HOUSE OF COMMONS

Home Affairs Committee

Oral evidence: Policing and mental health, HC 202

Tuesday 21 October 2014

Ordered by the House of Commons to be published on 21 October 2014.

Written evidence from witness:

- College of Paramedics
- Royal College of Nursing
- Royal College of Psychiatrists

Watch the meeting

Members present: Keith Vaz (Chair); Ian Austin, Michael Ellis, Paul Flynn, Dr Julian Huppert, Mr David Winnick.

Questions 123 – 182

Witness: **Lord Victor Adebowale CBE**, Chief Executive, Turning Point, gave evidence.

Q123 Chair: Lord Adebowale, my apologies for keeping you waiting so long. We had a witness who was giving evidence about the child abuse inquiry, Fiona Woolf, and therefore it took longer than we anticipated. My apologies to you.

Lord Adebowale: That is okay.

Chair: Firstly, on behalf of the Committee can I thank you for all the excellent work that you personally have done in this very important issue? In a real sense we are following up on your work and we are reading much of what you have done into our report into policing and mental health. We are keen to know what has happened since your report was written, whether you are satisfied with the progress that has been made or that more progress needs to be made as well, and this will be covered in the questions that we will ask.

I want to start by asking you about deaths in custody and vulnerable people when they get involved in the criminal justice system. I was absolutely astonished when I looked at the fatalities by type of death for the financial year 2012/2013 that showed the number of apparent suicides following custody at 64 and the road traffic fatalities at 30. It seemed that there had been a huge rise of 25 from the previous year. Why do you think this is on the increase?

Lord Adebowale: Before I attempt to answer that question, I should say I am giving evidence based on my experience as the Chair of the Independent Commission on Policing in London mainly. I will include some of the updates and the conversations that I have had. I could also draw on my experience as Chief Executive of Turning Point, which is a health and

social care organisation, and the NHS and MPS have the most up-to-date figures relating to policing and mental health. My work did not really look at deaths in custody. A lot of people think about deaths in custody is about the police response to mental health in London, so the focus of our work was not deaths in custody. I understand Lord Toby Harris is doing specific work on deaths in custody in that area, so I would refer you to him.

During the course of our work we did come across five cases of death in custody or while police were in control or after restraint, which was I found was five too many. As you know, Lord Harris, as chair of the independent advisory panel on deaths in custody, is looking into this issue in more detail, as indeed he should.

Q124 Chair: But the entry of people into the criminal justice system is on arrest and straight to custody, to the custody sergeant. Do you think that the police are equipped to deal with those who are mentally ill?

Lord Adebowale: I refer you to the findings of our report, which did find that the police were lacking somewhat. There were significant failures, at least 12, that are worth rehearsing. The first was a failure of the central communications command to deal effectively with calls in relation to mental health. So when people called the police and said that somebody is behaving strangely, there was a confusion about the information that the police going to the scene got, which would speak to your question. The other failures were: lack of mental health awareness among staff and officers, front line police, lack of training and policy guidance in suicide prevention, failure of procedures to provide adequate care to vulnerable people in custody, problems of interagency working, disproportionate use of force and restraint, discriminatory attitudes and behaviours, failures in operational learning, a disconnect between policy and practice, the internal MPS culture itself was a barrier to progress, poor record keeping and a failure to communicate with families. So those were the findings of our report that I think speak very clearly to your question.

Q125 Chair: We have read them and we are going to follow up when the Metropolitan Police come in. We will be putting it to them. My concern is this: it is for the hard-pressed custody sergeant, dealing with lots of different issues, in walks somebody who has just been arrested, are they sufficiently trained, do they know how to identify and when they identify is it joined up, does it then go to someone in the NHS who will then come down and deal with this issue, or are they just lost in the criminal justice system?

Lord Adebowale: We found that lack of training of both custody sergeants and the police on the beat was a key issue. At the moment, partly as a result of the work that the commission did, there is the introduction of the street triage system where the police are accompanied by people who are trained and have experience of working with people who are in mental distress. In London, there is also the roll-out of liaison and diversion schemes, which should prevent the scenario that you have just described from being too prevalent. We know that liaison and diversion is not new, in Liverpool they have been doing it for 20 years. In London, there are 10 trial sites at the moment that have been commissioned by NHS England. So what you should find over a period of time is that the police sergeant is supported by things like triage and liaison and diversion, and the proper training and support.

Q126 Chair: Can you confirm the figure that has been given to us that half of all those deaths in or following police custody involve detainees with some form of mental health issue? That is a figure that has been given to this Committee.

Lord Adebowale: That is not a figure that I can confirm at this stage. I think it is a figure that came out of the support organisation whose name has just escaped me.

Chair: INQUEST.

Lord Adebowale: INQUEST. It is INQUEST's figure and I am not in a position to look at how they came up with that figure, but it seems not unreasonable.

Q127 Chair: If we look at the system here, we want street triage to deal with this issue, if it does not—

Lord Adebowale: And liaison and diversion.

Chair: Indeed. If it does not, people get into the custody suite. That is another opportunity to take them out of the criminal justice system.

Lord Adebowale: Yes, street triage is a preventative measure; diversion is a way of engaging the NHS and ensuring that they do not enter into the criminal justice system without appropriate NHS support. There are also issues of transport from incidents. So it is not just one particular measure, it is a whole series of things that have to come into play all at the same time.

Q128 Chair: Of course, but if you look at each individual agency and if you would either mark them out of 10 or give them a grade, once a custody sergeants calls and says, "This person is obviously ill, they need help", how are the National Health Service doing? How would you grade them if you were the headmaster giving out grades on a report to help this Committee in a simple way?

Lord Adebowale: Between four and five.

Q129 Chair: Out of 10?

Lord Adebowale: Yes.

Chair: That is pretty low.

Lord Adebowale: Yes.

Q130 Chair: In respect of the police being able to identify?

Lord Adebowale: Well, since our report we know that there have been some improvements but you have asked a question that forces me to be quite crude in my response, I would be struggling to give more than five or six.

Q131 Chair: So that is pretty low for both organisations. Room for a lot of improvement?

Lord Adebowale: Yes, I would say so.

Chair: Thank you. Michael Ellis.

Q132 Michael Ellis: Can I just ask you, Lord Adebowale, about the police cells issue as a place of safety? The Mental Health Act 1971, do you think it should be amended so that police cells are no longer stipulated as a place of safety?

Lord Adebowale: I would say so.

Michael Ellis: You do think so.

Lord Adebowale: I do think so.

Q133 Michael Ellis: Could I ask you to say why? There are those who say the local NHS services are not able to fill the gap, if police cells were unavailable the nearest health-based place of safety might be miles away, especially in more rural areas. I am not saying I disagree with you about your assessment, it is just that it is not always easy, is it? If we have police cells that are no longer designated as a place of safety, doesn't that create rather difficult logistics?

Lord Adebowale: Our view is that police cells should only be used, if ever to be used, in extremis. Where someone is being held in a cell there should be appropriate health and support available, as is the case in Wood Green. As stated by the CQC, places of safety could be a hospital, a care home or any other suitable place where the occupier is willing to receive the person while the assessment is complete. So even in rural areas it would be possible to arrange places of safety in advance of incidents such that when the incidents occur they can be taken to such places. As long as there is a criterion for a place of safety, it could be delivered in settings beyond hospitals and certainly beyond police cells.

Q134 Michael Ellis: Do you think that would also cover the issue of safety for the general public as well as for the detained person?

Lord Adebowale: I did respond by saying that there are exceptional circumstances where it may be necessary to detain somebody in a police cell for their own safety and the safety of others but they should be in exceptional circumstances. If you were to change the wording of the Act, you would make those circumstances very clear as opposed to making it the default position that people go to a place of safety, which is a police cell.

Q135 Dr Huppert: It is a great pleasure to see you again, Lord Adebowale, and thank you for your excellent report. It has been very helpful for this inquiry. Just to follow on from the question of how we avoid using police cells as a place of safety, except perhaps in very particular circumstances, your report is very critical of the interaction between police and health services when there is a non-police place of care as well and in particular when health workers want the police to stay or confusion around that. Do you think there should be ways where police can be required to stay in a health-based place of safety? Should NHS providers or hospital staff in general be able to require police stay as a condition for accepting people under section 136?

Lord Adebowale: We did come across a few cases where the feeling was that the police were being used far too frequently where the NHS did not need to call them. There are some cases in health settings where the police may well be called but they should be few and far between. The police should be in health settings only in exceptional circumstances, for instance where someone has a weapon. NHS staff should be trained to de-escalate issues without calling the police in, which is standard practice in most health settings where you are dealing with vulnerable people who may be in distress.

Q136 Dr Huppert: Is there a particular role in that for liaison psychiatry?

Lord Adebowale: I would say that liaison psychiatry is an important factor in this. Any support that can be given from NHS clinical practitioners should be afforded but we are very clear—well I am very clear—that the police should not be in health settings or very rarely be in health settings.

Q137 Paul Flynn: We hear some very distressing cases of people who died in custody. Do you think that there is a connection between the political direction of the prison services and the police when there is a need to appear to be tough—all politicians regard being tough as being a way to win popularity—and the difference between the approach of someone like Ken Clarke and the person who took his job, that there is a hard man and a soft man approach? Do you think there is a danger when the people want to put forward a severe set of policies that the cost is paid by people with mental health problems and they pay a terrible price to win the crude populism of politicians?

Lord Adebowale: Forgive me; I am a Cross-Bench peer so you are asking me to comment on the politics of party politicians.

Paul Flynn: You have an enviable place in the Cross Benches.

Lord Adebowale: Yes, I can have a go at them all. I think that the issue is not so much about what senior politicians say and do but about the ability of the police to co-ordinate effectively with the NHS and for appropriate training, communication—the things that we looked at in our report were very practical. The recommendations that we made were very practical, they were not about the politics or even necessarily the policy, they were about the practice. They were about what happens when somebody calls the police and the ability of the police to pass on correct communication. It was about the liaison between the police officer and the London Ambulance Service; it was about how you keep records. These were very practical matters that should be happening, I would argue, regardless of what Mr Clarke says.

Q138 Paul Flynn: Do you think hospitals have the right to refuse admission to those who both have mental health disorders and are drunk? If they do have that right, do you think there should be alternative places in which they can be sent? Should there be dry houses available to send people?

Lord Adebowale: Actually, I don't. I don't think the hospitals should have the right to turn people away. Generally there is an issue between certain types of mental health illnesses, psychosis, alcohol and drug misuse, which we often find, and there is a case that staff are not willing to support someone with severe mental health issues if they are intoxicated. It is an unpleasant task but that does not mean that they should be barred from receipt of services. Dual diagnosis is a growing problem. It is rife in the health and social care system. More needs to be done in terms of providing appropriate staffing and training to ensure that intoxication is not a

factor against someone getting the health support they need, not least because if they do not get it then they will only come back in a worse state later and you generate demand. People who are intoxicated due to medication or have a condition that make them appear intoxicated, for instance if someone has Ataxia, where the symptoms may well mimic intoxication, you would not turn them away simply because of it. So A&E should be prepared for intoxicated clients and should apply their regular practice to help in these cases. The police should only intervene with someone who is intoxicated and experiencing mental distress if there is a clear and immediate threat to their or public safety, and when they do so it should be done in the safest possible manner. Otherwise we risk vulnerable people being taken to police stations and being refused the health care that they deserve.

Q139 Paul Flynn: Has there been an improvement in the quality and the training, the opening hours, of health-based places of safety recently? Does this extend to adults and children?

Lord Adebowale: What we do know is that the pilot triage services have started rolling out and liaison and diversion has occurred. We know the London Ambulance Service have changed their protocols but still 70% of transport to places of safety is carried out by the police. So I would not say that the improvement has been vast, no.

Q140 Mr Winnick: I am not sure I have the pronunciation right, I think it street triag, is it?

Lord Adebowale: Triage.

Mr Winnick: Triage, thank you very much. This was a scheme announced, as I understand it, in June last year where mental health nurses provide support to front-line police and accompanying police officers on patrol and so on. How would you assess the effects so far of the scheme?

Lord Adebowale: We looked at the cost effectiveness, we looked at the treatment, at what happened in terms of reducing the need for the police to get involved in a mental health crisis, and we welcomed the use of street triage in the report because we found that the evidence showed that a mix of having nurses available to travel in police cars, advice for core handlers, 24/7 phone support in an appropriate mix, depending on the demand in any one area, had a positive effect in the use of police. We know that nurses on the ground with the police in high risk areas reduce the need for ambulance and helped manage incidents more effectively. The programme-wide cost benefit analysis is yet to be made available. At the time of our report I think there was only one tentative analysis in Newham, as I recall, but I would not quote that as an example of it working well everywhere. In Cheshire, there was a rate of arrest under section 136 up to 55% higher than in other local authorities, when triage was introduced with a nurse attending all relevant incidents during the first six month pilot there was an 80% reduction in section 136 arrests with a cost saving £32,000. Instead of 136 being applied, 40% not arrested received mental health follow up and 15% were referred to substance misuse services. The police also have a far better understanding of the impact of mental health on public safety and crime. In Birmingham and Solihull, West Midland police operate a car with a police officer, a mental health nurse and paramedic who respond to relevant 999 calls. Over a 20 week period this approach helped more than 1,100 people and reduced the number of people being detained under section 136 by 50%. The evidence is fairly clear that triage in some form works.

Q141 Mr Winnick: The last two that you have mentioned, Birmingham and Solihull, are my constituencies of particular interest. Is it your view that you should cover the whole country, which as I understand it is not the situation at the moment?

Lord Adebowale: No. It is my view that the triage model, that is the mix of nursing, core handling, 24/7 support, in a ratio that is appropriate to local needs, should be available everywhere. On the available evidence it saves money, police time and probably lives too.

Q142 Mr Winnick: All in all you would favour its continuation for the reasons you have just stated?

Lord Adebowale: Absolutely.

Q143 Mr Winnick: You published a report, the "Independent Commission on Mental Health and Policing Report", in May last year, are you satisfied with the progress made by the Met Police in response to that report?

Lord Adebowale: I think it is still relatively early days. I would say that progress—I will not be satisfied until the chances of being killed or injured as a result of the police responding to your mental health crisis is zero or near zero. However, my understanding from the MPS is that as of this month, of the recommendations made in the report, 12 recommendations are now complete, 15 recommendations are completed in part or ongoing, one recommendation is far from completion—which is recommendation 23 around transportation, which refers to the London Ambulance Service, which is due to staff storages, I am told—and there are three recommendations that were accepted only in part. One was related to the measurement of public confidence, which was MOPaC agreed with the principle of improving public confidence and making efforts to measure this but felt the target was set too high. There was a recommendation around the use of mental health liaison officers that the police rejected on business case grounds, instead though they did bring in superintendent lead for vulnerable people, which would include mental health, and with regard to recommendation 28, which was regarding an agreed protocol for joint working on service provision with reference to approved mental health professionals, emergency duty teams and wider social care teams, the Metropolitan Police Service stated that this was beyond their remit. So I am satisfied that progress is being made and that the recommendations are being taken seriously. Am I sitting before you satisfied that we have change on the ground everywhere where it needs to happen? No, I am not.

Q144 Mr Winnick: On the ambulance response time and the need for further progress, are you in contact with the ambulance services in various places?

Lord Adebowale: I have received reports, and you will understand that having stepped down from chairing this commission I have gone back to day job so I do not spend lots of time with the ambulance service but I am aware that there are difficulties with the ambulance service in London.

Q145 Mr Winnick: Why?

Lord Adebowale: Well, the major difficulty appears to be one of recruitment. I understand that there is a shortfall in the numbers of paramedics, therefore restricting the ability of the ambulance service to respond in the way recommended in our report. I am told that the protocol that we found to be in operation during the course of our work has now been changed. So during the course of our inquiry we were told that the LAS protocol stated that if the call is in regards to someone with a mental health issue and the police were on site the priority is reduced for the LAS to attend. In short, they did not attend. But they have shifted that protocol in theory, however the practice is still that 70% of people are still being transported to places of safety in a police car in London, which is frankly unacceptable.

Mr Winnick: To say the least.

Q146 Chair: Inspector Michael Brown came to give evidence to this Committee, I am sure you know who he is.

Lord Adebowale: Yes.

Chair: He told us for the average police officer not a shift goes by without somebody coming in who has a mental health issue. Sir Peter Fahy, the Chief Constable of Greater Manchester, said that mental health is now the main issue—the main issue—facing Britain's police forces. Those are very powerful arguments, in a sense a cry for help from the police that more needs to be done. Do you think there is the political will—and I know you are a Cross-Bench peer so I do not mean this in a party political way—to see something is done? There seems to be a business case for doing something in the long run because it saves public money, doesn't it?

Lord Adebowale: There is no question about it. We found that there were more requests for police action regarding mental health than there were for sexual incidents and burglary put together in the Met and that it constituted between 20% and 40% of police time. So the business case is very clear. If this was the case in my business, I would be paying a lot of attention to this and ensuring that we were both effective and efficient.

There is a view held by many people that this is nothing to do with the police and that this is all a matter of other agencies not doing their job. We found that this is not the case; this is a matter of public safety and under article 2 the police do have a duty to protect life. So I remain concerned that not enough political leadership is being given to ensuring that the police response to mental health is seen as a core part of their duty. Having said that, I was asked to do this piece of work by the Commissioner of the Metropolitan Police, so he recognised that there was a problem in this area and asked me to chair a commission to look into it, which is an indication that he is taking it seriously. But I suspect since we have policing by consent, we need to push the police to ensure that this part of their work is delivered.

Q147 Chair: Indeed. Lord Adebowale, thank you very much for coming here today. Apologies again for keeping you waiting so long. We hope that you will stay in touch with this Committee, which builds on all the excellent work that you have done. We are most grateful to you, as fellow parliamentarians as well as a committee of inquiry, for all that you have done this area.

Lord Adebowale: Thank you very much, I am very grateful.

Chair: Thank you. Could we have Karla Wilson-Palmer, Dr Mary-Jane Tacchi and David Davis.

Examination of Witnesses

Witnesses: **David Davis**, College of Paramedics, **Karla Wilson-Palmer**, Royal College of Nursing, and **Dr Mary Jane Tacchi**, Royal College of Psychiatrists, gave evidence.

Q148 Chair: You have heard the previous evidence that has been given so we will not repeat the introduction that I normally repeat at the start of a session. I am very interested in the Crisis Care Concordat that was launched and the statement that was made, "We look forward to working together with others to ensure that the commitments made in the concordat become a reality as without this it is just a piece of paper." Perhaps I can ask each one of you in turn, what is your assessment so far on what has been achieved? Mr Davis?

David Davis: Thank you. Good afternoon, representing the College of Paramedics. The Mental Health Concordat has been agreed with the Association of Ambulance Chief Executives, obviously they would be able to comment themselves. The College of Paramedics welcomes any initiative that focuses on the mental health needs of patients that present to the ambulance service, recognising that the numbers of patients who present, where mental health illness or psycho-social problems are a factor that needs to be considered as part of the clinical care provided, need to be given a greater priority. The matters relating to ambulance response time and so on are probably better placed towards AACE, as they call themselves.

Karla Wilson-Palmer: Hello, I am team manager for Devon liaison and diversion and the Devon street triage pilot projects. I am not in a position to be able to give a broader spectrum view of the crisis concordat and everything it means, all I can say it means for my services that we welcome the opportunity to work together to provide better services, more joined up services for those persons who find themselves in crisis.

Dr Tacchi: I think the concordat is an excellent start and what it has done is get all the parties together that are involved in mental health crises and get them to start talking and working together. But what we have to do is we have to not just talk about it, we have to work together. So I think it is the first time everyone has realised that it is all of our responsibilities to work together to make things better and that is a good starting point. For me the actual getting it on the ground and making it work is going to be the issue. There are an awful lot of people involved and each area you go to people are at different stages and have different services so there will be local implementation of the concordat, which will be the thing that will make things better.

Q149 Paul Flynn: We have seen these figures that suggest the number of deaths in custody are now at the highest level since 2005, I believe, it goes a long way back. Have you any ideas on how the number of deaths can be reduced? We have heard claims of inappropriate restraint being used on prisoner and a lack of understanding. Anything else you would like to enlarge on those and suggest ways in which this dreadful total can be reduced?

David Davis: We understand, the College of Paramedics and its members, that the leading cause of death in custody from restraint is positional asphyxia. As clinicians who are

focused on the physical and mental health and well-being of patients, paramedics have a different focus to police officers. I might point out that police officers and paramedics work very closely together regularly and see ourselves operating as teams across the piece, but a paramedic brings a different perspective into looking at a different side of the welfare of the patient. So we believe that with the involvement of paramedics in these types of cases our focus on recognising, for example, someone who perhaps has a large abdomen being restrained on their front, we would be looking at matters relating to breathing and adequate oxygenation as a priority. So that level of clinical insight could bring some benefit.

There is also some suggestion from around the world—certainly in New Zealand and Australia—that has been brought to the College of Paramedics that there could be some benefits in using chemical interventions, pharmacological interventions rather than just physical interventions. That is something that we would like to examine and understand. I know that the New Zealand medical director is coming to the UK later in the year and that is something that the college is going to be looking at.

Q150 Paul Flynn: Are the pharmacological interventions safe?

David Davis: It is a highly contentious area because, of course, the type of agents that are used are also the same agents used in sedation and anaesthesia. However it is our view that with the very advanced skills of critical care paramedics who specialise in that area of the business there is an opportunity to exam the opportunities to use those pharmacological interventions. It is something that as a professional body we do not want to be developing in isolation. Recently we met as part of a coalition of professional bodies where we can hopefully guide each other.

Q151 Paul Flynn: We heard of a young man, Herbert, from Bath Road in Wales, and there were a series of errors. It should have been recognised that he was somebody known to the police for his mental health difficulties and it was not; it was a hot day; he was restrained from behind; he was wearing a coat; he was carried a long distance to the hospital; and there did seem to be a whole chapter of accidents where he was let down throughout the lot, which contributed to his death. Is there evidence that lessons from cases like this have been learnt and there is a better understanding of the use of restraint?

Dr Tacchi: The work that has been done with Newcastle University and the Met with regard to screening for custody sergeants to screen out physical and mental ill-health and signposting custody sergeants to the appropriate places for people to be or to get help. A really useful tool has been developed together with the NHS and the police. I understand that it is going to be rolled out, it is a question of it being employed with the IT systems.

You are talking about restraint but right from the very beginning making sure people are in the right place seems like a useful tool to use.

Q152 Paul Flynn: Most of these deaths are suicides and the graph is going up alarmingly. Have you any ideas why this should be and why there should be this continual increase?

David Davis: It is probably not possible to give accurate answers to that but one of the perceptions that members of the College of Paramedics have raised is that it feels very difficult to access crisis mental health services and it is felt, although again cannot be supported by evidence, that this results in members of the public who are suffering mental illness being unable

to access crisis care, with a particular issue being drugs and alcohol being a barrier to accessing services. The anecdotal belief is that the consequence of having difficulty in accessing those services means that members of the public with these illnesses go and end up getting worse before they access services. But, as I say, anecdotal.

Just coming back to the point you made about restraint. The members of the College of Paramedics are very keen to have greater knowledge and understanding about how to effectively manage restraint because it does not just apply to the Mental Health Act, it can apply to the Mental Capacity Act where it is necessary to treat patients where they lack capacity. The risks of death do not just happen in police custody, they can happen, as has sadly been the case in a couple of cases where patients have tried to jump out the back of a moving ambulance and lost their life as a result of that, which is the why the Mental Health Concordat and the joint working that we are seeing in a number of different areas provides some real potentials for benefit. An ambulance vehicle that can be appropriately locked, an unmarked vehicle that does not create the unwarranted attention or feelings of shame or embarrassment, and the ability for paramedics and police officers or mental health professionals and groups to be able to work together to complement the skills and competences that they have.

Q153 Paul Flynn: Do you think from the evidence we just heard that many policemen do not regard it as their job to look after those with mental health difficulties is a significant factor or is it a matter of resources? Is the training there? Do you think there is enough emphasis in police training because they seem to be the ones who first encounter people in distress in this way and are they properly trained? Have lessons been learnt?

Karla Wilson-Palmer: Can I answer that question? I think it is a whole big mixture of lots of different reasons. What I can see is I can see there are lots more training programmes, joint training programmes now available for police and health combined together. There are lots more health and police criminal justice teams working peaceably together, information sharing is improving, the roll-out of the national liaison and diversion programme, there is going to be better access for mental health services to pick up people at a much earlier stage and refer and signpost them on to the appropriate services and support criminal justice staff in being able to manage people more safely and effectively when they are going through criminal justice processes.

Q154 Paul Flynn: Can I say finally, we are aware that the crisis concordat was to encourage the police and health agencies to work closer together but is it happening? Is it all a plan or have you any examples where it has not been successful, or where measureable improvements have taken place?

Karla Wilson-Palmer: I am certainly aware of big changes, big positive changes, happening in the field of work that I am work in and I can see that being rolled out nationally. There is talk of ambulance services coming on board, the street triage pilots, that is certainly happening for us down in Devon. So I can see lots of positive changes. There is a long way to go yet for sure.

Q155 Michael Ellis: Do you think that police are currently doing things relating to mental health for which they were not trained, for which they are not equipped and should not be their responsibility? In other words, I speak to rank and file police officers who say quite frankly that they are not trained for some of the things that they have to do and that puts them under pressure. We sometimes seek to put them under pressure but they put themselves under pressure when they are not fully trained

to deal with some of these difficult situations. Do you think there is a gap there and if there is a gap, surely it is more than just resources that is causing this gap, it is a skills shortage and there are other issue, aren't there?

Dr Tacchi: I think it is very important that we are clear who has what roles and we cannot expect the police to become experts in the assessment of mental health, nor can we expect NHS services to become experts like the police. The only way forward is to work together so it has to be about collaboration. We are starting to see the street triage and people working together and you see quite quickly how just being even co-located, working together, having bases at the same place—where I work in Newcastle what the police do is they ring the local crisis team if they are thinking about a 136 and they have a discussion with a mental health professional. That is not in a policy, that is just what has grown up locally. It works and there are good relationships. However much training we do, I think that is great, but it is about relationships and collaboration and being very clear about what each of us does.

Q156 Michael Ellis: Sometimes police have to be medics, they have to be fire-fighters, they have to be mental health professionals, they have to be social workers; we expect them to deal with all types of emergencies and no doubt there are examples of good practice elsewhere in the country that can be replicated if they are known about. Did you have anything you wanted to add, Ms Wilson-Palmer? I am not forcing you to.

Karla Wilson-Palmer: I think there are lots of different models, as you correctly say, and they all do good work but they all work quite differently for lots of different reasons.

David Davis: If I may on your first question that asked about the view of whether police officers have sufficient knowledge, education and training in mental health issue, in the College of Paramedics' survey, only 37% of paramedics felt that there was a good level of understanding among police officers in certain areas of the Mental Health Act, but it would be disingenuous—

Q157 Michael Ellis: How many police officers thought paramedics had a good understanding of policing? That is another matter.

David Davis: Quite. That is absolutely right, but it is clear from the joint working of lots of paramedics around the country that rank and file police officers feel that there is a significant lack of knowledge and understanding around this area but the same applies to paramedics too. As a college we are very keen to see an increase in education and training for all paramedics, whether with partners in other agencies or directly face-to-face with patients, because although we work in partnership with police officers and often ask them to come and help us—as a front-line paramedic myself I have regularly done that—skills of de-escalation, appropriate assessment and being able to assess pathways of care are things that are currently a problem and have been proven to be enhanced as a result of joint and collaborative working.

Q158 Mr Winnick: I have one or two questions, perhaps particularly to Ms Wilson-Palmer representing the Royal College of Nursing. As regards children being detained in police cells, that remains a problem?

Karla Wilson-Palmer: Nationally, there are still children being detained in police custody.

Q159 Mr Winnick: Do you have the feeling the numbers are fewer than before?

Karla Wilson-Palmer: I would not be able to answer that question, I am afraid.

Q160 Mr Winnick: But it certainly remains a problem?

Karla Wilson-Palmer: No children should be detained in police custody under any circumstance, and there are still children being detained for sure.

Q161 Mr Winnick: One or three, as the case may be, on the question of advice that the police should give to try to reduce the possibility of a teenager attempting suicide on their release, are the police updated on this as far as your professional bodies are concerned?

Karla Wilson-Palmer: Liaison and diversion and street triage are about having mental health practitioners working alongside police, including police custody. So if there was a situation whereby you had a young person detained in custody who is about to be discharged and there are concerns about that person's vulnerability, they would have access to a mental health nurse who would be able to make an assessment on their mental health presentation, their vulnerabilities and risk factors. They would then be able to signpost that individual to the appropriate care or treatment and they would also be able to advise the police sergeant in the custody department how best to manage that situation, and what decisions they could potentially make.

Q162 Mr Winnick: But to try to prevent such a tragedy, a child taking his or her life, what I would really like to know from your two colleagues is if there is a sort of feeling that the police would be aware of it, if they have sufficient sensitivity and understanding that there could be a danger of a teenager committing suicide?

David Davis: One of the problems that we have is that as paramedics and police if we are called to a suicide or an attempted suicide, we are right there at the end of that journey and often children—because they are obviously under parental influence and guidance and, to some extent, control—may not necessarily present in the same way that an adult may to services. So the first time police and paramedics may see a child is at the point where unfortunately they have attempted suicide. However, there are warning signs and there are occasions when they present to our services, often mixed with drugs and alcohol, particularly in the teenage population where actually there are opportunities to be able to provide interventions, to divert them away. I know, speaking from personal experience, having seen the journey of a particular teenager from first presenting with an overdose of heroin to ending up very sadly a number of years later taking their own life, actually the biggest struggle was being able to access those services. But that was over a period of 10 years.

Dr Tacchi: You are asking are we increasing the awareness of the possibility and the need for assessment, and I think the concordat does that. So that means awareness among the police that these are issues that need to be addressed and the next thing is we need to make sure that the police have access to appropriate advice whenever they need it.

Q163 Mr Winnick: Thank you. Back to you, Ms Wilson-Palmer, I understand that you are involved in the scheme referred to in the evidence session just before you, the scheme operated in Devon and Cornwall, am I right?

Karla Wilson-Palmer: Just Devon.

Q164 Mr Winnick: How much time do you spend, or have the means to do so, in providing advice down the telephone compared to going out in a patrol car?

Karla Wilson-Palmer: You are talking specifically about street triage. Devon is a very large geographical patch and in order to provide a service to the whole of Devon, a street triage service, we have had to design a model that enables the police from all over Devon to access information and advice over the telephone, but also in the two main urban areas of Devon police are able to ask for us to be called out to attend and do face-to-face assessments, mental health assessments, just for the urban areas. Because it is such a big area there is no way we could be called out within the constraints of the budget to the whole of Devon for this pilot. So there is two ways.

Q165 Mr Winnick: How many are involved in Devon on this scheme?

Karla Wilson-Palmer: How many nurses?

Mr Winnick: Yes, how many nurses?

Karla Wilson-Palmer: I have nine nurses who are on a rota to cover four nights of the week at the moment but we are looking to increase the service to provide a day time service, Monday to Friday, as well.

I have just realised I did not answer your first question. The vast majority of the work that we do in street triage is over the telephone, providing information, advice and support directly to the police response officers or to the radio operators themselves.

Q166 Mr Winnick: You do this in Devon, I said Devon and Cornwall. It would be two large counties to operate with the same team but presumably the same is happening next door in Cornwall?

Karla Wilson-Palmer: No, just in Devon at the moment. We provide the service to Devon and Cornwall Police who are one of the first four national forces to be identified to be funded for street triage.

Q167 Mr Winnick: Do you think Cornwall will follow?

Karla Wilson-Palmer: It is very complicated. Just Devon.

Mr Winnick: I see, okay.

Q168 Chair: Can you just clarify on which nights this happens and does it happen at weekends?

Karla Wilson-Palmer: It happens at weekends, it happens on Thursday night, Friday night, Saturday night and Sunday night between the hours of 8.00 pm and 6.00 am. Those were the hours that it was identified that the vast majority of section 136s occur, hence why we chose those hours. But, as I say, we have reviewed it and we are going to be increasing the service.

Q169 Dr Huppert: Can I put to you some of the issues that I raised with Lord Adebowale just before? Firstly, Dr Tacchi, in terms of people arriving at hospital, if somebody is very ill and perceived to be aggressive, how far should it be treated as a health matter for hospital staff to deal with rather than call the police?

Dr Tacchi: You are talking about people who are mentally unwell?

Dr Huppert: Yes.

Dr Tacchi: My experience of—

Dr Huppert: Sorry, let me clarify, somebody who is in the hospital setting and being aggressive, at what stage—because of course you do not know that they are necessarily mentally unwell right at the start, so presumably you have somebody who has the symptoms and presents in a certain way?

Dr Tacchi: I suppose it depends in what setting. If we are talking about an emergency department, so they are not an in-patient—

Dr Huppert: Yes.

Dr Tacchi: Yes, a lot of it would depend on the circumstances and the staff available but in a health setting, and I think David has alluded to this, the techniques of de-escalation and trying to avert aggression and violence are quite different from those used by the police often. So they will be the first port of call and then, relatively unusually, relying on the police, apart from when there are weapons involved or specific risks to both the person themselves and others. My experience is that the staff themselves, especially in mental health services, are fairly adept at managing that internally. It is only a matter of when we talk about violence to others, to the public, in a place like emergency departments where you might need extra help.

Q170 Dr Huppert: That is interesting. Do you think the situation at the moment is good enough that the police are not called inappropriately?

Dr Tacchi: I think the trouble is it is patchy so there are some areas where things are contained quite well within health and other places where they are not. My own experience is that it is quite unusual to call the police in those circumstances but I know that there is anecdotal evidence of the police feeling that they have been called inappropriately. Again, I keep saying this, it is about if we had really good relationships with each other then we would know what each other did and I think these things might not be so much of a problem. My own experience is that the police are extremely helpful in situations where there might be potential violence and will come and help you do your job in the community, not necessarily in the hospital.

Q171 Dr Huppert: Ms Wilson-Palmer, would you agree with all of that?

Karla Wilson-Palmer: Yes, I was thinking to myself there are quite a few assaults of members of staff in A&E departments and we cannot lose sight of that. People who assault staff in A&E come from all different walks of life. Some of them may have mental health problems, some of them might not. At the time they often have not had assessments, people do not know what they dealing with, so I think we have to think safety first. Most of the times I have been aware of it I have felt it very appropriate for police to be called when there have been threats to the staff, I am just thinking in A&E departments.

Q172 Dr Huppert: I should probably declare for the record I used to be ambulance technician with St John Ambulance, although I do not have anything like the same depth of experience. Mr Davis, it is a different setting that you are exposed to?

David Davis: It is, but we work very closely with colleagues within the A&E departments and I can think of a number of cases over the years where patients have ended up becoming violent. I think the key to managing these problems is to understand probably three issues: firstly, that acute A&E departments are not necessarily the right place of safety, in the same way that police cells absolutely are not an appropriate place of safety in our view. We know that patients tell us that when they go and sit with physically sick people and they are at the back of the queue and they are potentially low priority, it can be a very unsatisfactory environment and they may very well discharge and end up cycling around the system. So that is the first thing. The second thing is in order to avoid people ending up in A&E, violent because they have been restrained or because they have had their liberties taken away from them, the schemes that colleagues here have been involved in stop those cases and those patients presenting to A&E in first place. Then it is about understanding the drugs and alcohol component as well. There have been a number of schemes just looking at drugs and alcohol in isolation around the country where people have been able to dry out, so to speak, and be looked after and kept safe with people who are used to negotiating and de-escalating. But the police definitely have a role to play when physical safety becomes an issue because, like you say, everyone has multiple skills and competences and people who work in the generalist areas have to know a lot of things, but for physical restraint and keeping people safe, we rely on the police to do.

Q173 Dr Huppert: You were talking about training for paramedics that the college does, can I just check, do you also provide that to emergency care assistants and others that are within the ambulance family?

David Davis: Yes, so the College of Paramedics is the professional body as opposed to a college providing education and we set the curriculum for paramedics. However, our members are often involved in providing support to educate the ambulance technician and emergency care assistant grades, but it does not fit within our remit. AACE may best be spoken to.

Q174 Dr Huppert: Just to move on to this issue about places of safety, there have been a number of concerns. We have been told about the health-based place of safety, lack of beds, limited opening hours and so forth. I would just like to pick up, in particular, this practice of refusing patients that are brought to a health-based place of safety on the grounds of intoxication or other reasons. Are there other reasons that you have come across for hospital staff refusing to admit somebody brought under section 136?

Dr Tacchi: I think this has come about from misunderstandings from the past about what it is that we are doing in a 136. Historically there was a feeling that Mental Health Act did not cover people who were intoxicated and that might have been where the confusion has arisen. The Royal College of Psychiatrists have very clearly stated that people who are intoxicated and have a mental health problem are our business and it is our responsibility to look after them. So refusing people on the grounds of being intoxicated with a mental problem must not happen.

Q175 Dr Huppert: But it still does. We have had quite clear evidence about that.

Dr Tacchi: That is right, and we have to make sure that we have adequate facilities for people. One of the difficulties is you cannot really make an assessment until someone is sober, so that is the issue. What do you do for the period of time until the person sobers up? There is no place at the moment and that is what we need to have, somewhere safe, somewhere to be so that they can be safe and be assessed appropriately.

David Davis: The pilots that colleagues have spoken about around the country say that the refusals reduce significantly when the referrals are being made by a multi-professional team. In terms of the section 136 detaining, it is something as a college we would like to explore, potentially opening up the legislation to include paramedics as it is in areas of Australia and elsewhere in the world, recognising that it comes with very significant responsibilities so that it is not always a police issue. I know that perhaps you have also considered issues of detaining within the home, which again presents a real problem.

Q176 Chair: Final question from me. Lord Adebowale in his evidence to us said that the biggest reason for poor ambulance response, in London in particular, was the lack of recruitment for paramedics. As you represent the Royal College here, what can we do about that?

David Davis: It is well recognised that we have been facing a crisis in paramedic numbers. There are a couple of reasons for that. We have seen an unprecedented rise in demand in terms of 999 calls for ambulance service. It always used to be the police ahead of ambulance in terms of gross numbers of calls but I believe the ambulance service has taken over now. I was given a figure a couple of years ago that the annual increase in the numbers of 999 calls for the ambulance service now exceeds the total number of annual calls to the fire service. Not to say they don't do a very important job, which they do.

What are the numbers? That is difficult. We are currently working on a project with Health Education England jointly—

Q177 Chair: Who becomes a paramedic?

David Davis: Now? Historically, it used to be ambulance drivers who worked through the non-emergency vocational career to become paramedics in in-house training and education. That was the route that I took but predominantly—and this is the work that is being done with Health Education England—it is likely to become a solely graduate career, whether that is in-house vocational graduate education within ambulance services or students coming out of university. I think it is important to give you a sense of the numbers. There is a general acceptance that there are perhaps 2,500 to 3,000 too few paramedics. If we expand in developing specialist areas, as we wish to in mental health and supporting services such as 111, the numbers could be as high as 6,000, which is a very significant problem. It is something that we need to work in partnership to

get through because it takes a good number of years—between two to four years—to train a paramedic.

Q178 Mr Winnick: Could you give some indication of salary for the position, on average?

David Davis: That is fairly easy. A registered paramedic is an agenda for change band 5 generally across the country.

Q179 Chair: How much is that?

David Davis: That would work out, including unsocial hours' premium and the cost for working out of hours, between £25,000 to £32,000. Forgive me if I am not exactly right. Specialist paramedics would operate at band 6, which would range between £30,000 to £40,000-something; an advance paramedic would be around band 7, which would be between £35,000 to £50,000. The top end is after a number of years of having progressed through pay. The vast majority of paramedics sit in band 5.

Q180 Mr Winnick: You would not consider that to be a disincentive?

David Davis: We know that the biggest incentive to retain paramedics is by giving them a career structure and the opportunity to develop academically and in practice, which has been reflected in Sir Bruce Keogh's recent report into urgent and emergency care that the role of specialist paramedics in primary care have a key role to play. As a college, we believe that the mental health arena is a key area that we need to develop advance practice. With that comes additional responsibility and the ability to earn additional money.

One of the things that may impact on this area is the potential for independent prescribing. There is a business case currently going through NHS England in that regard.

Q181 Mr Winnick: We know the feelings, Ms Wilson-Palmer, of nurses, do we not, regarding salaries and the rest of it, and the concern that has been expressed very recently?

Karla Wilson-Palmer: Yes. Indeed.

Q182 Chair: Indeed. Indeed is a very good word to end this session. I thank all three of you, Mr Davis, Ms Wilson-Palmer and Dr Tacchi, for your evidence. We are coming to the end of our evidence sessions, not today but in the near future, if there is more that you think we should look at, let us know. We would love to have come to Devon and Cornwall—or perhaps Devon and not Cornwall—to have a look and see what you are doing but it is just time that is a problem for us now because we are keen to get this report ready. If there is anything we have missed out, please do not hesitate to write to us and we will include it in our evidence. Thank you.

Dr Tacchi: Thank you.

Chair: That concludes the formal session.