



Home Affairs Committee

Oral evidence: [Policing and mental health](#), HC 202

Tuesday 2 September 2014

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Written evidence from witness:

- [Inspector Michael Brown, West Midlands Police](#)

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Members present: Keith Vaz (Chair); Ian Austin, Nicola Blackwood, Michael Ellis, Paul Flynn, Lorraine Fullbrook, Dr Julian Huppert, Yasmin Qureshi, Mark Reckless.

Questions 88 – 122

Witness: **Inspector Michael Brown** (aka Mental Health Cop), West Midlands Police, gave evidence.

Q88 Chair: I call the Committee to order and welcome Inspector Brown, who is giving evidence to the Committee on our inquiry into policing and mental health. This is an ongoing inquiry that will encompass a number of different sessions. We are most grateful to you, Inspector Brown, for coming. Can I begin by asking any members to declare any interests that are over and above what is in the register of members' interests?

Inspector Brown, first of all I commend you on the work that you have done on policing and mental health—in particular your own blog, which is the source of enormous information for all concerned. Your interest in this subject mirrors the Committee's interest and that is why we have you to give evidence today. You have said that mental health issues are core business for the police. What exactly did you mean by that?

Inspector Brown: When I first joined the service in 1998 it became obvious in the first weeks of being operational on the street that the number of incidents the police are called to were certainly varied. This was very much a part of the business that, if I am frank, I had not anticipated when I joined.

I did not join the police with a particular interest in mental health issues or the police role around it; I just found myself quite startled by how much of it there was. When you start to understand the nature of some of that demand, the only conclusion I could draw was that not all of it, by any means, is knowable, preventable mental health crisis that might be dealt with by other agencies. Some incidents, by their definition, are unpredictable, unknowable events. The police service, in some circumstances, is going to have a role in resolving that.

Q89 Chair: It is difficult to put a percentage on it, but are you able to help the Committee with a percentage of the number of people within the criminal justice system, those who are part of the system, who come before the courts as perpetrators of crimes or who go to custody officers? Do you think there is a particular percentage who have mental health issues?

Inspector Brown: Yes. I keep coming up with the figure of 20%. I know it is a figure some other commentators have shared as well. Lord Adebawale mentioned the figure 20% in his report last year. I came to that figure just through my operational experience. Because of my interest in the subject as an operational duty inspector in the police, I sometimes kept a ready reckoner on my desk as to how many people who were missing on my division at that particular time were missing with mental health problems; how many people in custody were people with mental health issues and needs of various kinds.

I used to keep a snapshot, look at an hour of policing, and think how many jobs that came through on the 999 system were connected to mental health. I just kept coming back to figures that were roughly around 20%. There is research that puts the figures in those territories as well. If you look at police custody, estimations of the numbers of people coming through custody arrested for criminal offences who also have some kind of potential mental health need tends to figure around the 20% figure. I use that figure excluding people who present purely with drugs and alcohol in their system—if you include that, the number goes up.

Q90 Chair: Is that going up or down? You have been around a considerable time. You have studied criminology and the criminal justice system. These kinds of debates have been going on in Parliament for many years: the concern about the number of people with mental illnesses who are part of the criminal justice system. Is this going up or down? There does not seem to be any action being taken as a result of these concerns.

Inspector Brown: I genuinely would find it difficult to say whether it is going up or down because so many people argue about the definitions of mental disorder. What do you count as a mental disorder when you are trying to quantify people coming through custody or calls made to the police?

There is difficulty in extrapolating from the data we have the numbers of people who are suffering from mental health problems because we know some people go all the way through police custody, even sometimes seeing medical professionals or mental health professionals, and still manage to get out the other end of police custody without anyone discovering or suspecting they have a mental health problem. I think we need so much more research and so much better data if we are going to be certain as to what we have and then be able to conclude whether it is going up or down.

Q91 Dr Huppert: First, can I congratulate you for all the work that you have been doing and for your very interesting and quite detailed briefing document? There are a few other things to press you on, if I can. Your figure of about 20% is interesting when you think that roughly one in four people will have a serious mental health condition during their lifetime, so it is broadly comparable—although I know those numbers do not quite work out exactly. Can I talk to you about how you think the interaction with the NHS works? Can you just expand a bit on what you said in the written documents? How effectively do you think the NHS supports frontline police officers?

Inspector Brown: It is variable and it is not just about supporting police organisations. It is also about the support of the mental health professionals individually to the police and it is, by definition, variable. I have had many a frustrated hour in an operational position where you just feel that you cannot get something done. I have also been stunned by the lengths that some mental health professionals go to, to go that extra mile and make things work.

What I would say is that in a lot of areas of England especially where the code of practice requires there to be joint operating procedures between the police and the NHS, in my experience, having read literally dozens and dozens of them, some of the joint operating protocols vary in quality in terms of how close they get to established legal frameworks and statutory codes of practice, as well as NHS and police guidelines. If you want to pick an area of England where those procedures are not as well developed, you are going to find that the co-operation between the police and the NHS is difficult.

There are many areas of the country, though, where the procedures are pretty spot on and you would have to be quite pedantic to be picky with them, and areas find they have very good working relationships. 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 could be and where training does not happen and, therefore, where frontline staff come into conflict with each other.

Q92 Dr Huppert: We will come on to things about training shortly, but I think it is very important. I am sure you know all about the street triage pilots and the efforts there. What is your assessment of them? Have they been successful? Are they the right way to go?

Inspector Brown: I want to see them fully evaluated after they have run for a decent length of time. I have said on my blog, and it is a matter of record, that I have one or two questions about triage, but I broadly welcome the fact that they are a positive initiative that gets mental health professionals and police officers talking to each other at all levels, sharing perspectives about what each other's jobs are about. It is said time and time again that police officers need more mental health awareness training, and I would not necessarily argue with that for a second, but I would also say as a caveat that mental health professionals probably need more police awareness training.

I have been asked numerous times in my career to do things that are just illegal. No malice involved; just mental health professionals not understanding what police powers are, what police procedures are, or practical things about whether you can force entry to a premises or whether you can detain somebody in certain circumstances. Street triage brings professionals together very closely where they can work very much hand in pocket and learn from each other as they go along. That has to be a way to improvement.

Q93 Dr Huppert: Policing and mental health have not always been seen as going close together. You have made quite a name for yourself with the work that you have done. Have you been supported by the police service throughout that? In particular you have been very prominent on Twitter. I have seen a lot of things. Have you had any problems with being able to be outspoken on Twitter without problems from within your force?

Inspector Brown: It is a matter of record that there was an investigation into a couple of tweets that I put out publicly in February this year, and it was a couple of comments that followed a debate about street triage. Following a programme on the BBC, there was a dialogue on Twitter about triage and I expressed some views around how you make the world a better place, for the want of a description.

Somebody chipped in with the idea that what we needed a lot of was mental health professionals in police stations training the police how to do mental health. I said there are no issues around that at all; clearly mental health professionals have an expertise police have not got and that is welcome, but there needs to be a boundary around that because what mental health professionals are not are legal experts and justice professionals to take justice and legal decisions that the police are responsible for.

Within the dialogue around that I was perceived as being very critical of the NHS. But your question about whether the police have supported me—absolutely. Throughout the whole time I have been tweeting and blogging, there has been active support at senior level in my force for my doing that, and there has been since that event in February.

Dr Huppert: Good. I commend you and hope you continue doing it. It is making a big difference.

Q94 Mark Reckless: Do we want to be spending time training mental health professionals in police powers and the legal position? I understand you have had a particular to-do in terms of comments that I think you understandably made through Twitter, but is it not the role of the police officer to say, where necessary, “No, I can’t do that”, rather than training all mental health professionals to know what police powers are in a particular circumstance?

Inspector Brown: Clearly I am not referring to an exhaustive understanding of all police law; I am referring to certain basics around things like when the police can and cannot detain somebody under the Mental Health Act, for example. I could give dozens of examples in my own career where health service professionals, be it in mental health or be it from accident and emergency, have asked police officers to go to a private house to do a “safe and well check”, as it is called, on somebody who may be at risk with a view to detaining them under the Mental Health Act.

Of course, the police service do not have the power on a private premises to detain anybody under the Mental Health Act, so asking the police to go and do that puts the officer in a position where they are present at a private address where somebody may not be necessarily well. There may be an immediate need to do something in terms of safeguarding them, but the police service do not have a power to do that under the Mental Health Act.

Q95 Mark Reckless: What should happen instead in that circumstance?

Inspector Brown: There was a stated case in 2010, the case of Sessay, where the Metropolitan Police had detained a lady ostensibly under the Mental Capacity Act in a private dwelling. That was successfully challenged in the courts as being unlawful, but the judge in that case ruled that what should have happened is that an AMHP and a doctor should have attended the premises at police request in order to consider an assessment. That is a very difficult thing to achieve in practice—to ring up crisis team services, for example, and ask them to attend an address at no notice in order to conduct an emergency mental health assessment.

Q96 Mark Reckless: Should the mental health professional be asking that doctor to go to the address, only then asking for police involvement, or do the police need to be there in order, potentially, to protect the doctor?

Inspector Brown: Just to be clear, what I am not saying here is that there is no role for the police because clearly if somebody, to give a real example, has walked out of accident and emergency expressing suicidal ideas and there is a concern for their welfare because of the way they presented or their known history, the police have a role in terms of finding that individual to try to make sure that they become safe.

The only point I am making is that if that person is encountered in a private dwelling, there is no power for the police specifically to detain that person under the Act so that they can then be removed to a place of safety for assessment. In those circumstances what we would need is the ability of the police to then call upon a crisis team or mental health professionals to be able to respond in a reasonable timescale to that private address, if need be with a warrant from the courts—sometimes necessary if you are going to have to force entry—and then conduct that assessment.

Q97 Mark Reckless: To what degree does the duty of medical confidentiality impede the police from doing more on a proactive basis to help some of these people, would you say?

Inspector Brown: I have never thought that is a particular impediment. Most of the time, in a critical situation or an emergency or urgent matter, normally the information that you would want to get is shared. Even if sometimes you have to ask for it, it is normally given when you seek if it is not given proactively.

Q98 Mark Reckless: The crisis care, if you can call it that—is that the way forward? Is that the lever to improve the situation or, as you said before, are we more reliant on the local partnerships and personal relations, as they may be?

Inspector Brown: One would assume it is intended to all fit together. The concordat is a broad framework for all aspects of policing and mental health, from the criminal justice issues, liaison and diversion, right the way through to the operation of places of safety and pre-emptive work to safeguard people at risk. There is no reason why the concordat cannot be successful in achieving that. The crucial thing is going to be whether it is led in order for areas to bring themselves together around a table and sort out the various local issues that arise from the actions and the recommendations in the concordat.

Q99 Ian Austin: I would like to pick up on this issue of training as well. I have a few questions I would like to ask about that because in your submission I think you said that there is an urgent need for validated professional training for police officers at all levels. What training do police officers at different levels get now? What do you think they should get? Who do you think should deliver it? How do you think it should be validated?

Inspector Brown: When I joined the service I had four hours of training in my initial phase. I have since had four hours of training from my own force. When they developed a new force policy on mental health, there was a four hour training package that went with that. I have worked in areas

where, on a local basis as a local initiative, extra training has been provided from a particular mental health trust to a police division, for example. How much—

Q100 Ian Austin: Four hours?

Inspector Brown: It was four hours when I initially joined. It was four hours subsequently, when I had about eight years in my career.

Q101 Ian Austin: That is typical for police officers in general, do you think?

Inspector Brown: Specific to the subject of mental health, yes, but it is fair to say that issues around mental health are and always have been mentioned in police public order training, police personal safety training and in other areas of training where it is specific to the issues of control and restraint and so on. Mental health is mentioned within other training, but as a bespoke training package, so that perhaps officers understand more about what schizophrenia is, what dementia is, what autism is, all of those kind of training inputs. They were four hours when I first joined and four hours somewhat later and then there were some local initiatives, which I know occur around the country. Some forces do provide more. Some police divisions provide regular and refresher training, but it is very much a locally-led thing.

Q102 Ian Austin: That was when you joined. You got four hours. How much training would somebody joining the West Midlands Police get now?

Inspector Brown: I would have to check, and I am happy to clarify, but my understanding is they would get about six to eight hours in their initial phase. Obviously, my particular police force have not recruited for some years. What the training process will look like when they next take in recruits later this year, I am not quite sure.

Q103 Ian Austin: Six to eight hours is not a lot, is it?

Inspector Brown: No, it is not a lot. When you think about the complexity of mental health law in operational situations, I sometimes make a comparison to the legal training that we give police custody sergeants to be in charge of a custody area. They get a one-week law course covering all aspects of PACE and, of course, by the time somebody is a custody sergeant they have passed promotion exams in law. They have a level of experience within the police that is commensurate with being a supervisor.

For mental health, a lot of the incidents that we deal with are dealt with by frontline police constables who have not taken those legal exams and have not had a one-week mental health law course. I am not suggesting that a one-week mental health law course is necessarily the answer, but I must admit that I personally do think, for the risk and threat that it represents to vulnerable people in the service as a whole, given the tragedies that we have seen in history, that we need to be thinking about a three to four, if not a five-day mental health course for at least some officers, if not most of them.

Q104 Ian Austin: Presumably the six to eight hours is just factual descriptive stuff about mental health. It is not going to be about the particular vulnerabilities people with mental health problems face or how to deal with them and all of that, is it?

Inspector Brown: No, it is not and I think there is a balance to be struck. For example, recently on social media a gentleman put forward the argument that the police needed particular training in recognising and responding to people with autism and Asperger's syndrome. I do not necessarily disagree with that, but I asked him, just to test his thinking out, how much training he felt we should get on that. His answer was at least four hours. I then made the point that if you speak to all the different charities and organisations who represent vulnerable and ask, "How much training do you think the police should have in your particular area of interest"—so that would include learning disabilities, Asperger's, schizophrenia, personality disorder and so on, the list is quite long—if you add that up and every one of them had a four-hour input, you would end up with a one-week course before you had even begun to talk about the Mental Health Act.

There is a balance to be struck about what you can realistically put in and, of course, one of the key things is, in my view, we should not be trying to turn police officers into something that approaches a psychiatric nurse. That is not necessarily the point, but I think there something about how you recognise people at risk and some kind of working theory as to why they may be vulnerable at that particular point.

Q105 Chair: You have referred to officers being street corner psychiatrists and that is what you want to avoid. You have done a lot of comparative research, I would imagine, with other countries. Is there another country where they do this better than we have managed to achieve? The Scandinavian countries are usually better at dealing with these issues than others. Have you looked at any other country?

Inspector Brown: Yes, I have. I was fortunate enough earlier this year to go to Cape Town to speak at an international police event and the room included representatives from the Danish police. They were the ones who came up at the end of my input and said, "That was all very interesting, but it does not mean anything to us because we do not have those problems". Everywhere else in the room, which included Canada, Australia, the United States and certain African countries, they all broadly nodded at certain issues that I would raise in Britain as being areas of difficulty for the police, but the Scandinavian countries did not. They spoke about mental health services responding rapidly to police requests for urgent assessments. They did not feel they had any particular difficulties with legal structures impeding their ability to keep people safe.

Q106 Chair: If this Committee was looking abroad to try to find some answers, because clearly we do not have the answers at the moment despite attempts by successive Governments to try to deal with this issue—the police themselves, you have just told Mr Austin, don't have sufficient training—it would be to look at Denmark and some of the other Scandinavian countries?

Inspector Brown: Yes. I would also highlight Canada because, although the Canadian police currently have certain difficulties with some incidents being investigated and there are difficulties in Canada as well with perceptions on the part of police officers' families around what services may have done to support police officers with mental health problems, the Canadian Mental Health Commission has just published a report on police training that shows that they are way ahead of where we would be if we were trying to compare the inputs that we give and in how they validate and deliver training to their police officers.

Q107 Lorraine Fullbrook: I would like to ask, following on from Ian Austin, about the four to eight hours of training received by officers. You have previously submitted to the Committee that the four to eight hours includes awareness of various types of mental disorder and legal frameworks, as well as implications for operational policing, including crime investigation. You have said that it varies locally and is wholly inadequate.

Do you think this type of training is adequate for police officers in the case of trying to de-escalate a situation of somebody who suffers from a mental health issue and who may not be violent but perceived to be violent? I am thinking particularly of the James Herbert case. His parents believe that had he been spoken to and had the officers been properly trained, rather than restraining him, his death may not have occurred. We took evidence from the inquest inquiry as well. What is your position on that?

Inspector Brown: I would say that all that echoes what you hear if you look around the world at representative groups and other families. Certainly in the United States just in the last fortnight there have been four different fatal shootings where families have come out quite quickly and said almost exactly similar things about the American police use of firearms.

De-escalation: although it is not a word that you hear—at least I have never heard it in my police training—I would argue that the personal safety training that the police service get does involve teaching police officers de-escalation techniques. That having been said, when you compare the use of force by the police to the use of force by mental health services, it is often said that the mental health services teach de-escalation to a far better degree and they are trying to create space for people who are at risk rather than trying to control people who are at risk.

One of the obvious points is, of course, that the police service do not operate in defined mental health units where there are ultimately exits and entry points. We often deal with people in public places where the risks are not just around that particular person and what that particular person may represent to themselves; it is also something about passing traffic, other members of the public, whether they are on the top of a bridge or a building and so on and so on. As a general acceptance of your point, I would say that, if mental health training for the police was amplified, one of the things you would probably want to see in there is a bit more about de-escalating mental health crisis and start getting the word “de-escalation” into the language so that police officers think in terms of de-escalation and then think about what the tactics are to manage that.

Q108 Lorraine Fullbrook: Just following on from that, is there a case, therefore, for best practice to be shared between NHS staff in mental health units or psychiatric hospitals and the forces in terms of de-escalation?

Inspector Brown: Yes, I certainly think it needs to be looked at. Mental health control and restraint training is very situational-specific, usually to inpatient wards. In other areas of policing and mental health, where the police are called to incidents in private premises or in the community by mental health services, what you often find is that mental health professionals in those environments are themselves not trained in control and restraint.

For example—and this is a real example—an elderly lady in a house had been sectioned under the Mental Health Act because she suffered from dementia and had become quite unwell. When the services sought to ask her to get in the ambulance to take her to the hospital where she would be admitted and detained she refused and lashed out with a walking stick. They backed off

from that and the police service were called in to be the people who did the coercive side of that lady's admission.

Q109 Lorraine Fullbrook: But was that the police officers themselves using their own de-escalation techniques? Is this where it comes in that it varies locally as to what happens?

Inspector Brown: I would argue that, from my experience and from crowd-sourcing this on social media, most police officers and paramedics tend to say that in the community settings where mental health professionals operate to detain people under the Act and then admit them to hospital, in most instances you tend to find that the mental health professionals present are not trained in control and restraint at all.

Q110 Lorraine Fullbrook: What is your view on the use of tasers on those who are perceived to be violent who have mental health issues—not necessarily violent, but perceived to be?

Inspector Brown: In the operational role that I was in until Thursday of last week, I supervised a team of 24 police officers who included officers who carried a taser. I had a couple of observations around it, that being my first deployment as a supervisor in a role where I am overseeing the officers' use of that. First of all, most of the time that a taser is drawn it is not discharged; it is what we call "red-dotted"—in other words, it is pointed at the person, a red dot is fixed on their body and then officers issue instructions to put down a knife or to back off or whatever the context is. Most of the time that it is drawn it is not used and, therefore, from that point of view, if drawing it and threatening the use of it ultimately allows the police to resolve the situation safely, where it perhaps otherwise could not be if the officer did not have a taser, then I would welcome that.

What I would say is that, in my experience, there have been some incidents where people suffering quite acute mental health crises, psychotic episodes and so on, have been tasered by the police and it has literally had no effect. Even though the taser has hit the individual in the appropriate place, and the barbs are sufficiently spaced to allow the electrical current to run, it has not necessarily then led to the muscular reaction that you would expect to get from a taser. There have been incidents where officers have used it, hoping that would bring a knife-related incident to a conclusion, and it just did not and suddenly it became two officers who are now effectively without a taser trying to deal with somebody with a machete or a knife.

Q111 Lorraine Fullbrook: But you do think they have their part to play?

Inspector Brown: I think they have a role, yes. Paul Jenkins, who used to be the chief executive of Rethink, once put out a line in the media that I think basically said they should never be used on people with mental health problems. I am not sure I can get to that conclusion because I can think, in my own experience, of situations where it has been used by being drawn and not being discharged and it has been highly effective.

Q112 Paul Flynn: The case of James Herbert was a very distressing one. I think we were all moved when we heard the evidence from the parents and a friend. It seemed to be that the police were aware of this person's mental health problems but they used restraints, which ultimately led to his death, it was thought. In your evidence you talked about people suggesting that when suspects

become aggressive or violent the view is that they are best taken in to police custody. Would you agree with that statement?

Inspector Brown: First of all, many of the people that the police are restraining in these kinds of acute mental health episodes are not necessarily suspects. They could just be vulnerable people detained under the Mental Health Act. They are not accused of doing anything wrong. In terms of the principle of restraint, at the beginning of my career I was absolutely told, just through the working practices in Birmingham where I worked at the time, that if somebody was detained under the Mental Health Act and they were resistant and aggressive, even outright violent, they absolutely had to be transported to police custody.

As I have become interested in this subject, and I am sure the Committee have seen this, if you survey over the last decade or more you will find literally dozens of examples of people who have been restrained to death where they have got mental health problems. Possibly they have used substances prior to their detention by the police as well. In other cases they had not used any substances at all. The whole notion of restraint then becomes one discussed by the IPCC and the coroner process.

When I was getting interested in this, I found a case that occurred within an NHS setting, a restraint-related death involving a man by the name of David Bennett who was known as Rocky Bennett. Mr Bennett died in a Norwich hospital in the very late 1990s. Obviously, it being a health-related death, there was a Strategic Health Authority inquiry rather than IPCC inquiry and clearly it was done from a medical and health perspective rather than one of outright criminal liability because the criminal investigation into his death had finished.

The SHA inquiry in that case talked about restraint a lot. It is on page 55 of their report where they clearly said that anything that is more than a transitory restraint of somebody with a mental health problem should be dealt with as a medical emergency. It went on to say, beyond that, that if you are going to get in to a situation where you feel you have to restrain, if you have gone past all the other options and feel you have to restrain somebody and it is going to last more than a minute or so, you should start thinking not only in terms of it being a medical emergency but you should have nurses trained in the use of defibrillators. They should have access to drug trolleys. They should even be able to call upon a doctor within 20 minutes.

Clearly I was not present at either Mr Herbert's or Mr Bennett's death, but if you compare and contrast those two incidents, as well as many others, you could well argue that the medical risks involved in restraint are arguably just as serious when the police are doing it in a community setting as when mental health nurses are doing it in a medical setting. 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.

Q113 Paul Flynn: Is there any evidence on questions of those who commit suicide or try to commit suicide in custody that being in custody itself is one of the major factors and, if it has been addressed, are they far more likely to commit suicide because of their incarceration?

Inspector Brown: It is not something I know a phenomenal amount about but I know people have written in academic literature on prisons and custody generally that, yes, being detained is a trigger factor.

Q114 Paul Flynn: Is there any improvement? Do you think there is any realisation that, particularly if a case like James Herbert's takes place, that restraint should not be used except as a last resort? In his case there was no history of violence at all and the reason why he behaved the way he did was that the restraint, it appears, frightened him.

Inspector Brown: Of course. As I say, I cannot comment on that particular case. I was not present at it but, in general terms, I could say in my own career that I have known instances of restraint where I would struggle to think how else you might safeguard somebody from a risk that is very obvious if you do not restrain them. Therefore, it is a difficult decision around whether you leave somebody exposed to a risk or a danger or whether you expose them to a new risk and danger by restraining them in order to detain them under the Mental Health Act.

Q115 Paul Flynn: Finally, to become more like Denmark do we have to change the attitude of the police or the health service?

Inspector Brown: We have to change the attitude of our whole society towards mental health.

Chair: We have other witnesses, colleagues. We are going to be brief in our questions, which I know we always are—but especially now.

Q116 Michael Ellis: Mr Brown, as far as these issues are concerned, I was in the criminal justice system for some time as a barrister and for many of the people who appeared before the courts, as I am sure you know, mental health issues were not uncommon. I want to ask you what the police powers are as far as initial contact with someone who might be suffering from a mental disorder. What are their options? Do those options differ if it is day or night? Do those options differ, for example, if it is in a private place or in a public place?

Inspector Brown: It certainly does not differ whether it is day or night, albeit the response you then subsequently get from the health service may vary but, in terms of the police ability to intervene in some way, the time of day would not alter it. Section 136 of the Mental Health Act is a public place power only. There has been a lot of debate about whether that should be changed. I know the Government are looking at that at the moment. All I would say on that subject is Britain is one of the few countries in the western world that does not allow its police service to intervene in a private premises. The Republic of Ireland, Canada and Australia all allow some form of private place intervention.

In terms of the police options, of course, if you then find that police officers are in a private place you will find numerous examples of officers arresting people to prevent breach of the peace or for what might be quite minor criminal offences, purely as a method by which to safeguard somebody. The view being taken is that it would be better to arrest somebody for a minor offence, remove them to custody, see whether or not their mental health requires assessment in police custody and, if it does, you can always, on public interest grounds, take no further action on the criminal offence rather than leave somebody at risk in a private premises where the response from the health service may be—

Q117 Michael Ellis: They use a device to get around the issue of it only being possible to pursue if, in a public place, they make initial contact with someone who they fear is suffering from a mental disorder?

Inspector Brown: Yes. There have been other stated cases where officers have done something like, unlawfully I must say, detain somebody in private premises under breach of the peace provisions, remove them to a public place and then use the Mental Health Act, which the court said was unlawful.

Q118 Michael Ellis: But, just quickly, do the options differ day and night, not in terms of police response but in what is likely to happen as far as detention of an individual is concerned?

Inspector Brown: The options for detention will probably still be there. If the area concerned has a mental health place of safety, an A&E department and a custody suite, those will almost operate 24 hours a day.

Q119 Yasmin Qureshi: When someone is detained using section 136 they have to be seen by a doctor and obviously an approved mental health professional. If they, after the assessment, come to the conclusion that the person is not ill enough to be admitted to hospital then what do you do?

Inspector Brown: If they were purely detained under section 136 you release them because the AMHP in that assessment will have the statutory responsibility; if any safeguarding is needed that does not require inpatient admission, the AMHP is responsible for putting that in place. Whether that is a referral to their GP or a referral to a community mental health team, the AMHP would be responsible for putting that in place. From the police point of view, you would just release the person knowing that the AMHP has that duty to take forward anything else that may need to be done.

Q120 Yasmin Qureshi: I understand what the legal position would be but, in practical terms, you have somebody who perhaps is not sufficiently unwell for section 136 but is clearly not in the right frame of mind or their condition does not appear to show that they are fully able to look after themselves. If there is not any social services or anybody else to look after them, what happens? Do you still, on a practical level, say, "All right, the law says we have to release you. Off you go"?

Inspector Brown: In the real world I will not pretend that there are not cases where sometimes police officers think, "I can't believe that three weeks ago we detained somebody and they were unwell to a certain degree and they were sectioned and on this occasion they have not been". I will not pretend that does not occur about, at the end of the day, the statutory responsibility for making applications for admission belongs to the AMHP and any required safeguarding that takes place outside of hospital is also the responsibility of the AMHP.

I think any further concerns by the police, if there were any, would presumably just be articulated by the custody sergeant to the AMHP as the AMHP was going out of the door. I know I have personally done that on a few occasions but, in general, the AMHPs know perfectly well that, if somebody is mentally ill to some degree but not sufficiently unwell acutely to need admission, they still have responsibilities to make appropriate referrals and follow up.

Q121 Dr Huppert: Can I just look at the issue about the use of police cells as a place of safety? Obviously it is somewhat controversial. There is a huge difference in different forces. I think your force is commendably low in the use of police cells but others are orders of magnitude higher. Why

are we not able to put people into NHS-based facilities like the one I saw near Cambridge? Should we change the Mental Health Act so that police cells simply cannot be used as a place of safety?

Inspector Brown: My personal view on the last point is, yes, I think we should change the Mental Health Act. India does not allow police cells to be used as a place of safety, albeit they have different terms for those structures. Other countries do not allow it. I do not understand why a country as developed as Britain cannot disallow it either.

But the reasons why NHS services often turn people away are typically four or five different things. It is that the person presenting is aggressive or resistant. It is that the person presenting is under the influence of drugs or alcohol. There are some areas where access to places of safety are restricted if you are under the age of 18, which is something I will admit I have never understood and found that when you probe away at those arguments they are sometimes winnable arguments, frankly. There are one or two instances of services wanting to make the distinction between mental health and learning disabilities, which seems a bit unusual because it is then expecting the officer to make that call as to whether somebody who is detained has a mental health problem or a learning disability. Of course, what happens if they have both?

In terms of NHS exclusions, my point of view, having been responsible for a two-year period for trying to get West Midlands Police from a position where we have no 136 provision at all in a health setting to the point where we have provision that now means 98%-plus of people access health provision, the barriers along the way around NHS access were the things around drugs, alcohol, aggression and children, but they must be winnable arguments because 98% of the people in the West Midlands are going. It is about how the services are commissioned, because the commissioners in the West Midlands were very committed to getting through those problems. I know that in other areas some commissioners lack some of the knowledge around some of these things.

Q122 Chair: Of course the police themselves on the front line are very concerned. Mr Reckless and I were at the Police Federation conference this year when we heard of the resolution by, I think, Devon and Cornwall police force, members of the federation, who wanted action taken on this subject. They did not feel that they were the right people to deal with this issue. There seems to be a demand by the profession itself that there is action taken. Do you agree?

Inspector Brown: Yes, undoubtedly, because I still maintain that, at the end of any improvements we could make, mental health will still be called police business, but there is so much mental health-related demand you have to wonder whether it is being pushed down the line so far that it becomes a crisis preventably. The crisis care report from MIND a few years ago quotes the services. It said, "I feel like I have to have one foot off the bridge before I can get support." Of course, if things have reached that far and the police are now cordoning off the roads around the bridge to try to talk somebody down, if that was a preventable intervention with a known service user I would argue we have let that thing go too far.

Chair: Inspector Brown, thank you very much for coming to give evidence today and please carry on with all the good work that you are doing. If you feel there are any areas that this Committee should look into before we conclude our report—we will be concluding this inquiry at the end of November—please let us know. Feel free to contact this Committee because you clearly have a great deal of knowledge about this area and, like us, you want to make sure that progress is made.

Inspector Brown: Thank you.