Steve O’Connell AM (Chairman): This morning’s session is around mental health and policing. The Committee has done a significant amount of work on the past. However, it is clear to us that interactions between the Metropolitan Police Service (MPS) and Londoners with mental health issues is increasing and we wanted to reflect on that and reflect on earlier reports and progress made. We have some excellent guests this morning, if I may say so.

What I would like you to do, guests, is if you could just briefly introduce yourselves? You will have plenty of time later to talk about the organisation. Perhaps you would just briefly introduce yourselves.

Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): My name is Andy Trotter. I am the Chair of the Oxleas National Health Service (NHS) Foundation Trust in southeast London, which provides mental health and community nursing, and I was a police officer for 45 years.

Vicki Nash (Head of Policy and Campaigns, Mind): Hi. I am Vicki Nash. I am Head of Policy and Campaigns at Mind.

Lord Victor Adebowale CBE: I am Victor Adebowale. I am the Chief Executive at Turning Point and I was the Chair of the Independent Review of Police and Mental Health in England.

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): Good morning. My name is Anne Shuttleworth. I am the newly elected Diversity and Equality Lead/Secretary for the Metropolitan Police Federation.

Steve O’Connell AM (Chairman): Thank you very much. Welcome. This is in the context of Lord Victor’s report [Independent Commission on Mental Health and Policing Report] in 2013 – and he came back in front of this Committee in 2014 – and also in the context that only last month Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) published a report, again, on this subject and, in a very crowded field of reports, there was the final report of the Independent Government Review. There has been a lot of work going on, which identifies the fact that this is an important issue.

I will start the questioning, if I may, and this is mainly around scene-setting at a high-level and about demand. This is to all of you. Again, remember the context of this Committee is scrutinising the MPS and scrutinising the Mayor and the Mayor’s Office for Policing and Crime (MOPAC) on behalf of Londoners.

The Mayor’s Police and Crime Plan talks of transforming the MPS and making it fit for the 21st century. In that context what does a service that is fit-for-purpose look like in response to mental health needs in London?

Lord Victor Adebowale CBE: The report that I completed in 2013 set out pretty much the description of what an aware mental health police force should look like with 27 recommendations, but to highlight the key aspects, one is a frontline police force that is fully trained and fully aware of its responsibilities, updated on a regular basis, and a leadership that is aware of the culture within the police force because it is not just what is
happening out there; it is also about the mental health of policemen and women; strong partnerships between the police and the NHS. My report, while focused on the police, referred to partnerships with the NHS. The police cannot do it alone and so there needs to be strong partnerships with the NHS. Examples are things like the triage services. At the time I did the report, there was more response to mental health incidents by the police than there were to robbery and sexual offences put together. That situation has increased, as HMICFRS has pointed out.

**Steve O’Connell AM (Chairman):** These were responses to incidents that were primarily mental health incidents, as opposed to other offences that it was discovered later had mental health --

**Lord Victor Adebowale CBE:** We did not make that distinction.

**Steve O’Connell AM (Chairman):** There is a distinction there, is there not?

**Lord Victor Adebowale CBE:** Part of the problem with being unable to make the distinction en-route to the incident, as we found in 2013 when we did the report, was that the police information technology (IT) and communication systems were not up to informing police officers on the way to an incident whether it was a mental health incident or not or, indeed, any information about the individual they were going to meet. They were often faced with a fight-or-flight position, really, without the information.

I have to say that having received an update from the MPS, it is clear that a lot of activity is taking place in the MPS. We are not in the same position that we were in in 2012.

**Steve O’Connell AM (Chairman):** I am going to ask you in a minute a little bit about updating on progress and so you give some more detail around that. Thank you, sir.

On this high-level point, would other colleagues like to say what they would like to see generally as an approach in the MPS in the 21st century?

**Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust):** We have a very strong partnership with the MPS and actually I have been very impressed with, both at a strategic and at a local level, the partnership that we have at the moment. We meet regularly with our partners in our boroughs to talk through particular issues and, at an operational level further down, there are regular meetings to discuss incidents and to debrief matters. Clearly, things from time to time do not go well, but I find it is a very good, strong partnership with a leadership that is very interested in this issue.

Quite clearly, the MPS is under great strain as far as resources are concerned and, quite clearly, they have anxieties about, as has been highlighted in the Her Majesty’s Inspectorate (HMICF&RS) report that you referred to about the amount of time they spend on mental health matters, but I find a real willingness. We are not into blaming each other. There is a real willingness to work together, which I am very impressed with at the moment.

**Steve O’Connell AM (Chairman):** That is an improvement probably of what you have heard and experienced a while back?

**Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust):** Absolutely. From my own personal experience in the past, there has been a transformation in the MPS approach to this.

**Steve O’Connell AM (Chairman):** Yes. Thanks very much.
Lord Victor Adebowale CBE: Can I make one point more, Chairman, if I can? One of the indicators that the MPS has moved on is disproportionality. The disproportional experience of black and minority ethnic (BAME) individuals in relation to mental health and policing would be reduced and actually would disappear altogether.

Steve O’Connell AM (Chairman): OK. We are going to pick up on that subject in a little bit. Thank you very much for that. Vicki?

Vicki Nash (Head of Policy and Campaigns, Mind): I would really echo what Andy and Victor have said in terms of what a true future vision looks like. You want to make sure that you have a very well-trained force that is competent but also compassionate, particularly when it is needing to deal with people who are experiencing a mental health crisis and are in an emergency situation. You absolutely need a multiagency approach and so it is about how the services work together, both paramedics and ambulances, together with the police, together with the health service. It is about putting patient’s experiences at the heart of that and their experiences should be driving the priorities and the improvements that you see in that. The MPS has made good progress on that. There is still a long way to go. There is lots done and lots to do.

Steve O’Connell AM (Chairman): We are hearing certainly from Andy and Vicki that there has been progress made and we will get on to detail about what more needs to be done. From a Federation point of view, Anne?

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): Do forgive me here because I am new to this and I have had to do a little bit of running around and do a bit of homework --

Steve O’Connell AM (Chairman): That is fine.

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): -- because I can speak only from a Federation perspective. I cannot sit here and speak from MPS management’s perspective. It is not for me to comment on --

Steve O’Connell AM (Chairman): No, we want to hear from the Federation perspective.

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): Yes, and so this is from my perspective, having just taken this role and beforehand been an on-borough representative looking after officers who were in all sorts of dire straits because of dealing with mental health issues, whether inside buildings or outside. A lot of progress has been made. From what I have just read this week, I am quite amazed to see how much work has been done. Anything that reduces stress and risk and complaint for police officers has to be a good thing. Anything we do that improves what we are doing has to be good.

I have represented officers whose cases of complaint have gone on for a very long time with the stress that causes. Very often we forget that police officers perhaps just go out to do a day’s work, not going to look for any trouble at all, just to do their best. That is what they joined the job for. They go out to do their job and - lo and behold - something goes wrong and they get a complaint or they get served a notice of misconduct or worse. From there on, having represented and supported officers in the past, I often find that they then become victims of mental ill-health themselves.

Yes, just in a week, having read this in a very quick time I have to say, I am highly impressed with where we are with this. There is more work to be done, but that is from the Federation’s perspective. I hope that is helpful.
Steve O’Connell AM (Chairman): You are right, but the work that we are doing is looking across the whole spectrum from Londoners with mental health issues and the problems that they face to officers who are going out in the mornings to do their duty and are confronted often with Londoners’ very complex mental health issues and they need training around that.

Len Duvall AM: You may not be able to help me with this question, but just to give me some pointers for going in the right direction, a lot has happened and the direction of travel is in the right direction. I get that with the various reports from Victor’s report in 2013 and national reports. Is one of the tests that when I come to ask the right people -- we seem to be very good when something goes wrong and learning the lessons around that. In the day-to-day bits of managerial interactions and partnerships, is there any mechanism where we pick up on some of the minor things that go wrong that then can be addressed in terms of some of this work? That is the strength of partnership working. I ask this question of you because no doubt we will follow up and ask questions of MOPAC and the Mayor’s Office or the police around those interactions from their point of view. Do you get a sense that some of those, not major crisis incidents that we have to form inquiries about because they have gone terribly wrong, but some of those day-to-day encounters where people learn from it or do not learn from it on the job whether they could have done better. I am quite interested in some of those. They are not minor because they are big but they have not become a catastrophe in that sense of those issues. I would just like to get a feel about that from --

Steve O’Connell AM (Chairman): You are allowed some detailed questions later but perhaps you would respond?

Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): We do have meetings at an inspector level with our middle management on a regular basis and so I meet with the Borough Commanders and sometimes at Scotland Yard to talk with those there, but that goes on regularly, regular meetings and meetings to look at where things did not go right because they do not on both sides quite frequently. However, what I do like is the much more intelligent dialogue between us on that. For example, there might be real frustration for a frontline officer when we have taken a long time to find a bed, whose responsibility, who did it, who got one. That sort of thing happens quite a lot. There is a form that they used to handover a voluntary patient to the accident and emergency department (A&E), which the MPS designed and which is really good. It does not always get used and it is going back over that and just helping with the frontline, but it is an intelligent approach and it is a thoughtful one. In the middle of night things can get heated sometimes and our on-duty directors will be called up to try to sort something out, but they have the mechanisms in place. Those are the things that really gnaw at people when we do not get it right. At the moment, the relationship is fine and it works well.

Vicki Nash (Head of Policy and Campaigns, Mind): I will just add to that. If you get the day-to-day processes right, it should dramatically reduce when you do have those incidents and those crises. The work of the local Crisis Care Concordat (CCC) groups that were set up as part of the broader CCC work were absolutely looking at how we get the small bits right and the details and the forms right. Are we duplicating effort? What is the handover? How can we smooth out all of those transitions? Since the foot has been taken off the pedal around the CCC at a national level, that has inevitably had an impact at a local level as to how successfully those local groups are still meeting and it would be variable. That was completely designed to take that multiagency approach and to deal with the small things as well as the big things.

Lord Victor Adebowale CBE: Specifically, there are two things. One is whether the MPS is capable of organisational learning from small incidents? One of the recommendations in the report was recommendation 6, the implementation of an Organisational Learning Strategy. You can have as many small conversations as you like but if the organisation is not learning, then you are back to square one.

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There has been progress on the establishment of an Organisational Learning Board. The question that might be asked by you of the MPS is, “Give me six points that the organisation has learned”.

More specifically, on the transportation and the partnership with the London Ambulance Service, what we found was that the computer-aided despatch (CAD) system - and I am going from memory here - if a policeman or policewoman was present at an incident would reduce the -- that is a problem. I know that work has been done to ensure that people who are mentally ill and have committed a crime have appropriate transport at the time and that the ambulance response is equal to any other response because, from a policeperson’s point of view, they need the support of the other emergency services as opposed to being abandoned by those services because of resource issues. There is a specific conversation that has been had, which I am pleased to see has been had, about transportation and ensuring that the police get the support they need from the London Ambulance Service, and there are signs of life in terms of the MPS’s organisational learning.

Steve O’Connell AM (Chairman): OK. Thank you for that. A question really now from me to Lord Victor particularly regarding your report. When you came to the Committee in 2014, you said that 12 out of the 28 recommendations were in place - this was four years ago - and the others were ongoing. Is the MPS in a better significantly better place now than it was? What more is left to do particularly with reference to your recommendations?

Lord Victor Adebowale CBE: Crikey. That was a nice short question! I have received updates from the MPS. What I can say is that they have a response to each of my recommendations, which was not the case when I was last before you. I can safely say that most of the recommendations are in progress if not completed.

There are some notable completions taking place in partnership, it would appear, with the Mayor’s efforts in his report on policing, in particular pages 101 and 75, where there are things like trialling mental health investigation teams to work in partners to problem-solve. That is in place. I am hoping it is being rolled out.

The provision of measures to divert victims is also in place and is being rolled out. We now have 100% occupation of diversion schemes, which was a particular recommendation of my colleague Keith Bradley, Lord Bradley [author, The Bradley Report, 2009], and so that is happening. That has happened.

They are starting to think about reviewing the health service for people in custody in partnership with NHS England, which was one of my recommendations. They have not done it yet and it has taken a long time, but they are getting to a point where the NHS is involved in health, which is a key intervention to prevent deaths and injury, which is why it will work.

Therefore, to be fair, the MPS has done a lot but has not completed everything. My summary would be that they have done a lot of work on some of the key issues that will prevent death and serious injury but there is still a lot more to do and of course this is set against a background of increasing demand.

Steve O’Connell AM (Chairman): Indeed. I assume that you are working with the MPS and scrutinising to ensure that it is attempting to deliver your recommendations. I am just interested. How is that process?

Lord Victor Adebowale CBE: I am not the fulltime Chair of the Commission --

Steve O’Connell AM (Chairman): No, I am sure you are not, of course.
Lord Victor Adebowale CBE: -- but I have attempted to engage with the MPS on recommendations because I went out with the police and I spoke to 55 families and relatives of people who have died or have been injured in terrible circumstances, and so I feel a personal attachment to this work.

Steve O’Connell AM (Chairman): Yes, of course.

Lord Victor Adebowale CBE: It has been challenging at times to get the information - I have to say that - but I understand the MPS is under tremendous pressure and so I am sympathetic to that view. I have gone out with the police on more than one occasion. It is a very tough job. They did provide my colleagues with an update on the report. One of the recommendations in the report that I did was that the MPS was more publicly accountable for its work on this and that the Commissioner [of Police of the Metropolis would give an annual report to the public on its work in relation to mental health because the public have to have confidence in the police’s response to mental health incidents. Over a million Londoners have mental health challenges. I am not sure that has happened but, as I say, progress has been made and they have been more than willing to talk to me about that when I have requested it.

Steve O’Connell AM (Chairman): We will be pursuing later the Mayor and MOPAC context. Before I bring Peter [Whittle AM] in, my last question to you: you have talked about progress being made and you sound quite optimistic about the way that it is moving within the resource limitations. Is there any particular one or two recommendations that are disappointing you particularly where the progress has not been made or are they all moving in the right direction?

Lord Victor Adebowale CBE: I am an impatient man generally when it comes to these things.

Steve O’Connell AM (Chairman): Quite right, too. Good.

Lord Victor Adebowale CBE: Death and serious injury as a result of poor leadership or poor resourcing of this area is unacceptable. I am generally impatient. I will always say that the MPS could move faster because the slower they work the more risks individuals out there are taking. I would generally say we need to move faster. The rollout of things like Thrive LDN are indications of good practice. The way the Basic Command Units (BCUs) are working is good. I would like a clearer public acknowledgement of the police’s responsibilities in relation to mental health. They do have a responsibility under Section 2 of the Human Rights Act 1998 to do that and to do so publicly. They are making progress. I cannot say in all honesty that I am really pleased that everything is fine because it is not.

Steve O’Connell AM (Chairman): Yes. You need to keep on that pressure and being an impatient person for change. Thank you very much.

Peter Whittle AM: Some of it has been covered, but what are, first of all, the material factors that might get in the way of the MPS addressing mental health effectively? What are the material issues?

Lord Victor Adebowale CBE: The key material issue is resources. It is not a secret. The MPS has been very clear about the lack of resource. There are two. There is the lack of resource which has only got worse since I did the report and that is not a secret in terms of police numbers and that will put pressures on the front line. That is obvious. There is a second issue which is the pressure that the NHS and organisations that work with the NHS have been under since my report has been written. For instance, it is an indication of the police’s determinations that we have the shifts in the custody suites and we now have nurses in 100% of them. That is an achievement given the pressures on the NHS. The conversations that they are having with the NHS around
what happens in custody suites and commissioning health is also an indication of what they are doing under really stressful resourcing conditions.

My concern is that as HMI [CF&RS] pointed out, the fact of the matter is that other services that are under tremendous pressure are not responding to the increased demand and, in those circumstances, the police are being used as a last resort, which is where I came in.

**Peter Whittle AM:** They are not responding purely out of lack of money?

**Lord Victor Adebowale CBE:** The indication would be that they are being forced to respond because other services do not have the resources to either deal with this issue in a preventative way or indeed respond to it appropriately in a crisis.

**Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation):** They plug the gap where the other services are failing to meet demand.

**Peter Whittle AM:** The report we are talking about also talks a lot about the need for a greater understanding, not on a material level, as it were, but in another way. I wonder how that could be achieved. Perhaps I could ask Andy. You were a policeman for 45 years. Is Oxleas Trust anything to do with Oxleas House in Queen Elizabeth Hospital?

**Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust):** Yes. That is one of our buildings.

**Peter Whittle AM:** My father was there with Alzheimer’s and they treated him very kindly.

**Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust):** That is good to hear.

**Peter Whittle AM:** He died there, actually. That is by the by, but in your experience, therefore, of 45 years, what has to change in general? Is it an attitudinal thing? What is it?

**Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust):** There has been an absolute transformation - there would be - from when I started, which was a very long time ago. Not only at senior level but at individual police officer level, the sensitivity and understanding of these issues has absolutely transformed over the years. It has been often through crises and through dreadful incidents that there has been a lot of learning that has made those great changes, but also through the training and, to be frank, the calibre of those people coming into the organisation. They are much more aware of societal needs across the board and that has made a big difference.

I can only add that we have a police officer working with us fulltime. We have liaison in custody suites and in courts as well and so everyone is trying to work together. However, echoing the point that has been made, there are huge stresses on the numbers of beds that are available and pressures on the Section 136 suites where the police officers take people who have been detained under the Mental Health Act 1983. I can speak for south London and we are working with other partners across south London to look at the adult mental health crisis pathway because we have mental health patients waiting in A&E for a long time, with or without police officers, and sometimes it is hours before we can have them properly assessed and then find a place for them. There is no other class of person that gets treated in this way and so that is the area we are really working on.
For example, we have a patient assessment suite that sits next to Oxleas House where we can take people from A&E to a safe place and look after them while we look at them and sometimes they get over that crisis. It just might be drink or drugs-induced. We can care for them there far better than they can in A&E because the pressures there, particularly with the winter crisis coming up, are getting greater and greater. This is an area of real focus for us all because, as I say, no other class of patient would be treated this way.

**Lord Victor Adebowale CBE:** May I just say a couple of things? In response to your question in terms of the police attitude, there are three things that matter but all are happening. The first is that we made a recommendation around training of police officers. That is now being rolled out in terms of how they respond to mental health incidents. Also, I am pleased to note that there is improved training about how to remain mentally well as a police officer, which is being rolled out.

Secondly, I know that Mind is doing some work with the police as an employer. I am slightly disappointed that they are not taking advantage of some of the digital mental health apps out there that can be used by police officers privately without having to refer. One of the issues was police officers who were under pressure feeling embarrassed about saying so. The availability of some of the digital interventions that can be used securely could be a rapid response to that.

Finally, the MPS might give itself some credit for the fact that the leadership of the MPS, under the old Commissioner who started this in the first place --

**Peter Whittle AM:** [Sir Bernard] Hogan-Howe, yes.

**Lord Victor Adebowale CBE:** -- and under the current Commissioner, seems to be in place. The leadership of the MPS - and ultimately this is about leadership - seems to be as concerned as we are about the mental health issues. Those are signs that there has been a shift in the culture and the practice.

**Peter Whittle AM:** Can I just ask one thing, Andy, that came out of what you were saying there? You talked about drugs and people who have drug addiction and what-have-you. This in a way points out the whole problem. Do you treat somebody who is maybe in a state because they have overdosed or whatever it is? Does that become a mental health thing or is that a drug thing, as it were, to the layperson?

**Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust):** Sometimes those mental health issues are exacerbated by other things. It could be drink. It could be drugs. It could be a whole range of different issues. People can arrive with us with a multiplicity of things that we have to look at. Some of those are physical matters as well, hence they have to go to A&E for treatment as well. Sometimes those people are in immediate crisis and that takes a while for the professionals - and I say this as a non-clinician - to assess that patient and see what help they need. Sometimes a period of time in stability and safety can assist those people recovering and getting back into their lives.

I am always interested in trends and I always ask, “What are you seeing that is different at the moment?” We are seeing a whole range of different things happening now, which are leading to more and more young people coming into our establishments, and a rise in dementia as we have an aging population and the comorbidities that people can have as they get older. We are seeing pressure across the board on the system at the moment.

**Vicki Nash (Head of Policy and Campaigns, Mind):** I would also say that the complexity of people who are presenting in crisis has increased and, partly, that is because they have not been able to seek support or have not been able to get support at earlier stages. You have that snowball effect where lots of different things then start to impact on a person’s mental health.
**Peter Whittle AM:** If a homeless person is picked up for vagrancy or something like that, it is also maybe a mental health thing.

**Vicki Nash (Head of Policy and Campaigns, Mind):** The vast majority of people who are rough sleeping will have serious mental health problems as well as substance misuse problems. For people who are not in those dire straits and who are struggling but might have a roof over their heads, however poor-quality that roof is, you often hear that they are presenting to services asking for help, are told by the mental health service, “We cannot treat you. You cannot have access to talking therapies or to a psychiatrist until you have fixed your drug addiction”, but they cannot get access to help for the drug addiction. They are stuck in this perpetual lack of support for any of their support needs. Understandably, then, things just snowball and they end up in crisis and often will be picked up by the police.

**Peter Whittle AM:** Thank you very much.

**Steve O’Connell AM (Chairman):** Thank you very much. We are now moving to the actual frontline response. We have touched upon training and the challenges faced actually on the front line and colleagues will have some response to that. Caroline, you are leading on this question.

**Caroline Pidgeon MBE AM:** Thank you. You have talked about how the training has been rolled out to frontline officers, but your report really talked about issues with MPS culture, discriminatory attitudes and behaviour, and the disconnect between what might be the leadership policy and the practice on the ground. Training may have been rolled out and there is a tick there, but are you seeing real improvements in mental health awareness on the ground among frontline officers? Maybe we will start with you, Victor.

**Lord Victor Adebowale CBE:** I have to admit I have not been out with the police prior to this meeting and so I do not know. I was concerned when I did do the report. I went out several times and I was concerned. I had lots of sympathy with the police because they were faced with extremely stressful situations but were not being debriefed or getting the support that they needed. We did come across a number of really quite sad cases. There was one case in particular where the suicide had taken place of a police officer, which I thought was directly related to the culture within the MPS.

I have no measure and I do not have evidence from what has been presented to me as to whether that culture has shifted or not, other than the fact that the MPS states that they are training police officers and engaging with police officers in how they look after their own mental health. There was a specific recommendation in the work I did about the police taking responsibility or taking their duty of care for their own officers seriously. The response has been that the specialist senior officers now provide police officers with advice and training as to how they should look after their mental health. What I do not know is what impact that has had culturally, though.

**Caroline Pidgeon MBE AM:** Anne, do you have any feel both in terms of officers and their own mental health and the support they get and also in terms of how officers routinely are able to deal with the public on the ground who may have mental health issues?

**Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation):** Let me speak from my own perspective as somebody who is nearly at the end of their service, having been based in victim-based roles throughout my service. The one phrase that I do not see mentioned when it comes to the mental health of police officers is ‘burnout’. Burnout occurs more than people realise. Culturally, we have moved on. A lot of our younger officers have a better understanding of mental health issues. They are much more conversant
with what is going on in the mental health world than my generation would have been. Attitudes have shifted massively, which is a good thing. I can tell you that for a fact.

However, from my perspective, officers very often make mistakes or things go wrong because they get to a point where they are overwhelmed with the volume of work that is coming in, the fact that they just seemed to rush from call to call and are expected to give this gold-star service every single time. That is fine for a while. When I first came into the job I was made what was called a ‘SOIT-trained officer’ very quickly. ‘Sexual Offences Investigative Techniques’ rolls off the tongue really easily. I managed to do that for a period of about three years, continuously working my day job in response. Every single time a sexual offence, a rape or whatever came in, it was mine. I got to a point where that was fine and then I started burning out. My ability to empathise and sympathise naturally as a human being started petering out. It was, I hate to say it, a feeling not that I did not care but I could no longer cope with listening to people’s issues all the time and them offloading and me absorbing it.

What the MPS used to do back in the day for people like me was to rest us and rotate us. You would have a period of time where you would deal with these jobs and then you would be stood down and given something else to do. You refreshed yourself and you did not burn out. However, now, because of the position we are in in terms of resources, officer numbers, the volume of calls we have and the complexity of what we deal with now -- goodness me, I would not sit here and knock any one of our partners, other emergency services, anybody in social work, anybody at all, because we are all struggling. We are all doing the same job and all trying to achieve thing here and so we do get it, but we do not very often take into account that we are burning officers out.

Now, the BCU model - I hate to say it - has caused problems which I am not in a position or at liberty to discuss because you can ask my senior managers at the next meeting in January [2019] if you wish to talk about that. That has put more pressure on people because they are being expected to move and to take on more work and take on greater responsibility. I am very concerned that we are - I hate to say this - in some respects almost paying lip service to looking after our officers.

Another example I will give you is about the counselling services. Since we have outsourced a lot of our resources, I am afraid I have concerns because, yes, we do try to look after officers’ mental health but there is still for some of us a stigma that, if you show out, you are seen as weak. Culturally, it is always going to be under the surface with a lot of officers because it is the sort of job where you work with a team of people and do not want to let your colleagues down. If you show out and say, “I cannot do this anymore”, you feel you are letting your peers down all the time and so you just keep going and keep going. Then somebody realises one day that you are not very well and that you need to have counselling or whatever and you phone up counselling services and find it does not work like it used to. It does not work in the respect that it is flexible. It does not work in the respect that it understands that we are a 24/7 service. It tells us when we are going to go to it and how it is going to be run from its perspective and if we miss any of the appointments we do not get them back. Where an officer might need 10 counselling sessions, they are not likely to get them because shift-work will prevent that.

I am concerned about burnout. I am concerned about how we rest officers, how we rotate them and how we do really look after them. Bear with me; I have only skim-read some of this. I can only speak from experience and these are the experiences I am finding. Unfortunately, having been a working rep, it always ends up being too late by the time the officer would come to me. I hope that answers some of your question.

**Caroline Pidgeon MBE AM:** Thank you for that. It does not pick up the training point and what training they are getting in dealing with people with mental health issues.
Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): From what I have been told - and my senior managers will have greater detail about this - I know that we have a BCU mental health toolkit rolled out, which hopefully by the time we all are BCU-live in February next year [2019] will be in place. Mental health teams are going to be much more sophisticated than they used to be. There is a lot of work going on there. I can see real improvements in that. Our probationary student constables are getting mental health input. Our officer safety training sessions also include mental health input, particularly when it comes to restraint.

Talking from a Federation perspective but not from an MPS perspective, my role overlaps very much with the Health and Safety Secretary’s and our Territorial Policing lead as well and from a personal perspective. I have started to identify that we do not deal with autism very well as one particular subject on its own. That is everywhere. That is part of what we are dealing with. On a personal level I am looking at that from a Federation viewpoint.

However, the MPS is putting everything it can into training wherever it can, with Mind also coming in on the back of this wherever possible. That is what I have gleaned from where we are at the moment.

Caroline Pidgeon MBE AM: Can I go on to Vicki and Andy? Are you seeing from your work and experience improvements in the awareness of mental health issues in the frontline staff of the MPS police? What does a baseline level of competency in mental health awareness actually look like for police officers? I will maybe start with you, Vicki.

Vicki Nash (Head of Policy and Campaigns, Mind): Yes, training and awareness is always a really interesting topic to talk about because it can so easily be ticked when everyone has watched a 30-minute online video and then it is all done and dusted and they know all about it, whereas obviously the reality of something as complex as mental health is that it requires much more understanding. There is always going to be a question when an organisation has said, “Yes, we are improving our training”, about what the training looks like.

Interestingly, I had an email from someone in the MPS last week which was about a new training package that they have and they wanted us to look at it, and so we will. They are asking the people who know about it and that is a good sign.

A litmus test for how good training really is is whether people with lived experience of mental health are involved in the development and the design of that training and also in the delivery. That can still be done if it is an e-learning as well as any face-to-face training. That would be a question that I would suggest you ask them in terms of what the training really looks like. Does it have people who have had really terrible experiences and also really great experiences with the police to be able to bring that forward and also input from the mental health practitioners and people who know what they are talking about?

I cannot answer that question as to how good the training is, but I would say that they are indicators of quality training. The fact that they have been in contact with us to look at it is a positive sign, but I have not seen the actual content.

In terms of the issue around the impact that that has in terms of levels of awareness, what we do know is that there has been an increase in the number of interactions with people with mental health problems or callouts that have mental health elements to them. That has increased. It varies across police forces and across the country. It is as low as 2% in some areas and up to 40% in other areas. However, by and large, more police
are reporting that they are coming into contact with people with mental health problems. That could be seen as a proxy indicator that they are actually clocking it earlier and they are identifying it, which again is an indication that maybe the training is coming through and they are just a bit more aware and are spotting it and then that is being felt through the reporting. On the other hand, we know that there is increased demand, and so it is probably a combination of the two things, really. In terms of whether the awareness is hitting the front line, that is an area to further explore.

Just to finish really and to put it into context, we do hear from people who talk about how fantastic the support has been from the police when they have been in a mental health crisis, which is, if anyone has not been in that situation, incredibly scary and you are very frightened. To be dealt with compassionately, with empathy and with care by the police, who traditionally have not been seen in that way, is so important for a person’s recovery. That can be done very effectively, but we know that not everyone has that experience.

The final point on that is to think about it within the context of other personnel that people might come into. In 2015 when the Care Quality Commission (CQC) released a report, it found that the police were perceived as being more successful in providing caring and empathetic responses to people in crisis than staff working in A&E or specialist mental health services. Therefore, again, it is important to put it within a context. There are still lots of improvements that can be made, but they seem to be getting it right better than the health service, which is more worrying.

**Caroline Pidgeon MBE AM:** Andy, do you have experience through your trust of dealing with real frontline officers. What changes have there been? Is the training enough? We are told that - I do not know - training to do specialist driving is three weeks and the mental health training is probably a couple of hours. Is it enough?

**Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust):** There is huge demand on training. For everything that happens, someone usually puts a training recommendation in every report on every aspect of policing. In my interactions I would say they are at three levels. Certainly, at the strategic level, you have, clearly, people who are very aware of these issues and really committed to them. At the local Inspector and chief inspector level, when we have our operational meetings, I have found again some really committed officers. We have had table-top exercises to talk through various incidents, which have been very helpful indeed to iron out some of those problems and rubbing points. I see only a snapshot of the frontline officers, but I do visit what we call our Section 136 suites, where people are taken by the police when they have been detained under the Mental Health Act and I do talk to the officers when I have a chance to not only of the MPS but British Transport Police officers and Kent police officers as well. I have almost invariably been very impressed with their sensitivity, the use of appropriate language, their kindness and care when dealing with some very challenged people. That is my take on it.

Clearly, we do have issues and from time to time we have things, as I said earlier, that do not go well on both sides and we do look at those and we do debrief those. Occasionally there are things that cause us some concern, but we raise it with the appropriate people within the MPS to talk those things through. In the main, from my experience, whatever they are doing, I am seeing the evidence of much improved performance by them.

**Caroline Pidgeon MBE AM:** Can I just ask on a different issue in terms of contacting the police? People ring 999 or they ring 101. They are being encouraged more and more to report things online. Are issues around mental health being lost in that? Is there a risk that you are concerned about or that you have picked up that something needs to be done to adjust that to make sure it is not lost?
Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): I cannot talk for the London Ambulance Service, but it is very involved in all of these matters as well and very much involved in the 111 service from the health service side of that. There is a greater awareness from the operators about what they are dealing with. Quite clearly, you do not know on that first call whether you are dealing with a terrorism incident or a mental health incident or a crime matter; hence the police must attend. They are, generally speaking, pretty quick to investigate and find out what those issues might be.

One of the real issues from the police side is the sheer overwhelming number of calls. We know that 999s have gone up year on year. We know that 101, which was brought in to alleviate that pressure, has gone up year on year. It is one of the reasons we see Crimestoppers getting more and more calls: because literally people cannot get through. That is one of those anxieties when you need help and just cannot get through to get that help.

However, I can only reiterate, as I say, local relationships and strategic relationships I find are very strong.

Caroline Pidgeon MBE AM: Vicki, you nodded on that. Is there a risk around mental health issues not being identified or as quickly?

Vicki Nash (Head of Policy and Campaigns, Mind): I was thinking when you were talking, Andy, about some of the work that is done outside of London in Cambridgeshire and Peterborough. One of the innovations that they have developed is on the health side and looking at the 111, which is the equivalent of 101 for health, but you are talking about people who end up being picked up by other parts of the system. They have brought in 111 and you can press 2, essentially, for mental health emergency help, which has seen a dramatic reduction in the use of police being called out and in A&E attendance. They are able to provide them with alternative supports or alternative places to go. It will be interesting to see whether innovations like that get picked up in the long-term plan that is due out next week.

Caroline Pidgeon MBE AM: Is that a pilot?

Vicki Nash (Head of Policy and Campaigns, Mind): It is pretty well established now and it has been rolled out, but we can send you more information and put you in contact with the people who work on that.

Caroline Pidgeon MBE AM: That sounds very good.

Steve O’Connell AM (Chairman): Where has that been rolled out? I did not catch it.

Vicki Nash (Head of Policy and Campaigns, Mind): Cambridgeshire and Peterborough, and there will be other pockets. This is the classic example within the health service. There are pockets of really interesting stuff that is happening, but whether people hear about it is another matter.

Caroline Pidgeon MBE AM: That might be useful to pick up because mental health issues, with a really pressured system, could get lost.

Lord Victor Adebowale CBE: Could I make a point about training? I found that the worst thing that can happen to someone is that they are killed as a direct result of a police interaction. I found that those interactions were largely around the issue of restraint.

One of the recommendations that we made was that the police were trained in alternative forms of restraint other than pain restraint. A couple of things have happened. First, there has been a national memorandum of
understanding [Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings] signed between the College of Policing and the MPS and other police forces about retraining. Lord Carlile [of Berriew QC CBE] did a quite good piece of work with the College of Policing and then there is the Olaseni Lewis [Seni’s] law and the work that we did with South [London and] Maudsley [NHS Foundation Trust]. I would hope that the police response to mental health is informed by proper training as to what to do in those restraint situations, which are extreme and rare but they have resulted in deaths.

I would also argue that training at the end of the day is about impact and you can only measure impact by talking to the people who have been at the receiving end of police activity. In order to do that, you have to measure two things: how they felt after the event, which is effectively what I did with 55 people, and disproportionality. I am afraid that black people were treated generally worse than white people. It is possible to evaluate training, but you have to evaluate it in relation to whether the experience of the service has changed as a direct result and whether the experience of those more likely to be damaged by that service has changed as a direct result.

Vicki Nash (Head of Policy and Campaigns, Mind): Just to pick up on that, the Independent Mental Health Act Review, which came out last week, did make a recommendation around equality issues, particularly looking at police interactions with people from ethnic minority communities under the Mental Health Act 1983. That needs to be effectively monitored and addressed. That was a very clear indication that we still have an awful lot to do in that space, for sure.

Lord Victor Adebowale CBE: There is a lot to do, yes.

Caroline Pidgeon MBE AM: Lovely. Thank you.

Florence Eshalomi AM: Thank you. I just wanted to come back on that last point quickly. You may be aware that there is an update on the review of the Government’s work on deaths in police custody. There is going to be a parliamentary statement later on today. One of the things that they are focusing on is support for families, which will address some of the stuff about accountability because, again, we do see that the majority of the people who are unfortunately dying in police custody are from BAME backgrounds and they feel that the system does not support them. I just wanted to know if there was anything you wanted to add on that bit? That is the other bit in terms of the failure of the system.

Lord Victor Adebowale CBE: I was not aware of the statement --

Vicki Nash (Head of Policy and Campaigns, Mind): It is really helpful to know.

Lord Victor Adebowale CBE: -- but I am aware of the issue. We worked with one organisation in particular and what we found was exactly that: the families of victims and indeed survivors of cases where things had gone badly wrong were often under-resourced compared to the police and the police took a defensive position. One of the recommendations that we made was that resources were made available - and not much, but resources - and that the police worked in partnership with some of these organisations so that, when things did go wrong, the families had proper support and were able to seek advice in response to the police.

I do not know whether that has happened. I know that an advisory group is being established. I do not know who is in it. I do not know which organisations are represented.

Florence Eshalomi AM: OK.
Susan Hall AM: Can I just ask a very quick one? Are officers encouraged to use body-cams when they are particularly making arrests? Sometimes more restraint is needed if somebody is not well. It is just so that the officers are covered as well. These body-cams are important for both sides of the situation. Are they particularly encouraged?

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): They are, yes. As far as we are concerned, they have been a great success.

Susan Hall AM: I know in general, but I mean --

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): They have reduced complaints massively and I get the impression the officers are using them more continuously now than they ever did. For anything that involves somebody with mental health issues, I would suspect and I would say they are going on straight away and are being used as a tool evidentially for the protection not just of the officer but of the person, for both sides.

Susan Hall AM: No, for both sides. That is what I am saying. Absolutely.

Vicki Nash (Head of Policy and Campaigns, Mind): It was talked about quite a lot through the passage of Seni’s law when it was going through Parliament and also in the Policing and Crime Act and you are seeing absolutely more of it. I cannot remember what actually made it into the legislation because there is quite a lot of toing and froing, but, absolutely, you are seeing that on a more day-by-day and case-by-case basis it is being used.

Lord Victor Adebowale CBE: Body-worn cameras are not a substitute for well-trained and well-resourced officers that are supported --

Susan Hall AM: No, that is not what I am saying at all. What I am saying is that sometimes what actually happened at a scene needs to be seen by everybody on both sides of the situation. That is what I am saying. Thank you.

Vicki Nash (Head of Policy and Campaigns, Mind): Yes.

Florence Eshalomi AM: Coming back to the frontline response, we know that a few years ago they trialled a street triage process. Officers could, in a sense, have access to a range of activities to help frontline and community policing to identify people with needs. Do you feel that the MPS’s triage model has helped to identify and address the mental health needs of suspects and victims?

Lord Victor Adebowale CBE: When we looked at the triage model, which I think was piloted in Newham --

Florence Eshalomi AM: In nine boroughs.

Lord Victor Adebowale CBE: -- we thought was a highly effective model and we recommended that it should be rolled out. Since then, they are trialling the mental health investigation teams to work with partners. I am not quite sure whether that is the same thing, but the model that I observed was an excellent model and helped both the police and people with mental health challenges and de-escalated situations so that it was less likely that a Section 136 or any other kind of restraint was necessary.
What I do not know is whether they have been rolled out universally. It is, again, this point about how there is good practice but we do not know whether it has been rolled out in exactly the same way as the practice recommends or whether it is been adapted and, if it has been adapted, then the question is how you evaluate its effectiveness needs to be raised.

**Vicki Nash (Head of Policy and Campaigns, Mind):** That is really important because lots of people talk about street triage but it actually looks quite different in different places now. In some places you have a mental health nurse in a police car. In others you have someone in the control room, which seems to be a very effective method. It has been all labelled ‘street triage’ but it looks quite different in different areas. What we do need to see is a much better whole-scale evaluation of what works because we could be wasting money on things that are not as effective as in other areas. I am not saying that they are taking place in London but the absence of a proper evaluation of that means that you just start to see things that are adapted but do not really fit fidelity to the model in terms of effectiveness.

**Lord Victor Adebowale CBE:** My argument would be that in areas of high demand, the street triage model that we saw in Newham is effective and should be working in those areas.

**Florence Eshalomi AM:** Yes. From the report it states that in 2017 street triage was available in only nine of the 32 London boroughs. I am sure some of that is probably down to funding and we do not need to go into detail about the pressures, but equally, if this is something that works, should we essentially be taking that message back and ask if this could be rolled out across all the boroughs across London in a form that works?

**Lord Victor Adebowale CBE:** London is a high-demand area. It requires a partnership between the police and the NHS for it to work, but it might. What I observed is that both services benefit.

**Vicki Nash (Head of Policy and Campaigns, Mind):** Yes. Quite a lot of planning at least of mental health crisis care work takes place at a pan-London level. I sit on one of the boards that looks at that area. There is no reason why street triage cannot be factored into that. They have been looking at how to redesign section 136 pathways. If you take the whole package, what does street triage look like? It may well vary locally because of local need and local geography and boundaries, but as a Londoner myself I would like to know that if I was in a crisis it should not really matter where in London I live. I should be able to get a good quality service that gets me to a place that is safe and helps me recover.

**Lord Victor Adebowale CBE:** On that point, that means properly available and well-resourced section 136 suites. At the time I did the report I was very concerned about the state of section 136 suites. I know that that has been improved certainly in the case of the Maudsley. What I do not know is whether we have sufficient numbers and sufficient support for those suites to ensure what has just been said by Vicki is true.

**Florence Eshalomi AM:** The other bit of accountability and frontline response is services being offered to young people. Again, we look at a number of London boroughs. The two boroughs I represent, Lambeth and Southwark, where there is a high number of young people presenting with mental health needs and not getting the treatment that they require. In the Police and Crime Plan that we have here at City Hall, do you feel that there should be something different in terms of how we deal with young people presenting with mental health needs?

**Lord Victor Adebowale CBE:** In the report that I have read - and I do not know whether it is up-to-date - on the Police and Crime Plan, page 101 refers to young people. We had an all-parliamentary group on this very issue only last week and there is a huge increase in demand and an inconsistent rollout of things like trauma-informed services to support young people. That should be of concern to us because what we do
know is that young people with mental health challenges aged between 16 and 35 are five times more likely to have physical challenges as well. This is a real issue for the NHS and for the police and I am not quite sure that we have a consistent way of tackling it in London.

Vicki Nash (Head of Policy and Campaigns, Mind): By and large, from the conversations that have been happening around the redesign of section 136 across London and the CCCs when they were up and running and working effectively, children and young people’s needs were not effectively met by either of those and that was widely acknowledged. They are definitely not being met on the health side. The police will struggle, inevitably, to meet those needs because of the unmet need in health. It is a fairly horrifying situation if you are a child or young person needing help for a mental health problem at the moment. You are really lucky if you get anything.

Florence Eshalomi AM: Thank you. Andy, is there anything you wanted to add on children and young people?

Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): Yes, on children young people and our partnership across south London with Oxleas [NHS Foundation Trust], South London and Maudsley [NHS Foundation Trust] and South West London and St George’s [Mental Health NHS Trust], we have been looking at the whole of the Child and Adolescent Mental Health Service pathway because we are very conscious of the fact that the service has not been as good as it should be. When people are detained, they are sometimes placed in premises or in hospitals many miles away. Already, we are bringing people back. The journey time now is much reduced and we are bringing people back into south London.

We are also working together to provide urgent care for young people in a way that we could not before. Those three trusts working together are beginning to make a real difference. We have very strong partnerships on forensic as well, again bringing people back into our area. Not only is it better for the patients and families; it actually saves money as well.

The third limb of that is the adult mental health crisis pathway we are looking at, which is a much bigger challenge. We are looking at 700 beds across the whole of south London. This is a real big issue. We are particularly looking at section 136 suites. There has been a lot of work done pan-London looking at the ideal locations and size. It is an excellent report. Unfortunately, there is no money attached to those reports. As has already been said, South London and Maudsley have excellent section 136 suites for themselves there, but that just copes with the boroughs that they cope with. We are amalgamating two of ours together so that we can provide more 24-hour staffing for that.

The key to it is not just getting people in; it is how we prevent people coming in, whether triage actually works, looking at the evidence and what we mean by ‘triage’, looking at crisis cafés and the evidence around those. Again, we have to look at the evidence. They all cost a fair bit to run. Twenty-four-hour home treatment teams are a real key to this because, if someone presents you at 3.00am in the morning and you are a psychiatrist making an assessment, if you are not going to bring them in and if you are not going to section them, you want to be confident that there is a service that you can refer them to straight away to look after them. There is a massive risk associated with this for everybody. If we can bring those things in more consistently, we can provide a package of care. It is better for the patient. It reassures the clinicians as well that they are doing the right thing.

Adult mental health wards are not the best places for some people and we can do our very best to prevent people going in, but it is one of those things. Where do you put that investment in? What is the evidence
base to show that works so that we can reduce those costs at the other end when we are faced with increasing pressure and demand across the board on these issues?

Let us not forget that a good 50% of people who present we have never seen before. It is not just about dealing with the ones we know. It is about the ones we do not know. We have to have facilities to deal with them.

We know roughly what we have to do and there are some positive noises coming up from the Government at the moment about the priority being given to mental health. We are awaiting some announcements on that to see what that translates into.

**Florence Eshalomi AM:** Yes. Thank you.

**Steve O’Connell AM (Chairman):** We are moving to the next set of questions. First of all, I would like to welcome students from the Warren School in Barking and Dagenham. Good morning to you. Welcome to City Hall this morning. This is the Police and Crime Committee and we are talking about policing and dealing with Londoners with mental health issues. I hope you find this interesting. You are welcome very much.

Again, apologies to Members. We still do not have the representation from the National Police Chiefs Council. We are trying to communicate and that has not gone well. I apologise to you but there you have it.

I am conscious of time as well and so we probably do need to move on slightly. The next set of questions, Sian, you are leading on.

**Sian Berry AM:** You have touched on some of the issues I wanted to ask about initially already. What I wanted to ask was: what should the ideal response be when a police officer encounters someone with mental health needs, a victim or a suspect? Victor, you have said care, empathy and a sympathetic and compassionate approach is more of what you are already seeing from officers. Andy, you have also said that the use of language you have seen significant improvements in. Is there anything else in terms of risk assessment or professional tools or something that officers should be considering when they encounter somebody that you have not mentioned yet?

**Lord Victor Adebowale CBE:** We did make recommendations in the report about specific risk assessment tools. The Newcastle risk assessment model was one that we recommended and the police have either adapted that or adapted a similar assessment framework.

Again, it comes back to training. The College of Policing has recommended that police officers have a two-day training and so it is not hours. At that level, there has been a clear recommendation about the amount of time. The MPS, like we have said before, does provide training on an ongoing basis around suicide prevention and responses.

However - and this is important certainly in the findings of the Commission - it is not just the police. What we cannot have and what is really dangerous is when the police officer turns up and then rings because most of these incidents are not criminal. They are health emergencies and, therefore, there should be a health emergency response. In an ideal situation, the police officer should be able to call for an ambulance. The ambulance should arrive with an appropriate vehicle with a trained medical officer who is capable of working with the police to reduce the anxiety of the individual because it is a frightening situation. Where there is no risk to the public or an individual, the person should be transferred if necessary to an appropriate setting for further treatment in an ambulance, not in a police car. That would free up the police to do what they should
be doing and there would have been fewer incidents and fewer deaths. The ideal situation does not involve the police for very long and for very much because the appropriate response is a health one at the end of the day.

**Vicki Nash (Head of Policy and Campaigns, Mind):** The area to really concentrate on is the pace and the effectiveness of the handover or the transfer between the different agencies, whether that is police to ambulance or police to health or ambulance to health. That is where we still have significant problems and that is both in terms of the personnel that were involved and the vehicles that were used. Conveyancing is a huge issue still.

Again, it is important to put it into context. The dramatic improvement that we have seen in the reduction of the use of police cells is something to be really commended. I know the MPS works so hard on that to get that number down. It is extraordinary the amount of work that has gone in to make that happen. You are now dealing with the consequence of police officers having to wait for an awfully long time before they can find someone a bed or be admitted to A&E and so you have the knock-on effect in the system.

We have always been very clear at Mind that police cells are absolutely no place for anyone regardless of their age to be in if they are in a in a mental health crisis because they will often need physical help as well as help for their mental health. You do not get either of those in a police cell very well.

**Sian Berry AM:** Can I ask Anne? You were quite eloquent earlier on about the toll it takes on officers if they are having to effectively be healthcare practitioners for periods of time. Ideally, you would triage and would call in the correct services and hand over quite quickly. It seems from the evidence we have that increasingly officers are trying to avoid taking people to police cells as their place in safety but are having to spend time on the phone trying to arrange for other places to go.

**Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation):** Absolutely.

**Sian Berry AM:** Meanwhile, presumably, they are also caring for the person who is in trouble.

**Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation):** Yes, and this takes hours. It can take a whole shift. Sometimes it can take a whole shift. It can take eight hours. Going back into the history, when I first joined, I remember spending eight hours at Charing Cross Hospital with my then governor desperately trying to get the health service to take somebody in who was very unwell and almost having to abandon them there because there was almost an argument going on.

We have improved massively, I hope, since then, but dealing with people with mental health issues is not a five-minute job, as we all understand. We are talking about empathy and sympathy and caring for somebody. I have sat with people before and I know all my colleagues have sat there for three or four hours just talking to people and I am quite happy to do that. I have no issue with that, but I have calls coming out and people screaming in the background and I do not have the luxury of spending time.

Officers are frustrated very often because my colleagues in the main are really good people. They join the job to be good people and to help people. They get really frustrated when they have constant calls, “Have you finished?” “Have you done this? Have you? What are you doing?” “I am dealing with this really unhappy, mentally ill and confused young person. Leave me alone. I want to get on with it. Give me the resources to do this.” It is a struggle and it can take that whole shift. It is very draining and it is frustrating. We want to do our best for people.
Quite rightly, as has been mentioned by everybody here on the panel and people like you, we should not have people who are mentally ill in cells at all. I am not great on Acts and sections and I never was. I cannot quote Acts and sections in law, but one thing that sticks in my mind is clause 4.4 of Section 136, which says that we are not employed to diagnose. It is not our role. Therefore, at what point does our care stop? How far do you want us to be trained? Do you want us to be the equivalent of psychiatric nurses and doctors? How far do you want our training to go? There is going to be a limit to it, definitely, and people have to decide where that limit finishes and whether that is sufficient or not. If it is not and it goes wrong, people have to take responsibility for that.

Yes, it is a timely thing and we want to do our best. As I said earlier, we are struggling with other agencies, the NHS particularly. I am losing the thread of this question.

Sian Berry AM: Do not worry. Thank you. Can I ask Andy to come in, maybe? You have described already what you are doing to prevent police having to take responsibility for too long for people.

Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): Back to your original question, if I was a police officer, I would be saying, “I want the NHS to take this away from me”. The real challenge we have is that that is not going to happen for a while. The recommendation in Professor [Sir Simon] Wessely’s report on the Mental Health Act talked about the use of ambulances rather than police vehicles. Police vehicles take more mental health patients in than ambulances do. We would need a very different London Ambulance Service if it is to cope with that.

There are pressures on the other end. It is quite right that it has been said that we do not want people in police cells. Equally, when we were inspected a couple of years ago, we were criticised for having too many people waiting in our adult mental health wards on sofas to see if there was a bed available. Our opinion at the time was that this was a safe place to be. At least they were with us in our premises and we could look after them. The result of that is you shunt people back into A&Es and back into police vehicles and so the pressure is from both ends. There is a pressure on the reduction in the use of police cells and pressure on adult mental health beds and not having alternatives, which we are seeking to do. We now have more people waiting in A&Es and waiting in the back of police vans, but we are conscious of this. As I said earlier, we are opening up our patient assessment suite that sits between the two when can get them in there and other hospitals and other trusts are doing this as well. I visited one in Southampton just a few weeks ago to look at what they were doing down there.

We all recognise this issue and we have to take the pressure away for the benefit of the patient and for the benefit of A&E staff - they do not want to be dealing with these people, either - and for the benefit of the police. People can wait, as we have said already, for many hours and police officers, quite rightly, do not see this as part of their role.

There are a number of issues for us to look at here and we are making progress, but I would absolutely understand the frustration of the police about the pace of the progress.

Sian Berry AM: Thank you. Victor, can I add another question to what you are about to say? The other thing you already touched on earlier as well was the conclusions about inequality in terms of race, in terms of disabilities and other things that lead to certain groups being treated for these actions and being taken into custody and things for mental health issues. We also have again the independent review which was mentioned already of the Mental Health Act 1983 which did have recommendations for monitoring particularly the equality issues. As well as chipping in on this earlier issue, can you outline anything else you want to add on that? Also, to Vicky as well.
Lord Victor Adebowale CBE: I am going to say two things. Nobody is suggesting that the police have nothing to do with mental health. In fact, in the report, it did say it was core business. At the time, it was nearly a fifth of police work, therefore, it is core business. The question is where that is balanced with the duties, the clear duties of the services like the NHS to support them. The less the NHS and social care do, the more the police have to do and that is the answer, in a way. They should be trained sufficiently to carry out their duties in response to public demand but in public need. They are not psychiatric nurses; they are not psychiatrists; they are not approved mental health professionals (AMHP); they are not those things.

In relation to your question about discrimination, I found in the report that there was a disproportionate impact on BAME young men in particular in relation to the MPS response to mental health. The answer to these questions in the following things; we need to monitor outcomes and experience of those communities. The Mental Health Act review I was involved in has made recommendations that will help by giving more say to people with mental health challenges as to how they wish to be treated before incidents and during incidents. We will ask for a review that will impact on disproportionality, but we need to be ever alert to the experiences of BAME people in relation to the police response to mental health. The only way to do that is to monitor it and ensure there is a reduction in the current disproportionality which reflects disproportionality across the mental health sector.

Sian Berry AM: Do you feel like there is any monitoring going on? Is there any ongoing monitoring at the moment and have they taken on board the recommendations?

Lord Victor Adebowale CBE: They do take on board the recommendations. What I am specifically trying to find is whether they are monitoring the experiences of BAME clients. I do not think that is clear in the information I have. What they have set up is an advisory group or they are setting up an advisory group to support the police in this work. I would suggest that group has sufficient expertise in the experiences of BAME communities in relation to mental health and policing and that they put in place some measures that they are accountable to that august body for reporting against.

Sian Berry AM: Vicky, would you like to add anything?

Vicki Nash (Head of Policy and Campaigns, Mind): Yes. Just to pick up on how this interplays with the Mental Health Act review. By and large, we have already welcomed the findings and the recommendations in the Mental Health Act review. We were also involved in that. It talks specifically around some of the racial inequalities that we see within the mental health system. What we need to see are very concrete commitments that attach themselves to the implementation of that review, hopefully through the legislation that will come as quickly as it possibly can, given the context we are currently operating it in.

There were missed opportunities within the Mental Health Act review. We were looking to get rid of community treatment orders specifically. They have been shown not to be very good. They are very disproportionate, used for people from BAME communities for a whole variety of reasons, which all talk to the institutional bias and racism that we have in our systems. That would have been one way to make a greater difference in that area and the review did not go that far. It talked about restricting its use, but we would like to have seen them gone completely because it would be symbolic, but it would also have a very practical reality to how people experience the mental health system if you are from a BAME community.

Sian Berry AM: I am trying to move on. I am trying to move through the questions quickly.

Steve O’Connell AM (Chairman): I am conscious of time. We do need to move on.
Sian Berry AM: Yes, I will do that. I want to move on to police calls to mental health facilities. The data we have here is that they receive 13,000 calls a year from mental health premises and about 4,000 officer attendances happen as a result of those calls. One of the recommendations from the review of Dame Elish Angiolini DBE QC was there should be a very high threshold for police going into healthcare settings. You have already talked about issues with restraints. I wanted to ask, as this still seems to be happening a lot, how this can be reduced and what could be done to improve how police are trained to deal with callouts to mental health facilities. Who would like to comment? Would you, Andy?

Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): Yes, we do call the police in for a range of reasons. It could be assaults on staff and other incidents like that. It could be to help us with a particularly challenging patient. Generally speaking, the response we get is very positive. From the staff’s perspective, and they do suffer many assaults, they clearly want to be supported and they want matters investigated because we have a range of patients that have been brought in. Occasionally, there are tensions about what the police will attend and what they will not attend. Again, we usually have a debrief afterwards if there are some areas of concern. On occasions, they do arrest people.

I can see, from the police perspective, what they are then going to do with someone who already may be either a voluntary patient with us or someone who is subject to a section. It is a pity [Chief Inspector] Michael Brown OBE [Mental Health Coordinator, National Police Chiefs’ Council] is not here because he is quite an expert in this issue; but around capacity and whether or not capacity is relevant or not to the police investigation in the first instance.

It is an area of concern that our staff have about the protection that they have from assaults. I do see the dilemma for those who are attending. There are times when our staff cannot cope with somebody and do need help. Our staff are often no more expert than others when they are dealing with somebody who is very violent indeed. We do need assistance to deal with people on occasions and, generally speaking, we get that.

Sian Berry AM: Can I ask are you aware which officers attend when there is a callout to a mental health facility? Is it the normal response officers?

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): It would be the response officers, yes.

Sian Berry AM: Nobody with any particular training?

Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation): No. It would be your call response teams would go out, as far as I am aware.

Vicki Nash (Head of Policy and Campaigns, Mind): We hear, anecdotally in this space, from police who often do turn up and what they have been asked to turn up to is not what they would see as core police business. You do hear examples of that as well as examples where they absolutely should be called out. I would echo the points that Andy [Trotter] said around the assaults on staff although I would also add to that to try to understand what is going on in those circumstances that someone becomes incredibly agitated. Sometimes that cannot be helped but other times, there is a question as to whether you have the right support and training of the staff that are on the wards. Have they got anything to do with their time? When you are in a patient setting, what people tell us that it is an incredibly poor experience in many places still. That all adds to the very uncomfortable atmosphere that you are creating in some wards.
The other aspect to that is about the level of violence and assault that takes place on patients themselves, largely from other patients but also from staff, including sexual assault which has been vastly underreported, and police are not called out for those. The CQC published a report specifically on sexual safety within a mental health setting. That is worth looking at. This is an incredibly complex kind of setup. There are always many different aspects to any one story that goes on within

Steve O’Connell AM (Chairman): I think we have that.

Sian Berry AM: These people are very unwell. In terms of restraint, is it preferable to have medically trained people doing that rather than the police being called there, in terms of safety?

Lord Victor Adebowale CBE: The police were trained in pain restraint which is not

Steve O’Connell AM (Chairman): That is the point. I am going to cut across. That is the whole point about the officers that respond, which are clearly response officers, that they have the proper training. I want to bring Susan in.

Susan Hall AM: I will be quick, Chairman. I have huge sympathy and understanding for what Anne [Shuttleworth] said earlier. It is a shame the police officer is not here. I wonder if you know the answer to this Andy? I was with police officers when they took somebody, who tried to commit suicide, into hospital. I offered to stay with this person; it was a resident, but the police could not leave then until they had handed her over. They were not required in any way. She was in a bad way because of what she had done to herself, but they had to wait. They were there hours. Has this got any better? The drain on police resources in so many different areas is getting wider and worrying because they are spread so much thinner. Has that time been reduced by any amount?

Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): I would not like to say that it has. When they go to A&E, they will be triaged there. They might have some physical problems as well as others. If they decide it is a mental health issue, they will then call in the appropriate mental health trust, and there is then a delay for that. It does take time to assess people; this is not a broken leg, this is much more complex in how we assess people.

I know there is a huge frustration from the A&E staff as well as the police about how long that can take. As I said, this is an area that, certainly from our trust perspective and the South London partnership, we are all looking at and very conscious of because it is a terrible experience for the patient, let alone the police and the staff. How can we improve that; make it safe and make it proper? There is a huge challenge.

The analogy I was making with someone the other day; if you had an eye problem in London, you would probably self-refer to Moorfields who have one of the world’s best hospitals here and open with its own A&E. What about mental health? Is A&E the right place to go? Quite rightly, we have said the police cells are not, but I am not entirely convinced if A&E is the right place either. It is not going to get any better as we get into the winter pressures. This is a whole new discussion. It is an NHS issue, it is a huge funding issue. We need to be starting to think ahead about what we are going to do with people in crisis. How are we going to help them? I am not convinced that taking them to A&E is the answer. At the moment, it is what we do.

I called in at the Queen Elizabeth [Hospital] in Woolwich on a Thursday afternoon. It is not our hospital, it is our neighbour’s hospital. I found seven mental health patients waiting, one of whom had been there 20 hours. This was a Thursday afternoon. This was not a crisis time. If you talk to staff across the country, they will repeat these stories. The issue for me is how do we deal with this? I do not think we have it right.
Lord Victor Adebowale CBE: I would have to agree with Andy. This is the very pinnacle of what we call parity of esteem. If you cannot have parity of esteem in a crisis, then I would question whether you have parity of esteem at all. I absolutely agree with the comments of Andy.

Susan Hall AM: Thank you.

Steve O’Connell AM (Chairman): Thank you. The last set of questions which Unmesh is leading on is looking forward, going forward in the context of limited resources, what longer term improvements we can look at.

Unmesh Desai AM (Deputy Chair): Thank you, Chairman. Good afternoon, panel. I have three specific questions and some of your earlier answers already touched upon issues dealing with longer term improvements. If I can be very specific, my first question is to all of you. It is about the CCC. We had the benefit of the Inspectorate’s report which was a fundamental review of the Concordat. In your view, what needs to be changed with regards to this Concordat? If I could start off with you, Mr Trotter.

Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): Personally, I have no concerns about the Concordat at all. That development since has been very positive, and I have no complaint whatsoever about the police response. In fact, I have a lot of compliments, not only about the MPS. I know you do not oversee the British Transport Police but looking at the work they do on suicide prevention, there is some remarkably good work that is being undertaken there.

The points I have made already; the ball is very much more in the NHS court, about how the NHS responds to these challenges and demands. The police have done a great deal, always a lot more to be done, as there always is. The real issue for me is how we respond as a system to help people in crisis.

Vicki Nash (Head of Policy and Campaigns, Mind): On the Concordat and to declare an interest around the Concordat because Mind project managed the Concordat for the first couple of years of its life, funded by NHS England and Government; Government first and then it is NHS England. The Concordat, when it was operating at its most effective was a thing to see in terms of getting those national bodies around the table, working together, tackling some of those wicked problems that we have within the system. Since, the foot has been taken off the pedal, largely from national Government. The infrastructure and the support that is available to local groups has gone away which has meant that some will carry on and have carried on and are still doing good work, but many others will have fallen by the wayside.

We know, particularly on the health side, in some areas, the NHS are not coming to the local groups anymore which is a real shame after so much good progress had been made. It is coming up to its fifth birthday in February [2019]. It is a very important time to work out what to do with the Concordat. One of my personal pet peeves is to regularly chase government officials as to when the steering group is going to meet on a regular basis. It is quite painful getting them to do much about that, to be honest. You could be waiting a long time for the Government to do much on that, particularly in the current context. My suggestion would be for London to take a view on what it wants to do with that body going forward because it has all the right people around the table. It is focused specifically on crisis care and you could do a lot of good work, but you could be waiting a long time to get a steer from national Government on that.

Lord Victor Adebowale CBE: Was the Concordat after my work on --

Vicki Nash (Head of Policy and Campaigns, Mind): It came after, yes.
**Lord Victor Adebowale CBE:** This is the thing. I agree with what Vicky said. London could lead the way, should lead the way. If you could keep looking up, you are going to miss what is happening when you look out. Focus on London, firstly.

Secondly, the interest from MOPAC and this Committee in this piece of work should not be underestimated. The fact you have been able to focus on this as a requirement in good policing in London, I would urge you to continue because this is not all done. You need evidence to be factually having an impact and you are in the best position to do that. That is the first thing.

Secondly, it should be acknowledged that the police are taking this stuff seriously. From the top, what we need is more evidence that would change the inexperienced, forgive me, at the bottom because I agree with you that many police go into the police force to do a good job. If my recommendation is implemented, then they should be able to do that.

There are other parts of the Assembly that should pay attention to how they add value to this, in particular, what powers the Mayor has to influence what the NHS does. It needs to be joined up with your concerns, therefore, we do get examples and we do not get examples where we have things like triage. We get triage everywhere. We get a London that is capable of looking after all its citizens all the time, not just some of its citizens some of the time. The specific pressures need to be resolved outside both the NHS indeed, and the police. Some of this is about what is happening with community groups and their engagement with young people and how young people are supported in such a way that they do not need these responses in the first place because they are brought up in a community that looks after them.

I would say that we have made a strong start. We have pushed it a long way and we need to keep pushing it because the police are under a lot of pressure. This cannot be allowed to fall off the tree, as it were, but we have made good progress. The future is looking interesting.

**Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation):** I confess to know virtually nothing about the CCC. If anyone wants to give me a potted version in two minutes, that would be helpful.

**Steve O’Connell AM (Chairman):** That is fine, a lot of honesty in this Committee.

**Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation):** That is something that I would presume Mr House [Sir Stephen House QPM, Acting Deputy Commissioner, MPS] would be better qualified to talk about that in January [2019] than I would be.

**Steve O’Connell AM (Chairman):** We shall pose that question perhaps in January.

**Anne Shuttleworth (Diversity Secretary, Metropolitan Police Federation):** Yes.

**Unmesh Desai AM (Deputy Chair):** Because of time, I would stress I have one more question, very specifically, to you, Mr Trotter and Ms Nash. A lot of people earlier talked about the Mayor. What can the Mayor do in terms of improving the identification of mental health needs likely to create more demand for support from health services, at least in the short-term? Of course, the Police and Crime Plan commissioned from the Health Commissioning priorities to improve community health care for offenders in different settings. What role does the Mayor have; what can he do?
Andy Trotter OBE QPM (Chair, Oxleas NHS Foundation Trust): The Mayor has a big role in all of this. He does not have control of the Department of Health’s funding obviously, or the Clinical Commissioning Groups. The symbolism of the Mayor’s leadership, London wide, to coordinate these activities is very central to us making progress. Coordinating activity, influencing, pressurising; all those things are absolutely central to making progress in London.

Unmesh Desai AM (Deputy Chair): You see the pressure of his office. Ms Nash?

Vicki Nash (Head of Policy and Campaigns, Mind): Yes, I would agree with that. You have seen that in terms of the role in the past couple of years that they have played around Thrive LDN. You also see that in the conversations that happen at pan-London level around mental health broadly. I have often been saying to the NHS, “You have lots of other tools in your toolbox when it comes to London”. Often, the conversation can be dominated by the NHS and local authorities play a huge role; they are often underrepresented in the conversations that we have. Again, the Mayor is an element of that and can provide additional clout and noise. We need to translate the noise into action on the ground.

Lord Victor Adebowale CBE: I have just stepped down from six years on the Board of NHS England. What I can tell you is that, other than I am exhausted, there is a real opportunity in the notion of population health and place-based health for the Mayor to influence how health plays its part in London. I note that in the Mayor’s Policing Report of 136 pages, the vulnerability and mental health is mentioned on seven of them in separate areas. Pages 9, 15, 17, 75, 101 and 107 refer to this. What would be really powerful is if there was an overall strategy that brought it all together and pulled in the health and the policing and focused on those people at the sharp end of the inverse care law which states that those people who need the health and social care and indeed protection the most, tend to get it the least. The Mayor has a tremendous leadership and convening role to play. He can hold up a mirror to the NHS in using the experience of Londoners as evidence for how it should really work.

Steve O’Connell AM (Chairman): Thank you very much for that. Guests, thank you very much for your contributions. We have a question-and-answer (Q&A) with the MPS and MOPAC in January. Sir Stephen House QPM [Deputy Commissioner, MPS] will be there, no doubt. We shall throw him some questions to get the context; we have not seen him yet.