MOPAC | MAYOR OF LONDON
OFFICE FOR POLICING AND CRIME

Date: Friday 21 July 2017
Location: Chamber City Hall
Hearing: JUSTICE MATTERS – Mental Health and Vulnerability

Start time: 11am
Finish time: 1pm

Sophie Linden, Deputy Mayor for Policing and Crime, (Co-Chair)
Andy Bell, Centre for mental health (Co-Chair)
Natasha Plummer, MOPAC
Dr Paul Dawson, MOPAC
Cdr Richard Smith, Metropolitan Police Service
Jacqueline Dyer, Mental Health Taskforce/THRIVE
Patricia Cadden, NHS England
Dr David Ndegwa, Consultant Forensic Psychiatrist
Dr Fatima Bibi, MAC-UK
Andre Mathurine , MAC-UK
Antony Miller, Penrose & Equinox
Julien Vantyghem, HMCTS
Emily Treder,
Aveen Gardiner, Community Rehabilitation Company
Kate Gilbert , NPS
Tabitha Brufal MoJ
Dot Connellan MoJ,
Bernadette Keane, Victim Support
Caroline Hirst, L.B. Lewishm
Annabel Cando, Criminal Justice Services
Rafik Hamaizia, Guest

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you very much for coming. I'm Sophie Linden. I'm Deputy Mayor for Policing and Crime. I'm going to be co-chairing this with Andy and we'll go round and introduce ourselves in a minute. Just to, I'm sure you all know, just to remind yourselves this is a meeting held in public and is also being webcast. So, shall we go round just very briefly to introduce ourselves?

Andy Bell (Centre for Mental Health) (Co-Chair): So, I'm Andy Bell and I work at Centre for Mental Health.

Cdr Richard Smith (Metropolitan Police Service): I'm Richard Smith. I'm the Metropolitan Police Lead for safeguarding.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): Counsellor Jacquie Dyer, the Vice Chair for England's Mental Health taskforce and the co-chair of THRIVE London.

Annabel Cando (Criminal Justice Services): Annabel Cando, Project Manager together for Mental Wellbeing, mental health charity.

Patricia Cadden (NHS England): I'm Patricia Cadden. I'm here in place of Matthew Bazeley today from NHS England and I'm the Head of the Health and Justice System Team.

Julien Vantyghem (HMCTS): Julien Vantyghem, Head of Crime Her Majesty's Courts and Tribunal Service.

Kate Gilbert (NPS): Hi, hello I'm Kate Gilbert, National Probation Service, London; and Head of Victims and Stakeholder Engagement.

Aveen Gardener (Community Rehabilitation Company): I'm Aveen Gardener, Head of London North for London CRC here to replace Helga Swinnenbank(?).

Antony Miller (Penrose & Equinox): Anthony Miller, I'm Director of Operations for Penrose delivering services for people with mental health in our own residential or community bases.

Caroline Hirst (L.B. Lewisham): Hi, I'm Caroline Hirst. I' a service manager in a joint commissioning team in Lewisham but I also chair a collaborative commissioning group for South London around CAMBS.

Emily Treder (Healthy London Partnership): I'm Emily Treder. I work for Healthy London Partnership and I'm programme manager in the mental health crisis care programme focussed on section 136.

Dr Paul Dawson (MOPAC): Paul Dawson, I'm the Head of Research at MOPAC.

Dot Connellan (MoJ): I'm Dot Connellan from Ministry of Justice in Offender Health in the Community Team.

Tabitha Brufal (MoJ): I'm Tabitha Brufal from the Ministry of Justice and again we work on the community mental health and substance misuse.

Bernadette Keane (Victim Support): Hi I'm Bernadette Keane. I'm the Services Director for London for Victim Support and the Lead for the National Homicide Service.

Dr David Ngegwa (Consultant Forensic Psychiatrist): David Ngegwa, London and North NHS Trust.

Rafik Hamaizia (Guest): I'm Rafik Hamaizia, I'm an expert by experience.

Natasha Plummer (MOPAC): I'm Natasha Plummer the Head of Engagement here at MOPAC.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you very much and I do really thank Andy for co-chairing this with me. I think it's really useful and important that we have people from not necessarily within City Hall driving some of the agenda and posing the questions in terms of the scrutiny and accountability and raising the issues because it is with you experts that really understand it that we really need to get to the bottom of what we need to do.

Today, and I'm sure we're all aware, today we're looking at in terms of mental health and vulnerabilities and the significant impact that has on policing and crime within London. We're looking at -- and today we want to look at the victims, witnesses and offenders on what more can and must be done to provide the right responses to the victims and witnesses and offenders; but also to provide the right support and resources needed to really make a difference to their lives. I'll hand over to Andy in a minute but the first part of today we are looking at the journey, a journey of people through health and justice and their pathways. We do have the police and crime plan which has commitments within it around ensuring a better join-up, looking at a trauma informed approach and making sure that we have that ability to really make a difference and to look at the actions of all partners. And it is all partners that are going to make a difference in this area. As with every area of policing, crime, it really is not just down to the police and I know we all agree on that.

I know change can be difficult and we are all working within very very constrained resources and very difficult times, absolutely aware of that and today is about really looking at how working together and coordinating properly we might be able to make progress despite the really difficult financial circumstances we are all working in and will continue to work in, in the year ahead.

I really hope that we will be able to understand the current environment, understand those that have experienced services and understand and look at their experiences because as we all know it's so important to always think about the people that lie behind the discussions, the people that lie behind the statistics in these circumstances. We haven't got much time and so I really do ask you to be brief and succinct but we must make sure that we do cover the ground. So thank you. Andy.

Andy Bell (Centre for Mental Health) (Co-Chair): So, in this first session, first of two sessions we're going to look at a range of issues along the pathway people take. So, first of all, we wanted to hear about MOPAC's commitments in the policing and crime plan; we wanted to hear about changes to the Policing Crime Act which is particularly in relation to places of safety and the preparedness of system partners in London to respond to those changes. We wanted to look at the use of community orders and particularly focussing on the mental health treatment requirement as part of that. We wanted to look at what alternative services and interventions are available; what support is available for victims in the criminal justice system and we wanted to explore access to interventions and particularly how we can prevent people who end up going through revolving doors as is sometimes described and we'll then look at a later session particularly at gaps in the system. So I think first of all we're going to hear from Natasha Plummer to go through MOPAC's response to mental health difficulties and vulnerabilities in the plan.

Natasha Plummer (MOPAC): Okay, I'm going to talk briefly about the police and crime plan and give a bit of an overview of our priorities and key principles. The police and crime plan was launched in April of this year and it's underpinned by two key principles. The first is putting victims first ensuring that they are at the heart of everything we do; and the second relates to reducing inequalities in our communities and that's about ensuring a basic quality for all Londoners and enhanced provision for those with the greatest need.

There are five key priorities in the plan. The first is about ensuring a better police service for Londoners; ensuring a better criminal justice service for Londoners; keeping children and young people safe; tackling violence against women and girls and standing together against hatred, intolerance and extremism. Through our police and crime plan what we aim to do is to support vulnerable people who come into contact with the police service and the criminal justice service across the board and to also reduce the number of young and vulnerable people who come into police custody through more effective diversion. And part of what we want to do for that is to help improve life and health outcomes for both victims and offenders as Sophie mentioned earlier.

There are four clear commitments that relate specifically to our work in the mental health and health arena that we'll be talking about today. The first of those that we'd actually like to do some work where we'll trial dedicated mental health teams in two areas of London where we'll have police working together with other partners to problem solve cases and address the underlying issues linked to mental health that might be impacting on a person's offending behaviour and also victimisation.

The second relates to some work that we will do around reviewing both the appropriate adult schemes across London as well as local authority accommodation for young people and specifically around the availability of mental health beds so that we can actually have a more effective response to people who come into custody who shouldn't be there and can be diverted away.

And then the third of those is around thinking about how we commission our services so that we recognise and respond to the underlying trauma that we know people often suffer who are both victims and offenders and have trauma informed approached through our commission's services. We have significant commissioning budgets, £47 million over the next three years for

victims' services and £78 million for our London Crime Prevention Fund where we commission with and through local authorities a range of services. So we have some opportunities there to work with you in making sure that those services are appropriate and effective.

And as part of that what we want to be able to do is influence local commissioning priorities so that we can actually align what we're doing with your programmes of work so that actually we are all working more effectively together to deliver better results for people who come through the system and having that continuity of care between settings particularly for young people is really important and we don't always get that right at the moment.

So, part of our ask today is really to think about how we can work together to gain your support for our commitments in the police and crime plan which we can't deliver actually by ourselves - it requires a partnership response and to think about how we more effectively align the work that we are all doing that operates in the same space and often with the same people. Thank you.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you, Natasha. That's really helpful. Those are the commitments that we've got within the police and crime plan that I think it's very important that we actually also focus on what the data is telling us and what we know about what is happening in London. And one of the things that we'd like to ensure continues is a sharing of data and the sharing of that data so that we can really get an accurate cross-London, pan-London picture of what the need is, where the vulnerabilities are, and also where we might be needing to prioritise. I just wanted to hand over to Dr Paul Dawson who's from the Evidence and Insight team in MOPAC to take us through the data.

Dr Paul Dawson (MOPAC): Thank you. So it's my role really just to give some key insights into the session and for this first section which the first two slides really just looks at the everyday day of mental health on the police. So I draw attention to the graph in the middle of the first slide. So this is the number of calls to the police services that have a mental health line and essentially what you can see is an incredible and consistent demand in London. So, as you can see there's nearly 6,000 calls each month that have a mental health code and they've worked out at around 260 calls per day. And as you can see an incredible consistent demand.

I would also point out from this first line that you can see 21 per cent of detainees answered yes to mental health assessments whilst in police custody in the financial year 2016/2017 and we can see that around 20 per cent of mental health calls originated calls originated from hospitals and mental health units. That really starts to show the links between the Met and partner agencies.

And I would also draw attention on this first slide to the potential mismatch in terms of the numbers around mental health treatment requirements. So at the bottom of the slide you can see that in 2016 there were 391 mental health community order MHTRs and 277 suspected sentence MHTRs and that's national data. So that's a potential mismatch in terms of the calls that are coming in and the numbers of individuals and the actual numbers of orders that are being given.

And then briefly my second slide here: this just presents the uneven demand that we see across London in terms of mental health. So two figures: first on the left this gives us information on

victims and suspects with a mental health code and as you can see, a massive variation across London. What I would point out that the top five boroughs in the table equate to around a quarter of all victims and suspects in London. And similarly the chart on the right gives a number of calls to police with a mental health code and again the top five boroughs receive a quarter of all calls to the Met police. So this really for me raises questions around understanding demand, resourcing demand and prioritisation of how the Met manages demand when the demand is so unequal across London.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you. Thanks, Paul. That's really really helpful and really … in terms of prioritisation I think we would like to come back to that, Richard, if we may but also I think it's a question for other partners as well around what that means for the top five local authorities where there is such demand, what that means in terms of policing but also what that means in terms of capacity to respond to that demand not just from a policing point of view.

Thank you very much to Jacquie Dyer for arranging and introducing MOPAC to a service user called Michael. He can't be here today but I'm thanking … I want to thank him for his courage so in talking to us about his experiences. He's not here but Natasha's going to tell us his experience having talked to him herself. Is that right?

Natasha Plummer (MOPAC): I didn't talk to him.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): You didn't talk to him. Sorry.

Natasha Plummer (MOPAC): So I'm going to talk through Michael's case study. It's the first of three and Rafik will be talking later. Thank you. And it's really important to get that lived user experience and I think that really brings to life some of the issues that Paul talked about in terms of the data.

Now Michael was 16 years old when he first experienced the onset of symptoms back in 1980 and he was actually hospitalised for two weeks at that time. He managed to function quite well for a number of years but between 1988 and 1996 he suffered some significant life events, the death of his father and the breakdown of his marriage. However between those episodes he was able to actually function quite normally and despite some periods of hospitalisation established a good family life.

However, following those significant family events things began to deteriorate and his health also plummeted. By 2003 he found himself jobless and feeling suicidal and very unable to cope. So for a long period of time he felt very unwell and he was in and out of hospital over several years. But he didn't have his first contact with the police until 2011 and at that time he was arrested and spent nine weeks in Belmarsh and he was eventually assessed as being unfit to go on trial and was sent to a medium secure unit. He actually, that was beginning of his road to recovery and by 2012 he was actually discharged and was able to get his life back on track. And since 2013 he's been working as a lived experience expert.

Now, there was some interesting points about Michael's story as he told it to our colleagues but he was fairly positive actually about his experience and his interactions with the police and the

CJS and indeed about the mental health services that he received. But he did highlight some particular issues which I think we will see become a kind of recurring theme as we go through.

Firstly, that, from his point of view, there was never any early intervention. All of the interventions he received were reactive rather than proactive so although he had a history of mental ill health and he was known to have that actually he was never actually given any support until he was in deep crisis. And for him that was obviously a significant issue because it meant that his life was able to deteriorate and might not have had he been having consistent support.

And while his experience of the police service was actually relatively good he felt he recognised that actually they didn't understand his needs. They didn't recognise his mental ill health and that for him there was probably a training need there in terms of officers being able to understand what they are seeing and how to respond to it. But also them being able to provide better communication and information both at the time of arrest and when he was sent to prison about what was actually happening to him.

And then the third thing that he said that would have really made a difference would have been to have some kind of mental health services support at the time of arrest and when he was sent to prison to help navigate those systems so that he could understand what was happening and actually those support things could have been put in place as he was being passed through the system. And so those were the three key learning points that came out of his case for him as he explained them to us.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you very much and I'm sure whilst his circumstances and individual circumstances are always different for everybody, often I'm sure going round the table knows that there's very often recurring themes of early intervention, better information and then better mental health services support and those are always recurring themes in many of the discussions and people that we meet. So I will open up the discussion for the wide … for all of you in a minute but I just wanted to bring Commander Richard Smith in who could update us on changes in legislation in relation to the Police and Crime Act as well as the mental health training for the police given that training is often highlighted as a key area of concern and including by the Independent Commission on Policing and Mental Health in their report five years ago. Be really grateful if you'd just give us an update.

Cdr Richard Smith (Metropolitan Police Service): Thank you. First, as I turn to section 136 in the changes under the Policing and Crime Act I think it's … I'm really grateful for what Paul Dawson said earlier on about the likely underestimate of the demands that we're currently seeing around mental health, certainly the experience of our frontliners it is considerably higher than the 2.5 per cent of calls that's actually recorded at the source of the calls. So we know that already. It's natural that people will focus very much on the crisis end of our business so therefore section 136 and the key changes that are coming under the Act are firstly that the Act will prohibit any children being kept in police custody after being detained under section 136. That's an absolute prohibition. And also we're waiting for guidance from the Home Office but adults will be taken to police custody only in what's termed, "exceptional circumstances" and whilst we wait for guidance on that we're expecting that that is when it is simply not safe to have them detained in a health based setting.

Now we obviously have some requests of our health colleagues around some of these changes which I'll come to shortly. Other key changes are the maximum detention period will reduce from 72 hours to 24 hours as a maximum and naturally that brings focus onto how efficient and how quickly the system can move somebody to get appropriate help in a health based setting. So that becomes incredibly pressing for us because any extension to that can only be made for clinical reasons, not simply because maybe a bed is not available.

And also there is a requirement where practicable for our officers to consult with a medical health professional before exercising their powers under section 136. Now the word practicable obviously comes into play there but again we would hope that that could happen in if not every case then virtually every case.

So what does that mean? In essence what we feel that service users need, people in crisis need is first of all that sometimes the police are not the most appropriate service to be dealing with their health based crisis. So where it's possible at the point of the call to transfer that to health services that is usually more appropriate for them. If however the nature of the call is such that police are called and we understand that that can happen, particularly in public places where there is a genuine risk and police attend, then our request of health colleagues is that there is a consistent picture across London on how those officers receive immediate help and advice from an accredited professional which we do not currently have and we would like to see.

At that point what we found through some of our triage trials is sometimes section 136 is not appropriate and not necessary. Where it is necessary though what we then need is that there are appropriate health based places of safety available 24 hours a day seven days a week that those people can go to get the appropriate care staffed by health professionals who are able to … are trained in restraint for example so that we don't need to have police officers called to those locations. We are not there yet. We know we're engaged with the Trusts through the Healthy London Partnership (HLP) and we really welcome their engagement there. But for us the changes to the Act really highlight the importance of moving forward on some of the developments we've had under the HLP and I know Emily has worked really hard through there.

That's the crisis side. I think it is also important to note that whilst section 136 the mental health crisis draws the attention a huge amount of our demand is more chronic around antisocial behaviour with people with mental health conditions either being seen as causing that behaviour because of their condition perhaps or being more vulnerable towards it. And officers find themselves called repeatedly to the same incidents. We're establishing mental health investigation teams. We have them in two place in London already, to problem solve those issues but quite clearly police are not able to do that themselves. What we need is the engagement from local mental health trusts, named individuals that those individuals can liaise with in order to problem solve those issues for the benefit of the person suffering from the mental health condition. This, while we talk about demand it sounds as if we're kind of selfishly trying to reduce the work that we want to do. It's not about that at all; it's delivering the most appropriate service to people who are vulnerable in London and also enabling us to then shift some of our resources into other areas of crime, disorder and keeping the city safe. Is there anything else that you need?

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Just wanted to see if you could touch on sort of prioritisation given the … given what we've learnt today and I'm

sure everybody was very aware of around the top five boroughs and how that links in with the work that you're doing.

Cdr Richard Smith (Metropolitan Police Service): Yes certainly. So, you've … I've already mentioned that we have a trial in two locations. Data that we have -- there is priority around that frankly in that whilst the data was showing us there's a disparity around where the demand is we don't feel that we're getting a full picture yet on exactly where that's happening and we're really keen to see that improve.

There's also for us a priority to establish some of those triage services and 136 coordinators us in those areas because where we have the areas in highest demand of course that's where we like to see these services in place as quickly as possible.

Alongside that of course there is the training requirement for our front line. We have delivered training on mental health issues through professional development days to almost 25,000 officers on the front line as well as additional training around the health based risks of people in crisis which is delivered through the six month in-training and officer social training. And then alongside that specific training for those officers we have working in custody because we also, as has been pointed out nearly over 20 per cent of people coming into custody suites tell us that they are suffering from some mental health condition so the specific training for those.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): When you say you haven't yet got a full picture of where the demand is, is that because of what you're talking about in terms of the underestimate --?

Cdr Richard Smith (Metropolitan Police Service): Yes.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): -- or that you need more data for those reports that are coming in because you haven't got the data through the CAD calls?

Cdr Richard Smith (Metropolitan Police Service): It's an underestimate and I think having looked at this yesterday in some detail, what is happening is some of the calls are able to be classified as a mental health call at the point of receipt. But only 2.5 per cent of them are. What we're finding is when officers are deployed to those quite often they will find a mental health element to the call and College of Policing estimates put the estimate of those calls as around 20 per cent of the calls that we deal with will have a mental health element in some way, whether that's through antisocial behaviour or a victim who's suffering from a mental health condition or indeed a suspect. That 20 per cent is reflected in the people coming into custody so that we know with only 2.5 per cent of our calls at receipt being identified as mental health we know that there is a further 18 to 20 per cent that do have that element within it that we are not currently capturing. It is for us to do that.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Is that … okay. So that's a sort of action coming out of today is to get that better analysis so we really understand where the London prioritisation … okay.

Just wondered if we could bring Emily Treder from the Healthy London Partnership in if you might be able to you know -- Richard's touched on the changes to legislation and the pathway and particularly around young people and then only in exceptional circumstances for adults. I was wondering what the work … what you were doing through London Partnerships to try to ensure that the other partners are ready for this change?

Emily Treder (Healthy London Partnership): So I think it's recognised at the moment that the current section 136 pathway in London is really variable and inconsistent. There's capacity issues at the site. There's inadequate staffing. Staff are currently pulled off in-patient ward when a section 136 arrives at the site. So what we've been doing over the past two years is we've developed a pan-London section 136 pathway and a specification for place of safety sites which is a minimum standard that all sites in London and the section 136 pathway should adhere to. And we have done that in partnership with London's three police forces, the ambulance service, emergency departments, mental health trusts and the voluntary sector as well as over 300 service users have been involved.

So the next step which has really been the focus of this year is implementing this new standard of care and one of the key pieces of work is creating centres of excellence so creating these place of safety sites in London that have the 24/7 staffing that is needed as well as a dedicated more specialist service. So we're working through that at the moment that will develop over the next three to six months. Looking at where these sites should be in London as well as how many we actually need and continuing that pan-London model of care for this pathway.

I think it has been acknowledged before that section 136 is a really important piece of the broader crisis care system and we need to ensure that when we get the section 136 right those alternative crisis models before section 136 that they're also … so they're actually preventing people from getting to their crisis point so that includes the street triage models, crisis teams, crisis houses but also ensuring once an individual is detained that those pathways at the end so there's adequate bed provision as well and there's adequate community support when someone's discharged from the site.

So this work is progressing and I think over the next 3 to 6 months we'll start to see decisions being made in local areas through the partnership working on where these sites will be and how they'll operate.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Can you remind me what the timetable … because you said the next three to six months --?

Emily Treder (Healthy London Partnership): Three to six months about decision makings about the provisional piece but in terms of implementation going forward I think they'll be different in different London areas. So for example in Southeast London they've actually a one step ahead of the game and have already developed a central place of safety site at the Maudsley Hospital. So that's one area that is sort of completed but different London areas will be different timescales.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): How does that relate to the timescale that the police are having to work under? Because we've got the legislation

but I believe the powers haven't yet been enacted. Do we know when that's going to happen or … just in terms of the join up for the new duties and responsibilities and the provision?

Emily Treder (Healthy London Partnership): So I think the … yeah.

Cdr Richard Smith (Metropolitan Police Service): In terms of the join-up the provision that Emily's outlined we would want anyway and is required now regardless of the change of the Act but the change in legislation simply makes that more urgent and more pressing. We are expecting guidance from the Home Office imminently. Clearly the general election put a pause on some of that work. I'm looking towards Elena(?). I know that we haven't had the guidance yet but we're expecting it very very soon.

Elena: September …

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): But that's … Is that the enacting regards the legislation?

Cdr Richard Smith (Metropolitan Police Service): The guidance will be as how we apply the legislation. So for example some expansion on what exceptional circumstances might mean. So in September we should have that guidance and then it can be enacted once we've got that.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): I'm not sure … sorry, I'm not sure that quite answers my question in terms of the enactment of the legislation. I know that this is the provision that you would want anyway but will the provision be there when the legislation is enacted and how we make sure there is that join-up? I mean it's probably not a (inaudible) but that is a question that we do need to pose because really good work happening in both area, but actually there will be duties and powers that may not be able to be met fully if this doesn't join up.

Emily Treder (Healthy London Partnership): More recently we've also conducted multiagency training sessions with the Met Police as well as our mental health trusts as getting people together to discuss what the changes will be, what needs … what can be done in the short term, what can be done in the more longer term to ensure that we're ready for the changes when they come.

Cdr Richard Smith (Metropolitan Police Service): If I can come in there? So the first change that no children will be kept in custody, we are not keeping in custody already.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): (overspeaking) significant changes.

Cdr Richard Smith (Metropolitan Police Service): That adults is only exceptional circumstances, we've reduced that year on year by 92 per cent and this calendar year I think we've only had three in the whole of London. So we're already there on that element.

The where practicable will enable us to function even if some of the measures are not yet in place but that is not desirable. We'd like to have that mental health advice available to our

officers of course. The area where I think we'll be most pressured is the reduction of 72 hours down to 24 because we already regularly see a significant delay in providing a 136 bed and I think that's where the focus will really come once the legislation is enacted.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Okay that's helpful. That's really helpful. Thank you. That's really good. Just wondered Patricia in Mathew's absence I wondered whether you might be able to comment on whether NHS England on what you think about the preparedness for this and how that coordination is happening?

Patricia Cadden (NHS England): With regards to the joint work that our team in Healthy London Partnership has done is recognising that there is this particular crisis with individuals who are picked up from the streets and going into custody or individuals who are picked up from their homes and going into custody, I think there's recognition from the mental health trusts and voluntary sector working within the custody setting about the need for individuals to be properly assessed and held in a more appropriate setting. And I think as Cdr Smith is saying that's happening but it's not fully being able to be utilised yet simply because the resources aren't quite in place. But most certainly with regards to the liaison and diversion service that's … we have full coverage across all of our London police custody suites and courts and we're trying to make sure that people are not either entering into prison custody or are managed better whilst in police custody. I think some of the work that Emily has outlined with regards to the mental health trusts and working with CCGs is more of a crisis response required and I think from the … there's a national mental health delivery plan and I think it would be useful for everyone around the table to share that with them so that they can see actually some of the actions and investment from NHS across the country around improving investment within crisis teams within the hospitals and setting up hospital based liaison mental health teams too.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): That's for crisis. What about, Richard, talked about chronic demand in terms of --

Patricia Cadden (NHS England): The bed situation.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Well, the demand there and how that can be changed and improved but also in terms of outcomes for service users, how you can drive that through as well?

Patricia Cadden (NHS England): Yes. With regards to picking up on some of the secure bed issue I think there will be a significant challenge with the 24 hour turnaround within police custody given the fact that it will take some time for a mental health assessment to occur to enable those individuals to identify where that bed is going to be. I think there needs to be some work done with my colleagues within specialised commissioning in NHS England as well as the CCGs where we can find appropriate places within a hospital, so a psychiatric intensive care unit or low medium or high secure unit bed space. And then I think with regards to some of the key points that Natasha brought up around earlier intervention most certainly that's a key driver in the mental health delivery plan in looking at what services we might be able to provide at an earlier space so greater access to IAPs and more interventions for individuals with IAPs to have more --

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): IAP, sorry?

Patricia Cadden (NHS England): It's Improving Access to Psychological Therapies and it's mainly to do with common mental health disorders rather than more serious and mentally ill individuals. But certainly with regards to the increase in access to IAP avoids people's mental health need escalating and becoming worse over time. And then with regards to the issues that we have with the management of people in the community who have severe mental illness that most certainly should be managed within the community mental health teams. But we know that there are some challenges with people disengaging from that treatment and I think being picked up to start to reengage is the most important point too.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): So, and what's the picture because we've had the picture painted of demand and the underestimate of demand in (overspeaking) and we know that that's significant? Then, if you map that onto provision and capacity what does that look like in terms of … maybe we'll come onto that in terms of gaps but …?

Patricia Cadden (NHS England): Yes, so it's definitely going to come --

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): What's the mismatch in that?

Patricia Cadden (NHS England): I think we can -- the mismatch is about the amount of beds that we have for individuals within the community. And I think with the -- as people may see through the national mental health delivery plan there's currently review taking place within specialised commissioning to look at what beds are needed at which places so that the individual is sent to the right secure unit as required or into a PICU for --

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Sorry?

Patricia Cadden (NHS England): Sorry, Psychiatric Intensive Care Unit (PICU) within a hospital in order to have their crisis needs met to stabilise and then come back out into the community. So I think the specialised commissioning CCGs will be looking at the demand and how that will be reflected within the care models. What we're looking at now just very quickly to answer, in London we have adopted through the five year forward view the new care models for secure unit management within specialised commissioning where in the north of London and in the south of London commissioners and providers have come together to build to … with the intention to provide better pathways into secure units where appropriate rather than it just being seen as something that's between commissioners and providers and were separate. These new care models are supposed to enhance and support the patient through the pathways irrespective of whether they've come from criminal justice or just from general community.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Richard, did you want to come in?

Cdr Richard Smith (Metropolitan Police Service): Yeah, if I may? Just to highlight how this plays out in practical terms and what I'm going to describe would apply just as much to 136 on the street as the circumstance I'm going to talk about. So we do find that we will have people in our custody suite, 21 per cent saying that they suffer from a mental health condition

who we then arrange for a mental health assessment for and this might be juveniles as well as adults and then find that they are not mentally well enough to be in custody. At that point we can no longer detain them under the Police and Criminal Evidence Act and are seeking a bed for them to go to. Sometimes we are then told there is no safe place for them to go to within the health environment and potentially then we are left in the invidious position of somebody who would be at risk of great harm if they were to be released from custody. But without a legal reason to keep them there and no safe place to take them to. What do we then do with that person who is in crisis and desperately needs help? And we already start to see these pressures creeping in now, the change in legislation will put us into that position perhaps more frequently so there is a real urgency to this provision of health based places of safety and beds for people who are in crisis because a custody suite is absolutely the wrong place for them to be. At the same time, sometimes it is at least a better place than out on the street but that cannot be the appropriate way forward for us as a partnership.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you.

Tabitha Brufal (MoJ): I'm Tabitha Brufal from the Ministry of Justice and I'd just like to comment on that particular point from a Ministry of Justice perspective. So we have health and justice partnership board which is co-chaired by our Director General, Justin Russel, and the DH Director General and last month our Home Office colleague raised this particular point and said how great a concern it was to the police. She gave an example of the force in Birmingham actually referring themselves to the Police Complaints Commissioner because they felt so uncomfortable about having to detain people outside of the limit. So it's an issue that as a department we also raise with NHS England partners. I don't think we came up with a particularly easy solution but we're aware of those concerns.

I'd also like to just add in pressure actually from within the prison system. So again nationally we see there are lots of prisoners who have been assessed as needing transfer to a secure bed and there are some considerable delays there and that is another … it's one of the key health concerns that our minister, Dr Lee has and is something that he will continue to place interest in over the next year.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): So I think one of the things that I'd like to come out of this today is to have a look at that mismatch and look at in terms of all three, the three, how that will in terms of provision, the legislation coming in and then a mismatch around beds as well as taking into consideration the prisoners as well; how great the mismatch is and what pressure that's going to put on the police but also obviously the pressure, the difficulties that's going to have on individuals. We really really do need to have a look at this because it is going to have an impact.

I was going to hand over to Andy now because I am meant to be co-chairing.

Andy Bell (Centre for Mental Health) (Co-Chair): I haven't been needed yet. So, we've had a couple of questions that have been given to us in advance by members of the audience so I wanted to relay those and I shall pick on particular panel members to answer them so be aware and probably just quick answers to each because we've got a lot to talk about.

So, first question I think probably is for Cdr Smith if you don't mind? And what we've been asked is, "Will there be a clear commitment to MPS training on mental health and will this be monitored in line with statutory equalities duties to ensure competence and fairness in dealing with service users"?

Cdr Richard Smith (Metropolitan Police Service): Okay the first part of the question we're already delivering training around mental health to our front line and to everybody that's recruited into the police service in London. There are two separate sessions of training around mental health issues for all of our recruits and then they go into that professional development days during their routine training where mental health has featured as I said to all of our front line. And I mentioned also that specialist training into custody. So I don't know if that fully answers that first part of the question?

The second part, you have to remind me, I'm sorry.

Andy Bell (Centre for Mental Health) (Co-Chair): It was whether this is monitored in line with statutory equality duties?

Cdr Richard Smith (Metropolitan Police Service): We do as I said … so we know how many people we've delivered that to so in terms of monitoring, yes, we do monitor the training that we deliver if that was the question.

Andy Bell (Centre for Mental Health) (Co-Chair): I think broadly I guess there is a question about the effectiveness of the training which would be subsequent to it from my point of view?

Cdr Richard Smith (Metropolitan Police Service): Yeah and I think you're absolutely right. It is relatively easy to measure how many people we deliver training to; it is much more difficult to know whether that individual then leaves with a full understanding and more difficult still in six months' time to know that they have remembered that, not just in mental health terms but everything else that we expect our officers to remain updated on every single subject that they cover. That is much more difficult to measure.

Andy Bell (Centre for Mental Health) (Co-Chair): Okay thank you. Maybe that's an area for further thought.

Okay I've got another question. I am going to rush through these because we've got a very very packed agenda. And this one is open to anyone who volunteers first to answer so fingers on buzzers. "What can people in this meeting all of us here collectively do?" and again this is a question we've been asked to put, "What can we all do to take the most vulnerable people with serious mental health problems from being further cut out of care and could there be a proposal that we perhaps all agree to to put pressure on or lobby the government to do more to support care of people who have serious mental health difficulties, many of which services are already stretched to breaking point?" So would anyone perhaps not a member of the government as we're asking about lobbying you, like to hazard an answer to that about what we might be doing? If nobody puts their hand up I'm going to ask Jacquie.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): I'm still meditating on the previous question actually. I think that we've got a particular challenge in London that certain communities are over-represented in mental health services, particularly secure mental health services.

When you look at the top five areas, Lewisham, Lambeth, about the demand in victims and suspects and CAD calls to the police, you see Lewisham, Lambeth, Hackney and Croydon, in particular are places where there's high populations of people from Black and Minority Ethnic Communities and that is of concern.

It also then makes me think about the thing about is there robust use of the Equalities Act, in relation to police training, because that is of great significance, because wherever there's decision-making that takes place along the pathway, then an awareness and an understanding of the differential manifestations and needs of people from different communities, is absolutely paramount.

I say that, particularly when you look at the secure settings, such as like with the new care model sites and so forth, in that we've -- I'm involved in the new care modes sites and we did a bit of research -- because we're looking to transform secure services and we did a bit of research which was looking at the experience of people from African and Caribbean communities in some of these medium secure and lower secure settings, compared to that of their white counterparts. What you find, in terms of the decision-making process, is that African and Caribbean communities have longer lengths of stay; their levels of over-representation are way way way above their proportion within London actually, which has the worst profile nationally, in terms of disproportionality.

So, that brings me back to what are the things that we could do London wide? I think it's about really engaging more closely with communities to actually be involved more robustly in some of these alternatives, or working alongside some of what the statutory services actually provide.

So, what I'm working with, in terms of to address that issue at a local level in Lambeth, is a partnership across the police, the local community leaders, the local authority, the NHS and working together with the communities to tackle the very issues that we're talking about today but, that the communities are robustly involved in helping to deliver to identify what those solutions might be and to help to implement those kind of solutions.

So I think that we have to have much more intimate and robust conversations with our local communities, particularly those that are over-represented in what the data is saying here and be really closely responding to what the data is saying.

Cdr Richard Smith (Metropolitan Police Service): If I can respond to just one point that Jacqueline has raised and then look at what we can do together. Yes we do, we invest an awful lot into diversity inclusion and equality training for all of our staff, but you raise a very good point around disproportionality, for example, around 136, which is another reason why we are really really keen for that health advice. So, from an accredited mental health professional, that the officers have got that advice available to them on the street, or even before, so that when they're making decisions around 136, they have that clinical advice to base it on, rather than having to do that without medical advice. So that's one of the things that we feel will help.

In terms of what we can do as a partnership, I think relationships, key relationships both at frontline and local management and PAN London are absolutely key, so the healthy London partnership has a huge amount to play for us there. But also, for senior leaders to commit to reality checking, so that when there is an agreement signed off, when we have -- the partnership achieves some guidance, for example, that senior leaders, both within health and police and the other partnerships, are actually reality checking at the frontline that that's being delivered; I think that's key.

Then, what could we do in terms of engagement with central government? I think the point has already been made, certainly for me, in terms of police data: we could be better at capturing the data around this demand so we fully understand the volume of people that we are dealing with who need this more specialist care and are drawing on our various services. We don't, I think, have a full enough picture in order to advise; I'll say advice rather than lobby, government on exactly what the picture looks like.

Andy Bell (Centre for Mental Health) (Co-Chair): It's all right, we can lobby government in the voluntary sector, so we're all right and I guess there is something about even the underestimates are still quite large numbers. Anthony, you want to come in and then I'm going to move us on because otherwise we're going to be here forever.

Antony Miller (Penrose & Equinox): I think all of the discussions that we've had are around some of the crisis point interventions that we're looking at and how some of those can be brought on board to resolve some of the challenges. But I think it's the early intervention, which was touched on earlier and the prevention; if we can stop people getting to that crisis point and understanding the rationales for why they've been brought to those points, we can save a whole lot of discussion and a whole lot of money by breaking those barriers down.

I think some of the work we can with CCGs at the local levels trying to implement information where people can start to look at this mental health not being a stigma to certain communities; we need to break that type of understanding within local communities and then that will feed up through regional and national agendas. But until we do that, we're constantly going to be revisiting the same crisis point, reactionary types of services that we're currently delivering and to be honest, that we're struggling to deliver because the demand is increasing.

I wanted to touch on some of the data that was --

Andy Bell (Centre for Mental Health) (Co-Chair): I need to move us on, sorry.

Antony Miller (Penrose & Equinox): Okay.

Andy Bell (Centre for Mental Health) (Co-Chair): I think I'm handing back to you.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Okay, thank you very much. Just if there were any other issues that we haven't -- one of the things that Paul, Dr Dawson raised was around Mental Health Treatment Orders and what looks like very very low take up, or low numbers nationally and I'm not sure if we've got the figures, but have we got the figures for London? No.

Dr Paul Dawson (MOPAC): No, we've got the national figures

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Whether there was any -- whether, Julien, you had any comments around that, or from the Ministry of Justice around why there is that low take up? Is that to do with not enough capacity to provide what would be in that order, or is it an issue around the journey to the courts?

Kate Gilbert (NPS): Do you want me to respond from a London perspective? Obviously, the National Probation Service role is to write Pre-Sentence Reports in court and the court makes a decision about whether or not they wish to seek a psychiatric assessment. In recent years we don't require a Section 12 doctor any more for the court. Julien might be able to say this better than me, but the court needs to be satisfied that the treatment will meet the needs of the service user; that it will help their condition.

There needs to be clinical treatment available after, once the order's been made and also the service user needs to consent. So there are several layers to making an MTH requirement. Consent is not always required in all other aspects of criminal justice requirements in a Community Order or a Suspended Sentence Order, but it is on a Mental Health Treatment Requirement.

I think it's also fair to say that some of the service users we see, are already in treatment and they are linked into services and they are already attending those appointments and there isn't much merit in making a requirement for somebody to attend, if they're already engaging with a clinician and you don't want to overlay that, some compulsion that might damage that relationship.

Also, I think it's fair to say that mostly the areas where we're looking for MTHRs are where the offender has committed a reasonably serious offence and also the treatment has to be available, so we're talking about a service user who meets the clinical requirements that are usually severe and enduring. Anecdotally, we know that that threshold is, with budget cuts, rising. So there is -- there are some issues here.

I think also, the break in the link, we don't require a Section 12 doctor any more to do that assessment, so courts can get a treatment assessment from a range of different qualified practitioners and I think Liaison and Diversion have helped us massively over that -- in that area in London and I think it's just the Croydon area where there still isn't Liaison and Diversion. So that's helped us massively, speeding up the process of getting those reports because delays was a big issue.

There are also, if you break the link between a Section 12 doctor writing the report, then you break the link between where the treatment comes from. So, a Section 12 doctor would have been employed by the treatment provider. So, I think, to some extent, that journey's now a bit easier, but it doesn't actually mean they have the resources, in terms of treatment, to attach to that order. So I think there's a range of issues there that make it still a reasonably complex requirement to achieve on reports.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): I'll just bring Julien in and then sorry, did you want to …?

Julien Vantyghem (HMCTS): I'm just picking up on Kate's point, following the Bradley report. The focus has been on improved identification and intervention, because we don't want people coming through the Criminal Justice System, unless they really need to come through the Criminal Justice System. There have been some considerable improvements; there's still room for further improvements, but having the mental health practitioners at the court or being able to access those for listings arrangements changing, so we can adjourn cases often to set dates, has improved that.

The timeliness has improved as well. Frequently, courts experience difficulties in getting the necessary reports and cases were adjourned for considerable periods of time and in some instances, in the worst scenario, months on end and some of those people were in custody.

That also had implications because people ended up with custodial sentences at the end of the day, because they would have served longer term than they would have received by way of a custodial sentence on remand. So it ended up being dealt with by a disposal that perhaps wasn't properly best suited to deal with that person's need.

We're far more joined up in our approach and we're dealing with these cases a lot smoother through the courts, so I don't think just seeing the number of mental health treatment requirements just going up isn't necessarily an indicator of success because really we should leave the Criminal Justice System to deal with. There would be certain levels of offending that will need to go through the Criminal Justice System, but there are other that are not.

Picking up on Kate's point: the courts are very conscious of the need that when people are engaging voluntarily, imposing a court order and layering it on top of that, by way of mental health treatment requirement, may not be the right thing to do because the consequences, in relation to breaches in relation to those individuals.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Okay, did you want to …?

Tabitha Brufal (MoJ): Yes, so from a Ministry of Justice perspective, this is one of the issues that we're very very concerned about. So we are seeing a full year on year in the number of mental health treatment requirements, but also in drug rehabilitation requirements and alcohol treatment requirements. Very often offenders will have a mix of needs across all three.

What we have seen from our Ministry of Justice analysis is something that hasn't been published yet, but will be shortly, is that actually, mental health treatment requirements are associated with a reduction in reoffending.

So I know there is a debate and I used to be a clinical psychologist, so I understand the clinical concern about making treatment compulsory. But I think there does seem to be something about that sort of degree of compulsion that might perhaps help people to stop falling out of treatment. So I think perhaps you raised earlier the point that actually sometimes people are put back in touch with services, but then they drop out.

So nationally, in the autumn we hope to announce five pilot areas where we are going to really work with NHS England, with local clinical commissioning groups to actually try to increase the number of mental health treatment requirements. We'd be delighted if alongside those pilot areas, there was a focus on this within the MOPAC area.

Jeremy Hunt, who is Health Secretary and our new Justice Secretary are very interested in this area and in working together on it. We've seen in Milton Keynes there has been a focus on getting offenders into treatment and they've been extremely successful and we would like to see a focus like that in other areas of the country as well. Andy is very supportive of this approach and has worked with us.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you. I'll just bring Aveen Gardiner from the London CRC in in a minute. But obviously, if you're going to talk about pilots and working alongside, we would like to have a conversation with you, given the demand in London, whether one of those pilots is appropriate -- should be in London, given what we know about the issues in London and the impact of resources. Aveen, did you want to …?

Aveen Gardiner (Community Rehabilitation Company): Yes, just in terms of Mental Health Treatment current numbers, in the London CRC is 33,000 service users on our books and as of yesterday we had 133 Mental Health Treatment Requirements. So, although we can talk about the difficulties that we can have in recommendations and treatments, what the Milton Keynes pilot did show actually is we can up those numbers but, the resource has to be there on the other ends. What tends to happen is that the Mental Health Treatment Requirement again, is aimed at the higher end. Touching on Anthony's point, when we're looking at people with clinical depression, anxiety, post-traumatic disorders, they aren't at the entry level in a sense for a Mental Health Treatment Requirement, because there isn't the treatments in the communities for them.

The other factors that can sometimes be about Mental Health Treatment Requirements is the issue of dual diagnosis. Often, if you've got somebody that's got substance misuse; we've got heavy substance misuse within the Clinical Justice System, assessing them for treatment brings up difficulties in the Milton Keynes pilot; they're treated, regardless of whether somebody was a substance misuse -- user or not and so that upped the numbers of people being able to go through. But it was a commissioned service, so it does come with costs.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Right, do you want to …? Sorry, did you want come in as well?

Kate Gilbert (NPS): I think it's just useful to point out that both the NPS in London and the CRC actually commission our own services to meet this gap. So, we commission together in the NPS; we have together workers in our offices providing support to our service users.

So although we don't have many Mental Health Treatment Requirements, we have psychologists working alongside our staff, helping service users who don't meet the local treatment needs. So we are subsidising the Health System by doing that.

Aveen Gardiner (Community Rehabilitation Company): We're commissioning St Andrews who are providing on a RAR (Rehabilitation Activity Requirement) what St Andrews are providing in Milton Keynes, in terms of Mental Health Treatment Requirements, to look at those that go under that very high threshold and they run in ten offices. We've had a 127 of those complete in the last ten months.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): But I think this points to what we need to look at, in terms of -- I take the point that a simple just upping of the numbers may not be an indication of success however, you know it's -- the numbers are very low; we know they can work. So there must be a way or developing and understanding of what would be the appropriate -- an estimate of what the appropriate number should be, given what we know about mental health needs and demand.

I think it points actually to the need for much better join up from London CRC; with the NPS and the transparency and accountability around that that we've been talking to the Ministry of Justice about. What we want is in relation to some more devolution down to City Hall around pulling -- bringing this together, because actually if we do I think we might be able to start to really bring this together.

So, I think what I'd like – if we can – is to learn from coming out of this, is to have an understanding about what would be the right -- you can do those projections. If you can; what the right level of requirements – Mental Health Treatment Requirements – should be in London? Is the reason it's not coming through the courts is it -- or coming through, because of the issue of the capacity or issue of consent, so that we have a proper understanding so we can try to unpick that and make some progress on that. Because if they work we can use them where it's appropriate.

Does anyone else -- Bernadette, did you have anything on victims, in relation to the discussion that we've had in terms of support services and …?

Bernadette Keane (Victim Support): I can tell you what happens with -- in Victim Support: all our staff are trained in mental health, but it is quite low-level and we would work in partnership with the local mental health providers in the borough. So, it depends on where the service user lives. So it's obviously a very different picture across London.

But for us, I know this is really obvious, we obviously want to see the services there for the perpetrators, because that's the way we're going to support the victims.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Yes, okay.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): May I?

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Yes, of course.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): I would just like to add another thought. The inquest into Sarah Reed's sudden death was held at City of London Coroner's Court. It started on Tuesday, 4 July and concluded on Thursday, 20 July 2017.

The jury's verdict found that the Inner London Crown Court processes of obtaining psychiatric medical reports were not sufficiently timely. This is another aspect that we need to deal with. The jury found the delay particularly difficult to understand; if a timely Fitness to Plead assessment had been performed as requested by the court, then Sarah Reed would not have suffered a mental health crisis in HMP Holloway and would have received appropriate treatment within a mental health hospital. The jury concluded this delay significantly contributed to her subsequent death.

I think these are -- there's so many aspects that we need to consider and this a highly relevant aspect in the context of things and particularly pertinent that this came out today.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you and important that we understand the issues as to why that there wasn't appropriate timeliness and understand what that verdict says in relation to the discussions we've having today, so thank you.

I was going to move on, if that was all right, to the second part which is around looking at, well, we've called it, Mind the Gap, which is exploring more the interventions and the support for offenders whilst in the system, but the particular focus on young people and children.

We've had -- this part of the session follows on from the broad conversation around the opportunities of statutory partners and non-statutory partners around the table, as well as the data that we've had. I wanted to thank Rafik for coming; he's going to tell us his story and thank you.

Rafik Hamaizia (Guest): Thank you very much. Hi guys, I'm here to talk to you about my experiences of growing up.

I've got a long-standing history of mental health problems but, when I was young I also a bit of a little shit and I was kicked out of school quite a lot and sent to pupil referral units and I think that was the beginning of the end, if you like.

After going to America for a while, I was homeless for a little bit in New York and I picked up on some gang stuff that I brought back with me over here. Ultimately, I ended up on some quite serious charges over here when I came back. I ended up in a young offenders. I had an intermediary throughout the court; I was quite unwell. It was the judge's last case.

My QC said that the psychiatric report was missed somehow, throughout that process and then, when I ended up in Feltham they basically said: "Well, it's just too late, you're in the young offenders; you've got to go through that procedure now, being in there."

The problem with that procedure is that when the process starts in a young offenders, for example, you have the assessment by the psychiatrist based at the establishment and then you get referred to a gatekeeper, or something like that; this is how it was back then anyway then and then to the nurse's needs assessment, so the nurse from the ward that you've been referred to.

Then thing is, during that process when you're a management issue and you're in a young offenders, what ends up happening is that you just end up getting transferred. So that's what happened to me quite a lot. We call it, "transferred" I call it, "banned" because they'll do, when you go to court next time they'll mark your file. When I say, "They" I mean the Prison Service, will mark your file as, "Not to return" so you can figure it out.

So, I got quite a lot of, "Not to returns" from Feltham and then to Reading and then to Little Hay and then it got to the point where they said, "We don't think we can really manage you in the young offenders estate, so we're going to re-categorise you" they call it starring up, "We've going to re-categorise you to the adult estate" and then I was, "Sent up north" as they call it and ended up in places like Durham and Lincoln.

A lot of the times these were either in health care facilities within the prison estate. I would argue that they're more like segregation units because the thing is the resources tend to get focussed onto the wings where you've got 200 people or you've got 10 people in the health care wing and resources are low, so where are you going to focus them to. So we spent a long periods of time; at one point I spent about a year in solitary confinement. Some of the establishments I got moved to didn't even have a health care facility.

So it was actually towards the end when I was in Lincoln that there was actually quite a decent governor there and he said, "I don't know why this has happened to you. I'm just going to keep you here" and then I was transferred to a medium secure and the experience was a little bit up and down, depending on where you are. I've had better experiences with the NHS than the independent sector.

Towards the end I had quite a good Multi-Disciplinary Team; a good relationship with my psychiatrist; a good continuity of care, in terms of having the same psychiatrist on the pre-discharge ward, all the way to the community.

I was quite a vocal complainer, shall we say, when I was in services and I became friends with the CQC compliance inspector for my local service and then I was offered the opportunity to become an expert with my experience, for the Care Quality Commission. So upon discharge I've done about 150 inspections for the Care Quality Commission now, which is quite in a short period of time, because it's only been about two to two and a half years. I've been doing various other things, in terms of a lived(?) experience consultancy and I'm about to study a masters.

The thing is when I speak to people sometimes, I was having a conversation the other day on the NICE Guideline Committee that I sit on; someone said, "You know, Raf, it's amazing that you went from that to that, you know, how did it happen?" I say: "You know, it's not that's amazing because it costed quite a lot of money now when you think about it. I'm about a £10 million investment from the tax payer when you actually look at this."

Really, in the end, all I really think I needed was the appropriate service and the right opportunity; having the right conversation. It just takes a couple of people to say: "Raf, you know what, we can give you an opportunity; we can give you a job. Raf, you know what, you haven't got GCSEs; you haven't got A'levels; you haven't even got a degree, but we think that you can work at Level 7 and we'll give you a scholarship to do a masters."

Sometimes it just takes an opportunity in the appropriate service, because someone touched upon dual diagnosis. It's also about co-morbidity, because sometimes if you have two diagnosis you'll end up on one service or the other. The issue with that is, for example, in my case I was on a learning disability ward; how does that make any sense? It's not fair on myself, but it's also not fair on the people there.

I guess, in terms of resources, not only in my case but generally, we tend to spend a lot of money on outcomes that we're not really paying for. I think my kind of experience, particularly within the young offender estate, I'll just say the kind of provisions that are in our -- we know that they're not fit for purpose already, full stop. So, let alone for people, young people who have mental health problems as well.

We know the majority of people in gangs have got some sort of mental health problem. The majority of people in young offenders' institutions; the majority of people in prisons, but are those things taken into consideration where we're saying, "These things aren't fit for purpose anyway?" So, even when we do say they are, that's even exacerbated by the fact that you have quite vulnerable people in those kind of institutions.

Some of the notes that were kindly put down by MOPAC were, I felt a little bit like a Pokémon card when I was in -- when I was being detained because I was being traded back and forth. I think the assessment process is very flawed and had there been the right service and the more early intervention, that would have been something that would have made a big difference.

To be honest with you, I think it always goes back to the people referral unit; I don't know what everyone's experience of that is, in terms of your field, but certainly mine is. It's where I had my first fight; it's where I smoked my first spliff. We used to do phone robberies at lunchtime. You're meeting other people from other areas; people who now, a lot of them are dead, in prison or gang members; people that tend to be from BNE backgrounds. People that come from the most part quite -- areas of a lot of deprivation. There needs to be a look at that.

The staff always used to say, "One student in a pupil referral unit is equivalent to a whole classroom" and I always used to say, "Well, you've got ten people in there, so it's like 250." I think if there's more of a focus on early intervention and how people are treated from a young age, we can probably save a lot of pain and suffering and about £10 million.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you very much. That's a really important testimony of your experience and good luck with your masters.

Rafik Hamaizia (Guest): Thank you very much.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Fantastic. I think you put it incredibly well, "Is the appropriate services the right people and the right conversations at the right time" sounds simple, but it's very difficult to deliver. So it's the right people to have those right services and the right conversations, so thank you.

We do have the testimony of another service user who was going to be here today, but I'm afraid she had to attend a funeral, but she specifically wanted her story to be noted by Jacqui. Would you be able to do that? Thank you.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): Service User C is a transfer experience from about 2005 and in secondary school she was always sort of perceived as being aggressive and naughty. She had older friends and was regularly getting into trouble.

Between the ages of 13 - 14, she started getting involved in violence and gangs. She had a social worker and was sent to Nigeria because of behavioural issues and she was there for one and a half years. She returned when she was 15 years old, but still with aggression and clearly a bit physically stronger. She left home and lost contact with her parents at that age.

She was put into a hostel at the age of 15 by the local authority, which was a hostel for people who were 18 years and above; inappropriate clearly. She was still involved in the gang lifestyle. Several of her friends were killed; clearly, that would be very traumatic for her.

She left home and lost contact with her parents at that age. She was put into a hostel at the age of 15 by the local authority, which was a hostel for people who were 18 years and above. Inappropriate, clearly. She was still involved in the gang lifestyle. Several of her friends were killed. Clearly that would be very traumatic for her.

Between the ages of 15 to 18, she was arrested several times for shoplifting and providing for friends. Her best friend passed away. She suffered post-traumatic stress disorder and attempted suicide. She was taken to hospital and seen by a psychiatrist, but only had a follow-up with a GP who prescribed antidepressants.

She went to an adult learning college and got back into education, however, and she had a very supportive teacher who gave her a chance. Lost another friend just before university, suffered another depressive episode, but went on to university and had a great teacher at university. Had access to mental-health services at that point, and found the workers were not actually relatable and found it hard to engage.

She did start talking to her parents again in her final year at university. Suffered from manic depression, became very weak, but worked very hard and graduated with a 2:1.

Present day, now works as a specialist support worker in a therapeutic house for people in contact with the criminal justice system, and she's also doing psychotherapy training and plans to do a master's in mental health.

I think there are key points that need to be highlighted here. Lack of recognition and support about a mental-health situation and needs in the very early stages of her pathway. So we can see a clear emphasis on the necessity for early intervention. The professionals that were involved didn't appear to really assess her, her issues were, her social worker, the police and services. She was also considered older to be than she was, and as such was never provided with appropriate support at the age of 15. Police and the local authority failed to undertake a statutory duty of care to a minor under the Children's Act 1989. Education gave her more focus and direction, and with the support of teachers who were sympathetic to her situation. She believes everybody should share a responsibility for mental wellbeing of young people, including communities, police and criminal justice agencies.

I think that sums up her experience in her words very well, and is a lesson for us all.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you very much and the themes are very much similar, of different individuals and probably different issues, but very similar in terms of early intervention, importance of individuals being there at the right time and the right conversations. And another master's coming out of it, which is fantastic. Please do wish her well.

I just wanted to open up and maybe Dr Bibi from MAC-UK, whether you could just give us some, from your perspective and your organisation's perspective, what you think about some of the services and what the key points for intervention should be particularly around young people.

Dr Fatima Bibi (MAC-UK): Sure. I'm so reassured to hear Rafik's story, and also the story we heard from Jacqui, because there are so many themes that resonate with the young people I work with. So I work in a community-base setting with young people who are deemed as dangerous to society. So, you know, involved in serious youth violence and involved in gangs. And actually the learnings from this project have been so profound in helping myself, as clinical psychologist, and the mental-health services I work with in thinking about the optimal interventions for these young people.

So what we find quite a lot is that actually the young people who are the most chaotic, the most vulnerable and who are in need of the interventions are the ones who are least likely to access them, even if it is made a compulsory part of whatever order they might be a part of. And the reasons for that are manifold.

First of all, Anthony pointed out quite rightly that actually lots of people who end up at the crisis point often have very difficult experiences with mental-health services, or services as a whole. Often very mistrustful services. And the way that mental-health services are currently set up, not only are they inaccessible for certain communities and certain groups, but also the interventions that we're using are not always the most helpful.

What I've learned from the work that I'm doing in Tottenham at the moment is that actually more community-based interventions, where we are enrolling lots of different organisations. So some of the work that we do involves not only community members, but we involve probation, CRC, housing, education, DWP, and actually the interventions that we're doing that seem to be the most effective ones are the ones where we are taking a holistic integrated partnership approach.

I think the reason this is important is because lots of these young people present with complex multiple mental-health and physical wellbeing needs and actually the interventions they need are beyond just mental health; they need holistic wellbeing approaches. It's no coincidence that most of the young people I work with have come from some of the most deprived parts of London. So we work specifically in Northumberland Park, and actually have experienced serious amounts of trauma, exposure to criminality, family breakdown, intergenerational health, social and race inequalities.

And actually the intervention that I'm offering as a psychologist, although it incorporates depression, trauma, substance use, it also targets social inclusion. And I think what I've learned

from the people I've worked with it's really important not to marginalise and institutionalise our young people. That actually whilst delivering the interventions we're delivering, we also need to focus on social inclusion. How do we offer meaningful opportunities for young people to rehabilitate and take part in mainstream society?

So actually on top of the work that we do in trying to help them to not reoffend, access mental-health opportunities, we also try to we take what we call a "strengths-based approach". Each young person, or any person, has many and multiple strengths, and actually if we're able to find ways to access those strengths, we are more likely to strengthen opportunities for people to rehabilitate and reduce the chances of mental-health breakdown and reoffending.

So what we're finding with lots of our young people is the interventions look very complex. We're based in the heart of the community and actually our work involves coordinating the care for some of these individuals across our police, probation, mental health, housing and all of these other services. But very importantly providing opportunities for young people to forge out different lives for themselves. So working very closely with DWP and other businesses and local services to give young people opportunities, in spite of having lots of complex needs and an offending history.

Actually what we're finding, more and more, is there seems … you know, the work that we're doing seems to be opening up lots of avenues for doing more prevention work. So Rafik quite importantly mentioned that's lots of these young people's trajectories start at that PRU (Pupil Referral Unit), and actually if we are able to get the right interventions to the families we must never be treating young people in isolation; we need the families, we need anybody that's involved in that network to be on board with that intervention, which then means we might be able to change the course of some of these young people.

Just lastly to say some of the work that we're doing is increasingly being involved with the criminal justice system and we're delivering interventions to people who are transitioning in and out of prison, because that's the time we find most young people become vulnerable, and also want to engage with services. Actually so we're specifically trying to embed ourselves, where we can, into those organisations to enable young people to have access to these opportunities.

Also making sure that when they are in a point of crisis, in the absence of services that will hold them, there is a service somewhere in the community that can hold them. So we are actually getting some of the most complex individuals, in the midst of psychotic breakdown, who are not meeting the threshold for a bed, coming and saying, "Actually, you know what? I need to be helped somewhere", and actually what we are able to do is focus on lots of different parts of their life to make sure that they are getting all the right interventions they need.

So anyway sorry, I probably said lots of different things.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): No, it's very helpful. Before I bring other people in, just one of the things I was struck by is that you said young people aren't accessing the services. What do people round the table know about why it is and what can be done to try to change that? You talked about community-based interventions. Yes, Caroline, I was wondering from the Children's Commissioner's point of view.

Caroline Hirst (L.B. Lewisham): Yes, so I'm here representing CAMHS Commissioners really in South London. What's been really helpful I think nationally is the Future in Mind agenda, which has really put a lot of emphasis on early intervention, prevention and resilience, but also around access as well. There's also a focus on supporting vulnerable families.

There's been a huge drive to improve access into community services, evidence-based community services. So traditionally CAMHS provision generally seems to be more clinically available. So a traditional clinic model. What local areas are trying to do is develop new and innovative services that are actually perhaps delivered in partnership with NHS agencies, but also through voluntary sector providers that are offered in the community, and offering alternatives.

So when we've consulted with young people, what they tell us, and it's like adults ourselves if we were to go for any kind of treatment, you might prefer an online service, you might prefer telephone, you prefer the face-to-face or you might prefer something that's anonymous or you know, there's different approaches and young people have told us that as well. So what we've tried to do, or what we're all trying to do locally, is commission new services that are actually available in different ways. So perhaps similar to something like MAC-UK, we're offering outreach into the community, giving young people different options.

But I think what we have to do is think about what our clinicians, what people with really good training can do, but actually reaching it out into the community. So linking with social-care partners. So when young people present in schools or through social care, they're not hitting thresholds for specialist services. Having really clearly defined pathways in place for early intervention so that you've got a range of professionals around the table really thinking about what is available locally to support those individuals. But I don't think those individuals, or those services, can do it alone. I think it's having clinical experts that can help identify where there is a clinical need and supporting how they might respond to that.

So I don't know if that helps just to give some insight into what is actually happening locally.

Andy Bell (Centre for Mental Health) (Co-Chair): I think that is really helpful. The research we've done, and we've looked at very consistently, shows that children and young people, in particularly those who are most excluded and most marginalised, first of all, it's a battle to get anywhere near services and this issue of threshold is coming up time and again in this conversation. When you do get near to it, they're offputtingly clinical. They're constantly poking and prodding you for a diagnosis. Even the formality, the clinical nature of it, the nature of the kind of buildings it's provided in, actually scare away people who have actually finally got contact with it, and I think that the approach that you're describing is incredibly important.

I guess the question is how will we know when we're seeing progress in that, and what will be the markers of success in terms of holding the system to account for implementing Future in Mind in London?

Caroline Hirst (L.B. Lewisham): Can I respond to that?

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Just quickly and then I've got Anthony and Bernadette and then Jacqui again.

Caroline Hirst (L.B. Lewisham): Me first. Yes, there's an awful lot going on in terms of assurance, so from NHS England's perspective, the Five Year Forward View for mental health. Previously mental-health services haven't really for children had any targets set. Now there are really stringent targets that are laid out in terms of access into evidence-based services, in terms of workforce development, also around waiting times. So CCGs are being very much held to account, which I think is absolute necessity, because you have to measure progress. So there's investment going in, but it's actually demonstrating and having really quite good contractual arrangements with your providers, and good relationships with them to allow you to see the progress. But gathering that baseline information at the start of any new intervention, and then tracking that through on a monthly or quarterly basis, really tracking whether that impact has been made.

So there's been investment last year around waiting times, because actually what we want to try and do is when a child does require mental-health provision, that they access that quickly to prevent escalation. So actually by driving those CAMHS waiting times down, they're actually rather than waiting six months for a service, they're seen within a few weeks. But actually having other alternatives in place for when perhaps a service isn't quite available, but having something else available that can perhaps see them through while they're perhaps waiting for support. So I think there's a lot that's actually happening in terms of KPIs and measuring that trajectory.

Antony Miller (Penrose & Equinox): I just wanted to touch on a point that Jacqui revealed through Case Study 3, and it's with the pharmacological treatment models that are used to support people with mental health, and very often that's in exclusion to everything else.

One of the things that my service is, it works with criminal justice system, so people come through the pathway of either prison or secure units, and then through residential support in services that we deliver to get people back into the community with resilience, so they live safely and securely. But one of the challenges that we face is the medication very often leaves individuals unable to function in some instances, and some of the work that we do with some of our Trusts is to work closely with them to look at how we can reduce … (Interruption)

So the work that we're doing with some of the psychiatric teams in the Trusts that we work with is that cooperation between the community based element and the clinical element. We've seen some success in how we can work together to reduce the level of medication being used with individuals with mental health. Introduce talking therapies which are going to address some of the underlying issues that lead people often to mental-health breakdowns. This leads to individuals living more successfully in the community and break away from the revolving-door scenario of just re-engaging with the mental-health services through criminal activity or through Section 136.

I think if we can start looking at some of those measures, we're able to reduce the impact that is being felt by the NHS, by prison services and by police, which is where the pinch points are really being felt.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Bernadette?

Bernadette Keane (Victim Support): I'd briefly like to tell you my story. So my son has got mental-health problems. He's got Asperger's syndrome and he had challenging behaviour, and he did this really I got referred to do this really innovative course called Non-violent Resistance in my local CAMHS, which was Lewisham. We did have to wait for a year. But just thinking about what you said about innovative I don't know if any of you have heard of it?

It's based on the teaching of Gandhi, and it was just so successful. We went from the most awful situation where I thought I was going to lose my son to my son saying, "Yes, mummy". I used to think, "'Yes, mummy?' That's me".

So in my experience it was definitely innovation. My local CAMHS. You were taught NVR, and I now go and talk to other parents about it. You can't get it in every borough in London. So my son and it was a peer-support model. So we haven't mentioned peer support, so I'd really like to say I think that's a really effective model for mental health and for all the things we've talked about today. So it's a group of parents, and I know you've mentioned the family. My son wouldn't have got better without me being given the skills to deal with his behaviour. So there was a group of us with therapists and some parents who had gone through this programme.

So we were taught the skills, and it was all about de-escalation and giving lots of love and rebuilding your relationship before you worked on the behaviours. So I don't know if that was my main point. But, yes, innovation, involving the family, and peer support. I think those are really key things and my life is transformed. My son is 16 and he's doing fantastic, and he doesn't have any interventions at all with anybody.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you very much for sharing.

Bernadette Keane (Victim Support): And we live in Lewisham, yes, so it was great to see Lewisham doing something really good.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Jacqui did you want to now bring Rafik in, and I must bring Paul back in to look at some of the data.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): I just want to emphasise that, okay, we talked a lot about the sort of more high end of the system, the statutory elements and so forth, and I just want to bring it back to a more kind of like local grassroots level across the city and why.

So in my borough where I'm a local councillor, I did a little survey in my ward about the community's awareness of mental-health services, and actually nil. So the expectation very, very, very, very poor of mental-health services. So people don't know where to go when there's a mental-health crisis or mental-health vulnerability taking place within their family which leads to going to services at the point at crisis, being detained under a 136 or some such thing.

And actually there's an additional feature which is certain communities, the communities which that are largely over represented within London in detained mental-health settings, there's a fear because of the deaths that actually happen in mental-health services. Most recently

Olaseni Lewis, a 23-year-old died in a mental-health hospital in South London and the interface between the relationship with the police and mental-health hospital was actually critical. Because the mental-health services we've talked about specialists and clinical knowledge and clinical skills and whatever and our expectation or our assumptions that in those settings people are highly competent actually the mental-health staff stood by, called the police to come in and to help restrain the man. Eleven police held down this 23-year-old. The first time the parents had actually gone to the hospital looking for help, and their son died on that occasion. I just want to mention that.

I think there's a crossover then as a result of that, tracking back, because who wants it to get to that point? Tracking back, there's a crossover with the Thrive London agenda, which is one of the aims is about improving everybody's understanding of mental health. And I think that it's absolutely vital that we equip the London population, and all services, with the skills to understand mental health and be more emotionally literate, so that people who having the conversations about their emotional health and wellbeing, right across from families, schools, that the whole network in communities, and also all the professionals that are across the piece.

I think that it's also vital that the services or the outcomes that we want to work towards, and therefore the activities that we might do in each of the boroughs of the city are actually co-designed and co-delivered and co-created with the communities that are actually being served. So there's not necessarily one model that fits everybody throughout London, but that each area has particular challenges.

So for example, in my area in Lambeth, there's a massive level of over representation of Black Caribbean children and Black African children and mixed White and Black Caribbean children that are being permanently excluded from schools. I mean, so one of the things that I'm doing is actually having these conversations with our communities, in an intergenerational way.

So for example, I mentioned already the partnership model in Lambeth, which is Black Thrive. We are having discussions with our communities around prevention, access and experience and we've got a particular working groups which is children and young people, and they're looking at what's the particular problems that they're experiencing. We're equipping them with the data, the intelligence, the local intelligence, and they're co-creating and helping us to help solutions. I think this is the way forward.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you. That's brilliant. Rafik did you want to …?

Rafik Hamaizia (Guest): Yeah, just to really support everyone's point. I think that the three main areas that we've been talking about in the last few points about awareness, community, engagement and peer support after Jacqui just spoke, I may as well not even talk, because you guys covered all my points.

But I mean, on the point of community engagement for instance, I think there's a we always talk about partnership working and that's very good. Yeah? Because we've got different agencies working together. The thing is, sometimes there's a danger to that. So for example when we're talking about probation and police and for example psychologists working together or mental-health teams, sometimes you're bringing the mental-health element into that kind of

us and them, authoritarian relationship as in I have to do this and these are part of the people who might recall me or breach me of my licence or something like that, or whatever order.

The other element about the community engagement is: you guys come from Tottenham, and you say you work in Tottenham, you would know that people on Broadwater Farm are more likely to listen to someone like Clasford, the local community leader over there, rather than the police.

Dr Fatima Bibi (MAC-UK): Can I just quickly say, that actually our service is set up with the community. So Clasford has actually been involved in setting our project up, hence we have lots of people coming.

Rafik Hamaizia (Guest): I had a feeling. So just to clarify that. So that Experts by Experience programme for example, the Care Quality Commission, they've got I think £21 million from central government in relation to affording that initiative. And the point of that is that actually people are more likely to listen to people and engage with people who have actually experienced similar things to themselves. Particularly with young people. I mean when I speak to young people, I mean, it's almost an instant moment when I tell them my experience because you can almost immediately see their shoulders relax and that kind of level of engagement and that whole relationship is improved, and that's where you can have the conversation.

Also other elements that obviously we probably won't have time to go into today, but cultural elements when we're talking about awareness. I mean when I was younger, I remember a lot of people used to kind of say things now, when I reflect on it, and I say, "Maybe that guy wasn't possessed". I think now maybe he was showing symptoms of paranoid schizophrenia. And when we're young and people used to say they saw Jesus or they're hearing Jesus. And I think that sometimes our culture and where we come from, particularly in BME communities, we still have the mentality of back home.

So whether that's us I was born here, but you know, my parents are from back home and in a lot of communities sometimes where we come from back home, mental health is perceived differently, particularly in specific communities. And that needs to be taken into account and some work around there on the awareness perspective.

But I think peer support is really important and although there is not a lot of research in that area at the moment, there is some research, particularly in inpatient settings for example that it actually reduces length of stay, it has better outcomes and it's more cost-effective.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): I'll just bring Paul in and then I'll hand over to you. Paul, did you want to just take us through some of the data which I think we'll look at cross proportionality and effective contact and engagement.

Dr Paul Dawson (MOPAC): Yes, so I have just three slides that I'll go through. Issues around being a part of effective engagement and contact, and also touches upon some inequalities.

So Londoners want a fair a legitimate police service, and core aspect of that is fair treatment. So on this slide, there are two figures here. The top figure looks at victim satisfaction. So MOPAC have a large-scale survey that interviews around 16,000 victims a year, and one of the things we look at is their satisfaction with the police, as a victim.

The main point on the top graph is you can individuals with a self-identified mental-health issue, 10 percentage points less satisfied than individuals without a mental-health issue. And we also see that individuals that self-identify with mental health are also more likely to report to be vulnerable but also say that this is less likely to be met by the police.

Then I will draw your attention to bottom part of this chart. This looks at victimisation, comparing victims with mental health to all victims of crime. I would particularly highlight on this, as you can see from the chart, that individuals with mental health, so mental-health victims are four times more likely for example to be victims of sexual offences than victims without a mental-health issue.

So, you know, for me this is really showing what the quality of the encounter being important. The risks around managing vulnerability. It also raises issues for me once again about training. It's not just delivering training; it's ensuring the quality of that training and then following up, looking at the evaluation of the training, the sustainability of the training.

So the next slide just continues the theme about a fair encounter. So this is presenting some key findings from a small piece of research that MOPAC did. It contrasted service users' and carers' perceptions versus police perceptions around managing mental-health cases. So with these focus groups with service users and carers and they spoke quite strongly around how the police didn't understand them, didn't understand their illness. Communicated quite poorly with them. So a lot of the findings echo what we find in some of the case studies.

But where I thought it was interesting is then we did a number of surveys with police officers and we asked them about how they experienced such encounters. And the officers kind of focus on issues around potential risks and the unknowns in those encounters. So for example over a third of officers spoke about being fearful of their safety in such encounters, and half kind of not wanting to make it worse, and 30 per cent not wanting to make the wrong decision.

So once again this for me shows a potential mismatch between the service user-carer expectation and the police response. And once again it raises questions around communication, fair treatment, respect and training.

Then there's my last slide. So this just presents one quarter of data that we received around admissions into psychiatric units. I'm being aware of time; I'll just make the core finding, in that, as you can see, younger Black individuals over two times more likely than one would have predicted based on population to be admitted into those services. This was just based on one quarter of data. So, you know, if we can get better data sharing, we'll be able to enable much richer insights into these kind of issues.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Andy, did you want to …?

Andy Bell (Centre for Mental Health) (Co-Chair): Thank you. That's really helpful. There's a whole range of issues there, some of which have come up previously in the discussion, some of which are new. If we can take them one-by-one, because I think there's something about the differential experiences of people with mental-health difficulties, particularly as victims in their relationship with the police, so I'd like to pick that up with police colleagues, and then to look specifically at the equality and disproportionality issue, particularly for young Black people in London.

So perhaps I don't know, Commander Smith, if you want to start? We talked about training and the impact that may have on some of these negative experiences, but how can we be reassured that some of this is going to be dealt with in terms of people with mental-health difficulties?

Cdr Richard Smith (Metropolitan Police Service): I think first of all around the data that we've seen on satisfaction. This is a key measure for us, but what we know certainly is people with mental-health conditions are more likely to be victims of certain crime types, and you've highlighted that around sexual offending and around violence.

What we also know is in the general population, the satisfaction reported by victims of those type of crimes are lower than for other crimes. So for example, the satisfaction for burglary victims is a lot higher than those around violence. Some of that is about our ability to get the outcome that people want, particularly around sexual offending and violence, and something about the offence itself. So I would suggest that the disproportionality is not necessarily solely because that person has got a mental-health condition, although that's clearly a factor. It is also linked to the types of crime that they are victims of. So it's a very complex picture. And I'm not saying that to decry the fact that we are trying to train our staff to make sure the interactions they have with people with mental-health conditions are better.

The other point I think is some of the comments that we saw on the interactions themselves take us back again to that point about who is best placed to deal with somebody with a mental-health condition, particularly at point of crisis? And I accept that those comments were not all about crisis interventions, but if you are in a mental-health crisis I'm no expert but somebody who arrives who is wearing a vest and has safety equipment, or effectively weapons, with them, and radios, so there are a number of voices being heard, is not necessarily the best person to be helping somebody who is having a mental-health crisis.

And factor into that the amount of violence that our officers face in their daily job anyway, so they arrive to every call uncertain of what they're going to be dealing with. The officers that went for example to Grenfell Tower or London Bridge or Westminster Bridge. When they set off to a call, they don't know what they're going to encounter. So they already arrive with a certain sense of concern for their safety and the safety of others. So again that's being taken into the encounter. They know this. The training that we give them recognises that. But there is a reality there.

When I was a borough commander very recently, ten of my officers that came to work every day, ten officers a month, were injured in assaults. Every month. And we never managed to get it below that. What other group of employees come to work every day with a reasonable chance that they will be assaulted in what they're doing?

So that is being taken into the encounter, and think it's something we really need to recognise in the training we give them that they are already turning up to any call concerned for their safety and the safety around them, and running a risk of being assaulted. Then add to that fact they're dealing with somebody with a mental-health condition that with the best will in the world and the best training in the world, they will not fully understand in the way a health professional will.

So it returns us constantly to this point of having the advice and assistance from our colleagues in health available to officers who are trying to deal, quite often, with people in crisis who desperately need to get to the right kind of help, which police officers who are called to that, because we are an emergency service available 24/7, where others are not.

So I don't decry the data. We would like to do better for everybody in London, and including people with mental-health conditions, but there are certainly some factors within that that lead us to this position; it is not as simple as just delivering better training and then the problem will go away. We really do need assistance from our partners in making sure that we quickly get people the help they need.

Andy Bell (Centre for Mental Health) (Co-Chair): Can I pass that on to because I think there's an important point there that we've time and again this morning about services being reactive, rather than proactive, and I think that it's an important theme that's come up time and time again, and we really need to think that through.

But we know particularly that people who have been the victims of violence and assault, do have that is a very significant risk factor for poor mental health. It's also a risk factor for the police officers working with people, secondary trauma as it were. What health support is available and offered proactively to victims of violent crime within London that and is that adequate to meet needs? I don't know if colleagues from the NHS are able to respond to that?

Patricia Cadden (NHS England): Certainly from a sexual offences position, there are services that are commissioned through MOPAC with Rape Crisis centres, as well a jointly commissioned service, both with NHS England and MOPAC for the havens for the sexual-assault referral centres that are most of the referrals through there come from the police, and that's certainly somewhere safe that someone can come and be forensically examined as well as be offered therapeutic support in order to manage their recovery.

With regards to other violent crimes, I'm not clear as to the Health Service response as a wider picture, but certainly from our point of view, that's what happens around sexual offences.

Bernadette Keane (Victim Support): At Victim Support, we provide support for all victims of crime including those who have experienced homicide. So we will – we can also commission more specialist services, such as counselling, maybe because the wait would be too long through the NHS. So we do have a budget to commission private services. So there is … obviously the budget's not huge, but I wouldn't like you to think there's not support for people who are victims of crime, and we are commissioned, funded by MOPAC, for that service.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Certainly, recently as part of the knife crime strategy increased the amount of money so we can specifically commission services for young victims of violent crime, because there just has not been enough services for young victims, especially around knife crime and dealing with the trauma that's associated with that. We've increased that from about £300,000 to £1 million as part of the knife crime strategy.

Andy Bell (Centre for Mental Health) (Co-Chair): If you want to come in and then I'm going to move on to the next question, because that's an important question.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): I think the support for the police is actually really very critical, because I don't think the police should have been put in the situation with an African Caribbean youngster in that hospital, where you ended up 11 men restraining him, till he's dead, 11 policemen.

So we look at what's more support might the police have? Those outside of the hospital setting, actually in the community, when people are showing mental-health issues. I think, yes, health-based sort of conversations and support in whatever ways is sort of like possible. But also I think that members of the community need to be more involved in that, because of the assumptions and the stereotypes that start informing the decision-making process. If those professionals on either side, health or police, is not as astute about culture. And this is one of the key things that keeps happening that we don't actually deal with. And you see some of the disproportionality actually emerges from that.

Another feature that I want to mention, and why it's so important to do some of that community-based work, is for example in my borough, stop and search education for the community. When the community say, "Oh, this is taking place, we're in partnership with the police, the community will attend". When the police do it on their own without being in partnership with the police, the police the community doesn't attend. I mention stop and search because actually when you think about somebody's how are a lot of young people actually developing psychosis and a lot of men are developing psychosis within African Caribbean communities. It's increasing. But with women it's anxiety and depression amongst the black community. The psychiatric morbidity most recent survey.

When I do focus groups up and down the country, what they talk about is that they get into a state of being paranoid actually from all the stop and searches that they receive. Yes? So if you are going from your childhood into your early teenage years constantly having to monitor your back because of these stop and searches, then we understand how that comes about. So I think there's also a necessity to look at how we conduct those stop and searches in a way that doesn't add to people's distress.

Andy Bell (Centre for Mental Health) (Co-Chair): That's really helpful. Thank you. And it does take us on to this important question of disproportionate negative experiences in both mental health and criminal justice systems, particularly of young Black men. It does affect black women as well, but focusing particularly on young Black men. Because we know about the very dramatic difference in outcomes and experiences. It would be useful very briefly if there are any areas of solution that haven't yet been talked about that anyone wants to raise. We've talked about co-production, we've talked about working with communities much more; are there any

other elements that anyone wants to bring into the discussion? We've heard about the importance of educating people around stop and search. Is there anything else in the way of solutions we need to put on the table, particularly for young Black men? Yes.

Dr Fatima Bibi (MAC-UK): 98 per cent of the young people I work with are young Black men. Actually what they share is that the experiences that lead to a relationship, a breakdown in the relationship, help seeking and professionals and authorities, actually starts at school. Actually one of the possible interventions is to provide better health or mental-health interventions in schools for young people who are experiencing what are perceived to be behavioural problems, or other behaviours that are difficult to manage in the classroom. Actually seeing whether there might be some value in being able to put the support around a young person a lot earlier on, so there isn't a cumulative effect over the course of a period of time.

And actually the data shows that it's the trajectory for young Black men seems to go very wrong actually at around 11, 12 years old. There is something to be said for being able to put in some sort of help earlier, much earlier on before they reach that point. So that would span both primary and secondary.

Andy Bell (Centre for Mental Health) (Co-Chair): That's really helpful. Thank you. The evidence is that age 11, Black boys have as good mental health as White boys of the same age, so there is something happening in teenage years.

My simple question from that is therefore who is responsible within London for ensuring we address this disproportionality for young Black men? It feels like it's something that is not one single agency's issue to solve alone. So who is bringing together the various agencies that need to be part of this, including education? And what will be the steps taken to help to take this very, very seriously?

I don't know if anyone is able to either hazard a guess to that or volunteer?

Dr David Ndegwa (Consultant Forensic Psychiatrist): Just thinking education it's well organised and it's an institution or something and I think they are in a very good position to carry out some of the early interventions. I think one should be thinking of a sort of whole-school based, whole population intervention. Maybe psychologically informed school environments. You would be thinking about things that increase resilience, things that reduce risk-taking behaviours for example, substance misuse, which is a big problem in subsequent onset of psychotic illnesses.

You'd be thinking of also sort of involving the community and families in a different way, but I think schools should have a primary so I'm thinking of social-emotional competence training programmes actually. There's a lot of similarity between the psychological treatments that are offered to people in prison once they have committed serious offence, so called offending behaviour interventions. The psychological treatment offered in psychiatric hospitals once your psychosis is treated. The sort of psychological interventions that are offered to "normal" people. Thinking skills, things that enhance your ability to benefit from a range of things. So if that was kind of packaged, maybe became part of a curriculum for example and was offered to everybody, not just people who are at risk, but was offered as a kind of inoculation sort of

process, you offer it to everybody. Of course there would be services for those who are at risk. I think that would be a very good start.

Andy Bell (Centre for Mental Health) (Co-Chair): So should the Mayor be writing to the Secretary of State for Education?

Dr David Ndegwa (Consultant Forensic Psychiatrist): Yes. It happens in some schools in the independent sector, in America, where we tend to pick up most of this psychological intervention in the states of Colorado and other places. They have whole-school systems for offering this. I think it's a very important thing to consider.

Jacqueline Dyer (Mental Health Taskforce/THRIVE)?: May I just add to that, sorry?

Andy Bell (Centre for Mental Health) (Co-Chair): And then Anthony wants to say something and then we need to finish.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): Just quickly, there's an opportunity then to influence the schools' and children's mental health and schools' Green Paper that would be really useful in this regard. Because I actually think that it's absolutely vital that mental-health awareness and all the things that you've mentioned, David, should be integrated into that, as well as our taking it at a London-wide level. Robust school cultures.

Dr David Ndegwa (Consultant Forensic Psychiatrist): The level at which you are offering it in school, you should not be describing it as "mental health"; it's just a way of making you a better student.

Andy Bell (Centre for Mental Health) (Co-Chair): The way they're implemented is for experts to think about. I think what we're saying is it should be there.

Dr David Ndegwa (Consultant Forensic Psychiatrist): Yes.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): Yes.

Andy Bell (Centre for Mental Health) (Co-Chair): It's worth remembering all the case studies started with school exclusion.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): Yes, exactly.

Andy Bell (Centre for Mental Health) (Co-Chair): Very, very briefly, Anthony.

Antony Miller (Penrose & Equinox): So my organisation delivered a conference specifically on this over representation of BMEs within forensic mental health. One of the solutions was the early intervention at schools, and Dr Ndegwa is absolutely right; you don't want to package it up as "mental health", because you drive people's wish to get involved away.

But it needs to be we are all part of this, and I think sometimes and again, as Dr Ndegwa said, it's not just delivering that message to one group within the school. It's the whole school population. And then that education needs to be moved right through, through schools,

through colleges, through universities, because that's then how you change the attitudes within our society towards mental health and what that means for all of us sitting in this room, and indeed the population of London.

Through that change in our understanding and how we conceptualise mental health, we then have a more open discussion about the causalities of mental health. Then solutions come out of those discussions. But without that general acceptance that this is experiences that affect all of us in some way or another, you will continually have marginalised groups who are struggling to have their voices heard. So it needs a wholesale inclusion model.

Andy Bell (Centre for Mental Health) (Co-Chair): That's very helpful. So there is something about making a clear case to government around the education and mental-health reforms, but there is also something about how in London we're going to bring these various partners together to address the disproportionality for young Black men and young Black women as well. I'd be reassured if I was able to hear something about how that's going to be taken forward, but I need to hand back to the Deputy Mayor.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Thank you very much. In relation to some of the disproportionality issues, we've certainly picked that up within the Police and Crime Plan around looking at that disproportionality and how we bring partners together around that. So it's certainly something we will be taking forward.

Thank you very much. It's been a really wide-ranging discussion with a number of points that I think well, we will look to take forward. From earlier on around the particular pressures around the change in the timings from 72 hours to 24 hours turnaround, and the need for mental-health assessment and that being a particular pressure point that really needs to be responded and what the timelines are.

That mismatch between provision and demand and not just beds but sort of capacity for the mental-health services and CAMHS to respond and how we look to work with through the London health partnerships as well as the NHS, work to really understand that and to provide some progress around that.

This issue around schools and education and working with families, and what role the police have in that, and, you know, there's convening but the police have a particular role around their enforcement powers and what they've got to do. So it really is that partnership approach which can make a difference to this. In particular around I'm really interested in what you are saying about the schools. MOPAC has commissioned a whole-school pilot in Croydon to look at violence reduction. It's in early stages and there may well be some findings form that which would be helpful to look at what should be happening in schools and what we might be able to try to encourage through all schools.

Then there's the issue of timeliness and peer support and interventions and, you know, the right interventions happening at the right time. I think that's an issue for everybody around the table, whether it be probation, prisons, the police, and the voluntary sector and how we can knit that together.

So those are the sort of issues that I will definitely be taking forward very quickly.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): Just also the opportunity to align with the other mayoral strategies in terms of THRIVE London, the strategy around inequalities, et cetera, et cetera.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): And those discussions are taking place. I assure you they are taking place.

Jacqueline Dyer (Mental Health Taskforce/THRIVE): Oh, I know but I'm just emphasising how important that is in this context.

Sophie Linden (Deputy Mayor for Policing and Crime) (Co-Chair): Yes, and we'll take that as an action forward as well.

Thank you very much and thank you for your time.