Justice Committee

Demand-led policing: service of first and last resort

Written submission from the British Medical Association Scotland

The British Medical Association is a politically neutral registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of over 168,000. In Scotland, the BMA represents over 16,000 members.

We welcome the opportunity to provide written evidence to the Justice Committee on the theme of 'demand-led policing as a service of first and last resort'.

We were interested to note some of the remarks made by Cabinet Secretary for Justice Michael Matheson in the record of the official report of a recent evidence session of the Justice Sub-Committee.

It would perhaps be useful to address what he said as the issues raised cover some of the key areas in which doctors have frequent experience.

Firstly, he stated that there is no other out of hours service for individuals presenting as vulnerable or in distress so people's default is to contact the police. He then went on to say that the police might then take someone in that situation to an accident and emergency department, where they are often kept waiting for several hours, with the individual then being discharged with no other immediate service input.

Lastly he talked about his belief that the challenge for the future is for Police Scotland to collaborate with other parts of the public sector including with the health service, local authorities and third sector organisations which would allow for individuals who are vulnerable to have their needs met much more effectively.

We have taken the views of a number of our members who have experience in this area; doctors working in primary and secondary care and from a range of specialities including GPs, emergency department doctors and psychiatrists, all of whom have extensive experience of working with local police services. They report that for the most part these relationships are good and that the help and support of the police is indispensable.

But there are challenges and BMA Scotland would identify the main issues as follows:

Scope of the problem within the community

Police will regularly have to deal with a broad spectrum of people who may be experiencing distress and be vulnerable for a variety of reasons including an underlying mental health issue.

The following scenarios cover some, but not all of the situations in which police might be called: a person suffering from dementia who is missing, having wandered off

from a nursing home or their own home; someone suffering from acute psychotic symptoms and behavioural disturbance which might be caused by physical or mental health difficulties; individuals with personality disorders, who can often cause a great deal of distress for those involved with them. At the other end of the spectrum lies the frequent problem of people intoxicated with drugs and/or alcohol.

During the working day, much of the above can, and should, be managed by community mental health teams for patients already known to them, and also for new patients. The police continue to have a key role where there is risk to the public or health care workers or where the presentation is unlikely to be health related.

Out of hours, however, the risks to health care workers may be higher and the resources are lower. There is usually only one centralised emergency community mental health service for each health board with relatively small numbers of people on-call overnight. Patients already known to daytime working hours health services will not typically be well known by these services. These services are rarely first responders other than to well-known patients, with them instead responding to referrals not just from the police, but from out of hours health services including emergency departments and out of hours GP services. Access to emergency social services, or the ability to find out what care and support services a wandering, demented patient or someone with mental health issues has in place, is extremely limited after hours or at weekends.

It is, indeed, therefore very common for the police to be first responders for many such patients, and it is very difficult to imagine how this might change in reality. The challenge is how other agencies can assist the police in dealing effectively with such presentations in the absence of any other effective crisis response.

At the moment, the majority of such people are taken to emergency departments. The police have a statutory right under the Mental Health (Care and Treatment) (Scotland) Act 2003 – the MHA - to take a person from a public place who appears to be mentally disordered and who appears to be in immediate need of care or treatment to a place of safety to facilitate an assessment by a medical practitioner. It is almost invariably the case that these places of safety are emergency departments. It should be noted that this does not need to be the case, however, and a place of safety can be a person's own home or a local community mental health service. When the police take such patients to emergency departments, they are rarely seen as having a medical priority as they usually do not have any serious life-threatening conditions or need for immediate physical health care. They are therefore triaged according to presentation (including level of distress, what doctors are told has happened to them prior to arrival at the emergency department, how they are behaving), and this means they will often wait hours for assessment. What doctors cannot do, because other patients also need to be seen, is guarantee to give patients brought to the emergency department by the police priority over others. This has certainly been a point of discussion between hospital departments and the police at local level because of the limited number of police on duty, particularly out-of-hours, which means spending time in the emergency department leaves their police colleagues more thinly spread elsewhere.

It would be worth the police and health services exploring, locally, how services can be optimised for patients who reach emergency departments, and how the use of emergency departments might be bypassed altogether in situations when the patient does not have any physical injury or significant concern about their physical health. The nature of local services varies across the country, and so it would not be possible, at present, to come up with a national approach to this although there could be common approaches taken in different areas.

It is also worth highlighting that the Scottish Ambulance Service is also responsible for responding to patients with emergencies in the community and is dealing with some of these issues too.

Patients within hospitals

Probably one of the most common experiences for the police is of dealing with patients who have absconded from hospital, whilst detained under the MHA, or whilst having conditions or symptoms which raise significant concerns about risks to themselves or others. A typical scenario in a general hospital would be somebody admitted with an overdose of paracetamol requiring treatment for perhaps 48 hours, and leaving before receiving treatment, thus placing their health and life at risk. A typical scenario in a psychiatric hospital is a patient absconding. Sometimes it is possible to assess such patients at the time as to whether or not they should be detained under the MHA, but on many occasions the patients simply run off from the ward. If they have been seen by a fully registered medical practitioner earlier that day, then a detention order under the MHA could potentially be made in their absence.

Regardless of whether the patient is detained or not, it is rarely possible for nursing staff in general hospitals to physically prevent a patient from leaving, as they do not have the specialist skills, training, experience, and resources to do so. It must be remembered that they are not trained in control and restraint, and even in psychiatry, such training tends to centre as much on de-escalation as on physical restraint. It is therefore not at all uncommon that the police are asked to try to track down such individuals and either bring them back to hospital if detained under the MHA; or persuade them to come back to hospital or use place of safety powers if not detained.

Doctors recognise that this is something which the police find a particular burden, especially when the patient is not detained under the MHA, or absconds frequently. We are aware of occasions where some police officers have refused to be involved in trying to retrieve patients who are not detained under the MHA, or where it appears to have been perceived as a low priority. This problem exists in emergency departments too. Sometimes police will stay with a patient they bring in but other times they decide to leave the patient in the care of the emergency department. Staff cannot restrain patients who are determined to leave so if police do not stay they can then on occasion be called back to deal with the fact that the patient has subsequently absconded. This is frustrating and wasteful of time but it is an example of the pressure on police resources in these scenarios.

Patients taken by police to emergency departments

As mentioned above, such patients are often subject to a considerable delay in being assessed. There is the delay to be seen in A&E and then a further delay in waiting for a psychiatric review once referred. Mental health services across Scotland have varying arrangements for input into emergency departments: this can further delay definitive assessment and management and tie up police resources waiting with such patients. As Mr Matheson has stated, it is not at all uncommon that following assessment such patients are simply allowed home. There are many reasons for this. It may be a simple matter, for example that the patient has sobered up over a period of time. At the other end of the spectrum doctors could be dealing with a well-known patient where there is a management plan in place, or where a specialist assessment determines that hospitalisation would not be of benefit to the patient at that time.

To non-specialists, it is often difficult to understand that some patients can present in an apparently very disturbed way yet are discharged. It can also add to confusion about why mental health services may be seeking a rapid police response for other patients who may seem to present with the same problems. In addition the discharge of such patients after assessment does not mean that the assessment was not necessary. It is often relatively easy to explain these issues to the police present at the time, but there may be a bit of disquiet when such cases are discussed by police constables with their superiors. Indeed, there have been cases where such patients have been arrested as the police did not feel that their duty to maintain the person's safety had been satisfactorily discharged. There may be a communication issue worthy of further discussion at that point, but this then touches on the issues surrounding medical confidentiality.

In order to explain to police the nature of medical decisions, it would often go against such confidentiality. The issue of sharing of information amongst public organisations is a complex one. Anticipatory care planning is an area which is being explored by some health services as a means of reducing emergency department attendance. The potential role in the sharing of relevant information from anticipatory care plans with the police might well be a helpful strategy to consider - particularly when this pertains to risks to the patient, the public or health care workers.

Suicidal patients

One thing that we believe has changed is the willingness of prosecutors to consider certain behaviours as criminal – for example it was the case in the past that self-harm or suicide attempts where the individual was not considered to be mentally ill would sometimes be prosecuted as breaches of the peace. That is no longer the case (because of policy by the PF rather than any change in law) and this leads to police being put in what they find a difficult situation.

Situations occur in which police bring a person for psychiatric assessment, it is determined that either the person does not have a mental illness or does not require treatment for mental disorder and they are not offered a psychiatric admission but yet the person is still expressing thoughts of self harm. In the past, it was common for the police to then charge the person and keep them in custody. This is no longer

the case, and the officers involved often find this situation very difficult to deal with as they believe themselves to be potentially accountable if the individual does end up harming or killing themselves. This can cause conflict as sometimes police will try to encourage NHS staff to admit the individual. This is a difficult area, since many doctors and members of the public agree that it is inappropriate to criminalise self-harming behaviour.

People under the influence of alcohol and/or drugs

Behavioural disturbance, distress or incapacity through alcohol intoxication or drug use has become an increasingly common problem and can be fraught with challenges. In addition resources in emergency departments and acute hospitals to allow such people to sober up have, by and large, been removed.

Whilst we recognise why changes were made to the rules about detention in cells, this can bring new challenges for emergency departments. Where an aggressive patient cannot be safely managed and is not fit for psychiatric assessment because of intoxication, detention in a police cell might be the 'best' option – but if police are no longer willing or able/allowed to do this, that results in admission to hospital with two police escorts.

These individuals are a significant cause for concern in custody and there have been adverse events. There is provision in the Criminal Procedures (Scotland) Act 1995 for arrest in some circumstances, but there may be anxiety amongst custody officers for very understandable reasons when it comes to managing these individuals within police cells.

Patients with dementia

With a growing, ageing population we are seeing people living longer lives but with that comes the fact that we have an increasing number of people living with dementia and frequently requiring the support of multiple agencies. Adequate provision for these patients can often be patchy, and when things go wrong in the community, or health and social care plans are not in place, an inpatient bed in an acute unit is often the only resolution. Often, as a consequence of failure to secure appropriate social and mental health support systems, coupled with under-resourcing both in terms of funding and staff, the police are expected to pick up the pieces when such patients present in public places. We need clearer agreed pathways as to the correct course of action when this occurs and for appropriate services to be available throughout the full 24 hours so that the fall-back position is not the police and emergency departments/acute admissions.

Patients who have absconded from psychiatric units

The issue of patients absconding from psychiatry wards may be more prominent now than it was in the past – this is on account of a combination of factors, not least the process of closure of long-term psychiatric beds. We have a higher proportion of detained patients in acute wards now than was the case in the past and the case mix is very much more to the serious end of the spectrum of mental illness. De-institutionalisation as public policy has been undermined, to an extent, by a failure to

invest in community resources including secure and highly supported placements; there has been a reduction in hospital beds everywhere and in-patient units are often under a great deal of pressure, with patients often boarded into hospitals distant from their local area.

Police skills/attributes

It is important to give consideration to the unique skills which the police have when dealing with vulnerable individuals or those who present risks to others. (It should be noted that the vast majority of people who present risks to others do not have a mental disorder.) It can probably be summarised in two factors. Firstly, police officers are trained in restraining individuals to a level beyond that which even psychiatric nurses are trained. They also have the equipment to deal with this when necessary. Secondly, police officers have authority. This often comes into play in the situation where a patient has absconded from hospital and the police have been asked to locate them. The simple fact of being visited by the police is often enough to persuade them to return, whereas being visited by another agency would not have such authority. Police officers also have the powers to detain a person into custody who poses a risk to others and is found not to have a mental disorder.

Conclusion

In summary, BMA Scotland understands the challenges faced by the police and recognises that they are spending a considerable amount of their time dealing with vulnerable people

Our members say the police do a good job, often in difficult circumstances - often feeling, quite realistically, that they are dealing with things outwith their remit. That said, the police do have a role to play and they are very effective in managing an immediate response to people who are in distress or mentally ill, and to people behaving in a way that is violent or could be deemed a threat to the public.

The police role in such situations is reflected in legislation including the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Criminal Procedures (Scotland) Act 1995 which lay out clear duties for the police in terms of, for example, detaining patients, responding to patients who have absconded, and taking vulnerable people to a place of safety for assessment.

To make any major changes to the current situation, however, would require a major investment in health and social care services. Ideally we would have an urgent response community support service of well-trained staff in appropriate numbers who could respond 24/7, and link in with the police where appropriate.

In the absence of such investment, relatively local meetings should be set up between the police and health and social care services that could examine the issues the police are facing in a particular area.

We are aware that such meetings have taken place in some parts of the country, but we see a need for a regular programme of meetings. The purpose of such meetings would be to explore how, working collaboratively, local services might, at the very

least, try to streamline options for the police. Simple things e.g. diverting from emergency departments, could make a big difference, but we believe the arrangements for this would have to be made locally.

It is important that both clinicians and managers from the non-police side are involved in such discussions too so that they have a shared understanding of what respective agencies are trying to achieve.

We would also be interested in considering a national forum that brings together police, mental health, emergency and primary care services to consider the problem, and develop generic solutions that can be applied at a local level.

British Medical Association Scotland
17 January 2017