Inquiry by Joint Committee on Mental Health Bill

Memorandum from the Independent Police Complaints Commission

1. The Independent Police Complaints Commission (IPCC) has been established under the Police Reform Act 2002 and assumed its statutory powers on 1 April 2004 when it replaced the Police Complaints Authority (PCA). The scope, powers and duties of the Commission differ significantly from those of the PCA and, with substantially greater resources available to us, the Commissioners and staff now operate from four regional offices covering England and Wales. We have investigative powers and staff employed as investigators which are already being used in a number of significant and high-profile investigations such as into police fatal shootings and deaths in custody. In addition, the Commission is required under the Police Reform Act to secure and maintain public confidence in the system of arrangements for dealing with public complaints against police and the investigation of police misconduct.

2. Accordingly, the Commission must be alive to issues that affect general policing and from our early experience the importance of mental health as an issue affecting policing has been widely noted. To reflect this the Commission has made this topic area one of its main priorities for policy development and inter-agency liaison and this topic is likely, also, to feature in the Research and Publications programme of the Commission during its initial years. We draw your attention to the research undertaken by the PCA prior to its abolition, which had

begun consistently to draw attention to the presence of those with mental health problems amongst the 'at risk' groups in contact with the police service whose behaviour and needs can present some of the greatest challenges. We wish to make the following observations upon the contents of the Government's Draft Mental Health Bill.

3. Impact of new powers of compulsion on police contact with the public

In its philosophy and specific powers, the Mental Health Bill envisages the greater use of compulsory powers in relation to patients living in the community. Conventionally, compulsion in psychiatric treatment has been restricted to institutional care and nursing staff are neither trained for nor expect to use forcible treatment methods with regard to patients living in the community. Accordingly, the police only become drawn to assist in the apprehension and forcible conveyance of those subject to powers and requiring compulsory treatment in an institutional setting. Where the threshold for admission is serious mental disorder and the person's incapacity to make appropriate health care decisions for themselves, then the removal to hospital and involvement of the police may, though often distressing for the person, nevertheless be reasonably necessary and the police involvement a necessary precaution. Where, however, a person's failure or refusal to participate in compelled treatment in the community (under a non-residential treatment order) triggers their return to hospital when they are still largely capable of making their own decisions, then we envisage it will be much more problematic for the police to become involved in support of psychiatric carers. This will be so particularly if a person in such circumstances must be forcibly removed to institutional care and physical restraint must be used to do so. The IPCC envisages complaints concerning

police involvement to be likely to follow such incidents and, indeed, for these to pose a high risk of harm where the physical resistance to action is sustained and police training or resources deficient.

4. Warrant to take or retake a patient

We note that Clause 225 enables a Constable to enter premises specified in the warrant issued under this Clause, if need be by force, and remove the patient there and when they do so *may* be accompanied by any person who is a registered medical practitioner or an authorised person. Later in the Bill we note that under clause 227 the police presence and actions are part of a multi-disciplinary intervention, where a constable *must* be accompanied by at least one approved mental health professional and at least one registered medical practitioner and under clause 228 the constable must be accompanied by at least one approved mental health professional. There seems no evident logic to these variations. We would commend to the Committee this multi-disciplinary approach and the benefits of applying the principle *consistently* to *all* those interactions when the need to employ police powers brings them in contact with a patient required to be detained under mental health legislation.

5. Urgent removal to a place of safety

The provisions of clause 228 are a new provision compared to the 1983 Act providing just such a multi-disciplinary approach which we commend to the Committee. Information from an approved mental health professional triggers an intervention by a constable permitting entry to premises, forced if necessary, and the removal of the person there to a place of safety for a *limited* period of time (6 hours). A Justice's Warrant may provide for further detention but not beyond 72

hours. It is an approach which would meet with our approval, save in relation to the comments below about the period of time for permitted detention.

6. Removal to a place of safety from a public place

Section 136 of the Mental Health Acts 1959 and 1983 has now been reproduced in Clause 229. Under this power, the police will continue to arrest and detain for assessment in a 'place of safety', very often comprising a police cell, persons found in public who appear to be disordered and require some form of care or control. The possible facilities specified as affording a 'place of safety are reproduced from the previous legislation. There is no attempt in the draft clause (it refers back to the wording of Clause 227) to limit the occasions a police station will, inappropriately, be used for the detention of a person arrested in these circumstances. The Commission recognises that, on some occasions, hospital or other premises are simply not available and a police station must, as a last resort, be used for the purposes of temporary detention. However, the draft legislation makes no attempt to limit the circumstances in which this happens only to wholly exceptional occasions. Since 1990 the Mental Health Code of Practice has strongly discouraged the use of the police station as a place of safety (as does current Home Office guidance), in the interests of the person detained and to ensure early and effective assessment. Current evidence suggests that far too often now a police station cell is the first not last resort, routinely used for this purpose.

7. If the Committee considers it necessary to retain a police station under the bill for use on rare occasions as a last resort then, at least, the Commission considers –

7.1. That there should be a positive duty placed under the bill upon the relevant health authority to assess need and provide/procure adequate such facilities (for example, registered care provision) to act as intermediate care prior to assessment and a decision on residential detention, in a similar manner to which other intermediate care facilities are provided for other patients in need of healthcare;

7.2. That a period of detention of 72 hours in police station is wholly inappropriate for the purposes of the assessment needed. An assessment when a police station is used should be completed within a maximum period of 12 hours.

8. Use of force by police when in hospital or other institutional settings

The Commission is aware that, from time to time, hospital or residential care staff seek the assistance of the police to deal with violent or threatening behaviour by a patient being treated in that institution. In particular, CS spray has been used in hospital settings; police officers have been required to restrain patients brought to hospital for assessment or treatment for lengthy periods as part of the admission process and police officers also become involved when moving a patient from one facility to another or even to quell a disturbance which erupts in a ward setting. The Commission regards it as generally regrettable when this occurs since the appropriate response to a person's mental health crisis is the employment of highly trained and skilled therapeutic staff who are well-informed as to the cause or causes of the person's disordered behaviour and are able to use physical restraint if this is necessary, but within the context of the person's treatment. It is often entirely inappropriate for police staff with no knowledge of a patient, who are uniformed and carry self-defence weaponry, to become engaged in these types of incidents, particularly in secure unit settings.

9. We would look to the Mental Health Bill, or to regulations made under it, more closely to regulate the management of restraint in psychiatry to ensure the human rights of patients are fully and effectively respected and police officers are not drawn into these events unnecessarily, inappropriately and possibly on occasions unlawfully.

10. In addition to improvement of the legislation there needs to be greater clarity possibly in the code of practice about application. Too often at present, when a mentally disordered offender is diverted from the criminal justice system to hospital it is the police who are called to escort the offender when the duty rests on the health service.

11. The IPCC wishes to engage fully in the debate over the reform of mental health law and would be happy to participate in the Committee's inquiry as it finds useful.

IPCC
27TH October 2004