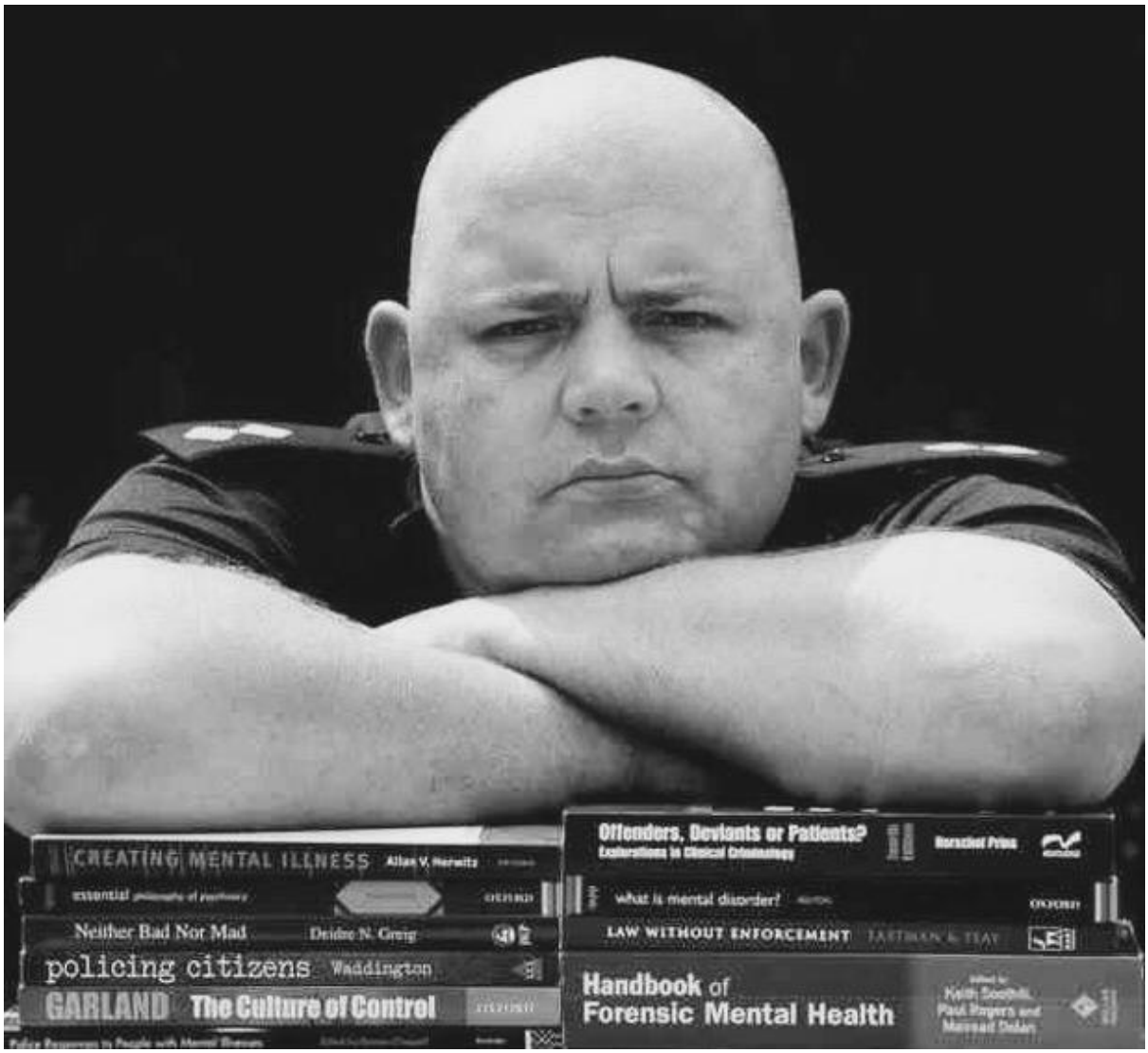
MENTAL HEALTH COP

A VENN DIAGRAM OF POLICING, MENTAL HEALTH AND CRIMINAL JUSTICE

Volume Two – 2012

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

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



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JANUARY 2012

01st January 2012

What Would You Do? –

Let's imagine this: you join your new job and get trained. It's all very exciting, you've wanted to do little else apart from this your whole life.

You start going to work and are asked to undertake one of your reasonably infrequent functions in a particular way. You see it done like this countless times and although not ideal, it always seems to end up OK. So you start doing likewise without a thought to the contrary.

You learn later – not because you are told, but because you learn of some unfolding events – that the way in which you have been asked to complete this function is a breach of statutory guidelines that were not really made known to you during your training. It turns out they were issued by a Secretary of State under the authority of an Act of Parliament and therefore carry a force of law. You read them and are fairly surprised how little bearing they have on reality.

You learn of this because you see some of your colleagues who have done what you would probably have done, broadly in the way you would have done it, getting into some quite serious trouble. This is not just, "the boss having a word" type trouble or even "formal warnings" trouble. The boss has been going along with it too and when they did your job, they did what you and your colleagues have been doing, in the same way you've been doing it. That was the way that they were asked to do it too. This has been the case for decades and your organisation is getting into trouble along with your colleagues.

The problem is, you have started to realise the 'trouble' in which your colleagues and your organisation have found themselves, is actually quite serious legal trouble. They have been on the receiving end of advice, direction and / or sanction from a statutory regulator because they broke the law. Sued in the civil courts – successfully; told that they have breached people's Human Rights. There have even been prosecutions in the criminal courts and high-profile Coroner's Inquests. Some colleagues actually did sit down with their families to start considering how they will live their lives after being sacked and imprisoned. A few of those discussions ended in personal tragedy: mental health & well-being affected, physical illness following weight gain, weight loss and problems in

terms of marriage-ending conversations and personal and professional problems.

Of more importance than a lot of this, are events that have befallen people to whom you, your colleagues have owed a professional duty of care who have been badly let down, despite the efforts and intentions of you all.

The mustered responses to these suggestions of wrong-doing in these different arenas all somehow sounded horribly inadequate, somewhat like a Nuremberg Defence. Of course it turns out – but you admit to knowing this all along – your first responsibility is to the law; not to preferences, directions and personal or even professional opinions which are at odds with the law.

So, you read up on this in detail. What you learn, is that the law wanted you to do it differently all along and if you keep doing what others have done, you could well end up in very serious legal trouble. The ability to do it properly relies upon others who don't see it your way and over whom you ultimately have no control; and who don't end up in such trouble as your colleagues when it goes awry. But you learn that various things others don't want you to do are not actually illegal and would considerably assist you in demonstrating that you did the right thing, as far as you possibly could so.

So what would you do tomorrow?

2nd January 2012

Awards –

Pleased to announce that after just one full month of operating(!) and nearly 7,000 hits, the blog has started to be recognised. Today, it won a runner's up award from This Week in Mentalists for Best New Blog. Chuffed!

Meanwhile, most of you might know I publicise the blog through Twitter – see links on the right hand column of the blog. I have been nominated for the 2011 'Most Informative Tweeter' award and I currently lead the category with just **five days of voting to go**.

If you might wish to vote either to support the blog, the issues it discusses, the police or mental health, please consider doing a new tweet containing the follow text – **NB**: *the underscore is crucial!*

@TheTweetAwards_ vote @mentalhealthcop Most Informative Tweeter

Don't worry if you don't use Twitter, you can still show support, voting via the website. **There is no need for a Twitter account**, you just need an email address.

Thanks to those who support the blog and for ongoing encouragement and feedback received.

4th January 2012

Is A&E a Place of Safety? –

ANYWHERE can be a Place of Safety under the Mental Health Act as long as the occupier is temporarily willing to receive the patient. This is stated in s135(6) of the Mental Health Act. Of course, the Act also declares that hospitals and police stations are places of safety (PoS); and the Code of Practice requires a joint protocol to exist which indicates which PoS should be used and in which circumstances. So if a hospital A&E department agrees to accept someone for assessment, treatment – in what sense are they still not a Place of Safety? It's wordsmithery.

I'm not going to recall the story of an officer who once removed someone to a GP's surgery to find the doctor happy to help and let his surgery be used. Or the child who was taken home and assessed there once officers were happy it was clean and safe.

Of course, ideally, A&E would be used for medical emergencies and treatment of physical injury only; a psychiatric or dedicated PoS would be used for more or less everything else; and a police station only as a last resort. But what if the middle option doesn't exist at all; or it doesn't work properly? What if the police know, that resort to the cells may well be medically risky and potentially illegal?

We should remember: regardless of domestic law and local protocols, whatever ends up happening MUST survive contact with articles 2, 3 and 5 of the ECHR. There have already been successful human rights based challenges around s136 and more are pending (MS v UK). Statutory regulators have given direction to police forces that their acquiesance to inadequate local NHS arrangements would constitute a human rights breach in certain circumstances. We also know, that attempting to get direct access to healthcare would make the difference when trying to decide whether or not officers were negligent.

Some people are potentially too ill to be in a police station, but not ill enough to be in A&E.

I can give multiple examples of incidents where officers have 'done as they were told' by their NHS areas who wrote protocols saying things like "The police station is the place of safety" or who documented such gems of clinical clarity as "people arrested under s136 who are violent or intoxicated

should go to the cells". Such cases have ended very badly indeed, worst of all for patients. We all know, alcohol can mask other problems and resistant behaviours can be symptomatic of all sorts of things.

BUT(!) before my colleagues in A&E point out – quite rightly – that A&E is (usually) not 'designated' as a PoS; that it is not equipped to act as a place of safety; that it is unsuitable as an environment and should only be used if patients have got additional medical problems or injuries that indicate A&E is appropriate. I have this to say:

- You could say all of that about police stations – few Chief Constables WANT their police custody blocks used as a PoS and there is probably more public material against the use of police stations than against the use of A&E.
- The word 'designated' only appears four times in the whole Code of Practice and never in chapter 10 which discusses PoS protocols – the word doesn't appear in s135(6) MHA at all.
- **Legally, there is no such thing as a designated or a non-designated PoS.**
- We know from published research, that approximately 15% of people who go to A&E have mental health problems.
- We know that 5% of people who go to A&E are there JUST because of mental health problems.
- We know that A&E have psychiatric liaison services, called by various names, but all who provide psychiatric assessment, including formal assessment for admission, if required.
- So let's not pretend that A&E do not do mental health.
- We also know, that in some NHS areas, the managers of A&E Services do not know who the managers of MH services are, even though their frontline operational staff have daily contact and have to improvise integrated care pathways into secondary MH services where necessary.

I also understand that if areas had a properly commissioned, staffed and overseen PoS service then such tensions as I've seen which appear to exist between A&E and the police may not exist at all. In the absence of such a facility, or in the absence of being able to access it, police officers have been forced into various dilemmas, especially those of us who read Chapter 10 of the Code of Practice (Wales) and the Royal College Standards and then wondered why our experience bore no resemblance to this Nirvana described within.

Problematically, when A&E say "we're not a place of safety" they are often undermined by their own decision-making. If one arrested an elderly, female dementia patient and removed them to A&E asking for help from the NHS whilst explaining that the cells are full of howling drunks, robbers and rapists and that you'd really rather not subject your octogenarian to

that environment, you'd probably get in. <<< *Real example.* So you are a PoS on some occasions? OK, now I'm really confused: on what basis are we picking and choosing? Do these decision survive contact with Equality Impact Assessments?! Strikes me they probably wouldn't!

This whole blog post is a TOTAL AND UTTER RED-HERRING because instead of A&E and the police getting at each other, not supporting each other; arguing about the minutiae of legal terminology neither are qualified to handle and contorting the Act and Code to support their particular point of view, the **actual point is busy being missed**: properly commissioned, established and resourced Places of Safety in dedicated facilities which operate to nationally agreed standards.

Other debates are white noise.

4th January 2012

True Story 3 –

This week a man went to an A&E department to seek help in crisis. He is a known mental health service user and had become unwell after 3 weeks of not taking medication – he had run out. Arriving at A&E at 10am, he was triaged and they rang for the crisis team to come and assess him.

By 4pm, he was starting to get frustrated with the wait. He had already started protesting about the length of time it was taking and staff were becoming anxious about him and his behaviour. So they called the police claiming, "He's threatening staff" and "about to kick off". Five cops on a blue light run across the city later and they were there within 8minutes. The man appeared controlled and calm enough, albeit vocalising his frustration at the waiting times. He used a few naughty words, but not directed at anyone, just in the anxious parlance of someone who is fed up of waiting.

A&E staff indicated that crisis were on their way, that they want the man removed from the department. The attending sergeant asked who the man was fighting and what threats had been made. He indicated that he wanted to arrest the man for the threats and violence. No member of staff would confirm any threats or violence were made at all.

"So he's frustrated with waiting and said so, perhaps in a grumpy or even belligerent fashion?" That appeared to be so. "and you want him arrested for this because he's got mental health problems?" Yes. The police contacted the s136 suite: if they arrested him MHA would they assess him? No, apparently not. Why not? Because they wouldn't, that's why not. He should be removed to the cells and assessed there. Why?!! Because he's been threatening and violent towards NHS staff. No, he hasn't. Yes he has. NO – HE HASN'T. We're not dealing with him.

The sergeant took the view that it was not necessary to detain the man s136. He wasn't attempting to leave A&E; to the extent that a police sergeant can tell, he doubted whether the man would be sectioned; he wasn't posing a risk to himself or others. The decision not arrest was treated with opprobrium by the NHS staff in both A&E and MH camps.

But the law requires that it be *necessary*, to exercise s136. If the detention is only going to coerce the man through a process with which he is willing to comply if only it gets realised this side of bed-time, then what is the utility? We are probably agreed that there is none.

So he went unarrested and I'm telling the tale of the man who the NHS wanted to see arrested because he vocalised his frustration at a six-hour A&E wait.

4th January 2012

Exclusion Criteria

"Exclusion criteria" is my term for those aspects of someone's presentation which often mean a person detained under s135/6 of the Mental Health Act are denied access to a Place of Safety in a psychiatric setting with a presumption that it will be possible, legal and safe to detain them in police cells. (Occasionally, a PoS is within a dedicated part of A&E, established for the purpose of MH assessment and I include them here.)

I have come across the following exclusion criteria:

- Drugs
- Alcohol
- Aggression
- Children
- Learning disabilities.

If you examine samples of people detained the above would amount to some 40 – 60% of the total, depending on your sample – I've sampled it at least ten times. The justifications for such exclusions are usually given, as follows:

- **Drugs / alcohol:** you cannot assess someone under the MHA when they are under the influence of substances. Fine: doesn't mean it's medically appropriate to have them in a police cell, though. 17% of deaths in custody involve drugs, alcohol and mental illness and 5% of deaths are people detained under s136. Let's think about what we're doing before we exclude to the cells.

- **Aggression:** it is not safe to have violent patients in A&E or in a psychiatric unit and they should be in the cells until they calm down. Again, I understand this. But what if the person is so floridly psychotic as to need constant restraint to prevent head-banging or self-harm? NICE guidelines for this cannot be applied in a cell block and the experts who gave evidence at the Rocky BENNETT Inquiry described the need for ongoing restraint as a medical emergency.

- **Children:** it has been said, that there are safeguarding issues to having children in an 'adult' setting and it is to be avoided. This is not correct, if the PoS involved is a distinct facility within an MH ward. What are the safeguarding risks if the only people that child will come into contact with are trained, vetted professionals and / or their own parents / families?

- **Learning disabilities:** I've heard it argued that where the police detain someone with a learning disability, that person should be excluded from the PoS and either taken to the cells or LD services should establish their own PoS facility. How do the police tell whether someone has an LD or an MH problem? What if they have co-mobidity?

As I bounced off these debates I was more or less breathless. How can the answer to a notional, theoretical safeguarding risk to a child be to put them in a cell block where quite possibly some man will be under arrest for raping boys or possessing indecent images and where at any moment whilst the child is being moved around the cell block to the Doctors room, the toilets or showers the local response team might drag in a violent drunk or domestic violence offender who wants to fight the world? <<< That's a safeguarding issue.

How intoxicated is intoxicated? Some areas use Breathalyzers to determine the answer; but some are zero tolerance – any alcohol at all and you can't come in; others use the drink / drive limit, others use double the drink / drive limit. Some don't use Breathalyzers at all because the senior service psychiatrist has said, "It's pretty disgusting if you think about it. What is it actually telling you?!"

Three pints of beer in one person will render them quite intoxicated; with others it won't touch the sides and whilst neither could drive a vehicle lawfully, one of them may well be able to hold a sufficiently cogent conversation with an AMHP to be assessed under s136.

Aggression is a really difficult one: the police are always very keen to lock violent people in cells and keep people safe. The problem comes whether that action is consistent with keeping the detainee safe. The tragedies which have befallen individuals and their families include those which involve violence which is symptomatic of a medical emergency; or which requires ongoing restraint which causes further medical problems, perhaps because of underlying poor health or previous medical problems.

These are the reasons why protocols on s136 need to include sensible mitigation of medical risks before we condemn intoxicated and / or violent detainees to the cells; and it is why mainstream mental health services need to have proper pathways to their LD and CAMHS services, for those occasions where those services' patients are detained and removed to a place of safety.

This means about six to eight organisations getting around the table to trash it out and it has happened in the real world and it works well with ongoing support across the organisational boundaries.

4th January 2012

The Neighbourhood Policing Sergeant –

When I was promoted to sergeant, I had to cover 24/7 duties for my area as a 'response' sergeant but I was also given a 'patch' – or 'beat 36' as it was imaginatively called. With my fellow sergeant we covered this diverse area, which included the 'village centre' of a diverse city suburb and a residential area with a massive burglary problem. We had our 12 cops and had to answer 999 calls and we had to provide 'community' policing – it would now be called 'neighbourhood policing' but it would be done by people who don't also work 24/7 answering 999 calls.

The village centre had about a dozen pubs with some niche bistro restaurants as well as many very novel independent shops and it had a particular problem with the on-street consumption of alcohol by some middle-aged men. These guys could be found drinking a couple of 3 litre bottles of cider for breakfast and had very many complex alcoholism, poverty and housing problems. As I look back on it now, very probably mental health problems that I didn't think about at the time. It was right in this area that my most demanding 'firearms incident' happened when I was later a police duty inspector.

I started a notebook for community contacts: within little time I had the council ASB contact, the environment health contact (for noise and other problems) the ward support officer; the graffiti guys (who could clear up); various numbers for third-sector agencies who operated in my area covering issues like, alcohol, drugs, homelessness. I had community development officers numbers and I got to know these people well enough before I became the sector inspector for the area some 18 months later. What did I not have?!

Most neighbourhood sergeants in the police do not know the names of their community mental health team managers. I've asked the question a lot to test my theory. They would know who to ring if they had problems associated with the above-mentioned issues, but not if they were dealing with a neighbour dispute where one resident was getting annoyed at the sub-criminal, barely anti-social conduct of someone who had obvious mental health problems. They'd find out, but it would then be attempting to resolve some complex neighbourhood policing problems by dealing with an unfamiliar face. I advised a neighbourhood inspector today for exactly this kind of situation: he admitted he had no idea how to work out whether

someone engagd in ASB and thought to be mentally ill was known to a GP or a CMHT. No contacts within NHS community based, primary care or secondary care MH services.

For reasons like this, I've suggested numerous times that neighbourhood team sergeants should invest in some non-chocolate hob nobs (the true mascot biscuit of the police service) and invite them for a coffee (we can do tea, if absolutely necessary). I can't imagine they'd be short of things to discuss: CMHTs are constantly undertaking visits, assessments, dealing with patients who have risk histories. CMHTs and AMHPs tell me that arranging police to attend some of their MHA assessments is often very difficult. Imagine how easy it would be if you were on first name terms with the local neighbourhood sergeant and had his / her mobile number in your phone and their shift pattern on a spreadsheet so you'd know when they were on? Even if you needed the police when the Sarge wasn't available with their team, they'd be able to get police to you when you needed them.

Equally, how much business could be done from a policing perspective? Principally, it was a vision of Lord BRADLEY's in his 2009 report, that there should be early intervention and diversion as a result of greater integration of neighbourhood policing and community MH services. If these sergeants and MH team leaders were acquainted and supportive? One could imagine early ID of repeat callers to the police, cross referenced by MH to their patient list, leading to early, joined up approaches to emerging problems. One could imagine, advice and support across the agencies as the natural by-product of supervisory professionals who know and support each other. I could see sergeants attending the occasional MH team meeting to help them understand legal issues affecting the service; MH team leader coming on police briefings to raise awareness of MH issues and help officers understand how to identify those potentially at risk or in need.

This happens naturally between the police and the council / trading standards / immigration – why not so often between the police and mental health services? It doesn't have to take more than a couple of hours and couple of phone calls over several months and an exchange of email addresses.

6th January 2012

@TheTweetAwards: WINNER! –

I was humbled over a week ago to find myself nominated for @TheTweetAwards as "The Most Informative Tweeter". I'd never heard of the tweet awards, to be honest, but @RoulaRoo (a twitter account run by 3 Dalmatians!) quite unexpectedly put me forward and things went from there! OK: there was a degree of lobbying and some strategy – I started to annoy even myself with how often I was boring the hell out of people to vote for me!

Well guess what: **we won**!

So far more importantly – in the course of winning we attracted 300 new followers, including some new senior police officers and national mental health charities; as well as numerous mental health and social care professionals, students of different disciplines and various interested folk. We attracted dozens of **frontline operational police officers**, towards whom the advice here is primarily directed. This shows that officers are interested in this and keen to get it right – if only they knew was 'right' was. It is always a pleasure to receive a tweet or email from a response officer who took the advice on and made a difference for vulnerable people, as @kawgparker and others have been kind enough to highlight following the award.

So the principle method of advertising the blog is now being followed by 25% more people, some of them quite influential folks. Various responses I've had to the award indicate that the very agenda I'm so passionate about will be moved on as I'd hope to see it; and all to the benefit of those people we're aiming to serve here: **mental health service users**.

Thanks to those who voted for me and to those who support the blog.

At the risk of inappropriately introducing a speck of humour, I leave you with a celebratory tune – the mentalhealthcop song. <<< *tongue firmly in cheek!*

Michael./

8th January 2012

West Midlands Police –

I am delighted to report that the (award winning!) @mentalhealthcop Twitter account by which this blog is distributed is to become **official** West Midlands Police media next week.

The simple reason it has not been official until now was that having spent three years of my career as a policy lead on mental health, I have since moved to become a frontline 24/7 inspector. I am now responsible for volume crime investigation and criminal justice partnerships in a local area so this was no longer my official responsibility in the force. The blog and twitter were my own way, in my own time, of maintaining my involvement in this area of policing. The hope was to continue to raise awareness within the service and amongst partner organisations and the public.

But I have continued to undertake occasional work for 'headquarters' on mental health and I usually receive ten or twelve professional advice queries a week by phone call and email from my colleagues who know I can help with this sort of work. This week it was a Senior Investigating Officer for a murder inquiry, a s136 protocol query, a Contact Centre supervisor who wants to understand better whether or how to deploy officers to calls involving mental health; and Greater Manchester Police. So as I remain involved, a blog seemed a good way to raise awareness whilst ensuring an available resource towards which I could point people.

After mentioning on Twitter that official recognition beckoned, I've had a couple of queries about this and they included the question, "Won't that erode your free speech?" I admit to thinking this a curious question, so I thought I'd quickly explain why it won't:

Absolutely ALL police officers are subject all of the time to the Police Standards of Professional Behaviour – a professional code of conduct. They are subject to this 24/7 – on duty and off. I've been subject to requirements contained within that document since the beginning of my career, nevermind the beginning of the blog, and whether or not it was 'force-recognised' is beside the point. It is for that reason, that I have always carefully considered the material I put on here ahead of doing so. One blog post went unpublished for several days after writing it, because I just wanted to think things through again. Others have been deleted or not started at all.

As perhaps you may expect for a police inspector – there is much information, many data and incidents in which I've been involved or to which I've been made privvy which are **never** going to be mentioned on here because it relates to confidential, restricted information not available in the public domain. If you wanted to check or if you pressed me on it, you'll find **everything** on this blog is publicy available information. Yes, it has been collated and presented by me in a particular fashion, I've expressed views on its application from an operational police officer's point of view, but it is ALL publicy available law, guidance and data.

I am conscious that some of the blogs have generated debate. For example, blogs on s135(1) warrants for assessments on private premises and the blog about the concept of Excited Delirium. I'm further conscious that presenting information to police officers about how to handle situations where their local MHA protocols are either non-existent or inadequate for the situatino in hand, it could be perceived that I've just asked officers to declare UDI – Unilateral Declaration of Independence. Once might wonder how this stacks up with my professional standards obligations?

So let me address that point head on:

A police officer's first responsibility, based upon an oath of office sworn in from of a Justice of the Peace, is *to the law*. We know that if you spend ten minutes on Google you'll find published protocols in some areas of England and Wales that are inadequate for the purpsoe and others that are pretty decent. So where it is that a legal duty may conflict with the requirements of a local MHA protocol the officer's duty is to uphold or comply with the law. Protocols between agencies which are required by the Code of Practice to the Mental Health Act should be important and are very usually to be followed but because they have the legal status of 'guidelines' they can and should be set aside if they do not cater for the situation in hand.

So it can not be a form of 'UDI' if it's what Parliament laid down or what our national regulators and policy organisations are outlining is in the best interests of vulnerable people in contact with the police.

8th January 2012

Practical Advice For Police Officers: section 135(1) –

*During a formal assessment in a private dwelling conducted **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.* <<< This is what I refer to as 'the legal caveat' which will be mentioned below:

'**RAVE risks**' is term I use below and it means a risk of one or more from this list: *Resistance, Aggression, Violence or Escape*.

If you are a duty sergeant or frontline cop asked to attend an assessment in a private premises, it is important that you do not just attend and do as you are told, but think about the reasons to be there, risks to be faced; and the resources required to conduct and control the assessment.

Think about it in light of the 'legal caveat' above – "No powers to use force until …" Additionally, you should remember that there are Health & Safety as well as Human Rights obligations upon the attending professionals.

IS THERE A WARRANT?

- *Does the AMHP already have a warrant under s135(1) at the point of requesting police support?*

- **YES** – and so you **must** attend the assessment because only the police can execute the warrant.
- You should request the AMHP to provide relevant risk information which allows a proper determination of police resources, do your own background and intelligence searches on PNC etc.; then muster your officers, stop reading this and crack on.

IF THERE IS NO WARRANT?

- As*k whether there is there a risk of a 'RAVE' once inside the target premises?*

- **NO** – you are not actually *obligated* to attend the assessment, because the AMHP has authority to enter the premises and to assess, detain and convey to hospital if admitted.
- If there no more risks than an AMHPs 'normal business', for what purpose are the police required?
- That said, nothing prevents Chief Constables or officers deciding to help out, as long as they are aware they are not obligated and managing the potential to stigmatise the patient.
- Service users often remark about inappropriate reliance upon and involvement of the police.
- If you wish to agree to do so, then request the relevant information / intelligence checks, get resources and crack on.

- **YES** – *Is the RAVE risk from the patient to be assessed?*

- **NO** – it may be possible to obtain a warrant but it is almost certainly not necessary because you and the AMHP have legal powers to achieve a safe assessment.
- Do your information and intelligence checks, risk assess it to determine appropriate resources, read section 115 & section 129 MHA in light of s3 Criminal Law Act and crack on.
- **Ensure that the AMHP is aware of 'the legal caveat'** and that until an offence or a breach of the peace is anticipated, **it is their assessment to control and lead.**

- **YES** – you should ask the AMHP to secure a warrant under s135(1) on the grounds that the criteria for getting this warrant appear to be met and the existence of a warrant would significantly assist the police to safely, proactively mitigate those risks which the AMHP themselves identifies as likely.
- Document the response to this request and if it is obtained, refer to '**Is there a warrant**', above.
- If it is not obtained, refer to the bullet points in '**If there is no warrant**' above.

WHY ARE THE GROUNDS MET?

I have blogged previously about the grounds for getting a warrant, the powers it affords to the police and the things which the police cannot prevent in a private dwelling if there is no warrant.

Where an AMHP is telling you that a person will be resistant, aggressive or violent in the face of a conversation with professionals or will just leave the premises or seek to escape, it would be fair to describe the person as "being kept otherwise than under proper control." I **hate** this terminology, if I'm honest. It is appallingly outdated, offensive, patronising etc., but it is

currently the language of the Mental Health Act. Moreover, if such reactions are likely from patients because they have not been taking prescribed medication or adequately caring for themselves, they will be able to be described as "neglected" even if that is self-neglect.

As such, grounds for applying for the warrant are met. Suggestions that warrants cannot be obtained if access to the premises is already possible should be rejected as inaccurate in my view. Reasons why are in that previous blog post.

Not all AMHPs will agree with the above – this is fine. We are allowed to have our opinion and this position is based upon NPIA Guidance endorsed by the Department of Health.

9th January 2012

Where Does 'Mental Health' Live? –

Here's my theory about why some police forces have historically scratched their foreheads a bit about how to properly own and develop policy and practice on policing and mental health. I would say at the start however, that the service have really 'brigaded themselves' properly on this over the last few years and made real progress.

There have been genuine and very necessary debates within each force about which part of a police service should 'own' mental health; where it should 'live' within force headquarters departments.

Explanatory note for non-police readers >>> police forces are run by the Chief Constable who has a Deputy (Chief Constable). They have varying numbers of Assistant Chief Constables dependent upon population size. Lead responsibility for the range of policy issues faced by all forces is divided across the Deputy and Assistant Chief Constables. Some larger forces may have an ACC 'Criminal Justice' and an ACC 'Operations'; whereas a smaller force may have one ACC responsible for both. Portfolios for ACCs can include 'Intelligence', 'Crime', 'Criminal Justice', 'Security' and 'Local Policing'. etc.. In addition, each force will have local areas for the delivery of 24/7 and neighbourhood policing known as 'Divisions' or 'Local Policing Units', etc.. These are run by Chief Superintendents whose local area often matches a mental health provider; sometimes a couple of local areas match a provider.

If you're with me so far(!), you'll have spotted that mental health cuts across *all* of these; and that there is also a potential tension to be managed between local ownership and corporate control. Most of the mental health issues which affect the police do not sit in any one of these portfolio areas:

- Section ss135/6 Mental Health Act and AWOL patients are probably a 'local policing' issues;
- Criminal investigation of mentally disordered offenders and public protection or safeguarding are probably 'crime' issues;
- Police custody, and criminal justice liaison and diversion services are probably 'criminal justice' issues. Etc., etc..

In addition, there are only a few police forces whose NHS services are commissioned and provided conterminously by one Primary Care and

Mental Health Trust. So most forces have the challenge of striking that incredibly difficult balance between delegating the issue to local areas who can work closely with their partner agencies; and retaining sufficient control to achieve the consistency needed to deliver accountable policy and training to the HMIC and the IPCC. It is for these reasons that many forces have experienced moments of confusion about how to properly progress, especially because we know that there are several approaches amongst a force's mental health providers to the same legal or medical issue. Which one is right?!

(Massively important that I point out – the police also present this problem back to the NHS and local authorities. Most ambulance services work across multiple police forces and can find it frustrating to get police consistency. AMHPs who have worked in more than one local authority have often said the same when discussing police forces' responses to s135(1) warrants and assessments on private premises, we vary massively. NPIA Guidance should assist in addressing this.)

So all taken together, Chief Constables most usually have to delegate responsibilities to local police commanders to work with their mental health trusts and local authorities to ensure that proper policies and protocols are in place in their areas, whilst attempting to have consistent minimum standards in policy and training across their force which local commanders strive to ensure are replicated locally.

Many forces achieve this by deciding what best fits their internal and partnership structures and then choosing an Assistant Chief Constable to bring together all relevant local areas, HQ departments and partners into a working group on mental health. They balance off the tensions by controlling at HQ those issues for which the force must be certain of particular standards to comply with law, leaving the rest to local procedures.

It is therefore clear why achieving effective policy and procedure around policing and mental health is complex!

So whilst I remain unsure why so-called 'Excited Delirium' is a very real life-threatening medical condition in my local A&E, but not my local psychiatric unit, I am certain that forces should treat it as a very real phenomenon until the debate ends one way or the other – this approach should **not** be up for debate in local police areas, for the reasons I've previously given and it's up to local commanders to ensure that this is realised.

11th January 2012

The Police and The Mental Capacity Act –

It is important we understand at the outset: this Mental Capacity Act stuff can cause nightmares for partnership working because of the number of myths which already exist and because the police and many parts of the NHS have had little or no training. I'm going to do a couple of posts on it – first explanatory and then later I'll do a punchy 'guidance' post for police officers applying it.

Update (May 2012) >>> A simple, handy tool to approach decision making when thinking of the Mental Capacity Act is The CURE Test.

Some police forces appear to have latched on to the MCA in various circumstances, but in particular for its potential to help resolve mental health crisis situations in private premises. There has now been a significant stated case about the MCA – the 'Sessey' case – after the Metropolitan Police considered its application to attending private premises where someone was suffering from mental health problems. In circumstances where they did not or could not get an AMHP to attend and assess under the Mental Health Act, officers considered whether the MCA allowed to 'remove' someone to a place of safety, as if under s136 MHA, in order to be assessed for admission to hospital under the Mental Health Act.

It was agreed between the claimant and the Commissioner that there was no power to do this and the court ruled that detention in the place of safety pending assessment, had been unlawful.

Here's my rule of thumb: if you can avoid taking decisions – including mental health care decisions – implied by the Mental Capacity Act because there is time to call an ambulance or other health or social care professionals, you should do so. Any intervention should be restricted to those circumstances where you absolutely *must* intervene in order to preserve life or prevent serious injury and this means having regard to s4B MCA – only where intervention is necessary to mitigate an immiment, life-threatening risk. Principally, decisions around capacity and healthcare should be taken by healthcare professionals – this sentence is not my view, it is a requirement of the Code of Practice to the MCA.

SO HOW DO YOU APPLY IT?

- One should determine whether someone has capacity with reference to the test in s2 MCA – nobody is asking for scientific assessment, just a properly considered decision.
- Whether or not someone can take a decision for themselves is determined by the approach in s3 MCA.
- One may then undertake proportionate acts to safeguard someone's best interests (understood by reading s4 MCA) , in accordance with principles explained in s1 MCA.
- Officers would then be protected from any legal liabilities ordinarily arising from that act, by virtue of s5 MCA, as long as they acted in good faith to do the right thing – the proper legal terminology is that you acted in the best interests of someone whom you reasonably believed lacked capacity.
- If doing the right thing involves the 'restraint' of a person, it must be done in accordance with s6 MCA.
- If one has assessed as per s4 MCA and acted in accordance with the principles of s1 MCA and acted within the spirit of s5 MCA, (then s6 MCA if restraint is required) it will provide a legal 'defence' to the action taken, as long as it was done in good faith.

- There is a good explanation of how to consider the principles which underpin the Act, within chapter 2 of the Code of Practice to the MCA.

REAL EXAMPLES

1. The police are called to a private dwelling to a report of an out-of-hours GP with ambulance and family, attending to a man in his 80s who needs removing to A&E. The GP explains that the man is thought to have had mild dementia for some while although he normally lives on his own. The man is frail and confused because he has contracted a urinary tract infection which had affected his congitive functioning because it had become quite acute. He'd become extremely confused over the last three or four days and become unable to look after himself – not eating or drinking – and he has soiled much of his house because he has not been using the toilet. The GP explains that the infection has caught hold so severely that because of frailty, the man's life is genuinely at risk if he is not taken to A&E shortly and treated with antibiotics. Between him, the paramedics and the man's daughter and son-in-law, they've tried to get him to A&E, but he is refusing and they need help. The GP confirms that the man lacks the capacity to take this decision, because of the infection and his dementia.

2. You attend street to a report of a robbery where man has been badly beaten whilst on his way home from a night out. He appears intoxicated, but he has sustained head injuries in the beating and his wallet and phone have been taken. He is wandering in and out of the road when you arrive and all attempts to verbally manage him and encourage him to safety have failed. You use a low level of force to get him out of the road and the paramedics arrive. They express serious concern about the head injuries, because his face is already badly swollen and cut. You all attempt to get the man into the ambulance for removal to hospital, but he declines. Between you and the paramedics, it is suggested that his intoxication probably prevents him understanding the extent of his injuries and the potential consequences of them not being assessed and treated more or less immediately. They cannot rule out the possibility that the injuries sustained have been very serious indeed, potentially life altering and everyone is agreed that because of alcohol, disorientation and quite possibly shock and pain from the injuries themselves, he lacks capacity to decline treatment.

NOT A SUBSTITUTE FOR THE MENTAL HEALTH ACT

The 'Sessey' case showed that where police officers attend a private dwelling to a non-life threatening situation – or not immediately life-threatening – that they should not use the MCA because no power to remove someone to hospital exists. The court reminded us that the statutory response to mental ill health on private premises, is for Mental Health Act assessment to occur led by an AMHP. If the urgency of the assessment means that only one DR can be involved, they can use the emergency admission mechanism under s4 MHA. The case was unequivocal, that the MCA should not be used to subvert the need for this approach.

(Potentially, officers consider the MCA because of an inability to secure prompt attendance to mental health crisis situations by mental health professionals. The answer to this, is closer partnership working with crisis teams and agreed support between the agencies and senior officers should ensure that this achieved through robust, reviewed protocols.)

There is more to be read on this within the NPIA Guidelines (para 6.3.1 on p87) and it is also worth reading the Code of Practice to the MCA particularly chapters 2 and 4.

11th January 2012

Should I Stay or Should I Go?

Should the police remain at a place of safety once they have arrived at the location? – to be clear at the outset, I'm referring to the psychiatric place of safety to which most people are removed. I am not referring to A&E when it used because of additional medical emergency or physical injury – the open nature of that environment means officers should remain until the person is either discharged entirely from s136 following assessment or transferred to the main place of safety.

There is nothing whatsoever in the Mental Health Act or the Code of Practice (Wales) to the Mental Health Act which answers this question – and everything else is guidance and opinion. This question is a sticking point in how place of safety processes work. I was chuffed to see the BLOG getting a mention on a nurses' internet forum following which a (student?) nurse made a comment which prompts this post: "In theory the police should remain with the person until this is completed … now that we insist they remain with them until it has been decided whether or not further input is required they are reluctant."

Of course the police are reluctant, not least because there is no legal basis at all for this claim. And even if this question is addressed morally rather than legally, it is probably fair to remark that the public would wish to see their police deployed in way that means they are **not** remaining with patients in hospital pending assessment **unless** the patient poses a risk to staff where it's obviously vital that the police protect their colleagues in the NHS.

But it is clearly understood that because of the extent of assaults on NHS mental health professionals – 68% of all assaults on NHS staff are on MH professionals – support from the police is needed in some cases.

Here's the problem: responses to undertake assessments of patients who are removed to a place of safety are often measured in hours and half-days. Average response time to the place of safety in my home area (not my force) is over eight hours and the mental health provider refuses to allow the police to use the facility at all unless the chief constable agrees that two officers will remain at that location with the patient throughout the entire duration. That PoS facility has no nurse to meet, greet and triage the patient and so the irony of the arrangements is that if the police had

removed the person to the cells, they would have been seen by a police doctor within 90 minutes (average) – the place of safety facility in my home area quite effectively delays access to necessary healthcare.

And of course this comes at a cost. When you have two large towns covered by four police officers at night and two of them are twenty-five miles away 'guarding' a non-resistant mental health patient – the PoS cannot be used for anyone who is violent – it means there is, for example, less capacity to respond to calls to Accident & Emergency that drunk patients are being aggressive towards staff.

One police force in the north of England were kind enough to share with me a copy of the legal advice they had received from a barrister on this very point. They sought counsel's advice on their obligations to remain and he was very clear: "None whatsoever, in law, unless remaining there is necessary to prevent crime or protect life."

So what's the way forward?

As ever, local protocols should reflect the core roles of each agency and the Royal College Guidelines. Parliament did not make it an obligation upon the police to remain in all situations, the Code of Practice implies there will be some situations where the police do and some where they do not, and the Royal College Standards clearly envisage the police leaving even in some situations where patients are 'disturbed'. Ultimately it all comes back to proper commissioning and resourcing of Place of Safety facilities which sits with PCTs.

In time-honoured tradition I prefer the compromise that all patients removed to a PoS are risk categorised as LOW, MEDIUM or HIGH. Low risk patients are an NHS responsibility, once they police have arrived, researched background and risk and provided a full handover of information to the NHS. High risk patients are a joint responsibility – medium risks cases should be judged case by case dependent upon the professionals involved and the patient.

Where dispute remains about whether the police stay, my force operates to the rule that we stay if we asked to do so, but if the attending officers disagree with the need for it, the case is referred to managers at the time and if still unresolved, the next day for review. Working on the principle that there should be objective risk information to which nurses should be able to point to justify that request; some nurses have had feedback about inappropriate retention of the police. Equally, some officers have had feedback following an insistence upon leaving when the nurse had not agreed. This mechanism is proving over time, to **build trust** and lead to fewer disputes than when the process first began.

Perhaps a way of summarising all of this, it to observe that it is not for the police to staff and resource NHS places of safety because they PCT would prefer not to do so; but it is for the police to protect the professionals who work there from very real risks of assault.

AFTERTHOUGHT – just in case any healthcare professional reading this is thinking, "But I don't have legal authority to keep the person in a PoS for assessment, only the police can do that". Yes you do – s136(2) MHA. If patients are asking to leave, keep the door shut, if they start to get aggressive because of this, then the risks have raised at least to medium so call the police back.

11th January 2012

"It's Not In The Public Interest." –

In May 2004 Martin Constable assaulted one of his psychiatric nurses, Helen Kelly. He inflicted life altering injuries which caused her to be off work for over six months and shattered her professional confidence.

Constable also went on the smash-up a Doctor's office at Penn Hospital in Wolverhampton and despite this matter being reported to the police and taken to the Crown Prosecution Service, it was decided not to prosecute him. The reasons behind this decision were given publicly that "It is not in the public interest."

Fortunately, she was supported by her NHS Trust and by the NHS Security Management Service's Legal Protection Unit to bring a private, criminal prosecution against Martin Constable for grievous bodily harm. Over 18 months after the incident he pleaded guilty to wounding and was sentenced at Wolverhampton Crown Court to ongoing detention under the Mental Health Act and to pay Helen Kelly £2,500 in compensation. At the stage, the CPS stepped in and picked up the bill, whilst reflecting on the combined errors of the public criminal justice system.

What I have learned in working in this field of policing for several years, is that when one wishes to have a conversation about why the NHS can sometimes appear to be 'closed' to complex, demanding and outright violent mental health patients who come into contact with the police you will be referred to an incident like this one. "Why should we put our staff at risk, unless you'll help protect them by staying with them and prosecuting patients who assault them, wherever possible?" **Try answering that whilst sounding credible.**

So whenever police officers feel like getting on something of a high-horse about mental health issues they think should get 'sorted' by NHS services which fall somewhere short of their preferred standards, they should think of cases like Helen's and consider what it is like to walk a mile in her shoes. In fact, I did once send a constable to spend most of a day in his own casual clothes shadowing a nurse on a mental health ward – when he briefed the team about the experience the following day, their collective attitude towards inpatient violence and AWOL patients changed.

These issues are opposite sides of the same coin – it's about trust and confidence between the agencies and their professionals.

Helen Kelly reported that the police "went through the motions" and that even when officers were taking her statement told her that "it wouldn't go anywhere" because Constable was a mental health patient. Cynical officers may imagine that she's over-estimating the sentiment for effect, but I remember hearing a senior detective say exactly this when told that "a section 3 patient has assaulted another section 3 patient overnight." "Well that's not going anywhere is it?" "Well not unless you investigate it boss, but you're the detective."

I am convinced that mental health professionals and their employers understand that some violence against staff cannot be prosecuted because there are clinical reasons why it would not succeed – one trust in my area reports just 16% of its violent incidents to the police, reflecting such thoughts. Martin Constable was perfectly able to be prosecuted and his psychiatrist said so at the time of the incident. Moreover, it was known that the day before he'd assault Helen Kelly, he assaulted another member of staff. All of this is unlikely to inspire confidence in the victim or create a professional impression of what might be able to be done.

Of course, if Constable potentially posed "a risk of serious harm to the public" – and I think we can agree that violence like this would probably pass the threshold – then prosecution should have been actively considered because even if the legal system found him unfit to stand trial because of his mental health problems, it can still impose a hospital order under s37/41 of the Mental Health Act to ensure public protection. These are also issues for the Crown Prosecution Service, because prosecution recommendations by the police have to be ratified by a CPS lawyer.

I have blogged previously about these issues – inpatient violence against staff; how liaison officers for psychiatric units can improve matters; how to properly investigate allegations that do get reported and to secure appropriate background information; finally, how to approach the question of whether to 'divert' from justice and so on.

Justice does not stop at the hospital gate.

14th January 2012

England and Wales; Scotland and Northern Ireland

A couple of years ago, when helping to write national guidelines for the police, I was introduced to the word 'Welshified'. It was explained to me that the way in which those guidelines were initially drafted 'wouldn't work in Wales' because there was a different Code of Practice. Within a few days I had read this document and whilst it is certainly different in many regards, for policing purposes it is sufficiently similar to mean that the police in Swansea and Birmingham do face almost identical challenges when involved in the application of section 135 and section 136 Mental Health Act. The paragraph numbering is different when legally referencing a local protocol, but how the police manage someone after arrest under s136 MHA is identical.

The UK does not have one piece of Mental Health legislation, but has four separate national jurisdictions. I have been privy to cross-border conversations between police officers who assume that because the law is written differently there must be massive differences in the issues and that the service may not be able to learn from each other's experiences to develop better responses.

I am not claiming that the legislation is the same – it is not and in some parts it varies quite considerably. But the **police parts** are *very broadly* the same:

- Although England and Wales share a Mental Health Act, they have two separate Codes of Practice, and Wales has a devolved health system to Cardiff;
- Scotland has a devolved NHS to Holyrood along with its own legislation and Code of Practice;
- Northern Ireland has a devolved NHS to Stormont and its own legislation and Code of Practice.
- The provision of certain mental health services – notably the four 'high secure' hospitals for dangerous mentally disordered offenders – is cross border:
- Wales has no 'high secure' care and always has used Ashworth and Rampton hospitals in England, wherever necessary;

- Carstairs in Scotland is also for 'high secure' patients from Northern Ireland.
- All of the Mental Health legislation is written to allow cross-border transfers and the recovery of cross-border AWOL patients.

For policing purposes, the most stark contrast is the law in each area around the timescale for detention in a 'Place of Safety': 72hrs in England / Wales; 48hrs in Northern Ireland and just 24hrs in Scotland. Quite why it can take three times as long to assess people in Birmingham and Swansea than in Glasgow; and twice twice as long in Derry as Glasgow is beyond me but Scotland does show what is possible if we legislate to keep timeframes short. (There was suggestion in the 2004 Mental Health Bill that English / Welsh law should be reduced to 12hrs, but this did not make it into the Mental Health Act 2007).

A Scottish police force sought advice last year about challenges faced by their service: the NHS were demanding that police officers remained in a Place of Safety after detaining someone for their own safety under section 297 of the Scottish Mental Health Act. The NHS there had apparently rejected a suggestion that the approach being pushed in various parts of England – where the police are able to leave low risk patients in NHS care – should be translated north of the border. Apparently "The law is different here." Well the words are in a different order, but s136(2) MHA(E) and s297(2) MHA(S) amount to the same thing. It is perfectly possible – and some would argue just as desirable – that patients are not criminalised by the inappropriate use of police officers to 'guard' low risk patients.

For policing purposes many of the remaining debates are the same in each area:

- **Removal from a public place** – s136 MHA (England / Wales) = s297 MHA (Scotland) = a130 MHO (Northern Ireland).
- **Removal from a private place** – s135 MHA (E/W) = s293 MHA (S) = a129 MHO (NI).
- **Place of Safety** – is a legal concept in each jurisdiction and arguments prevail regarding access, exclusion criteria and police support to the NHS.
- **Patients absent without leave** – s18 MHA (E/W) = s303 MHA (S) = a29 MHO (NI).
- The significance of the Codes of Practice in each area.
- Approved Mental Health Professional (E/W) = Mental Health Officer (S) = Approved Social Worker (NI).

It's almost as if someone sat down to write the same thing three different ways and all of the British police service is a gateway to the mental health system in each part of the UK – 'street corner psychiatrists' as they are in the rest of the developed world.

All of this legislation is now available on the 'Legal Resources' page and the issues within this BLOG are more than broadly applicable across the UK and, indeed: abroad.

14th January 2012

The Senior Officers' Checklist –

Policing mental health issues has got the ability to get complex, for reasons outlined in other blogs. However, what a police area needs to have in place to tackle it effectively is remarkably simple. Sometimes, it is ongoing debates about 'where mental health sits' that prevent the recognition of this simplicity.

I once wrote 'one side of A4' for chief inspectors on local areas, to summarise what they need to have in place to be successful. This version includes one or two extra explanations as I'm not backing it up with a verbal briefing:

People

- *A senior officer* – as the 'strategic lead' for MH and partnerships – possibly the local superintendent or chief inspector. Someone with authority around resources, budgets and training who can authorise solutions to problem trends and agree a police area's commitment to protocols / partnership.
- *A lead inspector* – as the 'tactical lead' who is the point of contact for other agencies in day to day problem solving and leads for ensuring that police responsibilities are delivered.
- *Local neighbourhood policing team* – an officer to act as a liaison point for any inpatient psychiatric unit. This need not be the creation of a full-time role, but someone who is a regular point of contact. It could well be just 5% of someone's role but would save the whole BCU massive amounts of time and effort.

Protocols

- *Place of Safety protocol* – following the arrest / removal of anyone under section 135 or section 136 of the Mental Health Act (or equivalent Scottish / Northern Irish legislation).
- *Assessment of Private Premises protocol* – for the planning and conduct of assessments with or without the police, with or without a warrant under s135 (or equivalent law).
- *AWOL protocol* – for the reporting and searching; the recovery and conveyance of patients who are absent without permission, inc those who fail to return from leave or to recall.

- *Conveyance protocol* – for the movement of patients in various circumstances, but including urgent transfers between mental health facilities.
- *Mental Capacity Act protocol* – to control the use of the MCA and ensure it is not inappropriately used.
- *Mentally Disordered Offenders protocol* – to ensure appropriate diversion and prosecution of offenders and timely assessment of needs in police custody.

Oversight

- *A strategic meeting twice or thrice a year* – involving senior staff: to review protocols and their effectiveness, to agree plans around joint training and awareness raising for both police AND mental health professionals. (Yes, the police need MH awareness training – but MH professionals also need legal or 'police awareness' training.)
- *A tactical problem solving meeting* – involving the lead inspector, to review cases which have been problematic and to lead on reinforcing agreements by understanding feedback from the other organisations; to give feedback and direction to staff where required.

Training

- *Delivery joint training* – sufficient to ensure the above protocols are understood and that frontline professionals network and talk about problems by sharing their experiences from opposite sides. *<;<;<; This has been extremely positive and successful where forces and MH trusts have tried it.* But it takes some organising!
- *Service user involvement* – in delivery of training it can be extremely powerful, not only for police officers, but having seen service-users explain to MH professionals what it feels like to be locked in a police cell for over a day when detained under s136 was powerful.

The above doesn't necessarily take long, as many good protocols exist from which areas can cut / paste or 'borrow with pride' and of course there is a blog with many resources and answers(!) but much is formally outlined within national guidelines which are badged by the Department of Health.

To end on a positive, hopefully humourous point: the BEST awareness training for police officers I have **ever** seen was done by two learning disabilities' service users and a support worker delivering LD awareness training:

Two young men in their twenties who spoke about their lives and loves – they had those police officers eating out of the palm of their hands and listening attentively by the simple expedient of basing their simple message

about equality and respect around anecdotes involving football and pubs, girls and sex. It was perfectly pitched to be funny without being inappropriate and it broke down barriers and superbly challenged assumptions and probably prejudice.

The police officers stood up at the end and applauded those two men. It was wonderful to see!

15th January 2012

AWOL Patients: part 1 –

Let's be honest from the outset: police time spent investigating the whereabouts of missing people is sometimes accompanied by a background of frustration. In my own experience this is often the case when the person who has gone missing is 'persistent' because of the number of times they have 'gone missing' and this is especially so if the circumstances amount to the whole thing being preventable or the responsibility of others.

Children's Homes and mental health units feature prominently in the volumes of any area's missing persons numbers and most officers have experienced that awful tension which is created by knowing that all reports must be taken seriously and promptly investigated, but that sometimes reports are made to the police because it gets the monkey of someone else's back. Occasionally, this can be a person who could have prevented the person going missing in the first place. <<< *There – I said it.*

Mental Health professionals should read the case Savage v South Essex Partnership Trust and s127 of the Mental Health Act. When the family of a missing or dead mental health patient makes a criminal complaint under 'section 127' to the police, they have just as much of a right to expect that allegation to be recorded and investigated as any other potential victim of crime.

Update (Feb 2012): >>> They should also read the case of Rabone and another v Penine Healthcare NHS Foundation Trust which has brough about considerations of neglect and human rights relating to inpatients who are not formally detained under the MHA. There is a blog post on these cases for those who want to read more.

Such investigations never go down well with professionals of any organisation, especially when discussion may turn to an organisations policies, procedures and training and to their legal duties, as outlined in the 'Savage' case. In the future, one can imagine Corporate Manslaughter legislation being considered as a method to challenge the potential liability of organisations' policies, procedures and training around security, physical maintenance, door-locking policies and external fencing meeting required specifications, where installed, etc., etc..

There are a range of situations in which a missing patient can be AWOL under the Mental Health Act:

- *Absconder* – a detained patient who leaves the ward without permission
- *Fail to return* – Patient who has been quite properly allowed authorised leave (under s17 MHA) and who fails to return to the location at the appointed time;
- *Fail to surrender* – A patient who has previously been in hospital, but has been released into supervised community treatment (known as a CTO or community treatment order) but then 'recalled' to hospital under the Mental Health Act for any number of reasons. Failure to surrender to recall at the correct time creates a condition of being AWOL.
- *Recall of conditional discharge* – a patient connected with criminal proceedings who has been properly released as a community patient (known as 'conditionally discharged restricted patient') who has been recalled to hospital under s42 MHA by the Secretary of State for Justice. The secretary of state will issue a warrant for the patient's recall.
- **NB** – *I'm going to do a separate blog about informal patients who go missing – ie, those not detained under the MHA. It is a post in its own right.*

One of the challenges around AWOL patients and partnerships is that **a missing patient for the NHS is not necessarily a missing person for the police**.

For example: if a quick telephone call by ward staff confirms that a patient who was afforded s17 leave and who has failed to return on time is at their home address or other leave location – ostensibly safe and well – then they are AWOL from hospital without being a missing person because we know their whereabouts. Perhaps more importantly, the Code of Practice to the Mental Health Act states that such a scenario is primarily an NHS responsibility. (*Para 22.13 CoP MHA*). Let us just say that attitudes towards this particular legal guidance vary.

Section 18 of the Mental Health Act (and equivalent legislation in Scotland and Northern Ireland) is the legal power to return AWOL patients to their ward and it is not a power directed solely or even firstly at police officers. AMHPs (and MHOs / ASWs) as well as anyone else authorised by the hospital from which the person is missing may also do so.

s18 MHA is a power of 'arrest' for the purposes of the Police and Criminal Evidence Act 1984 and therefore reasonable force may be used under s117 PACE to discharge it.

In December 2011 a man walked into an A&E in my force area to ask for help after spending 3 days AWOL from a mental health unit in another part of the force. Although not injured or in need of A&E treatment he was an NHS patient who needed to be returned to the psychiatric unit – indeed he *wanted* to be returned there! He was not resistant or violent or aggressive and yet the first response of the A&E staff was to call the police, rather than the ambulance service or the psychiatric unit who are ultimately responsible for *their* patient's repatriation.

The response of the A&E department when the police said, "either contact the ambulance service to do it, or contact the psychiatric unit" was shock, disbelief and demands to speak to police supervisor. Fortunately the sergeant concerned knows me and has me on speed dial.

If the police service are required to recover a patient – for example, because of RAVE risks or urgent unpredictability – then this should not lead to the police acting alone (unless there are urgent, high risks and delay would be unwise): it should just be to assist a mental health professional and / or the ambulance service.

Police officers who recover an AWOL patient should **always** call an ambulance – Dorset Police knows why and chapter 11 of the Code of Practice says so.

This post continues in part 2 – AWOL Patients.

15th January 2012

AWOL Patients: part 2 –

This post follows on from part 1 on AWOL Patients ––

Police officers who recover an AWOL patient should **always** call an ambulance – Dorset Police knows why and chapter 11 of the Code of Practice says so.

(Equivalent guidance in Wales, Scotland and Northern Ireland. Also see the BLOGs legal resources, above).

So which situations should automatically be reported to the police? Well, the Code of Practice talks about three situations should always and immediately be reported:

- *Patients subject to 'part III' of the Mental Health Act* – this means patients connected to criminal proceedings, either before or after trial / conviction.
- *Patients who are 'dangerous'*;
- *Patients who are 'particularly vulnerable'* – if anyone has a grey pencil of the correct shade to help us understand where vulnerable becomes particularly vulnerable, I'd be grateful to learn where you got it!

Nothing else MUST, by law be reported immediately or at all. However, as the police carry the responsibility of searching for people whose location is not known, so expectations around AWOL patients outside of the above three situations should be set out in a clearly defined protocol. This document should include:

- **The duties of NHS staff before, during and after making reports:**
- *A search of the hospital* – so that a dead patient is not found in the shower four days after 'going missing', for example!
- *Information should be provided to the police* – the future date upon which a police ability to use s18 MHA to bring the patient back expires <<< you should see the look on some nurses' face when you ask for this. *(Para 22.15 CoP MHA.)* It is a duty for the reporting MH professional to specify the date, not leave the police to work it out.

- Finally, the Department of Health laid to rest in national guidelines the myth than MH trusts cannot take and provide photographs of missing patients, to assist police missing persons investigations.

A final point for me: if a patient is missing for more than a certain period of time, the NHS will often 're-allocate' the bed to new patients. I'm told some areas use a 24hrs or 48hrs timescale.

If the patient is found after this time, **there is no authority in law to hold that person in police cell** until bed management arrangements can be sorted out. Section 18 allows that AWOL patients "subject to the provisions of this section, be taken into custody and returned to the hospital or place". In this sentence 'taken into custody' does not mean taken into a police 'custody' area! It means taken into a condition of 'legal custody'; ie, by the detaining authority exercising a duty under s18 MHA.

15th January 2012

AWOL Patients: part 3 –

When a psychiatric unit inpatient is not detained there under the Mental Health Act but has embarked upon voluntary treatment, different legal frameworks apply to their recovery if they absent themselves from care. Indeed, 'legal recovery' may not be possible at all without a full MHA assessment coordinated by an AMHP.

Nurses (of the prescribed class) and doctors have authority under the Mental Health Act to detain informal patients in certain circumstances but once patients have crossed the threshold and left the immediate hospital grounds, these authorities cease to apply. The police have no authority to detain an informal patient because they have absented themselves from care or because of any perceived need that they should return. The may only detain under s136 MHA if the criteria for that apply. Although such patients are regarded as 'missing', they are not formally AWOL under s18 MHA and liable to immediate re-detention.

So where informal patients are reported missing and the police locate them in a private dwelling, officers have no authority to detain them at all. It raises a question which should be borne in mind by mental health professionals and the police at the point an informal patient is reported missing:

"What do you actually want the police to DO, if we find them and cannot detain under s136 MHA?"

There are a couple of options:

- Confirm that the person is immediately safe and well but leave the patient in that known location and refer their whereabouts to the ward staff who may or may not then exercise the proper procedures to have an AMHP led assessment to detain the person formally under the MHA and have them (re-)admitted to the ward.
- Remain in as close a proximity to the patient as you are legally able to do and *immediately* contact a crisis team service for urgent re-assessment under the MHA.
- **Which of these two will be appropriate should be based not just on professional opinion when reported missing; but on officers' opinions about the context of them being found.**

Neither option is filled with certainty and legal control from a police point of view and both of them raise previously highlighted questions about assessments on private premises: would you want to leave a psychiatric patient pending MH services arranging follow-up? How long will it take for Crisis to gather an urgent assessment together?

If and when a patient is re-assessed, the AMHP and DRs will determine necessary further follow-up and care. But as these issues will all come to a head when a patient is found, it is important that protocols for AWOL situations cover informal patients and the extra considerations which this blog imples.

It is also **vital** that NHS professionals understand both the lack of legal authority to recover informal patients and the duty of care which may necessitate timely support to the police in order to prevent patients who are at risk from being left where they are found for a want of legal authority to do otherwise.

15th January 2012

Warrants under s135(2) MHA –

Warrants under this subsection of the Mental Health Act, relate to the recovery of AWOL patients. There is a power of detention for AWOL patients under s18 of the Act and this is a power of arrest for the purposes of PACE (allowing reasonable force to be used). This power is exercisable not just by police officers, but also by AMHPs and anyone authorised by the relevant hospital to do so. However, it gives no authority for anyone to force entry into a premises, should that be necessary. The warrant enables the police to do so, in order that a patient may be retaken and returned.

The case of D'Souza v DPP (1992) highlighted the need to the police to have a warrant under s135(2) MHA if they are to enter a premises without permission or by force. In the particular case, the patient concerned had made his presence in the dwelling known to the attending officers, but he but opposed the officers' entry. They claimed to rely upon s17 PACE to enter: this allows entry to 'protect life and limb' which the Court of Appeal ruled requires demonstration of a high standard. There must be a genuine belief by the officers that life was both literally and imminently at risk. As this was not the case here, entry was ruled unlawful.

I have previously placed heavy emphasis upon correct understanding of s135(1) and the criteria for obtaining warrants. There are a few pitfalls in understanding this one, too; but they contrast with s135(1).

In no particular order:

- This warrant can ONLY be obtained if entry to the premises has been refused or refused entry is apprehended.
- Whilst it is still good practice for the police to be accompanied by a mental health professional, it is not strictly *necessary* and the police *may* apply alone for this warrant and execute it. There is an example below of why this may be important.
- Officers must simply satisfy a Magistrate of the presence of mentally disordered person who is AWOL under the Act.

TRUE STORY

Some years ago, officers on my area were undertaking missing persons enquiries into a s3 High Risk missing patient. He had been absent from hospital for over a fortnight and medical opinion was that without medication, he would become psychotic and he had previously attempted suicide and been a violent threat to others. He also routinely used drugs which made problems worse.

Over the fortnight, all police activity had been done and re-done: addresses searched, bank accounts tracked, friends / family and professionals interviewed at length, CCTV enquiries at locations it was believed he may have visited. His mobile phone would have been 'pinged' for information and whereabouts if we had known whether or not he had one. The investigation had received close scrutiny from an assiduous superintendent who made sure the pressure on the inquiry remained high.

During a particular night shift when my team were on, we were given information that this man was now at a premises where we had previously visited more than once and fully searched. It is fair to describe the occupant of the premises as obstructive and abusive, disdainful of the police attending there at all. She had made complaints about our attendance, arguing that because we had been told by her he was not there and never visited, we should desist from ever coming there again and she would allow no further searches.

The information was good, however – corroborated by other intelligence once we did some more checks. I decided to send officers to get a Magistrate out of bed and apply for this warrant on the grounds that reused access to the premises was apprehended and I despatched officers in a plain police vehicle to keep an eye on the address and plan our containment of it. Whilst in dressing gown and slippers in his hallway, the out-of-hours Magistrate took advice from an on-call legal clerk who (wrongly) advised him that the police were not able to apply for this warrant at all – it required an AMHP. In fact, he quite roundly reprimanded the officers for their error and sent them upon their way.

The officers informed me more or less immediately once outside the Magistrate's house that this had occurred and I asked them to knock the door again before he got back into bed and brief him Magistrate that I wouldn't attend within 10 minutes to make a representation that this was an error on the part of the clerk and a serious barrier to this patient's welfare and public safety. I wasn't actually sure if this was the appropriate method of seeking to correct a decision but I took my Mental Health Act with me. I will simply describe the conversation as very awkward, as there was a reluctance to question the advice of a clerk. Quite an experienced once, it emerged.

However, pointing out that the warrant could quite lawfully be granted and that no mental health professional was available to attend with us, it was incumbent upon me to highlight that the recovery of a violent, psychotic patient would be delayed and that I would not have come to make a fool of myself in person unless I was sure. It was also fair to say, the decision and representations would have had to be documented and legal advice sought from force solicitors around the refusal to grant the warrant.

It took 45 minutes of the magistrate (not a stipendiary, legally qualified Magistrate) reading, asking questions and re-reading, as well as talking to the clerk to reach agreement that it could be granted; and it was.

30 minutes later: one patient detained, removed to the hospital facility from which he was missing who did not have an available bed and wanted him detained in the cells. <<< That, however, is another blog!

15th January 2012

The Future of the Blog –

I'm now going to have at least a full week off from blogging after having posted a piece about s135(2) warrants which brings to an end a set of articles about AWOL patients. Incidentally, I've noticed today's AWOL blogs have been especially well-read – I wonder why?!

There are now 55 posted articles on different aspects of policing and mental health – this has covered law, guidelines, partnerships and other difficulties. I have tried to address each of the particular sticking points about particular functions, like s136 and s135 and offer practical guidance for solutions either operationally, or within discussions about setting local protocols. Within, I have been critical of some police practices, as well as some mental health and NHS practices.

Although there is still more to do, I can foresee that before I reach 100 pieces I will have exhausted what I want to say and what I want to make available. Apart from some presentational tinkering to make it more of a standing resource, with a particular focus on frontline police officers there will be nothing more to say beyond the occasional comment on a noteworthy news event or court case.

It's then a question of getting on with it – *"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has."*

The trick with this stuff has always been and will always be – whether professionals, especially leaders, in our police and various mental health, social care and other organisations actually *want* to take the necessary time to get their heads around this kind of material, the difficulties of working in partnership at the interface of many NHS organisations. Do they then want to train staff to succeed?

I am convinced that it is ill-founded perceptions of complexity that prevent this: we all too often don't understand each other or each other's roles. But we DO understand what the issues are:

- *s136 Place of Safety arrangements* – drugs, alcohol, violence, children, learning disabilities.

- *Assessment on Private Premises assessments* – occasional inappropriate use of the police; frequent misunderstanding about warrants.
- *AWOL patients* – minimising numbers by understanding prevention; understanding roles for notification, search and recovery.
- *Diversion and prosecution arrangements* – how should we decide who to prosecute and when?
- *Inadequate police responses to violence* – NHS staff in psychiatric facilities all too often deserve a better response than they get when they have been assaulted at work. Improved investigation and greater use of out of court disposal and formal prosecution.
- *Police support to the NHS* – the extent and type of that support for urgent transfers, medication etc.. That speaks for itself.

There is a checklist for senior officers on this blog, which I know has already been picked up by some senior NHS managers. It outlines a template with links to other references and sources.

The Police Superintendents' Association of England and Wales have just confirmed to me that it is being emailed to all 1,400+ of their senior officers next week. Credit where it's due: that is humbling and I'm extremely grateful for such support.

I am convinced in an era of public service reviews, there are long-term *financial* as well as opportunity cost savings to be found within this area of business. Not least because a death-in-custody inquiry following a controversial detention and the use of a controversial pathway costs millions. <<< And *that* is not even the most important cost. Far greater the cost to the family of people who will forever feel let down and to general public confidence in policing. If it is perceived that the police cannot keep vulnerable people safe and do the right thing, then what hope more complex tasks?

What I know from my own professional outlook is this: if partnership protocols and arrangements are not put into the kind of order that would survive contact with domestic and European law, I will be thinking very carefully about whether to comply with them. My **first duty** is to the law and I'm not only entitled, but obligated to resist breaching it. When I am implicitly invited by poor or non-existent local arrangements to decide whether to breach laws for which there is no excuse OR breach a local protocols for which there is every explanation: **it's not even a hard decision**.

So the real challenge here is *leadership*. I have met many dedicated, committed, inspirational NHS leaders during my years working in this area and some without the faintest idea how to start approaching this area of

business and who assume that if they do nothing, the police will indefinitely continue to put their arm in the mangle, to plug gaps in services.

Equally, I know senior officers who recognise the need to make progress here and are actively committed to it; but some are caught in the headlights of how to proceed amidst almost unfathomable NHS commissioning structures and there are a very few who don't seem to grasp the need to proceed at all because mental health disasters have not featured on their radar. Either way, police officers have for years been quite frustrated at their safety, good will and legal integrity being taken for granted and deserve to be led.

In approaching the issue of organisational shortcomings, we tend to look first through the window and out to the world. We would do well to look in the mirror at ourselves.

There comes a point where it's 'leadership time' because we can't just keep talking about this for ten more years: **are we going to do this properly or not?** Because if 'not', I just need to know this so that I can police in a way which ensures that the right people will be accountable afterwards when I've done my best.

23rd January 2012

Lee Dixon –

Last week, Lee Dixon was 'sentenced' under s37/41 of the Mental Health Act having been found responsible for attempting to murder two police officers in Darlington. PCs John WOOD and Carl WOOD (not related) were commended by the Judge for their 'considerable bravery' in detaining Dixon as he made concerted efforts to stab one of the officers in the face. Each emerged from the incident with their stab-vests bearing piercings from the knife.

It could have ended so very differently and previously. It has done so on other similar occasions.

This case has prompted debates on blogs and comments elsewhere, not just from police officers. It seems to be causing the usual questions to be re-asked about apparently unpredicted or unpredictable violence by people with mental health problems.

- What does this mean about 'care in the community'?
- Should Dixon not have been detained in hospital, given the risks he clearly posed?
- What does this mean about violence by people with mental health problems?
- What does this mean about the prediction and mitigation of risks?

CARE IN THE COMMUNITY

As far as I can establish at the point of writing, Lee Dixon was not known to mental health services in his area. Therefore, questions 1 and 2 should not apply. It means little if anything for 'care in the community' or inpatient care because mental health services were not given the opportunity to intervene: for whatever reason. It is like asking what the police were doing to mitigate risks for predatory or acquisitive offenders after learning they've never been arrested before, or featured in police intelligence about offending in any way. As police officers, we know that many of our offenders are well known, but that this can happen from time to time.

The movement towards de-institutionalised mental health care has been taken up the world over and is unlikely to change. Whatever police officers may think about this, it still needs policing properly. However, if you take time to learn about pre-1950s institutionalised care, one will see that it was not without significant problems in terms of crime and human rights. (Some critics will argue that inpatient care has not improved sufficiently since that time.)

VIOLENCE BY PEOPLE WITH MENTAL HEALTH PROBLEMS

Question 3 is harder to answer: questions are being asked in the case of Durham social worker Claire Selwood who was repeatedly stabbed in 2006 by a mental health patient who had disclosed to his psychiatrists before release from hosptial that he would kill her. She is currently appealing against a court ruling which rejected her claim that the NHS Trusts who cared for her attacker had failed to alert her to the risks and breached their duty of care. It will be interesting to see how the appeal proceeds given that the successful argument in the lower courts was simply that the NHS Trusts owed her no duty of care at all. Questions have been asked and answered in relation to the care and treatment of individuals like Ikechukwu Tennyson Obih who stabbed and killed PC Jon Henry in Luton in 2007; and Earl Butler who stabbed and killed DC Michael Swindells in Birmingham in 2004 where shortcomings were identified by the independent inquiries, but such investigations would not apply to Lee Dixon.

Questions about violence by people with mental health problems is politically sensitive for a range of reasons. Campaigners will argue that violence is under-reported, misunderstood and misrepresented. Professor Tony Maden, professor of forensic psychiatry at Imperial College, London, received some criticism following his 2007 book 'Treating Violence' wherein he described the link between schizophrenia and violence as being " no longer controversial … there is a highly significant association between psychotic mental illness and violence in the community, of a similar order of magnitude to the association between smoking and lung cancer." (Oxford, 2007, p23).

One is often greated with the non sequitor retort that mental health service users are far more likely to be victims of crime that perpetrators. Of course, these two prevalences are entirely unconnected. Whatever the statistical prevalence of each, one tells you nothing about the other. Moreover, it has been claimed that this claim comes from poorly conducted, not validated research without a control group or peer review. In three seperate research papers conducted on a group of 700 patients between 2001 – 2007, violent victimisation and commission was broadly similar at around 21-23%.

RISK PREDICTION

Well obviously, if someone who suffers from a mental disorder which may be associated with raised risks of violence is not known to or not engaged with mental health services, then the ability to predict risks will be limited or non-existant. The ability of criminal justice agencies to manage those risks will usually be limited to situtations where s136 MHA may be applied or where offences have already been committed. Of course, the police also can and do refer people at (all types) of risk to mental health services and other agencies to secure a multi-agency plan around how to mitigate risks. I do not know whether this could have happened Dixon's case.

However, where patients have been known to the mental health services and then very seriously offend, there is an inquiry into their treatment and care with a view to ensuring that lessons are learned. There is now a large number of these reports – two more due shortly on the separate cases of Darren Stewart and David Neal – which all say roughly the same thing: information sharing and / or care planning and / or risk assessment and / or follow-up after disengagement. Tony Maden argues in his book for a closer examination of risk assessment tools, stands up for those tools which exist and suggests more robust use of them.

EARLY INTERVENTION

I once attended a meeting in an area who were looking at their forensic mental healthcare pathways. They brought together a multi-agency group of professionals to help bring different perspectives to bear on the problem of 'early intervention' – how to target services early on towards people with needs which put them at risk to prevent them the need for criminal prosecution and detention in secure care. They were currently spending 55% of their total MH budget on just 3% of their patients: those who were detained in medium and high secure hospitals following criminal sentencing under the Mental Health Act. The proportion of the budget spent on this group of patients had been rising for several years and therefore the remaining 97% of patients had access to dwindling resources which in turn made it harder to ensure early intervention to mitigate against others coming into contact with the criminal justice system.

Of course, the problem is how to identify from a whole population group that small cohort of inviduals who present the trigger factors for early intervention hoping it will mitigate against future risks. This starts to get into very difficult and complex ethical territory as there has been suggestion by some mental health professionals of medicating people in risks groups before the onset of illenss or offending. Of course, if Lee Dixon was unknown to services – for whatever reason – then his detention in secure care at approximately five times the cost of prison is unavoidable.

23rd January 2012

Threatening Self-Harm –

The police service often get called to incidents in private premises where people are threatening suicide or self-harm. These incidents are very difficult to address because on the one hand, cooervice powers are severely restricted; but on the other to do nothing at all and subsequently find that a person who may be mentally ill and / or lack capacity has seriously injured or killed themselves would be devastating, not least for the person and their family.

Don't forget to consider a properly trained hostage / crisis negotiator for these kind of situations.

Such incidents in public places are comparatively straight-forward: as long as an officer believes the person to be suffering from mental disorder, s136 of the Mental Health Act is in play. But where s136 cannot be used, let us remember police powers in private dwellings:

"During police attendance following a spontaneous incident or during a formal Mental Health Act assessment in a private dwelling conducted ***without*** *a warrant under s135(1),* ***the police have NO powers to use force until:*** *EITHER an AMHP has 'sectioned' the patient OR unless a criminal offence is attempted or a breach of the peace apprehended."*

Let us also remember, that when officers' start realising this and their thoughts drift towards concepts of 'mental capacity' there are certain limitations on the police use of the Mental Capacity Act – unless someone is actively attempting to cause themselves death or serious injury, the MCA is probably of no application.

- **Call an ambulance** – there is a very real sense in which this is a healthcare situation: a mental health crisis in progress. Nothing in law prevents police officers asking healthcare professionals to attend or for advice.

- **Call the 24/7 MH Crisis Team** – whether or not they can attend, they may well be able to provide useful information or advice.

Parliament decided in 1983, that the way to coercively manage such a situation, if that becomes necessary and appropriate, is for an AMHP and a

DR to undertake an MHA assessment for potential admission under s4 MHA. This was reinforced by the 'Sessey' case. If need be – for example, because the police were obliged to leave the premises for want of a legal reason to remain – this should then be done after obtaining and executing a warrant under s135(1) MHA with police support.

Whether or not such course of action is appropriate / necessary, is a healthcare decision – so call them to ask their advice about whether it may be needed. It also means, should there be no response, you have an audit trail of attempts to do the right thing and it puts into context any subsequent action taken or not taken.

Note for MH Crisis Teams and other NHS staff >>> if such a phone call comes in, please don't tell or encourage the officers to trick the patient outside for s136 to be used: that would be to **incite false imprisonment** which is triable in the Crown Court and as you're asking the officer to act illegally, you should expect them to say 'No'. They may phrase it differently and should be unmoved by representations that it may be ethical. *It is illegal.*

Principles about the operation of the Mental Health and Mental Capacity acts suggest concepts like 'the least restrictive' principle and the importance of patient autonomy and dignity. Here's a controversial thing that many police officers find counter-intuitive: people often self-harm to relieve their own mental distress and *have the legal competence (or 'capacity') to take the decision to do so*. <<< The first time I thought about this, it sounded instinctively wrong.

If dealing with this, I would encourage thinking in the following order:

- **Call an ambulance** – if nothing else, they have training to make assessments around Mental Capacity to a greater degree than the police (although I know paramedics who say it is not enough training). The ambulance service may or may not be able to make links with other NHS services, like out of hours GP or Crisis Teams. That is a matter for the NHS which they may not resolve until unrelenting feedback for the need to be able to do so.

- **Call the 24/7 MH CrisisTeam** – to secure what information you can, seek advice and ask for a response to the incident if the patient is known to them. Especially if the person is known to them, often worth reminding tha the police have no powers, etc., as per the above.

If any officer reading this thinks, "There's no point doing that, they won't respond!" I would say this:

You may be right or wrong about that. Either way, it becomes clear evidence that you have attempted to act in the least restrictive way, if subsequently other action becomes necessary. It shows you have recognised this is a healthcare situation and called healthcare professionals to advise, guide or deal. **This is important for any subsequent review of the handling of the incident.** Of course, they may actually respond! It has been known.

And if you get to the end of this, and find yourself standing in someone's dwelling just you and them, unable to secure NHS support, you must remember this: you have a duty towards them in terms of Article 2 ECHR (right to life) and Article 5 (right to liberty) and you're now standing right in the middle of the conflict between these two rights – if you *genuinely believe* that their life is at risk if you leave; if you *genuinely believe* that because of mental illness, drugs and / or alcohol that they lack capacity; you may consider that legal framework as the best you have available. If you do not believe these things, it may be that you have to leave – however, involve supervisors in this decision as it is a serious one.

If you thought they might act on the threats when you leave, would it be defendable to remain in their dwelling with them (even if as a trespasser) ensuring they do not take an overdose or self-harm? Possibly: this may be an anitcipated breach of the peace if you thought it imminent and the violence or threats were offered towards you. Where it was all directed by the individual at themselves, it is not clear from caselaw that this would amount to a breach of the peace.

Get your sergeants and inspectors involved – to start taking ownership and to start going up the NHS management structure to push for a reponse wherever you believe you – but preferably the ambulance service! – have assessed someone as lacking capacity and that to continue to seek a more comprehensive NHS response was in their best interests.

Would it be more or less defendable than leaving?

23rd January 2012

'RAVE' Risks and Litter Collection

For years I've overheard discussions about when the police should be involved in certain mental health situations and when they should not. Some things, by law, *must* be done by the police – executing either of the s135 warrants, for example; detention under s136. Other things can be done by many professionals – re-detain an AWOL patient; detain and convey a newly detained patient to hospital. So if we understand the things the police *must* do; how are we defining the things we do not want the police to do at all, or only when certain criteria apply?

It's all part of 'the remit' game which I so detest and which is seen not only between organisations like the police and mental health services, but also within those services. An entertaining half hour can be spent listening to dual diagnosis, adult mental health and forensic specialists discussing a particular drug addicted, offending patient and who should lead the handling of their care (buy popcorn and drinks, it can last a while). And I throw no stones from my greenhouse as it's like listening to police officers discussing whether a particular offender is a CID or PPU inquiry – only to find they're committed with other stuff that they see as more important want 'uniform' to pick it up. It's so utterly tedious and misses the victim (or patient).

COLLECTING LITTER

We would not expect the police to collect litter on a high street full of pubs on a busy Friday night – picking up chip papers and empty bottles. But if the detritus left there presented an immediate, hazardous danger to the public – we would tolerate them taking the time to do so. Although there is not statutory responsibility on the police to collect litter, there is a duty to protect life and prevent harm. So we routinely judge when a line has been crossed and intervene after the line. Sometimes this intervention is achieved by a poor quality quick fix: shifting something to the side of a pavement or road, for example. It can be properly collected and disposed of later, by the appropriate authorities but at least we've removed the immediate risk.

I once found myself sitting in a meeting with a another inspector from one of our local boroughs – he was the 'partnerships' inspector and was actively

involved in improving mental health partnerships in his area. We were discussing whether or not the police should attend an MHA assessment on private premises and went on to discuss whether or not a s135(1) warrant should be obtained. (See the blog index for posts on those subjects). There were two AMHPs present from the local teams and it was genuinely supportive, inspiring attempt to make their local protocol better.

We all seemed agreed: the police should not be routinely used at MHA assessments without s135(1) warrants – nor were they asked to be, I should point out. But there are some assessments where the police *should* be present, with or without a warrant. How do we define what these circumstances look like. **I had a lightbulb moment** because we all love a memorable mnemonic! –

RAVE Risks:

- Resistance
- Aggression
- Violence
- Escape

Heightened likelihood of certain risks compared to the normal 'risks' of these kind that mental health professionals face everyday and mitigate by joint or team working, or through particular training / planning.

THIS APPROACH IS NOT PERFECT – and it is a 'rough rule of thumb' and NOT a strict policy. Nothing will ever substitute professionals talking to each other, with a view to understanding what is to be achieved and why joint working might be needed. And we should all bear in mind, we might need support – call it a favour, if you prefer – next week and we'd hope for reciprocation.

This approach should not come as a shock to the police: we all understand that there are tasks which normally sit with other public sector agencies and which we do not regard as 'police business'. But if we're honest, we undertake them from time to time: usually where dangers present themselves as with the litter example, above – but there are many others.

So the same applies to policing and mental health: some things are NHS responsibilities and should literally *never* involve the police; other things will fall to the police because of the risk or harm involved and / or because of the short notice nature of the emerging need.

- This might be police led – s136 MHA; urgent recovery of high risk AWOL patients;
- It may be the police acting in support of the NHS – MHA assessment in private.

- It may be a primary police responsibility – criminal investigation of assaults on NHS staff.

But if there is a discussion around initial doubts as to whether it is appropriate to be involved in something which is not a primary police responsibility: ask whether there are any 'RAVE' risks? It will get you to *very probably the right answer, most of the time* – if that helps?!

Crucial – **start** your discussions on this basis; don't end them on it!

23rd January 2012

The Duty Inspector –

This page is intended to list the questions which very often drift to the attention of 'the duty inspector' on local police areas. It contains links to guidance and other blog posts which might help to resolve frequently asked questions and queries.

Mental health issues very frequently come to the attention of duty inspectors: where PCs and Sergeants need advice in lieu of training, where they hit barriers with partner organisations, where disputes exist about whether the police will or will not resource a mental health related incident and will deal with representations or complaints from other agencies or the public.

If your local arrangements don't look like the answers provided below, it is probably legitimate to ask for your local arrangements to be reviewed, as they are based upon law and national guidelines.

(Non police readers who want to know more about what a 'duty inspector does – or police officers, for that matter! – should read the bottom few paragraphs, which outline the role a bit more.)

- *We've arrested someone s136* – how do we deal with it properly?
- *A psychiatric inpatient has assaulted a nurse (or other patient)* – can we or should we arrest them?
- *An AMHP wants police support at an MHA assessment* – should we go and do we need to ask for a warrant?
- *A&E are asking us to arrest someone under s136 and remove them to the PoS* – can we / should we do this; aren't they a Place of Safety?!
- *A detained patient has gone missing or failed to return* – who is responsible for getting him back?
- *An MHA patient has gone missing or failed to return* – can we arrest them and can we force entry to a premises in order to do so?
- *A informal patient has gone missing* – can we bring him back?

- *A offender in custody has been 'sectioned' but it's a serious offence* – what do we do?
- *We're at a job in a private place where someone is threatening suicide* – what can we do?
- *The NHS can't or won't respond to a private premises* – can we use the Mental Capacity Act?
- *Officers are thinking about using the Mental Capacity Act* – how should they decide someone's 'capacity'?
- *We're being asked to restrain a patient so they can administer medication* – can we / should we do this?
- *We're being asked to move a psychiatric patient from one MH unit to another* – can we / should we do this?
- **NHS / SOCIAL CARE FAQs ABOUT POLICING RESPONSES –**
- *< More to follow shortly. >*
- *I see so many different ranks of police officer and I don't know who is in charge!* – what does it all mean?

Happy to add to this list if there are further queries – just email me on mentalhealthcop@live.co.uk

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***For non-police readers*:** every police area entrusts the minute by minute oversight of its police operations to a duty inspector – an officer of my rank. You become responsible for the oversight of all officers on duty at that time and / or the provision of legal and policy authorities to officers from neighbourhood policing teams, 24/7 response shifts, CID or PPU detectives, etc., etc. and this can amount in some areas to over 100 officers at some points. Initial appointment to this rank usually finds you left 'in charge of the shop' (especially at evenings and weekends) for the first time and you inherit a world of statutory responsibilities to authorise house searches, surveillance and youth justice disposals; as well as the call out of more senior or specialist officers; mobilizations of other areas' officers in the face of critical incidents or public disorder.

You are the accountable officer for police activity and in charge of the initial management of all critical incidents – murders, shootings, rapes, child abuductions and high risk missing people. You are responsible as a disclipline authority for the intial handling of professional standards

matters, including deaths in custody; police traffic collisions and excessive use of force complaints.

When I first became an inspector, further advice and support out of working hours meant ringing a superintendent or chief superintendent at home, or overnight; or calling out senior detectives for murders and professional standards issues. Now, there is often a superintendent on duty covering the force area, but they usually become involved in tactical decisions only at the request of the duty inspector.

It is the first 'command' rank hence the apparently unusual cultural practice of PCs and Sergeants addressing this officer as 'Sir' or 'Ma'am', more informally as 'the boss'.

23rd January 2012

Forcibly Medicating Patients –

I mentioned in a previous blog that when I first joined the police, it was not unusual to be called to the old Victorian hospital on my area to assist in restraining patients who were being medicated against their will under the Mental Health Act. It seem intuitive – mental health colleagues facing violence and danger from someone who is also a risk to themselves, the police have a duty to prevent harms and risks like this so surely there is a legal authority to do it?!

Well, as is often the case with the law, things are not quite that straight forward! –

LEGAL ADVICE

Once upon a time, a police service who often faced calls to help restrain patients for enforced medication took legal advice on the subject from a barrister who specialised in criminal and mental health law. They did so not only because they faced regular calls and wanted to understand their responsibilities and obligations, but also because they had been severely criticised for doing so after patients complained and wanted to understand where the line was over which they should not step. They were kind enough to share that barrister's view written opinion with me. It can be paraphrased as follows:

'Whilst acknowledging the role of the police to keep people safe and the unpredictability of some violent patients on inpatient wards, it does not logically follow from a duty to keep people safe and prevent crime that the police have a legal right to use physical force to allow mental health professionals to forcibly medicate. This remains true even where the necessity of forcing this medication upon patients is justified under the Mental Health Act. To do so, it may well be argued, would be an assault.'

I must be clear: I'm am not saying the police cannot restrain. For example, when there is a crime, a hostage situation, barricades in rooms where weapons are brandished or concealed, etc.. **Anything** involving crime can be deal with accordingly and the legal authority to do so comes

from s3 Criminal Law Act 1967; or from the Police and Criminal Evidence Act 1984 if searches or arrests are being made.

It is the continuing of restraint after the crime has been dealt with, into a condition of restraint for medication that this legal opinion questions. *I'd be interested in other legal views*, if available.

OPERATIONAL GUIDANCE

This caused me to think: of the nurse or junior doctor in a mental health unit at night who has a quite unpredicted and unpredictable need to administer medication by force, or to move someone to a seclusion facility using restraint techniques. Where do operational officers stand if they are called to assist?

Well, various reports including that into the death in psychiatric care of Rocky Bennett have made it plain that NHS facilities should have sufficient restraint trained staff on duty to deal with predictable needs as well as access to contingency arrangements. A requirement to restrain one patient for clinical reasons is not unlikely in mental health care and should be part of routine business for most. I'm imagining, like the police service, NHS trusts should have generic and specific health and safety risks assessments and procedures to account for managerial decisions on staffing, training and deployment to fulfil these statutory requirements.

But this also raises the question of **what should the police actually *do*** if they are asked to restrain or convey – for whatever background reason?

No cop wants to expose NHS staff to risks that they genuinely believe they need help to face. But at the same time, compounding problems by doing the wrong thing is just as bad or worse should disaster occur. I can give examples where my officers and I have attended inpatient units and the mere presence of uniformed police calmed down a situation sufficiently to allow NHS staff to get on with things. No assaults, threats or resistance. But that is not always enough:

I would suggest that the removal of imminent and serious risks from weapons would be justified, using force to prevent crime, but then officers should then **contain, not restrain** until such time as the necessary NHS intervention is marshalled by clinical staff pulling on their arrangements via their managers.

Again, if you're thinking this is unrealistic: you never know til you ask and asking will put into context the subsequent action taken or not taken.

ROLES AND RESPONSIBILITIES

The enforced medication of psychiatric patients is a *clinical* issue; the seclusion of psychiatric patients is a *clinical* issue; the (urgent) transfer of a patient to a more appropriate mental health facility for more appropriate care and treatment is a *clinical* issue – so it should be *clinically led*. Even where the police are required in those rare situations of urgent transfer to A&E because of serious or potentially life threatening medical problems, this should only be in support of other NHS services, including the ambulance service.

It must be tempting for police officers – practical people that they usually are – to say, "Let's just get on with this and get it sorted" not least so they can 'get back out [on patrol]'. Well, IPCC investigations are currently ongoing into officers who did exactly this – criminal investigations. It comes back to that question about the role of the police in mental health care: it is to apply the quick fix, to restore immediate safety until proper process and procedure can take over as soon as possible afterwards.

Even if attending a psychiatric unit and containing a situation took three officers four hours until NHS arrangements took over; this is little compared to the time and trouble it would take to deal with the situation incorrectly and then have to put the wheel back on or deal with the fallout of tragedy. It is also fair to comment, that if the NHS are able to rely upon a police willingness to 'muck in' for expediency, what incentive is there to ensure that ward managers have access to proper contingencies for these kinds of situations?

It is for this reason that I argue that senior police officers on BCUs need to be certain that their NHS partners understand what can and cannot be done and where the role of the police stops. Whilst acknowledging the grey areas and the duty to support NHS colleagues at risk, the police are constituted for a certain set of functions and the provision of clinical mental health care is not part of it.

24th January 2012

FAQs –

The blog now has a Frequently Asked Questions page, also available through the header on the blog.

Initially, it contains the questions I placed in the blog for Duty Inspectors, but it occured to me I should make this available more easily and that it may be added to. I plan to write some stuff later, answering questions from the NHS side about policing which will be added to this page.

If anyone would like any other particular question added / answered, please email me on mentalhealthcop@live.co.uk.

Michael./

24th January 2012

Place of Safety Training –

I've spent nearly six years of my life (which will be 20% of my career by the time it should end!) working towards the introduction of s136 Mental Health Act Places of Safety. I've been involved in getting six up and running and improving a lot more.

We realised early on, that it's all very well making them exist and writing a protocol, but if operational staff then don't know how to make the process work, navigate the pitfalls, etc., etc., it will have been in vain.

Section 136 of the Mental Health Act is actually quite easy to get right! (Section 297 of the Scots MHA and Article 130 of the Northern Irish MHO is no different in this regard.)

To that end NHS West Midlands (the SHA) funded production of a training video, which is available on YouTube. It was supported with time and staff by West Midlands Police, West Midlands Ambulance Service and the Heart of England NHS Trust (representing A&E within the pathway).

The video was primarily around how to get the point of arrest to point of assessment. So it deliberately **stops** once a person is in either:

- A&E
- Mental Health PoS
- Police cells.

This was quite deliberate. It's the 'early identification and management of risks' bit joint working needs to improve upon – we've almost always got the assessment / admission part correct.

Used as the basis for multi-agency training where professionals from each of the above organisations along with Learning Disabilities professionals and AMHPs / social workers; it got them all in the same room at the same time, to be trained *together*. It also allowed them to discuss / debate / argue / agree what the problems have been. It worked well.

I've delivered the training which sits around this video over fifty times across my force area. It is publicly available on YouTube – so here it is, in case it's useful:

- Part 1 – introduction
- Part 2 – RED FLAGS and A&E
- Part 3 – Place of Safety
- Part 4 – Police Station
- Part 5 – main messages.

This is not OSCAR winning acting and we have no shoestrings left – the police officers were brand new and mucked in fearlessly after a roadside training session on s136 (they hadn't reached that stage of training yet!); the paramedics were staying up off a night shift, sustained by police coffee; and the A&E sister was somewhat press-ganged by her consultant with about 4 minutes notice. Most seem to suggest, we've knocked together something useful and it has been used around the country as the basis to improve other PoS pathways.

I hope you agree.

25th January 2012

Chief Constable's Award

I went back to work today after a week off and waded through emails and letters. I was delighted to read this: >>>

Dear Inspector Brown,

I am pleased to inform you that you will be awarded a Chief Constable's Award for your outstanding contribution in the role of Mental Health Liaison Officer for West Midlands Police. Your commitment and professionalism has resulted in significant savings in resources and delivered an effective partnership response between the police, ambulance service and NHS, to provide an ethical and sensitive response to those members of the West Midlands who are in crisis.

Yours sincerely,

Chris Sims, OBE QPM – Chief Constable

25th January 2012

Section 136 Arrests Within A&E –

The police are sometimes called to A&E and requested by medical or nursing staff to implement a police holding power under mental health legislation – either s136 MHA(EW), s297 MHA(S) and a130 MHO(NI).

To implement one of these powers and then remove a person from one health building to another is counter-intuitive to a lot of officers and where local PoS arrangements rely upon the use of police cells it can appear utterly perverse. If someone has presented themselves to the NHS and then been either bounced between different parts of it, or indeed turned away completely and incarcerated in a police station for 'care', you'd struggle to explain that easily to a common sense expert, wouldn't you?

- **Some of the questions that arise:**
- Is A&E a place of safety? – it certainly can be; so it depends. See a previous blog post on this subject.
- Is A&E a place to which the public have access? – yes, it is. (If you want to read more detail on why, I have written about that seperately.)

The fact is, nothing in law prevents s136 / s297 / a130 being exercised in relation to someone who is currently standing in an A&E department, even if they've been triaged and are pending treatment. **Of course, *whether* it is exercised is quite another matter!**

The police officers involved – NB, not the medical staff! – have to be individually convinced that the grounds for exercising the authority are met. Sometimes, convincing them may just be a matter of good communication as to what has gone on and sharing any relevant information. Saying, "he's mentally ill we want him arrested s136" is not enough! << *real example!*

I previously posted a true story where A&E wanted someone arrested under s136 but the police resisted this, believing the legal justification for doing so was not there. Where such differences of view remain, the only route through the woods is dialogue. The police would ultimately have to accept medical decisions around healthcare, so must the NHS accept police decisions around arresting people. Both have access to proper channels of communication, if they remain dissatisfied, but police holding powers should not be utilised to punish patients for getting frustrated with waiting

or for the convenience of the professionals involved. They should be used *only* to ensure access to assessment and / or care that would not otherwise be achieved without the imposition of that detention.

Arresting someone – yes, it is an arrest – is a serious business which can affect life opportunities. Even MHA holdings powers can and sometimes will appear on enhanced CRB checks for employment. We should all understand how important employment opportunities are to people with mental health problems and therefore, we need to recognise that the legal coercion of an individual is a big step.

Of course, there are other examples in reverse: where a patient in A&E has become disturbed or aggressive to a degree that means they need to be controlled for the safety of others and officers have declined to arrest by saying, "He's already in a place of safety" or "A&E is not a public place". Such things are either misunderstandings of law, or the presentation of false argument to justify inaction.

Someone may well be in a building which *could* be a place of safety but if there is no urgent need for physical healthcare treatment and it is 'just' a case of needing MH assessment which will problematic in A&E because of the person's presentation and the environment, it may be necessary to arrest. If the person should be in A&E because they have serious medical problems, but are also in need of urgent MH assessment and possibly admission, it may be necessary to arrest s136 and keep the person within A&E for that course of action to unfold and proper assessment to take place.

All cases on their merits, but I repeat: you *can* arrest s136 / s297 / a130 in A&E but whether you *should*, will very much depend on the circumstances. Let's **put the patient's needs at the centre of the decision**. Now there's a thought!

26th January 2012

"You're Under Arrest For Being Ill." –

I've had a few questions today about the legal terminology "arrest" for the detention of people under s136 Mental Health Act 1983 in England / Wales; which would also apply to a130 Mental Health Order 1986 in Northern Ireland. Things are different in Scotland – see below:

I've also had queries via twitter today – @mentalhealthcop – about wording upon 'arrest' or detention; CRB checks for s136 and so on. So here are a few bullet points which should address them all. Let me know if I missed any and I'll add to this:

Is this an 'arrest'?

- In Scotland you have been 'detained' and the word 'arrest' is not legally applicable.
- If you have been 'detained' or 'helped' or some other vernacular that may be preferred, then in England, Wales and Northern Ireland you have, in law, been 'arrested'.
- Detention under s136 MHA is a 'preserved power of arrest' in England and Wales, by virtue of s26 and Schedule 2 of the Police and Criminal Evidence Act 1984.
- Detention under a130 MHO (NI) is a 'preserved power of arrest' in Northern Ireland, by virtue of s28 and Schedule 2 of the Police and Criminal Evidence (Northern Ireland) Order 1989.
- We should probably remember, Scotland's Mental Health Act was comprehensively redrafted in 2003 and criminal law in Scotland does distinguish between being detained and being arrested. This is unique to Scots' Law.
- I'd also like to think it was a deliberate decision to non-criminalise the language.

Why call it an arrest, then?

- Because in England, Wales and Northern Ireland, the fact that someone is 'arrested' is then a trigger for other authorities a constable has access to which may assist in keeping someone safe:
- The person detained can be searched for articles that the officer believes may be something that could be used to cause someone harm, or to escape from detention.

- These search authorities – s32 PACE(EW) / a34 PACE(NI) – do not arise unless people are 'arrested'.
- Finally, the legislation in play in England, Wales and Northern Ireland is basically a 'lift' from the Mental Health Act 1959 – they even left the important section numbers the same, for ss135/136.
- Was this so the police didn't have to learn anything new?! Who knows!

Some miscellaneous points:

- You do NOT need to 'caution' a person detained under the mental health acts, because cautions – or 'reading the rights' – relate to offences and some detained MHA / MHO is not detain /arrested for an offence.
- When explaining to a person what is going on after deciding to exercise this legal authority, there is no specific need to use the word 'arrested' or even 'detained', BUT >>>
- There is *very* clear requirement to ensure that the person is told in a way appropriate for them what the officer is doing and why that they may understand what's happening to them.
- Using the word arrest may aggravate, stigmatize or confuse someone so it is to be avoided and an alternative choice of words used which is as clear, reassuring and unalarming as possible.

- If you have been arrested under MHAs / MHO – whether or not subsequently admitted to hospital under the mental health law – you do NOT have a criminal record or a criminal conviction.
- The fact that you were detained MHA / MHO may be mentioned on a CRB check, but it has been suggested to me that forces vary in their approach to this and some treat disclosure on a case by case basis.

- Whilst detention under s2 or s3 MHA would not figure on a CRB, detention in hospital under s37 – a hospital order – or s37/41 – restricted hospital order – would feature.
- These are orders imposed by criminal courts instead of or following criminal conviction for an offence and therefore are appropriate for CRB disclosure.
- Equivalent orders in Northern Ireland are a47 MHO(NI) – a hospital order – or a47/48 MHO(NI) – restricted hospital order.
- Equivalent orders in Scotland are the hospital order under s58 Criminal Procedure (Scotland) Act 1995 and the restriction order under s59.

- Officers need to make the whole thing look, feel and sound as *unlike* a criminal justice process as possible, bearing in mind you'll probably be stood there in a uniform.
-

- That's why conveyance should be via ambulance wherever this is possible.

Mental Health Act / Mental Health Order warrants:

- All of the above would apply to detention under the terms of a warrant under s135(1) MHA(EW) or a129(1) MHO(NI) BUT >>>
- These are NOT 'arrests', in law. They are probably best described as 'detentions'.
- Scots' Law allows such warrants under 292 MHA(S), but again it is not an 'arrest'.
- There is no power to search the person, under s32 PACE (EW) or a34 PACE (NI).
- The other points, above concerning cautions, CRBs, information and wording upon detention, would not apply.

Let me know if I missed anything and I'll add to this post! Hope it helped.

Due acknowledgement here to @TaypolStudents and @BridgendPC from Tayside Police via Twitter who helped me understand Scots' mental health law to put together this blog! #teamwork #TeamTayside

27th January 2012

Mind The Gap: part 1 –

I've tweeted and blogged previously that there are some limited circumstances in which police officers may find themselves without powers to act in a healthcare situation to keep people safe, but without being able to ensure or motivate an NHS response either.

My comments about this have caused some to think I'm advocating an extension of police powers to allow for greater coercion, expansion of a police state, etc.. I want to say a little bit, so that I'm clear about what I'm getting at:

In a public place all over the UK, the police have powers under mental health legislation as well as powers of arrest for criminal offences, breach of the peace and so on, which would allow them a range of options to prevent harm where risk prevailed. **In a private dwelling this is not the case**. Whilst the powers of arrest for crime and breach of the peace remain, there is no legal authority for the police to act alone or unilaterally, where faced with sub-criminal risks by a vulnerable person, often towards themselves.

This may include, for example, someone threatening to harm themselves at a later point in time, perhaps by overdose. It would also include people playing around with legally possessed medication or knives etc., where they are not yet committing an offence. Again, let's remember: it's not illegal to possess a knife in your own house or legally available medicines. Illegal to threaten the police with that knife or attempt to assault them with it, but until such time as you do, it's your house and your knife whether you're chopping onions or wondering whether you might self-harm with it after the police have left.

Whilst remembering that the police once there would have positive duties to protect and balance human rights under Article 2 (life), Article 3 (inhumane and degrading treatment) and Article 5 (liberty), we should also remember the reality of what I call the 'legal caveat':

"During police attendance following a spontaneous incident or during a formal Mental Health Act assessment in a private dwelling conducted ***without*** *a warrant under s135(1) or equivalent law,* ***the police have NO***

powers to use force until: *EITHER an AMHP – MHO in Scotland / ASW in Northern Ireland – has 'sectioned' the patient OR unless a criminal offence is attempted or a breach of the peace apprehended."*

After the 'Sessey' case we were reminded of Parliament's required response to mental health crisis in private, which may require MHA assessment and it involved an AMHP and DR undertaking assessment for consideration of admission under s4, or an AMHP securing a warrant under s135(1) for removal to a place of safety – s292 MH(S)A; a129(1) MHO(NI):

So one tweet I posted said this: "**#UK** is almost alone by not allowing its **#police** to force entry under **#mentalhealth** law to a private dwelling to deal with an **#MH** crisis." This statement is true – feel free to look up Mental Health Acts from the six states of Australia, several from Canada and from South Africa for a start. Because I also posted other tweets on the difficulties faced by the police at around the same time, this one should not be read in isolation, as advocating an extension of police powers.

I also said this: "Either the law should enable the police to manage MH emergency in private dwellings safely; preferably, it should ensure that the NHS do so." I have also made it clear that I don't mind which, ultimately.

Incidentally, a proposal to bring equity with other international jurisdictions on this issue was contained within s228 of the draft Mental Health Bill 2004, which was set aside before being enacted. It was a proposal subject to enhanced scutiny of front line officers by mental health professionals and only for a very brief time, after which an Magistrate's warrant would have been required for further detention.

I understand why this is controversial for some – your home is your castle, etc..

What I do think it is fine to say, is that there is a lack of legal ability – a gap – to ensuring that MH situations brought to police attention can ensure management which will consistently prevent disaster. Notwithstanding the greater tragedy to a vulnerable individuals or their families, we can also imagine coverage of an incident which read, "Police do nothing known, suicidal mental health patient." It is utterly unconscionable.

So my position is this: I don't mind what the solution is to a position whereby society expects a *de facto* response from its police service as mental health crisis responders but doesn't equip them to handle the variety of demands faced. But if it does so without entirely equipping them to manage it adequately whilst also not ensuring a response to this from its health service, then we have a problem.

There is a gap. And **that** is all I'm saying, whilst highlighting just a couple of solutions.

What, if anything, should be done about this, is absolutely a matter for others. I'm certainly not advocating for an expansion of police powers. This will become even more important in coming years as health services continue to reduce their mental health capacity and I think we should prepare for an upturn in such calls to the police.

<<< Read a follow up which addresses some reaction to this post. >>>

27th January 2012

Chief Constable Simon Cole –

<<< Delighted to post my first guest blog, by Chief Constable Simon Cole from Leicestershire Police. Mr Cole became ACPO Lead on Mental Health and Disability in 2011. >>>

Taking over an ACPO Portfolio always seems to bring with it a very steep learning curve. As ACPO's new lead for mental health and disability I do find myself engaged in trying to approach that challenge.

There are some very real issues to confront. Notably the Equality and Human Rights Commission report 'Hidden in Plain Sight', which has really focused the service on how it is supporting those experiencing disability harassment. The report outlines ten critical incidents and then highlights a series of areas where improvements could be made.

I am now chairing ACPO's EHRC Coordinating Group, which is pulling together the service's response to the report. It is quite clear that the service is very much on a journey, with the requirement to record disability hate crime having been implemented in April 2008 but very different rates of reporting. Different forces have taken different approaches, but those who seem to be making the most progress have engaged with disabled members of local communities (very much in the spirit of "nothing about us without us"), they have had clear expectations set by their leadership and they are continually working to increase the amount of reporting and access to our services.

Training is also key. Many forces have delivered their own bespoke packages; certainly my own has done more than one set of training following on from the learning from the Pilkington case. The National Policing and Improvement Agency is now ensuring that disability hate crime features in their core leadership packages, that information about the EHRC is available on the POLKA system and that there is a link between the EHRC report and other ongoing pieces of work around violence and situational vulnerability.

The EHRC is not the only piece of work that is ongoing within the portfolio. I recently met with the mental health practitioners representing each of the ACPO regions at a mental health forum hosted here in Leicester. It is clear

that great strides are being made around dealing with Section 136 of the Mental Health Act and places of safety, with some forces reporting 80 per cent-plus of mental health detainees going straight to places of safety. The guidance talks about police cells only being used in "exceptional" circumstances and only where risks are "unmanageable" to health staff. It also suggests that all transport around mental health should be made by ambulances. Making sure that this is the reality of local delivery is now a key aim for the portfolio.

At the same time, work to introduce NHS-led and commissioned services into the police custody environment grows apace. There are now some ten forces working within an early adopter scheme with another twenty places available this year. Details have been circulated to ACPO colleagues and at present it looks like this will be over-subscribed and some choices will have to be made. All of this is about putting the patient first and ensuring that access to proper mental health services is allowed to happen. ACPO guidance on dealing with individuals with mental ill health and learning disability is a really useful document that helps to shape what we should be doing on a day to day basis as a police service, and includes custody. It is well worth a look.

There are other pieces of work that have great significance. I was proud to sign the 'Stand by Me' police promise with MENCAP at a recent event here in Leicester. The promise is that the service will stand by people with a learning disability to end hate crime, and there are ten pledges which I would summarise about being accessible and supportive in a way that I am sure we will seek to be. For instance, the ninth pledge is that we hold regular beat meetings and ensure that they are open to people with disabilities. I know that the Minister for Disabled People, Maria Miller, recently spoke at a debate in the Palace of Westminster where she encouraged police forces to sign up to the promise. At present over half have done so.

Many will recall the Bradley Report, a seminal report for the criminal justice world. Lord Bradley reviewed the dealings of the criminal justice system with those with mental health problems or learning disabilities and made a number of recommendations. That was in 2009. In 2012 those recommendations are being assessed and I have been invited to represent ACPO on the overarching strategic review body. This is important work and it will be interesting to see how consistently Bradley's recommendations have been taken forward.

All of this fits within the Government's 'No Health without Mental Health' cross-government mental health strategy. That will be further supported in the coming months with a cross-government hate crime strategy.

I was privileged to share the stage at the recent ACPO Autumn Conference with Mike Smith, Chair of the EHRC Inquiry. While Mike acknowledged that the police service has made positive strides to improving service to disabled communities, he set out a fundamental challenge to us all. His challenge was that people with disabilities simply did not believe that public authorities would respond to their call for improved service. Their disbelief was based on 20 years of raising the same issues and feeling that there had not been a significant response. I have been lucky to inherit a portfolio that has already started to shape that response; I know the service will respond to the challenge and improve what we are doing.

<<< First posted on the ACPO Chief Officers' Blog and reproduced with permission. >>>

27th January 2012

Mind The Gap: part 2 –

Some debate has resulted from this morning's post about 'gaps'! I want to suggest that what I'm trying to highlight has to a degree been mis-interpreted so I'd like to add to my first thoughts without editing them and or by extending the post. A part 2 is required!

A comment has been made that the Judge in the 'Sessey' case clearly stated that there was no 'gap' in the law. This is correct – the law offers the potential for all situations to be managed and in that sense there is no gap.

What the law does NOT do, is compel those who would actually need to be present in order to manage those particular healthcare situations, to be there. Often, they choose not. In that sense, there is very real 'gap'. And I've been required to fill it – repeatedly; and without the benefit of the skills, or legal authority.

Purely because somebody lacks capacity – and it's not always clear that they do – it doesn't immediately mean that you can, to quote a healthcare professional, "drag them by the wrists to hospital". It would have to be proportionate to the risks faced by not doing so and those risks are not always clear amidst a legal presumption of 'capacity'. And(!) to which hospital?! A&E will probably say "psychiatric place of safety" and vice versa.

- In a private premises, it is perfectly possible – however unlikely! – for an ambulance and / or crisis team to attend sub-criminal, non-life threatening situations to discuss with the police the necessary care pathway and the legal route to it. This would ensure a health lead to a healthcare situation and access to available health and social care pathways – if they existed.
- Thereafter, an AMHP and one DRs could choose to attend and make assessment for someone's urgent admission under s4 MHA, using a warrant under s135(1) to facilitate access to that assessment, if thought fit. How quickly such things can occur, would depend on how well resourced such services were.
- Regardless of those two points: in a private premises, should matters be urgent, life-threatening, etc., the Sessey case does not prevent police use of the Mental Capacity Act – the point in Sessey was that the Metropolitan Police Commissioner agreed his officers had used it

unlawfully. The police could call an ambulance as soon as they'd decided to use it, to get the health input and we know this already happens in some areas.

- Where Mental Capacity Act based intervention is being considered in non-urgent, non life-threatening cases, the capacity assessment should be determined by healthcare professionals wherever possible – ambulance, probably – and nature of the intervention would have to be determined by healthcare professionals. Not only do they have better training in capacity assessment, the MCA code requires that approach.

So the 'gap' that I'm referring to, is mainly one of public policy and resourcing, not law. It is a gap which exists where NHS services either can not, will not or do not choose to respond to such situations in order to provide a health lead to a healthcare situation. For whatever reason which I do not judge.

I'm grateful too, for two tweets today, highlighting from a service user's point of view, that they recognise the gap I describe. One of them described it not as a gap but "a gaping chasm." The other has 'written insightfully about being stuck in the gap' and it is well worth a read.

If anything about a situation involved criminal offences by the person concerned or a legitimate anticipation of a breach of the peace and it was not possible to get very prompt NHS ownership of the situation, then the police would undoubtedly have managed those risks by affecting an arrest. It's where such arrests cannot be made, and the NHS can not, will not or do not respond that the 'gap' exists. So the gap is not legal – unless you count a lack of obligation on the NHS to respond – but it is in terms of public policy because NHS organisations do not have accept that it could be their role.

Those of us who have stood in the dwellings of vulnerable people know about this gap: sometimes with known mental health patients, trying to find ways to resolve situations of risk where no arrest can be made, where it is not clear that people lack capacity – remember: we're obliged to presume that people have capacity – and no clear NHS ownership forthcoming.

But it only exists so long as NHS commissioners or managers choose not to target resources at ensuring a non-criminalising, health-led and rapid response type approach to community mental health crisis.

28th January 2012

Assessing Intoxicated Patients: part 1 –

The debate about alcohol, mental health and legal assessment under mental health law is interesting. When attempting to configure proper s136 / s297 / a130 arrangements, alcohol – along with drugs, children, learning disabilities and violence – is one of the five sticking points of discussion. In fact it is usually the biggest sticking point, not least because it often accompanies the ones about resistance, aggression or violence.

For some years now, I believe the police have fully understood that you cannot undertake truly meaningful assessment of patients who are detained by the police under mental health law, unless they are sober enough to participate in that assessment. We fully understand that alcohol can mask other medical problems, but also that it can cause someone to appear mentally disordered who may not be and that it may contribute along with drugs to presentations which may give a 'false positive' if assessment was conducted to early. **No problem with that at all.**

So how sober is sober?! >>> Well, any cop will tell you, that when dealing with drivers who are required to give a breath sample, you develop a range of stories over your career.

There will be:

- Some appear quite drunk, who blow under the limit.
- Some who don't appear to be affected by alcohol at all and was only breathalysed arising from the procedural requirements at a traffic collision but who failed the test and was prosecuted.
- Some get arrested and prosecuted for drink-driving but their driving not noticeaby affected before you stopped them, smelled the alcohol and they failed the test.
- Some people – actually, most people – get arrested and prosecuted because they are over the limit and their driving noticeably affected.
- Some people get arrested but are not prosecuted despite appearing affected but are simply not over the limit (or under the influence of drugs).

Once you get experience in this area, it's quite bewildering how perverse the impact upon people can be, especially when trying to compare that to

breath-alcohol levels**. The fact is, alcohol affects people in different ways and we need to work with that.**

So what does this mean for mental health act assessments and in particular, what about the practice which is routine in some areas, of requiring patients who arrive at a 'Place of safety' to submit to a breath test **as a condition of entry to that location**?

Most police officers have experience of having arrested people under s136 / s297 / a130 and then seeing that because the person has had just *some* alcohol, no mental health professional will go near them until they are stone cold sober and they are denied access to health facilities and NHS oversight.

Equally, I've known examples where patients who have been accepted into an NHS place of safety are breathalysed, not as a condition of entry, but as a clinical aid to whether it may yet be possible to interview them under the MHA and the AMHP / psychiatrist have decided to proceed with it when the patient has registered 70ug / 100ml. This is *twice* the UK drink-drive limit.

I was amazed, but they did it; and they defended doing it because the patient was cogent and coherent despite the alcohol. Using the breathalyser as an aid to practice seems far more reasonable.

This post continues in >>> Part 2.

28th January 2012

Assessing Intoxicated Patients – part 2

This is a continuation of a previous post >>> Part 1.

- If you demand **total** sobriety from some patients – absolutely zero alcohol in someone's system before MHA assessment – where does this leave those with a dual diagnosis, who are alcohol dependent, and whose health would be put at risk by enforced withdrawal? – *let's be honest, with some people who are alcohol dependent, it could kill them.*
- If you breathalyse patients as a condition of entry to a Place of Safety, which threshold are we using? – some use 35ug / 100ml which is the drink-drive limit; some use 0ug / 100ml; others use 50ug / 100ml – *where is the evidence based medicine behind these limits and the research?*
- A senior psychiatrist in Wales, present to represent the Royal College of Psychiatrists at s136 meeting I attended in Cardiff some years ago, described the practice of breathalysing patients as a condition of entry as "pretty disgusting if you think about it: clinically meaningless, morally repugnant and potentially dangerous." *<<< I can quote this because I wrote it down immediately and have used it many times to other psychiatrists.*
- If you are excluding someone from an NHS facility on this basis, are you assuming that it will be appropriate, legal and safe to detain them in a police station; and that any such decision is not accountable to the courts in the context of subsequently adverse consequences? – *I'm thinking now of corporate manslaughter legislation, as well as potential human rights consequences under various Articles of the ECHR.*

The fact is, the Code of Practice (England / Wales / Scotland / Northern Ireland) does NOT ban assessment under the appropriate mental health law, purely because of someone being under the influence of alcohol and it is not always medically appropriate to sober up in the cells. And as ever, we should not have one organisation forcing upon another a state of affairs that is unconscionable. **Cross agency support is vital.**

The English Code of Practice for example actually goes so far as to say, (para 4.55) that "if it is not realistic to wait [to stave the effects of alcohol], because of the patient's disturbed behaviour and the urgency of the case,

the assessment will have to be based on whatever information the AMHP can obtain from reliable sources."

So it is possible, however unpreferrable. *<<< That is my only point.* Because it raises the question of when or why not? And that is a matter for the AMHP.

I know of several Places of Safety who will refuse point-blank to allow anyone access to their facility if under the influence of alcohol. **At all: full stop.** Others will say that they will not, but in practice will allow it if someone is not drunk, but has just 'had a drink'. In fairness to the NHS, I know that they are nervous about trying to set something up where it is not just black and white – in some areas the police have previously taken the 'michael' and immediately started using them as a drunk tank. **This is highly inappropriate.**

Alcohol can sometimes mean that someone should be removed to A&E: either because consumption has reached dangerously high levels or because it is believed (by paramedics?) to be masking something else that needs ruling out. Things like head injury, diabetes and so on.

We do understand in the police that people who are drunk sometimes need to 'sleep it off' and that this will involve police custody. However, focus over recent years on the circumstances in which it may well be medically dangerous to leave someone in a police station cell for hours even with constant supervision by a police officer whilst they 'sober up', has actually contributed to a **reduction in the number of deaths in custody** over the last 10yrs or so.

As 17% of all police contact deaths are people in custody with a combination of drugs, alcohol and mental health problems – 5% are people arrested under s136 – it is vital for senior managers who write and review local protocols to make sure that the NHS do not simply erect 'exclusion criteria' on alcohol.

If they do and a custody sergeant worth their salt has read PACE Code C, they will remark upon para 9.5 and Annex H in their custody record as they transfer the person directly to A&E, which of course would be quite legal. Whether it would be legally for A&E or the NHS to decline a patient believed to be in medical need would be something for a court to decide. If done in good faith it would be a necessary and proper mitigation by a custody sergeant of what could, quite possibly, be invisible risks way beyond their competence.

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FEBRUARY 2012

1st February 2012

#polmh – episode 1

For those of you who use Twitter, you should search the hash tag #polmh and you'll see a useful discussion this evening loosely around policing and mental health. I wanted to record something of a summary of what (for me, at least) was a fairly chaotic thread of tweets!

We had contributors from the following backgrounds or categories:

- Service users – most importantly! After all, this is why we're here.
- AMHPs.
- Adult mental health nurses.
- Learning disabilities nurses.
- Various third-sector reps.
- Police officers.
- Mental health law trainer.
- Carers.
- MH advocates.
- NHS Security professionals.
- Solicitors.
- Paramedics.
- Victim Support.

The discussion kicked off with a starter based around, "What are the barriers to patient centred partnership working?" and got going initially about SLAs and respect for patients. During a wide-ranging discussion, there were various themes emerging, arising from which people seemed to agree on the need to improve the following areas of business:

- The respect, patience and tolerance for patients in need; also their carers and families.
- The legal knowledge of professionals involved in a decision-making: indeed various professionals were correcting others as the debate went along(!) and people were commenting that they learned a lot from the event.
- The need for managers in all organisations to recognise the value of joint training, whereby police, AMHPs, nursing staff get quality training led by or involving service users.
- The need for the police to improve their response to criminal offences against NHS staff and other patients who are assaulted.

- The need for joint operating protocols to minimise a certain amount of localism where it takes things to the point where forces have several different arrangements which affect their consistency.

I hope that others found, as I did, that it was a worthwhile event and there seems to a consensus to do it again. I keep coming back to this; the way that we learn about each other's perspectives is to spend time understanding and asking and debating. If social media can contribute to this happening less formally then it's worthwhile for that reason alone.

It feels like it should empower every one of us to go into work tomorrow and push for better arrangements with a new energy.

2nd February 2012

Section 136 and Children

There are various references to children throughout posts I have done so far, but it has been suggested I bring together in one piece a few thoughts about police dealings with children with mental health problems. I think it might take a couple of posts so I thought I'd start with **s136 Mental Health Act** and equivalent legislation. My favourite subject!

Firstly, all the standard stuff about s136 applies to children. If you look at the FULL INDEX, above, you will find loads of different articles about s136 and alcohol, exlusion criteria, private premises, responsibilities, etc., etc. as well as practical guidance for police officers. All that still applies, plus the requirements of involving specialists for children in the assessment. There are some additional practical issues, though:

The use of s136 is not age restricted. My own force has arrested children as young as 11 and 12 under the Mental Health Act, as well as some very elderly people. The first problem you encounter when children are detained is a reluctance of the general mental health or NHS services to have anything to do with them, even as a holding position until Child and Adolescent Mental Health Services (CAMHS) are available.

- When NHS services design and develop Place of Safety facilities, they tend to be within the 'general adult' units, because most people detained are adults of working age.
- CAMHS are often a distinct part of a mental health trust because of the specialist nature of the work OR they are a totally separate mental health trust altogether.
- So, some NHS areas do not allow their PoS to be used for people under 16 or sometimes under 18.
- Of course, the PCT could commission in way that overcomes this problem, and whilst some do, more don't.
- In many areas CAMHS specialists are simply not available 24/7 or out of office hours to respond to s136 detentions or children in police custody for offences for criminal offences if MHA admission is thought necessary.
- Where the police in one area arrest an 19yr old under the Mental Health Act, they go to an NHS facility, arrest a 17yr old and they have to go to the cells.

- The numbers of people being arrested under the MHA in any area is predictably low – perhaps as few as 2 or 3% of total numbers. In some areas, this amounts to 2 or 3 children a year.

What justification is given for this?

Often, it is a theory that placing a child in an 'adult' PoS, within an adult mental health unit, presents safeguarding risks. It is relevant to explain, that if a child is EVER admitted onto an adult mental health ward, rare though that should be, the NHS Trust have to undertake significant safeguarding functions, exceptional reporting requirements and special nursing arrangements. However, this relates to a child fully detained under the Mental Health Act on an adult psychiatric ward where there are other adult patients. How there is a 'safeguarding risk' to a child in a PoS within an adult unit where there are locked in a bespoke facility for one person, with controlled exit / entry points and where the only other people present with the child will be trained, vetted professionals and / or the child's family, I'm unsure. Indeed, I know NHS lawyers and others have rejected the whole argument that it is any safeguarding risk at all. **Especially when compared to the alternative.**

Of course when you ask where the child should be taken instead and they explain, "the police station" you immediately win the counter-argument: "You want me to take this child *for safeguarding reasons* to a place where I cannot possibly control whether or not there could be drunken, violent men; child pornographers, rapists and burglars? Say that back to yourself and listen to it more carefully: in proximity to **violent / drunken / sex offending adults?**"

Incidentally, those who argue the kids or anyone else for that matter, should go straight to the cells should be reminded to read para 10.22 of the Code of Practice: when an NHS facility is not available or non-existant, there should be no automatic presumption of the police station being used. Why don't we run these kids home, assess the safety and suitability of their home address, the cooperation or otherwise of parents / guardians, etc.? If satisfied it would be appropriate explain, "Your son / daughter has been formally detained by the police under the Mental Health Act and needs to seen and assessed by a Doctor and an AMHP. If you agree to let me remain here with your child, they can be held here for assessment. If you don't agree to my remaining here, I'll have to take them to the police station." <<< All legal, if done with care and attention to safety and suitability. Which parent would say "No"? Probably the ones whose houses you would assess as unsuitable so you wouldn't have asked.

What must it be like to be 13yrs old, arrested whilst undoubtedly scared? – I don't care how tough they *think* they are or claim to be: you get arrested or detained by the police when you're mentally ill, you'll be

scared. Imagine being taken to a sparse looking cell block not knowing what will happen, where you find there are people thumping on cells doors FOR HOURS; screaming abuse and telling custody sergeants that they hope their kids get cancer; that they are going find and rape their wives (usually verbalised more graphically). Put my son there and I'll be off to see a solicitor.

Of course, using police cells instead of an 'adult' mental health facility PoS, it still won't overcome the ability to engage CAMHS specialists in the pathway of assessment or admission, if required.

I once took a senior NHS manager to a cell block in my area. Fortunately, his hospital was just across the road from the busiest custody facility in the force and it is a listed building from the 19th century, so the custody area looks like the set from Porridge. A multi-level, Victorian Gaol.

I couldn't have arranged things better if I tried on a Wednesday afternoon – howling, fighting drunks, screaming shouting. Hysterical female shoplifter being booked into custody screaming about picking up her kids from school and spitting at the arresting officers; there was a rapist in custody being dealt with by the Public Protection Unit as part of his sex offender registration requirements. The custody sergeants were looking a bit stressed and just grunted when I explained who I was, why I was there and so on. I gave the NHS guy the tour and showed him the medical room: this is a 'cell' that has had a medical 'bed' put in it, a desk with two chairs and a few kitchen cupboards for forensic and other kits.

I just looked at him and asked, "Have you got any kids?" I didn't hear the answer because the drunks were screaming.

No child detained under the MHA goes to a police custody area in my force.

3rd February 2012

What We Need the NHS To Know

If you are a mental health or social care professional, the police need you to know some 'stuff' when it comes to their involvement in mental health incidents and Mental Health Act procedures.

I've written this to help oil the wheels of understanding because I keep being told in response to this blog and Twitter that explaining reasons for police actions / inactions, is *key* to understanding alternative perspectives. By no means am I suggesting that this stuff is simply not understood: it represents a list of things that more than one mental health or social care professionals has got confused or been wrong about, in my operational experience. I hope you find that it is helpful, which is its intention.

*This is **crucial!*** >>> **NB:** writing this post does *not* imply that the police have nothing to learn and / or are perfect: very far from it! I hope the police read this post as well, but the **whole point** of this entire blog is that we all have things to learn, including me.

So in that spirit here are just some thoughts:

- **General:**
- The police, like every other agency have finite resources.
- Despite the fact that police theorist Egon Bittner asserted that "there is nothing which could not become the proper business of the police", it does not automatically follow that everything *is* the proper business of the police.
- Just because you do not have a legal authority to do something, does not mean that the police *must* have this authority.
- Just because you do not have resources on hand to do something, it does not follow that it is always going to be legally or logistically possible, even if it is desireable, that the police are called in to do it.
- Decisions by your organisation not to train or deploy staff to undertake statutory functions, does not always automatically create an obligation for the police.
- Asking the police to convey someone who is in legal custody under the MHA may very well be an implicit request to handcuff the person – ask about force policy in your area because many forces require 'compliant handcuffing' of those being transferred between locations.

- **Assessments on Private Premises:**
- Where you want to do an MHA assessment on private premises, and you identify "RAVE risks" which require the police, the officers may well ask you to get a warrant.
- Yes – you can and sometimes should apply for a warrant even though you already know that you'll get in.
- The potential that a magistrate may misunderstand the law, or that their legal clerk may do so, does not mean we should assume they will and not try to do the right thing.
- There is **no legal power to search** someone you have sectioned in a private premises.
- There is **no legal power to search** someone who has been detained under s135(1) warrant for removal to a place of safety.
- An AMHP may delegate their authority to detain and convey under s6 MHA to another person, but may not *compel* that person to accept the delegated authority.

- **Removal to a Place of Safety:**
- Once someone is in police custody, it is ultimately a decision for the police to decide where a person should be removed to because they bear the legal consequences of the decision.
- A&E can be considered a potential place of safety if the officers are clear or in some doubt as to whether the person arrested needs medical assessment, prior to psychiatric assessment.
- Nothing in law prevents the police asking a psychiatric place of safety to handle a detention, even if that location has given generalised indications that they will not – it can be crucial to the officers' demonstration that they've discharged their duty of care.
- How much alcohol is too much; how much resistant behaviour? If some is OK but more is too much; *you* should be prepared to help define that boundary because we think it's a false dichotomy anyway and we're simply not trained to call it properly in light of possible clinical risks.
- Nothing in law prevents the solution to a s136 quandry being improvised outside the terms drafted in a local protocol. The question is whether what was done was *lawful* and whether the officer feels able to defend their action in the *context* it was taken.
- It would be lawful to ask a PoS in a neighbouring area if they would be prepared to handle a case, if the normal location is occupied, unwilling to accept – especially where the person is ordinarily a resident of or a patient in that neighbouring borough.
- If would be lawful to take someone to a private dwelling, as long as the occupier is wiling to accept the person being detained there; ie, the parent of a child detained.

- The police are obligated to remain in a NHS place of safety after removing that patient there, only where this is consistent with their primary function to prevent crime, protect life and mitigate "RAVE risks" which are beyond the ability of the NHS.

- **AWOL patients:**
- If you report an AWOL patient, you are obliged by law to furnish the attending officers with legal information about the power of re-detention, if any.
- If you know the location of a person at the point of reporting them AWOL, it is *your* responsibility (or that of the NHS) to coordinate the repatriation.
- If someone turns up at a location asking to be taken back to the NHS facility from which they are AWOL: transportation presumptions should be directed towards your relevant organisation, usually the ambulance service. If the police are required, it will be in *support* of this organisation, not in lieu of them.
- If you are reporting an informal patient going missing, please have instructions ready for what you actually *want the police to do* if they find the person – if they find the patient in a dwelling, they have no powers to do anything at all, unless the individual is committing an offence or a breach of the peace.
- Guidance and support will be required, possibly quickly so there needs to be a pathway.

- **Offences by Psychiatric Patients:**
- The officers are going to want to know background information, relevant to their legal decision-making.
- Amongst other things this will include legal status under the MHA: previous relevant behaviour on the ward (if any); opinion of the RC as to prosecution; whether or not the patient has been AWOL during detention or afforded any s17 leave.

- **Enforced medication of patients / transfers between MH facilities:**
- It has been questioned as to whether the police have any legal authority at all to restrain patients for medication.
- This is a responsibility for the NHS and incidents of insufficient staffing or training should be addressed with NHS managers.
- It is a matter for NHS managers to ensure commissioned arrangements to transfer patients between NHS facilities for clinical purposes.

- Only where urgent transfers are required, for example, to A&E for urgent care, should the police be used and even then, it would be to support the ambulance service, not replace them.

The above would represent my reactions to requests for support from the police or to reactions from the NHS that the police had done the wrong thing. I can assure you it's provided so that we all understand each other a little better.

4th February 2012

It's Cheaper To Do It Properly

Update June 2012 >>> Since writing this article, I have been informed that the figures of people detained in police custody in my force for 2011/12 were just twenty-three … that means over 97% of people detained are going to a healthcare facility. Greater than my wildest imaginations, frankly.

Like many forces and most public sector organisations, my force is redesigning how we deliver police services over the next few years. There is obvious focus at the moment on budgets, costs and cuts; as well as a whole world of politics upon which I am going to focus **not one jot** except to say this: we all know how the public sector is looking to doing more with less, or at least achieving the same with less. I'll come back to this at the end.

My force have had various requests over the last year or so from individuals and organisations regarding the operation of the Mental Health Act involving the police. Last week, you may have seen a short BBC Newsnight piece concerning deaths in police custody during which Freedom of Information Act figures were mentioned. The BBC sought figures from every force in England and Wales on their operation of s136 Mental Health Act and details of where individuals who were arrested were taken (hospitals or police station). It was nice to send it back saying over 90% of people detained go to hospitals, which puts us in one of the best places in the country.

It wasn't always like this. In 2005 when I started work on mental health issues, 100% of people detained under the Mental Health Act went to police custody as a place of safety for the want of any other options. This was not without consequence and not without cost – measured in many different ways.

Today I dealt with two other questions from an FoI applicant for information about the 'costs' involved in s136 – although they didn't say whether they meant costs measured in time or money or both!

One could look at police involvement in the operation of various parts of the Mental Health Act in cost terms. In fact, I know forces have done this to establish how they should cut them. They (mis)-read the Code of

Practice to the Mental Health Act and said in fairly blunt terms, "We have no obligation to do X or Y or Z, so we won't because it will save money." Cue: unexpected consequences both in terms of NHS reaction, public or patient reaction and other unpredicted problems of 'failure demand' which meant things took even longer and resulted in operating tensions, complaints and legal actions, etc.. **Costs went up.**

Equally, Primary Care Trusts have sometimes to declined to ensure resources for Place of Safety provision. Cue: responses from the police attempting to improvise though an inappropriate, resistant system and avoid detention in the cells; tragedies in police custody arising from failure to identify and manage medical risks. **Costs went up.**

Shouldn't we just focus on **doing the right thing?** Healthcare delivered by healthcare professionals, supported by the police where this involves risk, in an environment suitable to the person's immediate needs?

I found myself many times over the last few years talking about 'doing the right thing' to manage medical risks and to treat people properly, as we'd want to be treated. When I did so, I faced suggestion from many that it would drive costs up; NHS staffing things they hadn't previously staffed, two police officers supporting a patient for hours in an NHS PoS instead of one officer or a custody assistant doing a constant watch in the cell block. Well, even if that were true, wouldn't it be worth it to know we'd done the right thing?

Average detention time in police cells in my force is around 12hrs; average time in NHS PoS is more around 4hrs. One member of staff for twelve hours or two of them for four. Do that maths and you're still winning the overall cost argument, aren't you? But that's not why you'd do it: **it's the right thing to do.**

But having sat with a calculator for just fifteen minutes yesterday, I was struck by something when answering questions about money. There is usually no focus in costing these services on costs resulting from current 'failure demands'. Things like, legal actions, which have occured against the NHS and the police arising from s136. I am confident I could show that costs to the public from high profile tragedies nationally – including criminal and civil cases; as well as Coroner's Inquests and human rights challenges – have been over £100m. Yes: **over one hundred million pounds**.

But by focussing upon doing the right thing, it is possible to show the following for just one police force detaining 1,000 people are year under the MHA:

- The financial costs to just one police force of doing s136 properly, is £180,000 a year less than if they were to continue doing it badly and

it comes at **no extra overall cost to the NHS** if they think creatively about service re-design for staffing.

- The opportunity costs to a police force of doing it properly is reprented by 25% less time spent engaged in s136 pathways and it comes at **no extra cost to the NHS**.
- The additional costs to doing it badly – for example measured in terms of 'failure demands' (putting things right) or in terms of formally investigating complaints, court costs of all types, etc., are not normally counted but they stand at **tens of millions of pounds** (for one force).
- By the time one factors in these costs from 'failure demands' as well as these operating costs, this equates to over fifty full time police constables.

So we can say this very confidently: to 'do' s136 Mental Health Act and Places of Safety correctly is in the interests of patients to get faster assessment, more reflective of their needs in more appropriate environments with better joint managements of risks across the agencies, but that, **far less importantly(!)**, it actually costs **less** to do it that way, not more.

Pleased to report: this blog was highlighted by John Seddon (Vanguard) in their System's Thinking monthly newsletter. Extremely grateful for that.

5th February 2012

Controllers and Call Handlers

Call handlers are gateways into the police – officers get despatched to almost everything after a call handler answers a 999 call or a 101 non-emergency call and agrees that it is appropriate to send someone. They must 'grade' the job to a suitable response time, start the process of getting officers despatched if it is an emergency and start logging and checking information pertinent to the handling of the incident. Often this involves remaining in discussion with the caller to elicit more information.

They work alongside what I will generically call 'controllers' – people who sit on the other end of police radios to the operational officers and between them all, they are a crucial part of the so-called frontline (whatever that is).

If non-police readers want to read a bit more about this role, please see the bottom section of this post. The following blogs will be of relevance to Contact Centre staff / supervisors:

AWOL patients –

- If MH services are reporting patients AWOL whose location is known, the Code of Practice to the Mental Health Act makes it their responsibility to repatriate that person (Chapter 22 CoP MHA).
- If police support is required – because of RAVE risks – then this can be done to *support* them; not to replace them.
- Any report of dangerous, particularly vulnerable missing patients of 'Part III' patients, must be reported to the police *immediately* so you should inform duty supervisors immediately.
- This applies whether their location is known or not and the police should be involved in their recovery ASAP.

Assaults by psychiatric patients on ward nurses or other patients –

- This is the thing the police get wrong the most and getting it right is crucial to demonstrating that the police have responsibilities were not properly discharging too.
- Patients who are assaulted and staff who are assaulted are entitled to report their crimes and to expect them to be properly investigated.

- There should be no assumption that where a detained mental health patient has hurt someone, that it is 'a waste of time' or 'not in the public interest' or 'something we can't do anything about'.
- An investigating police officer should be asked to look at it and supervisors should be involved from the start.

Assessments on private premises –

- The Police should attend these incidents if MH services are requesting police support because of RAVE risks; OR if they already have a warrant under s135(1) MHA. (A warrant means the police MUST attend as only the police can execute it.)
- If no warrant, but there are claims of RAVE risks, it would be helpful to all if you asked for early detail as to what these are. Sergeants can decide whether we are sending two student constables in a panda, a firearms team or something in between the two which might involve officers with dogs, tasers, riot gear or none of that paraphernalia.
- Also, if those RAVE risks comes from the person to be assessed, you could inform the MH professionals that the police officers will probably ask for a warrant under s135(1) MHA – don't mind their response, just log the request and refer it to supervisors.

Calls to restrain patients who need enforced medication –

- There is a genuine question as to whether the police have a legal authority to do this *at all*, in lieu of properly trained, equipped and skilled nursing professionals.
- If requested to attend because of RAVE risks early information to the caller that the police will only be able to contain immediate threats whilst the NHS marshal their staff, resources and contingency plans will be helpful to all.
- For example, this may mean if someone has armed themselves with weapons, it would be right for the police to ensure removal of the same, before then containing ongoing RAVE risks whilst NHS staff put plans in place.

Calls to transfer patients between MH facilities –

- This is a clinical function for MH trusts to undertake via their conveyance providers it is *not* automatically a police matter, if at all.
- If police support is requested because MH trusts don't have access to a (suitable) conveyance provider; the police role should be to contain immediate threats whilst it is decided the NHS invoke *ad hoc* their arrangements via duty managers / directors.

- The police should **not** be moving people under restraint between facilities, unless it is literally a life-threatening situation for example, removal to A&E which can't wait.
- If police supervisors do agree that for a want of other options, it is appropriate for them to transfer patients, they should ensure clinical supervision of the patient (by doctors / nurses as well as paramedics) during the transfer, especially if ongoing restraint is needed which poses high risks.

Mental Health Crisis in a Private Premises –

- The police have no powers in a private dwelling to manage a mental health crisis unless there is an (attempted) criminal offence or an apprehended breach of the peace.
- Where you despatching officers to jobs in a private dwelling, support to their decision-making could well come from the local Crisis Team who may have information which would assist a safe resolution of the job.
- Officers and controllers / call handlers should also be considering, as appropriate – ambulance, emergency GP and / or crisis negotiator if there is a serious risk to life ongoing.

Controllers and call handlers can access intelligence and command and control systems, so that they can be a repository of information even while an officer is driving to an emergency. Often, before an officer has even arrived at a call, the call handlers and / or controllers have established full nominal details, risk histories, convictions, previous address attendances, warning markers around all manner of subjects, including mental health, drugs, violence, which may affect how the officers approach an incident. With certain types of call, they actually resolve the issue without the need to despatch an officer and often in order to do so, they refer some matters to their own supervisors or the duty inspector, before agreeing how to proceed.

They are KEY to the management of calls for service involving mental health matters. This is true not only because they must identify calls which are emergencies and afford them appropriate priority, but also because they may often handle complex people making threats of suicide, sometimes talking to them *for hours* by phone, in order to try and elicit just enough information to know where to start a search.

Call handlers and controllers can consider whether someone, especially certain repeat or persistent callers are actually people with potential mental health problems. Forces are at various stages with their thinking

about how to refer such cases to the neighbourhood policing team for that area, so that local officers may then liaise with health or social care services in order to see whether something might or should be done.

6th February 2012

Future of the Blog – part 2

I'm going to have another period away from blogging new posts – probably a fortnight or so. This is partly to spend some time trying to make it more useable as a resource; partly to spend some time trying to get it more widely circulated and known about; and I'm coming towards the end of what I want to say and want to plan out what's left to do.

I'm going to spend some time writing some very small posts reducing various mental health jobs for the police down to half a dozen bullet points or less, with links to the fuller posts containing explanations, legal references, guidelines, etc., etc.. I'm also going to revamp the Index, the FAQs and play around with the categories. Thereafter, I'm going to limit myself to one weekly post until I'm done.

Ultimately, this stuff will succeed or fail based upon the extent to which police officers (inc senior officers) want to get knowledge to equip themselves and it will always depend upon over-coming problems in the way mental health services are provided, which is outside the control of operational police officers. It is probably within the sphere of more senior officers than we realise.

I was interested to learn over the weekend whilst reading, that where police services engage proactively in partnership work at the right local level, **mental health related policing demands can be reduced by 50%**. WOW!

Thanks for the support you've given the blog by reading and / or circulating to colleagues and other organisations.

Michael./

8th February 2012

Rabone, Savage and s127 MHA

Interrupting my blog-posting hiatus because of a judgement from the UK Supreme Court in the case of Rabone and another v Penine Healthcare NHS Foundation Trust which was published this morning. This case in now on the legal resources page of the blog.

Following on from the case of Savage in 2007 where it was ruled that hospitals' MH Trusts owed a legal duty of care under Article 2 of the European Convention to detained MHA patients, the Rabone case has now given a similar judgement on voluntary, non-detained MHA patients.

Melanie Rabone was admitted to a mental health hospital as a voluntary patient after a suicide attempt and had been assessed as posing a high risk of suicide whilst suffering a major depressive disorder. It had been written on her case file that the risk of suicide was significant enough to mean that if she should try to leave the hospital, she should be detained for assessment under the Mental Health Act. Notwithstanding this, the hospital granted her two days of home leave against the wishes of her parents and after spending a day with her mother, claimed to be going out to visit a friend and hanged herself.

The hospital admitted they had been negligent and settled a damages claim brought by Melanie's estate, but denied having breached Article 2 of the European Convention. Her parents continued the case to argue that a breach of Article 2 did occur and that this is a distinct issue from the settlement of a damages claim.

This is important: this ruling does NOT mean that voluntary patients can never be granted leave or that they can always be stopped from leaving wards by exercising a their own choice. It pertains to cases where there is a real risk of suicide and whether or not someone's medical condition should prevent them exercising that choice.

Today's publication of the Supreme Court judgement makes it clear that with regard to patients with mental health problems, there is a difference between voluntary and detained patients. However, the court stated that this difference must not be exaggerated and that the difference between Melanie and "that of a hypothetical detained psychiatric patient would have been one of form not substance." Her medical notes were inscribed with

instructions that should she try to leave the hospital, she should be detained [under nurses' and / or doctors' holding powers] for assessment under the Mental Health Act. The Supreme Court stated that this was the necessary approach because of the suicide risk and it endorsed the Court of Appeal ruling reached in the Savage case.

These two cases now being current case-law issued or endorsed by the highest court in the land, it raises the question for me about professionals' and trusts' potential liabilities under s127 MHA (willful neglect of a patient). I'm thinking about the required police response to complaints of neglect if it is alleged or shown that steps were not taken to ensure relevant patients were subject to holding powers where they should have been; as well as questions for NHS organisations around corporate manslaughter where policies, staffing, training or procedures, etc., are deemed insufficient to discharge these duties.

What should happen if frontline cops attend reports from mental health services to AWOL patients where the overall circumstances amount to concerns about leave being granted for patients who didn't return; or to inaction in failing to prevent someone from leaving? "Err, Sarge! …" Serious stuff.

If you work within the mental health system, it is worthy of consideration that the police service do receive complaints, albeit rarely, from families of alleged neglect by other professionals and these complaints must be investigated as any other criminal complaint. So where do we think s127 MHA comes into either of the granting of s17 MHA leave for detained patients or home leave for voluntary patients; as well as to the prevention / management of AWOL cases?

Could it be 'wilfully neglectful' to fail to detain someone who needs detaining or to grant leave to someone who is a high suicide risk, in breach of the principles outlined by this case? Potentially, yes. Could it be 'wilfully neglectful' to prevent an AWOL case which was preventable? Again, potentially, yes. As with everything, **all cases on their merits**.

Worthy of thought.

9th February 2012

Notional s37 MHA

*<<< **UPDATE**: since publishing this post a range of professionals have suggested it properly sums up the MHA detention framework. >>>*

This is a post which is not directly about policing and mental health, but about prisons and mental health. I have decided to post about it because it shows the tangle into which you can get around understanding this law. OK, it's also because I got asked the question and hated to admit I didn't know! So then I got interested even though this will never affect the police directly. Sometimes the consequences will affect us indirectly, but more of that at the end!

<<< This post does not apply to Scotland, becuase the law is different. It applies to Northern Ireland whose Mental Health Order has exactly similar provisions, albeit the articles of the Order are numbered differently to the sections of the English / Welsh Act. >>>

I'm posting this partly to see whether I've now understood it correctly! – so you should absolutely feel free to comment if I haven't and I'll amend the post. Based on Twitter, I'm half-thinking that by eventually bashing this into shape there will be various professionals who might benefit as the tweets went on into the night trying to sort this out!

What is a 'notional s37' MHA patient?

- **Firstly, some law:**
- **s37 MHA** – a **"hospital order**
- This can be imposed as an alternative to criminal sentencing following a finding of guilt by a criminal court; or if a person is 'unfit to plead, unfit to stand trial', following a finding that they did the act alleged.
- **s41 MHA** – a "restriction order"
- This can be imposed upon a s37 order where a patient poses "a serious risk of harm to the public"; and it prevents DRs granting leave, hospital discharge or hospital transfer without Ministry of Justice permission.
- **s47 MHA** – a "transfer direction"
- This 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.

- **s48 MHA** – a "transfer direction"
- This authorises the moving of remand and other prisoners to a hospital, as per s47 MHA.
- **s49 MHA** – a "restricted transfer direction"
- This imposes restrictions upon leave, discharge or transfer without Ministry of Justice permission, as per s41 MHA.
- **s50 MHA** – is a "remission direction".
- A remission direction can remove a s47 or s48 MHA patient back to prison if their detention in hospital for mental health treatment is no longer required.

If someone who has a mental disorder is found guilty of a criminal offence, it is available to the court to sentence the person to detention in hospital under s37 MHA. It the person poses a particular risk of serious harm, this s37 Hospital Order can be restricted under s41 to manage those risks – this is known as a "37/41 order". The restrictions imposed by s41 are not upon the patient, but upon the Doctors managing the patient. They are not free to authorise hospital leave under s17 MHA, hospital transfer under 19 MHA or discharge from the MHA entirely, as they are free to do so for s37 patients. They would need Ministry of Justice approval for these things.

If a person was sentenced to prison for the offence and thought or found to be mentally ill whilst serving a prison sentence, then they may be transferred by the Ministry of Justice from prison to hospital under s47 or s48 MHA, known in each case as "transfer directions". Once they arrive, they are to be regarded "as if" they had a hospital order imposed upon them under s37. The transfer directions can also be restricted by s49. So a s47/49 transfer direction AND or s48/49 transfer direction, each equate to a s37/41 order.

All clear so far?!!

WHERE DOES "NOTIONAL s37" COME FROM

The phrase "notional s37" does not appear in the Mental Health Act. Various contributors to the debate last night (that allowed me to start getting my head around this!) implied that someone 'becomes' a s37 patient automatically when a s47 or s48 runs out. s47(3) shows that this is not true. Once a person arrives in hospital, by virtue of s47(3), they will be treated as if they had been given a hospital order by a court from that time.

So 'notional s37' is in effect, parlance or informal terminology. Someone to whom it relates is in fact detained in hospital following a transfer direction under s47.

If the patient's need for inpatient hospital care comes to an end before the original prison sentence has ended, they can be remitted back to prison to complete their sentence under s50 MHA. If the prison sentence ends whilst they are detained under s47, they continue to be treated 'as if' they had been sentenced by a court to a hospital order under s37 and remain detained until the responsible clinician determines it is appropriate to release, or until a Mental Health Review Tribunal orders it.

Once the sentence is fully finished, the 'prisoner' is fully a patient and becomes entitles to benefits, etc., etc., but they are a patient detained under the original transfer direction – either s47 or s48 – which demands that they be managed "as if" they had been originally sentenced to a hospital order under s37.

HOW THIS CAN AFFECT THE POLICE

There are two circumstances in which this could affect the police:

1. **Being requested to use s136 MHA outside prison** – because a transfer direction was requested by detention in prison ends before the person can be moved to hospital.
2. **A notional s37 patient becoming AWOL under the Act** – from where would an officer get a power to redetain; and what power if any to force entry to a premises in order to do so?

Firstly – sometimes, there are problems around this s47 process. The need to transfer a convicted or remand prisoner to hospital arises with insufficient time to identify a suitable hospital bed and / or for the Ministry of Justice to issue the transfer direction. Sometimes a sentence completely expires, but mental health professionals cannot 'section' someone who is in prison. So it gives rise to a somewhat contrived solution:

"Hello, police? Can you come to HMP XYZ and when Mr SMITH gets released from prison, arrest him under s136 MHA and take him to a place of safety so we can section him?" Yes, this really does happen. I'm aware of it twice in my force in the last year.

I'll be honest: I think this is highly ethically questionable, however legal it may be. Imagine having gone through the experience of prison with an untreated mental health problem requiring inpatient hospital care that has not been possible to arrange. Then either, you think you're getting your liberty back and suddenly find yourself arrested at the gate, denied

anticipated freedom; OR the idea of total unsupported freedom and responsibilty amidst a serious mental health problem causes massive anxiety and you are made to think you'll be released without support?

Secondly – because the person in hospital is being treated "as if" they were a s37 patient, the same rules apply. s37 is the only provision within Part III of the Mental Health Act that leads to someone being regarded as straight-forwardly AWOL under the Act. Police officers, AMHPs and anyone authorised by the hospital managers can redetain a person unders s18 MHA if they are AWOL in order to return them to hospital. There is no power of entry: a warrant under s135(2) MHA must be obtained if entry needs to be forced in order to do so.

The Bradley Review suggested that all s47 transfers should be completed within 14days whereas currently it is two or three times this long; if not more.

Incidentally – my first ever arrest in the police was a gate arrest from a major prison – but he was a fairly rampant burglar who went straight back to jail so no ethical problem applied! :-)

10th February 2012

Understanding Self-Harm

I think I've explained that originally, my interest in this area of policing arose from professional frustrations; a professional lack of knowledge of what I could or could not do; what I must or must not do when responding to incidents. I had no personal reasons to develop this interest and this crucially means I lacked a personal insight.

Frankly, probably along with many members of our society and many cops, I could not even begin to understand why some people self-harmed when they were in crisis. As a constable and as a sergeant, I had been involved in detaining, restraining and / or arresting many vulnerable people who had self-harmed or were attempting to do so. I could not see the necessity or the point: I **just didn't get it**. As such, the experience of policing events involving those who had self-harmed or were threatening or likely to do so, was frustrating to me because of my own perceptions: the sheer lack of necessity, as defined be me.

But this is not about me, is it? If fact, the last thing it is about, is me.

The moment that it clicked for me, was during a night shift as a sergeant, when one of my officers and I arrested a young woman who had cut her arms apart again with a razor blade and who was head banging in her hostel when staff called the police. After having to arrest her, we removed her to A&E for treatment to her arms and the young probationary constable I was with just asked her outright, "Why do you do this? I want to understand." I'd never thought to ask the question at all and both the answer and the subsequent exchange between the two of them over the next hour made it click. For me at least.

The woman explained that it made her feel better. The sensation of the pain, the physicality of bleeding was matched by a release of anxieties and fears which abated her depression and quieted down the voices she heard. In short, it brought (at least) temporary relief from her demons. She then said something quite innocuous which nailed it for me, although it still feels like a silly example, even now: "Plenty of people get this from doing sport. They go out to push themselves, end up pushing themselves to pain and hurt and derive both pleasure and a physiological, mental release." I play squash and sometimes you really push yourself; it

hurts, you can't breathe but it doesn't seem to equate. But something did click around the concept of 'release'.

It doesn't even make sense to me having typed it up; but something in my head clicked. That she articulated it so clearly and rationally, whilst awaiting her cuts to be cleaned and dressed made me realise that to her, this was a rational act; regardless of what I thought.

Years later, a colleague in another police force rang for advice. Officers in that force had attended a private premises to a call involving a known mental health patient who was self-harming. Upon arrival, officers established that she was open to services and contacted the local MH crisis team. Upon checking records, it was established that she had been seen earlier that day by her professional team and was believed to be doing OK. The officers wanted advice about the fact that she was currently self-harming and were asked, "Is it serious self-harm or just superficial cutting? If it's just cutting, just let her get on with it, it's what she does." And that was that.

After my 'penny-dropping moment' and the fact that I'd since spent three years working on nothing other than mental health issues for the police, I understood this. I actually had to remember I'm a cop and think about what they'd be wondering, "How the hell do I know if this is serious self-harm or superficial cutting?! I'm not a doctor?!! Does she have the capacity to take this decision in light of its consequences?! It's all very well saying you saw her earlier today, but what if she's taken something which has changed all the risks?!! What if I think it's superficial and leave her to do it, as per your advice, only to find she bleeds to death after I've gone?! I'm going to be asked the basis upon which I've assessed the incident, in light of your advice. Anyway, even if I think it's on the more serious side, I haven't got any bloody powers in a private dwelling?! Any chance of some help here?!!" Or something similar.

This blog post is about something crucial to the policing of mental health incidents: officers are often told that we need to have greater understand of and insight into mental health issues and what it's like to live with them. This often leads to calls for more / better training, perhaps including insight from service-users. All fair enough – my own journey has done part of that for me. Sympathy / empathy or lack of, for those at risk from mental illness, is one of the most remarked upon features of feedback to the police.

Although important, it's not actually helping me police the event, though. **Not one bit.** Do we leave her there to her own devices and how do we determine that this is correct, safe and defendable; or do we intervene and if so, how and on what legal basis? <<< *That is the training and the leadership we really need* because all the sympathy / empathy in

the world is futile if we then go and do the wrong thing and either leave someone at risk or criminalise them.

12th February 2012

Printing Blog Posts –

I was asked to add a PRINT icon to the blog, so that posts may be easily printed – this has now been done and all posts, both old and new, contain it at the bottom of each post, amongst the sharing icons for Twitter, Facebook, and LinkedIN, etc.. I've been informed that a large UK ambulance service is printing some of the material to distribute on training days to paramedics and technicians, which is great news! Somewhere, this lead to the print query which I hadn't realised needs to be enabled. It now is.

The whole idea of this blog is that it gets used to prompt debate and / or make the world a better place, so feel free to use it as you will – printing, copying distributing, etc.. I don't mind whether this is electronically or by hardcopy but **I just ask one thing:** *please* ensure the authorship of this stuff is acknowledged as it has been ten years or more of my life and work in the making and I retain the copyright!

That said – fill your boots.

Michael./

12th February 2012

Is Mental Health Police Business: part 1 –

This post is a direct response to @ConsultantHead on Twitter who has responded to a few tweets recently and asked this question in a serious way. I thought it deserved a post because you can't answer this properly in 140 characters and because my answer may be of broader interest given how the blog is going at the moment – over 22,000 hits in eleven weeks!

People tend to understand the involvement of the police where resistance or aggression is present and where someone is reporting a criminal offence for invesitgation (whether violent or not). But otherwise, why would the police become involved?

Well – **the police do not necessarily have to become involved.** However, as a 24/7 agency a certain amount of crisis demand is going to come the way of the police, as they do have a certain emergency social services function, whether they like it or not. They do not doubt these responsibilities where it comes to safeguarding children, for example. It is also fair to remark that the pejorative 'bad /mad' debate implies a false dichotomy: even if one accepts those labels or their euphemisms, there is no reason why someone could not simultaneously be both able to be held criminally responsible as well as mentally ill. How you bring such things to a conclusion is legitimately 'police business' because of the victim who is entitlted to justice.

Nothing in law prevents the NHS and social care organisations structuring themselves to deliver 24/7 community based mental health care, including staff who are trained in control and restraint for those circumstances where the use of minimal force is required to compel. Indeed, in Portland, Oregan (US), they are experimenting with an approach to community mental health crisis whereby they despatch an emergency social worker in response to 911 mental health calls not involving violence. Where they do involve violence, the police back-up the social worker for lower level calls and take the lead for more dangerous situations. No reason why not – if we chose to do so. In fairness, would an AMHP in a private premises be more use to a non-violent crisis patient than the police? They certainly can bring together a legal resolution to the situation which is beyond the reach of the police.

The Mental Health Act allows for the restraint of patients in wards, for enforced medication and treatment without consent; and for the detention and conveyance, by force if required, of patients who are newly detained under the Mental Health Act or who are recovered from being AWOL. Depending on the type of situation nurses and / or an AMHP can do all of this, and AMHPs / hospital managers / DRs can delegate authorities for various things.

So it does invite the question, where should the police become involved and why do they?

- **Serious aggravated resistance:**
- We would probably all agree, that there comes a point in the management of resistance and aggression, where the police are the only agency trained, equipped and available to deal.
- Nurses on wards being threatened with knives; patients barricading themselves in rooms with weapons, patients in the community who are to be assessed by an AMHP and DRs with a view to admission who have histories of very serious violence against mental health professionals and the only realistic way to keep the AMHPs and DRs safe, is for the police to be invovled in mitigating the risks.
- Once involved, it is very likely that such conduct amounts to a criminal offence and it is legitimately the role of the police to decide whether to prosecute someone for breaking the law.
- All of this is police business and it's not controversial as long as the way in which they do it, reflects the patient's needs, their dignity and takes account of the medical impact upon people with mental health problems of policing of this kind.

It is fair to point out by way of example, that there are instances in many forces of AMHPs wishing to undertake MHA assessments in the community and the only safe way to do it, is to secure a warrant under s135(1) MHA and have it executed by a full police firearms team. I've known of this at least half a dozen times. But as stated above, we all 'get' this involvement of the police in management or prevention of serious violence.

- **Passive resistance**
- There is a real debate here; often between front line police officers on 24/7 shifts and frontline mental health professionals; and the answer to it, is 'senior managers'.
- What if a patient has been given a weekend of home leave, all properly authorised but they fail to return to hospital on time? A phone call reveals they are at home but they have said on the phone they don't want to come back and will not do so.
- Who should go to recover them and / or use force if it is needed?

- As it is not a criminal offence to passively resist admission under the MHA; or to refuse to return to hospital if AWOL, the police need not be involved from a criminal investigation point of view.

Nothing in law prevents the NHS sending the relevant community mental health team and / or some nurses trained in control and restraint to attend the patient's house and use authority under s18 MHA to recover them and nothing prevents NHS organisation issuing whatever equipment they think may be needed for these tasks. Usually, objections from the NHS to suggestions that they should do this are met with, "We haven't got enough staff" or "We haven't got enough trained staff" or "Well, you've always done it before."

Whether you think this then makes the matter a police responsibility will probably vary from person to person. A part of me admits to thinking, "If you are going to get yourself into the coercion business, you should train and prepare to coerce; not just legally or morally; but physically." This is true not least because restraint training for the police is by necessity very different to the training for mental health care professionals.

If may say so, I tend to find it is mental health and social care professionals and their managers who do think that their decisions not to resource, or train or equip makes things police responsibility. I have no problem at all with this point of view, although it is not one I share. I only remark that **patients often don't agree** – in my experience.

This post is continued in Part 2. >>>

12th February 2012

Is Mental Health Police Business: part 2 –

<<< This is a continuation of a previous article – Part 1.

Nothing prevents the police from acting as the coercion force to administer the Mental Health Act should a Chief Constable choose to do so – as long as the way in which it is done, doesn't breach other governing frameworks, like the Human Rights Act. Ultimately however, police resources are also finite and Chapter 22 of the Code of Practice to the MHA (Chapter 29 in Wales) states that the recovery of AWOL patients, for example, should be done by the NHS with the police supporting "where necessary". Police supervisors would be on safe legal ground to, at least initially, resist this type of request by arguing it is the legal responsibility of the NHS. The person remains *their* detained patient whilst AWOL and the NHS still owe legal duties of care by virtue of the European Convention on Human Rights; the CoP MHA instructs them accordingly and the importance of the Code of Practice has been declared by the highest court in the land!

But if the request arises from the NHS not having trained or available staff at that time, regardless of why this comes about, does it then become a police function to step in to keep people safe?

Well, how unsafe it may be for that patient to remain un-recovered will vary from patient to patient. Some will become at significant risk, others will be fine for several days or until a CMHT or AMHP can be organised to undertake recovery or assessment for admission. So sometimes you step in, sometimes you don't. Some police supervisors don't want their names to be the thing the IPCC read before a vulnerable person caused themselves harm, as they are unconfident of how to rationalise to attempt to push it back to the NHS.

- **What does "where necessary" mean?**
- If it means, those situations where the NHS can not or will not do something, then it means one type of demand upon the police.
- If it means, not unless properly trained NHS professionals have tried and failed or legitimately assessed the level of resistance and aggression as requiring police skills, equipment and training, then it means something else all together.
- It is also important to think about what powers the police have: if the above AWOL patient was a voluntary patient, not a detained MHA

one, they have **no legal powers whatsoever** unless the person is committing an offence.
- I remain totally unconvinced that "where necessary" kicks into place where the NHS have taken some deliberate decisions not to resource things that we all know sit with them.

This is why senior managers need to meet, set strategic partnership arrangements and ensure the development of proper protocols backed up by training. They also need to ensure proper channels of communication between 24/7 service managers – this would be the duty inspector, for the police.

There is a chasm on some issues like this – and what the police should do with an intoxicated s136 patient – and the width of it varies by area. In some areas, the very notion that mental health professionals would recover AWOL patients is considered sheer fantasy and as I've previously posted, attitudes towards the Code of Practice vary greatly. You can correctly quote it all you like, some professionals don't have a moral problem disregarding the Code where their managers have said they should for whatever reason. That is my experience.

Parliament legislated that the legal powers of detention, conveyance, admission and recovery are also available to AMHPs, and anyone else. So local protocols should reflect at least some circumstances in which they use them. Otherwise, it is self-evident we are working against the will of Parliament. In what circumstances do or should AMHPs and / or hospital managers delegate to other healthcare or social care professionals legal authorities to coerce passively resistant patients and what training and staffing is required to make this work in reality. **I've never, ever known it in my experience.**

So, which police supervisor is now going to step up and say, "I know you're telling me there is a vulnerable person in that house and that you are refusing to go and get them" or "I know you've sectioned this person who is refusing to move and you're refusing to shift them but however reasonable or outrageous that may be, I'm now going to do nothing, even though to act and plug your gaps would not be illegal." Takes a confident, knowledgeable sergeant or inspector to do that. Often, they'd be thinking: how do I defend this to the IPCC if the person takes their life after my refusal to act and then the MH nurse or AMHP cites my refusal?

I've known some police officers regard this as emotional blackmail and call it as such in discussions. Never oils the wheels but none of us like being taken for granted.

My answer is this:

- I don't like to reduce to simplistic criteria the necessary partnership responses to complex issues where all situations are unique and where we need to think about things.
- I just don't think you reach a position very easily where 'this' belongs to the NHS and 'that' belongs to the police.
- s136 shows very clearly where nightmares can unfold if organisations polarize responsibilities: **we need to repsect and support each other.**
- This means we all need to admit our shortcomings: the NHS need to get better and faster at managing low-level passive resistance where parliament intended them to act.
- The police need to understand: the point at which it becomes necessary for the NHS to seek support from the police will vary from nurse to nurse; AMHP to AMHP and to stop obsessing about whether stuff is 'yours' or 'mine'.
- We also need to massively improve investigation of inpatients who assault staff and other patients.
- As a rough rule of thumb, I use the approach of 'RAVE risks' – where there is an anticipated, heightened likelihood of Resistance, Aggression, Violence or Escape, I support the notion that the police should be involved.
- But RAVE risks are a *start* to a conversation; not an end and they refer to risks raised above those which can be mitigated and managed by available NHS resources; or which cannot wait for the marshalling of those resources.
- If this comes around because of perceptions on the part of police officers that the NHS haven't resourced, trained or responded accordingly, the place to take that up is in a meeting between senior managers.
- So whether you agreed to plug a gap or decided you were entitled to say "No", the place to take the frustration is your inspector or chief inspector's office as a starter for ten.
- There should be meeting structures in your area to where this can be taken and those managers will find much available material on this blog to help them get past certain arguments which emerge as barriers.

I hope that helps!

14th February 2012

No Beds: part 1 –

This is the first of a couple of blog posts on a particular problem in police custody upon which I have worked for several years in my attempt to find an answer. A subsequent blog will get into the full legalities of police custody on this point, but let me test the water with this:

Where individuals arrested for substantive criminal offences are assessed under the MHA as needing hospital admission, it is occasionally the case that there is (apparently) no bed available in a psychiatric unit. The frequency of this varies from area to area; I know of some who report having this problem only very, very rarely indeed.

It leads to all manner of attempts to find other psychiatric units with availablo beds, sometimes out of the patient's normal area; sometimes in the private sector. There is a cost to this and some NHS areas are very, very reluctant to go for out-of-area or private sector beds if at all avoidable.

Meanwhile, back at the police station and whilst the bed management nightmare is ongoing, the PACE timescales to which the police must operate when detaining people who are arrested but not charged with an offence start to expire. It brings about a legal urgency which tends to focus the minds of custody sergeants who must at all times be satisfied that there is a legal basis upon which to detain someone.

If PACE runs out, then the MHA must provide a legal basis for detention or the person should be released. Except that releasing someone who is profoundly mentally ill and by definition a risk to themselves, possibly also to others, is utterly unconscionable; whilst keeping them detained without authority could be argued to be one or more of several potential legal breaches, including false imprisonment and a Human Rights violation. You may be able to charge them with a criminal offence, but if you're only doing it because you cannot immediately divert them to an NHS psychiatric bed, where is the ethical framework at play here?!

LEGAL ARGUMENTS

I have seen written legal opinion from a barrister and policy reports from the Mental Health Act Commission (now the Care Quality Commission) which says you solve it like this:

- The DR – not the AMHP – has a **legal obligation** to find a bed for an admission which has been identified as necessary;
- The AMHP has a **legal obligation** to make applications once the criteria of s13 MHA are satisfied.
- Notwithstanding the contents of Chapter 4 to the Code of Practice upon which AMHPs tend to reply when explaining that they can only make applications to hospitals who are making a bed available; the Code of Practice as we recall is "not binding instruction; nor is it mere advice – it is statutory guidance which must be followed unless there are cogent reasons for departure."
- Could the cogent reason be, "This person can no longer be lawfully detained by the police, because PACE timeframes are expiring as we speak and the person is too much of a risk [to themselves or others] to be released."
- This brings the AMHP and DR into a degree of conflict – "Which hospital do you want me to apply to DR?" whilst the DR is not ready to answer that question.

This scenario is addressed in previous reports of the Mental Health Act Commission (now the CQC). Refer to –

1. The 08th Biennial Report – para 4.45; and

2. The 09th Biennial Report.- para 2.49.

Although these documents date from the late 1990s, they have never been repealed or superseded from what I can establish. Remember, this is guidance from the statutory authority who oversees the Mental Health Act and their documents are legally reviewed before publication:

- They suggest that where this situation arises, a hospital is chosen from the 's140 list' held by the PCT and the AMHP makes the application anyway and then;
- Conveys the patient to the hospital where the bed problem is to be managed in a setting where the patient can start receiving (at least some) care in a context of legal detention.
- The 's140 list' is a list of hospitals who have been identified by the PCT to the Local Social Services Authority (LSSA) as being in a position to receive patients in cases of special urgency.
- PCTs are required to specify these hospitals by virtue of s140 MHA.

- I once wrote in a private capacity to nine PCTs asking them to provide a list under the FoI of the hospitals which they have specified to their LSSAs as being in a position to receive patients in circumstances of 'special urgency':
- I got **one** response and it made no sense at all to my question.

- **NB:** I am *very* aware, that the Richard Jones 'Mental Health Act Manual' states in the notes to s6 MHA that this approach is questionable.
- I notice he says nothing at all about the interpretation of s13 MHA and very little about s140 – I admit to finding this curious.
- What he stops short of saying, is that it's **wrong**.
- What we can all agree is wrong – legally and morally – is a mental health patient in need of admission, being left in a police cell for days, whilst bed management problems are resolved.

Such a scenario unfolded in Greater Manchester Police in 2004 and led to a person who had been arrested for an offence being held in the cells for over 3 days, despite having been identified as 'sectionable' after approximately 6 or 7 hours.

That case ended with GMP instructing counsel to seek an emergency injunction ahead of a full Judicial Review for a failure to provide beds / make applications. Perhaps unsurprisingly, by the time their barrister was poised to enter the High Court a bed was found. The IPCC investigated this case and concluded that whilst many illegal things occurred and it was all outrageously unsatisfactory, this had been beyond the control of the police who had a duty to keep the detainee and the public safe – the situation had arisen from a failure within the NHS. The IPCC concluded that the amount of representations made by the police at all levels up to Chief Superintendent to all levels of the NHS showed they had done everything within their power to influence a different outcome.

THE LAW IS THE LAW

We must remember: legal duties are legal obligations and they are capable of legal challenge. Whether a private individual wishes to bring legal action in the civil courts or not – against the police or the NHS – public authorities which include the police and the NHS have a 'positive duty', ie a pro-active obligation, to protect European Convention Rights. Argubaly, the police should be thinking of things like this, to protect that person's Convention rights. Such rights – under articles 2, 3, 5 and 8 – come into play when we are talking about the detention in the cells of someone suffering mental disorder, without clear legal authority, whilst the NHS are busy demand managing beds.

However difficult it may be, these background legal obligations come in to play and must be addressed without the police being left in the middle of a "damned if you do; damned if you don't" scenario.

Final observation: these positions always seem to involve cross-border stuff: ie, police in Area 1 arrested a person from Area 2 in Area 1 for an Area 1 offence; the dispute about beds is whether Area 1 or Area 2 should have to provide it if neither have an obvious answer – more likely still if there's more than 50 miles in between the two.

17th February 2012

Victimology and Mental Health

Here's what just some criminal justice professionals think about victims of crime who have mental health problems:

- They will be unreliable witnesses in court;
- Their version of events in an incident must be inherently flawed because they have mental health problems.
- Supporting evidence must be available to support their allegations which would not be necessary for 'normal' victims.

I don't aim these accusations at the police alone, the CPS have had their problems too, but national mental health charities have long lobbied that the police need to improve their responses to victims with mental health problems. I have seen this for myself: I remember once being at a morning meeting in the police where a senior officer was being told, "last night there was an assault at [the local mental health unit] where a s3 patient has assaulted another s3 patient." Without further information she replied, "Well that's not going anywhere is it?" Well, not unless you investigate it and gather the evidence it's not, no. What if the victim is competent to give evidence; what if it's all on CCTV; what if three other patients and five nurses witnessed the assault?!!

Justice doesn't stop at the hospital door; victims of crime are entitled to a proper, professional response. At the same time, it is fair to say that victims with mental health problems do represent an additional challenge because particular legal procedures can apply to victims and witnesses who are vulnerable and / or intimidated under the Youth Justice and Criminal Evidence Act 1999. This would potentially include a victim with mental health problems. Special interview procedures can apply, whereby specially trained officers conduct video interviews in lieu of written statements and it is all done in a way which should minimise the potential for suggestibility – vulnerable people saying what they think the officer wants to hear. Furthermore, particular procedures can apply at court to make giving evidence easier or fairer.

So I don't immediately understand why victims who have mental health problems can't have their allegations taken as seriously as any other victim? Of course, *some* patients' account of their crime reveals cognitive

problems of a type that can render *some* evidence unreliable, and very rarely all evidence. But not **all** patients and **all** evidence **all** of the time.

The police and the broader criminal justice system deal all the time with victims who tell part of a story; who blatantly lie and who contradict themselves and / or other available evidence or make mistakes. Sometimes this is because they have made a genuine error of recall during a short, unexpected and frightening incident; sometimes because they were drunk. Imagine saying, no drunk victim can be report crime because their evidence is inherently unreliable?! It would be greeted with outrage and rightly so, yet we seem to be in this position sometimes with mental health victims.

One of the cases of which I am most proud in my career for victim care and investigative tenacity involved a man who had mental health and substance abuse problems and I'm going to narrate the tale:

He was being repeatedly and rapaciously targeted by a local drug dealer: robbed, extorted, abused, threatened, held hostage for days and from time to time being made to work as a slave. He was assaulted for the fun of this man who continuously tortured him with verbal abuse and violence. Every time this man suffered an offence, he reported it to the police and one day he reported it to my team (I was a sergeant at the time). We established quickly, because he told us, that he was a repeat victim so we established the extent of this.

He represented a serious challenge as a victim / witness: he was almost constantly drunk; he frequently failed to show up for appointments during the investigation; his personal hygiene represented a very serious impediment to an operational officer spending an hour in a small room at a police station to take a statement. My constables kept saying, "I can hardly stand to breathe in there" and this was no under-statement. He was a very poor soul who had been arrested for shoplifting alcohol many times from the local mini-supermarket, such was his alcohol addiction, so he had many convictions for dishonesty which made him a prosecution witness nightmare.

When he reported the latest robbery to my team, we established that there were approximately one dozen reports in our area with him as a victim which were either being handled by CID, another policing area or by other teams in our area, where he lived. Always the same offenders. Meanwhile, I had a constable who wanted to be a sergeant who lacked some credible investigative experience of more challenging crime investigations so I asked her to gather all the reports from everywhere else – we didn't experience much resistance, if I'm honest. I said to my PC-come-Sergeant, "Go prove": and she did.

It took MONTHS of effort; I remember the number of failed appointments to get statements from the victim; the number that were rescheduled because he was drunk; the inconsistencies in his evidence. But I also remember the look on her face when she came back from Crown Court after having hunted down the victim to get him to court because he was drunk again and forgot. **Four year in custody** for the offender. What a result.

Of course the police and criminal justice system also have responsibilities to deal with offence investigations where victims are patients in psychiatric hospitals and other kinds of care institutions. We've seen this most recently at Winterbourne View in Bristol but there have been other cases. I'm going to do a separate blog post on that issue, as it's a subject in its own right.

18th February 2012

Arrest For s136 or For An Offence? –

Certain situations present police officers with incidents which could lead to an arrest for a criminal offence OR an arrest under s136 MHA(EW) / s297 MHA(S) / s130 MHO(NI). It therefore raises the question, how does the officer make the decision as to which?

Some forces issue guidance on this; others don't. Amidst the possibility of doing either, or both, and it all being lawful, my view on how to tackle this very important decision – which often has to be taken very quickly and without the benefit of full information and background – is reflected in four bullet points; for reasons I will then go on to explain.

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

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

On the second point: the police do get called to jobs where families or friends of patients have needed help to manage challenging behaviours and within that there is an offence. However, whether they rang to complain of assault or to get help from a mental health point of view, is not necessarily clear. Whilst remembering force domestic violence policies, it is important the police don't immediately get it wrong from the family's point of view.

Here is a scenario:

- A man in standing in a car park, adjacent to a road with a bus-stop. There are three or four people waiting for a bus. The man is mentally ill and he is shouting in the general direction of the people, swearing a bit and being abusive towards them, he is dishevelled and clearly hallucinating.
- The people are worried about what he may do and call the police.

- This is an offence under s5 of the Public Order Act – threatening or abusive or insulting words or behaviour, likely to cause harassment, alarm or distress.
- Do you arrest for the public order offence or under mental health legislation?
- **Mental health law:** *every* day of the week.
- No-one was being hurt, it is obvious he has a serious mental health problem and needs care and support.
- Should that MH assessment conclude that he is not mentally disordered at all, he can still be then 'dealt with' for the public order offence, if that is deemed necessary.

Repeat the scenario again, almost exactly as above, but this except this time add in the obvious possession of a knife and make the threats a bit less generalised and more towards the individuals who are very fearful of what the man may do.

- He would be committing offences by possessing the knife as well as more serious public order offences of threatening violence; or assault by using it if the incident escalated further before the police arrived.
- Do you arrest for the public order offence or under mental health legislation?
- **Criminal offence for me:** *every* day of the week.
- Although no-one had yet been hurt and it is obvious he has a serious mental health problem and needs care and support; he is engaged in very worrying behaviour.
- Mental Health assessment and if need be, full admission to hospital under mental health laws are available from police custody.
- The decisions about the offences committed can then be taken in conjunction with decisions about his mental health care.

If the DRs and the MH assessment team in police custody conclude that immediate and compulsory admission to hospital is necessary, the man could be bailed by the police to re-appear after assessment and treatment in hospital. Discussions about his potential criminal liabilities and / or any consideration of charging him with an offence despite his mental health problem then occur in light of fuller information about his mental health problem. For example, if it is believed that a long stay in hospital under the Mental Health Act is necessary, bail could be cancelled.

What does this balance achieve:

- It means that fewer people are criminalised for minor offences, when in reality their presentation was directly connected to their acute mental health problem.

- It means that any patient who does commit a more serious offence – and this is comparatively rare – is still properly investigated for their liability, but this is done in conjunction with the NHS and in light of urgent MH needs.

This all links in the 'diversion' debate (oh, how I hate that word). Getting it 'right' at the start saves time, effort, money and it manages expectations correctly across the organisations involved. Remember, there can be up to 7 different organisations involved in a care pathway after arrest.

In some police areas, the difference between this kind of approach and a 'Mental Health Act wherever possible' approach, is a **reduction in 40%-50%** of the 136-type cases. Such mental health powers were never intended as a substitute to substantive police powers to arrest for crime and a previous Code of Practice to the English / Welsh Mental Health Act used to say so.

It ensures a response to more serious offending which captures intelligence and in some rare cases will lead to prosecution – let's not forget, the only route into some parts of the Mental Health Acts / Orders in all jurisdictions of the UK, is prosecution and via the courts. To ensure that people who need such treatment and care after offences were committed, it is necessary to prosecute them. I make no judgement about whether this is right or wrong, but that is the law of the UK as it stands today.

The police getting it 'right' at the start is important; but you'll never achieve precise criteria to guide decision-making: all cases on their merits in the judgement of the police officers attending. It's therefore important that we train them properly.

18th February 2012

Delivering Effective s136 Policy

This if the first in a series of short posts which aims to bring together all the blog posts which will allow policy leads in police forces or police BCUs to set about reviewing, revising and delivering proper procedures and training on various protocols which are requierd: in this case on Places of Safefy, usually folllowing detention under s136 MHA.

If you are a police officer charged with ensuring proper s136 arrangements in your area – either establishing them, or reviewing what you've got – you need to look at certain things proactively. Not to do so, will increase costs and risks, it will potentially contribute to suggestions of law breaking – whether civil, criminal or human rights – and may attract the attention of the Coroner should the worst occur.

You will probably find a predictable list of barriers to ensuring that arrangements work for a person detained so let's remember, that ss136 / 297 are not about the police OR the NHS, it's about the person detained.

I could list these issues as subjects or questions / obstacles, but either way you'll face the following issues:

- "It's too expensive at a time of public sector cuts to put the proper arrangements in place": No, it's actually cheaper to do it properly.
- "OK, but violent people need to be taken to the cells": Maybe, but let's first make sure the violence is not attributable to something clinical.
- "Children can't be brought to this Place of Safety": why on *earth* not?
- "A&E is not a place of safety": It can be and often it needs to be. There is *no opt out clause* for them to exercise.
- "People who have had drugs or alcohol can't be assessed, so take them to the cells": That may be extremely dangerous, so let's make sure it isn't before we think about that.
- "OK, but the police will have to stay at the Place of Safety until the assessment has completely finished": There is no legal basis for this at all, it should only happen where there is ongoing risk to NHS staff.
- "Why are you calling an ambulance every time, that just delays things": we need to ensure that what we think is a mental health matter isn't something else or masking something that means the person needs to go to A&E.

- "Sorry, we just can't do it like this": that's up to you, but we know what's right and we know our legal responsibilities whether or not you agree. We are obliged to resist attempts to do it in a way which does or could break laws.
- "The police don't use this power correctly, you need to sort it out": quite possibly *mea cupla*.
- "We need to make sure your police officers are trained properly": we do, and your mental health professionals.

It's also important within these discussions that things within the gift of the police to influence which sometimes contribute to or directly cause the NHS to adopt positions implied above, are understood.

- **Why don't the NHS understand that violence can be clinically attributable?**
- Well of course, they actually do! But many A&Es and PoS services have some *very* bad experiences of the police leaving extremely challenging patients with them without thought as to the risk this leaves them with. So they resist: and this is to be human.

- **Why wouldn't the NHS understand that drugs and alcohol can mask other problems?**
- Well of course, they actually do! However, in addition to the point about violence, there is a legitimate expectation upon AMHPs that MHA assessments are delayed until individuals can be meaningfully interviewed, wherever possible.
- The debate about where someone should be managed until an AMHP agrees to assess them should be clinically lead, balancing any ongoing risks of the alcohol, with the risks to their mental health of being held in a cell block.

- **Why don't the NHS have resources to 'staff' a PoS properly so the police can leave?**
- Well, often such resources can be de-deployed from other functions, but if the police are using s136 fairly indiscriminately and not arresting for criminal offences, including drunkenness offences where this would be more appropriate; it makes that so much harder for the NHS.

Everything is linked to everything else, but this is a flavour of how to address the barriers and obstacles I faced doing this work across many areas over several years. The best advice I can give to any professional, regardless of which organisation they work for, is try to put history out of your mind and design things afresh; look at everything from the opposite point of view

This stuff is perfectly do-able if you have the will to make it happen. And it's cheaper this way and it's **better for patients** which is more important than anything else.

18th February 2012

Does This Blog Reinforce Negative Stereotypes?

This is going to be a challenging post: in good faith and in a way that is measured, reasonable and welcome, it has been questioned whether or not this blog is reinforcing negative stereotypes of people with mental health problems. In particular, is the blog reinforcing that mental health patients are violent and dangerous?

Whilst I do not recognise my own instincts in any suggestion of reinforcing such stereotypes, it is important that think back over 90 posts with all of their mention of risk, crime, violence, resistance, aggression and so on. I have very frequently typed these words and more besides in various contexts during my posts, so it probably is right to reflect on my own assumptions and subliminal messages.

I welcome this cause to reflect and do not mind the question one bit.

Let me start by making one rather obvious point and by listing various thoughts and statistics I keep in my mind during the writing of this blog:

- **I am a police officer** <<< *by definition* this means that the perspective offered here is one arising mainly from criminal investigations and offences of all kinds; as well as requests to assist or lead in the management of risks, sometimes very serious, unpredictable risks. I cannot blog from any other point of view as I would have no other relevant experience on which to base it.
- It also means it is not written from the perspective of someone with considerable experience of mental health situations which *do not* involve risk, badness and criminality either **by or against** people suffering from mental health problems.
- I have got direct operational experience of being requested to undertake tasks which do not involve crime or any risk at all, but which are made because the police are a 24/7 body of people who can support other public agencies.
- Such requests carry risks of stigmatisation and criminalisation I've blogged about in an effort to raise awareness about how we *reduce* them. It was a stated intention of the blog to engage a wider debate

about how we de-stigmatise and de-criminalise the experience of patients by ensuring that the police are used only of necessity and where used, it is done right.

- But either way, violence – its assessment, its mitigation, its management and its prevention – is a limited part of being any kind of professional involved in mental health issues and this reality cannot be avoided.

- **So all of that having been said, I keep these things in mind whilst writing –**
- Most mental health charities have a "1 in 3" or "1 in 6" type claim to make, about the number of adults who will suffer with mental disorder during their lives.
- No-one seems to be able to explain why some charities think twice as many people will suffer mental health problems than other charities.
- It is frequently said, that mental health patients are more likely to be victims of crime than perpetrators – I will admit I've never understood the point of comparing victimisation rates with commission rates. It's not at all obvious at all that this tells us much, either about victimisation or commission which are fundamentally different things.
- Research on many important things in this debate is – as far as I can tell – under-developed, contested and uncertain. I make no claim to being an academic and whilst I research the blogs, I am not in a position to conduct a full literature review on everything.
- There are some *very* valid criticisms to offer about pieces of research upon which some rely to make their point about mental health. I regard the whole field as one loaded with agenda of various types: political, philosophical and ideological.
- Many of the "1in4" type studies are self-reporting studies and other likert scale assessments which are notoriously unreliable. Often these studies have not been peer-reviewed.
- The definition of mental disorder changes depending on who is using it and in what context it is being used.
- Definitions also vary across borders and one only has to look at the DSM-IV and ICD-10 to see this.
- If one did wish to have a discussion about violence and mental health, the statistical prevalence would vary by sub-group: those suffering depression or dementia or paranoid schizophrenia or anxiety disorders or autism – it's very dangerous to generalise about 'mental health and violence'; BUT –
- Violence by mental health patients is a legitimate point of public concern following various incidents which may have been blown out of proportion by the media, but the response to an investigation of such incidents are by necessity, police work.

- So I'm back to where I started about my perspective and it's perfectly possible to put almost any point of view about mental health and / or violence, if one wished to do so. You'd find the 'research' to justify that position if you tried.
- But mentioning risk, aggression, violence or escape (from psychiatric detention) cannot, of itself, be a reinforcement of stereotypes when the intention is clearly to reduce stigmatisation and criminalisation to absolutely minimal levels and where is is predicated on the need to better manage or mitigate?

I would hope that I've made in plain in various posts that I think both the NHS and the police need to look at and improve their responses to mental health incidents; their capacity for effective joint working and their operational delivery of the legal frameworks of the UK. These issues undoubtedly have the potential to stigmatise and criminalise; from all sides. It has been a matter of massive personal regret that I have found myself compelled to act in certain ways at work, precisely because what we all know should be happening, can't happen.

Here is my own (strictly personal) view: where the police are inappropriately used or relied upon to administer the Mental Health Act, it has the potential to stigmatise service-users and criminalise them. I take the view for example, that the NHS should **always** lead the recovery of AWOL patients whose whereabouts are known, because coercing passively resistant patients with the deployment of uniformed officers is inappropriate. That said, some (but not all) NHS managers disagree with me about that and do not, can not or will not do it.

It is also my (strictly personal) view, that the lack of proper research and evaluation of operational risks leads to inappropriate resource deployments: whether NHS, police or both. There are various systemic reasons why the management of risks which do exist, sits with the police: these include availability of NHS resources, legal knowledge of police and NHS professionals as well as failures to agree. Most cops have stories to tell about going to jobs and wondering, "Why on earth is this a police job?" Why not the ambulance, the CMHT or the Crisis Team?

- Are most mental health patients violent? **No, self-evidently not.**
- Is violence in the social, policing and health responses to mental illness an issue that requires heightened awareness? **Yes.**
- Why? **For various reasons:**

- 68% of assaults on all NHS staff are within the mental health sector (NHS SMS 2010).
- The professional risks of assault at work is far higher within the mental health professions than in other health professions, or in the police / fire services.

- Failure to identify, plan and information share around risks has cost lives in the past – not just service-users, but professionals and members of the public.

- Does this mean that most mental health patients are violent? **No – not at all.** Most mental health patients on wards do not assault nursing or medical staff.
- Does this mean that we cannot or should not discuss violence. **No – it is vital that we do.** Not only so we learn the lessons of history and prevent mistakes being repeated, but so that we also work on approaches to appropriate management.

I want a social or public sector structure that only uses the police to support the administeration of the mental health act when there are RAVE risks present in an incident which are legitimately beyond the skill or capacity of properly trained, deployed 24/7 mental health or healthcare professionals to manage. If we can achieve this, we will have arrived at a place whereby any stigmatisation or criminalisation by involvement of the police is defendable in light of the specifics of the situation. Obviously the police will always have a role when responding to or investigating crime.

That means I would love to see a health and social care system integrated and organised in way that means it can manage the community and inpatient care it exists to provide without unnecessary reliance upon the police to do tasks which the NHS or social care organisations could manage for themselves. Again, this means appropriate professionals undertaking appropriate interventions for vulnerable people without stigma. The delivery of this rests with NHS and Social Care managers, outside the sphere of control of the police.

So whether this blog in general or this post in particular is reinforcing negative stereotypes, is probably a subjective assessment by each of us: dependent upon the definitions we're applying to the concepts here; our understanding of prevalance, of both mental disorder and violence. Difficult stuff to weigh, given what we currently know.

20th February 2012

Safe and Well?

<<< This is a guest blog from Ella Shaw – author of Diagnosis: LOB – who works for the ambulance service after a debate we had about the conduct of 'safe and well' checks for health situations. I wondered aloud why the ambulance service don't undertake these checks for NHS organisations when they are oriented around mental health or even broader health issues, supported by the police only where risks are involved? To read my thoughts, you'll have to read her blog which is a wonderful insight into the country's 2nd best emergency service! ;-) >>>

Why do the ambulance service not undertake "safe and well checks?"

This is a question posed to me by @MentalHealthCop not only to prompt debate between the two of us but also in a hope of encouraging discussion and gathering opinions from all fields in the Police and NHS. It is a good question and one which I have no doubt the police have repeatedly asked but as with every open question there will always be multiple answers. As a result, we have agreed to write a blog and post it on each other's site in a hope of offering a balanced answer from both sides of the fence.

I have spoken about problems around treatment for mental health patients at length in previous posts, most notably in 'Mental Health: No ones responsibility'. There is a huge issue within the NHS surrounding mental health and the lack of access to good care. There are many barriers in place preventing easy access, moreover an apparent unwillingness by anyone to take a stand on the issue. It has become increasingly difficult for the ambulance service and the police to take people directly for assessment without having to go through A & E first which often leads to patients absconding and not getting the required treatment. Unless the patient is under section the police have no powers to detain them in a hospital as the 'place of safety' requirement has been met. Hospitals in turn have neither the resources nor the inclination to detain a patient who doesn't want to be there and they are subsequently reported as AWOL. As a result, if the police find them, an ambulance is called because the patient may need to go to hospital again. Similarly if an ambulance comes across a patient, at the first sign of mental health the police are called 'just in case.' The question posed aims to look at the latter but in doing so may affect the former.

RAVE is a mnemonic for determining if the police are required based on various risk factors surrounding mental health:

- Resistance
- Aggression
- Violence
- Escape

If any are deemed likely the police are called. However, it is becoming increasingly common for them to be used to provide *'safe and well'* checks for patients who have missed outpatient appointments, home visits or self discharged from hospital. When I initially read the question my initial response was *"cheeky git, don't palm your work on to us"* but in all fairness is it a job for the police? Is it even a job for the ambulance service? The purpose of these checks are to assess the patient for a possible return to hospital or to give a full explanation of risks regarding discharge. On face value it doesn't seem to be in the remit of the police, especially with the limitations of power within private dwellings. Equally, is it the responsibility of an emergency ambulance crew who's limited training on mental health patients makes them ill-equipped to properly deal with and advise the patient on his / her needs. Surely this is something that can and should be carried out by community mental health services, not emergency ones?

The stigma surrounding mental health and the many 'grey areas' that exist around it mean we as an ambulance service are very wary of it. I have personally been seriously assaulted by a mental health patient when there were no red flags or RAVE risk factors on the patient's name or address and therefore the police were not called. As such, the thought of doing 'safe and well' checks poses a number of risks to crew safety. At most we work as a crew of two, same-sex or mixed. It is more than possible that both members of said crew are inexperienced, with little or no dealings with mental health patients. We also have little self-defence training (half day conflict resolution lecture) nor any means of personal protection, other than run, should things turn south. Obviously RAVE is there to remove these risks as much as possible but, in instances where there are no RAVE risks and the situation becomes volatile, the police are better equipped to deal with it than us. As such police are requested as standard by our control or ourselves as soon as we suspect it is a mental health job. My point about the risk we face and staff needed to subdue said risk is often evident in the number of resources the police assign to one job. They have the security in numbers when needed which we do not. More often than not it's a case of them not being required and leaving shortly after no risk is identified but we appreciate their presence all the same.

The other question that arises from this is *"Are 'safe and well' checks an appropriate use of an Emergency Ambulance?"* Obviously, the answer is no, it isn't an emergency *per se* but this age-old debate isn't only about mental

health issues. We respond to a number of different calls that we shouldn't, but with the way society is and the way the service is heading, perhaps these things should be in our remit. It's a question of what the public want from its ambulance service. In an era of health promotion and alternative care pathways, an ambulance could be used to assess a patient and refer on to mental health services directly, therefore negating the need for an A & E admission. If this is the case, then perhaps this is a good use of an ambulance. Unfortunately, the idea of different health services working together and for each other is lost in our 'each for their own' society. Resourcing also plays a huge part. To say the ambulance service is stretched thin is a huge understatement. There simply are not enough ambulances or staff to man them. In London alone 25-30 staff are leaving each month through natural wastage and these staff are not being replaced. There simply isn't the budget to replace them. If 'safe and well' checks were part of our job something would have to be done to combat the increased work load. Obviously in the big picture, the increased cost to us would be mirrored by a decrease in cost to the police and a decrease in hospital costs but I doubt 'the brains behind the operation' will see it that way. Let us not forget, there are targets to meet!

For arguments sake, let's say that we do take on some of the safe and well checks, what can we actually do? We have no more powers than the police in a private dwelling, so we can't force someone out of their home without going down the capacity route. That in itself is very difficult to implement and prove, so is only done in extreme cases. All we are left with are referrals to GPs or local mental health crisis teams. But for anyone who has had experience of trying to contact either outside the hours of 9am and 5pm Monday to Friday will know the difficulties we face. In reality we are in no better position than the police to assess or refer. It may be suggested that a paramedic or EMT are better placed to access but I'd have to disagree. We have no training on it at all. Unless you count the two-hour PowerPoint presentation on 'mental health disorders and the law.' We are probably less actively involved in mental health than the police, so are not exposed to it unless there is a medical need. The police will say it isn't their job either to access a patient and it isn't. Surely it is something that should be done by Crisis Teams. Again though, very elusive. It seems that the attitude is very much *'if we don't answer, we don't have to do.'* As a result the slack is picked up by us and the police.

Looking at the ambulance service's 'Vision and values' it appears these safe and well checks are indeed as part of our job and I do agree with that. We are there to meet the needs of our patients and the public, be it the trauma we all crave or the mental health we all fear. You can't be selective with what illnesses and ailments you go to. In terms of the police, the Met's 'Working together for a Safer London' mission statement shoulders an equal responsibility to us by promising to work with all of its citizens and partners. Mental Health is a huge problem and a huge cost to the country

and be it medical need or in the interest of public safety, both the Police and Ambulance service share the burden. There have been trials where a paramedic works alongside the police on weekend evenings with the purpose of reducing the need for an ambulance for minor injuries. Perhaps a similar trial could happen with mental health policing? Unfortunately the powers that be seem to have their heads in the sand and are pretending mental health isn't an issue that needs addressing, but it isn't going away. I think if common sense is used, the deployment of services can be cut down. We don't both need to be there all the time. The officers and medics on the front line are more than capable but it's a matter of attitude and policy change from above. To do so, open and frank discussions between all services are necessary. Where there are no RAVE risks the ambulance service could be involved and where there are the risks, the police will be involved. I think we need to get away from calling the other when the need isn't there. As I said we are no better placed to refer on to appropriate care pathways than the police and they are in no better place to remove a patient from a private dwelling than we are. It's about education and knowing each other's remits and limitations.

A huge part of it is also getting the already established mental health services more involved with our work and to take more responsibility for what is essentially their job. Historically, mental health facilities and their staff have been very obstructive with dealing with other professionals, making for a hostile working relationship. Gradually, as mental health is becoming widely accepted as a genuine medical and social problem, these barriers are being broken down and dialogue is becoming possible. There is no reason they cannot have teams of their people doing the 'safe and well' checks where no RAVE risks exist. If anything, they are the best placed to do so but exactly what they can and can't do I'm not entirely sure. If I'm honest, despite my interest in mental health, my knowledge of their services and powers are limited in part due to my lack of dealing with them but also the fact they don't advertise what they can do. If everyone is going to work together there needs to be more transparency and honesty about our roles. We all need to know what each other can and can't do. We must know each other's strengths, weaknesses and procedural limitations and, until then, there will be no progress at all.

In response to the question … why not indeed! But let's answer all the other questions that arise from that one first! Let's all get together and thrash it out. Chance would be a fine thing …

To read @MentalHealthCop's thoughts on the same subject, you'll have to read my blog!

21st February 2012

Signals From Noise

It has often been said when discussing problems within the Criminal Justice System that in reality, it is not a 'system' at all. It is a collection of separate organisations – police, Crown Prosecutors, Courts, Prisons, Probation – who are 'managed' by different parts of Government (Home Office and Ministry of Justice) and who have very necessary links to other apparatus of society including education and health. It is *not* a single, controllable 'system'.

These agencies have for a while been operating to different targets, standards and goals and are not and never have been a coordinated whole. The farce of targets and functionalisation, costing money and lives.

Much the same could be said for the 'mental health' system. Care is provided by different parts of the NHS – primary care (GPs) and secondary care (MH trusts) as well as specialist services, NHS Direct, A&E and so on. Again, this is not necessarily as coordinated as PCT three-year strategic mental health plans may imply.

Consider the links that mental health must have to other apparatus of society: this care continuum must be provided in contact with local authorities and a criminal justice system whose very *raison d'être* could be said to be diametrically opposed to that of mental health services (individual care / public safety). Remember: you can only enter certain parts of the mental health system, via the criminal justice system: thus creating another larger 'system'. All clear so far?!

Information sharing is a problem when looking at the *de facto* system which has evolved. The police gather so much information about mental health (from arrests, s136, AWOLs, etc..) which NHS services could use to look at 'their' system and some of it could be key to proper long-term thinking.

If shutting down mental health beds to save £100,000 on inpatient care means that over the next five years two patients will end up prosecuted for serious offences and placed in secure services at £250,000 a pop, then you've saved nothing at all, but you have created victims and criminalised patients along the way. Brilliant. Manchester NHS looked at this the other way around a few years back and chose to invest £500,000 on a comprehensive approach to 'diversion', thereby reducing the number of

people entering secure care. They've made the money back already and more besides, in avoided secure care costs.

I posted three questions on Twitter this morning, to provoke thought:

- How many people in your area who are arrested under s136 are current or previous mental health patients?
- How many AWOL patients in your area are repeat reports?
- How many people arrested in your area are current or previous mental health patients?

In some areas the answer to all three of these questions is **fifty percent**. These figures in your area, may not be exactly the same, but you need to understand what they are because understanding these numbers will be a signal (from noise) about what may be right or wrong with your system.

Now some of this information sits with the police and sometimes with mental health services: some can only be established by sharing information into a joint pool. The police need to tell mental health who got arrested, in order to allow them to establish if they are current or previous patients and therefore provide necessary follow-up to those who were not flagged in police custody as having a potential mental health problem. Let's remember, that the police usually spot 10-15% but sharing this information can identify up to 50%. What does the figure for your area tell you, if anything, about mental health care or policing? Maybe nothing, but probably loads.

Why not do it?! It would not be prohibited by the Data Protection Act 1998.

What about s136 MHA (EW) / s297 MHA(S) / a130 MHO(NI)? In some areas, as many as fifty percent of people detained under emergency police provision are current or previous patients. In some cases, by studying the nature and variety of this demand and by treating it as a signal, you learn something about up-stream provision which may have prevented the s136 becoming necessary. How many of your detentions are repeats?

- One sample in one area of my force showed that just 1 person accounted for 3% of detentions; and had been arrested in other mental health trust areas of the force.
- Proper evaluation of this demand made it clear: she was usually arrested s136 whilst committing victimless, quite low-level offences but it always emerged that she did not have a mental health problem of a nature or degree that warranted admission to hospital.
- We found out later that MH professionals were busy asking, "Why don't the police realise she's not mentally ill and just prosecute

her?!!!" but it emerged she'd never been arrested by the same officers twice.
- So a strategy was formulated – via the 'system'(!) – that she would be arrested and prosecuted like anyone else.
- **Result:** reduction in s136-type demand, prosecution for offences, remand to prison (because of her previous history of absconding and offences on bail), conviction for the offence and a short-term period of imprisonment.
- Upon release from prison, there have been no more similar offences 12 months after release and no more s136-type detentions.
- Easy isn't it?! … and not just about upstream interventions by mental health; this is an example where different police action is key.

By not identifying these signals an officer may end up arresting someone for a serious offence, rather than under mental health law and then it is quite possible that just some of those patients will end up in the criminal justice system and subsequently back in the mental health system via Part 3 of the MHA(EW) or Part 8 MHA(S). By the time you then find health authorities paying £250,000+ a year for secure care instead of a fraction of this for effective community or occasional inpatient care, you realise the error of failing to examine signals from noise.

We properly understand the nature of the demands we face because we don't study them.

21st February 2012

Who Is Protecting The Protectors?

This post is retrospectively dedicated to the memory of PC David Rathband who struggled so bravely to cope after life-altering physical but also mental injuries. **He died of those injuries in February 2012** having been shot whilst serving the area in which I was born and bred.

<<< Warning: this blog contains some very blunt descriptions of horrendous incidents I have dealt with in my career. >>>

Employment as a police officer can lead to triggers for serious, enduring mental illness. I have seen this, I have managed police officers who have experienced some horrendous things. I have known police officers who are now diligently serving their communities and who have had periods of time in hospital, including detained under the Mental Health Act, as a result of their work. I think this problem is far, far greater than we realise and not only within the police, but also across all of our Armed and Emergency services.

Most police forces' Occupational Health departments have access to psychiatric professionals, also to counselling services. Mine employs a psychiatric nurse for a certain number of sessions per week and he is a busy man. But the most impactive way I can think to illustrate some of the cultural issues of mental wellbeing within police is to ask you to listen to the officer who set up the first mental health support group within UK policing: Sergeant Susanne Barnett from Devon and Cornwall Police. It's an inspring talk, well worth listening to.

I reflect back upon the first part of my own career and am now grateful that I have not suffered serious mental health consequences of some of my own experiences and of course, our Protectors work whilst living lives as full of normal stresses and strains as any others: divorce, alcoholism, financial problems and living a life full of shifts, stress and anti-social hours. **This stuff is a problem.**

This is list very quickly put together, because there were so many things to choose from … there is NOTHING unique about this list. **All officers have got one of these.**

- The five-year old boy who was fatally struck down, having his head crushed by a bus in a freak accident in front of his mother on a busy arterial road in rush hour: I was the duty sergeant who turned up to coordinate.
- I was the first officer on the scene of an especially horrific murder and watching a man die in front of my eyes, one of my officers doing frantic first aid, covered in blood whilst we waited for the ambulance. We tried to do something, *anything* for his girlfriend who'd witnessed it all. I can remember her screams now.
- Going through the door of two different flats (two different incidents) to deal with armed, barricaded men who had equipped themselves with knives and threatened to kill whoever came in.
- I recall putting training into practice and one of them tried their best to kill me and my colleagues with his knives. We were grateful the training and kit worked – I was especially intrigued in the other one to find the man sticking a 10 inch carving knife into his neighbour's chest in a room that looked like an abattoir.
- **We hadn't known his neighbour was in there and he was bloody lucky not to die.**
- I remember driving down a road on a routine patrol, chatting about rubbish with my mate and suddenly seeing two men running from a house: one persuing the other, the second carrying a gun. I remember watching the gun getting levelled *at us* and thinking, "Is he going to shoot us?!!"
- I remember going to work at 7pm on 09th August 2011 and thinking, "where the hell do you even start?!!" and spending twelve hours making decisions about which member of the public's 999 call would go unanswered, deployment of officers into the riots and ongoing worry for their safety and welfare.

- I remember developing standard gag lines to deploy to friends and family and colleagues that are **all** about me insulating myself from this 'stuff' to avoid taking it all in. "It could be worse, it could be my [son / wife / family]" etc., etc..
- Not intended to be hurtful, or insensitive and not spoken at work: **defence mechanisms, everytime.**
- Because if I thought too much about it … I can feel my heart rate raising as I type that up.

I've been *lucky* enough to find ways of coping with this. There is no strategy to follow, you either find it a way of coping or you don't and it's *all* luck. It's not to do with 'being strong' and other macho stereotypes: I've seen some 'big strong people' brought to their knees through this stuff we deal with purely because they were not so lucky – that's *all*.

My colleagues and I work in an organisation that is not as conducive as it needs to be to managing the mental health and wellbeing of staff, but let me be clear: **this is not** necessarily because of any lack of effort on the part of the police or senior officers, although it would be folly to pretend that there are no individual examples of indifference or ignorance. I would also sound a gentle alarm across the whole public sector as I've experienced it that I see too much pressure put on frontline staff to 'deliver' stuff, whilst being constrained through poor-systems of work within the gift of managers to change and because of targets which actually pervert their staff's ability to get it done right. Some managers unwittingly erect barriers to success and then think they have to 'sweat the assets' – ie, the people – to get stuff done and that is *never* right.

I have seen the service invest *real* time, effort and money in services, support networks, structures, and so on. We're employing psychiatric professionals and counsellors; we're training staff as 'diffusers' to look at staff welfare after critical incidents; to act as 'First Contact Advisors' (a term used in my force) to provide a confidential sounding board and to act as a signpost to support services and advice. All of this relies upon the creation of a culture in which, proactively ensuring positive mental wellbeing and an atmosphere in which it is protected and fostered.

Like many other 'tough' services – Armed Forces, Ambulance, Fire – we're just not as good as we need to be as human beings at seeking help when its first required and not feeling afraid to say we've found something hard to deal with. Officers in my experience incline to their own social and informal support structures and this is to be normal and human.

However, studies have suggested that psychiatric morbidity in professions like emergency services and Armed forces is far higher than in the general population. PTSD is under-identified and more prevalent; suicide rates are higher than the normal population and when you note that amongst people who have secure employment, income and other things which one might associate with insulating against suicidal ideation and sudden deterioration in mental health. There were almost 70 suicides by Royal Ulster Constabulary GC officers and more since the inception of the Police Service of Northern Ireland.

Mental wellbeing within our Emergency and Armed services is important. **Who is protecting our protectors?**

See a similar blog post by Ella Shaw – author of Diagnosis:LOB – about mental wellbeing in the Ambulance Service.

25th February 2012

"If You Leave, We'll Call The Police!"

This blog is a response to a post by Sarah Bellamy, author of 'A Carer's Eyes'. Her post "If you leave, we'll call the police" concerns her partner, Chris, and his experiences in Accident and Emergency. (Sarah has also written a follow-up post.) It's all about the duty of care to A&E patients who have mental health problems and what, if anything, A&E staff could or should do, to stop patients leaving – in what circumstances can they do so. There has been a good debate on Twitter about this post, with professionals chipping in with various views but I want to give it more than 140 characters.

This story struck me, because of several incidents I am aware of in my area; one of which I was involved in. The best example concerns a man who was taken to Accident & Emergency after an ambulance had been called to him. He was self-harming, appeared suicidal and had a history of mental health problems and clinical depression. During several hours in A&E, his cuts were cleaned and dressed, and arrangements were put in place to assess him under the Mental Health Act.

Whilst waiting for this to occur, the chap became increasingly agitated and anxious, he started saying he wanted to leave. Staff did their best verbally to encourage him to stay, but he decided to go. They let him leave or did not stop him and the police were not called. The police did become involved in the incident, however: because 60 minutes later they were dealing with a man threatening to jump from the top of a multi-story car park and within 90 minutes of him leaving, they were dealing with a suicide by jumping.

Following the inquest, the hospital contacted the police to tighten up procedures around mentally ill or otherwise vulnerable patients absenting themselves from A&E. They were very keen to be able to immediately report people who walked out – not that they need permission – but also wanted to talk about what, if anything their duty would be to keep people from leaving, where engaging any risks may be consistent with expectations upon nursing or healthcare assistants, security officers.

- Patients in A&E are not considered hospital inpatients for the purposes of the Mental Health Act, so Doctors' and Nurses' holding powers cannot be used.

- Only the police can instigate ss136 / 297 / a130 detentions, so that is not an option for the NHS or their security.
- What about common law (doctrine of necessity) or the Mental Capacity Act 2005?

Well – it turns out that the Coroner had written a 'Rule 43' letter to the NHS Trust, requiring demonstration of tightened procedures, and closer liaison with the police for those cases where someone's departure needed to be prevented but couldn't be.

Clearly, NHS staff once they accept someone into their department and commence assessment and treatment, owe various legal duties to patients: Human Rights duties around no deprivation of liberty (Article 5), inhumane treatment (Article 3), right to life (Article 2). We've seen recently in the Rabone case, that human rights obligations around the right to life can extend to non-detained mental health patients, albeit Michelle Rabone was an admitted patient; but duties around risks, prevention would remain. It is also true to say, these duties can conflict: what if there is doubt about whether the MCA would allow detention pending arrival of the police (art5) but there is a real fear if someone leaves they will kill themselves (art2)?

It is clear that in many circumstances, A&E staff would be obliged to let most patients leave if they wanted to. People often walk out of A&E against medical advice – the mere fact of doing something 'unwise' does not immediately mean that someone lacks capacity to take the decision to leave. Equally, capacity is situationally specific to the decision being taken: at the same time, someone may have the capacity to decline a drink, but not to decline a course of medical treatment. Quite possibly, that could come about because the consequences of not having a drink and zero or trivial, whilst declining medical treatment could be life-threatening.

So it is a complex business for A&E to make decisions about what, if anything they should do. There have been various reports about integrating mental health care with physical healthcare, including from the Academy of Medical Royal Colleges. The preface of this document states: "It is a matter of shame that this document is needed. But needed it most certainly is." and goes on to detail common, regrettable problems in integration. It recommends more training in mental health for A&E nurses, etc., and closer work with or the creation of liaison psychiatry services.

Meanwhile back in A&E: the duty of care owed to patients who are there, not least because of Human Rights obligations, could be covered by s44 of the Mental Capacity Act which creates a criminal offence of wilful neglect or ill-treatment of those who lack capacity. It puts the police in tough position if families allege or officers suspect that someone who should have been prevented from leaving because of a lack of capacity was not

prevented and nothing else done. What if relatives make criminal complaints to the police so that such circumstances are fully investigated?

Capacity assessments are often required on individuals who come through A&E departments where decision-making is affected by mental health, drugs / alcohol, head injury; organic conditions such as dementia, etc.. And these things cannot be entirely separated from physical illness.

In my area about two years ago, a man jumped from a bridge over the motorway network. He'd had a drink, but wasn't drunk and he had a history of depression and this was (to him) a serious suicide attempt. He broke his leg particularly badly in the fall and suffered other physical injuries less serious than that. When he arrived in A&E he attempted to decline all treatment maintaining that he wanted to be allowed to die and was making remarkable efforts to try and leave. The medical staff got into their assessment of capacity and took the view that he lacked the capacity to take the decision to leave, because the alcohol and his mental health prevented him from fully understanding the consequences and they detained him using hospital security. They also called police back to A&E and requested he be detained under s136 for full MHA assessment. He was sectioned to an orthopeadic ward as his leg injury needed an operation.

So, it really isn't as simple as saying that if someone wants to leave A&E that they can unless the police have got them under arrest. A&E would get this completely if you gave them the example of an extremely confused 87yr old dementia patient in their night-clothes found wandering who was picked up by the ambulance service and brought in. If she tried to walk out into the night, they'd put a gentle arm around and stop her from doing so. They may well also be calling security or police, but they'd do something and they would be right to do so if the opposite was to let a dementia patient wander off.

No-one is suggesting that A&E should be sitting on people (although I have dashed to A&E after a 999 call to see hospital security doing exactly that – most recently to stop a alcoholic from drinking the A&E hand-gel when they knew that his medical condition was so developed following decades of abuse that alcohol could well kill him.) But there are duties of care, and these are not necessarily fully understood because in some areas I know, the senior MH managers and the senior Acute Trust managers don't know each other. I've also seen each of them refuse to meet each other and the police to try and draw services together, for these kinds of things.

I found those conversations involving refusal – they were asked directly to do so – **utterly breathtaking**.

27th February 2012

Mental Health in A&E

There has been some posting and tweeting recently about mental health in A&E, and very interesting it is too. Against a backdrop of questions about what A&E can do, what they can't do; what care they give for people who self-present or are brought in by ambulance. Amidst such conversations during the work I did on trying to develop Mental Health Act places of safety for those detained under ss135/6 (or s297 / a130) I wondered about the extent of mental health presentations to A&E.

NB: *I wish I could now re-find the on-line research article which gave these stats(!) but I remember the proportions anyway – if I land upon it, I'll put the hyperlink in here! You can tell I'm not an academic!*

The article studied presentations to major A&Es over a certain period. There were two statistics from the sample which settled the question of mental health.

- **1 in 6** of all patients presenting to A&E had some form of mental health presentation;
- **1 in 3** of those were present in A&E *just because* of their mental health problems.

- *Therefore!*
- **5%+** of A&E volumes in the sample were mental health only;
- **15%+** had mental health problems as a part of the overall picture.

This is why I find it unusual to read reports like that from the Academy of Medical Royal Colleges which talks about how usual it is for there to be little training for nursing / medical staff in A&E. For 15% of the demand?

Several times in my career my officers and I have been faced with the following situation, not unlike those considered by Sarah Bellamy in her posts about her partner Chris. (Post one and post two):

A person has presented to A&E or been taken there by someone other than the police because of mental health problems which may or may not have included medical issues wuch as injury, overdose, self-harm: remember, the ambulance service's only option for a mental health call is "A&E" because they have no pathway to other parts of the NHS.

Once there, A&E commence triage and if need be arrange a mental health act assessment. Prior to the assessment taking place, or having taken place and admission being necessary a bed having not been found, the person becomes unwilling to stay – I'll be frank: this usually occurs at a point where they have waited a period of time that would start to test most people's patience. Eight or nine hours is not uncommon; more has been known.

The person having then decided to leave the department, a phone call is put in to the police reporting a high risk missing person. Immediate thought by me: what does 'high risk' mean with regard to the legal ability (or duty?) of A&E to consider trying to prevent the person leaving … especially for example if a patient has already been deemed in need of admission under the MHA? If the risks associated with the person leaving were so high, why aren't security usually found in attendance and / or why haven't the police already been called?

(I need to acknowledge here, that police responses to such requests can be unhelpful – nonsense such as "not a public place" and "already in a place of safety" get trotted out.)

Cue police activity and within half an hour or so the patient has been found. Let's imagine they are found in a public place, they can either persuade the patient to return, or detain them under s136 / s297 / s130. Let's imagine they find them in a private dwelling because they went straight home – they can do nothing other than inform NHS services of the patients whereabouts. Of course in the latter situation, A&E will no longer be interested in the practical problems of the police having no legal powers at all, because they are now a police responsibility; MH services will provide their usual response when police call for assistance to a private premises.

If one does persuade the person to return or uses s136 / s297 / s130 to enable it to occur, the response at A&E will be telling. Once you arrive back, they will almost certainly (in my operational experience) refuse to have the person returned to them. "What do you want to do with the person?" "Arrest them under s136 but they can't come back in here." "Seriously?! They were here for nine hours and now they're banned? For being mentally ill and frustrated at waiting times / bed unavailability." I used to worry about this course more when in practice it meant banishment to the cells because of there being no NHS place of safety in existence.

It has made me wonder in my more frustrated moments why A&E don't have a routine policy of ringing the police every time they have a mental health presentation asking for the person to be arrested. This sounds extremely facetious, doesn't it? But think the law through: s136 and similar powers can be used if the person 'is in a place to which the public

have access, appears to be suffering from mental disorder and is in immediate need of care (or control) in their own interests (or for the protection of others).' Taking that paraphrase as it stands, one could argue this applies to anyone banging on the door of A&E for help.

All of this is a red-herring though: whether or not NHS Places of Safety exists and operate effectively in any area, there are going to be problems. The variety of demands – the types of incident – which lead to the need for access to community mental health crisis services, A&E services or emergency services like police or ambulance are not integrated. These organisations are not one coordinated system and they have conflicting operating models which leave gaps and create tension.

Perceptions in the quality in the service received by those in need will be determined by the efficacy of the system to flow seamlessly from one part to another. Currently, there are obstacles of various types scattered left right and centre because the service provision for such cases is functionalised into as many as eight different organisations who do not necessarily know or talk to each other.

MARCH 2012

1st March 2012

OFFICER DOWN – PC David Rathband

PC David Rathband 1968 – 2012

It is tragic to get up this morning and learn of the death of PC David Rathband whose life was irrevocably changed in July 2010 when he was shot and blinded in an unprovoked attack with a firearm.

He was found dead at his home in Northumberland last night and I'm sure everyone's thoughts are with his family, his friends and his colleagues in Northumbria Police at the news of this tragedy for them. I'm especially mindful of his children to whom it was clear he was devoted.

David's actions in the immediate aftermath of being shot were heroic as he continued to do his job, not just to get himself urgent help but to start 'policing' the event despite horrendous injuries.

I defy anyone to suffer such a life altering event without suffering massive personal costs, of various kinds; and we know that officers are at far greater risk than most of suffering from PTSD (post-traumatic stress disorder), depression and other mental health problems as a result of their job – far more about that at a much more appropriate time.

Although it was a rare and extreme case, this shows how vulnerable police officers are in the aftermath of serious events at work and so I ask again: Who is protecting the protectors?

This is so very, very sad and our thoughts today should be with David's family, friends and colleagues.

3rd March 2012

Broken Windows –

It was announced on 03rd March 2012 that James Q Wilson, US political scientist, had died, aged 80. Wilson was author, along with George Kelling, of potentially the most important piece of writing about modern policing: **Broken Windows**.

For those connected to policing, it is worth half an hour of anyone's life to read this … and then read it all again once you've thought it through: it is of *direct* relevance to those interested in policing and mental health for reasons outlined in the article itself.

First published in March 1982, in The Atlantic Magazine.

4th March 2012

Earlier Intervention –

There was a really interesting debate on Twitter last night between two mental health professionals who responded to one of those tweets I throw out to provoke debate and thought!

https://twitter.com/MentalHealthCop/statuses/176021284273143808

In response to this, the following figures emerged:

- Community mental health care costs (on average) – £3,500pa
- Prison costs – £39,000pa
- Medium Secure mental health care costs – £190,000pa
- High secure mental health care costs – £300,000pa

A primary care trust once informed me that they are spending 55% of their total mental health budget on detaining 67 patients within medium and high secure hospitals, them having been convicted on an offence in

circumstances where it was argued they posed "a serious risk of harm to the community". Most were detained under one of two types of mental health order:

- An order for compulsory treatment after conviction for an offence (s37 MHA);
- A direction to transfer a convicted person from prison to hospital because of mental ill health (s47 MHA);
- Each of these orders can be 'restricted' to prevent the person's release until such time as the Ministry of Justice is safety that the person no longer poses a risk of serious harm to the public.

Forensic professionals last night observed that they often have to deal with people in the forensic mental health system – which is the medium / high secure hospital estate – purely because people have not been picked up or helped before their lives get to a point where they commit a serious offence. Indeed they went further and argued that they often deal with people who have committed a serious offence *in order* to get the criminal justice system to enable access to the mental health system. Access which has otherwise proved too difficult.

The PCT who are spending 55% of their budget of 67 people, serve a population in which c2,500 people need their services. This means 55% of the budget on 3% of the people. The other 97% have 45% of resources to share between them and it is against this background that some forensic mental health professionals are arguing they are seeing people in circumstances where prevention may have been possible earlier.

Of course, this is not a new discovery: this has been part of the 'Bradley' debate since 2009 when Lord Bradley published his review of mental health problems or learning disabilities in the criminal justice system. Lord Bradley himself was the latest in a line of notable people to lead such reviews after the Reed Review in the early 1990s and the Butler Review in the 1970s. They are running at fifteen year intervals, currently. Another one in the mid-20s perhaps?

Meanwhile, areas have given thought as to how they can approach liaison and diversion differently. I recall hearing Craig HARRIS from NHS Manchester give a briefing at an event a few years ago where he explained that by investing £500,000 a year in proper liaison and diversion services, working with Greater Manchester Police and criminal justice agencies, they had reduced the number of people entering the criminal justice system who end up being sentenced to, or transferred into, secure care. You only have to do this twice a year to save the need to spend £500,000. Of course, it is not as simple as this, because you are still then providing other mental health services and there are various costs associated with criminal justice operations and so on. But it is fair to claim, as he did, that this approached

significantly reduced costs. Not only by by providers adding value earlier, or differently; but sometimes by providing healthcare at all.

So what form did this take? I'll do a longer post on this in due course, but it basically involved earlier and better liaison between police and mental health professionals at the point of arrest; the establishment and successful development of 'mentally disorder offender panels' who would meet to share information on those who were being investigated or who had been arrested, in order to determine whether prosecution was in the public interest and whether it was or not; what mental health or social care interventions may be needed.

This links to a point I've made before: if someone has been arrested, the practical variable which will determine whether they are diverted or not, is "whether they are sectionable under the Mental Health Act" on the day they are arrested. If so, divert; if not, investigate / prosecute as normal based upon the evidence.

This has two problems for me:

- **Premature CJ decision to take no action:**
- If a person is 'sectioned', do they police immediately say, "no further action" (NFA) on the criminal offence or do they – as I strongly believe they should – release the person into mental health care under sectioning, whilst releasing them from arrest on bail, subject to a requirement to return to the police 30 days or so later.
- What if someone was released 'NFA' when sectioned and the s2 assessment concluded that they were not mentally disordered; or that their condition was in no way a barrier to a prosecution / caution / fixed penalty notice, etc.?

- **Criminalisation of those who are not sectionable.**
- The opposite scenario is one where a patient does not need to be detained in hospital because their mental health condition is not sufficiently acute, but where there is or has been an issue with access to healthcare (for whatever reason).
- What if enabling that access were to address substantive issues that led that person to offend? To see this one through, why not complete the investigation in custody and again, bail the offender (possibly with conditions to meet MH services and / or engage in assessment of needs) for a brief period to allow fuller establishment of proper care arrangements?
- Decisions about prosecution could then be taken on the basis of engagement / outcome / public interest.

NONE OF THIS means that offenders should not be prosecuted, merely that greater care should be given to the decision and its impact. Whether

or not a discussion between an MHA assessment team and a custody officer can determine this properly at 2pm on a Sunday may be doubtful. Of course if an offence were serious, if there were bail risks, inc. to the individual themselves or of harm or to the public – nothing prevents prosecution in such cases even if the person is 'sectionable'. That would happen then and there. In such situations the police, via the CPS, can inform the court of the medical recommendations made by the DRs when assessed under the MHA and the courts have options under the mental health act to remand for assessment / treatment. This then facilitates decision-making by the courts pre-trial and during trial.

This is not as complex as it can sound; it's actually about getting back to what the legal frameworks actually are. It's about closer partnership working between health / social care and criminal justice agencies but as the pathway for this stuff is as many as eight organisations working together in flow; and this will require strong leadership at all levels.

4th March 2012

Mental Health Units –

The police generically refer to the different types of hospital unit in terms of 'low' or 'medium' or 'high' security. In reality there are many different types of mental health hospital and this terminology is not necessary correct or helpful, not least because some hospital sites have a mixture of security levels with 'medium secure' wards within larger 'low secure' facilities. All clear so far?!

Against this lack of clarity – for those who are not mental health professionals – I have been asked to do a post explaining the main types of unit and some differences between them. To do so, I am going to mention some units in my force area to explain their provision.

High Secure or Special Hospitals:

- There are only four of these in the UK: Broadmoor (Berkshire), Ashworth (Merseyside), Rampton (Nottinghamshire) and Carstairs (Scotland).
- These hospitals take patients from all over the UK: predominantly, patients from Wales are in Ashworth and those from Northern Ireland and Scotland are in Carstairs.
- These institutions are occupied by patients who almost exclusively entered the mental health system via the criminal justice system and have been detained under Part III of the Mental Health Act.
- This includes some extremely high-profile individuals like Ian Brady, Peter Sutcliffe, Beverly Allitt and so on.
- The security in facilities such as these are consistent with a category B prison and in parts, Category A.
- Average stay in hospital for High Secure patients is measured in very many years: usually 6-8, but some patients will never be released.

Medium Secure Units:

- There are many of these facilities across the country, three of them in my force area, which will become four later in the year.
- **Reaside Clinic** is a male medium secure unit (MSU) for adult men.
- **Yardley Green Clinic** will open later in the year and is also a male MSU. This is being built because of increased demand for medium

secure services within the West Midlands region – there are a decent number of patients accommodated 'out of area' at any given time.

- **Ardenleigh** is an MSU for Women and Children. There are only 80 or so 'forensic beds' for children in the country. 20 of these are in Ardenleigh.
- **Brooklands** is an MSU for patients with learning disabilities.
- Again, these units are often populated by patients who have entered the mental health system via the criminal justice system, especially via Part III of the Mental Health Act 1983.
- They sometimes accept patients who are moving down from High Secure care with a view to ongoing rehabilitation and potentially, for release.

Low secure and general adult psychiatric hospitals.

- There are many such units in any police force area; of all sizes but 'low' secure and 'general adult' are not the same thing.
- Some facilities include Psychiatric Intensive Care Units (PICUs) which provide enhanced levels of care and security at this level – lower staff / patient ratios, etc..
- Some are specific to client type: ie, men, women, older adults, children or learning disabilities.
- Some are mixed estates, including some with mixed (sex) wards and they prove controversial to some patients who find themselves detained with members of the opposite sex.
- I have heard strong representation from some adult female patients about being detained on mixed sex wards with male patients; raising concerns amongst other things about being rendered vulnerable to sexual advances or even sexual assault;
- Some 'low secure' facilities have a medium secure ward; with enhanced levels of security for a very small number of patients. For example, my force has a learning disabilities facility which is a low secure or general LD unit. However, it has one part for just eight patients, which is a medium-secure unit.
- Low secure and general psychiatric hospitals often deal with patients who were previously detained in MSUs, as patients move through rehabilitative programmes towards release.

Step down facilities:

- Most areas have facilities which might be termed 'hostels' and which are often referred to as step-down facilities.

- These are places where patients may still be bound by legal frameworks under mental health law, but which are supervised semi-independent units where patients live with support.
- Again, a method of allowing patients to take move in stages from complete detention under the MHA to complete release without exposing patients to so much that it renders recovery impossible.
- Sometimes such facilities have a focus on supporting patients with particular issues like drug or alcohol addiction who do not need full inpatient care.

One thing that gets confusing about many of these facilities, is their ownership and coverage. All of the High Secure hospitals are National facilities, but are operated by local mental health units, like West London Mental Health Trust for Broadmoor. In the West Midlands, Reaside Clinic (MSU) is run by Birmingham and Solihull MH Trust but takes patients from all over the West Midlands region, not just from Birmingham and Solihull; Ardenleigh's children's unit is a national facility.

This has been a fairly simplistic run-through and I hope it struck the balance of being helpful without being over-complicated. Sometimes, a name alone is insufficient to know which type of facility a hospital will be, but in fairness to mental health units, the stigma associated with mental health means they may not wish to advertise such issues.

One example as to why: when I was a local inspector in an area of Birmingham, proposals were unveiled to build a new mental health unit in an area of the city which generated a high level of inpatient mental health demand. It was to be a 'general' facility built in that part of the city specifically for low risks patients *from* that part of the city. A series of public meetings were held by the mental health trust to brief the local community and allay any fears. I would say that no amount of persuasion by the trust was able to convince the community that the people detained there would not be extremely dangerous homicidal patients who represented a real risk to the safety of the community. The anger at the meeting ensured that the police present were not just explaining how partnerships work in practice, how we respond to AWOL patients, etc., etc; but that we were actually required to 'keep the peace'.

The same thing happened again a few years later when consultation took place for a new medium secure unit – again a facility to ensure that patients were given care in their own area rather than being shipped 'out of area' for a want of beds. In fact, the MSU proposals were raised in Parliament and led to public protests.

By sheer coincidence of timing, I was then policing the area where the established MSU was based. On the very day of a public meeting for the proposed new facility there was an escape from the existing facility of a

dangerous offender who did pose a risk. My name ended up in the local evening paper doing one of those "Do not approach this man, please call 999" type media notices as we reached the stage in the missing person's enquiry where a press release would be done. Unfortunately for the mental health trust, everyone who attended the consultation meeting turned up with the evening paper to wave at them.

5th March 2012

Offences Against Patients –

I was asked a while ago to blog on the subject of criminal offences AGAINST patients, committed by professionals. Clearly, a very difficult issue. It is right that we cover it on here because we've discussed the equally difficult issue of offences against staff by patients.

Since the request I have been gathering some thoughts together as such allegations are rare and I have only been involved a few which would apply. The challenges to the police are clearly enormous and the stakes for the accused professional are potentially career, or even life-altering. But it is right that vulnerable people in the care of or in contact with the state's agents should be safeguarded and are entitled both to a duty of care and to access to justice.

So professionals must ensure they understand the boundaries of the law and patients must feel able, without pressure or intimidation, to raise their concerns. This includes the right to raise concerns to the police if they wish, because like everyone they should have a fundamental right to access justice and the police must make a proper response. There have recently been various criminal convictions of mental health professionals for behaviour relating to patients not least at Winterbourne View, in Bristol. There have also been very serious cases of abuse in Kent and Sussex, amongst others.

Here are some I have experienced or advised upon:

- Allegation of neglect by MH professionals under s127 MHA: family complained that when staff 'allowed' a s3 patient a few hours' unescorted leave so that he could attend court for an administrative hearing to set a date for a drink-drive trial, they were neglectful. The man having been arrested and charged with the offence two weeks before he was sectioned, he was allowed to attend court alone. Afterwards he did not return to the hospital but killed himself by jumping in front of a train. The inquiry failed to establish sufficient evidence of neglect against any one member of staff to bring a criminal prosecution, but it did uncover evidence and information used in disciplinary hearings which led to dismissal and professional de-registration.

- Another allegation of neglect under s127: again, family members making complaint that when MH professionals failed to stop a s2 patient from leaving the ward, they were neglectful. This case had all of the overtones of the Savage case, except that the patient did not commit suicide. Still, should potential neglect following formal allegations by judged on actual or potential consequences? Legally: the latter. In this case, a nurse was prosecuted for neglect and acquitted at court.
- Called to a hospital BY staff to a report that a s2 patient had smashed a window to try and escape from the unit. Upon arrival, it was established that decisions to allow release had already been taken by the Responsible Clinician but that the patient had not in fact been allowed to leave despite her wishes. Cue: investigation into whether ongoing detention amounted to false imprisonment of the patient by the staff. Patient was almost immediately allowed to leave and would not cooperate with police officers when they offered to investigate. Informal warnings all round to nursing staff and referral to managers about a potentially illegal detention. There was no ability to take formal action without the victim's evidence. There is a legal right to use force to damage things if you have a 'lawful excuse': ie, escape from illegal detention.
- Several times in my career, probably six or seven times, I have warned – and in one case threatened to criminally investigate – mental health professionals who have incited the false imprisonment of patients. This always happens in the same way: the police are called to or sent to a private premises to deal with mental health emergency and because we keep having to be reminded not to use s136 in private places, we attempt to engage health services to come and take responsibility for mental health risks. Because of a difficulty in responding, or perhaps a preference not to have to, there have been several examples of CrisisTeams or AMHPs suggesting – or even explicitly *asking* – the police to essentially trick the patient outside to use s136; or to just use it anyway in a dwelling. Incitement to false imprisonment? Very potentially, and a clear denial of patients human rights (Art 5 and Art 8 ECHR to mention just two).

Of course in addition, there are several examples I've heard about where patients allege that restraint was unnecessary and disproportionate, therefore claiming that it is an assault. Such examples are familiar to police officers because we often investigate instances where people have deliberately used force on others who alleged it was either outright illegal, or illegal by virtue of being disproportionate.

To convict anyone of a criminal offence, it remains true that the matter must be proved in a court beyond all reasonable doubt that the accused is guilty. Prior to the matter of a trial, an investigation would have to conclude that there was sufficient evidence to charge the person with an offence and

that it was in the public interest to do so. Sufficient evidence to charge means that a jury, properly directed in accordance with law, is more likely than not to convict. In reaching these decisions, a CPS charging lawyer would be guided by the Code for Crown Prosecutors.

Excessive force allegations are always difficult. As a police inspector, I often have to take complaints against police officers' use of force and the problems are analogous. Police officers and mental health professionals are allowed to use force. The fact that someone did not like it; thought it was disproportionate; was hurt or injured by it or even just disagreed with the need for it: none of these things *of themselves*, render the force illegal. In reaching a decision about whether force used was unlawful, investigators, the CPS charging lawyers and ultimately a court would have to take into account the accused persons' explanation of why force was lawful. The police use the acronym PLAN: proportionate, legal, appropriate and necessary. There is a background model for the use of force called the Conflict Management Model which assists officers in understanding how to consider the use of force and how it should be appropriately rationalised against threats. Health services have different training, models and acronyms but there is still a structured approach.

The Mental Health Act implicitly authorises mental health professionals, including AMHPs, to use force where required in particular circumstances. This could be to detain and convey for admission; to restrain on a ward to prevent an assault; to prevent someone leaving a Place of safety prior to assessment (s136(2) MHA); or to forcibly medicate under the Mental Health Act. Patients will obviously have their perception of whether force used was reasonable, whether it was done in the least restrictive way or proportionately to the risks exhibited. Crucially, the mental health professional may also have a view based upon their assessment of risks. These perceptions are invariably not going to be the same.

The fact that there will be a divergence is par for the course in any investigation of assault, especially where the person accused is ostensibly acting lawfully by using force. To move to a position where an allegation of assault is formally prosecuted, it is necessary to pass the evidential hurdles described above.

Perhaps most importantly for me, it is *vital* that police officers and CPS lawyers take seriously, allegations by patients who are often vulnerable and detained by the state in circumstances which are not always gratifying. It is equally important that criminal investigations are fair to the accused, whose careers and livelihoods are at risk if guilty of professional misconduct. That said, investigations into a service user's allegations would be conducted on the same basis as any other: an accused is innocent until proven guilty; entitled to legal representation if investigated and the evidential hurdles are the same.

It is vital that service users, whether as victims or witnesses, are not immediately dismissed as unreliable purely by virtue of having a mental health problem. It is vital that 'special measures' to support vulnerable witnesses or victims are considered and this may include the use of specially trained police officers to take accounts in video interviews, rather than by taking written statements. And then: all cases on their merits.

5th March 2012

PC Nina Mackay –

This post is dedicated to the memory of PC Nina Mackay, Metropolitan Police, who died in service from stab wounds in 1997.

Magdi ELGZOULI is shortly to be released from secure mental health care. In 1997 he killed Nina Mackay as she entered his flat with other officers to arrest him for breaching bail following a previous arrest involving possession of knives. He subsequently pleaded guilty to manslaughter on the grounds of diminished responsibility and has been within the secure or forensic mental health system since.

We've known his release is coming: in 2008, the Daily Mail reported the potential for his release, amidst knowledge that ELGZOULI had been having four hourly periods of leave from hospital to assist with reintegration. The latest Daily Mail headline suggests that he is now deemed safe … unless you are a police officer. Psychiatrists are reported to be worried that encounters with the police on patrol could adversely affect his mental state. That's not the total of what I'm worried about.

Notwithstanding sensationalist headlines, legitimate questions are being asked this morning about whether the decision to release is correct; whether he should ever be released; and especially about any decision to release which is taken in the face of suggestions that he still potentially poses a risk to police officers.

Because if this doesn't work seemlessly, guess who is going to get called?

- Police officers are the very people who will be 'offender managing' him in the community as part of the Multi-Agency Public Protection or MAPPA arrangements, along with community forensic mental health services;
- Police officers will be the ones to arrest him on recall if this doesn't work;
- Police officers have all manner of unplanned, immediately necessary contacts with very many members of the public. Why wouldn't this happen with this man?
- Police officers in the United Kingdom are routinely equipped with a stab vest, an aluminium tube and a small tin of pepper.

- Also, they are usually equipped with an extraordinary compulsion to face danger despite their accoutrements.

It was reported in 1997 that he was an exceptionally prolific user of cannabis and we know the association this can have with inducing psychotic states and with raised risks of violence in a very limited number of schizophrenia patients. <<< *This statement is NOT about stigmatising all patients*: we are specifically debating here a convicted homicide patient, with a history of violence and drug abuse. Nothing here should be construed as having wider applicability.

The police, under our 19th Century Peelian traditions, actually *are* the public and are entitled to just as much protection in the face of forseeable risks as anyone else.

Nina Mackay's father, retired Metropolitan Police Chief Superintendent Sidney Mackay, has stated his view that the man who killed his 25 year old daughter should **never** be released. There has been call for some while that anyone who kills a police officer, mentally ill or otherwise, should never be released as it symbolises far, far more than an attack on the person of the officer. It is an attack on the State itself.

I want to cover a question from @ProtectRPolice who asked how the decision to release would have been taken:

Firstly, as a 'restricted hospital order patient' (s37/41 MHA), ELGZOULI's doctors were never and are not, fully at liberty to take important decisions about his release, his leave from hospital or even the kind of hospital in which he'd be detained. By virtue of the Crown Court imposing this order upon him, it is signifying he poses "a serious risk of harm to the public" and so becomes subject to oversight by the Ministry of Justice's Mental Health Unit.

The MoJ MHU takes decisions of behalf of the Secretary of State for Justice (currently, Ken Clarke) about the detention, leave and release of restricted patients and does so in the public interest, to protect us from these identified harms. So doctors can do nothing without MoJ say so and they, the MoJ, are known to refuse and frustrate requests made by psychiatrists about leave or release for restricted patients.

When the time approached where DRs believed that ELGZOULI may be suitable to have leave from hospital – probably escorted, supervised leave to begin with – they would have had to prepare a comprehensive risk assessment and satisfy the Ministry of Justice that this was safe, proportionate and that contingencies were in place should anything go awry. As leave increased in time and / or frequency and / or supervision, the DRs would have had to complete ever more risk assessment, evidencing

the appropriateness. This would remain true up until any suggestion that ELGZOULI be released from hospital.

Secondly, whilst detaining under s37/41 as a restricted patient, ELGZOULI would periodically have had opportunity to apply to a Mental Health Review Tribunal to secure his release. This is a panel consisting of a Judge (or a QC who is a Recorder), a Psychiatrist and a lay person who must consider whether it is appropriate to release.

Thirdly, when released it is far from the case that ELGZOULI will just be shown the door and allowed to get on with it. He will be released from hospital under a system called 'conditional restricted release' (s42 MHA). This means that various conditions will be imposed upon him and supervised by community forensic mental health specialists. Such conditions may include, initial residence in a hostel or 'step-down' facility where 24/7 staff can supervise albeit far less restrictively than when he was in hospital. If successful, residence may subsequently move to supported housing or an independent dwelling but there could still be other conditions, ie, that he continue to comply with outpatient and other medical appointments which are intended to ensure ongoing supervision and management of risks.

And for all this time, ELGZOULI will be subject to close oversight by MAPPA – Multi Agency Public Protection Arrangements. These will provide a multi-agency framework within which information about risks should be shared and assessed, so that agencies other than mental health services can take appropriate action, either in terms of ongoing supervision (police offender managers) or in the event of a trigger incident – absence, further offence, etc. – can instigate contingencies. MAPPA offenders often have trigger plans prepared to be instigated immediately with people like police duty inspectors overseeing their immediate implementation. This could be a patient not complying with residence requirements, medical appointments and so on; or could be in response to particular incidents, like a 999 call to the police to this man or his place of residence.

If **at any stage** the clinicians fear that rehabilitation and recovery are threatened and that risks are manifested, the Ministry of Justice can issue a warrant for his return to hospital. At such time, he would again become subject to the legal frameworks of s37/41. Of course, the warrant would be executed by the police arresting him … which is how the problems started in the first place and where Nina Mackay was tragically killed.

One can imagine that if arresting him for any reason to return to hospital, nothing other than armed police would be deployed given a previous homicide offence against an officer.

As to the subject of whether he should ever be released; and what, if anything, should be done around potential risks police officers would face if they had cause to have dealings with Elgizouli – this is the most difficult part of it and does all of the above mitigate risks adequately? Maybe, maybe not.

It can never be ruled out that 'normal' uniformed police officers may come across him; whether by chance or because of a call which does not reveal nominal links which allow trigger plans to be considered or implemented. Whether officers will *know* they have come across him is uncertain – over time the conditions applied to his release may loosen and his ability to travel as he wishes will increase. The fear is, a chance encounter with an unarmed, uniformed officer and we're straight into 'PC Jon Henry' territory: an officer unknowingly dealing with a mental health patient who proceeds to commit a grievous offence.

As for the reported logic in the latest Daily Mail headline that he is safe as long as he is not living in an area with many police; this just seems too absurd for words. I'd love to know more about this: however, London is very heavily policed: almost 25% of the police for 15% of the population. But then, I've come across some pretty strange thinking in my time working mental health so there is just something in my head than cannot rule it out … fingers crossed all round that this has been properly thought through.

The structures are certainly there to suggest it should have been: **let's just hope the checks and balances have worked**.

12th March 2012

A Response to The Masked AMHP –

This post is a response to a fascinating perspective from The Masked AMHP about criminal responsibility – incidentally this blog in general, is a *great* insight into the role of an Approved Mental Health Professional and has taught me a lot. AMHPs are charged many crucial decisions about the implementation of the Mental Health Act – this prize-winning blog is well worth a read.

The post on criminal responsibility came after a dialogue with a reader, to allow more time for thoughts on responsibility. It flows from that post that I wanted to provide some of my own from an investigator's point of view.

The discussion point began with dialogue about whether a female patient with a diagnosis of paranoid schizophrenia should be prosecuted for attacking her kitchen boiler by damaging it. She did this, because her condition caused her to think the boiler was talking to her. The essence of the post is that "the crucial point here is to do with mental capacity".

Legally speaking of course, the start point is, that you can damage your own property if you want to. You can even damage jointly owned property without fear of prosecution, because it's your property to damage. However, you may not do so in ways which endanger the lives of others, and whether so endangered deliberately or recklessly. This second, I will call it 'aggravated', version of criminal damage is where it starts getting complicated because you need to explore what was in a person's mind when they damaged a boiler.

So if this patient lived in rented accommodation, where the boiler belongs to a landlord or housing association, offences of 'simple' damage or aggravated damage are possible. If she owned the property and the boiler was hers, it is only an offence if the damage was aggravated arising from it causing serious risks to others.

I have blogged before about using mental capacity frameworks as a guide to investigation and prosecution, and whilst there is some relevance to decision-making I can't agree that it is the key point. Of course, the Masked AMHP is (I think!) as much referring to how a health or social care professional may approach the issue of whether to report the offence for

investigation, as much as the investigation itself. I'll come back to this point nearer the end.

Taking it that an offence has been reported, the proper legal approach to investigation / prosecution is not around mental capacity, but about the satisfaction of a two stage legal test:

- **The Evidential Test** – is there enough evidence to charge?
- **The Public Interest Test** – is it in the public interest to prosecute?

THE EVIDENTIAL TEST

This in itself has two parts:

1. whether or not the *actus reus* of the offence can be shown (the act done);
2. whether or not the *mens rea* can be shown (the guilty mind);

The *actus reus* is usually quite straight-forward in offences involving mentally disordered offenders. Unlike acquisitive criminals who seek to evade identification, capture and conviction, there is often an 'up-frontness' about offending behaviour by mentally disordered offenders. So:

- there will either be boiler damage or there won't;
- there will either be admissions of causing the damage or there won't;
- there will either be witnesses to the causing of the damage or there won't.

So you then move onto the next question of whether or not the *mens rea* is proved. Well, for the simple offence of causing damage, it requires a low-level of intent, *mens rea* would be easy to show even if someone was mentally ill. It would be far harder for the aggravated version of the offence where proof must be offered of *intent* or *recklessness* of the risks to life being caused.

Rather than provide any further, turgid explanation of all this, I would refer people who want more detail on it to Crown Prosecution Service Guidelines on Mentally Disorder Offenders. Suffice to say, the law regards everyone as sane and responsible for their actions, unless the contrary is proved in court and it is a matter for the defence to raise insanity.

Simply put, that someone is mentally ill, does not automatically or even often preclude the potential for the 'mental' element of an offence to be proved at the point they punched someone, damaged or stole something.

PUBLIC INTEREST TEST

It is my view, that far more often, the real issue of whether or not a mentally disordered offender is prosecuted, is the public interest barrier. And this is where the Masked AMHPs use of mental capacity as a framework to approach whether to report is particularly useful. Notwithstanding the views about 'defining behavioural boundaries' and 'showing consequences to actions' and 'therapeutic jurisprudence'; it remains the case for all offenders, that there must be a public utility in a prosecution. I think there would be, more often than we currently recognise – for a range of reasons I've covered in other blogs.

Most solvable criminal offences are *not* prosecuted. Where we know who the offender is, less-than-formal mechanisms are employed whereby we informally warn; we reprimand or caution; we issue fixed penalty notice fines and we arrange restorative or reparative justice without reference to the CPS, courts or prisons. We also sometimes put a criminal offence to one side, even where *actus reus* and *mens rea* could be proved, because it is clear the public utility is better met by a mental health intervention or schools intervention or an employer's sanction.

This is where for mentally disordered offenders (and young people) 'diversion' comes in – oh, how I just **hate** that word. If someone is mentally ill, to a degree that warrants a therapeutic response, it may not be necessary to prosecute at all, if the necessary, available mental health intervention takes care of immediate risks and mitigates against recurrence. Indeed, it may provide longer-term rehabilitation. For example, the re-offending rate for restricted hospital patients is about 6%; that for prisoners and community sentences sometimes ten times that rate.

Of course, all cases on their merits: if someone with a very real mental disorder who can be held responsible for their actions, is unwilling to engage with mental health services; it may be that we discount diversion before charge and take someone to court. The courts then have powers under Part III MHA to manage the issues around liability, fitness to plead / stand trial and The Masked AMHP is absolutely right to point out that "you cannot make any blanket judgments according to diagnosis, along the lines of 'someone with a diagnosis of schizophrenia lacks capacity', or 'someone with an emotionally unstable personality disorder has capacity.'"

These cases can be complicated. So where someone "lacks capacity", you may still seek to prosecute them because they've raped someone and all the balances and protections of the court, the criminal justice and potentially the Mental Health Act are needed. This can only be done under our Constitution by a criminal court.

But we can agree at the end, as the Masked AMHP concludes: "So the brief answer to the question posed at the beginning of this post: "are people with mental disorder responsible for their actions?" It all depends …"

12th March 2012

Why I Hate the Term 'Diversion' –

If there is something I could ban in the police / mental health debate, it would be the use of the word 'diversion': **literally, banned**! Perhaps we could legislate?! And 'liaison' isn't much better and should also be avoided. Let me explain:

If I get in my car in Birmingham to drive to Cardiff I will begin to follow a certain route having determined my destination before departure – I always enjoy the M50 / A40 route through Herefordshire and Gwent, stopping somewhere around the border for coffee. But were I to find I need to 'divert' to Bristol, I would have to start to undo my route and find a new one, but not from Birmingham. Had I known in Birmingham I needed to go to Bristol, I'd have driven straight there, down the M5. It wouldn't have been a 'diversion' at all. So I 'divert' not from Birmingham, but from somewhere like Monmouth or Usk, to Bristol. And when I get there, I am in Bristol, not Cardiff.

It is utterly impossible to be in both Bristol AND Cardiff simultaneously.

Of course, if at the start I do not know where I need to end up, I'd either stay at home until I knew; or drive to the point in the journey but no further, where I'd need to make the decision. (There is excellent coffee at the services at Junction 8 of the M5.)

And this is why 'diversion' is not the word we need: it is perfectly possible, in fact often it is desirable, that someone is within both the Mental Health and Criminal Justice systems and whilst the first destination may be prison, it may that we could not possibly know this when we set off. But set off, we must. Mental health care can be provided in prisons by 'inreach' teams before identifying a need to move to hospital, but still subject to criminal justice frameworks within the Mental Health Act (ie, a restricted transfer direction under s47/49 MHA). It may then be that the person is remitted *back* to prison, once treatment for mental disorder has been effective enough to ensure that the patient no longer needs inpatient mental health care, but may again receive 'inreach' mental health care from the NHS.

The hypothetical person in the above paragraph is in constant contact with mental health AND criminal justice structures – is not 'either / or' and this

would remain true for most international jurisdictions like Australia and Canada, etc., where parts of the mental health system can only be access via criminal justice processes and who have also come to rely on policing as a frontline emergency psychiatric service following the deinstitutionalisation era. And I don't like 'Liaison' either, I'm afraid! Apart from the fact that the word is too frequently used in policing to mean nothing at all, and all too frequently spelt with just one 'i'; it also implies something about mental health and criminal justice which doesn't reflect what we're actually doing.

So here's a touchy subject: we know that many people in prison have mental health problems. Some of these are addictions which led to the need for acquisitive offending in the first place, but whilst addictions are 'counted' as mental disorders, they are not always disorders that require inpatient mental health care. Other prisoners have psychotic conditions and campaigners have argued that more of the psychotic prisoners need to be move across from prison to health. No argument about that here.

Professor Jill PEAY from the London School of Economics – one of our foremost academics on mentally disordered offenders, whose book Mental Health and Crime is a seminal text – wrote about a "model of plurality" in her article on Mentally Disordered Offenders in the Oxford Handbook of Criminology (4th Edition). She argued that we must increasingly recognise that not all mental health care for offenders needs to be provided within the mental health estate and accept the inevitability of just some, lower-level mental health care being provided in prison. We need to recognise the need for the provision of mental health care *within* prisons. Just like much other healthcare is delivered within prison.

Of course this is like arguing for the need for Cardiff to be IN Bristol whilst simultaneously Bristol is WITHIN Cardiff: it sounds more like the premise for an episode of Doctor Who than a structure by which to determine the pathway through two mammoth systems of state coercion and control.

I object to 'diversion' for one more reason: it implies 'this' or 'that'. A bifurcation in structure which simply doesn't reflect the way we have philosophically constructed our legal frameworks and which doesn't address the complexity of whether mental health causes crime or vice versa; or whether they are coincidental concepts?

And because we've allowed this bifurcated, unsophisticated approach to emerge as a result of our lexicon, we have had to find something which is a single determination of whether someone is 'mad' or 'bad'. We have decided that it is whether or not someone is 'sectionable' under the Mental Health Act when arrested and the first part of this post shows why we didn't need an overly simplistic division between 'this' or 'that'.

So we are in a place where some mentally disorder offenders who are 'sectionable' are not prosecuted in the public interest when indeed they should be, to ensure that Part III of the Mental Health Act balances risks, assessment and treatment needs. We are also potentially criminalising mentally vulnerable people who are not (quite) 'sectionable', when a diversionary-style approach may be the one which best mitigates against future re-offending risks.

So the challenge is two-fold:

- How do we conceptualise the relationship between mental health and criminal justice in a way which avoids the 'either / or' of liaison and diversion?
- How do we ensure an approach which avoids unnecessary ciminalisation of vulnerable people through over-simplification?

And(!) – **WHICH WORD SHOULD WE USE?**

12th March 2012

Arresting People Is Easy –

This story is a while old, but I've delayed telling it to put a bit of distance there. I was contacted by an 24/7 operational police officer about this job – the way in which they used the blog at the scene of an incident and achieved an unorthodox, but undoubtedly better, outcome for a family after a difficult incident is something I was fairly chuffed about, to be frank: to think that this work is making a difference in a part of the country I don't police and helping frontline cops through the maze of mental health and criminal justice to achieve better outcomes makes those late evenings blogging to Newsnight and Question Time all worthwhile.

One evening the police were called to a domestic incident whereby a husband had been stabbed. Upon arrival, there was an emotionally charged, difficult incident ongoing where an elderly man had sustained a knife wound, thankfully not life threatening. It came about because of his attempt to stop his wife self-harming when she had tried to use a kitchen knife. He eventually felt he had to physically intervene there was a struggle which resulted in him sustaining the injury and the police were called by other members of family who felt it was all getting out of control.

The police officer who attended the incident and gave this feedback was the duty sergeant for the area. Upon arrival they had a head full of 'domestic violence' policy because a husband has been stabbed by his wife. In most forces of the United Kingdom, domestic violence policy basically says – this is a very crude simplification to make the point – if there is something you can arrest somebody for, the idea is that you do so; in order to remove the offender, calm the situation and allow officers to speak to victim without offender hovering over them. This allows full preservation of all available evidence, including photographs, scenes of crime examination if necessar and a proper handling of victims in a sensitive way which reflects that criminal investigation barging into marriage is a difficult, emotionally laden business. So in theory, the woman who had stabbed or slashed her husband could and some would argue should have been arrested for wounding, sometimes referred to as GBH.

However, when the circumstances were explained it was clear that the offence took place in the context of a struggle around self-harm and mental health. Family explained the lady's history of depression and mental health problems. Questions were being asked about 'capacity' and thoughts were

turning to proving criminal responsibility, *mens rea* and public interest tests for prosecution. And of course, none of this was prioritising the fact that both parties involved had medical problems: the 'offender' had her mental health problems and she was clearly very distressed; the victim had physical injuries that required hospital treatment.

So, the blog came out: courtesy of an iPhone whose owner had bookmarked the home page. Quick reference to posts about "mental capacity" and "do they have capacity" and unorthodox solutions were starting to be considered. What prevents the whole scene being properly preserved and examined with Scenes of Crime photographing everything, seizure of the weapon used; potentially seizure of clothing from those involved to preserve evidence; but NOT arrest anyone? Why not contact mental health services and prepare an assessment pathway for the suspect; remove the victim to A&E for treatment and see what the outcome of mental health assessment is before criminalising the situation?

Now this type of response would possibly be considered to be outside most police force's policy on domestic violence. So to ensure it was appropriate, the sergeant contact the duty inspector – senior officer for the area that evening. The Inspector asked all the difficult questions that Inspectors should, in order to satisfy himself that nothing would be 'lost' from an evidential point of view and that there were gains to be had in approaching things this way.

In actual fact: force policies merely require 'positive action' by the police.

Here's the difficulty with some mental health jobs where it involves domestic abuse which needs to be taken very, very seriously.

Does this mean that suspects, including this one, escape liability for their actions?

- Not necessarily: nothing prevents prosecution of any suspect in a case like this. But it does mean, that prosecution should it be required, occurs after mental health assessment. It also means, that should prosecution not be deemed necessary, the person has not been criminalised by removal to police cells for all the impact that we know this can have upon people in crisis.

Does this mean, that victims are placed under pressure not to prosecute because the suspect has mental health problems?

- Not at all – the victim would (and was) still spoken to at length about the incident in order to establish background, precise circumstances and of course, for their views about how best to handle it can be

expressed. It would be quite wrong for police officers to imply one way or the other whether or not a victim should seek prosecution of their partner in a case like this, but that does not mean victim's views about the incident should not be heard by the police.

- Indeed, it is often the case that without a victim's express support for a criminal prosecution, it is not considered to be in the public interest to prosecute in any event.
- Of course, in cases involving significant domestic history it may be that prosecution without a victim's consent is the only way to ensure future safeguarding of people who may or may not realise the ongoing risks they face.

This case shows that it is easy to arrest people: it would have perfectly defendable for these officers to just arrest the woman, remove her to police cells for mental health assessment and criminal investigation. In due course, conclusion would have been reached about whether to detain MHA, to prosecute or to do neither of those things. But this incident also shows that people who care for those who suffer mental health problems do sometimes come to harm themselves by virtue of trying to keep their loved ones safe.

The response given by the police needs to reflect a really delicate balance between following policies and procedures which have been painstakingly designed to balance and mitigate risks, with taking action that is in the best interests of those involved and which takes account of the views and needs of the people involved.

In this particular case, the victim of the matter did not regard himself as a victim or wish to be treated as such. He viewed himself – whatever you or I may think about this – as a loving husband trying to keep his wife of many years safe. He wanted support and help for her: the police were in a position to facilitate this as the lady was not only assessed quickly by mental health professionals, but admitted to a mental health unit where she is now engaged with appropriate professionals working to prevent violence and aggression.

So officers "did the right thing" by thinking outside of the box in order to strike this balance. And it sounds to me like they did it superbly.

13th March 2012

Police Officers As Psychiatric Nurses –

I spoke recently to a former police colleague who is now a psychiatric nurse. I am aware of a couple of police officers who used to be psychiatric nurses earlier in their careers. I admit to thinking that this dual professional perspective must be fascinating, not least because it's clear to me after the work I've done – with no professional or personal background in mental health – that there are many cultural differences between the NHS and the police. It caused me to wonder how people adapt to the second phase of their career in such a culturally different organisation.

I am aware for example of an incident to which the police were called where a psychiatric nurse was being rapidly approached by a patient who had somehow acquired a knife and was making to hurt him, verbal threats and a manner which indicated an intention to try to stab him and / or others. The nurse was stood next to a healthcare assistant and there were other vulnerable patients nearby. So bearing in mind NHS policies on control / restraint, the avoidance of control / restraint techniques which involve the deliberate application of pain; the requirement to demonstrate the least restrictive principle he decided that the only reasonable way to properly mitigate that very real, potentially lethal threat was to punch the patient in the face to cause sufficient distraction and disorientation to allow him to push them backwards, off-balance and get the knife off them. They then got into a restraint situation until other staff and the police arrived.

Reasonable? Well in law, yes. Desirable? Definitely not: no-one would want this. But whether or not this is considered therapeutic / dignified and so on is a separate debate. Any investigation into nursing professional standards or healthcare standards would have to take account of the person's right in law to defend themselves: quick attempts to verbally de-escalate the situation were tried and they failed, the risk to people was imminent, the reaction was one that couldn't be thought through as there were seconds to react, so what else was left? Everyone – including psychiatric nurses on inpatient wards – has a legal right to self-defence under s3 Criminal Law Act 1967 and when faced with a potentially lethal threat, it becomes all the more reasonable to ensure that the level of force used to protect oneself is sufficient to make sure.

Afterwards, the patient made a complaint of assault to the police and did have a facial injury. The police there and then were able to determine from

witnesses that the nurse faced a very real threat and could arguably have done little else than use the force that they perceived to be the minimum necessary to ensure his own safety and that of others to whom he owed a duty of care. No further action and no protracted investigation to work it out; the nurse's conduct was reasonable, therefore lawful, according to three witnesses.

Now I'm aware that if you were to have a conversation with many psychiatric nurses – and I have – they would tell you that they are 'not allowed' to do things like this. Well it depends what you mean by 'not allowed'. Like all things mental health (and policing) you have laws, codes of practice, regulations, policies and protocols and these things are collectively intended to guide and control the behaviour of the state's agents towards vulnerable people. There are conflicts within these frameworks: whilst a local policy may say many things; if this is in conflict with the law, there is a tension, eg psychiatric nurses cannot use techniques which involve the deliberate application of pain (CoP). But what if to try things which do not do so, is to put oneself at risk of assault? The law allows people to use "reasonable force" to defend themselves. Laws and statutory regulations trump Codes of Practice; Codes of Practice trump local policies and so on.

So such belief as "You can't punch a patient" is demonstrably nonsense but to say so, *most crucially*, is **NOT** to put an argument for doing it or doing it more. It is *merely* to say that all dynamic situations must be assessed on their merits in light of the law. No-one would *want* to do such a thing.

Meanwhile, I wonder about we'd do our jobs if more had that dual background: would mentally vulnerable victims and witnesses get a more sensitive hearing when reporting crime; would there be a greater willingness to stop AWOL patients from leaving wards? What would attitudes be like towards the situations in which one of the organisations is wanting the other to use force?

As ever, the reality is that policing and mental health is not as far apart as many would believe. I know that mental health services very often call upon police officers and their skills in inpatient settings; I know that at least one Chief Constable has suggested he may need to employ psychiatric nurses to assist in managing mental health related demands. There is still a lot of room to learn from each other to improve how we work in partnership.

16th March 2012

Not In The Public Interest –

It is a phrase mental health professionals are very used to hearing, "Sorry, it's not in the public interest" [to prosecute a mental health patient with an offence]. It is a phrase the police and the Crown Prosecution Service have often used to defend the decision to take no formal criminal action against a patient who has assaulted, or stolen or damaged property, especially where the patient is an inpatient. Of course, it is often the case that they will have been *quite right* to do so.

I want to explore in this post whether we are currently drawing the line correctly in the sand and / or whether we are thinking correctly about the public interest in prosecuting mentally disordered offenders.

The Code for Crown Prosecutors is a statutory document, issued by the Director of Public Prosecutions under authority granted to him by the Prosecution of Offences Act 1985. By law, Crown Prosecutors MUST have regard to its contents when reaching prosecution decisions.

Government policy on the prosecution / diversion of mentally disordered offenders has, since the 1990s, been reflected by Home Office circular 66/90. Jointly issued with the Department of Health it reflects the "the desirability of ensuring effective cooperation between agencies to ensure that the best use is made of resources and that mentally disordered offenders are not prosecuted where this is not required by public interest."

If you have never read this document, I would strongly encourage you do to so, as 22yrs after publication it is still the current government policy document on 'diversion'. It makes numerous references to 'not prosecuting, except where required by public interest' and so this has to be worthy of further consideration. It is of note, that the document does encourage police officers to think from the very beginning of their response to incidents of the potential to divert from justice: it lists the use of s136 Mental Health Act as a diversionary approach. Of course, if an incident gives rise to a situation where an arrest could be made for an offence AND / OR under s136 Mental Health Act, the Circular encourages detention under the Mental Health Act if the offence is minor.

The Code for Crown Prosecutors (from p10) lists various considerations that would both tend in favour and against prosecution. For example, that a

victim is a public servant; that the offence involved a weapon; or that prosecution is necessary to stop a repeat of the act: all are reasons to lean *towards* prosecution. That the offender has a serious mental health problem; that they would receive only a nominal penalty; or that the seriousness and consequences of the offence can be adequately dealt with by out-of-court disposal with which the suspect agrees to comply: all of these lean *away*.

It is not a question of counting these factors decide whether 'for' or 'against' has more going for them. It is also a question of balancing the value of each. Having worked on the concept of 'diversion' for many years, I have come to the conclusion that offences which are very minor (for example, 'summary-only' offences which are triable only in the Magistrate's Court) are the only ones which should be completely set aside in favour of s136 arrests or set aside from police custody by diversion under the Mental Health Act.

What I mean by this: if an officer has attended an alleged assault, and there are no injuries to the victim despite being hit, it may be consistent with justice to arrest s136; or to take no formal action at all on the assault if a mental health problem is identified only after removal to the cells. We should remember the potential for informal and out-of-court disposals to provide a positive impact. However, had someone been injured to a standard of actual bodily harm or more, then arresting for the offence becomes important. Had the person been removed to custody after arrest, regardless of the stage at which mental disorder was first suspected, it is important that the 'No Further Action' option is not *immediately* selected.

I want to argue for greater use of police bail to determine appropriate conclusions.

Home Office Circular 66/90 argues that admission to hospital for compulsory admission for assessment or treatment (s2 or s3 of the Mental Health Act) may often by sufficient to negate the public interest in prosecution. I have two questions to ask about this, to promote consideration of whether this is always true:

- How many times are you going to do this before reviewing whether to do it again is consistent with the public interest?
- If you are going to do it, should police bail not be used to keep the person within the 'grip' of the justice system until the outcome of assessment / treatment is known?

RECIDIVISM

I can give examples of where offenders have been arrested and diverted on multiple occasions. My favourite example – the most extreme one I have, to ram the point home! – is a man who was arrested 55 times in 5 years and whose offending patterns represented a clear escalation of behaviour over that period. What started as minor public order offences and shoplifting became theft and actual bodily harm; which became robbery and grievous bodily harm. Although much had occurred to mitigate the risks he posed – diversion to mental health services, anti-social behaviour order, and so on – it appears no-one got close to saying "Hang on" and re-thinking the case-by-case approach to escalating risks.

How many times is arrested s136 and / or 'diverting' under s2 or s3 MHA going to acceptable, before we wonder whether it is working in the longer term. Indeed, how many times is diversion under s2 MHA with release to community treatment after just a few days or a week going to happen at the expense of consideration of prosecution? <<< In case of doubt, this is no criticism of the decision-makers to divert. I have genuine questions about the total knowledge of the decision-makers in both the police and mental health services when they are considering case 47 of 55. Were they aware of cases 1-46? If not, do the information systems they have access to in police custody at 4pm on a Saturday allow them to find out? These things link to my next question.

USE OF BAIL

In my view: the use of police bail before charge can be the answer to a lot of this. If someone is arrested for an offence and removed to custody, but then assessed under the MHA and in need of admission, if they are arrested for what the law calls 'either-way' offences or 'indictable only' offences, then they should NEVER be just released without further action by the police because they have been delivered into the care of mental health services under s2 or s3. They should be bailed for 30 days, under an obligation to return to the police station.

Whilst in the care of mental health services, various things will then occur or apply:

- The investigating officer will then engage with MH professionals to share / request information relevant to making the right CJ decision.
- If the patient is assessed and released to community care within days or a week or so; then they remain under a duty to return where they

can be assessed for fitness to interview by the FME, the investigating officer by then having a clear understanding of the MH issues.

- If the patient is assessed and deemed to be sufficiently unwell to remain in hospital, perhaps 'converted' to s3 of the MHA for treatment for up to six months, then bail can either be cancelled or varied, depending on the case.

This means, that a revolving door of 'diversion' is avoided; risks are better understood and mitigated.

NOT IN THE PUBLIC INTEREST

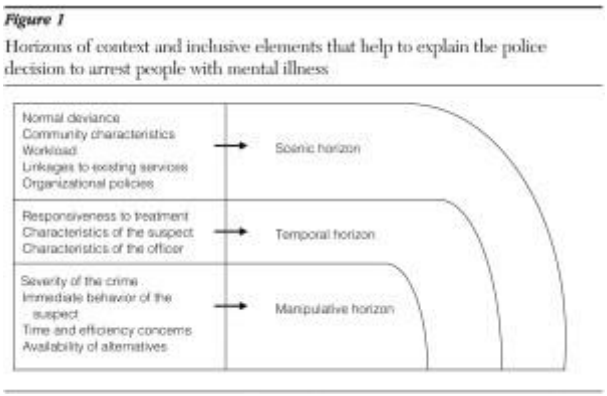
In some areas, such as Greater Manchester Police, they have formalised these information sharing mechanisms into Mentally Disordered Offender panels. Meetings of a certain frequency which come together to discuss the relevant cases, rather than do it *ad hoc*, case by case. For me, whilst there may be little public interest in prosecuting offenders in certain circumstances, that public interest begins to increase as ongoing offending behaviour continues, or even escalates. By the time you have someone with half a dozen arrests, perhaps starting to increase in seriousness or frequency, it is already *beyond* the point whether prosecution should be considered to access bail and sentencing options which are only available to courts.

For example, where someone is prosecuted for an offence, even where they are considered 'sectionable' under s2 MHA, a Magistrate or Crown Court have powers under s35 MHA to remand to a hospital for assessment, treatment or reports. This then places the right information in front of the trial about the person's mental health and criminal justice background to make the right decisions at court. These outcome could include a Mental Health Treatment Requirement as part of a community sentence – very under-used sentencing option – as well hospital orders or restricted hospital orders. We should also have in mind during investigations, the potential for public protection and 'offender-management' approaches, such as drug-testing, MAPPA and so-on.

We need to think more about the value of prosecution in the public interest, but only where the background of particular patients or the individually serious nature of an offence necessitates it is proportionate.

16th March 2012

Horizons Of Context –



A very short post, to highlight an important article, which is probably most relevant for mental health and social care professionals seeking to understand police decision-making: "Horizons of Context: Understanding the Police Decision to Arrest People With Mental Illness" by Dr Melissa MORABITO, now of the University of Massachusetts, Boston.

This article covers the criminal justice literature on decision-making since the 1960s, starting with Egon BITTNER's work and offers a framework within which it is proposed that arrest decision-making occurs. It attempts to put down the "criminalisation hypothesis" offered during the 1970s and 1980s and in my opinion, succeeds.

This is potentially also useful for the empowerment of police officers who feel subject to unjustified criticism around their arrest and detention of mentally ill suspects or those who are in need of immediate care.

23rd March 2012

Black Swans –

Since starting this blog, I am very conscious that I have quoted a lot of law, hyperlinked to Codes of Practice and guidelines etc., etc.. All very technical stuff and often very dull; but aimed at equipping police officers to do the right thing in their operational reality as well as in strategic discussions about partnership arrangements. It was also intended to allow service-users and other professionals to see their worlds from a police officer's point of view, to understand our obligations and limitations as well as our shortcomings.

As I look back upon my own time as a constable and sergeant, I can sometimes shake with fear at some of the things I was invited to do and which I entered into in good faith, doing my best. I didn't know any better and I can also now see I was one of the lucky ones, for whom nothing went awry. It's fair to say, I was party to processes I wouldn't wish some of my enemies to be subject to, for a want of alternatives and knowledge of how to do it differently.

It's right to say that police service has a moral as well as a legal obligation to police effectively and with compassion, within the law for the benefit of society. That is all important, noble stuff. However, it is not the main reason I want to raise my colleagues' and others' awareness of policing and mental health: I want to help them **do the right thing** and **keep them out of trouble**. I got interested in this work, because I wanted to know enough to keep *myself* out of trouble after seeing things go badly awry.

I want to try and help them do this whilst they police a society which stigmatises mental health problems and whilst working alongside a politicised mental health system that is chronically underfunded and structured wastefully (like the police). Of course, it's not a "mental health system" at all; not in any real sense. Care is spread across multiple NHS organisations who often don't talk to each other and whose commissioning is not properly integrated: ambulance services; local authorities; General Practitioners; Mental Health Trusts including community mental health and crisis services. And of course Accident & Emergency departments who "don't do mental health" despite it being 15% of its demand.

Often, police officers and their 4-8hrs of mental health training get themselves into trouble in ways that they do not foresee: when they run to

emergencies with all the right intentions to help, support and keep people safe. Where supposedly unpredictable events occur and wheels fall off it suddenly becomes apparent that for the want of better training and responsive NHS structures, problems where actually quite predictable, however unlikely.

This is an important distinction about risk: **unlikely events are not inherently unpredictable**.

I have talked at length with some police officers who have been involved in very difficult incidents involving the death of someone with mental health problems following police contact. Ironically enough, some of those officers have gone on to develop PTSD and other grave mental health problems, sometimes leaving the service completely, their lives affected forever through ill-health and divorce, amongst other issues.

I say this not to attempt to promote the impact upon some police officers of doing their job above the permanent, tragic impact to a family by losing a loved one in the custody of the state; but it is important to understand with some mental health incidents officers can legitimately say, "I actually did what my training and force or joint policies asked me to do" with a sense of bewilderment about how they've ended up facing allegations of neglect and human rights violations in a court.

There are some local authorities areas who do not actually have joint operating policies on the four areas of business where joint approaches should be outlined in such a way. Yet these documents are legal requirements?! I don't understand.

It is the least that junior officers should expect in this complex area of business: that there are clear expectations of what should occur – PlanA or PlanB or PlanC, according to the partnership structures that exist at that time. If an area has not managed to set out expectations in a joint protocol, the law of the UK and Europe still apply anyway.

The point here is: some police tragedies involving mental health incidents are not entirely **un**predictable for the fact that they were unlikely. I sometimes read of cases that went awry and think, "Why on earth did you do that?" There are various predictive factors which should raise our alertness to the possibility of tragedy – alcohol, drugs, violence – but because these are events are so rare, and because they usually do not end in horrific consequences, they can *appear* unpredictable. <<< *This is a significant cognitive bias in operation.*

Risks which 'stack the deck' towards a serious untoward incident should be mitigated every time, and to the 'Nth' degree where the impact could be disaster.

26th March 2012

True Story 4 –

When I was a uniformed constable there was an urgent request for the police to support mental health professionals at a Mental Health Act assessment in a private premises. This support escalated into an incident and a criminal investigation I will remember for the rest of my life.

It involved a man with a history of mental health problems who had previously been a detained patient and who lived on our area with his wife. The beginning of the story starts with a 'trigger' event – an anniversary – which caused him to leave home in crisis. His wife reported him missing to the police and a few days had passed during which attempts to find him were unsuccessful. One afternoon, he returned home, psychotic and extremely unwell. His wife immediately informed mental health services and it was quickly decided that he would be assessed at his home for admission under the MHA. When the professional team arrived at his address, he was quite disturbed and they tried their best to de-escalate a serious situation where his psychotic behaviour was cause for significant concern. One of the professionals rang 999 for urgent police support.

Just prior to the officers arriving there, the man made threats towards the professionals who decided to withdraw for their own safety. He attempted to keep his wife within their ground floor flat whilst threatening her, but the social worker managed to grab her and pull her out fearing for her safety also. They made a further 999 call to the police who arrived almost as the 2nd call to the police was concluded.

Believing the man to be in his own flat on the ground floor, they began to brief the two constables as to what had occurred and that they needed help to get him 'sectioned'. Unknown to everyone discussing this in the street, the man had gone to the upper flat in the communal block and knocked on his neighbours door. He stated that he was 'the law' and as soon as the door open he punched his neighbour hard in the face, knocking him to the floor and jumped on his chest, sitting astride him. He spent approximately 10 minutes punching and strangling him, attempting to gouge his eye and getting to the point where the victim was almost unconscious. He then proceeded into the victim's flat from the entrance way and took a 10 inch kitchen knife and returned. He attempted to stab his neighbour who had recovered sufficient consciousness to realise the attack and who suffered the most horrific defence wounds to his hands and arms as he attempted

to deflect the knife away from his torso during several vicious attempts to stab him.

The police having entered the communal block they heard the fighting and called for more resources. Officers in a public order van with riot shields entered the flat and used force to stop the attack, by which time the man had numerous serious stab and slash wounds. As the police entered the room, he was busy driving the knife into the victim's chest, causing a punctured lung. He was taken by ambulance to hospital where the A&E consultant told the police to start a murder enquiry because he was certain the man would die. In addition to puncturing his lung, an artery in his arm had been severed.

The offender was removed directly to a medium secure unit on the authority of the mental health professionals present – the ONLY time in my career I've known this happen. The only time I've ever heard of it, in fact. Fortunately, the victim did not die, which can only have been due to the skill of the A&E staff and the speed with which paramedics and A&E worked together.

Several days later, I moved onto CID and became responsible for investigating this case, closely supervised by the Detective Sergeant who let me loose on it. I had to take the statement of evidence from the victim, something which took me two whole days spent with him in hospital – the longest statement of evidence I have ever taken, covering 24 pages of (my fairly small) writing. Spending an hour writing, giving him a break from it, then another hour, etc., until done. It was clear that the impact upon him, not just in terms of physical injuries, was enormous. He asked so many questions about the mental health system and the criminal justice system: he wanted to know, as many victims of unprovoked violence do, about the mental health history and care history of his attacker as well as what would happen to him. I had to research this overnight in between my two days of taking his statement to give him half a chance comprehend what may have changed his life forever.

The suspect was eventually well enough to be brought to the police station for interview. It was the most 'open' interview I've ever known: no real questions, no challenges against his account, just an open opportunity for the man to explain what happened and what he was thinking. His responses amazed me: a detailed knowledge of Norse mythology and a delusional, paranoid link between this folklore and the need to eliminate his neighbour. He was charged with attempted murder and having been cleared of this offence on the grounds of insanity, he was detained in hospital on a s37/41 hospital order in a medium secure unit.

NB: 'diminished responsibility' applies to murder charges and present an opportunity to substitute an alternative conviction whilst providing for a

disposal into the mental health system for manslaughter. Where an offender is charged with any other, lesser offence, the prosecution can offer a defence of insanity – a legal concept, not a medical one. If the defence of insanity is successfully demonstrated, then the person is *cleared* of the offence: **not guilty**. However, such a defence having been successful, it opens the possibility of detention under Part III of the Mental Health Act, usually s37 MHA, restricted by s41 MHA. This is an indefinite detention under the MHA which I have explained elsewhere.

I know the issue of violence by mental health patients is extremely difficult and powerfully emotive – it has been suggested that stories like this reinforce stigma and unrealistic stereotypes because they significantly over-emphasize the potential to be the victim of such an attack. I get that completely. I can only repeat the point that this blog is about policing and the role it plays in supporting mental health processes as well as the role it plays in protecting society from harm as we do with all manner of violent crime. Incidents such as this are an infrequent but recurring part of policing. Most are far less serious incidents and get referred to the police as a part of the wider, more extended mental health system. This is where my 'venn diagram' of policing, mental health and criminal justice is relevant.

It may be argued – it fact, it is *argued* – that inquiries, which frequently follow serious offences by patients already known to mental health services, often highlight recurring themes. It it is for those reasons that I argue for far more and for closer working between police forces and mental health trusts; and that I argue 'diversion', if not correctly considered, has the potential to 'stack the risk deck' in favour of events like these although it is by no means certain that all could be predicted or prevented.

26th March 2012

Police Ranks and Roles Explained –

<<< This is a post primarily aimed at non-police readers. >>>

I once wrote a small guide for Birmingham and Solihull Mental Health Trust, explaining police ranks and roles. Here it is, made generic to whole UK, to explain what it means for health and social care professionals. You are only likely to see the first three in operational situations; the next three in local partnership meetings or during extremely serious incidents.

NB: *Can I ask police officers not to point out the gross-oversimplification that this represents?! It is an indicative guide only for non-police readers and I'm well aware of how it doesn't survive contact with detailed reality in all areas!*

And before I list them, all ranks up to and including Chief Superintendent, can be uniform or detectives. They are of equivalent rank – so a uniformed sergeant 'outranks' a detective constable, and so on.

Senior detectives – Inspector to Chief Superintendent – are also sometimes referred to as Senior Investigating Officers. The more serious the matter, the more senior the SIO. So murders are usually Detective Chief Inspectors or Detective Superintendents. Serious violence or sexual offences, Detective Inspectors or Detective Chief Inspectors … and so on.

FRONTLINE COPS

Police constable – officers who turn up to public 999 calls, investigate volume crime or take initial action at critical incidents. Also work on neighbourhood teams to target long-term problems.

Likely to be the ones supporting MHA processes like assessments on private premises; investigating volume offences against NHS staff by inpatients, detaining people under s136 MHA and locating / recovering AWOL patients.

Police Sergeant – supervise teams of officers, overseeing police operations, volume crime investigations, demand management issues and take initial control of critical incidents.

Usually at least two or three in each borough on duty at any time, as well as one or more working as "The Custody Sergeant" in the cells. They are the first port-of-call for queries about police responses.

Police Inspector – Senior operational officer 24/7. Oversees all officers on duty at that time – there is usually just one "duty inspector" in operational command at any time.

Oversees responses to critical incidents, can "call out" senior / specialist officers out of hours, as required. Final arbiter of police response and resourcing disputes: internal AND external.

LOCAL SENIOR OFFICERS

Chief Inspector – Usually two or three working on any borough. Would oversee "Response Teams" and / or "Police Neighbourhood Teams" or "CID / Investigations / Offender Management".

Also like to act as senior public order or firearms commanders and critical incident managers. One of them will be "The DCI", a senior detective, responsible for all crime investigation locally.

Superintendent – Usually one or two on each borough. Responsible for "Operations" or "Crime" or "Partnerships". Also carry a range of particular statutory authorities and also act as senior public order or firearms commanders.

There is a superintendent on-call for every area; or one working 24/7 in most police forces.

Chief Superintendent – head of a policing area or headquarters department.

They are responsible to the Chief Constable for all policing activity in their area. This person is the 'local police chief' to whom all local partnership, crime and operations matters are directed.

Otherwise known as "The Boss".

FORCE SENIOR OFFICERS

Assistant Chief Constable (Non-London) – between one and five per force, dependent on size. Responsible for a certain policy area forcewide, as well as "territorial" oversight of two or more boroughs.

Commander (London) – head of a major department or group of boroughs. These are the chief officer rank.

Deputy Chief Constable (Non-London) – the senior discipline authority for each force and as name suggests, the 2nd in charge for the force. Has certain policy responsibilities and an overall eye of force performance. One per Non-London force.

Deputy Assistant Commissioner (London) – oversees groups of departments or boroughs in London. There are eight of them.

Chief Constable (Non-London) – "The boss". Larger forces' Chief Constables tend to have been CCs elsewhere first. Dave Thompson (West Midlands) is an exception to this precedent.

Assistant Commissioner (Metropolitan Police) – there are four ACs and although they carry similar responsibilities to ACCs it is on a far broader scale and equivalent in rank to Chief Constables.

MOST SENIOR METROPOLITAN POLICE OFFICERS

Deputy Commissioner (Metropolitan Police) – similar roles / functions as per Deputy Chief Constable of a non-London force.

This police officer – currently Craig MACKAY (former Chief Constable of Cumbria) – is the 2nd highest ranking officer in the UK and is usually a former Chief Constable. He was appointed by HM the Queen on the Home Secretary's recommendation.

Commissioner (Metropolitan Police) – "The Boss" and **the most senior UK police officer**.

Cressida DICK was appointed Met Commissioner in 2017. She is the first female commissioner and was previously Assistant Commissioner in the same force. She was appointed by HM the Queen on the Home Secretary's recommendation after a period of time seconded to the Foreign Office.

29th March 2012

Mental Illness and Cannabis –

I was asked to consider writing a post on mental illness and links (if any) to cannabis. I'll be honest, I did wonder whether the debate behind that and all of the science that goes with it was not just a bit above my pay-grade? Then I learned something about a policing incident in which I was extremely interested which opened this up for me so I thought I'd put down a few thoughts:

Over the last few years, the UK has been on something of a journey regarding cannabis. When I joined the police, it was a Class B drug under the Misuse of Drugs Act 1971 – this legislation governs our society's approach to drugs to this day. In 2004 it was re-classified to a Class C drug on advise from the Advisory Council on the Misuse of Drugs. However, it was re-classified in 2009 to Class B for what were described by the Chair of the Council, Professor David NUTT, as 'political reasons'. He had previously described cannabis as "less harmful than alcohol or tobacco" but the re-classification decision went ahead, called for by some senior police officers and supported by the Home Secretary. This was despite the Council's advice amidst a public debate which tried to link cannabis to the development of some psychotic conditions and longer-term mental health problems.

I once heard someone describe the taking cannabis as having all the joys of smoking like cancer with the "added bonus of mental illness". And this was by a psychiatrist. In my career, I've met a lot of people who use cannabis; some of them to quite a startling degree. Throughout that time it has been "received wisdom" amongst many officers with whom I have worked that prolonged use of cannabis over many years can lead to mental health problems. But when it was declassified in 2004, this link was denied or deemed to be of little significance. This potential link was more acknowledged in 2009 when cannabis was reclassified although as stated, this was opposed by the Advisory Council. The dispute lead to the sacking of Professor NUTT and subsequent resignations by other members, in protest at the dismissal.

We know that cannabis is considered by some people with medical problems, to ease suffering. Some patients with multiple sclerosis have campaigned to have cannabis de-criminalised (as opposed to legalised) for use in the treatment of some medical conditions. Meanwhile, we know

some patients with mental health problems report that cannabis can ease the impact of auditory hallucinations and other symptoms. Other patients have reported they cause them.

I am aware of some police interventions with people under the influence of cannabis which have lead to them being admitted to a hospital on the grounds of being mentally ill. I am aware that some of those led, just a few days later, to the person being released from care because the effects of drugs had worn off and it was no longer believed that they sufferred from a mental disorder. (I am also aware of a case where this occurred after a man drank a bottle of red wine having also taken over-the-counter medication to assist him to stop smoking – the two things produced a chemical effect which made him present to police officers as if he were mentally ill. The MHA assessment team agree and detained him s2 MHA.)

Of course, there are some examples of people who regularly use large amounts of cannabis being repeatedly detained by the police under emergency detention and sometimes admitted to hospital, only to continue a revolving door approach when the effects wear-off and psychotic behaviour dissipates. The 'interesting case' I referred to at the top involved a family complaining at a police decision to implement detention under mental health law (s136) but the assessing professinoals were also sufficiently satisfied by the man's presentation in the (MHA) Place of Safety, to admit him s2 MHA for 28 days. Does this not validate the officers impressions, that experienced mental health professionals also thought he was mentally disordered and sufficiently to justify 28 day detention in hospital? Yes, in my view.

As I became interested in policing and mental health, I did a little bit of reading around this area and spoke to mental health professionals. There seemed to be consensus that excess cannabis use in some people can indeed induce temporary psychotic states and long-term use could lead to long-term problems. I have since seen studies (meta-analyses) which state that there could be as much of a three-fold risk of developing schizophrenia or a schizophrenia-like illness; and other studies make similar claims. It has also been suggested that substance abuse is a predictor of disengagement from psychiatric treatment. *[I will shortly add links to studies which have been drawn to my attention implying the link between cannabis and mental health to be negligible.]*

In discussion around this, I was once told an interesting statistic which I've tried out on a range of mental health and / or dual diagnosis professionals. (For those who don't know, "dual diagnosis" means mental health and substance abuse problems.) The statistic was: that **90% of people with a dual diagnosis** are patients with mental health problems who 'self-medicate' with drugs, including cannabis, and / or alcohol. 10% are people who have mental health problems, associated to their original

abuse of substances. I've heard this expressed a few ways: 90/10, 80/20 or 70/30. But the point seems agreed anecdotally by those in the field, that most dual diagnoses are people developing substance abuse problems after self-medicating.

So my lay person's impression is that if substance abuse leading to mental health problems is the minority of dual diagnosis conditions; and if substance abuse is predictive risk factor for disengagement from treatment, then addressing substance abuse problems is key to effective mental health strategies at the population level. When one then also thinks about the impact of alcohol on society … problematic.

A final point: police forces have often been asked – indeed, some have offered – to take drugs dogs into psychiatric facilities to help identify patients who possess illicit substances or to identify whether drugs have been brought in. Knowing a few dog handlers quite well, it's fair to say that those who have done it have sometimes reported that the dog thought it was Christmas because every 'find' gets a reward (usually a toy, sometimes a snack). In some wards, no issues at all.

Reactions to suggestions by staff, or offers by police, that drugs dogs could be used to help with drugs problems have been mixed in my experience. I've seen some professionals argue it is highly inappropriate, but some have immediately found conflict with their colleagues who know there is a drug use (or even drug dealing) problem on the ward. In addition to pointing out that hospitals have a legal duty **not** to knowingly tolerate drug use or supply on wards (s8 Misuse of Drugs Act 1971), it is also relevant to point out that patients who do not wish to use or supply drugs find the presence of such factors on ward life to be extremely negative at an already difficult time. It contributes to feeling unsafe, amongst other things.

I've never had a view that cannabis is benign, notwithstanding its image in some quarters and the links to mental illness now seem more clearly understood. In the spirit of balance I **will add** links to studies which imply the link to be negligible, althought in the face of both sets and my own experience and various service users' feedback, my instinct is away from them. It is also clear that substance abuse generally needs to be tackled for any mental health strategy to be successful at that population level and I'm not even vaguely satisfied that this is properly understood.

The main point of this blog is not to side particularly with one view or another – although you'll clearly see where my personal instinct lies. If mental health professionals are sometimes mistakenly convinced or temporarily convinced that reaction to cannabis use is consistent with mental disorder; it must be accepted as reasonable that police officers will sometimes think this. Especially, this is the case where police decision-

making must occur within minutes or seconds, rather than in an MHA interview which can take an hour or so. It has sometimes become necessary to 'section' people under the MHA for 28 days to fully work this stuff through.

APRIL 2012

4th April 2012

The Emperor's New Clothes –

Earlier today a mental health professional engaged in research described many efforts to arrange and develop Liaison and Diversion services as "The Emperor's New Clothes" because they too often rely upon models which do not operate when people find themselves arrested and which sometimes fail to ensure the public interest is met by engagement with the services to which people were 'diverted'. All too often, the whole thing relies upon police officers to identify those potentially suffering from mental health problems and then has the potential to regress into an ineffective, half service which is more about the police than mental health.

Have I mentioned how I deplore the term 'diversion'?!

Of course, we know that leaving identification to police assessments and / or to self-declaration is prone to problems – just like investigation of crime by nurses is prone to problems of competence. It's not what they are trained or constituted for. I've always worked on the idea that around 12-15% of people arrested and brought into police custody are 'thought' to have a mental health problem. This would include: police suspicion based upon behaviour or information from police systems; self-declaration by individuals and / or information from third-parties at incidents.

This figure is mentioned in published research (JAMES, 2000; RIORDAN *et al*, 2000) as well as found by me when I did research for an MSc dissertation some years ago. However, we always thought that this would under-identify mental disorder, because some less obvious conditions; including non-psychotic conditions, some learning disabilities and / or autism. We know that sometimes such conditions are not identified by mental health professionals with time to examine people against a background of years of training. Not really surprising that the police miss things when some decision must, of necessity, be taken quickly without time to check, ask or refer.

I heard last year of a criminal justice mental health team in the south of England who used to get a daily fax from their local police listing names, dates of birth etc., of **all** people arrested by the police. They found that 50% of arrested people were *currently* known, *previously* known or *should* be known to and engaged with mental health services. So the police are

potentially spotting less than a third of people coming through custody who should be considered for assessment, referral or diversion. One third.

So what does this mean for Liaison & Diversion Services, delivered to the vision of Lord BRADLEY?

Ideally, we'd hope to see mental health professionals deployed to screen everyone in police custody, with the benefit of access to health records systems like Epex. Of course, the police arrest people 24/7 all year round. In my force alone there are thirteen 24/7 custody offices and in my borough, we arrest about 750-800 a month. To have a professional available to see everyone, it's quite possible you'd need psychiatric nurses or other appropriate mental health professionals working 24/7 covering two custody blocks. Regardless of which grade of nurse / professional used, it's going to be expensive business and this is usually where the vision falls flat and thoughts turn to cheaper alternatives. This is where 'The Emperor's New Clothes' comes in, because in reality diversion services often seek to turn 24/7 business into something that can be managed without face-to-face screening and on more of an 'office hours' basis and that's where initial problems start to emerge.

How else would you do it?

- What about an L&D scheme operating 15hrs or 8hrs a day?
- What about attempting to use police bail to delay investigative decisions until a person has been 'referred' to an L&D type screening or triage service, operating office hours Monday to Friday?
- What about importing a screening tool developed by MH professionals, but administered by the custody sergeant or custody staff around MH?
- What about linking the development of police healthcare commissioning by the NHS to improved training for police custody nurses / doctors, to screen all patients for mental health and / or allow them access to medical records for secondary mental health care?
- Why can't the police share information 'fast-time' with mental health services about people under arrest in the first couple of hours of their detention and then have an assessment response based upon that information sharing? For example: if the person is / has been known to MH services; OR is suspected by the police to be suffering mental ill-health, then a response is configured.

- Well, if you're screening on a less-than-24/7 basis you risk missing something: clearly, the more hours covered, the less would be missed and you cannot hold someone in police custody just to screen them for mental ill-health when the professionals come back on duty in the morning.

- This is fine, as long as the person is not a 'bail risk' – is it a responsible CJ decision to bail someone, if they have a history of offending on bail, failing to surrender back to custody, etc., etc.. Some people cannot and should not be bailed before or after charge.
- Screening tools are being trialled and / or used around the UK for various reasons to identify various things – not just in the police station, but also in other parts of the CJ system, including prisons. Of course, some tools take 30mins per person to administer; some are better than others at identifying generic mental health concerns; others may be good for identifying certain problems, like learning disabilities. Of course, you couldn't possibly have two screening tools to use as they aren't enough hours in the day or in the 'PACE clock' (custody time limits).
- I think the NHS becoming responsible for commissioning healthcare in police custody has lots of opportunities, if it is done correctly, to improve the extent to which screening and mental health identification is then integrated into wider health provision. But we know there can be difficulties for experienced mental health professionals identifying the correct cohort, so generic medical / nursing staff may also reasonable be expected to miss some identifications.
- This fifth option does still leave a gap, but it risks missing people who are and never have been known to MH services and about whom there is no suspicion at all of mental ill-health. Maybe THAT is where you then apply a screening tool? Of course, best of luck persuading the NHS that it would be legal to share this information: which it would.

Whichever you may prefer, you still end up back at the heart of the dilemma for Liaison and Diversion: once you've identified someone with mental health problems – whether unmet need or not – what is the 'right' criminal justice decision and how do you ensure that diversion 'worked' before you surrender the possibility for prosecution of positive criminal justice action?

I know from my MSc research, that the practical determinant of whether someone is prosecuted for an offence whilst mentally ill is "whether they are sectionable under the Mental Health Act on the day they were arrested". If you are sectionable, you will most likely be diverted; if you are not, then you probably won't be. This discovery invites consideration of why people with enduring mental illness, who do not happen to be so acutely unwell upon arrest to require immediate admission, are not also considered for the potential to be 'diverted'. It also invites consideration of why we are not seeing more serious offences prosecuted of those who are mentally ill. Insanity is a defence to be raised in court and "every man is presumed to be sane and responsible" according to law.

This comes back to the false dichotomy of the 'mad / bad' debate: we seem to have ingrained an approach which says you are either criminally responsible OR you are mentally ill. In fact, you could be both. Or neither and we more urgently need a criminal justice decision-making model which reflects this.

Finally, failure to get this right in police custody is not without cost. I've mentioned elsewhere that the costs of high-secure and medium-secure care for convicted offenders is considerable <<< *understatement*. A primary care trust once told me that they spend around 55% of their budget on 3% of the patients – those detained in secure care. However, a separate mental health trust once explained that an investment in proper Liaison and Diversion had paid for itself within two years, because of earlier identification of unmet mental health needs which subsequently reduced the number of people requiring secure care after prosecution for offences.

In other words, as I've said before, when you consider *all of the costs*, including the costs of failure demand *and* the obvious service-delivery costs across the health / justice systems: **it's cheaper to do it properly**.

6th April 2012

Suicide –

As a police duty inspector, you get informed of every sudden death – suspicious or otherwise. You attend the suspicious ones and ensure detectives of varying seniority and forensic officers attend; but suicides are usually always intially presumed suspicious to be certain of a thorough examination of the circumstances. Initial action is taken by the police to preserve the scene and any relevant information on behalf of the coroner. Of course if then thought suspicious, criminal investigations are initiated and this early judgement is crucial to how things are subsequently handled.

Here's a recently published fact to get you thinking: suicide is the leading cause of death in under-35s, according to the Office for National Statistics (2009 figures, published October 2011). This is also true in Australia and probably elsewhere.

Police officers are invariably called to all suicides and most of us have been to several. My first was to a man on remand in prison for raping his step-daughter and who killed himself in the very cell at HMP Birmingham where Fred West had ended it all several years previously. He'd been convicted and was awaiting sentence – he left a letter of admission and of apology having denied the offence throughout the trial – and he decided to hang himself. It was an interesting, yet deeply harrowing and equally thought-provoking day at work.

Institutional suicide is especially interesting, not least because places like prisons and psychiatric facilities are most usually detaining people against their will. They owe a legal duty of care which immediately raises questions in any police response around potential offences and other statutory or regulatory violations. It turns the police from a partner organisation to the independent investigating authority, except that in deaths in psychaitric care it is not always the case that the police are called. Perhaps another blog would be interesting on the subject of responding to sudden death, including suicide, in psychiatric care because various campaigners highlight inadequacies in the investigation and independence in the scrutiny of those matters … that's for later.

This post is about the effect upon police officers of dealing with reports of sudden death, especially suicide. It is a post which follows on from "Who Is Protecting the Protectors" – meaning the protection of police officers'

welfare and mental health; their protection from the impact those events can have upon officers, perhaps at a much later time.

I'm going to cover:

- Police officers and 'coping'
- Police force responses and training
- "Suicide by Cop" <<< *in a seperate post.*

POLICE OFFICERS AND 'COPING'

Of course, officers have their idiosyncractic responses: humour, alcohol, exercise or maybe something else entirely. Some officers seem to have no issue in handling death and disaster at work – whether or not they do, is often not clear. They just seem to switch it off at the end of the day … or perhaps they take it all home with them?

In addition to my first suicide, I recall my first death message: I had the job of telling a woman that her mother had died – **on Mother's Day.** <<< *I am NOT making this up.* It was therefore my duty to do this on the very day that was guaranteed to provoke the most emotive memories for every Mother's Day in subsequent years. As if missing your mother on Mother's Day isn't hard enough: to remember that was the day she died suddenly, you weren't with her and were told by a fresh-faced young cop?

Some police officers "don't do death". I know of several who will go out of their way to avoid sudden deaths, suicides, death messages and everything connected to it. There are a range of tactics for the experienced constable or sergeant – inspectors can't avoid it because there is only one of you at any given time in operational command. But the experienced constable knows to ask, "Does your probationer need to do a [death message / sudden death]?" Why not take opportunity to avoid something unpleasant and harrowing if another officer 'needs' to experience how to handle such incidents?

When I was a tutor constable and a shift sergeant, I used to ask the control room for our area to given my any sudden death report that came in, whether or not it was on our particular part of our area. My probationary constables had to 'do a sudden death' in order to get their initial training competencies signed off. It all sounds very macabre, but if it involved delivering a death message, so much the better for getting it done, dusted and out of the way. Surely better to allow a newer officer to have to undertake the task under the closer supervision of trained tutors and / or supervisors to gauge their personal reaction as well as their professional handling and properly 'debrief' the event in way that may not be done for more experienced officers?

POLICE OFFICERS AND TRAINING

So what of training and what of support when it needs to be more formal and professional? All forces train officers on all aspects of sudden death. Not just how to 'police' it in terms of scene preservation, referral to senior officers / detectives; but also how to manage death messages – the big "dos and don'ts". Training encourages officers to seek guidance and welfare support if required and not to presume that they are expected to 'tough it out'. It deliberately involves trying to ensure any cultural preconceptions about 'being tough' are dispelled and make people aware that they can seek after-care. Having said this, there have been calls to improve police training on handling suicide, following the Bridgend suicides in South Wales.

Most forces have a variety of support mechanisms and there is much to be said for the very informal ones which exist through the natural support and camaraderie of working on a police team. I actually find, when you've dealt with something really tough, cops have a got a fantastic propensity to support each other and I don't mean through the sudden outburst of a "macho" nonsense. I mean groups of officers who know each other well enough in a close-knit team to know when humour, sympathy or silence may be best – this is true across emergency and armed forces, from what I've learned.

The development over the last couple of decades of better training and support mechanisms within the police has also been important and includes access to officers who are trained in initial support following critical events and can include formal, professional support from counselling services, over a long period of time, if required. Specialist support for officers involved in particular roles is also available: child protection detectives; firearms officers, road traffic investigators and many more besides.

I note with interest that there have been academic studies of the impact of dealing with suicide on mental health professionals, however I can find nothing comparable for police officers or other justice professionals. (Any pointers from readers who know of any would be appreciated.)

Of course, one of the most difficult jobs a police officer could potentially deal with, could be the suicide of a another police officer. I'm instantly unable to stop recalling the suicide of PC David RATHBAND just over a month ago and the police officers and paramedics who dealt with the initial response to the discovery of his death. I'm also aware of others such as the suicide in a mental health unit in Sussex of Sgt Richard BEXHELL in 2009.

This article is continued in a second part concerning "Suicide by Cop". >>>

6th April 2012

Suicide by Cop –

<<< This post is a continuation of a previous article on Suicide.

"SUICIDE BY COP"

Something which needs to be added to this 'general' duty to respond to suicide is a comparatively new phenomenon being somewhat inelegantly described as "Suicide by Cop".

It has been noted in several inquests or legally comparable hearings abroad, that police officers can be placed in a very difficult position by someone intent on achieving their own death. This occurs by inducing officers to use lethal force, 'having' to shoot the individual because they are deliberately creating an impression or a reality whereby others are at grave risk. It attempts to force the officers to do the least worst thing and kill the suicidal person to maintain broader public safety and of course, during investigation subsequent to all police shootings including incidents like this, links are often made to victims' mental health histories which compounds the emotional complexity of the action taken seen in hindsight.

Of course, this is extremely delicate and controversial territory, but undoubtedly some cases have involved this. The Inquest into the death of barrister Mark SAUNDERS – fatally shot by the Metropolitan Police in 2010 heard that the police inspector in charge of the tactical firearms officers consider throughout the incident that 'suicide by cop' needed to be considered. Inspector Nick BENNETT described this phrase as 'inelegant' and ultimately it was not clear whether this was such a case. However, the impact upon police firearms officers who kill members of the public – even where this is lawful and necessary – is potentially massive.

Firearms officers have often said that you cannot know how an individual armed officer will respond to taking that ultimate professional decision until they've done it and the stresses involved in post-incident management of police firearms usage mean that to then learn you were used as a 'method' of suicide can surely only compound the emotional reaction? Such things have caused police forces to consider "less-than-lethal" options for handling

armed conflict and for example, it was speculated during the hunt for David RATHBAND's attacker that he wanted 'suicide by cop'.

When Northumbria Police went to the extent of trying to detain him by using (unlicensed) Tasers – rifle-style weapons with a longer firing range than normal pistol-style Tasers – he took the decision to kill himself using his shotgun. However, conscious of his desire to be 'taken down' by armed police, Northumbria Police senior officers took a decision to deploy these unlicensed, 'less-than-lethal' options to prevent his death. Bearing in mind he'd already attempted to murder a police officer, threatened to kill yet more and gone to significant lengths to advertise his desire to die, this approach was an extraordinary one to detain him alive. (The decision around using the weapons was somewhat vindicated by HM Coroner as reasonable in the circumstances, a genuine attempt to achieve a non-fatal outcome; but ultimately not until after the Home Office withdrew the operating licence of the company who supplied the weapons. This in turn lead to the suicide of Pro-Tect director Pete BOATMAN, a former police inspector and of course, this had to be attended by … police officers from his own previous force in Northamptonshire.)

On the face of it, reports of 'a suicide' to be dealt with can appear straight forward: you call a senior officer, who gets a detective and forensic scene examiners; you preserve everything til that is done by which time most-decision making is out of the hands of your frontline police officers. Of course, in truth the complexity and the emotional impact can be huge given this wide range of circumstances into which the police are drawn when dealing with suicide, including quite dynamic attempts to achieve death by actively suicidal individuals.

SUICIDE AND CRISIS INTERVENTION

Finally, a few comments upon suicide attempts to which the police are called in an attempt to persuade an individual not to take their own life. Within the last few months at work, I have personally attended two incidents whereby my officers and I have been invited to persuade someone not to kill themselves. One involved threats by an out-of-area mental health patient to jump from a very high bridge over an arterial road into Birmingham which had to be closed for the duration of the threat. He was eventually persuaded back over the barrier and arrested under mental health law. The other involved a man who barricaded himself into his own bathroom with a knife and threatened to take an overdose and / or self-harm. His wife called the police in desperation after he own attempts to ensure his safety failed. He was persuaded, hours later, to come out and go to hospital – bearing in mind the police had no legal powers in this private dwelling as his conduct never quite reached 'breach of the peace' territory and he committed no offences. Both incidents involved calling for

"hostage / crisis negotiators", although the first one was resolved before they arrived on scene. Their skills at the second were very impressive indeed.

More needs to be known – as in *proper* research – about the impact upon officers; about effective training to prepare for and handle calls to suicide; and about how the police could improve their responses to "suicide by cop" and to post-suicide family liaison.

25th April 2012

Monthly Update: I've been a bit busy! –

I've had a quiet few weeks on here. As well as some time off over Easter when I took my son's Under7 rugby team on a tour to Lancashire and had one of the BEST weekends for years, it has also been due to planning and work around our restructure at work and a massive amount of time being spent on that ahead of 'D-Day' in July.

I've been busy on the mental health front and thought a little update may be of interest – I'm going to start a regular 'update' blog instead of blogging on specific subjects all the time. Frankly, I'm running out of topics that I haven't already covered but want to keep covering a bit of what I'm up to and a bit of stuff in the news. There may well be specific posts too, as news or events dictate or if I or you come up with some fresh ideas!! (There is one coming up entitled Mexican Standoff which is a very interesting true story!)

Last Friday I spoke at an event at York Racecourse where I had been invited by Dr Keith RIX to talk to an audience mainly comprised of mental health professionals – including a large number of psychiatrists. I spoke mainly about how we should consider the investigation and prosecution of inpatients on psychiatric wards where there are assaults on staff or other patients. It was delightful to meet Dr Simon WILSON from the Institute of Psychiatry because he and I co-authored a published article on inpatient violence without having actually met! Having worked on that it was clear we'd sing from the same page and this proved to be the case. A gentleman who shared my distaste for what he called the 'inappropriately dichotomous' nature of the debate on diversion.

I have blogged about inpatient violence several times and it remains an important issue for the NHS. 68% of ALL assaults on NHS staff occur in mental health trusts whereas some may have presumed it as the "A&E on a Friday night" thing. However, in some trusts anything from 15% to 25% of those assaults get reported to the police – some trusts report NO offences. There is much work to do on this area where the police recognise they are not consistently providing the best investigative response and the NHS need to recognise that they are not always as forthcoming as they could be with background about someone's mental health history with (properly disclosable) information to inform the legal decision-making by police and CPS. Bad outcomes all round where those failures emerge and

one way around this is to have an inpatient liaison officer who gets to know what they're doing.

I've also been progressing details around an idea I had about six years ago which I've been trying to get off the ground since. My ACC has agreed that we should pilot this idea to see what value it adds:

Police officers lack training around mental health and also around laws / procedures on mental health law. This type of feedback is a regular feature of mental health professionals' and service users' feedback about their experience of policing. Because X or Y or Z didn't work (to their satisfaction) or because attitudes may not have quite been where those individuals would have preferred to see them, "The police need more mental health awareness training". Maybe … probably … more training on many things would be nice. However, if you are a regular reader of this blog or if you look at the INDEX of posts and the FAQ page, you'll see that there is much to learn! (It's has taken my a decade of getting obsessed after getting curious to develop any knowledge I've got.)

My standard response to this response about police mental health awareness training – EVERY SINGLE TIME – is that such claims may well be true, but mental health and social care professionals needs more "police awareness training" around procedures and law. Most AMHPs I've met, can't explain s135(1) properly, for example – although many can. Most mental health nurses on wards who are asking for patients to be arrested following assaultative behaviour, don't realise that we arrest people to commence and investigative and criminal justice process, not for the convenience of NHS staff. If there is no complaint of an offence or no evidence of liability, arrests don't occur however desirable someone may think that would be. (You should see the list of people I'd arrest in a fantasy world where we do it because I think it would be a good idea.)

My idea for police training is this: rather than give thousands of officers 4-8hrs training in the hope they'll learn the contents of this website and then recall it all effortlessly in the 2-5 jobs per year where such detailed knowledge is required. Let's remember, a lot of 'mental health jobs' don't necessarily involve specialist procedural or legal knowledge at all, such as jobs where criminal arrests need to be made of suspects with mental health problems.

So! – let's give a certain percentage of cops 3 or 4 days of mental health training including:

- Mental health awareness: inc learning disabilities, autism, personality disorder as well as 'functional' mental health problems like schizophrenia, bipolar and depression.

- Law knowledge around s136, 136, AWOL, inpatient violence, supporting NHS agencies in enforced medication, conveyance etc.,
- Knowledge of where to secure resources, help; how to avoid or mitigate against critical untoward events;
- Resolution of incidents by de-escalation, moving away from the use of force.

Then, deploy those officers with that raised knowledge and WITHOUT branding them as experts of ANYTHING which approaches crisis services to jobs involving mental health issues. We will categorise all MH jobs into three categories.

1. **High risk** – critical or complex incidents: inpatient psychiatric violence; s136 cases involving A&E and prolonged restraint, s135(1) or 'Assessment on Premises' jobs;
2. **Medium risk** – non critical volume incidents, AWOLs; standards s136 jobs, criminal suspects in police custody.
3. **Low risk** – Any other business.

The idea is, we ALWAYS deploy these officers to Category 1 jobs; we deploy them where possible to Category 2 and ensure their advice is sought if not possible; we let 'normal' officers deal with Category 3 but our specialists are there for advice, if felt needed.

This is not original! – the US, Canada and Australia have started off this concept after it was commenced in Memphis, US. Each nation seems to be adapting it, but this pilot would appear to be the first time the UK have considered it and after six years of trying to give it a go, I'm really excited by what it may achieve.

Finally, I was delighted to give a very informal talk about policing and mental health at the main mental health unit for my home county and very impressed at their biscuit collection. I was invited to do it after by a psychiatric nurse who used to be one of my PCs when I was a young ignorant sergeant. I spent two really very enjoyable hours giving a police perspective on supporting "psychiatric emergency" and "criminal suspects who are mentally ill". (I usually divide general talks on this work into those two categories and cover: s136, s135, AWOLs and some other bits in the first section; prosecution, diversion and inpatient issues in the second. Loads of great questions and engagement and at the end a crisis team manager said, "My team love your blog." Given it was originally written for police officers' reference, those are warm words which make blogging in the evenings and in my own time very worthwhile indeed!

(Incidentally: the U7s rugby – 10 played, 7 won, 1 drawn and 2 lost. Given 1 draw and 1 loss was them playing U8s at Blackburn, we were proud as

punch and I got to watch my son score his first competitive try and then go on the 'make' the winning try in one of his games … proud as punch.)

25th April 2012

Mexican Standoff –

Properly considered a Mexican standoff is a three-way situation where guns are pointed around in a circle: each person holds power over one other and is simultaneously at someone's mercy. Difficult to resolve that! This story involves police, ambulance and A&E and is a true story given to me by an exhausted police officer who was amidst this last weekend. The incident starts off around 5am at the end of already an exhausting night shift of drunks and domestics and an officer who'd already tweeted that they were dead on their feet from fatigue.

I'm going to let this dedicated front-line police officer tell the story! – and let it speak for itself, frustrated language included. I'll just point out first that since posting this story, Ella SHAW – author of DiagnosisLOB – has commented on her own blog and reinforced the officer's fears around unknown, unassessed medical risks.

I'll add just this – I like the idea that my blog is being pushed about at 6am on a weekend, helping officers through jobs like this – it is EXACTLY why I spend evenings writing and blogging and it's so accessible to anyone with a SmartPhone.

Had this job not had a happy conclusion, I sugggest the officer concerned would have had little difficulty evidencing that she'd done her best in the circumstances and questions would have headed towards the NHS. As they should.

<<< **UPDATE ADDED A WEEK AFTER INITIAL PUBLICATION OF THIS BLOG:** >>> *This officer was called back to the same patient a week later after she'd been released after MH assessment – and was injured in another scuffle of the same kind.*

The person has now been **prosecuted.** The ambulance service **refused** to attend: >>>

"Here is the full story of the MH debacle and the Mexican Standoff I had this morning with the NHS … Police called by Ambulance to assist them as a well-known self harmer has taken cocaine and has some unusually bad reaction to it. She feels dizzy and sick and it was enough to ask for medical help because it was weirder than her normal reaction to cocaine. I am a

good 45 mins away from scene and so firearms vehicle attend. In our force it seems that once you have a gun you lose the ability to think for yourself and (god forbid) the ability to actually use your powers as a police officer … a bit like inspectors! ;-)

Helpful firearm officer asks over the airwaves "she says if we leave her she will kill herself. I don't know what to do so can a local officer please come and help me". Thanks for that. Try communicating with her for a start!

I get there. Firearms say "thanks, see ya" and leave me to get off and finish on time. Ambulance say – there is nothing wrong with her AND I QUOTE "apart from her her heart rate being a fast from the coke". They know this frequent flyer and stand with their arms crossed saying can you get her out of the ambulance as we need it back on the road. Roughly translated as – I want to go home and I am tired of her again.

Girl says – if you leave I will kill myself. I now have no choice whatsoever. Oh, and I then remove the razor blades she has concealed in her hands which both firearms and ambulance failed to notice.

So I '136' her because I feel that if we leave, bearing in mind her mental health history, her substance abuse and her stated intent, she will make a serious self-harm / suicide attempt. Ambulance says – we are not taking her in, you take her in the police car. Out comes your blog for first time to highlight the first breach (of the Code of Practice).

FIRST standoff – I explain our/their policy of ambulance to 136. I explain this is not a criminal justice incident it is a HEALTH incident: me police; you NHS. Ambulance say we won't take her unless you sit in ambulance with us. Fair enough – I agree in order to get this progressed.

Get to A&E for the SECOND standoff of the morning – **they did not even let us in, we had to stand in the foyer** of A&E. I explained the Red Flag (drugs) and why she needed medical assessment. They did not want to do this – roughly translated as I am tired and I want to finish thank you. Still in the foyer of A&E and not even over the bloody threshold I stand clutching my iPhone in one hand (with your legislation and blog) and my police Blackberry in the other with our policy on it re 136. Because the doctor asked our girl 2 questions (being name, DOB) and she did not answer, she declares this patient will not cooperate and asks, "Please take her away." No monitoring, no communication apart from 2 questions repeated by a stroppy nurse. I say – are you happy she has the capacity? They say yes. I say – how do you know as you have only asked her name and DOB? They all shout at me.

I say "OK, if you are refusing treatment, please sign here and I will remove her, then if she dies in custody or at the MH unit due to cocaine intoxication

and a lack of capacity that you haven't assessed, I can evidence that I have tried to get her medical care and this has been refused."

THIRD Mexican standoff – I am liking Mexican Standoff for the blog title – please sign here. "No" … we are AND I QUOTE "Not allowed to sign anything relating to treatment unless your Chief Constable asks for it in writing". I write – refused to sign. They are not happy I have written their names down and shout at me.

My theory is that if you are convinced that you are right, and can back it up – why are you scared of giving your name? Or signing?! They knew they were wrong but they wanted to go home after working all night. Me too.

So, I ask can you please phone the MH Unit which is 50 yards away and ask if we can take this girl there or will they refuse us? Oh no, we cannot phone. Good will tank now running on empty. I am now *aching* through tiredness and frustration to the point where I may need admittance to the MH unit myself and I'm more than one hour off late already and I'm not done.

I take her to MH Unit who agree to accept her under 136 even though she has had a drink because I have to argue a FOURTH Mexican standoff of " Custody and cells is not the right place for this lady, she is not a criminal, she is not well and the custody sergeant will not detain here there given the lack of medical assessment so far knowing she feels unwell after taking cocaine".

All my NHS colleagues went home on time, only me off late. I felt so let down by them that I could have screamed. I nearly lost my cool in A&E and I did share a piece of my mind because they were being SO obstructive. They failed to see that if our girl died from the effects of the drugs – they assume she was telling the truth about what she'd taken – then it would be ME and not them losing their job, unless I did this properly.

So, that is the sorry saga of the shit service provided to MH patients by the NHS this morning. Good night."

UPDATE: *>>> please see a blog post on this very story by DiagnosisLOB whose blog in general is highly recommended.*

26th April 2012

One Friday Night …

As my interest in mental health developed into just some knowledge around it, I noticed that the phone started to ring more frequently. I now get around 20 emails a week asking something about mental health – often specific legal or procedural questions after jobs have proved difficult.

Sometimes it rings when I'm at home and for a range of different reasons, but it tends to be one of two types of officer ringing. Senior investigating officers for serious crime inquiries involving mentally disorder offenders where a 'sectioning' process is proving difficult against a backdrop of PACE (custody) timelimites; OR duty inspectors to whom frontline officers have referred numerous types of problems needing answers and leadership.

One Friday night around 9pm the phone rang and it was a duty inspector on the phone, someone I know very well. She'd been faced with an AMHP who was clearly dissatisfied with her final decision around a request for police support and felt she had nowhere else to go with it. She quickly explained she was managing an extremely busy evening as duty inspector, having been at work for half of her shift, which would end at 3am. For all intents and purposes, she had run out of police: prisoners in custody, prisoners detained with a double-guard at hospital, crime scenes, 999 calls ongoing to which a small group of officers were responding, 'job to job' and intent on writing up all the paperwork at the end of the demand.

Somewhere in there, a call had come in for police to attend the ward of a general hospital to support mental health professionals who had 'sectioned' a man who now needed to be transferred to a mental health unit very nearby. (I later calculated you could walk 'door to door' in approximately 7 minutes.) The reason for the request for police officers was that upon being told he was to be transferred, the man had said "No, I'm not going there. You're not sectioning me." When I eventually got involved in this incident and asked various questions, I failed to establish what had been done, considered or tried, between "No" and the call to the police. I need to be extra-clear here: the man was not violent, was not threatening violence and if there were any resistance or violence in his previous contact with mental health services, none of this was being disclosed to the police.

Initially, at around 8pm the police contact centre sergeant had explained that in light there being of no immediate risks or threats, there was little

prospect of police support for 'several hours' because of other demands which had to be prioritised. This had led to a further phone call asking to speak to the Duty Inspector who was promptly told by a bed manager that she was under an obligation to send officers to the hospital. She again established that there was no violence, threats or attempts to abscond and explained that there was no prospect of this occurring any time before approximately 11pm, perhaps later. That's when legislation started to be quoted with an insistence that she was 'obliged'.

She rang and I told her to leave it with me and police her area. The three telephone conversations I had were some of the most revealing I've ever had: of the extent to which the law was being misrepresented to involve the police in Mental Health Act processes – I'll leave you to decide whether it was deliberate misrepresentation or not:

The dialogue of that evening was repeated for my benefit, and I reconfirmed that sectioned patient was not violent and had not threatened to be. The bed manager then said, "So in the circumstances, the police have to attend and move the person."

"Setting aside the most important point, that there are no police free to actually do this, currently, could you tell me where's that written down in English law?"

"What do you mean?"

"You're telling me that we're legally obligated and I'm asking you to tell me where this is demonstrated so I can look at it for myself. If I'm honest, I disagree and I don't believe what you've just said to be true."

"Err, the AMHP at the hospital said that if she asks you to do it, you have to."

"Perhaps you should get her to ring me then?"

Approximately fifteen minutes later the phone rang and the formality of summaries and checking questions were again completed. The AMHP sounded fairly frustrated by this stage. "I've been here for over 3hrs with this case and this man has needed to be moved since this afternoon!"

"Why wasn't he moved this afternoon?"

"The police were not available!"

"Why does it need the police? Where were the relevant mental health professionals this afternoon and why did they just go home without resolving this, expecting the gap to be plugged? Three times this evening,

I'm not hearing anything about violence or resistance or aggression. I just keep being told that he's said he's not prepared to move."

"Well, that's right."

"So what has been tried since then?"

"What do you mean?"

"I'm not sure how I can ask it another way. Have you gathered a nurse or two and attempted to direct him – perhaps with hospital security nearby – or did you just ring the police?"

"I just rang the police. I'm here on my own!"

"So where are the out of hours Crisis Team or community team, to support the process? Your organisation employs thousands of people, literally. It must be possible to get two or three nurses with right training who can come and encourage, persuade or even compel this man in the right way?!"

"Well it's not possible … that's not in the remit of the Crisis Team."

"Seriously?! It's not the remit of the police either and it's like us telling police officers they can arrest people but then not training them in how to deliver upon that in reality. In any event, I've rung back to argue against this idea that the police are legally obliged. Nothing in this incident currently is making it a priority over the volume of other calls currently being received. The only free officers in the area are literally running from 999 call to 999 call. The reality is, you can't get the police for a few hours yet. If that changes, they'll let you know. But it's quite wrong to push against that decision by arguing they are obligated, because they are not. As and when officers become free from other, higher priority calls, they will consider a request to support."

"But the police ARE obliged: of course they are! This man has been sectioned and I need the police to move him, because he says he won't go!!"

"You'll need to tell me where that's written down in law: that it must be a police matter purely because you say so. This man is in YOUR legal custody if YOU'VE sectioned him. this is by virtue of s137 of the Mental Health Act and your authority to detain and convey comes from s6."

"I can delegate that the police move him." The smugness of the remark was almost unbearable.

"Yes, I understand that you can delegate under s6, but I also understand – if you actually read s6: all of it – that *nothing* in that section obliges the

person to whom you would prefer to delegate, to accept your delegation or direction. At the moment, for reasons explained, the police are not accepting it. So the person remains in your custody, entitled to your duty of care."

"No that's not right. Actually, can I ring you back?!"

Fifteen minutes later …

"I've spoken to a colleague" … she proceeded to read out all of s6 MHA from the Richard JONES Mental Health Act Manual. (The 'MHA Manual' is standard equipment for AMHPs: a textbook I have had cause question on a few occasions, not least because I've come across three different bits of written opinion from barristers which do not accord with this reference tool's contents.) … "just how do you want me to do it if you're not going to help?! I've got another MHA assessment to do! If you won't do it, I'll have to leave him here to do my other assessment and if he walks out, it's down to you."

"But it's not, though is it? It's down to your inability and that of one of the largest mental health trusts in Europe to pull on resources which are consistent with managing just one passively resistant patient. Why can't you ring your managers or MH trust managers to have someone authorise the necessary contingency arrangements? You are a major health trust, you must have out of hours arrangements and some contingency planning? And it's only fair I inform you that I'm now going to record your threats to walk out and leave the man, in case that should become relevant during any investigation subsequently."

"This is ridiculous. We're not trained, you're the only ones who can use force."

"Again, I'm afraid you misunderstand. You have all the powers of a constable in this situation so you are simply not correct in law. In fact, the police have no powers here whatsoever, until they accept your delegated authority, which we're currently not accepting for the reasons given. Therefore, as things stand YOU are the only one who can use force – or anyone you can persuade to accept your delegated authority which does not currently include us."

"This is outrageous. I'm going to have to leave him here. I'll record you're refusing to help."

"Yes, we are – but only temporarily and for the reasons given."

I subsequently learned that the section papers were **destroyed** by the AMHP who did indeed walk out on the patient, leaving him on the

ward. This may or may not have been mentioned in the letter that was subsequently written. Incidentally, the patient remained on that medical ward overnight and following a persuasive discussion with a subsequent AMHP the following morning went to the hospital without any problem at all – **no force was used whatsoever**.

Incidentally – conversations like this are more likely if AMHPs and police officers work in an area where managers have declined to ensure there is a local protocol which covers who will do what and when. Police managers who try to do so may wish to reflect on why mental health services will sometimes train inpatient nurses to use control and restraint techniques which are deliberately designed to be therapeutically appropriate; whilst community nurses are most usually not trained. I still cannot work out why this is the case when physical coercion may needed in both contexts.

MAY 2012

2nd May 2012

Guest Blog: Mental Health and Crime –

<<< This is a guest blog – actually a 're-blog' – by Dr Jez PHILLIPS, senior lecturer in Forensic Psychology at the University of Chester. Reproduced with his permission, I'd nevertheless direct you to his blog for yourself, replete with insight and resources which are well worth a look. He's also starting a fascinating piece of research on police officers who tweet. >>>

The relationship between mental health and crime, as with that between the brain and crime, is one that is both complex and controversial. The media has, unfortunately, often represented this link in a negative way, leading to the perception that people committing certain types of offences are all mentally ill. This is, of course, far from the case. Yes, some individuals with mental health problems do commit serious crime, there is no doubt about that. But far more people who suffer with these conditions don't, and pose no danger to other people at all. The misperceptions and misunderstandings that surround the links here do, I believe, really need to be tackled so as to reduce the stereotyping that is so often thei result.

In my drive to provide people with information to make up their own minds, I have listed more articles and resources on this issue below. The same problems often occur in research that examines these links as I mentioned in an earlier post. Studies are often correlational in nature and therefore causality is almost impossible to infer. And yet these studies are often wrongly portrayed as 'proving' links when in fact they do no such thing.

So another complex issue here and one that, rightly, causes a huge amount of debate and comment. I hope the links here help improve your understanding of this issue and perhaps inform your own thinking on it.

Article and report links:

Misconceptions, crime and mental health disorders. Excellent article here http://www.mentalhealthy.co.uk/news/512-misconceptions-crime-and-mental-health-disorders.html

A Review of the relationship between mental disorders and offending behaviours.
http://www.criminologyresearchcouncil.gov.au/reports/mullen.pdf

Dangerousness and mental health: the facts. Excellent resource from MIND here http://www.mind.org.uk/help/research_and_policy/dangerousness_and_mental_health_the_facts

The relationship between mental disorders & different types of crime. Useful research abstract from last year here: http://onlinelibrary.wiley.com/doi/10.1002/cbm.819/abstract

Gender, Mental Illness and Crime. Useful and thorough US report here http://www.ncjrs.gov/pdffiles1/nij/grants/224028.pdf

Severe Mental Illness Alone Does Not Predict Violent Crime. More input into the debate here http://www.medscape.com/viewarticle/587839

Violence and mental illness: an overview. A useful article from 2003 here. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/

The link between mental health problems and violent behaviour. Excellent article from Nursing Times. http://www.nursingtimes.net/nursing-practice-clinical-research/the-link-between-mental-health-problems-and-violent-behaviour/204481.article

Schizophrenia does not influence risk of violent crime. Useful short article here http://psychcentral.com/news/2009/05/21/schizophrenia-does-not-influence-risk-of-violent-crime/6016.html

4th May 2012

MS v United Kingdom –

On 03rd May 2012, MS won his claim for a violation of Article 3 ECHR (inhumane and degrading treatment) after his arrest in 2004 under s136 Mental Health Act. He was detained in a Birmingham police station and subsequently admitted to a regional medium secure unit after more than three days in a police cell. If you are unfamiliar with this case, I'd recommend reading the summary of the ECHR judgement. It is a decent overview of this case and the full judgement is only for the really interested amongst you! Not an overly long one – for an ECHR case!

This blog is longer than any other I've written, but I'd argue it is such an important case, I wanted to give it due coverage.

I've actively monitored this case almost from its beginning – I heard of the incident within a month or so of it happening as I first starting working on mental health issues. When posted to headquarters in 2005 to work full-time on mental health, I started using it as an example of why we surely need s136 provision in NHS establishments during an early period of work on 'places of safety'. It is even more important now that the case has been won (subject to any appeal).

A few years later when I was again posted to work on mental health issues, specifically to ensure s136 MHA provision in NHS buildings across my force, I continued to cite this pending European case and also had to gather together material from my force for Home Office lawyers to contemplate their legal reaction to the challenge. This involved reading the all of case papers from the initial claims made in the British Courts and forwarding summaries of policies and procedure in place at that time.

I remember saying in 2009 after reading the initial claims, that I thought the claimant would win and that in many ways I hoped that he did. Over eight years later, he won his claim that his detention and lack of care amounted to inhumane and degrading treatment – a contravention of his European Convention Rights (article 3).

At the bottom of the blog, I've begun to post some viewpoints which have entered the 'blogosphere' and will add to the list as I discover more. But there are four points I want to make about this case:

- Place of Safety arguments
- Accessing Psychiatric 'Beds'
- Media coverage
- Implications

PLACE OF SAFETY ARGUMENTS

Firstly – I publicised this verdict on Twitter today and received many replies. A few of them asked why this man was taken to a police station in the first place. Quite simply: there was nowhere else he could have been taken. In December 2004, there were no NHS facilities in Birmingham which were 'designated' as a place of safety and no healthcare establishment of any kind would allow itself to be used on a casual basis as a place of safety.

However, **that is not the main issue here**: not only did the judges in this case not criticise the use of a police station, they actually stated that because of the allegation of violent assault against his aunt, prior to arrest, the decision to remove him to a police station was both valid and lawful. Far more importantly to the decision-making, it was the **only** available option. The judges welcomed the developments in NHS provision around the force since this case but reminded that they were obliged to judge his treatment on that day.

I am informed via one lawyer on twitter that he was surprised the action was under Article 3 as opposed to Article 5 (right to liberty) because there is already European case-law which stipulates that a location should reflect the nature of the detention being endured – *Aerts v Belgium*. There is also a very erudite explanation of MS v UK by Mind in-house barrister Martha Spurrier on the UK Human Rights Blog which is well worth reading too.

Finally, it causes me concern as to whether the detention of mentally vulnerable individuals in police stations in the future, where behaviour and presentation is acutely agitated and distressed, will bring automatic considerations upon custody sergeants that mean they are unwilling to detain people in the cells amidst fear of legal repercussions. Let us not forget, it was only yesterday that police officers were criticised for not pushing back against and overtly challenging *medical opinion* where it related to safety and appropriateness of detention in police cells and we also know that detention of people in psychiatric crisis is prone to surprises of hidden, masked medical risks.

When someone is arrested under s136 MHA – whether they are removed to police cells OR to an NHS place of safety – they are not detained under a part of the Mental Health Act which allows medical treatment without consent. In this case, once MS was received into Reaside Clinic, he was

restrained and forcibly medicated by psychiatrists, consistent with the care he required and this point was agreed by his lawyers. Such enforced treatment cannot legally occur whilst detained under s136 and certainly not in a cell. It was the *need* for such medical treatment, the inability to render it and the subsequently ongoing degradation which amounted to inhumane and degrading care.

ACCESSING PSYCHIATRIC 'BEDS'

MS was quickly assessed by an FME and then subsequently by a psychiatrist whilst in custody. The speed of his initial medical assessment and his MHA assessment was not a major issue here – in fact, the speed of the MHA assessment was faster than the average at around that time. In any event, as I understand the verdict, it was the time taken to realise an admission *after* his MHA assessment and the consequent treatment endured which formed the basis of the court's view that his detention had violated Article 3.

It does raise a question about the contingency arrangements that the NHS have access to where there is a clinical need for a particular type of bed. In this case, there was debate between psychiatric intensive care and medium secure as to which was the clinically appropriate place. It is not the first instance of which I am aware where detention in police cells has lasted for several days for the want of being able to access a bed within the NHS: discussion (disagreement?) occurring between providers or specialists has been cited before.

In Manchester – also in 2004 – during another case investigated by the Independent Police Complaints Commission (no link on internet that I can find), it took imminent legal action by the police in the High Court to motivate the discovery of a bed. This is something that I have had to do three or four times in circumstances that were becoming similar and each of these examples usually revolve around an inter-area debate about which MH trust would provide a bed to a man arrested out of his home area; OR to a debate about which type of specialist psychiatric facility is the appropriate one.

MEDIA COVERAGE

I want to make just a few quick points about media coverage today. There have been news articles written by the Daily Telegraph, The Independent and The Guardian all of which fail to address (or understand?) the most important point: detention in police cells was not, *per se*, the important legal issue. It was the inability to secure the man's onward admission into

the NHS and the subsequent degradation suffered that was complained about.

Having read the articles – all published within a hour or two of the judgement – I had to wonder that the journalists had read the summary but not the full judgement because the tenor of their coverage – tell me if I'm being over sensitive, won't you?! – implies criticism of the police when in fact, **there was none**.

Action brought in the English civil courts was NEVER brought against the police **at any stage**: only the NHS. The police and the Home Office were merely involved parties, but were not subject of the proceedings. And so I wondered about the extent to which the journalists understood that the conditions of this detention came about for the want of being able to access the NHS for a Place of Safety or for the want of the NHS being able to bring around adequate admissions arrangements in an appropriate facility after MHA assessment.

I found myself asking where the questions were about why PCTs in a major UK city, at that time, did not commission and ensure any PoS provision; consistent with the requirements of a Code of Practice (1999) to the Mental Health Act and various bits of national guidance? Where are the questions about why PCTs don't seem to have any answers when you ask them for policies and procedures around the realisation of urgent arrangements for admission, as implied by s140 Mental Health Act? (Most of them just ask, "What's section 140?!") Why does it sometimes take police services threatening legal action against the NHS – as in the IPCCs 'Manchester' case – to bring about the provision of responsibilities?

These are the reasons, in my personal opinion, why the MS case occurred as it did. The ECHR judges made mention many times in their judgement of how genuinely concerned the police were about the welfare of MS, how keen they were to see him transferred out of police custody into an appropriate healthcare facility. Having read the custody record maintained by the custody sergeants involved, this is the thing which shines through the most – concern for welfare.

It is also right to record that the psychiatrists and other professionals involved were not 'passive' but actively attempting to work through their service arrangements to realise a bed admission as soon as possible. There was no benign neglect on the part of any professional, or any agency – just a range of professionals trying to do the right thing.

FUTURE IMPLICATIONS

I have written before about s136 MHA and Places of Safety, that in partnership discussions it is often the case that you come across mental health professionals and / or commissioning managers who wish to impose what I call exclusion criteria on patients being allowed entry to an NHS place of safety. Were those common criteria to be applied by the NHS today – and in very many areas, they still are – then the detention of individuals like MS would again end up in police cells in circumstances where cases like may lead to a Convention violation.

Royal College of Psychiatry Standards do make clear that NHS facilities should still be able to receive s136 detainees even where behaviour is highly disturbed. This case, representing judgement on the positive legal duty owed by public authorities to those detained by the state, gives another reason – as if more were needed – why police stations should not be used as a place of safety.

When I have tweeted statements suggesting that police stations should not be used for s136 detainees, you always get replies which give behaviours upon arrest like those of MS as a reason why police stations should still be used on an exceptional basis.

We now know what the answer to that is: MS v UK.

OTHER BLOGS on MS v UK:

1. UK Human Rights Blog by Rosalind English
2. UK Human Rights Blog by Martha Spurrier – a reply to Rosalind English

7th May 2012

More Blogs on MS v United Kingdom –

To underline what I consider to be the importance of MS v UK, I want to do this short post just to highlight a couple of other blogs that have emerged to feed any thinking you may be doing on this case and it's implications / ramifications.

Interestingly – both are published on the UK Human Rights Blog by human rights barristers. They offer opposing views about whether the case under Article 3 should have succeeded at all.

1. Blog by Rosalind English
2. Blog by Martha Spurrier

Both very well worth a read on a very important case.

9th May 2012

The CURE Test –

A short BLOG on something which I think provides a **very** useful tool for police officers – for that matter, many other professionals – to consider how to approach the issue of 'capacity' when vulnerable people are making decisions. This was originally drawn to my attention by @meditude on Twitter and I'm very grateful for that.

It has since been slightly added to after feedback from MCA trainer @mattgrahamdrum.

It is simple to consider and easy to remember.

The "**ID A CURE" Test** means –

- **Impairment** – is there an impairment (temporary or premanent) which prevents the person from being able to 'CURE', as below; OR
- **Disturbance** – is there an disturbance of the mind (temporary or premanent) which prevents the person from being able to 'CURE', as below; OR

AND – only *one* of the follow factors need be satisfied 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 patient retain the information in order to make the decision?
- **Employ** – can the patient employ the information to make the decision effectively?

The Mental Capacity Act invites consideration of whether someone, in fact, has capacity to take certain decisions for themselves and as a precussor to decisions about whether / what may be in someone's best interests, if it is believed that they lack capacity. The Code of Practice to the Act does make clear that such considerations do not require a 'scientific' level of reasoning or evidence – but it does require evidence of a thoughful (enough) approach against presumption of capacity.

It should be remembered: the fact that someone's decision may be considered 'unwise' is not in itself sufficient to assume that they lack capacity. People may take decisions to self-harm, decline medical treatment and so on.

Reminder – police officers, wherever they possibly can, should defer decision-making around mental capacity to healthcare professionals. The ambulance service – from whom this mnemonic is "borrowed with pride" – have better training than police officers around this business and the CoP MCA requires it. It may also be possible or necessary to contact mental health crisis services or out of hours GPs, depending on circumstances.

For more information, read my main blog on The Police and the Mental Capacity Act.

Police intervention should be restricted to the circumstances outlined in s4B MCA – only where intervention is necessary to mitigate an immiment, life-threatening risk where delay would leave the incapacitated person exposed to the risks officers have identified.

9th May 2012

Twitter and 'LIVE' suicide threats –

When I started Tweeting, I anticipated dialogue with all manner of service-users, professionals and carers concerning incidents where the police had become involved in mental health issues of all kinds. I predicted that this engagement may be valuable, not just in terms of being able to explain police processes and law to people who wanted it, but in my continuing to understand from those who use the police service how we could do it better and to share knowledge and practice issues.

If I'm honest, what I did *not* predict was being contacted in relation to 'LIVE' suicide incidents by people on twitter who are concerned for others making specific or generalised threats of suicidal ideation on their timelines. In hindsight, that was quite naive of me. There have been five such examples in the nine months or so I have been on here that I've been brought into by concerned tweeters.

I'll be honest – each one immediately fills me with a sense of dread: Twitter accounts are often anonymous, people are 'looking at me' (virtually) as the police officer to 'do something' and yet obviously, I've often got no more information than anyone else about where in the UK or the World the account owner may be.

One of the incidents a few months ago, involved someone in Australia, but more than that was not immediately clear and only only one of them has come in whilst I've been 'at work'! Another came in when I was up to my eyes at the time with my son's U7 rugby team playing a series of matches at a kids' rugby tournament – I could do little more than give two tweets of general advice to the person who alerted me. Ironically, that person was then traced by the police to a location about 10 miles from where the kids were playing rugby.

Sometimes engagement of local services has come around as a result of me getting into a dialogue with the individual and eliciting enough information to make my own phone call to mental health or police services. More often, it involves advising those who have raised the alarm – who actually are linked to that person on Twitter and have a level of engagement already established with them – to offer help and support. In two cases, it involved a few hours of tweets or DMs to get the person to

focus on something other than their suicidal thoughts and agree to disclose enough information to get the support to them.

This post attempts to briefly show the power of social media and online 'communities' in pointing out that in all five cases so far, it has been possible to establish sufficient information to contact appropriate health or police services to begin 'safe and well' processes. Local professionals could then decide what necessary further action to take, once they achieved contact with the individual.

It is now entirely obvious that such cases would come to my attention given the subject issue I tweet and blog about – social media is yet another mechanism by which people secure networks of all kinds, for a variety of different reasons. Why would crisis support in mental health crisis be excluded from the other kinds of help and support that social media offers to people may otherwise believe they are alone?

This is why when I heard about the Sunday Times writing an article about tweeting police officers (in my force area, actually – Solihull) wasting their time on Twitter, I wanted to push back with examples from my own experience. I don't know whether those (para-)suicidal thoughts were expressions of serious intent, a cry for help or even (potentially) an attempt to gain attention or manipulate … in a sense it doesn't matter one jot whether they were. They created a condition in which we would all expect to see public services acting to ensure that those at risk were identified, found and that their safety was ensured – all the other considerations of motive and intent are secondary.

Eventually, if not already, one of these incidents will lead to the identification of someone whose life is at serious risk from their own mental health problems and where a response initiated via Twitter or other social media leads to them being saved from an attempt on their life. We can then legitimately ask again whether some journalists still thinking policing and social media is a waste of time?

If it is, it's a waste of my *own* time – this is not my job: it's just something I do because it's right.

10th May 2012

Thinking Correctly Under Pressure –

A couple of years ago I worked for two years with @UKprisonhealth on the West Midlands s136 place of safety work – trying to get NHS provision, of the right standard, in all local authority areas across the region. He is a psychiatric nurse by background, working at the time in Offender Health in the Strategic Health Authority, now working in a prison healthcare setting.

During that time we became a bit of a double act – very similar in our outlook to s136, despite coming at it from two very different professional perspectives. Frankly, as I was first getting to know him, I spent time wondering whether he would also be one of the "Violence goes to the cells" type of mental health professionals that I'd met so many times. "Can't assess unless sober – to the cells"; "Can't have children in an adult PoS – it's a safeguarding issue." etc., etc.. I feared the usual exclusion criteria.

The opposite proved to be the case and I found a natural ally, now a friend. He taught me that there are actually sound clinical and therapeutic answers to those objections and they can be knocked down. When we then 'went in to bat' against NHS managers in local areas who came up with the usual objections: we were able to knock them down with legitimate argument. He also had backing from his managers around certain clinical issues and arguments that buttressed the whole thing even further. It got to the point where if one of us could not make a meeting around s136, we just represented each other – I spoke for him and the SHA, he spoke for the police which I'm sure you'll agree is proper partnership. Frankly – and this is no slight upon my colleagues as MH is a niche area of policing in many regards – he understood the police arguments far better than other police officers and was a better representative of our position. I hope he feels the same.

Any rugby fans out there? … bear with me on this: I'm taking it somewhere relevant! I'm especially thinking about those who watched England lift the World Cup in 2003?! The England rugby team in the build up to the World Cup actually practised "Thinking Correctly Under Pressure" otherwise referred to as T-CUP. Clive Woodward actually talked about the 30 seconds leading to Jonny Wilkinson's famous drop goal as being the most intense example of England employing their T-CUP strategy.

In the build up to that drop goal, Steve Thompson had to decide whether to go for the easy, safe throw or – as he did – throw it to the very back of the lineout; Matt Dawson had to decide whether to throw it straight to Wilkinson or judge whether he was close enough to the posts and run the gap gaining precious yards; Martin Johnson recycled the ball and took forward just a few more yards so that Dawson could get back in position for the crucial throw to prevent Neil Back making it … ALL OF WHICH was necessary to put Wilkinson in the right place with the *maximum* chance. Any other decisions by the lot of them may well have diminished Wilkinson's chance of making it. Team game. They won … and I got to watch it with a very unamused Welshman!

So why not think about this in policing where many decisions are taken under pressure; why not have mental health professionals understand that decision-making and applying the T-CUP strategy?

In 2010, @UKprisonhealth and I were invited to run a workshop at a mental health and social care conference in the East Midlands and this came at a point where we were making real progress with s136 and had 'delivered' in our first (major) area – Birmingham. If you can sort s136 in Birmingham, you can sort it anywhere as demand, acuity and diversity is high.

We decided to run a simulation exercise for the (predominantly mental health and social care) delegates on police s136 decision-making. It was not focussed upon MHA assessments, but upon whether to arrest and for what; and where to go with them and why; and how to cope with a non-responsive or obstructive NHS system or individual professional, etc., etc..

We did it by having a power-point that had time-exposure slides so that there was only a certain amount of time to reach judgements and then it wasn't time for more discussion – it was time for a **decision**: are you going to do THIS or THAT? Are you going HERE or THERE … why?! … and what happens if THIS is the consequence?!! How will you defend it?

We used our voices 'tactically' – OK, we **shouted** some parts of our information feed to give an urgent, pressurising effect; we more quietly spoke other information and understated it although it was important people took heed. I think we managed to create pressure, urgency, uncertainty and confusion. Within this, we needed THIS or THAT; HERE or THERE.

Decision time.

Predictably, the 'hypothetical' problems we threw in were not unrealistic: they were of the type described on this blog many times before when discussing s136 and to which I've alluded, above. Equally, the negative consequences to some decisions were not actually hypothetical at all:

medical catastrophe, death in custody; degrading, undignified conditions, etc., etc..

The result was startling:

The professionals were placed under time pressure with brash alarms going off. The inability to continue any discussion but to be *forced* into a decision was not without worry, uncertainty and frustration for them. The intakes of breath and protests when the not-very-hypothetical disasters kicked in were palpable. The whole thing lasted no more than 10 minutes, but we blasted them through a not untypical s136 job with common issues.

At the end, people commented upon how they'd been 'put through the mill'; how they felt worried, pressured and had undergone an emotional reaction to the exercise. Of course, this was exactly what we wanted and discussion around it revealed that the laws, considerations and inquiries that influenced how the exercise was put together were actually a very real set of considerations to officers who are thinking about pitching up on an A&E who insist they are not a place of safety or who are faced with place of safety staff who want to turn away a patient who is far from intoxicated but who has used drugs or alcohol.

As we walked out, I think I said something like, "I think they got the point!"

13th May 2012

Using Force on Vulnerable People: part 1 –

In early March, Humberside Police were called to an incident where an Approved Mental Health Professional (AMHP) and two Doctors had 'sectioned' a 59yr old man who suffered early onset dementia. The MHA assessment did not initially involve the police – one presumes because the mental health professionals predicted no need for their involvement. After the decision to 'section' had been taken, there were problems persuading the patient, Peter Russell, to undertake the journey to hospital and the police were called. It is a terribly sad case.

The subsequent events have been subject to much debate in both print and broadcast media, after one of the attending officers used a Taser, in order to manage the situation they faced.

Wherever you think you may sit on the "should they / shouldn't they" debate: this is NOT a simple decision or a straight forward issue. So I'd invite you to challenge yourself by considering the opposing view to your own instinct.

The police were called after Mr Russell became agitated towards the NHS staff, Once the first officer arrived (alone), there were "significant levels of violence" both *towards* and then *by* the police. Mr Russell was tasered by after the second officer to arrive had been 'thrown across the room' and eventually six officers attended and manually restrained him, including the use of leg restraints. This was described by the media as Mr Russell having been 'tied up'. Thereafter he was conveyed to hospital and arrived without injury whilst two police officers were injured.

Presumably because this whole affair pertains not to a criminal, but to a vulnerable patient, the use of force in this way has generated this debate about its appropriateness. Of course, resistance and risk is still resistance and risk notwithstanding whether the reasons behind it are crime or illness – and let's remind ourselves again that these are not mutually exclusive categories.

I'd incidentally observe that the most significant, the most demanding and the most threatening violence I have ever faced in my career came from various mental health patients I was obliged to secure and convey. Often this is precisely because of cognitive problems arising from their

condition. Burglars often stop fighting you when you've got control over them and they realise they are going to jail. Patients often don't, because the fact of being subject to the use of force, potentially to the use of handcuffs and other restraints, compounds the original fears and confusion, causing greater resistance.

Amongst other things, it has been suggested that the officers should have 'de-escalated the situation'. Various other suggestions involved asking why they did not 'slip something in his tea and come back later' – quite what they should have slipped him, I'm not sure. Why did they did not 'leave him to calm down and come back later'? Well, maybe it was because any number of things could have then occurred for which the officers would have been directly liable arising as it did from a deliberate decision to walk away from a man who was in the legal detention of the state, by virtue of the actions of the mental health professionals who 'sectioned' him.

I am very familiar with, utterly sympathetic to and keen to explore, whether training for police officers could be improved to reduce the need to use force. In particular, I am aware of various international initiatives to improve overall mental health training for police officers and there are undoubtedly things that could be learned. Indeed, I have pushed now for over six years for a pilot of just such an approach in the UK which I'm glad to say may well be piloted in my force area later this year. Whilst those initiatives in the US, Australia and Canada often do report decreases in use of force incidents, research has suggested that there could be various reasons for this not simply the fact of improved training.

I have got **no idea whatsoever** whether the force used was legal and done in accordance with guidelines. Neither have very many other people. The specific details are known only to those who were there; and to those senior officers from Humberside Police who have reviewed the matter and written a post-incident report for the attention of the Police Authority.

Senior officers have repeatedly publicly backed their officers for their actions in this difficult situation.

So I'll say this:

- By virtue of an AMHP and DRs decision to 'section' a patient, they are in **legal custody** by virtue of s137 MHA.
- The officers are under a **legal duty** to deliver patients so detained into the safe care of the receiving hospital.
- Failure to do so could constitute any number of types of neglect, particular if there had been specific negative consequence arising.
- MHA assessments are risk assessed and planned – to one degree or another – in advance of occurring

- In deciding whether the police should be involved in incidents of this kind, AMHPs start from the position of wishing to employ the 'least restrictive' method of detention and conveyance.
- They did so and set out on this particular assessment without the police.
- As they did not 'pre-book' police attendance, there was no advance sharing of background, risks and so on.
- So the officers walked into that incident mid-nightmare and potentially quite oblivious to various important things. Decisions were taken very quickly.
- Calling the police to an MHA assessment because of unpredicted (or unpredictable) risks is not a decision that AMHPs take lightly – actually, most will say they try to avoid it wherever possible.
- AMHPs and DRs are not trained (at all, usually) in restraint techniques – so it was "leave him there or call the police" time.
- Whether a debate occurs about whether community based psychiatric nurses SHOULD be trained, to be deployed to events like is entirely beside the point – there was no predicted need for the police, so presumably there would have been no predicted need for such nursing staff.
- Once present at an incident of this kind, the police officers must balance their duty to safely detain and convey the patient; with a duty to protect themselves (from being assaulted) as well as a duty to prevent crime (against Mr. Russell's wife and the attending mental health professionals).
- This means, if there is a suggestion that the officers should / could walk away temporarily and return, it would be balanced off against the risks of not doing so.

Ultimately; you have just TWO broad choices: you back off / walk away (temporarily to de-escalate) OR you use force in accordance with laws and guidelines. Of course, BOTH of these choices carry risks – **neither is perfect**. Each may work, depending on the circumstances; the professionals present may or may not have reached a consensus, but the police have been placed in the driving seat – ironically enough, probably quite reluctantly! – and have to balance how to deliver the safe outcome in *their* professional judgement.

This post continues in >>> Part 2.

13th May 2012

Using Force on Vulnerable People: part 2 –

This is a continuation of previous post >>> Part 1.

THE RATIONALISATION OF THE USE OF FORCE

It was commented that much time and effort was spent by both the NHS professionals AND by the police, attempting to resolve this situation without resort to force. Officers are not allowed to 'escalate' to higher levels of force like CS, batons and Tasers unless they have tried and failed with lower level interventions OR unless the nature of the resistance faced is quite obviously not going to be safely managed with those lower level tactics. So, if you find yourself suddenly facing a man with a knife, you will start giving verbal directions – "Put the knife down. Get back, stay back!" etc. – but you will NEVER think about using close, manual handling techniques or strikes because it would put you in very close personal danger. You would be quite entitled to reach straight for your equipment and to use it if the verbal instructions were disregarded.

If the confrontation began at a much lower level, like verbal resistance and passive physical resistance to being manually restrained, it would not be defendable to reach for a Taser or anything else except maybe handcuffs. But if in the course of attempting to take someone's arms and guide their wrists into a set of handcuffs, if they lashed out and punched you or threw you across a room; you would be entitled to disengage from manual handling restraints and think about using CS, baton or Taser. That said, if you are in someone's house or amidst a crowd, using CS may be a quite inappropriate decision – you could just as well take out yourself, your colleagues or third parties if you use it and become indirectly exposed to its effects. So you'd think about using your baton or Taser if you are equipped with it – not all UK officers carry a Taser. If the initially verbal or passive resistance becomes active, aggravated and seriously aggravated resistance, then escalation from manual handling techniques to the use of personal protective equipment can be justified.

Whether everyone would *choose* to do so in circumstances where it were legally justified, is another judgement entirely.

THE ALZHEIMER'S SOCIETY

If you listen to the Jeremy Vine Show on BBC Radio 2, you'll hear from Jeremy Hughes, Chief Executive of The Alzheimer's Society who was more interested in pointing out "It is a real failure of support and a failure of care, which I'd take back a step before the police's role. The police are doing what they are trained to do … why did it get to a stage where the Doctor hadn't been aware of a need for support earlier? It is very unlikely that you'd get such a rapid progression in the space of a morning where suddenly someone was in need of support where previously they didn't." In fact during this interview, despite the clear concern for the fact that the incident occurred at all, the main criticism appeared (to me) surround whether medical intervention could or should have occurred earlier.

Mr. Hughes went of to suggest the officers could have "Withdrawn a little bit to calm him *in* the situation, rather than move him to somewhere else. Let his wife sit with him, let the family support him rather than rushing him when he's feeling volatile, he's already feeling disoriented and sensitive. The more you pile things on, the more different people coming into the room … a police officer in uniform could be one very upsetting, destabilising event in itself." Of course, what Mr Hughes or Mrs Russell may have thought about any assault that could have been prevented by restraint but which was not prevented because of a decision taken to 'de-escalate' by withdrawal is not known. "I wouldn't want to be condemning the officer involved because the officer is doing what he's been trained to do and what they've been asked to do. But as we've heard the officers have been trained to use force to achieve a result, what they haven't had is specific training on dementia."

I want to make a quick remark about dementia specific training and will return to this more fully in a future blog. Having worked within this part of policing for many years, there are always calls by specific groups for great 'awareness' training of, for example, dementia. But also of Learning Disabilities; of Autism; of Schizophrenia, of Personality Disorder; of Brain Injury. Place that on top of 'generic' awareness training on 'mental health' and all of a sudden, you haven't taught the police any LAW and you've been in a classroom for a week. It is my view having sat through a lot of seminars, conferences and specific training events of the kind described, that condition-specific training is needed only to the extent that it is necessary to dictate and explain a need for a different kind of response – whether Mr Russell was suffering from dementia or any other kind of condition, what difference to the response was needed to that which he would have required if he had suffered from bipolar disorder? I would argue none – many training inputs that I have attended, run by national charitable organisations for different specific conditions say rather similar things:

"patient communication, de-escalate, be careful about language and communication, avoid the use of force."

To have police officers in a position of being more knowledgable about conditions cannot be a bad thing in itself, not least in terms of an improved ability to recognise those who suffer from various types of mental health problems. However, I would argue that detention under s136 MHA of a schizophrenia patients is little different in effect or application to that for dementia patients or those with personality disorder. Communication skills and de-escalation techniques are little different for brain injury patients than for those born with a learning disability.

In this regard and having sat through numerous training events, general and specific, I have long believed that the specialist training needed by police officers is on **autism**. I need to blog more about autism, so will leave my explanation for this to those posts in the future. Otherwise, in my personal view, other conditions bear specific explanation in the context of good, general mental health awareness training.

This case is extremely difficult and quite rare. It is for that reason it has reached national media, but regardless: it remains the case that the use of force is a balancing act of considerations – risks of intervening versus risks of non-intervention. No-one thinks that use of Tasers is an inherently good thing, let alone on a middle aged dementia patient. But in the descriptions offered of this incident, one can just 'hear' the progression through the Conflict Management Model.

OTHER MEDIA LINKS

- BBC NEWS
- BBC Look North – includes interviews with Mrs Russell, Supt KELK and Sarah Moody (Alzheimer's Society).
- Daily Telegraph
- Daily Mail
- Jeremy Vine Show on BBC Radio 2 <<< *This link will expire soon as this is on iPlayer.*
- Wherefore Care
- Report of the Chief Constable – of Humberside Police to the Humberside Police Authority

14th May 2012

You Can't Both Be Correct …

This week on tweets I'm going to focus on "Mental Health Act Assessments on Private Premises" and section 135(1) MHA. (You can follow in Twitter, via the link on the right hand column of the blog.) This follows the disturbing case of Mr Peter Russell, a dementia patient who has subject to the police use of force to 'section' him after an MHA assesment at his home.

I'm going to outline a particular problem from a police officer's point of view. Let me just say **unequivocally** before I do so, that this is one example of the kind of thing we all do to each other and the police revisit this sort of thing on our health, mental health and social care colleagues every day.

So this is not about me trying to get on a high horse – I am aware that this could be viewed as the police throwing stones from greenhouses. In fact, this is as much about getting police officers to think through the problem as it is about trying to draw to AMHPs attention, the issue of consistency.

Disclaimer over!

At various times over the last few years I've been asked to speak to a room full of AMHPs about policing and mental health. Inevitably, the subject of **MHA Assessments in Private Premises** comes up with all its usual quandaries:

- Should the police attend at all?
- If so, when and who decides?
- Should there be or could there be a warrant under s135(1) MHA
- Who makes that decision if there are disputes between the police and the AMHP about it.
- If there is a dispute, should the police still attend?
- Who risk assess the operation?
- more questions besides …

I've addressed each of these in other blogs so I won't rehearse them here, but as I've continued to be involved in discussions on this it remains clear that there are misunderstandings and misconceptions about this piece of law and the legal framework that would surround such an assessment if it were conducted without a warrant. (I have even this year had

disagreement with a Mental Health Act Commissioner, which felt very odd indeed – that it were needed at all seemed unexpected; that it were unexpectedly needed explained a lot.)

The reaction I get to my standard "s135" speech is mixed: more confused faces than nodding heads, but always mixed. I'd like to make an outrageous generalisation to keep the point short: but the nearer to London you get, the more heads tend to nod and the further north you travel the more one sees copies of Richard Jones being pulled from bags and the commencement of frantic page turning. Particularly looking forward to speaking at an AMHP conference in December in Leeds! *(Note to self: pack riot gear.)*

The inconsistency encountered by the police is probably on two issues – at least in my experience:

- Understanding of when the police are obligated to attend an MHA assessment – no, it's not when the AMHP says they should.
- Understanding of the legal criteria for obtaining a warrant and how that understanding should link to decisions of whether to seek one – and therefore, when it would helpfully allow the mitigation of the very risks that necessitate police attendance in the first place.

My point is this: whatever you may think of the view I've taken on other blogs – views, incidentally which were formed in conjunction with national agencies followed by triangulated legal advice from independent MH Counsel, as well as police and health lawyers – **YOU CAN'T BOTH BE CORRECT!**

- The obligation for the police to attend either exists, or it does not.
- The grounds for getting a warrant are either met; or they are not

The stakes on this are high: the names of service users, mental health professionals and police officers who have died during the attempt to undertake MHA assessments can be found. Also, we heard last week of the case of Peter Russell where an assessment led to regrettable – although some argued, necessary – tactics to secure his safe admission after becoming resistant upon being detained under the Act. Such a case as Peter Russell's is a critical incident in the sense of having the potential to affect the public's confidence in the police.

And so this short new blog is just a reminder that it is incumbent upon us all to keep talking, learning and developing our understanding of the legal frameworks which govern us; to ensure we iron out our inconsistencies as much as we can. Within this, I include myself which is why I invite comment on this blog from anyone who has a perspective to offer.

14th May 2012

Invictus Trust –

Please watch this video from The Invictus Trust, in Cornwall and read their website for the story of their origins.

Invictus is an amazing and still small charity trying to bring good from tragedy, in an area of the UK where **suicide rates are higher** than the average and where **75% of those who take their own lives are men**. Suicide is, in fact, the leading cause of death in young people nationally.

So operating in a place where the challenges are greater than normal, where incomes are below and unemployment is above the national average; at a time when economic conditions are challenging – Invictus is attempting to bring positive action and a positive message around the mental health of young people.

This short film has been recently produced to help raise awareness of their work. Please consider supporting them via their website if you possibly can.

INVICTUS

Out of the night that covers me,
Black as the pit from pole to pole,
I thank whatever gods may be
For my unconquerable soul.

In the foul clutch of circumstance
I have not winced nor cried aloud.
Under the bludgeonings of chance
My head is bloody, but unbowed.

Beyond this place of wrath and tears
Looms but the Horror of the shade,
And yet the menace of the years
Finds and shall find me unafraid.

It matters not how strait the gate,
How charged with punishments the scroll,
I am the master of my fate:
I am the captain of my soul.

William Ernest Henley (1849–1903)

16th May 2012

Putting Your Arm in the Mangle –

Policing some mental health issues is can be like putting your arm in a mangle: you sometimes want to try and avoid it if you can, you fear that if you do it at all, you'll get pulled in far more than you originally hoped and that there could be a degree of pain and disorientation involved as you all of a sudden wonder how you're in up to the shoulder. Let me explain!! >>>

We know that in theory, many responsibilities around the operation of mental health law, ideally sit with health services. This could cover arrangements around assessment for admission to hospital, transportation issues; and all kinds of circumstances where restraint is needed. In practice, they often cannot or do not sit with health and / or social care professionals and there are a variety of reasons for this. Sometimes, it is a lack of commissioning or contingency arrangements; othertimes it is unpredictable events and occasionally it is down to lack of training or even a lack of legal knowledge about what it is possible or necessary.

For example, the Code of Practice to the MHA requires commissioners in England to ensure they have commissioned appropriate transport arrangements for the movement of patients – there are comparable provisions elsewhere in the UK Codes of Practice.

Clearly, if a patient was suddenly seriously injured or ill in a psychiatric facility, it may be necessary in a hurry to ask for police support to assist in transferring to A&E because of escape risks or risks to others, because treatment cannot be delayed at all. Othertimes, the need to move patients from here to there can be planned in advance or delayed until appropriate non-police conveyance is arranged. Some mental health providers have limited access to transport other than their ambulance service and not all MH trusts feel they get an adequate response. Equally, I've heard ambulance services argue that the way in which they are commissioned does not involve them providing transport for every kind of MH related transport scenario and police support is sought for the want of alternatives.

Most situations like this involve mental health staff with a genuine need to move patients and officers having an instinctive reaction that the need for movement is perfectly valid enough. **The debate is whether or not to put your arm in the mangle.**

Not all of these situations involve "**RAVE risks**" – this is my 'rough rule of thumb' to cue whether or not the police should be involved in essentially health or social care situations. Hence it is not always clear why the police may have been called. That having been said, I have heard several non-police opinions that even where "RAVE risks" are involved for detained patients, mental health providers should still have arrangements, if necessary through contingency planning and escalation to duty managers, to effect the movement of resistant patients from here to there without resorting to the police, unless that need emerges unpredictably and needs rapid response.

I have posted previously on being called to a psychiatric facility to face a request that a violent patient be restrained so that they can either be forcibly medicated under law AND / OR moved to another mental health unit that has a seclusion facility. Such requests are not an everyday occurance, but nor are they rare. **These situations are loaded with risk.**

There are risks associated with restraint of psychaitric patients. Not only have questions been asked (by counsel who gave legal advice to a UK police force) about whether the law allows the police to restrain patients *for the purposes of* allowing nurses or doctors to forcibly medicate, there are problems with understanding the underlying risk factors associated with it.

We know from research, that the physical health and wellbeing of those who live with severe and enduring mental illness is poorer than those who live without. We know that life expectency is significantly reduced by 10 or 15 years; sometimes more. Therefore the restraint of man in his early 40s, ostensibly fit and healthy, could be akin to the restraint of a 60yr old man. We – police or psychiatric staff – should therefore enter into those situations with caution:

- **What are the potentially unknown risks?** – poor physical health, underlying health problems, complexities around drug / alcohol (ab)use.
- **What is the exit strategy from restraint?** – you can't just KEEP restraining somebody, under anyone's guidelines. How are we getting out of it? Are psychaitrists going to use rapid-tranquilisation, seclusion or can we turn techniques to RESTRAIN into a condition where we CONTAIN once any immediate threats are mitigated (ie, weapons)?
- **What happens next?** – what is the plan for moving from that condition just after restraint ends to the police withdrawing entirely from the situation and the situation returning to 'normality', even this is a 'new normality'?

LET ME BE COMPLETELY CLEAR: I am not suggesting that whilst the risks around the reason for caling the police prevail, that we slip the kettle on an discuss *ad nauseum* a load of contingencies when time may be of the essence. But planning and joint operating protocols around calling the police to psychiatric facilities should include advance consideration of this kind of thing.

- What happens if we're asking the police to restrain for meds?
- What happens if we're asking the police to restrain for transfer?
- Where does the transport come from? – Ambulance, other secure transport provider or police?
- What influences that decision?
- Has this been commissioned / agreed in advance?
- Who does the escort – **NB** the police should *NEVER* do this alone.
- I'm told that NHS guidelines also state if the patient was sedated prior to transfer, they should be accompanied by a Doctor. <<< *Can any NHS staff tell me if this is correct, please?*

WHO IS IN CHARGE OF ALL OF THIS? – the NHS or the Police?

I am going to blog later about something else that has massively influenced my thinking on policing and mental health: Black Swan Theory. In short, this is the study of high impact, low probability events, originally in the financial sector. Characteristics of such financial events are that they were not predicted, they are low probability and high impact and after the fact, they become rationalised as if they *were* predictable.

This is what policing and mental health can be: it's often the case following controversial incidents of contact death and restraint – or the controversial use of force – that inquiries reveal unknown, unpredicted, unpredictable events. They almost always allude to a cluster of variables which *in hindsight*, make the events somewhat predictable when in fact, they often were not.

As such, may be we need to think about all this a bit more to develop a robustness against 'negative' Black Swan events – and so that we don't put our arm in the mangle?

18th May 2012

Place of Safety Training

OK – I admit I've become excited by learning how to upload YouTube videos into a blog! So I thought I'd shout out a 'Training DVD' that was jointly developed in the West Midlands by the police and the NHS. It was designed to provide a generic understanding to all staff in all agencies about how s136 should work.

The training materials support the regional agreement in the West Midlands about how Place of Safety processes should operate. That said, the underlying principles of this were subsequently disseminated by the National Policing Improvement Agency as the template against which all PoS provision should be judged so it is potentially of wider application.

All five videos total only 22mins and were deliberately designed to apply to all. I've put a page under 'Police Guidance', above, with these on for easier access in future – **I hope they may help how to approach things.**

UPDATE >>> *I admit I've also become excited by how to upload microsoft documents into blog posts and have now added copies of the various s136 products produced between my force and the Strategic Health Authority*

- Birmingham PoS Protocol (version 2 which will be updated soon for the Children PoS development).
- PoS Aide Memoir – a multi agency tool.
- PoS Birmingham Training – a powerpoint used to deliver PoS training.

Part 1 – Introduction

Part 2 – A&E and RED FLAGS

Part 3 – Place of Safety

Part 4 – Police Station as Last Resort

Part 5 – Main Messages

20th May 2012

Thank You For Messing Us About –

A recent experience at work just had to become a blog – mainly because this is about the third time that this has happened to me. Police resisted becoming involved in a mental health job – causing delay, inconvenience and frustration to the frontline professionals involved – and were then thanked for doing so, because the resistance and the escalation it caused brought to managers' attention issues faced by frontline NHS staff. This is something that frontline staff were grateful for, because their attempts to address the same problem were not, in their view, listened to or acted upon.

Officers were requested to attend a premises after a very elderly lady had been detained under the Mental Health Act. The request was for officers to use reasonable force to coerce her to hospital, the AMHP having explained that she had to go because she'd been 'sectioned'. The lady did not agree on the need for it or the legalities of it, so reasonable attempts to persuade, encourage and direct having been tried and failed, the police were called.

The control room in the relevant area despatched officers to the address to assess the situation after the lady was described as verbally aggressive but quite rightly on the part of the police, there was a reluctance from the start. I say this because the thought of two taser-equipped police officers, in stab vests with batons coercing an octogenarian from her home is not attractive. Aren't we supposed to use force in the 'least restrictive' way?!

Only this week, **I've blogged** on the back of publicity for an **incident in Lincolnshire** where the police use of force on a dementia patient was massively criticised, despite the fact that "significant levels of violence" were displayed and despite most people, including me, not knowing the full facts. The internet was alive with a broader debate about whether the police should be the agency to coerce people *at all*, where it is in the context of MHA admission. So today, my force were asked to coerce a substantially older patient who was verbally and passively resistant to admission. At no stage had she attempted to hurt anyone.

The duty inspector in this particular area was quite clear to his staff: "We're not going 'hands on' first. That's not our job. If the NHS find that resistance to their attempts to move this lady escalates to violence towards them and they are at risk of being hurt, then we'll assist. But it's not

dignified for this woman to be dragged to hospital by the police when she's probably fairly frightened by the prospect already." He deployed his officers to assess the situation, they tried verbally reasoning – as I'm sure the AMHP already had – but to no avail.

I got brought into this to advise the duty inspector on whether he was on safe grounds to continue to refuse? His approach stacked up to me. What happens if the officers say "OK, let's crack on" and then restrain the patient only to break her arm – bearing in mind she was in her late 80s? You can then see the headline, "Police break elderly dementia patient's arm" and then we're talking about policing again, rather than about decisions taken by the NHS – consciously or otherwise – to have no appropriately trained mental health resources available to the AMHP to avoid the use of the police.

Meanwhile, the AMHP who had been there several hours with someone in custody escalated the issue to an AMHP-lead in her area – why were the police not agreeing to this and what was she to do? In the conversation I had with the AMHP-lead, I outlined that in my view there needs to be something in between the patient saying, "Sorry I'm not going" and the AMHP saying, "Call the police". NHS Trusts often employ thousands of people, community based and inpatient based – why can't they arrange to deploy two C&R trained staff?

I've said this before: if you want to be in the coercion business, you should expect to find yourself in situations in which you need to coerce. A patient, once sectioned, is actually in the legal custody of the AMHP and parliament gave the AMHP "all the powers of a constable" in these situations *for a reason*. This should be reflected in acceptance that there are at least some situations in which those powers should be used. Yes, I know that the AMHP can delegate authority to anyone else: but they may not DIRECT anyone else to accept that delegated authority. Again, we must presume that parliament legislated like this *for a reason*. Low level, passive resistance would seem the place, as far as I'm concerned, to see AMHPs and / or their NHS or Local Authority colleagues using appropriate training to act for themselves.

To be clear: *nothing* that I'm writing here implies that anyone expects AMHPs or C&R trained nurses to manage serious aggravated resistance by patients intent on deliberately hurting NHS staff.

It took several more hours for the AMHP lead to attempt to engage senior managers to consider what, if any, contingencies could be accessed to deliver therapeutically relevant restraint and for that manager to then ask to speak to me. By then it was nearly 5pm on a Friday afternoon so people were going home. Senior managers had nothing in their toolbox, one presumes because nowhere in the planning of the delivery of mental health

services was the 'need to coerce after MHA assessment' scenario considered. And of course, no-one in that area had remembered to write and agree a local policy with the police on "MHA assessments in private premises." <<< This is a requirement of the Code of Practice to the Mental Health Act – oops.

So there's it is >>> having established there was absolutely no other way to get the job done, the police did the right thing and attended to coerce, paramedics and AMHP in support. It had reached the point that unless the police did it, the AMHP would have chosen to walk away because of an inability to complete the task. Obviously, no-one was going to leave an 80-odd year old woman in her address alone when she posed a risk to herself.

Predictably it took nothing more than an officer taking her by the arm, pulling her gently to her feet whilst telling her to sit in a wheelchair whilst trying to calm her verbal distress at being moved. The sergeant involved explained that it was "barely any resistance at all" to get the job done. Why could that not be done by an AMHP a paramedic or a CPN? No reason at all, if we're honest.

This story is far from rare: the point I'm making in this post is the AMHP-lead saying this: "You resisting in this way has caused this to get escalated to senior managers, I've been able to register this matter as a clinical incident and the Chief Executive will hear about this. It may be that the police resisting this will cause managers to discuss things frontline staff have raised for years, but which haven't been addressed." <<< *Read the paragraph again and think about it.*

So – we think we got thanked for taking the trouble to cause significant inconvenience and delay to a frontline AMHP – albeit we checked at every stage and repeatedly that the AMHP wasn't at risk or the lady's health deteriorating. The AMHP was aware that any sudden change in the situation ring 999 for police and / or ambulance. One can only hope that next week, people take seriously that there are important discussions to be had about how we make the processes of coercive sectioning as dignified and humane as it can be, balanced against managing risks and threats which may, from time to time, require the police.

UPDATE >>> *Since publishing this blog a few hours ago, I have already had AMHPs and other mental health professionals from other areas 'nodding' at the above including an Older Adults Psychiatrist suggesting that this is a police force quite rightly putting dignity first. One MH professional pointed out that in their area, the police would not have been called because there is a commissioned service upon which to call in this situation.* ***This needs to be wider practice.***

20th May 2012

Policing, Mental Health and the Academic Gap –

I was delighted to be asked by Dr Jez Phillips from the University of Chester to write a post for his blog. It is a goldmine of articles and resources in forensic psychology and his fear of crime research project is detailed on there for which he needs support especially from tweeting police officers. I'd encourage you to check out his research and his resources and to follow him on Twitter (@DrJezPhillips).

My contribution to his blog was entitled "Policing, Mental Health and the Academic Gap".

I am delighted to be asked by Jez Phillips to write a guest post for his blog – what an honour. It struck me that if a serving police officer is to write for an academic's blog, one should point towards the subject of academic research and operational policing. Apart from anything else, this is a subject dear to my own heart having taken a keen interest in academic development throughtout my career. Also, my work on policing and mental health within the service has led me to ask so many questions and often one finds there is no answer at all. I've said many times: there's a lifetime of research here for someone and I occasionally I wish it were me.

I want to cover just three substantive points:

- Policing and mental health
- Policing and academia
- Research gaps in the real world

POLICING AND MENTAL HEALTH

Anyone who reads my blog will know that policing and mental health is a *vast* subject. Not only in terms of its potential complexity, but also its breadth. It gets into the most important social and public debates that we have, in some of the most challenging circumstances: public protection, the protection of the state – or lapses of both. We touch on life-threatening

medical emergency, deaths in custody; the diversion or prosecution of offenders, vulnerabilities of every kind as well as emotive issues of unpredictable violence.

Some research estimates that mental health issues affect around 15% of all policing: either in connection with victims, witnesses, or suspects; or because of incidents that involve no criminal offences at all. I think this is in many respects an *under-estimation*. For example, I know that police officers often 'spot' around 15% of people coming through police custody suits and for one reason or another, ask the 'mental health questions'. However, were the names, addresses and dates of birth to be shared with the local mental health provider, what would we find?

How many are known to the local mental health trust? Well, there was a localised initiative in Sussex which found that 50% – yes, *HALF* – of all people arrested were either currently known by, previously known by or needed to be known by their secondary care mental health provider. As secondary care deals with severe and enduring mental illness, we should remember that around 17% of NHS patients needing mental health care are supported in primary care, by their GP.

We don't even know the size of the problem.

Policing and mental illness can also be about profound episodes of public confidence in policing. Death in custody inquiries are disproportionately populated by contact between police officers and service users whilst at their most vulnerable; and often their most challenging involving substance (ab)use. I have written more blog posts on the subject of s136 Mental Health Act 1983 and Places of Safety, then on any other subject within my area.

At least one contact death inquiry per year is focussed upon police detention under s136 and yet it remains the case that most people arrested by the police under this provision are removed to police stations in stead of health facilities. This happens against a backdrop of so much guidance and so many guidelines that police stations are not appropriate for detaining mentally ill people in need of nothing more than assessment, treatment and care.

POLICING AND ACADEMIA

Policing in many regards is the last public sector vocation-profession to tie itself up with academia. Whereas years ago teachers, nurses and social workers were taught in vocational training institutions with a good spread of placements and 'on the job training', this has now given way to university education, albeit it still interspersed with vocational placement within the

context of that degree. We can see that policing is moving towards this, and not before time:

There are various university courses now on 'policing', at the Universities of Staffordshire, Wolverhampton and Teeside, amongst others. It would be remiss of me not to highlight the BSc (Hons) degree in Policing at Wolverhampton because of its strategic liaison with West Midlands Police – it is a requirement of the degree that students are accepted as special constables and serve a certain numbers of hours of voluntary service during their three-year course. Furthermore, there is a second year module on 'mental health' delivered by the Nursing school of the university, a recognition of the link between the two subjects that I have not seen in any other institution. It is my privilege to have delivered a guest lecture on this course for the last few years.

Of course, the University of Portsmouth entered the higher education market for all manner of criminal justice professionals several years ago, through distance learning as well as campus based provision. I know that many police officers have seen this and other higher education provision as the key to professional advancement, but we remain a distance from police training being university based.

Increasing links with academia are forging this path: the **Universities Police Sciences Institute** is a joint venture between the universities of Cardiff and Glamorgan and South Wales Police. UPSI provides research, training accreditation and closer ties between the frontline and peer-reviewed research of national and international recognition.

The most interesting link between academia and policing is the **Violence Research Group** at Cardiff University. The work of Professor Jonathon SHEPHERD is truly inspirational: his analogy of how research and professional practice in medicine is a world away from that in policing, but how the latter needs to m've towards the former, is astounding. I can see the benefits of this and hope within my career, we'll have stepped towards that kind of vision.

RESEARCH GAPS IN THE REAL WORLD

Policing will play an increasingly important part in the provision of mental health care in the future, in my view. Linda TEPLIN wrote in the early 1990s that police officers were "street corner psychiatrists" and if anything, this is truer now than ever. One theory is that as the 'de-institutionalisation' of mental health care gave way to 'Care in the Community', policing increasingly filled a gap in crisis care and crisis support. Initially, this brought law enforcement techniques and practice into crisis management and there were predictable consequences.

In most countries there has been more than one controversial use of lethal force in relation to someone who is mentally ill. **Andrew Kernan** in the UK is just one of several such controversial deaths. Following the fatal shooting in Memphis in 1988 of a service user, US police departments started to adopt "Crisis Intervention Training". This represented an alliance between the police and local mental health providers and universities to give officers accredited training to deal with mental health service users using techniques and approaches likely to reduce the need for the use of force and to increase 'diversionary' approaches to avoid arrest / prosecution. I'm looking to introduce a similar approach to this in the UK and will be trialling something later in the year.

Meanwhile, there are many other academic questions and areas of research activity that need tackling. We need to know more of the "what, where, who, when and how" of policing and mental health. Basic research needs doing to establish "what works" as so much about criminal justice approaches to mental health remain based upon assumption or upon research undertaken by interest groups such as mental health charities. There is a dearth of peer-reviewed, high quality academic research on this topic and in my own view as a practitioner with a quasi-academic interest, I'd like to see this plugged by non-political (small 'p') research in a neglected area of policing and criminology research.

So – **does diversion work?** I'm still not convinced of the reports I've read from various charities that the legal frameworks of the country that we have fully specified what we're trying to do in the 'diversion debate'. I'm still not convinced we know what 'diversion' is or the legal frameworks within which it actually operates. Far to much assumption, stigma and unreality. Accordingly, how do you begin to assess whether it 'works'? Whatever that means …

So – **are police shootings properly understood?** I'm not convinced that we understand sufficiently the dynamics that are at play when the police use potentially lethal force against people with mental health problems, some of whom we know are putting themselves in harm's way with a raised risk of being subjected to force.

So – **how does the justice system react to victims with mental health problems?** I'm not convinced that we have a criminal justice settlement for victims and witnesses. In our adversarial model of justice, focus upon what makes a 'good' witness, discriminates against those with mental health problems and we know from the case of **R (B) v DPP (2009)** that victims do not always get a fair deal in our justice system.

So – **how do we find ourselves unable to guarantee effective crisis care?** I'm not convinced that legal cases which have highlighted shortcomings in our social response – R (B) v DPP (2009; MS v UK (2012)

– are absorbed as 'lessons learned' and taken forward into the development of services.

I'm nearing my word limit, which is the only reason I have stopped asking questions. There are many **more** to be asked. This issue will not abate during the coming years: we know psychiatric services are withdrawing further from the provision of inpatient, outpatient and crisis mental health care and we know that internationally this means the police service will be sucked into the vacuum. It is therefore even more important that we understand the size of the problem and ask ourselves, "What works?" on the basis of understanding what is needed.

22nd May 2012

Section 136 and the FME –

The Force Medical Examiner, or Forensic Medical Examiner, is the doctor who comes into police custody suites to undertake various medical functions. The terminology for these professionals has changed over the years and is now officially the "Approved Healthcare Professional" which is helpfully confusing when I want to discuss AHPs in the context of functions they must undertake with AMHPs (Approved Mental Health Professionals under the Mental Health Act)!

For that reason, I'm going to persist with the outdated term, "FME"!

When I joined the police, the FMEs were a load of local doctors, mostly GPs, who were on a rota. My station and two others had four of them and they were in each subsequent 7 day period "first choice" then "fourth choice" then "third choice" etc.. Many of them earned more from being an FME than they did from being a GP because they worked about 24/7 for a week, then had two weeks 'off' (because 3rd and 4th were rarely called) and then a week of being called 'occasionally'.

Presumably because of cost and some debate about skills, training and clinical governance, somewhere around 2002, my force contracted a private provider to undertake all medical functions in the custody office and elsewhere, introducing nurses for certain functions rather than doctors.

The FME has an interesting role with regards to s136 and it varies across the country. Legally, once someone has been detained by the police and removed to any place of safety, they must be seen by a "Registered Medical Practitioner" and an AMHP. The RMP needs to be a doctor and there is no specific requirement that they be "**s12 approved**". Section 12 approval relates to doctors who are declared to have "special experience in the diagnosis or treatment of mental disorder". Many functions for doctors under the Mental Health Act 1983 require a "s12 doctor" but s136 MHA is not one of them. In fact, many FMEs in fact ARE "section 12 approved".

The Mental Health Act Code of Practice states that the RMP should ideally be s12 approved, but stops short of mandating it.

Force Medical Examiners being used outside police custody

Sometimes, local s136 policies specify that even where a person is removed to an NHS place of safety, the FME should still be involved in the s136 assessment. There are a few problems with this which then emerge in reality.

Firstly, some force contracts with their medical provider, do not cover it and therefore some FMEs are told by their contracted employer not to undertake such functions. Assessment under s136 MHA is a statutory responsibility for the NHS and therefore, the NHS should ensure that the commissioning of PoS services ensures the availability of whatever kind of DR they believe is the most appropriate. This has caused tensions and problems, because it sometimes only became known that FMEs were involved, once contracted medical companies were overseeing FME schemes.

It turns out, RMPs can claim a statutory fee for s136 and MHA assessments, so plenty of FMEs were happy to do it. But then some NHS areas started trying to suggest that as the doctor "worked for the police", the police should pay that bill. Err, no.

I have recently been looking for a reference which I'm sure I once read in the Code of Practice to the MHA, which indicated that PCTs should not rely for the delivery of services upon third-party organisations that are not directly commissioned. Contracted police FME services are one such example, where reliance by the NHS on a service they did not commission and do not control, can lead to operational problems. PCTs must ensure they have answer to "how s136 gets done."

I suspect some of this may change in the future when the NHS takes overall commissioning responsibility for healthcare in police custody, at the point of writing this, it remains true.

Force Medical Examiners in police custody

FMEs have been used in various ways for s136 assessments in the cells. In some forces, the local authority WANT the FME to get involved in a 'screening assessment' before the AMHP is notified, ostensibly so that the FME gets rid of any s136 detention which is obviously inappropriate. In other areas, the local authority specific DO NOT want the FME to make any decisions whatsoever around s136 MHA, because they want to bring their own RMP, usually off the "section 12 approved" rota.

Each of these scenarios poses a different, interesting question: if the FME is screening people out, on what basis are they doing so? I ask because I

know that some doctors think the question to ask of s136 patients is whether they are 'sectionable' under the Mental Health Act. In fact, the purpose of s136 assessment is not (just) to establish whether the person is 'sectionable', but "whether they are mentally disordered for the purposes of the Mental Health Act" and to identify subsequently necessary care pathways. These could be inpatient OR outpatient pathways.

The second quandary is interesting: if the FME gets to police custody with a view to doing "FME things" and staying 'out' of the s136 process – police want FMEs to confirm fitness to be detained in the police cells, levels of safety observations which will be undertaken whilst the person is there, helping with decisions around whether they need removal to A&E for any purpose perhaps after a physical examination – what then happens if the FME who is an RMP thinks the person is "not mentally disordered within the meaning of the act"? The Codes of Practice to the MHA and to the Police and Criminal Evidence Act 1984 both state that if an RMP believes the person is "not mentally disordered" etc., then the person should be released and s136 comes to an end. To detain beyond that point would be illegal; a false imprisonment by the police.

However, in more than one joint operating protocol that I have read, the policy states that no-one detained under s136 MHA in a place of safety will be released until they have been seen by both a doctor AND an AMHP. Which could amount to a false imprisonment, in some cases.

I also know of local protocols where the local authority want the FME totally removed for the s136 process, even where they are in police cells. This usually stems from a history of incidents where the local authority found that FME decisions were way off mark, leading to the unnecessary release of people who were quite unwell. But of course, the custody sergeant is obliged to call an FME for reasons above, that are nothing to do with s136. Safer Detention guidelines and PACE require it.

I understand the importance of the AMHP role in s136 assessments. Not only do AMHPs make arrangements for full MHA assessment if the "s136 assessment" indicates compulsory admission to hospital may be needed. Also, even where admission may not be necessary but where the person detained is suffering from mental disorder within the meaning of the Act, the AMHPs role is to ensure the relevant community follow-up. This may take one of many forms, including referral to the patient's own GP, or community based mental health services.

So a tension in police custody can emerge, depending on how local s136 protocols are drafted: the custody officer is responsible for managing this tension and my advice is this:

- Notify the FME for assessment as soon as practicable after 'detention authorised'.
- Notify the AMHP as soon as practicable after 'detention authorised' of the s136 detention in your cells and give the FMEs estimate time of arrival. The AMHP can then choose whether or not to be present at the same time, as preferred by the CoP MHA.
- If the FME arrives first and assesses the person to any degree, the question to ask is, "Is this person mentally disordered within the meaning of the MHA?"
- **If yes** – continue to detain for the AMHP.
- **If no** – section s136 has been brought to an end by virtue of this assessment. Unless you think for good reason that the Doctor is way-off in their conclusion, in which case contact your on-call senior FME (most forces have this) and notify the AMHP.

Footnote: "Not mentally disordered" after removal to A&E

The references highlighted above about RMPs indicating that someone is not mentally disordered has one further consequence that is worthy of mention in this context, although it is not about FMEs. Where a person has been removed to A&E – presumably because of additional RED FLAG injury / illness which makes this necessary – it could be that an A&E doctor states that a person is "not mentally disordered …" etc.. Where this occurs, it again raises the question of whether s136 should be brought to an end, irrespective of whether the AMHP has arrived or been notified of the detention and undertake an interview.

After much discussion on this point it comes back to the Code of Practice to the MHA (para 10.33): "If the doctor sees the person first and concludes that they have a mental disorder and that, while compulsory admission to hospital is not necessary, they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP."

22nd May 2012

Whilst I Was In Bed …

*<<< If there's one thing from which I derive **very real** satisfaction, having blogged away now for six months, then it is emails from frontline officers saying how the blog material has come in useful in operational reality. To get such a story as this one where it is clear a better patient outcome has been achieved for someone whilst I was lying in bed after NIGHTS is gold dust. This feedback comes from Twitter's @NathanConstable, a blogging / tweeting frontline police inspector who is worth a follow and does good blogs on policing issues. >>>*

Your site has AGAIN proved invaluable today as I have quoted Paragraph 10.22 of the MHA Codes of Practice to a ward manager.

THE CIRCUMSTANCES

A man was seen yesterday by a support worker, at home, who felt he needed an MHA assessment but he left the house before it could be jacked up and he was reported missing as she had concerns for him. He was located several hours later by police who detained him under 136.

He was conveyed to the PoS but they didn't want him for a variety of reasons. Eventually the night Inspector went down there himself and told them he would be staying there whether they liked it or not.

As I came on at 0700hrs this morning and just three minutes into briefing, we had a call from the hospital saying that a patient was kicking off, that he had assaulted three members of staff and five of them were restraining him. I did not realise at this point that it was the same male.

My view at this stage was that this is something they need to be handling themselves with their appropriately trained staff. However, when it became apparent that he was pre-section and still detained only on 136 I had to revisit that and I sent a unit with specific instructions NOT to remove him from the hospital unless it was absolutely necessary. By this time the patient (still not assessed) had been moved into a secure room by the hospital staff and was no threat to anyone any more.

Apart from their initial unhappiness about our lack of attendance they were then extremely unhappy when the officers refused to take him away. This led to the Ward Manager calling me to discuss.

His view was that the hospital was not an appropriate place for him, they "couldn't handle" him and he needed to be detained in a cell. My response to that was that a police cell was not appropriate, the HAD handled him and he was now detained in an appropriate place of safety.

Not content with this the ward manager informed me that the room being used was not THE PoS. To which I quoted 10.22 and said he had effectively improvised one.

He persisted that by using the room it was denying its use to a hypothetical service user who might need it later. He even went as far as to say that it would be on my head if a 80-year-old dementia sufferer ended up in police cells because they couldn't use the room.

My answer to that was – why are you worrying about hypothetical "what ifs" rather than dealing with the service user you have in front of you? If an 80yr-old dementia sufferer turned up I would improvise my own PoS and take her home rather than convey her to a cell.

The debate continued with him accusing me of thinking it was alright to assault staff. I said that is not the case at all – his medical and clinical status is not yet ascertained so I don't know whether his actions are criminal or not yet – if they are we will deal with them but that is not the priority right now – his assessment is.

Then he moved onto the fact that the patient was unlikely to be sectioned as he had been examined before. I asked him three questions.

Question – "What happens if he is Sectioned?"

Answer – "He stays in hospital."

Question – "What happens if he isn't?"

Answer – "He is released."

Question – "What happens if he is so violent that the AMHPs cannot conduct the assessment or make valid assessment." … it took him a while to admit that in that eventuality he would be detained for further assessment to which I said, "Two out of three of those scenarios involve him remaining in hospital and the other see's him walking out. Where does a police cell come into this?"

I then explained that it wasn't a question of having police officers involved – I was quite happy to supply a double crewed unit to ensure no crime was committed before or during the assessment. For me it was a question of WHERE this would take place and I would not, under any circumstances, take him to the police station now he was secured in a safe and secure room.

The ward manager reluctantly accepted this – **which suggests to me that I was right.**

The inevitable, "I will be making representations about this" came out but the question is – was I right? I think I was. I will accept that had I known he was pre-section in the first place that might have changed my initial "how quickly we got there" approach but not the eventual outcome.

The fact that seven hours later we are still there is something I have to accept. Their other problem was a refusal to change their schedule for the day. Common sense dictates that they bump this guy to the top of the queue – and assess him – we know where we all are and the room is either utilised fully or he is released thereby freeing it up. Problem solved. Unfortunately they seem to have had a series of **unavoidable meetings** which is delaying the whole process. What a surprise.

The outcome was, he's been detained under s2 MHA and admitted. I doubt I have heard the last of this one!

MY COMMENTS

Was this duty inspector right? Feel free to add your own comments to this post. For me, **certainly**.

He has provided a response which ensured ongoing security to prevent further assaults and whether or not the NIGHT shift should or could have left resources at the PoS to prevent assaults from occurring in the first place, is not clear in terms of the risk background. But that is not an issue for *this* inspector.

It is quite right to point out, that PoS solutions can be improvised notwithstanding what a PoS protocol stipulates the designated places to be and para 10.22 obliges the police AND the NHS to think of the alternatives. This may not be "textbook": it might not be what all NHS staff think is the right thing – but we've all got personal views on this stuff, haven't we? It was **lawful**, reasonable and ethical and it probably caused a faster assessment of MH need in a more appropriate place than if the police had just got back in their box and done as they were told. Of course,

had they done so, I've got various medical and legal situations playing out in my head which would have rendered acquiescence questionable.

Let's not forget the criteria for use of a police station is "*unmanageably* high risk" and the officer points out, they managed it and then were supported by the police thereafter. Let's also remember: the **Royal College of Psychiatrists Standards on s136** indicate that people detained should be taken to and left with NHS services "even where they are disturbed" (p8). That ongoing police support was provided may be considered 'extra' to support a service that doesn't function as agreed by relevant national agencies. We should also remember that the recommendations of the Rocky Bennet Inquiry indicated that where psychaitric patients are in need of ongoing restraint, they should be detained a place with access to a Doctor and defibrilator. That include no police station that I'm aware of.

It is for that reason that I smiled when I read the paragraph above "You've effectively improvised one." Can we doubt the commitment to investigate the assaults against staff or ensure they are not repeated? Not really. Removing the man to a police cell doesn't un-assault the staff; nor does it ensure fast assessment of need. Providing two cops to remain at the unit keeps the situation from re-escalating and represents a recognition from the police that the risks have raised and that whatever the rights and wrongs of the way the service is commissioned or the fact that staff would potentially prefer to operate outside the law and national guidance, **the police have done the right thing in my humble view.**

23rd May 2012

Turgid Buffoonery –

Discussion about mental health and policing often turn to the law. Not only in terms of who can do what, but also in terms of how or when it should be done. Some of these debates are delicious because in many respects the law is quite vague and many people COULD do certain things, but who SHOULD do them can be a cause of tensions and reasonably differing opinions. Sometimes, different opinions can be less reasonable.

I have a theory that in an attempt by professionals in each agency to cause the others to do certain things or to do certain things better, differently or faster; we've entered into myth-making on a near industrial scale and that this is represented in certain "legal" discussions.

As a police officer trying to get my head around mental health law some years ago – an effort I still make when I find myself uncertain – I found it very different in nature to law that I had studied in promotion exams for the police. Far more inclined to be vague.

It is interesting that the syllabus for the legal examinations to sergeant and inspector do not include examination of ss18 and / or 135-8 of the Mental Health Act 1983 – these are the main sections for the police. There are other sections of interest to those of us who are more involved in policy work around this, such as 6, 13 and 140 and all of Part III MHA. Of course there's then the Code of Practice to the Act: **all police supervisors should read** chapters 10,11 and 21, 22; and chapter 4 for those of us a touch more interested.

I find the **Code of Practice** itself interesting – the police have loads of these things for different laws and I've previously blogged about the difference in some cultural attitudes between the police and the NHS towards them. I was interested last week for example, to be told of an NHS area who WANTED a mental health patient detained in the cells because they were under the influence of alcohol: "we cannot assess someone whilst they're under the influence because it breaches the Code of Practice and we ignore this at our peril". Well, it actually doesn't – this is more mission creep: it is advised against except in some very specific circumstances. However, my main concern was that this remark came from professionals seeking the removal of a person to the cells when a perfectly available NHS PoS was sitting there, empty. They were worrying

about hypothetical future patients, yet to be detained when someone was in need of the place – if we detain someone else in half an hour, we'll cross that bridge at that time. In the meanwhile, you want the police station used as an automatic second choice when you're not unable but simply unwilling to let the NHS PoS be used?! Please read 10.22 to the Code of Practice to the Mental Health Act 1983 and then read R (Munjaz) v Ashworth Hospital Authority (2005).

So, after a day at work as the duty inspector where I was exposed to some nonsense about missing patients, MHA assessments from NHS and to myths about the "capacity" of offenders by police officers, I just wanted to quickly list some other rubbish that I've heard in my time. I hope to provide balance by being equally dismissive and disparaging of nonsense heard from each side. Many of these things are urban myths and have become ingrained in some areas' operating practices.

I am only including things in this list if I have reached a point of being utterly bored of hearing them owing to their frequency:

- The police cannot arrest under s136 MHA if the person is in A&E
- To decide whether or not to prosecute a mental health inpatient for an offence, the police need a statement of evidence from a psychiatrist affirming the patient's "capacity".
- Only the police can keep someone detained against their will in a Place of Safety, after being removed there under s135(1) or s136.
- Only the police can use physical force to restrain a patient in a community MHA assessment, in order to compel that person to hospital once 'sectioned'.
- It is always the role of the police to recover AWOL patients.
- If the police are in a private dwelling dealing with a mental health crisis, they can use the Mental Capacity Act to remove the person to A&E or a place of safety.
- Victims of crime with mental illness are inherently unreliable at court.
- Once you've detained a patient who is AWOL from hospital, you can keep them in a police cell if the hospital to which they should be returned does not have a bed.
- A&E is NOT a place of safety.
- An AMHP cannot use force on a person who they've just 'sectioned' to move them into an ambulance.
- Paramedics cannot use force on a person that has been sectioned by an AMHP [who has properly delegated authority under s6.]
- An AMHP can order or instruct the police or ambulance service to detain and convey under s6 MHA, someone for whose admission to hospital has been applied.
- If we don't have a bed into which the admit someone who needs 'sectioning' then we don't have a bed and that's the end of it.

- Violent patients detained under s136 MHA should always be detained in the cells.
- A person who is detained under the MHA in hospital can't be arrested or prosecuted.
- You cannot get a s135(1) warrant for an MHA assessment if you already know you can get access to the premises.
- The police can neither apply for nor execute a s135(2) warrant on their own.
- You cannot arrest and remove a s37/41 hospital order patient from a secure unit after they have committed a serious offence.
- You can't stop psychiatric patients leaving a hospital ward and going AWOL if they want to.
- You cannot arrest an inpatient for an offence, unless the RC in charge gives permission.
- There is no point, legally, in prosecuting a s3 patient for violence on wards because they'll end up back in the same place getting the same care from the same professionals.

I might add to this list if more comes to mind – feel free to add your own, below! But this stuff is just **turgid buffoonery** – some stuff is just "wrong". Which other way do we need to describe "wrong"?! … and we all do it to each other.

27th May 2012

Monthly Update: The Use of Force –

The use of force by the police in relation to incidents involving mental disorder is the thing that has occupied my thoughts this month. Always controversial, often very necessary, but occasionally capable of question in terms of how the situation was brought about that it fell to the police to use force; or how situations escalated to such a degree that the police believed the use of a high level intervention was necessary.

We heard in early May that Humberside Police used a taser during an incident where dementia patient Peter Roberts was 'sectioned' under the Mental Health Act. My post on that incident generated a welcome debate on twitter. Shortly after this, I wrote about an incident on which I'd been asked to give a view in support of officers who were inclined to resist requests that they should be the first professionals to lay hands on an elderly dementia patient who was resisting admission to hospital under the Act – verbally and passively.

The fallout form the first incident should be causing us to ask questions about how routine the second type of incident actually is; and why do some NHS areas often have no coercive capacity other than the police? Important to re-state: I'm referring to **low level, passive and verbal resistance** – no-one is exepecting NHS staff to put themselves at risk of assault or serious harm, but unless such risks are likely, the police may well legally be obliged to consider resistence or refusal in some circumstances. More to be done here in partnerships.

Of course the use of force by mental health or social care professionals is controversial, not just because all use of force needs to be very carefully judged but also because when engaged in undertaking such functions, it is quite possible that the person using force, despite best efforts, planning and proper training, may find themselves assaulted during the resistance of the person being moved, detained or restrained. I'm aware that over two-thirds of assaults on NHS staff are against mental health professionals; I am aware that many mental health nurses will say they've only ever been assaulted by 'older adults'. This makes the discussion about our joint approach and training / deployment of properly trained NHS staff **more important**, not less.

My own view, is that Parliament legislated in that way that it did – to allow force to be used in realising the effects of the Mental Health Act – with a range of circumstances in mind. For example, it reserved certain powers under the Act to the police – execution of warrants under s135, detention of people in immediate need of care or control under s136. The obvious question to ask is why powers under s18 MHA (recovery of AWOL patients) were **not** reserved exclusively to the police; why the powers of detention under s6 **are** reserved to an AMHP, albeit it with the ability to delegate those powers. We should then ask what the practical implications are of AMHPs being unable to direct or instruct other professionals (like ambulance or police) to detain and convey under s6 on their behalf.

I can't get my head past this: Parliament's intentions, or the effect of their legislation, is that some MHA patients should *sometimes* be detained and conveyed using health and social care professionals **only**; other situations should involve the police being in the background of efforts in case things escalate suddenly; and the police should be the lead agency where the patient can fairly described as 'dangerous' or 'violent'. **NB** – 'dangerous' and 'violent' do not simply mean 'resistant' or 'verbally aggressive'. Perhaps those later epithets indicate where officers should be in the background, in support? We need to ask ourselves in a far more meaningful and sophisticated way, what the words "least restrictive" means.

For me, it means uniformed police officers are never the first thought when force should be used.

I repeat my model for indicating where the police should be involved in the execution of Mental Health Act related processes: **RAVE risks**. As far as I am aware, this is the first attempt to put together a framework to help professionals **on all sides** understand situations in which the police should be involved, because any suggestion of it causing stigma or the appearance of 'criminalisation' (whatever that means) can be explained against the risks to all of the police not being involved.

AUTISM AWARENESS AND THE USE OF FORCE

At the end of March, the High Court ruled in a civil action brought against the Metropolitan Police, involving a case where officers restrained an autistic teenager at a swimming pool. The case of ZH v Commissioner of Police for the Metropolis provoked an understandable outcry, not only because of the use of force being used, but obviously because the use of force was ruled unlawful in this instance, therefore representing an assault and a false imprisonment.

Again, it brings into focus the specific issue of Autism about which I will try to blog during June if time allows. I have heard many times that officers not only need "mental health awareness" but they also need particular awareness of sub-categories of mental disorder: learning disabilities, Alzheimer's / dementia; autism, personality disorder, etc.. They are more. Having attended many conferences, events and training sessions on these issues over the years, I offer this view: of course, officers need training that includes reference to and explanation of these sub-categories and their differences. However they only need specific awareness training of particular sub-categories where the training is able to outline why a necessarily different response to individuals is required. For me, the only example of this is Autism. And this may be because it is highly contested whether Autism should be viewed as a mental disorder at all.

Whatever we think the need for officers to reflect on their communications; de-escalation and the use of force and many other aspects, it is often the case that these things are generic across sub-categories of disorder. incidentally, I'd got further – whenever I hear charities talking about how to communicate well with service users where they are in crisis or at risk, I always think, "That's how we should communicate with everyone all of the time, anyway!" Avoid jargon, be clear, don't patronise, don't deny their emotions as it may escalate situations, etc.. However, in the particular case of police responses to members of the public on the Autistic spectrum, we need to be aware that things are different. This is perhaps why Autism is the only sub-category of mental disorder with its own legislation: the **Autism Act 2009**.

DE-ESCALATION TECHNIQUES

Contrary to popular belief, "de-escalation" techniques are very much a part of officer safety training: it's just that we don't call them that. Officers are only permitted by law, to use force after trying and failing to use "tactical communications" and "officer responses" to de-escalate, or having reach a conclusion that force is required immediately to ensure safety and prevent crime. In other words, if you can talk someone down, you have to or you have to try. You can only move to various levels of force once satisfied that it is "Proportionate, Legal, Appropriate and Necessary" to do so: you must PLAN, your use of force.

This will continue to be controversial and force will again be used because the administration of the Mental Health Act involves the coercion of fellow subjects; whether by NHS staff and / or the police. That's why we must continue to think and talk about how best to do it, very much with safety AND dignity in mind.

27th May 2012

Policing and Autism: part 1 –

Autism is the one sub-category of mental disorder which I believe warrants a *special* consideration in how the police service approaches its responses to individuals and to incidents. Argubaly, this is necessary in order to challenge the notion that it is a mental disorder at all. Debate about that is ongoing an depending upon whether you are talking medical, legally or socially, you may get different answers.

I argue that police officers need specific awareness of autism and Asperger's – not only in relation to potential recognition of such conditions, although that is difficult even from trained professionals – but also into de-escaltion, the use of force and implications for justice. This article is necessarily broad-brush and will followed up in future with some specific posts on certain issues, including by guest bloggers who have offered to help.

Firstly, those in our society on the autistic spectrum are the only service users to benefit from specific legislation – the **Autism Act 2009** which gives rise to specific statutory guidance. Secondly, autism and Asperger's can present in exceptionally low-profile ways, especially low profile to police officers. Only when exposure to social situations has brought about an adverse reaction can it become obvious that a police officer is dealing with someone who may need to be considered as mentally disordered or "on the spectrum". Thirdly, from time I have spent listening to speakers in training events and conference which have included professionals, academics and parents or carers, it is clear that achieving a diagnosis *at all* can be extremely difficult and that access to appropriate services can be even harder once a diagnosis is obtained. Fourthly, given debates about whether it is even valid to consider autism and Asperger's as a mental disorder, it occupies a position of ongoing ambiguity in terms of how it is classified and this links to all sorts of other debates about legalities and implications.

If you don't know very much about Autism and Asperger's Syndrome, then you should consider reading more about what they actually *are* on the National Autistic Society website. It is replete with information and resources and there is a specific guide for Criminal Justice professionals. It is also fair to say, that health and mental health professionals have been accused of being under-aware of the spectrum in their delivery of

mainstream mental health services and that they should be seeking to do more and know more about it.

Police officers would do well to bear in mind the following (all too brief) advice whenever they know or suspect they are interacting with someone with autism; but also, **do** look on the above websites for far more:

- **Communication must be clear** – avoid jargon, acronyms and metaphors; your speech may be taken very literally so bear this in mind.
- **Patience is a virtue** – rushing, issuing ultimata and orders can heighten tensions; force, as ever, is the last resort, only where absolutely needed.
- **Take account of familiarity / routine** – taking advice from or including people familiar with a person, their routine and their normality can reap huge benefits and avoid inadvertently escalating situations.

THE INVISIBLE DISABILITY

I once heard a parent speak of "The invisible disability" of her son's autism at an event where I was asked to speak about policing in relation to autism and mental illness. Her son's diagnosis had been achieved only after he was arrested by their local police and after they had contacted her following arrival at the police station (he was 16 at the time). Discussions in custody led to the young lad being 'diverted' without being charged and the subsequent health sign-posting led to his diagnosis. Interestingly, she made it clear that it was the police custody sergeant suggesting that he wondered whether autism was an issue, which lead to that being considered. **The custody sergeant's daughter was autistic.** The FME who had already examined him upon arrival at the station, had not raised such concerns. It lead to a second medical examination to achieve the required sign-posting and this led to diagnosis. The main thrust of her input, concerned a lack of services to support her family after battling to even get that far.

Other stories are not so positive: I remember a few years ago hearing of a case where an adult man with a diagnosis had presented his "**Autism Alert Card**" to a custody officer after arrest. He had been arrested after being followed by a police car and required to stop – the UK police have a legal authority to stop any driver without what the Americans would call, "probable cause". Quite simply, the young lad was driving a large, expensive vehicle which would cause the "are you really insured to drive that?" question. Because the young man knew he hadn't committed any kind of offence at the point where the blue lights went on – he hadn't, it

was a routine stop-check – he chose not to stop because he knew he'd done nothing wrong.

Of course, failing to stop for a police officer *is* an offence which meant the police started the relevant processes to get him to stop. By the time this was achieved there was sea of blue flashing lights and police officers which the man struggled to handle and comprehend – he was arrested for a minor public order offence and taken to custody. The police promptly ignored his "Autism Alert Card" which indicated who should be contacted for advice and so they failed to join the dots between the card itself and the legal requirement to ensure an appropriate adult who would have then supported him in custody and presumably given the police a lot of information. Autism is a mental disorder for the purposes of the Police and Criminal Evidence Act 1984 and the Mental Health Act 1983.

*This post is continued. >>> **Part 2**.*

27th May 2012

Policing and Autism: Part 2 –

<<< This is a continuation of another post – ***Part 1****.*

APPROPRIATE ADULTS

Of course, this links to broader issues about appropriate adults which I worry about. I think those who are autistic and find themselves arrested are particularly at risk with this next point: appropriate adults are required by PACE for anyone who is mentally disordered or appears to be mentally disordered. Individuals with Asperger's Syndrome and high-functioning autism may not necessarily 'appear' mentally disordered (whatever that means) and even where a diagnosis is made known, through alert cards or other information, an appropriate adult should be sought. It is not necessary to further question whether the person appears to 'need' an appropriate adult and this is a mistake often made by Doctors in police custody, both FMEs and those in MH assessment teams. Appropriate adults are provided for those under 17 and those who are or appear mentally disordered: this is whether or not they appear to be in 'need' of such support. I know plenty of street-wise 16yr olds who know the police custody procedures inside out and probably do not, strictly speaking, 'need' an appropriate adult but I cannot imagine a custody officer not ensuring one is called. We need this kind of attitude in relation to all those in police custody who are mentally disordered, especially where autism and Asperger's is involved.

Custody sergeants should remember when deciding about appropriate adults: we do not care what a doctor thinks about the utility or value of having or not having an appropriate adult. We care about whether the person is "mentally disordered within the meaning of s1(1) of the Mental Health Act." If they are: appropriate adult. Autism and Asperger's are within this scope.

This links to something I'll reserve for a later post: prosecution related decisions for autistic suspects. I have never known someone who is known to have or is suspected of having autism be 'sectioned' under the Mental Health Act after arrest for an offence. We know from other work I've blogged about before, that whether or not someone is 'sectionable' is often

a determining factor in deciding whether or not to prosecute and I've argue before that this is both legally and morally wrong. We need to be more sophisticated than that and autism is a point where it is even more important because of the potential of a prosecution decision's impact upon the person and their life. More on that in June.

ZH v METROPOLITAN POLICE COMMISSIONER

This case from March 2012 involved an incident where officers were called to a swimming pool to deal with an autistic teenager who had "fixated" at the water's edge. Against the advice of his carers from his school, the swimming pool manager called the police because of apparent breaches of the rules governing who could be 'poolside. The police subsequently proceeded to take hold of the young man to move him from the water's edge and he jumped in. After he eventually came to the side of the pool, he was pulled from it and then taken to and detained in a police vehicle until arrangements were made for his care to be taken over.

Action was taken against the Metropolitan Police for assault against the young man 'ZH' (touching him at the poolside without lawful authority) and for false imprisonment (detaining him in handcuffs in the police van without lawful authority) and on both points, the case was won – a violation of his Article 5 rights and a breach of disability discrimination law.

Reading **the case judgement**, is actually a very useful way to understand the arguments put forward by ZH's legal team as to why the whole situation should have been handled differently. In itself, it is a helpful insight into how to approach this kind of situation where there was no immediate risk and efforts not to tolerate supposed 'inappropriateness' of ZH fixating on the water unnecessarily and unlawful escalated the whole incident.

FINALLY

Notwithstanding my support for specific awareness training and awareness raising of which these blog posts aim to be part, it is probably worth a reminder about the limitations of awareness training from a frontline police officer:

Sometimes, the action taken by the police at an incident, is necessary irrespective of whether anyone involved – victim, witness or suspect – is living with any form of mental, psychological or developmental disorder. Whether or not officers can recognise a (broadly defined) mental disorder will vary from incident to incident and officer to officer. We should bear in mind however, sometimes psychiatrists with ten years post-

graduate training who have days in which to clerk and assess a patient can miss autism and Asperger's. We need to remember that policing, of necessity, is often emergency reaction to unknown factors and whether a police response is capable of being tailored will always be uncertain.

Last year I attended an event to speak where there was also an input on autism and Asperger's from a police Chief Superintendent whose son is on the autistic spectrum. Having covered a lot of information he wanted to leave the presentation on a 'high' and I am going to shamelessly steal his conclusion, hoping you recognise the power of this story. Watch this video to **learn about Jason McElwain**.

28th May 2012

What Do All The Sections Mean?! –

It has only just occured 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.

This run down is not perfect! – far from it. I'm happy to tweak if you think it would add value.

Michael./

30th May 2012

What do the police think of AMHPs? –

Here is a touchy one! – I was directly asked what the police think of AMHPs? The question struck me as a strange one as there are over 136,000 police officers and thousands of AMHPs – neither is an easily described group of people demonstrating personal or professional conformity!

However, the question got me thinking: I mulled over various things and decided only a blog will suffice as there are many strands to any attempt to answer! And of course, there's MY answer which because of my interest in this subject may look a bit different to the more general, distant impression of a frontline police officer who isn't especially interested in this area of work. It is undoubtedly impossible to answer the question directly, a synthesis of 136,000 views is unrealistic; even just my experience of different AMHPs is varied – as will be yours of police officers (if you are an AMHP). These joint experiences will probably probe the heights and depths of admiration and respect; frustration and obfuscation.

We do this stuff to each other where it doesn't work so well.

Firstly, I'm not sure that all police officers know what an AMHP is – there's no clue in the title. I know that some still think of the old 'Approved Social Worker' title and perhaps because of the clue 'Social Worker' that spoke for itself. There is certainly less clarity about what the new title actually represents. Usually, experiences are restricted to two types of situation: s136 MHA detentions and Mental Health Act assessments; either on private premises or in police custody after people have been arrested for offences.

What I thought would be useful to get close to an answer, is to list questions that have been posed in my direction following incidents. I think the questions where police officers come into contact with AMHPs represent a balance of uncertainty, ignorance, and frustration; enquiry, interest and expedience.

- Haven't AMHPs got all the powers of constable after 'sectioning' someone? – why don't they ever use them? This usually alludes to use of force debates.
- If an AMHP knows someone needs to be 'sectioned', but there's no bed available isn't their job to find one – I know the answer is no, but

it is often assumed the AMHP is in overall charge of the bed identification and overcoming the problem if there are any.
- If there's no bed available for a 'section' application to be made and we're running out of time to legally hold them; how can someone just be left in the cells?
- Why do several AMHPs tell me you can never do a mental health assessment on someone who's got *any* alcohol in their system at all, but some AMHPs are prepared to do it as long as someone is not obviously drunk and can engage?
- When they're sorting out MHA assessments, why don't we get a full picture of the risk history if the police are being asked to then manage that risk? We're sometimes sent in blind of half-prepared.

Two of my own from getting more involved in this work – because I've only ever ONCE seen the first point done; I've known the lack of answer to the second point be something that has caused police forces to take legal advice and start legal proceedings against NHS organisations where patients are otherwise left illegally in police cells:

- If someone's in custody for a criminal offence, why do the MHA assessment professionals not think about Part III MHA as an opportunity to balance care that's needed and public protection. It's only ever "Part II or nothing" and this sometimes misses a trick.
- Are AMHPs aware of, and what do they think of, s13 MHA, taken together with s140 MHA and the guidance published (after legal advice) by the former Mental Health Act Commission (now the Care Quality Commission) in their **Eighth** and **Ninth** Biennial Reports – paras 4.45 and 2.49 respectively? – what do we think this means? *<<< This is a genuine question, not a dig. It's ultimately untested in the courts, but I know what I think it means (for whatever that is worth).*

The final thing I'd say – those of you how 'know' me well will recall this is a recurring theme in my interaction with AMHPs:

- Most AMHPs I've met, don't properly understand s135(1) MHA and this misunderstanding can be a causes of significant operational friction.
- It is frequently misunderstood that an AMHPs delegation of detention and conveyance authority under s6 is not something that can be directed. It is dependent upon acceptance of that authority.

Penultimately, the Richard Jones Mental Health Act manual contains opinion and views that are at odds with various examples of legal advice to the police service from barristers who specialise in Mental Health law. I'll let you decide for yourself what you think that means and I hope this post is seen as an effort to engage a debate. Fire it back!

MY THOUGHTS

I'd like to say this: many AMHPs I've known and worked with a very impressive people, and those I now network with on social media are commanding professionals full of knowledge and experience. They have to balance far longer term implications in their decisions the most police officers and have a confidence about how to do so in circumstances where most of us would want to just err on the side of caution and keep someone detained or locked up.

I've known officers ask, "How can they not section him?!" whilst demonstrating a lack of insight into the role, the law and the complexity of turning someone's chaotic medical and social circumstances into a "YES / NO" decision about detention when operating on occasions with very limited information. And there's an over emphasis on these decisions where they were supposedly invaldiated by a later outcome. There seems little recognition of where these (often brave) decisions worked to the benefit of a vulnerable person and in no small way contribute to their longer term recovery and prosperity.

I would also add that I think AMHPs are often left in a position of some isolation within the broader health monolith that they operate. Why can't AMHPs who need to co-ordinate coercive activity call upon trained health professionals to help them coerce where this is low level and consistent with the dignity of managing vulnerable people? I've known AMHPs express regret when they ask for police assistance because they, like the officers concerned, know it's not necessarily the best way through the woods of delicate situations. But for the want of other options they have no choice but to ask.

I wondered what the reasons were behind changing the role from a social work monopoly to one that involves other (often very suitable) professionals. Now that we're seeing mental health social work being excluded from CMHTs, I am asking myself that question afresh because as I've become fascinated by this area, I think that the social work role in particular brings something precious to both community and inpatient care that would be (or will be!) sadly missed as we appear to re-medicalise our approach to mental illness.

31st May 2012

Social Media Holiday –

I'm off work on holiday from tomorrow, so I'm not going to blog again until at least mid June. I'm imposing a social media ban upon myself whilst I go to Cornwall and do 'Dad' things, read some books and see good friends with my wife and son.

Thanks to all for the support the blog has recently received, especially as May has been a **record month** of interest and use. The **Quick Guides** seem to be getting used if the blog hits are anything to go by and I've had emails to say they were effective in altering outcomes – that's what this blog is all about.

When I get back, I'm going to start thinking about bringing the blog to life with different types of resources as I try my hand at a podcast and some other stuff that could be used as training or briefing materials.

I hope you all have a great Jubilee Bank Holiday and a relaxing half-term. I want to leave you a short video to think about; something which caused me to really think. It is a five-minute speed-lecture, a rapid *tour de force*, by **Liz Kearton** entitled **"Madness, Reason and Unreason."** I put it up to get you really thinking – it should do so regardless of whether you end up nodding or shouting!

JUNE 2012

16th June 2012

Should We Have To Do This? –

The police are far from perfect in their handling of mental health issues: and even if we could skill up and widely train officers to the right standard, it would still be fair to question how we define the role we want the police to play. The distinction between 'health jobs' and 'crime jobs' is a false one: many are both, some are neither. How you decide to afford priority to either in making initial decisions is frequently complex and best done case by case.

This is why we see disagreement about police involvement and police decision-making. From issue to issue and from incident to incident, this debate can occur for a range of reasons:

- **their (comparative) lack of training and knowledge** – compared to mental health professionals and compared to other areas of policing, the amount of MH training is still small.
- **their inability to access NHS or other services** – knowledge of what 24/7 or emergency services are available is sometimes limited and to be fair to officers, consistency of mental health services varies enormously so there is no 'mental map' in an officer's head of what exists behind the emergency they are dealing with, to enable them to identify the correct pathway into healthcare or assessment of need.
- **we should also acknowledge that stigma or even fear of the unknown around mental health issues can play a part** – our officers are drawn from society and we know that some individuals and our society as a whole structurally and individually discriminate against individuals suffering from mental ill-health. We would be naive to think that all police officers approach incidents involving mental health matters with the correct attitude. That reinforces why training is required – on awareness and law as well as on the 'map' of local services which can response, assist and support.

I also from time to time come across the "we shouldn't have to do this" argument. It is this issue I want to discuss here in more detail. We know from this week's **Parliamentary debate on mental health** – the first major debate in years – that the nature and the appropriateness of the police role was being questioned by Nicky Morgan MP. The Loughborough MP, who should be congratulated for securing the debate in the House of

Commons, and ACPO lead on Mental Health & Disability, Chief Constable Simon Cole from Leicestershire Police, were interviewed on the **Radio Four Today programme** (approx 2hrs40mins) about the nature of mental health provision and the way in which the police become used. Many good points were very well made by both.

So against this backdrop, demand drifts to the police and the question can often arise "should the police be dealing with this?". There are two answers to this question.

HERE AND NOW

Imagine a scenario whereby a service user had stopped answering their door to their CPN and had stopped taking medication because of a genuine belief that they had recovered and no longer needed it. Let us further imagine that the follow-up of that patient's disengagement with mental health services was poor or non-existent and as a result of a deterioration in their condition the police needed to exercise their authority to remove the patient to a place of safety, we could have a debate about how or why it became necessary at all? Why didn't the CPN follow it up, etc., etc.?

You could add more scenarios to this list: hospitals who fail to stop patients leaving when it would be reasonable, possible and legal to do so … not all AWOL patients are preventable, but some are. You could ask about requests for the police to convey compliant or only very slightly resistant patients and wonder why community based assessment teams don't deploy sufficient staff, or appropriately trained staff, to manage levels of resistance that are entirely consistent with the responsibilities of mental health professionals without them being placed to risk.

I have three responses to these situations:

1. **A lot of policing is about officers intervening where a variety of other social controls or institutions have – for whatever reason – not worked.** Some parents do not take responsibility for their children and bringing them up in a way which prevents them shoplifting or abusing neighbours; sometimes lapses of security by the Prison Service mean there is an escaped prisoner that the police have to find; individuals go out on many evenings and fail to exercise the personal responsibility needed to prevent alcohol related crime and disorder. I can't help but wonder why any potential disgruntlement with mental health issues, may be different in nature?

2. **Right here, right now is potentially not the place for this conversation:** if a mental health patient has absconded from hospital, all the arguing in the world about why someone did not keep the door shut, or exercise a nurse's holding power under s5(4) MHA is doing nothing at all to find the patient. Let's get them found and safely returned, let's put that argument towards managers who control our partnership interface and let them sort it out.

3. **These frustrations tend to build in officers who cannot see police shortcomings:** we know that police responses to reports of assault by patients against NHS staff is inconsistent and sometimes way short of what is required; and we know that sometimes a correct police instinct to resist involvement in something is taken too far and sometimes NHS staff or patients end up being exposed to risks. Let's do the right thing and argue later if it remains an issue.

PARTNERSHIP WORKING

Whatever the rights and wrongs of the 'Here and Now' observations, the solutions are in proper partnership structures at all levels. Some areas of the UK do not have effective partnership structures and I know from my own experience that unless managers in health, social care and policing are meeting and discussing regularly the issues their staff face, then problems can gradually build. I'm at a loss to understand for example, why police and NHS services are changing so much about how they operate, without in some instances reviewing their joint operating policies for how stuff gets done against this changing background.

For example, we know from the Home Secretary's speech at the Police Federation conference that she is looking at the role of the police in supporting mental health process: frankly, to reduce the amount of police time it consumes. We know that Chief Constables are doing likewise following public statements by Sir Peter FAHY, the Chief Constable of Greater Manchester Police. Sir Peter described the police service as being 'overwhelmed' by mental health demand.

Frontline staff need to know that managers are in rooms trying to square these circles, including by improving their own understanding of laws, guidelines and procedures. Debating the role of the police with healthcare professionals who are not sighted upon, in some cases not aware of **Royal College of Psychiatry Standards on s136**, the content of the **Code of Practice** to the MHA or NICE guidelines on **Short-term management of disturbed behaviour** or on **Suicide and Self-Harm** inevitably means we're not being effective. I am aware that some Health and Wellbeing

Boards are not including the police in their membership and yet I will have a small wager they will be considering strategic health issues that have a direct bearing on police services.

That's why I firmly believe that frontline staff need to keep firing their operational reality into their managers; why managers at tactical, operational and strategic levels need structures to guide us through this changing landscape of public service reform and why if they don't, we will be discussing police restraint of dementia patients in ten years time. But for whatever period we're busy making things 'right', **let's keep everyone safe and do the right thing.**

17th June 2012

Armed Forces, Criminal Justice and Mental Health

Around this 30th anniversary of the Falklands War I have been thinking about veterans and their mental health. I'm not really sure where this post will go as I start writing it, because early internet browsing makes me already realise that we don't know as much about this subject as we need to.

I decided to write something as the final commerations of the Falklands War took place and because of nothing more than two statistics I've heard during the commerations of the South Atlantic conflict:

1. More veterans of the Falklands War have taken their lives by suicide since the conflict than were killed during it.
2. 10% of the prison population are former Armed Services' personnel.

And of course, that means both categories come to the attention of the police as we are almost always called to suicides and almost always involved in the investigation and prosecution of offenders. But I am caused to ask myself what specifically, if anything, the police do to identify ex-forces personnel as they come into contact with the police for minor offending and what could be possible to identify people who may benefit from support.

The irony of this, is that I know how strong the links are between the police and the Armed Forces: very, very strong. I have served alongside ex-forces personnel and I would go so far as to say that they have been amongst the most impressive and professional people I have worked with and from whom I learned an enormous amount. In particular I recall working with three ex-Military police officers (at the same time) and those men taught me the kind of police officer I wanted to be. A group of police officers I used to work with went to the Commando Training Centre in Lympstone for a charity weekend of fund-raising for Help For Heroes and raised a substantial amount to support injured personnel and veterans.

The charity Combat Stress state that they are currently supporting over 200 Falklands Veterans who more than 30 years after their service, are suffering from Post Traumatic Stress Disorder and that, on average, our ex-forces personnel wait 13 years before seeking help with their

struggles. In 2012, the Ministry of Defence is launching phase 2 of its mental health awareness campaign "Don't Bottle It Up", complete with publicity materials to encourage current personnel to come forward and seek needed support.

So what is this telling us? Well, firstly, we should remember that above I have just mentioned the Falklands Conflict because of the current anniversary. Obviously we have recently had men and women serving in Afghanistan, Iraq and Libya as well as elsewhere. The numbers killed and injured in our ongoing conflict in Afghanistan alone far exceed those in the Falklands and the combat is of a very different type. This can only be a significant generator of mental health related demand – some now; some in years to come.

The debate about policing and mental health in which I am mainly engaged often focusses upon the issue of recognition: how officers can identify all people who are potentially at risk because of mental health problems? Charities call for greater understanding of different sub-categories of mental disorder including dementia or autism, personality disorder or learning disabilities – all with an aim in mind that earlier identification can lead to earlier, more appropriate supports. The justice system also operates on similar principles for children although it may be far easier to spot a 14yr old than someone with a personality disorder.

Well, should it not be argued that the police should also be giving thought to our ability to identify and 'divert' Armed Forces personnel when they first come to police contact? Is it not the least we owe to those who have served our country that we think about how resettlement into civilian life with all its potential employment and adjustment problems, as well as some veterans' mental health problems? We never routinely ask in police custody whether someone is ex-Armed Forces. Why not?! – we ask so much else and a minority of the custody sergeants working in cells blocks will probably be ex-Armed Forces themselves and all of them will be supporters of our troops.

This has to be something we can do more on: if 10% of the prison population are veterans, what is the proportion going through the CJ system to non-custodial outcomes? We ask so much of our Armed Forces, this strikes me as an area of policing and public policy that needs more thought and whilst I'm not quite sure what I have just said is coherent: I would hope it has you thinking.

17th June 2012

Folie à Deux – Madness In The Fast Lane –

A very rare psychiatric disorder is at the heart of this story – folie à deux, sometimes known as 'shared psychotic disorder'.

I remember flicking on the TV one evening to find my colleagues from the Central Motorway Police Group in one of those 'fly on the wall' things. I often used to pay passing attention to CMPG shows as my old inspector moved there and I always wondered whether I'd ever see him on TV!

I'd heard a rumour about a job where a couple of twins were found wandering down the central reservation of the M6. After officers got them safely to the side of the carriageway and were trying to establish who they were and how they got there, etc., etc. they each ran into the carriageway and were wiped up by an HGV and a car driving at full speed. You can hear the officer immediately radioing for ambulance and senior officers for "two suspected double fatals". Why wouldn't you?! Can you think of a someone who fought an HGV moving at 60mph and survived? As if this story were not amazing enough – the women *did* survive and despite their injuries they then started FIGHTING THE POLICE.

Utterly staggering and all captured on camera … but the story then took another unbelievable twist that was not shown in the original programme and which became a BBC Documentary first aired in 2010.

Watch this (four-part) programme which totals about an hour – Professor Nigel EASTMAN is interviewed in the latter part of it and he explains how rare this is and how this condition can affect more than two people – folie à trois. It is an *utterly breath-taking* documentary and shows our emergency services at their very best:

- **Subsequent parts of the documentary:**
- Part 2
- Part 3
- Part 4

19th June 2012

Learning Disabilities and the Police –

I want to highlight a few issues around Learning Disabilities – not least because it is **Learning Disabilities Week 2012**. This is not only to provide information with links for the benefit of police officers who may need to know more – most of us do; but also briefly covering some issues for the benefit of service users and their families of policing issues such as disability hate crime.

I am especially interested in the subject of learning disabilities because I spent my summers and Easters at university working with school groups of teenagers with profound and multiple learning disabilities. I also have a cousin with Down's Syndrome.

BEER, SEX AND FOOTBALL

I have to start this blog with the story of the learning disabilities training for frontline police officers I attended a couple of years ago. A borough in my own force area had arranged a local LD organisation to provide training to all frontline police officers. Two service users attended with a support worker and took police officers on a journey of awareness raising through the medium of humour. After explaining a bit about themselves, these two lads took our officers on an inspiring and hilarious journey about LD in the context beer, sex and football! The guys had stories about their favourite pubs, their girlfriends and their frustrations with West Bromwich Albion all linked to their lives living with autism and Down's Syndrome, respectively.

In the room there were several officers who spent some of their Saturday afternoons going to the same pubs before the match and doing the same things. You could see the lights going on that these were just two normal guys who happened to have learning disabilities, but who also knew a lot about football. When the officers who supported rival teams started engaging in football banter you just knew this had worked and the officers actually stood up and applauded at the end – it was wonderful to see and I'd encourage police areas to link with local organisations who could do likewise!

WHAT DO POLICE OFFICERS NEED TO KNOW

Learning disabilities are life-long conditions which are caused for a variety of reasons, often genetic or developmental. LD is associated with the development of the brain before, during or shortly after birth. It should be distinguished from a 'learning difficulty' such as dyslexia which does not necessarily affect intellectual skills; and from neurological conditions like dyspraxia.

The spectrum of various learning disabilities is wide and can include conditions which would be genuinely difficult for police officers (and some medical professionals!) to 'spot' – high functioning autism or Asperger's syndrome, for example. Other learning disabilities, sometimes referred to as the "profound and multiple" learning disabilities (PMLD), can mean that individuals have several serious health conditions and these often have a deep impact upon their lives.

Police officers need to know that everyone with a learning disability is an individual and that despite any label which can be applied, their condition will mean something specific and unique to them. It does not, for example, immediately render them an unreliable victim or witness; it does **not** mean that they can not be relied upon to tell the truth: in fact, with some, the very opposite can be true!

Learning disabilities are legally classified as mental disorders, for the purposes of s1(1) of the Mental Health Act, but one significant difference about LD is that the MHA cannot be used to 'section' someone "unless that disability is associated with abnormally aggressive or seriously irresponsible conduct." Identification of someone with a learning disability automatically triggers entitlements to certain legal protections: vulnerable or intimidated provisions for victims and witnesses; or appropriate adults in police custody for suspects and those detained there under the Mental Health Act.

ACCESSING SERVICES AND SPECIALISTS

A practical difference police officers sometimes bump into can be timescales associated with processes that may be necessary after a police intervention. For example, if someone had been detained and removed to a 'place of safety' (s136 MHA), the AMHP is under a legal duty to attempt to access a "section 12" doctor who has experience in learning disabilities. In many areas, such doctors are not available 24/7 and therefore some assessments get delayed until a doctor is available the following morning. I have often wondered hypothetically about what would occur if a learning disabilities patient was detained under s136 on Good

Friday … the 72hrs under s136 would run out before the following Tuesday morning.

Identification of an inpatient 'bed' can also prove problematic if a police action has leads to a decision to admit someone to hospital under the MHA. Learning disabilities beds are far fewer in number than acute mental health 'beds' and in high demand therefore an ability to access them is correspondingly limited. I have known PoS services with average assessment and admission times of three or four hours take twelve or more hours to identify provision for an admission. However, the number of s136 detentions made by police officers which are found to involve learning disabilities is small.

Obviously, there are many organisations and individuals very well placed to go into more detail about conditions, rights and impact and I would encourage you to look at the Mencap website. In particular they have sections about learning disability, including a range of conditions, and about the Stand By Me campaign which aims to raise awareness about disability hate crime and improve police forces' response to it. Most – but not all! – forces have supported this campaign.

LEARNING DISABILITIES AND MENTAL HEALTH

The term "co-morbid" or "co-morbidity" relates to people who live not only with a learning disability, but also with a mental health problem. There is a higher proportion of people with LD living also with mental health problems than those without a learning disability – we should consider the potential for ineffective policing responses to crime and anti-social behaviour to contribute to this.

Again a practical point for officers at all levels: comorbidity can lead to interesting discussions about how services respond for example to cell blocks if it transpires that an arrested individual has co-morbid MH / LD – who leads on it, being chief amongst them. This can be worse if there are different NHS providers in your area for mental health services and for learning disabilities.

Officers need to be aware of the link between LD and MH because they are NOT the same thing: the Mental Health Foundation have an interesting webpage on the subject.

LEARNING DISABILITY HATE CRIME

It is not just in relation to learning disabilities, but disability more broadly, that the police service have found themselves in difficulty around protecting vulnerable victims. Fiona PILKINGTON is undoubtedly the most high profile recent case to demonstrate this and the details of collective organisational failures, as well as lessons learned and improvements, are well documented elsewhere.

The Stand By Me campaign is Mencap's awareness raising initiative on disability hate crime and I think it should be seen as reassuring that many parts of the justice system, including police and CPS, have disability hate crime champions to orchestrate. It also needs to be acknowledged that this area of policing demands ongoing attention to ensure we get it right. I know very well from my 'day job' in the police as an Investigation Team inspector, that the processes in place around hate crime of all kinds ensure extra scrutiny during initial reports and subsequent investigation – much of this as a result of lessons learned from the past. However, **we must not** fall into the traps of either assuming witness evidence can not be relied upon OR assuming that so-called 'low level' harrassment and anti-social behaviour can not having a devastating impact upon people's lives.

We should remember this >>> most people with a learning disability report that they have been *abused, harassed or been a victim* of crime **as a result of their disability**.

What is clear, is that the service as a whole and individual officers need to know more about Learning Disabilities and as ever, only spend time in

rooms with professionals, service users and their families will do this properly. **Please support Learning Disabilities Week 2012** by sharing this blog post to raise awareness.

I'm grateful to Mencap for permission to include their badge on this blog.

19th June 2012

Insanity –

Insanity is a legal concept not a medical one. In fact, forensic psychiatrists who deal all day with mentally disordered offenders rarely use the term. Often their use of it is with regard to their completion of psychiatric reports for the criminal courts. Otherwise, as one psychiatrist recently said, "I don't go to work and ask people how they're getting on with the insanity!" It just is not a medical concept.

We've known for decades that psychiatry and law are two massively high profile, important public disciplines and yet there is much to be said for the argument that they are incompatible. As I write in 2012, the law on insanity relates to a case which occured in 1843 Victorian England, *R v M'NAGHTEN*. If psychiatry were still operating to early Victorian standards we would still have county asylums and all the injustices and abuses that they often represented. Yet legally, we're still right there!

M'NAGHTEN RULES

Daniel M'Naghten shot Edward Drummond, the private secretary to Prime Minister and founder of the modern police service, Sir Robert Peel. Mr Drummond died of his injuries five days later and in 1843 there was no option of convicting for manslaughter on the grounds of dimished responsibility. Because the court found M'Naughten insane, he was acquitted of the offence and detained in Bethlem Hospital, London under existing mental health law. He was subsequently transferred to the "Broadmoor Asylum for the Criminally Insane", now Broadmoor Hospital. A House of Lords committee were asked to advise on a set of rules to govern findings of insanity and their report contained a quotation which has formed the basis of the Rules and which breaks down into four parts:s

"Every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong."

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

This remains the legal code for insanity in very many legal jurisidictions, including Norway, Australia Canada, Hong Kong, the Republic of Ireland and most of the United States. There are more. Nearly two hundred year old law and not substantially updated in light of undoubted developments in medicine and psychiatry – remember, what were thought mental disorders in the nineteenth century have been revealed to be a vast array of different neurological or psychological conditions and let us remember that asylums were also used for various categories of socially awkward individuals – for example in some cases, young single mothers. Of course, society now has a very different view about mental disorder now compared to 1843 so we should hope that the law keeps up!

The issue is actually more problematic in practice. One of the tensions between the NHS and the criminal justice system, is that mental illness is often cited by police or CPS as a reason not to prosecuted. I've written about prosecution elsewhere. But if the M'Naughten rules are still law, then "every man is presumed to be sane and responsible." So why do we get cases of police or CPS saying that because someone is mentally ill they can't be prosecuted "because we can't prove the *mens rea*" or "because he lacks capacity". Is *mens rea*

R v BURKE

The recent case of *R v MB* (2012) is interesting to consider: not because of insanity specifically – MB was found unfit to plead – but because the judgement examines the relationship between the two elements of an offence and is of relevance to how the law views the two. A quick reminder for those who may not have read earlier posts or would benefit from a reminder: all criminal offences involve an 'act done' – the *actus reus*; and the 'guilty mind' – the *mens rea*. For example, in an assault trial it would involve proving a punch thrown (the *actus reus*) and an intention to cause fear of unlawful violence (the *mens rea*). So for example, if a police officer punched someone (using reasonable force) in order to prevent a crime, the officer's force would not be 'unlawful' and therefore the *mens rea* element of assault is not complete and the officer would be not guilty of assault.

MB, who suffers from Asperger's syndrome, was arrested and prosecuted for voyeurism under the Sexual Offences Act after he lay on his back in a swimming pool changing area and was alleged to have looked under the dividing panels into the adjacent cubicle. A mother was changing her two youngs boys and the children were naked at the time. Having been found

unfit to plead, the court had considered whether he had committed the 'act done'. In other words, they had to consider the act of the offence and seperate it from the mental elements. If a court are satisfied of the 'act done' in the case of someone who is unfit to plead, they can still impose certain orders, for example a restricted hospital order under the Mental Health Act (s37/41). Because this was a sexual offence, they could also impose a requirement to comply with the 'Sex Offenders' register' and impose a Sexual Offences Prevention Order (for example, to ban someone from visiting communal swimming pool changing areas or to at least impose conditions or restrictions on those visits.)

To convict someone of voyeurism it must be proved that not only that they looked at someone in circumstances where that person had a reasonable expectation of privacy, but that they did so *for the purposes* of sexual gratification. So in the MB case, having been found unfit to plead, the judge directed the jury that they need only be satisfied that he lay on the floor and looked, he did not direct that the extra element of the offence was complete – the *part about "purposes of sexual gratification"*. The Court of Appeal ruled that to prove the act was done, it was necessary in this case to prove MB was seeking sexual gratication. As they were not directed to do so, the jury had not determined this, and therefore the finding that MB had 'committed the act' was overruled. Therefore, so were various orders imposed upon him.

THE LAW COMMISSION

Today I attended an event hosted by my local CPS which involved a presentation by Professor David Ormerod from the University of London on insanity and automatism. Prof Ormerod is a Law Commissioner and currently undertaking a scoping exercise on the law relating to these areas. Within a month his team at the Law Commission will publish a scoping document containing 75 questions, not all of which will be of interest or relevance to all, but they seek the views of anyone and everyone on the subjects raised. All of this, is with a view to making suggestions to the Ministry of Justice about whether the law on insanity (and automatism) needs to be reformed; and potentially how. I encourage you to look at the Law Commission's website and to contribute your experience where appropriate.

Incidentally, M'Naghten was arrested and charged; appeared and committed, tried and acquitted all within **two months** of the incident – it may be the Victorians were on to something after all?! And had these rules been in place, he'd have been found guilty.

27th June 2012

Conveyance of Patients –

I have just finished a discussion about the conveyance of patients who are detained under the Mental Health Act. This is a subject which has now reached the political level because the UK Home Secretary indicated in her speech to the Police Federation conference in May 2012 that she wanted to try to ensure that police officers spend less time "escorting mental health patients". I know that she is looking at how this can be achieved in conjunction with the Department of Health.

There are various situations in which the police convey patients – some of them are inevitable, some of them potentially avoidable:

1. **Following a police led detention under the Act –** s136 detention for example; or following the re-detention by the police of someone who is AWOL from hospital.
2. **Following an application for someone's admission under the MHA –** typically, the sort of situation in which an Approved Mental Health Professional and one or two doctors have 'sectioned' someone and seek police support for conveyance of that detained person.
3. **Following a request that a psychiatric inpatient be transferred –** typically, this may the need to transferred someone to another psychiatric unit or to A&E if an inpatient has urgent physical health problems.

Situation 1 is unavoidable – if the police detain someone and no other method of conveyance is available, then "you are where you are". The Mental Health Act Code of Practice states that conveyance of anyone detained under the Act should be done by non-police transport, wherever possible – so there is legal basis for asking the ambulance service to support you. This is not only because what you think may be a mental health problem could be something else besides; but also it is concerned with ensuring the dignity of people who have not been arrested for an offence. Their transportation should reflect this status as 'patient' rather than 'suspect'.

In fairness to police services, some Ambulance Trusts have strong views about conveyance of mental health patients, especially following police detention. One senior paramedic (not in my own force area's ambulance service) once curtly asked me, "Do you really think that's a good use of an

intensive care unit on wheels?!" I couldn't give two hoots whether it is or not, if I'm honest: it is a *legal requirement* from the Code and I'd happily achieve non-police conveyance another way if there was an established mechanism by which to do so. As there usually isn't, you'll be asked anyway. If the NHS then want to say no, that's up to them but I'll be mentioning it to the Coroner should the need arise and they can explore the NHS commissioning and conveyance arrangements if they need to. You can then explain Chapter 11 of the Code of Practice in the context of your decision.

Such legal situations would include: sections 135(1) (warrant to a place of safety), 136 (emergency removal to a place of safety), 18 (AWOL patients) and 138 (absconders from PoS detention). If you don't request an ambulance, you'll never get one so why not try? If you do try and fail – for whatever right or wrong reason – then it's on the audit trail that you tried and this is key: Dorset Police and either Kent or Sussex Police (*link to follow when found!*) have each had situations in the last couple of years where they removed someone by police vehicle after detention in the above legal situations and the person died *in transit*. I also have an example from my own force of a man who was detained by officers under s136 where it was perfectly reasonable of them to do so. Because they called an ambulance to the scene, paramedics were able to do standard physical observations checks which included a blood sugar test and as they did this the man collapsed and was rushed to A&E. Had he been taken to the police cells in a car, he probably would have collapsed in the holding area of the cell block and the A&E consultant who treated him suggested it was possible he may have died. It turned out that he was an undiagnosed diabetic and has no mental disorder at all.

Situation 2 could be better planned – this includes the "Mental Health Act Assessment on Private Premises" situation. I have a great deal of sympathy with AMHPs here. They are required to co-ordinate assessments and then the admission if it is required, but they often don't have access to the resources to make this happen. In some situations where ambulance and police are required to convey, they find a "catch-22" ongoing where the police won't even despatch an officer until the ambulance is there or *vice versa.* Presumably this occurs because neither agency wants to then be told that the other emergency service has been diverted to [*insert your preferred emergency here*] and be asked to crack on unsupported. Paramedics don't want resistant, escape risks in the back of their ambulance; the police don't want people with medical problems in their police cars. Happy times for AMHPs.

What happens where the conveyance is required not just because of a need to move someone, but a need to move someone who is presenting risks to safety – either their own or that of others? Although unclear about why the police would be called to convey someone who is compliant, I can

understand why an AMHP may want the police because of what I've previously called RAVE risks. But what precisely is the role? Where does the potential for harm turn a situation where the police are in the background, in support of an AMHP, to one where they take the lead in the physical coercion of someone who is presenting actual violence and danger? I've posted elsewhere about debates that go on about the coercion of patients – should it always be a role for the police or should mental health services have trained staff available? Obviously this question links directly into the subsequently necessary question of conveyance and who will do it.

However, this again often comes back to commissioning. In many areas, as well as designing services in a way which means control or restraint trained staff are not available there are often no planned arrangements for achieving conveyance of patients after MHA detention – it is a question of asking and hoping for a 999 ambulance to be available. You can easily see why AMHPs with actual patients in the real world turn to the police for help. In some areas they have arranged the non-999 vehicles to undertake this task, with a 'bookable' system. In other areas, few in number, there are contractual arrangements with a private organisation who can be requested by the AMHP for conveyance, including staff with some capacity to manage resistant patients.

Situation 3 is arguably not a police responsibility – except where urgent risks need to be mitigated. The Code of Practice clearly states that it is the responsibility of Primary Care Trusts to ensure they have properly commissioned arrangements for conveyance of patients. This is an area of business where some police forces have just issued a fairly blunt directive: we do not convey patients between psychiatric units, ever. Such direction is not just about demand on resources which could be prioritized elsewhere. It is also about questioning whether the police are the correct people to make urgent transfers of detained patients. What kind of medical or paramedical supervision is needed? In whose legal custody is the person if they are being moved by the police and / or ambulance service and / or doctors and / or nurses? Who is in charge of this where medical risks have blended into safety risks?! What do we do with disagreements about transfer?!! It goes on …

SEDATED PATIENTS

One point to make very clear, is that there have been incidents where police officers and paramedics are asked to transfer detained MHA patients who have been sedated – para 11.5 of the MHA CoP states, *"Patients who have been sedated before being conveyed should always be accompanied by a health professional who is knowledgeable in the care of such patients, is able to identify and respond to any physical distress which may occur and*

has access to the necessary emergency equipment to do so." Paramedics I have spoken to do not usually regard themselves as 'suitable' professionals. There are issues around what drugs they are licensed to administer and the issue of not wanting to supervise patients where the dosage of medication was administered by someone else where it involves estimates about patients and travelling time.

Ambulance services often refuse to convey sedated patients where the trust who seek support for conveyance are not supplying a doctor or suitable nurse. **It is perfectly proper to suggest that the police should do likewise for even more reasons.**

Some requests for transfer arise from the fact that a patient's condition warrants a different type of mental health unit. For example, a patient initially admitted to a Psychiatric Intensive Care Unit may need to be moved to medium secure care. A patient on an acute admissions ward, may need to be secluded but the hospital or clinic in which they are detained may not have a seclusion facility or it may not be available. There is a legitimate difficulty in gauging where police responsibilities lie and I'm going to make a specific post out of the considerations that may apply to the 'rapid transfer' of a patient to another psychiatric unit where mental health professionals are seeking police support in a hurry because of unmanageable risks. For now, I just keep coming back to a question I've asked inpatient nursing or medical staff when faced with these requests: "before we get police officers and paramedics to improvise their way through this, what contingency arrangements do you have access to through your managers?" Too often the answer is: "None." Actually and quite frankly: I've never known the answer be anything other than "None."

And can I end by just saying this – *conveyancing* is what you do when you buy and sell a house; **conveyance** is about the movement of people or stuff! ;-)

JULY 2012

2nd July 2012

True Story 5 –

I loved the area where I worked as a PC – Winson Green in Birmingham. For a young police officer, it was a brilliant grounding in the demands and complexities of police work and it involved more than the average dose of mental health incidents.

Early one Sunday evening, my mate and I were driving around in our car having had a fairly quiet afternoon. We were called to an address near to the old Victorian mental health hospital to a guy who had regularly been detained there under the Mental Health Act. The lad in his early 20s lived with his parents and had become unwell after stopping his medication. His parents had contacted mental health services and the Crisis Team attended and sectioned him: all without police involvement.

As soon as he was told that he was going to be sectioned, he ran into the kitchen and grabbed a large knife, threatening everyone present. The AMHP and the doctors immediately left the premises for their own safety, trying to pull his mother out of the address as they left. She refused to go and her son promptly barricaded himself into his bedroom. He piled furniture behind the doors and was doing who-knows-what in there with that knife.

We arrived, the first car there. As our sergeant was having a day off so the neighbouring area's sergeant came over to us and demanded two more double crewed cars. It was obvious that negotiation may well be futile and time was of the essence. I was despatched back to the station to get the public order van and public order kit for four of us. The sergeant quickly put his instructions out that we were to get the 'riot' gear on and take long protective shields – we were being sent in to restrain, detain and convey this guy to hospital. Getting police public order kit on with all the pads and gloves, helmet and shield is not as quick as you'd hope but all the while the sergeant and the lad's mother had been trying to keep him engaged and talking. They faced a barrage of abuse and threats, he said he was going to kill whoever came in the room first.

When we took ourselves and our shields upstairs, I know I was thinking of the training we do on this kind of thing in annual public order training. As "Level 2" public order officers, we rehearse each year how you deal with such incidents: how you enter the room, how you link and move with shields, how you keep yourself safe given that you're being required to face

a man armed with a knife, acutely mentally ill who is threatening to kill people. This was the first time in my career – alas, not the last – when I was being required to put this training into practice. So the four of us got ready. The sergeant was telling him what was going to have to happen if he didn't put down the knife and come out of the room, he was taking care of all the comms and legalities around trying less restrictive things so that if we did have to act, we were doing so because all else had been tried and failed. None of it worked – time to earn our pay.

We moved into position and tried forcing the door open. There was a considerable amount of furniture behind it and he obviously heard us preparing to enter, so two of us pushing against the door made no difference. We were stood at the top of the stairs, two of us side by side and the two other in public order gear were behind us. The sergeant was half-way down the stairs watching. He tapped the wall to the left of the door a couple of times and said, "Why don't we take the wall down?!" His mother confirmed that she just wanted it safely resolved and didn't care about walls or damage.

So with her permission, one of the rear pair took 'the key' (a large red door enforcer) to the wall and made easy work of the plasterboard. The two guys behind us were then able to start pushing furniture through the hole they'd made and we put pressure on the door again. This time it worked – we were able to push the shields against a wardrobe and chest of drawers, push them out of the way and get in.

This young man was looking about as startled as I felt and I could clearly see he had this large kitchen knife in his right had, raised at us. He started shouting ,"Fuck off, get out!" and then "I'm gonna fucking stab you!" in a threatening voice as he moved towards us. We were shouting too, "Put the knife down, put the knife down!" and were able to pick up some momentum once we had navigated the furniture. The front two of us moved at him quickly and jointly struck him with a forward movement of our shields.

When we practice this in public order training, we're working against a trainer who is padded, booted and protected and really intent on fighting – it's hard work. Doing it for real for the first time made me realise the trainers are correct: when you use these tactics on a target wearing jogging trousers, trainers and a t-shirt, the impact is significant. Having been struck by two public order shields – knife still in hand, abuse still coming – he was propelled back against the wall of the bedroom and we followed up with shields, pinning him to the wall. His arms we splayed to the sides although his right hand retained hold of the knife. One of the two officers behind us took care of the knife. They then took control of his hands in wrist locks and between us he was slowly manoeuvred into position where he was handcuffed to the rear, stood up. Once the knife had been taken

from him, he didn't actually resist that much so there was no need to restrain him on the floor or anything similar.

He was quite obviously distressed and again, training kicked in: with the physicality over and a high level force no longer needed or justifiable, we could try to talk to him, to reassure him. Helmets came off and we looked a bit more like human beings trying to look keep him safe. I'm not sure how successful it was, but it was clear that he'd have seen a change in our manner once the knife was out of the equation and he'd begun to stop resisting. The AMHP was still around, but the doctors had left. The sergeant had called an ambulance to the scene somewhere whilst we were busy and the young lad was checked over before being moved to the psychiatric unit where the AMHP had applied for his admission.

Was this level of force needed and justifiable? Absolutely. This was in 1999 – it was only two years previous to the incident, that PC Nina Mackay of the Metropolitan Police had been fatally stabbed entering a building to arrest a mentally ill man for breaching bail conditions. Of course in subsequent years, PC Jon HENRY from Bedforshire Police and DC Michael SWINDELLS from my own force would each die from stab wounds by mental health patients. We knew that this man had taken a knife; we knew he'd made threats to harm; we knew that nothing short of this level of force would suffice without putting ourselves at grave risk. The sergeant had spent a lot of time explaining this to the lad's mother. Ultimately, once she knew he was uninjured bar a few red marks where the shields struck him, she was satisfied that we'd done our best and kept him and ourselves safe, ultimately.

There is no overarching point to this story: it is just an example of a job I was once involved in; for it's own sake after feedback that more 'real-life' jobs would be welcome on the blog.

2nd July 2012

Whose Decision Is It To Divert? –

I read a news article this week about another independent review into the treatment and care received by a mental health patient who went on to commit a serious offence. The review argued that there were three major opportunities for mental health services to intervene which 'may' have prevented the killing.

(Incidentally, another way of saying the same thing, is that there were three opportunities to intervene which 'may not necessarily' have prevented the killing, or may have just delayed it and / or displaced the identity of the victim. In any event, that is not what this post is about.)

This is about examining – from a police perspective – the considerations that should, could or would have been in play when police officers, prosecutors and mental health professionals were managing the earlier offending behaviour. Inherently, they were managing it unaware of what would happen in the future. This was one part of what the report apparently argues represented a potential intervention point. **Diversion**.

The police and the criminal justice system have a role to play in the management of offenders with mental health problems, even where they are 'sectionable'. Let us remember something I have now written countless times on this blog: **some parts of the Mental Health Act 1983 can *only* be accessed through the criminal justice system**. So it follows that some people with mental health problems should be prosecuted – usually where offences are more serious or risks to the public are significant.

It can be inferred from the reporting of this case (the full report does not yet appear published online) that he was arrested for assaults and assessed under the Mental Health Act. Following assessment concluding that he required admission to hospital because he was "suffering from a mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment" the decision was reached to take no further action (at that time) for the assaults.

Why not take action? <<< I ask this question not because I think it is obvious that action could or should have been taken – it may have perfectly proper not to do so and I am certainly not armed with the full facts. I ask the question in order to prompt a more generic consideration in all our minds about the types of situation in which the police may say, "Well,

regardless of your intention or preference to admit under Part II of the Act, we're going to seek criminal prosecution and let the courts manage it, if need be via Part III of the Act because we believe there is a public interest in so doing."

NB: A reminder for those unfamiliar with the details of the MHA –

- **Part II** is concerned with direction admission to hospital of patients where they may have committed no offence at all; or if they had, it was minor and able to be set aside in the context of their mental health problem without risk to the public.

- **Part III** is a serious of provisions specifically reserved for patients concerned in criminal proceedings and they include remand for assessment provisions, as well as treatment and restriction provisions for those who require them. Most international jurisdictions have mental health law distinctions of this kind.

This is a difficult business: no-one wants to criminalise and stigmatise a vulnerable person at all and certainly not unnecessarily; but we do wish to make sure that those who have been shown to cause harm to the community in random attacks are managed as well as they can be, in proportion to the risk they pose, to prevent further or more serious attacks. Often this means diversion from the police station; but occasionally it can take appearances at court and / or full psychiatric assessment under Part III of the Act and pre-trial hearings to establish whether diversion from court is appropriate or whether someone should stand trial.

What I do not know in this case, is the extent of any other offending background known to the police or risk background known to mental health services. In a sense it does not matter. The case of R v Rosso (2003) was not about a prosecution or diversion dilemma, but it did involve an appeal against the imposition of a s37/41 hospital order for an offender who had been convicted of an assault involving a knife. The assault, more through luck than anything else, was not a serious as it may have been. But again, it involved a patient who was reluctant to engage with mental health services and continued to pose a risk. He was prosecuted for an offence of assault against police officers who were assisting an AMHP to 'section' him – in fact, the AMHP had 'sectioned' him when the assault took place – and he was nonetheless prosecuted for assault and stood trial. Having been convicted of the offence, he was sentenced to a s37/41 order, despite no previous convictions for violence. The Court of Appeal upheld this conviction and sentence when he challenged the legality of the officers forcing entry to a hotel room to detain him.

The report makes clear that on previous occasions where 'Mr Z' had been detained under the Mental Health Act, it was following two assaults on the same day on two women involving the use of a weapon. Elsewhere in his care, there was indifference to medication regimes and stated threats to harm. So it may reasonably be inferred, prior to the attack Lucy Yates, that Mr Z may have posed "a significant risk of harm to the public" as laid down by s41 of the Mental Health Act 1983. It is also obvious from the fact that he was 'sectioned' that two psychiatrists and an AMHP thought he suffered from a mental disorder "is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment." So I am interest in what consideration if any, was given to prosecuting him for the attacks on those two women, with a view to seeking or asking the court's consideration of imposing a restricted hospital order under s37/41. Such orders need not follow only the most serious offences, but can follow from more minor matters where it is obvious that serious risks are presented.

Unnecessarily criminalisation leads to the reinforcement of stigma against those with mental health problems and even discussing the response to people with mental health problems who have (allegedly) offended is something which has previously led to suggestions that this blog reinforces a false relationship between mental health and violence. Of course, whether the relationship is false is something still debated.

Meanwhile back the in custody office, the custody sergeant has got a man in custody, arrested for assaults on two women with a weapon. There is information about non-compliance, threats and risk. The person has been assessed as being in need of admission to hospital and the AMHP coordinating the assessment seems both willing and able to arrange for admission. Are you going to 'let' the mental health professionals take the person under s2 or s3 MHA, or might you wonder about a prosecution in the public interest?

In fact, is it even your decision to take if medical professionals are saying admission is needed?! Well actually – **yes it is**. The position of custody sergeant is key to diversion, even though the responsibility for charging suspects sits with the Crown Prosecution Service, it is a custody officer's decision as to whether 'allow' admission under Part II by taking no further action for the criminal offence where it is suggested as necessary following MHA assessment in police custody. Should they prefer to see consideration of charges being brought, they can refer the matter to the CPS. Should they choose to 'divert' they can exercise a decision to release the person from police custody under the Act, but also subject to police bail.

This all provides a good framework in which to balance all risks and vulnerabilities: **if only we used them!**

OTHER MEDIA AND LINKS

- BBC News
- Daily Mail
- Report into the Treatment and Care of Mr Z.

4th July 2012

Sectioning the Elderly –

Alan Bailey from Greater Manchester suffered from Alzheimer's and was sectioned under the Mental Health Act in March 2011. He fell whilst in hospital in April 2011 and subsequently died – a true tragedy for him and for his family.

The manner of his being 'sectioned' under the Mental Health Act has featured in the Inquest into his death, which recorded a verdict of accidental death following his unconnected fall. The Coroner has criticised a decision by a police officer to handcuff him whilst being moved to the ambulance that would convey him to hospital. The officer claimed that he was attempting to undo the straps on the paramedic chair that was being used and that he had become resistant and agitated. The force subsequently offered evidence that the risks of handcuffing (and presumably the implications for dignity) were weighted against the alternatives, which broadly would have consisted of manually handling him.

This all re-visits the debate about the use of force on vulnerable people after the Coroner is quoted as saying, "This is totally ridiculous officer" and saying that the handcuffing decision "beggars belief".

I've posted about this in the last few months and won't repeat all of that again. Suffice to say, that I repeat my point about mental health professionals often stating that elderly adults are capable of inflicting serious injuries when they lash out or resist being compulsorily detained under the Act whilst suffering organic mental disorders like Alzheimer's. I know of older adult professionals who will say they have lifelong visible injuries and the officer's job was to prevent such things.

I will restate the bigger questions this further example raises – but they are generic observations, not specific to Mr Bailey's case:

> **Patients who are resistant, aggressive, violent or pose risks of escape** (RAVE risks):

- If it is decided that alternatives to compulsory admission cannot be achieved and / or are less safe than pursuing (coercive) admission; if attempts to achieve admission without use of force have been tried

and have failed, who should be deployed to use force to reinforce that legal decision to 'section'?

Some thoughts:

- Is it *always* a police role and if so, is police training fit for such purposes?
- If it should *not* always be a police role, who in the NHS is going to do it and when is the line crossed where it is argued it has become a police role?
- Regardless of who does it, how does one move an octogenarian from "here" to "there" when they are perceived as posing a 'RAVE risk'?
- If the answer to the previous question should not include the word "handcuffs" or "proactive blanketting", how does one move someone who does not want to be moved?
- Are the alternatives to handcuffing safer? – these would include things like doing nothing at all, using manual handling to control arms, or legs?
- What are the potential medical implications on the elderly of being manually restrained by a police officer?
- Are NHS personal safety techniques for restraint more appropriate?
- If so – why don't the NHS deploy such staff to MHA assessments in support of AMHP?
- Some areas **never** do this and refuse to consider it, because they argue that force in the community is a police responsibility.
- They argue this, despite the fact that **no such thing** is written down in UK law.
- Do we expect police officers to keep filling gaps in NHS services, using their training as it is outlined to them by the Home Office and then to face criticism for doing so in courts?

I fully understand, frankly I support, the concern of Mr Bailey's daughter, Sandra Coombes. She said, "I was particularly upset to hear the manner in which a frail, elderly man was handcuffed and held by straps to restrain him in an ambulance to hospital … not only the excessive use of force, but to send a policeman to accompany him was unbelievable."

There we have it, and from the families of vulnerable patients – they would prefer the police not to be involved in the detention and admission of vulnerable people like Mr Bailey.

So how are we going to do it?! – especially against a backdrop of knowing that such escorting of patients is being looked at politically?

UPDATE >>> Since the original publication of the Manchester Evening News article, this has been picked up by the Daily Mail, also. Sir Peter Fahy

has replied to the criticism of HM Coroner for Stockport, saying "This is a medical issue and not a police issue. Medical staff receive extensive training to deal with patients in this sort of situation and to recognise warning signs. There is no way we can replicate this level of training. Basically I do not want to have police officers trying to restrain elderly people in medical situations. We are presently negotiating a new protocol with the NHS on police being called to deal with mental health issues."

I will be going to Greater Manchester Police on Monday to talk to them and their NHS colleagues about exactly this issue.

7th July 2012

Biology, Psychology and Sociology –

During a discussion this week about police responses to particular types of individuals who come to police attention a question was put about acute anti-social personality disorder. It revolved around a man who had been in contact with the police on at least one occasion in every year since 1999 and situations typically revolved around hostage situations, barricading himself in his flat and severe slashing and self-harm. The police were spending and inordinate amount of time responding to these situations, one of which had involved a female police officer being held by this man for a few hours against her will. More often however, the situation did not involve him committing offences, but did involve what any police officer or lay person would call mental health problems. Hence most police responses involved attempts to access medical services, often through the use of s136 of the Mental Health Act and removal to a place of safety.

The story had a frustrating end for the police officers however. Although occasionally the man was sectioned under s2, he was often released within a few days or a week. Acute anti-social personality disorder. So he has got a mental disorder? He has a mental disorder he's engaging in severely destructive behaviours, occasionally involving risk to other people and sometimes involving him using weapons to hurt himself? So why can't he be kept in hospital and treated?!! Especially – why can't he be kept in hospital for treatment when there is now a litany of evidence that if not detained, he will continue to engage in further behaviour that bring him back to police attention in sub-criminal, barely criminal or obviously criminal circumstances?

As I got interested in this area, I kept hearing people talking about 'the medical model' of mental illness. I also kept hearing people talk about the psychological model and the psycho-social model of mental illness. I'll be frank: this confused the life out of me. Illness is illness isn't it? … and that means doctors and nurses, right?!

Well – it turns out that it's not. I learned of various 'approaches' to mental health and I would be grateful for any feedback on what I'm about to write, without ripping me to shreds for the simplicity of this explanation for the benefit of police officers! – to describe me as 'out of my depth' here, is somewhat of an under-statement! If you want to read more by someone

who knows what they are on about, I recommend Stuart Sorenson's blog on the subject of 'models' of mental illness.

THE MEDICAL MODEL

The approach to mental ill-health, as illness or disease. A considerable amount of time and effort over the last 175 years has been spent attempting to uncover what have been assumed to be underlying causes of 'brain disease'. History has seen psychiatrists from Emile Kräpelin onwards working to understand causation in mental illness and to classify it into discrete disease entities, identifiable through symptom clusters. The medical model, with psychiatry as a specialist sub-discipline of the broader medical profession, sought to use the two traditional approaches of medicine to cure disease entities: pharmacy and surgery. The use of drugs to treat mental illness really took off in the 1950s with the discovery of the anti-psychotic chlorpromazine and pharmaceutical developments continue to the present day. More infamously, a more 'surgical' approach mental illness – psychosurgery – included leuchotomies (or lobotomies) as well as Electro-Convulsive Therapy. ECT is still in use today, although the law now means in cannot be forced upon people.

Psychiatry became controversial for some during the 20th century because of its history and its more infamous techniques. It also became associated in some regimes to state supression. Some of that history is reflected in current practices: for example, psychiatrists in Germany need the legal system to independently authorise and oversee its practice of compulsory admission following various problems involving psychiatrists during World War Two.

Of course modern professional psychiatry is inter-disciplinary in nature and legal frameworks around compulsory admission or treatment focus ever more on personal autonomy, consent and the right of appeal against state enforce treatment in the context of universal human rights.

THE PSYCHOLOGICAL MODEL

Of course, psychological approaches to mental health issues have become more widely known about in recent years. Clinical Psychologists (and forensic psychologists) are more frequently found in multi-disciplinary teams now than they were even thirty years ago but medical recommendations to 'section' can still only be taken by psychiatrists. The law is still drafted with the medical model in mind, although AMHPs take the civil liberties decision to detain.

Looking at mental illness from a psychological point of view, or attempting to address mental health problems using psychological techniques (often via 'talking' therapies such as Cognitive Behavioural Therapy) is often claimed as successful with conditions like personality disorders and Post Traumatic Stress Disorder. It's about examining how to relieve symptoms of mental ill-health by addressing how people think about their experiences in order to contextualise them or find coping mechanisms for historic events or for the onset of anxieties, depression and crisis. Good books to read on this include "Doctoring the Mind" and "Madness Explained" by Richard BENTALL.

THE SOCIOLOGICAL MODEL

Looking and mental illness from a sociological point of view, entails looking at social structures and the pressures they bring to bear on societies and social groups as well as upon individuals and their particular circumstances. Necessarily, this involves poverty and debt; family life and education; and employment and equality. Far too simply: is it reasonable to predict that someone who suffers a difficult childhood, poor education and struggles into adulthood with little or no employment prospects in a life maintained amidst poverty, drug and alcohol abuse may suffer from mental 'health' problems; is it it possible to look at an individual struggling to cope in any kind of abusive relationship without wondering about whether their consequential symptomatology would be relieved if that abuser were removed from the equation one way or another? Of course it is. A good book on this, is Allan HORWITZ's "Creating Mental Illness".

A NATURAL VENN DIAGRAM

Of course, in reality, suffering mental illness is a balance of all of these things: notwithstanding ongoing debates about causation we know from research that genetics and biology do have an impact upon propensities in mental disorder. The extent of their influence may be debated, but no-one doubts that influence is there. Can we remove the relevance of social structures and circumstances as well as individual psychology from experiences of mental illness? Again, no.

I am going to stop there before my attempts to explain further embarrass me and people who know me! – so where does this leave us with the acute anti-social personality guy at the start?!

There are three ways in which society can respond to individuals like this, regardless of their diagnosis or specific condition:

- coercively – and detain under Mental Health Law for compulsory assessment or treatment
- coercively – by prosecution under criminal law with a view to disincentivise or incarcerate
- non-coercively – and by seeking to 'engage' individuals in relevant recovery / treatment programmes

Of course, the law allows a 'blend' of these approaches: after prosecution, it is possible for Magistrates to impose a 'Mental Health Treatment Requirement' as part of a community sentence, although this is not often done. It obliges individuals to engage with health services amidst a threat of sanctions if they do not. There are other versions of how these things can blend.

You will notice that mental health law kicks in when risks are posed: not when health is at risk. *<<< This is the heart of it all, for me.*

It was only recently when the Mental Health Act 2007 was enacted to amend the 1983 Act that the definition of mental disorder and 'treatability' requirement for personality disorder was expanded. When I first joined the police, it was almost always the case that upon discovery of personality disorder, mental health professionals would decline to admit someone to hospital or bring their detention to an end, even where they posed a risk to others. In particular, such individuals were often thought more suitable for criminal prosecution where offences had been alleged. That's where it can start to get fractious: he's suffering from mental disorder (PD) and posing a risk to himself or others, but can't be detained?! OK, but when we tell the CPS he's got a mental disorder, prosecution considerations start to turn to 'diversion' (whatever that means).

So the police service have two broad options when faced with repeat callers like this who often absorb a phenomenal amount of resource:

- Where there is no criminal offence: keep referring the matter incident by incident to the NHS and where repeat callers and becoming high consumption callers;
- Where there is a criminal offence, consider using it as tactic to achieve a 'blended' approach through the justice system: assuming of course that 'diversion' has been tried and failed.

A whole book was once written to an individual who, on a much more serious scale, represented this dilemma for health and justice professionals: Garry David, from Melbourne, Australia. Deidre GRIEG's book "Mad or Bad" is a brilliant exposition of how the State of Victoria wrestled with the debate about how to manage a high-demand individual who posed a significant risk to the public, who had a diagnosis of mental

disorder, but who it was repeatedly argued could not be detained under normal mental health law. Eventually, the State enacted the Community Protection Act 1991 – a law specifically designed for Garry David and no-one else. An extraordinary case which brings this whole debate in to a sharp focus.

11th July 2012

The Restricted Hospital Order –

I've written before about how the prosecution of suspects who have mental health problems can be in the public interest – usually for more serious offences but also where indicators of serious future risk are obvious. To say such a thing is not to argue for the unnecessary criminalisation of vulnerable people, but to observe that the legal system which exists around offenders with mental health problems is one that is effectively owned and controlled by the criminal justice system. You may have a view that this is not correct – I'm merely writing in the context of this being the law as it stands.

The law was not particularly written with informal 'diversion' in mind – whatever that means – although obviously nothing prevents an argument that many situations involving vulnerable people offending are so straight-forwardly obvious as to render prosecution unnecessary or plainly ridiculous. Where prosecution has occurred, it does not necessarily mean that those instigating it are arguing for conviction or imprisonment: merely for the relevant arguments and issues to be considered by independent people – judges / juries. Within the justice system there are a range of mechanisms by which to properly assess how society should then manage the complex challenge of 'offender-patients' which are thrown towards mental health professionals and the criminal justice system.

These include:

- Informal approaches to 'diversion' before charge
- 'Unfitness' considerations about whether defendants who are charged are fit to plead or fit to stand trial – where such arguments are successful concerning 'fitness' a court can consider whether the defendant 'did the Act' without the associated 'mental element' (or *mens rea*)
- The insanity defence, where's defendants argue that they can not be held responsible for their offences because of a 'disease of the mind'.

In each of the latter two cases, it is available to a court to impose a hospital order under s37 MHA upon any defendant who is found 'unfit' or 'insane'. Even if a court has found a defendant 'fully' guilty, criminal courts can still choose a hospital order as a sentence after guilt, if the criteria are satisfied. It is necessary for the imposition of a hospital order that two

doctors give evidence that the defendant is suffering from a mental disorder of a nature or degree that it appropriate for them to be detained in hospital.

The Hospital Order can therefore be a sentence upon conviction OR a diversion, depending upon 'fitness', a successful defence of insanity; OR a finding or plea of guilt. Prior to making a full hospital order under s37, a court may choose to impose an 'interim hospital order' under s38. This allows detention of a person, intially for twelve weeks, but renewable for four week periods up to a maximum of twelve months, to determine whether a 'full' hospital order is apporpriate. All clear so far?! – good! :-)

THE RESTRICTED HOSPITAL ORDER

If, whilst imposing a hospital order, a court are satisfied that "it is protection of the public from serious harm" to 'restrict' the hospital order, they can impose restrictions under s41 MHA. Specifically, only the Crown Court may impose

NB: the restrictions imposed are NOT upon the patient: they are upon the Clinician in charge of the patient's care. They are prevented from doing certain things without the authority of the Secretary of State for Justice who discharges these responsibilities through the Ministry of Justice's Mental Health Unit:

1. Authorising the patient to have leave from hospital
2. Authorising the patient to be transferred to another psychiatric hospital or step-down facility
3. Authorising the patient's discharge from hospital to community based care or from the MHA.

In order for these things to occur, the psychiatrist in charge of the patient's care must secure MoJ permission – very often it is given after proper risk assessment at suitable point in the patient's recovery; but sometimes it is denied.

Therefore, a restricted hospital order is a serious legal tool used sparingly: it detains 'without limit of time' someone who has committed a serious act or who poses a serious risk and whose ongoing detention is required for their treatment and for public protection. Such orders are often in place for several years but this point is crucial: re-offending rates after release from hospital are superb compared to re-offending rates from the criminal justice system generally. Roughly 6% of patients re-offend after discharge from s37/41 care compared to around half of prison releases. They are extremely effective in longer-term recovery or 'rehabilitation' terms.

Legal note: *a Crown Court may make a restriction order; but a Magistrates Court may not. Magistrates have a power under s43 to 'commit' a case to the Crown Court if it appears that a restriction order is appropriate.*

PUBLIC PROTECTION AND OFFENDER MANAGEMENT

When a patient subject to a restricted hospital order is released from care, it is *never* just a case of releasing them to try to rebuild their lives after what may have been years of detention. Firstly, patients are often first transferred through different kinds of facility, including 'step-down' facilities such as semi-supervised hostels, or similar; before being considered suitable for discharge. Even then, s37/41 patients are always subject to 'conditional restricted release' under s42 MHA. This means that the patient moves formally into a community care system and a (forensic) community mental health team will support them after release. However, until authorisation is given for full discharge from the MHA the patient can be recalled at anytime to hospital where grounds for concern exist. The MoJ may issue a warrant for recall under s42 which authorises the police to remove a patient back to a specified hospital where the individual regains their original status as a s37/41 Restricted Hospital Order patient.

Furthermore: anyone who is sentenced or diverted to a restricted hospital order for a certain set of offences – all serious sexual and violent offences are included in the list – will become subject to Multi-Agency Public Protection Arrangements – or MAPPA. These multi-agency procedures ensure that in addition to psychiatric services caring for the person as a patient in the community, there is relevant information sharing to the police and probation services and other relevant agencies to assist in monitoring risk. A joint strategy is then developed to ensure appropriate supervision from the range of relevant agencies – the police call this: "offender management".

PRISON TRANSFERS

A similar legal framework to the restricted hospital order exists for prisoners from the prison system. Where a prisoner develops mental health problems or is found to have mental health problems of a nature or degree that makes it appropriate for them to be detained in hospital for medical treatment, the Ministry of Justice can authorise the person to be transferred into the mental health system. For convicted prisoners this occurs under s47 MHA, whilst unconvicted prisoners who have been remanded in custody by the court pending trial or other prisoners (like immigration detainees)

can be transferred under s48. If the MoJ is satisfied that it is necessary to impose 's41 restrictions' upon the prisoner, they may do so under s49.

From the time a prisoner transferred under s47 or s48 arrives in the mental health system, they are treated 'as if' they had been sentenced to a hospital order under s37 – with the restrictions, if appropriate. Should they have recovered sufficiently before the end of their original prison sentence they can be remitted back to prison under s50 MHA. If they remain in hospital at the point where their prison release dates arrives, the person moves from the legal status of a transferred prisoner to become purely a patient and remains detained in hospital until the clinician in charge of their care authorises release or discharge.

I hope that gives all too quick an overview of some complex legislation, including how / whether / why mental health orders from the criminal justice system impact upon public safety? It also shows why prosecution of just some offenders is sometimes necessary in the public interest. Of course the trick, as always, is for this to be understood and considered by those taking decisions on the 'frontline' of all agencies – because can appear to be something close to rocket science or brain surgery for most of us!

15th July 2012

Section 136 and CRB Checks –

***** THIS POST IS NOW OUT OF DATE *****

Update 10/08/2015 *>>> This blog was written prior to legal changes introduced in September 2012 and prior to new statutory guidelines in August 2015. A summary of the relevant 2012 changes can be read here and a BLOG on the 2015 guidelines here.*

The post remains here, unchanged, merely for historical curiosity and in case of interest in how the system developed.

I have been asked about Criminal Records Bureau checks and police detentions under section 136 of the Mental Health Act several times on twitter so I have decided a blog is the only way to reasonably explain my answers because the 140 character limit demands welcome brevity on a lot of occasions but also prevents a complex argument being able to be made clearly.

BACKGROUND ON CRB CHECKS

Firstly, I am no expert on CRB checks so I'd encourage you to read more for yourself. I can outline that the bureau itself is an agency of the Home Office and exists "to help employers make safer recruitment decisions." There is a helpful factsheet about "eligible positions" published by the Home Office which shows the types of job which come under the statutory purview of CRB checks.

There are two types of check: basic and enhanced. A basic CRB check is for disclosure of convictions and cautions only and even then, it is subject to the Rehabilitation of Offenders Act 1974. After a relevant period, most convictions become considered 'spent' and would not be disclosed. The period of time until they are 'spent' varies by offence type and obviously, there more serious the crime and the more serious any sentence given, the longer the period until 'spent'.

The only convictions which never become spent are those which attracted life in prison, those which lead to a sentence of imprisonment greater than two and a half years and those involving preventative detention – this

means a *criminal* sentence of preventative detention and does not include MHA detention. A sentence to a hospital order (under s37 MHA) is 'spent' 2 years after discharge from it, or 5 years after sentence to it. Again, we should remember that a hospital order is imposed only after being prosecuted in the criminal courts.

Enhanced checks are undertaken for those working with children or vulnerable adults in a regulated activity, also for appointments connected to security and the law. I have had two CRB checks in my lifetime, one when I joined the police service and one when I started coaching rugby at my son's rugby club because of my access to the boys in that group. Both were enhanced checks. Enhanced checks offer the opportunity to disclose additional, relevant information known to the police or other authorities which may have bearing on an employment decision and this is not restricted to convictions / cautions. This could include details of mental health detention, if considered that it might be relevant. It could also include information about arrests for offences which did not lead to prosecution.

There is one other authority to mention by way of background which is of relevance to a broader background about CRB checks and employment suitability: the Independent Safeguarding Authority. The ISA maintain a list of those who are barred from working with children and vulnerable adults and refer information or evidence about relevant individuals to the police or other authorities if it believes that such a person is attempting to seek such work.

SECTION 136 CRB CHECKS

Alastair Campbell touched on this subject in a guest blog by Eileen O'Hara whilst campaigning for greater awareness of mental health issues. The blog is well worth a read as background to the potential impact upon a service user of a mental health related disclosure, setting out the impact of enhanced CRB check.

- Does disclosure of s136 or MH detention have the potential to massively discriminate unfairly? – **absolutely.**
- Should previous detention under s136 always be disclosed? – **absolutely not.**
- Should previous detention in hospital under the MHA always be disclosed? – **absolutely not.**
- Does disclosure have the potential to destroy access to one of the most important rehabilitative opportunities? – **absolutely.**

So given that a s136 Mental Health Act detention is NOT a conviction or caution, is it ever necessary to disclose it. Unfortunately, yes it is, in my opinion.

I've written about section 136 MHA on this blog more than upon any other subject within my area of interest. This authority for police officers to detain can be used in a range of situations and it is these contexts that are key to understanding any potential decision to disclose it on an enhanced check.

- Some s136 detentions involve no criminal offence whatsoever being committed by the individual – it is used purely in relation to someone at risk and in need of care and assessment in their own interests. <<< These detentions would need extremely careful consideration for disclosure. Obviously, that still covers a broad range of situations and of course, the relevance of any s136 situation would diminish over time.
- Some s136 detentions involve the commission of lower level, minor criminal offences which are set aside by the officer at the point of deciding what they should arrest for. <<< These detentions would need careful consideration too, especially where the assessment received took that person into a pathway of care and support.
- Some s136 detentions involve the commission of more serious offences, but because of circumstances or a desire on the part of the officer to prioritise a recognised mental health issue, the s136 route is chosen for assessment of need before decisions about the criminal offence.

Each of these links to the broader debate about criminalising people and to whether we should look at things as 'black / white', or 'health / crime'. I've consistently argued on this blog that this area can be clear-cut, but that we should view many situations as a shade of grey. Somewhere in there, each of us will have our view as to where a line should be drawn. It is precisely because of that I would welcome clearer guidelines about mental health related disclosure in enhanced CRB checks.

WHEN MIGHT IT BE NECESSARY TO DISCLOSE?

In some situations of s136 Mental Health Act being used, it is clear that the circumstances amount to an obvious risk to other people. The definition of s136 itself talks about "care or control, in that person's own interests or for the protection of others." In the debate on twitter, I suggested a few circumstances where disclosure may be needed:

1 – Someone was arrested for an offence but diverted which involved weapons or sexual offending

2 – The circumstances amounted to neglect of vulnerable people, ie children or the elderly.

It should also be borne in mind that police officers disclosure other medical information and other non-conviction based information during enhanced checks. Specifically, someone's fitness to drive may be affected by certain medical conditions and where concerns exist, for example following the policing of traffic collision, officers often inform the DVLA of information found during investigations. Furthermore, in the case of R (on the Application of X) v Chief Constable of the West Midlands Police (Court of Appeal, 2004), Lord Woolf made it clear that a Chief Constable was under a duty to disclose information "if it might be relevant." Note the emphasis on *might*, rather than *is*. Of course, anything might be relevant to anything else, but decisions taken to disclose have to be consistent with other legislation, including disability discrimination and Human Rights legislation.

Only the employer can fully understand the relevance of a disclosure to their advertised vacancy and to any decision to employ and obviously there is a clear potential for prejudice. The Supreme Court case R (on the Application of L) v Commissioner of Police for the Metropolis (Supreme Court, 2009) upheld the view given in the 2004 case whilst showing that Human Rights legislation is engaged when making decisions to disclose.

Therefore, by law, it is the duty of the police to disclose in a balanced way that which *might* be relevant and it is the duty of the employer to decide the relevance of that disclosure. I know that I say this a lot, but it remains true in this debate >>> we may or may not agree with this as being the correct way to deal with things, but it is the law as it stands today. It is therefore **not** the case that the police hold power over employment decisions: these still ultimately rest with employers and we are therefore in the territory of talking about our whole society's discrimination against people who have suffered mental ill health.

DISCLOSURE POLICIES

I would like to see all forces examine their approach to s136 disclosure and perhaps even see a broader review on all Mental Health Act disclosure. The Alastair Campbell blog by Eileen O'Hara focusses upon disclosure of her time in a psychiatric unit receiving treatment for bipolar disorder, rather than upon a s136 detention. She goes on to point out that the disclosure did not affect this employment opportunity because the employer decided it was of no relevance. (It is worthy of note that she was seeking employment with a mental health charity, more alive to the issues implied by this debate.)

20th July 2012

The Criminalisation Contingency –

This is a post about an aspect of mental health provision that has long puzzled me and various other police officers: direct patient access to specialist mental health services like medium secure units, based purely on clinical need.

There have been a range of incidents in my own experience, some have featured in media or legal cases, where problems have emerged in rapidly accessing secure care – the case of MS v UK (occurred 2004, ECHR ruling 2012) shows this best, in my view. These may be considered 'hard cases' and I'm very familiar with the adages and metaphors which arise from drawing general conclusions from rare, difficult events … I'm also aware that if such arguments were advanced in relation to a police or NHS inability to respond appropriately to rare physical health problems such issues wouldn't stand up one bit. Anyway …

Once upon a time a man who was detained by the police under s136 of the Mental Health Act was removed to police cells as a Place of Safety (PoS) for a want of any other options. He was extremely unwell: floridly psychotic, delusional and / or hallucinating and so disturbed that he was clearly frightened of the officers who were attempting to reassure him and feared they were attempting to poison him by offering a drink. He preferred to drink from the toilet.

The MHA assessment which took place occurred within a short-period, but it concluded that the patient needed specialist services. Even if we set aside the debate which ensued between the psychiatric intensive care unit (PICU) and the medium secure unit (MSU), there was still a significant delay in accessing the MSU to which the man was eventually admitted. This was not isolated: I can recall a murder investigation in which a suspect was deemed in need of medium secure care by the initial MHA assessment professionals and subsequently by forensic psychiatrists who did a specialist assessment. I can recall a man who was arrested for attempting to murder a police officer who was taken to Accident & Emergency initially because of injuries inflicted to his arms by police officers repeatedly batoning them, to prevent themselves from being stabbed.

In each of these three cases – I have got more – the clinical assessment reached a conclusion that the intensity of care required and the safety

implications of detaining a particular patient for compulsory admission all indicated access to a medium secure unit was appropriate. Once admissions decisions are made, there are various legal duties which fallout of that: not least to ensure subsequent handling of vulnerable people in such a way as to ensure their European Convention rights. Usually this is around articles 2 (right to life), 3 (inhuman degrading treatment), 5 (deprivation of liberty), 8 (family / private life). There are others.

But here is the rub: it is often argued to police officers – and it was in these cases – that MSUs do not directly admit patients 'from the street'; or from a police station after arrest under s136 MHA or a criminal offence. For some, the whole raison d'être of MSUs and of forensic psychiatry and is to deal with patients who are in the criminal justice system and most usually, this means having been charged with a criminal offence and manages via the courts. Patients are then legally managed under Part III of the Mental Health Act 1983 (the sections from 35-55) which contain provisions for remands and assessments; hospital orders and restricted orders for public safety and transfers to and from prison.

But why not patients who have been picked up by the police but are not yet charged? … we are still talking about patient-offenders in contact with the criminal justice system.

In each of the examples mentioned above, the police were repeatedly asked to charge the 'offender' with a criminal offence first, to have him placed before the Magistrates Court – they were all men – before they are admitted. The problem was that the evidence for a criminal prosecution simply did not (yet) exist in two of those three cases. In the third example, it could have been argued that a charge was possible but this would have involved prosecuting a vulnerable suspect without affording them any opportunity to say anything to the investigating officers about their involvement in the incident and this.

In the murder example, the suspect-patient had been found standing in a house in which there was a dead body. There was no direct evidence that he had killed the person, no known forensic evidence (although that was immediately preserved in order to be fast-tracked) and no ability to interview the suspect to get more evidence because the mental health problems requiring admission, they were unfit for interview by the police. Furthermore, another man was arrested in the premises and it was unknown whether one of them, both of them or neither of them had been involved in the woman's death. So for reasons, unconnected to awkwardness on the part of the police and prosecution, there was no ability to prosecute because the evidence was not yet sufficient.

In the s136 case the man was subsequently suspected to have assaulted his aunt quite seriously and prosecution was called for. Unfortunately for

those who wanted it, his aunt steadfastly refused to make any complaint against her nephew and would not stand in court to say what had happened. With no other independent evidence at all – the assault took place in a private dwelling – there was a clear legal barrier to prosecution. If you don't want the person who has assaulted you to be prosecuted, that will most often be listened to and reflected in the legal decisions taken by the police or CPS.

So why do we appear to have designed a service which often applies a condition of access which requires criminalisation of people who may not yet be able to be prosecuted for legal reasons. Clinical need is clinical need, surely?

What are the ethics and issues in linking access to clinical care to, arguably, unrelated matters such as criminal justice status? Occasionally, arrangements which deny or significantly delay access to care have been regarded as a breach of law so we do need to look at this issue.

A naively simplistic question: why are we not making access to care contingent merely upon clinical criteria?

UPDATE on 27/07/2012 *– since publication of this post I have been given feedback from various mental health professionals, including AMHPs, two parts of which I would wish to add here.*

1) Several have said, it is inappropriate to admit someone to an MSU from a s136 detention, that the person should go via PICU or acute admissions ward. <<< Fine. My point was never about where patients should go, that is for others to decide, not the police. My point was, that wherever they need to go, it should be able to be realised in timescales which avoid breaches of the Human Rights Act.

2) Others have said, that as an AMHP, they are ***prevented*** *from making applications to PICUs or to MSUs, but restricted to acute admissions wards. Again, this is not an issue for the police, except where the location to which the AMHP is restricted refuses to accept a patient because of their risk history of current presentation.*

It seems to me that if MS v UK is saying anything, it is this: clinical care criteria should lead to available pathways and delays in realising this are what lead to adverse judgements.

21st July 2012

Illness and Insanity –

It is really important that we distinguish between illness and insanity, because whilst they may overlap, they can often be uncorrelated and they are distinct concepts from two different worlds – I deliberately don't restrict this observation to mental illness, either.

Illness and / or mental illness are *medical* or *psycho-social* concepts; insanity is a *legal* or *socio-legal* one. Actually, neither of them are perfect or completely clearly defined.

Physical illnesses (like neurological disorders), organic conditions (like Alzheimer's or dementia) and injuries (to the brain) can lead to cognitive problems which could have bearing on potential criminal liabilities for acts done whilst ill / injured.

Let me give my punch-lines in blunt form, first of all:

- The fact that someone is / has been mentally ill or otherwise cognitively affected by an illness does not *automatically* mean that they are insane.
- The defence of insanity requires a 'disease' of the mind, but the defence of automatism can also cover other behaviours which may have arisen from injury.
- People who offend whilst ill, do not always offend *because* they are ill – **each case on its merits**.
- Even where offences are partly or wholly attributable to an illness, it does not mean someone is *always* 'insane' or can raise a defence of automatism – **each case on its merits**.

I have previously written about 'insanity' and commented that it is a legal concept, not a medical one. Forensic psychiatrists often use the term 'insanity' only in the context of writing reports for court processes, to inform the legal process. They rarely use them term otherwise, and certainly do not discharge their duties as mental health professionals according to it. **Insanity is a legal concept, not a medical one**, and it is not an ideal one, at that.

I will let you read more on insanity in that original post to save repetition but here want to focus again upon debunking the myth that a crime committed by someone suffering from mental disorder should be bifurcated

into crude categories which define our social response. I also want to argue for greater joint education in this arena for professionals on all sides.

I have previously written about prosecution generally and about prosecution decisions specifically being determined by one important variable: **whether or not someone who is arrested for an offence is 'sectionable' under the Mental Health Act**. If you are, you start to be thought about in terms of 'diversion' (whatever that means) and if not, you don't. This is too blunt – we need to be far more sophisticated. You are agreeing with me about this if you agree with both of the following statements:

- If someone has a (history of) mental illness, it is not always necessary or appropriate to formally prosecute them for an offence, nor does it always have utility.
- If someone is suffering from a mental disorder of a nature or degree that does require admission, it may still be necessary and desirable to prosecute them in the public interest to allow Part III of the Mental Health Act to take its majestic course.

It was never the intention of Parliament for this 'sectionable' variable to become the determining factor of how to proceed. The now legendary Home Office circular 66/90 which still encapsulates Government policy on the approach to the prosecution of mentally disordered offenders does talk about reaching a distinction between those who should be prosecuted in the public interest and those who could or should be 'diverted', whatever that means. It does not just give any simplistic criteria for determining 'diversion' but suggests a careful weighing of relevant issues, case by case.

In my own view, if we are to conceptualize how to categorise mentally disorder offenders – something which I think is extremely prone to generating very poor outcomes indeed – then we should be thinking of way more than half a dozen categories, combining the seriousness of the offence, the nature and degree of someone's mental disorder, the availability and desirability of treatment options where they live. It is such a silly idea that I can't get going with it.

Making decisions about how to move forwards from crime committed by someone who is suffering from mental disorder is amongst the most complex work that criminal justice or mental health professionals will ever undertake. This is not my view: it is that of Professor Jill PEAY in her book Mental Health and Crime (2010) which I commend to you all. As such, the trick surely is to understand what we are trying to achieve, the context in which we are trying to achieve it and the available options by which to do so? This will then lead the decision-makers to narrow their field of options to suit individual circumstances – and we need to learn how to do this *jointly*. This means sharing information, establishing structures by which

to do so and **allowing health decisions to be influenced** by police / prosecutors **and vice versa**.

We need to have police officers and prosecutors who properly understand Part III of the Mental Health Act 1983 – the remand provisions of ss35/36 are still massively underused and misunderstood; but we also need healthcare commissioners and practitioners and who understand the criminal justice system and the inherently artificial entry conditions to services that we find criminalising, excluding and stigmatizing their client group, exposing them to risks.

26th July 2012

Stress –

I am hearing a lot of discussion at the moment about stress in the police. With regard to policing, we know that various things are contributing to potential pressures upon officers: a pay freeze along with the rest of the public sector, a review into pay and conditions, recently increased pension contributions, the extra workload that comes with policing a certain sports festival in London and the amplification of the impact of all of that, by recently having to back-fill gaps in private sector security provision along with our colleagues in the Armed Forces. We also know that policing is facing reform and that some officers have very strong views on it. I make no remark about the politics of all that, except to say they amount to **stressors**, for some.

I must be clear here: I am not referring to that sensation most of us have from time to time, of feeling that we could just do with a good break from it all. I am referring to stress and anxiety becoming clinical issues that begin to affect people's health and then their lives. We know that stress and mental health problems have overtaken physical healthcare issues as a reason for time off work and within just my own sphere of knowledge, I am aware of officers also currently coping with bereavement, financial difficulties because of frozen pay, divorce, parenting difficulties and combinations of all of the above. Whilst those issues are not exclusive to policing, add those to police officers' professionals demands to alter the time you have to start and finish work and / or the location in which you must work, we can see how things build up.

A distinguishing feature of policing (and Armed Service) that stands out for me from all other professions is that of **compellability**. Police officers and armed forces' personnel can be *compelled by law* to undertake duty – in other areas of the UK, including extended duty; AND at short or no notice in circumstances where employees cannot. This clearly has the potential to impact upon people negatively.

I remember when I did my MSc in Criminology some years ago, an academic was interested in the concept of 'private policing' – in other words, policing-type services, provided for money by private sector organisations. He was attempting to suggest that it was little different to 'public' policing and was making various political points about economics and purchase-power. His lecture involved him 'board-blasting' some

important words about what constituted the essence of policing in an attempt to show that private policing was no different to the public variety. He got students to shout out many of these words and when he reached the point where he was asking if there were any final additions I said, "Compellability". I had to go on to explain that my boss can order me not to go home and can cancel my rest days at zero notice and can order me to the other end of the UK, should the need arise and the personal or financial implications of this are for me to manage. He had no idea of this, bless him.

I would like to argue that it is this feature of service – the compellability – combined with normal life on earth, that has the potential to contribute to the development of stress and anxiety related disorders because sometimes, something has got to give. For some, it will be their health, even if they are actively trying to look after it.

I am recently aware of an officer who was *ordered* to take two days off because of their manager's concerns. In fairness, they hadn't had a day off in over a month. As I am one of my force's 'Bronze' public order commanders, I had to work in that capacity on (another) of my rest days last weekend: a force operation which was nothing to do with my 'day job'. When I rang my boss on Friday morning to explain I'd been asked to deploy to this and would be working long days for the foreseeable future, he actually took the time to check whether I wanted Monday off to balance the impact – nice touch.

Some officers deployed to London at the moment are there for several weeks and I know that many of those officers have got young families at home and they are married to full-time serving police officers who are also facing alterations and challenges to their duties. Quite frankly, if it were not for my son's grandparents and his aunt and uncle; as well as the parents of some of his friends who know the bind we're in over the summer without an ability to take leave – I haven't got the faintest idea how my wife and I would make it to September without committing child neglect OR neglect of duty. Because of our support structure, we're planning furiously week by week, but we know we'll be OK. I can see very easily how everything I've written about above, can compound for some into more serious problems, leading to mental health problems.

The question is then: what support is there for officers facing such difficulties. I have written before about police support to those who deal with critical incidents or suffer life altering injuries in the course of their duty – for example, PC David RATHBAND. There is mixed feedback from officers about the support they received whilst suffering from Post Traumatic Stress Disorder but this can include police rehabilitation centres like Flint House, in Goring-on-Thames. There are others.

I know, even outside of these extraordinary times, of officers who were 'sectioned' under the Mental Health Act, because of clinical conditions that necessitated assessment or treatment in hospital. We know the police officers have higher than average suicide rates and higher than average PTSD diagnosis rates. The support for stress, depression or anxiety disorders that have built up, accumulating over time is more difficult to define: obviously NHS systems exist for everyone and GPs manage about 83% of all the people who suffer from mental health problems. Many GPs are excellent and officers would do well to remember that their GP can provide support, advice and signposting to appropriate services for these kinds of conditions – all confidential to the officer. Also, most forces occupational health departments have the ability to support or signpost officers and these can be considered also.

Forces but also individual line managers in policing, must ensure they are aware of their officers' mental health this summer. I know we've got an Olympics to police; and that we are where we are with pay and conditions and with police reform etc., but actually a conversation or phone call from a boss can go a long way to mitigating impacts upon some. My boss's first response was not about me having to work three very long days at short notice on a force job – it was one about my welfare and not the Monday morning meeting for my day job that my very capable sergeants can cover. Not feeling like a number matters to most cops, so actually we need to make sure we're all supporting each other in these extraordinary times.

Along with thousands of others, I'll be deployed away from home this summer – the first time in my life I've spent this amount of time away from my son. Although he loves having a cop for a Dad, he's not too chuffed about it. So please spare a thought for the officers and armed forces doing this *and more* as they rise to the challenge of facilitating this major international event – and if you are a police officer, look out for your mates as some of them are working under pressures we can't see.

29th July 2012

Conditional Discharge under s42 MHA –

In 2005 I was given the job of writing a 'force policy' on mental health. The first time we'd ever had an internal policy document on mental health issues. Whist researching it, amongst other things, I opened up various communications channels to get feedback about what officers wanted to find in it: which operational quandaries needed answers? I got hundreds of emails and as the policy grew, I tried to ensure that everything we'd been asked to cover had been covered. Some nine months after starting write it, it was formally approved by the Chief Constable for publication and I could not have been happier with the feedback I'd be given from the authorising policy committee. Then I got an email from a grumpy officer …

"Sir, knowing that your new mental health policy had been published, I tried to find the answer to a question and was disappointed to find that it wasn't covered!" It was about section 42 and 'conditional discharge' under the Mental Health Act … I had to be honest, I'd never heard of it! No-one had raised it during our consultation or suggested it needed covering and I had no personal experience of it at all! I had to quickly add a half page to the policy on AWOL patients and then at least it was covered should anyone else need it in the future. Typically, no-one has asked me a question about this ever since, either: not until I was asked twice in the last week. So here it is! –

- If someone has been made subject to a restricted hospital order (otherwise known as 37/41 order), they will eventually be considered for release in to the community, often after many years of detention.
- Where release is considered, it is rarely the case that the patient is just "absolutely discharged" and subject to no further legal restrictions at all;
- More usually, patients are "conditionally discharged" under s42 of the Mental Health and the 'conditions' imposed will vary from patient to patient:
- They may include conditions upon residence, clinical supervision of various types; and could include others like drug testing or prohibitions of various kinds.

After such release, should there be cause for concern about a patient's wellbeing, the Secretary of State for Justice can issue a warrant under s42(3) to recall the patient to hospital, whereby they are then again a

s37/41 restricted hospital order patient. The patient can be recalled to the hospital in which they were previously detained, or to another hospital which should be specified on the warrant being issued by the MoJ.

WHO DETAINS / CONVEYS THE PATIENT?

By virtue of s42(4), a patient who has been recalled by warrant, is to be treated for the purposes of s18 MHA as if they are AWOL under the Mental Health Act. In other words, the power to retake a patient is the same as for those who are AWOL. This means that any of the following people can re-detain the patient.

- An Approved Mental Health Professional
- Staff from the hospital [to which the patient is recalled]
- A Police Officer
- Anyone authorised by the managers of the hospital [to which the patient is recalled.]

Chapter 22 of the Code of Practice to the Mental Health Act should be born in mind, with regard to this "AWOL patient", as well as chapter 11 on conveyance. This means:

- It is the role of mental health services to re-detain the patient, where their location is known.
- The police should be involved in this process where this is consistent with the need to manage risks.
- **NB:** it should be borne in mind that *everyone* who is subject to conditional discharge under s42 has been a restricted hospital order patient. By definition of their sentence in a Crown Court this means they "pose(d) a serious risk of harm to the public".

It would therefore be fairly difficult to imagine a situation in which such a patient did not trigger police involvement against the "RAVE Risk" model which I advocate. As ever, clear communication and planning is required to prevent the "No, we think you should just do it" approach on either side.

29th July 2012

Community Treatment Orders –

The Mental Health Act 2007 introduced into English / Welsh law, the notion of supervised community treatment (SCT). Up until this Act, most mental health patients were either detained in hospital or they were subject to no legal restrictions or obligations at all. This new legislation allowed the discharge of patients into the community, subject to some conditions and with an ability to recall them to hospital, if it were adjudged that their rehabilitation in the community was not being effective.

So, s17 of the Mental Health Act 1983 (leave of absence) now contains a range of additional sections (sections 17A to 17G) which govern the operation of Community Treatment Orders and most importantly for the police, recall and revocation of CTOs.

It is not a perfect analogy, but officers may benefit from thinking of a CTO as being similar to the operation of police bail conditions: someone is released from police custody subject to certain conditions and if those conditions are breached, then the person can be taken back into custody. CTOs are very similar, but it is not just a breach of a condition that can lead to recall, but also a general sense that recall is necessary in the interests of that person's health.

A person is recalled by the service of a notice, usually done by post or by hand to their last known address and it should include a place and time they should go to a specified hospital – not necessarily the hospital from which they were originally discharged. The Responsible Clinician may then detain them there for up to 72hrs to make further assessment of how the patient's care will be handled. This may mean, full revocation of the CTO and the patient again becomes an inpatient under s3 MHA; or a further attempt at managing the patient on their CTO, potentially with altered conditions.

CTOs are used thousands of times per year. Indeed, concern was raised in 2010 about whether they were being over-used because they were being issued at ten-times the rate of initial estimates. The original intention was that CTOs would prevent a "revolving door" in mental health care, which assisted in breaking the cycle of a small number of patients going from admission to discharge; and then to crisis and re-admission. In practice,

they are being used more often and not just for patients in a revolving door situation.

POWER TO RECALL / REVOKE

If the Responsible Clinician (the psychiatrist in charge of the patient's care) is satisfied on various grounds that it is appropriate to recall the patient to hospital, then they must serve notice upon the patient. As mentioned, the time / place will be specified. If the patient does not show up at that time and place, they are regarded as AWOL under the Mental Health Act and may be retaken into detention by an AMHP, the staff of the specified hospital, a police officer or anyone else authorised by the managers of the specified hospital.

NB: officers should be cautious to ensure that there is a recall notice in place. I once got asked for advice on a case where a man had been arrested for an assault, without officers knowing that he was mentally ill at all. Once in custody, a family member contacted the police and informed us of this fact. The custody sergeant then rang the relevant mental health professionals to begin to gather information and to inform them of the patient's arrest so that mental health assessment could be undertaken prior to any potential interview for assault. She was promptly informed that the patient was a SCT patient and they had been recalled from their CTO. It quite quickly emerged that there was no evidence to support a charge of assault, primarily because the victim to it would not give a statement to the police or offer any evidence at all. As such, the custody sergeant had a man in detention for assault which needed to end because the legal decision around prosecution had been reached – to take no further action. However, mental health services wanted the man detained because he had been recalled, until arrangements could be achieved for his admission to the relevant unit.

The custody sergeant did not know what a CTO was or what powers the police had but did have the presence of mind to ring to demand a copy of the recall notice or some other written indication that a legal decision of recall had been taken. There seemed to be problems in achieving this and mental health staff were getting frustrated with the sergeant demanding copies of things, whilst she was getting increasingly concerned about whether he ongoing detention of the man was legal because of their unwillingness or inability to provide the assurances she sought that she was acting legally.

It unfolded that the recall notice had **never been issued**. They *wanted* to recall him, but had not yet done so. As such, it was the case that the man was being held illegally by the sergeant. He was promptly released amidst much frustration on the part of mental health services and a certain amount

of grumpiness on the part of the custody officer who felt somewhat professionally violated – reminders were thrown about regarding Article 5 ECHR and staff were asked to put in place safeguarding arrangements for him, should they have ongoing concerns. Obviously, they could ring again if the recall notice was properly issued and ignored.

Yet again, we got close to the point of the police being incited to falsely imprison someone without lawful authority, because of convenience or preference.

SUMMARY

- If someone has been recalled to hospital, there is a power for the police to re-detain them if they fail to do so.
- However, if the re-detention is pre-planned – rather than something that emerged from an unrelated arrest, as above – then the same considerations should be given as for the recovery of any other AWOL patient.
- Mental health service should lead a detention if the whereabouts of the patient is known, with officers supporting only where this is consistent with RAVE risks.
- Where there is any need or request to hold someone in police custody at any stage, officers should check that a recall notice has been issued and seek a copy or other written confirmation – this is like the legal basis to act under s18 MHA by arresting or holding someone.

AUGUST 2012

1st August 2012

College of Policing –

A few months ago, I was asked if I would write a short piece for the College of Policing newsletter to coincide with Mental Health Awareness week. I never did get 'round to publishing it on the BLOG, so here it is, reproduced below. Remembering to do this now nicely coincides with another development for me personally, which involves the College of Policing —

From the start of September, I will be seconded from West Midlands Police to work for the College full-time on mental health issues. After more than three years of "mental health policing" not actually being my 'job' and my efforts to contribute to this being mainly via social media, I am about to start a full-time posting which involves me having the opportunity to focus upon nothing but this. Exactly what this role involves will emerge over coming weeks as I'm sure the College will have in mind a list of things they've been asked to do and the new ACPO lead on mental health, Commander Christine JONES from the Metropolitan Police will no doubt make her views known on this matter, too!

I **couldn't be more chuffed** about all of this – and before publishing the newsletter piece below, I want to finish on a slightly naughty point, concerning something I said in 2011 as my previous posting on mental health came to an end. I had a strong conviction leading up to my return to operational policing that the profile of mental health issues within policing was still rising and that we were far from having sorted it all – very far from it. More and more forces were appointing mental health leads to drive this agenda, more senior officers were becoming interested in it. I had previously been seconded part-time to the College's predecessor organisation, the National Policing Improvement Agency and saw for myself the efforts some police forces were beginning to put into this area of work and the extent to which a few were still sleep-walking. I had a strong feeling that there was still a lot more we could and should do and those ideas instead became the material you've read in this BLOG over the last three years. It was partly written so that when questions flew my way, I could point people to the BLOG rather than keep answering the same questions – a bit of self-preservation and demand management – but it was partly to outline how much further we all need to travel.

So in February 2011, with that sense of a job not yet done and with queries flying my way from around the country as new officers began the steep learning curve of being required to work on mental health without any

training on the matter, I remarked to a former boss of mine that I thought I would keep being sucked back towards this work and that the phone would probably ring around August 2014 with an opportunity to get involved in this again because more needed to be done. It turns out I was wrong: but only by the small matter of eight hours!

So a very exciting new opportunity beckons me – to be a part of developing and updating training and guidelines within the College of Policing that will be used around England and Wales by all police forces and to support those forces, if required, in taking forward the increased focus that is now being given on policing and mental health. As this secondment was being negotiated, the College asked me to contribute to their newsletter and this is what I wrote —

COLLEGE OF POLICING NEWSLETTER

There is much to be said about policing and mental health that could improve the world. We could talk about fairness in health funding or how NHS services are commissioned and delivered. We could get extremely specific about place of safety services, ensuring a proper response to incidents in private premises or the difficulties encountered when managing vulnerable detainees who are also intoxicated by drugs or alcohol.

However important all of that is, absolutely none of it – ultimately – is within our control and I have long since thought that whatever our view of our mental health system or wider NHS, there is much that individual police officers, individual police forces and now the College of Policing could do to improve our ability to manage demands connected to mental distress in society.

Three years of using social media to raise awareness of all things policing, mental health and criminal justice has taught me that most officers want knowledge and training on this.

Most of the questions I receive – dozens of them each week – are legal in nature:

- What powers do officers have, what are the responsibilities and powers of other professionals?
- What is it we could do and what is it we should do to ensure the safety and wellbeing of others without trespassing on the responsibilities of others?

The more I learned about mental health law, the easier it has become to police operationally – including in those situations where partnerships are not operating in an ideal way, for whatever reason. Even if the system

doesn't work perfectly, I understand how I can do the best that is possible to survive scrutiny with criticism.

We need knowledge – predominantly of the legal kind.

I would love to see the College of Policing develop a set of training products and resources that reflect the needs of all officers – mental health touches every area of policing, at every rank. Build our knowledge and thus our confidence to impact on this expanding area of business. The queries I receive come from response officers, custody sergeants, neighbourhood policing teams, investigators of all kinds from uniformed volume crime teams, to detectives and SIOs. They also come from inspectors, superintendents and ACPO officers about how to better structure partnership arrangements.

Duty inspectors and Force Incident Managers have particular needs, I would argue and I remain convinced that the United Kingdom needs training programmes of depths that reflect the complexity and the risks inherent in this work.

We also need to utilise technology to deliver support to decision-makers: internet resources, smart-phone apps with clear legal materials and it would be ground-breaking if the College of Policing could work on that material jointly with other professional colleges, including paramedics, social work and the medical/nursing Royal Colleges.

If the solutions are inter-agency, then the leadership and training needs to be too.

7th August 2012

The Public Interest –

I keep encountering stories of incidents where potentially very serious crimes may have been committed and the criminal justice system appears to take no action because we have 'transferred the person into the care of mental health professionals' or similar. Responses to crime where we fully and completely divert people into the mental health system without necessarily knowing the nature of the relationship between a suspects mental disorder and the act they are alleged to have committed. That is, if there was any relationship at all. I first wondered about all this when I was a custody sergeant – it seemed to me that if someone came into custody for an offence with mental health problems, they were never prosecuted if they were thought so unwell on that day to need hospital admission.

It seems fair enough that we give priority in most circumstances to health issues, but surely that isn't the end of it if the original offence is serious? … or where someone is offending a lot?!

It's all about how police officers and prosecutors interpret Home Office Circular 66/1990. This is the current – yes, the *current!* – government policy on diversion of mentally disordered offenders from the criminal justice system. This document is now approaching its twenty-fourth birthday and has not been superseded or updated. It's really is worth clicking the link to see a facsimile copy of a typed document! … *that* is how old our current government policy is.

It's all very twentieth century, along with our mental health laws.

IN THE PUBLIC INTEREST

I often wonder about crime incidents where no specific reference is made in the police press releases we see about what is going to happen next. For example, a man in Essex recently discharged a high-powered air rifle towards police officers and mental health professionals who were there to conduct an assessment under the Mental Health Act. Having shot at them nine times he was swiftly arrested but all we currently know is that he was sectioned. What happens with the firearm side of things? … if you shoot at the police nine times you generally expect to face a judge at some point so I would always expect to hear why this isn't happening or that the

investigation is continuing pending more becoming known about the suspect's mental ill-health. It's about the public understanding how they are protected from future armed threats without a prosecution that has the potential to imprison someone.

I use this merely as an example because of the wording of the media coverage: not being involved in this particular case it may well be that the investigation is ongoing and the man is on bail. My point is that we don't know because this sort of thing isn't mentioned by press releases. Some may be wondering what business it is of the public to know this information, given that someone being sectioned is a medical matter and attracts considerations of confidentiality? We saw following the murder of Christina EDKINS in Birmingham (2013) a press release which announced the suspect had been sectioned and it made no reference to the investigation continuing – it inadvertently created the impression that him being sectioned was the end of the matter and there was a predictable public uproar, especially on social media. Whether we like it or not, the investigation of and the police response to serious crime is something which attracts public interest and it is in the public interest to understand why some of us who offend seriously are not prosecuted.

You will notice in some other high-profile cases in recent days that we have been told suspects are retained on police bail after being sectioned under the Mental Health Act. I would like to see this more often – it either reassures the public that matters are still looked into or ensures we explains why they're not. The recent examples include the 47-year-old man who was arrested for a bomb hoax on a Qatar Airlines flight into Manchester Airport; and also the 23-year-old woman who was arrested (by my response team) on Monday evening on suspicion of administering a noxious substance to numerous people in a residential care home. In each case, the inquiry is still active despite the person being 'sectioned' and both police forces were content to say so.

This means that once psychiatrists have established the nature and degree of any mental disorder, they can then decide what support is required and whether or not a prolonged stay in hospital under s3 of the Act would be necessary. In due course, investigating officers can determine whether the psychiatric issues and the broader circumstances of arrest still give rise to the need for a prosecution in the public interest. If a prosecution does follow – which it usually should for indictable-only offences, those triable only in the Crown Court – then Part III of the Mental Health Act 1983 allows the courts all the options it needs to manage any risk to the public whilst still ensuring that people receive any necessary treatment or care.

OUTCOMES FROM DIVERSION

Let's not forget this: diversion was never intended to mean that people responsible for serious offences do not face justice and in the main we do expect to see people charged where they have committed more serious matters. Being charged and going to court does not presume guilt, but it does allow the courts to request full psychiatric reports and allows them to weigh the circumstances – criminal courts have a huge range of options available to them that are not available to the police and prosecutors or to doctors and AMHPs. We should never forget that most people who are diverted from police custody under the MHA after arrest for an offence are under section 2 of the Act. This simply means that mental health assessment is occurring against a certain. background and it may conclude that there is nothing to know.

Examples exist of patients being sectioned only for the conclusion to be reached that they are not mentally disordered – at all! So imagine if this conclusion was reached after someone had been arrested for a serious offence and then diverted? … what happens with that original allegation and the victim's rights to justice? Perhaps nothing, unless the suspect had been retained on police bail when sectioned or otherwise followed up by an investigating officer who didn't close their mind to the possibility that someone's mental health problem may be quite incidental and entirely unrelated to the original circumstances. Perhaps more importantly, diverting people from justice and taking no formal action on criminal allegations assumes a relationship that often just isn't there: mental disorder does not usually *cause* criminal behaviour. There are normally other contributory, far more important variables in play likes drugs and alcohol. And even if you did have a case where someone's mental disorder was a causative feature of a serious offence: Part III of the Mental Health Act may still have a role to play in balancing public protection and the right to treatment.

Hospital Orders are the main sentencing option in Part III – they authorise the inpatient admission of those who have committed acts of crime, irrespective of whether they were found guilty of an offence or whether they were thought to be insane or unfit to plead or stand trial. The fact that hospital orders can be imposed both with and without conviction is what shows us that the law makes no assumption about the relationship between mental health and criminal offending. Where a hospital order has been imposed – whether or not it was restricted under s41 – the person concerned will then be subject to MAPPA processes upon discharge from hospital. MAPPA will ensure a risk management plan is drawn up after information sharing across relevant agencies and this will form the basis of ensuring as far as we can, that any risk of further offences is minimised. But MAPPA only applies to mentally disordered offenders who have been made subject of a hospital order.

If you don't prosecute someone for something, you can't get a hospital order which means they will never be subject to MAPPA and other risk management processes that the police service and probation services have. All well and good if that offender was arrested for shoplifting in an isolated incident but not if they've shot at the police nine times causing the AMHP to be run for their life or if their offending behaviour is more serious and / or repetitive.

I've written specifically about my vision for liaison and diversion elsewhere on this blog and it addresses what I see as real shortcomings in the way we hear these new services currently framed. We need to be thinking about potential sentencing outcomes and public protection frameworks when suspects are in police custody otherwise we will end up building hidden risks and *that* is not in the public interest.

9th August 2012

Are We Failing Police Officers? –

TRIGGER WARNING: *this post discusses suicide and mental ill-health very specifically amongst police officers – those affected by these issues should carefully consider whether or not to read on. There is support available via the links and phone numbers at the bottom of this page, if needed.*

Two separate news articles from opposite sides of our planet caught my attention this week: each of them referring to suicide and mental distress amongst police officers. In the state of Victoria in Australia, the Chief Commissioner has set up two separate, but clearly related, external inquiries into police deaths and depression. These reviews emerged after seven police officers in the last two and a half years took their own lives. Set against a workforce of over twelve and a half thousand, that number may not seem large but that department estimate that as many as thirty officers are currently at risk of suicide.

Meanwhile, a police sergeant in Toronto took his own life after leaving a suicide note specifically attributing his decision to work-related issues and his battle with PTSD. His family is calling for the inquest to examine the officer's claims against a background that includes other police suicides and a former police sergeant's criticism of the support he received for PTSD. And let's face it: these two countries are *not* alone and this issue does not just affect police officers. There are more deaths of US police officers after suicide than after homicide each year. Queries a year or two ago to Her Majesty's Inspectorate of Constabulary revealed that police forces here do not collate data on suicides, but we know there have recently been several and that policing in the UK is considered one of the higher-risk professions.

So, are we failing police officers? … or emergency first responders?

POLICING AND MENTAL ILL-HEALTH

Mental ill-health in policing generally is a subject we don't discuss very much: having asked these men and woman to go and do a pile of stuff the rest of us wouldn't do, it should come as no surprise that the police, like paramedics, are four times as likely to suffer from stress, depression and anxiety when compared to the population as a whole. When I do talks that

touch on the broad subject of mental health and policing, you often find questions asked about mental health *in* policing. You don't have to look hard to find something to say, either – individual anecdotes of suicides by serving officers, perceptions of in-house support and more general comments about the extent to which we don't seem to have fully understood this. We know from research that acute levels of stress in policing are probably connected to non-negligible levels of mental illness.

If you spend even a short amount of time on social media, you will bump into numerous examples of current and former officers living with mental health issues and plenty of those will say that they felt unsupported at key times. It must be said, that prevalence of distress and suicide risk has been linked in some instances with criminal or disciplinary procedures against officers so it is always going to be difficult in some cases to be both impartial prosecutor and supportive employer. I'm aware of several legal actions ongoing by former officers under employment law for alleged failures in a duty of care or because they have alleged failures to support employees suffering from mental distress or give proper regard to mental ill-health when it comes to personnel processes. Of course, mental health problems are classified for the purposes of the Equality Act as protected characteristics. Officers who experience mental health problems at work are – in theory, at least – no different to officers who become physically disabled after an assault or accident. And as with physical health problems, disability can arise for all manner of reasons, including work related reasons.

So where is the narrative that talks about police work as a line of work that can carry a cost in terms of mental health?

Asking this question is not to ignore that other professions – including other emergency first-responders – are also at raised risk of inflicting psychological distress upon their staff. In particular, rates of PTSD in police officers (and in other first-responders) are concerning. More concerning still, are the support mechanisms available in many cases. We know that amidst public sector cuts, some police forces are having to reduce the counselling and other support that is able to be offered to staff and that NHS support for counselling and CBT can involve as much as an eighteen month wait.

POLICE SICKNESS

The demographics of recruitment and retention don't help trends in police suicide and mental ill-health. Reporting on suicide in the population as a whole puts young and early middle-aged men right in the danger zone, when it comes to predicting overall probabilities. The Samaritans produced

a very comprehensive report on suicide in the UK and Ireland this year and it provides detail on age and other demographic factors.

So in a profession that is still comprised mainly of men, the profession-level risks become amplified and obvious. Every time I read initiatives about male mental health, I must admit I think about my predominantly male colleagues up against a culture that suggests you should be able to cope and a structure that may struggle to support you anyway.

You can see clues about police culture all around and much academic time has been given over to studying it. Suffice to say here: none of the seven police officers in Victoria who took their own lives sought help from their employer. So where suicide is the leading cause of death generally in men from certain age groups, we should be concerned about the risk of suicide in a profession that has higher than average rates of psychological distress and mental disorder and which is predominatly male. Of course, female officers are affected too and whilst female suicide rates are much lower than those for men, female rates of self-harm are much higher. It means we need think about how staff may be differently affected and think way beyond suicide.

The above report from the police in Victoria is not the first to make the claim that more days are lost to sickness in the police to mental health and other psychological problems than to physical health problems. And sickness days lost to stress, depression and anxiety is on the rise. Reports suggest that since 2010, sickness arising from mental health and psychological problems is up significantly. In the North East of England, three police forces reported percentage rises of 260%, 122% and 37% compared to three years previously. Even a 37% rise is significant and despite my efforts, I couldn't find a news article suggesting that any UK police force had seen a decrease. Let me know if you find one.

It's worth noting the emphasis placed by forces upon the potential for personal circumstances to give rise to this trend. In response to the story of north-east forces as well as elsewhere, senior officers have been keen to stress this and of course, that will be part of it. But it must be said, there seems to be a lack of acknowledgement of the role that police work pays in causing distress and illness amongst officers. In 2007, psychological problems were listed at the top of those reasons that cause long-term absence in a report by the Health and Safety Executive. It would be really interesting to read an up to date version of this report.

IT'S TIME TO CHANGE

For some while now, I've felt that we need to see the development of a charitable organisation specifically aimed at supporting police officers (or

999 personnel as a whole) suffering from psychological distress and mental health problems. I keep seeing the effort, the work and the impact of Combat Stress in drawing attention to and supporting our Armed Forces Veterans. The issues in policing and emergency services work being different, with obvious overlaps, it strikes me that there is a gap that needs filling. So it seems we could be doing a whole lot more and talking about this would be a good start – the Time To Change initiative has long since focussed its message on the importance of an open dialogue about mental health problems, but they also highlighted that policing is in the top two professional groups to be comparatively unaffected by its campaigns. Yet how many times have we heard police officers who have found themselves living in distress say something similar to, "I would have thought I was the sort of person to affected by mental health problems."

There is the knuckle of the problem – there is no type of person. It's about the broader human condition and the way we live our lives. In my humble opinion.

Are we failing police officers? – let's just say we have a long way to go. **Who's protecting the protectors?**

NB: if you have been affected by the issues in this post, you can talk to the Samaritans for the price of a local phone call on **08457 909090**.

12th August 2012

Voluntary Attendance –

This post is about trying to ensure a non-prescriptive framework for how police officers should consider whether or not to detain someone under the Mental Health Act when it is legally possible to do so, as opposed to helping people access relevant services without detention. So it is about two, frequently opposing philosophies: the principles of autonomy from the least restriction and of security from necesary control.

We know that where (UK) police officers encounter individuals who actively want to access some kind of healthcare support for their mental health problems, they traditionally have four options. They are not always available because legal powers vary between public and private places and because 24/7 Crisis Team services usually only respond to patients already receiving mental health care.

Nevertheless, the four options are —

1. Advise the person to contact their GP (primary care), in due course
2. Advise the person to contact their MH CrisisTeam (secondary care), if one is available
3. Assist someone is accessing Accident & Emergency (urgent, unscheduled care), more or less immediately
4. Use legal provisions in the Mental Health Act 1983, if appropriate.

It does get us into all manner of problems where we think something needs to happen straight away because you have to decide whether to use the Mental Health Act in order to remove someone to a place of safety or whether to point them towards A&E or accompany them there. This is a remarkably complex decision, as the rest of this post should explain. It is made difficult by some important principles of law that creates a tension for the officer who might detain someone: a tension which you could almost always argue remains unresolved no matter which decision is taken.

NICOLA EDGINGTON

The most high-profile example of this decision – at least in my mind – was the decision taken in the case of Nicola EDGINGTON in south London in

October 2011. Metropolitan Police officers had accompanied her to an A&E deparment on a voluntary basis, without detaining her. It must be said, in the first instance that it was questioned whether the officers could have legally detained her at all, having first encountered her in a private place. That said, Nicola having exercised a free decision to move from that private place to A&E she then attempted to leave and the argument was suggested that Metropolitan Police officers should have detained her under s136 MHA at that point, particularly because she had a previous history of homicide and everyone accepted that she was worried she may kill or hurt someone.

She was not detained. Having then remained in A&E for further mental health assessment she was admitted to a psychiatric unit as a voluntary patient and moved to a ward. She then absented herself from that location and travelled to Bexleyheath where she attempted to kill Kerry CLARK, and then did kill Sally HODKIN. I have previously written about this case if you want more detail on it and read about the IPCC investigation that looked at this decision-making. Suffice to say, I'm now waiting to read the independent review of Nicola's treatment and care when it is published by NHS England.

So we know from this and other cases, that police decisions to leave individuals in healthcare settings who may be a risk to themselves or others is precarious business. But an 'err on the side of caution' approach directly conflicts with principles of handling people in the least restrictive way. The 'least restriction' idea is a core principle of the Mental Health Act Code of Practice, outlined very early in that document and referenced through-out. Any conversation about a decision to use mental health law – or about the particular manner in which it is applied – doesn't last very long before officers are reminded about the need for least restriction. It is an important part of the ethical application of the MHA, that restriction and restraint is only used when it is absolutely necessary to do so and the no more coercion and control is used that is absolutely necessary. Anything less could represent a human rights violation.

So at the heart of this dilemma and the method by which any tension is managed is the following question: Why would a police officer legally detain a person in order to compel that person into a process that they are willing to enter? And the answer for me lies in the definition of the word 'necessary' and in the ability of services to make sure in some case that someone not only *enters* a process of assessment, but also *finishes* it.

WHAT DOES 'NECESSARY' MEAN?

Police officers are used to considering the word 'necessary' because every arrest made under criminal law carries with it the need for a necessity test,

under section 24 of the the Police and Criminal Evidence Act. When I joined the police, we used to talk about 'arrestable offences' and if you were suspected of having committed one you could be arrested for it and that arrest would be lawful. The end. So if you knew that an allegation of assault (ABH or GBH) had been made against and you turned up to the police station to have your say about the incident or help the police with their enquiries, you may be arrested. This changed some years ago and it is now a legal requirement for the arresting officer to show why an arrest was actually 'necessary', against established legal criteria now made plain in the Act.

So we understand about 'necessity' and it's implied and inherent links to the least restriction principle.

Let me amplify these points with real examples:

Officers encounter an elderly man who is confused and disoriented. Some enquiries reveal that he is almost certainly a missing person from a neighbouring police area and he is out in winter, obviously very cold. An ambulance turns up at the officers' request and checks him over they state that they need to take him to A&E to get him checked over medically and the police area from which he is missing are telling his relatives he's been found and his wife and son are now heading to the A&E concerned.

The man is happy to go to A&E and not resisting at all, saying he'd welcome a cup of tea. The grounds for s136 were undoubtedly met: he was "believed to be suffering a mental disorder, in immediate need of care in his own interests." This is one version of the definition of s136. **Was he detained?** – NO. **Did he need to be?** – NO.

Police officers encounter a young woman in her twenties who is asking for help and saying that she "needs to be sectioned". She wants to be assessed and admitted to hospital for a period of time and has a history of suicide attempts, including a serious overdose and significant injury after self-harm. She has also been considered a high-risk missing person after having previously self-presented to A&E departments and having left in a suicidal state before being the Crisis Team arrived to assess her needs.

Although the woman is happy to go to A&E on a voluntary basis, there is the potential that this decision could change, especially if there is a protracted wait for the Crisis Team. Should she leave, there could be a significant risk to her wellbeing based upon background factors. **Could she have been detained?** – YES. **Was she detained?** – YES, because this ensures she remains detained pending the assessment outcome and ensures her various legal rights are in place.

In this latter case, if officers had not legally detained her under the MHA, she may either have been left at A&E and again become a potentially high-risk missing person should she leave; OR officers would have still remained in hospital to ensure she didn't leave hospital, not having legally detained her. So she would have been detained *in fact*, but not *in law* – and I'll guess that no thought would have been given to her legal rights under s131 MHA or PACE.

VOLUNTARY ATTENDANCE

So you're the police officer at the incident and let's assume that all four options mentioned at the start of this post are open to you as possibilities: you can advise contact with the person's GP or Crisis Team; or you could offer to assist someone to access A&E or you could use section 136 of the Mental Health Act.

For me, the first three options are only available where risks and threats involved mean that we need to be sure that someone will *complete* the process of assessment. This may include suicide risks, someone who has taken an overdose, someone who has previously sought help and then disengaged before being seen in circumstance of some concern that need to be avoided.

Of course, something like street or telephone triage with mental health services may render an instinct to detain null and void so any decision taken must be based upon the fullest available information. But necessity needs to be judged in terms of whether the risks of a person not remaining engaged to complete an assessment are so serious as to need negating. If they are not so serious, then principles of least restriction should mean that sign-posting, referral or voluntary attendance are perfectly proportionate responses to incidents. We all accept and understand that physical injury or illness does not always require *immediate* A&E attention and so it is true of mental health issues.

19th August 2012

Personal Responsibility

I'm going to have to be careful about the tone of this one: it just mind end up sounding a bit like a lecture or a telling-off! And I should be clear that this post is not just aimed at professionals in policing – what I am about to say is of applicability to *anyone* who has to deliver their profession within the constraints and opportunities of our mental health and capacity laws.

So whilst trying very hard not to sound too much like Mr GILBERT from the Inbetweeners, here goes —

If you are a professional reading this, you will have taken many decisions in your career which are, fundamentally, **legal decisions**. Section 136 MHA detentions; decisions about whether to grant leave under the MHA and recall a patient from it; the application of the Mental Capacity Act or issues around the application for and execution of warrants. There are countless other examples. Of course, the origins of these decisions may well be based on practice judgements, health and safety considerations or the attempts to prevent harm but as soon as you get into this territory you will come up against legal considerations. So we need to know the law.

So here's the rub: we actually have to know the law, which means we might have to study it. Here's another rub: whether or not we have a training course on offer, we might still have to know the law, which means we might have to study it. Finally, here's a real spoiler: whether or not we know the law and whether or not you have studied it, you're still accountable to it. Ignorance is no excuse, etc., etc..

STANDARDS OF KNOWLEDGE

My personal view, is that the standard of legal knowledge across the professions is actually quite shocking. I am prepared to be so blunt because I actually don't think this is the fault of individual professionals. I know that I had my views early in my career about police training, but I have subsequently come to think that legal training within various mental health professionals is far from great. The only real exception I make to this generalisation is the training given to AMHPs, because they are legally warranted and professionally examined on the Mental Health Act. It doesn't prevent the occasional myth pervading that professional group, but their legal knowledge is usually spot on.

I've noted a few times on previous posts that I get loads of queries via social media or email about mental health law each week and and most of them are really quite basic. "What is a s37 patient?"; "Have I got a power of entry for this situation?"; "I had a job the other night, whose responsibility is to do this?"

Of course, some questions are more elementary for some professionals than others. A while ago medium secure unit in another area to mine reported a 'voluntary' patient missing and told us "The Secretary of State has issued an order for his return to this hospital." This information is actually very confusing about the legal status of this patient and what, precisely the police are allowed to do if or when they find the man. It seemed to me that there could be contradiction or confusion within the

request. Since the local police area were asking officers across the force area, including mine, to attend various addresses and search for the man, I asked the duty inspector for the hospital's area to enquire of the reporting nurse, "We're just trying to clarify police powers here: is this a conditionally discharged patient and is this 'order' you're on about a warrant from the MoJ under s42(3) of the Act?"

Silence on the phone line.

Now this probably won't mean much to your average response officer as conditionally discharged patients being recalled is so comparatively rare that most officers will go a whole career without encountering the situation – it's only the fifth or sixth that I'd ever been connected to in the real world. Nurses working on medium secure units will see this far more frequently and as they are an important link to ensure that the police are properly briefed on these situations, it's important they understand their powers. Most crucially, the word 'voluntary' should never have been used in this context: the police have no powers over voluntary patients, unless we encounter them in public places and feel that section 136 should be applied. So can you imagine if this man – who it turned out had been a serious sex offender leading up to his hospitalization – were found by the police in a private address (where they would have no powers) and left there because of confusion as to his precise legal status? Imagine the horror if he offended after police contact with that opportunity to re-detain him having been missed?! It's too awful for words.

It turns out that our guess was correct: he had previously been in hospital as a restricted patient and then conditionally discharged under s42 MHA. For whatever reason to do with his care, he had been recalled to hospital and would again become a restricted patient. So at last we understood what we could and couldn't do.

This is not a knock at an individual nurse tasked with phoning the police: it is just the more potentially consequential tale from the last few months to highlight the point. There could have been the story of the woman who had been assessed under the MHA and an AMHP had applied for admission to hospital. She had not travelled to hospital on the night of the application and the following day, staff attended her home address to convey her to hospital and she refused to open the door. Could the police just force entry? …. not with a warrant we can't, no. There could have been the one about the police being asked to physically coerce the Community Treatment Order patient back to hospital before anyone had served a recall notice. The list goes on.

The police are potentially worse: perhaps you'd expect that because although mental health is core police business we know that we're not quite there yet with the provision of training. This week alone, "What's a s37

patient?", "Can we force entry to re-detain a s3 patient?", "Can't we just use s17 of PACE instead of getting a warrant?".

The list goes on – legal training all 'round.

PERSONAL RESPONSIBILITY

Here is a list of resources to help, but you might have to read and internalize them! —

- What do all the sections mean? – each important section of the Act, summarised into one or two sentences.
- Quick Guides – covering very common and some not-so-common scenarios under the MHA / MCA.
- Knowledge Check – one post which summarises into around 500 words the most crucial information.
- **But you might have to actually read it and internalize it!** – try doing it as an act of studying, rather than trying grab information at jobs when pressure is on.

I was remembering recently that the police legal syllabus doesn't include very information on mental health. The Blackstone's Manuals (2015) don't include more than passing reference to the Mental Health Act. They certainly don't include detailed knowledge of the Mental Health or Mental Capacity Acts into the legal syllabus that is the basis of the first part of both the sergeants' and inspectors' promotion exams. The examination is based upon surveys of operational supervisors as to what knowledge is needed and yet mental health doesn't feature at all, despite it being daily business! I would estimate I get several dozen queries a week about what different legal structures mean or what police powers are implied. I can't imagine how many officers with such queries don't raise them.

The hope behind the above resources was that they would allow quick reference about the sections of the Act and what those sections mean officers can do.

We have seen that the police are only going to be as good as the information they are given. Most MHA related scenarios for the police are not instigated BY the police – the obvious exception being section 136 MHA which most officers understand pretty well. Otherwise, the police are almost always acting in support of or on behalf of mental health professionals who will need to ensure police officers are properly briefed to be able to act quickly, professionally and legally.

This is important stuff and it may well mean that each of us needs to spend at least a couple of hours (or more!) **actually reading the law** itself,

taking *personal responsibility* for ensuring we are well positioned to discharge our responsibilities and to work in partnership with each other.

Over to you!

29th August 2012

Inappropriate Detentions –

I'm amongst the first to admit that police officers lack the necessary training to ensure that they get s136 detention decisions consistently correct. I've written about this before, offering my view as to how the dilemma should be approached. I've also acknowledged the point made by some mental health professionals: that police officers occasionally use s136 where it is blatantly illegal – for example, in private premises – or where other powers of detention should be preferred.

What I'm also clear about – and it seems fair to mention this when I'm prepared to accept problems in some officers' usage of s136! – is that many detentions are only necessary at all because patients cannot directly access the NHS services they need or in a timescale that suits them. That's where the police often find themselves involved in taking detention decisions and I want to amplify this point yet further – some s136 detentions follow decisions taken by the NHS to seek the detention of patients or to refer incidents to the police which they ideally wouldn't. Some patients try and then fail to access their CrisisTeam or their community mental health team and end up coming to police attention when they have "one foot off the bridge" (to use a phrase from the Mind Report on Crisis Mental Health Care.) Other patients are actively deflected to the 999 system by our mental health system. Indeed there is some emerging suggestion that existing community and crisis teams are now more included to deflect demand to the police where they know the police have access to street triage service.

INAPPROPRIATE DETENTIONS

Two mental health trusts in the last month have used social media to broadcast their street triage schemes and have specifically stated that they are going to be working with their police services "to reduce inappropriate detentions". I will admit to smarting a bit at the very idea of this! Whilst accepting that forces use section 136 in very different ways and that this includes usage which may be questionable, there are many forces using s136 quite lawfully and appropriately.

There are two types of detention that seem to get labelled inappropriate –

1. Those detentions which are straight-forwardly illegal and those which should have been made under other laws.
2. We also see an emerging narrative that suggests because street triage has reduced use of s136 by a certain percentage figure, that number represents the total number of interventions that were inappropriate.

I can accept point one: I will argue vigorously about point two!

We should remember that the threshold to be satisfied for detention is actually remarkably low in the United Kingdom – far lower than in certain other countries where equivalent powers require the police to apprehend violence or harm. Mental Health Act provisions in the United Kingdom merely require the officer to be satisfied that someone immediately needs care in their own interests, a much lower threshold. As such, a greater number of circumstances can be legally justified as requiring or allowing detention.

We should also remember that far too many people who talk about section 136 MHA think that the only important measure of its effective use is the number of people who are subsequently admitted to hospital as inpatients. I've dispute this for many years: how can we argue that section 136 was inappropriate if someone in immediately need of care was kept safe from harm until assessed only for the assessment to conclude that they weren't known to the mental health trust but needed referral to the CMHT or various forms of social support? Or a patient who is already known and s136 reveals that their care plan wasn't working for them and this can be rectified?

RE-WRITING HISTORY

This alludes towards a narrative that alters how some people, including me, think we've ended up with a mental health care system consumed with criminalising vulnerable people and ensuring the justice system plays a key role in gatekeeping healthcare in a way that wouldn't be tolerated in any other arena of illness.

I've tried over the last decade to understand how I ended up – *as a police officer* – frequently gatekeeping this entry to our mental health system? Why did someone *want* the wellbeing of patients so acutely unwell that no junior doctor would go near them without bleeping the on-call registrar or consultant to be left in the hands of response officers and custody sergeants?!

I can't avoid concluding something along these lines –

- We (quite rightly) started mass de-institutionalisation of mental health care in the 1960s.
- This followed on from the discovery in the 1950s of the first generation of anti-psychotic medications.
- As the decades rolled through the 70s, 80s and 90s, we reduced the inpatient population of our mental health system by over 80%.
- We subsequently failed to invest adequately in our community mental health care system – CMHTs, CrisisTeams, etc..
- As a consequence of non-investment, the criminal justice system is drawn in to fill the vacuum that exists —

- So we see the **prisons** providing 'inpatient' mental health services for thousands of vulnerable people who arguably need hospital care;
- And we see the **police** providing 'community' crisis responses to thousands of people who arguably need accessible community care.
- We also see **probation** drawing together social provision for offenders after sentencing of all kinds.

Of course, this crude summary that misses various important medical, social and political issues but it at least suggests how we have ended up with the police playing such a prominent role in our emergency mental health care system and why that demand has been growing in most major jurisdictions over the last two decades.

The police never prepared for this, of course: promises of sufficient investment in community care were repeatedly made to suggest there was no need to worry about reduction in the inpatient estate. In fact, you'll notice that these are the messages that have been put out over the last few years as the NHS has decommissioned approximately 10% of its inpatient estate since 2010. And meanwhile, police contact with vulnerable people has been rising, use of section 136 has been rising and the number of people criminalised after being arrested under other provisions whilst unwell, has been rising.

SO WHAT DOES INAPPROPRIATE MEAN?

So back to the original point: I think the trusts concerned believe 'inappropriate' to mean the police using section 136 where a mental health nurse may not have recommended or requested it. Of course this **doesn't actually mean** that police officers actions were inappropriate!! … back to the two bullet points above, what does inappropriate' mean unless it is illegal detention, or detention that should have occured under other law?

But an officer acting lawfully and properly where they may not have needed to do so, if only the patient could be referred to mental health services more or less immediately is not 'inappropriate'. It's like debating a mental

health nurse defending themselves by the use of force; the fact that when a police officers turns up it won't be necessary because the officer will protect the person, use force and arrest the offender, doesn't mean that the nurse is acting inappropriately by defending themselves *lawfully*. But they would be acting inappropriately by defending themselves *unlawfully* – through excessive force, for example.

Of course it's really easy to construct a narrative about how the poor police keep stuffing things up in mental health: we can point to the deaths in custody, the various IPCC inquiries and other complaints and legal cases. Even the MS v UK case (2012) was presented by the media as being the police treating people appallingly when in fact, it was a legal action against the Mental Health trust for not expediting the admission of acutely ill psychiatric patient. We have seen deaths in custody where the NHS have effectively wiped their hands of some patients who were at that time in their care – including where various statutory guidelines have been breached – and then had to watch as the police officers who were left with it gripped the rail in a criminal court.

So is whilst I'm pleased that someone is attempting to articulate what street triage is actually for – I've previously complained that no-one has articulated a particular vision or aim – I'm concerned that the narrative re-writes a significant part of the problem: mental health services are insufficiently accessible and flexible to those in need, especially those already known to secondary care services. As a consequence of this, many vulnerable people and mental health related demands drift not only to the police, but also to the ambulance service, and we then see that outcomes are not consistently what mental health services would hope them to be.

Is anyone actually shocked at this?! – that if you place a police officer in the position of a mental health professional and give them almost no background information about the person they're dealing with, that they will be risk averse about the situation by comparison? It seems perfectly predictable to me. But if we had an NHS system that was accessible to those who want it, largely on the patient's terms, then we often wouldn't have to put police officers in that position in the first place.

This is what street triage is teaching us as the results start to emerge: that if you simply get a mental health nurse to interact with the person in a timely way, that largely does the trick. So why don't we just make mental health nurses and their services accessible – able to call on police support when needed and *vice versa*?

SEPTEMBER 2012

4th September 2012

Appropriate Use of Section 136 –

I've got a feeling I've written about this before, several times … but never in one post. It has become necessary because of various things written over the last few weeks about s136 MHA and purported rises in its use. I wrote recently about a 135% reported rise in the use of s136 MHA, reported in official NHS figures.

Dr Martin Webber started the debate off, I responded to add support and some more perspective to his sensible questioning of the figures and his views about why they may have come about. Since then, I've been reading various comments about that debate. The latest came to my attention just now and it includes another remark about the "low number" of people who are detained under s136 MHA and then admitted to hospital as a result.

Let me be totally clear: whether or not someone is admitted to a psychiatric hospital following detention by the police under s136 is not the only relevant indicator of whether the s136 authority was used "appropriately" in the first place.

Here are just a few scenarios:

- Person arrested s136 and sectioned under the MHA or admitted to hospital informally – can we all agree that this suggests the police were correct to use s136 in the first place?
- Person arrested s136 and assessed and then referred to or re-referred to a community mental health team. This could either be their CMHT, a Home Treatment Team or Assertive Outreach, depending on the circumstances and the patient and previous contact with the NHS – can we all agree that if the officers felt compelled to detain immediately to mitigate a risk to others OR to ensure that persons best interests, this suggests appropriate use of s136?
- Person arrested s136 after acting in a way which was consistent with a lay person's perception of behaviour that could be attributable to mental disorder and after assessment is referred to a health care professional. This could include their GP for lower level mental disorders or to other kinds of healthcare professional … for example it is not rare to hear of patients with epilepsy or diabetes being detained s136 and then the nature of the health problems leading to

a non-mental illness orientated health referral. Can we agree, that if the officers were acting in good faith in thinking a person was suffering mental disorder from their behaviour and presentation at the point of detention, that this was appropriate use of s136 because the legal criteria for detention were met?

My favourite story ever, was the undiagnosed diabetic in Dudley who would have died had officers not detained him s136. Had they left him as a slightly vague sounding guy having a pint in the sun, he would have collapsed there some while later. As it happened, because he was "inappropriately" detained because of his diabetes, he collapsed into the arms of paramedics who had been called to the s136 detention and then rushed to A&E where his life was saved, according to the A&E consultant who treated him. Ask those officers about his presentation that influenced their detention decision and they are describing things that many people argue are potential indicators of mental disorder.

So when would detention NOT be appropriate?

Well, if detention were illegal in the first place, it would be inappropriate. I've written before about mental disorder and emergencies in private premises. Where officers manufactured the presence of someone outside their private dwelling so that they could be detained under s136, it would be illegal and inappropriate.

What else? – well, officers detaining individuals where they did NOT have a reasonable belief that the person concerned was, in fact, suffering from a mental disorder. I've heard healthcare professionals and AMHPs representing that officers have locked up drunk in the High Street for bizarre behaviour where it is far more likely that alcohol is the source of their unusual conduct or presentation

What of these figures about admission, then?

I've read in the articles linked above, that "as few as 25%" of people detained were admitted. Am I being too protective if I assume that the other 75% are implied to have been inappropriately detained because they were not admitted? What I want to know, is how many of those 75% were both of the following:

- Detained by the officer knowing that the detention was illegal or not really necessary.
- Detained by the officer whilst presenting in a way where it was unreasonable on the part of the officer to suspect that the person was suffering from mental disorder.

This very debate took place in one borough of my force several years ago. The consultant psychiatrist concerned was disturbed that "just" 40% of those detained were admitted. I asked how many of the remaining 60% were referred to a mental health or health care professional OR were acting in a way where it would be a reasonable 'shout' for a lay person to suspect that they were suffering from a mental health problem. He didn't know … nor was he prepared to find out actually, he insisted those were irrelevant issues.

Irrelevant?! A person detained s136 and referred to a CMHT for non-acute mental illness or to their GP was not relevant to determining relevant usage by the police?! It subsequently became necessary to do a larger piece of work in another area of my force where we found the following outcomes.

- Approximately 40% were admitted under the MHA or informally.
- Approximately 40% were referred to a healthcare professional for an identified, unmet need.
- 20% were released without any further action –

Of this later category, half were behaving or presenting in a way were NHS staff agreed that it would have been a reasonable presumption on the part of the officer that the person was mentally ill. In other words, 90% of people were appropriately detained and in 10% of cases, it was questionable.

Now! – shall we devise a series of exercises about what is a crime and test the NHS? I've got a series of examples involving fairly hideous badness, none of which are crimes. At the heart of this is the question of how trained we want our police officers to be as almost quasi-psychiatric nurses.

We need to raise the standard of this debate and we need far, Far, FAR more research.

6th September 2012

Risk Not Connected To Status –

Today we learned that two police officers would be prosecuted for misconduct in public office following the death from positional asphyxia of Colin Holt just over two years ago. This detention caused various commentators on Twitter to talk about the inherent difficulties, sometimes hidden, of using s136 of the Mental Health Act. Colin Holt had not been detained under s136 – he had (presumably) been re-detained after becoming AWOL from hospital under the MHA.

But here is the problem and it's at the centre of issue I have with some mindsets regarding the detention of people with mental health problems:

The medical risks from the original mental health or medical condition are not inherently related to the legal framework under which someone was detained.

There are many service users who have tragically died following contact with the police who were detained under law other than mental health law – Colin Holt was not one of them because he was detained in a private dwelling for being AWOL, but Sean Rigg was detained for a public order offence and we are still not clear what Michael Powell was detained for. Kingsley Burrell-Brown and several others were detained under the Mental Health Act.

In Colin Holt's case the media are currently reporting that the police attended his home address after he was reported AWOL under the Mental Health Act. Health professionals alerted the police to his whereabouts, apparently. I must therefore assume that he was being re-detained under s18 MHA when the restraint incident commence – this the authority for AMHPs, police officers or anyone authorised by the managers of the hospital from which the patient is AWOL, to redetain them and return them there. I could be wrong about this – there are other possibilities, but this blog is about assessment of risks regardless of what laws are being applied.

What am I trying to say? – simply that it **does not matter** one iota WHAT legal framework someone is under when it comes to discharging a duty of care. I worry that the process that we hope cops will follow after using s136 is so prescriptive that people fail to think. I suggest we can certainly see this in some of the cases I have mentioned and I'm afraid to suggest that

mental health professionals speculating about rigid process around 136 reinforces this without justification.

Nothing in UK law, ultimately, *obliges* British police officers do **anything** other than what they genuinely believe to be necessary to keep people safe and protect their Human Rights. In fact European law *obliges* them to do exactly this.

The risk a patient presents when they are arrested *for any reason* is the risk that they present whether they are arrested for a crime or for a Mental Health Act assessment. If they are presenting with RED FLAGS, which – we should recall – includes the ongoing need to manage patients who require ongoing restraint, then their medical well-being should be prioritised. That one officer may choose to arrest MHA whilst another would have chosen to arrest for a public order offence doesn't affect the clinical risk and both officers should be thinking about medical and clinical risks where they have identified mental health problems. And yet hear all the time, stories of mental health staff having views in different directions about which legal framework the police should adopt and when. (I remember once offering a view on what care should be provided and when I was patted gently on the head and invited to run along – we should remember who is responsible for making relevant professional decisions and develop respect for professional autonomy. This doesn't mean we should not listen to each other.)

Therefore, whether one has arrested someone under s136 Mental Health Act or under other MHA provisions; for criminal offences or for other legal reasons like immigration or court warrants – if mental ill-health is suspected we should be aware of the RED FLAG criteria and the potential need to call an ambulance. If the legal provision used is anything from the MHA, then the use of the ambulance service should be *automatic* and it should be attempted, even if it is thought that it would lead to a refusal. Where detention is made under other legal criteria, calling an ambulance should be considered where there are fears around RED FLAGS.

Finally, as a reminder arising from what we are speculating on today – it is vital that front line police officers learn laws around AWOL patients, including the requirement of the Code of Practice that where the location of AWOL mental health patients is known, it is for the hospital detaining them to recover and repatriate them. The role of the police is to assist mental health professionals where this is necessary and consistent with their – to prevent crime and bring offenders to justice; to protect life, protect property and maintain the Queen's Peace.

"Can you attend [location] – Mr [name] is believed to be there, AWOL from [psychiatric unit]."

- Request the NHS to lead the recovery – note any refusal.
- Resist requests to be involved where there are no evidenced RAVE risks.
- If having tried and failed on points 1 & 2 – call an ambulance to the address to support the repatriation to hospital and note any refusals.
- Once detention affected – RED FLAGS to A&E, otherwise proceed to the intended location.

We need to distinguish **medical threats** from **legal status** and get rid of the rigid process-mindset that prevents us THINKING about the potential risk factors that should affect the quality of our response. We also need to have a health and social care system that gets on with letting cops make their decisions, rather than speculating with the benefit of 20/20 hindsight what should have happened at a job two hours ago if only they had been there to misunderstand the Law of the Land and actually participate in what the law says is a health and social care responsibility. <<< *Said it.* If we cannot understand *why* the law says this, then our problems are more serious than I fear.

10th September 2012

Suicide Prevention –

Across a range of posts I have written, I have alluded to what we should try to call "suicide prevention". The police have a crucial role to play for very obvious reasons, as we are often called to crisis situations where other options are limited, or where the nature of the crisis becomes an emergency. Section 136 of the Mental Health Act is often used in the arena of suicide prevention, because it allows officers to take a coercive decision to protect someone where the legal criteria of necessity are met. However, this power is limited to public places and officers often find themselves invited into private dwellings to protect vulnerable people.

The Government will today publish a new 10-year strategy for suicide prevention. This comes against a backdrop of economic and social factors which have given rise to suicide levels, including amongst younger male adults who are three times more likely than women of similar age, to take their own lives.

Some criticism of the use of s136 is that it is considered wherever someone threatens to kill themselves and I want to spend a paragraph on this. To use s136 officers must be satisfied of the need for emergency intervention in a public place, but on the grounds of mental disorder. Is it a mental disorder to threaten to kill yourself? Not inherently. There could be any number of issues ongoing, without the presence of mental disorder, which lead to such statements being made. There are two possible reactions to this, in my view: are police officers the appropriate professional people to be making those judgements of whether a particular threat is or is not an indicator? Secondly, on what grounds should they try given that the context of that judgement will range from situations involving long periods trying to "talk someone down" from a height, or acting in an instant to prevent an imminent or expected disaster? Practicalities dictate that the longer you have to explore the context and background, perhaps to involve specialist "Crisis Intervention" negotiators, the more likelihood that officers may reach a nuanced decision that threats are not indicative of a mental disorder. The less time you have, the more you may have to assume it is for the want of time and skill to tell.

I have recalled before a particular incident of my officers and I meeting a young man sitting in a communal grassed area hear his home, drinking alcohol but far from drunk and clearly very depressed. A local resident had called the ambulance service because he was sitting rubbing a bottle against his neck and the ambulance service requested police support. Officers got there first and established that he had lost both of his parents in the previous few weeks, both suddenly and separately, and he was struggling with his grief. The bottle had caused a minor mark to his neck – not even a cut – that required no formal treatment, perhaps just cleaning. The paramedic who arrived asked us to remove him to a place of safety but having spent 20 minutes talking to him, we weren't convinced of a mental disorder. When directly challenged to confirm that the paramedic, as the lead healthcare professional, was stating that this man was "suffering from a mental disorder within the meaning of the Mental Health Act", he declined to do so.

So these can be complex judgements to make in some situations. The more obvious point to make, is that we cannot and should not rely on s136 or other police interventions to sustainably lower suicide rates, because by the time it comes we already have "one foot off the bridge".

We know that men are three times as likely to kill themselves as women and we know that patients and those with unmet health needs sometimes have to find themselves with "one foot off the bridge" before they can access mental health assessment or support. We also know that about 87% of patients with mental health problems are under the care of their GP, not their mental health trust. So when patients need to access out of

hours assistance, they can often hit the problem of not being known to 24/7 Crisis Services run by mental health trusts, but being unable to access their out-of-hours GP for mental health support. This often leads people to emergency services, such as Accident & Emergency, the Ambulance Service and increasingly, the police service.

Of course, none of these emergency providers are equipped, commissioned or constituted to provide anything other than the most basic intervention. The ambulance service can choose to do nothing or take someone to A&E; the Emergency Departments themselves undertake basic triage and make referral to out-of-hours mental health trusts; the police can either do that – it is rarely popular – or utilise the "Section 136 pathway" to remove someone to a Place of Safety.

Police forces are actively looking at suicide prevention and I am sure we will see later, the role of the police noted within the new Suicide Prevention Strategy, launched today on September 10th. British Transport Police in particular, have well documented problems around the prevention of suicide, not least because of the tragedy this represents to individuals, but because of the absolutely enormous cost to the UK economy of shutting railway lines for investigations. As we know, suicide rates have been rising, which probably contributes to perceptions around increased use of s136.

I am very much looking forward to reading the new Strategy and I will link it at the foot of this post once it is published, but what we can already say is that it will need to re-address gaps which we have existed for years and which we know are spoken of, time and again. I also fear that it will be unable to address the underlying political, social and economic issues which we know contribute to suicide levels, alongside medical and psychological factors.

12th September 2012

The Mind Media Awards 2012 –

The Mind Media Awards 2012 will be hosted by Stephen Fry, the charity's President, in November 2012 in London. This event will celebrate much media contribution to raising mental health awareness, from soap-opera story lines such as Ian Beale in Eastenders; to the awareness campaign within rugby by Sky Sports, "State of Mind." Click the 'Mind' link above, for a full short-list in all categories.Stephen Fry has said, "The Mind Media Awards is a fantastic opportunity to celebrate those actors, writers, programme makers, journalists and **bloggers** who are helping to dispel the myths around mental health and reduce discrimination."

That was my emphasis in the quotation as I am delighted to report that the "Mental Health Cop" blog has been **short-listed** in the Digital Media category as a "useful resource accessed by both police officers and service users, clearly explaining the legal processes, police procedures and human and civil rights associated with mental health problems."

Thanks to those who have offered congratulations – I am most pleased to have received those from operational police officers from constable to superintendent who are using the blog material to expand their knowledge and to make a difference in the way they and their officers respond to mental health incidents to achieve better, safer, more dignified outcomes for patients, carers and families. <<< **That**, of course, is the whole point!

15th September 2012

The Yorkshire Ripper –

A documentary from a few years ago was recently re-run on Channel 5 – I caught up on it last night having not seen it before. It focussed upon the mind or the mental state of the Yorkshire Ripper and by half way through I found myself fairly frustrated and wanted to document some thoughts. It took just a few minutes for the narrator to introduce the "Mad" versus "Bad" fallacy *<<< I have written about this recently.*

BACKGROUND

Peter Sutcliffe was arrested after two uniformed police officer officers in Sheffield spoke to a man sitting in a car with a prostitute. Having been arrested, the man asked permission to urinate nearby and was allowed to do so. Later, the police returned to the scene and recovered a hammer which caused suspicion to rise that the man may be 'the Ripper'. And so he was, bringing to an end the biggest man-hunt in British criminal history. Sutcliffe explained to the police that he was acting on instructions from God to kill prostitutes.

After he was charged with the trail of murders, Peter Sutcliffe was remanded to prison. He was assessed by several, eminent forensic psychiatrists whilst he was on remand and formal psychiatric reports were completed by clinicians who had been asked by both the defence and the prosecution. They broadly agreed on all important aspects: Sutcliffe suffered from paranoid schizophrenia and it was suggested that 'diminished responsibility' would be appropriate should there be any suggestion of accepting a plea to manslaughter.

At the trial, the Judge, Mr Justice Boreham, declined to accept the defendant's pleas to manslaughter without the psychiatrists being questioned as to the basis upon which they had reached that conclusion. Was this motivated by public interest or, as some have suggested, politcal pressure? Who knows. Regardless of why, three forensic psychiatrists were questioned in court prior to any plea. It was eventually suggested that medical conclusions reached were based upon an acceptance by the forensic psychiatrists of Sutcliffe's version of events. Because the judge felt that it was at least possible, if not probable,

that evidence from the police inquiry showed Sutcliffe's account to be lies, a full trial before a jury was ordered. For example: not all of the victims were prostitutes and there was evidence of a potential sexual motive, hitherto denied.

The jury heard all of the arguments before finding Peter Sutcliffe guilty on all the charges and they rejected the 'diminished responsibility' argument and convicted him of murders and attempted murders.

MAD VERSUS BAD

The documentary kept raising the "Mad" versus "Bad" debate. It presented the issues before the trial as being a question of the jury working out which label applied. As I previously wrote, this is not what the jury were being required to do: they were being requested to form a view on legal guilt for murder; with the option of convicting him of manslaughter on the grounds of diminished responsibility, if they felt that the legal criteria for this were met.

No-one particularly disputed that Sutcliffe suffered from schizophrenia – except the defendant himself. All the reports on Sutcliffe said more or less the same thing. It was more a question of degree as to whether his illness gave rise to diminished responsibility. Even once he was convicted and imprisoned, the prison psychiatrists had him within the hospital wing, arguing that he was mentally ill and of course eighteen months after his conviction an all counts, he was moved from Parkhurst Prison to Broadmoor High Secure hospital, in Berkshire. He remains there to do this day.

Using the phrase non-legally, the documentary kept asking about 'sanity' … of course 'insanity' as a defence to a criminal charge is not available where the charge brought is murder. The only alternative which may reflect an acceptance of the role someone's mental illness can play in their homicides, is the 'diminished responsibility' defence. (Strictly, it is a partial defence.)

NOT TWO SIDES OF A COIN

I wanted to write on this point again: to show this case reinforcing the point that the "mad / bad" thing is not about opposite sides of the same coin. "Mad" was is vernacular for a medical condition; "Bad" implying criminal responsibility. Concepts around illness and insanity are from two different worlds: medicine and law. Sutcliffe was and is argued by psychiatrists to be mentally ill – this was always the case. The question for the jury around this point was whether the legal criteria for 'diminished responsibility' were met. The jury took the view that it was not.

This may be right or wrong: certainly the documentary reports that psychiatrists within the prison system thought he was "insane", thereby showing the documentary confused the legal concepts quite badly. Notwithstanding whether he was or was not insane or mentally ill, having been convicted of multiple murders, the law allows for only one sentence: life imprisonment. Had he been convicted of any other offences at all – including attempted murders – then it would have been open to the judge, even if the jury convicted him through a finding of guilty having rejected any insanity defence, .

Of course, eighteen months after admission, he was transferred to hospital under s47/49 of the Mental Health Act 1983 – which in its effect legally transfers him into a detention exactly like a restricted hospital order. Exactly like, except in one important regard: should he ever be deemed to no longer require detention and treatment in a psychiatric hospital, he can be 'remitted' back to prison under s50 MHA.

The documentary reports that this was "official recognition" that he was ill. Again, wrong: it was official recognition that the criteria for transferring him to hospital were met. It was recognised that he was ill when he was tried, convicted and sentenced. Just not, in the opinion of the jury, sufficiently ill to mean that the diminished responsibility criteria should apply.

20th September 2012

The "Policy as Law" Fallacy –

A particular dislike of mine is something I call the "Policy as Law" fallacy: the pushing forward of a particular organisation's policies or preferences, as a legal explanation for action or inaction in a way that suits them. There are various examples in the police and mental health arena, some of them by the police:

- **"This hospital is not a place of safety"** – that's fine, but s135(6) says that hospitals *are* places of safety – whether you are 'designated' is quite a different matter, and even then, not a trump card for laws.
- **"AMHPs have no power to use force to detain and convey someone when they're sectioned"** – that's fine, but s6 MHA says otherwise.
- **"Nurses can't stop someone from leaving a place of safety if the police have already left."** – perhaps you'd like to take legal advice about s136(2)?
- **"Police officers can't transport a mental health patient in a police vehicle because we're not insured to do it."** – wrong. Which other way do you want "wrong"?!

There are more and each of the above examples have been said to me over my time and presented definitively as **law**: I once did a blog post listing loads of myths that bedevil the police / mental health partnership but the point here is not to repeat them, but to focus on the impact upon partner organisations and operational practice that these misinformed attitudes and views can have.

DRAWING IN THE HORNS

I met with a group of mental health professionals following an incident where officers and AMHPs reached an impasse about how to resolve a situation involving a passively resistant, patient who had been 'sectioned'. It was suggested to the officers that only the police could assert the use of force but those officers resisted doing it for various reasons. It was suggested to me that the police service was 'drawing in its horns' to do less and this was promoting problems because no-one else could use force on patients. Ironically enough, the professional who argued

this went on to subsequently describe how twenty years ago, he may well have found himself inclined to put an arm around a client to encourage them to move somewhere once sectioned, but not anymore. He suggested it was no longer appropriate because of the potential for allegations to be made.

So which law were you using in that made it possible in the 1980s that doesn't apply now?! – the law twenty years ago is still in place now. In fact, you've just decided a different approach and you're pretending this is law.

Nothing has changed, legally speaking, but now it is often assumed that should any force be necessary at all, the police should and will do it. This is mental health services 'drawing in its horns', surely? But regardless of the rights / wrongs: my point here, is this policy decision is getting represented as the **law of the land**, which it is not. It is a policy decision by an organisation or a practice decision by a professional that they will not do something they could do, if they so chose.

Obviously, in light of adverse publicity, criticism by HM Coroners and legal judgements, police services have been looking at their obligations and their opportunities. To give just one example, the point where AMHPs should consider calling for support to convey a resistant patient is where the situation becomes 'dangerous' or 'violent' (chapter 11 of the Code of Practice to the MHA). If AMHPs are no longer willing to put their arm around someone and give an encouraging push-type hug to oil the wheels before calling in the paramilitary force of a stab-vested, tazered-up police officer, then we can see why we are creating gaps where non-dangerous, non-violent patients who are passively or minimally resistant. Gaps get created by organisations unilaterally defining boundaries without reference to other affected agencies and putting themselves at the front of the decision-making process, rather than the patient.

It is not so much the gaps that I am concerned with here, I have written about them elsewhere. It is the operation of partnership procedures in such a way as to allow an organisations unilateral declaration of what it will and will not do, be represented as 'law'.

It often isn't law: it is often just "made up stuff" to suit the position of the professional or the organisation putting the argument. We all do it.

I have heard many times both mental health professionals and police officers say things that they believe are laws, which are actually just their own views or preferences, or the policies of the organisations they work for. For example, I remember a police force who once stated on their intranet site that they will not use the Mental Capacity Act. Full stop: **ever**. This led to a complaint against them after an incident where a GP

and paramedics needed to remove an elderly man to A&E for potentially life-saving treatment for an extremely serious infection which had affected his cognition and his capacity to make a decision about treatment. The problem was that someone at their police HQ had represented this policy as "There is no legal authority for [area] Police to remove someone to hospital under Mental Capacity Act. [Area] Police will not use the MCA to justify the use of force."

INHERITED THINKING

So why does an agency's policy decisions become hard-wired and why do they often end up being presented as 'law' when they are often they opposite?

Well, I suspect we could sum it up as a combination of Chinese Whispers and received wisdom. I know that I've put out emails at work on a range of subjects and subsequently heard myself totally misrepresented. For example, every time I've ever explained 'Assessments on Private Premises' I have never, **ever** said, "No warrant means no police" and early on I learned to stress precisely that I am not saying "No warrant, no police". Yet many AMHPs have told me that this is how cops have interpreted what I have said. Is it impossible to conceive that somewhere in Mental Health Land that similar 'wisdom' is being received and is evolving into something new that is slightly awry?

You often see this when you have partnership arrangements between one police force and multiple mental health providers. MH Trust X won't do something legal because they insist it is illegal; MH Trust Y is more than happy. I'm sure Trusts covering two police forces probably have similiar frustrations.

I have lost count of the number of AMHPs who have told me that once a patient is 'sectioned' and needs removal to hospital that they have no legal authority to use force on that patient, that only the police have. This could not actually be any more incorrect. In actual fact, **the opposite is true**: once 'sectioned' the patient is in the AMHPs legal custody and only the AMHP has authority under s6 MHA to detain and convey. Of course, they may delegate this authority to someone else – paramedics or police are favourites – but the AMHP may not compel a paramedic or police officer to accept that delegated authority and until such time as they have, the only person with authority over that patient is the AMHP.

MULTI-AGENCY TRAINING

I cannot stress how important multi-agency training is, to this whole arena. I think it should be mandatory, every year. If organisations sit in

their silos deciding how they will unilaterally develop their practice and how they will operate, without involving their colleagues from other agencies, it is inevitable that gaps between them will emerge. Other, relevant professionals will not get the opportunity to be involved in that. It is about understanding the whole of the police / mental health interface, *as a system*.

Meanwhile, where policies are presented as law, or where policies contradict laws – yes, there are examples – we should expect some of those affected by that to push back, not least to protect themselves from legal liabilities, but also from resourcing demands that aren't theirs or are best shared. This is precisely why we should all ask ourselves about the provenance of our knowledge and ensure we're standing on solid ground.

25th September 2012

One Vision –

I'm not sure anyone knows the size of the problem, regarding how many people with mental health problems become involved in the criminal justice process. I've stated previously that if we leave the police to their own devices, they will spot around 12-15% of detainees in police custody and suspect a mental health problem which needs at least the Force Medical Examiner's attention. If the custody sergeant had fired off a list of all people arrested in the preceding 24 hours to the local mental health trust, they would have found that as many as 50% of those people arrested are known, have been known or need to be known by secondary care mental health services.

Then even if we knew the size of the 'problem', do we have an adequate understanding of what we're trying to do, or how where arrests for criminal offences have been made and mental health issues are suspected or known? Do we have one really clear vision?

APPROPRIATE DIVERSION

I keep hearing and reading things which talk about "appropriate" diversion (whatever that means). Who is deciding 'appropriate'? And on what basis? What factors of variables influence that assessment of 'appropriateness' and who decided them?

For example, we could conceive of a situation where a young, unemployed mother, who has a history of suffering from depression and anxiety disorders under the care of GP, who is caught for shoplifting food from a supermarket to feed her kids because of ongoing money problems. We could conceive of an adult man, without dependents who has a history of schizophrenia under the care of a community mental health team, with a history of short-term admissions to a psychiatric unit, who is caught shoplifting the same foodstuffs from the same supermarket to feed himself because he has been living rough in crisis for several days.

Imagine that upon arrest and medical assessment in the police station – firstly by the FME, but followed by Mental Health Act assessment by the NHS – a similar conclusion: neither person was in need of admission to

hospital under the MHA. We have two very different contexts to similar offending. Should this affect the outcome? There will be CCTV and store security witnesses for both (most usually there is, in large supermarkets where offenders are caught and detained – actually, the CCTV is often highly impressive and extremely clear); there will be evidence of either security or police officers recovering items, there will be a police interview in which questions will either have been answered or not.

In each case, we can see unmet need: perhaps the former is more around money, social support; perhaps the latter is around psychiatric care that breaks a cycle of "crisis – admission – release". Either way, we have passed the "evidential test" for prosecution. Is it in the public interest to charge (or caution)?

This is potentially where police officers or prosecutors get into **very** subjective territory.

CONTEXT IS EVERYTHING

Various things could alter the above scenarios, what if the theft occurred had occurred amidst threats of violence, which makes the offence robbery? What if, it still having been 'simple' theft matter, the store detective had been assaulted whilst detaining the offender pending arrival of the police; or if the officers had been assaulted? Would these aggravating features alter the perspective on an 'appropriate' criminal justice disposal or diversion decision?

Would the previous offending history be relevant? What if the single mother had never been arrested before; what if the man living rough had been arrested several times for offending whilst in crisis and had a history of non-engagement with mental health services?

It's all relevant isn't it? As I've frequently remarked, Professor Jill PEAY of the London School of Economics has argued that decision-making at the interface of criminal justice and mental health is the most challenging that either group of professionals will undertake. You can see from the above, that the 'appropriateness' of any decision to prosecute and / or divert someone is complex and subjective.

So what are actually we trying to do?!

UTILITY

One could argue about what the 'right' decision is – and whose decision it is. Is it the decision which address any unmet health or social care needs whilst using criminal justice powers to ensure or encourage engagement; or is it the one which maximizes the possibility or preventing further offences? How do we make decisions where we are not sure or are these the same thing?!

What matters, is **utility** – and to know this, we must research and learn more about the efficacy of prosecution and diverision (whatever that means).

It could be the decision which ensures an appropriate legal framework to ensure over-parternalistically that unmet needs are 'met' to discourage further offending – that framework could be one focussed upon 'therapeutic jurisprudence' like prosecution for the man in crisis to achieve a Mental Health Treatment Requirement on the back of a community sentence. This may successfully address his previous non-engagement with MH services because if he now doesn't engage he ends up back before the courts. But maybe he won't care?

I suspect we often confuse the "evidential test" and the "public interest test" – these are the two parts of the Code for Crown Prosecutors which must be weighted in order to establish whether a prosecution is a) possible and b) necessary. I am convinced from my experience it is far more frequently possible to prosecute a mentally ill offender than we think: even if they are in need of hospital admission. Where I think we need to articulate a clear vision is around necessity; or "the public interest."

In 1951 the Attorney General said in Parliament, "It has never been the rule in this country – I hope it never will be – that suspected criminal offences must automatically be the subject of prosecution." He added that prosecution should occur only "where it appears that the offence or the circumstances of its commission is or are of such a character that a prosecution in respect thereof is required in the public interest."

This is another reason why I'm unconvinced of the word "diversion" for the deliberations that criminal justice and mental health professionals have to make, because a consideration of just some of the issues around two hypothetical, fairly straight-forward shoplifter cases reveals the difficult balancing act that is required to get it right and the assessment of the public interest by police, prosecutors is sometimes something I don't think we get right.

We should not forget cultural issues within this debate: public attitudes towards sentencing are a political and social reality and the validity of our justice system and our policing is inherently connected to public trust in their actions.

For all these reasons, we need to be better co-join our criminal justice and mental health services to undertake the work at the interface and in order to do so, we need a clearly articulated vision of what we're trying to achieve so we can use all the legal tools at our disposal:

- prosecution / diversion,
- cautions / conditional-cautions,
- police / court bail,
- Part III MHA, inc, s35/36 MHA;
- community sentencing, inc MHTRs; etc.. – to do so.
- prison << *Yes, it has a place.*

A main problem is, too many people don't really know in practice what the list I have just given, actually means.

27th September 2012

The Custody Sergeants' Seminar –

A couple of blog ideas occured to me this week and fortunately, they overlap!

I spent Wednesday morning in Stoke-on-Trent speaking at the Police Federation custody seminar – check out the Twitter hashtag #NCFseminar for more. Twitter followers who were not able to be there asked if I would write up my half-hour presentation into a blog, given that they were unable to attend. As half of my presentation touched on custody issues around handling of "criminal suspects who are mentally ill", I thought that a very complex story I also heard this week would best exemplify the input.

Whenever I do presentations on policing and mental health issues, I always split it into two parts, and mould each part to the particular audience.

- Police responses to mental health emergencies
- Criminal suspects who are mentally ill

So, with custody sergeants and custody inspectors in the audience, it was obvious we need to talk about "the police station as a place of safety" and "the custody sergeant's decision around the 'diversion' of offenders" (whatever that means).

PLACE OF SAFETY

I outlined the journey that West Midlands Police undertook between 2005 when I first started a serious attempt ot understand how we get to a position of having health-based places of safety in every area. I explained the West Midlands process:

- Arrest – under s136 MHA
- Ambulance – called every time
- Assess – the clinical needs of the patient

- RED FLAGS to A&E
- No RED FLAGS to the psychiatric place of safety – it is for them to determine how much alcohol or resistance is too much, not the police.

- Police station as a last resort – if you can't improvise around it. << *Yes, improvising solutions is legal as long as it is assessed carefully.*

The major learning points around this were:

- Custody officers need to think about para 10.22 of the Mental Health Act Code of Practice and would benefit from reading all of Chapter 10 and 11 of the document,
- It is worth, for legal and clinical reasons, enquiring of arresting officers who have removed people to the cells under s136 to explain their decision-making against para 10.22
- Consider para 9.5 and Annex E to Code C of PACE against the decision to detain in the cells – it may end up being that as soon as 'detention authorised', it's off to hospital, transferred under PACE.

Finally, I covered a couple of issues around improvising around the location used as a place of safety: recalling the story of the officer in the south of England who had detained a 13yr old girl who appeared mentally ill. Having been declined access to the NHS facility on the grounds of her age alone, the officer was faced with taking her to cell block. Before doing so, he ran her home where he found a concerned mother, a clean and safe environment and somewhere infinitely better than a cell block full of criminals for a 13yr old girl with a history of self-harm. So he explained to the girl's mother she could either get the kettle on and accept a cop in her house for a few hours; OR he'd have to remove the girl to custody. Guess what she did? What would any responsible parent do?

Was this in the policy? No. Was it legal, was it better than custody?! Definitely. The FME and the AMHP came to the house a few hours later and assessed her and referred her needs to the appropriate NHS team, having decided that admission was not necessary.

CRIMINAL SUSPECTS WHO ARE MENTALLY ILL

I was told today of a most complex case. A young man with a distinctive appearance arising from his particular learning disability, who had also suffered a brain injury following an accident in his early teens. He was alleged to have committed a serious offence involving a weapon, in circumstances where it could be argued he posed a serious risk. Police inquiries led to concerns that this incident against a stranger was not the first offence, but the others committed towards family or carers, they have never been reported to the police. There were serious problems during the investigation because of particular legal difficulties around identification procedures. And because of a significantly reduced IQ and communication capacity the suspect was prevented from providing meanginful consent to

– or capacitous refusal of – things within crime investigations which are required by law.

The police balancing risk (to the public from further offending) against the need to ensure access to any necessary assessment, treatment or care; it represented potentially the most complex challenge to criminal justice and mental health professionals I have ever known.

At the Police Federation conference, I outlined that there were several things custody officers could do, right now and tomorrow, within the law, without the need for policies, protocols or procedures, which would significantly improve police management of 'diversion' and prosecution decisions, including where arrests occur in complex cases like the above. And it quite simply rotates around the custody sergeant's use of police BAIL under the Police and Criminal Evidence Act 1984.

Previously, I have written that in police custody the factor of whether someone with a mental health problem is 'sectionable' under the Mental Health Act 1983 is the single influencing variable which determines whether someone is diverted from the criminal justice system to the health system.

- If you are 'sectionable', you'll probably find no further action taken for the offence
- If you are NOT 'sectionable', your mental health problem will probably be of no particular relevance to the decision made.

We need to be more sophisticated than this. Also – what are we diverting people to and will it work? Most people diverted from police custody under the Mental Health Act are detained under s2 MHA for assessment of a mental disorder. As this admission provision leads to a range of outcomes, why are we taking very premature decisions about the criminal offence before we know the assessment conclusion. One of several things could happen after admission under s2:

- Conclusion of serious mental disorder "of a nature and degree" requiring detention for treatment under s3 MHA.
- Conclusion of less serious mental disorder which can lead to referral to a community mental health team or a General Practitioner.
- Conclusion that there is no mental disorder whatsoever.

So what happens if it's option 2 or 3 and the original offence which led to 'diversion' (whatever that means) was not entirely trivial?!

Why don't we just make it a matter of routine that all people diverted to hospital are bailed under s37(2) of PACE and the Investigating Officer reqruired to liaise with the Responsible Clinician for the patient to find out the conclusion? They can then either cancel police bail if it becomes clear

that prosecution cannot occur – whether for evidential or public interest reasons – OR, they can allow the patient who has since been released to answer bail and an appropriate criminal justice decision be reached.

With a limited few patients who have committed a serious offence before arrest and where allowing diversion (whatever that means) into a non-secure or low-secure psychiatric unit would be potentially inappropriate, it remains open to argue to the Crown Prosecution Service that charged be brought in order to allow Part III of the Mental Health Act to take its majestic course – a course which could lead to the granting of a hospital order or restricted hospital order under the Mental Health Act. These orders better balance the right to treatment and care with issues around public protection.

CUSTODY SERGEANTS

Back to the young man with a learning disability. The custody officer would be key to decisions if this man were arrested. Whilst profoundly disabled, there is also a public interest factor arising form the risk he posed. Notwithstanding our legal system requiring CPS authorisation to charge someone and medical decision-making to detain someone under the Mental Health Act, the custody officer retains a key constitutional responsibilty:

The custody sergeant has the authority to deny immediate ability to the Mental Health professionals to remove someone from custody under the Mental Health Act because of their legal decision under the Police and Criminal Evidence Act that there is sufficient evidence to charge and that it is in the public interest to do so. These are legal decisions reserved to the custody officer under s37 PACE and as it is about the administration of our criminal law, it would trump an AMHP's civil decision under s13 MHA to apply for admission.

So we now know, that the custody sergeant is a KEY constitutional position. Not only charged with ensuring safety, dignity and wellbeing for those in custody, but also for making nuanced decisions with regard to the most challenging decisions that would ever be required of any police officer. Often, these people can be found making them, whilst the shift are dragging in yet more drunks, yet more domestic violence offenders into busy, noisy custody offices, lacking in natural light and air.

It is difficult work that I'm proud to say I have done and that is why, notwithstanding my current rank, I remember everytime I step into a custody block that I'm not in charge there.

The custody block belongs to the custody sergeant – **that is all**.

29th September 2012

Too Long and Too Complex –

The Metropolitan Police have set up an independent commission to examine issues around policing contact with people in mental health crisis. The only police representation on the group will be Chief Constable Simon Cole, the ACPO Lead of Mental Health and Chief of Leicestershire. Otherwise, there will be various mental health professionals. There has been some disquieted reaction by organisations such as Inquest and Black Mental Health UK and today the Deputy Commissioner, of the Metropolitan Police, Craig Mackay, appeared before the London Assembly with regard to this review.

This post focusses upon a remark by the Deputy Commissioner, the second most senior police officer in the Metropolitan Police:

"The standard operating procedure is over 100 pages long and individual officers don't have much chance of being able to understand the complexity of it. This is why we wanted an independent commission to do a root and branch review."

SIMPLIFY!

It got me thinking about this whole blog – now approaching 200 articles and 160,000 words, which is roughly two PhD theses. On just s136 Mental Health Act alone, there are 23 articles covering various issues. They were deliberately written as explanatory pieces, not operational guidelines to be accessed in a crisis. Such posts came later in the form of the Quick Guides, in order to *simplify, simplify, simplify*.

We can see from just overlooking s136 how complex a subject it can be. It is often said when I've done training or inputs on this stuff, that it is complex and this is right. We are talking about police responses to legally demanding situations, involving medical complexity, often in an emergency. Therefore we all know, that to give any operative a chance, we have to *simplfy, simplify, simplify*.

We should also bear in mind the frequency with which operational officers deal with different mental health jobs. In my force there are around 8,000 officers and we detain around 1,000 people a year under s136 MHA. Bearing in mind that the number of officers who are likely to come

across a scenario where s136 would be exercised is approximately 4,000 is still means the hypothetical 'average' cop doing this stuff once every Olympics. How many MH assessments in a private dwelling – well my borough does about 1 MHA assessment a day and far fewer than half of those involve the police. So there are about 125 cops likely to attend and these jobs happen about once or twice a week – could you remember the legal complexities of such things – bearing in mind that AMHPs can't always agree – if you're doing it about once every two years?! *Simplfy, simplify, simplify*.

How easy is it to recall even simple operating models on MH jobs, if you're doing it once in a comparative blue moon? … and let's be frank: **it is made more complex than it needs to be by the NHS** –

- Some will deny officers access to a PoS for children – others won't.
- Some operate a zero tolerance to drugs and alcohol – others don't.
- Some will deny anyone who is resistant – others won't.
- Some will demand officers stay after arrival, even if the patient is calm – others won't.
- Some will say 'excited delirium' is a real, life-threatening medical emergency – others will say it's been made up by the police to justify killing people through the excessive use of force!

These are just some of the things I could list … so how do we make it simple for cops?

This is where the Quick Guide series of posts comes in: written to make operational reference tools from the larger, substantive posts which tries to explain backgrounds, problems, solutions and provides links to case-law, guidance and other relevant news articles or material. The Quick Guides are more about "Consider this; bear these things in mind; take a good faith decision according to what you know and act in the person's best interests. Now: crack on."

SIMPLICITY

But actually, s136 and Places of Safety is EASY. All of the above complexity and debates about exclusion criteria can be summarised into one brief model and this model can be applied to EVERY NHS AREA, whether or not they provide their Place of Safety services in accordance with guidelines.

This is crucial >> if they DO provide PoS services properly, it will work well and we'll all be happy. If they do NOT, then application of the model will make the NHS part of the decision-making around where someone ends up and they will be professionally and legally obliged to account for this in the event of untoward events:

- Arrest – under s136 MHA
- Ambulance – called every time
- Assess – the clinical needs of the patient

- RED FLAGS to A&E
- No RED FLAGS to the psychiatric place of safety – it is for them to determine how much alcohol or resistance is too much, not the police.
- Police station as a last resort – if you can't improvise around it. << *Yes, improvising solutions is legal as long as it is assessed carefully.*

It is therefore my view that police officers can and should apply this model, irrespective of their local arrangements because to do so would always be to act legally, against laws, codes of practice, guidelines and to act morally correctly.

Other debates about whether or not the police service could / should be involved in issues which are principally health and / or social care matters can be determined with reference to another, even simpler model – Are there any "RAVE Risks"?

- **R**esistance >> **A**ggression >> **V**iolence >> **E**scape.

Where there is "Resistance or Aggression", we're helping the NHS achieve their objectives to prevent crime and a breach of the peace, where there is "Violence and Escape" risks, we're leading the operation with NHS support. **This stuff isn't actually hard.**

These things can combine, for example if Mental Health Act assessments on private premises:

- Do we get involved in such assessments? >> Only if there are RAVE Risks or a s135(1) warrant.
- Having got involved to ensure safety against such risks, someone is detained under a s135(1) warrant for a place of safety? Ambulance – Assess for RED FLAGS and then one of three things … etc..
- Having got involved in MHA assessment without a warrant and someone is then 'sectioned' – do we convey? >> We'll support the NHS in doing it if the RAVE Risks continue to be relevant.

Of course, senior officers need to accept that this is complex business and the breadth of incidents which fall under the "policing / mental health" banner is very wide. Professor Jill PEAY commented in her book "Mental Health and Crime" (2010) that work at the interface of mental health and criminal justice is the most complex that either set of professionals will ever undertake.

I would encourage everyone connected to this work or this debate to read Professor PEAY's book if they get the opportunity.

I would respectfully suggest senior officers also need to reflect upon whether there force has a co-ordinated strategy around simplfying and improving policing responses in partnership, along the lines envisaged by the ACPO / NPIA Guidelines on Police Responses to Mental Ill-Health and Learning Disability (2010).

COMPLEXITY

Of course, one of the reasons that police services find that mental health is made complicated, is that we deliver far less training on mental health issues in relation to the proportion of our work that this business represents, than in other areas of policing. That this remains the case is surprising for a few different reasons. If for no other reason, we know that many very high-profile tragedies in policing have involved issues around mental health matters: these have included the deaths of patients during police responses to mental health emergencies as well as the deaths of members of the public and of police officers from offenders who have mental health problems and relevant risk histories.

I remain convinced that our society's response to the diversion of offenders (whatever that means) can unwittingly 'stack the deck' towards the building of hidden risks because we still have not defined what 'diversion' is and what we're trying to achieve. We still see official reports talking about "appropriate diversion" without defining it. This is a problem.

It is also true, that forces which maintain partnership arrangements with several mental health trusts and local authorities often acquiesce to often to individual mental health trusts preferred arrangements which are overly localised. The law on s135(1) is the same in Bristol and Birmingham; the law on s136 is the same in Newcastle and London. So why the differences? I don't mean differences in local arrangements, I mean why do trusts maintain differences which imply differences in **law**? It self-evidently obvious that the law is the same.

So we need models that take this business and simplify, simplify, simplify. This blog contains many … we can make more. The Quick Guide Series of posts turns most MH issues into a series of bullet points in under 300 words. If I can work out how to fund it, we need to develop a SmartPhone app with this material on it – meanwhile, why not save blog pages to your homepage? I've got stories now of cops waving iPhones at NHS staff to "oil the wheels of partnership!"

This stuff is there to be used / adapted / improved upon. **Fill your boots.**

30th September 2012

The Appropriate Adult –

Did you see the dramatisation of the Fred West story last year, entitled "The Appropriate Adult"? It was genuinely amazing, extremely well written and acted and rightfully won three BAFTA awards for Emily Watson (Janet Leach, the appropriate adult) and for Dominic West (Fred West) and Monica Dolan (Rose West). Do look it up if you didn't see it (available on iTunes, apparently).

The story of Janet Leach was fascinating – contacted by Gloucestershire Police to act as appropriate adult for Fred West after his arrest and then thrown straight in to the horror of his crimes and the development of something of a non-romantic relationship between them. Janet Leach successfully sued the Chief Constable of Gloucestershire for the impact upon her life and her mental health of being exposed to the intricacies of the investigation without support or proper preparation and it has affected how the role is understood.

AMENDMENTS TO THE CODES OF PRACTICE

This post is a general one, arising from a fascinating debate I had in custody when I was the duty inspector for my area and intended to highlight two changes to Code C of the Codes of Practice. A man with a history of schizophrenia who was not presenting as acutely unwell and who did not require assessment for formal admission under the mental health act, had been arrested for causing damage at his bail hostel and detained for interview.

He required an appropriate adult and a professional from local services attended to help. As soon as the man walked into custody, he asked about whether a solicitor had been requested by the detainee – it hadn't. He been offered a solicitor, but had declined the opportunity. The appropriate adult immediately stated that it is law that all vulnerable adult detainees have an appropriate adult and it is fair to say his manner irritated the custody officer somewhat, not least because it simply is not the law of England that all vulnerable adult detainees have a solicitor – another example of the "policy as law fallacy".

The debate it generated was around whether an appropriate adult has a **legal** right to insist upon a solicitor, where the adult concerned does not wish to have one. Obviously, the PACE Codes of Practice were pulled for frantic page flicking and there were a difference of views amongst the officers present. As it happens, Code C of the Codes of Practice has just been updated in 2012 and it contains a crucial update for this discussion: in the 2008 Code, para 6.5A outlined the right of appropriate adults to insist upon a solicitor, albeit they could not force the person they were supporting to see the solicitor if they were adamant that they did not wish to do so. *Crucially* >> this 2008 version related to **juveniles only**, not to vulnerable adults.

As such, it could be viewed that where the appropriate adult insisted when the detainee is a vulnerable adult, they had no right to do so in opposition to the detainees own views. As of July 10th 2012, para 6.5A has been amended and now reads:

*"In the case of a person who is a juvenile **or is mentally disordered or otherwise mentally vulnerable**, an appropriate adult should consider whether legal advice from a solicitor is required. If the person indicates that they do not want legal advice, the appropriate adult has the right to ask for a solicitor to attend if this would be in the best interests of the person. However, the person cannot be forced to see the solicitor if they are adamant that they do not wish to do so."*

(The words in bold are my emphasis to highlight those added by the 2012 Code amendments.)

On the face of it, we can understand why the law may have been amended to allow appropriate adults to insist. The category of vulnerable in police stations will cover many people with varying degrees of mental disorder including detainees who lack any insight into the surroundings, the legal process in which they have become involved. Also, it encompasses individuals who a very capable of understanding custody processes to a degree that the need for an appropriate adult at all is often questioned. However, the law is clear: if someone is, or appears to be, mentally disorder (within the meaning of the Mental Health Act) then an appropriate adult will be called.

SECTION 136 AND PLACES OF SAFETY

One other amendment in the 2012 update which affects policing and mental health issues, is para 3.16 regarding the role of appropriate adults during s136 or MHA assessments. This now states that the appropriate adult has no role in these assessments and is not required. This brings to an end an anomaly:

As the 'appropriate adult' role is something unique to police stations, it is something that is not required where the police have detained someone under the Mental Health Act and removed them to an NHS Place of Safety. However, the need for an appropriate adult has always been preserved in the PACE Codes where the place of safety used is a police station. Some have questioned why, given that the AMHP and the DRs who undertake the assessment are independent professionals whose very *raison d'être* is to ensure the welfare and wellbeing of those they are assessing. Because of this, it is fair to say, that some custody sergeants have not always ensured that an appropriate adult is called during the booking in, in order to come to the station and support the detainee, including by helping them understand or exercise legal rights in the station.

It is now clear: we still need appropriate adults for booking in procedures when the cells are used as a Place of Safety; we do not require them for s136 or MHA assessments in police custody.

30th September 2012

Autonomy and Mental Capacity –

When you read this post, please don't think about the pros and cons of vulnerable people being legally represented in custody. This post is not about solicitors for vulnerable people. Think about the right of personal autonomy – to take one's own decisions where we have the capacity to do so. This post is **not** a police officer lamenting about how great it may be if only people were not legally represented – either because it would be faster to deal with people or for any other reason.

I can't imagine, for example, a situation where I would not want my son to have a solicitor if he were in police custody – guilty or innocent of any allegation; or if detained under the Mental Health Act.

This post is about how I want to live in world where we respect personal autonomy as far as we possibly can do so – there will come a point where my son has the right and the responsibility to make his own decision and this will happen well before he is eighteen years old. I'm sure I will wrestle with this as generations have before me.

I wrote about a case previously briefly in "The Appropriate Adult" and having done so an alarm bell later went off in my head regarding something altogether more important arising from it. You may remember, there had been a disagreement between a mental health professional who had come to act as an appropriate adult and the detainee they had turned up to assist. An adult man, suffering with schizophrenia, had been arrested after being alleged to have caused criminal damage. He was still awaiting interview when I left the police station to come home there having been something of a delay after his arrest because of the need to secure a Force Medical Examiner's opinion about the impact of his schizophrenia upon the investigation, including consideration of whether a full Mental Health Act assessment may be needed.

We learned at the end of the FME's examination, that the man was known to local community mental health services, had a forensic history as well as the previous convictions that we already knew about. That said, mental health services informed the FME that he had been engaging with care after release from prison and they agreed with the FME that formal assessment for admission was not required. The man was taking medication, keeping

medical appointments and was stable in his recovery. He was living free from any restriction on liberty arising from his mental illness; restricted only by the terms of his prison licence for his offending behaviours.

Therefore, the question for the police officers was whether he did or not did commit criminal damage; to make a decision about whether he should be charged with this and what impact, if any, that decision may have on his licence. So we need to interview him and the FME had rightly said he would require an appropriate adult. Unfortunately, there was no-one from friends or family who could undertake this role so we sought support from the local authority.

The appropriate adult who turned up was experienced and one of the first things he asked was whether the man had requested a solicitor? He had not done so, despite it being offered. The appropriate adult stated that a solicitor should have been called, incorrectly insisting that "all vulnerable adults in custody have to have an appropriate adult. It is the law." It is not the law – not at all.

This disagreement became fascinating for two reasons: firstly, incorrectly quoting the laws within PACE to a sergeant is guaranteed to wind them up – especially the professional, experienced and knowledgable custody officer on duty at that time who knew without looking it up that what he had just heard was nonsense. It was also fascinating for another reason: the detainee protested to the appropriate adult in front of the custody officer and said he didn't want one.

SO WHAT DOES THE LAW SAY?

Paragraph 6.5A of Code C of the Codes of Practice to the Police and Criminal Evidence Act is the answer: it provides that the appropriate adult has the right to insist upon a solicitor being called if they believe it is in the detainee's best interests, however it reinforces that detainee cannot be compelled to see or accept the solicitor if they are adamant that they do not want one. The law on this point was only amended in July 2012 to allow the appropriate adult to insist upon calling a solicitor.

So at this point my thoughts turned to the concept of mental capacity around this man's decision and his own personal autonomy. The law of England demands that this man be presumed to have capacity to take his own decisions unless an assessment concludes that he does not. An unwise decision is not, of itself, reason to argue that someone lacks capacity and any attempt to take a decision against the wishes of someone else in their best interests should be predicated upon an assessment that they lack capacity.

Is it unwise to decline a solicitor in police custody? Maybe, but not necessarily. Maybe he knew exactly what he wanted to say about the allegation and was confident of doing so? Who knows …

But many public sector organisations who agree to support mentally disordered suspects in custody have a blanket policy of insisting that all detainees be legally represented. As many of the professionals who undertake this role are mental health professionals who operate in a world of patient empowerment against a legislative backdrop that attempts to respect individual autonomy, it seems at least curious that there is no individualization in this regard.

I also had one further concern: did the appropriate adult inform the detainee in proper terms about his legal rights whilst he was busy attempting to over-rule him? – of course, it is not the role of the appropriate adult to give legal advice. Maybe the detainee needed a solicitor to handle his appropriate adult, rather than the police?!

So was it made absolutely clear that a solicitor could not be forced upon the man and if he continued to resist his decision would be respected? Home Office guidance to Appropriate Adults is available and it makes this clear. In light of the fact that the appropriate adult incorrectly believed he had a right to insist the detainee be represented, it seems likely that he declined to explain the truth to the man detained, mainly because he did not know what the truth was. As he was determined to exercise a policy of seeking legal advice against the wishes of a detainee – who we should remember was not acutely ill, not in need of admission under the Mental Health Act and who is presumed, by law, to have the capacity to take decisions – it seems improbable that a proper explanation of his legal rights was provided – that if he insisted upon not wanting a solicitor, none would be forced upon him.

Now – all of this is difficult stuff, isn't it? Anyone could read this and suggest that this is just a police officer arguing outrageously against the legal representation of vulnerable people in custody. Actually, as stated at the start of this piece, what I am actually arguing for is **respect for personal autonomy**. This post is not about legal representation, that is merely the vehicle for making the point. If this man lacked the capacity to take the decision about legal representation – and there was no reason that he did following examination by a s12 Doctor – there is a legal opportunity to manage that. Let us remember that an unwise decision does not mean someone lacks capacity and let us remember what the appropriate adult is for – it is to assist in communication and ensure fair treatment from the police. Investigating and interviewing suspects without legal representation is not inherently oppressive or unfair – it happens everyday in this country where people have taken a free choice not to be represented.

Having arrested, detained and reviewed thousands of people in police custody over fifteen years, there are a range of valid, weird and private reasons for this. Why should people with a mental disorder be treated any differently when their treatment is safeguarded by the appropriate adult ensuring proper conduct by officers and clear communication of what is occurring? The man was demonstrably concerned that the appropriate adult's decision to over-ride his wishes would – in his own opinion – unnecessarily extend his time in custody. You may judge the importance of such a reason for declining a solicitor. My point is, that it is his decision to make.

As I say – this post is not about legal representation **at all**; it is about **autonomy**.

OCTOBER 2012

2nd October 2012

Absconding & Escaping –

I have covered AWOL patients on various blogs and in various situations, the police have a power of arrest under section 18 of the Mental Health Act to retake patients and convey them to the hospital from which they are missing or to which they have been recalled. There is no power for officers to force entry in order to exercise this authority and a warrant must be secured under s135(2) in order to do so. AWOL situations include:

- Those who absent themselves from hospital without permission; OR
- Those who fail to return from authorised leave on time; OR
- Those who fail to surrender to recall whilst on a Community Treatment Order.
- It also includes 'conditionally discharged' restricted hospital order patients where the Secretary of State for Justice has issued a warrant to recall them.

Absconding or **Escaping** (from lawful custody) is different and it involves individuals who escape or run off after they have been detained for removal to a place of safety OR who run off before arriving at hospital having been "sectioned" – it covers the PoS situations under both s135 and s136 and all the "sections" under Part II of the Mental Health Act, like s2, 3 and 4.

There is a power to retake such absconders under s138 MHA.

TIMESCALES AFTER ABSCONDING FROM s135 OR s136

Where someone has been detained for removal TO a place of safety; or detained AT a place of safety, they are in legal detention for up to 72hrs in order to allow assessment of their need for treatment or care. Should they escape, they are regarded as having absconded and can be retaken into custody for up to 72hrs. The precise time limits for re-taking a patient depend on when they ran off.

- If they absconded after being detained by the police but BEFORE arriving at a place of safety, the 72hrs begins at the time of absconsion.
- If they absconded after arrival at the Place of Safety, the 72hrs begins at the time of arrival at the PoS.

So, if someone was arrested under s136 at 1000hrs on 02nd October and whilst in transit to a place of safety, they escaped at 1015hrs, they can be re-detained under s138 MHA at any time until 1015hrs on 05th October.

If someone was detained under the terms of a s135(1) warrant at 1400hrs on 03rd October and arrived at a place of safety for assessment at 1430hrs on the 3rd, but escaped from there at 1800hrs on 03rd, they could be retaken at any stage until 1430hrs on the 06th.

TRUE STORY

Officers in south Wales attended a premises with an AMHP and DRs to potentially assess a resistant man under the MHA for admission. As it happened, there was no need to force entry because he opened the door when they knocked on it and allowed access. Upon entering, they found the house to be in some disarray and felt it was not an appropriate environment to conduct a proper assessment. The decision was taken that he would go to the place of safety, but because they did not want to agitate him by making explicit mention of compulsion and detention, he was not informed of the warrant and it was not executed. He had been asked if he would go the place of safety and had agreed to do so. He was allowed to collect some possessions and entered a room to get clothes from the drawers. He then went straight out of a window, running off.

There then broke out a dispute between the MH services and the police officers' sergeant about whether the police could / should have prevented the absconsion and whether he was 'unlawfully at large' or had 'escaped lawful custody'.

Had he absconded? No – the warrant had never been executed so he was 'free' to leave in the sense that he had not yet been detained. Could the officer have executed the warrant to detain him as soon as it was obvious he was going out of the window? Well, possibly – it depends on whether they could physically prevent the escape. Has the patient committed an offence of escaping from lawful custody? No – because he had never been detained.

Of course, he could be detained under s136 if found in a public place or if he returned to the home address and the police re-visited it within 28 days of the warrant being executed, it could still be used to detain and remove to a place of safety. Had the warrant been executed, the 72hrs would have commenced at the point where he absconded with three full days in which to utilise the authority afforded by s138 MHA.

RARE & OBSCURE CIRCUMSTANCES – A LEGAL ODDITY

Some of the 'other things' than come up in Absconding & Escaping which are NOT situations where someone is AWOL, including patients who are detained in hospital under sections 35 or 36 of the Mental Health Act – where they have been remanded to hospital by criminal courts during the pre-trial or trial process. Such remands for forensic assessment include a provision that if such a remanded patient absconds they may be retaken without warrant ONLY by a police officer. This is in contrast to almost all other AWOL and Asconding situations where AMHPs and / or other staff authorised by relevant hospitals may re-detain patients and return them. The provision, under s35(10) instructs the detaining police officer to remove the person not to hospital, by to the court who ordered the remand to allow them to re-consider the case.

So absconding from Part III remands means only the police may act and when they do, they must remove the patient back to court, not back to hospital.

6th October 2012

MAPPA –

Multi Agency Public Protection Arrangements are information and risk sharing procedures which are required by law, following the Criminal Justice Act 2003.

MAPPA is intended to ensure that potential risks posed by violent and / or sexual offenders are properly understood and managed as well as they can be to prevent further serious offending and re-offending. The Ministry of Justice issues guidance on MAPPA under s325(8) of the Act – Version Four of this statutory Guidance was published in 2012.

MAPPA arrangements "are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders." but it is not an agency or organisation in itself, more a framework within which many organisations come together to jointly manage risks by sharing information.

WHO IS INVOLVED IN MAPPA?

MAPPA involves two types of agency:

- **The Three "Responsible Authorities"** – Police, Prisons, Probation
- **Various "Duty To Cooperate" Agencies** – inc Housing, Health (child / adult) inc Mental Health, Education Services (for juveniles), Employment Services, Youth Offending Teams, Electronic monitoring services.

The relevance of MAPPA to mental health is that s325(3) identifies those services as "Duty To Cooperate" agencies and s327 identifies MAPPA eligible offenders as including mentally disordered offenders (of a certain kind, see below). It is incumbent upon all statutory agencies that they have systems in place to ensure eligible offenders are promptly identified within three days of being imprisoned or admitted to hospital; that information is appropriately shared; and that risk assessment leads to a risk management plan being developed.

So for example, if Nottingham Crown Court imposed a restricted hospital order upon a patient who was then admitted a a psychiatric unit in Birmingham, the hospital would have a duty to identify to the West Midlands MAPPA Co-ordinator that someone who was 'MAPPA eligible' had been admitted. If upon release from hospital the person stayed in Birmingham, then West Midlands MAPPA arrangements would manage the risks and threats. If the person moved back to Nottingham upon release, the West Midlands MAPPA co-ordinator would transfer the case back there.

WHAT KIND OF MENTALLY DISORDERED OFFENDERS ARE ELIGIBLE?

Not all sexual and / or violent offenders have to be managed by MAPPA arrangements. It is only when the seriousness of the offence passes a certain threshold that these legalities kick in. The following offenders MUST be subject to MAPPA arrangements:

- Convicted of specified sexual or violent offence – such offences are listed in Schedule 15 CJA; AND
- Sentenced to 12 months custody OR sent to hospital by court subject to s37 MHA 1983, with or without restrictions under s41; OR
- Section 45 or 47 MHA prisoners ; OR
- Other dangerous offenders under s3 or "Notional s37" with previous relevant convictions.

So you will see from the above, that this has a potentially serious implication for Liaison and Diversion. If someone is arrested for an offence and they are diverted away from the criminal justice system before being sentenced, they can never be subject to MAPPA arrangements around the management of risks. You may think this is a good thing, because it avoid the necessity of a vulnerable person being subject to the stigma of MAPPA management.

However, consider a real example: an offender who was arrested for a serious offence committed whilst extremely unwell. The offender was so unwell, in fact, that they were admitted directly to a medium secure unit under s3 of the Mental Health Act having been unable to be interviewed about the offence because of an urgent need for treatment without consent. The CPS lawyer who subsequently took a view that the man should not be prosecuted because they has already been admitted to a medium secure facility to receive necessary treatment for the florid psychosis being suffered at the time was then denying the potential of MAPPA to protect the public.

This of course would mean, that if the man were released from hospital, there would potentially be no joint planning to mitigate risks and

threats. However, any prosecution leading to a conviction would undoubtedly lead to a sentence longer than 12 months OR to a restricted hospital order and therefore to MAPPA arrangements.

INFORMATION SHARING

Obviously, information sharing between agencies is key and MAPPA arrangements themselves came about in part because there were some notorious examples of public services not sharing relevant risk information to protect the public. "The purpose of sharing information about individuals is to enable the relevant agencies to work more effectively together in assessing risks and considering how to manage them. This points towards sharing all the available information that is relevant, so that nothing is overlooked and public protection is not compromised."

Whilst MAPPA was a very new concept, professionals and agencies struggled with information sharing. The existence of MAPPA and its legal significance does not allow carte blanche exchange of information. The guidance states very clearly that all information sharing must still be legal in its own right. So for example, a psychiatrist who attends MAPPA should not be sharing with the other professionals any medical or confidential information that they would not be prepared to share by picking up the phone to the police or the Probation Service because they had concerns.

LEVELS OF MAPPA

In all areas there are regular MAPPA meetings. The frequency of it is determined locally, dependent upon the number of offenders being managed. About five years ago, I was an inspector in charge of an intelligence / offender management office and I line managed the sexual and violent 'offender managers'. All MAPPA cases were broken down into three levels, the lowest being offenders subject to sole agency management by the police. For example, if an offender had committed an offence at the less serious end of the MAPPA spectrum and had for several years been monitored without concern about re-offending, these 'offender managers' would ensure regular contact and monitoring, they would visit the offenders at a frequency determined by their inspector and there would be a formal review about the monitoring arrangements as frequently as the inspector deemed necessary. This would often be every three or six months.

For more serious offenders where there is a suggestion of re-offending or where there is intelligence about risks of offending, there would be a discussion in the regular MAPPA meeting where level 2 and level 3 cases were discussed. Within these confidential meetings, relevant agencies

would discuss cases and jointly determine how to mitigate risks. This could include, for example, the police sharing intelligence about offending with mental health services who could bear that information in mind when doing home visits or clinical supervision. It could include mental health services sharing concerns they had arising from their work, which might need police or probation input. In some cases, concerns about offending could lead to the police undertaking surveillance, for example.

VICTIMS RIGHTS

Within MAPPA, **victims** have rights to know when offenders are to be released (from prison / hospital) and whether or not there are any conditions being imposed upon the individual. They have a right to know when any imposed conditions cease.

7th October 2012

Mental Health Screening in Custody –

The issue of how to better identify people with mental health problems in police custody keeps coming up. It was raised in the Bradley Review (summary) and there have been various suggestions over the years. Last year, an initiative started in Lambeth police custody and there have been recent calls to specifically improve screening for women's mental health in police custody. There are various methods to do so:

- **24/7 psychiatric nursing in custody** – expensive. Questionable whether it would be viable in less busy custody offices. Also, research from the 1990s (JAMES) showed that where psych nursing was available, something like 15% of people in custody got identified as having a mental health problem. This figure is only slightly higher than the 10-12% that the police would have spotted for themselves – it would still see some learning disabilities patients being missed.
- **Screening Tools** – of various kinds: IT based tools which can cost thousands and which take inordinate amounts of time to use per person detained. I've known some people keen to sell things which would take 30 minutes per arrest to screen. Not practical.
- Other problems around screening tools include the fact that they are often specific to particular issues like Learning Disabilities, rather than generic to a breadth of mental disorders. Obviously, it would be impractiable to have two or three different screening tools and use the lot to ensure that every base is covered because it would take too long per detainee.
- **Better Police Training** – never a bad idea. How well do you want us trained? Given that fully trained psychiatric nurses don't spot that many more than police officers, would it really be the silver bullet?

So here's a thought!? …

Why can't all police custody areas and their local mental health trusts establish one or two phone numbers that the police ring EVERY SINGLE TIME someone arrested arrives in custody? In fairness, you could do this in many police encounters where arrests or detention were being considered and who knows what better ideas we could come up with, together? After the police provide the name, date of birth and address of the person arrested they give just one piece of information: whether or not the police

have concerns that the person detained has a mental health problem – in the street, you'd only call if you had those concerns.

This view could arise for a range of reasons:

- Police or FME observations of the person's demeanour / behaviour.
- Police information systems indicating prior knowledge of a mental health problem.
- Self-declaration by the person detained when asked by the custody officer
- Third-party information from someone involved in the incident being policed that the individual has a mental health problem.

Of course, the precise source of the information would not need to be disclosed, merely the existence of a suspicion. Meanwhile, in HealthLand those nominal details could be cross-referenced against NHS records. In order to preserve medical confidentiality, there would be no need to actually tell the police anything: the mental health trust would merely decide whether they are coming to custody to assess the person?

ONE OF THREE OUTCOMES

- **If the police / FME have concerns and the patient is a known MH patient** >> turn out the CrisisTeam and screen the person in custody.
- **If the police / FME have concerns and the patient is NOT known as a MH patient** >> turn them out and screen.
- **If the police / FME have NO concerns and the patient is NOT known** >> don't turn out.

So what do we need to make this work? One or two phone numbers into the NHS which could be answered by someone who can access health records and notify the CrisisTeam, if that is required. Maybe one for office hours and one for out of hours … who knows.

How often would we be phoning? It obviously varies by area, but in my area's custody office for example, we detain on average around 25 people per day. That's one phone call per hour (average).

What would be the benefits? Well, in one initiative in the south of England, it was established that as many as 50% of people who are arrested are either currently known, previously known or need to be known by the mental health trust. If we therefore structure our response on indirectly accessing that data to influence the response of our health colleagues, in addition to those incidents where the police have concerns, I am suggesting the 'capture rate' would rise dramatically. Of course, if

that were in addition to good risk assessment questions, so much the better.

Is it beyond possibilities that organisations as large as police forces and mental health trusts could not establish an arrangement whereby it is possible to make one phone call an hour to the NHS and say "Michael Brown has been arrested, [DOB / ADDRESS] and we've got concerns based on historical information of MH problems". It would potentially capture a far, far clearer picture of the number of detainees in custody who have a history of mental health problems and better identify individuals who could be diverted (whatever that means).

Just a thought … and of course this principle could apply outside of custody, too! Officers at incidents with the ability to access mental health nurses and their advice or information. It'll probably never catch on.

9th October 2012

Remand for Forensic Assessment –

The provisions of section 35 and section 36 of the Mental Health Act are not used very much, probably as a result of the preferred policy of diversion (whatever that means) from the criminal justice system. Each section allows criminal courts to remand someone to a suitable hospital for assessment and care, as well as for a court report to be written to assist the court in reaching the correct conclusion before or during trial.

The most recent high profile example of these mechanisms being used, was the remand to hospital which followed the intial appearance at court of Phillip SIMELANE. He was prosecuted for the murder of 16 year old Birmingham schoolgirl, Christina EDKINS in March 2013 and will stand trial later in the year.

One of the first difficulties with these remand provisions, is that neither of them allow defendants to be remanded to hospital after their initial appearance at the Magistrate's Court. You'll note, for example, that Phillip SIMELANE, having been charged, appeared directly before Birmingham Crown Court.

- **Section 35 is for defendants pending trial before the Crown Court or having been convicted or found responsible before the Magistrates Court** – The provision allows a remand to hospital so that a report may be written on the defendant's mental condition. The Crown Court may exercise this power for defendants awaiting trial; the Magistrates may do so only where the patient is convicted OR the Magistrates are satisfied that they did the act or made the omission with which they are charged.
- **Section 36 is a power for a Crown Court to remand a person to hospital for treatment pending their appearance for trial** – This requires the written or oral evidence of two doctors and is available for any offence punishable by imprisonment, except for offences where the punishment if convicted is fixed by law. So section 36 cannot be used in murder proceedings, for example.

I have been involved in a few investigations where the potential of these remand provisions were being considered in police custody before charge, with a view to better assessing and managing certain offenders. There are

a few problems associated with it, not least of which is that no-one in practice really seems to know what this all means.

Firstly, mental health services sometimes use Part III provisions, of which these remands form part, as a key criteria for accessing secure, forensic services. I have written before, that clinical need is clinical need regardless of the legal framework that sits around it, so I have always been nervous about hearing that clinical judgements are sometimes made upon legal contingencies that cannot be relied upon. To give a specific example, I remember a being asked to advise a senior investigating officer (SIO) in a murder investigation where a patient who was arrested for the offence was in need of being admitted to a medium secure facility, according to the MHA assessment team and the forensic psychiatrist who also turned out to the cells. However, there was simply not enough evidence to charge him with the offence at the time and the SIO wanted the man admitted and bailed for further criminal inquiries. There was something of a stand-off because initially, there was a reluctance to admit him to the unit under s3 MHA without him being charged – also because they were struggling for an available bed. I'm not sure how status within the criminal justice system as a suspect or a defendant, alters the clinical need.

Secondly, there can be no control by police or clinicians over the courts. A recent example in a guest blog highlighted how an MHA assessment lead to a conclusion that a man needed to be remanded under s35 to a forensic unit for assessment, having been charged with assault. However, upon arrival in court he pleaded guilty and as the offence was comparatively minor, he was given a conditional discharge as his sentence and released. Presumably, there was panic in the mental health services to then have him detained under s2 or s3 from the court cells. Something which could have been done the previous evening from police cells under more controlled conditions. The courts have a duty to act proportionately also and remanding someone to a psychiatric hospital for up to twelve weeks for a comparatively minor offence could be argued disproportionate and in my view, discriminatory. Do you know the background you must have to be remanded to prison for twelve weeks for a minor offence?

Only this week, I'm aware of a mentally ill man being in custody for a serious offence who in the opinion of mental health professionals needed hospital admission for assessment and treatment. Rather than 'section' him, they encouraged that he be charged with the serious offences and remanded under s35 – this was probably a reasonable suggestion on their part, in fairness to them … but the court took a different view and he is now in prison whilst psychotic. Not great.

Thirdly, we have to bear in mind the old problem of how we make decisions in police custody about how to manage any mentally disordered offender. How is information shared before charge, to ensure that

investigating officers properly inform prosecutors who can then make *informed* decisions in courts. We see again and again, reluctance to share information with criminal justice agencies despite that having a direct bearing on how our system manages the most complex of "offender-patients". This is deeply ironic, given the creation of a non-existent axiom between secure mental health care and criminal justice.

Finally, I have an underlying concern about how these decisions may affect "fitness" assessments in police custody. In two cases I have known where MHA assessments have led to suggestion that people should be prosecuted for a "Part III remand", it has been obvious from the description given and from written notes left in custody, that clinicians did think that someone was "suffering a mental disorder of a nature or degree" that warrants admission. We know that being remanded under ss35/36 does not bring the defendant under the full auspices of the Mental Health Act. For example, someone remanded may not be treated without consent under Part IV of the Act. There has been caselaw where a s35 remand defendant has ALSO been 'sectioned' under s3 so that Part IV provisions may be used. Confused?! You should be – with regard to how these decisions that are little researched are played out in police custody before charge. What would it say about decision-making if we knew that in custody someone was not 'sectionable' because they should be prosecuted and remanded for a court report, only to find that once remanded they were 'sectioned' under Part II anyway?!

NB: *Important legal point* >> If patients who are remanded to hospital under sections 35 or 36 escape from hospital or whilst being conveyed to hospital: **only the police** may redetain them and they must be taken as soon as possible **back to the court** which remanded them. This is unlike AWOL patients or Absconders / Escapers from places of safety.

12th October 2012

School Homework –

My seven year-old son came home from school a few weeks ago with some maths homework. It was a series of number problems where he had to predict the next number in a sequence based upon the appearance of a pattern:

2 – 4 – 6 … ?
3 – 6 – 9 … ?
10 – 20 – 30 … you get the idea!

He rattled through it fairly quickly and we ended up having a chat about it. I ended up suggesting that he should say to the teacher "I've written what I think you want but there wasn't enough information to be certain!" (I admit that I like stirring his head and getting him to question things!) It's child's play isn't? … literally?! How could the answers be anything other than 8, 12 and 40? Well the answers could have been any number of things, depending on the rule or rules in operation in the pattern.

The first answer could be 10 – if the rule was "sum of the last two numbers" … and that would make the second answer 15 and the third 50.

Even if the examples had included the first four or even ten integers in a sequence rising by consistent values, there could be a complexity in the rule which means that guessing the next as any seven year old could, leads you to choose the obvious but incorrect option which has disastrous consequences.

What has the over-simplified prep school homework that is teaching my son to look for the obvious and not to THINK got to do with policing and mental health?!

It's about NOT leaping to obvious conclusions and it is about the dangers of NOT THINKING. My son's teacher is an excellent teacher and they are going through this exercise for a reason relevant to 7yr olds; but where police officers are encouraged by overly simplistic mental health policies to do things which make presumptions and / or assumptions about what they are actually managing, we can now see how we stack the deck in favour of untoward events.

Alcohol, drugs and resistance are often said to be triggers or exclusion criteria that should see people removed to police custody after detention under s136 Mental Health Act. We see this 'pattern' in so many s136 policies including in a draft protocol I reviewed for another force earlier in the week.

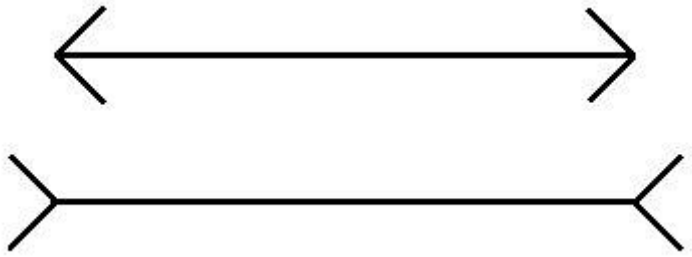
It even appears intuitive – you can't usually assess drunk patients; resistance or violence can render NHS facilities unsuitable because they are often not designed or constructed to the standard required to handle disturbed detainees. So the next part of the sequence according to the pattern that has emerged is cells. Right?!

No – because the rule that should be operation in every police detention of someone who is mentally ill, should be that we don't have enough information to know what the next step is.

We need to establish the rules – how do we do that?!

- You call an ambulance – **every time**.
- You remove someone presenting with a RED FLAG to A&E
- You only remove someone to a police station when you know that it is clinically safe to do so – because a paramedic or A&E staff or psychiatric PoS staff have helped you understand the rules in play.

So while we're at it, which of these horizontal lines is the longest?



Even though you *know* I'm playing mind games and that they are actually the same length, you still *see* the lower line as longer, don't you?! Cognitive illusions can be just as powerful as visual ones … you work it out!

Meanwhile, my seven year-old son is questioning a bit more and that is **NEVER** a bad thing, although his teacher looked fairly exhausted at 4pm today! :-)

Incidentally, this is the first post I have ever written, entirely on my iPhone using the WordPress App. It's worth getting, even just to read blogs, but great for writing and maintaining them!

16th October 2012

999 What's Your Emergency? –

There was quite a debate about the above programme when it was aired on Channel Four last night – you can watch it for a limited period of time on the Channel Four 'catch up' website. Last night, it all focussed upon people's "state of mind", ie mental health issues and it was all set in Blackpool, covered by Lancashire Police and the North West Ambulance Service.

Using the hashtag #999whatsyouremergency there were various comments flying around the Twittersphere. Some warmed my heart – a combination of people expressing sympathy for some people who came to the attention of the 999 services in a variety of formats and some who quite obviously did not believe the kinds of mental health demands that hit the ambulance and police services on a daily basis.

I was amazed that at no stage in the programme did the editors attempt to signpost people in crisis to support, to prevent things getting to the stages shown in the programme. Any number of organisations could have been mentioned.

I had a few observations:

- Listening to call handlers using terms like "fruitloop" wasn't very helpful for me – unprofessional.
- I could do without hearing that someone who has taken an overdose has "been stupid". Do people really overdose "for a laugh"?!!
- I could do without hearing "These people" to refer to everyone (in the country or the world?!) with mental health problems.
- There also was an underlying assumption that many demands were not really police business and if only the police and the paramedics didn't have to respond to mop up after other, often unmentioned agencies who were absent …

I've written before on this blog, that mental ill-health incidents are *core police business* – where people's safety is at risk or where crimes are being committed. Notwithstanding that one guy in the programme was mentally ill, the fact that he was seen with two knives means it is perfectly proper to seek police involvement – possession of knives is a criminal offence, even if you are possessing them in order to harm just yourself because of

a mental illness. It doesn't mean the police will automatically prosecute and criminalise him, but it does mean we have a role to "make safe and signpost", if nothing else.

Policing is only necessary at all because some people don't self-police. The existence of an alcohol industry and many of our fellow subjects' inability to drink and behave responsibly forces untold costs upon the public purse and causes mass demand for policing and emergency medical services. We're not banning pubs or alcohol, though, are we? We're not talking in terms of locking up drunken offenders for inordinate periods to ensure they are not free to drink again next weekend. Yet more harm and cost is caused to our society from drunk young men and, increasingly, women.

Why not just lock up all of "these people"? – is it because we, ourselves, along with most people are or have been in this group and we know general labels around alcohol related violence and disorder do not apply to *us*?! << *Stigma in operation.* We do actually *know* that the relationship between alcohol and crime is far more direct than the links between mental illness and crime and that the costs – measured in lives lost and money – are **far** greater.

MENTAL HEALTH CRISIS IN PRIVATE PREMISES

I also want to focus on something specific: watch the programme from around 27 minutes – they are following a particular job from 999 call to police attendance where a man rings up to say he's taken a "massive overdose". After officers force entry to the premises they find him in a private dwelling committing no offence, having potentially taken over 40 tablets. I'm not sure whether these tablets or the quantities involved were potentially damaging but the paramedic immediately says, "We're going to take you to hospital". The man **refuses to go**.

Remember the law in this situation?

- This man is *presumed* to have the capacity to take his own decisions, including about medical care.
- The taking of an unwise decision does not, of itself, render him without this capacity.
- The police have NO powers in a private dwelling to act under mental health law unless there is an attempted or actual criminal offence – there isn't – OR unless they anticipate a breach of the peace.
- (Remember: a breach of the peace is an *imminent* risk of violence following the judgement of *R v HOWELL* [1981].)
- Did we anticipate an imminent risk of violence when he's slumped on the sofa declining treatment ?

- I'm not sure I did – **not for a minute.**

In these circumstances our colleagues in green should have been invited to undertake a mental capacity assessment and start making decisions. *Remember* – he is presumed to have capacity unless demonstrated otherwise in an appropriate assessment. As paramedics are there, on hand, it is *their* responsibility to undertake this. Should *they* feel that he lacks capacity, given that the ingestion of tablets that could have profound health consequences, it could be argued he can be removed under the MCA to hospital but **only** where this is the least restrictive option, to the medical threats faced. This lack of capacity would need to be demonstrated.

(Incidentally, once arrested, did you notice the ambulance service trying to back off from this non-criminal healthcare situation at a rate of knots?! Quite rightly, a paramedic was persuaded into the police vehicle to accompany the officers and the patient but in reality, he should have been primarily in the care of the paramedics being accompanied by the police, if need be.)

If this whole blog is about anything at all, it is about educating officers who attended these incidents not to put their "arm in the mangle". Attend to ensure protection of life, by all means. Force entry, by all means. Once you've established that you are in his house with paramedics and he is alive and not committing an offence, we should then look to assist our ambulance colleagues to take over the lead decisions.

We need officers who can remind them that the clinical decisions around this man's capacity to take drugs and kill or harm himself is *theirs*. This is not my personal view, this is **the law of the land**. The decision about what to do with him, if they feel they cannot leave him there because of any lack of capacity is *theirs* and we can help them, if they need it.

Given that upon arrival in Accident & Emergency, he is being uncooperative with nursing staff attempting to triage him but not actively trying to leave, I'm wondering why we are devoting a police officer to sitting with him? For those who would argue that we might as well stay because otherwise we'll have a high risk missing person I would ask this: following this logic, why do we not just put a police officer in every single psychiatric hospital in the country to stop missing persons, otherwise we will end up with a high risk missing person?

The police have finite resources and they must be targeted against public priorities. What I saw in the second half of this programme was the police failing to distinguish between the necessary initial response we MUST provide, the support to our ambulance colleagues that we SHOULD provide and the ongoing healthcare issues which then become NHS

responsibilities. Of course, because the man had been arrested for a breach of the peace, we got our arm caught in the mangle, **right up to the shoulder** and ended up "policing a patient" … again.

18th October 2012

South Africa –

There will be **no updates** on the blog for a couple of weeks as I am delighted to be going on holiday to South Africa!

Me being me, I therefore did a bit of reading around policing, mental illness and criminal justice in South Africa – **the natural Venn diagram**:

During the last few weeks I have managed to make a couple of loose links with the University of Cape Town, who have circulated the blog to a few staff in the psychiatry and criminology departments! Not sure if they'll be quite at the stage to put the kettle on when I get there in a week or so, but good to make links and see what comes from it.

Having spent a few hours on the internet looking at mental health issues in South Africa, I know that the South African Police Service, of course, face demands like any other police force for intervention with people suffering from mental ill health and who are in crisis. There are also numerous internet stories of crimes both BY and AGAINST vulnerable people with mental health problems. Quite how the presence of mental illness affects police responses to such crimes – if at all – is less clear. The evolution of the South African system and the interface between law and psychiatry has, in part, been affected by high profile incidents like elsewhere in the world. In 1966, the South African Prime Minister Hendrick Verwoerd was stabbed and killed by Dimitri Tsafendas, a temporary employee in Parliament in Pretoria. Found not guilty of murder by reason of insanity, Tsafendas was detained until his death in a psychiatric hospital, suffering from schizophrenia. This incident triggered a commission of inquiry under a judge into the issue of Mentally Disordered Offenders and to the updating of South African mental health law – the 1973 Mental Health Act. This was modernised again in the Mental Health Care Act 2002.

There is a shortage of trained mental health professionals in South Africa – fewer than 400 psychiatrists for a population of around 50 million people; half of them working in private practice and only a few dozen forensic psychiatrists. (In the UK there are over 3,000 consultant psychiatrists as well as the junior doctors in mental health, for a population of 63 million. This includes hundreds of forensic specialists.) As demands for criminal justice intervention in mental health crisis often result from an inability to access or maintain support from mainstream services, it is hardly surprising

that the police are involved given the number of psychiatrists available to the public of a developing nation. One tweeter based in Durban indicated that in her experience mental health issues rarely affect police responses to criminal incidents where suspects are thought to be mentally ill.

Recently, I came across a YouTube clip of Dr Vikram Patel presenting on the subject of global mental health and what he calls 'task shifting' – an initiative to have certain aspects of medical care administered by non-clincial, but trained volunteers. This is in operation in South Africa, though the PRIME programme at the University of Cape Town and is partly funded by the UK Department for International Development.

MORE READING / FURTHER LINKS

- The South African Mental Health Care Act 2002
- A brief history of South African mental health law
- Dr Vikram Patel talking about global mental health in developing countries.
- The PRIME website.
- Taking Stock: Mental Health in South Africa
- Suicidal Ideation in the South African Police Service
- The Mental Health Gap in South Africa: a Human Rights Issue.
- The South African Mental Health Federation – an umbrella organsation for mental health charities.
- The World Health Organisation (UN) report on South Africa's mental health system (2007).
- Recent research article on the South African Police Service's use of "Section 40" MHCA 2002.

Not much more to say than that – I'm now signing off for two weeks amidst celebrations by Mrs MentalHealthCop that we will be well within an internet, wifi and twitter free zone for much of the fortnight. I will try to send a picture from the top of Table Mountain, just to gloat. :-)

NOVEMBER 2012

5th November 2012

PC Alex STYPULKOWSKI –

This is a picture of PC Alex STYPULKOWSKI from Hampshire police – officially the **bravest police officer in the country**. Let me tell you why –

In November 2010, PC STYPULKOWSKI was deployed to support social services to 'section' a man under the Mental Health Act. The operation included armed officers, but Alex is an unarmed, frontline cop. The officer was honoured in front of politicians, senior officers and his family, along with dozens of other very brave nominees who won their regional bravery awards.

The man was known to have a history of violence, including having previous barricaded himself in a premises taking his mother as a hostage. << I am fascinated to know whether this operation was undertaken with a warrant under s135(1) because those who know my views on the "warrant or no warrant" debate will realise that when I first read this story, I got this far into it and started thinking, "I hope they had asked for a warrant, whether or not they knew they could get access to the premises." Anyway … more of that later!

This excerpt from the BBC News article tells the story: "He arrived at the scene and chased the man but became separated from his colleagues and ended up in a dark road surrounded by bushes and trees. The man turned to face him, brandishing a screwdriver, telling him: "You're going to die." The officer used CS spray on the man, but he continued walking so he struck him on the leg. When he fell he dragged the officer with him and, as they struggled on the ground, PC STYPULKOWSKI said he could feel sharp blows to his back and neck. Another officer arrived and the man ran off, with both officers giving chase. The man was eventually arrested after PC STYPULKOWSKI's colleague used a Taser stun gun."

PC STYPULKOWSKI described the experience of being repeatedly stabbed with a screwdriver as "sobering" – "Adrenalin has a lot to answer for. I knew I was alright, he was a dangerous guy and needed to be caught. I did what my colleagues would have done for me.

The officer received "near-fatal" injuries in detaining this man. Alex has rightly received the highest praise from politicians and senior officers alike

or his actions, my own rather late contribution to this coming as I learned of this award whilst driving to the airport two weeks ago.

I would like to suggest that the officer is quite correct, however: whilst atypical in terms of the injuries sustained, it is a weekly occurence in most police areas across the country that the police are asked to mitigate risks during Mental Health Act assessments, including with regard to people who have previous engaged in violent and sometimes, armed resistance to detention. By the time such requests are received, it is too late to do anything that may prevent the situation getting that far – it is a question of mitigating properly to manage such situations as safely as possible. This is why planning of such assessments, information sharing need to be improved and **this incident shows precisely why** a warrant under s135(1) should be secured for those assessments where there are RAVE Risks arising from the patient to be assessed. *<< I will continue to attempt to find out whether or not this was the case and update the blog, but I have been told by a contact in Hampshire that he is "almost certain" there was no warrant in place.*

Far more importantly: my congratulations and admiration for PC STYPULKOWSKI on his award – *very richly deserved indeed*.

7th November 2012

Actually Using the Mental Capacity Act -

We are still behind where we need to be in using the Mental Capacity Act: I heard recently from an AMHP asked to under take a Mental Health Act assessment in an A&E department after police officers had 'removed' the person there "under the MCA because they wouldn't come outside!" …… we also heard in the cases of 'Sessy' [2011] and ZH v Commissioner of Police for the Metropolis [2012] how the Metropolitan Police had 'used' the MCA: –

No, no, no, no … **NO!** – where there are no acute medical emergency or life-threatening situation, but 'merely' a concern about mental ill health and a perception that early assessment was needed, it does not follow at all in law the MCA can be 'used' *by the police*. I don't say 'merely' to minimise the impact of the seriousness upon individuals of their condition, or of the importance of assessment, treatment and support – I use it to (badly?) differentiate between such events and *imminently* life-threatening medical or psychiatric emergency.

No ambulances were called, no AMHPs requested, no CrisisTeams engaged. So potentially, such removal as mentioned by the AMHP, above, was illegal as agreed by the Commissioner of the Metropolitan Police in Sessey. The phrasing of the background to these officers' decision also implied to the AMHP that if they *had* been able 'get' the person outside their own house, they would have detained them under s136 MHA. This is **also illegal**: in no way could officers argue in such circumstances that they had "found in a place to which the public had access" etc., etc..

Here is –

1. A Quick Guide to the MCA –

2. A longer article with links to sections of the Act

3. A short screening tool to assess capacity – the "ID a CURE".

Police responses to mental health crisis in private premises can be complex and I have written about them previously. The police service has no powers in a private dwelling to coercively manage such situations unless additionally, there is a criminal offending committed or attempted; or

unless there is a Breach of the Peace ongoing or apprehended – **OR** unless the health service are involved in supporting the care pathway and the decision-making.

My advice to officers on those situations is contained within a Quick Guide on the subject. It can be difficult to manage. In many areas, a CrisisTeam will not respond unless the person concerned is known to, or 'open' to, mental health services already – even if they do, CrisisTeams out of hours are usually nurses so cannot immediately initiate removal to a place of safety and cannot undertake formal MHA assessment. Many AMHP services will not respond directly to a police or indeed to an ambulance service request to assess someone. Out of hours GPs will often not respond to such instances at people's homes to indicate whether formal assessment is required and activate that where it is.

As such, officers can find themselves in a position where they have followed the above Quick Guide and reached the point where they are *still* standing in a private dwelling along with a vulnerable person and being able to secure no support from the NHS or social care services, except perhaps for paramedics. As stated: the ambulance service often have no greater ability to access out of hours mental health crisis pathways than the police – sometimes, less ability.

So, if you find yourself standing there with all the criteria for s136 having been met except for the geographical one, what can you do? Any one of three things, obviously ranked from low to high risk situations, depending upon the features on the incident:

- **Leave the person in situ** >> whilst making or having made relevant referrals to appropriate referrals to NHS or social care organisations.
- **Remain in situ** >> whilst continuing to lobby for an assessment oriented response.
- **Use the MCA to remove the person** >> having reached a point where it is argued it may be legitimately used.

In circumstances of non-imminent threat, decisions about the use of the MCA are for healthcare professionals. This would include paramedics where they have been called – they often have greater MCA training than police officers and it is a CoP requirement that the police defer these decision to 'health' where possible. But if you've tried everything else and failed to secure a resolution, it starts to make the use of the Mental Capacity Act justified as long as the criteria for using it are met.

Should the police be unable to engage the ambulance service or if they have to act with urgency before they arrive, this is the Quick Guide to the

MCA, including a very practical tool to assess capacity shared with me by a paramedic and known as the "ID a CURE" test.

But let's not be too quick to say, "Let's just use the MCA" because it really is just **not** that simple.

EXAMPLES

A woman in her fifties is in her own home and she calls 999 threatening to kill herself. Police are despatched and gain access to the premises, they find a woman who is under the influence of alcohol. Police intelligence checks reveal previous attendances at that address in order to undertake mental health related support to the NHS and warning markers on PNC for mental health issues, suicide risk and self-harm. Upon arrival, the police find someone who is under the influence of alcohol but not drunk, she has self-harmed although the injuries are superficial and she states that she has been trying to call her CMHT all day but not been able to get through. There are no criminal offences and there is no anticipation of a breach of the peace

Can you use the MCA to remove her from her dwelling? No. Are you yet certain that she lacks capacity about the decision she is taking to drink and self-harm? Even if you were, is the yet known to be the least restrictive thing to do? There is no imminent, life-threatening risk, no literally *urgent* medical care that is required. So how do you proceed?

- **Contact one or more of the following:**
- Ambulance
- CrisisTeam
- Patient's GP

If they respond and take the lead, fine. If they do not – for whatever reason you then have the following dilemma:

- In light of what you know, do you reasonably believe that she lacks mental capacity (see the "ID a CURE" test).
- In light of the threats and risks, is it *proportionate* to remove the person to A&E for assessment / treatment of injury?

Maybe – are there friends and family that could be brought into the situation? … would that help?! … if ultimately the answers are "No!", or if all of that has been tried and failed, what do you do?!!

We will probably find different answers to this and they will be influenced by experience and personal judgement. If you are going to 'use' the MCA to intervene – because not to do so when you reasonably believe the person

lacks capacity to take decisions around self-harm or treatment would be negligent – ensure that the documented approach for doing so complies with the sections 2-6 of the MCA and that you involve your supervisors.

Again: a Quick Guide to the MCA – a longer article with links to sections of the Act – the "ID a CURE" screening tool.

8th November 2012

In Immediate Need of Care –

This post is influenced by a comment on an internet forum for AMHPs that I've been allowed into – it's an excellent way for professionals to use social media to support each other and share opinions on difficult or unusual circumstances:

An AMHP asked the question about how it could be possible to get the police to understand the "care" part of the phrase "in immediate need of care or control" from the definition of s136. I'm not entirely sure of the circumstances of any incident to prompt the query but must imagine that it included officers not acting to detain someone who was in immediate need of *care*, but not necessarily in immediate need of *control*.

It is a *really* good point to raise and something I covered when I have delivered training on the use of section 136. UK mental health law allows intervention by the police based upon an officer's view that they are purely in need to "immediate care OR control". *Are you imagining the type of thing the distinction gives rise to?!*

My preferred example usually focusses upon a real event: my attendance as a sergeant at an incident along with one of my constables where we were dealing with a chronically depressed man expressing suicidal ideas. The man was not hurting himself, had not hurt himself and was sitting alone and lonely in a church yard in Moseley in Birmingham on a cold evening. He'd had a bit to drink but was way, way short of being able to be described as drunk and after we struck up a rapport, we were able to secure his nominal details and discretely check him out on police systems. We learned enough about his history to have reliable information that he had a history of mental illness, although just one conviction many years previously for a minor assault.

Five criteria must apply to use section 136:

1. A constable finds, in a place to which the public have access;
2. someone who appears to be suffering from mental disorder;
3. is in immediate need of care OR control;
4. in their own interests or for the protection of others.
5. [the intervention is] necessary.

Did we take his threats to self-harm seriously? **Yes** – they were specific, they involved preparation on his part, which was why he'd started drinking, why he'd gone to Moseley and why he had a certain volume of medication on him, which we found later. Did we believe he was suffering from a mental disorder? **Yes** – because of his current presentation, his known history and the reasons for police attendance at his home address in the past. He was found in a place to which the public have access and therefore three out of four criteria for detention under s136 were met.

The only remaining question to satisfy the legal criteria was, "Is he in immediate need of [either] care OR control, in his own interests or for the protection of others?" **Yes** – he was not in immediate need of *control*, because the application of his plan was a few hours away yet, but the need for him to receive care was immediate to prevent things getting to a point where the alcohol had taken a real hold and he then took a potentially incapacitous decision to ingest medication and overdose. No-one else was at risk here but to walk away would have been unconscionable and it never crossed our minds so it was certainly "necessary."

So detention under s136 Mental Health Act it was – removal to a place of safety, which in the days before my PoS work was police cells, and we arranged for him to be assessed by a Doctor and an AMHP. I can remember that he was assessed as being in need of hospital admission and agreed to go voluntarily. He was kind enough to write to our Chief Superintendent a couple of months later, expressing gratitude not only for what we did but also *how* we did it. It was extremely gratifying to read the letter, as he was quite obviously grateful for our intervention and in a position to regret that things got that far for him. (It was a matter of regret to me then and still is now, that we had to put this guy in a cell block – that could never be the right place for an Armed Services veteran, struggling to come to terms with his experiences in the Gulf War and Kosovo and his personal life having broken up since leaving the Army. I almost wish we could have just called the AMHP and DR to the churchyard, if I'm honest …

Section 136 of the Mental Health Act is not just about controlling dangerous people – far, far from it although it can be used in such situations, of course. I worry about perceptions that this may be what it may is for and that this may affect our more general view of people suffering from mental ill-health. Far more frequently, in my experience, s136 is about being able to intervene to ensure care for vulnerable people: those who are at risk by virtue of their condition but posing no threat to anyone but themselves.

This is why, despite some of my reservations about the way s136 MHA is drafted, I think British mental health law for emergency intervention by the police, is in many respects much better than other jurisdictions. It could also be argued to be less criminalising, allowing lower level, more pro-

active interventions than would be the case if the police were scanning for "danger signs" or similar.

Worth getting your head around this if you are a police officer – it opens up the use of this power to various vulnerable groups, including rough sleepers, street-drinkers and other vulnerable groups who often attract the attention of the police.

If you are an Armed Forces Veteran in need of support following your service, please click the "Combat Stress" picture on this blog to take you to their website. There are loads of resources and contact numbers on there – and NEVER forget how grateful the people of the UK are to you for your service.

9th November 2012

Upholding The Law –

One feature of policing commented upon by Professor PAJ WADDINGTON in his excellent book, Policing Citizens, was that the police are not automatically on the side of the party who brought them into any particular dispute. They are independently attested, accountable to the law. I've been asked by two mental health professionals to write up a story of an incident I was involved in many years ago, which flew in the face of their colleagues expectations regarding patient rights. It followed discussion about how the admission or detention of voluntary psychiatric patients is handled, especially with regarding to any decision they may make to leave.

A woman was admitted to a psychiatric ward as an informal patient and had been there for around three weeks. During this time, she had left the ward on one occasion and been reported missing. She was taken back there with her consent by police officers and it is my understanding that whilst remaining as an informal patient she had made representations that she wanted to leave.

A bit of law here – paragraph 21.36 of the Code of Practice to the Mental Health Act 1983 makes it clear that "Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward."

One particular autumn evening, my officers received a call to a psychiatric ward. The senior nurse wished police officers to attend and arrest a patient for causing damage to the ward. We were also informed it was the second time that day, the police had been called for damage – the first incident having been managed by the shift which preceded us – and it was the third time that damage had been caused. The NHS staff had handled the first incident 'internally' and the early shift had 'informally warned' her about the second offence at the request of the staff who did not wish to see the woman arrested.

Upon this second call to the police and third incident of damage, the staff were explicitly asking that the woman be arrested. In accordance with the policies I had established whilst working on mental health at headquarters, I sought a range of information which included the legal status of the patient. This is when I was informed that she was 'informal' – ie, not

detained in hospital under the Mental Health Act. I asked the senior nurse about the damage and all three incidents had been damage to windows or doors which would have allowed some kind of exit from the ward. I began to get curious and asked if she was trying to leave again, bearing in mind my questions had already revealed the previous missing patient report. The nurse confirmed that she was making remarks that she wanted "out". So have you now held her under a holding power? – No. On what basis is she legally detained?! – the consultant has written up that she's not allowed to leave. On what grounds?!! ……

The particular consultant in charge of her care had gone home for the day. The on-call consultant was not her "Responsible Clinician" – this is the term for the named clinical leader in charge of the patient's care. I asked the nurse to let me speak with that on-call consultant and phone calls were put in. As it happened, they were in the hospital on matters connected to another patient and came to the ward we were on.

At this stage my thoughts were: here is an informal patient who is free to leave the hospital and doesn't even need to ask permission (see the above legal point). They are not being allowed to leave and have caused damage to windows and doors which are exit points. The nurse refuses to confirm that the MHA has been applied to make their detention legal, either s5(4) MHA, the nurses holding power; or s5(2) the DRs holding power.

Is this person now unlawfully detained? … a false imprisonment?! Quite possibly.

More law – if a legal complaint is made of false imprisonment, it is first necessary to establish whether an 'imprisonment' has occured. If it has, the onus is then upon the detaining authority to demonstrate that this 'imprisonment' was lawful, usually with reference to the law under which they have acted. Although this was true before the Human Rights Act 1998, it was well encapsulated in Article 5 which prohibits "detention except in accordance with a process proscribed by law."

Final piece of law – when you cause damage to something, you have a defence to a charge of damage if you can show that you caused the damage lawfully. This, for example, is how the police justify causing damage to someone's front door, if we force it off in order to then arrest them for an offence or search the premises under a legal authority.

So here we have two conflicting legal dilemmas – has the hospital got a clear legal authority for detention? No – they describe the patient as informal and therefore free to leave, but they are not being allowed to leave. Has the patient got a lawful reason for causing damage to the trust's property? Yes – they are not necessarily legally detained by the trust and

are therefore entitled to use reasonable force to free themselves from this detention.

In walked the consultant on-call. I explained that I fully understood he was not the RC in this case, but that we'd been called to an allegation of criminal damage and had started forming a view that the damage may have been caused lawfully by a patient who was unlawfully detained. I understood that the patient was not known to him and he'd presumably want to speak to the nursing staff to get the background, but I was in the position of wondering whether the offence here was being committed by the trust, not by the patient?!

After 10 minutes with the nursing staff, he repeated to me that the RC involved had written up in the notes that the patient was not to be allowed to leave the ward. I responded that I understood this and didn't have grounds or qualifications to question that clinically – what I did have grounds to question, now that we had been invited into the scenario, was the legality of it. Under which part of the Mental Health Act 1983 was she now detained? This wasn't mere intrusion for it's own sake on my part, either – this information was crucial to my subsequent actions and would either render her damage unlawful and open her to arrest and prosecution because she was properly and legally detained, but without this it would render her a victim of false imprisonment who is being denied her right to leave.

It became necessary to point out, that unless I was provided with legal reassurance that she was lawfully detained, it would be necessary to consider investigation of staff for what they now knew to be an illegal detention which would make it a criminal investigation and make them liable to arrest. Perhaps they would like to discuss just one more time whether to apply the Mental Health Act or allow the patient to leave?

Fifteen minutes later and after a phone call by the on-call consultant to the actual Responsible Clinician, **the patient was released**. She declined to make a formal complaint of false imprisonment against staff but was made well aware of her right to do so and / or to speak to a solicitor at a later date and she went on her way. All the staff involved that night were asked to take on board my informal warnings that they may well have acted illegally and in particular that nurses should be advised they cannot simply rely upon illegal instructions from doctors to detain. **They must be certain of their own grounds for acting.** *<< This is no different in the police were junior officers cannot blame illegal direction from senior officers for their actions. They must be independently satisfied in their use of force or their use of arrest.*

Unusual story for the police to get involved in, but it shows the importance of asking the right questions. I have previously written about how to deal

with reports that patients have offended and it includes a series of questions to ask. **They are important questions, for a wide range of reasons.**

12th November 2012

Breathalysing Patients –

I have referred during a few posts to the practice in some Places of Safety of staff 'screening' patients before agreeing to their entry with the use of a breathalyser. Time for a specific post about it, following it coming up on Twitter in the context of discussing Section 136 and Alcohol.

The police have understood for years that mental health or Mental Health Act assessment can be impaired by alcohol. Whilst the practice of assessing someone for full admission under the MHA whilst patients are under the influence of alcohol is NOT prohibited, Chapter 4 of the Code of Practice does suggest it should be carefully considered against the potential to delay an assessment. << **This is important** … I have heard numerous AMHPs and other mental health professionals state that you cannot – *ever* – assess patients whilst they are intoxicated. This is simply **wrong**, both in law and in practice. It may be *preferrable* to wait, but it is not *obligatory*. And of course there is a difference between someone who has 'had a drink' and someone who is 'intoxicated' or 'drunk'.

I want to start off by re-sounding a quick alarm bell towards the police use of section 136 – there are some areas of the UK and some officers where use of this important authority is quite inappropriate. Some officers arrest people who are drunk when there are no reasonable grounds to suspect any additional mental illness. Officers' observations of drunk people which are unaccompanied by additional information to suggest a real mental health problem, are usually *insufficient* for officers to be confident that section 136 is the right approach. Forces need to work on this, through decent training to operational officers. That said, mental health professionals need to understand that where officers do know that they are dealing with someone with a mental health history, section 136 is not off-limits because of the current presentation involving alcohol. This would exclude dual diagnosis patients from healthcare and potentially prevent other masked healthcare concerns being brought to the swift attention of paramedics or other healthcare staff.

BREATHALYSING PATIENTS

That now having been said! – I have heard senior psychiatrists suggest that breathalysers should be mandatory before an NHS trust agrees to 'allow' someone to enter a place of safety. I've heard other senior psychiatrists

describe the practice as – and I quote it, because I wrote it down at the time! – "Fairly disgusting if you think about it." … and if we are going to do it, bearing in mind there is no legal power to insist that a patient submits to a screening test, what are we going to do with the reading it provides? What is the threshold to be applied and to what purpose?

And what do we think it is telling us?!

Are we saying that the reading, measured in micrograms of alcohol per 100ml of breath, will then determine access or will it just be indicative as to how much someone has consumed and roughly how long it may be advisable to delay an assessment? Is it really ethical to conduct these tests in a car park outside the PoS?! – yes, it does happen.

- How alcohol affects people will vary from person to person
- How alcohol affects the same person will vary from time to time

Some Place of Safety services who use breathalysers as a screening tool for entry, use the drink drive limit as the cut off point – 35ug /100ml breath. This is about two pints of beer / lager for most people or a large glass of wine. Others use 50ug or some use double the drink drive limit of 70ug. Why such variation?! Where's the evidence base for one limit over another and how does it impact upon the s136 population it affects? The truth is, we do not know because it is not researched.

DRINK DRIVE LIMITS

The drink drive limit is set on the basis that most people will be sufficiently affected in their ability to drive if they are over the limit, that it is not worth the risk in allowing them to do so. It does NOT equate with being 'drunk' for the purposes of other law. For example, I would say that most people I have ever arrested for drink-driving were not 'drunk' – but they were definitely over the legal limit. They were neither 'incapable' nor 'disorderly', for example and could not have been arrested for those offences – but they were still over the limit and I would not want them to drive past my son's school at 4pm.

So I would argue, and there are enough psychiatrists and other doctors who would argue likewise, that a screening breath test tells you nothing of relevance to the decisions you are trying to make about whether someone is fit enough to undergo mental health assessment. I was moderately over the drink drive limit a few times on my recent holiday as South Africa produces very nice red wine … I'd never have driven a car whilst exploring the Boschendal but I would question whether I was ever so intoxicated that I couldn't account for myself or my medical history had the need arisen.

And we also know that someone who is alcohol dependent can be taken to a very dangerous place, medically, if they are suddenly forced to completely sober up. We see police doctors 'prescribing' alcohol to a few detainees on occasions to ensure that they don't sober up entirely. There is a police force in England who had a near-tragic event in their custody after the NHS excluded a mentally ill, alcohol-dependent chap who had been detained under s136. Fortunately for the Chief Constable, his custody sergeant was switched on and got him to A&E quickly.

EXCLUSION TO THE CELLS

Of course, if the presumption of health professionals is that failure of such tests will lead to exclusion to the police's cells until sufficient sobriety has returned, then they should think again. We know that alcohol can mask other healthcare problems – diabetes, head injury, epilepsy. We can name the people who have suffered untoward events in custody because of such an approach to alcohol which is too casual. We also know, that patients who are resistant being excluded to the cells can also lead to untoward events and illegality. We all know the cross over between alcohol / resistance and mental health in s136 detentions. Any custody sergeant worth their salt would be aware of para 9.5 and Annex H to Code C of PACE which covers the sergeant's duty to ensure that people with unmet health needs get appropriate clinical attention. Whilst this often involves calling the privately contracted FME, it could also involve calling an ambulance and / or transferring someone to hospital. That is the difficult judgement call that custody sergeants with first-aid certificates have to make every time someone becomes detained.

An A&E Doctor once said to me, regarding the development of sound protocols for clinical care in A&E, "We wouldn't assume that someone's potenitally bizarre or disruptive behaviour was attributable to alcohol, until we had ruled out everything else. This includes diabetes, head injury and loads more besides. Only when we are happy that those are not a risk, would we write someone off as simply 'drunk'." The police service should be wary about deviating from this approach in custody and we should certainly NOT assume that the application of exclusion criteria by a psychiatric Place of Safety has been done following a proper triage by paramedics and a physical assessment, etc..

A tweeter this morning informed that when they ring their PoS service to inform them of an arrest, the first question asked is, "Have they been drinking or violent?" If the answer to either is, "Yes" then they refuse admission. Presumably because a telephone conversation with a police controller is sufficient insight and examination of the patient to be confident that is a safe decision?

17th November 2012

Police and Crime Commissioners –

Yesterday in England and Wales, forty-one people were elected to the role of Police and Crime Commissioner for their area. This is a new role to "oversee and hold to account" police services and their Chief Constables. These new PCCs will have a range of statutory functions and in the 'debate' which occurred in the run up to the election, I have heard various things about the "Police" bit of the role, but comparatively little about the "and Crime" bit.

I would be bold enough to suggest that new PCCs should read this blog and understand the complexity and extent of the relationship between policing and mental health, which is rarely understood properly.

Bringing this blog post around to the issue of mental health and criminal justice, I looked at various websites and twitter feeds for prospective candidates to see what, if anything, was being said on mental health. We know that high profile incidents have given rise to public concerns about crime, safety and police responses connected to mental ill health so it is legitimate business on which to seek information.

One unsuccessful candidate in Devon and Cornwall was tweeting various facts about the number of offenders who have mental health problems, attempting to link the offences and their status as offenders to their conditions. Maybe this is sometimes true, but we know that this is not always the case. He even suggested he would employ mental health staff! Another candidate, who went on to win in Derbyshire, tweeted about ensuring that people with mental health problems do not inappropriately enter the justice system. Again, none of us would disagree with that. I looked for the definition of 'inappropriately' but couldn't find one. Noble idea, though. The problem always is that by the time the police and CPS are contemplating putting someone with mental health problems into the justice system, the time for things that may have prevented the need has sometimes passed. So I guess I'm saying, that this means we need to think of the Commissioner's potential to influence 'upstream'. Early intervention, liaison and diversion, for example.

The role of PCC is envisaged to be one that involves the Commissioner networking, building partnerships and alliances with a range of other agencies and their area's senior professionals – including in local authorities

and very probably in health and social care agencies. I worry just a bit, that when PCC candidates were giving media interviews and talking about their intention to build inter-agency partnerships, they often lapsed into a list of such agencies and usually did not mention health or mental health. Local authorities, schools and other criminal justice agencies are far more obvious candidates with direct links to crime issues.

This post, if anything, is a plea to successful PCCs that they consider in detail the nature of demand which arises from health and from mental health issues – and I don't just mean demand that arises from the NHS and demand in relation to crime. We often see very easily how such incidents could have been prevented, or better managed with closer, integrated partnerships and as I understand it, this is precisely what the "and Crime" bit of the PCCs role is intended to do.

So as your elected representative, they can be written to regarding issues like this. You can find out more about your area and your PCC via the BBC News PCC Election webpages.

NB – *all forces have a PCC except for the Metropolitan Police whose PCC functions are absorbed within the role of the Mayor of London. The Mayor has a "deputy mayor for policing" whose sole focus is on a par with that of a PCC.*

17th November 2012

Big Boys Don't Cry –

10CC told us years ago, that big boys don't cry – it's a cultural thing, isn't it? No matter that people can be devastated by relationship breakdown or unrequited love, you just get on with it. Keep calm and carry on, and all that?

Some years ago, a friend of mine had a few health problems. Nothing major, but concerning enough and after various ineffective treatments and possible diagnoses from his GP, it became quite frustrating for him. His GP then suggested that if various things had been ruled out and if treatments had been tried and failed, it may be that the symptoms – his very physical symptoms – were attributable to stress. During a normal chat about how he was doing, he told me the 'stress' theory and seemed fairly indignant at the idea – after all, he was "a bloke!"

He wasn't worried about anything, he was fairly hardened to the grit of real life, he had a good job that he enjoyed, lovely wife and son, although he was professionally ambitious and wanted a bit more from his career. He had a very decent lifestyle, etc., etc. … he just wasn't "the sort of bloke to get stressed!!" And in many regards, he wasn't – he was always as calm as a coma in the middle of extraordinary chaos in his job and had worked himself into a secure position in a notoriously insecure professional world. *<< But that's not what stress is, is it?!!* Or rather, it's not the total of what stress related disorders can be.

Stress takes many forms – yes, you can have obvious stressors caused by straight-forward 'worries' like financial problems, redundancy and if they endure, it can have health and mental health consequences. Stress related symptoms can kick in after bereavement or just because your life has fewer hours in the day than are needed to get your work done with some kind of balance to the rest of your life. Again, we've probably all had that for short periods – when it becomes a long-term issue, it can lead to health problems of various kinds.

So I asked him to remind me exactly how long the symptoms had been coming and it had been just over a year. And I said, "And your lad is nearly 18 months old isn't he?" His face went white. I asked what life was like for him and his wife, who also worked full-time after her maternity leave, in an important and demanding job. Fairly awful, it turns out. His wife

suffered with post-natal depression and he'd struggled to get his head around it and I had known there had been serious complications for his wife, during the birth of their little boy. Their relationship since the birth had been hard – practical and functional and little time to spend as a couple as they'd struggled to balance work / home / life, etc., but he'd written it off as something just to be pushed through by putting his head down. It certainly wasn't the child-free lifestyle they had both enjoyed before becoming parents where two adults earning good money could always do what they wanted, whenever they wanted. He felt somewhat, 'trapped' and couldn't see an end to this phase of his life. Now I'm not a psychiatrist or a psychologist, as you know … but that sounds like it's got all the parts, doesn't it?!

This month, Movember is not just about prostate cancer as it traditionally is – it is about **raising awareness of mens' mental health**. Men, especially middle-aged men, are at far higher risk of their mental health problems, leading to suicide. This is especially true after events like redundancy or divorce, where risks are especially high. Theories as to why, include such events representing the most direct threats to our notions of masculinity, which represent that bloke as less than manly. I'm not a sociologist, either … but that works for me. I'd like to know more.

There are fewer organisations on male mental health than you may think. Especially when you consider the suicide rate. The CALM Zone is a charity attempting to raise awareness and offers support. The Mens' Health Forum (website currently offline) also provides information on how mental health issues affect men. Obviously, groups like the Samaritans have a 24hr helpline as well as online resources and your General Practitioner can probably offer more support and information than you realise.

My friend took a big gamble and took a big decision to move his job, away from an organisation who had helped him get his foot on the ladder and supported him to get established. A difficult decision, which cut his professional apron strings and lead to suggestions of disloyalty, etc.. However, he was moving to somewhere which he knew would represent a far better work / life balance and deal with his professional frustrations and ambitions. He hasn't had any health problems for years and has taken steps, very deliberate steps, to balance his life and ensure that daily reality doesn't squeeze him and his wife, too much. Especially now they have two boys! Now, I'm not a doctor as you know …

If any man wants to access information or support for mental health problems, there are resources on the MIND website. There is also a very useful report for those who wish to know more about how mental illness can affect men.

19th November 2012

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Endless Shades of Grey –

One of the most demanding challenges within policing, but especially when dealing with mental health issues, is the need to make black and white decisions from situations involving endless shades of grey. Police officers, by virtue of their role, are frequently making decisions which amount to gambles because they often don't know all that they would prefer to know when making professional choices.

Let me give just two examples:

- **The Investigation of Crime**
- If someone is arrested for an offence and appears to be suffering some kind of mental disorder, the custody sergeant would, of course, get health and social care professionals involved to assist in helping, assessing, signposting, etc.. Once this is done, the sergeant will be required to make decisions about that criminal allegation – firstly, about whether there is enough evidence to charge someone with an offence; but also around whether to divert the person from justice (whatever that means) or to prosecute them into the criminal courts – the public interest test.
- However, that sergeant will often not be told details of the healthcare assessment. Indeed, sometimes the health professionals themselves will be operating blind, because it could be out of hours and the patient from another area of the UK when little can be established about their health background. How confident are you now about whether to criminalise someone further or to divert them from the cells?!

- **Ensuring Appropriate Medical Care After Arrest**
- Where police officers detain people under mental health law who are in need of care or control, they are often dealing with people who are resistant or intoxicated. We know from hard lessons that resistant presentations can be attributable to other medical conditions like head injury, diabetes or epilepsy and we know that alcohol can mask symptoms or cause premature conclusion that someone is "just drunk".
- Where as a police officer you know your A&E will say "We're not a place of safety" and your ambulance service will say that you "don't need an intensive care unit on wheels for a 136?!", you are left to

gamble, sometimes with that person's life and wellbeing. Not a great place to be!

So how to you turn these endless shades of grey into black and white? These hypothetical situations are chosen deliberately. In the first case, it is easier to stall the decision by using police bail to find out more. In the second, if you get that wrong, you will be accused of professional shortcomings and there is no way to stall the decision. In the first case, you take time to find out more; in the second, you err on the side of caution and take the 'careful' option.

In other words, it's about risk assessment, isn't it? By this, I don't mean that it is about filling in reams of paperwork to document a range of issues. There is a simple model that I use in a range of situations at work, which was taught to me by an engineer(!) and was used by him in the construction of some seriously well know buildings:

PROBABILITY x THREAT = RISK

- Low probability of a small threat being realised, you are dealing with low risk situations.
- High probability of a small threat being realised, you are dealing with something you must take more seriously.

For example, if assessment of a building plan concluded a real, but low, probability that the building will fall down with people in it, you would revisit the plans! If there was a high probability that the building's cosmetic exterior would not maintain its shiny appeal because of weather damage, you may decide to just roll with it and build in a maintenance programme.

The problem situation which bedevils decision-making around policing and mental health is: **very low probability of a significant threat being realised**. For example, there are over a million arrests a year in the United Kingdom and in that context, deaths in custody or following police contact are statistically rare. Having said that, there are some obvious warning signs and predictors and drugs and alcohol, resistance and mental ill-health are right up there with the best of them.

The investigation and / or prosecution of offenders with mental health problems is as complex as it gets but it is often not time critical. Police officers and CPS are weighing up, the strength of the evidence, the victim's wishes, the public interest in preventing any further offending alongside that information, potentially incomplete, about the offender's mental health; their level of engagement with mental health services, if any; the impact upon the individual of being prosecuted or not prosecuted. Not

easy, is it? What if you didn't know a nugget of information that was crucial about threats and risks?

There may always be the possibility of a serious untoward event after someone is detained under mental health law. This could come from the underlying condition itself, from the consequences of any restraint that became necessary or because of action taken by that person after arrest, for example to self-harm. It's always *possible* someone may die in custody, but it's *very, very unlikely* that they will. How do we identify which should go to custody anyway and get an FME, which should go to A&E to see someone far faster or for an intervention that cannot be provided by an FME in a police station?

Both of these situations can benefit from the kind of risk model, above; simple though it is. Determine the risk in the situation by balancing probability versus threat. Deal with "unknown unknowns" according to the scale of risk you are determining. So where you are pondering someone's safety in custody because of the potential for drugs or aggression to be masking a medical condition, call an ambulance and / or remove the person to A&E for advice in the paramedics think it is needed. If the risks and threats around diversion (whatever that means) are less serious or not indicated, you may be more inclined to use bail before charging someone, to give the police and the NHS time to find out more.

You can't mitigate all risks – you have to run with some of them. The trick is to spot the low probability but high impact events and take steps to mitigate those, because it's at the heart of public confidence in policing – especially where it will always be said in hindsight, that it could or should have been predicted.

23rd November 2012

You Can't Help Some People

I was once told by a very senior manager in the NHS about an observation that a social care manager had made of me, regarding attempts to develop effective joint protocols and procedures: "He'll just make constant reference to the law – talking to him is a waste of time." Or words to that effect. Read that again and *think* about it! What do we think he's inferring?! I'll admit I laughed.

I once delivered some joint training to police and health / social care professionals where we discussed mental health crisis in private premises and I was reminding everyone that to use s136 in private was illegal. I was challenged about what to do in the "999 What's Your Emergency" situation – you may remember the job? … the one where the police and ambulance services are in a house with a man who has taken tablets in an apparent suicide bid whilst drinking. He is not offending and he is refusing to go to hospital. (If you don't remember, click the link to read another blog before continuing!)

"He needs to be arrested", said the AMHP on the course.

"For what?"

"For being a nuisance."

"That's not an offence."

"He still needs to be arrested – he's taken tablets."

"What if he's got the capacity to take that decision?"

"That's just ridiculous! – he's at risk."

"So are you when you drive a car – probably far greater risk. What are we arresting him for?"

"You have to keep him safe."

"So when the officer gets to custody, does the custody sergeant arrest the officer for false imprisonment?! – I'm just trying to understand what you're saying here!"

My point in this post, is two-fold – the law of our country is the law, whether or not you like it or you agree with it. Secondly, there can be some situations where the law empowers or protects professionals and those to whom they owe a duty of care, but there is something that prevents them from going with it.

CONVEYANCE OF PATIENTS

For example, both chapters 10 and 11 of the Mental Health Act Code of Practice talk about the transportation of people who are detained under the Act being done via a method that is not a police vehicle, wherever possible. There are few reasons why the Code specifies this:

Firstly, it is about patient dignity – if they are in the back of police vehicle surrounded by uniformed cops, they will feel like and be assumed to be a criminal. An ambulance achieves the full status of "patient" and reflects the legal nature of the detention. Secondly, it is about paramedics bringing something to the party which would otherwise be absent. Police officers are usually medically qualified with a basic first-aid certificate. They are not paramedics or nurses and therefore lack the training and equipment to consider medical tests or basic medical obs at the point of arrest, to fully consider whether someone's presentation IS attributable to a mental disorder or some other kind of illness.

Now we know that an absence of an ambulance in an MHA detention by the police can cause problems. In Dorset and in Kent in 2009, individuals died in police vehicles during a detention or transfer under the MHA when it could and should be argued that the ambulance service should have been called. So why weren't they?!! …

THE AMBULANCE SERVICE

I have got nothing other than total admiration for paramedics. I have some seen some truly amazing things as a police officer of their skill and the care they offer, often under difficult circumstances. However, in some parts of the UK, the ambulance service have divorced themselves from the requirements of the MHA Code of Practice – I was once asked "Why do you need a rolling intensive care unit on wheels?!" When I recently said, "All detentions under s136 should lead to an ambulance being called because

chapters 10 and 11 of the CoP specify conveyance by a non-police vehicle", it led to long discussion.

Apparently, the ambulance service were struggling to resource car crashes and heart attacks, never mind turning up to 'simple' mental health jobs that don't really need a 999 ambulance. There was no point calling because they won't come. Apparently.

I'm not really sure I care less. >;>; The law of England says we call an ambulance (or whichever transport provision is commissioned for MH work.) A police officer in the audience suggested that they should speak to their ambulance service and agree a protocol about this. I wondered aloud whether they had a protocol with the fire brigade about being able to call them when the police station burned down? Apparently not, but it wasn't clear why if we need to agree things in advance. Seemingly, the police need a policy in which the ambulance service agree to be called. Yet they don't have a protocol about coming to RTCs or to domestic assaults. So why do we need one for mental health jobs?! Section 136 can be about the urgent management of psychiatric and medical emergency – surely we can just ring 999?!! This is stigma and discrimination in operation amidst presumptions others will think likewise.

And just in case anyone is thinking, "well it's just a Code of Practice, it's not law", you should read the case of Munjaz to remind yourself of what the House of Lords said the significance is of a statutory code of practice.

Last night my officers were dealing with a man who had been arrested for causing criminal damage and he had been tasered by the police and restrained by six officers. He was sectioned under the Mental Health Act and directly admitted to a psychiatric intensive care unit. I was in the custody area when the AMHP was looking to affect the transfer and she asked for police officers to undertake it. I said we'd help to undertake it, but she should call an ambulance.

"What for?"

"Because the law says you should."

"But they won't do it – he's been violent."

"And we won't do it without clinical supervision because he's acutely unwell."

"It's a waste of time!"

The custody assistant rang West Midlands Ambulance Service with the information against these protests – "Can you attend the police station to assist us in transferring a section 2 patient to a psychiatric intensive care

unit? … he was tasered earlier when we arrested him and has a significant risk history, but we're going to support the transfer with four police officers."

"Yes – we'll be there in 7 minutes." And they were. *<;<; West Midlands Ambulance Service are my favourites, because they* get it*, almost every time. When I hear stories elsewhere in the UK, I admit to thinking, "WMAS wouldn't go that" and everytime I test my theory, they step up and we work well together. I hope they feel the same.*

Why is it, that you can't help some people?! The law says you do it and you're not even prepared to try. You've got it in your mind that it's pointless, or that someone won't respond and against that backdrop you risk the safety of patients (remember Dorset and Kent) by not complying with the law and this is despite the fact that you are putting yourself in the position where if you face difficult questions after something has gone awry, you may well struggle to answer them. Even if you attempt to do the right thing and it doesn't work because you've rung the ambulance service just after they all went to a ten-car pile up on the motorway and they are legitimately struggling to support you – at least you've tried to do the right thing and subsequent actions are seen against that backdrop. And then having convinced many this was the medically correct and legally appropriate thing to do, a police supervisor said, "Actually, don't call an ambulance until we've agreed it with them."

Your laws were consulted upon with stakeholders and debated in Parliament. They are there for a reason and you'll are judged against them – whether you like it or not.

NB: *the picture has no relevance whatsoever! – it's the view from our apartment in Cape Town. It cheers me up to look at it again so I thought I'd share it, just for its own sake! :-)*

25th November 2012

Guardianship –

Just when you think you've got it all sorted out in your head – and just when you've been nationally recognised! – there's a curve ball thrown at you!? Typical.

Incidentally, this has happened to me before … I spent a year writing a proper mental health policy for my force in 2005/6. In doing so, I solicited officers' views about **ANY and ALL** questions and queries on mental health so that I could ensure they were addressed in the policy. I carefully listed everything they asked to ensure that what they wanted addressing in operational guidance was included. I considered it a job well done when I published it until a sergeant rang me up to complain that the situation he wanted advice on wasn't mentioned at all and that my new policy "wasn't very much use, really". Thanks, Sarge!

Today, an AMHP presented a situation to me that I've never encountered before, albeit I have read about "guardianship". I read about it partly to try to understand why the police never seem to get requests in connection with it. By definition, guardianship involves patients who remain at liberty and therefore a reduced need for coercion reduces the need for the police. << *That's one of the saddest sentences I've typed on this blog, as the police should not be just the coercive arm of the mental health system.*

In fairness to the AMHP who I know well, he hadn't dealt with this kind of situation before either and his need for police support caused me to think I should cover the subject, in case some officers across it.

WHAT IS GUARDIANSHIP?

It may be that some think of the legal status of mental health patients as being either "inpatients" or "outpatients". Inpatient in a psychiatric hospital, either voluntary or detained under the Mental Health Act; OR "outpatients" under community mental health teams.

Guardianship is something in between, but in my experience, the police service hear of this very rarely indeed – probably because by definition of it, patients are prepared to engage with it and considered able to live in an

arrangement where their physical liberty is not totally restricted. It should be noted in particular, that guardianship is *totally* different to Community Treatment Orders, and should not be confused with it, although both are options for community care which impose restrictions or limitations of various sorts.

Under Section 7 of the Mental Health Act, a person may be placed in to guardianship upon the application an AMHP or the patient's nearest relative if they have received the medical recommendations from two doctors. A criminal court can also instigate guardianship under section 37 of the Act, if two medical recommendations suggest it is appropriate after a conviction for an offence or a finding of the act being done.

A patient received into guardianship may be required by the guardian to do certain things: "reside at a specified place, attend specified places at times for medical treatment, occupation, education or training; to ensure access for any registered medical practitioner or Approved Mental Health Professional."

TRANSFERS AND WARRANTS AND AWOLS

Where a patient is received into guardianship in one local authority, it may become necessary to transfer them to a new guardian in a new area, much like inpatients are occasionally transferred between hospitals. All of this is covered in s19 of the Act and if need be, that transfer can be effected by the use of reasonable force.

Where access to a premises is not enabled, a warrant can be sought under section 135(2) to force entry in order to transfer a patient under guardianship. << *This is what the AMHP was asking for, in the example which gives rise to this post.*

If a warrant is secured for this purpose, then the police will need to be involved because only the police can execute the warrant. Of course, any conveyance which is subsequently necessary, should be done in accordance with the Code of Practice which presumes ambulance transfer.

If a patient absents themselves from the care of the guardian, then they become AWOL for the purposes of the Mental Health Act and may be re-taken by a police officer, an AMHP or anyone authorised in writing by the guardian or the local social services authority. If entry to a premises must be forced, in order to re-take someone received into guardianship, then a warrant under s135(2) is required.

This is **no different** to the re-detention of an inpatient AWOL from hospital under the MHA. Of course, guardianship being less restrictive on a patient's

liberty, having been re-detained and returned to the guardianship from which they were AWOL, they cannot be then compelled to remain there, unlike an inpatient under a section like 2 or 3.

REFERENCE MATERIALS

- Mental Health Act reference guide from the Department of Health
- Code of Practice to the Mental Health Act
- MIND – an outline guide to the Mental Health Act 1983.

26th November 2012

Autonomy, Risk and the Politics of Control –

Here's a controversial and provoking thought: the Mental Health Act is not, *ultimately*, about healthcare. It's about security.

It's not about individual autonomy and recovery, it's about the politics of control. This is not my view: it is a position considered by many people who question the medical model of mental illness and its associated legal framework. It gets you directly into the debate about 'revolving doors' in mental health and / or criminal justice. Efficacy and recovery; recidivism and rehabilitation.

There is a presumption in UK law of capacity and individual autonomy. People are presumed able to take their own decisions, even where those decisions may be considered unwise. People who could be considered in need of healthcare often decline to receive it, including people who suffer with mental health problems. If you are reading this and have begun asking yourself if this is really true because, with mental health patients, we imagine that we reach an objective threshold after which we would employ the law to detain, assess and treat … think about the decades that have passed whereby patients with personality disorders who engage in seriously self-destructive behaviours were not detained until the criminal law detained them. Think about the inability of our system to divert such patients and the inability to access proper services in prisons. Look at the case of Garry David in Australia, to see a serious example.

It is a daily occurence for those of us working in the emergency services, to see a range of people declining care for injury or by leaving Accident and Emergency departments before being seen – this includes patients with mental health problems and those who under the influence of various substances. We often have to do a certain amount of running about in relation to it, just to be sure patients understood the implications of walking away from the NHS without treatment that had been deemed important.

Mental health care in most western countries, is available to those who both need and want it. It may not always be available in the timeframes that people would hope for or in the manner they would prefer to see it provided, but that can also be true of people who have physical healthcare needs or people who need policing services. But it is also made available through legal – and if need be, physical – coercion to those who may *not* want it:

The state takes a role in paternalistically determining that some people who do not want mental health care should receive it anyway and deploy the apparatus of the state, ultimately in the form of the police, to enforce the removal of certain people to psychiatric hospitals in a range of situations.

AUTONOMY

Over two years ago, I was delighted to be invited to the Essex Autonomy Project where I listened to various inspiring academics taking about autonomy. This including figures such as Professor Phil FENNELL (Cardiff University Law School) and Professor Wayne MARTIN (Essex University School of Philosophy). The aim of the project was and still is, to bring together academic thinking across a range of disciplines and to target practitioners on the frontline to consider issues around autonomy and capacity. These seminars over two days – OK, it included a very nice dinner in a beautiful Essex village that shattered all of my northern preconceptions around Essex! – switched on the lights around a range of issues we call 'autonomy'.

Those of you who have never heard of or read the United Nations Convention on the Rights of Persons with Disability should give it a bash. One thing that has always interested me in learning about mental health law is this issue of capacity. I've written before, right at the start of blogging, about how the word 'capacity' has been seized upon for various reasons, in differing contexts. The fact that the Mental Health Act can be used with regard to people who can take capacitious decisions, as well as those who cannot, is a peculiar feature for me. Once, when listening to an academic talking about the putative reasons behind pre-emptive detention under mental health law, he challenged us to explain why you would think it morally right. All of the answers focussed on risk and prevention of its realisation. None of it focussed upon healthcare.

Then he hit us with various predictive facts: at the population level, other things are predictive of far greater risk and yet we do nothing anywhere like as invasive. Young men drinking alcohol on weekend evenings: they pose far, far greater threats to our society than people who suffer from mental illness and it can easily be argued that cognitive functions are often at least as imparied when young people drink to excess as when they are mentally ill. It is equally true that young young men aged 18-25yrs driving cars will cause our society great harm in any given year. Yes, we regulate the purchase of alcohol and criminalise certain behaviours (like drunkenness, serving alcohol to intoxicated customers, etc., etc..) and our market economy disincentives young drivers to drive or incentives them to drive responsibly, depending on your view.

THE POLITICS OF CONTROL

British academic Professor David Garland wrote in his pre-eminent book "The Culture of Control" about how the emerging policy around criminal justice, including where it overlaps with mental health care, is about proactive control, to reactive response. In a brilliant exposition of this – you must read his book – he detailed how successive governments across the world and of all political flavours, have gradually shifted criminal justice policy and social / welfare policy, to systems that attempt to control, because of the political fallout of failing to prevent *certain* high-profile events and other so-called welfare ills.

When I think about the role of the police in this shifting paradigm, one sees how police officers have been increasingly given powers to manage the fallout of deinstitutionalisation in mental health care. Not only in diversionary mechanisms like section 136 of the Mental Health Act, but also in the emergence of various orders like CTOs and ASBOs under mental health and criminal law, to name just two. We see a decrease in our society's tolerance of *certain* risks. For me, one of the most interesting feature of those risks, is that they are capable of being the threats of "otherness": we are not interested, generally speaking, of acknowledging the risks which pervade our society at a cost of lives and millions which are about us "all".

And all of this takes me back to wanting to talk about stigma.

27th November 2012

Over the Border –

Here is a common situation around Mental Health Act assessments, either for those in police custody as suspects for something or relating to people who have been removed to a place of safety under the MHA:

What do you do when there are inter-area disputes about who should deal?

This occurs in a few scenarios:

- The detainee is arrested in area A by the police from area A but for whatever reason, is taken to a custody office or place of safety in area B – they may be 'known' to services in area A.
- The detainee is arrested and detained in area A but they are from area B – they are known to MH services in area B.

You may have another few versions of this scenario and it doesn't actually matter whether areas A and B are next door to each other (like Birmingham and Solihull) or considerably further apart (like Birmingham and Newcastle). The point will remain the same, nothwithstanding that it is easier to travel to Birmingham from Solihull than it is from Newcastle.

PLANNED ARRANGEMENTS

I have been a various rooms where this debate emerged. For example, the Place of Safety service for Coventry in my force area, is also used by Warwickshire Police for detainees from their area. It obviously raised the question, "Which AMHPs?" for the assessments. Coventry were understandably not keen on the sudden increase in hundreds of 136 assessments each year, mainly for a client group that they did not know. This also occured in Birmingham and Solihull where the comparatively low number of detainees in the latter meant that they achieved a health-based Place of Safety solution by reaching agreement to use the service in Birmingham.

In each case, proper discussion brought about an agreement about which area's AMHPs would respond and there were both "office hours" and "out

of hours" versions of that agreement. It is not usually these scenarios that causes problems in my experience because where areas know that an arrangement will deliberately remove people "over the county line", you plan for it and agree the response in advance.

UNPLANNED ARRANGEMENTS

It is when these situations emerge unplanned, that problems can emerge in my experience. For example, in my force area, it is not unusual for my officers to arrest someone and transfer them to a custody office in a different local authority. Most people go to our local custody area, but with peaks and troughs of demand across the force, this cannot always occur. It is also frequently the case that my officers arrest people within our policing area who are not resident there. It is often the case that where the person detained needs some kind of health or social services support in custody – for example with mental health assessments or appropriate adults for juveniles – you can get dispute.

It seems perfectly sensible to me, that where people are known to services in their own home area and are in need of support in custody, that it comes from professionals or teams that know them. So I fully understand the instinct that if a Solihull resident is known to their community mental health team but detained s136 and taken to Birmingham, it makes sense to offer that assessment to professionals from the "home" team. However, if there is an inability or unwillingness to undertake that assessment, where does the responsibility lie to ensure it gets done? It lies with the area where the person has become detained, in this example, Birmingham.

How we make it be any other way? … section 13 of the Mental Health Act sets down the duties of local social services authorities around being able to undertake assesments for patients "in their area". **NB**: not *from* their area. If we extended the geographical quandry to Birmingham / Newcastle, we would see how obvious it is. If assessment is needed in central Birmingham, we're not going to be able to compel an AMHP from the North-East to do the assessment – we'd have a country of AMHPs waving to each other on motorways. Nothing prevents AMHPs from different areas sharing information to support the assessing AMHP, but the duty would sit in Birmingham.

DISPUTE RESOLUTION

I have seen such disputes less over the last few years, but they re-emerge when, for example, police services start recofiguring their custody provision and then achieve a consequential impact upon AMHP services. In several

police forces that I can think of, we have a move towards establishing "super-blocks" for custody: larger facilities with thirty cells, perhaps as many as fifty cells and they are sometimes geographically situated to be accessible by officers from more than one geographical area. It's all part of the "shared-services" mythology.

This can be a nightmare in waiting for the area on which the foundations are actually laid, but no different to other public sector configurations. I am aware, for example, of a very large NHS hospital trust whose building is rather past its best. They are building a brand new hospital on a new site about 1 mile down the road – just over the border! I've wondered whether the AMHPs in their current area have the opening date of the new hospital red-circled on their calendar and a team 'do' booked! … or whether AMHPs in the new area have a large black cross on theirs?!

Ultimately, unless a local agreement between neighbouring areas has been reached to do things in any other way to ensure provision, the AMHPs who work in the area where the assessment is needed have the responsibility for undertaking it, although the Code of Practice to the MHA does allow them to offer that assessment to AMHPs from the patients home area, especially if it is an adjacent area. This makes sense both in terms of knowing the patient and in terms of knowledge, for example, of any statutory aftercare they are receiving (under s117 MHA).

KNOWLEDGE CHECK

So! – just to test you: what if the police from area A have travelled to area B to make enquiries into something they are investigating and then arrest someone from area C in area B for an alleged offence in area D and remove them to a custody office on area E?! << *A real example!!* … this is fun, isn't it?!

I'll leave that one with you! ;-)

28th November 2012

The Utility of Force –

The use of physical force, by anyone, has only two outcomes: it either moves / hurts / kills people; or it moves / damages / destroys things. Whether any broader, secondary purpose is achieved by that use of force – whether the force has 'utility' – is quite another matter again. This is why the use of force by Armed Forces, Police Services and others is controversial and needs to be better understood.

These are NOT my thoughts – although I sincerely wish they were! The book I took on my honeymoon was "The Utility of Force" by General Sir Rupert Smith and as soon as I finished reading it, I started reading it all over again. It is a fascinating rummage through the last two hundred years of military history which was my main interest, but it is interspersed with such a clarity of thought about how one achieves a 'utility' in the use of force used as to render the book one of the most important things I've ever read.

Since then (over 7yrs ago!), I've continued to think of the utility of the police service's use of force in the terms how SMITH explained his own approach. I would imagine some reading this are thinking about how appropriate it is for a police officer to be taking things from someone with a military background and considering them as being of any relevance to mental health issues? Well, reading the book – I encourage you – would reveal that SMITH's main argument about why conflicts in the last fifty years have been often failed or been perceived to fail – Vietnam, Iraq, Bosnia, etc.. – is because it was believed force in and of itself could bring about political solutions. He rightly argued that it was a political and strategic failure to link the use of force to the expectations of the populations in those countries, that often meant that force was not perceived as legitimate. And as soon as we use the word 'legitimate', one will think about controversy in the UK around the use of force in public order situations – G20, student protests, Summer Riots – to see the parallels. I'll let you decide for yourself where there was a wider view of the 'utility' of the force used.

THE LEGITIMACY OF FORCE

We have also had high-profile uses of force with regard to mental health related crises, too, where the question of legitimacy has been raised in connection with the chosen tactics. So what does all of this mean for us?

Well, utility is judged not only in terms of whether the force achieved the pure objective it was intended to bring about. For example: was that person safely moved from here to there, utilising techniques that may have (temporarily) hurt or discomforted them, in order to do so, but whilst maintaining legitimacy because of reasonableness, proportionality and dignity in the meanwhile. In other words, did officers managed to secure an arm-lock, in order to allow handcuffing, thereby achieving greater control over a resistant subject and thereby force them into a vehicle for transport somewhere else? It is judged in terms of legitimacy.

Read back the above paragraph whilst imagining an illegal arrest for which there was no justification at all. You will immediately recognise that this force lacks 'utility' and legitimacy. It is illegal, it is unjustified, it would not command public support. Read it in the context of officers who, without resort to any greater force than that which was described, managed a threat posed by a knife-wielding offender intent on street robbery and there is immediate 'utility'. Lawful, necessary and almost heroic given the risks to them and the fact that they could have 'justified' in legal terms, a high-level intervention. Of course, a lot of situations are not as clear-cut as this.

We know that police officers occasionally are called to exceptionally violent situations involving highly resistant people. Occasionally – thankfully, rarely – these situations involve mental health patients in crisis, sometimes suffering from delusions and paranoia that officers may be intent on causing them harm. Restraint situations in cases like this are always challenging and let's be frank: there have been some extremely high-profile disasters involving deaths in police custody or following contact. The Metropolitan Police has established an independent commission to look at such cases and the wider issues and I'm sure that restraint will be a feature. The techniques involved, the training given, the alternative options that may, or may not, have existed, etc..

ROCKY BENNETT

I have heard it suggested that where possible the police service should look to CONtain rather than REstrain patients presenting with disturbed behaviour. Maybe there will be something in that for some situations and I'm sure we all recognise that officers handle things in different ways, which

inevitably means some will resort to force sooner than others. There may well always be just some circumstances where police officers are going to have to get 'hands on', to protect people from themselves, or to protect the public and I can't help but keep thinking about this and remember the Independent NHS Inquiry following the death of David (Rocky) BENNETT. I keep thinking about it because it was **not** a police case:

Rocky BENNETT died following a restraint incident at a psychiatric hospital in Norwich in 1998. During the Inquiry which followed, there was a considerable focus upon restraint techniques, medical implications, safety and clinical management, etc.. It also focussed upon various issues for the NHS around race – indeed, it may be argued to be the 'Stephen Lawrence Inquiry' for the NHS, which explored the concept of 'institutional racism'.

Rocky had been racially abused on his ward by another patient during the course of a day and his representations for protection from this led to a perverse decision that *he* would be moved to another ward. Not the perpetrator. He resisted this and was restrained. He was held in the prone position for a long period of time and died before he was moved.

Here are various things that were said during the Inquiry:

- Any patient who required physical restraint was by definition in a **medical emergency –** p52.
- Wherever a mentally ill patient is detained there should be a fully equipped resuscitation trolley;
- There should also be people who were capable of giving drugs and using the equipment, including a defibrillator. – p55.
- There should be a doctor in every place where mentally ill patients are detained, or if that is not possible foolproof arrangements should be in place twenty-four hours a day to ensure that a doctor will attend within twenty minutes – p55.

Think about the medical implications for the police service picking up violent, resistant patients – irrespective of whether there could or should have been any form of 'upstream intervention' – and then think about the clinical care that will be provided in custody. We couldn't deliver on any of this – not even nearly. Think about the physiological implications of restraint, especially where it may potentially continue for more than a few minutes now that you've reflected upon this incident.

THE ROLE OF THE AMBULANCE SERVICE

If a patient in hospital requires restraint by nursing staff and they are a medical emergency, why wouldn't a similar patient in the community who 'requires' restraint by the police also be? And if we regard that they are,

what medical input do we need and when? We know that if you try to leave things until you are in police custody, you can have already had a disaster. So it has to be faster than that. Quick run in a police car to A&E? We know that if you do that, you can have had a disaster by the time you get there. So we need emergency medical care to the scene. Would you agree with me, that can mean only one thing: **the ambulance service**?

If force is going to have 'utility' and public support, it will have to able to be seen during the sharp light of hindsight as being the least restrictive option, other methods of ensuring safety having been dismissed or even tried and failed. And once done, such interventions will have to be managed and be seen to be managed as medical emergencies – and this is **not** easy, which is why we need our colleagues in green. We need an acceptance that when the police are required because of safety concerns to become a lead agency in the response to psychiatric emergency, that they recognise this and / or can absorb and act upon information. We then have to manage such interventions quickly and by bringing the detained person before competent medical authority as quickly as possible – or **preferably bringing that authority to them**.

I recently delivered some awareness training to a multi-agency audience and when I said, "Call an ambulance to every s136 detention and to every detention of any kind involving RED FLAGS which are connected to mental ill-health." The room looked at me like I was unwell. There were various 'reality' checks offered – that their ambulance wouldn't come, hadn't agreed, didn't see the need, etc., etc., etc.. **I'm not actually sure I care** – if we are dealing with complex needs and significant vulnerabilities that can be raised significantly by police interventions, we need medical support and the ambulance service is the NHS on wheels. Officers have got a right to call for them, when they think it is appropriate. Whether they come or not, if we are talking about restraint, especially where it is prolonged restraint, then we need to give that person and emergency medical authorities the chance to assess whether this patient falls within NHS guidelines for the management of acutely disturbed behaviour AND / OR whether the police or paramedics have misjudged a presentation that is attributable to something else – like head injury, diabetes or a stroke, etc..

This requires proper commissioning, but it also requires frontline knowledge and there are already too many cases where this has not occurred and we can name the patients and frontline professionals who have been let down by a non-integrated police / health / social system.

Incidentally, in case you were wondering – Mrs MentalHealthCop took some books on honeymoon that I thought were truly awful too! … and read them!!

30th November 2012

I Predict a Riot –

An article was recently published in The Voice, regarding a concerns about the deployment of police officers into a mental health unit "in riot gear". Apart from having various reservations about the article itself which I'll come on to shortly, I wanted to more generally cover the subject of this from the point of view of being a police officer who has twice pulled on his "riot gear" to do exactly this. I've also done it on another occasion to safely 'section' a young man in a community MHA assessment setting. I have also been the duty inspector for an area who has *asked* officers to do this and in my 'policy and partnership' work on mental health, have been involved in numerous debriefs where mental health staff request the police to lead on the management of serious violence and aggression on psychiatric wards.

The article states that a local Councillor has called for an explanation of the reasons why officers were called, amidst concerns about previous events where police interventions in mental health crises were followed by disaster. There is now an inquiry ongoing into the incident by the mental health trust concerned. All of this is more than fair enough, because public services should be accountable and transparent about the work they do for us all.

Whilst this sort of thing is comparatively rare, it is not a one-off.

THE VOICE

Firstly, let's deal with the article. I have a few concerns about it –

- **It doesn't even begin to explain why the officers were called:** Crimes can and sometimes are committed on psychiatric wards, including some serious ones. For all I know from this piece, the polcie response could have occurred following an armed threat where staff and patient's lives or safety were at grave risk. Such things have been known so it would have been helpful, not to say balanced, to have had the context to the incident. "Riot police called for patient who broke tea mug" would also have been equally helpful, because it would then allow the reader to contextualize the concern

because of a potential over-reaction. << *This is example is not flippant: my officers were once called – without their riot gear! – to staff complaining of criminal damage to a mug.*

- **The Metropolitan Police do not appear to have been asked for a comment.** They are neither quoted, nor referenced as declining to comment.
- **It does not mention the reality of violence against mental health staff within the NHS:** 67% of violence against the whole NHS was directed to mental health staff during NHS Protect's last publication on the matter. This includes grievous bodily harm and sexual violence, some of that involves weapons or improves weapons.
- **I've got about four more objections**, but you get my point?

DOES JUSTICE STOP AT THE HOSPITAL GATE?

During detailed discussions over many years with mental health professionals, a senior forensic psychiatrist asked whether "justice stops at the hospital gate?" I don't mind sharing that (NHS) healthcare appears to stop at the police station gate, but managed to focus just in time! He's quite right – as am I – that the core roles of the police don't service do not entirely stop within hospitals, psychiatric or otherwise. The police may be reluctant on occasion to respond to or investigate criminal offences within mental health units, but we should remember we are still in a period of transition where this might be expected. When I joined the police, we simply didn't get called to violence on wards to investigate / prosecute, merely to help to restore safety.

No-one, presumably, thinks that every single 'offence' by a mental health patient should be reported and the NHS Protect report shows that this is not what happens. A major trust in my area reports 16% of its violence against staff and other patients to the police. Other cases are handled as clinical issues or assessed by the staff as lacking a public interest or being cases where a suspect would be unlikely to be held responsible for their actions, because of their condition. Contrary to some officers' beliefs, there is no wholesale reporting of every misdemeanour for investigation – far from it.

So when NHS staff ring the police, they have often gone through the process of trying to decide whether the situation was clinically attributable, potentially in the public interest and potentially supported by admissible evidence. After all, a victim of crime is still a victim of crime even if that offence was committed by someone whose mental disorder mitigates against their liability for that act.

SERIOUS AGGRAVATED RESISTANCE

Where particular situations on psychiatric wards reach a point of crisis and weapons have been produced or used and / or where barricades have been erected in rooms, it doesn't surprise me to learn that staff ring the police. These were the two situations I was involved in as a police constable, but I would remind you that such occurances are *rare*. Whilst in some hospitals, staff training is such as to afford the 'deployment' of nurses with control and restraint training, tackling armed patients threatening to kill is potentially on another level. Mental health services, unlike the Prison Service, does not necessarily train and equip their staff to deal with the upper end of resistant behaviour – what the police would call 'serious aggravated resistance'. You may have a view on this, but I can understand why they don't.

So if a decision has been taken to use force to resolve an armed stand-off, or a barricade situation, this is going to involve officers in protective equipment – sometimes called, "Riot Gear" – or officers equipped with tasers or in very serious cases, firearms.

I totally understand the intuitive that we don't *want* "riot police" on psychiatric wards, but it needs to be understood that mental health professionals have been slashed with knives, punched to such an extent that their jaw or their eye sockets have been broken and they have been left with life altering injuries, arising from their work. Not just physical injuries, but serious, debilitating psychological trauma. Whether or not such events could have been prevented or their likelihood reduced through earlier intervention or better care planning, is arguably beside the point if you are the police officer called there.

The fact that tonight's emergency may have been prevented by something else happening last Tuesday is irrelevant to the police officers who have to attend and prevent crime, bring offenders to justice, protect life and property and maintain the Queen's Peace. The predictability of the situation is immaterial to those officers – they must police what is in front of them. **We are where we are** … and all that.

PREVENTION AND RESOLUTION

Of course, it is incumbent upon mental health professionals to prevent the escalation of situations which may, unchecked, become cases of the type we are talking about – cases which are quite rare, actually. Naturally, we should be aware of the impact upon vulnerable patients of seeing "tooled up" cops running into their environment with shields, police dogs or tasers

in order to forcibly subdue another patient, especially one who may already suffer from delusions or paranoia.

As with many of the debates around criminalisation of vulnerable people, I'm not sure I want a society where the reality that we are 'policed' is kept from some of our citizens, especially where the safety of our public servants is compromised. As long as intervention is proportionate, I think there is much to be gained from acknowledging the reality that if you pose a serious risk to others, the police can or will be called. If there is to be safe management of such events without resort to policing, then NHS managers will have to undertake considerable work to achieve this. It's do-able in theory; potentially more difficult in practice.

Of course, the officers weren't in "Riot Gear", they were in protective equipment. Overalls are still overalls whether the purpose for wearing them gardening, decorating or repairing your car. Language is important in mental health – as policing is a *de facto* part of our mental health system, this must extend to the officers, too.

DECEMBER 2012

6th December 2012

Forcing Entry –

Various topics I have written about include reference to situations where the police may or may not have a legal authority to enter private buildings – if need be, by using reasonable force – in connection with mental health related incidents.

I want to cover this again, pulling it all into one post so that there is a searchable reference tool to what we call "police powers of entry".

Firstly, I want to dispel a myth that the police need a warrant from a Magistrate's Court in order to be able to force their way into your house. This is **not always true**, as there are various statutory authorities for the police to enter buildings without a warrant.

POLICE POWERS

The police have a right to force entry to buildings in about five different types of situation – I am generalizing slightly to keep this clear:

- **In order to arrest someone for what the law calls "an indictable offence":**

  – An indictable offence is one which can be tried in the Crown Court and includes things like theft, burglary and robbery up to an including violent offences like ABH and GBH; or sexual offences and murder. – So there is no authority to force entry to arrest someone for a "summary only" offence, which is handled in the Magistrate's Court – things like drunkenness offences or minor traffic violations.

- **In order to save life and limb:**

  – The officer must believe that the risk to life is serious and imminent: see the case of Syed v DPP [2010].

  – Officers once argued this justification for forcing entry in relation to an AWOL patient and the court ruled that there was insufficient justification to believe that the patient's life really was in jeopardy. This was in D'Souza v DPP [1992].

– The court reminded us that where life was not imminently at risk, a warrant should have been obtained – see below.

- **To search a premises for evidence after arrest for an indictable offence:**

  – It may be necessary to search someone's home, for example, to see if there is evidence of the offence contained there. This could include anything from stolen property, to clothing (which may assist in identification issues) or other forensic evidence like blood stained shoes.

- **To prevent or apprehend a breach of the peace:**

  – This is what is known as a 'common law' power. Where officers believe there is likely to be a breach of the peace or where they believe that there is a breach of the peace ongoing, they have a right to force entry in order to prevent it or stop it. Worth remembering, that the case of R v HOWELL [1982] defined a breach of the peace as requiring "an imminent risk of violence".

- **Under the terms of what are commonly called "search warrants":**

  – This would include warrants issued under the Theft Act 1968, the Misuse of Drugs Act 1971, the Firearms Act 1968 and many others.

MENTAL HEALTH RELATED ENTRY TO PREMISES

There are **no** specific powers for the police to force entry to a premises for mental health related issues, unless covered by one of the situations listed above. Where a person with mental health problems is suspected of an offence or where they are actively attempting to take their own life, then officers would have powers to enter, as above.

But where officers or mental health professionals wish to enter a property where no criminal offences are being committed or attempted and where no-one's life is at imminent risk, they must either have permission from the owner / occupier, or they must have a warrant from a Magistrate's Court.

It may be worth noting: where two people live a house and one person consents to the police or mental health professionals entering the address, this makes entry lawful even if the other person objects to it. So, for example, where someone has asked MH services to come to their home in order to assess or support their partner, the partner's objection to the situation would not render their presence illegal and the police and mental

health professionals would be acting "in accordance with their duties". << I use this terminology deliberately, because whilst most people realise it is a criminal offence to obstruct a police officer in the course of their duty, fewer people realise it is also an offence to obstruct an AMHP in the course of theirs.

MENTAL HEALTH ACT WARRANTS

There are two types of warrants which the Magistrates Court can issue which would then allow the police to enter a house without the permission of the owner / occupier. Both are contained in section 135 of the Mental Health Act:

- **Section 135(1):**

  – This is a warrant which can **only** be obtained by an Approved Mental Health Professional and it allows the police to do two things:

  – Enter the premises by force, if need be;

  – Remove the person in respect of whom the warrant is issued to a "Place of Safety" for assessment.

  – The police **must** be accompanied by an AMHP and a Doctor when they execute this warrant.

- **Section 135(2):**

  – This warrant allows the police to enter by force any premises where a person is believed to be, if the person is liable to be detained or re-detained under the Mental Health Act.

  – For example, this includes:

  – Forcing entry in order to return someone to hospital who is AWOL under the Mental Health Act

  – Forcing entry in order to take someone to hospital in respect of whom an application for admission has been made, usually under section 2, 3 or 4 of the Mental Health Act.

  – **NB:** this warrant can be obtained by the police on their own and executed by the police on their own, if need be.

– Good practice would be for the police and mental health professionals to undertake these things jointly, but time does not always allow it.

USE OF FORCE INSIDE A PREMISES

The police have a statutory right to use reasonable force to prevent crime and arrest offenders – this is covered by section 3 of the Criminal Law Act 1967. It means, for example, that if officers have been granted permission to enter a premises by a patient's mother, but his father attempts to obstruct the AMHP from undertaking a proper MHA assessment, the police would be entitled to use reasonable force to prevent the father from obstructing the AMHP (a criminal offence), even if they were in the house with permission only from the patient's mother.

Where the police are acting under the terms of a warrant issued by a Magistrate's Court, it also follows that they are entitled to use reasonable force in order to ensure that the obligations within the warrant are fulfilled. This would allow officers to use reasonable force to detain / convey a patient to a place of safety under a s135(1) warrant, for example.

10th December 2012

Theory into Practice –

This post seeks to show the theory of many things I've written about, operating in practice:

Christopher HAUGHTON from Wembley has today been found guilty of attempting to murder **PC Tom HARDING** and **PC Alastair HINCHCLIFF** in Kingsbury, North West London. He was also convicted of two offences of causing GBH with intent and two of ABH in connection with the same incident in November 2011 after attacking several other officers who arrived in support of their colleagues.

Already remanded to Broadmoor Hospital, the judge has indicated he will be detained there without limit of time when he is sentenced later in the week – this is a section 37/41, Restricted Hospital Order.

Presumably, Mr HAUGHTON has been remanded to hospital after his conviction under s36 MHA, which provides for the remand of convicted but unsentenced prisoners to hospital.

This case is interesting to highlight for a range of reasons, all amplifying in practice, points I have made previously on other blogs:

1. Although seriously unwell, assessed as having paranoid schizophrenia, he was still able to be held responsible in law for his violent actions.
2. He has not been found 'unfit' for anything or legally 'insane', but has been fully convicted by a jury – mental illness is not an automatic defence to criminal liability. He could have chosen to run an 'insanity defence', but this is not often attempted precisely because, where successfully done, it would lead almost certainly to the same outcome: a s37/41 Restricted Hospital Order.
3. This case shows, that even where an arrested suspect is "suffering from mental disorder of a nature or degree" that makes detention in hospital appropriate, it does not follow that an offender must be diverted without charge. Where the evidence exists and where the public interest exists, prosecution can occur – insanity is an issue for the defence to raise if they believe it is relevant – not one for the prosecution to proactively rebut.

An officer has asked on Twitter why Mr HAUGHTON was diagnosed only after the attack; and why not before it? I don't know – of course it is possible that he had never come to the attention of the NHS mental health system before but that is speculation and I'm trying to find out more. We do know that he had been arrested before: he had previously been remanded by the police and was on bail from the courts for a previous attack upon police officers, in October 2011.

I'd be really interested to know whether that previous arrest had led to any referrals to mental health system or whether he was assessed for mental health issues at the time, perhaps in whilst in police custody. << We should remember, that whether or not he had been assessed, it does not follow that anything was 'missed'. Everyone's mental health fluctuates over time. Maybe we'll learn more in due course.

Detective Inspector Keely SMITH, the Senior Investigating Officer, remarked upon how the officers continued to detain Mr HAUGHTON despite knowing the extreme threat he had begun to pose, including directly to them. PC Tom HARDING has stated that he feels he owes his life to his colleagues: "I owe my life to the bravery of my colleagues. I cannot praise them enough for their courage in what was a harrowing ordeal. I believe they represent the finest officers of the Police Service and it is an honour to serve among them."

The judge, after sentencing Mr HAUGHTON to a Restricted Hospital Order, said, "It seems appropriate to draw to the attention of the Commissioner the court's appreciation of the very considerable courage of the three police officers. All three acted in a very difficult situation with very considerable courage and the public is in their debt."

I'm sure we all wish the officers a speedy recovery from their injuries and thank them for their undoubted bravery. We should not forget, though – the very real potential for psychological injury which may yet to be felt. << *Who Protects The Protectors?*

UPDATE >> *On 17th January 2013, it was announced that the Metropolitan Police would roll out wider deployment of tasers and this occurs following a long review of this particular incident as well as broader exmaination of other officer safety incidents. Here, the officers equipped with handcuffs and a protective vest; some CS spray and an aluminium tube. Police incapacitants are not-infrequently found to be ineffective where police officers are dealing with people under the influence of drugs or alcohol and / or where they are believed to be suffering serious mental health problems.*

12th December 2012

Joe Paraskeva

At the Court of Appeal today, Joe PARASKEVA has successfully appealled his sentence following an act of arson in a psychiatric unit where he was detained under the Mental Health Act. The appeal comes after a hard-fought campaign by his mother, Linda MORGAN over a two year period and it is beyond doubt that today's judgement imposes the correct legal framework as Joe's condition continues to improve. The campaign website is "Justice for Joe".

I wrote a blog-post on this case last year to attempt to explain how it may have come to pass that Joe entered the criminal justice system as a convincted arsonist in the first place; especially when it was clearly very likely that his condition and detention under the Mental Health Act at the time of the offence played a significant role in the incident.

The essence of the issue appeared to be, reflected in last year's post, that having been detained by two psychiatrists and an AMHP and the incident of arson having occured, the psychiatrist who subsequently gave opinion during the criminal investigation stated that despite Joe being 'sectioned' at the time, he was not suffering from a mental disorder. As I wrote, "This may have been right or wrong, but it appears to have been the view offered" and as a result, Joe was prosecuted. The court then reached its conclusion in terms of a sentence in light of that information.

Today's Court of Appeal judgement appears to show that the psychiatric assessments which influenced the original criminal justice process were inadequate and the Lord Justices of Appeal were entirely satisfied that Joe "was suffering from a mental disorder both at the time of the offence and sentence." As such, he sentence has been changed to a Restricted Hospital Order, under section 37/41 of the Mental Health Act 1983.

This case therefore keenly highlights the importance of how the criminal justice and mental health systems interact, or how they some times do not interact effectively. But most importantly, I'm glad to learn from the publicity around the Appeal, that Joe's condition continues to improve and that he has now achieved the status of "patient" rather than "prisoner".

- BBC News article
- The Guardian article

13th December 2012

Mens Rea –

If you want to prove a criminal offence, you have to prove two things:

- **Mens rea** – the guilty mind.
- **Actus reus** – the act done.

I'll get rid of the issue of the *actus reus* first because for our purposes here, it's quite quick to do so: you've either got witnesses and CCTV that show the assault, the damage or the theft or you haven't. You've either got circumstantial evidence like forensic evidence which implies the act done or you haven't.

It is obviously with regard to the first part, that we get into detailed discussions about the potential liability of a suspect who has mental health problems. *Mens rea* is also sometimes referred to as, "the mental element" of an offence. I wonder about the extent to which 'the mental element' and 'mental health' get conflated and confused? Surely someone with mental health problems cannot form 'the mens rea' because there is something 'wrong' or 'dysfunctional' in their cognition?

Maybe …

The 'mental element' of offences varies enormously: for a person to be guilty of driving a car without insurance, they must simply be found driving a car on a public road without insurance. Whether they thought they had a policy of cover is not the point: it is whether they did, in fact, have cover that matters. This is what the law calls an offence of *basic intent*. By virtue of a stated case, mental illness is not a defence in law, to an offence of basic intent.

Other offences require certain states of cognition, especially where an offence requires some form of *specific* intent. For example, to commit grievous bodily harm *with intent*, contrary to s18 of the Offences Against the Person Act 1861 (OAPA), a person must have a deliberate intention to inflict grievous injury. A punch to someone's face which breaks their eye socket, but which was intended only to frighten them and blacken their eye, would not reach this threshold. Such an offender may be guilty of committing GBH *without* intent, contrary to s20 OAPA.

MENTALLY DISORDERED OFFENDERS

I'll just quickly repeat my dislike for this term, MDO, before stating that much debate has been consumed over the years as psychiatrists and lawyers try to debate this one out and inform each other. In the West Midlands, there has been a productive engagement between NHS forensic mental health services, the Crown Prosecution Service and the Police as they seek to work through these complex issues. My standard joke at these events has been to wonder aloud whether I got invited to give a police perspective or simply to keep the Queen's Peace as the psychiatrists and lawyers get going. They are always interesting discussions.

I have heard lawyers and police officers state their understanding that an offender who is so seriously unwell that they have been sectioned under the Mental Health Act is "surely unable to form the mens rea?" Well, it depends. Did you find him driving without insurance or grievously injuring NHS staff? The allegation against a suspect / defendant would influence the answer.

The psychiatrists have often responded by explaining that it would be highly unusual for a patient to be so ill, for example because of psychosis, or so totally affected in their congition by medication, to have absolutely no insight whatsoever into their actions. Such cases do occur, but are rare

For example, very recently Christopher HAUGHTON was convicted of attempted murder – which is probably the most difficult offence on the statue book to prove, in terms of the high threshold for specific intent – and yet his mental condition was such that he was "suffering mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment." In other words, if his mental condition had been assessed notwithstanding the commission of an offence, he would have been detainable under section 3 of the Mental Health Act. But he was fully responsible for the offence, despite his paranoid schizophrenia.

DOCTOR KNOWS BEST

So surely, to establish whether or not someone's mental illness affects their cognition, capacity or liability for an act done, you ask the doctor in charge of that persons care? Or, ask a doctor who assesses them?

Not necessarily – clearly a psychiatrist is very likely to have very relevant information to offer and opinion to give. However, this is not a scientific a process as you might hope. A senior academic forensic psychiatrist helped

me understand many years ago that asking him about mens rea or intent or reckless, is to put legal questions to a medical officer. Would you ask a lawyer a medical question? Well, you might ask a lawyer who specialists in medical law a basic medical question, but if it was a significant question around the provision of clinical care, you would not.

You'd ask a doctor!

The forensic psychiatrist concerned also pointed out that whether or not legal thresholds around intent, reckless or mens rea are met – these are potentially matters for legal officers like police officers, prosecutors and judges, but ultimately are a matter for juries. You'll remember my blog about the Yorkshire Ripper – five eminent forensic psychiatrists saying broadly the same thing, three of them giving evidence to the court, but the Judge did not just accept these opinions at face value, he put the whole affair before a jury to decide. This happens in many cases far less notorious, not least in the Christopher NAUGHTON case.

MENS REA AND THE PUBLIC INTEREST

It is my view after working in this area, what we often pretend to be difficulties in proving *mens rea*, are in fact implicit instincts and assumptions about the public interest test. I have heard officers say that they've been to a psychiatric unit where a nurse or another patient has been assaulted and they've said, "You can't prove the mens rea so we can't prosecute".

If the allegation is of actual bodily harm, you need to show is that the person knew they were punching, slapping or pushing someone with the intention of hurting or moving them – and you're home! The fact that they were suffering a severe delusion and *thought* they were punching a Norse God (real example) is not the point: they *knew* they were punching someone with a likelihood of hurting them or causing them fear.

Whether the mythological delusion is sufficient to cause you to believe that a different, diversionary approach is more appropriate is not the point, as far as establishing *mens rea* is concerned. You may well be able to prove *mens rea* to a relevant standard, but think there is a better option than prosecution and that there is little public interest in doing so … **that is a separate matter**!

14th December 2012

Your Home Is Your Castle –

The reach of the state into your home is severely curtailed compared to its reach into public places: the notion that an "Englishman's home is his castle" is actually very real, in the sense that you can require the police to desist from certain activities in your house where you would have no comparable right in the High Street. This has implications for how the police response to mental health emergency in private places – whether it is a spontaneous incident as we had at work last night; or whether it is a planned incident where the police support health and social care colleagues in undertaking Mental Health Act assessments.

SPONTANEOUS EVENTS

Yesterday – amongst the child rape allegations, firearms / armed robbery incidents and the predictable amount of domestic abuse – my officers had two different "mental health on private premises" jobs, both involving known mental health patients and both the result of 999 calls. Each involved community mental health patients who had self-harmed after abusing substances – one drugs, one alcohol.

One of my sergeants was supervising an incident where a community patient had self-harmed and taken an overdose of medication after drinking alcohol. She was presenting in exactly the way that I highlighted in a previous post about an episode of "999 What's Your Emergency?" – she was not committing an offence or breaching the peace and was declining the paramedics' offer of a trip to hospital for assessment. The Sarge shouted up to ask about the Mental Capacity Act angle, correctly recognising that we cannot use s136 in the woman's house. As the paramedics were standing there, I suggested that they go about the business of assessing her presumed capacity to take her own decisions whilst attempting to engage the crisis team and the AMHP. After the crisis team and the AMHP declined to do anything which would have brought about an MHA assessment – as per the Judge's reminder in the Sessey case where the police were criticised for 'using' the MCA – the officers and paramedics were able to persuade the woman to attend.

There was no response from the CrisisTeam because "you can't do a Mental Health Assessment on someone who is intoxicated." Well actually you can, if you *absolutely* have to – and I would have thought that attempting to do so, to keep someone safe where there are no other legal options for the police or paramedics to safeguard this vulnerable person might be just such a scenario. Maybe it's just me – but the end result was 24/7 emergency mental health services were disinclined to agree they had a role with regard to their known patient. I was only grateful that they didn't incite the illegal arrest under s136 Mental Health Act as I have known in the past, "Just get her outside and arrest her", etc.. Err … no.

Of course, the fact that the police and paramedics had *tried* to engage community mental health services was an important part of contextualizing any subsequent decisions they took.

At the end of the shift, I led four officers and a sergeant into a building during a second incident where another known mental health patient had self-harmed, seriously injuring himself. He had a history of attacking paramedics with razor blades after getting into a psychotic state following the abuse of cocaine so when the 999 call went in to West Midlands Ambulance Service, they called for our support – quite rightly. We also had knowledge of the man and I arranged for the "riot police" as they are **not** called to start coming towards us just in case the six of us – two with 'tazers' drawn – were unable to quickly safeguard him. Fortunately, things went swimmingly and after some cracking team work with West Midlands Ambulance Service whose paramedics were absolutely brilliant with this guy – off he went to Accident & Emergency and we went home after filling the forms in.

PLANNED ASSESSMENTS

The myths around section 135 continue to abound – including the debate about whether you can or cannot obtain a warrant. I spoke at an AMHP conference in Leeds last week where I rattled through some of my views on this and saw heads nodding throughout. But I have continue to hear internet forum objections and frustrations around police responses and queries for planned assessments, in particular when it comes to the subject of section 135(1) warrants –

I want to dispel (again!) some myths so that we **stop making stuff up** that affects decision-making and contributes to risks:

- There is absolutely **no requirement whatsoever** in law to try to secure access before applying for a warrant
- There is absolutely **no requirement whatsoever** to evidence why you think access would be refused.

- It is perfectly legal to apply for a warrant as a contingency "just in case". The police routinely secure warrants "just in case" in many other circumstances.
- If an AMHP would apply for a warrant, they need only be able to evidence one or more of four things: neglect, ill-treatment, lack of control or the fact that someone is living alone.
- The warrant is not just about gaining access: it is also about the safe management of the assessment once you are in the premises.

Of course *whether* you apply for a warrant is a different thing altogether! …

It has been recently assumed that I am arguing here for a "no warrant, no police" approach to the planning of Mental Health Act assessments on private premises. I have repeatedly said that I am not – actually, I'm wondering how else to make this clear?! **I am not saying "no warrant, no police".**

I am arguing for a *proper* consideration of how to safely manage the RAVE risks which caused the police support to be requested in the first place. Let us remember: in a private premises, without a warrant, the police service have **absolutely no powers whatsoever** to do anything coercive until there is an attempted criminal offence, a (real) breach of the peace or until the person being assessed is 'sectioned'. Until one of those three things occurs, the police are simply without a coercive power to intervene. They are human beings with a mouth and a certain skill set that may persuade, influence or encourage. Whether this is sufficient to keep everyone safe, will vary from case to case.

Let me clear about a final point: I believe that I can identify at least four MHA assessments in private premises where the *absence* of a 135(1) warrant has led to the realisation of risks which would have been immediately preventable and they were risks that were forseeable in circumstances where the grounds for a warrant would be met. The risks were manifested in serious injuries to service users, mental health professionals and police officers – life altering injuries. I wonder what the Health & Safety Exeuctive would say? Actually, I've asked them: the warrant could be considered a necessary part of proper risk assessment and the absence of an obtainable warrant could be relevant to any of their investigations.

The fact that such events are rare would be fair enough if the realisations of the risks concerned had led to trivial consequences. But where we are talking about self-harm injuries to GBH standard or attempted murder, it seems fair enough to raise the issue for debate – if we are asking police officers to take risks on our behalf, to mitigate risks for us, we need to give them the tools to do the job properly wherever the law allows.

The castle analogy at the start lead to a gratuitous opportunity to post some great pictures of my favourite castle: Bamburgh in my home county of Northumberland. Believe it or not, Bamburgh was a key location in the medieval England and as the seat of the Kings of Northumbria, once rivalled London it its significance!

14th December 2012

Can You Use Section 136 in A&E? –

Recently, I had emails via the very excellent Inspector Jan PENNY in Thames Valley Police, drawing me into a debate in her area about the use of section 136 in an Accident & Emergency department. The definition of s136 makes it plain that you can only exercise the power in "a place to which the public have access" and TVP officers were consumed with the detail of what this meant.

The post I wrote last year on Section 136 Arrests Within A&E addressed the question of whether A&E is "a place to which the public have access" and I definitively stated that it was, without detailed explanation about the kind of arguments that break out. In light of Thames Valley's difficulties, I want to put that detail out there, with a nugget of information I only discovered tonight.

ACCESS TO A&E

In many A&E departments these days, they have entirely public waiting areas into which absolutely anyone could walk should they wish to do so but many have introduced controlled access to the treatment areas. You often have to be let through a door which has a security swipe system controlled by nursing, medical and security staff. You absolutely cannot walk into those areas just because you want to; it is completely conditional upon staff permission to do so on their terms, at times determined by them.

Recently, police blogger Inspector Gadget wrote about this access system representing a problem even for police access, such is the level of control exercised over them. To what extent is the area of A&E beyond these doors "a place to which the public have access." Well, it turns out there's an easy answer to this, after some have spent hours torturing themselves with legal definitions that were never relevant to begin with.

PUBLIC PLACE

Legal debate about this often turns quickly to the legal definition of a public place. The problem is that there are different definitions depending upon which Act of Parliament you are reading. The Road Traffic Act is different

to the Public Order Act, etc., and in any event, s136 MHA does not refer to "a public place", it refers to "a place to which the public has access." We must assume that these are different things, otherwise Parliament would have used the same phrase to ensure the same meaning.

The Thames Valley officers had removed a person from the access-controlled treatment area under s136 and the detention of that person in the cell block was refused by the custody officer as potentially illegal. This decision rested upon an interpretation of "a place to which the public have access" that focussed upon an interpretation which implies totally free, entirely unrestricted access, or access granted because of the satisfaction of an entry criteria which, in theory, anyone could meet, such as payment.

Actually, section 9 of the Public Order Act 1936 would imply that A&E treatment areas are fair game for s136: a "public place includes any highway and any other premises or place to which, at the material time, the public have **or are permitted to have** access, whether on payment or otherwise." (The bold is my emphasis.)

RED HERRINGS

Whichever side of the fence you sat on until now, the answer is actually specifically clear. I have tonight been re-reading the Sessey judgement and found something I had failed to spot when reading it previously: paragraph 39 of the judgement is referring to the difficulties faced in achieving an urgent admission under the MHA with regard to people who may be inclined to leave the hospital. It states:

"If a patient evidences an intention to leave the hospital before the s.4 application is completed, hospital staff may contact the police who have the power to detain the patient under s.136. We do not accept that there should be any problem with the use of s.136 in these circumstances.

The Accident & Emergency Department of a hospital is a place to which the public have access and accordingly it is a public place for the purposes of s.136."

So there it is – it is beyond doubt, following a High Court ruling. Of course, now that you know you **could** detain someone under s136, you'll need to decide whether you **should** detain them … and what you then actually *do* with the person is quite another debate again because nothing in this post or that court ruling will help you with the wisdom that "A&E is not a place of safety."

Well, actually, it can be … and it often is … and it all depends. See another of my posts for that debate but remember that ANYWHERE can be a "Place

of Safety" – including my Mum's house – dependent upon the circumstances and the rationale behind the choice. So to the argument put forward on Twitter that a local arrangement between the police and mental health services; A&E and the local authority that A&E is not a Place of Safety, I say that a rose by any other name, is still a rose.

16th December 2012

The Course of Justice –

This post summarises the justice process, as it would apply to a hypothetical person with a mental illness.

POLICING

Initial Response – Professor PAJ WADDINGTON argued in his 1998 book, "Policing Citizens" that the police spend more time not enforcing the law, than they do enforcing it. This is no different for offenders with mental health problems. It still remains open to all police officers to exercise discretion by giving advice or informal warnings; or to utilise an 'out-of-court' criminal justice disposal, like a fixed penalty notice or caution.

In addition, officers who respond to incidents involving a criminal offence, have the option to refer individuals to mental health services or to take the individual into custody to ensure a faster referral, for example under s136 of the Mental Health Act.

Investigation – the investigation of a criminal offence, should include assessment of any public interest in there being a prosecution. All cases on their merits, but in some cases it is obvious early on that investigation will be required because of the nature of the offence and / or the suspect's background, either in terms of health or previous convictions.

Arrest – if a suspect is arrested, they will be taken before the Custody Sergeant at a nearby custody suite. The custody officer is responsible for the health and welfare of detainees whilst detaining and also for key legal decisions about whether prosecution should be brought or bail granted, for example. Anyone suffering from mental disorder is likely to be examined by a police doctor – the Force Medical Examiner.

If you are arrested, it does not follow that the police have decided you will be prosecuted: they may take advice in custody from mental health professionals, they may arrange formal assessment for admission under the Mental Health Act and / or interview a suspect. Depending on the outcome of any such assessment, there should be consideration as to whether it is appropriate for a person to be interviewed or further

investigated or whether they should be diverted (whatever that means) *from* the justice system and / or *to* the health system.

Diversion – where offenders have potentially serious mental health problems which may prevent them from being interviewed about the allegation by the police, they can be diverted for one fo two reasons. Either there is insufficient evidence to yet charge them with the offence they were arrested for and the investigation is ongoing; OR, despite being there sufficient evidence to charge them, it is not (yet) considered in the public interest to do so. In some situations it is possible and desirable to charge the offender with an offence despite questions about their mental-ill health. All situations turn on their individual merits in light of medical assessment in police custody.

In the first example, offenders will be diverted to the health system whilst still being kept on police bail and the investigation will continue whilst they receive assessment and / or treatment. When a point is reached where they are considered fit for interview, the suspect can be questioned either by returning to the police station or in hospital. If they were diverted in the public interest, they may still be retained on bail to ensure that once in hospital they engage with mental health services.

Either way, diversion from the police station does not mean the end of the investigation or any dropping of charges: it is way to ensure that proper medical assessment is undertaken and the investigation continues whilst this occurs. Where a person is eventually interviewed, they would normally have an appropriate adult present. << This is someone to help ensure that a vulnerable suspect understands what is going on.

COURT

Prosecution – If the police believe that there is sufficient evidence and public interest to charge a suspect with an offence, they will often take advice from the Crown Prosecution Service about doing so. Whilst some cases can be decided by the police, the inclusion of a suspect's mental health history often adds a layer of complexity which often sees cases referred to the CPS.

The CPS have to weigh the evidence and public interest in a prosecution, with reference to the Code for Crown Prosecutors, issued by the Director of Public Prosecutions. This is the statutory guide to all lawyers making prosecution decisions. The CPS also have the option of asking the police to go down the route of various 'out-of-court' options, like cautions or conditional cautions.

Bail – where it is decided that someone should be prosecuted, the custody sergeant at the police station will have to decide whether or not someone is granted bail to appear before the Magistrate's Court, or whether they are remanded in custody by the police to appear before the next available court – there are remand courts six days a week, so the worst case scenario is an offender being prosecuted and denied bail on a Saturday afternoon, who appears in court on Monday morning. Usually, it means appearing at court the following morning.

In law, there is a presumption that bail will be granted – if the police are to deny bail it must be justifiable against one or more criteria laid down in the Police and Criminal Evidence Act 1984. These criteria include a risk of further offences, interference with justice; a likelihood that the defendant will fail to surrender to the custody of the court. It does also include one justification that is of application of offenders with mental health problems, which is a risk to the defendant themselves, for example from self-harm or suicide.

Initial appearance – someone who appears before a court is required to enter a plea to the charge(s). If a defendant is considered by their legal representative to be unfit to plead, because of a mental health disorder, then the court can manage that situation in a range of ways. This can include adjourning to a further hearing, granting bail and allowing mental health assessment, perhaps arranged by a court diversion scheme. It certain circumstances it could also include remanding a defendant for psychiatric assessment and treatment.

For more serious offences – indictable only offences – the initial appearance can immediately lead to a case being sent, or committed, to the Crown Court.

Remand – I have written a previous blog post about remands by the court for psychiatric assessment, but of course it is also open to the courts to remand a defendant to prison, even where there are concerns about mental ill-health. We know that this happens so we need to raise it – it happens more than it should.

This can sometimes come about because someone's mental health problem is less serious and not something which requires inpatient mental health care. Prisons have hospital wings and in-reach mental health teams who can provide a level of care.

If a prisoner whilst on remand is identified as requiring hospital treatment for their mental health disorder, then they can be transferred under s48 MHA to a relevant mental health unit.

People also tend to think of being remanded as being incarcerated – be that in prison or hospital – pending trial or sentencing. Actually 'remand' simply means "to be ordered back" and when someone is given their liberty by the courts but under a duty to return, they are "remanded on bail". Such bail may have conditions applied by the court, for example to reside at a particular place, a curfew or to desist from contact with named individuals or from going to certain places.

Trial – whether a defendant stands trial in the Magistrate's or Crown Court, the trial processes are sufficient similar for this post's purposes to be dealt with together. The obvious difference is the Crown Court involves a judge and jury, whereas the Magistrates Court is presided over by between one and three Justices of the Peace.

They can hear issues around whether a defendant may be 'unfit to plead' or 'unfit to stand trial or they can proceed to hear the case on the evidence. If they do reach a finding that a defendant is unfit to plead or stand trial, they may then proceed to establish whether the defendant did the "act accused". For example, did they take an item without permission or hit someone: the *actus reus* of an offence, without considering the *mens rea*.

Sentencing – depending upon the conclusion of the court, they can impose several sentences or orders at the end of the court process. Where a trial has occurred and guilt is established, this can range from community punishments, fines up to and including imprisonment depending on the offence. It can also include, for community sentencing, a Mental Health Treatment Requirement.

Where there has been a finding of 'unfitness' to plead or stand trial, or where there has been a successful defence of 'insanity', the option of imposing a hospital order or restricted hospital order starts to present itself. Only a Crown Court can impose a hospital order, so if the Magistrates have handled a less serious case and believe this to be the right outcome, they must ask the Crown Court to consider the case as being one suitable for such an order and handle the sentencing.

PRISON & PROBATION

Where an offender is sentenced to imprisonment but has a mental disorder, assessment of that health need in prison may lead to a conclusion that such care can be delivered within prison by the in-reach mental health teams. This is usually for less serious conditions and / or where the prisoner consents to treatment – the mental health act cannot be used in prison to force mental health treatment upon prisoners.

Where a more serious condition requires treatment under the Mental Health Act, potentially without consent, the Governor may request assessment of the prisoner for potential transfer to hospital. Under either s47 (convicted prisoners) or s48 MHA (remand and immigration prisoners), the prisoner may be transferred to receive hospital care and, if needed, treatment without consent. A prisoner transferred to hospital may either end their sentence in prison or be remitted back to prison once treatment has been completed and inpatient care is no longer needed.

HOSPITAL & DISCHARGE

I have written elsewhere about what happens where a patient has been sentenced to a hospital order or restricted hospital order. Important to remember that these orders can be imposed upon a defendant either following a finding of 'insanity' or 'unfitness' which means that the defendant is unconvicted but detained under mental health law"; OR they can be imposed after conviction for an offence, as happened recently in the case of Christopher HAUGHTON.

This post is indicative only – it is not intended as an exhaustive explanation of the detail, but an overview and I am well aware that it doesn't clarify absolutely everything.

17th December 2012

The Samaritans Media Guidelines –

It has come to my attention in recent weeks that not everyone in the media game are aware of the Samaritans Guidelines on the reporting of suicide. Especially as new media gives rise to official organisations tweeting and blogging, there are new pitfalls. One excellent twitter account within my force area recently wanted, quite rightly, to highlight some excellent work by police officers in keeping someone safe following a suspected suicide attempt and fell straight into the traps we are advised to avoid. As a result, all West Midlands Police Twitter account-managers have now had the guidelines circulated to them.

The essence of these guidelines is to avoid certain methods of reporting which may have indirect consequences or offer indirect information. As such, they are of relevance not only to traditional media, but to those of us using new media to inform and educate. I am far from perfect in this, I admit to taking deep breaths after I fully read the guidelines for myself and immediately had thoughts about this blog and things I have written in the past.

These guidelines are worth reading **from start to finish** if you want to report or mention suicide.

The resources you need are:

- The Samaritans website
- The web-page for all kinds of contact with the Samaritans –
- Their 24hr helpline is: **08457 90 90 90** (charges apply)
- They can be emailed on: jo@samaritans.org

- The 2008 Media Guidelines (UK)
- The 2009 Media Guidelines (Ire)

If you are tweeting and / or blogging on the subject of suicide, don't forget to offer access to a support helpline for people who may be affected by reading your materials. In addition to the Samaritans, other resources are available in connection with mental health issues from major mental charities like Mind and Rethink.

Please take the time to read these guidelines.

17th December 2012

Newtown –

The public debate, if we can call it that, which has followed the utterly tragic events in Newtown, Connecticut has been predictably disappointing. We have had Piers Morgan piling in with pronouncements that people under 25, criminals and anyone with a mental health history should be banned from possessing guns – why don't we just ban guns, Piers, then we won't have to argue semantics over your surprisingly vague idea?! …

We have had tens of thousands of circulations on Twitter of potentially the worst article I have ever read about mental health and violence following an atrocity and we must not forget that the speculation about Adam Lanza's mental health history began hours and hours before anyone in Newtown was talking on the record about it. And even when they started talking it was all "might" and "maybe" and "a bit".

Here's my point: even *if* he had a personality disorder and autism or Asperger's – and we are far from knowing anything of the kind, for certain – did this cause the incident? Plenty of people live in the US with such conditions whilst having access to firearms and they don't commit such atrocities; plenty of people in the UK without such access to firearms who don't simply choose a different weapon. **Something else or something extra is going on here** but I do know this: no-one sufficiently knows this man's mental state to be proclaiming anything meaningful.

WHAT ON EARTH IS GOING ON?

We had all the usual stuff: "surely he MUST be mentally ill to kill 27 people?" Why *must* he? The 7/7 bombers killed far more people than that, equally indiscriminately and without any moral or legal basis for their attack. And yet I cannot recall any speculation about their mental ill-health? Nor was any mental ill-health history brought up in the aftermath of the attack, as far as I can establish. So it's not indiscriminate slaughter *per se* that gets us to speculate about mental illness. It has to be something else and I'll come back to that at the end.

We also had a predictable amount of people saying, "We must discuss mental health issues." Ostensibly, that was the underlying plea in Liza

Long's appalling output. I'm all for discussing mental health issues: in fact many would wish that I discussed it less. But mental health issues were not the only factor at play here, were they? There was the whole issue of **guns**, quite obviously; but there was also the issues of culture and of social structure. The UK is often held up in comparison to the US around gun laws, precisely because our legislation controls possession of guns, almost entirely. But we are also a very different country in terms of culture and social structures – this is relevant to a debate that transcends the Atlantic about a tragedy in which a British boy died.

Of course, whether the issue being raised in Liza's description of her own son's behaviour were mental illnesses or other behavioural / educational problems is also not clear and a matter of taxonomy which varies from country to country. Some UK Child and Adolescent Mental Health Services (CAMHS) will not accept referrals for 'Oppositional Defiant Disorder' or 'Intermittently Explosive Disorder': not unless accompanied by additional psychiatric issues. So is the request here for better mental health care, or specialist educational / parenting support? Who knows – it is far from clear. No-one questions that society should do all it can to support parents who struggle with parenting challenges, but we should be wary of over-medicalizing the issues. **Research suggests this can makes things worse**.

It is beyond doubt and hardly controversial to point out that the United States of America has a particular culture around guns and a particular problem with gun crime. 9,414 gun deaths in the US so far this year – actually, that figure will have gone up by the time you are reading this compared to when I wrote it – whereas there have been 39 in the UK. Even allowing for population differences, this is a problem almost **fifty times** the size of ours. So the issues around the whole politics of US gun possession is very relevant, not least because other mass killing-incidents involving firearms, have not involved a suspect with mental health problems and killings by people with mental health problems almost never involve guns. We heard the political right of the US moving to point out somewhat unhelpfully that "guns don't kill people, morons with guns kill people." As Eddie Izzard pointed out: the gun helps.

In the UK mass-killing in Cumbria in 2010, evidence was offered to the inquest into the death of the suspect, that he was suffering delusional beliefs and paranoia at the time of the event, but whether those professionals offering that view formally examined him whilst he was alive, I cannot establish.

HOW DO WE BALANCE THESE THINGS?

Even if you could take the relevant issues of gender, age, mental illness, access to firearms, etc., and undertake an analysis of the contribution each would have made to the tragedy, how significant would mental illness have been? Well, it depends: we know from research that where mental health disorders are connected to violence – either causally or co-incidentally – some kinds of disorders are more connected than others. Treating Violence (2007) by Professor Tony MADEN is an extremely important book which does argue that there is some way to go in our understanding of this and that there *are* raised risks of unpredictable violent behaviour from *just some* mental health patients. Even then, such risks are most often manifested against a certain set of treatment and social backgrounds. The website Hundred Families has attempted to highlight the recurring problems which we all regret hearing again and again. But in this particular case, I would be very tempted to argue it counts for little – because if illness in and of itself were perceived to give rise to grave risks, we have in all major jurisdictions to handle these risks.

Significantly for this debate about Adam LANZA, such conditions were not the ones that are being speculated upon as being relevant in Newtown. *<;<; And we need to remember that we are still in the speculation phase and people are providing very vague information.* To read an excellent blog post about Autism / Asperger's in light of Newtown, see this post by Emily WILLINGHAM.

We also had the usual debate about 'insanity'. I am well aware that I am at risk of terrible pedantry when I point out *again* that this was misuse of a legal term that has a specific meaning. Where we use the term outside that meaning, I admit to not being sure what on earth people are getting at, precisely. This is more than being picky, on my part. 'Insanity' gets used to mean a wide variety of things: it can be used as a pejorative insult or as a generic description of mental illness as well as in other ways. I'm not sure what's going on with that or where to start deconstructing it.

BRASS TACKS

So here are some bullet points to bring together my thoughts on this whole affair:

- Speculating about mental illness before we know anything substantive is stigmatizing – and being ultimately proved right about there being some mental health history, doesn't detract from that stigma.

- Just because there is some kind of mental health history, doesn't mean that the relevant social issue at play is mental illness – we should ask whether it was *causal* or *co-incidental*, to the incident.
- For example, we know that drinking alcohol is a bad idea if you are going to drive a car – this does not mean that all accident involving a driver who had consumed alcohol were caused BECAUSE the driver had consumed alcohol. Always easier just to blame the drink-driver, though, isn't it?
- Failing to even acknowledge other contributory factors, like guns in this case, renders any analysis fairly shallow – if you want to take about murder, let's talk about men, let's talk about young men, let's talk about access to guns and knives, let's talk about poverty and social exclusion, as well as drugs and alcohol. All of these things are important to any overview.
- Objecting to the way in which a particular argument is put across, is not to deny the importance of the issues it purports to debate – I object to Liza Long's blog because it is poorly conceived, in my humble view. I don't object because it is wrong to discuss mental illness or even to discuss mental illness in connection with violence.

THE AMERICANIZATION OF MENTAL ILLNESS

Of course, one elephant in the room here is how 'Americanized' some debate about mental illness has become. We shouldn't forget that the conditions listed by Liza Long – Oppositional Defiant and Intermittently Explosive Disorder – are not conditions recognised by all clinicians as valid. Some will even say it's nonsense. The *nature versus nurture* debate as well as the biology, psychology or sociology debate about mental illness are relevant here. We should remember, the United States is culturally, academically and socially different to western Europe in how it conceives, describes and handles issues around mental ill-health. **Don't under-estimate the importance of this.** I recommend Creating Mental Illness by Allan HORWITZ.

My theory is, that we're straight into the mental illness debate because of our human need to demonize the people who commit atrocities of these types – this is a normal human reaction and is to be expected. We saw how this was done after 7/7 – it was not done by creating a moral panic around mental illness: we chose a different 'folk devil'. In this incident, like with others before and yet to come, we chose mental illness because it will prevent the need to discuss culture and guns laws where this is long, long overdue.

If you don't know what I mean by Folks Devils and Moral Panics, then you've got some reading to do!

Finally, no words can describe my admiration for the staff in the school who we now know took steps in the face of mortal danger to prevent yet more lives being taken. **They deserve the admiration and remembrance of us all.**

18th December 2012

Beyond The Call Of Duty –

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Michael Brown: beyond the call of duty

Observing people with mental health issues in custody encouraged a copper to start an award-winning blog

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Mary O'Hara

The Guardian, Tuesday 18 December 2012 16.00 GMT

Jump to comments (14)

Inspector Michael Brown: "I didn't envisage my blog would have 7,000 followers. I know psychiatrists read it. A lot of mental health nurses read it." Photograph: Graham

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Following the Mind Media Awards, I was flattered to be asked by journalist Mary O'HARA, – herself a Mind Media Award Winner – if she could profile me for the Society Guardian pages. After carefully navigating the whole "police officer talking to the media" thing we met up – on the very afternoon that Lord LEVESON published his report!

Here is the article for you to read: I could not be more chuffed to have been given coverage and flattered it was from such a renowned mental health journalist. Not only is it likely to drive more traffic to the blog it is going to raise awareness of the important role played by UK police officers in our *de facto* mental health system. I also learned the usefulness of the word 'opaque' to describe mental health law!

Mary brought with her a professional photographer and I'm sure he knows how to work a camera better than the rest of us: I can only apologise for his raw material and suggest that even photoshop must have its limits!

21st December 2012

Humbug –

I'm not a massive fan of Christmas, to be honest. Ever since I heard Mr WARREN do his infamous "Bah, Humbug" assembly at school when I was a teenager, I've had something resonating in my head. As well as activating anxieties around a general principle of mine – that if something takes longer to plan than it does to do, it is inherently unworthwhile – there is also all the cultural abuse that goes with it.

So when I was a PC and a sergeant, I always used to volunteer to work the main Christmas shifts so that people with kids could have the time off that they often wanted – and I was always grateful for the money! As a young sergeant I once worked a double shift on one Christmas Day and just watched the number of domestic abuse incidents unfold as the day wore on.

Now that I am "that dad" and married, it is always more difficult to square away. Whilst personally, I could still take it or leave it to a certain extent, it really is beyond 'special' to see my nearly 8yr old in his element with our family and I've cherished the last few years.

I had Christmas Day / Boxing Day off last year, but this year, it is my turn to work right through: 'Nights' on Christmas Eve into Christmas Day, and then 'nights' again into Boxing Day. These are always difficult shifts to do because it has never ceased to amaze me how many people will ruin their family's Christmas through self-indulgent, usually alcohol related-behaviour – and often the volume of demand on emergency services is extremely high. All too often, it is only once the handcuffs are on and that it dawns on intoxicated people that they may have just ruined everything and it can very quickly all become the fault of the police for having arrested them in the first place.

Of course, Christmas can be difficult for lots of other reasons and the profile of crime and of incidents will change. Police forces often prepare for an up-turn in domestic abuse incidents; in alcohol related incidents and for an upturn in calls around mental health issues. For many people Christmas comes at a 'cost', in terms of their mental health and this can be manifested in suicide or self-harm incidents as well as in allegations of crime or abuse.

Mind reports that anxiety and depression can increase by up to a quarter or a third as people struggle with the financial impact of Christmas. In addition, there can sometimes be little or no access to day-to-day NHS mental health services as GPs and CMHTs reduce cover to a minimum or are not available at all. CrisisTeams will still be there, but as they operate different access criteria across England / Wales, this will be of less or no relevance in some areas. The mental health lifeline – I mean this literally – can be A&E and 999 emergency services.

999 services are there to do what they can and in an emergency are available to be contacted – **that's what we're here for.**

ACCESSING HELP AT CHRISTMAS

If you or a family member need to access help or support for mental health issues (or domestic abuse) over Christmas, there are a range of options, in addition to trying any normal NHS supports that you would have available.

- **Telephone Helpline Numbers:**
- The Samaritans 24/7 Helpline – **08457 909090**
- 24/7 National Domestic Violence Helpline – **0808 2000 247**
- Mens' Advice Line – **0808 801 0327**

- **Online resources:**
- The Samaritans
- Mind
- Rethink
- Womens' Aid
- Refuge
- Mens' Advice Line

I must leave it there because I still have to buy Mrs MentalHealthCop a final Christmas present, but I sincerely wish a Merry Christmas to all of you who read, use and support the blog. I've you weren't reading it, I wouldn't be writing it!

See you all in 2013 with some new ideas.

26th December 2012

Taser –

This blog is a difficult one: when my name was read out at the Mind Awards, one of the loudest 'whoops' in the room came from Paul Jenkins, Chief Executive of Rethink. He was kind enough to congratulate me afterwards and from the leader of one of our country's major mental health charities, it is not without real significance for me. However, that he has been kind enough to signal he's looking forward to this blog which I've indicated in advance will disagree with him, shows his willingness to debate and engage. << This is *precisely* how we will improve the debate about mental health and the role of the police, so it is in that spirit that I write this blog to Paul.

BACKGROUND

Most broadsheet newspapers have covered remarks from Paul Jenkins about the use of Taser on vulnerable people, suffering from mental ill-health. Paul is quoted as saying:

"It is completely inappropriate for police to use a Taser gun on someone who is threatening self-harm, and we are very concerned to hear that this is happening in some police forces. If someone is clearly in great mental distress, having a Taser gun used on them will seriously exacerbate their condition. People who take anti-psychotic medication may also be vulnerable to suffering a fatal injury if Tasered, as some medications greatly weaken the heart. If police are called out to a situation where someone has threatened to self-harm, there are other steps they can take without needing to resort to extreme force. Firstly, it is extremely important to try to talk to the person who is in distress, and police should consider bringing a properly trained crisis negotiator to help with this. They should also call an ambulance and speak to a mental health crisis team, who are better placed to act in a mental health crisis and who will be able to provide crucial advice and support in this situation."

Vicki Nash, head of policy and campaigns at mental health charity Mind, also said: "Tasers are extreme and controversial weapons that we believe should only be used as a last resort by police. Tasers can cause extreme distress so to use them on people who are experiencing a mental health

crisis, and already displaying signs of distress, can make things even more traumatic. We urge police to ensure they are equipped with the tools they need to make difficult decisions quickly. A better understanding of mental health problems would allow police to recognise those experiencing a mental health crisis, and de-escalate a situation before resorting to weapons such as tasers. There is no substitute for comprehensive mental health training."

Firstly, in the continuum of force available to the police, Taser is never going to be the last resort, although usually close to it. Earlier this month, my team took a 999 call from the Ambulance Service regarding a mental health service user and the very first thing I did was instruct taser officers and a sergeant to the scene. Why? Because 999 services frequently deal with this particular man and he has a long and predictable history of getting drunk whilst ill, self-harming and then attacking paramedics and police officers with razor blades. Sending taser officers does not mean they will even use that equipement, but it gives them the option, if required. Officers who have known him for years will say that attending to him with a tazer drawn has reduced the instances of him attempting to hurt people, paramedics won't go near him without police support anyway and here's the key: he has never actually been tasered. Officers have fixed an aim on him – known as being 'red-dotted' – but they have **never** needed to discharge the equipment. This is an example of taser being 'used', despite not being fully utilized.

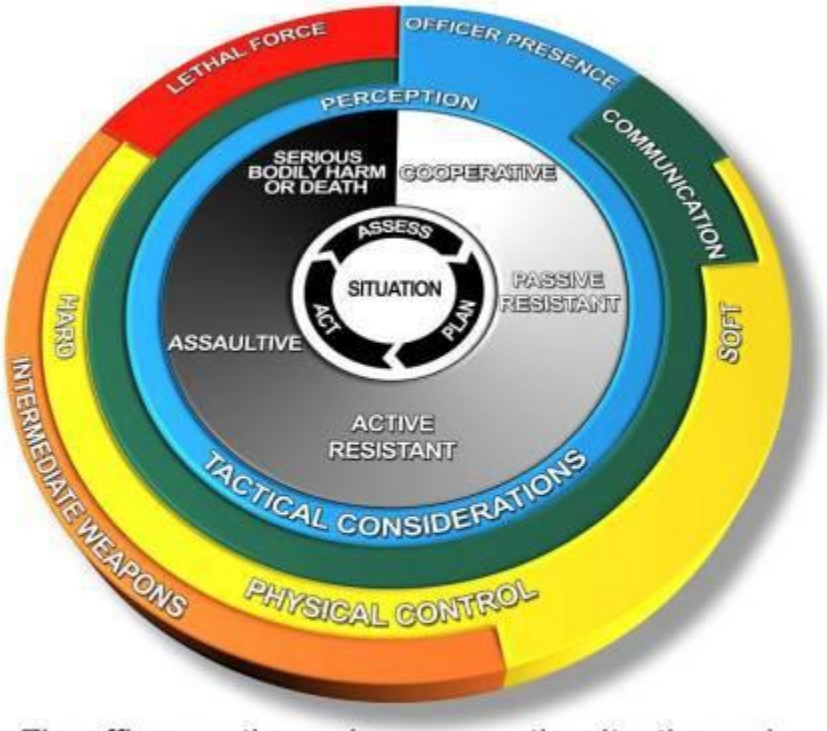
Secondly, hostage negotiators are fine ideas. I personally have never, ever known a situation last long enough for them to arrive although I know of plenty of incidents where they have been invaluable and have patiently negotiated difficult situations to a conclusion. In my experience, some front-line cop has always managed to "talk them down" or bring about a resolution first.

Thirdly, whilst calling ambulances and mental health crisis teams are noble notions, there is a practical reality that makes police officers read such ideas and – I'm afraid to put it so bluntly – laugh out loud at the thought of it. As a police officer put it recently "We can't get the ambulance service to heart attacks and car crashes, never mind mental health jobs." Mental health crisis teams are a step further, like throwing the meta-physical "seven".

The 'last resort' in the continuum of force is shooting people with firearms. It was precisely such incidents like the shooting of Andrew KERNAN in Liverpool and Keith LARKINS in London that lead to the Home Secretary to consider the introduction of so-called "less-lethal" options in 2007. I have written previously about the use of force on vulnerable people and of the utility of force.

THE USE OF FORCE

NB: *nothing you are about to read suggests that officers should not take all the opportunity that time and risk allows to de-escalte and communicate. Hours, if need be. This blog is about what happens after that.*



The officer continuously assesses the situation and selects the most reasonable option relative to those circumstances as perceived at that point in time.

As a police inspector on a 999 response team, I am responsible for certain decisions about the police use of force – I am consulted by the police control room countless times a shift to make decisions where force may be needed, because risks may be present. I have to take decisions about whether we send 'normal' cops, or we send taser officers, dog handlers, or any combinations of the above. If I believe that armed officers may be required, I have to fire that one further up the chain of command and sometimes, I'd prefer to take decisions for which time does not allow – sometimes things are just as good as they're going to get and we've got to crack on to keep people safe.

A senior officer in another force shared with me a real story that perhaps highlights some of the dilemmas that officers face when deciding how best to deal with those who are experiencing acute mental ill-health:

Earlier in 2012, a man with a long history of mental health episodes and contact with police and health professionals, was found in a public place. Officers were concerned for his safety and detained him under section 136 of the Mental Health Act. He was taken to a health based place of safety where he was detained by medical staff. The following day he absconded from the unit and was reported as a high-risk missing person to the police. Officers were diverted from other duties to join the search. After some time the man was found when he made it back to his home address, in a town about a dozen miles away from the secure unit. Officers returned him to the unit.

Sometime later police were called again to the secure unit as staff requested help as they had lost control of the man. He had been put in a relaxation room but had managed to gain access to a sharp implement and was slashing himself. The officers that attended estimated that the man had 70 to 80 self-inflicted slash wounds. He did not respond to verbal engagement by medical staff or attending officers.

TACTICAL OPTIONS

At this point officers had the following options on a continuum of force;

- Do nothing – unconscionable.
- Let staff try to restart communications – that had already broken down.
- Communicate – tried to no avail.

- **Restraint techniques** – man is armed with a sharp implement.
- **CS spray** – not ideal in an enclosed space as it would 'take out' the cops, too.
- **Baton strikes** – risking serious injury to the man by striking him with a metal pole.
- **Strikes by hand or legs** (distraction strikes) – man is armed with a weapon.
- **Shield tactics** – delay in assembling trained staff and shields may be prohibitive.
- **Taser** – risk of reaction to discharge.
- **Firearms** – unlikely to be authorised in this situation and only possibly capable of leading to death / serious injury.

In front of their eyes the man was getting increasingly more out of control, and his level of self-injury was increasing by the second. Communication was having no effect. Medical staff couldn't help. The man was still self harming. **The man was tasered.**

Officers immediately regained control of him and he was given rapid first aid for his multiple injuries. There was no long-lasting impact, beyond shortening the length of time that he could self harm. The following day the man was assessed and released. That evening he was found by police in the centre of his home town after reports from a member of the public of a man self harming….officers again detained him under section 136 MHA.

IN EXTREMIS

Tasering a patient in a secure unit sounds extreme. Given the circumstances officers took a decision that resulted in safe detention that enabled medical treatment to be given. All of the available options carried risks. Taser was assessed as being the least risky of all the risky options available, hence it was used to good effect. I have known taser be deployed in several situations like this senior officer's story. I have also received emails from mental health professionals praising officers patience, courage and tact and reaching the 'taser' conclusion only after trying other things or being so pressured by the need to manage risks that there was no time. I have specifically followed up every taser incident I have known to ask mental health professionals their views on it being used and have **never** found any criticism or reservation being levelled.

Human beings using force on other human beings is never going to be perfect science. It will always be about selecting the least worst option and about attempting to minimise risks. The reason I find the debate on this subject fairly shallow is because it involves words like "never". Whether or not we agree, the Home Office have licensed this equipment for use by the police and it is issued. If you want a political debate about whether this is correct, then that's fine. Meanwhile, cops who are issued with this equipment and led by people like me have to make decisions respecting its use: do we use it in some situations or do we instead strike people with metal poles and spray them with CS?

Or do we ask people like PC Alex STUPYLKOWSKI to risk life threatening injuires from sharpened weapons whilst acting without such equipment? I'm wondering whether PCs Tom HARDING and Alastair HINCHCLIFF wish they had been equipped with taser when they were sent to Kingsbury armed with a metal pole and a small tin of pepper whilst being expected to detain Christopher HAUGHTON? The Metropolitan Police are reviewing the availability of Taser in light of Kingsbury because getting into the non-taser tactical options listed above meant Mr HAUGHTON had opportunity to attempt to murder two police officers and grievously injure several more.

No one thinks tasering 'the vulnerable' is inherently good, but just every now and then – very, very rarely – it may be the least worst thing to do

with officers facing risks that could kill them or inflict life-altering injuries. I say this in knowledge that using taser may well exacerbate someone's condition but repeat the point that by the time the police are crisis managing risk situations where people are self-harming, non-communicative and posing a risk to themselves or others, it might – just might – be the the least worst option available.

For a real example, we can see the Buckingham Palace incident in February 2013.

MEDIA LINKS

1. Daily Telegraph

2. The Independent

3. Nathan Constable's blog on the police use of Taser.

UPDATE 28/12 *>> I am grateful to Paul JENKINS for reading and re-tweeting the blog to show an alternative point of view. Paul took on board operational realities for the police and rightly insisted that this should not prevent a broader 'policy' debate about how these situations come about. I totally agree with him about that! Would also encourage you to read Nathan Constable's blog which shows a real example of the operational reality around police decision making, from first hand experience (trigger warning).*

28th December 2012

The Least Worst Option –

There was a point as a young officer, when I got really frustrated by my inability to always do the right thing at work. In mental health terms, this could include working in a city where no place of safety (PoS) service existed at all and as a consequence I spent countless hours and days of my life that I will never get back, sitting in cell blocks and A&E departments, responsible for patients who should long since have become the responsibility of mental health services. It used to drive me up the wall, to be honest: why have a legal Code of Practice that states how s136 or a PoS should work, if we just ignore it? Who polices the implementation of these legal frameworks?! Whoever it was, it did not seem to be very effective.

Meanwhile in the real world, we were busy detaining people under the Mental Health Act, recovering AWOL patients and supporting NHS and MHA procedures. To be doing so in a context of imperfect options, meant I learned a very important in lesson police-work and life: **decision-making is, sometimes, about selecting the least-worst option from a whole range of things you'd prefer not do**.

Some real examples from policing and mental health:

- Would you rather release a murder suspect in a gravely psychotic condition into the street without any supporting care / structures **OR** wilfully detain them in your cells without any obvious legal authority to do so, risking all the civil, human rights and potential criminal liabilities this entails?

- Would you prefer to remove a patient under s136 MHA who is intoxicated, resistant and / or aggressive to an A&E department who have been known on occasion to patronise, complain or refuse to deal because they are "simply NOT a place of safety" **OR** would you prefer to take them to custody where the sergeant bemoans your decision because resistance or aggression might be, but probably isn't, a risk factor for clinically significant issues which place the person at grave risk in the cells?

- Would you rather see a self-harming, non-responsive service user who has a history of hurting paramedics and police officers and is crisis whilst in possession of razor blades or knives struck to the arms

with a metal pole knowing it could break their arm **OR** would you prefer to see them struck with 50,000 volts from a police taser – all in the decision-making of keeping people safe?

THROWING YOUR TEDDY FROM THE PRAM

It is fruitless to stamp your foot in frustration or throw your toys from the pram – even where the situation arises because of a short-coming somewhere else or a lack of insight by someone else. It really doesn't matter whether an AMHP could do this or that; whether A&E are right or wrong; whether the custody sergeant is being too risk-averse – **you are where you are**. You have to take *this* decision and grab the nettle; not insist upon the hypothetical one you'd *prefer* to take because it's not available to you.

Doesn't take long to work it out, does it? – you take **the least worst option**. The most defendable thing in the circumstances, perhaps the morally correct thing. Or do you? To do so, philosophically speaking, is to act in the utilitarian tradition of moral philosophy, or to act consequentially. Consequentialism interests me greatly, but I'll let you find out more about that for yourself.

Sometimes, you may take these decisions in the real world whilst fighting other battles – let me explain:

The first dilemma – this was a situation in my police force area some years ago and I've come across it several times. There was an inter-area dispute about a patient. He was resident in Area A, but had allegedly offended and been arrested in Area B. After the MHA assessment, the poor AMHP was left in one hell of a position which had a knock-on consequence for the police: the first recommending Doctor waved goodbye at 5pm intending to play no further part in searching for a high-demand bed within a Medium Secure Unit (MSU). The search would resume at 9am, apparently. The problem for the custody officer was the detention clock on the murder suspect ran out at 2am and there was, for various legal reasons, insufficient evidence to charge him with murder. What was he then expected to do?! The first bullet point, above, was his very real dilemma.

"Well, if there's no bed, there's no bed. That's all we can say." It actually isn't! – the state has various legal duties here so we'll have to talk to a court about people breaching them, if you really insist? Oddly enough, a bed was found whilst we were planning for 'the least worst thing'.

The second dilemma – this one plays itself out again and again in the UK and has featured in various inquests into high-profile deaths in custody. It's all very well there being a legal framework and various Royal College

guidelines, Codes of Practice and this and that, but the officers deciding whether to take a detainee presenting in a challenging way will have to take their decision in the environment in which they work, not the one in which they would prefer to work. It's all very well saying, "Violent or aggressive patients cannot be safely detained in a psychiatric place of safety" or an Accident & Emergency Department, but if they are presenting in that way because of underlying clinical conditions or if there are ongoing risks from any restraint being applied to prevent harm to self or others: what do you want the officers to do?

We know from the MS v UK case, that the courts have shown an interest in the police related conditions where psychiatric patients are detained. We need to absorb the learning from cases like this and weave it into our psyche about what 'good' looks like. And we need to do it together because if this situation presented itself again, I think I'd resort to the first solution and speak to the force solicitor.

The third dilemma – this gets to the heart of the police use of force on vulnerable people. It is beyond doubt we would rather not use force at all and would happily spend hours talking people into the safe resolution we would all prefer. But if time is not on your side as the attending officer and the alternative is to watch someone self-harm until they can self-harm no more or put police officers at risk of death or life-altering, career ending injury, we may have to take the decision to use force. If we had to take it against a background of knowing some potential short-coming in previous health or social care responses, it can only add to frustrations.

Would we rather 'risk' the use of police equipment which may well cause physical injury by breaking bones or causing bruising, or the use of a controversial weapon which some will say is linked to the death of people who may be suffering from underlying health conditions that are literally invisible and potentially unknowable to the officer whose job it may have become to use force?

THE HUMAN RIGHTS ACT

Many people don't like the Human Rights Act. I actually do. I haven't come across a so-called 'stupid judgement', which when read doesn't make sense. << *This doesn't mean I agree with every judgement!* I just don't think it is anything like the caricature present by our media. I had to study it, extremely superficially, for my inspector's exam and couldn't find anything to dislike. I would also recommend you follow the UK Human Rights Blog, which is invaluable.

Two quite incidental pet facts of mine to point out, frequently misunderstood:

1. The European Convention on Human Rights was law in the UK before the Human Rights Act 1998. The HRA simply made challenges under the European Convention possible in the British Courts, although current appeals against the finding of British Courts can ultimately still go to Strasbourg.
2. The European Convention and the European Court of Human Rights is not the same thing as the European Union. Quite different. Leaving the EU, doesn't get you out of the ECHR or vice versa, even if you think one or both of those things is a good idea.

Human Rights considerations are relevant to all three situations above. The right to life is covered by article 2 ECHR; the right not to suffer inhumane or degrading treatment is covered by article 3; the right to liberty, except in situations prescribed by law, is covered by article 5.

By virtue of these provisions, the above three situations represent a conflict. All three bullet points are a challenge to police officers as to which provision they would rather breach. So how do you decide?

CONSEQUENTIALISM

If you want to read more about consequentialism and decision-making in ambiguous circumstances, I suggest you read the work of Dr Toby ORD and those towards whom his work points. He is a research fellow at the University of Oxford and apart from the fact that he is known for being the academic who intends to give over £1m of his salary to charity in the course of his career, Toby's work on consequentialism and moral philosophy, as well as on decision-making in uncertain conditions, is nothing short of **absolutely fascinating**.

It is against this philosophical background and practical reality, that I argue we must learn how to reach for **the least worst option**, measured in terms of potential and actual consequences for the well-being of other human beings. The opposing philosophical position – deontology – just doesn't cut it for me and can't be easily applied to operational policing which is, by necessity, pragmatic. Notwithstanding that "we don't know what we don't know" in various mental health related situations, this doesn't mean there isn't a rationale, intuitive framework for assessing how to act in ambiguous circumstances.

But form your own view – this is simply mine.

29th December 2012

From Mental Health Act to Prison –

How can it be the case that someone who committed offences whilst detained in hospital under the Mental Health Act can be imprisoned? Does this not mean that 'the system' has failed to take account of mental disorder as a causal or coincidental factor in his sentencing? If we know that prisons are already occupied by people suffering from mental disorders, how can imprisoning people for their actions whilst they were compulsorily hospitalised under the Mental Health Act be right? Surely something has gone wrong?

Maybe … but not necessarily.

These questions are amongst the various ones arising from the case of Norman HUTCHINS who was convicted at Leeds Crown Court and yesterday sentenced to three years in prison. Mr HUTCHINS had been accused of assaulting NHS staff whilst he was detained under the Mental Health Act and of breaching his rather unique Anti-Social Behaviour Order which in effect banned him from all NHS establishments in the country – whilst not detained or taken there against his will! He was convicted of racially aggravated assault, two common assaults and three ASBO breaches and sentenced to three years.

So how can he be 'responsible' for his actions, if he was detained under the MHA at the time? – detention under the MHA will 'cover' a broad variety of patients with a myriad of different mental health disorders, all varying in nature and degree. Detention, in and of itself, does not automatically imply a lack of insight or responsibility for one's actions. Think about the difference, for example, of a new patient to an acute admissions ward, suffering from psychosis and whose cognition is severely affected by drugs, whether prescribed, proscribed or both.

Compare and contrast that with a patient who may have been an inpatient for many months, even years: a patient who is near release from detention who has had very many periods of "s17 leave". Imagine that leave to have occurred initially for a few hours, accompanied by staff and which has been built up over time, without adverse incident, to weekends or even weeks of unaccompanied leave arising from which the patient has grown in their recovery and been responsible for managing increasing aspects of their

lives. These two hypothetical patients do not present the same considerations, do they?

Now – imagine that each of these patients punches a nurse, committing actual bodily harm:

- Would our criminal justice response by the same to each? **Highly unlikely.**
- Would such patients' previous risk-history influence this? **Very probably.**
- What does this mean will happen? **Each case in its merits.**

If he required inpatient treatment under the MHA, surely him now being in prison denies him this? – maybe. But that presupposes that his condition at the time of detention is the same as his condition at the time of sentencing. It is also pertinent to observe, that if an offender-patient had been detained under section 2 MHA for assessment of suspected mental disorder, it may be that conclusions were starting to be formed about the nature and degree of someone's condition and / or how any proposed treatment should proceed. Such treatment may not be needed at all – patients sometimes are discharged from s2 MHA after psychiatrists conclude that someone is not suffering from mental disorder at all. Remember the example in an earlier blog of the young man who drank a lot of red wine after taking medication to help him stop smoking? It may be that discharge was held up by social, rather than medical issues, for example around housing. These things have been known.

Healthcare is available within our prison system. As a prison in-reach nurse once reminded me, people are sentenced to prison, not to prison plus poor health. There may well still be challenges around this and it is fair to point out that the NHS took over the commissioning of healthcare in prison precisely because of problems of equity of provision. However, prisons have in-reach mental health teams and of course the mental health professionals who work in them may make application for certain prisoners (convicted or remand) to be transferred to hospital, if someone's condition necessitates it.

- Not every prisoner with a physical healthcare problem is in hospital for it;
- Not every member of our society with a mental health problem is in hospital for it;
- And so it follows that **not every prisoner with a mental health problem is in hospital for it.**

Of course, I recognise the practical difficulties that exist in obtaining beds and achieving transfers and of the NHS's surprise at the amount of unmet mental health need when they took over prison healthcare. Lord Bradley's

review (summary) set the objective of being able to achieve all such transfers within 14 days. Practitioners often cite the timescales as being counted in weeks or months but then that is a "resources" issue, not a legal one. It may also be a political or social issue for many of us. I also fully recognise the potential of prison to exacerbate or cause mental health problems. This is, obviously, why sentencing decisions are important and taken by judges only after the fullest consideration of the overall context and the relevant issues.

THE CHALLENGE OF "PATIENT-OFFENDERS"

Offenders like Norman HUTCHINS would present a significant challenge to any country's mental health and criminal justice interface. Professor Jill PEAY described the work of professionals at this interface as being amongst the most difficult that either will undertake – see her book, "Mental Health and Crime" (2010).

Mr HUTCHINS was legally represented by Counsel throughout his trial and he refused to participate in it, choosing to remain in the Court's cells throughout. The law presumes he has the capacity to make such decisions as well as his current refusal of healthcare in prison, unless formal assessment suggests otherwise. The court had powers to consider whether he was unfit to plead or stand trial and they had the power to impose a hospital order upon him as the appropriate sentence, if they thought this were justified by the medical view of his condition. And yet despite all of this, they did not do so.

Notwithstanding any argument about miscarriages of justice, we must consider that this conclusion was a reasoned position after due process, rather than an aberration. This remains the case even if you don't agree with the outcome or think the law should be amended.

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.*

30th December 2012

Section 17 Leave –

Many reports of patients "going AWOL" are actually better described as patients "becoming AWOL" because they have failed to return from leave. A legal condition of being AWOL occurs in various circumstances and not just in relation to patients who suddenly decide to leave a mental health unit without permission. Often, it is because they have been granted an authorised period of "section 17 leave" and failed to return from it.

I've heard a few officers grumble about this, especially if the person concerned has been an AWOL patient a few times by failing to return. "Why would you grant leave if they're not going to come back?!" … type grumbles.

Section 17 leave is an important part of care and recovery and is used in relation to a lot of longer-term mental health patients. It should not be confused with discharging a patient subject to a community treatment order which is granted under s17A of the Mental Health Act. Section 17 leave may be used to grant shorter periods of leave from hospital in the build up to discharging patients on to a CTO, but they are distinct legal concepts.

It would be quite inconceivable for hospitals to admit someone under the MHA with an acute mental health condition that may mean someone is severely self-neglecting in many important day-to-day ways and then keep them detained until a 'big bang' event where they are entirely released. Appropriate use of s17 leave can assist in preparing patients for discharge and by allowing them to build up personal confidence and a level of personal responsibility that ensures when discharge does arrive they are prepared for it. If upon discharge, the imposition of a CTO is appropriate to continue to ensure recovery, then that can also be considered.

We should remember: some patients were so unwell upon their admission that provisions of the MHA are used to take over very basic aspects of day to day living that a lot of people take for granted, like control of financial affairs, etc.. To return to a position where patients who may previously have been financially abused or reckless with their money have control of it, is not always going to be something that can be achieved by an "all or nothing" approach. Equally, there are other reasons why patients who find themselves compulsorily detained need careful management and support

as they recover and this is what section 17 leave is at least partly intended to facilitate.

THE LAW

Section 17(1) covers the Responsible Clinicians entitlement to grant leave with any conditions that may be necessary "in the interests of the patient or for the protection of other persons." The RC also has a right under s17(4) to recall patients from leave, revoking their leave of absence.

Where a patient who has been granted leave fails to return to hospital upon its completion, or where they fail to return if recalled from such leave when it is revoked, then they become absent without leave, under the MHA. This then entitles an AMHP, anyone on the staff of the relevant hospital, a constable or anyone else authorised by the managers of the hospital, to take the patient into detention under s18 MHA and return them to the hospital. << There is **no power of entry** in respect of this authority. Should entry need to be forced in order to detain someone under s18 who is AWOL from s17 leave, then a warrant needs to be obtained under s135(2) MHA.

A CHRISTMAS TALE

A few days before Christmas, I became aware of an incident the police were asked to attend at an address in connection with a section 3 patient who had been afforded a few hours of accompanied leave. The leave was to visit relatives ahead of the Christmas period and conditions had been attached to the grant of this leave by the Responsible Clinician in charge of a patient's care. The leave was for a specified number of hours; to visit a particular address and that the patient must be accompanied by three staff throughout.

The police were called because the patient had decided, not unreasonably, that they would prefer to spend Christmas with their family than return to hospital and they refused to do so as the leave period drew to a close. When staff had attempted to encourage the patient to return it was reported they had become verbally resistant and the police were called. I admit that this fairly innocuous little job got me thinking about the broad role of the police in our whole mental health system.

Do as you're told or we'll call the police. << Is this unfair?

The leave in this particular case had been accompanied leave and as with all such events, would have been risked assessed and this, one presumes,

would have included decisions about staffing: how many staff, which staff, and any particular training or experience required bearing in mind the specific needs of the patient, etc., etc.? And yet officers found a patient who was compliantly getting into a vehicle as they arrived. They found relatives wondering why the police had been called who went on to describe the person as 'upset' rather than resistant or aggressive.

It raised questions in my mind (again) about how we get to a position where the risk assessment around accompanied leave includes no ability (or willingness?) to manage resistant or potentially just reluctant patients.

I'm sorry to bang this drum again, but: do we see a connection between patients' perceptions of the police and police perceptions of patients, if the contact between the two groups is often predicated upon conflict and the need for the use of force? In just the same way that relationships between the police and other parts of the community can be positively developed, so can this be done here, but only if we all move beyond thinking of the police as the paramilitary wing of a coercive mental health system. The Ardenleigh liaison officer story shows this very well, indeed.

But if we are always building our contacts around conflict, including where it is low level and within the skills set of trained psychiatric nurses, is it any wonder there are trust and perception problems?

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End of Volume:
528 Pages
177,000 Words

Total to date:
711 pages
230,000 words