section, and (b) section 4B." << The "following provisions" of the section is basically about court orders from the Court of Protection which will almost always not exist when paramedics and police officers are responding to 999 calls.

Section 4B of the Mental Capacity Act is then key to understanding what can be done, *in extremis*:

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

1. The first condition is that there is a question about whether D is authorised to deprive P of his liberty under section 4A.
2. The second condition is that the deprivation of liberty is wholly or partly for the purpose of giving P life-sustaining treatment, or doing any vital act;
3. The third condition is that the deprivation of liberty is necessary in order to give the life-sustaining treatment, or do the vital act.

Section 6 of the Mental Capacity Act is important when it comes to the use of any restraint:

- "If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless two further conditions are satisfied. The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P and the second is that the act is a proportionate response to the likelihood of P's suffering harm, and the seriousness of that harm."

1. For the purposes of this section D restrains P if he uses, or threatens to use, force to secure the doing of an act which P resists, or restricts P's liberty of movement, whether or not P resists.
2. Nothing stops a person providing life-sustaining treatment, or doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition while a decision as respects any relevant issue is sought from the court.

In other words: whether you are a paramedic *or* a police officer – or for that matter a doctor or a person's relative – you cannot deprive someone of their liberty except where they lack capacity and it is necessary to give life-sustaining treatment or to do "the vital act" to prevent a serious deterioration in their condition and any restraint used must be proportionate to the risks to the person from inaction. There are no additional permissions or authorities for paramedics or medics than there are for police officers or even members of the public: only a far better skill

base upon which to base a decision. This is why the Code of Practice requests the police to defer their decision-making, wherever possible to more appropriate people.

Also ask yourself this to look at difficult decisions from the other angle — could inaction constitute an allegation of wilful neglect, as outlined in section 44 of the Mental Capacity Act?

SCENARIO BASED DECISION-MAKING

@NathanConstable had asked if I would write this blog in response to his own list of questions and situations. Amongst them were three types of situation —

- **Patient suffering from a serious physical illness and deemed to lack capacity to decline medical treatment**
  —– examples in the real world have included an elderly man with a serious urinary tract infection which has so affected his cognition that he can no longer take care of his basic needs including ensuring that he eats and drinks properly. A GP is advising that unless treated at hospital, he may die. Others examples have included a man who is intoxicated and was hit by a car during a road traffic collision who now has an open head injury and is declining treatment. Paramedics present are advising that unless treated at hospital, his condition could deteriorate into unconsciousness and in theory could be fatal.

- **Patient suffering from a serious mental illness and deemed to lack capacity where there is active self-harming or overdose risks**
  —– examples in the real world have included a lady with known MH history in her own home with knife to her own throat. It is known that she has consumed alcohol, taken tablets in an attempt to OD and she already has cut her neck, albeit superficially, and she is still holding the knife to her throat threatening to harm herself yet further. Whilst officers / paramedics are attempting to persuade her to put down the knife, she starts to quite vigourously cut into her own neck.

- **Patient believed to be suffering from a serious mental illness with future suggestions of self-harm or overdose**
  —– this is the "Sessey" situation where the Metropolitan Police got it wrong. This is where the judge in the case reminded us that we should be calling an AMHP and a DR to do an assessment under the MHA, if need be having secured a warrant under s135(1) MHA. It is important that this is tried and documented as having failed, preferably with reasons why, before considering anything else.

It is my view that the MCA could be relied upon to defend an intervention in the first two cases as long as it was believed that the person lacked capacity. I would rationalise each intervention in my paperwork, roughly as follows, fleshed out with particulars of the incident and names of other advising professionals:

"Accepting that the MCA does not generally allow me to deprive someone of their liberty, I considered that such an intervention were necessary, aware of the requirements of section 4B of that Act. Without depriving [the person] of their liberty and removing them to hospital for urgent treatment I could reasonably anticipate on medical advice that their life would be at risk or there could be serious deterioration in their condition. I assessed their capacity using a standard tool in the limited time I had available and / or sought medical advice from the ambulance service about the risks of not acting who agreed a lack of capacity. Against that background, I took the view that I had a legal duty to intervene to act in this person's best interests given a lack of capacity to the particular decision of accepting medical treatment. I considered whether or not other medical professionals could have provided support, assessment or treatment in the home and it was advised that the nature of the medical conditions involved [specify them] prevented this approach. It was therefore the least restrictive thing to do to remove the patient to hospital using as limited as restraint as possible where I advised medical staff of the legal circumstances of the patient's removal and recommended that any decision by A&E to continue to deprive the person of their liberty should immediately be backed up by seeking appropriate authority from the Court of Protection for an ongoing deprivation of liberty."

SESSEY v SLAM and the METROPOLITAN POLICE COMMISSIONER

I want to finish by just summarising the case of Sessey which always gets brought up in these discussions – do you remember the case?! —– the Metropolitan Police "used" the MCA in a private dwelling in order to remove a lady to a mental health unit place of safety where she would be assessed for admission to hospital. In essence, they "used" the MCA instead of following the legal procedure to use the Mental Health Act, by arranging for an AMHP and DR to attend, with a s135(1) warrant if needed, to assess the lady in her home or remove her to a Place of Safety. Relying upon the MCA, she was taken to a PoS anyway subsequently assessed and admitted under s2 MHA. The lady challenged the original decision to remove her from her home and the Metropolitan Police admitted in settlement of the case that they had no power to do so.

It is important to remember what that case was about and therefore what it was NOT about: it is clearly stated in paragraph 1 of the judgement —

"The issue that arises in this case concerns non-compliant incapacitated patients, that is those who are not willing to be admitted and do not have the capacity to consent to admission, to psychiatric hospitals pending the making of an application for their compulsory admission to hospital for assessment under section 2 Mental Health Act 1983."

So what is this case NOT about? — it is not about the potential of the MCA to offer a solution to very dangerous situations arising from someone's incapacity following either mental or physical illness where someone is at imminent risk of serious harm, like in the first two scenarios, above. It very definitely *is* about scenario three, above.

MORE RESOURCES

- Mental Capacity Act 2005
- Code of Practice to the MCA '05 (2007)
- The stated case of Sessey v SLAM and the Commissioner of Police for the Metropolis.

- My original post on the Police and the Mental Capacity Act
- The "ID a CURE" test – a capacity assessment tool to aid decision-making used by the ambulance service.
- A "quick guide" to the MCA
- A subsequent post on Actually Using the Mental Capacity Act

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The Paramedics' Series -

Mental Health Assessments –

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There are three kinds of 'assessments' that are referred to when people get into the parlance about mental health and it is important that police officers and paramedics understand the three and how **they connect:**

- **Mental health assessment** – this is an informal assessment of mental health by a clinician. Could be a force medical examiner in police custody; it could by Community Psychiatric Nurse (CPN) from a Community Mental Health Team (CMHT) visiting a person in their home; it could by members of the MH CrisisTeam in response to an out-of-hours call. It could also be something that police officers think paramedics can do! The purpose behind a generic assessment of someone's mental health will vary from case to case: it could be a part of routine care planning; it could be a necessary precurser to formal assessment under one of the two mechanisms below.

- **Section 135/6 assessment** – This is a statutory process of assessment undertaken jointly by an Approved Mental Health Professional and a Registered Medical Practioner (RMP) whilst someone is in a place of safety having been detained by the police. This process is intended to identify whether someone may be suffering from a mental disorder, whether there are any unmet mental health or social care needs arising from it and / or whether or not someone may need to be fully assessed for admission under the Mental Health Act. It is good practice, but not a strict requirement, that the RMP in the assessment is "section 12 approved" – this means "having special experience in the diagnosis or treatment of mental disorder".

- **Mental Health Act assessment** – this is the formal process of considering whether or not a person may need to be admitted to hospital under the Mental Health Act. The process will usually involved an AMHP, and two RMPs one of whom MUST be "section 12 approved". Following assessment, they have the option of admitting the patient to hospital under the MHA, under section 2 or section 3

of the Act, or on a voluntary basis; OR they may refer the ongoing care of the person to a community-based mental health team or to their GP. In urgent circumstances the AMHP and one "section 12" RMP can apply for admission to hospital under section 4 of the Act but only where waiting for the second RMP would present ongoing risk because of the inaction.

WHAT DOES THIS MEAN?

In various situations where paramedics and / or police officers encounter situations where they are wondering if someone needs a "mental health assessment", it is important to be clear about what we mean. Imagine the emergency services in someone's private premises, worried about someone who has self-harmed or is threatening to do so.

This does not automatically mean that someone needs to be formally assessed for admission under the Mental Health Act, but they may need a mental health assessment of some description. This is one of those situations where police officers may call you for advice / support, or if you are concerned about keeping someone immediately safe, you may call them.

Difficulties in this situation may present themselves in one of several ways:

- If it is thought that a safe, secure assessment under s135/6 is needed, neither the police service nor the ambulance service can guarantee this – you will need to engage the duty AMHP and this may have to occur via the crisisteam, depending on your local arrangements. Remember: the police have no legal authority in someone's private dwelling unless there is a criminal offence or a breach of the peace.
- If it is thought that a full Mental Health Act assessment is required, you will still need to engage the duty AMHP, possibly via the CrisisTeam.
- It is only when the assessment is a generic evaluation of someone's mental health or mental capacity is it going to be the case that you consider either contacting the person's out-of-hours GP of the CMHT / CrisisTeam.
- This is why the ambulance service ends up taking people to A&E – with a voluntary, consenting patient who potentially has unmet mental health needs, A&E is the only available option unless the situation can lead to them being detained by the police, for example because of an offence or because of them having been encountered in a public place.

SOMEBODY NEEDS TO DO SOMETHING

There is a phrase once used to do describe the function of policing "Something's happening that ought not to be be happening about which somebody ought to do something NOW!" It will often by applicable to paramedics as well and in mental health situations it may be better faced together: some people react well to the police – whether through fear or favour – others react far less well, but paramedics can be seen as more appropriate or approachable. They key is to mutual support, but an understanding of the above types of mental health assessment can only make influencing people, whether the are patients, AMHPs or CrisisTeams, more manageable and predicated on knowledge.

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The Paramedics' Series -

The Use of Force –

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This afternoon I did a lecture at the University of Worcester to a group of undergraduate, student paramedics. This is one of four universities in the West Midlands for training student paramedics and I'd gone there full of ideas of what we'd discuss – all issues covered on the previous five blogs:

Somehow, and without planning to do so, I ended up involved in talking about self-defence and "reasonable force", because the issue of personal safety came up in a question and it suddenly struck me that we're about to send these young people into situations where – let's be honest – they can face some awful abuse, provocation and violence. In starting to think about the PARAMEDIC SERIES of blogs, I spoke to Ella Shaw who was once hit over the head with a lump of wood and had her hand broken by a person who she continued to care for despite the violence. Let's not forget: some ambulance services feel it is appropriate to issue "stab-vests" to their staff because of the risks they face. It just makes me hold me head in my hands, on occasions. So I want to make sure they're as safe as possible especially if the police are not right there to deal with it.

And so – "do you know what you're entitled to do to defend yourself?" seemed a relevant diversion when the subject came up at Worcester.

SECTION 3 OF THE CRIMINAL LAW ACT 1967

This is the law that allows EVERYONE to protect themselves when faced with an attack or personal violence: this is the law that is debated on the news whenever we get the those stories about what you can do to defend your home against burglars, etc., etc.. It states –

"A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large."

To paraphrase a judge from a recent court case who was asked what "reasonable doubt" meant, he answered "It is a doubt that is reasonable. These are ordinary English words." The same applies

here. One student said, "If someone was trying to stab you, you'd be entitled to punch them in the face to stop them from getting you and then run away." << *What he said* … as long as simply running away was not going to keep you safe.

The force anyone uses to defend themselves is judged in the particular context it was used. I gave the example of a paramedic at an incident who was busy using scissors to cut clothing from a patient to access a wound and assess or apply the correct treatment. If, whilst holding scissors, someone attacked you and your flinch-based, instinctive reaction in pushing out your hands to deflect the blow resulted in scissors hitting someone, it doesn't mean you'll be arrested for stabbing your assailant, even if they were injured. Self-defence is judged in its context and if you assault a paramedic holding scissors, whilst they are not allowed to deliberately stab you, any claim to lawful defence of themselves would not be rendered useless because their instinctive reaction happened to involve an aspect which caused a more serious consequence. If pushing someone away from you to keep yourself safe was lawful, pushing them backwards would still be lawful even if they tripped as they went backwards and then hit their head on the floor, fracturing their skull, for example.

DETAINING PATIENTS

On a different, but related issue, it is worth covering some law about the detention of patients under the Mental Health Act where paramedics are often brought into the situation for conveyance purposes. When an Approved Mental Health Professional has 'sectioned' a patient under the Mental Health Act, they are obliged to convey that person to the identified hospital for admission. They have a legal authority, under s6(1) of the Act, to "detain and convey" the patient and have "all the powers of a [police] constable" in order to do so. Something of relevance to paramedics and police officers, is the concept of a "delegated authority" to detain and convey; and the legal concept of paramedics assisting police officers in the execution of their duty and vice versa.

Under s6(1) MHA, an AMHP may delegate their authority to detain and convey to anyone else. It is quite frequent that this request will be made of police officers, especially if the AMHP has found that it will be reasonable to use force in order to effect the admission but equally, it could be made of paramedics. There are a few things about this delegated authority that you need to know, whilst reminding you that different ambulance services have different policies about whether or not their staff will accept this legal option.

In some trusts, it is declared that paramedics will not become responsible for legalities around conveyance. They will provide the vehicle, oversee the clinical wellbeing of the patient whilst in transit and support the detaining

authority, but they will not detain / convey. In other trust areas, paramedics are allowed to accept delegated authorities for low risk patients who are not resistant to being taken to hospital. So it's important to understand your area's procedure. It's still worth knowing the following things however, to manage your discussions with AMHPs and police officers.

- The AMHP who wishes to delegate their authority to someone else, may not *compel* anyone else to accept that authority.
- Anyone who does choose to accept it then also assumes "all the powers of a [police] constable" with regard to that patient in that admission process.
- In other words: they have a right to use reasonable force to effect the admission.
- **GET THE AUTHORITY IN WRITING**: by getting involved in the forcible admission of a patient who is resisting it, you may reasonable anticipate the need to justify anything that you do.
- By virtue of para 11.10 of the MHA Code of Practice, the form of an AMHPs authorisation to detain / convey should be agreed in the joint protocol for your area on conveyance. Usually, in writing.
- By virtue of para 11.17 of the MHA Code of Practice, the AMHP who is requesting the (police or) paramedics to detain and convey should "provide" that authority to do so where the person is unwilling to be moved.

WHO GOES HANDS ON?

This all brings you and us to the question of who goes "hands on" with the unwilling patient? It is commonly thought that this is a matter for the police. After all, we're trained to use force aren't we and we're the ones who are carrying batons, CS spray and occasionally tasers for resistant people. What if the patient is concerned is 83yrs old and has diabetes, blood circulation issues and Alzheimer's? Are we still in the zone of thinking this is a police responsibility?

Police forces have been known to say things to the effect of "This person is not actively resisting admission" and decline to be the first agent to use force. This could sound like a petulant refusal, couldn't it? We should remember that police training in personal safety issues is predicated upon verbal communications followed by the use of techniques which involve the deliberate application of pain – justifiable in some situations, but are they really appropriate to the elderly dementia patient? Well, the MHA Code of Practice talks about the restraint of inpatients in hospital and makes as point saying that "pain compliance techniques" should be avoided. We've seen police involvement in the restraint ot dementia patients become criticised in the courts and in the media.

This does **not** amount to the police saying "leave it with you" – but it should involve consideration between the AMHP, the police and any other professionals on hand about how we proceed. There is a very real risk about the use of force by the police on vulnerable people: the use of techniques which involve pain may result in injury and other subsequent psychological problems – it is not to be undertaken casually. That is why a discussion about how things will proceed is always useful and I know senior paramedics who have talked about their potential to do what they call "proactive blanketing" to help in the management of patients who are passively resistant to being detained and conveyed. And the police should support this or other approaches where possible because whatever level of force is used, it has to be the "least restrictive" thing in the circumstances. It's at least arguable that uniformed, stab-vested police officers using pain compliance techniques on the elderly would fail this test.

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The Paramedics' Series -

What Is An AMHP? –

To see any of the other **Paramedic Series** blogs, refer to the index:

An Approved Mental Health Professional is a person who is warranted, or authorised, to make certain legal decisions and applications under the Mental Health Act 1983. Usually, this person will be a social worker who has undertaken additional training to become warranted but in 2007 the law was amended to allow other mental health professionals to undertake this role. So it is now possible to see psychiatric nurses, occupational therapists or psychologists becoming AMHPs. The majority are social workers.

Police officers and paramedics will encounter AMHPs in two common enough situations, as well as very occasionally in some rare situations:

- **Place of Safety assessments** – Decisions around people who have been removed to place of safety by the police under section 135 or 136 of the MHA will be coordinated by an AMHP and will involve a Doctor. These assessments may then subsequently involve the second kind of situation:
- **Mental Health Act assessments** – decisions about whether a person will be offered inpatient hospital care, either on a voluntary or statutory basis, will be coordinated by an AMHP and will involved one or two doctors depending on the kind of MHA assessment was organised. Usually it will be two doctors for consideration of admission under section 2 or section 3.

MENTAL HEALTH ACT WARRANTS

Certain things that can happen under the MHA may require the need force entry to a building and this is only possible with a warrant from a Magistrate. There are two warrants in particular worth knowing about and AMHPs are often the people to apply for them –

- **Section 135(1)** – this is a warrant to force entry to a premises and / or remove a person from a private place to a place of safety for assessment, potentially for their initial detention under the MHA. **Only an AMHP can apply for this warrant** and it can only be executed by the police whilst accompanied by an AMHP and a DR.
- **Section 135(2)** – this is a warrant to force entry to a premises it take or re-take a person in custody who is already liable to be detained under the MHA or is missing from hospital. **An AMHP or a police officer can apply for this warrant** and whilst the police could execute the warrant alone, it is suggested best practice for the police to be accompanied by a mental health professional.

DETENTION AND CONVEYANCE

If as a result of a Mental Health Act assessment an AMHP decides to apply for the detention of a patient in hospital, that person becomes in the legal detention of the AMHP, by virtue of s137 MHA. The AMHP is subsequently authorised by s6(1) MHA to"detain and convey" the person to the named hospital for admission, using reasonable force if necessary.

The AMHP can ask other professionals to detain and convey on their behalf, assuming the right to use force and this request is often made of the police, who will in turn often ask for an ambulance to be the vehicle used to convey. Paramedics are sometimes asked to assume this authority and you should check with your own Trust as to how to handle those requests. It is certainly lawful to do so, but whether local policy allows it, varies from trust to trust.

OTHER FUNCTIONS OF AN AMHP

- **AWOL patients** – where a patient is absent without leave from hospital, an AMHP is authorised along with police constables and others to retake the patient into custody and return them to the hospital from which they are missing. I've never known it happen, but it's on the statute books and it would be legal.

- **s42 Warrants** – Where a patient has been detained in hospital after a criminal trial, subject to a restricted hospital order they can be discharged into a form of community care. If the Ministry of Justice thinks it necessary, the person can be recalled to hospital by the issuing of a warrant. AMHPs can be encountered whilst waving warrants asking for police / paramedic support to retake and repatriate a person specified in such a warrant.

- **Guardianship** – when decisions are being taken about the detention of some people under the MHA or the discharge of patients from

hospital, one opportunity is for a person to be made subject of Guardianship, which means that they live with a nominated position who assumes certain responsibilities with regard to that persons care. AMHPs co-ordinate applications for guardianship and transfers between hospitals / guardians.

FURTHER READING

Don't forget three methods of using this blog to find out more:

- There is a full index of over 700 posts on all manner of topics.
- There is a series of "Quick Guides" originally intended for police officers, but some will be of interest to paramedics.
- There is a "search" facility in the top right hand corner: by entering any keywords on policing / mental health will bring up the relevant posts, including entering sections of the MHA like "s136".

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

The Paramedics' Series -

Is It "Necessary"? –

To see any of the other **Paramedic Series** blogs, refer to the index:

This post is about the circumstances in which it may be necessary for paramedics or A&E to ask the police to instigate detention of a person under section 136 of the Mental Health Act. That said, it will be relevant to police officers in understanding how to react to the request!

In both policing and in healthcare, it is generally acknowledged that prevention is better that cure or an effective response – we'd all rather prevent the disaster, than deal with it effectively. It saves time and effort, it also prevents the unnecessary suffering of either patients or victims. A few incidents give rise to this post, about the police intervening in a preventative way in situations that may well be led by our health colleagues, but into which the police will eventually be drawn if we do not proactively assist.

Many scenarios start in the same way —

The ambulance service is called to a situation where they are dealing with a patient whose mental capacity or mental health is in question. Perhaps it is someone with an established mental health diagnosis who is in crisis, has self-harmed or is asking for help; perhaps it is someone who is intoxicated through drugs or alcohol or has suffered a medical condition or injury which gives rise to incapacity. In the latter case, I'm thinking of things like the elderly man who had a serious urinary tract infection, so severe it had affected his cognition and ability to look after himself. Or perhaps it's a very drunk person or a crime victim with a head injury.

We know that paramedics can sometime be found spending hours patiently and often successfully negotiating with people to persuade them into the back of an ambulance for removal to A&E. We also know, that once those patients arrive and the paramedics have long since moved on to the next 999 call, people have time to think again about whether they will remain where they have been persuaded to go.

IS IT NECESSARY?

In considering whether the police detaining someone, either under section 136 or a for an offence, paramedics and officers need to ask themselves not only whether the use of legal coercion is necessary *now*, but also whether it is necessary to ensure that the person detained remains engaged in the assessment or treatment process to a conclusion. "Necessary" does not just mean "necessary to start the process off" but also "necessary to make it end well." This kind of dilemma was at the heart of the IPCC's criticism of Metropolitan Police officers in the Nicola EDGINGTON case: do I need to coerce someone into a process they appear willing to engage in? Well, if you need to guarantee they see it through to the end, then you may do!

Obviously, being detained by the police does not mean that paramedics or A&E staff can force whatever treatment they want upon patients – people retain a right to take most decisions for themselves, until an appropriate legal framework has been applied to determine otherwise – but it does mean that people can be lawfully safeguarded until appropriate assessment has occurred. After that, people may well be at liberty to take unwise decisions.

Someone detained by the police, for example following an episode of self-harm, may not initially wish to attend hospital or undergo assessment under the Act. If detained under s136 because of immediate concerns for welfare, that decision becomes one for professionals. So if paramedics are attempting to persuade such a person to travel with them to A&E and are concerned about whether they will go or whether they will remain there once arrived, it is perfectly legitimate to ask police officer to consider the case on its merits to apply section 136.

In terms of assessing whether that action is necessary, officers need approach the decision with care. No doubt, an audit trail will be made by the ambulance service about their views and concerns and the requests made of other agencies – this is merely competent professional practice.

So we need to ask ourselves three questions —

1. Will this person attend A&E without being detained?
2. Even if they will, is it likely they will remain engaged to the end of the process that follows?
3. If the person did disengage and leave, how will any subsequent events be judged in light of the decision I am taking *now*?

It is equally valid and necessary for A&E staff to ask themselves the question where people are brought in by paramedics or where they have

self-referred for mental health reasons – will this person remain here of their own volition and what will I do if they try to leave?

If that answer to the last question is "ring the police and ask them to find the person and detain them section 136" then I'd like you to ask yourself the question *now* about how likely it is that the person will try to leave? If you think it very likely, and they would be at significant risk, I'd prefer to know now and have a conversation to prevent the development of a high-risk missing person inquiry.

PARAMEDICS AND A&E STAFF

So my message to our emergency care colleagues is this — when you are dealing with patients who are suffering from a mental disorder, who appear to be in immediate need of care or control, in their own interests or for the protection of others, you are *quite entitled* to ask police officers to exercise their authority under section 136. It is then for the police to justify whether or not they do so.

I recall a recent case where A&E rang to report an "extremely suicidal" woman had left A&E, whilst part way through the MHA assessment process. She had been taken there by the ambulance service and without any police involvement. When officers first took the details to start the high risk missing person enquiry, I recall thinking, "If you had just rung about an hour ago, asking us to 136 this lady, I wouldn't have brought policing in my area to a halt in order to find her before she seriously hurts herself with most of my team running around the area checking addresses and searching for her." I also wouldn't have subsequently had to manage the practical difficulty arising from the fact that she was located in her own home to which I could not secure lawful access. I couldn't get an AMHP and DR down there to do an MHA assessment, either!

But of course, paramedics and A&E staff have mixed experiences when they ask the police to do this sort of thing – it is *precisely* because they've asked in the past and been turned down that they are often reluctant to ask. Of course, some of those decisions will have been correct, but we can't be arrogant enough to insist that they *all* were.

The above anecdote shows this. No police officer in Britain is going to like the idea of going in to an A&E department and exercising a detention under section 136 MHA, because it immediately gives rise to a load of questions for police supervisors, in particular —

- Firstly, can I even use section 136 in Accident & Emergency? – there are loads of debates about secure doors, about the phrase "place to

which the public has access" and about rights of access and egress, to and fro.
- Secondly, why can't hospital security attend the department and ensure the person does not leave – can they even do that?
- Thirdly, if section 136 is used, will it immediately mean A&E wish to see the person removed, either to a psychiatric place of safety or to police custody – we know that there could be certain problems with removing some people to custody and there are issues in some areas with NHS PoS provision in mental health facilities.

COMMON MYTHS

So let's knock down the myths one at a time —

- Yes — A&E is a place of safety (because anywhere can be a PoS) but not one that has been set up to detain people against their will. Neither nursing nor security staff in that department will have the training, skills or even the legal authority to detain people against their will.
- Yes — you absolutely *can* use section 136 MHA in an Accident & Emergency department. This was part of the ruling in the Sessey case so we should now stop pretending that we cannot do so far various spurious reasons. Whether you *do* use it, will be a different assessment, but you certainly can rely upon it if you feel you need it.
- No — hospital security cannot just sit on people or detain them, unless there is a criminal offence and or unless they can argue that the situation is covered by the Mental Capacity Act, which may be rare.
- No — it won't automatically mean, that if section 136 is exercised that you *must* remove the person to another location. The normal decision-making should apply. If there are RED FLAGS, stay put, if there are not, ensure you can be accepted elsewhere before you move anywhere and take advice about the safety of the conveyance during transfer.

So all this should bring us back to making a decision which puts the needs of the patient at the heart of our thinking.

NOVEMBER 2011

In the beginning …

28th November 2011

New Blog on Policing and Mental Health –

This is a test-post for a new blog about policing and mental health. I'm not at all sure how this will pan out but various people have repeatedly encouraged me to get blogging so we'll give it go and see what happens with the reaction and the debate.

MY BACKGROUND

I am a serving police inspector with almost 14yrs service. All of this has been frontline 24/7 and community policing except for three years which I have spent in a headquarters role working as a specialist on mental health issues. I have spent time seconded to a national body supporting all 43 forces in England and Wales.

I am blogging in a personal capacity and **my views do not represent the official policy of any police force or organisation.**

MY INTENTIONS

1. To promote a debate about the role of the police in the implementation of the Mental Health Act – the police do not have legal powers to resolve every type of MH crisis and this is not widely understood.

2. To promote debate about the investigation and prosecution of criminal suspects who are mentally ill – when / how should we divert from justice, who should take those decisions and how?

3. To provide practical advice and links to resources for front-line police officers on how to navigate through a legal and medical minefield. Successful resolution of incidents involving mental health issues can involve "PlanA" when necessary partnership structures and responses are in place but "PlanB" needs to be understood for when they are not.

All ideas on how to develop this space gratefully received!

30th November 2011

I remember when I joined …

Like most UK cops who joined in the 1990s, I took my two-hours of mental health awareness out onto the streets with me after initial police training. For me, this meant patrolling and responding in one of the most deprived and diverse parts of a large UK city where MH related demands for the police were frequent and often serious.

6 or 7 of my first 10 arrests involved mental health issues; usually for the suspect, but one involved a victim who was targeted and I had a 136. In police custody, there was a poster on the wall for the 'Diversion' team: the magic phone number which lead to the emergence (eventually!) of mental health professionals and often they removed your suspect from custody under the Mental Health Act. "What happens after assessment or treatment if they've offended?" Not much apparently, they were all NFAd for the offence once sectioned – no further action.

My area was home to an old, Victorian mental health hospital and it was in the process of closing when I joined, only two wards remaining. Most of the building was unlit and I readily admit to being terrified when my tutor constable took me in there to deal with incidents – you could hear screaming echoing down empty corridors and it was like the set of a bad horror film. Psychiatric nurses would call for police assistance if they needed help to medicate or seclude patients. "Are we allowed to hold people down whilst nurses or doctors inject them?" No-one had any idea – it just seemed like the right thing to do, to help our colleagues in the NHS and keep both them and the patients safe. That's what the police are for, surely?

To be fair to the staff, they were not working in a state of the art facility and were dealing with some very disturbed and violent people. Assaults on staff were at epidemic levels. "If a patient smashes a nurse's face in, GBH standard, do they ever get prosecuted?" Not in the public interest, apparently: ever.

My education was broadened by dealing with some community MH jobs: another probationary constable and I were sent to an address to see if an AWOL patient had turned up at home. We established quite quickly she was in there, alright; we were outside and she wouldn't open the door. Because she was absent from where she was legally obliged to be

and because the hospital said she was a risk to herself, we shouted up, "Sarge, can we not just kick the door off and take her back there by force?" He had no idea. Neither did the inspector.

It dawned upon me very quickly – I didn't have a CLUE what I was doing with this stuff and neither did anyone else.

One of those 10 early arrests included my first s136 job. A young chap in a fairly florid state, wandering in and out of traffic on an arterial route out of the city at rush hour, shouting at drivers who were bashing their horns and braking. We arrested him and searched him, recovering cannabis and a knife and as we were within visual distance of the A&E we walked him over. I had remembered that a 'Place of Safety' was "a hospital, a police station or anywhere else temporarily willing to receive the patient." I had high hopes of a cuppa, if I'm honest. I'd already spent time in A&E pulling out drunks and other people who abused our A&E colleagues. Those people took a lot of grief in a demanding job and I hoped they thought we always supported them when they needed help. They'd realised that if you pour a hot drink down a young policeman he'll hang around longer or will even come in just to take a sneaky break from patrol. All of this deters trouble in A&E.

How on EARTH was I to know that they and the rest of the NHS in my area had exempted themselves from the requirements of a Code of Practice, issued by the Secretary of State under the cover of law? "A&E is not a place of safety", apparently. No psychiatric unit operated one, either. This confused me, I'd already learned that if you breach a police Code of Practice, sergeants and inspectors start pulling you aside for very awkward conversations you don't enjoy. Yet here, the whole NHS in a major city WANTED the MHA Code breached and the A&E sister wasted no time in telling me. No cup of coffee for me and more importantly, no access to healthcare for the young bloke who was removed to the cells.

It was clear I needed to know more law and I started to ask questions.

30th November 2011

Section 136 Mental Health Act part 1 –

"The legal duty of care owed to people detained by the police exists, whether or not the infrastructure through which to discharge this duty exists or not." I have said this countless times in meetings in order to convey that human rights obligations such as the right to life (article 2) the right to not to suffer inhumane and degrading treatment (article 3) and the right not to be deprived of one's liberty except in accordance with law (article 5) are real. All public authorities have a positive duty to protect these rights in the way they conduct their business, including police forces and primary care trusts.

It should also go without saying that police officers cannot commit criminal offences such as malfeasance in public office (wilful neglect), false imprisonment or breaches of the Health & Safety Act. Nor can they be encouraged to do so. Chief Constables now need to be (personally!) mindful of Corporate Manslaughter legislation. If the Home Office, Coroners, HMIC and the IPCC have already repeatedly stated that officers need to be mindful, for example, of the impact of prolonged restraint, should officers not consider the necessity of it to be a medical emergency? Certainly the medical experts who gave evidence at the Inquiry into the death of Rocky BENNETT thought so following catastrophic restraint by NHS staff in a psychiatric hospital.

It is for this reason that police forces and police officers need to know PlanA and PlanB for the detention and handling of people with mental health problems. PlanA is achieved by organisations working together at high level to ensure proper 'pathways' exist to manage people with appropriate dignity, according to need. It means organisations recognising the potential to have to place a temporary package of security AND care around people with complex, potentially unknown needs. PlanB means knowing how to do your best, if PlanA can not be realised.

Section 136 of the Mental Health Act brings officers into contact with a wide variety of people – confused, dementia patients wandering in the street; individuals who are psychotic because of drug intoxication; those suffering from suicidal thoughts or paranoia; those who have actively self-harmed in one way or another. They need to be especially mindful of how to handle situations involving an 'acute behavioural disturbance', excited delirium or anything where prolonged restraint is perceived to be necessary. Of

course, it also brings the police into contact with people who are not mentally ill at all, but may appear to suffering from mental disorder to a cop – I will blog separately about the diabetic's life that was saved following arrest under s136.

Most people seem to agree that police stations are not an ideal place for those arrested under s136, but in 2008 the Independent Police Complaints Commission found that 65% of those detained were removed to the cells either because there was no alternative or because the facilities identified in their area declined to accept them. Most usually this was because the person was under the influence of drugs or alcohol; because they were violent or because they were children. (Yes – some mental health places of safety facilities will not accept anyone under 18.)

So – if police officers operate in an environment where the ambulance service has not been commissioned to respond to mental health crisis to assist with clinical decision-making, does this mean a cop can't call for a paramedic's assistance in an obvious healthcare situation; if A&E has declared that it is not a 'Place of Safety' under the MHA, does this mean that if the police are handling someone who may be suffering from a physical condition or whose psychiatric condition is also a genuine medical emergency, that they cannot remove people there and ask for help? Can a violent presentation in and of itself justify detention in a police cell when it *may* be a manifestation of a medical emergency that we haven't ruled out? Clearly, three 'NOs!' on those counts. Of course, the NHS are at liberty to say no but that would be for them to justify.

We should remember – 17% of deaths in police custody involve people who are mentally ill; 5% of deaths in custody are s136 MHA.

Chief Constables and Duty Inspectors therefore need to have a PlanB – "If my NHS partners either have not, can not or will not ensure appropriate pathways for those arrested under s136 or if an individual healthcare professional blocks that pathway, how do I lead my officers in way which ensures that they can do everything that is reasonable to protect the medical integrity of those they have detained; and to protect themselves from accusations that they have broken the law?"

30th November 2011

Excited delirium –

<<< UPDATED ON 31/01 – a Radio4 programme on Excited Delirium will be on iPlayer for a limited time and is a very worthwhile listen. >>>

The question of whether excited delirium (ED) is a real medical condition is way above my pay-grade. But in reality, police officers find themselves refereeing an aetiological debate by arbitrating various doctors' views. Decisions about how to respond to someone suffering from this 'syndrome' contain no shades of grey: because ED (syndrome) is either a real medical condition which needs to be regarded as a medical and psychiatric emergency where life may be at risk, or it is not.

How does a police service give clear guidance where there remains an ongoing argument between clinicians who call for more research? Well, where issues of *clinical* risk are concerned, it is perfectly proper to argue that the police should acknowledge their limitations and seek the correct advice from suitable professionals.

Internationally, clinicians have suggested that excited delirium has been 'made up' by the police, perhaps to medicalize excessive force and deflect liabilities for inappropriate restraint? I've heard this argument made in the last month in my own police area. Certainly, ED does not appear as a recognised disorder within in the international classifications of disease, the DSM-4 or the ICD-10; it is not due to appear within DSM-5. There has also been significant caution urged in Canada against the use of the term, notably during the 'Braidwood Inquiry' conducted by a retired judge.

But for those police officers who find themselves patronised by clinicians who would seek the removal of ED patients to police cells without reference to medical authority, here is some more information regarding this supposed condition:

Paul COKER (London, 2005), Nadeem KHAN (Lancashire, 2007) Ricky PENFOLD (London, 2008) and Jason PEARCE (Shropshire, 2009) all died following which inquests ruled that they *probably* died from ED or complications arising from being restrained whilst suffering it. Odisseas VEKIARIS (Melbourne, 2009) was ruled to have died from excited delirium according to the Victorian Coroner. There have been further cases in Canada, New Zealand and the US and inquests (or equivalent hearings)

considered medical and pathological evidence pertaining to the cause of death – before ruling individuals to have *probably* died from or following ED.

Simply put: whether this a real condition or not, is unclear; what contribution drugs or restraint may play is not clear.

So here are some further considerations for police officers and police forces when they are obliged to decide whether to listen to this doctor or that doctor:

- The Independent Police Complaints Commission has given police forces recommendations to improve training and awareness of this condition: it is now a regular feature in police public order (riot) training, as well as in first-aid training and personal safety (restraint) training.
- Guidelines produced by the National Policing Improvement Agency for the 'Safer Detention' of people arrested by the police, highlight that excited delirium is a medical emergency – pp31 and 51.
- Guidelines produced by NPIA for 'Police Responses to Mental Ill Health and Learning Disabilities' which highlight that the condition is potentially life threatening and necessitates removal to A&E – pp54, 97 and 107.
- Perhaps unsurprisingly, both sets of guidelines were produced after extensive consultation with medical professionals – the mental health guidance in particular is **overtly** and **explicitly** badged by the Department of Health.
- The phenomenon is not restricted to police contact deaths, either: as well as prison incidents, there have also been deaths in psychiatric detention which have led to the excited delirium question being raised and again ruled as relevant to a cause of death.
- A joint psychiatric-pathology text has been published on the subject which states, "For all practical purposes, an acute psychiatric episode with agitation and violence is synonymous with excited delirium" warning that death can follow in minutes – p4.
- Other medical work is available with a large number of reputable emergency physicians putting their names to it and to the need for further research,
- The National Institute for Health and Clinical Excellence published *statutory* guidelines for the NHS in 2005 on the "Short-term management of disturbed / violent behaviour in in-patient settings and emergency departments." There are three separate academic references within it to ED in the context of restraint risks and it outlines various possible pharmacological interventions to mitigate clinical threats. If the document envisages and advises on ADB-type presentations within NHS settings, surely where those manifest to the police the issue becomes one of how the police get the patient to

a suitable medical location for those interventions to be considered, as quickly and safely as possible?]#

- That **none of the above** present a definitive argument that ED is real; it clearly gives a basis for police forces to consider whether it may be.
- It also gives a basis for police forces to consider how to approach situations where officers may be thinking about or required to engage in restraint situations.

So whilst there may doubt about ED as a real medical condition – indeed, it may be nothing more than a euphemism to describe any number of potential medical or non-medical presentations – there is no room to argue that the police can easily dismiss it. Sufficient people argue it is a very real threat to the safety of people detained despite not being is not in relevant textbooks and not being acknowledged by all medical professionals.

Asking police officers to make these judgements about healthcare needs in dynamic, unfolding situations is not only unrealistic but potentially dangerous. When more is known about ED, we can look at this again; but until that time every police constable in the UK has the legal right – actually the *duty* – to ensure that prior to taking violent people to the police cells, that it is medically appropriate to do so to avoid catastrophe for patients and their families.

DECEMBER 2011

1st December 2011

Where we're going next

Just a few short thoughts on what I'm going to try and cover on this blog as and when time permits and to invite any thoughts:

This is mainly a 'to do' list for me, however please leave a comment if you'd like me to bash together thoughts on any other aspect of policing which involves mental health issues … there are loads more, but these will be the priority:

- Liaison and diversion in custody for criminal suspects who are mentally ill.
- The prosecution of psychiatric (in)patients
- The police and 'Crisis Intervention Training'
- s136 Mental Health Act – parts 2 and 3
- MHA assessments on private premises s135 Mental Health Act – the challenge for AMHPs!
- AWOL patients
- Police support for the enforced medication, seclusion or transfer of patients

Finally – this doesn't all have to be serious so I'll thank those who have given early support to this embryonic blog by sharing the police mentalhealth song … enjoy!

Michael./

1st December 2011

Practical advice for police officers: s136 / s297 / a130 –

How to 'do' s136 Mental Health Act (MHA) properly: *<<< this also applies to s297 MHA(S) and a130 MHO(NI).*

1. Call an ambulance to EVERY arrest; without fail.

2. Remove anyone suffering from a potential medical emergency or physical injury to A&E

3. Remove other detainees to the psychiatric place of safety in your area – it is not the role of police officers to pre-judge issues around admission to a place of safety where drugs, alcohol or resistant behaviour is involved. That is for the NHS to decide.

4. Only when all three have been done and any other (improvised) alternatives have been rejected*, consider removing to a police station. It is a PoS of *last resort*, after all.

Objections to this approach.

1. "Calling an ambulance takes too long and isn't necessary". Tell that to the man in my force area who was an undiagnosed diabetic who appeared confused as his blood sugar levels went heavily awry. He appeared potentially mentally ill to the police so they arrested him s136. The fact an ambulance was called meant that when he collapsed it was into the arms of a paramedic who had just done a routine blood sugar test who could then begin treatment as he was rushed to A&E. His consultant said, if he'd been removed in a police vehicle to the cells, he probably would have died by the time it all unfolded and an ambulance had arrived. And if that's not enough, it's also legally required by para 10.17 to the Code of Practice to the MHA.

2. "A&E is not a place of safety!" **Oh yes, it is; because ANYWHERE can be a place of safety** for the purposes of the Mental Health Act, as long as it *agrees* to receive the patient. Take a potentially mentally ill person to A&E because they've self-harmed, overdosed or because they've got a head injury and A&E for *that* person, for *that* time and for *those reasons* is a place of safety under the MHA. It doesn't mean they're agreeing to open the floodgates to everyone, but criteria should be agreed for when A&E is necesary and it doesn't mean the person remains in A&E

throughout; once the emergency medical matters have been managed, the person can be transferred to a more appropriate Place of Safety. Your 72hrs starts, however, when your detainee is *accepted* into A&E for treatment / assessment.

3. "People under the influence of drugs or alcohol or those who are violent should be in the cells." Once we know it's medically safe, then perhaps that *may* be necessary. If that just takes a paramedic's say so and the PoS is already full, then fine. But it *may* need a trip to A&E to rule out the possibility of alcohol masking something else. If you put anyone into a police station against their will – s136 or otherwise – then PACE kicks in and it states Code C to PACE that the custody sergeant **must** ensure appropriate clinical attention for detainees. This involves either, calling an Approved Healthcare Professional (FME) to custody or calling an ambulance / transferring to hospital. It is not automatically correct to hold someone in a cell for several hours pending an FME – remember; the FME is there to provide *advice* to the custody officer, *not* to provide healthcare for the detainee. **That remains a legal responsibility for the NHS**.

* Don't forget – the MHA allows 'improvised' solutions to PoS problems; the Code of Practice to the MHA implores consideration of this in para 10.22 – "the police station should not be considered the automatic second choice if the first choice PoS is not immediately available. Other options should be considered." So if you've detained a 15yr old girl and A&E is not appropriate, the PoS can't accept, why not remove her to her own home and risk assess the appropriateness of it in terms of safety, the environment, cooperation of family / parents, etc.. Would her parents be willing to allow the police to keep her there for an AMHP / DR to attend an assess? If not or if it's not an appropriate, safe environment, off to the cells we go knowing we've tried but I'm **damn sure** I'd want my son at home with me and a cop rather than in a police cell block.

We know this is right because it is consistent with all the guidance and laws pertaining to s136. Alter this approach and you're breaching something.

3rd December 2011

Cultures and Codes of Practice –

I realised early on that a Code of Practice to an Act of Parliament was taken very seriously indeed. There are many Codes which affect the police, PACE alone has several: Code A for stop / search; Code C for treatment in custody to name just two of the more important ones. There are more for PACE and others for other Acts. I'm not pretending they're ALWAYS complied with, I'm suggesting that supervisors examine breaches when they see them; that structures exist to LOOK for breaches; and there's a reaction even if it's just a quiet word. It is often more.

Codes of Practice are issued by the relevant Secretary of State under an authority granted to them by an Act of Parliament – each represents statutory advice and direction on the matters within and are serious authorities. Although they can be breached you need "cogent reasons" to do so and must be able to defend the breach. Otherwise, you must do what it says.

It is against that backdrop that I first read the Code of Practice to the Mental Health Act.

Once upon a time I handled a complaint where the police in AreaA had arrested someone under s136 MHA within AreaA's geographical boundaries, the man being resident in AreaB. They removed him to AreaA's A&E because of a head-injury sustained prior to arrest and contacted AreaA's psychiatric Place of Safety (PoS) once he was deemed medically fit for onward transfer. AreaA PoS would not agree to accept him because he continued to be aggressive and to head-bang anything he was allowed to stand near. They wanted him removed to the cells.

Rather than immediately do this, the police officers contacted AreaB's PoS and pointed out that he was a mental health patient known to them and they agreed to have him taken there for assessment. As that was being sorted, however, he started again to head-bang and managed to re-open the head-wound. The police took him to AreaB's A&E on direction of AreaB PoS staff and his injury was treated again. Eventually, he was sectioned into a MH unit in AreaB.

Following family representations to both the police and the NHS about the overall management of the incident and the amount of bouncing around, I

was quite surprised to hear NHS colleagues say: "This man was moved about too much because the police should NEVER have taken him to [AreaB]. This is a breach of the locally agreed policy and he should have gone to the cells in [AreaA]." Apparently oblivious to the point that if had we had done so, he almost certainly would still have re-opened his head wound and back to AreaA A&E we would have gone, it is also correct to say that this action would have breached para 10.22 CoP MHA.

This CoP paragraph outlines an expectation that following an inability to access the 'first choice PoS', there was a legal expectation upon the police to consider alternatives before resorting to the cells. Nothing in law prevents the police 'improvising' their way through problems of NHS access by contacting the man's own home area PoS and asking – not ordering! – those NHS professionals if they would be prepared to allow him to be assessed there. They were, at least until his re-aggravated his injury.

BARRISTER IN CIVIL ACTION: "So officer, prior to condemning my client to the cells of your police station, universally regarded as the most inappropriate place of safety; what alternatives did you consider?" … POLICE CONSTABLE: "Errrr, the NHS told me to do it." We can imagine the fun a barrister could have with that.

Action should be governed by the patient's needs; not the organisational convenience of the NHS – or the police, for that matter – and it certainly should NOT deliberately breach a Code of Practice issued by Parliament after relevant stakeholder consultation across the nation.

Apart from anything else, how did that policy get through legal checking?! … just asking.

3rd December 2011

International Crisis Intervention –

In 1988, the Memphis Police Department shot and killed a mental health patient amidst a crisis incident to which they had been called. This incident served as a catalyst for a total re-examination of police approaches to incidents involving mental illness. It is something I have been pushing for in the UK for 5yrs or so.

The principle is this: take a certain proportion of police officers and train them very well on mental health issues: recognition, de-escalation, stigmatization as well as law and enhanced knowledge of local MH and support services. Once trained, use these officers differently: send badged 'CIT' or 'MHIT' officers to calls involving MH crisis. Research suggests that officers trained will be less likely to use force, reducing injury; less likely to arrest because of enhanced communication skills; more likely to arrest for mental health reasons than for crime; more likely to 'divert' from justice than prosecute.

In some areas, they have gone further: Vancouver Police now use one such officer, paired with a psychiatric nurse to provide a partnership response to crisis. Why not?! Oregon Police are now going to send a social worker to 911 calls, where no threats of violence are involved; backed up by a police officer if there are such threats.

So why not do it here?

I'm convinced that the service will, eventually. It will take recognition at senior level, that mis-management of mental health issues represents a strategic threat to the service; affecting public confidence in policing and the service's ability to keep people safe during crisis. The solution to many common policing issues involving mental health, is the knowledge and confidence of police supervisors to recognise when to intervene and when to resist calls to do so. This requires detailed legal knowledge and training and experience. We recognise these principles in the way we train custody sergeants. It will happen in mental health.

Ironically enough, this approach is nothing revolutionary: many issues within policing require the despatch of a specially trained or appropriately qualified officer. Rape and serious sexual offences are perhaps the best comparison: no sooner have the police despatched a 'response' officer to a

report of rape, they will have notified a police supervisor and started the summoning of an 'STO' and / or a PPU detective. This is because the earliest stages of response to rape are key, not only to victim security and reassurance, but also to evidence preservation and investigative integrity amidst a host of complex variables.

Eventually, the service will realise – if it hasn't already – that doing the same thing over and over again expecting different results is something Einstein commented upon.

4th December 2011

Section 135(1) Mental Health Act 1983: part 1 –

The simplest way I can explain how the police should approach determining whether they will attend a Mental Health Act assessment in a private premises by an AMHP, the whole debate about s135(1) Mental Health Act and what they should consider *before* they get to a location, is to explain how I'd react to a request:

CAN YOU HAVE THE POLICE?

- You can have police officers to support your MHA assessment on private premises IF you can demonstrate raised prediction of 'RAVE Risks' from anyone at the premises – this means Resistance, Aggression, Violence or Escape – OR the existence already of a s135(1) warrant.
- NO RAVE / NO WARRANT = no *obligation* for the police to attend: we'll decide whether to give you a hand on a case by case basis, dependent upon other demands on the service at that time.
- The information which supports a likelihood of a 'RAVE' must be objective and evidenced.

WARRANT OR NO WARRANT?

- Once you've established a RAVE; I'm going to ask you to get a warrant if the RAVE comes from the patient to be assessed because I will argue the grounds for getting one will always be met in light of your identified risks.
- If you choose not to get a warrant, that's up to you but I'll then explain I have NO POWERS inside that premises to mitigate those raised risks until there is an attempted criminal offence, an anticipated breach of the peace; OR you formalise an application for admission under the MHA.
- I will ensure you realise that legal responsibility for the planning and execution of the assessment sits with you, until such time as the police can legally intervene, because of crime / BoP;

- This means there is no power to stop the patient locking themselves in a bathroom, boiling kettles, leaving the premises, accessing balconies or picking things which may be used as weapons; UNLESS it constitutes an (attempted) offence OR (anticipated) breach of the peace; OR until they're 'sectioned'.
- I will still ask you to get this warrant, even if you demonstrate that you can already ensure lawful access to the premises – ie from a spouse or parent – nothing in s135(1) requires a demonstration that access has already been attempted or that it is apprehended that access will be refused.
- If you tell me that a Magistrate will not grant a warrant if they know access can be gained, I will draw your attention to para 10.10 CoP MHA and ask that you ensure a proper briefing to the Magistrates to ensure they realise that they can grant this warrant, even though access is enabled. This is almost unique in English / Welsh warrants and you should remind them of this.
- You can appeal a Magistrates decision, if you wish to, via the High Court. (LSSAs can arrange to train Magistrates via local Court User Groups.)

PROCEEDING WITH A WARRANT

- If a warrant is granted, I will determine the police resources to attend, the equipment they will take, if any, in additional to their normal uniform / equipment. This is because if I am executing a warrant, I am responsible for safety issues once inside.
- I will brief my officers that once the warrant is executed, they may use reasonable force to control the movement around the premises of the patient or any third-parties (*DPP v Meaden*, 2003; *Connor v Chief Constable Merseyside*, 2006) and that they may exercise a decision if risks cannot be controlled, to remove the patient to a Place of Safety.

PROCEEDING WITHOUT A WARRANT

- If you establish a 'RAVE' from a third party – ie, spouse, parent, housemate – and the grounds for getting a warrant are not met, I will still ensure officers attend to manage the risks and will brief them on s129 Mental Health Act and the offence of obstructing an AMHP in the course of their duty.
- I will remind them, that they can use force under s3 Criminal Law Act 1967 to prevent a third-party from interfering with your assessment, as along as you've gained lawful access from another source.

- Ultimately, if anyone persists in attempting to obstruct you, they can be arrested for that offence.
- However, the planning and risk assessment for those 'RAVE' risks where there is no warrant is YOURS, alone.

AFTERWARDS

- Once 'sectioned', the police will not convey the patient alone and any request for police to support conveyance by ambulance or other agreed method will be contingent upon a clinically qualified person, either paramedic, nurse or doctor travelling with the patient.
- Authorities to detain and convey will be in writing.

This will ensure appropriate use of police officers, risk management by you or us, depending on who is leading; it will also ensure the defendability of police actions in all circumstances.

5th December 2011

True Story –

One evening in I was driving around my area after 1am when I was called to some job or other – I was the acting inspector for the division that night, the senior officer. Whilst driving to it, I saw a man who would have attracted my attention if I hadn't been on the way to something, hovering near a bin outside Boots. Couldn't quite quantify it, but something struck me and I wished I had the time to stop and speak to him.

About 25 minutes later, my job having been squared away, there was a call: "Boss, a member of the public has reported seeing a man waving a gun around and he's then tucked it in his waistband." As soon as the controller gave the location I knew EXACTLY who it was. I was able to confirm having seen a man who met the description and we commenced the standard procedure: set an RVP for the police officers, call for a firearms officers, a good dog handler was on that night so we wanted him too … I also knew we had officers in a plain car that night so I ordered them to quickly run the length of the road, pass the man to confirm he was still there and then take up a position south of him, keeping him under observations from a safe distance. I ordered all the uniform officers to RVP at the front of the police station, which was on a small road off the main road on which the man stood, keep them all out of view but very nearby. They got lined up. All of this happened within 6-8 minutes of the call.

As we awaited the arrival of the firearms car, things developed. The plain clothes officers reported that the man was waving his gun around pointing it at passing vehicles and occasionally at himself. I took a deep gulp as I heard the force control room inspector give the armed officers urgent authority to arm: I realised for the first time in my career, I was the senior officer on the ground of a live, dynamic firearms incident and I started to realise what I'm paid for. There were constables standing looking at me as if to say, "Come on then, what are you going to do?!"

Firearms told me which direction they'd be arriving from; I ordered the unmarked officers to make certain locations to block the street as the armed officers approached the man, the dog handler started rolling his van towards. This was it.

Firearms slowed their car as they passed the street on which I was sat; we made eye contact and I gave the order for everyone to move up and support them. They rolled their car down the gentle hill and towards the man who was still waving the gun. I pulled my marked car onto the street about 100 yards behind them with a clear view. They accelerated the final stretch and pulled their unmarked firearms car across the road towards the man who was holding a black pistol in his hand, accelerating those last yards. I was now moving down the street on foot towards them with a clear view. I could see marked cars at either end of the road blocking traffic.

"ARMED POLICE – PUT THE GUN DOWN, PUT THE GUN DOWN!!" The man backed off towards the shop fronts and started frantically looking around. The two armed officers moved into the fighting arch (one at 2 o'clock; one at 10 o'clock, to the man) – the PC passenger had his MP5 carbine rifle pointed at the man and the driver, a firearms sergeant, had his pistol drawn. The man then darted to his left before the sergeant could move to a new position and off up the street … towards me and the officers blocking my end of the road. We saw the footchase start and the three of us, all unarmed, naturally moved into a position to block his path. As he and the officers got closer the PC with the MP5 screamed at us to "GET OUT OF THE WAY!"

The dog handler was running up the street after them all. The suspect ran past us and off. I screamed to an officer at the other end of the road to protect the firearms car which had been abandoned with it's doors opened – in fairness, their first priority wasn't vehicle security. But they cornered him whilst he was still holding and waving his gun and then something struck me:

What on EARTH do I do if they shoot him? It occurred to me that I must think they are about to shoot him if I'm working out what I'll do next. Running up the street to where they were, I was checklisting: preserve the scene, duty superintendent, professionals standards, preserve the weapons, senior firearms officers for their welfare support if they discharge their weapons and kill him, scenes of crime officers, mobilise officers from other divisions to take over duties from my officers who become witnesses to the event, mass debriefs? Anything else?! BLOODY HELL, they're going to SHOOT HIM. I really thought they were. I got an ambulance on the way, just in case.

Then I witnessed the most amazing feat of bravery I've ever seen; I doubt I will see better in my career. As they cornered the man, they kept insisting "PUT THE GUN DOWN, PUT THE GUN DOWN!" but it made no difference. The firearms sergeant then lowered his pistol whilst his colleague 'covered' the suspect and drew his police baton, exactly like the one I was carrying. He went straight into the tactics that all police officers

are taught, trusting his colleague to take the shot if needed and he waited. And waited. And waited.

When the gun was waved at the right angle, he batoned the man's arm once as hard as he could, jumped into his body space and pushed him hard to the chest. The man fell. Within seconds, the police dog handler was in there, as was I, as was one of my constables. The man was handcuffed and arrested and searched, after everyone had grabbed their breath. The suspect had four knives – large, sharp, military style knives – and it turned out the gun was a re-activated handgun which was LOADED. This had been REAL and he had more ammunition on him.

Once it was safe to focus upon the man, it was clear he was floridly mentally ill; psychotic and he was removed to custody. He was subsequently sectioned under the Mental Health Act and taken to a medium secure unit. He subsequently claimed he could not remember the evenings events; AT ALL. Ironically, I will never, ever FORGET that evening. I even know the date more than seven years later and everytime I drive down that street or go to one of the pubs on it, I remember what we did that night. I was delighted to learn later, that co-ordination of the incident was used by the Firearms Unit as an example in the real world of good practice on how sergeants and inspectors should do it.

I'd never felt prouder to be a British police officer in all my service as that man was taken into custody, uninjured but for a modest forearm strike. We all know other jurisdictions in which he would have been shot dead before he'd had a chance to run off. To watch that firearms sergeant – now firearms inspector – put his own life in danger, totally trusting his colleague; to bring that man into safe custody with such a low-level use of force was truly inspirational. They received Chief Constable's commendations for bravery based upon my report. Quite rightly.

6th December 2011

Psychiatric Inpatient Violence: part 1 –

I've been in loads of rooms with hundreds of police officers talking about mental health. If you ask them which mental health related issues make them feel as if they're left struggling, they will probably say "s136 MHA and getting into a Place of Safety." If they don't say that, they'll say "AWOL patients." Ask them which issues the NHS feel let down by the police and you'll hear tumbleweed. The police are perfect, obviously!? …

My colleagues in the NHS have said to me, that they feel they get an extremely tough deal when they are assaulted at work. Most police officers are stunned to learn that over two-thirds of violence against the NHS is directed towards mental health professionals. My officers arrested a man this evening for punching a nurse twice to the ribs and whilst it was obvious he was mentally ill, it was equally obvious after a short discussion with those in charge of his care that this fact was not at all relevant to the assault. When I go to work tomorrow, I look forward to hearing that he was charged with the offence.

We were also at the hospital yesterday because of a violent patient, albeit acutely unwell and highly unlikely to be prosecuted because the nature of his condition, but four of my officers running through the door was just enough to make him realise that if he wanted to fight the world he could expect a response from people who know how to react accordingly. He calmed down almost immediately and no-one got touched, let alone hurt.

But when it comes to inpatient violence against staff, the police have often said some extremely incorrect and foolish things:

1. "We can't arrest someone who's been detained under the Mental Health Act."

2. "Well, if he's mentally ill, he lacks the capacity to form the mens rea [the guilty mind] to be held responsible for the offence in law."

3. "Unless your Doctor gives me a statement of evidence stating that this man had capacity to form the intent, I'm not arresting him."

Nonsense, all of them. However, it is received wisdom in many areas.

ERECTING BARRIERS

The reason these barriers have been erected are not always illegitimate: if someone is detained under the Mental Health Act, it may well be that they cannot understand the nature and the quality of the acts they do; but it may not! It is true, that to prove some offences in a criminal court, a specific type or level of intent needs to be proved beyond all doubt. For example in an attempted murder investigation, it must be shown that the defendant was trying to kill the victim, not just trying to hurt them, even if seriously. If someone is extremely unwell, delusional and hallucinating, perhaps highly medicated, it may be that this level of intent cannot be shown. However, if an offence is very serious, it may not represent a total barrier to a charge, for sexual assault or serious violence, for example. We should remember, only criminal courts can impose certain orders under the MHA for patients who are deemed unfit to plead or unfit to stand trial: the law envisages their prosecution some cases.

Big message – each case should be decided upon it's individual merits.

Also, a really practical point: if a person is arrested from a psychiatric unit where they are detained under the MHA and taken to police custody; and if the investigation for whatever reason cannot immediately result in a charge and the person is bailed for further enquiries or psychiatric assessment or legal advice; I have known psychiatric units refuse to take patients back. So you then get a very irrate custody officer with a sectioned mental health act patient in their cells with no clear legal authority to keep them there and no ability to return them. Hospitals need to realise that arrests are part of the criminal investigation processes subject to certain laws and not simply a mechanism to transfer responsibility from one organisation to the next because the first has declared UDI that it cannot cope. Hospitals retain a duty of care to the patient.

The benefits of prosecution must be considered. Clinicians have argued that a failure to prosecute patients for criminal acts on psychiatric wards, breeds an environment of danger and fear which is not therapeutically conducive, including to other patients who may be the victims – it is not just NHS staff who are attacked or harassed. Prosecution can ensure that patients are forced to accept the social consequences of their decisions, as other members of society are. It helps define behavioural boundaries and I will tell a true story in the future of one such case where I will argue that prosecution was in the patient's interests to prevent him seriously offending and destroying his life.

THERAPEUTIC JURISPRUDENCE

To realise potential benefits, however, there are some serious hurdles to prosecution which must be cleared. The Code for Crown Prosecutors – the guide to prosecution decisions for CPS Lawyers – is a statutory document and the Prosecution of Offences Act 1985 obliges prosecutors to have regard to its contents when reaching charging decisions. It states very clearly that to prosecute, it must be more likely than not that a court, properly directed in accordance with law, will find beyond all reasonable doubt that the defendant did the act accused – the *actus reus* – and that they had the requisite guilty mind – the *mens rea*. It also states that prosecution must be in the public interest and that a suspect suffering from significant mental ill-health is a significant away from it being in the public interest to prosecute.

However, this must be balanced against other factors: where a victim serves the public, where prosecution is necessary to prevent repeated offending, where the type of offence is overly prevalent in that location, where weapons were involved, etc., are all factors which may push against the mental ill health of a suspect. The police and CPS should start from a neutral position and weigh each case on its merits and the CPS has produced guidance on the prosecution of mentally disordered offenders.

Prosecuting psychiatric inpatients should be considered where this may positively influence the type of Mental Health Act detention which governs a patient's care. I have been involved in the decision to investigate many s3 MHA patients who have committed acts of serious and sexual violence against NHS staff and battled through the information sharing problems – a blog in its own right! – as well some CPS lawyers who did not understand the benefits of a prosecution and the positive opportunities it represents. CPS are currently undertaking a national programme of training for their lawyers on mental health awareness, the Mental Health Act and prosecution decision-making. Such patients, if convicted can be made subject to a s37 hospital order, possibly 'restricted' under s41 of the Mental Health Act if the defendant is judged to pose a 'risk of serious harm to the public', which then alters the framework of their care.

It also ensures for serious violent and sexual offenders, that when released they are subject to MAPPA provisions which will ensure a robust, statutory framework to mitigate against future re-offending. It also ensures that when released from MHA inpatient care, it is subject to conditional discharge and recall under s42 MHA if Community Forensic Teams identify the emergence of risks, following failures to adhere to conditions of release. This could include residence, outpatient appointments or medication compliance, for example.

Suffice to say, justice does not have to stop at the hospital door: nurses, doctors and other NHS staff are entitled to state protection and redress when they are assaulted at work and the fact that one major mental health trust in my area reports just 16% of the violence they suffer to my police force shows that NHS staff do acknowledge occasions where someone has been assaultative because of their condition and that some minor matters from patients will not be in the public interest. Even then, it doesn't mean a uniformed officer giving a stern, however informal warning to patients can not have a very positive effect on ward safety. We need to broaden our thinking.

7th December 2011

Psychiatric Inpatient Violence: part 2 –

Quite a number of responses to my first blog on this subject, so I'm going to follow it up immediately, to address some queries that have been raised.

HOW SHOULD THE POLICE PROPERLY RESPOND TO ALLEGATIONS OF CRIME

1. **Ensure that the complaint made is a 'first-party' complaint**. The CJ system is victim-lead and the majority of the time, it will be necessary to have victim evidence to commence a prosecution. If complaints are made by managers, it is still necessary to deal with victims properly and get their involvement in the investigation wherever possible.

2. **Preserve evidence in the normal way** (victim & witness statements; CCTV / forensic evidence, if relevant). There is nothing specifically different about securing evidence for MH offences; even if the victim is a patient with MH problems, they can be interviewed by an 'ABE' or 'V&I' officer (specially trained for vulnerable victims / witnesses).

3. **Collect the 'background information' to the patient** to assist in legal decision-making. This will include legal status, clinicians opinion about prosecution, clinical barriers, history of AWOL, etc., – see below.

4. **Balance the evidence and the background information and make a decision** by forming a view as to whether it is best to arrest the patient immediately and remove them to police custody; or whether an interview should be arranged at a later stage, perhaps within the hospital itself or by appointment without arrest at a police station.

BACKGROUND INFORMATION

Several police forces have developed pro formas to secure factual information and / or opinion from clinicians to support legal-decision making.

In one area they simply ask whether "are any clinical barriers to prosecution?" and the Responsible Clinician says 'Yes' or 'No'. Several forces have started using a pro forma I developed within my own force

alongside a major mental health trust (with significant forensic mental health care responsibilities) and the CPS – it is a request under the Data Protection Act for answers to a series of questions which are relevant to the legal decision-making of the police and CPS regarding diversion / prosecution decisions.

The 10 questions are:

1. what is the patient's legal status under the Mental Health Act 1983 (including SCT patients);
2. a headline of the psychiatric condition, if known;
3. what is the RMO's / RC's opinion on prosecution? Are they any clinical barriers to it?
4. an outline of the NHS management plan, should a prosecution not occur;
5. any known previously unreported offending, relevant to the current investigation;
6. any previous history of absconding from psychiatric care;
7. any known failure to return following s17 MHA leave;
8. any known relevant failure to comply with care plans, including any medication programme;
9. is there any information concerning any intended criminal offending;
10. is there any information concerning any continued threats to staff health and safety.

WHY DO IT THIS WAY?

The questions address the opinion of the clinician – they don't have to give one, but it's never unhelpful – whether there are any clinical barriers; it secures factual information such as current legal status under the MHA; as well as questions for which the relevance may be questioned. Why is it necessary to ask about patients going AWOL, or failing to return from leave? Well, if patients get diverted from justice instead of prosecuted, it is because the public interest is met by their engagement with mental health services. If we know they are going to abscond and fail to engage, it adds more weight to a thought about prosecution. For these reasons, the pro forma includes explanatory notes for each question asked, to ensure clinicians understand the relevance of it.

(A full version of this document can be see in the (forthcoming) article by WILSON, MURRAY, HARRIS and BROWN: Psychiatric In-patients, Violence and the Criminal Justice System.)

A final point for now – this approach secures an audit trail of what was known at the time decisions were taken. Let me explain why this is important. Once upon a time (in galaxy far, far away) one of my officers attended a psychiatric hospital to a s47 (ABH) assault. A nurse had been

punched and sustained swelling and a clear red mark to the face, below the eye. It became a black eye within 24hrs. Officers asked the above questions and they were partially answered, the on-call psychiatrist arguing other material was medically confidential. This is fine – what information to disclose must be a matter for the NHS within their guidelines for confidentiality

As the man was not previously known to the police for any offending behaviour at all; it was decided that given his status under s3 MHA, the one-off nature of the incident and a lack of any other aggravating factors and the fact that there was doubt as to whether the violence was 'clinically attributable' that no further formal action would be taken. Officers spoke to and warned the offender.

A few days later, more senior NHS representation were made arguing, "His history of escalating violence and the premeditated nature of the offending must justify a charge, surely?" Re-examination and further disclosure completely changed the way in which the matter could be seen. It turns out he had been assaultative with staff on the wards where he had been detained for six weeks. Not only was the violence becoming more frequent, it was also becoming more serious.

It was now clear, that prosecution to prevent further offending was necessary; that action to protect staff and other patients was required. Police systems could evidence other assaults in that facility: an interview with the man, a denial of the offence and a visit to CPS later and a charge was authorised for s47 assault. He was given a serious fine after conviction following a guilty plea and staff subsequently remarked upon his changed behaviour within the ward to which he was returned.

Background information from the NHS is vital, because it provides the context within which offences can be seen. As seen here, the background can make one incident look like two different sets of circumstances which merit different criminal justice responses.

09th December 2011

Criminalisation of the Vulnerable –

My bio on twitter states I'm interested in criminalisation. I've had comments made about my 'mission' to eradicate criminalisation: I want to make a few comments on this and I want to be absolutely clear at the start.

- If by criminalisation you mean that the access to necessary services if and only if you have had contact with the criminal justice system; then YES – I'm trying to end criminalisation.
- If by criminalisation you mean, as I do, proper, lawful, defendable decisions taken which are proportionate to incidents and individuals brought to the attention of the police or courts; then NO – I'm not trying to end criminalisation.

Some criminalisation of individuals is absolutely necessary and let me give just two obvious why:

1. Offending behaviour is occasionally little or nothing whatsoever to do with the fact that someone has a mental health problem. Sometimes, mental illness is a mitigation to be considered, not a defence to the whole affair.

2. If offending behaviour poses a "serious risk of harm to the public", the relevant sections of the Mental Health Act (1983) can only be accessed via the criminal justice system, so prosecution is constitutionally necessary not only to the issue of public protection, but quite potentially in the best interests of the patient.

But here's my main claim: policing, quite rightly, UNDER-CRIMINALISES mental illness. Let me explain why:

Most legal jurisdications have an equivalent of s136 Mental Health Act 1983 – s297 of the Mental Health (Care and Treatment) (Scotland) Act 2003; a130 Mental Health (Northern Ireland) Order 1986. This legal power is exactly intended to allow police officers to respond to situations, including those involving minor criminal offences, and upon recognising a mental health crisis, prioritise that whilst (at least initially) ignoring the criminal offence. More often than not, the offence is set aside if someone is acutely ill.

- We also know from research (BITTNER, MORABITO) that where police officers have an opportunity NOT to arrest at all, because they can refer to or access services, they will take this option where appropriate. Of course, if those services do not exist or decline to respond, that is beyond the control of police who should and do take appropriate decisions.
- We also know from research (JAMES, RIORDAN) that where opportunity exists to divert offenders from police and / or court custody after arrest / prosecution, that this is often done where services exist.

If you set up a hypothetical police incident involving an offence and run it through 100 cops; and then re-run it whilst explaining that the person is acutely mentally ill, the number of officers arguing for an arrest interventions will drop. The nature of the arrests will also change because some will choose Mental Health Act instead of the Public Order Act or arrest for assault or damage.

In other words, where the opportunity NOT to criminalise exists, police officers and courts will often take it, but whether such services exist is something that is ultimately a matter for the NHS. Numerous times I've heard CJ professionals – police, prosecutors and magistrates – regret an inability to access services or access them in a timely fashion and regret yet further the subsequent necessity of arrest or prosecution or remand in order to continue to maintain public safety or the safety of the individual.

What I do know is this: there is anecdotal evidence from professionals I have worked with that without the ability to access Place of Safety services, police custody or court custody diversion services, some offenders will end up prosecuted until eventually they are subject to Part III MHA orders and require secure mental health care. As one MH trust I know is currently spending over 45% of its whole MH budget on high secure and medium secure care for approximately 60 of its 2,500 patients, the longer intervention is left for those who are mentally ill AND criminally offending, the more this budget will be squeezed by ever greater numbers of patients requiring secure care.

I'm advocating diversion where it is available and appropriate; I'm advocating that where it is not, the criminal justice system has a responsibility to prevent crime, protect life and property. Sometimes this necessitates a regretable prosecution, always done with a heavy heart.

10th December 2011

Assumptions to Avoid –

I just want to crack some assumptions that are often made. My top three fears, because wheels can fall off:

- **Alcohol preventing a meaningful assessment under the Mental Health Act** – it does not follow that it is medically safe to detain someone in a police cell until they're sober. Custody sergeants who believe that patients need clinical attention that cannot be provided by an FME are *obliged* by law to transfer that person to hospital, which inevitably means A&E. I could but won't give an example of a man who was arrested under the MHA whilst under the influence of a modest amount of alcohol and the A&E Consultant who subsequently treated him stated that if he had been removed to the cells prior to his collapse from undiagnosed diabetes, it all could have ended in fatality. **ALCOHOL / DRUGS CAN MASK THINGS** – so let's rule it out before we lock someone in a concrete room away from healthcare?! >>> Paramedic, doctor or nurse; as dictated by the need of the patient.

- **The police service do not have a legal authority to resolve every kind of situation** – mental health professionals sometimes do think that the police should be responsible for certain social functions. My particularly favourite is being asked to conduct a 'safe and well check' on a patient who has rung a GP or CMHT indicating some suggestion of self-harm or suicide. I'm not talking about pre-planned assessments involving an AMHP and DR, possibly under s135(1); I'm referring to checks the police are often asked to conduct alone, on behalf of the NHS who have concerns. I'm a particular fan of pointing out that in someone's own home or any private dwelling, the police have no powers under the Mental Health Act and **can only act coercively** if there is an (attempted) **crime** or an (anticipated) **breach of the peace** or an **imminent risk to life**. And without these things, if we are told to leave a private dwelling, we become trespassers if we remain there without permission. Someone sat in their own home in (lawful) possession of items which might be used to cause harm some while later, is insufficient to allow coercion by

the police, even if mental disorder is suspected. **PARLIAMENT HAS DECIDED**: the solution to mental health crisis in a private dwelling is an AMHP and a DR (with a s135(1) warrant, if needed) conducting an assessment with a view to emergency MHA admission under s4.

- **s136 of the Mental Health Act 1983 CAN and sometimes SHOULD be used in relation to people who are drunk** – although not often! Those who are KNOWN mental health patients about which there is objective information available to the arresting officer of mental disorder, are the target of this comment. It means, that once a period of sobriety has been managed – whether that be A&E, Place of Safety or police station as determined by the needs of the person(!) – an assessment can occur with an AMHP and a DR to identify ongoing needs, medical or social. I could but won't give an example of a patient who died where I am convinced that if the police had arrested him under s136 MHA when they were so intoxicated they could not stand, the person would be alive today. **NOTHING IN UK LAW** prevents the use of s136 MHA – or s297 MH(Scot)A or r130 MH(NI)O – with regard to people who are under the influence of alcohol. Just make sure there is *objective information* about MH in addition to an officer's perception to validate that approach. It then ensures their substance abuse issues – one-off or ongoing – are managed once sober in the context of their overall mental health care … or it should.

10th December 2011

Why Are some Mentally Ill Patients Treated Like Criminals? –

I wouldn't normally subject you to two blogs in one day, but I have just come across the case of Joe PARASKEVA. Joe is a young man who was sentenced to serve an IPP, or indeterminate sentence (for public protection), following a conviction for arson. This offence was committed whilst detained under s2 Mental Health Act in a Hackney psychiatric ward following which he was arrested, charged, remanded, tried and imprisoned.

His mother, Linda MORGAN, launched a campaign to have him transferred from prison to hospital, to continue to receive treatment for his mental health problems and various national charities took up his case to highlight it as being especially harsh. This case serves to demonstrate the very real challenges discussed hypothetically in previous blogs about in-patient offending and how to reach a prosecution decision. It shows how serious the consequences are.

Highlighting Joe's case back in June, an article in the Guardian by Amelia GENTLEMAN asked the question, "Why are some mentally ill patients treated like criminals?" as if to imply a black / white distinction between mutually exclusive groups. It is this ever-offered distinction I wish to contest as it is absolutely clear to me that we must get better at recognising the grey areas which necessitate blurring it.

And we **must be prepared to debate this**: we cannot have a situation where we unnecessarily and outrageously criminalize (young) people with mental health problems; but nor can we have a situation where those with mental health problems who offend are unable to be held to account by the law where this is both possible and appropriate. I remind: **some parts of the Mental Health Act 1983 can only be accessed via the criminal justice system**. This may be right or wrong, but it is the law as it stands today.

I regularly post this on twitter; "Should offenders with mental health problems be diverted? 'Depends; and no policy from government, police or health has ever said otherwise'." For all the words that have been written over the decades, nothing says ALWAYS YES or ALWAYS NO. **It is a complex decision** with far-reaching consequences.

For this reason, not all diversion decisions should be taken by the police at the investigation stage.

Whilst being horrified about Joe's case, one can see why he's endured the route that he has. Clearly two psychiatrists and an AMHP felt able to 'section' him, originally under s2 MHA. However, the psychiatrist(s) who offered information during the criminal justice process stated he was not suffering from mental disorder. So one can at least begin to understand why a prosecution was considered?

Trust me(!), it is often a difficult task to persuade the CPS to prosecute someone who was sectioned on a mental health ward at the time of the offence but clearly the CJ process has proceeded in Joe's case on the basis of views that following assessment under s2, Joe was not suffering from a mental disorder. This may have been right or wrong, but it appears to have been the view offered at the time. Subsequently, after conviction, further opinion has suggested in fact, that Joe does have mental health problems so thankfully he has been transferred back to hospital from prison under s47/49 and is receiving treatment and care. The originally imposed sentence can now be served out as a restricted hospital order, subject to the ongoing assessment of clinical need.

Far more generally than this one case – it is perfectly possible to suffer from mental disorder; AND to be 'sectionable' under the law; AND STILL be capable of understanding the nature and quality of acts done. Equally, it is perfectly possible that someone's mental disorder and / or their treatment, may render them UNABLE to understand the nature and quality of the act done and a prosecution would not be possible. There are some cases where it may not be easy to know and a fuller psychiatric assessment may be needed and / or a fitness to plead or fitness to stand trial hearing becomes necessary.

Let us also remember, that 'insantiy' – a legal concept, not a medical one – is a *defence*, to run at trial. It is a matter for the defence to raise, not one for the prosecution to pre-emptively negate in advance. To determine which may be the case in any particular investigation, the police, the CPS and then the courts will need INFORMATION which allows them to know or to at least infer what they may be dealing with.

<< **Update** – 12/12/12: Joe PARASKEVA took his case to the Court of Appeal on 12th December 2012 and after reviewing the medical evidence and securing a new update, the Court ruled that he "was suffering from a mental disorder both at the time of the offence and sentence." As such, his sentence has been changed and he has been made subject to a Restricted Hospital Order, under section 37/41 Mental Health Act.

- The BBC News article
- The Guardian article

11th December 2011

True Story 2 –

Once upon a time in galaxy far, far away there lived a North African man in a bed-sit. He had entered as an asylum-seeker – albeit his claim had been denied. Our story commences at the point where he was part-way into the Home Office's appeal's procedure, some three years after his arrival. Throughout the period, the man had ongoing problems with his mental health, exacerbated by cannabis use, and he was often psychotic. He had been arrested no more than 6 times, but each time was assessed in custody for his mental health. These assessments occurred after his drug-induced psychosis had eased and he was never referred to services. In any event, there were grounds to believe he would not have engaged with them anyway.

One evening, the police were called to the address in which his bed-sit was contained. An old Victorian, terraced building of some stature, it was long past its best and someone had destroyed its former character by carving into half a dozen one bedroom 'flats'. The 999 call was concerning: a man had threatened the caller with a knife and attempted to stab him. The man had escape uninjured and barricaded himself into his own flat. The man was now kicking off the door and he was stacking furniture against it door and locking himself in the bathroom.

Two uniformed constables in a standard response car rushed to the scene, more were coming and this story pre-dates the availability of taser. Upon arrival, they could not get through the communal door of the premises and nothing could be heard. Control rang the caller who promptly appeared through a window at the top of the building screaming, "Here!" as he threw down his house keys. The officers let themselves in, batons drawn but not 'racked' (extended), and made up the stairs.

As they reached the first floor landing, they came across the offender, our asylum-seeking North African man who was acutely disturbed. He was also heavily armed, it turns out with not one, but three knives – one of them drawn. An officer screamed, "put the knife down" and deployed CS spray which had precisely *no effect whatsoever*.

The man continued towards them, he was slashing at them with the knife and he pulled out another from a pocket. The officers were forced backwards having to choose between being cornered or moving down the

stairs. They chose the latter and actually ran down the stairs, whilst calling for urgent assistance. The control room called for a dog handler, supervisors and firearms officers.

When they reached the bottom of the stairs they turned to assess what they had: the man was walking down the stairs, chanting. They both racked their batons and decided to confront him as he slashed at them. (They later argued, that had they left the building, the man was no longer contained and they had less control. A different way of saying the same thing is: "I'd rather put myself in potentially mortal danger than let those risks unfold towards the public.")

The man kept shouting and chanting. "Get back, put the knife down! Get back, get back!!" The offender thrust the knife towards one of the officers, his colleague batoned him to the upper arm – no effect – and then to the arm not attempting to stab his mate. The 'attacked' officer used a 'figure of eight' technique to stop the knife getting close to him or his body armour and feared he would be stabbed – his vest got slashed. The officers were now beginning to feel the effects of CS spray – the man with the knife was not. Getting a bit more desperate, they batoned the arms, repeatedly to try and cause the knives to drop. One officer batoned one arm enough times and with sufficient force to break the bone in the forearm – twice. The offender *still* kept attempting to attack. The other officer, still shouting, repeatedly batoned the other arm, breaking it once.

The officers moved around the small lobby, just about big enough to allow three people to dance. They kept shouting, they batoned him again, then one officer 'rushed' him, just after a final strike and they both wrestled him to the ground. The man kept fighting on the floor, with a three breaks to two arms, as if impervious to pain without releasing the knives. After arresting for attempted murder and handcuffing him, other officers transferred the man to A&E where he was assessed and sedated. Some while later, he was assessed under the Mental Health Act and admitted to a medium secure unit with appropriate treatment to his arms.

The police officers who dealt with this incident now both suffer from PTSD. One in particular has permanent trouble sleeping, he suffers – present tense – flashbacks and has had counselling because **he feared he would die** and he *deliberately* and *instinctively* took that risk upon himself to contain broader risks to the public. He is very aware of cases such as that of PC Jon HENRY from Bedfordshire, who was fatally stabbed whilst dealing with an armed, resistant mental health patient.

Because the man was admitted under s3 MHA to a medium-secure unit, the CPS were reluctant to prosecute him at all. After all, he'll end up back in the same unit getting the same care by the same people, so what's the point?! This was *despite* his repeated incidents of drug-induced psychosis and his previous violent crimes. To persuade the CPS, it took specifically

worded representations about evidence, public interest, Code for Crown Prosecutors and the CPS's own guidance on mentally disordered offenders, including an explanation of the benefits of a s37/41 order in cases like these. Three lawyers later and it was then worth charging the man (with GBH with intent) and putting him through the criminal justice system – it also means, having been found responsible for a violent offence, he will be subject to MAPPA when he is released, to better manage any risks he poses and subject not just to release, but to 'conditionally restricted release'. In effect, these are licence conditions which allow him to be recalled to hospital, if needed.

He was found unfit to stand trial but pleaded 'guilty' the act done and was given a restricted hospital order. **None of this helps the police officer sleep or stops the flashbacks.**

The most tragic thing about this story, is that it is not that unusual and most cops have got at least a few of these stories to tell. I would argue that by bringing an understanding of MH and the MHA to bear on the case, I persuaded the CPS to charge. In the long run, it better protects the public as this man will be subject to oversight by MAPPA when he is discharged from hospital and will be subject to recall by the Ministry of Justice if he does not comply with community treatment. Had he not been prosecuted, he would not have had that scrutiny – investigating cops need to know how to press these buttons.

12th December 2011

"Do They Have Capacity?" –

I've had a couple of comments (presumably) from police officers, regarding issues raised on the blog which raise a question over our use of the word 'capacity'. I've also heard the question hundreds of times, "Do they have capacity?" It is almost as if we've worked out that this is the legal magic bullet to make black and white clarity from shades of grey complexity.

Of course, some would argue that the first error is to ask legal questions of health professionals (and vice versa). That aside, an officer commented that they seek confirmation from hospitals who are reporting AWOL patients, "do they have capacity to refuse treatment?" In turn, this then influences their policing response. Whether this means "capacity to refuse treatment at the point they went missing" or "capacity to refuse treatment now" is unclear. If someone 'with capacity' went missing (without agreement) and has subsequently spent a day and half bending their minds inside out with crack cocaine, they may not necessarily have capacity if they are found by the police in the local drug den.

Of course, it is right that the police understand what they are being asked to do. I've often raised the point – if the NHS are reporting AWOL patients who were NOT detained under the MHA, are they asking for a 'safe and well' check or are they asking that if the person is found that the police should contact an AMHP to initiate an urgent MHA assessment for potential re-admission under the Act? (Remember when despatching the police: we have no legal powers in private premises under the MHA without an AMHP securing a warrant under s135(1) or making an application for admission; and *if* the location of the patient is known, it is a role for MH services to recover the patient themselves, only being supported by the police where necessary because of risk.)

But I've heard this same question asked of DRs when patients assault staff, "Does he have capacity?" or "Does he have capacity to form the intent?" Capacity for what?! Capacity is situationally and task specific. At the same time, someone may lack capacity to decide whether to accept life-saving medical treatment, whilst retaining the capacity to decide whether they should eat a meal. Someone who has capacity to decline certain medical treatment now, may not have that capacity in 24 or 48 hour's time. It is a contextual and fluid concept so however it is addressed

it needs to reflect the difference between the 'mens rea' for a common assault and that for a GBH with intent; as well as addresing 'insanity' laws.

Of course, 'capacity' is not the correct question for some of these situations anyway. All cases turn on their merits, obviously, but some assaults are committed by patients who 'lack capacity' (in the general sense that this means anything at all) and they are detained against their will under a section of the Mental Health Act; but they "understand the nature and quality of the act" for the purposes of criminal investigation / trial.

A forensic psychiatrist once remarked, "I don't ask you what drugs to prescribe, so why are you asking me legal questions?! I can tell you he's got schizophrenia and I can remark in general terms about cognitive reasoning and I can advise about whether there are any clinical reasons that prevent prosecution. Whether that all amounts to 'capacity' or 'intent' or 'recklessness' is a matter for legal officials to decide because these are legal not medical concepts." (And of course, where patients who might lack capacity do understand the nature and quality of their act, it may or may not be in the public interest to prosecute them for it.)

So, 'capacity assessment' is not the panacea to policing situations that some think it is – it may not tell you what you actually need to know. This is why professional training for police officers in MH issues is necessary.

12th December 2011

People –

Sometimes, I listen to protracted debates at work around divisions of responsibilities. Is a particular type of burglary or robbery a local CID job or a force CID job? Is a neighbour dispute neighbourhood policing or 24/7 response job? How do we determine whether a fraud is for Economic Crime – value or complexity? – and who investigates it if it is not serious enough? Does any of this matter?! Well, only up to a point – I don't like to play the 'remit game', as it often misses the victim.

So I was interested a few weeks ago in a squaring-off between two sergeants over some routine business which, when I was a sergeant, I'd have been *humilitated* to think reached my inspector. I wouldn't have wanted him to know I couldn't sort it out, being so utterly straight-forward. But notwithstanding how simplistic it was to *us*, it was *extremely* important to the victim.

I made it known that these 'stripes' should talk to each other and reach some professional compromise because "if two people paid £40,000 a year each want to bore me *again* with the fact that they are unable to sort out a shoplifting, they'll both get a decision they don't like." Both sergeants had good reason to say 'no' but that wasn't getting the victim a police service. I didn't actually care who took it on because the victim was more important than either them. I didn't hear anything further and the victim got what he needed.

This brings to me to mental health: there is always scope to argue that the police or mental health professionals should do this or that and I work in an urban area where resources are (comparatively) plentiful. But I've been reminded by colleagues who work in very rural areas, that agencies often do favours 'above and beyond the textbook' because they have to, to get things done. Police officers cover school crossing patrol for the council – unheard of in cities – and GPs let their surgeries get used as a 'place of safety' when a PC is struggling to get someone removed 45 miles to a psychiatric unit. (I mentioned this in my area once and was patronised out of the building.)

In many examples we could debate, laws and guidance don't actually prescribe work to be the responsibility of one agency or another. Managers are required to acknowledge that they have no stick with which to beat the

other party; they must, for practical purposes work out how to support each other and compromise. So whilst I have a rough rule of thumb as to the basis upon which police support for MHA processes should be agreed – Resistance, Aggression, Violence or Escape (RAVE) – I'm not at all sure how this holds up in West Cornwall on a wet Tuesday evening. It may well be the case that the Penzance inspector is happy to assist whenever he can because he knows he'll need a CMHT or AMHP colleague next week to act as an appropriate adult for an arrested offender when they have no legal obligation to do so. (It is a 'he' – I checked! What a job to have?!)

Working together, improvising together and compromising together is *vital* wherever you work: because the centre of it are *real people* who need assessment, help or support. That is more important than *anything* else, if we're honest – as long as no-one is doing anything illegal.

13th December 2011

The Custody Sergeant –

The police custody sergeant probably has the most difficult job in UK policing. In my humble view, it is more demanding than being a 'duty inspector' where you are responsible for almost everything going on. A *constitutionally* significant role, it is recognised as a quasi-judicial authority for the purposes of the European Convention on Human Rights.

Here's the reason why it's difficult: your first responsibility is to safeguard the health and welfare of detainees as well as the integrity of the legal process that should surround their detention in your care. You are expected to chace, chastise and charge senior detectives and senior officers to ensure legality and proportionality. You must assert yourself in the face of investigative delays.

It was my *utter privilege* to be a police custody sergeant. It made me feel like I had become a **real** sergeant, at last. The role defines that rank: your testing ground for an ability to appropriately control other police officers' activities, to assert your personal authority and integrity. Your training makes you realise that the duty inspector cannot 'pull rank' to over-rule you, except in some very particular circumstances. If they try, they must *by law* be prepared to explain themselves to a superintendent. My favourite ever custody sergeant once faced a tirade of near personal abuse from an inspector over a particular decision he took. Having patiently listened whilst he was berated he just quitely picked up the phone, asking control room to ring the superintendent at about 3am. The inspector backed down within seconds.

But most custody officers I've known life their professional lives in a form of fairly acute proactive anxiety, relating to the potential for a death in police custody or following police contact. Procedures relating to detainee searching, background checking, risk assessing and health screening can take over half an hour per prisoner when book someone in, especially if they do not speak English. Some of them quite rightly put arresting officers through a quasi-judicial cross-examination to satisfy themselves of the risks they are about to take responsibility for managing as well as the integrity of the arrest. Only this month, I'm aware of a custody sergeant jumping up and down because an arresting officer had allowed a person to take (prescribed) methadone *after* being arrested. So they are the legal and physical guardians of society's final emergency dumping ground and

can often be found rolling around on the ground to keep people from hurting themselves through self-harm and disturbed behaviour.

Mental health issues bring particular challenges and frankly, frustrations: when a s136 arrest is brought in, the custody sergeant has a right to expect that this will be a position of last resort, an exception to the norm. But in 2008, over 65% of people detained for a place of safety were taken to the cells. They should be asking questions of the officer such as "What alternatives have you considered, where else have you tried?" Their legal and professional duty is not to a local mental health policy, but to the law, wherever those two things are different – and many of them are.

They are bound to act in accordance with Code C to the Codes of Practice to the Police and Criminal Evidence Act 1984 and directed by Safer Detention guidance. These documents guide all aspects of treatment and detention and where medical matters are concerned, stating that the custody sergeant must ensure appropriate clincal attention and highlighting the risks of unprompt assessment / treatment of clinical risks involving alcohol, drugs and mental health. Whether this is all possible via an FME will depend on the condition and the availability or ETA for the FME. Where the sergeant feels that appropriate attention cannot be obtained in custody, they are *obliged* to call an ambulance or transfer the person to hospital.

Alcohol, drugs and resistant behaviour are particular warning signs for custody officers, especially if the person has been arrested brought before them without reference to paramedics or doctors. The IPCC reported in 2008 that 17% of all deaths in custody involve detainees with mental health problems, usually complicated by drugs, alcohol and resistant behaviours. 5% are s136 Mental Health Act.

A decision by a custody officer to transfer someone to an A&E department, having determined in good faith that the possible clinical risks are too great to be managed within a small concrete room by a doctor without much kit or cannot yet arrive, is lawful. Failures to do until it is potentially too late have in the past been grounds for suspension, disciplinary action and even criminal prosecution.

Of course, this doesn't even *touch* custody sergeants' legal responsibilities to determine levels of evidence and public interest for criminal inquiries; to refer a case to the CPS for prosecution or not; to manage police bail; to manage requests from solicitors, appropriate adults, doctors, nurses, intepreters, mental health assessment teams; of course we should not forget the need to oversee police officers, immigration officials, customs and excise and other police forces unfamiliar with local procedures to ensure that all adhere to legal frameworks during the chaos of a busy custody office. Oh, yes: food, drink, exercise, washing, observations levels and reviews of the same; hospital transfers, extra legal considerations for juveniles and complaints as well as legal reviews for some of the necessity

of ongoing detention. All of which gets thrown into turmoil by the next fighting drunk coming through the door at near-zero notice.

This is serious business: it is the primary duty of custody sergeants to ensure some of the most demanding detainees are kept safe whilst vulnerable, under arrest. This should **always** take priority over everything else.

14th December 2011

Section 135(1) Mental Health Act 1983: part 2 –

I previously gave my own thoughts about how to approach an assessment on private premises or s135(1) job. I'm going to do it again, to deliberately set out a different way to approach the planning of it and in order to provoke thought / debate.

Approved Mental Health Professional's (AMHP) should bear in mind that the below reflects guidance to the police service from ACPO and is endorsed by the Department of Health: it may well become more wide-spread in future. It is a basis by which to mitigate risks being highlighted that necessitate police attendance. I know that some have supposed it is just the erection of artificial barriers to securing police support: I want to dispell that myth here. **It is about safety, including yours:** whether you are an AMHP, a police officer or a patient.

If it is anticipated that there will be risks of "resistence, aggression, violence or escape" (RAVE risks) then the grounds for obtaining a warrant under s135(1) will usually be met. As a warrant would *significantly* assist in the mitigation of those risks, the police may ask for one to be obtained. Of course, the final decision as to whether to do so rests with the AMHP, but a police supervisor should be thinking from a risk assessment point of view: "What can I bring to this operation which will mitigate risk?" A warrant may well do that.

Where a warrant is obtained, it ensures that the police officer who executes it has two powers otherwise unavailable to them:

1. Power to enter the premises, by force, *if need be*; AND / OR
2. Power to remove the individual to a Place of Safety, *if thought fit*.

Case law has upheld that police officers' would have the right to use reasonable force in order to *safely* execute a warrant on a private premises in order to prevent its execution from being interfered with. (It is also a criminal offence to obstruct a police officer and a separate offence to obstruct an AMHP.) For example, it may be necessary to briefly control the movements of parties in the premises, either the patient's movements or to prevent third-party interference.

The criteria to be satisfied to secure a warrant are that the individual to be assessed *"is or has been neglected, is or has been ill-treated, is or has been kept otherwise than under proper control, OR is living alone and are unable to care for themselves."* So, four potential grounds against which to obtain a warrant, only one of which need to proved to the Magistrate.

Finally(!) – where a warrant is being applied for despite no attempt to enter having yet been made, OR where it is known that access to the premises can be lawfully secured, the reasons for still applying must be documented (CoP MHA, para 10.10). <<< This means, you can seek a warrant even though you know you can get in, but you'll have to outline the necessity of it to the Magistrates as most of the warrants they grant cannot be authorised when access is freely available. *s135(1) is different*. **s135(2) is not**!

To lawfully grant a warrant there is NO requirement to demonstrate:

- that access to the premises has already been attempted;
- that refused access to the premises is apprehended;
- that there is a specific indicator of resistance, aggression, violence, or escape (RAVE); only those points in subsection (1) need be satisfied.
- that the power to remove the individual to a Place of Safety WILL be used; that it *might* be needed where the criteria for granting are met, is sufficient to allow an application.

The police are allowed to have a view about whether a warrant should be sought or not, as they are being asked to mitigate (sometimes considerable) risks and must do so lawfully. The planning discussion should include full disclosure of risk information under the Data Protection Act 1998, because warrant or no warrant – it is a joint statutory responsibility where everyone has the same objective and responsibilities to each other. They all need to fully understand the risk information and work together as *one team*.

Without a warrant there is no police power to intervene by force within that premises until someone's conduct amounts to an attempted or actual criminal offence, an anticipated or actual breach of the peace; OR until an MHA application is made. So even bearing in mind offences of obstruction – to the police or to the AMHP – there is no power to prevent the individual from:

- Completely denying access to the premises (unless another person may lawfully grant it);
- Moving to a room which can be locked (bathroom / cupboard / loft);
- Picking up knives, cutlery or other (improvised) weapons;
- Boiling kettles or picking up hot-drinks;
- Accessing areas where there are windows / balconies;

- Leaving the premises – if they do leave, s136 criteria may or may not be met.

I am not advocating a "NO WARRANT = NO POLICE" approach. If the RAVE risks come, for example from a third-party at the address, it may not be possible to get a warrant, but it will still be necessary to have the police.

Think it through and do let me know what you think.

16th December 2011

Psychiatric Unit Liaison Officer –

Once upon a time in a police force an inspector got a new posting – no, this was not me. He was put in charge a busy city suburb, with retail and residential areas, very demanding and diverse.

As all good inspectors do, he sought out his crime maps for the intelligence analyst and looked at his monthly, six-monthly and annual crime, broken down by crime type: robbery, burglary, vehicle crime, violent crime, anti-social behaviour, etc., etc.. Several things stood out but on the matter of violent crime, one thing stood out in particular. A specialist psychiatric facility for women and children. Very, very high levels of reported violent crime.

The new inspector asked the local neighbourhood sergeant to get a constable to look at this properly at roughly the same time as a certain HQ 'mental health lead' was looking at the issue of inpatient violence against NHS staff and other patients. Several cups of coffee and a few hours of very informal 'training' later and that neighbourhood PC disappeared into the unit with offers of ongoing advice and support from her boss and from me.

Initially not allowed to enter in uniform or wearing handcuffs, baton, CS, etc., it was a matter of building trust. The unit had a very high levels of sickness amongst staff, who often needed considerable periods off work with visible injuries and others who suffered from stress and depression at a relenting volley of crime that was effectively unaddressed. Of course, there were the standard challenges discussed in two other blog posts – here and here: why would you investigate / prosecute those detained in a secure unit for assaults, especially if those suspects were children from highly disturbed backgrounds, often involving considerable abuse of all types? What information can you share in order to do so?

The officer formulated an approach: no reported offence would receive **no reaction at all**; however 'minor' the matter, if made aware of an incident, the patient would at least be spoken to and advised or warned. Reports would be delayed wherever possible, until she was next on duty and this would allow her to respond to ensure continuity of approach. Only if there was ongoing, immediate risk that needed an emergency response would

999 be used. Even then, her 'response' colleagues would simply ensure that safety was restored and refer the ongoing investigation to her.

Once the certainty of a response was understood, she was allowed to 'patrol' what became her favourite 'tea-spot' in uniform. When on the ward investigating other matters, she would take time to talk to patients who had been flagged for low-level, verbal threats. She told them what she could consider doing if anyone was assaulted. She pre-empted problems. Eventually, she was allowed to move around the hospital unaccompanied by NHS staff, with a set of keys and an NHS ID badge 'police liaison officer'. It was her 'beat'.

She had a range of responses to crime – including for minor offences and for those cases that were highlighted by the staff as being *inappropriate* for formal prosecution. It involved such informal police reactions as ensuring a written letter of apology to a nurse – welcome for many reasons if the offender was a child with literacy issues. Adults were invited to repay the cost of minor damage as many people in wider society are so invited, as an alternative reparation. Some offenders received fixed penalty notices for damage – fining them £80 and some received police cautions.

In a serious cases – which were thankfully few – and some persistent cases of repeated offending where informal approaches were tried first, matters escalated to formal prosecution and significant understanding from CPS colleagues when provided with good background information from the NHS. All of this was a joint approach between the NHS and the police / CPS and as a result, a couple of s3 patients became s37/41 restricted patients because highlighted risks which had led to their original admission to hospital, were realised against staff within the unit. It became clear that they represented a 'serious risk of harm to the public' and prosecution ensured public protection after release by ensuring the justice system managed risk.

Very little of this involves arrest and removal to the cells, she would arrange interviews of suspects, with appropriate adults, solicitors and doctors assessments of 'fitness to be interviewed' inside the unit.

Guess what happened? - violent crime reduced **massively**; staff sickness levels reduced **massively** – to a point where the worst unit in the trust for sickness is nearly one of the best. Better continuity of care for patients with regular staffing; a safer environment for all staff and patients. How much work was this? Initially, the officer said it was about 50% of her role, sometimes more. But once trust and procedure was established, it was an occasional thing that took little time at all, just regular passing attention and frequent ground-floor liaison between the agencies' staff.

This partnership working won a National Patient Safety Award.

18th December 2011

Policing and Mental Health –

Guest post originally written on the Not So Big Society Blog –

The police service is key to the delivery of effective community based mental health care. There is an inevitability of police officers being called to incidents involving service-users, carers and professionals because some will occur unpredictably and because a few involve responding to significant risks.

A fact of law: it is the police who must take certain decisions and exercise certain functions required by the Mental Health Act 1983. It is a matter of ethics and law: that the police should support colleagues in the health & social care professions as they administer the Mental Health Act, in order to keep everyone safe as they do so.

Research from the Centre for Mental Health suggests that as much as 15% of police work involves some dimension of mental illness – victims, witnesses and suspects as well as those who are not involved in the criminal justice system at all. It has been suggested that by a mental health trust as many as 50% of people arrested by the police are current or previous mental health patients.

Without wishing to stigmatise a very diverse group, we do know that at least some mental health incidents are high risk business and some psychiatric emergencies occur so unpredictably that the police are going to have a key role as first responders and gatekeepers to health services.

Most police officers I know want to know more about mental illness and mental health law in order to provide the best service. Most of us know police officers with mental health problems – some incurred as a result of the job we do. Every time I have ever delivered a briefing on the subject, there appears a genuine thirst for more knowledge because most frontline cops know that there is a set of persistent challenges and they would prefer to do the right thing:

- Removal of those who may be at risk to a 'Place of Safety' –under s136 Mental Health Act 1983.
- Patients who are absent without leave from hospital.
- The investigation and possible prosecution of offences involving those who are mentally ill, either as victims, witnesses or suspects.

A major is challenge is that the police know there is no such thing as 'the NHS' – in my region alone, it is 45 separate organisations and the detention of a vulnerable person under s136 Mental Health Act, for example, could necessitate contact with five or six separate organisations within 'the NHS'. It also involves the Local Authority and the police themselves: eight organisations trying to something unpredicted in as a short a timeframe as possible.

Agreeing local operating policies can be like nailing jelly to a wall.

It is obvious this can lead to tension between the NHS and the police about how responsibilities are divided, both at frontline and managerial level and is it is reflected in a divergence of practices across the UK. If an AWOL patient is at their home address and needs to be returned to hospital, should this automatically be a role for the police? Well, the Code of Practice to the Mental Health Act says 'no' but several MH trusts say 'yes' because they cannot ensure the resources to recover patients themselves. That having been said, if the police try to plug the gap focussing on wanting to ensure that people in need of hospital treatment are returned there for care by appropriate professionals, service-users report being criminalised and the victims of prejudice and stigma. They report that the police have been used inappropriately to 'control' them.

So what is the answer and what if we can not agree how to resolve differences? The use of the police to administer the Mental Health Act should be *proportionate* to the *actual* threats, not routine business.

But here's a controversial claim: the police, quite rightly, *under-criminalise* those with mental health problems. People in our society occasionally have contact with the police. A community care model cannot prevent this being true for those living with mental health problems but because it is typically argued that police involvement of itself is a criminalising experience, the service needs to ensure it knows what it is doing.

Where you put a typical crime scenario to 100 police officers and sought to understand how often they would arrest and / or charge a suspect and then repeated the exercise where it is known the offender has mental health problems, you will find a surprising result: the number of arrests will drop and the number of arrests which result in prosecution will drop. It is clear from research that where police officers have access to diversion services, they will take them and reduce unnecessary criminalisation.

But of course, most police contact with service users is not in situations where it is alleged they've broken the law. It is far more likely to be that someone is the victim of a crime or in need of support during crisis, either by the police or by the police supporting others.

A service user once said to me, "The worst that you can say of the police is that they are there for you 24/7. They might not always do the right thing, but sometimes that's not their fault. At least they'll come when you need help and try to do something."

*The author is a serving police inspector writing in a **personal** capacity. Read more about policing and mental health at his blog and Twitter account.*

18th December 2011

It's Good to Talk –

Just about three weeks into blogging and I'm well on the way to 5,000 hits. Earlier today, moved past 1,000 followers on twitter. So here's what I take from the interest that's been generated each of these social media: **there is a decent level of interest in this area of policing** and more work to do.

Frontline cops – I've got to mention these first, because this was my motivation for becoming interested in this area. I have already had both tweets and emails from PCs and Sergeants saying that they have used information from both sources in their jobs and achieved benefits for patients and efficiency for the service. For example, calling an ambulance to s136 MHA for example – we know this has saved one life in the last 12 months in my area alone. Ensuring that the police are accompanied by health professionals when attempting to recover an AWOL patient – we know that there have been contacts deaths where the police have done this unaccompanied. The custody sergeants seems to be tuning in frequently.

Social workers – and I'm going to specifically highlight @ermintrude2 and @444blackcat on twitter, but there are others, too. Professionals who are listening to and actively spreading the perspective of this police officer, embracing and encouraging a view on the Mental Health Act that is sometimes at odds with their own. That they are doing this when undoubtedly it challenges assumptions held by some social workers has to be commended. It gets and keeps the dialogue going.

Lawyers – who have been kind enough to comment and encourage, seeing as they do the challenges and difficulties into which agencies and service users and their families manage to get themselves. Probably wrong if I did not highlight @HumanRightsQC for his encouragement in tweeting and his feedback. But there are others too, who 'RTd' and have encouraged readership.

Doctors and Nurses – mostly psychiatric, but also including GPs and A&E professionals. People who have given a perspective, encouraged and given feedback about cultures on wards and the benefits / drawbacks of prosecution. Various opinions about mental health in general, in A&E as well as on psychiatric wards. Invaluable.

Service users – who have commented upon the blog and made known their positive experience when in the care and detention of the police, who tried to get them access to services. I've had positive tweets from MH professionals in my own force area, commenting upon the professional, empathetic attitude of frontline PCs during s136 detentions, etc..

Senior people – it is gratifying to see senior police officers who have followed, most of all @CCLeicsPolice who is the ACPO Lead on Mental Health & Disability. He has RTd the blog and sought to engage his wider followers on how he's taking this agenda forward, at a national level. There are more – enough to run a few police forces – and I'd hope this reflects importance they attach to developing this area of our business, because senior support is vital.

Students – from all of the above professions, as well as some living with mental illness. Our future in more ways than one.

Organisations – MIND, Revolving Doors, Centre for Mental Health, Rethink, Royal College of Psychiatrists, INQUEST: all have followed and RTd tweets and the blog which is taking the debate wider and this is most welcome.

What is clear from sitting in the middle of this, tweeting and the blogging is that we're not at all a million miles apart. Yes, I've had a few people offering a view that they don't always agree with me – s135(1) warrants and the issue of prosecuting inpatient offences prompted some response. This is fine. I'm not actually trying to offer too many personal views, but merely to represent guidance, where it does it exists; and to highlight the problems we know we have had as a society.

I'd encourage you all who read this and who follow on twitter to come out of any organisational trench in which you sit and talk to each other. It's fair to say, that in undertaking partnership working in this area of business, you will find yourself disagreeing with others. As long as you start with the humility that you don't understand the other person's job and you won't always be right, you'll probably learn more from each other by talking / debating than you ever will from reading this.

19th December 2011

Alcohol and s136 Mental Health Act –

There are a few ways in which s136 MHA is *either* misused or *perceived* to have been misused. I'd like to briefly discuss s136 and alcohol so police officers that may consider this when putting together local policies or making operational decisions:

I've heard it argued that s136 should **never** be used when someone is 'drunk' or even when there is *any* alcohol involved. Firstly, nothing in law supports this: it would be legal to do so if the arresting officer genuinely believes that the criteria for s136 are met, notwithstanding alcohol. It raises the question of how reasonable it is for an arresting officer to suspect that someone is suffering from mental disorder when the presentation is clouded by alcohol. That's fair enough – we're not psychiatrists. Therefore training is key.

Well, if there is reliable third-party information about mental illness, in addition to an officer's first impressions, this would validate thinking about s136. I have in my mind a scenario in which the police are called to a known service user, or one in which police intelligence checks are undertaken at the scene of an incident and they highlight 'markers' or previous arrests / detentions which imply a history of mental disorder. It is important to remember that the police do come across MH patients who abuse substances – in fact, that's one of the reasons that it is the police who come across them. I've been told a few times by dual diagnosis specialists how important it is that their patients are not discriminated against or excluded from services purely because of their presentation.

Of course, this raises the issue of how and where someone is managed until such time as an AMHP can conduct a meaningful mental health assessment with a DR, but that's a seperate discussion for later.

Finally on this point, it would be important for local monitoring of s136 to understand the assessment outcomes where s136 is used, including specifically where the detainee was intoxicated. One police force I worked with – not mine I'm glad to say! – used s136 fairly 'casually' where alcohol was concerned and the NHS there stated that over 85% of those arrested went home with a hangover, in need of a bacon sandwich and had no mental disorder at all. This was putting significant unnecessary pressure on the MH s136 service.

On the other hand I can think of at least one incident whereby if an intoxicated mental health patient – he could barely stand – had been detained s136 **he may not have died in a police cell**.

TRUE STORY FROM A PSYCH NURSE – once upon a time a man was detained s136 whilst intoxicated after hanging off a motorway bridge threatening to jump. He was assessed after 18hrs of sobering up (in the cells!) and admitted to hosptial s2 MHA. Two days later he started asking questions such as "Where am I?" and had suddenly appeared less disoriented. It turns out he'd been taking certain anti-nicotine medication and had sunk two bottles of red wine during a family meal *against the advice* surrounding use of this anti-nicotine drug. **Result:** temporary condition of appearing mentally disordered even to healthcare professionals so it necessitated detention in hospital under the MHA.

My advice to police officers around s136 and alcohol is this: You should question your own ability to tell whether someone's presentation whilst intoxicated is alcohol or mental illness because sometimes trained psychiatrists can not be certain. If there is nothing pointing to mental illness other than you own observation of behaviour, you should be careful – *you must believe that the person is suffering from mental disorder for the arrest to lawful*; but if you have good objective information that someone has a history of mental health problems or you have no other choice at all and / or do believe that all of the criteria are met, to use s136 is lawful despite what may be said later by someone who did not have to take the decision.

19th December 2011

Section 136 and Private Premises –

It is sometimes remarked upon with a smile or a smirk, the number of s136 arrests which occur in close proximity to someone's home address. The inference always is that the officers have been called to a private premises where no offence is being committed and found someone who they would detain s136 if only they were in a public place. Therefore arresting officers use their powers of human persuasion to encourage someone to 'step outside for fresh air' or to have a cigarette. I'm guessing there are few smirks at the practical reality of this: we know it happens and the CQC have commented upon it in their annual report on the use of the MHA.

Firstly, we should remember that **this is an illegal arrest** – in no way can you argue that you have 'found' someone 'in a place to which the public have access' if you have encouraged or enticed someone over their domestic threshold. However, we need to understand *why* this occurs as some cops would argue that it is the lesser of two evils. If not doing this leaves someone in a situation where they may take their own life and the police cannot secure timely NHS support, what would *you* do? You are being required to manage the conflict between their Article 5 ECHR rights and their Article 2 rights.

One of my regular tweets is to observe that the UK is almost alone in not allowing their police service to exercise some kind of emergency holding power in a private dwelling. Police officers have no relevant powers under the Mental Health Act for this kind of situation unless accompanying an AMHP in possession of a warrant under s135(1). Parliament decided in the 1950s and it remains law today, that the solution to non-life threatening mental disorder, non-imminent crisis in private is an AMHP and a DR making urgent assessment and application for admission under s4 MHA. If necessary they can secure a warrant and attend with the police. Again, I'm guessing there are few smirks at the practical reality of this – because I've never, ever known it happen. (I may have asked for it a few times and documented the response to assist with later justification of action I did end up taking.)

This leave officers in a difficult moral position – you are in a building with someone who may or may not have 'capacity' who may or may not be at risk from themselves, albeit not imminent risk where Breach of the Peace

powers would become available. How do you ensure they remain safe and get necessary assessment or referral or detention?

In a strictly personal capacity, I've written to both this Government and the previous government highlighting this position and suggesting one of two solutions – I offer no view as to which I prefer but would say my local MP was excellent – my first time of writing to them about anything at all, incidentally! The last government did attempt to rectify this position, in the Mental Health Bill 2004, but it was lost amidst re-drafts of what then became the Mental Health Act 2007. The current government "has no plans to do so."

1. Alter s136 so it allows detention in a private dwelling and removal to a Place of Safety for up to 6hrs; perhaps a power of entry on an inspector's authority?
2. Introduce clearer legal obligations for the NHS and Local Social Services Authorities to deploy relevant professionals to the situation within a short-time frame; I'd suggest within 2hrs.

Each has pros and cons – so I'd be interested in your views. What I do know, is that with the law as it stands, there are gaps and sometimes policing can be about doing 'the least worst thing' out of two unpalatable options in order to keep people safe.

20th December 2011

The Stigma in the Sand –

If we all gathered in a good pub – and I think we should – to discuss those mental health related tasks which belong to the police (at least initially) and those that do not, we would probably agree at the edges. Management of individuals who pose a risk to the public because they are extremely violent, perhaps in possession of weapons 'belong' to the police – mentally ill or not. Those with mental health problems who are **not** Resistent, Aggressive, Violent or posing a risk of Escape (RAVE) are the responsibility of the NHS.

Even where they are presenting 'RAVE risks', if detained by law in a psychiatric unit patients remain the responsibility of those staff who are more appropriately trained to cater for their particular needs with appropriate safety techniques and greater awareness of the medical implications of any particular intervention. So, responsibilities are contingent upon the situations in which they occur.

As we draw the extremes closer together, the black and white clarity of certain situations gently gives way to complex shades of grey where the answer may well depend on your personal politics, as much as any sense of a delineation between the agencies. I have heard psychiatrists argue that where patients on wards are violent towards staff, it is the responsibility of the police to keep staff safe, as we would A&E staff. Fair enough – I have said before that the police need to better at investigating violent crimes against NHS staff.

But what if that violence is clinically attributable and the required intervention needs to progress naturally to compulsory medication under ss58 or 62 MHA? I've read formally commissioned legal advice from a barrister which says it is highly doubtful whether the police have legal powers to restrain where that restraint is done with the intention of then medicating without consent.

Clearly lawyers and psychiatrists need to talk, but in the meanwhile we have decisions to make in the real world: when attempting to establish which responsibilities sit with the police, how does one begin to decide? Does the police view or the NHS view hold primacy if they are not the same thing? We accept the principle that although the police are a large body of people and resource many of our civic emergencies in lieu of

others – they are available 24/7 and at short notice – they are nevertheless constituted primarily for a certain set of responsibilities. We do not expect the police to visit patients to check if they have taken medication for their mental illness, for example. This is true even though we know that some patients may become a risk – most likely to themselves – if they don't.

I'd welcome your views, but I keep coming back again and again to the statutory responsibilities that I and every other police officer signed up to when we were sworn in by a Justice of the Peace:

- Prevent crime and bring offenders to justice;
- Protect life and property
- Maintain the Queen's Peace.
- Protect fundamental human rights

If necessary tasks sit outside these criteria, one could argue the police are not going to be best placed to discharge the functions. But it is not primarily because of discussions about resources that I make this point and believe it important: it is because of arguments around STIGMA. (And I'm familiar with the suggestion that it is easy to cite stigma or vulnerability or criminalisation to deflect attention from the allegation that police officers just 'don't do mental health'. I think this is nonsense.)

Service users have commented that 'setting the police' upon them, is a stigmatising and criminalising act, not always welcomed. I've heard mental health professionals who have delivered local awareness training for police officers highlight how some service-users suffer from paranoid delusions about the police – only to then find that professional WANTS the police to return someone to hospital when it is not immediately clear why the NHS can not do that themselves. How is this helping with paranoia?

I've expressed my reservations elsewhere about this criminalisation argument but one can understand why a patient may wonder why it were necessary to send uniformed officers to their home address to recover them whilst AWOL if they were not violent or even when they were not refusing to return at all? Was it really necessary, along with stab-resistant vests, batons and possibly taser stun-guns to have the implicit semiology of wrong-doing and overwhelming air of coercion?

It we are to achieve dignity for service users, then the use of the police in my view, needs to be restricted to those situations in which the skills, training and equipment of the police is necessary to mitigate the risks faced. Anything else is stigmatising. I appreciate the arguments that the police are a flexible body of individuals and easily deployable to such tasks – but where the risks do not necessitate uniformed, equipped, possibly armed police officers – taser or firearms – then we should as a society be able to convene a dignified, alternative solution.

21st December 2011

RED FLAGS to A&E –

Once upon a time, there was a s136 policy which contained the throw-away sentence, "If the person detained has physical healthcare requirements, they should be taken to Accident & Emergency first." I've also seen similar sentiment expressed "Where there are injuries or medical problems."

What does this mean? How injured is injured; what are 'physical healthcare requirements' and 'medical problems' and who is judging it?

This is not splitting hairs: the police service have been accused of neglect and human rights violations for ignoring presentations which may or may not have fit into the above broad statements and where it was later argued that the individual should have been regarded from the start as a medical emergency. **We need to give police officers a clue.**

Of course, the history of s136 with A&E has not been great. Many to this day will argue, "We're not a place of safety." **I'll deal with this one very quickly**: a place of safety defined by s135(6) as "a hospital, a police station or any other suitable place the occupier of which is willing temporarily to receive the patient". There are two clues in there for me, about A&Es who *agree* that someone should be in their care. For the period prior to being transferred to the 'preferred' location they are acting as a place of safety for the purposes of the Mental Health Act, even if just for an hour or so.

Some area's A&Es won't even discuss this – I once went to a major department at the earliest stages of work on this to ask for their help in understanding what should come to them and what should not. **I was asked to leave the building** before being allowed to explain properly why I was there. I could not get my breath, if I'm honest. Surely if you work with your local police force to help them understand the medical issues, it will reduce the number of inappropriate removals to A&E that you have to suffer? They weren't prepared to listen.

Another A&E was far more helpful – so we invited them to list for the police what should be taken to A&E. I thought you'd like to see what they said? They became termed as **RED FLAGS** and were made subject of formal training:

Dangerous Mechanisms

- Blows to the body
- Falls > 4 Feet
- Injury from edged weapon or projectile
- Throttling / strangulation
- Hit by vehicle
- Occupant of vehicle in a collision
- Ejected from a moving vehicle
- Evidence of drug ingestion or overdose (inc alcohol)

Serious Physical Injuries

- Noisy Breathing
- Not rousable to verbal command
- Head Injuries
- Loss of consciousness at any time
- Facial swelling
- Bleeding from nose or ears
- Deep cuts
- Suspected broken bones

Attempting Self-Harm (persistent except when under restraint)

- Head banging
- Use of edged weapon (to self-harm)
- Ligatures
- Especially where above accompanied by a history of overdose or poisoning

Psychiatric Crisis

- Delusions / Hallucinations / Mania

<u>Possible Excited Delirium</u> – two or more from

- Serious physical resistance / abnormal strength
- High body temperature
- Removal of clothing
- Profuse sweating or hot skin
- Behavioural confusion / coherence
- Bizarre behaviour

To assist in assessing the above, many police forces are now calling ambulances to the scene of the arrest, in order to ask, "Is there a RED

FLAG that necessitates removal to A&E?" Rule out any possible medical emergency or physical healthcare requirement BEFORE deciding to remove a person to a psychiatric unit and especially before removal to a police cell.

This approach has been circulated nationally and I was pleased to get a chance to go back to the A&E that threw me out 3yrs previously and discuss this with them. They breathed a deep sigh of relief and signed up to it within 15minutes as a having the very real potential to *minimise the impact* of s136 upon their department, particularly inappropriate impact.

It's good to talk.

21st December 2011

Your Place or Mine? –

At the very heart of some of the most difficult s136 cases lies the following problem: some individuals detained under this legal authority **cannot be managed by the police alone** in a cell – the **medical risks there are just too great**.

But equally, it is true that they **cannot be managed by the NHS alone**, whether that be in a psychiatric place of safety or within Accident & Emergency, if that were necessary. The **safety risks to NHS staff are just too great**.

A (now retired) senior officer once said something which I've repeated many, many times since: "I don't want to have a discussion about whether we'll be having a nightmare in custody managing acute medical risks; or you are having a nightmare in hospital with resistent patients. I want to talk about how we *support each other*, in the most demanding of cases. Both of us, in the same place, at the same time, having a nightmare together – it's simply a discussion about whether it's your place, or mine?"

Well, it is much easier to put cops in NHS buildings to protect and secure an environment than it is to put NHS staff with equipment into a custody office. Let's face it: the latter is impossible in a reasonable timeframe, if possible at all. As the NHS A&E consultant who put together the RED FLAGS pointed out, with some agitated behaviours the necessary kit to properly medically manage that small number of individuals who may be at serious risk, could not be taken to police custody anyway.

The debate about whether the police should stay in a place of safety is a particularly difficult one: I've seen it written down in joint operating protocols that only the police can keep someone detained under the Mental Health Act in a Place of Safety anyway. I've also heard it argued by mental health professionals and barristers that this is nonsense – certainly the Royal College of Psychiatrists guidelines say the police should leave patients within the care of the s136 suite (even if they are disturbed, which is not realistic in most areas.) It remains true, though that the police service have an obligation to prevent crime and this remains true within psychiatric units.

(**NB**: **A&E is different** – is was simply **never** designed to act as a PoS and is there for s136 detentions only where the management of acute medical risks and / or injury is necessary. In my view, the police should remain with patients who need A&E until such time as the patient is either transferred to a proper s136 suite or the cells; or until they are discharged from s136 entirely – whichever happens first.)

So again – as with a lot of this stuff – it comes down to teamwork across the agencies. But a starter for ten in partnership discussions around s136 MHA is that someone people are too complex in terms of their needs and their presentation to be either a police or an NHS responsibility. We have to *learn to work together* **putting the patient's needs first** and sometimes, we need to do it quickly.

22nd December 2011

The Munjaz Case –

One of the most worthwhile things I ever did was sit down in 2003 for a couple of hours on a night shift and read the Code of Practice to the Mental Health Act (Wales)- cover to cover. Twice. And then I read individual chapters of more relevance to the police – again and again and again:

I think **all** police officers, but especially sergeants and inspectors, should read chapters 10 (Place of Safety), 11 (Conveyance), 21 (Leave of Absence) and 22 (AWOL). If you're really feeling interested, you could also try chapter 4 (applications for admission) and chapter 33 (patients concerned in criminal proceedings).

But what was the point; what is the significant of a Code of Practice?

The reason I think this is both an interesting and important question is because culturally at least, it has appeared to me that the police and the NHS have different answers to it. As a legal document, surely the standing or status of Codes of Practice must be roughly the same across organisations?

Of course it would be utterly naive to suggest that the police never inadvertently or wilfully and without justification breach Codes of Practice to the various Acts of Parliament; or to suggest that all officers know all parts of the Codes which apply to them – most notably the Police and Criminal Evidence Act 1984. This Act alone has eight separate Codes, pertaining to stop/search, treatment in custody, ID procedures, etc., etc.. There are other Codes for RIPA (surveillance), the CPIA (criminal investigation and disclosure of materials for trial) and others.

It is drilled in to you early on: you only breach the requirements of these documents if you have a very, very good reason. You may or you may not have to learn this lesson the hard way because the culture of the service ensures that (formal) advice is given, or disciplinary action taken against officers who breach the codes without justification., the latter more likely if it were deliberate. Such 'professional development' has included senior officers at 'inspecting' or 'superintending' ranks, from time to time.

So it is against that backdrop that I have often been nothing short of stunned to find a more 'relaxed approach' by just some NHS professionals. **I repeat: the police are far from perfect.**

So here's my point – when local MHA protocols and procedures represent or *require* breaches of a Code of Practice, I and several other police officers start to get deeply confused as to what to do. Should we ignore a statutory document, issued by a Secretary of State under the authority of an Act of Parliament; OR should we disregard a local protocol document, which contravenes this statutory guidance? If we must breach something, how do we choose?

And so it was with some considerable interest that I came across the case of R (Munjaz) v Ashworth Hospital Authority which was heard by the House of Lords in 2005. In fact, it was a healthcare professional who brought this case to my attention as tool with which to push back against wilful, inexplicable breaches.

I'm not a lawyer and am not attempting to provide any level of legal analysis, but it is worth summarising the case: Mr Munjaz was detained in Ashworth High Security hospital in 2002, following his arrest and prosecution for serious offences. During detention he became violent and disturbed and the Responsible Clinician decided he should be 'secluded' for his own and others' safety. The Code of Practice contains a chapter (15) about how decisions around seclusion should be taken, managed and reviewed, including timeframes and oversight. Ashworth Hospital operated a policy which was very different in nature to that chapter of the Code and legal challenges commenced.

The initial question for the High Court was whether the policy of seclusion was unlawful, either because it contravened the European Convention on Human Rights OR because it contravened domestic law. Mr Munjaz lost his case in both regards – it contravened neither the ECHR nor UK law. However, this decision was overturned by the Court of Appeal. By the time it reached our highest court, there was an additional legal question at stake, following arguments in the lower courts: **"What is the status of a Code of Practice?"**

During the various hearings and appeals, different arguments had been put forward: was the Code of Practice – a legal document – "binding instruction" to be followed always; or was it simply "advice" which could be taken or not, as preferred by the individual hospital or doctor? The House of Lords ruled, by majority, that the document was neither of these things. Lord Justice Bingham summed it up:

"It is in my view plain that the Code does not have the binding effect which a statutory provision or a statutory instrument would have. It is what it purports to be, guidance and not instruction. But the matters relied on by Mr Munjaz show that the guidance should be given great weight. It is not instruction, but it is much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so."

(Incidentally – the House of Lords ruled that Ashworth's policy was **not unlawful** because it was a very specialist medical facility dealing with particular kinds of psychiatric patients. The breaches of the Code represented a thoroughly considered policy, appropriate for the kind of patients to whom it related and who were detained there. Much evidence was produced by the Trust to support their claim.)

So here's a frequent problem by way of example: in many areas s136 Place of Safety policy it will more or less say "A&E is not a place of safety except for injury / medical emergency; use the psychiatric facility but if it is unavailable or unsuitable, use the police station." However, para 10.22 to the CoP MHA states that the police station should not be considered the automatic second choice, if the first choice (psych unit) is unavailable: "alternatives should be considered". So when a custody sergeant asks, "What alternatives did you consider before coming here?" they are going to feel entitled to receive answers to those questions BEFORE they authorise the detention of that person in a cell block.

26th December 2011

Blog Index

I've added a page to the BLOG to index the posts for easier browsing of previous stuff. Click here to see it, but it's also on the main toolbar, above.

Thanks for the interest and support since starting in November, hope to post you some interesting stuff or to start more debates in the New Year.

Merry Christmas and Happy New Year to you all.

Michael./

26th December 2011

Diversion from Justice: part 1 –

I've mentioned that when I joined the police, there was a poster on the custody wall which contained a telephone number for the 'diversion' team. You rang it after you realised that your suspect had mental health problems and a psychiatric nurse would come and screen the person. They would then arrange full Mental Health Act assessment, if required.

I noticed over my first few years that whenever MHA assessment indicated that the person in custody was 'sectionable' under the Act, they were diverted and the criminal offence was NFAd – No Further Action. At first, this seemed fair enough – a person has offended but is very unwell and arguably, proving the offence would be difficult because of the 'mental' element to the offence.

I first thought about this very seriously when, as a custody sergeant, I had a similar situation but the professionals who conducted the MHA assessment said, "He's sectionable, quite psychotic but we think you should prosecute him." This went against the inherited thinking I was subject to at the time and highly counter-intuitive. Could you even do that? The psych nurse went on to explain:

"He's got a big forensic history and is highly risky. The offence you've got him for [armed robbery – threats with a knife; mobile phone and wallet stolen] is not trivial either. You're telling us he's got several convictions for violence and weapons. If you prosecute him and tell the Magistrates he's sectionable, they can remand him under Part III of the Mental Health Act, he'll get a fuller, proper assessment and it will work out better in the end."

"How?!"

"Well, the remand under Part III will ensure he still gets the treatment required, but in light of the risk he poses, there will still be a criminal processes informed by a full psychiatric report. It will properly determine whether he can be held responsible based upon the fullest information available. Even if he cannot be held responsible criminally, the court can then impose a hospital order for the protection of the public if they are satisfied he did the act."

"Sorry – can you say that ALL again? Only more slowly, please? And then explain what it actually means, especially that 'part III' bit? And I'll put the kettle on."

I admit I didn't believe a word of it. It sounded complicated. Would the CPS go for it?! Would it not lead to him going to the same hospital, anyway?! I took the decision to ring a psychiatrist I knew, apologising for the intrusion. "I've got this psych nurse in my custody office and I think he's making it up as he goes along. What do you think?" She was adamant he was absolutely spot on and said, "Do what he says, it's well thought through and constitutionally correct." And so we did: the man ended up getting a s37/41 hospital order after being found unfit to stand trial.

This sounds like a wasted prosecution, doesn't it? A big waste of criminal justice time? If the MHA assessment concluded he needed 'sectioning', then all that police, CPS and court time and trouble has just led to him being in the same place, receiving the same treatment by the same professionals. Right?!

Not quite – although initially, he's in the same place getting more or less the same care by more or less the same professionals, his detention under those particular legal provisions means there is much better management of future risk, less ability to demand to be heard in front of a Mental Health Review Tribunal (for potential release). Even where a tribunal does occur, it operates to different rules because there is a slightly different focus to take greater consideration of public risk. Even when release is achieved, it will be 'conditional' release and subject to oversight by MAPPA – Multi Agency Public Protection Arrangements. If community care even begins to look problematic or unsuccessful, the Ministry of Justice can recall him back to the status of a s37/41 patient.

This shows why greater understanding of criminal sentencing for 'offender-patients' is necessary for custody sergeants and investigators: rarely, but sometimes, the more difficult and long-term view is required and it's not just about diverting people from justice.

26th December 2011

Diversion from Justice: part 2 –

Some years ago as my interest in this subject area was developing, my force had supported me to undertake an MSc in Criminology and Criminal Justice at Cardiff University – I state this because they sanctioned my research project which is now publicly available in the university library and therefore, able to be summarised here.

I examined the issue of what the officers, in fact, did in police custody regarding criminal suspects who are mentally ill. The findings from my research have influenced my thinking on this subject. I want to share that with you.

(**NB**: *the below figures relate to criminal suspects for substantive offences – therefore, it does NOT include, s136 Mental Health Act; breach of the peace; court warrants; etc..*)

- **10,000 custody records were examined** from two different busy custody suites.
- 1,076 raised the 'mental health' question and were assessed by the FME
- **512 were assessed** by another medical professional *after* the FME – either CPN or AMHP led MHA assessment.
- (The remaining 564 of the 1,076 were deemed fit for investigation.)
- 415 of those 512 were *not* in need of hospital admission on that day.
- (The 415 were 'managed' in custody almost as if no mental health problems existed at all. Appropriate adults were obtained where needed, but the overall CJ outcome was consistent with 'normal' CJ outcomes for other offenders.)
- **97 were in need of hospital admission** following their assessment.
- 9 of the 97 were in need of admission under s3 MHA.
- 12 of the 97 were in need of admission on a voluntary basis.
- 76 of the 97 were in need of admission under s2 MHA.
- 97 criminal offences were not prosecuted.
- 97 suspects for criminal offences were not bailed pending the outcome of their assessment or treatment.

This fits with what we already know with other research in terms of proportions in police custody identified as having a mental health

problem. However, research about what then happened to those suspects, and why, is thinner on the ground. This raises big questions for me:

1. Why are we not 'bailing' people from custody if they are 'sectioned'; in order to allow the investigating officers to request information from clinicians that would assist in determining whether a prosecution may still be required? – perhaps this may only be necessary with non-trivial offences but some people who are 'sectioned' may or may not subsequently be found to be mentally disordered. How will we know of this unless investigators follow it up whilst the person remains on police bail. Some of 'the 97' were released with 3-7 days and found not mentally ill.
2. Are there not some offences within 'the 97' that may still suggest the need for a prosecution in the public interest, because of seriousness or because of the risk background of the suspect? For example, if a case in front of a custody sergeant was similar to those used as examples in previous blogs – one on a firearm's incident and another concerning an armed robbery.
3. It raises questions about the importance of the custody sergeant, in ensuring that investigations are not brought to too premature an end before investigating officers have followed up the outcome of decisions to 'divert' on the day of the arrest. Certainly, until the outcome of a mental health assessment is known, how can the 'public interest test' within the Code for Crown Prosecutors be weighed?

It also raises the question about whether 'diversion' is even the word we should use – it immediately implies a (false) dichotomy that those with mental health problems who offend are *either* a matter for the mental health system *OR* for the criminal justice system; almost as if the most important thing is the earliest possible decision about which will be the paradigm of choice. As Jill PEAY from the London School of Economics pointed out: we need "a model of plurality".

27th December 2011

Setting You Up To Fail –

Imagine this: you are the parent of a 19yr old who has asked to borrow the car because they are going out to meet friends on a Friday night. You agree to this but point out you will be in bed before they are home because you have an early start at work. At some point in the middle of the night you hear a car pull up outside, a door slams shut and you hear the door of the house open. There is a bit of noise as you hear someone come up the stairs and then everything goes quiet. You drop back off to sleep. When you get up at 6am, your car is not on the driveway. You try to rouse your 19yr old, you can tell they smell strongly of alcohol and cannot immediately account for the car's whereabouts.

There are (at least) four situations that fit these facts:

1. Your son / daughter decided to have a few drinks. Forgetting you needed the car for work on a Saturday, they decided to get drunk with their mates and left your car in the pub car park and got a lift home. Because they are fairly well-oiled, securing this information is proving difficult – **no criminal offence** involved, at all.
2. After arriving home with your car, they helped themselves to your vin rouge once home and went to bed. The car was stolen off your driveway overnight – **a vehicle theft**.
3. After having a drink whilst out, they brought the car home and drank precociously from your single malt collection. During the night, someone broke into your house via an insecure window, stole the car keys and took the car – **a burglary**.
4. Your son / daughter drove the car home after drinking themselves over the limit and drank more when they got home after being threatened with violence for the car keys on the driveway. They didn't tell you immediately because they knew you'd be outraged that they drove whilst over the limit and were going to think up a story in the morning – **a robbery**.

Now – imagine this: you ring the police, on the local non-emergency number. You say you need to report that you think your car has been taken. The operator asks how? You say your are not sure: your son / daughter took it out last night; you went to bed, they came home late and when you got up the car is missing. Your son / daughter can't tell you how at the moment.

The operator won't take your report – not only do they want confirmation that a criminal offence has actually occurred, they ask you to establish whether it was a burglary, a theft or a robbery and ring back. You point out that you don't know the difference and they decline to be any more helpful. Moreover, they ask you when you ring back, to contact the burglary squad, the vehicle team or the robbery squad, directly. What they don't tell you, is that the burglary, robbery and vehicle detectives do not take direct calls from the public.

This can be what happens to the police when they are handling what they think might be a person suffering from mental health problems.

I have been in several conversations with NHS clinicians and managers, where it was hoped that Place of Safety provision in an area could be separately set up for Adult MH, learning disabilities and CAMHS. Apparently, it is the role of the police to know which category a person fits into and to remove the person to the appropriate facility, having decided first whether or not the person might need to go to A&E for any 'urgent physical healthcare requirements'. Whatever that means.

How on earth would a crime victim be expected to know the actual, legal difference between burglary or robbery; or a police officer between a mental health problem and a learning disability? What if the person detained s136 has a learning disability AND a mental health problem (co-morbidity)? – sometimes it can take fully qualified senior psychiatrists 28days under s2 MHA to work out the answer to that one. After all, your robbery can also be a burglary in certain circumstances – who do we report that to?!

Obviously, the answer is not to request people to operate too far outside their area of competence. Victims have got the right to ring the police, even if they just *think* they are victims and it is the role of the police to gate-keep that and either deal with it, or refer it to the appropriate specialist team. It may transpire that they are not victims at all, but it may take the police to work that out.

The police have got every right to request an ambulance's support to help navigate the medical maze – not least because it is a requirement from the MHA Code of Practice (Wales) – but also, where there is some *genuine doubt* about the wisdom of proceeding to a cell block or place of safety because of 'physical healthcare concerns', it is not illegal to seek medical opinion via an Accident & Emergency department as the 24/7 gateway to the NHS. In fact the opposite is true.

28th December 2011

Fiddling at the Edges –

When 'diversion' is being debated, why is it that the examples used tend to be on the extremes? Murder and low value shoplifting; or rape and minor public order offences?

I think we're probably all agreed: if you are alleged to have murdered or raped someone then you should be prosecuted so that the courts can assess all of the relevant information in a criminal trial, including if necessary, issues around a defendant's 'fitness' to plead with the benefit of full psychiatric reports?

Equally, we're probably all agreed that if you've stolen a few pounds worth of goods when acutely mentally ill; or you've become distressed whilst floridly unwell and you are found swearing at members of the public who are subsequently anxious about your conduct – you should certainly be diverted from justice for necessary treatment and care. The criminal offence being very minor, is quite properly able to be set aside in the circumstances.

But life is not always that straight forward, is it? It's the slightly-more-serious, but not-the-end-of-the-world stuff that is more challenging. Here's a scenario that I think could go either way:

- A known community patient has robbed a postman of his letters. The robbery involved threats of violence and it was implied that the offender had a weapon. However, no weapon was seen or used, no injury sustained and the letters were recovered by the police after a prompt response and an arrest based upon description and the possession of everyone's mail. <<< *A true story, incidentally.*

So, upon assessment this patient was found to be sectionable. So do we divert from justice? (What now follows *is* hypothetical, to make the point.)

What if this was a first arrest? Although a known patient, he as never been in trouble before with the police and this episode of illness is particularly acute, perhaps as severe as it has been for him. He has no previous history of violence within mental health services, a solid history of engagement with services and staff are particularly concerned for his welfare, because this is so out of character after many years of

contact. Although it is an indictable-only offence (triable only in the Crown Court) and although it carries the potential for life-imprisonment: I'd be tempted to argue that he should be diverted on bail, and if all is well during and after treatment, no further action. After all, no-one was actually hurt and the public interest appears met if he engages with mental health services after diversion from justice.

However, what if this was his ninth arrest? What if they included two detentions under s136 which led to admission, 3 other MHA admissions to hospital in the last few years which occurred without reference to the police; a history of repeatedly going AWOL from mental health units in which he has been detained, a history of violence against NHS staff within those units? What if his previous criminal convictions included robbery, theft and violence, including possession of weapons; what if there were previous diversions from justice for offences almost like this one and following detention in hospital, he absconded from the unit and failed to engage? Would it still be 'right' to divert from prosecution?

(I fully accept that to prosecute the offence needs to be able to be *proved*, so wish to preempt a response which suggests the focus needs to be on this, rather than on the desirability of either course of action. However, this is a subject in its own right and will be a blog at a later date.)

Again, all of this just highlights why the false dichotomy of 'mad' or 'bad', of mental health OR criminal justice, is so flawed. It also highlights that if you re-read the two paragraphs above regarding potential, hypothetical backgrounds, they each represent a combination of information from both the police and from health or social care sources.

This is why information sharing remains key to everything. If you re-read the paragraph about the hypothetical '9th arrest' – take out of there the police information about convictions, AWOL incidents etc.. How would you feel as the psychiatric nurse receiving a patient after diversion with that police background and only learning about it later? Equally, what if you were the investigating or custody officer attempting to decide whether or not diversion should occur and you didn't know the health information about violence against staff on wards, or refusals to engage with MH services. Imagine diverting from justice and then finding a ward nurse was seriously assaulted or that the man absented himself and offended again, perhaps more seriously. **Information sharing is key.**

Answers on a post-card with a better word than 'diversion'. I've heard 'liaison' or 'engagement', but I'm not utterly convinced by either of them. Still thinking!

28th December 2011

How Do You Hold Mentally Ill Offenders Accountable? –

The issue of how to manage offenders with mental disorders is an international issue – this blog is prompted by an article from NPR News in Washington DC, "How do you hold mentally ill offenders accountable?", but I'm mindful of cases such as that of Garry David in Australia as well as an debates in the UK around offenders like Ian Brady and Peter Sutcliffe. (It is worth listening to the NPR radio piece which is on their webpage).

The interface between competing paradigms such as law and psychiatry – if it even exists except by default and if it works at all – is seen through the prism of these cases. The NPR article highlights the California 'Mentally Disordered Offender' law. This provision ensures that anyone in prison who is suffering from a serious mental disorder who assaults staff, will serve any 'parole' in psychiatric hospital. The debate within California appears to be whether the MDO law should be extended to *just some* psychiatric patients who assault mental health staff within state hospitals – ensuring that any assault committed by someone who is not 'so mentally compromised' [as to be incapable of prosecution] should be treated as a felony and lead to longer detention in hospital. (Felony is the equivalent to an indictable offence in the UK, something more serious which is triable in the Crown Court.)

We have seen that this debate rages on here in the UK: in 2010/11 around 68% of offences of violence against NHS staff were committed against mental health professionals. Those of us who have spent our professional lives pulling drunks and other idiots out of A&E for acts of opprobrium and buffoonery against NHS staff are usually surprised to learn that in terms of the number of assaults suffered, A&E comes a poor second to mental health units. I would even go further and say that in my experience, the offences against NHS staff in mental health units are often more serious, as well as being more numerous.

The question posed in the NPR piece seems to assume that we *should* hold mentally ill offenders accountable for assaultative behaviour, whilst stating that this should be without punishing them for being ill. So how do you do that?! Almost sounds like a perfectly unsquareable circle.

Firstly, it's fair enough of me to observe that not all psychiatrists and lawyers think that this is true. I have personally discussed these issues with a psychiatrists, one of whom stunned me by stating, "We should never formally prosecute patients for assaulting staff." One might assume his wife is not a mental health nurse, but he did put the argument that patient's lives are already wracked with stigma and difficulty without the criminal justice system piling on the pressure. Criminal convictions make it even harder to rehabilitate, recover and reintegrate into society after release from inpatient psychiatric care. After all, they make it harder to get a job and what is the one thing organisations such as NACRO point out is often the best thing you could do for a recovering psychiatric patient? **Secure meaningful, sustainable employment.**

I have heard lawyers (some CPS) dismiss the utility of prosecution by simply asking, "What's the point?" Again, probably not the father of a junior psychiatrist on the end of a good kicking which broke three ribs and a cheek bone. <<< *Real example.*

In the meanwhile, how do you hold mentally ill offenders accountable? Well, whether or not the criminal justice system has a formal role to play through prosecution into criminal courts; whether individual legal jurisdictions think 'MDO laws' are a way forward; whether legal reform is the answer – it seems that doing nothing about violence against staff is not an option and the 'doing something' option is available now.

Expecting any professionals to set aside what are confidence-shattering, unaddressed offences against them *personally* is something that police officers certainly don't accept – even less so when life-altering injury is involved. Why should mental health professionals and other psychiatric patients be less secure than others in society – why should "justice stop at the hospital gate?"

The role of police here can be key: even where offending is low-level or a 'one-off'. We already know that mental health professionals do not report offences to the police which they already believe are inappropriate for police or criminal justice involvement – one trust in my area reports just 16% of it's violence incidents to the police – so we know this is not about mass criminalisation by the NHS. When they do report offences, they want to see a reaction and I believe that they're entitled to get one. We know that it can have a very positive effect on ward safety, when properly done. This can and should involve all scales of reaction, from low level advice, encouragement, warnings, through to restorative justice, cautions and fixed penalty tickets as well as prosecution. I have blogged about this previously. For me, the important thing is that when healthcare professionals seek police or criminal justice involvement, **nothing fails to secure a reaction**.

The Australian and Californian examples show that ultimately, violent offenders with mental disorders who are incarcerated by law have to be somewhere and they are often the most demanding of prisoner-patients in our societies with the most challenging, complex needs. Whilst the debate about prison OR hospital is a very important one, it may not be as important as determining as a society how we really want the interface to work and then design it properly based upon evidence from good quality research.

Until then, we're improvising around the personal politics of those who hold influence.

29th December 2011

Whose Responsibility Is That? –

If one were to stay up late one night, perhaps with your favourite whisky, some Eric Clapton records and a flip chart, with the intention of designing some legislation calculated to cause the maximum amount of ambiguity, frustration and difficulty, you would do well to come up with anything better than **s136 Mental Health Act 1983**.

Here's why:

- Only the police can start it – what if A&E want it instigated and the police don't see the need?
- Only the NHS can end it – what if the police believe the need for s136 has ended or at least their involvement in it?
- When should a patient be removed to A&E?
- No-one has defined where police responsibilities end – when is it acceptable to leave patients in NHS care?
- No-one has defined where NHS responsibilities start – what if everywhere is refusing to accommodate a patient, but the police have very real concerns about the safety of using the cells as a place of safety;
- Many things that must be done are not specified to one or other of the organisations. *For example:* repatriating people who are not formally admitted after s136 – nothing says it is a police OR an NHS responsibility, so what if we don't agree?
- There are no legal or other guidelines about what *precisely* should happen where alcohol, drugs or aggression are involved – yes, agreements should be reached in local protocols, but what if agreement is not reached?
- The overall 72hr timeframe is the only legal timeframe specified, nothing else by law needs to happen within it. *

* Interestingly, the legal timeframe for the equivalent authority in Scotland is just 24hrs. In Northern Ireland it is 48hrs. (There was a suggestion in the draft Mental Health Bill 2004 that in England and Wales this should be reduced to 12hrs, but it was one point amidst many which saw the Bill thrown out.)

Add to this the potential for police discretion to be exercised in different ways about whether s136 should be invoked at all; discretion about

whether to select s136 when other powers of detention may be available – a drunkenness offence, a criminal offence, a breach of the peace – and one can see why NHS staff may be frustrated by police decisions and police may be frustrated by NHS reactions. Compound that with the exercise of NHS discretion – how intoxicated is too intoxicated; how aggressive is too aggressive. "The bloke we brought in yesterday was accepted and he'd had more to drink than this", etc..

Of course, the agencies also have their different aversions – the police want to minimise the potential for deaths in custody, 5% of which since 1998 have been s136 MHA and most have involved drugs, alcohol and / or aggression. The NHS wish to minimise the possibility that NHS staff may be assaulted and cannot undertake too meaningful an assessment until a level of sobriety has returned to intoxicated individuals. Quite rightly, they want to resist being used by their local police as a 'drunk tank'.

If the police detain a person who appears to be in their late teens, whilst moderately intoxicated and resistant who has injured themselves by self-harming and who it subsequently emerges has a learning disability, it will necessitate contact with the following agencies in this order:

- Police
- Ambulance
- Accident & Emergency
- s136 Place of Safety provider (if different)
- Local authority (for the AMHP or the duty AMHP scheme)
- Learning disabilities provider (if different)
- Either LD inpatient unit or LD community care provider.

That is potentially as many as **seven different organisations**, five of them within 'the NHS' and each with their own operating cultures and expectations around the role they should play within the s136 pathway. Try just getting 7 managers of an appropriate level in a room for a meeting.

Should any one of those providers not engage, either on the day, or more strategically in terms of agreeing the local s136 protocol then it will fall to the police either to convey, accommodate to ensure security and temporary care. If they are doing these things, how do the police know they've done everything they could in the event of the preferred pathway not working or not being available at all? Well, in the final analysis, the police have every legal right – actually a legal duty – to do all lawful and reasonable things to protect the human rights of their detainee and the integrity of their own decision-making. Here is a four-step approach which does **exactly** that.

End of Volume:
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