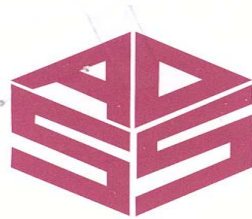# MPA

Metropolitan Police Authority

JOINT REVIEW

POLICING AND MENTAL HEALTH

ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES

London development centre for mental health

METROPOLITAN POLICE

Working together for a safer London

NHS

October 2005

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Chairs' Foreword

The Metropolitan Police Authority (MPA) is an independent statutory body responsible for maintaining an effective and efficient police service for London. Its primary tasks include securing continuous improvement in the way policing is provided in London, monitoring the performance of the Metropolitan Police Service (MPS) and consulting with the people of London.

In July 2004, members agreed that there was a need to consider, in depth, the approach taken by the MPS towards people with mental health support needs who come into contact with the police. In recognition of the complexity of this subject and of the interdependencies with health and social care providers, MPA members also agreed that they should not undertake this review in isolation. They invited key stakeholders to form a project board to undertake the work. It is our view as Chairs that this has been one of the key successes of the Joint Review of Policing and Mental Health. With colleagues we have been able to build consensus on how the challenges facing mental health, social care and police policy makers and service deliverers should be taken forward. We are committed, through supporting the implementation of this report's recommendations, to helping ensure better service provision in the future.

The project board understands that most people with mental health support needs have no special contact with the police. We also recognise that people who experience mental illness are far more likely to be victims of crime than they are to be perpetrators. However, it was also our view, that we, as a joint project board, would be able to add the most value, and make the most improvement, by concentrating on those areas where services are - or should be - delivered in partnership by the police and the NHS, and where people with mental health support needs enter the criminal justice system.

People with mental illness often experience stigma and prejudice. This can have a profound impact on the quality of their lives. As a project board, we recognise that we have an obligation to take a lead in challenging the misperceptions and myths that have developed in relation to mental illness. We also accept that public protection is an important priority, and that the NHS and the police service share duties to protect the well-being of *all* citizens.

We are indebted to the service users who agreed to talk to us during the review process. We wrote to a number of user groups, and a quarter of them agreed to share their experiences of the police and other service providers. We are grateful that they were so candid in the information they gave us. One of the striking things they told us concerned the poor levels of awareness about mental illness. We look forward to working with user groups to develop training packages that address this deficit and help challenge the stereotypes that surround mental illness.

We would also like to extend our thanks to the reference group that supported the review and to all those who gave presentations to the project board during the course of the review. We would like to thank Tammy Kelly and Fauzia Ashraf-Malik at the MPA for the support they have given the project board throughout the review period. We would especially like to thank Siobhan Coldwell, who has managed to make a whole range of information from many sources coherent in writing the report for us.

We found that improving co-operation and collaboration between agencies and improving support for people experiencing mental ill health is already on many local agendas. There are numerous examples of good practice that can be drawn on. However, we also found that the leadership and direction needed at the highest levels is not always in place. We have therefore recommended the formation of a pan-London alliance of all key stakeholders to help promote the development of that crucial leadership.

We recognise the scale of the challenges still to be overcome, and acknowledge the need to dedicate resources to ensure further progress. We will continue to work together to assign responsibilities for the achievement of the recommendations, and to develop appropriate monitoring mechanisms.

Richard Sumray   Professor David Taylor

Co-Chairs, Joint Review of Policing and Mental Health

SUMMARY

INTRODUCTION

The project board met monthly between September 2004 and June 2005. We undertook research into the key areas identified in our terms of reference and received presentations from policy makers, academics and service deliverers during that time. We wrote to user groups across London inviting them to participate in the review. Eight responded and their experiences have been integral to the conclusions we have arrived at. We also received written evidence from community police consultative groups, independent visitor panels and the Criminal Defence Service. In order to hear about the practicalities of joint working between agencies, we held a workshop that was attended by police officers, London Ambulance Service staff, mental health service providers (acute and community) and a forensic medical examiner. Finally, we convened a reference group of key stakeholders who provided essential support and challenge to the project board throughout the review period.

KEY FINDINGS AND RECOMMENDATIONS

Context

The links between violence and mental illness are far weaker than either the public or the police believe and the perpetuation of these myths has a profound impact on agencies' ability to deliver services to people who have mental health support needs.

We recommend that:

R1 **Multi-agency partners ensure training and awareness programmes highlight the need to eliminate discrimination and stigma to all communities and that all programmes are subject to full equality impact assessments.**

R2 **Partners work with Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) users groups in order to establish best practice in service delivery to these service users.**

R3 The MPS develops an awareness programme aimed at de-stigmatising mental illness and dispelling the myths of the links between certain types of mental illness and violence. This should be championed by the MPS leadership.

R4 The MPS and the NHS agree and apply a joint media strategy that will minimises the extent to which the press report on the mental health status of people accused of serious violent crimes including murder. Such a strategy should also aim to minimise the negative reporting on mental illness and the occurrence of violent crimes and murder.

Key interfaces

Strategic overview

There is currently no pan London partnership focused on addressing the issues facing service providers

We recommend that:

R5 A pan-London alliance is established whose remit includes providing strategic leadership to the activities of partner organisations and aims to achieve ownership of shared objectives and outcomes. This could also provide a vehicle to drive forward the recommendations in this report.

R6 Leaders of police, health and social services and local government, in London should convene annually as a matter of course to discuss the health challenges facing London, including mental health. This could provide direction and leadership to the pan-London alliance recommended above.

R7 Partners maintain the links developed through this joint review with key stakeholders (such as the reference group who provided on-going support and guidance to this project board). This could include deliberate engagement to provide a mechanism for monitoring implementation of the recommendations in this review.

Detaining a person for their own or other people's safety

Despite the existence of protocols, current arrangements are not working effectively, many boroughs do not have formal agreements, and those that are in place do not work well. The project board agrees that the use of police cells in these situations is wholly inappropriate, but also recognises that there are drawbacks to the other options currently available.

We recommend that

R8   In the short term:

- **Current s136 agreements in each borough are reviewed to ensure they address the following:**
  - **Identifying a place of safety that meets the requirements of the code of practice and the pan-London protocol, and is operationally conducive to local working arrangements (this may require a culture change from some organisations)**
  - **Addresses how s136 detainees who also appear to be intoxicated should be dealt with**
  - **Identifies designated health facilities best able to meet the immediate needs, including those which concern issues of diversity, of people who are extremely agitated and in need of restraint for their or other people's safety**
  - **Outlines handover procedures so that all necessary/relevant information is passed on to clinical staff**
- **Auditing processes are developed to ensure the implementation of s136 is evaluated and lessons learnt on an ongoing basis (as per the Code of Practice).**

R9   Agencies work together to develop appropriate s136 accommodation across London. This should include making joint bids for capital

money such as the funds recently announced by the Department of Health (Oct 05). In our view, the ideal would be an assessment centre that can address all needs of people experiencing crisis including:

- **Mental health assessment**
- **Restraint and violence including the capacity to resuscitate**
- **Medical triage**
- **Capacity to address the needs of people whose crisis could be caused by either mental illness or substance (including alcohol) misuse.**

R10   The MPS and NHS work with government departments to develop good practice on identifying the ideal place of safety.

Undertaking mental health assessments on private premises

Although protocols have been in place for a while, they have not been effectively implemented. A recent multi-agency review has resulted in minor changes to that protocol and a renewed commitment is in place to ensure its success.

We recommend that key stakeholders:

R11   Formalise the adoption of the revised s135 protocol and develop joint arrangements for monitoring the implementation of agreed arrangements.

R12   Ensure a timely evaluation of the revised protocol (the emphasis should be in following up the recommendation of the multi-agency review).

Criminal justice system

When a person with mental health support needs commits an offence, it should be followed up through the criminal justice system. As a starting point they have a right to be treated in the same way as offenders who do not have a mental illness. At the same time it is important that their mental health needs should be assessed and addressed, and that while they are in police custody appropriate care should be given. This may involve diversion into the mental health system but that in itself should not be a bar to progress through the criminal justice system as the presence of a mental illness may not be the cause of the offending behaviour. Mental health providers need to work with their staff to ensure they are aware of the roles and responsibilities of the police and that prosecution policies are developed and disseminated.

We recommend that:

R13   **The MPS ensures that mental health is given a high priority within the requirement of 24 hours training per year that Forensic Medical Examiners (FMEs) are required to undertake.**

R14   **In order to reduce the amount of time detainees spend in custody, agreements are established with mental health services to ensure that Approved Social Worker (ASW) attendance will be timely.**

R15   **That agencies work together to improve the availability of Appropriate Adults.**

R16   **If someone with mental health support needs commits an offence, it should be followed up through the criminal justice system. At the same time, it is important their mental health needs should be assessed and addressed appropriately, which may involve diversion to the mental health system.**

R17   **As part of their approach to reducing violence on mental health wards, Trusts should adopt the approach taken by Southwark police and the Maudsley in developing a prosecution policy and educating staff about how to deal with the police should the need arise.**

Skills and training

Ensuring staff are equipped to deliver timely and appropriate services is the biggest challenge facing the agencies delivering services in this area. The MPS has recognised that police officers lack the awareness of mental illness they need to respond effectively and is taking steps to address this. They have also developed a network of Mental Health Liaison Officers (MHLOs) but have yet to make the most of the opportunities that this provides. As a project board we are committed to ensuring that the opportunities for joint training are maximised and users are involved in developing and delivering training to police officers and other service deliverers.

We recommend that:

R18   **The MPS further raise the profile of the role of the borough MHLO within the organisation.**

R19   **A key function of the MHLO should be to proactively develop relationships with local user groups and voluntary organisations. Performance management mechanisms will need to be developed to monitor this.**

R20   **The MPS puts in to place a comprehensive training programme aimed at ensuring that all officers have an appropriate level of awareness of mental health and illness to enable them to deliver more effective services to people with mental health support needs. This should be developed with, and involve a diverse range of service users and where possible partner agencies.**

R21   **Local partnerships develop joint training opportunities such as scenario based workshops, particularly where practitioners are engaged in delivering services together.**

R22   **Partner agencies develop training programmes aimed at ensuring staff are aware of the role of police and their responsibilities. Likewise the MPS should ensure that its officers understand the roles and responsibilities of partner agencies.**

R23 **All training programmes are subject to an equality impact assessment to ensure that they identify and address the needs of service users from different communities in London and that they avoid perpetuating the stigma attached to mental illness.**

R24 **The MPS, NHS and other partners continue to explore the benefits of good practice models identified (such as the American models (see main text for detail)), with a particular focus on the context in which they are delivered and how this could be applicable to improving the quality of service delivery in London.**

Communication, Confidentiality and Information Sharing

Poor information sharing and communication breakdowns between statutory agencies are often cited as contributory factors in homicide inquiries. It is a complex subject and is often identified as a barrier to effective interagency partnerships. It is also a key concern for service users. We have identified improvements to communication and information sharing, whilst recognising the challenges involved.

We recommend that:

R25 **There should be a clear policy statement from a pan-London alliance that confidentiality will be respected, information will only be shared when it is either in the best interests of the individual or there is a concern for public protection and information will only be used for the purpose for which is being shared. We recommend that there will be regular data cleansing in recognition that people's mental health status can change and improve. Systems and processes will need to be developed in order to achieve this.**

R26 **There is a need to clarify the legal framework, for example using case studies, making it easier for practitioners to understand the circumstances within which information should be shared.**

R27 **Where possible (and we recognise that this isn't always possible), the individuals should be told that information is being sought from/shared with other agencies. The reasons for this should also be explained.**

R28 **The development and promotion of the use of crisis cards.**

During the course of our investigations it became clear that effective information sharing and communication is as much about the relationships between agencies as it is about the legal framework. This is particularly true in relation to sharing information outside 'crisis' situations. The board agreed that safer neighbourhood teams provide an excellent opportunity to establish local links with Community Mental Health Teams (CMHTs) and others (e.g. GPs) and that it would promote this approach. It is also clear that these teams could also provide a conduit for individuals accessing local services. However, we would caution in a number of areas:

- Local communities can be intolerant of mental illness. Safer Neighbourhood teams will need to balance providing an adequate response to local concerns with ensuring the rights of the individual concerned are respected and that their needs met.

- Information sharing at this level can be quite informal, and therefore safeguards need to be in place to ensure users' interests are protected. There is a risk that there could be problems with gratuitous information being shared.

- Whilst there is much to be learnt from the Multi-Agency Protection Panel Arrangements (MAPPA) processes, local networks at this level must avoid making the link between mental illness and dangerousness (a key characteristic of MAPPA), particularly in relation to people from black and ethnic minority communities.

We recommend that:

R29   All agencies hold accurate lists of key staff in partner agencies, along with their roles and responsibilities and that arrangements are established for ensuring that they are kept up to date.

R30   Locally based networking is facilitated though Safer Neighbourhood teams and CMHTs aimed at ensuring appropriate responses to individuals who appear to have mental health support needs.

R31   Borough arrangements are formalised to reflect good practice.

The management of violence

There is widespread misunderstanding about the prevalence of violence amongst people who are mentally ill. However, in a small minority of cases, violent behaviour needs to be managed.

We recommend that:

R32   The whole systems approach to reducing violence on wards identified in this review is shared as good practice with Trusts across London.

R33   Multi-agency work is taken forward to gain a better understanding of joint risk assessment and that lessons learnt and good practice are shared across London in a coherent and co-ordinated manner.

Implementation

In the recommendations in this report, the project board underlines its commitment to working together to ensure that the implementation programme is carried forward. We also acknowledge that we may need to dedicate resources to ensure this is implemented. The MPA will receive regular updates with an equivalent mechanism at the NHS through an existing London-wide panel. This plan will be monitored by a joint implementation group.

Section 1   Introduction

The Metropolitan Police Authority (MPA) is the independent statutory body responsible for maintaining an effective and efficient police service for London. Its primary tasks include securing continuous improvement in the way policing is provided in London, monitoring the performance of the Metropolitan Police Service (MPS) and consulting with the people of London.

In July 2004 the MPA's Co-ordination and Policing Committee considered undertaking scrutiny of policing and mental health. The committee felt that the scope of the issue to be addressed was too broad to be managed within the MPA's usual scrutiny process and would require the commitment of organisations outside the policing arena in order to make most impact. Members decided to commission a review of mental health and policing to be chaired jointly by the MPA and NHS with the involvement of other key stakeholders.

A project board was established to oversee the review. Its membership was as follows:

MPA

Richard Sumray (Co-Chair)

Reshard Auladin

Kirsten Hearn

NHS

Prof David Taylor (co-Chair)	Chair, Camden and Islington Mental Health and Social Care NHS Trust
Alison Armstrong	Director of London-wide Programmes on behalf of the 5 London strategic health authorities

| Stuart Bell | Chief Executive South London and the Maudsley Mental Health Trust (Chair of the London Mental Health Chief Executives Group until July 2005) |

Greater London Association of Directors of Social Services (GLADSS)

| Vivienne Lukey | Director of Specialist Services, Westminster City Council |

MPS

DAC Brian Paddick, Association of Chief Police Officers (ACPO) lead on Mental Health, MPS

Additional advice support and guidance has been provided by:

David Grant, Mental Disorder Programme Manager, MPS

Bruce Frenchum, Mental Health lead, Strategic Disability Team, MPS

Peter Horn, London Development Centre for Mental Health

Linda Van Den Hende, Director, Strategic Disability Team, MPS (retired March 05)

Scope and objectives

The joint review sought to add value to the MPS and NHS response to mental health related problems and develop closer links with partners working in this area. This involved understanding the existing pattern of services across London and the relevant working arrangements and organisational cultures in place before deciding which areas to focus on for improvement. In agreeing the objectives outlined here all members of the joint review panel committed their organisations to share information for the purposes of the review and to progress the recommendations of this final report.

The objectives of the joint review were to:

- Identify potential improvements in current services and facilities delivered by the MPS, NHS and other stakeholders to improve the safety, security and quality of care provided to people with mental health support needs.

- Identify communication channels and information gathering and exchange processes between agencies including any established protocols with a view to assessing how they could be improved.

- Explore lessons learned from recent cases, which may not have been handled appropriately, as well as examples of innovative practice to develop recommendations for improvement.

- Identify areas in which changes in process or policy would benefit service users and eliminate discrimination, particularly for key groups such as young black men, who may be experiencing more problems accessing mental health services, particularly where dual diagnosis is an issue.

- Clarify the human rights issues relevant to both public protection and individual mental health service users.

- Elucidate the myths and realities around the predictability of behaviour and claims that a proportion of violent and related undesired events associated with mental health problems could be avoided proactively.

- Create an action plan to address the issues identified, using the suggestions for improvement developed through consultation, including identified leads, deadlines and completion measurements and a monitoring system to track improvements.

Key exclusions

We recognise that people with mental health support needs are far more likely to have contact with the police as victims of crime. However, we have concentrated on those who come into contact with police either because the symptoms of their illness indicate they, or other people, are in need of protection or because they have committed a crime. We have done this because this is where we believe there greatest gains are to be made by a joint project board of this type.

The project board recognised at an early stage that in order to achieve the objectives set out above, it would need to place some limitations on the areas it would cover. The following areas were excluded:

- The availability of mental health services. This recently the subject of a review by the Greater London Authority (GLA) called 'Availability of Mental Health Services in London'. In addition, the subject of housing and mental health was explored by the GLA in July 2003 its report published as 'Getting a Move on - Addressing the housing and support issues facing Londoners with mental health needs'.

- The subject of restraint was not covered in depth as it has already been explored by an internal MPS review of restraint practices (published in September 2004). The joint review considered the recommendations and learning from that review.

- The review has not considered young people as a separate entity. However, we do believe there is a piece of work to be done to ensure that young mental health service users receive the level of care and support they need when they come in to contact with the police.

- We acknowledge that people with learning difficulties have support needs when coming into contact with the police. However, we believe these should to be distinguished from mental health support needs and therefore dealt with separately.

Section 2   Context

1.   The report 'Mental Health and Social Exclusion' published by the Social
        Exclusion Unit in the Office of the Deputy Prime Minister reported that
        "Depression, anxiety and phobias can affect up to one in six of the
        population at any one time'[1] although serious mental health problems
        such as schizophrenia only affect one in one hundred adults each year."

2.   The vast majority of people with mental disorders receive treatment
        voluntarily. Only around 10% are admitted to hospital on a compulsory
        basis under a 'section' of the Mental Health Act.[2] However, in London the
        rate of admission is twice that of the rest of the country. There are a wide
        variety of mental health disorders ranging from mild depression to
        illnesses like bi-polar disorder and schizophrenia, which are more likely to
        lead to contact with the police if left untreated.

3.   The GLA report 'Availability of Mental Health Services in London'
        published in 2003 found that the level of service provided to treat people
        with mental health disorders varied greatly across London:
        "The patient mix in London's mental health services includes much higher
        numbers of patients from more deprived areas than the rest of England. It
        has higher proportions of patients with psychotic illness and alcohol
        related problems... Standardised admission levels vary considerably
        between boroughs.... There is significant variation in the level of resources
        put into mental health in different boroughs".[3]

4.   Some sections of the community experience particular difficulties in
        accessing mental health services. The report Inside Outside, found that
        "There are significant barriers to minority ethnic groups seeking and

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[1] Page 9 Mental Health and Social Exclusion report, ODPM, published 2004
[2] From 'The Mental Health Act' at www.rethink.org
[3] Page 1 Availability of Mental Health Services in London, Greater London Authority August 2003

successfully accessing services...There is greater involvement of the criminal justice system, and in particular the police"[4].

5.   In addition, there is some evidence to suggest that drug and/or alcohol abuse may be related to underlying mental health problems and may play a role in triggering mental health disorder.[5] A study managed by the then NHS Executive stated that "Approximately half of the people who are treated for drug and alcohol problems have a complicating mental health problem"[6] A study carried out for the Home Office showed that people who are brought into police custody with alcohol related offences spent considerably longer in cells than other detainees[7]. This dual diagnosis presents police with a situation in which people with alcohol related mental disorders are spending extended periods of time within police custody, rather than in a treatment facility.

6.   Services aimed at treating and managing mental health, are provided principally by the NHS, in a multi-disciplinary approach with social services. The police are involved in some instances. Whilst in the vast majority of cases, agencies work well together, there are occasional high profile tragedies which result in homicide inquiries. An analysis of the findings of these inquiries[8] found there were common themes:

- Poor risk management
- Communication problems
- Inadequate care planning
- Lack of interagency working
- Procedure failures
- Lack of suitable accommodation
- Resources

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[4] Page 13 Inside Outside Improving mental health services for Black and Minority Ethnic Communities in England. National Institute for Mental Health in England, March 2003
[5] See SANE website factsheet: Alcohol, drugs and mental illness
[6] Page 19 Mental Health in London: A Strategy for Action, distributed by the NHS Executive
[7] Home Office report 178 Dealing with alcohol–related detainees in the custody suite, published 2002
[8] MIND, May 1999. Key issues from Homicide Inquiries

- Substance misuse

- Non-compliance with medication

- Involvement of carers

- Issues relating to ethnicity, culture and diversity.

7. Whilst some of the issues raised are beyond the scope of this review, we have tried to address some of the challenges put forward by these inquiries including risk management, communication, lack of inter-agency working and issues of race and diversity.

Myths and Realities

8. At the outset of this work the project board was clear that it did not want to perpetuate the myths related to mental illness. In order to do this we identified that we needed to elucidate those myths and realities particularly around the predictability of behaviour and claims that a proportion of violent and related undesired events associated with mental ill health could be avoided through being proactive.

9. We also recognise that we have an obligation to take a lead in challenging the preconceptions and myths that have developed in relation to mental illness.

10. The most commonly held belief about people experiencing mental illness is that people with mental health support needs are likely to be violent, particularly in respect of people with a diagnosis of schizophrenia. There is also a widely held belief that those with mental health support needs, again particularly schizophrenia diagnoses, are likely to be murderers. There is no evidence to support either of these views.

11. The relationship between violence and mental illness is complex, but there is only very limited evidence to indicate that people with mental health support needs are any more violent than the general population. There are no reliable statistics in this area so it is difficult to dispel the myths that have developed. However although there is a slightly higher frequency of violent behaviour amongst people who are diagnosed with schizophrenia,

patients who also misuse drugs and alcohol are more likely to be violent (suggesting that those who do not are no more violent than the general population)[9]. Furthermore, according to a study carried out in the United States in 2000, although delusions associated with psychotic disorders can lead to violence, they do not increase the overall risk of violence in sufferers in the year after hospital discharge.[10]

12.   This is significant as this myth impacts on the approach taken by police officers and others when dealing with people who have mental health support needs and therefore presents an educative challenge to service providers. Most police officers would only knowingly interact with people with a severe mental illness during a crisis. They may not understand therefore that many of these illnesses are episodic and that people with these illnesses experience considerable periods of well-being. Such misunderstandings can foster myths and stereotypes. It is crucial therefore that programmes are in place to de-stigmatise mental illness (this is discussed in more detail below).

13.   We discussed this issue with users who told us that they felt the approach taken by the police was often based on an assumption that the person was going to be violent. They also told us that one of the hurdles to breaking down the stigma they experience from the police is that interaction with them tends to be at times of crisis and is therefore negative. This must also be contextualised for black and minority ethnic communities, who have well-documented experiences of stigma and discrimination. Any educative programme will need to reflect this.

14.   We also heard from Professor Graham Thornicroft about stigma. He has undertaken research that supports the views outlined by users above. For service users this is a very stigmatising assumption and one that policy makers need to address, as it undoubtedly has a profound impact on the quality of service delivered.

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[9] Royal College of Psychiatrists "Changing Minds"
[10] Violence and Delusions: data from the MacArthur Violence Risk Assessment Study. Applebaum et al April 2000, American Journal of Psychiatry 157:566-572

15. As noted above, one of the myths perpetuated in respect of mental illness, particularly in the context of psychotic disorders, is that there is a greater threat to life. Again, there is very little (if any) evidence to support this assertion. Analysis carried out by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness demonstrated that key factors in "stranger" homicides (i.e. where the victim and perpetrator are unknown to each other) are more likely to be historical misuse of drugs and alcohol, rather than a history of mental disorder. Furthermore, between 1967 and 1997 the number of homicides increased, those where mental health was identified as a factor (i.e. where the sentence was a hospital order rather than a prison sentence), remained static.

16. In his presentation to the board, Professor Thornicroft informed us that in fact where mental health is a factor in a homicide the diagnosis is more likely to be depression than a psychotic illness.

17. One issue that was repeatedly raised through our investigations was the role of the press in perpetuating some of these myths. Professor Thornicroft, in his presentation to the board quoted some analysis undertaken by a media monitoring unit in Scotland, which found that up to 75% of coverage of mental health issues, related it to violence. Far too often, when tragedies occur, 'sources' are quick to claim that the alleged perpetrator has had contact with local mental health services. This provides no context as to whether the person was ill at the time of the attack, and is clearly a breach of that person's confidentiality. This is not to say that these issues do not need to be discussed at the right time and there is an inquiry process in place aimed at addressing any systemic failures in the care delivered to an individual found guilty of homicide.

18. We are aware that the MPS has drafted a policy statement aimed at ensuring this will not happen, but it is not clear when this will be implemented. It is also not clear that it has been shared with partners across London. The project board would suggest that the MPS should go further and publicly state that it is unacceptable for such information to be

disseminated. We also recommend that health and social care statutory agencies (e.g. NHS Trusts and local authority social services) need to acknowledge its responsibilities, to protect the public from the risks associated with the behaviour of a small minority of people with atypical mental illnesses where it is possible to do so.

19. We said at the outset of this process that we would aim to identify areas in which changes in process or policy would benefit service users and eliminate discrimination, particularly for key groups such as young black men, who may be experiencing more problems accessing mental health services, particularly where dual diagnosis is an issue.

20. There has been considerable research done in to the quality of service delivery by mental health services to black and minority ethnic (BME) communities, most of which finds that BME communities are badly served. Professor Thornicroft considered this in his presentation. In summarising the research he told us that evidence indicates that BME users (mainly African Caribbean, but also African):

   • Have more complex pathways to care although not necessarily longer periods of untreated treatment

   • More contact with police on the road to psychiatric care

   • High rates of compulsory treatment

   • Higher rates of onset of psychiatric disorders

   • Higher rates of admission to medium secure

   • Higher rates in high secure units

   • Higher suicide rates in younger men with psychotic disorders.

   He also noted that there is less satisfaction with treatment (particularly amongst services users with psychosis).

21. He went on to say that the literature tends to describe the problem, with little focus on successful interventions. There are, however some examples of more appropriate interventions and guidance with regard to BME communities. The Cares of Life project in Peckham is one such example. It uses a community development approach, which involves

training lay people from the African and Caribbean communities to work directly with people from these communities who have mental health support needs. The GLA has produced a report 'A Blueprint for Action' (a summary of this is attached to this report at appendix 4) which outlines a set of recommendations aimed at addressing some of these issues. Furthermore, following the publication of the NIMHE[11] report 'Inside Out', there is considerable activity in the NHS aimed at addressing the needs of BME service users.

22. One additional point made by Prof Thornicroft that the project board wishes to highlight is that there is significant evidence of substantial mis-recognition of behaviours that may be congruent in certain cultural contexts by both police and health professionals. We therefore urge partners to ensure training and awareness programmes highlight these issues and are subject to full equality impact assessments.

23. We discussed the issue of 'multiple stigma' with both BME and Lesbian, Gay, Bisexual and Transgender (LGBT) service users in order to identify whether they felt they received different treatment on the basis of race or sexuality. They told us that it was difficult to identify the basis of the stigma. This was backed by Professor Thornicroft who told us that international research shows there are generally high levels of ignorance and discrimination regardless of the composition of local populations.

We recommend that:

R1   Multi-agency partners ensure training and awareness programmes highlight the need to eliminate discrimination and stigma to all communities and that all programmes are subject to full equality impact assessments.

R2   Partners work with BME and LGBT users groups in order to establish best practice in service delivery to these service users.

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[11] National Institute of Mental Health Excellence

R3   *The MPS develops an awareness programme aimed at de-stigmatising mental illness and dispelling the myths of the links between certain types of mental illness and violence. This should be championed by the MPS leadership.*

R4   *The MPS and the NHS agree and apply a joint media strategy that will minimises the extent to which the press report on the mental health status of people accused of serious violent crimes including murder. Such a strategy should also aim to minimise the negative reporting on mental illness and the occurrence of violent crimes and murder.*

Section 3   Key interfaces

Introduction

24.   There are a number of situations that can lead to police involvement with people with mental health support needs, and many of these interactions will involve other statutory agencies such as social services and psychiatric services. These can include amongst others.

- Removing somebody from a public place for their own safety or the safety of others using section 136 of the Mental Health Act 1983 (s136), and taking them to a 'place of safety'

- Accompanying approved social workers and doctors to a person's home to undertake a Mental Health Act assessment (s135)

- Dealing with assaults against staff and patients on mental health wards

- Working in partnership to reduce re-offending of people with mental health issues.

25.   This section identifies those interactions as they take place at present, and considers how, using the information we have learnt during the review process, they could be improved.

Strategic Overview

26.   Arrangements for delivering services to people with mental health support needs varies greatly across London, not least because of the number of organisations involved. Whilst the MPS is pan-London, its 32 boroughs have local agreements with social services, mental health trusts and other health bodies. A further consideration is the transitory nature of Londoners, in terms of both working and living across boroughs.

27.   Currently there is very little overview of arrangements or leadership at a strategic level. The Mental Health Partnership Board, with representation from health, social services, MPS, probation and London Ambulance Service was established in order to oversee the Risk Data Sharing Project

Pilot and a series of multi-agency protocols setting out minimum standards to enable more effective partnership working around key issues such as carrying out mental health assessments on private premises. However, it is not within the Partnership Board's remit to make strategic decisions on behalf of their representative bodies.

28.   The chief executives of the 11 mental health trusts in London meet regularly and work collaboratively to address issues as they arise. They have worked with other partners, particularly through the London Development Centre to address for example the protocol for section 135 assessments on private premises and work with Multi-Agency Public Protection Agreements (MAPPA)[12] across London. The MPS is invited to this meeting, but involvement of other agencies is limited. There may be scope to develop this further.

29.   The project board heard throughout its investigations about the competing objectives of agencies involved and the limitations this puts on effective partnership working. Examples of this include four hour waiting time targets in Accident and Emergency (A&E) and the difficulty of arranging a mental health assessment within that period, and the need for police officers to deal with incidents as quickly as possible which may result in poor handover arrangements or in people being taken to a police station instead of the locally designated place of safety. Where we found examples of effective multi-disciplinary approaches, shared ownership of key targets was considered central to its success.

30.   This was supported by the findings of the Mental Health Summit[13] held in London in January 2005. The project board supports the conclusion of this summit that stated that "agencies need to translate their commitment to common goals in mental health into practical, joined up services."

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[12] Introduced by the Criminal Justice and Court Services Act (2000), these are multi-agency panels whose role is to manage the risks posed by dangerous offenders who have been released from imprisonment, key to this is a two way information sharing process.
[13] This conference was facilitated by the Centre for Excellence in the Governance of London and attended by a cross section of London's public, independent and voluntary sector organisations.

31. We are aware that work has started on developing a 'Strategic Framework for Mental Health and Wellbeing in London' and includes key partners such as the MPS, London's NHS and the GLA. Again, this may provide an opportunity or forum for reaching collective decisions and implementation commitment on London's mental health and policing issues.

32. Whilst gathering evidence for this review, we looked to other sectors where multi-disciplinary approaches are key to delivering effective services. We heard evidence from Hannah Miller, Director of Social Services at London Borough of Croydon and GLADSS representative on the Pan-London Child Protection Committee. We were interested to learn from their experience.

33. Child protection has experienced difficulties in recent years, with some high profile tragedies such as the death of Victoria Climbié. There was a clear need to demonstrate that agencies were working together to minimise the risks of another tragedy in order to restore public confidence in the system. The response across London was to establish a Pan London Child Protection Committee, which provides leadership at a senior level across all organisations. The committee agreed to the development of pan-London procedures in recognition that the issue does not respect geographical boundaries, there is considerable mobility within London and there is limited co-terminosity between statutory agencies. The committee has a tight focus on core issues, it considers learning from good practice as important but also learning from mistakes and is proactive about addressing challenges as they arise.

34. The delivery of timely, appropriate and safer services for people with mental health support needs, and those around them, has to be a higher priority for all agencies than is currently the case. It is clear from our investigations and consideration that the establishment of a strategic, pan-London alliance, focusing on mental health and involving all the key agencies, will be of great benefit in achieving more positive outcomes,

setting direction, and providing recognisable and coherent leadership to those working at an operational level.

35. That is not in any way to take away from the importance and value of strengthened relationships at a local (borough) level, where named people/postholders working together can do much to improve the quality of what can be delivered. Several of our later recommendations e.g. on training, understanding respective roles, consistent delivery using protocols, and review, are only likely to be effective if owned at the more local level as well as strategically.

We recommend that:

R5 *A pan-London alliance is established whose remit includes providing strategic leadership to the activities of partner organisations and aims to achieve ownership of shared objectives and outcomes. This could also provide a vehicle to drive forward the recommendations in this report.*

R6 *Leaders of police, health and social services and local government, in London should convene annually as a matter of course to discuss the health challenges facing London, including mental health. This could provide direction and leadership to the pan-London alliance recommended above.*

R7 *Partners maintain the links developed through this joint review with key stakeholders (such as the reference group who provided on-going support and guidance to this project board). This could include deliberate engagement to provide a mechanism for monitoring implementation of the recommendations in this review.*

Detaining a person for their own or other people's safety

36. Section 136 of the 1983 Mental Health Act gives police powers to remove a person to a place of safety if they appear to be suffering from a mental disorder and in need of immediate care and if the officer thinks that removal is necessary for the safety of that person or for the protection of others.

37.   A place of safety is defined in the Act as:

- Residential accommodation provided by a local services authority

- A hospital as defined by the Act

- A police station

- A mental nursing home or residential care home for mentally disordered persons

- Or any other suitable place "the occupier of which is willing temporarily to receive the patient".

38.   The Act is underpinned by a Code of Practice (revised in 1999), which states that each local authority area should have local agreements between health, social services and the police about the use of the power. Amongst other things, this should identify the locally agreed 'place of safety'. It also states that as a general rule "it is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital rather than a police station". In London, local protocols are based on a pan-London protocol developed by the London Development Centre for Mental Health with support from agencies across London. This protocol was piloted in a number of boroughs before being rolled out across the city.

39.   The pan-London protocol underlines the Code of Practice and states that it is preferable people detained using this power are not taken to a police station.

40.   We analysed 19 of the protocols that have been drawn up across the 32 London boroughs. This analysis identified that the locally designated place of safety varied depending on local circumstances. In most cases it is located within an acute mental health unit. Those that did not have a dedicated mental health unit, identified specific units within acute hospitals. Only one of the protocols reviewed makes specific reference to a police station, stating that if a crime has been committed or if the individual is (potentially) violent, then they should be taken to a police station, where a doctor and if necessary an approved social worker should

be called. The quality of these protocols also varies greatly. Consideration should be given to whether there is good practice to be drawn from them and shared across London.

41.   Our investigations indicate that in practice police stations are still used as places of safety and there are a number of reasons for this, principally that there are limited places available in mental health units and that the designated place of safety is not necessarily easily accessible by local police (e.g. not in the local borough).

42.   There are circumstances where police are directed not to use the locally designated place of safety. Following the tragic death of Roger Sylvester, the MPS (on the advice of the Police Complaints Authority [PCA])[14], police officers were directed to take people suffering from "acute behavioural disorder[15]" to A&E. This directive was implemented with no negotiation or consultation with A&E departments in London.
        (it should be noted that the existence of this syndrome is disputed in medical circles – however, we have used the term here as we are referring to policy guidance)

43.   Throughout the review we found there were weaknesses in current practices.

44.   Many of the service users with whom we spoke as part of the review told us about their experiences of the police, including being taken to police stations as part of a s136 detention. Some of the people we spoke to felt that they had been sympathetically treated by officers, but there were others who had less positive experiences. They raised a number of concerns:

    •   Being taken to a police station, and particularly placed in a police cell can be extremely frightening, compounding feelings of fear and

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[14] The PCA no longer exists, its role is now undertaken by the Independent Police Complaints Commission (IPCC). The IPCC has not rescinded this guidance.
[15] The PCA guidance indicates that the main features of this extreme state are a period of agitation, excitability, perhaps paranoia, coupled with great strength, aggression and non-pain compliance. Sudden collapse and death may follow.

paranoia caused by their illness. This is often exacerbated by the use of restraints (handcuffs).

- Users believe it criminalises their illness.

- Police cells do not feel safe

- They have no access to family or friends (this was particularly raised by some of the younger service users we contacted).

- Users often didn't have an understanding of what was happening to them and felt they were not kept informed during the period of detention.

45. Independent Custody Visitor Panels were invited to respond to the issues raised in our terms of reference. In their view:

- Limited availability of social workers and FMEs with adequate skills means vulnerable individuals are detained for too long and places an unnecessary burden on the police.

- Custody visitors need awareness of potential mental health issues so that they can ensure appropriate action is being taken.

46. During the review we held a workshop with frontline practitioners from the key services involved in delivering services to the mentally ill. This included police officers, ambulance staff, an approved social worker, a consultant psychiatrist and a FME. The aim of the session was to identify the challenges that they faced on a day-to-day basis and to think about how these could be solved. They raised a number of issues in relation to s136.

- Police and ambulance staff found that patients were not accepted by hospital staff (A&E) because the patient had been taking drugs or alcohol (mental health assessments cannot be completed if a person is intoxicated). This creates a problem as police officers are not currently allowed to transfer patients, following an initial conveyance.

- There are delays in accessing appropriate support (section 12 doctors and Approved Social Workers [ASWs]) if a person is held at

a police station (we were told that a person already detained may be less of a priority than someone who is in the community).

- Police officers lack adequate training to make good choices about where people should be taken.

- A&E staff may not accept patients particularly when they are violent, creating a dilemma when police officers are following guidelines.

- The time taken to convey patients and hand them over to hospital staff can be considerable, and can cause significant abstraction from normal duties (this can be compounded when the locally designated place of safety is not within the borough).

- Handover arrangements between agencies are inconsistent.

47. We are aware that the MPS and London Ambulance Service (LAS) are developing an agreement on roles and responsibilities in a number of areas, including transporting patients being detained under s136 by ambulance to hospital (unless they are violent).

48. We also heard from a consultant liaison psychiatrist, Dr Hodgkiss who works in a busy inner London acute hospital. Whilst accepting that police stations are unsuitable, he told us A&E also has serious limitations. These include:

- They are public places and as such patients who are considered to be at risk are free to leave (i.e. it is not possible to contain people)

- The physical environment is not appropriate for behaviourally disturbed and or intoxicated patients (equipment, chairs, cabling etc.).

- Excessive noise can be distressing for other patients.

- There are not enough adequately trained staff to deal with patients should they become violent (again creating problems in relation to police guidance).

It was also clear from his evidence that the introduction of local protocols may not have been effectively communicated to A&E managers.

49. He raised a number of procedural issues that impacted on the treatment of individuals.

- Poor handover between police and health staff
- No confirmation that patients have been searched
- Not always clear under which powers a patient has been brought to A&E
- No agreement between hospital staff (including security) and police that it is safe for the police to leave.

50. He also talked about problems of caring for dual diagnosis patients (i.e. those who have co-morbid substance misuse and mental health problems) who are intoxicated when they arrive at hospital. The hospital in which he is based has a 'clinical decision unit' which allows patients to sober up sufficiently to undertake mental health assessment. However, the availability of units (and bed numbers within them) across London is inconsistent.

51. Mental health units with section 136 rooms would appear to be the most appropriate accommodation for a person in distress who is waiting for a mental health assessment as trained staff are readily available to undertake assessments and provide care as necessary. However, as noted above there is limited availability in London. There are also drawbacks with their use, including the inability to meet the needs of patients who are struggling from being restrained by staff and need to be protected for their and others' safety (access to resuscitation equipment and life support teams is required) and a lack of capacity to address other immediate medical needs. Users also told us that while they were often better than police cells, they were often poor environments to spend considerable amounts of time in.

52. In investigating this issue, the project board looked for examples of good practice. There are units in London, such as the emergency assessment unit at Chase Farm Hospital in Enfield. However, these are not widespread, and have required considerable investment.

53.   Not all countries treat people with mental health disorders in the same way. A specialised police response to people in mental health distress based on the creation of Crisis Intervention Teams was devised in Memphis, and developed elsewhere in North America (e.g. Seattle and Ontario). The Memphis model was evaluated by the MPS restraint review project team. One of the key innovations in these schemes has been access to mental health treatment. Patients cannot be refused by the facility and police officers return to duty within around 15 minutes. The model has been adapted to fit local circumstances and has been credited with a reduction in the number of officer and civilian injuries as well as better services for users and greater partnership with mental health service providers.

54.   It is clear from our investigations that all agencies face challenges in operationalising section 136 and that London is struggling to meet its obligations under the Code of Practice. The project board agrees that people who are detained under section 136 should not be taken to police stations. As a starting point it is our belief that all agencies should be working to ensure the quality of environment where individuals are detained is respectful and able to meet the needs of that individual.

We recommend that

R8   In the short term:

- *Current s136 agreements in each borough are reviewed to ensure they address the following:*
    - *Identifying a place of safety that meets the requirements of the code of practice and the pan-London protocol, and is operationally conducive to local working arrangements (this may require a culture change from some organisations)*
    - *Addresses how s136 detainees who also appear to be intoxicated should be dealt with*
    - *Identifies designated health facilities best able to meet the immediate needs, including those which concern issues of*

> > *diversity, of people who are extremely agitated and in need of restraint for their or other people's safety*
>
> > ▪ *Outlines handover procedures so that all necessary/relevant information is passed on to clinical staff*
>
> • *Auditing processes are developed to ensure the implementation of s136 is evaluated and lessons learnt on an ongoing basis (as per the Code of Practice).*

R9 Agencies work together to develop appropriate s136 accommodation across London. This should include making joint bids for capital money such as the funds recently announced by the Department of Health (Oct 05). In our view, the ideal would be an assessment centre that can address all needs of people experiencing crisis including:

> • *Mental health assessment*
> • *Restraint and violence including the capacity to resuscitate*
> • *Medical triage*
> • *Capacity to address the needs of people whose crisis could be caused by either mental illness or substance (including alcohol) misuse.*

R10 The MPS and NHS work with government departments to develop good practice on identifying the ideal place of safety.

Undertaking assessments on private premises

55.   Section 135 of the Mental Health Act allows magistrates, at the request of an Approved Social Worker (ASW), to issue a warrant authorising a constable to enter premises and remove a person to 'a place of safety'. This is generally used when an ASW believes it is necessary to undertake a Mental Health Act assessment of somebody living in the community. Police officers are often asked to accompany ASWs if they believe that the individual has the potential to be violent or there may be problems entering the premises.

56.   Although a pan-London protocol was developed alongside the s136 protocol discussed above, it was not clear that it had been consistently or effectively implemented. The London mental health chief executives group, London Development Centre for Mental Health, MPS and the Greater London Association of Directors of Social Services (GLADDS) have been working together to address this. This work reviewed the protocol and recommended minor changes. It also concluded that the key agencies need to establish the means to collectively monitor implementation of the protocol.

57.   Some of the service users that we spoke to as part of the review told us about their experiences of the use of s135. They raised a number of concerns.

- Police officers attending assessments in uniform can send the wrong message to both users and their neighbours (we were told of instances where users escaped out of back windows or doors).
- Police behaviour can be 'overbearing and officious' and too often resorts to using handcuffs.
- Police can lack discretion when talking to neighbours.

We recognise that in certain circumstances it is entirely appropriate that officers attend these instances in uniform, but consideration should be given to this during the risk assessment process.

58. The use of s135 was discussed at length during our practitioner workshop. A number of challenges were put forward:

- There is limited understanding between the agencies about the role of others.
- There are frustrations about organising the assessment
- There is limited shared understanding of terminology and risk.

59. We were also told by a consultant forensic psychiatrist that in the borough in which he works, they are faced with the perverse situation that the more risk an individual is thought to pose, the longer it can take to arrange an assessment, particularly if the risk assessment shows that the person may be violent and police resources need to be brought in from elsewhere.

60. The project board fully supports the risk assessment process and is clear that it should be continued (notwithstanding the problems identified by practitioners). However, it is also clear that delays in undertaking assessments are not in the best interests of the individual concerned or the wider community, whose interests practitioners seek to protect.

61. The issues raised with regard to shared understanding between agencies are discussed in more detail below.

We recommend that key stakeholders:

R11 *Formalise the adoption of the revised s135 protocol and develop joint arrangements for monitoring the implementation of agreed arrangements.*

R12 *Ensure a timely evaluation of the revised protocol (the emphasis should be in following up the recommendation of the multi-agency review).*

The Criminal Justice System

62. We believe it is inappropriate that people with mental health support needs, who need to be detained for their own or other people's safety, are held in a police station. We recognise however, that when people with mental health support needs have been arrested on suspicion of committing a crime, detention in a police cell may be appropriate.

63. In our view there are two areas that require consideration in these circumstances. Firstly treatment during detention and then decisions about whether charges should be brought against people with mental health support needs who have allegedly committed crimes.

Treatment during detention

64. Dr Hilary Guite presented the board with the findings of a project she led on behalf of the Director of London-wide Programmes, which aimed to identify a prison interface care pathway. She found that if mental health needs are identified at point of arrest, the number of clinical assessments made prior to in-patient care is one to two and it takes less than 36 hours to access appropriate care. However, if care needs are identified after a perpetrator is sent to prison, the average number of clinical assessments is between seven and nine, and accessing care can take up to three months (sometimes longer). It is important then that processes are in place to ensure care needs are identified at an early stage.

65. The MPS have standard operating procedures (SOPs) in place for the management of detainees in custody. These contain a section on mental health needs. It is MPS policy to provide fair treatment that has regard both to human rights and individual need. It also states that treatment will be proportionate, legal and accountable and based on the best information available. The SOP instructs custody officers to access FME and ASW assistance.

66.   On arrival at custody, detainees are asked about physical and mental health needs including whether they are taking medication and whether they have ever attempted to self-harm, and it is then up to the custody officer to ensure that appropriate support (usually an FME and an appropriate adult) are made available. A record is kept of the responses and custody officers are directed to access medical support, even if the detainee has indicated otherwise, but the custody officer has any doubts about their medical or mental condition.

67.   Police officers and FMEs who participated in our workshops reported that there is a shortage of doctors who have specific mental health training and accessing ASW can cause considerable delays. This was echoed by the responses from Independent Custody Visitor Panels.

68.   Evidence from the Criminal Defence Service (CDS), part of the Legal Services Commission, submitted as part of this review, indicated that whilst defence solicitors are well placed to identify any mental health issues, it is not clear whether many have the skills to do so.

69.   Feedback received from the Independent Custody Visitor Panels indicated also that they had concerns about the availability of appropriate adults to sit with mentally ill detainees during their interviews.

70.   The project board supports the work being undertaken to improve the assessment of the health needs of mentally ill detainees. However, until the issues outlined about accessing appropriate professional expertise are addressed, it is not clear how the situation will improve. It should also be noted that we recognise the MPS commitment, expressed in the outcomes of the service review to modernising its custody estate and the services delivered within it[16].

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[16] The Service Review was a fundamental review of the organisation. One of the recommendations was modernise the custody estate by moving to large purpose built custody suites. Intrinsic to these recommendations was the commitment to build on the experiences of the MPS and others in ensuring 24hr access to medical expertise e.g. though the use of custody nurses.

We recommend that:

R13   The MPS ensures that mental health is given a high priority within the requirement of 24 hours training per year that FMEs are required to undertake.

R14   In order to reduce the amount of time detainees spend in custody, agreements are established with mental health services to ensure that ASW attendance will be timely.

R15   That agencies work together to improve the availability of Appropriate Adults.

Charging

71.   A decision about whether a person should be charged for a crime they are alleged to have committed is generally made on the basis of two tests. Firstly the weight of evidence and secondly on whether it is in the public interest to proceed. The CPS code of practice states that decisions to prosecute also consider the impact it could have on the person's mental state. Their guidance refers to the Home Office circular 66/90, which suggests other avenues such as diversion to hospital or support in the community should be considered. However the guidance also states that that if the offence is part of a pattern of behaviour, prosecution may be appropriate as a way of ensuring the patient accepts responsibility for their actions.

72.   Analysis from homicide enquiries has shown there is often a history of offending behaviour, which has not been addressed. Research also indicates that the charging thresholds are much higher for those with mental illness, indicating there is some reluctance to charge individuals who have a mental illness[17].

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[17] E.g. Entry into the Criminal Justice System: Survey of Police Arrests and their Outcomes. Phillips and Brown

73. We heard evidence from a number of sources about whether action should be taken against mentally ill people who have offended. Professor Genevra Richardson (Professor of Public Law at Queen Mary College, London) suggested that a starting point could be that the individual concerned has the right to be treated in the same way as everybody else, which presumes that they will be taken through the criminal justice system. She also suggested that there is a need to establish a record of what had happened. Our reference group endorsed this position, noting that having the full facts could enhance the care and treatment received by the individual concerned. This supports the view of a consultant forensic psychiatrist, who told us that a risk assessment can only be as good as the information available.

74. There are further considerations for example offending behaviour is not necessarily a direct result of mental illness and therefore should not be treated as such. Also, victims should be able to see that justice is being served.

75. We identified early on that the willingness (or lack of) of police officers to take forward allegations of assault against staff or patients who are in in-patient care was an issue. DAC Brian Paddick told the project board that the MPS is developing a range of protocols in order to address this point.

76. In her presentation to the project board Gail Miller told us about the approach being developed by the South London and Maudsley NHS Trust. She explained that the NHS has a zero tolerance towards assaults against staff and that this is undermined if police are not prepared to press charges against the perpetrators. Her multi-pronged approach includes agreement of a charging policy with local police. This policy challenges the assumption that patients are not capable and responsible for their actions. She has also worked with police colleagues to develop a fact file on how the police work with guidance on what to do and who to contact in particular circumstances. It is notable also that she is realistic about the practicability of zero tolerance and suggested that each case should be

treated on its merits. (The issue of violence is discussed in more detail below.) We are also aware that other Trusts are developing good practice in this area.

77. The debate about prosecuting mentally ill offenders is often centred around 'diversion or discontinuance', i.e. should the offender be diverted into the care system with the presumption that that the offending behaviour will be addressed at a later date, or should the case be discontinued. There is considerable evidence that cases against mentally ill defenders are discontinued at a much higher rate than non-ill offenders. The project board has also heard anecdotally that diversion is rarely used as there are very few suitable options.

78. Options such as bail have their place, allowing offenders to have their care needs met before being brought through the criminal justice system. However, processes need to be in place to ensure that that care is delivered (and the suggestion is that PCTs should share accountability for this) and that there is adequate follow-up through the criminal justice system. We are aware that the Health Partnerships (a joint unit resourced by the Home Office and the Department of Health) are undertaking work aimed at developing enhanced pathways for people with mental health support needs in the criminal justice system.

79. Dr Guite's work recommends that local protocols should be agreed between the police, probation services, the Crown Prosecution Service (CPS) and NHS and social care agencies. It also outlines what the policy should cover. The project proposes the establishment of criminal justice officers in each PCT to provide co-ordination between agencies. The project board endorses this work approach.

We recommend that:

R15   If someone with mental health support needs commits an offence, it should be followed up through the criminal justice system. At the same time, it is important their mental health needs should be assessed and addressed appropriately, which may involve diversion to the mental health system.

R17   As part of their approach to reducing violence on mental health wards, Trusts should adopt the approach taken by Southwark police and the Maudsley in developing a prosecution policy and educating staff about how to deal with the police should the need arise.

Skills and training

80.   In order to provide appropriate, timely services, practitioners require knowledge of mental illness and of how to respond in different circumstances.

81.   The MPS gave the overall lead for mental health to Deputy Assistant Commissioner Brian Paddick in September 2004. Responsibility for MPS policy around mental health rests with the Diversity Directorate (DCC4 (6)) although the Territorial Policing Directorate (TP) is responsible for offenders with mental disorders. Specialist Crime Directorate (SCD) units also have some involvement. A Mental Disorder Programme and project team has also been established. Their remit is to "Improve Safety and Service Delivery, so that :

- Our staff will be better informed regarding mental disorder

- Users will receive a more effective service according to their individual needs

- We will have better working relationships with our partners

- The minority of mental health service users who pose a threat to themselves or others will receive enhanced support and management within the community".

82. Each borough has a Mental Health Liaison Officer (MHLO) but the time they have available to devote to mental health varies according to other duties and training. A role description for the MHLO has recently been introduced and a performance needs assessment produced. Regular conferences are held for the MHLOs. The project board endorses the introduction of this role and urges the MPS to ensure that:

- Performance management mechanisms are developed so that consistent service delivery is achieved across the 32 boroughs
- MHLOs are given sufficient training and support
- The role is proactively marketed to all staff.

83. When we spoke to user groups, many were aware that the role existed but found it difficult to identify and contact the individual officer in order to raise awareness about the user group and establish on-going links. This is clearly a missed opportunity.

84. The review of restraint, initiated by the MPS following the death of Roger Sylvester, explored aspects of mental health care in detail (review published in September 2004). This identified the lack of awareness of mental illness and its symptoms. At present MPS training on mental health issues is limited to approximately two hours on probationer training. It is ironic that in the mid-nineties, the MPS training material, developed in partnership with the National Schizophrenia Fellowship (now known as Rethink) was considered best practice at the time. Whilst it needs updating to reflect current service delivery and best practice, it provides a foundation on which the MPS can build. The MPS recognise that the mental health awareness of police officers is a gap and have undertaken a 'training needs assessment' as a basis for building a training programme.

85. One of the striking things that came out of the user groups was a perception that that it was obvious police had very little awareness of mental illness – a common response was that the police were well meaning but ill-equipped.

86.   As noted above the MPS does have policy and procedure in place aimed at ensuring people with mental health support needs have those needs met if they come into contact with the police. However, it is of little use if officers are not able to identify those people.

87.   Skills and training were a key focus of the discussions at the practitioner workshop. Here, it was identified that one of the barriers to effective partnership working is a lack of shared understanding and of differing priorities. In particular they identified a lack of clarity around roles and responsibilities of each agency in the various situations that necessitate joint working. One solution they endorsed was identifying opportunities for joint training. This has been progressed to a limited extent by the MPS and LAS who held a scenario based workshop with practitioners in order to gain a perspective on how well agencies worked together. This is a good start, but clearly there is much more to do.

88.   It is not enough to say that a training programme needs to be delivered, and we are aware police officers are required to undertake a significant amount of training each year. It is important therefore that training is focused and based on 'what works' It should also be an integral part of the structured training programme. The project board heard evidence about training methodologies that had been successful. Professor Graham Thornicroft provided us with details of a research study he carried out with Kent police aimed at improving the understanding of mental illness and challenging the stereotypes. One of the conclusions was "experiential mental health awareness training did leave police officers feeling more informed and more confident in supporting people in mental distress"[18]. All the user groups we spoke to endorsed the principle of user involvement.

89.   We also looked for examples of good practice that are in existence within London already. We heard from the MHLO based in Bromley who organises for all probationers arriving on his borough to spend time with

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[18] Pinfold, Huxley, Thornicroft, Farmer, Toulmin and Graham: Reducing psychiatric stigma and discrimination. Evaluating an educational intervention with the police force in England. January 2003. Social Psychiatry Psychiatric Epidemiology.

local Community Mental Health Teams (CMHTs) and at the local mental health Trust. There are three key benefits to this approach - officers gain experience of the challenges faced by partners, they learn about the role of other agencies and they are able to spend time with people with mental health problems. There are other examples of this across the MPS.

90.   We also looked abroad for examples of good practice. The Memphis approach has already been mentioned in the context of s136. There are other aspects of good practice within that model. The Crisis Intervention Team (CIT) programme relies on a five day training course for volunteer officers including specific training in de-escalation techniques, awareness training in the different types of disorder and the medication taken to treat each one and some time spent with the mentally ill. Around 10% of Memphis officers are CIT trained and all dispatch[19] staff have also received a two-day training course covering mental health issues. Other north American models, for example in Seattle and Los Angeles stress the importance of training for staff.

91.   Los Angeles Police Department have established a mental evaluation unit (MEU), which provides a 24hr hotline for all officers. New recruits receive 10-12 hours training and when the model was introduced, all existing patrol officers received four hours training, with 1 hour planned annually. They also have CITs in place who receive 40 hours, with an additional 8 annually. Call takers receive ¾ hour training when they start working with an hour annually.

92.   Whilst there are examples of good practice such as those cited above, it is not always clear that they can be transferred easily to London, given the size and complexity of the health and policing arrangements. We would urge agencies to consider good practice when it is identified and, where there are merits to schemes, to consider how the learning can be applied to local (London) circumstances.

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[19] i.e. those staff dealing with telephone calls and ensuring an appropriate officer response

93.	In the course of its deliberations, the project board has concluded that training/awareness raising should include at a minimum:

All police officers need awareness in:

- Different types of mental illness, the behaviours associated with them and how they affect people
- What responses are appropriate in different situations
- Acute behavioural disorder
- Co-morbidity/dual diagnosis
- De-escalation training
- Local protocols
- Safe restraint
- Cultural awareness (so that mis-recognition is minimised)
- Reinforcement of positive role models

CAD operators

- Different types of mental illness and how they affect people
- What responses are appropriate in different situations

Custody officers

- As above
- Role of the FME/ASW

Mental Health Liaison Officers (MHLOs)

- As above
- Local statutory agencies
- Local voluntary groups, including user groups

Safer Neighbourhood teams including Police Community Support Officers (PCSOs)

- As MLOs

94.	The paragraphs above focus on meeting the training needs of police officers. However, we also found that there are gaps in understanding in the agencies with which the police interact. Raising awareness of the role of the police and the powers that they have, needs to be considered by other agencies. This was raised in our practitioner workshop and was a

theme in some of the presentations we received. Participating in joint awareness-raising sessions, such as 'scenario based' workshops enables practitioners to build a shared understanding of how to work together to best serve people with mental health support needs.

95.   The project endorses the general principle that joint training should be established where practitioners are engaged in joint service delivery.

We recommend that:

R18   The MPS further raise the profile of the role of the borough MHLO within the organisation.

R19   A key function of the MHLO should be to proactively develop relationships with local user groups and voluntary organisations. Performance management mechanisms will need to be developed to monitor this.

R20   The MPS puts in to place a comprehensive training programme aimed at ensuring that all officers have an appropriate level of awareness of mental health and illness to enable them to deliver more effective services to people with mental health support needs. This should be developed with, and involve a diverse range of service users and where possible partner agencies.

R21   Local partnerships develop joint training opportunities such as scenario based workshops, particularly where practitioners are engaged in delivering services together.

R22   Partner agencies develop training programmes aimed at ensuring staff are aware of the role of police and their responsibilities. Likewise the MPS should ensure that its officers understand the roles and responsibilities of partner agencies.

R23   All training programmes are subject to an equality impact assessment to ensure that they identify and address the needs of service users from different communities in London and that they avoid perpetuating the stigma attached to mental illness.

R24   The MPS, NHS and other partners continue to explore the benefits of good practice models identified (such as the American models), with a particular focus on the context in which they are delivered and how this could be applicable to improving the quality of service delivery in London.

Section 4   Communication, Confidentiality and information sharing

96.   Poor information sharing and communication breakdowns between statutory agencies are often cited as contributory factors in homicide inquiries. It is a complex subject and is often identified as a barrier to effective interagency partnerships. It is also a key concern for service users. In recognition of the complexity of this subject, the project board agreed that a key objective for this review would be to 'identify communication channels and information gathering and exchange processes between agencies including any established protocols with a view to assessing how they could be improved.'

97.   As a starting point we looked at the legal framework within which practitioners and policy makers operate. We also looked at the implications this has for practitioners. Finally, we have tried to identify how we can move the situation forward in a way that protects the human right to confidentiality for service users, but enables effective joint working between agencies.

98.   As noted above the legal framework governing information sharing is complex and in many ways contradictory. On the one hand, the guiding principle behind confidentiality is the protection of the rights of the individual as enshrined in the Data Protection Act, human rights legislation and common law. This is particularly true for clinicians. However, legislative developments and government policy direction since the 1990s has focused on the role of statutory agencies sharing information in order to protect the public and prevent crime – s115 of the Crime and Disorder Act is an example of this.

99.   Numerous guidance documents have been published by government departments and others, on how to interpret the legislation, but these are usually a restatement of the legal framework rather than useful, practical advice on how to interpret the law. Practitioners in some areas e.g.

doctors and psychiatrists are guided by their professional bodies, which can lead to further confusion, particularly as these are generally more conservative than organisational protocols.

100. This challenge was recognised by Dr Fairbairn, Registrar of the Royal College of Psychiatrists, who told us that doctors are driven by confidentiality as a core principle. He told us however, that the profession is under increasing pressure to show a duty of care to the public as well as the patient and this is leading to a shift in the College policy. The College has recently published revised guidance and good practice on information sharing in response to the changing pressures that psychiatrists face. He also recognised that the higher thresholds used by psychiatrists for sharing information can cause inter-agency tensions. This was underpinned by discussions between the project board and two clinicians from a south London Trust, one of whom acts as the Trust's Caldicott[20] Guardian.

101. The project board suggested that there could be value in engaging the Royal College in joint work with the police and others to develop a more collaborative approach to information sharing and will be taking this forward.

102. Our investigations suggest that whilst there may be no need for more information sharing protocols between partner agencies, there is scope to develop practical advice and frameworks which establish what information can be shared and in what circumstances.

103. It is clear from the presentations to the project board from clinicians involved in multidisciplinary service delivery, that there are some real cultural challenges to overcome. This is typified by the language used by different disciplines, for example clinicians talk about confidentiality, whilst some other groups talk about information sharing. However, we also heard about some positive developments being brought about by the

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[20] Each NHS Trust appoints a Caldicott Guardian to oversee information governance in the trust particularly in respect of patient records and confidentiality. They aim to ensure confidentiality, but will support legal and ethical disclosure where required.

introduction of MAPPA, including the recognition that information sharing could be beneficial to all those involved.

104. We asked users about their attitudes to the principle of information sharing. We heard mixed views. Many were adamantly against any sharing of information, whatever the perceived benefits may be. The main reason for this was a lack of confidence in how other agencies would use the information. They were also concerned about how long information would be kept for, the accuracy of records (particularly if the information is kept for significant periods). Underlining the points in the previous section (para 58 above), users were concerned that the police would not have the appropriate knowledge to use the information effectively. We did speak to some users who could see the benefits of information sharing, but they did put limitations on this, including that it should be restricted to identifying and addressing extreme behaviour. Seeking permission and involving the user should also be key.

105. The project board did consider the circumstances that would lead to the need to share information. There are a number of different situations that could drive a need to share information, from the emergency services requesting background information on a vulnerable person in order to establish the most appropriate response and whether the person is at risk, to consultant psychiatrists putting together a forensic history of their patient to MAPPA case conferences about individuals who are considered a risk. Improving processes and procedures to address the less immediate situations is likely to be easier than identifying processes to access and share information in emergency situations.

106. There are numerous challenges associated with sharing information in emergency situations:

- Practitioners do not necessarily know who to contact in order to access information about an individual at risk
- Each London borough and Trust has a separate information system (although in time there will be a single NHS patient records database)

- Out of hours services are limited.

107. There have been efforts in London to establish formal information exchange mechanisms aimed at addressing some of these problems, through the Risk Data Sharing Pilot. This was undertaken in three boroughs during 2004, and aimed to establish a database of 'risk information' about individuals who were considered to be vulnerable. The pilot provided a single point of contact for all agencies who may need information to ensure that service users were able to access appropriate care in an emergency. The database held information that was considered to be the minimum necessary to manage a situation safely for both service users and professionals

108. The independent evaluation of the pilot (carried out by Imperial College), found that whilst there were positive elements to the pilot, it was difficult to demonstrate that it had met its objectives because of the limited numbers of service users on the database, the short time period used for the pilot and the low enquiry rate during the pilot period. It also found that two thirds of the service users referred to the database had not been informed of their referral (although it was agreed the start that permission would be sought). The evaluation found that service users did not support the concept of information-sharing or the specific model used in this pilot. Users were particularly concerned about the stigma resulting from the association made between mental health and violence and the potential for discriminatory practice by police, This finding was supported by the discussions we had with user groups as part of this review.

109. Although the pilot was inconclusive, the evaluation found that the information-sharing framework was "efficient, legal, ethical and useful'. It also pointed out that it fulfilled a much needed role in London and provided a service that share information 'legally, safely and ethically". However, it noted that one of the reasons the pilot failed was the restriction to immediate risk and the imposition of thresholds. Given the

time and effort that was put into that project, it would be a shame if the learning in relation to the information-sharing framework were lost.

110. A further consideration in relation to information sharing needs to be what information is shared about individuals. The law[21] states that this should be:

- Adequate, relevant and not excessive
- Accurate and where necessary kept up-to-date; and
- Should not be kept for any longer than it is needed and should only be used for the purpose for which it was gained.

111. The project board agrees that there should be limits placed on what information is shared and that this should be relevant to the situation for which it is needed, such an indication of risk, next of kin and of the most appropriate care pathway.

112. During the course of our investigations it became clear that effective information sharing and communication is as much about the relationships between agencies as it is about the legal framework. This is particularly true in relation to sharing information outside 'crisis' situations. We heard from practitioners who engage regularly with colleagues across agency boundaries and it is clear there are a number of critical success factors. These include:

- Trust between the agencies that the information will be used appropriately, and acted upon (and establishing feedback mechanisms to reinforce this)
- 'Give and take' recognising that information sharing doesn't always need to be a two way process
- Recognition (articulated) that often when agencies are not 'sharing' it is usually because there is nothing to share.

113. We heard from a consultant forensic psychiatrist who is involved in MAPPA, who told us that these arrangements were proving to be a positive experience. A two-way information flow has been established and

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[21] Data Protection Act 1998

the agencies involved often had good information. He noted however, that one of the reasons it is working well is because confidentiality is taken seriously and is reinforced during the meeting and on meeting notes etc. He also noted that MAPPA is only relevant to a very small group of people. In his experience sharing information about non-MAPPA cases is variable, often depending on the personalities involved.

114.   This suggests that the establishment of MAPPAs across London provides a formal arena where a culture of confidentiality can be established and trust can be developed between agencies, which sets the tone for interactions between partners outside the confines of this meeting. The effectiveness of MAPPAs is monitored jointly by the Chief Executives of Mental Health Trusts and the probation service in London. This is to ensure that good practice is both identified and shared, and that poor practice is addressed in a timely way.

115.   As noted above, information sharing and confidentiality are contentious issues for users. One of the user groups we spoke to told us about crisis cards that they had developed with their local Community Mental Health Team (CMHT). These are credit card sized cards that hold basic information including the person's name, who to contact in case of emergency, the location of hospital notes, key worker, GP etc. We raised them with other user groups and found overwhelming support for them, not least because it puts the information in the hands of the user and is easily accessible in times of crisis.

116.   We began this section by stating that we would attempt to identify improvements to communication and information sharing. Whilst recognising the challenges involved, we do believe there are things that could be done.

We recommend that:

R25 There should be a clear policy statement from a pan-London alliance that confidentiality will be respected, information will only be shared when it is either in the best interests of the individual or there is a concern for public protection and information will only be used for the purpose for which is being shared. We recommend that there will be regular data cleansing in recognition that people's mental health status can change and improve. Systems and processes will need to be developed in order to achieve this.

R26 There is a need to clarify the legal framework for example using case studies, making it easier for practitioners to understand the circumstances within which information should be shared.

R27 Where possible (and we recognise that this isn't always possible), the individuals should be told that information is being sought from/shared with other agencies. The reasons for this should also be explained.

R28 The development and promotion of the use of crisis cards.

117. As noted above, the legal framework is complex, and there are cultural differences in attitudes to information sharing and confidentiality. However, in practice, even if a culture of sharing is established our investigations showed that practitioners are often unclear about how to access that information, or who to contact if they believe they have information that could be relevant to other agencies. Addressing this could be as simple as drawing up accurate lists of key staff in partner agencies, with their roles and responsibilities and publishing them across those agencies. Central to this has to be a commitment to ensuring that they are kept up to date.

118. It is also for this reason that we wish to promote the development of more effective partnership arrangements between mental health services and the police. Research into best practice in joint working between police and

mental heath services in the USA[22] showed that key success factors
included

- Leadership across the agencies at a senior level is necessary

- Information needs to be accurate

- Confidentiality can not be over-emphasised, with information
Disclosure scrupulously controlled

- For joint approaches to work successfully, each agency must
understand its role and the role of the other agencies involved.

119. Our own investigations and good practice identified in Westminster,
Camden and Bromley showed that a shared sense of priorities, trust and
confidence and 'give and take' were also key.

120. Our research indicates partnerships need to be established at two levels.
We believe it is incumbent on local partners to engage on a regular basis
at borough level to establish common ground, acknowledge culture
clashes and identify ways forward. We suggest this could be managed by
the MHLO and equivalents in other services but should be actively
supported by local borough commanders and local directors and chief
executives of mental health and social services.

121. The second level of partnership needs to be at the 'front-line'. During our
investigations we heard from Chief Superintendent Mark Gore, who is
leading the implementation of 'Safer Neighbourhood' teams across
London. This is the MPS's response to the need to develop community
based policing and are neighbourhood based teams of police officers and
PCSOs, whose objectives are to:

- Improve confidence in policing through a more responsive approach to
tackling insecurity and community tension

- Work together in reducing the signal crimes & disorders that matter
most to local people

- Support community contributions in policing their neighbourhoods.

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[22] The Police and Mental Health. Lamb, Weinberger and DeCuir, Psychiatric Services. 53:1266
Oct 2002

122. Chief Supt Gore told the board that one approach to achieving these objectives would be through enabling better working between key front-line partners and the sergeants managing these teams are being given support to ensure they have a clear understanding of local arrangements. However, teams are not being given specific training about mental health, how it can affect people and how local services are organised.

123. We were also told that as far as he was aware, mental health issues had not been raised by the teams that were in place (roll out will not be complete until 2007), although it was possible that officers were dealing with unusual behaviour without identifying it as a manifestation of a mental illness. The MPS does not have information systems in place to capture this sort of information.

124. A key benefit of these teams is that they build relationships with local communities and are therefore well placed to identify individuals who may be vulnerable or cause for concern. This could be an important proactive prevention mechanism, ensuring the timely provision of support and the avoidance of crisis situations.

125. The board agreed that these teams provide an excellent opportunity to establish local links with CMHTs and others (e.g. GPs) and that it would promote this approach. It is also clear that these teams could also provide a conduit for individuals accessing local services. However, we would caution in a number of areas:

    - Local communities can be intolerant of mental illness. Safer Neighbourhood Teams will need to balance providing an adequate response to local concerns with ensuring the rights of the individual concerned are respected and that their needs met.

    - Information sharing at this level can be quite informal, and therefore safeguards need to be in place to ensure users' interests are protected. There is a risk that there could be problems with gratuitous information being shared.

- Whilst there is much to be learnt from the MAPPA processes, local networks at this level must avoid making the link between mental illness and dangerousness (a key characteristic of MAPPA), particularly in relation to people from black and ethnic minority communities.

We recommend that:

R29   *All agencies hold accurate lists of key staff in partner agencies, along with their roles and responsibilities and that arrangements are established for ensuring that they are kept up to date.*

R30   *Locally based networking is facilitated though safer neighbourhood teams and CMHTs aimed at ensuring appropriate responses to individuals who appear to have mental health support needs.*

R31   *Borough arrangements are formalised to reflect good practice.*

Section 5   The management of violence

126.   As we have made clear in section 2 of this report, there is widespread misunderstanding about the prevalence of violence amongst people who are mentally ill. However, in a small minority of cases, violent behaviour needs to be managed.

127.   One area that the project board identified as a significant challenge was the management of violence on psychiatric wards. In 1998/99 an NHS Executive report found that there were an estimated 65,000 violent incidents against staff across the NHS, and the average number of incidents in mental health trusts was more than three times the average for all Trusts.

128.   The reasons for this are varied but include high occupancy on wards, enforcement of rules and denials of requests, poor intervention skills aimed at reducing tension, unpredictable ward routines and boredom are factors.

129.   Although the NHS has a zero-tolerance attitude to violence against staff, prosecutions are rarely taken forward, not least because of a reluctance by police officers to pursue the case.

130.   The project board heard that this sends out a contradictory message to staff, patients (who are as likely to be victims of such violent behaviour) and to the perpetrators about the seriousness and unacceptability of such behaviour.

131.   Clearly the NHS has a duty of care towards its staff and patients to minimise the prevalence of violence on wards and to ensure that the needs of patients are met. This is typified by the recent prosecution of a mental health trust using health and safety legislation. However, there are implications too for the police.

132.   We heard from Gail Miller, a Nurse Consultant from South London and Maudsley Hospitals NHS Trust (SLAM) who has been working with staff to identify the causes of and solutions to violence and aggression. Much of

her work is based on a 'safer services' model, which aims to move away from the short-term incident management approach and develop longer term, holistic preventative approach.

133. There are a number of themes within the model including recruitment and retention, staff training and education, robust complaints processes for users, carers and staff, information sharing, collaborative risk assessment, joint policy development, clear organisational boundaries and clear documentation and criminal justice liaison. There has been significant collaboration with police colleagues in the last three areas, including a focus on developing fact files on who to contact and how the police work, so that staff are ready when the police attend the unit. They have also developed a prosecution policy aimed at challenging the assumption that patients aren't capable or responsible for their actions. It also recognises that in a minority of cases where the patient is severely psychotic, it may not be in the best interests of the patient to pursue the case.

134. Although the model has not been subject to formal evaluation, Ms Miller reported that there was increased confidence to report incidents, and the severity of incidents had reduced, staff are challenging their own perceptions of violence and the focus on the service user within the training component is working well.

We recommend that:

R32   The whole systems approach to reducing violence on wards identified in this review is shared as good practice with Trusts across London.

135. The MPS has a Homicide Prevention Unit whose remit is to research, analyse and recommend strategies to prevent homicide and break the continuum of violence. They are working on a number of strands including mental health. They have undertaken some analysis of murders that they believe could be attributed to mental illness and found that the majority happen in the home and that the victim and the perpetrator are known to each other.

136. Whilst our reference group raised some concerns about how they had chosen their sample i.e. that the perpetrators had been in contact with mental health services in the 2 years preceding the attack, rather than using hospital disposal (which indicates that the person was ill at the time they carried out the attack), their emerging findings make a number of recommendations that chime with the findings outlined elsewhere in this report including the implications caused by gaps in forensic history. There is clearly value in continuing the work to identify risk factors associated with escalating violent behaviour in order to ensure that those individuals receive the support and care that they need to prevent such tragic incidents. However, the views put forward by the reference group suggest there is a need to agree a definition of mental health related homicide.

137. The project board would also underline the findings of the inquiry into the murders perpetrated by Anthony Hardy (published in September 2005), which highlighted the challenges faced by forensic psychiatrists in carrying out risk assessments.

138. As outlined above, the approach to risk assessment of the most dangerous mentally disordered offenders has improved in recent years with the development of MAPPA, and within forensic psychiatry there are tools available to undertake risk assessments. However, our investigations suggest there is still work to be done on developing risk assessments for those who fall outside MAPPA categories. The clearest messages about this came from our practitioner workshop, where participants told us that one of the barriers to effective joint working was the different understanding of risk and how to assess it between agencies. This underlines the need to undertake joint training sessions aimed at building an understanding between agencies about what constitutes a risk and what joint responses should be taken. We were also told that there was little or no analysis of 'near misses'. Joint learning from such experiences could lead to better understanding and therefore better service delivery.

We recommend that:

R33   Further multi-agency work is taken forward to gain a better understanding of joint risk assessment and that lessons learnt and good practice are shared across London, in a coherent and co-ordinated manner.

Section 6   Implementation

139.   We have made a number of recommendations as a result of our investigations. In agreeing these, the project board underlines its commitment to working together to ensure that the implementation programme is carried forward. We also acknowledge the need to dedicate resources to ensure this is implemented. The MPA will receive regular updates with an equivalent mechanism at the NHS through existing London-wide panel. This plan will be monitored by a joint implementation group.

140.   Arrangements to allocate responsibility and agree timescales for implementation will be established shortly. The project board plans to hold a conference to discuss the findings of this review. At this point a full implementation plan will be launched, with fuller details of the arrangements to monitor progress.

Appendix 1 – Contributors to the Review

Reference Group

Janey Antoniou,	Service user
Judy Clements,	Regional Director, Independent Police Complaints Commission
Paul Corry	Director of Campaigns and Communications Rethink
Patricia Diamond	Carer
Angela Greatley	Chief Executive Sainsbury Centre for Mental Health
Dr Hilary Guite,	Public Health Consultant
Fiona Hill,	Service user
Ian Hulatt,	Mental Health Advisor, Royal College of Nursing
Stephen Klein,	Regional Director, Mental Health Act Commission
Professor David Sallah,	Latterly Wolverhampton University
Margaret Vander	Development Manager Mental Health, London Ambulance
Marcel Vige	Diverse MIND
Melba Wilson	Deputy Chair, African Caribbean Mental Health Commission

Evidence Givers

Chief Supt David Morgan	MPS
Chief Supt Mark Gore	MPS
Inspector Paul Bather	MPS
Commander Andy Baker	MPS
Ruth Truelove	
Christopher Burrows	
Professor Graham Thornicroft	Institute of Psychiatry
Gail Miller	Nurse Consultant, South London and Maudsley NHS Trust
Dr Andrew Scott Reid	Coroner
Dr Andrew Hodgkiss	Consultant Psychiatrist
Dr Humphrey Needham-Bennett	Caldicott Guardian
Dr Simon Wilson	Consultant Forensic Psychiatrist
Dr Andrew Fairbairn	Royal College of Psychiatrists, Registrar
Dr Hilary Guite	Public Health consultant
Professor Genevra Richardson	Professor of Public Law, Queen Mary College
Simon Foster	Formerly MIND Director of Legal Services
Hannah Miller	Director of Social Services, London

| | Borough of Croydon |
| Kirsty Jarvie | London Risk Data Sharing Pilot |

We received written evidence from:

The Kensington and Chelsea Independent Custody Visitors

Lambeth Independent Custody Visiting Panel

Lambeth Community Policing Consultative Group

South Westminster Custody Visitors Panel

Tower Hamlets Independent Custody Visitors Panel

Criminal Defence Service, part of the Legal Services Commission

We also spoke to:
Wendy Ryan – Westminster Drugs Intervention Programme
Sue Lipscombe – Westminster Joint Homelessness Team

Appendix 2 – User group feedback

We held focus groups with a number of user groups across London. When we did this, we agreed that we would not identify group or individuals. In total approximately 70 people were involved in these meetings. We are extremely grateful for their involvement.

Summary:
Overall the experiences recounted to us by users have been mixed, and much of this tends to be down to individual officers. A number of the experiences recounted were fairly horrendous. Key themes that emerge are:

- Police officers often lack knowledge about mental illness and therefore don't make appropriate choices.
- Training needs to involve users
- Being taken to a police station is extremely frightening particularly when you have done nothing wrong. Police cells do not feel like a place of safety. Crisis houses are suggested as an alternative
- Users often didn't have an understanding of what was happening to them, they felt they weren't kept informed. They also reported feeling dis-empowered by the process
- There is widespread concern about information being shared by agencies.
- Users relayed a number of incidents where they had had been victims of crime but perceived that because of their illness they were not taken seriously by police or health staff
- Police in uniform to do a section 135 can be intimidating, particularly provoking concerns about what the neighbours will think
- Stigma is a real concern, particularly media portrayal
- There is little proactive contact between police and user groups

User group 1

Experiences with Police

User 1 has had 3 separate experiences that involved the police.

1st experience 1990: User was very violent, prosecution followed and was remanded to custody. After a month on remand in a prison hospital he was sectioned. He was assessed by a police doctor but this did not result in any treatment. He had no concerns about his interaction with the police, but regretted that it took so long to get to hospital – prison compounds mental illness.

2nd experience 2000. Very traumatic. User had isolated himself in his flat. Authorities decided to do sec 135 assessment. The police were very officious

and very overbearing. They broke down his door, and handled him very violently ("threw me to the floor", handcuffs etc) and took him to hospital.

3rd experience 2000: Found wandering by police in his dressing gown. He was taken by the police to a police station, put into a waiting room and waited there to be taken hospital. Police were very good on this occasion.

User 2: Limited experience of police 10 years ago, but found police courteous. She carries a crisis card that holds contact numbers, hospital numbers and location of where her medical notes are held, allergies and any dietary or other medical conditions. The User Group developed these crisis cards about 6yrs ago (with support from their local trust) and has found them to be very useful. When a review of these cards was done, a lot of users said 'Thank god I had that card on me'.

Trusts and PCTs provide a small amount of money to run a small user group. Though this isn't a separate grant, this comes out of the original that is handed out.

These cards have been useful for police, as they are able to identify when they are dealing with a MH service user.

The local police station knows of these cards, and the users also think that it is mentioned in the MH training that is going on.

This group believes that sharing as much information as possible between police and social service in certain circumstances would be very useful. "anything that can make it less traumatic".

E.g. User 1 was suffering for 2yrs prior to his arrest in 1990 and was coming to the attention of the police during that time (cautioned a number of times and arrested but released without charge). He thinks it's a shame that nothing could have been done, if there was more contact made by MH services, the incident he found himself in to be arrested could have been avoided. If he had more medical treatment, different medication perhaps most incidents like this can be avoided.

Comments were made around service users being afraid of their social workers and or psychiatrists, particularly as they don't want to be labelled. Although they recognise that this can sometimes be part of their condition.

Police holding a database on MH service users
Users don't see this as a problem, if it was held in local police stations and not to be nationally accessible. They feel they would be treated more sympathetically if they had their name on that register. It can be a distressing experience when the people who are dealing with you know nothing about your condition. It would give

MH service users more confidence knowing that if the police knew of their condition they would be looked after better.

User group has had no regular contact with the police, but on the odd occasions where there is contact, they are helpful.

Police only get involved when things go wrong and people are in crisis, so it is up to the mental health system to get things right so that police don't get involved.

Place of Safety
Users stated that this should be in a hospital not a police station. It should be a room that is welcoming, comfortable, provides cups of tea. A police cell isn't a place of safety ("trauma more like"). There is an assessment room at the courts that is quite nice and comfortable. There also needs more interaction from nurses, some they have come across are quite horrible. Another user stated that most areas have a hostel; it would be possible to have an emergency room attached to these hostels. This group is looking at creating a crisis house; it could be a possible alternative to a place of safety (they thought Haringey and Islington may have them). They are talking to health trusts about this crisis centre. There are also Crisis Resolution Teams in place nationally, who are there to deal with these difficult situations and places of safety. There is hope of obtaining funding for these crisis centres. CRT's are looking at saving money to help out.

User Group 2

User 1: 3 encounters, generally not too bad. She was taken to a police station rather than a hospital on first 2 occasions. Third occasion police came to her house as they had been told she had absconded from hospital.

1st encounter: outside London therefore not recounted.

2nd encounter: police didn't understand what to do, nor did they ask. They put her in a cell but didn't tell her what was happening. When she did ask about when she would be released, she was told they were waiting for a doctor. This seemed to take hours. The doctor said she could be released. No social worker was called. Doctor did ask if she was suffering from auditory hallucinations. Although she was, she said no in order to be released (she was undiagnosed at this point). She had hit a police officer, but wasn't charged. She thinks they realised she was acting out of character.

3rd encounter: the hospital had phoned the police as she hadn't returned after a day release. It was her intention to return. Police arrived at her door in uniform, which made her think something had happened to her mother. They did offer her police transport back, but she declined – didn't want the embarrassment of the neighbours seeing. No social worker in attendance.

In her view, visits like these should be done in plain clothes as people immediately think she is a criminal.

User 2: Hasn't had involvement with police for a while, but had 2 experiences.

1st encounter: was wandering round Victoria Stn asking for directions to the mind reading shop. Station staff called police, who removed her to a police station. She was held for about 2 hours, but didn't see a doctor. She felt the police didn't know what to do, didn't ask her any questions about what she was doing and didn't ask if she wanted to see a doctor. They released her after 2 hours, at which point she returned to the station ("it felt like a diversion from the mission").

2nd encounter: She was in Earls Court removing the call girl cards from the phone boxes. They asked her what she was doing, and took her home to her mother.

Looking back, she fells that it wasn't that they didn't want to do the right thing, but they didn't know what the right thing was.

User 3: Several experiences.

1st encounter (1990): police were called to her psychologist's house as she had taken all her clothes of and refused to get dressed.

She was taken to a police station at which point a doctor was called. She was later taken to hospital. Although they were quite sympathetic, she wasn't told why she was been taken there and they didn't let her get redressed when they removed her from the house.

2nd encounter (1997): she was handcuffed and taken to a police station. The handcuffs cut her wrists but they wouldn't remove them. She was put in a cell and seen by a social worker before being taken to hospital.

3rd encounter (2001): She was preaching the bible on a main road in the borough. 2 police officers stopped and asked her to do it quietly or to talk to individuals. She refused, was handcuffed again and put in the back of a van and taken to a police station. She had been preaching about scythes and ploughshares which the police interpreted as her having a knife, so they tried to search her. Her reaction was to spit at one of the officers (there were 2 male and 3 female officers present). She was told that if she didn't co-operate they would get one of the male officers to undertake the search. She was seen by a GP and a social worker (the police were aware that she was ill) and taken to hospital. Her mother later asked why she had been taken to a police station and was told by

police that she hadn't done anything wrong. She wasn't told that she could complain. She felt that she didn't have many rights.

User 1 noted that once police know about a person's mental illness, they are treated differently. She cited an incident where she needed to make a statement about an incident. She told the police that she had a mental illness and they refused to let her carry on without a 'sane' person there.

She is down as a schizophrenic, which isn't a helpful label. Most people don't know that it can refer to several sets of symptoms.

Information sharing

User 1: some reluctance, but accept it can be good thing. Initial view is that illness should be no excuse for malpractice. Thinks also that a register of bizarre behaviour may help reduce deaths in custody. But, she thinks training needs to go with it, so that information isn't negatively interpreted. It may not be appropriate for people to have information, but that goes for all services.

Training

There should be specific liaison officers, but all officers should have awareness. CMHTs get it wrong on occasion.

They advocate involving users in training. Police need to talk to users to understand the experience.

Media doesn't help reduce the stigma.

They need conflict management training, the focus doesn't need to be mental health.

Training should start at Hendon.

Liaison
There has been some liaison with the local police but the group felt they should be more proactive.

Place of safety
Not a police cell. It criminalises, and people aren't informed about what is going on. Also, it doesn't feel safe. Even if a crime has been committed the feeling was that people should be taken to hospital and charged there, or bailed to return.

There is a new mental health unit in their area, so they think police stations may be used less. At the hospital relatives are allowed to visit, which makes a difference.

User Group 3

User 1: arrested by 7 police officers as a 16 year old, and taken to a police station. Not told why. Police violent towards him, resulting in a large cut on his head. Arrested on a Friday evening. Didn't see police doctor of social worker until Saturday morning. Mother eventually contacted. Sent to hospital for 6 months. Wasn't told what was going on. Felt could complain, had no voice.

User 2: had different experiences. Where crime has been committed either they back off, even if there is no evidence that the illness has caused the crime, or they don't t know what to do so they take people to the police station.

User 3: detained under section 136. Wasn't told what was going on.

User 4: found walking through a building site. Arrested. Doctor's notes say that he had been breaking windows. Don't know where this came from, as it wasn't true. Left with view that police fabricates story.

Wider perceptions of the issues:
- Crimes against patients not taken seriously – everybody should have access to criminal justice system regardless
- Police don't respond when users are experiencing extreme paranoia – how do they know whether it is paranoia or not?
- Do get good police officers but they tend to at low ranks and therefore can't speak out
- Widespread feeling of conspiracy between statutory services. If you are detailed by the police you will end up on a six month section.
- Police fear people who are mentally ill and turn up mob-handed.
- Police don't have experience to identify whether people are ill or strange. Mental health professionals should be able to do this, but think they rely to heavily on the police perception.
- Community care not working and mental health services are being cut back which means people come in to contact. Not police's fault.
- Restraint is insensitively used. It is unpleasant anyway, but when you are psychotic and very frightened by everything it is even worse. The person that raised this didn't know how to get round this, but it needs to be done sensitively, particularly as people die from it. He suggested that extreme behaviour disorder was like an epileptic fit. Nowadays, no-one would dream of retraining somebody having a fit. Need experts for this.

- With regard restraint, poor experiences of psychiatric staff too, particularly around de-escalation. Although there is a feeling that as they know them, treatment is slightly better.
- Calling police to attend violent situations on wards puts police in difficult position, staff should be able to deal
- Handcuffs don't help any situation
- Consider being put in the back of a police van as a form or restraint, particularly when a person is picked up by four officers and put in. Ambulance is just as bad.
- Place of safety doesn't necessarily need tampering with, but people need to understand the act and what is says about considering what a place of safety is.0.2
- Illness is stigmatised and the system fails them, papers don't help
- Concerns raised about what will happen with new Act.

Information sharing:
- The group raised concerns about this as they don't trust the police or others to tell the truth.
- Users should be asked first and if they decline then no sharing should take place.

Training:
- Should be about being a good human being i.e. about being sympathetic, kind and empathic. These must be good skills for a police officer. All officers need training as it is usually beat officers who will come across somebody acting oddly.
- Police should spend time on wards.
- PCSOs need training too.
- Needs to be comprehensive. Managers particularly needed it so that they can provide appropriate leadership.

Other suggestions for improving the service
- Police should ask friend or family as first line of enquiry about approach to take
- Crisis cards would be a good idea. One user who takes Clozapine has one.

Other general issues re the review:
Need to test recommendations out with users.

User group 4

Experiences

General experience was that users were taken to a police station on breach of the peace rather than s136.

User 1: told by police that mentally ill people should be locked up. Experiences include having the police break into his house through a window and through the door. Usually arrested for breach of peace, following neighbour complaints of noise. Episodes often lead to section. General experience is that if his behaves well, he is treated well by police. Being broken into is very intimidating. Police often bring his consultant psychiatrist when they are called to his house. Told by one police officer that he should "do a runner out the back door" as there was no evidence that he could produce music at a volume neighbours were complaining about.

User 2: Argument with neighbour over garden plants growing into user's garden. Arrested for breach of the peace (the other party wasn't). She didn't feel she was treated seriously.

User 3: Put bleach in his eyes. Police were very good, took him to local hospital where he was transferred to the Maudsley.

User 4: police called as she was throwing things out of her window. Arrived with a doctor. She refused to answer the door so they broke it down and took her to hospital. On another occasion she was taken to a police station. Told police doctor she wanted to go home. The doctor told her that the best thing to do was to say she needed to go to hospital. Which resulted in being taken to Springfield.

User 5: had door broken down and was taken to hospital. Burgled as a result. Couldn't report it until much later when on weekend leave.

General perceptions
- Police can be very good
- General mistrust of the mental health sector
- Concerns that police don't take them seriously, particularly when they are victims of crimes or experiencing extreme paranoia

Changes for the future
Police need positive stereotypes of people who suffer from mental illness. Most are law-abiding, need to challenge the prejudices.

They also need to go out and speak to groups like this one.

NB when talking to the staff afterwards, they said they would like to invite the borough commander and the MLO to some of the events they were planning for World Mental Health day.

User Group 5

User 1: (experience outside London)
Arrested and sectioned. Feels labelled now. Spent 9 hours in a cell. No solicitor, despite asking for one. A doctor was called. No appropriate adult called.

Prejudice by police is no worse than that shown by anyone else in society.

User 2: Crisis about 4/5 years ago, became manic in public. The police were called – who then called a Jewish police officer to help. Arrested (not sure what for). Taken to a police station and to hospital the next day. Had mobile and money stolen either at the police station or at the hospital. Very upset. Doctor was called to police station but didn't see the user because he threw a cup of water at him. Was treated quite well by the police, he wasn't handcuffed and he felt they made an effort to minimise the embarrassment. He was taken to Homerton Hospital (he lives in Hackney) where he was sectioned. Thinks police here are very good compared to treatment he has had in Israel.

User 3: She thinks the police attitude changes when they realise that you are mentally ill. She was assaulted at a party and the police were called. When they found out she was a psychiatric patient they started laughing at her, as did the ambulance staff. The police made her feel like it was her fault. They did take a statement but it wasn't followed up. She was taken to A&E at the Royal Free. Has had other more positive experiences of the police, although the next one she recounted was not an indication of this. Called the police late at night to attend, neighbours causing trouble. She was told by 999 despatch that somebody would come straight away. Her local police station phoned at 9am to say that they didn't deal with this kind of incident. She has been trying to contact the local sergeant but he never returns her calls, the PCSOs tell her that he will visit her but he never does.

The assertion that the attitude changes when police find out that people are mentally ill is a widely held view amongst the group.

User 4 (recounted by a volunteer as the user didn't feel able to talk to us): She was suicidal, threatening to jump under a train. She called the police. 20 officers arrived and talked her down. Once it was clear that she wasn't going to do it, they grabbed her and put into the back of a police van. She was sick in the back of the van (she had asked for them to stop so that she could do it outside but they

refused). Ambulance was at the scene, but it was sent away once it was clear that she wasn't going to jump. She wants to know why this happened.

User 5: Shortly after being released from psychiatric care, she was having an argument with her husband on her driveway about her new car. He had crashed it and caused £1400 damage. She wanted the keys back. The husband called the police. Police asked her to come out on to the road, at which point they arrested her and took her to the police station. She doesn't know why they arrested her. In the custody suite she was told that she had to decide what to do, whether to go back to hospital or to go into a police cell (i.e. consent to treatment or wait to be sectioned). She thinks that if the police hadn't know she had history of illness, this wouldn't have happened. She had no history of violence. She also knows know that they couldn't arrest her on her own drive.

User 6: very good experience of the police. Ill last July, called the crisis team, police came too. Didn't want to go voluntarily, so police took him to the Denis Scott unit where he was sectioned. Seven years previously, similar experience. Found they were very courteous and considerate. Handcuffs weren't used. Experience of health services very different. Was sectioned at the right time, but could have been released much earlier. Had to appeal a number of times.

User 7 (again recounted by somebody else): person was manic so her friends took her to A&E , she didn't want to stay, police were called. They approached her and coaxed her back inside. They were very gentle with her.

User 8: Taken to A&E following overdose (by ambulance). Nurses very unsympathetic. Crisis team didn't see him until nearly 12 hours later. Wanted to leave but police advised him to say (thinks they were there anyway). Was sent home with medication – no beds available, with no outreach support. Now has 2 appts with psychiatrists, both 6-7 weeks after the incident.

User 9: Very good experience of the police as victim. A lot of support from local Sapphire Unit (deals with Rape) and St Mary's Haven.

User 10: victim of extreme domestic violence which triggered a psychotic episode. Stopped a policeman in Croydon to explain she'd been raped. She was extremely agitated so he took her to a police station. She was put in a waiting room which was extremely dirty so she stood in the doorway. As a result she was put in a police cell. This escalated the situation (claustrophobia). She was shouting and hitting the doors, she could hear them sniggering behind the door. She certainly didn't feel like she was in a place of safety. She felt very angry and distressed. She eventually was taken to the Bethlem where she received excellent treatment. The rape allegation was never followed up and was treated very unsympathetically. In dealing with her psychotic episode, she felt the police had no coping skills.

Two other experiences were recounted where it was felt the police over-reacted – one involved police arriving "all guns blazing" which led the user to jump out the window to get away from them.

None of the users present had had experience of section 135 (i.e. assessments on private premises)

Training

Hopefully training would challenge some of the bad attitudes. There is a particular stigma about MH. In this borough they have been asking for MH not to be included on anti-social behaviour checklists as they feel it stigmatises more. They also want to open a crisis house, but have had a lot of hostility. Newspapers don't help.

Members of the group feel that they get pigeon-holed by service providers – nurses, police, social services etc.

The group is involved in training with health workers. They feel this is very important, would request that police training includes this.

Information sharing

The group facilitator had strong concerns about the risk data sharing pilot, particularly as the users won't told that they were going to be on the database. It can generate real paranoia regardless of the objective of the project – users must always be told.

Para 39 of the NHS confidentiality code of practice is very clear. Everybody should use this as a starting point.

The group also raised concerns about how the information is used. Do officers, statutory agencies know what to do with the information?

User Group 6

Summary

A general comment was that a lot of discrimination is felt by LGBT.

Experiences with Police

1st User - Crisis or crisis intervention most used to information contact with police who seem friendly but with Mental Health this is not the case as they don't have contact with the police unless they appear mob handed which causes the

individual to become more distressed and perpetuates the increase in force and numbers used by the police to restrain. Therefore the crisis is the image problem that the police have.

2nd User advised that they had to call the police when a friend was being sectioned and they were generally very good – one of the officers had a degree in psychology and the approach was very calm and un-intimidating.

3rd User advised that they had an appointment with a client who had incident within the last 15 days and has serious mental health issues, a neighbour telephoned the police claiming there was a leak in the flat, which was an excuse for the police to get access. The person was committed but was not of any risk. Although the policeman, were very pleasant it was very upsetting experience as they broke into his home. Only 1 came into the property whilst the rest waited, although they may think they handled it in the best way possible he did not think it was good practice in the way in which the whole street knew what was going on because they had talked to the neighbours, they did not need to break in or give him the stigma that he now had within the street. It was the issue of no confidentiality, which was of most concern.

4th User Perception is that police policy is to command their instructions. When they entered the building they followed the instructions of the social workers and the doctors. The police were not perceived to be homophobic but they were impotent in that any questions were met with comments like "I am not a doctor you need to speak to him!"

5th User advised that if they are unsure of your sexuality it would affect the quality of their conversations with interagency communication. The Police are aware that homophobia is an issue that needs to be addressed and therefore acknowledge that there may be officers that need more appropriate training. However public sex law targets gay men, which may be seen as a good law for some homophobic policemen to utilise if they want to be unfair.

One user knew a person in crisis the police broke into to her home she bit an officer (allegedly) and ended up in prison.

Another user advised as younger person has very negative experience of a police officer who was very bigoted officer had not trust therefore perception is that there is no chance police would do anything.

Information Sharing
- Hate crime and the police have had a lot of experience of harassment deal with it from persons point of view of what value it would have to report if they have gone what to do with the information and how sympathetic are they?

- Issue of information sharing on the crisis card, question of accuracy of the information once it's written down its very inflexible. User has control different agencies will have different implications due to different interpretations on words.

- Issue of information going to one agency and not to all in relation to crisis cards

- Some implications card sounds good idea empowering information not practical. If agencies sharing not known to individual, some agencies could be dodgy. Real issue around understanding diagnosis – misinterpretation makes the interaction so much worse. – Many users come here because they want access to records use of crisis cards would make it complicated. Also need to ask the question of proof that the card belongs to the person claiming to be the user.

Training

- Statutory agencies if not been inside have no clear understanding of what that does – issue about being out and police checks, a lot of boroughs have LGBT forums, which could be enhanced by including mental health officers. When being vilified it is very difficult to protest the area of Mental health is compounded with discrimination.

- Police don't deal with it well although many would have had Illness such as stress and been on restricted duties in which case they would have been marginalised. Where are the officers that have got the experience or empathy to do the training? If organisation is excluding those who have insight how will they learn?

- Psychiatric hospital doctors training may be old school

- Need more then one LGBT Mental Health officer need to be working at various levels need to be linked into borough structures

- Hospital training, user groups, reciprocal arrangements. Better liaison with all the agencies – Liaison committee being involved in just gay issues not enough.

General Perceptions

- One user advised that post sectioning at hospital very good experience being recognised as a couple. Diversity officers involved.

- How could things change to be better? Institutional overhaul if cant create environment within police how can you bring it out?

- It was perceived that police were impotent and their only concern was putting sectioned lesbians on mixed wards, and if they wanted to talk to the police on the wards in private there was no where to talk. This can include instances when having things stolen, being abused, raped or bullied where there is no access to police

- Friend arrested for drunken damage but the store didn't press changes if they had a crisis card may well have prevented a lot of the episode. However if you are not confident to admit problems you will not show it and it may not work.

- Mental health deterioration – aware that police have moved on but would be very scared and mistrustful therefore becomes a double jeopardy issue a lot of people have a very similar experience.

- Move "out" officers if women raped goes without saying female officer needed. If it is a hate crime then need someone who understands the same applied to Mental Health.

- Speak out – would like to emphasis nothing like experience to understand the issue. – Handcuffs not just a LGBT issue, but a bad issue in general.

User Group 7

Summary

Meeting undertaken with a small user group who represented not only themselves as individuals but also other user groups.

Experiences With The Police

The group did not really recount individual experiences with the police although one persons comments were provided in relation to experience with the police the rest of the comments seemed to concentrate on the following headings:

Information Sharing

- It was suggested by the group that cross agency working was a very good thing but the issue of information sharing was difficult to overcome as info can be inaccurate with no opportunity to challenge or change which leads to wrong diagnosis or hampers diagnosis. This includes the assumptions that people who are not fully trained in the right fields may make because of the behaviour they perceive from the individual. The individual can sometimes have not knowledge of this inaccurate classification and very little access to challenging it.

- It was also confirmed that one of the group was involved in the Risk Data Sharing user group and was concerned that it was also the issue of not only having the right data but also about applying it properly.

Common Issues from the meeting

- Who collates the information?
- Who is this information shared with
- What is said about the individual (mad/bad), the two seemed to be linked?
- How long is it kept? How up to date or relevant is it?
- How this misinformation could prejudice the treatment received.
- Issue of powerlessness of the individual in this process.
- No dedicated telephone number/not widely publicised number for Mental Health Police Liaison Officer.
- Organisations seem to have "hunger" for information but not good at understanding it or applying it properly
- Up to date list and access details of social workers just as important information but more difficult to get hold of

Training

- Misconception that people are unable to change, control or recover from MI
- People with MH issues tend to get labelled with Psychotic needs by NHS etc not enough work done in realising the diversity within MI
- Training and education of the Police not as good as it should be.
- New intake of police tends to be very young therefore life skills and training not as developed to challenge stigma or prejudice
- It was highlighted that the British Transport police had done a lot of training on dealing with this issue and were much better then the MPS.

General Perceptions

- MI individuals feel vulnerable, as their statements or versions of events are not trusted.
- Police approach can be intimidating which can cause reaction.
- Different relationship with Health and Social Services then with MPS as they are seen as client by other two and not by the MPS.
- Only commonality between police and Social Services is that they overreact.
- Men given less priority by Social Services
- Crime victims with MH issues don't feel comfortable reporting it as feel not respected and will end up being locked up instead
- Group summed up police response to MH as antagonistic, stereotyping and lack of empathy.
- Concern was raised about the police concentrating on race as diversity issue not, sexual physical or mental Issue ability

- Issue of Home Office classification of Mental Health (mentally disordered offender) was considered to be inappropriate terminology by group.
- Create safe havens similar to those provided for rape victims.
- Use of voluntary groups or associations in the provision of alternative options does not always have to be state or public sector provision. These groups can have better idea of user group needs and issues.
- Could use similar system to emergency number on mobiles
- Communication between and within BCU staff should be good enough to know whom they are and how to get hold of them.
- Police training should incorporate some form of qualification or competency (recognised) to take on role of MHPLO
- Developing role of MHPLO
- More intensive and comprehensive on going police training in MH
- Need to embed it into the culture of the police avoid stigma challenge stereotype.
- Do similar card for MH to stop and search - know your rights leaflet.
- Training should come from people who have life experience of MH issues

User Group 8

Background

This is was a well attending meeting with a large user group representative of a range of ages, cultural and ethnic background as well as an even gender balance. The group were able to recount their personal experiences as well as friends and colleagues who had similar issues.

Experiences with the Police

- Police not looking at cause of incident just assuming person is mentally ill and putting them in hospital, (example of individual being victim of domestic violence and fleeing premises but this issue not being dealt with as promptly as it should have been).
- Individual comments related to police taking time to calm the situation and offering alternative solutions such as contacting family members or asking whether or not the individual wanted to be taken to a hospital.
- Police making arrangements for appropriate family members to collect individuals, waiting with them until they are picked up or taking them to agreed family member's home rather then putting them in a cell or taking them to hospital

Information Sharing

- Need to actually take the time to speak to the individual to understand what they are going through
- Not informed or advised by the police where they were being taken or why

- Confusion about rights or who to contact in such situations by all parties involved.
- Communication or lack of it between all the organisations involved such as police, hospitals, social services seems to cause confusion about type of response the individual receives and where they should be taken.
- Police should have dedicated, trained disabilities officer who knows how to deal with people who have mental illness. They should be on hand to help at all times.
- Mention of the Crisis Team as good idea
- The group generally did not have any problem with the issue of information sharing between agencies as long as it was done for the right reasons and done to ensure for the benefit of the individual.
- Use of ID cards was considered useful by some but not by others
- Use of Crisis card was considered a good tool but only if individual could complete the card and get the details confirmed by an agreed suitable other such as psychiatrist, nurse etc. this would allow people to take more ownership of their own health
- Police officers need more training and awareness about mental health issues

Training

- Need for greater sensitivity when dealing with Mentally Ill
- Need for Police to be more aware, trained and educated in how to deal with Mentally Ill
- Avoid being so heavy handed or rough in their approach when dealing with the Mentally Ill
- Avoid making assumptions that being mentally ill means being violent
- Police don't seem to be aware that it may be the medication making the person react and not in the individuals control.
- Should ensure that when police attending they should have both male and female officers there.
- Concern as whether or not Police Station, A&E or hospital were the best places to be taken when an incident does take place.
- Older more experienced police officers better at dealing with situations younger police officers don't have the knowledge, training or experience and therefore can be more insensitive or aggressive in their approach.
- Police should be trained by user groups or people who have experience of user groups so that they get the right perspectives
- Police mental health liaison officer should be more widely publicised and access details should be more available.

General Perceptions
- Mentally Ill people need to be treated with more respect
- Move away from stigma associated with being mentally ill
- Why should it be police that take the individual when there is an incident why can't it be the ambulance service? This may reduce the stigma associated with being mentally ill or having police involved.
- Contact with the Police can be intimidating
- Mentally ill living in the community have fewer day centres to go
- Feel more vulnerable living in the community, more prone to being victimised and harassed need more visible policing to get the support they need.
- Concern as whether or not Police Station, A&E or hospital were the best places to be taken when an incident does take place.

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We also had access to a number of Metropolitan Police Service standard operating procedures and policy relating to mental health.

Appendix 4 – GLA 'Towards a Blueprint for Action'

Towards a Blueprint for Action:
Building Capacity in the Black and Minority Ethnic
Voluntary and Community Sector Providing
Mental Health Services

A study for the African and Caribbean Mental Health Commission

executive summary

The African and Caribbean Mental Health Commission (ACMHC) in London commissioned this report in recognition of the need to outline an action plan to engage the BVCS (black voluntary and community sector) more fully in mental health services.

The aims of this report are:
- to examine the nature of service provision by black voluntary sector mental health organisations and assess the capacity building needs of this sector.
- to identify the economic and human benefits or value added impact that black and minority ethnic voluntary and community sector organisations have on services to black and minority ethnic communities
- to develop a Blueprint for Action to address the issues which arise in the research.

In addition to a literature review of the most relevant and recent publications and policy context, 30 questionnaires were sent to black-led voluntary sector organisations (25 returns) and 20 questionnaires to statutory bodies or funders (12 returns).

Key findings
- The key message from organisations was for the statutory sector to change its 'mindset', and to view the BVCS as equitable and complementary partners who contributed to community engagement and social inclusion and were involved in brokerage and advocacy, policy influence and the provision of culturally sensitive services and early intervention, resulting in reduction of overmedication, admission or re-admission to hospital. This is potentially cost saving (see Tables 4 and 5).

- The importance of black organisations that employ black staff who understand the social, cultural and political experiences of African Caribbean patients who have used mental health services cannot be emphasised enough.

- The lack of long-term funding was often stated as a serious problem affecting the sustainability and growth of BVCS organisations. For many organisations this resulted in an environment of instability for both staff and service users. In most cases projects found it difficult to access funding for their core costs, as opposed to project funding.

- Primary Care Trusts, social services and local authorities were the most common sources of funding for black and minority ethnic mental health voluntary organisations.

- None of the funding providers that participated in this study had ringfenced funding for black and minority ethnic organisations, although some funders were in the process of developing funds targeted at black and minority ethnic groups.

- Organisations responding recognised the need to diversify their funding sources. However, few had the capacity to put much energy into this in practice.

- Most organisations found the application process time consuming and few had access to assistance with funding applications.

- Organisations that were part of a network were at an advantage when it came to accessing information about funding.

- There was widespread acknowledgement that current capacity building provision was inadequate and that more was needed.

- Fundraising was the most frequently mentioned of all infrastructure development tools, followed by evaluation tools training, human resources, management tools, business development and payroll administration.

- Most organisations had ambitions to expand their services, develop the organisation and provide a more holistic approach to service user need, including through developing research and dissemination of information.

- Ownership of property should be a goal of capacity building provision to the BVCS mental health organisations.

- All black organisation respondents stated that training was needed in order to deliver the kind of service that they would like to offer over a sustained period of time.

- Few among the funders surveyed for this study demonstrated a palpable understanding of the importance of the BVCS or the unique set of challenges facing BVCS groups.

- Most respondents were positive about the benefits of partnership working, although small organisations reported that the power dynamic of working in partnership with statutory agencies was challenging as there was often an imbalance.

- Organisations spoke of a need for funders to 'get to know' the BVCS and individual black organisations.

- People with senior management roles and strategic vision in relation to the future operation of their agency, wished to have the opportunity to engage with the organisations as a partner; but as an efficient partner. This implied both an adequately resourced BVCS and a continuity of collaboration.

Summary of recommendations

These recommendations are endorsed by ACMHC and have the support of the Mayor of London. ACMHC hopes to work with a range of stakeholders with a view towards their implemention.
Please see section 7 for detail and explanations.

Recommendation 1
A statutory/voluntary sector compact should be developed with explicit recognition of the roles of the voluntary sector and protocols for joint working. This should take account of any work already underway in connection with the development and implementation of the national Compact on Relations between Government and the Voluntary and Community Sector, which was adopted in 1998.

Recommendation 2
A Mental Health Providers Information Exchange (MHPIE) should be established. It is suggested that an initial step will be to create a database and interactive website for providers in London. This will aim to facilitate targeted commissioning, appropriate support for clients and online information exchange between statutory and voluntary sector organisations. The website could also be used to hold e-training packages, policy developments, news items, etc.

Recommendation 3
The ACMHC or another relevant and expert body should work with others to co-ordinate and develop effective approaches to commissioning and to raise commissioners' awareness of the value of the sector. This may involve a brokerage service for commissioning which matched BVCS service providers to services needed by mental health statutory providers/authorities.

Sustainability and funding

Recommendation 4
Discussions should be initiated with NHS commissioners on exactly how much of the Department of Health's £50 million budget that has been set aside for buying in voluntary sector services will go to the BVCS. We suggest that ACMHC (and others) enter discussions now to ensure an amount is ringfenced for the BVSC which may be based on proportionality to the representation of diverse BME patients in the mental health system.

Recommendation 5
BVCS mental health organisations should be enabled to have increased access to good support. This could include eg; the services of a dedicated fundraiser shared between organisations based in the same area.

Recommendation 6
Funders (statutory and charitable) should consider a work stream that is dedicated to fostering relationships with the black mental health sector.

Recommendation 7
An agreed approach to funding should be developed to increase the sustainability and resourcing of the BVCS. This may take the form of secure medium and long-term funding agreements, which contain a built-in system of review.

Recommendation 8

NHS commissioners should target black and minority ethnic voluntary sector services for any outsourced mental health services for BME communities. A particular focus in this regard should be on those organisations who work with patients of African Caribbean origin. They should invest over a sustained period of time in established organisations with the requisite skills, which have identified a gap in service provision.

Recommendation 9

All funders (statutory and charitable) should set targets to ensure fair and equitable distribution of funds to black organisations, and information on progress should be made available on an annual basis.

Infrastructure and capacity building

Recommendation 10

A mental health development centre/unit should be established for the BVCS. This should be linked to existing regional National Institute for Mental Health in England (NIMHE) development centres in order to maximise use of resources. This BVCS development centre/unit would operate as a second-tier agency with strategic objectives linked to the wider objectives of the national NIMHE programme.

Recommendation 11

We recommend a further study to look specifically at the mental health needs and service provision for asylum seekers and refugees. We also recommend that statutory services should engage more actively with BME service users generally, in order to capture their views and experiences about which aspects of service delivery are valued. We note the work on the National Black & Minority Ethnic Census currently underway; but would also recommend the use of Race Equality Impact Assessments under Race Relations legislation to develop greater information and choice for BME communities.

Training (of both the voluntary and statutory sector)

Recommendation 12

It is recommended that approaches to training are identified and made accessible to the BVCS. This may take the form of existing training packages or could include the development of a suite of training packages which could be available online as e-training backed up with face to face training where appropriate. The training programmes offered could be targeted at both the voluntary and statutory sectors.

Recommendation 13

Shadowing schemes should be developed which can work both ways – NHS personnel seconded or placed in voluntary sector organisations or voluntary sector personnel placed in statutory services.

Partnership and dialogue

Recommendation 14

Recognised local BVCS groups should be resourced to facilitate a Critical Engagement Partnership (CEP). These groups should offer guidance, training and support to understand the various arenas of possible engagement (see table 7) and influence.

Recommendation 15

Steps should be taken to develop opportunities for a pan-London approach to promote dialogue and partnerships between those who hold/dispense funds and those who need them. This should encompass a wide range of sectors- including health service commissioners, local government, business, charities and others. Mechanisms for ongoing review should be developed in order to assess the degree of progress towards sustainability of the BVCS.

Recommendation 16

The roles, salary levels and location of CDWs need to be clarified. It would make sense that the community development workers (CDWs) work closely with the centre /unit suggested in recommendation 10, or are even located within the centre, which in turn could be located in the National Institute for Mental Health in England (NIMHE) or the ACMHC[1]. The black voluntary sector should be involved in the discussions around all of the above.

References

1   If located in ACMHC the emphasis would be firmly on services for African and Caribbean people, whereas within NIMHE this emphasis could be broader across African, Caribbean, Asian, refugee and asylum seeker communities.

Please note the full report can be found at www.london.gov.uk

Imperial College
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RISK DATA SHARING SERVICE: AN EVALUATION OF THE PILOT STAGE OF THE SERVICE

EXECUTIVE SUMMARY

Summary

This interagency information-sharing service, involving mental health services in Camden, Islington and Westminster, the Metropolitan Police, London Probation Area and London Ambulance Service was unprecedented. The model was shown to be efficient, ethical, legal and useful.

Introduction

- The Risk Data Sharing Service (RDSS) was set up to pilot a model of service which would facilitate information-sharing between statutory organisations involved in the care and treatment of people with severe and enduring mental health problems who pose substantial risk to themselves or others.

- It was hypothesised that allowing frontline staff access to key information about the identification and management of risk in urgent circumstances would lead to more appropriate treatment and care for mental health service users and would reduce serious untoward incidents involving them.

- The service model developed involved a 'Single Contact Point' staffed on a 24 hour basis by mental health professionals. They responded to requests from frontline staff in the participating agencies and made decisions about whether it was legally justifiable to disclose information about service users from a central database populated by referrals from community mental health teams.

- Mental health professionals (only) were also able to access information held by police, probation and ambulance services through the Single Contact Point. Information exchanged – in either direction – was the minimum necessary to identify the individual, to assess the nature of the risk and to manage the risk.

- The service was underpinned by an Information-Sharing Agreement signed by all the organisations involved.

Findings

- The service operated for 6 months (March – September 2004) during which time 160 service users were referred by the community-based mental health team (CMHT) caring for them.

- The service received 65 requests for information. Staff assessed 58% of these requests as justifying disclosure.

- There were no matches between the requests made and the service users referred to the service.

- The service was successful on several occasions in obtaining information from the police and probation services and passing it on to mental health professionals. The professionals who received information in this way found the service valuable, efficient and relevant.

- In most cases where information had been shared, understanding of risk had been increased and staff had been able to determine the least restrictive intervention for the service user.

- The staff working at the Single Contact Point had to make appropriate assessments and systematic decisions within very short timescales (usually minutes) and within the legal framework. Their backgrounds as community mental health professionals and a dedicated training programme assisted them to take on this innovative and complex role.

- Service users as a group do not support the concept of information-sharing, nor the specific model of the Risk Data Sharing Service, and have particular concerns about the stigma resulting from the association made between mental health and violence and the potential for discriminatory practice by police, ambulance crew and others if mental health status is shared.

- Two-thirds of service users referred to the Risk Data Sharing Service were not notified about their referral. It was clear that risk assessments are not routinely shown to or discussed with service users.

- Substance misuse was the factor most frequently mentioned (apart from deteriorating mental health), in 29% of referrals, as increasing the risk individual service users posed, either to themselves, or to others.

Conclusions

- The limited scope of the pilot (in relation to the geographical area covered, the short length of time of its operation and the limitation of responding to requests in only urgent or emergency circumstances) affected the capacity of the evaluation to reflect its applications and outcomes, particularly in relation to exploring the potential benefits for service users.

- The low number of enquiries to the service during the pilot is attributed to the difficulties of achieving cultural change in large public sector organisations, and complexity of communicating with frontline staff.

- The model of service developed for sharing information was viable, and would generate greater benefits if expanded across a wider geographical area. The pilot showed that the legal framework can support information-sharing as well as protecting the rights of service users.

- The pilot highlighted the poor quality or complete lack of information available to care co-ordinators about service users' history of contact with the criminal justice system. However, future development of the service could help mental health professionals to access this information and enhance risk management.

- The additional workload for CMHTs was not onerous, and has the potential to be reduced further by the process of referral being incorporated into the Care Programme Approach (CPA) where it could aid both crisis planning and risk management.

- Suggestions for reducing risk in given situations demonstrated that there are some general lessons relating to communication, non-threatening behaviour and the involvement of people known to the service user (such as family members or friends) which could be incorporated into training for police officers and ambulance crews. The need for better training in order to make effective use of information shared was emphasised by all stakeholders.

- A lack of knowledge of the legal framework governing information-sharing (and particularly of the Data Protection Act, 1998) contributed to the reservations of professionals about the service. The difficult balance between preserving confidentiality and public protection was also highlighted, but it was notable that mental health professionals citing the importance of confidentiality in relation to the information held by mental health services were keen to achieve easier access to data belonging to the police.

- Mental health professionals working with people unknown to them (in duty, crisis, intake and A&E liaison teams) were particularly supportive of the service, saying that access to this information would help them manage risk – to themselves, to service users and to others – more effectively.

Future potential

- The Risk Data Sharing Service has the potential to contribute to a broad range of circumstances, by expanding its scope to include non-urgent situations, forensic services, prisons and inpatient facilities, particularly at the point of entry to and discharge from institutions.

- Further development and expansion of the Risk Data Sharing pilot would provide opportunities for the police to protect people in custody and to manage pre-planned operations more safely.

- The service has the potential to support the work of the Probation Service, particularly in relation to Multi-Agency Public Protection Arrangements and the out-of-borough placement of offenders.

- The London Ambulance Service is currently working on improving its approach to mental health issues, and the Risk Data Sharing Service could support changes in staff understanding and handling of people with mental health problems, as well as contributing to the development of alternative care pathways for service users.

- Many lessons have been learned from this groundbreaking multi-agency pilot which are relevant to a wider mental health agenda as well as to future developments of this specific service.

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