



House of Commons
Home Affairs Committee

Policing and mental health

Eleventh Report of Session 2014–15

Report, together with formal minutes

*Ordered by the House of Commons
to be printed 3 February 2015*

HC 202
[Incorporating HC 908, 2013–14]
Published on 6 February 2015
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

Home Affairs Committee

The Home Affairs Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Home Office and its associated public bodies.

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1 Introduction

1. People who experience mental illness, like everyone else, can come into contact with the police for a wide variety of reasons, the common ones being they might be suspected of having committed a crime,¹ they might have been the victim of a crime,² they might be reported as missing,³ or they might experience a mental health crisis, where they may be so ill that their safety, or the safety of others, could be at risk. Lord Adebowale, Chief Executive of Turning Point, admitted that when he was invited to chair the Independent Commission on Mental Health and Policing, he thought mental health would have little to do with policing. In the report published at the end of his review, he said that mental health is core police business.⁴ One in four people will suffer from mental health illness at some point, and their illness brings with it a vulnerability that makes it likely they will come into contact with the police. This vulnerability is particularly relevant in a mental health crisis, and when they do so, it should be considered primarily as a health matter, so they can seek and receive support from a mental health team, or if they call 999 to ask for help, the first responders should be health professionals.⁵

2. Unfortunately, mental health services are not always available.⁶ The Rt Hon Norman Lamb MP, Minister of State for Care and Support at the Department of Health, has said that only 25% of young people with mental health problems had access to mental health services, services he described as “dysfunctional and fragmented”.⁷ Mental health services have deteriorated over many years and under successive governments. There is evidence that some people, particularly from black and ethnic minority communities, are reluctant to engage with mental health services if they have previously had a poor experience.⁸ This can lead to treatment being avoided or delayed, and people seeking help only when it reaches crisis point.

3. Access to mental health crisis care is limited, particularly at night.⁹ Where people do not have access to appropriate emergency healthcare, the police have become the *de facto* “first aid response to mental distress.”¹⁰ Many of the people that come into contact with the police in this way are already known to the health services—as many as two-thirds of those

1 The Prison Reform Trust estimate that 10% of men and 30% of women in prison have had a previous psychiatric admission

2 Mind and Victim Support, [At risk, yet dismissed](#), 2013. People who suffer from mental ill health are three times more likely to be a victim of crime than those who do not, and people who suffer from mental ill health are less likely to report crime.

3 See Mental health and missing, www.missingpeople.org.uk

4 Independent Commission on Mental Health and Policing, Report, May 2013; Q 122; [MIND \(PMH0027\)](#)

5 [Police Federation of England and Wales \(PMH0036\)](#)

6 BBC News, [Mental health services a car crash](#), 24 June 2014. Royal College of Nursing, [Frontline First: Turning back the clock? RCN report on mental health services in the UK](#), November 2014; [Mental health services cuts are putting patients at risk, BMA told](#), The Guardian, 25 June 2014

7 Q 284

8 [College of Paramedics \(PMH0047\)](#)

9 Q 7 [MacAttram] Q 196 [Kressinger] Q 152 [Davis]; [Police and Crime Commissioner for Cheshire \(PMH0033\)](#); [Self Help Services \(PMH0020\)](#); College of Emergency Medicine, [An investigation into care of people detained under Section 136 of the Mental Health Act who are brought to Emergency Departments in England and Wales](#), October 2014

10 Q 4

detained by the police under s. 136 of the Mental Health Act are already in receipt of mental health care.¹¹ And yet the police are not confident they are qualified or the right people to be dealing with such situations.¹² This inquiry is largely focused on what happens in those situations when the police are called to someone in crisis.

Contact with the police

4. Sir Peter Fahy, Chief Constable of Greater Manchester, has described mental health as “the number one issue” for most frontline police officers.¹³ Estimates vary, but we were given a range of between 20% and 40% for the amount of police time which involved a mental health element.¹⁴ Custody Sergeant Ian Kressinger of Devon and Cornwall Police, told us that about 40% of the people passing through his custody suite had some kind of illness, personality disorder, depression, anxiety, or were taking medication for something similar.¹⁵ And it was Devon and Cornwall Police Federation who first brought this to our attention when they proposed that health authorities accept their responsibility for the mentally ill, either within their own premises or a Police Station.

5. There is a clear feeling that the police are being asked to do things that they are not trained for.¹⁶ Rt Hon Mike Penning MP, Minister of State for Policing, Criminal Justice and Victims at the Home Office and Ministry of Justice, told us that:

If you have a mental health issue, you will invariably come into contact with the police, as the professional involved. That cannot be right. It is not the job of the police to be that first point of contact; they should be the last resort.¹⁷

6. Police forces work with all members of the communities they serve. Working with those with mental health problems will always be a core part of that work. However, we are concerned by the extent to which frontline officers are increasingly spending their time helping people with mental health problems. For many people experiencing an acute health crisis, a police officer is not the professional best placed to help them, nor is dealing with acute health crises the best use of police officers’ time and skills. We believe that the police should not be filling gaps in mental health services.

11 Health and Social Care Information Centre, [Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14](#), October 2014

12 Q 331 [The Police Foundation \(PMH0028\)](#)

13 [INQUEST \(PMH0042\)](#)

14 Q 89 [Michael Brown]; [ACPO National Mental Health Policing Lead \(PMH0013\)](#); [Association of Police and Crime Commissioners \(PMH0015\)](#); BBC, [Staffordshire reveals cost of policing mental illness](#), 15 October 2013

15 Q 194

16 [Association of Police and Crime Commissioners \(PMH0015\)](#)

17 Q 318

2 Detention under the Mental Health Act

7. The principle police power to detain someone having a mental health crisis is section 136 of the Mental Health Act 1983,¹⁸ which provides that:

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

A “place of safety” is defined in s. 135 as

Residential accommodation provided by social services, a hospital, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient.

Once a person has been removed to a place of safety, they may be detained there (or transferred to another place of safety) for up to 72 hours so that they can be examined by a doctor and interviewed by an approved mental health professional so that arrangements can be made for their treatment or care.

The use of section 136

8. The Mental Health Act 1983 Code of Practice on the use of s. 136 said that police cells should be used as a place of safety only on an exceptional basis, and that a “police station should not be assumed to be the automatic second choice if the first choice place of safety is not immediately available”.¹⁹ The table below gives the number of those detained under s. 136 and went to a police cell or to a health based place of safety in the last three years.

Year	People detained under s136 and taken to a place of safety		
	Total	Police cell	Health
2011-12	25,000	9,000	16,000
2012-13	22,834	7,761	15,073
2013-14	24,489	6,028	18,461

9. Practice on the use of police cells as a place of safety varies considerably between police forces in England and Wales. The table below shows the five forces with the highest number of detentions in police cells under s. 136 and the five lowest. It also shows the number of such detentions in the previous year.²⁰

18 The 1983 Act was amended in part by the Mental Health Act 2007.

19 Department of Health, 2008, [Mental Health Act 1983 Code of Practice](#), para 10.22

20 Health and Social Care Information Centre, [Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14](#), October 2014

Most people detained under s. 136 in a police cell		
Police force	2013-14	2012-13
Sussex	855	941
Devon & Cornwall	765	790
Avon and Somerset	420	646
West Yorkshire	380	673
Hampshire	340	593

Fewest people detained under s. 136 in a police cell		
Police force	2013-14	2012-13
Greater Manchester	< 5	206
Merseyside	< 5	5
Hertfordshire	< 5	2
City of London	< 5	50
West Midlands	5	50

10. There has been considerable pressure to address the use of police cells and the Crisis Care Concordat commits the Government to a 50% reduction over two years in the use of police cells as a place of safety for those in crisis.²¹ Apart from the simple totals, there are further concerns about how s. 136 is applied. A study from 2008 found that the rate of detention of black and ethnic minority people using s. 136 is almost twice that of white people,²² and the latest data available shows that children are still detained in most police force areas.²³

11. The use of section 136 of the Mental Health Act 1983 and reducing the detention of people in police cells is widely seen as an indicator of a police forces' performance in relation to mental health, and it has focussed attention on the problem. We support the Government's commitment in the Crisis Care Concordat to see the number of detentions in police cells under section 136 halved in two years compared with 2011-12.

21 The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. It was signed by 22 national bodies in February 2014. See <http://www.crisiscareconcordat.org.uk/>

22 Independent Police Complaints Commission, 2010, [Police custody as a place of safety](#).

23 Health and Social Care Information Centre, [Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14](#), October 2014

Removing police cells as a place of safety

12. Many submissions, particularly from the police, supported the removal of police cells from the statutory list of acceptable places of safety.²⁴ Simon Cole, Chief Constable of Leicestershire, and former ACPO lead on mental health, said that the inclusion of police cells on the list was “just plain wrong”.²⁵ In most cases, police cells are highly inappropriate places for someone in a crisis.²⁶ They are noisy and brightly-lit. If the person has threatened to self-harm then they may have to be strip-searched for a concealed blade. They may be placed in anti-harm clothing. All this can add to the distress.²⁷ There are examples of people who have died in custody because they were being detained by police officers when they should have been in the care of mental health professionals in a much more appropriate environment.²⁸

13. Her Majesty’s Inspectorate of Constabulary (HMIC) are monitoring the use of police custody as a place of safety. If there is no significant reduction in its inappropriate use by April 2016, then they will recommend police cells to be removed as a place of safety in the Mental Health Act 1983. The main objection to removing police cells as places of safety has been the lack of health-based places of safety in some areas to be able to care for all those detained under s. 136.²⁹ There is an issue of cause-and-effect here, with the use of police cells concealing inadequate commissioning by Clinical Commissioning Groups (CCGs). If police stations are to be removed from the list of places of safety in the Mental Health Act, without a parallel increase in the number of health based places of safety, then the total number of places of safety available in a given area would go down. The Royal College of Psychiatrists has said that, in such a scenario, where demand remained the same but capacity was reduced, access to the few health based places of safety may become limited to those in the greatest need. The threshold for access to care could go up.³⁰ A related objection is that in rural areas, poor local provision can mean the choice is between a health-based place of safety a long drive away or a much closer police cell. There seems to be an assumption that the list of all health based places of safety produced by the Care Quality Commission (CQC) is exhaustive and the only options available—a place of safety could be any suitable place where the occupier is willing to receive the person until the assessment is complete.³¹

14. Another objection is that there may be times when the patient needs to be held in a cell for the safety of themselves and the public. There may be cases where an individual is unmanageable in a health environment. Submissions from those who were unsure about removing the use of police cells as a place of safety entirely tended to support a reduction to only “exceptional circumstances”.³² Defining exceptional circumstances has proven

24 [Police Federation of England and Wales \(PMH0036\)](#)

25 Q 230

26 [Royal College of Nursing \(PMH0014\)](#)

27 Q 204; Q 216

28 [Police Federation of England and Wales \(PMH0036\)](#); [Michael Brown \(PMH0022\)](#)

29 Q 27

30 [Royal College of Psychiatrists Supplementary \(PMH0058\)](#)

31 Q 133

32 [Association of Police and Crime Commissioners \(PMH0015\)](#)

problematic in the past but there is broad support for there being more clarity around what it does mean—where a person’s behaviour would pose an unmanageably high risk to other patients, staff or users of a healthcare setting—and not just because no adequate NHS care was available.³³ Furthermore, if the explicit reference to a police station as a place of safety was removed from the Act it would not completely preclude the use of police cells in exceptional circumstances. It could still fall under the definition of “any other suitable place the occupier of which is willing temporarily to receive the patient”. The Government review of s135 and s136 did not come to a definitive view as to whether police cells should be removed from the Mental Health Act as a specified place of safety. It recommended:

Ensuring that police cells can only be used as a place of safety for adults if the person’s behaviour is so extreme they cannot otherwise be safely managed.

15. We recommend that the specific reference to a police station should be removed from the definition of “places of safety” in s. 135(6) of the Mental Health Act 1983. We recognise that there are concerns over the lack of health-based places of safety that exist in some parts of the country, particularly rural areas. However, this proposal has been under discussion for some time now and commissioners should have started commissioning appropriate place of safety provision before now. All areas need to do so, and be able to demonstrate that they have made progress by July 2015. The Government should immediately re-issue guidance to police forces and health trusts defining the exceptional circumstances in which police cells may be used as places of safety. The presumption should clearly be the health facility not the police cell.

16. The Government’s own review of s. 136 recommended ensuring that police cells can only be used as a place of safety for adults in situations where the person’s behaviour is so extreme they cannot otherwise be safely managed. Following the general election a new government should set out what they will do to ensure this happens if it will not amend the Mental Health Act 1983.

Provision of health-based places of safety

17. A health-based place of safety is generally either part of a mental health unit in a mental health hospital or on an acute hospital site, or part of an A&E department in an acute hospital. A recent survey by the CQC found that there were 161 health-based places of safety in England.³⁴ The majority (81%) are in mental health hospitals or (4%) part of an acute hospital’s mental health services. A quarter of health care providers told the CQC that they did not believe there were enough health-based places of safety in their area.³⁵ (Note two thirds of respondents to the Home Office review of s. 136 said that police cells were used because of a lack of health-based ones.³⁶) Not all the places of safety listed are adequately staffed, nor are they all open 24 hours a day,³⁷ enough for the CQC to remark

33 Q 134. See Department of Health and Home Office, [Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983](#), December 2014, Review Report and recommendations, pages 43-49

34 The Care Quality Commission surveyed the provision of health based places of safety in Jan-Feb 2014

35 Care Quality Commission, [A safer place to be](#), October 2014

36 Department of Health and Home Office, [Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983](#), December 2014

37 Q 22

that “occasionally, the stated opening times are theoretical.”³⁸ The Centre for Mental Health found that staff for many s. 136 facilities are from other wards, so there is pressure for them to return to other duties, and yet some CCGs did not appear to take this pressure on staff into account.³⁹ The vast majority of places of safety have capacity for only one person, and one in ten units told the CQC that they turned people away at least once a week because the place of safety was occupied.⁴⁰ At times, if there is no space, the patient waits outside in a police van.

18. The lack of health-based places of safety directly contributes to the number of people who end up being detained in a police cell.⁴¹ Inspector Michael Brown, Mental Health Co-ordinator at the College of Policing and author of the Mental Health Cop Blog, told us that, in the West Midlands, they had gone in two years from a situation where they had zero provision of health-based places of safety to a situation where 98% of people went to health-based places of safety. This was because those who commissioned services in the West Midlands understood and became committed to dealing with the issue. He said there was a need for NHS commissioners to recognise the need for sufficient places of safety, open 24-hours a day, seven days a week, and fully staffed.⁴² This commitment and understanding is not replicated in all parts of the country.⁴³

19. We commend the work by Inspector Michael Brown, and others who have championed the cause of mental health within the Police. His work online has been particularly impressive.

20. It is clear that too many NHS Clinical Commissioning Groups are failing in their duty to provide enough health-based places of safety that are available 24 hours a day, seven days a week, and are adequately staffed. CCGs must not only acknowledge local levels of demand and commission suitable health-based places of safety, they must also design local backup policies to deal with situations where places are occupied. Relying on the police to fill the commissioning gap not only imposes non-negotiable, external costs on forces, but it increases the risk to highly vulnerable patients. We recommend that the Department of Health, together with the Home Office, issue clear guidance to CCGs about the appropriate number of health-based place of safety places, having regard to local circumstances, within three months.

Exclusion from health-based places of safety

21. Access to some health-based places of safety is restricted by informal exclusion criteria. This might include cases where the person is aggressive or resistant, is under the influence of drugs or alcohol, is under the age of 18, has a history of violence, has committed a criminal offence, or has a learning disability rather than a mental illness.⁴⁴ Some NHS

38 Care Quality Commission, [A safer place to be](#), October 2014, 1.3

39 Centre for Mental Health, [Review of Sections 135 & 136 of the Mental Health Act](#), December 2014

40 Care Quality Commission, [A safer place to be](#), 1.4

41 Care Quality Commission, [A safer place to be](#), 1.4

42 Q 27

43 Q 121

44 Q 121; Care Quality Commission, [A safer place to be](#), 5.3; HMIC and Care Quality Commission, [A Criminal Use of Police Cells](#). The 1983 Act defines “mental disorder” as “any disorder or disability of the mind” (s. 1). This includes

trusts are reluctant to carry out mental health assessments of people who are from outside their home area. Mark Smith, Head of Suicide Prevention and Mental Health, British Transport Police gave an example of a case where he had taken someone to A&E to be treated for their physical injuries from a suicide attempt, but the patient was then initially refused a mental health assessment at the mental health unit next door.⁴⁵

Exclusion due to intoxication

22. It is relatively common for people with mental health problems who come into contact with the police to also have problems with alcohol or drug use. However, the NHS is often reluctant to take responsibility for these patients. When asked why this happens, Dr Mary Jane Tacchi, Special Advisor on Crisis Care to the Royal College of Psychiatrists, told us that, historically, there has been a “feeling” that the Mental Health Act did not cover people who were intoxicated. She said this was incorrect and that:

The Royal College of Psychiatrists have very clearly stated that people who are intoxicated and have a mental health problem are our business and it is our responsibility to look after them. So refusing people on the grounds of being intoxicated with a mental problem must not happen.⁴⁶

One of the difficulties, she went on to explain, was that it was not possible to carry out a mental health assessment until the patient was sober and it was not clear where the patient should go until they sobered up.

23. Patients often present with complex, multiple problems. Initial data from the Liaison and Diversion pilots show that, of the adults passing through with mental health, drugs or alcohol issues, 50% are experiencing more than one of these problems.⁴⁷ The NHS should be prepared to deal with patients presenting with multiple problems. When they are turned away, they are likely to come back in a worse state later on.⁴⁸

24. The NHS would not turn away a patient with a physical illness just because they were intoxicated. People with mental health problems have exactly the same right to NHS care as everybody else and it is shocking that patients are excluded from health-based places of safety on the basis of informal exclusion criteria. The guidance that people with mental health illness should be treated in a mental health facility needs to be repeatedly reinforced.

Alternative Places of Safety

25. A place of safety may include a local authority care home, an NHS or private hospital, an independent care home or, as we have already noted, “any other suitable place the

learning disabilities and autistic spectrum disorders, although the Code of Practice states that, in the case of a person with a learning disability, they cannot be detained unless their learning disability “is accompanied by abnormally aggressive or seriously irresponsible conduct on their part”.

45 Q 272

46 Qq 174-175

47 Liaison and Diversion pilots are discussed in the section on police and health service collaboration [NHS England \(PMH0055\)](#), para 13

48 Q 138

occupier of which is willing temporarily to receive the patient”. We heard support for the use of community-based places of safety where people could go in a crisis, including ones that addressed the specific needs of black and ethnic minority communities.⁴⁹ We heard support for the use of other NHS facilities, such as GP surgeries.⁵⁰ There are places of safety designed specifically for intoxicated patients to sober up, or ‘dry out’, before they can be assessed in the US,⁵¹ and similar examples have been trialled in parts of the UK and may be considered by the Welsh Government.⁵²

26. We note that the Government review of sections 135 and 136 said they would explore alternative places of safety. The fundamental reason for a place of safety is to keep someone safe until they can have a mental health assessment and a judgment can be made as to their future treatment. Where there is a clear gap between demand and provision, then we agree that alternatives should be considered. Anywhere used as a place of safety must adhere to relevant guidance and be able to secure the confidence of patients and their families. In particular, the staff, especially if they might be called upon to restrain someone, should receive validated training.

Public and private places

27. Section 136 can be used only in “places to which the public have access.” Where a person who is believed to be unwell and in need of assistance is in a private place, the police must rely on section 135 of the Mental Health Act 1983. This requires them to seek a warrant from a magistrate giving them power to enter the premises where the person is believed to be and remove him or her to a place of safety. The warrant can only be applied for by an approved mental health professional (AMHP) and, when acting on the warrant, the police must be accompanied by an AMHP and a doctor.⁵³ In a crisis situation, time might not permit the police to call on a mental health crisis team and a justice of the peace before the need to act, so they have found ways of getting around the problem, for example, by arresting someone on suspicion of a minor offence to enable them to be moved.⁵⁴

28. We received proposals to suggest changing the law so that police could enter private premises, if they were led to believe that someone was in need of care, to enforce s. 136 powers.⁵⁵ Michael Brown pointed out that other countries, such as the Republic of Ireland, Canada and Australia, do allow some form of intervention in a private place.⁵⁶ Simon Cole said he understood the frustration of those who wanted the law to be changed, because of the time spent waiting for warrants to be sworn, but he did not support a change. He said:

49 Q 28 [MacAttram]

50 Q 281

51 Paula Reid, Mental Health and Criminal Justice, [What can we learn from liaison and diversion in the USA?](#), July 2014. [The Police Foundation \(PMH0028\)](#)

52 Q 172 [David Davis]; [Welsh Government \(PMH0034\)](#)

53 Q 96

54 Q 116

55 See also the Department of Health and Home Office, [Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983](#), and the Centre for Mental Health, [Review of Sections 135 & 136 of the Mental Health Act](#), Dec 2014

56 Q 116

I do think there is a pretty profound issue for Parliament, which is: does Parliament want to enact something that means that the response to mental illness is the police have a power to enter a place?⁵⁷

At the moment the AMHP has to go to a magistrate to get a warrant. If the law changed, there is a risk that if the law was amended to allow the police and only the police to enter private property, then AMHPs might find it easier to call the police in order to gain access.⁵⁸ In either situation, the police might not necessarily be needed, except to execute the warrant.

29. There is a further issue around people found on private premises that are not a private home, in particular on railway property. Mark Smith of British Transport Police explained:

We have a specific issue with this inasmuch that the power [s. 136] applies to people who are in a place to which the public have access. Railway lines are a place to which the public do not have access, so our officers need to remove somebody from a place of danger, get them to a public place, and then make that judgment as to whether they need care and control for the power to be made out and executed.⁵⁹

His proposal was to amend the law so the power to detain under s. 136 was extended to circumstances which involve trespass, so including railway tracks and other places such as tall buildings, which may be accessed by people seeking to take their own lives.⁶⁰ The Government has agreed to extend the provision so it would apply anywhere but a private home. This would extend its application to railway lines, but also to private vehicles, hospital wards, rooftops of buildings, and hotel rooms.

30. We agree with the proposal to amend the Mental Health Act so that the powers of s. 136 could be used anywhere other than a private home. This would give the police power to deal expeditiously with people on railway lines and in high places to which the public do not have access. We believe that extending the range of settings in which the power could be used to include private homes would be a step too far. Extending police powers must be done with caution, as it is important that this does not reinforce the need for police involvement in mental health cases, as we believe it is important that it should be kept to a minimum.

57 Q 275

58 Q 227

59 Q 274

60 [British Transport Police \(PMH0025\)](#)

3 Detention of children under s. 136

31. In 2013–14, a total of 753 children were detained under section 136. Of these, 236 were detained in a police cell.⁶¹ This represents a reduction in absolute terms on the previous year, 2012–13, when 263 children were detained in cells.⁶² However, a child under 18 detained under s. 136 is statistically more likely than an adult to end up in a police station.⁶³ The table below shows the five forces with the highest number of children detained in police cells in 2013–14.⁶⁴

Children detained under s136 and held in a police cell	
Police force	2013-14
Devon and Cornwall	30
Lincolnshire	25
North Yorkshire	20
Hampshire	20
Sussex	20

32. There is a consensus that children should not be held in police cells under s. 136. Children are more vulnerable than adults, and they present mental health illness differently than adults. Half of the people who have lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.⁶⁵ Young people who come into contact with the youth justice system have higher rates of mental disorders, including self-harm and suicidal behaviours, than those who do not.⁶⁶ A recent Health Committee report into *Children's and adolescents mental health and CAMHS* said that it would be “unthinkable” for children experiencing a crisis in their physical health to be held in a police cell because of a lack of an appropriate hospital bed, and it should be regarded as a “never event” for those in mental health crisis.⁶⁷ The Government review of sections 135 and 136 said that the legislation would be amended so that under-18s would never be taken to a police cell under s. 136. Norman Lamb told us that the detention of children in police

61 Health and Social Care Information Centre, [Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14](#), October 2014; [Howard League for Penal Reform \(PMH0050\)](#)

62 [Royal College of Psychiatrists \(PMH0038\)](#), para 8.10

63 Care Quality Commission. [A safer place to be](#), October 2014, page 22

64 Health and Social Care Information Centre, [Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14](#), October 2014

65 [NHS England \(PMH0055\)](#)

66 [Royal College of Psychiatrists \(PMH0038\)](#)

67 Health Committee, Third Report of Session 2014–15, [Children's and adolescents' mental health and CAMHS](#), HC 342

cells was unacceptable and that he, alongside the Minister for Policing, would be writing to “every area of the country” to make it “clear that the practice should end now.”⁶⁸

Exclusion due to age

33. The CQC’s map of places of safety found that 56 (35%) of the 161 health-based places of safety do not accept young people under the age of 16,⁶⁹ and 16% do not accept those aged 16 and 17. For example, there are no health-based places of safety that accept someone under the age of 16 within Avon.⁷⁰ As with provision for adults, what facilities do exist often have space for only one person. If it is occupied, then the police have to look elsewhere, and this is compounded when the nearest health-based place of safety, designated for adults, refuses to take the child because they consider their facilities to be inappropriate. We were told of numerous examples of the police spending hours trying to locate somewhere other than a police cell.⁷¹ The Royal College of Psychiatrists has made it clear that children should not be excluded from a health-based place of safety because it does not have a separate assessment space for under-18s. The Code of Practice states that a child can be detained in a place of safety not specifically designated for under-18s, “if this is assessed to be a suitable environment for the child or young person at that time, given the particular circumstances.”⁷²

34. The fact that children are still detained in police cells under section 136 reflects a clear failure of commissioning by NHS Clinical Commissioning Groups. The de facto use of police cells as an alternative relieves the pressure on CCGs to commission appropriate levels of provision for children experiencing mental-health crisis. We support the Government’s proposals for a change in the law to ensure that children can never be held in a police cell under section 136 of the Mental Health Act 1983, which we recommend should be included in the next Queen’s Speech. In the interim, guidance on the detention of children in police cells under s. 136 must be made clear—that it is unacceptable and must stop. This guidance needs to be distributed to those working in the police and in the health service.

35. The fact that a place of safety is attached to an adult ward should not preclude its use for children, particularly when the alternative is a prison cell. The Mental Health Act Code of Practice is clear on this point, and we recommend that the Department of Health draw this to the attention of all providers of health-based places of safety.

68 Q 289

69 Care Quality Commission data on the number of places of safety in each local authority, their opening hours, capacity, and age restrictions is on the Care Quality Commission website.

70 [Avon and Somerset Constabulary and Police and Crime Commissioner \(PMH0032\)](#)

71 See, for example, Q 248

72 [Royal College of Psychiatrists Supplementary \(PMH0058\)](#), para 2.2

4 Police and health service collaboration

Street triage

36. Announced in June 2013, Street Triage is an initiative that sees mental health nurses accompany officers to incidents where police believe people need immediate mental health support. The scheme is funded by the Department of Health and supported by the Home Office. It started with two schemes in Cleveland and Leicestershire, later extended to another nine forces.⁷³ There are other, similar schemes that have been designed locally with local funding. The format of Street Triage differs according to local circumstances. In Leicestershire, a police officer and a trained mental health nurse in a patrol car are able to respond to any call with a mental health aspect. The Birmingham and Solihull version is similar but also includes a paramedic. In Devon, a team of mental health nurses based in the control centre give advice over the telephone to police officers at the scene. The nurses can, if need be, go out on call with a police officer.⁷⁴ They generally operate overnight when need is greatest and mental health services tend to be lacking.

37. The pilots are still being appraised but initial results are promising. Street Triage has helped to develop relationships and break down barriers between the participating agencies.⁷⁵ Importantly, the collaborative approach gives frontline staff access to both police records and medical records, giving them quick access to critical information on a person's previous contact with the police, clinical history and medications, and whether a care plan is already in place.⁷⁶ There is also anecdotal evidence that the mental health nurses are less risk-averse than the police officers when it comes to dealing with patients with a history of mental illness. So a nurse might be more willing to leave someone in the community rather than detaining and this confidence in time will be transmitted to police officers working alongside them. This had led to fewer s. 136 detentions and, in some places, it has led to a fall in demand for ambulances.⁷⁷

38. In Leicestershire, there has been a 30% to 40% reduction in the use of section 136 powers since 2013.⁷⁸ In Cheshire, there was an 80% reduction in the use of s. 136 in the first six months of Street Triage. Instead of being detained, people were referred to other care, for example, 15% were referred to substance misuse services. In Birmingham and Solihull, there was a reduction in the use of s. 136 by 50% over a 20-week period.⁷⁹ As a result of these preliminary successes, HMIC has recommended that all forces should carry out analysis to assess whether adopting such a programme would be cost-effective and beneficial in their particular areas by 31 March 2015, and if the analysis is positive, they

73 [Extending the street triage scheme: New patrols with nurses and the police](#), 20 August 2013. After Cleveland and Leicestershire, the next four were: North Yorkshire, Devon and Cornwall, Sussex, and Derbyshire, and the next five were the Metropolitan Police, British Transport Police, West Yorkshire Police, West Midlands Police and Thames Valley Police.

74 Q 164

75 [Royal College of Nursing \(PMH0014\)](#); [NHS England \(PMH0055\)](#); Qq 258-259 and Q 268

76 Q 29

77 Q 140

78 Q 248

79 Q 140

should work with their local mental health trusts to introduce Street Triage by 1 September 2015.⁸⁰ We did receive some evidence that questioned how Street Triage was being appraised and whether it was cost effective.⁸¹ We note that two of the earliest pilots were in Devon & Cornwall, and in Sussex, two forces that still detain high numbers of people under s. 136 in police cells.

39. Though early indications of the effectiveness of the Street Triage scheme are very positive, it is important that the scheme is fully appraised against a range of clear success criteria, including an analysis of the relative merits of different models of provision, and the results published. In particular, it will be important to understand why the number of s. 136 detentions has fallen in some areas but not to the same extent in others following the introduction of the scheme. That information will inform the analyses that HMIC has asked each force to produce with a view to adopting some form of Street Triage. We note that different forms of Street Triage are funded in different ways and that it is not clear what guarantees are in place to secure funding at the end of the pilots. We recommend that the Government give a clear commitment that funding will be made available for schemes which have been proven to be cost-effective.

Liaison and diversion

40. Liaison and diversion (L&D) is a scheme that places mental health experts within police custody suites and courts, to identify early when someone who has been arrested has a mental illness, and refer them to support.⁸² This would include someone, of any age, who has one or more of the vulnerabilities associated with mental illness, drug and alcohol dependency, and learning disabilities.⁸³ There are currently ten trials funded by the NHS, at a total cost of £25 million, with a further nine expected to be announced soon.⁸⁴ NHS England plans for L&D services to be available in all police custody suites and all courts by April 2017.⁸⁵ L&D is not an alternative to prosecution or out-of-court disposal where a person has committed a crime. The schemes are aimed at reducing re-offending by recognising when someone is ill or has a learning difficulty, and improving the treatment they get when they enter the criminal justice system.⁸⁶

41. Similar to Street Triage, Liaison and Diversion services are intended to ensure that a person with mental health problems who does come into contact with the police and the courts receives appropriate treatment. The prevalence of people with mental illness within the criminal justice system is a scandal and any initiative that addresses this should be welcomed. However, its success will clearly rely on the availability of appropriate mental health services to which clients can be referred.

80 HMIC, [Core Business: An Inspection into crime prevention, police attendance and the use of police time](#), September 2014

81 [The Police Foundation \(PMH0028\)](#); [Michael Brown supplementary \(PMH0052\)](#)

82 [The Bradley Report](#), April 2009; [Royal College of Nursing \(PMH0014\)](#)

83 [NHS England \(PMH0055\)](#); Q 33; [Faculty of Forensic and Legal Medicine of the Royal College of Physicians \(PMH0035\)](#)

84 The ten trials are in Merseyside, London, Avon and Wiltshire, Leicester, Sussex, Dorset, Sunderland and Middlesbrough, Coventry, South Essex and Wakefield. Q 262

85 [NHS England \(PMH0055\)](#); Q 33 [Williamson]; Q 283 [Lamb]

86 Q 283. See also Q 153; Q 125; [NHS England \(PMH0055\)](#)

Ambulances

42. The Codes of Practice for the Mental Health Act require that people taken to a health-based place of safety should be transported there by an ambulance or other health transport arranged by the police. The Royal College of Psychiatrists standards specify an ambulance as the preferred form of transport and the Crisis Care Concordat states that police cars or vans should be used only in exceptional circumstances. Transportation in a police car or van makes patients feel like they are being treated like a criminal, reinforces the negative stigma associated with mental health and adds to the stress of the situation.

43. The provision of ambulances to carry people to a place of safety varies widely. In 2013–14, 75% of those detained under s. 136 in the West Midlands were carried in an ambulance, whereas in London it was 30%, in Thames Valley it was 10%, and in Lancashire it was 5%.⁸⁷ For many parts of the country, no data is available. The table below shows the top five areas for the percentage of those detained under s. 136 and transported by ambulance.

% of those detained under s136 conveyed to hospital by ambulance	
Police force	2013-14
West Midlands	75
Kent	70
North Yorkshire	60
Warwickshire & West Mercia	45
Staffordshire	35
Note: data is not available for all areas of England	

44. Various reasons are given for this variety of performance: ever increasing 999 calls asking for an ambulance, a shortfall of between 2,500 and 3,000 paramedics, and the local relationship between the Ambulance service and the police.⁸⁸ The Government's review of the use of s. 136 found a polarised answer to transportation; the majority of respondents who were paramedics or ambulance staff said ambulances should not be used, while the majority of police respondents said police vehicles should not be used.⁸⁹ The Government has raised the option of using unmarked police vehicles instead of ambulances.⁹⁰

45. People encountering a mental health crisis should be transported to hospital in an ambulance if an emergency services vehicle is needed. Transportation in a police car is shameful and in many cases adds to the distress. Those affected, and their families, are clear that they wish to see ambulances used as transport to hospital. It enables the

87 Health and Social Care Information Centre, [Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14](#), October 2014

88 Qq 176-177; Q 145; [College of Paramedics \(PMH0047\)](#)

89 Department of Health and Home Office, [Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983](#), December 2014

90 Q 309

patient's health to be monitored on the way and improves access to healthcare pathways.

46. Reliable data on the use of ambulances to transport people under s. 136 is poor, but it is clear that the use of ambulances in these circumstances varies across the country. The relationship between the police and ambulance service at the local level is pivotal to how this can be improved. Forums that enable each to understand the priorities, roles and responsibilities of the other, such as partnership working and Street Triage, have been shown to work. To get to a point, such as in the West Midlands where 75% of people are taken to hospital under s. 136 by ambulance, require the ambulance service and the police to develop that local relationship. The Government must examine what the barriers are to poor performance of those ambulance services with regard to transporting people to hospital under s. 136. It must work harder to make sure examples of best practice are spread throughout the country.

47. Improvements can be made in how mental health crisis calls are received and processed by the 999 call handler. Such improvements can reduce the use of s. 136 and in turn reduce the demand on ambulances.

48. We recognise that there is a huge demand on all 999 services at a time of restricted budgets but, fundamentally, mental health needs to be seen on a par with physical health, and local commissioning of health services, including ambulances, must reflect that.

Delays waiting for a mental health assessment

In a hospital

49. People brought to a hospital A&E place of safety often have to wait between six and eight hours before they receive a mental health assessment. We know of one example where officers were required to wait 52 hours.⁹¹ The police officers who bring someone to hospital can be asked to remain until there can be a handover to NHS staff. The most common reason for delays was because an AMHP or a section 12 approved doctor was unavailable.⁹² Although there is no obligation for the police to wait till the assessment has been carried out, the guidance does recommend that they remain until a handover has taken place at the place of safety. Royal College of Psychiatrists recommend assessments should start within three hours, and almost 75% of health-based places already operate their own three-hour target.⁹³ The chance of delay increases when a person is detained outside office hours, but people taken to a hospital are less likely to encounter delays in assessment than those detained in police custody.

91 HMIC and Care Quality Commission, [A Criminal Use of Police Cells](#)

92 Care Quality Commission, [A safer place to be](#), 4.2. A section 12 approved doctor is one who approved by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder, for the purpose of making recommendations for compulsory admission to hospital or guardianship under Part II of the Mental Health Act. The [Centre for mental health](#) found evidence that police forces increasingly prefer to provide officers to support mental health staff in the 136 suite rather than use police cells.

93 Royal College of Psychiatrists, [Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983](#), April 2013; Care Quality Commission, [A safer place to be](#)

In police custody

50. HM Inspectorate of Constabulary has found that, for those assessed in police custody, the average length of time to wait for an assessment was just over 9½ hours. Most long waits involved people who had been detained outside office hours. A smaller number of delays were due to the person being intoxicated and unfit for assessment. All those detained received an assessment in the police station, or were moved to a health-based place of safety for assessment within 24 hours.⁹⁴ Our evidence told a similar story, with police telling us that people were risk-assessed on entry and, if necessary, kept under observation, which could require an officer to physically sit in the cell doorway for several hours.⁹⁵

51. Section 136 allows for the police to detain a person for a maximum of 72 hours and there was broad support for reducing this time from 72 hours to 24 hours. This would bring it into line with the time allowed under the Police and Criminal Evidence Act 1984 to detain somebody who has been arrested. It is worth reiterating that people detained under s.136 have not necessarily broken the law. Simon Cole told us:

It is absolutely outrageous that you can be detained for 72 hours for being ill and 24 hours for murdering somebody.⁹⁶

52. We recommend that the Government bring forward an amendment to the Mental Health Act 1983 to provide that a person detained under section 136 may be detained for a maximum of 24 hours. In tandem with this change, we recommend that the Government introduce specific time targets within which mental health assessments must be carried out, whether in a hospital or a police station. We recommend a target of three hours, in line of the standard of the Royal College of Psychiatrists.

What happens after custody

53. We found a lack of reliable data on what happens to people following detention under s. 136. The criterion for exercising s. 136 powers—that the person is in immediate need of care or control—would not necessarily result in admission to hospital. Dominic Williamson of Revolving Doors said one study showed that only 17% of those detained under s. 136 in hospital are further detained under the Mental Health Act once the 72-hour period has elapsed. He said it was unclear what happened to the other 83%.⁹⁷ This does not mean that 83% of people detained under s. 136 are then found to be perfectly healthy and sent on their way. The AMHP has responsibility for making a decision as to their care, and this could include an application for admission to a hospital, but the person could also be referred to a mental health service such as Community Mental Health Team, CAMHS or The Early Intervention Service, they may enter hospital voluntarily, be referred to a drugs or alcohol dependency service, or to their GP.⁹⁸

94 HMIC and Care Quality Commission, [A Criminal Use of Police Cells](#)

95 Q 211

96 Qq 276-277

97 Q 19; See also Qq 191-192

98 [Mark Standing \(PMH0046\)](#); Q 119; Q 120

54. **There is a need for better data on what happens to people following detention under s. 136 if they are not later admitted to hospital. The person could receive treatment in a variety of ways, and the treatment plan could involve several NHS or community agencies, so understanding if the person received the most appropriate care after contact with the police is difficult. If we are to move beyond using s. 136 as a measure of performance, there needs to be more information to determine if the person received the care they needed.**

55. We met Anne Popow who told us what had happened with her nephew, William Barnard, who suffered from schizophrenia. Following treatment in hospital, William was released on condition that he received a fortnightly injection administered in his home by a Community Psychiatric Nurse. His aunt told us that, after several months, he was informed that if he decided he no longer wanted to have this injection, he would not be forced to have it. He started to refuse his injection in January 2009. Six months later he stabbed and killed his grandfather John McGrath. His grandmother was also stabbed but survived. There was police contact with William during this time as he was the prime suspect in an armed robbery involving a machete in a local park. The police had ample opportunities to intervene. The communication between the police and the mental health team was poor when it was known that William was ill, refusing medication and a danger to others. The police who came into contact with William were not trained in how to manage him.⁹⁹

Joint working and the Concordat

56. The importance of joint working on mental health crisis care was a constant theme in our evidence. There is an acceptance that issues around policing and mental health will not be managed by the police themselves. Joint working builds relationships between individuals on the ground, helps each service understand more clearly what the other services do,¹⁰⁰ enabled greater sharing of information between agencies and improved access to different pathways of care.¹⁰¹

57. With specific regard to how the Mental Health Act operates, the Code of Practice require there to be local agreements as to how the relevant bodies work together. Michael Brown said that where these agreements are poor, the co-operation between the police and the NHS is often difficult. He said:

I think the extent to which the NHS supports the police is to do with personal relationships and partnerships. It tends to be that, where you have senior police officers knowing their senior health colleagues, they tend to have well established procedures, meeting structures and so on. They have methods of debating what the difficulties are and resolving them. They put joint training in place for operational staff at all levels. It is where you do not have those personal relationships and partnerships that you tend to find the protocols are not quite as tight as they perhaps

99 [Paul Bacon \(PMH0057\)](#)

100 Q 155; Q 63

101 Q 157

could be and where training does not happen and, therefore, where frontline staff come into conflict with each other.¹⁰²

58. On 18 February 2014, the Home Office and Department of Health published the *Mental Health Crisis Care Concordat, Improving outcomes for people experiencing mental health crisis*, setting out “the standard of response that people suffering mental health crises and requiring urgent care should expect, and key principles around which local health and criminal justice partners should be organised.”¹⁰³ The Concordat aims to focus on four main areas: Access to support before crisis point, urgent and emergency access to crisis care, the right quality of treatment and care when in crisis, and recovery and staying well, and preventing future crises.¹⁰⁴ There are two stages to the Concordat on a local level, signing up to the local declaration and submitting an action plan to deliver the aims set out in the declaration. All the local authorities in England have signed up to the first stage but there is notable pause in local authorities submitting their action plan. We have been told by Simon Cole that among the reasons for delay have been concerns that the local Ambulance Service will not be able to deliver on a single national protocol that set down response times of 30 minute.¹⁰⁵

59. The coalition government has recognised the poor state of current mental health services and it has made a commitment to put mental health at the same level as physical health. In addition to resources, there is a clear need for improved coordination between the organisations that come into contact with mental health sufferers. The Concordat has shown potential for bringing the relevant organisations together. Its success will be measured by how effective it is in those areas of the country where such relationships are not well developed, where there is an absence of local leadership, and where the commitment to addressing the issues is absent.

Data problems

60. There is a lack of adequate data to help understand several issues around police and mental health.¹⁰⁶ This makes it difficult to assess the amount of time and resources the police spend on dealing with mental health issues. Understanding the level of unmet demand in mental health is important in determining priorities and improving access. Therefore, it is important that we have reliable data on the number of people detained under s. 136 and what kind of place of safety they are taken to. Many of those who end up in police cells are there because they were refused access to a health-based place of safety, but previous surveys have all found difficulty in establishing why people were turned away. The CQC found problems accessing basic data on how often people were excluded from health-based places of safety.¹⁰⁷ HMIC has recommended that custody sergeants document when someone is brought in under s. 136 to their cells after being turned away by a health

102 Q 91

103 [HC Deb, 28 November 2013, Col 159WH](#) [Damian Green]; [The Police Foundation \(PMH0028\)](#);

104 Department of Health, [Mental Health Crisis Care Concordat](#), February 2014

105 [Chief Constable Simon Cole \(PMH0053\)](#)

106 [Police Federation of England and Wales \(PMH0036\)](#); See also [Rt Hon Mike Penning MP, Minister for Policing, Criminal Justice and Victims \(PMH0056\)](#)

107 Care Quality Commission, [A safer place to be](#), October 2014

facility, and the reason for refusal.¹⁰⁸ Custody Sergeant Ian Kressinger and Custody Sergeant Andy Shaw both told us that they had started recording that data and passing it up to senior officers.¹⁰⁹

61. Data collection around the use of s. 136 must continue to improve. People who suffer a mental health crisis and come into contact with the police are receiving different care in different parts of the country. Reliable data is important to assess where issues remain and fed back into discussions about mental health priorities.

62. Quantifying the scale of this issue is made more difficult by police data and health service data being collected by different bodies.¹¹⁰ The work of the Health and Social Care Information Centre, and the collaborative work by HMIC and the Care Quality Commission, have improved this significantly and helped highlight flaws in the system. The Care Quality Commission are continuing to carry out inspections of crisis care in mental health as one of their measures when assessing health trusts.¹¹¹ **We welcome the work being carried out by HMIC and the Care Quality Commission in collecting data on policing and mental health, and in particular on the use of s. 136 to detain people in police cells. We fully support the Care Quality Commission decision to measure the performance of mental health care providers' care for people in mental health crisis.**

63. Data is not collected by the Home Office on police sick leave as a result of mental health issues. The Chair asked the following written parliamentary question to the Home Office:

To ask the Secretary of State for the Home Department, how many days have been lost to long-term sick leave (a) in total and (b) for reasons related to mental health in each police force in each of the last three years.

Mike Penning responded:

The Home Office is currently undertaking work to improve the quality of statistics on the number of contracted hours lost to sickness absence. [...] The Home Office does not collect breakdowns of this data by reason for sickness absence.

64. We recommend that data on police sickness absence due to mental health issues is collected better. This would enable more effective examination of whether the work undertaken by police has a significant impact on their mental health and would help efforts to respond to these health concerns.

108 HMIC and Care Quality Commission, [A Criminal Use of Police Cells](#)

109 Qq 201-202

110 [Royal College of Psychiatrists \(PMH0038\)](#); [Police and Crime Commissioner for Cheshire \(PMH0033\)](#)

111 Q 261

5 Training

Mental health awareness and identifying vulnerabilities

65. We received a lot of support for improved mental health related training for police officers.¹¹² At the same time, we received views from a range of individuals and organisations that the police should not be trying to be mental health professionals.¹¹³ The main subjects for improved training were general mental health awareness training, de-escalation techniques and the use of restraint. Calls for improved general training covered areas such as identifying indicators, the “tell-tale signs”, of who might be vulnerable because of mental illness, and breaking down prejudices associated with mental illness.¹¹⁴ There was a strong sense that the people working in the police control centre answering emergency calls should receive extra training in this area, so they can better inform the police attending and if necessary request a paramedic.¹¹⁵

66. Once a detained person is taken to a police station, it is more likely that the assessment will take place at the police station, rather than at a health-based place of safety. The custody sergeant will talk to the officer bringing in the person to understand what has led them to be in the custody suite, they will go through a formal risk assessment, including asking the person if they have previously attempted self-harm or suicide. Police records checked to see if they have passed through before.¹¹⁶ Some people will present with obvious worrying behaviour, such as hitting themselves or banging their head against the wall of the van. Some will not present such obvious signs.¹¹⁷

67. The police can be trained to recognise some indicators, and the College of Policing current review of mental health training is moving toward an assessment of individual vulnerability rather than trying to identify specific mental ill health, learning disability or condition.¹¹⁸ However, there is a clear need for police officers in the custody suite to be able to call upon trained professionals for advice. The presence of doctors and nurses in the custody suites are a clear way for the needs of those with mental health problems to be recognised early and enable quicker access to medical records.¹¹⁹ The Government plans for NHS England to take over commissioning of health services in police stations by April 2015.¹²⁰ This should improve the minimum qualifications of those working in custody healthcare and the quality of the healthcare available.¹²¹

112 Q 125; [Jonathan Owen \(PMH0008\)](#); [College of Paramedics \(PMH0047\)](#). The College of Paramedics found large support among its members for mental health training for both police and paramedics

113 For example, [Alex Crisp \(PMH0051\)](#)

114 Q 60; Q 317; [Lord Adebawale \(PMH0054\)](#); [INQUEST \(PMH0042\)](#)

115 Q 124; Independent Commission on Mental Health and Policing; [College of Policing \(PMH0024\)](#)

116 Qq 188-190

117 Q 187

118 [College of Policing \(PMH0024\)](#)

119 [Faculty of Forensic and Legal Medicine of the Royal College of Physicians \(PMH0035\)](#)

120 [NHS England \(PMH0055\)](#)

121 Q 292; [Faculty of Forensic and Legal Medicine of the Royal College of Physicians \(PMH0035\)](#)

68. There is a need to improve training for police officers and civilian staff in identifying the signs that someone might be suffering from mental illness. This should be mandatory for all front line officers and include staff in the police control room. This is particularly important for custody sergeants, who must be adequately equipped with the skills to effectively deal with mental health patients who come into custody suites. Police staff then need to be able to get advice from a mental health professional—a social worker, doctor, or nurse—who is better placed to recognise medical conditions and illnesses, and is able to refer the person for further treatment. Such advice needs to be available to the police at all times, given that they operate 24 hours a day.

69. We are aware that mental health training varies across the country, particularly in the amount of time devoted to it—between four hours and one day—and the extent of online learning compared to face-to-face learning. British Transport Police (BTP) trains its recruits to deal with people with suicidal thoughts—there were over 4,000 suicidal incidents on the transport network in 2013–14, including 325 people who took their own lives on the railways. BTP officers get at least one day’s training on mental health, including training in suicide prevention and ‘softer’ skills to help officers deal with somebody in crisis. About 1,000 BTP officers, out of a total of around 2,800, have been through the Samaritans’ Managing Suicidal Contacts course—which is another full day.¹²² Lord Adebawale commended the work being done in London on mental health and suicide prevention.¹²³ We heard of considerable support for joint training on mental health awareness, and that this should be part of a nationally-agreed programme of joint training with other agencies, such as paramedics, mental health nurses, and charities.¹²⁴

De-escalation and restraint

70. The behaviour of someone having a mental-health crisis can be misunderstood and lead to them being treated in an inappropriate way, for example, their behaviour could be interpreted as dangerous and be met with inappropriate force. James Herbert was a young man who died after being detained by police in Bath in 2010. We took evidence from his parents, Tony Herbert and Barbara Montgomery, who both said James was subject to unnecessary force. Tony Herbert said:

We know with our son that because of his temperament, had there been any attempt to de-escalate, to communicate with him rather than overpower him, his nature would have meant that he would have been peaceful. He did not do anything violent through all of his life until he struggled against the restraint, which is not, in my view, violence.¹²⁵

122 Qq 234-245

123 [Lord Adebawale \(PMH0054\)](#)

124 Q 153; Qq 244-245; [MIND \(PMH0027\)](#); [Mark Standing \(PMH0046\)](#); [Police Federation of England and Wales \(PMH0036\)](#); Mind and Victim Support, *Police and mental health, How to get it right locally*, 2013, pp 24-25; [The Police Foundation \(PMH0028\)](#)

125 Q 62

71. There are real concerns that black and ethnic minority people are disproportionately detained under s. 136.¹²⁶ Matilda MacAttram of Black Mental Health UK said there was still a feeling in the black community that the young black men are presumed to be dangerous based on their physical appearance, and this perception determines how they are labelled and the treatment they receive.¹²⁷ At events organised by the Centre for Mental Health to hear views on experiences of detention under s. 136, black people more commonly reported the use of force and that force was used at an earlier stage during contact with the police.¹²⁸ Deborah Coles of INQUEST, agreed that there was a prevailing assumption that people with mental health illness would be dangerous, and that is doubled if the person is from the African Caribbean community. She said the answer was largely to do with training.¹²⁹

72. The police are trained to use control and restraint when they find themselves in situations where there is potential for violence. This can include various physical holds, handcuffs or limb restraints. In London, Lord Adebawale found a disproportionate use of force and restraint,¹³⁰ and a risk that police will use restraint when they perceive the person to be potentially violent, even when they have not exhibited any violent behaviour.¹³¹ Restraint was found to be a cause of death for 16 of the people who died in custody between 1998-99 and 2008-09. (These are all deaths not just those involving someone identified as having mental health illness.) Positional asphyxia was also given as the cause of death in four of the sixteen cases.¹³²

73. In certain situations, the behaviour of someone going through a mental health crisis could be interpreted as potentially violent when they could be delusional and afraid. The police are not always aware that the person they are dealing with is suffering from something that is a medical emergency where restraint is “about the worst possible course of action to take”.¹³³ Furthermore, being restrained may intensify that fear and lead them to struggle against the restraint. The parents of James Herbert said their son had not committed a crime nor had any history of violence, but because he was reported to be acting strangely he ended up being held down by several people—police officers and members of the public—restrained with his hands behind his back, and driven by police van, in a prone position, for over 40 minutes.¹³⁴ The parents of James Herbert were very clear that, in their view, James needed medical help and should have been transported in an ambulance.¹³⁵

126 [Royal College of Psychiatrists \(PMH0038\)](#)

127 Q 11; [Black Mental Health UK \(PMH0045\)](#)

128 Centre for Mental Health, [Review of Sections 135 & 136 of the Mental Health Act](#), December 2014

129 Q 53

130 Q 124

131 Independent Commission on Mental Health and Policing, pages 18-19

132 IPCC Research and Statistics Series: Paper 27, [Deaths during or following police contact: Statistics for England and Wales 2013-14](#). See also [College of Paramedics \(PMH0047\)](#)

133 [Jonathan Owen \(PMH0008\)](#)

134 Qq 70-76

135 Q 49; Qq 63-64

74. Mental health services train their staff in de-escalation, to try to create space for people who are at risk rather than trying to control them.¹³⁶ They are more likely to be restraining someone they know something about (their illness, level of medication, general physical health, etc.) and within a hospital setting. The medical approach is that anything more than a transitory restraint of somebody with a mental health problem should be dealt with as a medical emergency, and that if someone has to be restrained and it might last more than a minute or so, then there should be trained nurses available, defibrillators, drug trolleys, and the ability to call upon a doctor within 20 minutes. With reference to how the medical approach differs to the policing approach to restraint, Michael Brown said:

If the medical guidelines to nurses and doctors are, “You must treat this as a medical emergency, have drugs, defibrillators and a doctor within 20 minutes”, it paints a very fresh perspective on what the police should be thinking about doing when they are dealing with people in a community setting, in a street or in their own home.¹³⁷

In the rare circumstance when the police are called to manage a person seen as disruptive in a healthcare setting, the mental health professionals should manage the situation and retain responsibility for the safety of the person. It should only really happen if the patient represents particular danger, such as if they are carrying a weapon.

75. Mental health is clearly a large and growing element of modern police work. The current amount of training for new recruits is not enough. Some forces have developed their own training to address perceived gaps. There needs to be a national strategy for mental health training for all police. It needs to be updated on a regular basis. As a minimum, it should include awareness of common mental health illnesses, techniques in de-escalation, safe restraint, and awareness of what mental health services are available locally. Mental health awareness training should include a component that addresses why some people who are ill might be perceived as violent, and how these perceptions impact upon the BME community.

76. This needs to include joint training with mental health nurses, paramedics and Approved Mental Health Professionals, and training involving mental health charities and people who have been detained under s. 136. We commend those police forces that already do this, including Greater Manchester, West Yorkshire and Leicestershire. Joint training should include de-escalation training, to make sure police officers are familiar with the techniques taught in mental health services.

77. Restraint should only be used in limited circumstances. Improved training should be given to correctly identify the range of behaviour of someone having a medical emergency rather than automatically presuming that behaviour means they are violent. The training should be aimed at reducing the presumption to use force and restraint on someone who is ill.

136 Q 107

137 Q 112. See also Q 63

Deaths in police custody

78. IPCC statistics show that in 2013–14, 11 people died in or following police custody. Of those 11, four were identified as having mental health concerns, and of those four, two had been taken to a police custody suite under s. 136 of the MHA. Both were men had been restrained by the police, including handcuffs and leg restraints¹³⁸ Similarly, in 2012-13, nearly half (7 out of 15) of those who died in or following police custody were identified as having mental health problems.¹³⁹ The number of deaths in or following custody has fallen since 2010-11.¹⁴⁰

	Fatalities						
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Deaths in or following police custody	22	15	17	21	15	15	11

79. The best way to reduce the number of people suffering from mental health issues and who then die in custody is to reduce the number of people with mental health problems entering custody. All that can be done, needs to be done, to ensure that people going through a medical emergency are treated like someone going through a medical emergency. This includes providing sufficient resources to ensure mental health crisis care is available 24 hours a day, seven days a week.

Suicide following custody

80. The number of apparent suicides following police custody—that is within two days of being in police custody—has risen from 39 in 2011-12 to 65 in 2012-13 and 68 in 2013-14. Of the 68 apparent suicides following police custody, thirty-two suicides occurred on the day of release.¹⁴¹ There is a clear link between suicides shortly following police custody and mental health: 45 (about two thirds) of those who died were reported to have mental health concerns, and three had been detained under the Mental Health Act 1983 prior to their death. British Transport Police figures suggest 3% of suicides, or attempted suicides that result in injuries, on the railway were after police contact—often where the subject had recently been arrested or bailed for shameful offences.¹⁴²

	Fatalities						
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14

138 IPCC Research and Statistics Series: Paper 27, [Deaths during or following police contact: Statistics for England and Wales 2013-14](#)

139 [INQUEST \(PMH0042\)](#), para 9

140 IPCC Research and Statistics Series: Paper 27, [Deaths during or following police contact: Statistics for England and Wales 2013-14](#)

141 IPCC Research and Statistics Series: Paper 27, [Deaths during or following police contact: Statistics for England and Wales 2013-14](#). Previous mental health concerns include previous suicide attempts, depression & long-term mental health disorders

142 [British Transport Police \(PMH0025\)](#)

Apparent suicides following custody	45	56	54	46	39	65	68
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81. Custody staff are responsible for carrying out a pre-release risk assessment of those who pass through their custody suite, assess if the person is vulnerable and if there is a credible risk that on release they may commit suicide.¹⁴³ The custody officer needs to be trained to identify signs that would represent a risk of suicide and to be able to call upon healthcare staff in the custody suite who can provide expertise when necessary, and refer them to the appropriate support.¹⁴⁴

82. The recent increase in suicides following custody is highly alarming. The police must make sure that those who have been identified as vulnerable in custody are notified to medical staff. There must be a formal method by which this done and it must be followed. This will require additional training for custody staff but it also requires improvements in access to mental health nurses and doctors in the custody environment.

143 Independent Commission on Mental Health and Policing, Report, May 2013, pages 18-19

144 Q 161

Conclusions and recommendations

1. Police forces work with all members of the communities they serve. Working with those with mental health problems will always be a core part of that work. However, we are concerned by the extent to which frontline officers are increasingly spending their time helping people with mental health problems. For many people experiencing an acute health crisis, a police officer is not the professional best placed to help them, nor is dealing with acute health crises the best use of police officers' time and skills. We believe that the police should not be filling gaps in mental health services. (Paragraph 6)
2. The use of section 136 of the Mental Health Act 1983 and reducing the detention of people in police cells is widely seen as an indicator of a police forces' performance in relation to mental health, and it has focussed attention on the problem. We support the Government's commitment in the Crisis Care Concordat to see the number of detentions in police cells under section 136 halved in two years compared with 2011-12. (Paragraph 11)
3. We recommend that the specific reference to a police station should be removed from the definition of "places of safety" in s. 135(6) of the Mental Health Act 1983. We recognise that there are concerns over the lack of health-based places of safety that exist in some parts of the country, particularly rural areas. However, this proposal has been under discussion for some time now and commissioners should have started commissioning appropriate place of safety provision before now. All areas need to do so, and be able to demonstrate that they have made progress by July 2015. The Government should immediately re-issue guidance to police forces and health trusts defining the exceptional circumstances in which police cells may be used as places of safety. The presumption should clearly be the health facility not the police cell. (Paragraph 15)
4. The Government's own review of s. 136 recommended ensuring that police cells can only be used as a place of safety for adults in situations where the person's behaviour is so extreme they cannot otherwise be safely managed. Following the general election a new government should set out what they will do to ensure this happens if it will not amend the Mental Health Act 1983. (Paragraph 16)
5. We commend the work by Inspector Michael Brown, and others who have championed the cause of mental health within the Police. His work online has been particularly impressive. (Paragraph 19)
6. It is clear that too many NHS Clinical Commissioning Groups are failing in their duty to provide enough health-based places of safety that are available 24 hours a day, seven days a week, and are adequately staffed. CCGs must not only acknowledge local levels of demand and commission suitable health-based places of safety, they must also design local backup policies to deal with situations where places are occupied. Relying on the police to fill the commissioning gap not only imposes non-negotiable, external costs on forces, but it increases the risk to highly vulnerable patients. We recommend that the Department of Health, together with the Home

Office, issue clear guidance to CCGs about the appropriate number of health-based places of safety, having regard to local circumstances, within three months. (Paragraph 20)

7. The NHS would not turn away a patient with a physical illness just because they were intoxicated. People with mental health problems have exactly the same right to NHS care as everybody else and it is shocking that patients are excluded from health-based places of safety on the basis of informal exclusion criteria. The guidance that people with mental health illness should be treated in a mental health facility needs to be repeatedly reinforced. (Paragraph 24)
8. We note that the Government review of sections 135 and 136 said they would explore alternative places of safety. The fundamental reason for a place of safety is to keep someone safe until they can have a mental health assessment and a judgment can be made as to their future treatment. Where there is a clear gap between demand and provision, then we agree that alternatives should be considered. Anywhere used as a place of safety must adhere to relevant guidance and be able to secure the confidence of patients and their families. In particular, the staff, especially if they might be called upon to restrain someone, should receive validated training. (Paragraph 26)
9. We agree with the proposal to amend the Mental Health Act so that the powers of s. 136 could be used anywhere other than a private home. This would give the police power to deal expeditiously with people on railway lines and in high places to which the public do not have access. We believe that extending the range of settings in which the power could be used to include private homes would be a step too far. Extending police powers must be done with caution, as it is important that this does not reinforce the need for police involvement in mental health cases, as we believe it is important that it should be kept to a minimum. (Paragraph 30)
10. The fact that children are still detained in police cells under section 136 reflects a clear failure of commissioning by NHS Clinical Commissioning Groups. The de facto use of police cells as an alternative relieves the pressure on CCGs to commission appropriate levels of provision for children experiencing mental-health crisis. We support the Government's proposals for a change in the law to ensure that children can never be held in a police cell under section 136 of the Mental Health Act 1983, which we recommend should be included in the next Queen's Speech. In the interim, guidance on the detention of children in police cells under s. 136 must be made clear—that it is unacceptable and must stop. This guidance needs to be distributed to those working in the police and in the health service. (Paragraph 34)
11. The fact that a place of safety is attached to an adult ward should not preclude its use for children, particularly when the alternative is a prison cell. The Mental Health Act Code of Practice is clear on this point, and we recommend that the Department of Health draw this to the attention of all providers of health-based places of safety. (Paragraph 35)
12. Though early indications of the effectiveness of the Street Triage scheme are very positive, it is important that the scheme is fully appraised against a range of clear

success criteria, including an analysis of the relative merits of different models of provision, and the results published. In particular, it will be important to understand why the number of s. 136 detentions has fallen in some areas but not to the same extent in others following the introduction of the scheme. That information will inform the analyses that HMIC has asked each force to produce with a view to adopting some form of Street Triage. We note that different forms of Street Triage are funded in different ways and that it is not clear what guarantees are in place to secure funding at the end of the pilots. We recommend that the Government give a clear commitment that funding will be made available for schemes which have been proven to be cost-effective. (Paragraph 39)

13. Similar to Street Triage, Liaison and Diversion services are intended to ensure that a person with mental health problems who does come into contact with the police and the courts receives appropriate treatment. The prevalence of people with mental illness within the criminal justice system is a scandal and any initiative that addresses this should be welcomed. However, its success will clearly rely on the availability of appropriate mental health services to which clients can be referred. (Paragraph 41)
14. People encountering a mental health crisis should be transported to hospital in an ambulance if an emergency services vehicle is needed. Transportation in a police car is shameful and in many cases adds to the distress. Those affected, and their families, are clear that they wish to see ambulances used as transport to hospital. It enables the patient's health to be monitored on the way and improves access to healthcare pathways. (Paragraph 45)
15. Reliable data on the use of ambulances to transport people under s. 136 is poor, but it is clear that the use of ambulances in these circumstances varies across the country. The relationship between the police and ambulance service at the local level is pivotal to how this can be improved. Forums that enable each to understand the priorities, roles and responsibilities of the other, such as partnership working and Street Triage, have been shown to work. To get to a point, such as in the West Midlands where 75% of people are taken to hospital under s. 136 by ambulance, require the ambulance service and the police to develop that local relationship. The Government must examine what the barriers are to poor performance of those ambulance services with regard to transporting people to hospital under s. 136. It must work harder to make sure examples of best practice are spread throughout the country. (Paragraph 46)
16. Improvements can be made in how mental health crisis calls are received and processed by the 999 call handler. Such improvements can reduce the use of s. 136 and in turn reduce the demand on ambulances. (Paragraph 47)
17. We recognise that there is a huge demand on all 999 services at a time of restricted budgets but, fundamentally, mental health needs to be seen on a par with physical health, and local commissioning of health services, including ambulances, must reflect that. (Paragraph 48)
18. We recommend that the Government bring forward an amendment to the Mental Health Act 1983 to provide that a person detained under section 136 may be

detained for a maximum of 24 hours. In tandem with this change, we recommend that the Government introduce specific time targets within which mental health assessments must be carried out, whether in a hospital or a police station. We recommend a target of three hours, in line of the standard of the Royal College of Psychiatrists. (Paragraph 52)

19. There is a need for better data on what happens to people following detention under s. 136 if they are not later admitted to hospital. The person could receive treatment in a variety of ways, and the treatment plan could involve several NHS or community agencies, so understanding if the person received the most appropriate care after contact with the police is difficult. If we are to move beyond using s. 136 as a measure of performance, there needs to be more information to determine if the person received the care they needed. (Paragraph 54)
20. The coalition government has recognised the poor state of current mental health services and it has made a commitment to put mental health at the same level as physical health. In addition to resources, there is a clear need for improved coordination between the organisations that come into contact with mental health sufferers. The Concordat has shown potential for bringing the relevant organisations together. Its success will be measured by how effective it is in those areas of the country where such relationships are not well developed, where there is an absence of local leadership, and where the commitment to addressing the issues is absent. (Paragraph 59)
21. Data collection around the use of s. 136 must continue to improve. People who suffer a mental health crisis and come into contact with the police are receiving different care in different parts of the country. Reliable data is important to assess where issues remain and fed back into discussions about mental health priorities. (Paragraph 61)
22. We welcome the work being carried out by HMIC and the Care Quality Commission in collecting data on policing and mental health, and in particular on the use of s. 136 to detain people in police cells. We fully support the Care Quality Commission decision to measure the performance of mental health care providers' care for people in mental health crisis. (Paragraph 62)
23. We recommend that data on police sickness absence due to mental health issues is collected better. This would enable more effective examination of whether the work undertaken by police has a significant impact on their mental health and would help efforts to respond to these health concerns. (Paragraph 64)
24. There is a need to improve training for police officers and civilian staff in identifying the signs that someone might be suffering from mental illness. This should be mandatory for all front line officers and include staff in the police control room. This is particularly important for custody sergeants, who must be adequately equipped with the skills to effectively deal with mental health patients who come into custody suites. Police staff then need to be able to get advice from a mental health professional—a social worker, doctor, or nurse—who is better placed to recognise medical conditions and illnesses, and is able to refer the person for further treatment.

Such advice needs to be available to the police at all times, given that they operate 24 hours a day. (Paragraph 68)

25. Mental health is clearly a large and growing element of modern police work. The current amount of training for new recruits is not enough. Some forces have developed their own training to address perceived gaps. There needs to be a national strategy for mental health training for all police. It needs to be updated on a regular basis. As a minimum, it should include awareness of common mental health illnesses, techniques in de-escalation, safe restraint, and awareness of what mental health services are available locally. Mental health awareness training should include a component that addresses why some people who are ill might be perceived as violent, and how these perceptions impact upon the BME community. (Paragraph 75)
26. This needs to include joint training with mental health nurses, paramedics and Approved Mental Health Professionals, and training involving mental health charities and people who have been detained under s. 136. We commend those police forces that already do this, including Greater Manchester, West Yorkshire and Leicestershire. Joint training should include de-escalation training, to make sure police officers are familiar with the techniques taught in mental health services. (Paragraph 76)
27. Restraint should only be used in limited circumstances. Improved training should be given to correctly identify the range of behaviour of someone having a medical emergency rather than automatically presuming that behaviour means they are violent. The training should be aimed at reducing the presumption to use force and restraint on someone who is ill. (Paragraph 77)
28. The best way to reduce the number of people suffering from mental health issues and who then die in custody is to reduce the number of people with mental health problems entering custody. All that can be done, needs to be done, to ensure that people going through a medical emergency are treated like someone going through a medical emergency. This includes providing sufficient resources to ensure mental health crisis care is available 24 hours a day, seven days a week. (Paragraph 79)
29. The recent increase in suicides following custody is highly alarming. The police must make sure that those who have been identified as vulnerable in custody are notified to medical staff. There must be a formal method by which this done and it must be followed. This will require additional training for custody staff but it also requires improvements in access to mental health nurses and doctors in the custody environment. (Paragraph 82)

Formal Minutes

Tuesday 3 February 2015

Keith Vaz, in the Chair

Nicola Blackwood
Michael Ellis
Paul Flynn

Tim Loughton
Mr David Winnick

Draft Report (*Policing and mental health*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 82 read and agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 10 February at 2.30 pm]

Witnesses

Tuesday 1 July 2014

Page

Matilda MacAttram, Director, Black Mental Health UK, **Dominic Williamson**, Chief Executive, Revolving Doors Agency, and **Pat Kenny**, Member of Revolving Doors' National Service User Forum

[Q 1-37](#)

Deborah Coles, Co-Director, INQUEST, **Tony Herbert** and **Barbara Montgomery**, parents of James Herbert

[Q 38-87](#)

Tuesday 2 September 2014

Inspector Michael Brown, Mental Health Co-ordinator at the College of Policing and author of the Mental Health Cop Blog

[Q 88-122](#)

Tuesday 21 October 2014

Lord Adebowale CBE, Chief Executive, Turning Point; **David Davis**, College of Paramedics, **Karla Wilson-Palmer**, Royal College of Nursing, and **Dr Mary Jane Tacchi**, Royal College of Psychiatrists

[Q 123-182](#)

Tuesday 28 October 2014

Sergeant Ian Kressinger, Devon and Cornwall Police, and **Sergeant Andy Shaw**, Essex Police

[Q 183-228](#)

Simon Cole, Leicestershire Police, Former ACPO lead on mental health, and **Mark Smith**, Head of Suicide Prevention and Mental Health, British Transport Police

[Q 229-281](#)

Tuesday 11 November 2014

Rt Hon Norman Lamb MP, Minister of State for Care and Support, and **Anne McDonald**, Deputy Director of Mental Health and Disability, Department for Health

[Q 282-313](#)

Rt Hon Mike Penning MP, Minister of State for Policing

[Q 314-342](#)

List of printed written evidence

- 1 Alex Crisp ([PMH0051](#))
- 2 Association of Police and Crime Commissioners ([PMH0015](#))
- 3 Avon and Somerset Constabulary and Police and Crime Commissioner ([PMH0032](#))
- 4 Black Mental Health UK ([PMH0045](#))
- 5 British Medical Association ([PMH0017](#))
- 6 British Transport Police ([PMH0025](#))
- 7 Centre for Mental Health ([PMH0005](#))
- 8 Chief Constable Simon Cole, Leicestershire Police supplementary ([PMH0053](#))
- 9 College of Paramedics ([PMH0047](#))
- 10 College of Policing ([PMH0024](#))
- 11 Dan Smith ([PMH0001](#))
- 12 David Mery ([PMH0021](#)); ([PMH0043](#)); ([PMH0044](#))
- 13 Department of Health ([PMH0031](#))
- 14 Devon and Cornwall Police ([PMH0019](#))
- 15 Faculty of Forensic and Legal Medicine of the Royal College of Physicians ([PMH0035](#))
- 16 Her Majesty's Inspectorate of Prisons and Constabulary ([PMH0009](#))
- 17 Home Office ([PMH0039](#)); ([PMH0056](#))
- 18 Home Office and the Department of Health supplementary ([PMH0059](#))
- 19 Howard League for Penal Reform ([PMH0050](#))
- 20 Huw Jones ([PMH0002](#))
- 21 Independent Police Complaints Commission ([PMH0006](#))
- 22 INQUEST ([PMH0042](#))
- 23 Jonathan Owen ([PMH0008](#))
- 24 Lord Victor Adebawale CBE ([PMH0054](#))
- 25 Mark Standing ([PMH0046](#))
- 26 Michael Brown ([PMH0022](#)); ([PMH0052](#))
- 27 Mind ([PMH0027](#))
- 28 Muslim Women's Network UK ([PMH0011](#))
- 29 National Mental Health Policing Lead ([PMH0013](#))
- 30 NHS England ([PMH0055](#))
- 31 Paul Bacon, Bryan and Armstrong Solicitors ([PMH0057](#))
- 32 Police and Crime Commissioner for Cheshire ([PMH0033](#))
- 33 Police and Crime Commissioner for Greater Manchester ([PMH0029](#))
- 34 Police and Crime Commissioner for Northumbria ([PMH0012](#))
- 35 Police and Crime Commissioner for Sussex ([PMH0037](#))
- 36 Police Federation of England and Wales ([PMH0036](#))
- 37 Professor Louise Ellison et al ([PMH0007](#))
- 38 Revolving Doors Agency ([PMH0026](#))
- 39 Royal College of Nursing ([PMH0014](#))
- 40 Royal College of Physicians ([PMH0040](#))
- 41 Royal College of Psychiatrists ([PMH0038](#)); ([PMH0058](#))
- 42 Self Help Services ([PMH0020](#))

- 43 The Police Foundation ([PMH0028](#))
- 44 UKDI Ltd ([PMH0004](#))
- 45 Victim Support and Mind ([PMH0023](#))
- 46 Welsh Government ([PMH0034](#))
- 47 West Midlands Police and West Midlands Police and Crime Commissioner ([PMH0016](#))
- 48 Youth Justice Board for England and Wales ([PMH0018](#))

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All publications from the Committee are available on the Committee's website at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/publications/>

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Fourth Report	Her Majesty's Passport Office: delays in processing applications	HC 238
Fifth Report	Police, the media, and high-profile criminal investigations	HC 629
Sixth Report	Child sexual exploitation and the response to localised grooming: follow-up	HC 203
Seventh Report	Effectiveness of the Committee in 2012-13	HC 825
Eighth Report	Regulation of Investigatory Powers Act 2000	HC 711
Ninth Report	The work of the Immigration Directorates (January-June 2014)	HC 712

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