Dear Keith,

**HOME AFFAIRS SELECT COMMITTEE INQUIRY ON POLICING AND MENTAL HEALTH**

On behalf of the Government I am responding to the Committee’s report on policing and mental health. I would like to thank the Committee for its consideration of the range of inter-related issues affecting action on this important issue. The report marks another significant contribution to the debate on how best to address mental health issues in the context of policing which, as referenced within the report are now seen as core business for many frontline police officers.

Since the Police Federation Conference in 2012 I have been clear that more needs to be done to address the disproportionate amount of time front-line police officers spend dealing with people with mental health issues, regardless of whether or not a crime has been committed. That is why I have driven a joint programme of work with the Department of Health to improve the responses vulnerable people, including those with mental health issues, should expect to receive when they come into contact with the police and other public services.

The Committee flagged 29 conclusions and recommendations. I have set out in an attachment to this letter the Government’s response to each recommendation.

[Signature]

The Rt Hon Theresa May MP
The Government would like to thank the Committee for its report published in February on policing and mental health.

Since the Home Secretary first addressed these issues at the Police Federation Conference in 2012 significant progress has been made. In February 2014 the Home Office and the Department of Health published the Mental Health Crisis Care Concordat, and since then have continued jointly to roll out Liaison and Diversion schemes, piloted Street Triage schemes, and agreed the transfer of commissioning responsibility for police custody healthcare services to NHS England. In December 2014 we published a review into the operation of Sections 135 & 136 of the Mental Health Act 1983 which will underpin the next phase of work on this issue.

Whilst much has improved there is still more that we can do. We are committed to driving continuing improvement, steered by the overriding objective of ensuring that people experiencing mental ill health – whether or not they are suspected of committing a crime – get the right response from the police and their partners at the time they need it most.

Structure of this document

The Home Office, working closely with the Department of Health and NHS England, has considered the conclusions and recommendations in the Committee’s report and the government response is below. We have set out the Committee’s recommendations in bold text where they relate to action for Government or require government comment and provide the Government’s initial response in plain text. The responses below follow the order of the Committee’s recommendations.

In this document, we have referred in a number of places to pieces of associated work. Rather than referring to them in full in each instance, we refer to them in a shortened form as follows:

- the Concordat refers to the Mental Health Crisis Care Concordat, a government document developed jointly with over 20 national organisations and published in February 2014 which sets out the principles and good practice that should be followed by public services when working together to help people in a mental health crisis;

- the review of sections 135 and 136 relates to the Government’s Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983, which was undertaken jointly by the Home Office and Department of Health, (in partnership with the Welsh Government) during 2014. The Review’s recommendations were published in December 2014;

- the revised Code of Practice or Code refers to the Code of Practice: Mental Health Act 1983. The changes to the consultation draft of the revised Code of Practice reflect the responses received during consultation over the course of summer 2014, including the review of sections 135 and 136. This statutory
guidance was laid before Parliament in January 2015, and will come into force in April 2015. Health and social care professionals and managers and staff of psychiatric hospitals must have regard to the Code. As the regulators of the Mental Health Act 1983, the Care Quality Commission (CQC) will inspect healthcare providers against compliance with the Code.
1. **Introduction**

Conclusion / Recommendation 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)

The Government is in full agreement that the police should not be trying to deliver front line healthcare nor supplementing gaps in health provision. This is not the primary purpose of the police and they are neither trained nor equipped to do so. To the extent that it is inevitable that the police will come into contact with people with mental ill health in a range of situations it is right that they have appropriate training to recognise those in need of medical assistance – but they should then have the ability to gain swift access to the relevant services on behalf of the individual when needed. To this end the Government has made clear that it is determined to remove the police from unnecessary or inappropriate involvement in what should primarily be a medical response. It has done so through the testing of schemes such as street triage and Liaison and Diversion, and piloting a new place of safety to act as an alternative to police custody. The review of sections 135 and 136 has also recommended amending legislation subject to affordability considerations and further consultation.
2. Detention under the Mental Health Act

Conclusion / Recommendation 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)

The Government is clear that a person detained under section 136 of the Mental Health Act 1983 (section 136) should be taken to a health-based place of safety. Police stations are also recognised as places of safety under the Mental Health Act 1983 (the Act), but should only be used in exceptional circumstances. We have clarified this point in the revised Code of Practice. Paragraph 16.38 of that document states that it may be necessary to use a police station as a place of safety if the person’s behaviour would pose an unmanageably high risk to other patients, staff or other users if the person were to be detained in a healthcare setting.

In general, the overuse of police cells for people detained under section 136 reflects probable deficiencies in the service provision available from a number of local agencies. There are numerous reasons for police cells having been used too often, and these include local health-based places of safety lacking the necessary capacity, or refusing to accept the person for being intoxicated and/or bringing a real (or perceived) threat of violence. The overuse of cells may also have been influenced by some unnecessary use of section 136 by police officers, and lack of availability of Approved Mental Health Professionals (AMHPs).

The Government’s objective of halving the number of times cells were used in 2011/12 (8,667 times\(^1\)) by 2014/15 is on track to be met. During the first six months of 2014/15 police cells were used 2,282 times.

Conclusion / Recommendation 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)

The Government agrees in principle that ideally police stations and cells should not be used as places of safety simply because health-based places of safety are

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\(^1\) [https://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf](https://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf)
unavailable. However, the recent review of sections 135 and 136 of the Mental Health Act 1983 suggested that there may be occasions where a police cell would be more appropriate than a health-based place of safety – for example where the person concerned posed a very significant threat to others by virtue of his/her behaviour. The Government believes that for the time being it would not be prudent to remove police stations as places of safety from legislation. However, the Government has made clear its intention to legislate to ensure that the use of police cells is truly exceptional and is consulting on potential changes to legislation to achieve this. In the meantime, the revised Code of Practice has re-emphasised the point that the use of police cells as a place of safety should indeed be exceptional.

Conclusion / Recommendation 4 – The Government's own review of section 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)

The Government notes the Committee’s comments (see response to recommendation 3).

Conclusion / Recommendation 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)

The Government endorses the Committee’s comments.

Conclusion / Recommendation 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 place of safety places, having regard to local circumstances, within three months. (Paragraph 20)

Through assessing evidence gathered during the Government’s review of sections 135 and 136 and work with local areas on the Concordat, we understand that there are various, often complex, reasons why people of all ages are being taken to police cells under section 136 for assessment rather than to health-based places of safety.

The Government’s Mandate to NHS England for 2014/15 and as refreshed for 2015/16 sets out clearly that “we expect NHS England to make rapid progress, working with CCGs and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive
and high quality as other health emergency services." The Mandate also states that the Government expects “every community to have plans to ensure no one in crisis will be turned away” based on the principles set out in the Concordat.

It is the role of Clinical Commissioning Groups (CCGs) in England (local health boards in Wales) to understand the local demand and provide adequate levels of service, which may include increasing the capacity and staffing in health based places of safety – as the review of sections 135 and 136 highlighted. NHS England has a generic assurance process which considers how effective CCGs are in discharging their responsibilities. This is an evidence-based process which is designed to challenge where statutory duties are not being met. The revised CCG assurance framework for 2015/16 will have a particular focus on statutory duties.

The right level of provision of health-based places of safety, including contingency planning, is a matter for local judgement based on local needs. This will usually be undertaken in partnership with local communities, and described in the mental health section of a Joint Strategic Needs Assessment.

The current planning guidance for CCGs, issued in December 2014, which they must have regard to, and which will be part of NHS England’s assurance process, requires that CCGs ensure there is enough capacity in mental health services to prevent children, young people and vulnerable adults undergoing mental health assessments in police cells. We do not believe that there is a need for NHS England to issue further guidance in this regard at present.

Following the review of sections 135 and 136 the Department of Health and Home Office are working with NHS England to understand questions of local capacity and demand and to support local areas in planning to ensure that there is enough capacity to prevent children, young people or vulnerable adults, undergoing mental health assessments in police cells.

**Conclusion / Recommendation 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)

The Government agrees that based on the principle of parity of esteem between mental and physical health, which we have enshrined in legislation, people in mental health crisis should be able to access high-quality, responsive services on a 24/7 basis. We also agree that people detained under section 136 should not be excluded from health-based places of safety based on the application of arbitrary exclusion criteria, such as intoxication.

The CQC report *A safer place to be*² (published in October 2014), found that too many health providers have been operating policies that exclude people from health-

² [http://www.cqc.org.uk/content/safer-place-be](http://www.cqc.org.uk/content/safer-place-be)
based places of safety – including those who are under 18, people who are
intoxicated, people exhibiting disturbed behaviour, or because of the person resides
outside of that area. The CQC committed to carry out this report as part of the Crisis
Care Concordat (Action 3.10) – the Concordat is clear that such blanket exclusion
criteria are not acceptable. The revised Code of Practice states clearly that
“intoxication (whether through drugs or alcohol) should not be used as a basis for
exclusion from places of safety, except in circumstances set out in the local policy,
where there may be too high a risk to the safety of the individual or staff”.

We have repeatedly reinforced this message in our communications with local areas
and will continue to work with national partners including the Royal College of
Psychiatrists and the College of Policing to establish and promote best practice. In
November 2014 the Minister for Policing, Criminal Justice and Victims (the Rt Hon
Mike Penning MP) and the Minister for Care and Support (the Rt Hon Norman Lamb
MP) wrote jointly to police chief constables and Chief Executives of NHS Trusts on
this matter. The letter specifically asked them – particularly in areas where this was
happening most frequently – to work together to urgently address the unacceptable
practice of people detained under section 136 who should be assessed in a health
setting being taken to police cells instead.

Conclusion / Recommendation 8 – We note 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)

The Government agrees with this recommendation but would emphasise that
identifying and equipping suitable alternative places of safety is not an outcome that
can be delivered quickly. There also needs to be appropriate consideration of costs
and how these will be met after demand has been identified as an issue in specific
local areas.

To this end, the Government is currently piloting an alternative place of safety at a
Richmond Fellowship care home in Horsham, West Sussex. The pilot will operate for
a 12-week period and will be subject to a comprehensive evaluation which will be
shared with Ministers, senior health and policing leaders, and commissioners. The
pilot has been developed in line with relevant guidance to ensure the place of safety
meets the required standards. The Richmond Fellowship has ensured that their staff
have received all the necessary training to ensure they can detain people safely and
confidently.

Conclusion / Recommendation 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)

The Government welcomes the Committee’s support for the proposal to extend section 136 powers to all but domestic premises. We believe that this will significantly improve the ability of the police to act swiftly and more effectively to assist people who may be in crisis.

As the Committee notes, at present the Government does not intend to further extend the powers to apply in people’s homes. However, it is important that where a person is experiencing a crisis in their own home and where they may pose a risk to themselves or to other occupants, the appropriate organisations other than the police are able to act more quickly than is often the case at present to provide the right kind of assistance. We will continue to discuss this matter with relevant stakeholders.
3. Detention of children under s. 136

Conclusion / Recommendation 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)

We welcome the Committee’s support for the proposals regarding removing police cells as places of safety for children and young people, as set out in the review of sections 135 and 136. While Ministers have expressed a wish to see legislation amended at the earliest opportunity, next steps are subject to a full impact assessment and clear plans for implementation before a legislative timetable can be agreed. These considerations will inform early decisions for the next Government.

As previously mentioned, we understand that there are many reasons why children and young people are being taken to police cells for assessment under section 136 rather than to health-based places of safety, including in some areas their exclusion from the latter on account of their age. We would like the Committee to note that there has already been some success in reducing the number of under-18s detained in police cells under section 136 of the Act. In 2013/14 there were 236 cases, while data from the Police for the six month period April to September 2014 show the number of cases is down to 86, with more forces reporting no instances at all of police custody being used for this group. This number represents a significant projected decrease for the first time since data on under-18s began to be collected.

However, the Government has repeatedly made very clear its view that the detention of children and young people in police cells under section 136 is completely unacceptable and must stop now (except in the very exceptional cases where a police officer makes the decision that the immediate safety of the child or young person requires it). Ministers have written to NHS health providers and police forces to set out clear expectations to this effect, including that the reasons for a police based detention should be recorded according to the local policy and shared with relevant local authority children’s services. This approach is set out in the revised Code of Practice.

We acknowledge there are significant national gaps in the overall commissioning, provision and structure of Child and Adolescent Mental Health Services (CAMHS), which is why in August, Health Ministers set up the Children and Young People’s Mental Health and Wellbeing Taskforce. The taskforce, co-chaired by the Department of Health and NHS England, has considered and made recommendations on how more joined up and accessible services, built around the
needs of children, young people and their families can be provided. The Taskforce will publish its report this week\(^3\).

**Conclusion / Recommendation 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)

The Committee correctly identifies that chapter 19 of the revised Code of Practice sets out the government position with regards to the use of places of safety attached to adult wards: “*Unless there are specific arrangements in place with CAMHS, the healthcare setting identified by local policies as the place of safety should be used, and the fact that this is attached to an adult ward should not preclude its use for this purpose.*” As set out in chapter 16 of the Code, we expect local section 136 protocols and policies to identify the most appropriate place of safety to which a particular person – of any age – is to be removed. The Code of Practice emphasises that arrangements should be in place to ensure that above all, the child or young person is placed in a safe and suitable environment. Clearly, in all but very exceptional circumstances, a police cell will not be a suitable environment.

The Code of Practice provides statutory guidance to a range of health and care professionals, including managers and staff of providers, on how they should proceed when undertaking duties under the Act. The Department of Health worked with provider umbrella organisations such as the NHS Confederation and the regulator, CQC, throughout the consultation process on the Code and have involved them in communications work around the time of publication to ensure that providers are fully aware of the updated guidance. The Department intends to maintain constructive engagement with key stakeholders, including the NHS Confederation and mental health service providers, to raise awareness of the new Code and accompanying materials on an ongoing basis.

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\(^3\) [https://www.gov.uk/government/publications?departments%5B%5D=department-of-health](https://www.gov.uk/government/publications?departments%5B%5D=department-of-health)
4. Police and health service collaboration

Conclusion / Recommendation 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)

The Government agrees that early indications of the effectiveness of the street triage approach are very positive, and we have heard feedback from across the country to that effect. It is important to note that there are a number of models of street triage and local areas should be able to adapt the core principles of the approach to local needs.

In order to build on the core principles of street triage – health and policing professionals working closely together – and to ensure the approach is sustained, the success of current schemes needs to be evaluated in more depth. NHS England have commissioned an independent evaluation of the nine Department of Health funded pilot schemes, to help inform the future commissioning and sustainability of street triage services. Initial findings from the evaluation will be available in early May with further and final findings reporting in early autumn 2015.

This guidance will be shared with partners with a responsibility for commissioning services to respond to mental health crises, including CCGs, Police and Crime Commissioners and Local Authorities. The guidance will set out a range of success criteria that can be applied to triage schemes which will mean they can be tailored appropriately to local needs. At the broadest level, schemes should ensure that people experiencing mental health crisis receive a more effective response, with better access to the medical care they need.

Current triage pilots are measuring success in a number of ways, including the number of people detained under section 136, the number taken to police cells, and resource savings. We also know of a number of individual case studies which demonstrate that triage schemes have made an immeasurable difference and saved lives.

The nine Department of Health funded pilots are all moving to local funding arrangements. Some of these schemes are extending their hours of operation, for example, West Yorkshire is moving to availability 24 hours a day. Others are widening their geographical coverage, such as the service in West Midlands which has been extended to Coventry; and there are plans for the Thames Valley scheme to expand from Oxfordshire to West Berkshire and Buckinghamshire. We understand
that there are now locally funded schemes operating in at least 21 additional police force areas.

**Conclusion / Recommendation 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)

Early indications from the first wave of Liaison and Diversion test schemes (which went live in April 2014) are that mental health services are keeping pace with referrals from Liaison and Diversion services. The evidence from the trialling and evaluation of Liaison and Diversion services will be used to inform the future commissioning plans for mental health and related services.

By April 2015, these services will be available to more than 50% of the population of England, and it is expected that they will be available everywhere in England by April 2017, subject to Full Business Case approval by HM Treasury in October 2015.

**Conclusion / Recommendation 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)

**Conclusion / Recommendation 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)

The Government is clear that people detained under the Mental Health Act 1983 should be transported to places of safety by ambulance (or other appropriately staffed and equipped health vehicle), as reflected in the revised Code of Practice.

The Concordat states that police vehicles should not be used unless in exceptional circumstances, such as in cases of extreme urgency or where there is a risk of
violence. Following publication of the Concordat, all ten of the ambulance trusts in England agreed a new section 136 protocol which came into force on 1 April 2014 and should mean faster and more consistent responses to section 136 calls. This protocol involves a commitment that when people are detained under section 136 the ambulance service will aim to respond within 30 minutes to make a clinical assessment and arrange transportation. We understand from some local partners (such as in Thames Valley) that the new protocol has helped to address this issue, with a higher proportion of section 136 detainees being taken to places of safety by ambulance.

We agree that there should be more reliable data on the use of ambulances to transport people detained under section 136 and have taken steps to rectify this. The Government is working together with the Association of Ambulance Chief Executives (AACE) and the National Policing Lead for mental health to improve data collection on ambulance responses.

From April 2015, the Home Office is asking police forces to collect data on how people detained under sections 135 and 136 of the Mental Health Act are transported to a place of safety, including the reasons why a police vehicle was used (if that was the case), as part of a new Home Office Annual Data Requirement. The data for 2015/16 will be published in summer 2016 (see recommendation 21). In addition, the AACE is already collecting data from ambulance trusts on transportation of people detained under section 136 of the Act.

At a local level, we recognise that strong partnership working between police and ambulance services will help to reduce the use of police vehicles. As key signatories to local Concordat declarations, we expect local forces and ambulance trusts to understand each other’s roles and responsibilities and work together with CCGs to assess and plan for local demand. We have asked local areas to have Concordat action plans in place by spring this year – these plans should include actions to ensure that expectations around transportation will be met.

**Conclusion / Recommendation 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)**

The pilots of the street triage scheme are already demonstrating the value of closer integration of police and health professionals when responding to calls to deal with people apparently experiencing mental ill health (see response to recommendation 12). Some areas have extended this principle to having multi-agency control rooms with health professionals present to whom individual calls which appear to have a mental health component can be referred for immediate advice on the appropriate response. While such schemes are still relatively new, the Government welcomes such examples of closer integration of emergency and professional services and is keen to see emerging lessons and good practice more widely disseminated in the interests of better and more appropriate responses to some critical situations.
NHS England will shortly publish guidance ("Transforming urgent and emergency care services in England: Clinical models for ambulance services") which will put a greater emphasis on alternatives to conveyance and, when necessary, conveyance to destinations more appropriate to the patient’s needs than Emergency Departments.

**Conclusion / Recommendation 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)

The Government’s view is that the principle of parity of esteem between mental and physical health applies throughout the entire health system, including to NHS commissioned emergency services. We recognise the vital contribution that Ambulance Trusts can play in improving crisis care, which is why we have designated them as one of the key essential signatory organisations involved in local Concordat partnerships.

We have worked closely with the AACE in their role as a national Concordat partner, including their development of a national protocol for responding to section 136 incidents. Ambulance Trusts across the country have now signed up to provide initial clinical assessments within 30 minutes.

There is a clear expectation of parity of esteem across urgent and emergency care, which is explicitly addressed in forthcoming guidance “Transforming urgent and emergency care services in England: Clinical models for ambulance services” (see above).

**Conclusion / Recommendation 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)

The Government agrees with the Committee on the principle of this point; as a mental health assessment is the prime purpose for which people are detained under section 136, they should not be made to wait unnecessarily for these assessments to be undertaken.

The review of sections 135 and 136 included a recommendation that legislation should be amended to reduce the maximum length of detention under sections 135 and 136 from 72 hours to 24 hours, in any place of safety.

Working within the legislation as it currently stands, the revised Code of Practice states that wherever practicable detention in a police station under section 136 should not exceed a period of 24 hours.
We agree that the standard of three hours – set by the Royal College of Psychiatrists – within which mental health assessments (for people detained under section 136) should be completed, should be adhered to. The revised Code of Practice endorses this target as long as there are no clinical reasons to delay assessment.

The review of sections 135 and 136 considered the feasibility of creating a statutory minimum time period for the assessment to commence. However, the review concluded that while local agreements should set out a minimum standard for assessments including acceptable time frames, it will be down to local arrangements, availability, geography and staffing levels to ensure that the assessment can commence within a reasonable timeframe. It is unnecessary to provide for this in primary legislation and to do so would reduce the flexibility available for example if the person is under the influence of drink or drugs and the assessment cannot commence immediately.

Conclusion / Recommendation 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)

The Government agrees that there is a need for better data and transparency on various aspects of mental health care, including the actions taken following detentions under the Mental Health Act. The Government’s Mental Health Action Plan, Closing the Gap: Priorities for essential change in mental health4 (published in January 2014) identified the need for an “information revolution” in mental health. To that end, in partnership with Public Health England (PHE), NHS England and others, we have created the Mental Health Intelligence Network (MHIN).

The MHIN draws together comprehensive information about mental health and wellbeing to provide a greater insight into mental health problems, how they vary with age and in different parts of the country, and what the most pressing needs are in each area. It also gathers information about the services being provided and how effective they are.

We are currently considering how, through the MHIN, national Crisis Care Concordat partners can use and analyse available data and information to support the implementation of the Concordat at both a national and local level in order to improve our understanding of crisis services and the experiences of individuals in contact with them.

We have heard from partners in a number of local areas across England and Wales that they already use local information about what happens to people after a section 136 detention to understand performance. However, practice in this area does not appear to be consistent. From April 2015, local areas will have access to a ‘data toolkit’ developed by the Home Office and National Policing Lead for Mental Health to record this information in a manner that is consistent with other local areas.

**Conclusion / Recommendation 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)

The Government agrees that strong co-operation and co-ordination between local agencies is vital to improving the support people receive when they experience a mental health crisis. To achieve this, we want to see strong leadership shown by each and every one of the agencies that contributes to that response. Not only do we expect to see a high level of leadership within these organisations, but we also expect them to show leadership collectively, through strong governance and accountability around crisis care.

We have already seen this through a number of excellent examples across the country, such as in areas that have self-funded ‘street triage’ schemes, in some cases co-commissioned by health and policing commissioners. Many of these schemes involve multi-agency partners receiving training together, sharing appropriate information promptly and agreeing joint operational responses, based upon clear, locally-agreed protocols, all framed around the best interests of the patient.

Across England we expect that local versions of the Concordat should bring each area to a common standard of partnership working. Indeed, each local Concordat declaration required the commitment of a common minimum set of partner agencies from across health, social care and policing in order to be recognised. Following the signing of declarations in all areas by end of 2014, we have now asked each area to agree and publish an action plan by spring – progress toward this goal can be viewed at the following website dedicated to the Concordat: http://www.crisiscareconcordat.org.uk/explore-the-map/.

**Conclusion / Recommendation 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)
The Government recognises that reliable data is central to demonstrating progress. Not only will this provide a clearer picture of the demand placed on the police, but it will also help to show whether the right agencies are responding to people in crisis at the right times.

The Home Secretary announced on 23 October 2014, at the joint Home Office and Black Mental Health UK Summit on Policing and Mental Health that the Home Office will work with the police to pilot the collection of data on people detained under the Mental Health Act. This will include the number of detentions under sections 135 and 136, the age and ethnicity of detainees, place of safety used including where police custody is used, the reason for this, and the mode of transportation (including where a police vehicle is used, the reason for this). Forces will provide the data for 2015/16 – which the Home Office will subsequently publish – on a voluntary basis with a view to it becoming a mandatory part of the Home Office’s Annual Data Requirement for all forces in England and Wales from 2016/17. The figures will be published annually to provide greater transparency around the action taken by police and their partners.

In addition, the Home Office and the National Policing Lead for mental health, Commander Christine Jones, have developed a ‘data toolkit’ (Action 1.2 from the Crisis Care Concordat). The toolkit identifies more detailed information that the police can collect about their contact with people with mental health problems which they can use as evidence of demand to drive local improvements in crisis care. The toolkit dataset has been informed by a trial conducted with three police forces in August and September 2014, and is available to forces to use from April 2015.

**Conclusion / Recommendation 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)

The Government endorses the Committee’s comments.

**Conclusion / Recommendation 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)

The Government is acutely aware that police officers and staff are themselves at risk of developing mental health problems, particularly in view of the nature of the work they undertake. We agree with the Committee that improved data on police sickness absence and the reasons for absence would allow for better examination of the impact of their work on the mental health of officers and staff, and indicate where and what further support might be required by the police workforce to improve their mental health and reduce sickness absence.

Since 2005 there has been an initiative for forces to collect data on 12 categories of sickness, one of which is “Psychological Disorders”. This tool is used to a varying
degree by individual forces; no data is collected centrally. The Committee may be interested to note that the Home Office has recently completed a data improvement exercise on police sickness collection generally. However, this does not contain a breakdown by ailment type. We will, in conjunction with the College of Policing and the Police Data Requirements Group, give further consideration to the Committee’s recommendation.

In terms of the provision of support to police officers experiencing mental ill health, the Committee will wish to note that in October 2014, the Government allocated £10 million for England and Wales to help support emergency services personnel (and volunteers), funded through LIBOR (London Interbank Offered Rates) fines. Up to £4 million in funding was allocated to help mental health charity, MIND, to develop a package of targeted support and information for all such personnel. This will include anti-stigma work, establishing peer support groups and embedding training, and awareness-raising on mental ill health with employers, charities and other groups.
5. Training

Conclusion / Recommendation 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)

Conclusion / Recommendation 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)

Conclusion / Recommendation 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)

The Government agrees that the training of police officers and police staff in the identification of vulnerability, including the signs of mental ill health, is vital to ensure that people receive an appropriate response from the police service. The Government committed in the Mental Health Crisis Care Concordat, (action 3.18) that the College of Policing would undertake a full review of police training. The review includes a review of training, guidance and research for police officers responding to victims, witnesses, offenders and members of the public who may be experiencing a mental health crisis. This review will update the existing guidance and convert it into a new format, known as Authorised Professional Practice (APP).

The College of Policing is also undertaking a specific review of the use of force in mental health emergencies to ensure use of force training is fit for purpose. This will also identify the circumstances when mental health services may need to call upon police assistance to safely manage and help de-escalate a situation when someone is deemed too much of a danger to themselves or others to be managed by health staff in mental health hospitals. The training that the College of Policing is developing
will emphasise throughout the stigmatising effects of assuming that mental health is connected to violent behaviours.

The identification of specific needs and/or diagnosis of particular illnesses rests with health professionals. As such the Government supports the recommendation of the Committee that police staff should be able to get timely access to and support from mental health professionals. Indeed, the review of sections 135 and 136 recommended changing legislation to require the police to consult a suitable health professional prior to detaining a person under section 136 provided it is feasible and possible to do so. The importance of the police being able to obtain advice from mental health professionals is at the heart of a number of initiatives that are already underway. The expansion of street triage and Liaison and Diversion initiatives is ensuring that mental health professionals are more readily available to offer advice and support to the police, whether in person or by telephone.

The Government agrees that, in principle, multi-agency training in local areas can be hugely beneficial to all bodies involved in it. Whilst local multi-agency training is the responsibility of individual police forces and their partners, we are encouraged to see that the Committee has recognised police forces that are already doing this well. Additionally we agree that local training should cover issues such as de-escalation, the perception of connecting mental health issues with violent behaviours and how these perceptions may impact on the BME communities these agencies serve.

The Government has previously considered the benefits of joint training, most recently during the development of the Concordat, which states in section B4:

"Each statutory agency should review its training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations. Although it is desirable that representatives of different agencies be trained together, it is not essential. It is more important that the training ensures that staff, from all agencies, receive consistent messages about locally agreed roles and responsibilities".

We are looking for evidence regarding ambitions for improved training – including multi-agency – in local Concordat action plans.

Finally, the Government has committed to the transfer of commissioning responsibility for police custody healthcare services to NHS England. This transfer will mean that healthcare in all police custody suites will be commissioned in line with NHS standards and guidelines, and will provide a clear link between police custody and community health provision for the vulnerable detainee upon release from custody. The aim is for this transfer to be in effect from April 2016.

**Conclusion / Recommendation 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)
The Government is clear that any use of restraint must be lawful, proportionate and necessary in all the circumstances.

The Government strongly recommends that forces follow the police’s own national guidance in this area - the National Personal Safety Manual. Individual police officers using restraint must be authorised and must have fully up to date training.

However, to see further progress, the Government welcomes the review by the College of Policing of Authorised Professional Practice around mental health and the work to consider how current training should be updated around the issue of restraint in the mental health context.

At the Policing and Mental Health Summit in October 2014, the Home Secretary made a public commitment that there should be greater transparency of data in relation to the use of force and/or restraint by the police. The Home Office is currently working with the National Policing Lead and policing stakeholders to review the data available with a view to introducing new recording requirements on this issue in due course.

In April 2014, as part of a two-year programme, the Department of Health published guidance on *Positive and Proactive Care: reducing the need for restrictive interventions* for the NHS. The publication was part of work to develop a culture across health and social care where physical interventions are only ever used as a last resort when all other alternatives have been attempted and only then for the shortest possible time. The use of deliberate face-down restraint must never be deployed.

*Positive and Proactive Care* echoes the government position in the Crisis Care Concordat with regards to the involvement of police in mental health settings. The revised Code of Practice states clearly that “Providers should work with local police services to establish clear local protocols about the circumstances when, very exceptionally, the police may be called to manage patient behaviour within a health or care setting. In these cases, mental health professionals continue to be responsible for the health and safety of the person. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient’s physical and psychological wellbeing.” We have asked local partnerships to include explicit reference to their work on the use of restraint in Concordat action plans to be published by spring.

*Positive and Proactive Care* also states that “NHS Protect guidance indicates trigger points for the need to seek further assistance from the police service. If the police are called upon to help manage a dangerous situation they will use techniques and act in accordance with their professional training. Care and support staff have a continuing responsibility to alert police officers to any specific risks or health problems that the person may have as well as to monitor the person’s physical and emotional wellbeing and alert police officers to any specific concerns.”

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The revised Code of Practice states that with regard to the use of section 136, “There should be a clear local protocol about the circumstances when, very exceptionally, police may be asked to use physical restraint in a health-based place of safety” as part of jointly agreed local protocols and policies in place governing all aspects of the use of section 135 and section 136.

Conclusion / recommendation 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)

As one of the signatories to the Concordat, NHS England is committed to working alongside other agencies to improve the system of care and support for people in crisis because of a mental health condition, and to improve prevention and early intervention to prevent crisis whenever possible. NHS England will work with other agencies to make sure that all relevant public services support someone who appears to have a mental health problem to move towards recovery. NHS England is targeting £30 million investment in 2015/16 to enable a greater number of acute hospitals to establish effective models of liaison psychiatry, and has developed a clinical standard for liaison psychiatry on every day of the week, through its Seven Days Services Programme.

Drug and alcohol abuse is one of the factors that contribute to the causes of deaths in police custody. NHS England is working with Public Health England and the Ministry of Justice on a review of overdose whilst in police custody for both young people and adults to support the reduction of unexplained deaths, suicide and self-harm in prison and detained settings.

Conclusion / recommendation 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)

The Government shares the Committee’s concern about the general increase in the number of suicides, particularly those who take their own life following a period in police custody.

The College of Policing have produced APP on the arrest, detention and transportation of prisoners⁶. This APP makes clear the role that custody staff have in

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undertaking a risk assessment for all prisoners upon arrival within custody. The Police and Criminal Evidence Act Code C is clear that a custody officer must make sure that detainees receive appropriate clinical attention if they appear to be suffering from a physical illness, injury, a mental disorder or if they need clinical attention. The Government is clear that people identified as vulnerable within a custody environment should be notified to medical staff and mental health nurses to receive a proper assessment of their needs. Our ongoing work to improve the standard of healthcare provision within police custody, both in terms of the roll out of Liaison and Diversion services as well as the transfer of commissioning healthcare services from the police to NHS England with planned effect from April 2016, will contribute towards achieving this aim.
## Summary of Government response to the HASC's conclusions and recommendations

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<tr>
<th>Number</th>
<th>Recommendation / Conclusion:</th>
<th>Government response</th>
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<tr>
<td>1</td>
<td>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)</td>
<td>Accept</td>
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<td>2</td>
<td>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)</td>
<td>Noted</td>
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| 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) | (i) Remove cells as places of safety – reject  
(ii) Guidance on ‘exceptional’ – accept in principle |
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<th>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)</th>
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<td>5</td>
<td>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)</td>
<td>Noted and endorsed</td>
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<td>6</td>
<td>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. (Paragraph 20)</td>
<td>Accept in principle</td>
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<td>7</td>
<td>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)</td>
<td>Accept</td>
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<td>8</td>
<td>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)</td>
<td>Accept</td>
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<td>9</td>
<td>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)</td>
<td>Accept in principle</td>
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<td>10</td>
<td>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)</td>
<td>Accept in principle</td>
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<td>11</td>
<td>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)</td>
<td>Accept</td>
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| 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) | (i) Evaluation needed – accept  
(ii) Central government funding – reject |
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)
<p>| 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) |
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