Adults, Health & Public Protection Policy & Scrutiny Committee

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Title:	**POLICING AND MENTAL HEALTH**
Report of:	Policy & Scrutiny Manager
Cabinet Member Portfolio	Cabinet Member for Adults & Public Health Cabinet Member for Public Protection
Wards Involved:	All
Policy Context:	City of Choice
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1. Executive Summary

Members requested consideration of the issues associated with policing and mental health at the Adults, Health and Public Protection Committee. As responsibility for these issues falls across a range of stakeholders, representations have been sought from the local Borough police, MOPAC and our local acute mental health trust (CNWLFT). The following covering report explores some of these issues but the operational detail lies in the Appendices to this report from Westminster City Council, MOPAC and Central and North West London NHS Foundation Trust. The Police have agreed to provide a verbal contribution at the meeting itself.

Key Matters for the Committee's Consideration

- How well do stakeholders in Westminster work together to ensure that those with mental health conditions are given appropriate care?
- How well do the local Borough Police manage these issues?
- How can the local authority contribute to some the issues raised in the reports?

2. Background

2.1 There is no universally agreed definition of mental health and what constitutes mental wellbeing and mental illness. There are official definitions from both the Mental Health Act and the World Health Organisation (WHO) however. The Mental Health Act defines mental ill health as '*any disorder or disability of the mind'*, while the WHO describe mental ill health as the inability of an individual to realise their own abilities, cope with the normal stresses of life and work productively.

2.2 Mental ill health includes mental disorders and mental health needs. For clinical purposes, the term mental disorder is a broad category for all mental illness to match patients to clinically recognisable sets of symptoms and behaviours, for treatment. These mental health disorders are diagnosed using the 'International System for Classification of Disease' provided by the WHO. This system involves classifying mental illness into two broad categories of 'psychotic' and 'neurotic' illness.

- *Psychotic symptoms* occur when a patient's perceptions of reality are distorted. *Psychotic disorders* have medically defined phases referred to as 'the 'at risk' phase', 'the acute phase' and 'the recovery phase'. Disorders within the psychotic category include schizophrenia, schizoaffective disorders and borderline personality disorders; while

- *Neurotic disorders* refer to most 'normal' emotional symptoms such as depression and anxiety. Disorders within this category are referred to as 'common mental health disorders and include depression and anxiety.

2.3 It is important to note however there is often an overlap of symptoms and mental illness rarely fits neatly into one single category. In addition to this there may be a dual diagnosis of mental illness and substance abuse. In this case it can be difficult to distinguish between which symptoms are the effects of illness and which are the effects of being under the influence.

2.4 Particular social and environmental factors such as loud noises and bright lights can trigger reactions of stress that can increase the severity of symptoms associated with a particular mental illness. Without proper control and methods of coping this can lead to mental crises in which an individual can become at risk of harming themselves or others. In this case the police have legal power under the Mental Health Act 1983 to make a decision as to whether they should detain an individual under **Section 136** in the interests of safety for both the individual and the public.

2.5 Mental Health Need within Westminster:

2.6 There is a significant demand for mental health resources within Westminster with 17% of 18-64 year olds estimated to have a common mental health disorder. The level of child mental health need is lower than national average but still prevalent with 89 admissions between 2009 and 2010 for deliberate

and intentional injuries for under 18's, this is lower than the national average of 123 admissions.

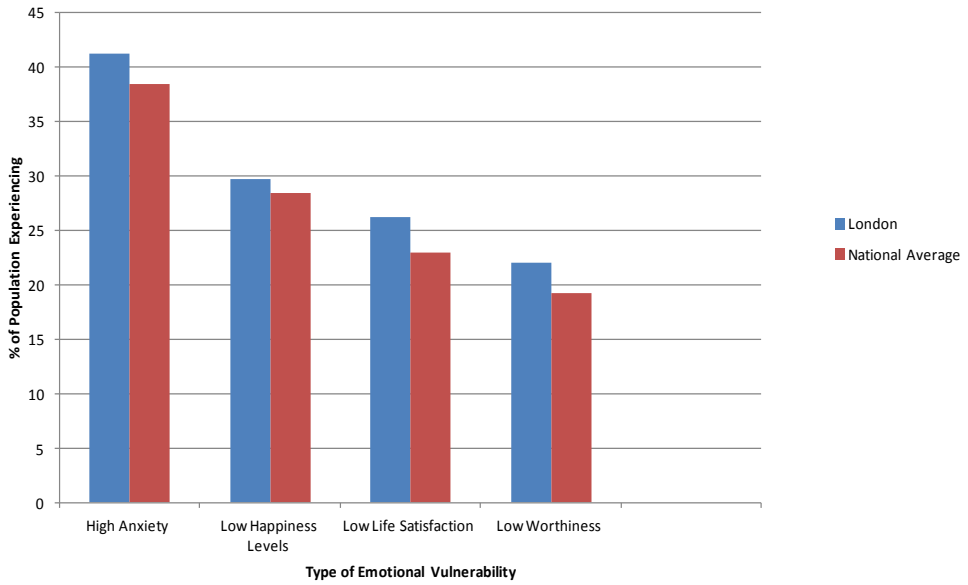
2.7 This need is reflected in the higher than average level of spending per head for mental health services. However there is indication of strain on resources with significantly lower than average contacts with psychiatric nurses.

2.8 **Mental Health Need in London**

2.9 There is a significant mental health need across London. Based on population statistics it was estimated that there were a total of 2,100,050 people experiencing clinical levels of mental illness across London. Of this figure 111,000 were children. It was further discovered that 3.3% of children suffer from anxiety disorders, a total of 38,000 people and at least 1 in 5 of the population aged 11-25 self-harm[1].

2.10 In addition to this a survey conducted by the Mayor of London revealed current levels of mental health vulnerability which are displayed in the Figure below. London has higher levels of all forms of emotional vulnerability than the national average. There is particular concern surrounding high anxiety levels and low life satisfaction. This suggests that there may be an increased demand for mental health care in the future.

Mental Health Vulnerability Across London Versus National Average for 2012-2013



Factors of Vulnerability

2.11 Mental vulnerability refers to the lack of ability to think logically and coherently which exposes the individual to increased risk of emotional or physical trauma.

[1] Mayor of London (2014) *The invisible costs of mental ill health* [Online] Available from: https://www.london.gov.uk/sites/default/files/FINAL%20-%20LMH%20-Full%20Report.pdf

There are multiple factors contributing to increased vulnerability which can be classified as follows:

Social Factors:

- **Homelessness -** a number of London's rough sleepers are located in Westminster.
- **Social isolation -** Westminster has one of the highest proportions of older people living alone
- **Poverty -** Westminster is the 15th most deprived borough in London with 14% of its neighbourhoods classified as being in severe deprivation.
- **Relative deprivation** - For the year of 2010 the % of the population living in the 20% most deprived areas lay at 21.7 per 1,000 people compared to the national average of 19.8.
- **High population turnover**
- **Unemployment**
- **'Troubled Families'**- 20% of troubled families experience domestic abuse, 85% of children from troubled families experience attendance and behavioural issues at school.
- **High crime rates**

Physical Factors:

- **Alcohol and drug abuse / Poor physical health / Physical inactivity**

3. Current Police Involvement and Powers under Section 136:

3.1 Section 136 is a set of current policies and procedures under the Mental Health Act 1983 that issues the police with a duty of care towards persons suffering from mental ill health by granting them the power to remove them from a public place to a 'place of safety' via detainment. Once an individual has been detained under Section 136 they are subject to arrest.

3.2 The power of arrest under Section 136 is a preserved power under Section 26 of the Police and Criminal Evidence Act 1984. Section 54 of the same act allows the power to search upon arrest.

3.3 The guidelines written within Section 136 were designed to take account of all the provisions of the law and Home Office, Department of Health and Mental Health Act Commission guidelines. They reflect a certain level of commitment

of all agencies working together to ensure the availability of appropriate care levels with the available resources[2].

3.4 The roles and obligations of each authority before, during and after detainment are outlined in Section 136. The main purpose of the Act is to ensure a place of safety is provided to reduce factors of vulnerability until a medical assessment can be conducted.

3.5 The Act was designed with the aim to optimise service user experience with the available resources at the time. However both population structures, cultures and resource availability change leading to the need for innovation to match a more diverse range of service users and meet a greater range of needs.

3.6 It could be said that nationally there is a lack of police training in mental health awareness and how to deal with mental health crises. Officer's such as Inspector Brown who delivers a blog called 'Mental Health Cop'[3] have recognised this issue themselves and raised concerns over the lack of resources available to them. Although they have the legal duty to care for people in mental health crisis they may not be able to deliver the correct standards of care.

3.7 **Legal Responsibility of Police Under Section 136:**

Deciding to use Section 136:

3.8 In order to use legal powers under Section 136:

- The person must appear to the officer to be suffering from a mental disorder;
- They must appear to the officer to be in immediate need for care and control; and
- The officer must think they need removing in their own interests or in the protection of others.

3.9 There are currently a number of issues with the legal powers under Section 136. Firstly an officer with no or minimal mental health training does not have sufficient knowledge to recognise the symptoms of mental illness. With this being the case it is extremely difficult for them to decide when the individual poses a risk to themselves and others. Nor is there a clear criterion for when a person has reached a point of crisis and instead it remains subjective. This can create inconsistencies in care across the board and poses a risk to officers, the community and individuals.

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[2] Metropolitan Police (2011) *Freedom of Information Act Publication Scheme: Mental Health Policy* [Online] Available at: http://www.met.police.uk/foi/pdfs/policies/mental_health_policy.pdf
Mind (2014) *Parliamentary Briefing from Mind: Mental health and the police* [Online] Available at: http://www.mind.org.uk/media/553151/mind-briefing-on-police-and-mental-health.pdf

[3] https://mentalhealthcop.wordpress.com/

Effects of detaining someone under Section 136:

- The person is considered to be under arrest;
- Section 136 does not used the word *arrest* but is the preserved power of arrest under the Police and Criminal Evidence Act 1984 under which reasonable force may be used;
- The person can be detained at a place of safety for up to 72 hours in order to be examined by a registered medical practitioner;
- The detainee is entitled to legal advice, regardless of what place of safety they are located in; and
- The detainee is allowed to request that one person to be informed of their whereabouts.

3.10 Although police custody is currently defined as a 'place of safety' under Section 136, in reality it is not a therapeutic location for someone suffering from a mental crisis. The loud noises, bright lights and social isolation can cause further distress and risk of harm to the individual. In addition to this, 72 hours can be a long time to detain someone who may be unlikely to have committed a crime. Mental recovery varies between individuals and some may recover more quickly than others. There is no set criterion for when a patient can be released from detainment and can be subjective, leading to inconsistencies in care standards.

Police Action following detention under Section 136:

- There is a code of practice that requires that the officer responsible for the detainment to pre-notify the chosen place of safety in advance and also to notify the Local Social Services Authority (ASW).
- In rare cases of extreme violence then no such agreements are necessary and the appropriate person must be taken immediately to a place of safety.
- For reasons of risk to the patient and avoiding stigma ambulances should be used where available for transfers.

3.11 This multi-agency approach to care allows the sharing of information between the police and the local services authority. However there could be a need for clearer guidelines in terms of the exact information that needs to be relayed to ensure records for all patients are consistent across the board. The transfer of a patient from one place of safety to another can be distressing, so a policy to transfer in ambulances, where available, provides a therapeutic environment with expertise and the resources for care. In addition to this the patient may already be familiar with some of the care staff which makes for an easier transition. However this may create care inequalities in which some patients are being transferred in ambulances whilst others in police vehicles.

Emergencies involving violent patients in psychiatric wards:

- Officers are often called to assist hospital staff when patients become violent.

- Although it is the responsibility of the hospital to ensure there is sufficient security and ability to safely restrain patients were necessary, it is often left to police officers in more dangerous situations.
- Every effort is made to ensure a police supervisor attends the scene in a timely manner.
- Police can take patients into custody if necessary and then returned when deemed appropriate.

3.12 Although it is recognised that there will always be a certain level of need for police involvement in detaining violent patients within care, it can damage police perceptions creating resentment and mistrust. This may then prevent them co-operating in the future. Removing patients from an appropriate health care based place of safety to custody suite will disrupt care plans and prolong recovery time. A police custody suite does not offer the necessary therapeutic environment for recovery and can cause further deterioration of the individual.

Transporting patients: Including dangerous and violent patients:

In transporting psychiatric patients and persons suffering from mental ill health, there needs to be a dedicated officer responsible for:

- Carrying out a dynamic risk assessment ;
- The deployment and actions of police resources; and
- Ensuring that any action taken by the police is proportionate, legal and necessary.

In the case of an NHS trust or health care provider requesting a transfer between hospitals:

- The police are qualified under law to conduct these transfers however the responsibility of the transfer lies solely with the hospital and not the police; and
- Any agreement for such a request must be authorised by the duty officer. The Duty Officer is responsible for carrying out a risk assessment, deciding how to deploy police resources and ensuring that any action taken by the police is proportionate, legal and necessary. [4]

3.13 There could be multiple issues with this; firstly communication between certain multi-agency partners particularly the NHS may be weak due to the strain on staff and resources. Therefore officers may not have the necessary information to conduct a full risk assessment. Without being fully aware of the level of care need of the patient they cannot provide optimum levels of care. Further to this the transportation of patients in labelled police cars can cause

[4] Open Government Licence (2015) *Mental Health Act 1983* [Online] Available at: http://www.legislation.gov.uk/ukpga/1983/20/section/136
ImROC (2014) *Person Centred Safety Planning can help manage risk and support recovery* [Online] Available at: http://www.imroc.org/risk-safety-recovery-launch/

further distress due to perceptions. This added stress may increase the severity of their symptoms.

Returning patients who are still under psychiatric care:

- If the location of the patient is known, the role of the police is simply to assist mental health professionals; they do not hold the main responsibility.
- It should be noted however that it should not be necessary to involve the police unless there is a case of violence or the whereabouts of the patient is unknown.

4. Person Centred Safety Planning Approach:

4.1 The current approach to risk management across all care, including the police force, is negative. This means that it is risk adverse and aims to minimise all potential harm to zero. This is an issue because minimising risk is not always in the best interests of the individual but rather of the care agency. In addition to this there is an imbalance in responsibility. All responsibility lies with the agency in immediate care of the person when it could be recognised that a multi-agency responsibility approach is required.

4.2 Best practise guidelines for risk management under Section 136 include the *person-centred safety planning approach*. This approach involves minimising risk while considering the best outcomes for the individual. It takes a more positive approach and believes that the main aim is to improve the care of the individual rather than hinder it through negative risk management. It accepts that risk can never be reduced to zero and full reduction of risk would compromise the care of the individual. There are a 3 main steps to this approach, as outlined below :

- Risk Inventory: Identifying Past Experiences of Risk
- Risk History: Understanding past risk experiences from different perspectives
- Personal Risk and Safety Plan

4.3 The *person-centred safety planning approach* ensures that the individual is involved in all aspects of their care and that there is consistency in the information recorded across all agencies. In addition, it also ensures that the minimisation of risk is in the best interests of the individual and not the agent of care. This model could be adopted by police agencies when assessing the risk an individual poses to both themselves and the community before detainment. Coupled with correct mental health training this could be the way forward.

5. Should the police be involved in mental health care?

5.1 There is much debate as to whether the police should be involved in the care of persons suffering from mental ill health.

5.2 Between 2014 and 2015 funding for the NHS increased by 0.1%, which has required the NHS to become more innovative in their use of resources under increased strain. In the case of a psychiatric bed not being available it could be in the best interests of individual to be detained in police custody where the majority of factors of vulnerability are reduced. With this in the mind the role of the police is fundamental in filling a care gap and ensuring the protection of the individual.

5.3 Others agree with this approach but believe that in order for it to be effective solution; the multi-agency approach needs to be improved. By working with the NHS the police can improve mental health care and reduce detainment statistics. For example, the 'Street Triage Scheme' in Oxfordshire' which involves mental health nurses attending police call outs has seen a reduction of 40% in people being detained under the Mental Health Act and a 73% reduction in police cell detention numbers.

5.4 A third argument is that police involvement could be effective if amendments were made to Section 136 under the Mental Health Act 1983. Some of the suggested amendments include *reducing the maximum time for detainment to below 72 hours* and *removing a police custody cell as a defined 'place of safety'*

5.5 Others think tanks argue that the role of the police is to deal with criminals and victims; not mental health patients. Mental health should be treated with the same value as physical health. Police involvement in mental health care could be seen as criminalising victims. Further to this issue the police may not have received adequate training on how to deal with mental health issues which can result in injury and violence during detainment. According to the Human Rights Commission between 2010 and 2013, 367 adults with mental health conditions died of 'non-natural causes while in state detention and psychiatric wards'. A further element to this argument is that as of current there are no age limits regarding minimum or maximum age of detainment. There are a number of safe guarding issues around the detainment of children and the elderly in police cells[5]. In 2011 children as young as 11 were held in police cells. For this year 35 out of 42 forces in England and Wales held children under 18 in custody under the Mental Health Act. There are a number of issues around this including the exploitation of children's rights under Article 19 and 37. This view is supported by Health Secretary Theresa May who proposed, under the last coalition government, that £15 million would be invested into the mental health care system to ensure that police cells were only used as a last resort and in the rare case of a patient's behaviour requiring that level of isolation. She also proposed plans to reform the use of Section 135 and Section 136 of the Mental Health Act 1983. These plans included amending legislation so those under 18 were never sent to police custody and reducing the 72 hour period for maximum custody.

[5] Metropolitan Police Authority (2005) *Joint Review: Policing and Mental Health* [Online] Available at: http://policeauthority.org/metropolitan/downloads/committees/mpa/051027-11-appendix01.pdf

6. Examples of Policing Practice:

6.1 There are a multiple examples of positive police practice across the UK regarding mental health. These tend to involve strengthening multi agency communications and improving awareness of mental health in the police service. Examples include;

- Police working in collaboration with charity volunteers. For example **Hillingdon MIND** provides appropriate adult volunteers who respond to calls every day of the week whenever an adult experiencing mental health issues is arrested or detained. They currently have 35 volunteers working closely with the police. In 2012-2013 they responded to over 260 calls and spent over 600 hours in police custody suites.

- The 'E Card' scheme has been adopted by **Lancashire Constabulary**. This is an emergency information card scheme which involves the NHS handing out free cards containing personal details for mental health patients to carry in case of an emergency. The card contains emergency contacts and care needs information. It has solved communication and patience issues between the police and clients. It has also reduced immediate contact time and allowed for more effective use of police resources.

- **Leicestershire Police** improved their multi agency approach and community contact with Leicestershire community through a once a month beat surgery called 'Cuppa with a Copper' in local psychiatric unit.

- The adoption of the 'Triage Car' scheme **Leicestershire**. An innovative partnership between Leicestershire Partnership NHS trust and Leicestershire Police. It involves mental health nurses accompanying police officers to mental health crisis incidents. It also acts as an on the job training scheme for police officers.

- The **Dyfed Powys Police** and **Hywel Dda Health Board** collaboration in training for mental health awareness. Student officers complete a day's training at a local acute psychiatric ward. After this they attend a placement with a local mental health charity. In addition to training it also provides officers with the opportunity to interact with service users and develop closer professional relationships with care service providers.

- **Essex Police** have developed a one day mental health awareness training course that is compulsory to all officers. The aim of the training is to raise awareness of mental health needs and improve expertise. It teaches background knowledge to mental illness, common symptoms and behavioural patterns for identification. It also teaches how to deal with crisis situations.

7. Examples of Negative Practice

7.1 It is recognised that the aim of the police is to provide the highest standards of care in terms of protection to the community. However due to a potential lack

of training and strain on resources there are circumstances in which examples of poor practice may exist;

- Unnecessary use of restraint;
- Poor communication skills with detainee, for example, not explaining what their role of an officer is and how they can help. Not informing the individual of their rights and involving them in their care plan
- Focusing on negative language and lack of responsibility
- When confronted with anger from the detainee officers attempt to defend rather than acknowledging the situation and attempting to diffuse it.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Mark Ewbank
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APPENDICES

Appendix A: Westminster City Council – Community Safety Commissioning
Appendix B: MOPAC – MAST Briefing Note
Appendix C: Central and North West London NHS Foundation Trust

BACKGROUND PAPERS

As referenced throughout.