Policing Mental Health in Derbyshire

2015/16

Insp Jon Clark
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Summary

The demand on the Force that mental health and associated incidents brings with it is well known. The policing of mental health within the county has shown considerable improvements in the previous 12 months, although there remains a lot of work to do. Over this period there has been:

- sizeable reductions in the numbers of people detained under section 136 per month
- a considerable increase in those being formally detained or requiring further treatment following 136
- the virtual elimination of custody being used as a place of safety for 136
- classroom training for 900 officers in the area of mental health, supported by a fully operational intranet page and supporting guidance
- a review of all policies and procedures to ensure policing responses are appropriate
- closer working relationships with all partner agencies
- the embedding of a control room triage operating model
- a full return of statistics to the Home Office, including completion of ADR, to inform the national debate
- a coordinated multi-agency approach to meeting the aims of the Crisis Care Concordat

The understanding of the overall demand however remains poor. The College of Policing would suggest that around 2% of all incidents dealt with by the police are linked in some way to mental health – many officers would argue this figure to be higher. The forces computer systems and the manner in which such incidents are recorded does not allow for any calculation of accurate figures in this regard. We can only accurately report on those occasions where section 136 is enacted, assistance is provided with a section 135 warrant, officers act under the Mental Capacity Act (MCA) or deal with someone by voluntarily taking them to hospital.

1. Section 136

The following chart shows the number of section 136 detentions per month (fig.1). As can be seen the overall numbers of s.136 detentions continue to show a downward trend – in quarter 1 an average of 23 persons were detained a month which dropped to 17 in the final quarter of the year. During this period there has also been a considerable increase in those persons either being admitted or receiving further treatment as a result of the use of s.136, with this figure now being approximately 55%. This figure does suggest that there remains some further room for improvement in preventing unnecessary and/or inappropriate detentions.
The use of section 136 however continues to place a considerable strain on policing resources. Over the past 12 months in the region of 180 police officer shifts have been spent waiting at health based places of safety with detainees. This figure doesn’t take into account initial time at the incident, transport, or completion of appropriate monitoring.

The average wait at a health based place of safety (HBPoS) has remained fairly consistent – in Q1 this was 2 hrs 21 mins, Q2 3hrs 12, Q3 2hrs 18 and Q4 2 hrs 30. The joint policy for the use of s.136 states that police officers should only remain at a PoS in order to prevent crime, therefore where there is limited or no risk of violence the police officers should be released as soon as possible. As restraint was used in only around 50% of cases, to assist with detention and transport, this suggests there continues to be a reluctance to release us from PoS'. In 49% of cases a lack of staffing at the PoS is listed as the reason for police officers being detained over 30 minutes. In only 17% of cases was the risk assessment such that police presence was required.

There has been a considerable reduction in the number of detentions in police custody over the past 12 months as shown in the chart below (figure 2). Considerable training in this area has been given and any section 136 detentions in custody are now considered as a departmental critical incident by Criminal Justice (CJ). As we go through 2016 we are likely to see a change in the law that custody will no longer be considered a place of safety for detained juveniles, although the force implemented this as a policy mid-2015.

The conveyance of those detained under the mental health act continues to be an issue. Figure 3 shows the percentages of 136 detentions that are being conveyed by police versus ambulance. Whilst the improvement is welcome the expectation of the Crisis Care Concordat (CCC), which is reflected within the conveyance policy, is that all detained persons will be transported by ambulance unless there is an exceptional need to utilise a police vehicle. There is clearly some considerable way to go to achieve this and with EMAS’ current capacity issues this is unlikely to show improvements in the short term.
Figure 4 shows why ambulances are not being used. The two main areas to look at are when an ambulance is not available, which as per the above comments is increasing, and when the police didn’t request. The on-going message to officers is to always request an ambulance to transport and whilst this needs to improve further the downward number of those when an officer doesn’t make a request is promising.

Fig. 2

Custody Detentions

Fig. 3

Conveyance of 136 Patients

Fig. 4

Reasons for Police Conveyance
One of the key areas in which unnecessary and/or inappropriate detentions can be avoided is by ensuring that advice and guidance is sought from mental health professionals prior to making a decision to detain. All officers and staff have been provided with details of relevant agencies to approach however the take up of this facility remains low. When advice is taken the number of times this is completed through the triage service has increased considerably – triage advice accounted for 90% of those occasions on which advice was taken in Q4. The issue remains the seeking of advice outside of triage hours.

Figure 5 shows the consistently low number of occasions on which advice is being sought with a disappointing drop in Q4 reversing what was an encouraging trend.

![Graph showing advice taken](image)

Of those detained between 72% and 87.5% were already known to mental health services and between 39% and 61% had previously been detained before. *(Please note the lower figure is where the question has been answered, the higher figure then includes those where this answer is not known.)* These figures further support the need to take advice given that so many are already known to services.

Other points to note in relation to s.136 detentions:
- 4% (10) related to juveniles
- Male and female was split 64.1% v 35.9%
- 94% were white European and 6% were BAME
- Intoxication was a factor in between 32.7% and 48% of cases

### 2. Voluntary Attendance

A voluntary attendance is when a person comes to the attention of the police, whether through incident attendance or interaction on the street, who expresses some kind of desire to hurt themselves, or who is exhibiting disturbing or unusual behaviour and whom police feel can’t be left alone. Often through negotiation and with the agreement of the person they are transported to
hospital, usually an Emergency Department (ED), in order for their mental health to be assessed. This is considered a relatively quick method of ensuring a person is taken to a place of safety without having to resort to the use of powers.

Figure 6 shows the monthly numbers of voluntary referrals and figure 7 shows the 12 month cumulative total. The latter shows the considerable rise in these interactions from September 2015. It can’t be stated with any certainty that the figures pre-September are accurate as a new monitoring form was introduced in June 2015 but evidence suggests it took some time for this to bed-in. Figure 6 does however show the accurate figures since this time of how many are being undertaken every month.

There are several issues with this approach:-

- often the person is presenting with no medical condition which places an unnecessary strain on ED resources
● the extent of the police’s duty of care is not well understood which could leave the force in a poor position should one of these persons ultimately harm themselves

● police officers are transporting without consideration of any potential risks and without powers to act in the event of an issue

The biggest concern is the issue of duty of care. Many of these persons are taken to ED with police officers often resuming having dropped off at the front door, or having taken them to the book-in desk. The force’s legal department suggests that by taking a person to hospital officers are accepting a duty of care for that person (full advice can be seen at appendix A). There is a benchmark for when a duty of care comes to an end with a 136 which is when a competent person has accepted the care of a person being fully aware of the risks and it is suggested this should be the same expectation with voluntary attendees. This approach would result in delays at hospital thereby increasing possible resource abstraction. It would be more appropriate for officers to be required to arrange relevant support within the community although the provision of such services is patchy.

3. Triage

Mental health triage has changed over the reporting year. At the start of the year a financial commitment from Derbyshire Healthcare Foundation Trust (DHcFT) through Hardwick Clinical Commissioning Group (CCG) allowed for street triage to continue. The force committed to retain the police officers for six months before reviewing their position. This subsequent review showed that triage was conducting less than ten face to face assessments per month, and even on these occasions it was unlikely the seconded officers were going to be required to use their police powers. It was also noted that the issue of s.136 was a particular issue in the north of the county but triage wasn’t available. It was agreed that triage needed to be expanded to provide county wide coverage.

On 15th September the mental health staff from triage moved to work from the force operations room (FOR) and on the 1st October the police officers were removed from the service. The triage service is now provided 4pm-midnight by a Community Psychiatric Nurse (CPN) based with the FOR and have been provided direct access to the command and control system. On this point there are some concerns over data security and the provision of direct access is under review. This change has considerably increased triage involvement in police incidents giving direct advice and guidance.

Case Example:
A female from Derby has been highlighted as regularly making calls to the police, EMAS and other agencies. Her ultimate goal is to seek attention and be admitted to hospital. Some previous calls have resulted in a full firearms deployment. She has been transported numerous times to hospital by the police and EMAS placing unnecessary demand on both those services and ED. She has been assessed numerous times and deemed not to have mental illness.
An evening in April she called the police saying she had schizophrenia and wanted to kill people. This was passed to triage for review and based on their knowledge suggested this was attention seeking behaviour and recommended no police attendance. She then called back again saying she had a gun – the advice and guidance was the same. She tried to call back numerous times. She also called the 111 service and tried to elicit a response from them but was again given advice from triage.
As a result no agencies were deployed to this female and an investigation is in process to prosecute her for wasting police time. Without the support of triage this wouldn’t have been possible.
The provision of triage is currently under review from all interested agencies and is reporting back to the Urgent Care Pathway Review which is being led by Hardwick CCG. The ultimate aim is that the county has a 24/7 triage hub capable of providing advice and guidance to numerous professional agencies, including the police. It is likely this service will be provided on a health site.

4. Policy and Procedure

The biggest change in policy over the last 12 months has been the introduction of the ‘Missing and Absent Patients’ policy which has replaced a previous AWOL policy that led to confusion and poor service. The new approach is a joint one with DHcFT which they have also distributed to those companies from which they commission a private service. It’s a policy that has led to a more straightforward approach to this critical area of policing whilst ensuring the hospital retains the appropriate level of overall responsibility. The protocol regarding the joint application of 136 has been updated and the conveyance policy is in the final review stage. Each of these has been written to be fully compliant with the CCC.

There is an issue around conveyance when a patient is to be transferred from one hospital to another. At present we have an agreement with DHcFT that sees the force provide overtime officers and a vehicle to facilitate this. The CCC is quite clear that the transport of mental health patients should only be by police in exceptional circumstances, yet there is an agreement in place where the police are the first port of call. It has been raised with DHcFT that we intend to withdraw from this agreement and are waiting for confirmation that they have found suitable alternatives before withdrawing our support.

Guidance has also been issued to response teams as to when they should be expected to respond to mental health inpatient units. This arose out of a growing expectation on the police to attend and assist in restraining violent or difficult to manage patients, often in cases where the police had no powers or legal basis on which to rely. This protocol was discussed and shared with DHcFT to ensure there were no surprises and is ensuring police attendance only where it is absolutely necessary.

Some areas of information sharing remain problematic and there are currently issues around sharing of information in cases that are non-emergent and don’t meet the threshold for safeguarding. These are being worked through however delays from DHcFT in moving this area forward have been considerable.

A policy / guidance will be prepared by the summer to deal with voluntary attendees and is pending a policy decision from the strategic lead.

5. Training

Through 2015 a staged approach was taken to training of police officers and staff in the area of mental health. In the January a mandatory eLearning package was launched with this then being followed up with a guidance booklet for all frontline officers and staff. At the same time an intranet
page was launched aimed at being a one stop location to provide advice and guidance to officers. Between May and November just under 900 officers were delivered a full days classroom based training. This training was delivered on health premises and primarily delivered by health professionals and was focused on the how to deal with persons with mental ill health and what was available to officers to help them. The formal evaluation of this training is yet to be done but initial feedback was very positive.

Training through 2016 and beyond will take more of an update approach targeting specific areas. This has already commenced with inputs to south division staff on their divisional development days.

6. Partnership Approach

There are some very strong and productive partnerships that have developed amongst those professionals dealing with mental health. This includes representatives from DHcFT, EMAS, city and county social care, Royal Derby and Chesterfield Royal, Derbyshire Community Health Services and in some cases patients group. There a number of groups / meetings that are constantly reviewing the whole approach to mental health with the force being represented on, or having an input, to each of these. Reductions in police time spent dealing with mental health incidents have undoubtedly, in part, been down to some of these relationships. We are also now in a position to influence the approach going forwards so that we can continue to ensure a person in crisis receives the most appropriate care.

The partnership approach has shown particular benefits when dealing with high volume service users through a repeat callers group, and representation at strategy meetings. The care plans being put in place are done so in conjunction with the police so that there is a coordinated approach.
7. Issues

The following section highlights the current issues from a policing point of view.

1) There are at times insufficient inpatient beds to meet demand. This becomes even more acute when the required bed is a psychiatric intensive care bed (PICU) or for a juvenile (CAMHS). DHcFT does not have either of these and so therefore have to approach other providers. This can take some time resulting in continuing police officer involvement and as can be seen in the below case example can place unacceptable risk on the force. This is recognised by DHcFT although plans to tackle this and alleviate the issues are not advanced and is likely to result in similar incidents continuing to occur. The alternative places of safety working group as noted in the above diagram is aware of this and considering as part of this work what would be suitable in such circumstances.

Case Example:
One Friday in April a male was detained to prevent a breach of the peace and was taken to Chesterfield police station. Whilst there he was subject to a mental health act assessment which deemed he was in need of hospital care, that detaining him under section 2 of the MHA was necessary and furthermore that he required a PICU bed. At this point he was released from the breach of the peace, however at this point the section 2 was not enacted as there was no bed available. Subsequently this male spent approximately the next 60 hours in custody, without lawful basis, whilst a bed was found.
On the same Friday a juvenile was detained for criminal matters and taken to St Marys Wharf custody. He was also subject to a full act assessment with a similar result to above with the only difference being the need for a CAMHS bed. He spent approximately the next 60 hours in custody, without lawful basis, before being taken to a hospital in Norwich.

2) EMAS capacity issues are resulting in either lengthy delays for ambulance transport, or simply non-availability. Officers are being directed to request an ambulance every time they detain under 136, utilise the MCA or are required to assist with a s.135 warrant and until they do we won’t understand the complete picture. It is clear however that EMAS cannot meet their response obligations leaving the police often to transport despite the clear risks of doing so. There is a proposal from EMAS to their commissioners to provide a mental health specific and dedicated transport service which would seem an appropriate response. Until this is in place, or should it not happen, then there will be a continuing issue of officers accepting unnecessary risks in order to transport patients.

3) Delays from arrival at a 136 suite through to the point officers are released continue to be excessive. This for the most part can be attributed to how the suites are staffed, i.e. one lone bleepholder who doesn’t have the capability to take ownership of the patients. Until additional staffing is put into receiving 136 detainees this will not change. This is being considered by the Urgent Care Pathway Review following national guidance to fully staff these suites. It remains imperative that we remain actively involved in these discussions.

4) An intoxicated detainee cannot be assessed and therefore when combined with issue 3 above the detention, and subsequent wait, with an intoxicated patient can be excessive. The
alternative places of safety group are currently considering what options there may be going forward so as to provide a more appropriate holding facility when these issues arise.

5) The demand placed on policing by mental health is much wider than those already discussed in this report. As a force however there is no way of properly assessing the total time taken to deal with this area and this will not improve with the introduction of Control Works.

8. Conclusions

In the past 12 months the force has managed to achieve a 26% reduction in the monthly average number of section 136’s being detained per month – this could equate to a minimum of 15 hours of officer time per month being saved. This has been as a result of close partnership working and considerably improving the training package available to officers and staff. The work of the Crisis Care Concordat group is making sure that those suffering with mental health whom come into contact with the police can receive the care they need, and are not automatically detained and taken to a police cell.

There remains a lot of work to do as highlighted in the issues section above – but as can be seen, other than the forces monitoring of mental health incidents, all of these issues are under consideration from a collaborative point of view.

The two main risks currently are the management of persons taken voluntarily to hospital and the capacity of EMAS to manage demand in this area – both of which will need to be closely monitored to ensure the welfare of patients and risks to the force.

As the force doesn’t understand the true demand that dealing with mental health places upon it this could be the subject of a commissioned audit so that we can formulate a realistic benchmark.

Overall however the picture of mental health policing is an improving one.
Appendix A

ADVICE NOTE

The background to this advice is that between April and November 2015, it was noted that a practice had developed of police officers, having been called to incidents wherein a person (whether victim or suspect) may have expressed thoughts of self-harm or suicide, go on to transport that individual to hospital, without calling EMAS.

It is hoped that by clearly understanding the responsibilities Derbyshire Constabulary has in this regard can assist in directing change and agreeing a multi-agency approach to this issue.

The Legal framework

The Mental Health Act 1983 provides for two scenarios where a police officer may lawfully remove a person to a place of safety:

Section 135 provides:-

(1) If it appears to a justice of the peace, on information on oath laid by an [approved mental health professional], that there is reasonable cause to suspect that a person believed to be suffering from mental disorder—
   (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or
   (b) being unable to care for himself, is living alone in any such place, the justice may issue a warrant authorising any constable . . . to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

(2) If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act or under section 83 of the [Mental Health (Scotland) Act 1984] [article 8 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005] to take a patient to any place, or to take into custody or retake a patient who is liable under this Act or under the said section 83 [article 8] to be so taken or retaken—
   (a) that there is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice; and
   (b) that admission to the premises has been refused or that a refusal of such admission is apprehended,
the justice may issue a warrant authorising any constable < . . . > to enter the premises, if need be by force, and remove the patient.

Section 136 reads:-

(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the
constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.

Thus, the powers of a police officer in the context of an assessment for compulsory admission to hospital are expressly and entirely provided for by this legislation. Further, a police officer is afforded express protection by the Act.

Section 137 expressly provides that the person shall be lawfully detained whilst being detained or transported in accordance with the Act.

Section 139 offers further protection to the police that no person shall be liable to any civil or criminal proceedings for acts done in accordance with s135 and s136, provided done in good faith and with reasonable care.

The police have core operational duties which include, for our purposes, protecting life. Recently (2013), the Court of Appeal has considered the police have a duty consistent with article 2 ECHR (right to life) where police were slow in responding to an emergency call.

However, in the context of this advice, in circumstances where section 136 does not apply, I cannot envisage that this duty is engaged.

There is no common law duty to give someone a lift to hospital. It appears to me that officers are effectively doing just that, I am sure with the greatest of intentions to ensure the individual gets that medical help and undoubtedly after the individual has developed some trust of the officer.

**Consequences of transporting patients**

Once an officer takes responsibility for transporting a patient, they accept a duty of care for that patient. That may be carried out without any problem whatsoever. However, there are a number of potential problems with this, which Inspector Clark has already highlighted as concerns:

1. Potential risk to the officers transporting patients: *(one example, where a patient becomes violent toward an officer whilst he is not acting in accordance with his duty yet in a manner effectively sanctioned by DC as accepted practice, this could lead to a PI claim against the Force)*;

2. The eventuality in the event the patient has a change of heart and does not wish to undergo treatment *(So, where a patient has a change of heart and section 136 has not already been utilised it is difficult to see how an officer could then assess that s136 is engaged. Any further steps to take that person for treatment where they, for example, say they just said words in the heat of the moment but have no such intention can only lead to an officer stopping the vehicle to allow them out. What then, if the person goes on to harm himself?)*

3. In what circumstances could officers find themselves unlawfully detaining patients? *(In ignoring those comments given as an example at pt. 2, then the Force could find it faces a*
claim for unlawful detention. The officer too could face a criminal or misconduct investigation in doing so).

In truth, there are numerous scenarios which could lead to civil, criminal or misconduct proceedings against individual officers or to claims being made against the Constabulary as a whole. There are a myriad of issues when it comes to mental health from an individual’s ability to communicate to that person’s capacity to understand or make decisions affecting him. A failure to respond properly to any one of these problems can result in litigation.

**The solution**

Where section 136 applies, then the officer should use this power to transport the person to a place of safety for formal assessment to take place. Where section 136 is not considered appropriate then the officer should seek the help of a medical expert. That may be EMAS or the crisis team. A proper assessment can then take place. Where there may be a risk of violence from that person, an officer may accompany ambulance staff.

In relation to the proper police response to those individuals with MH problems, guidance already exists for DC staff and officers in that regard so I will not repeat here.

My advice simply is for that guidance to be followed and for officers **not** to transport individuals to hospital simply to ensure they get to hospital. Where a hospital attendance is appropriate, then EMAS will be the first point of contact.