mentalwelfare commission for scotland

VISIT AND MONITORING REPORT

Place of Safety Monitoring Report 2018

August 2018

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Executive summary

Background

In 2016 we produced a report looking at the use of Place of Safety orders. We made some recommendations and promised to do a follow up report where we would talk to police officers involved in the use of the orders. We also said we would try to speak to individuals who had been removed by the police to a place of safety. We have been working with Police Scotland on this follow up report and are grateful for their co-operation.

Key findings

- There was significant geographical variation in the use of, or reporting of, Place of Safety orders.
- We were struck by the care and professionalism shown by police officers towards often highly distressed individuals at risk of self harm.
- Ninety two per cent of individuals did not go on to any Mental Health Act order within two days of the Place of Safety order.
- There seemed to be some lack of local co-ordination in the response to the distressed individual; often large amounts of police time were involved.
- The police felt that one service was refusing to assess individuals solely based on alcohol being involved, rather than assessment of their clinical state.

Recommendations

1. Psychiatric Emergency Plans are an important way of planning how services respond to people in crisis. They should be reviewed by health boards on a regular basis and at least every five years.

2. NHS Boards, Integrated Joint Boards (IJB) and Police Scotland should review processes to reduce delays in assessments, both to reduce time spent waiting by the police, and to reduce distress to the individual.

3. In taking forward the commitments in the mental health strategy to improve mental health outcomes for people in the justice system, and to respond better to distress, the Scottish Government and local agencies should develop models of service for people who are acutely distressed but do not require detention under the Mental Health Act.

4. NHS services and professionals should not refuse to assess people presenting in crisis for their mental health needs solely on the grounds of intoxication.

5. Police Scotland should examine the reasons for the significant variations in use of Place of Safety across Scotland and take steps to ensure greater consistency and appropriate use of legislation.

Place of Safety orders

Place of Safety orders can be used by the police under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 when they find someone in a public place who they believe may have a mental disorder and be in immediate need of care and treatment. The individual can be taken to, and detained in, a Place of Safety for up to 24 hours in order to be assessed by a medical practitioner, and for any necessary arrangements to be made for that person's care and treatment.

Police stations should only be used as the Place of Safety in exceptional circumstances, where it is the best option for the individual. There should be locally agreed Psychiatric Emergency Plans in place with designated Places of Safety – for example a local psychiatric hospital or Accident and Emergency Department. The aim of a Psychiatric Emergency Plan is to agree on procedures to manage the detention and transfer process in a way that minimises distress, disturbance and risk for the patient and others, and which ensures as smooth and safe a transition as possible from the site of the emergency to the appropriate assessment/treatment setting. The Police Scotland Standard Operating Procedure and the Mental Health Act Code of Practice both recommend these plans. As part of this report we asked for up to date plans from all health boards.

Following the assessment, there are a range of possible outcomes. The person may be admitted to hospital voluntarily, detained under the Mental Health Act, or may return home.

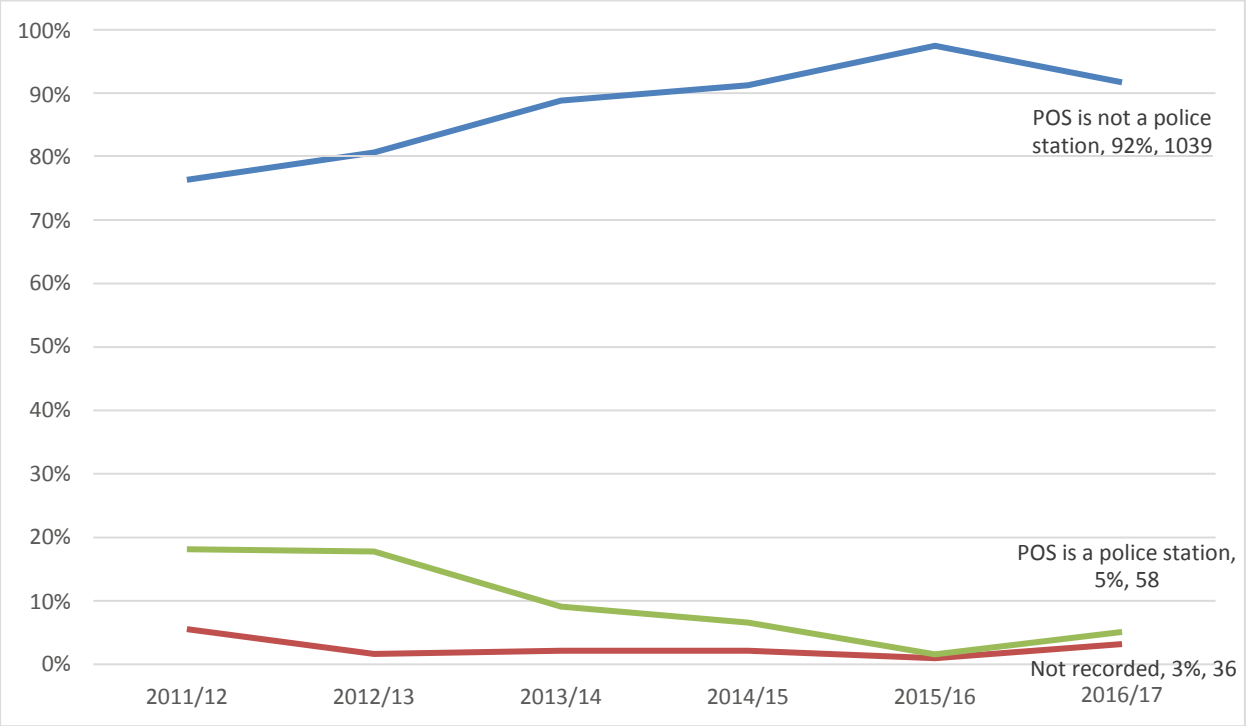
The police are required to notify the Commission of any person held under this power within 14 days and provide: details of the date and time of the removal from a public place, the circumstances giving rise to this, the address of the Place of Safety and, if the removal was to a police station, why this was done. They also have a duty to inform the local authority and nearest relative, if possible.

Details of the use of these orders are contained in our annual monitoring reports on the use of the Mental Health Act.

Why we produced this report

We wanted to look more closely at the information sent to us by the police and to identify any significant issues warranting further action.

Over the last 10 years we have been notified of increasing numbers of Place of Safety orders, which we believe is due to better reporting by the police, although it could also reflect greater use. In 2006/07 there were 130 notifications, rising to 1133 in 2016/17. Since 2011/12, the percentage where a police station was used has fallen from 18% to five per cent.



On the face of it, this is a positive story, with a small number of cases where a police station has been used.

Police Scotland

Police Scotland is the country's national police service. It came into being on 1 April 2013, replacing eight regional police forces and specialist agencies. It is the second largest police service in the United Kingdom.

Police Scotland currently comprises 13 local policing divisions, headed by a Local Police Commander who oversees the delivery of policing in each area. It is through these divisions that most of the service's policing functions are delivered.

There are a number of national specialist divisions whose remit covers major crime investigation, public protection, organised crime, counter terrorism, intelligence and safer communities. The Operational Support Division provide specialist support functions.

Policing Divisions and Area Commands

Policing Divisions	Area Command
Argyll & West Dunbartonshire	West Dunbartonshire, Cowal, Bute & Helensburgh, Mid Argyll Kintyre & Islands, Oban, Lorn & Isles
Ayrshire	East Ayrshire, North Ayrshire, South Ayrshire
Dumfries & Galloway	Galloway, Dumfriesshire
Edinburgh	North East, North West, South East, South West
Fife	Central Fife, East Fife, West Fife
Forth Valley	Clackmannanshire, Falkirk, Stirling
Greater Glasgow	Glasgow Centre, Glasgow North West, Glasgow East, Glasgow North, East, Dunbartonshire, Glasgow South West, East Renfrewshire, Glasgow South East
Highland & Islands	North Highland, Inverness, South Highland, Orkney Islands, Shetland Island, Western Isles
Lanarkshire	Monklands, Cumbernauld, East Kilbride, Cambuslang & Rutherglen, Hamilton, Clydesdale Wishaw, Motherwell & Bellshill
North East	Aberdeenshire North, Aberdeenshire South, Moray, Aberdeen City North & Aberdeen city South
Renfrewshire & Inverclyde	Inverclyde, Paisley, Renfrew
Tayside	Angus, Dundee, Perth & Kinross
Lothian & Borders	East Lothian, Midlothian, Scottish Borders, West Lothian

Each of the divisions has a risk and concern hub that is responsible for processing Place of Safety forms, quality checking them and submitting them to the Commission. It is the responsibility of the police officer who has used the power to fill in the form and send it to the hub. In 2017 a major programme of training for police officers in dealing with people they encounter who may have a mental illness was completed. In February 2017, Police Scotland published a standard operating procedure intended to provide guidance for police officers coming into contact with people 'experiencing mental health crisis', which covers the use of Place of Safety. This has been reviewed recently.

The report

This report looks in detail at the use of Place of Safety orders over a three month period in 2017 from 1 July 2017 to 30 September 2017.

There were 345 forms with notification dates in the period. We found 27 individuals had duplicate forms for the same incident (two duplicates in two cases). Duplicates appeared to arise because a form had initially been completed by the officer dealing with the incident and a subsequent form or forms had been completed by the concern hub. There were slightly more duplicates in this three month batch than for the previous audit exercise. Duplicate forms were removed.

There were 316 cases where a Place of Safety order was copied to the Mental Welfare Commission.

Of these, 53% were male and 47% female. Four per cent were aged under 18, including one aged 14 years.

	Female		Male		Not known		Total	
Age range	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Under 16	2	1%		0%		0%	2	1%
16-17	5	3%	6	4%		0%	11	3%
18-24	32	22%	29	17%		0%	61	19%
25-44	68	46%	91	54%	1	100%	159	50%
45-64	39	27%	39	23%		0%	78	25%
65-84	1	1%	4	2%		0%	5	2%
Grand Total	**146**	**100%**	**169**	**100%**	**1**	**100%**	**316**	**100%**

There were 245 individuals involved. Nine per cent (27 individuals) had more than one incident, and of these the majority had two incidents. Ten people had more than two incidents in the three months.

Number of individuals	Number of incidents	Total incidents
1	8	8
2	4	8
7	3	21
17	2	34
245	1	245
		316

We were interested in how many people had been, or would go on to be, detained.

Ninety seven per cent had no other order under the Mental Health Act (Care and Treatment) (Scotland) 2003 (MHA) at the time of the Place of Safety incident. Six people were subject to a formal order. Two people had an Adults with Incapacity Act order.

Ninety two per cent had no further Mental Health Act orders within two days after the Place of Safety. Of the eight per cent that did, about half (13) had an Emergency Detention Certificate (EDC) and half (11) had a Short Term Detention Certificate (STDC). One had a Nurse's Power to Detain applied. In three cases the EDC/STDC was revoked within a day.

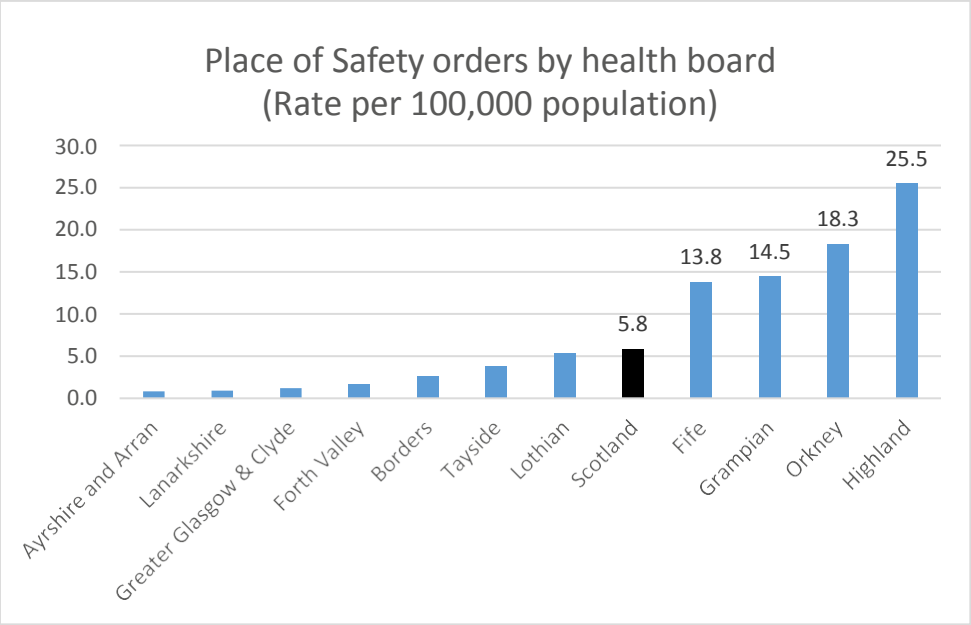
Seventy nine per cent had no MHA orders in the period of two months before and two months after the Place of Safety, 18% had new MHA orders in that period and three per cent were on existing orders which continued.

It is striking how few people who were taken to a Place of Safety went on to be detained under the MHA. This suggests that the police are responding to someone who is very distressed and perhaps threatening suicide, but once assessed they are deemed not to be detainable under the MHA. There may be issues about services able to respond to acutely distressed individuals.

A proportion of people may have been supported in the community before or after the event, or be an 'informal' patient, but the Commission does not have information about this.

During the three month period, 95.6% of removals by police were to a hospital unit with only 4.4% (14) being to a police station. Twelve of these 14 happened in one area where the police involved felt the local mental health service refused to assess people who had been drinking.

Place of Safety orders by health board

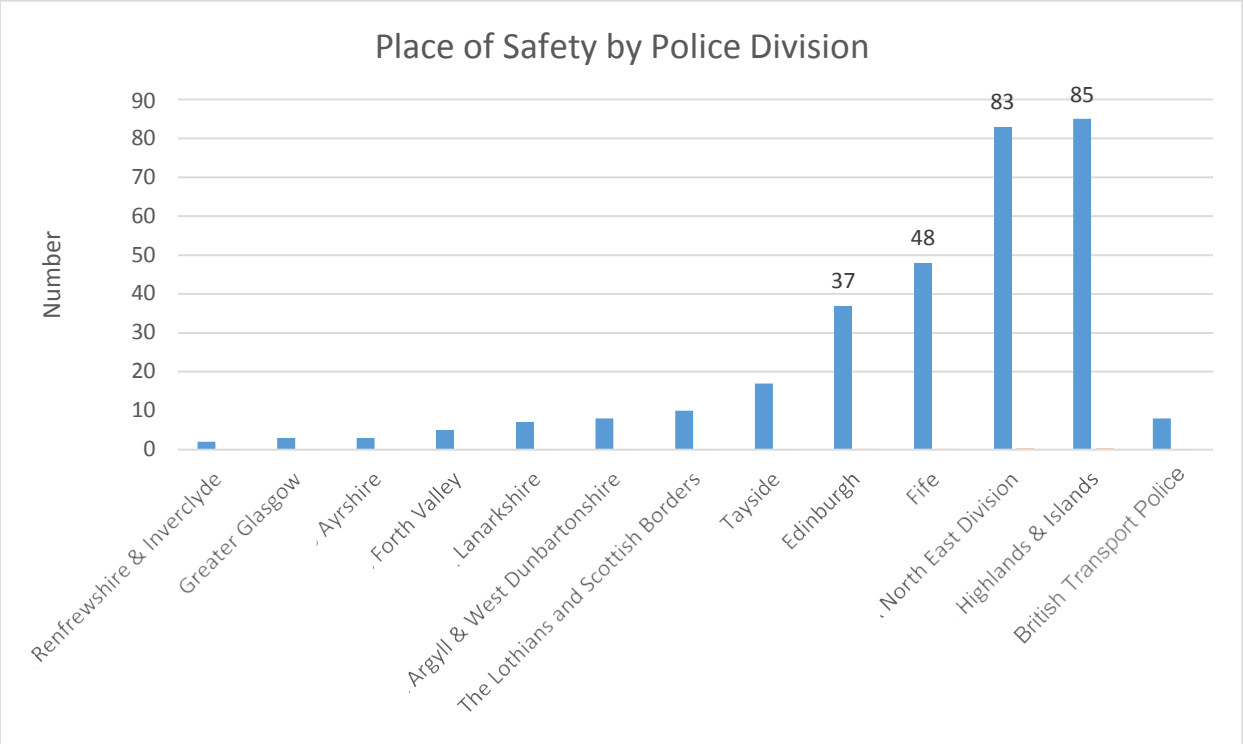


There was wide variation in the rate of use of Place of Safety.

Looking at the rate per 100,000 population for use of Place of Safety, Highland Health Board (25.5) had the highest rate, followed by Orkney (18.3), Grampian (14.5) and Fife (13.8). The rate in Highland was almost five times the Scotland rate (5.8).

The variation may relate to the availability of community triage or related services, where front line NHS staff are able to assist the police in dealing with situations, either over the phone or in person, or to the efficacy of reporting processes.

Police Divisions and Police Offices



There is great variation across Scotland in the number of Place of Safety forms returned to the Commission by Police Divisions.

North East Division (27%, 85) and Highlands & Islands (26%, 83 including 15 incidents dealt with by road policing officers) reported the largest number of incidents in the three month period, an average rate of almost one a day. Fife (15%, 48) and Edinburgh (12%, 37) also reported high numbers.

British Transport Police completed Place of Safety forms for a further three per cent (8) incidents in the period relating to Glasgow, Edinburgh and Aberdeen.

Officers from 88 police offices were involved with incidents. Some offices deal with relatively high numbers of incidents. The majority of offices dealt with one to three incidents in the period.

Telephone interviews with police officers

Preparation for the additional telephone interviews exercise

We met with senior officers from the Safer Communities Division.

A police liaison officer was agreed. All arrangements were made with him.

British Transport Police is a UK body and it was agreed with Police Scotland that we would not aim to interview any British Transport Police officers.

Extracting the sample

We aimed for police officer interviews to be as close to the actual date of the incident (POS notification date) as possible. Section 298(2)(b) of the MHA says that the Commission should be notified of a s297 removal from a public place within 14 days. Whilst conducting our sample extract we found that 57% were returned to us within the 14 days, a further 33% within one month but for 10% there was over a month delay before we were informed of the event.

We therefore extracted forms processed from the start of August 2017, in five batches during August to October. The data on the Commission information processing system was examined and a sample was selected to obtain a wide range of place of safety incidents across the criteria: police division, police office, place of safety/hospital or police office, urban/rural, gender, age group, location of incident and type of incident.

A total of 241 forms were processed; 82 (34%) were selected and names of police officers forwarded to police liaison; 56 potential interview dates were set up and 43 (77%) of interviews were achieved.

Arranging telephone interviews

The Police Scotland liaison officer organised interview dates centrally by contacting each separate division and forwarding dates to the Commission.

Interviews followed a schedule agreed with Police Scotland and lasted around 10 to 20 minutes.

The achieved sample

Incidents concerned 21 women and 22 men and ages ranged from 14 to 79 years.

We obtained interviews with all 13 police divisions across 40 different police offices with 43 separate officers (all police constables apart from one sergeant). Two interviews were with road policing officers.

Police Division	
Argyll and West Dunbartonshire	3
Ayrshire	1
Dumfries and Galloway	1
Edinburgh	2
Fife	4
Forth Valley	2
Greater Glasgow	1
Highland and Islands	6
Lanarkshire	4
Lothian and Borders	5
North East	9
Renf and Inverclyde	1
Tayside	4
Grand Total	**43**

The incidents occurred in 12 health boards (excluding Shetland and Western Isles).

Places of Safety concerned 18 hospitals and two police offices. We had selected all the incidents in the three month period where the Place of Safety was a police station, and achieved four interviews in relation to this. In two of these cases the individual was subsequently moved on to hospital.

Hospital as Place of Safety	Total
Balfour Hospital	1
Borders general	2
Carseview Centre	2
Cowal Community Hospital	1
Crosshouse	1
Forth Valley Royal	2
Midpark	1
Monklands	1
New Craigs	5
Queen Elizabeth	2
Royal Alexandra	2
Royal Cornhill	9
Royal Edinburgh	3
St Johns	2
Stratheden	1
Whytemans Brae	3
Wishaw General	3
D Division HQ, Dundee	2
Total	**43**

Who notified police?

We asked police where the initial information came from and how they became aware of the situation.

In our sample, a small number of people communicated their distress and intentions themselves; by calling the police direct (at least one was a frequent caller to the police), or by phone to relatives/friends, sending text messages or pictures. The relative then notified police. There were also examples of individuals making calls to other agencies e.g. NHS 24. One individual came to the police station and was found to be suffering delusions.

The police were also contacted by concerned members of the public, family members and friends, and staff who were already in contact with the individual e.g. hostel staff. Family members or friends called police e.g. ex-partner, spouse, parent, grandparent, fellow students, neighbour.

Concerns were also reported by professional services: direct from other UK police forces or national traffic police; by hospital or general practitioner where an individual had 'absconded' from assessment; by social work concerning someone who had left secure care; by ambulance control.

Police came across situations during regular police work: being flagged down in the street by public/friends; during routine follow up of an unrelated incident; stopping an individual behaving suspiciously and potentially suspected of a crime.

The concerns expressed were varied and wide ranging. In many of the cases the individual had been speaking about plans to hurt or kill themselves.

Individuals were said to be 'agitated' 'distressed' 'upset' 'crying'. There was less mention of the individual 'appearing to hallucinate' or 'being delusional'.

Police spoke of being informed of behaviours which were unusual, for example, near a home environment: 'lying on the ground', 'being on the roof of a nearby house', 'in the street in pyjamas', 'removing clothes'; in the home environment 'smashing up home', 'shouting and banging'. On roads or near water/bridges: 'being on wrong side of parapet', 'edge of carriageway', 'running into traffic', 'running around', 'being rowdy', 'acting bizarrely, erratically', 'shouting at passing cars', 'punching bus stops'.

Less often mentioned was a known diagnosis or past history of mental illness or previous self-harm or suicidal events, and where it was, it came from closer family, friends or professional services.

The police first response from the control room

Police have to consider the information they have and make an assessment of risk. This involves consideration of information received, the locality, time of day, others involved etc. In three cases there were potential concerns about children in the home which necessitated immediate investigation.

In at least one case the situation was confirmed via CCTV.

Was the person already known to the police?

We asked whether the individual was already known to the police at all.

Police will check their own information systems and the Vulnerable Person Database.

Eleven were not known to the police. Fifteen were known for low level crime (including four who also had mental health problems). Two officers referred to the individual as 'not wanted' by police. Seventeen individuals had a known mental health history/involvement with police (two were 'regular' 'frequent caller'). One was known to psychiatric services only, with no police involvement.

Missing persons

In at least seven cases the individual was classed as a 'Missing Person'. This obliges the police to escalate their level of response.

How much police and other resource is involved

The amount of police resource and other professional resources involved in these incidents varied very widely. In some cases the fire and rescue service and the ambulance service were involved. It was not unusual for many hours of police time to be taken up in stabilising the situation, transporting the individual to a place of safety, waiting for an assessment and then ensuring the safety of the individual afterwards. On some occasions the entire shift of two officers was taken up.

Several officers commented that they wanted a faster response from the NHS, even advice by telephone could be helpful.

Police assessment at the scene and moving to a S297 Place of Safety order

On arrival at the scene of the notified incident, police assess the situation and decide whether a s297 or some alternative action is appropriate. The situation is fluid and constantly evolving, and police may be there quite some time.

Officers on the ground discussed the situation with the senior in the control room and after the incident as decisions were being made.

"Call to ambulance service from partner expressing concerns for woman and her behaviours, felt there was no option, had to put interests and safety of woman and child first. Constable sought advice from direct supervisor who advised POS for assessment." Quote from police officer.

Where was the person removed from?

In our sample, the individuals were removed from a wide range of public places.

Around half (19) were removed from near a home-like environment.

A smaller number were removed from buildings open to the public.

The remainder were located at roads, bridges, piers, rivers, cliffs, railway lines, public parks, car parks or other isolated spots.

There was one form where the officer said the s297 was applied in the individual's living room, but the actual form said it was applied at the police station. Section 297 cannot be used in a private place although this may reflect a gap in the current legislation when the police need to respond to an emergency situation.

Does the person have a mental disorder and are they in need of immediate care and treatment?

In assessing the situation, officers took into account many factors. Police referred to what the individuals themselves were saying, their behaviour, presentation and their emotional state. They also took into account what other people were saying, what was already known, and other physical evidence. They assessed the locality and potential risk to the individual or to others, and the need to secure the individual's or others' safety.

Most commonly (27) the individual's active suicidal behaviour or intent was a factor.

"Wanted to wake up dead, intimated he was not happy with his life and he wanted it to be over". Quote from police officer.

In a third or more cases (15) it was the person's behaviour, or what they were saying, that suggested mental disorder.

Situations where the police felt the need to use place of safety included:

- Where the individual was already at a dangerous locality (bridge, busy road, railway line, cliffs) and apparently already acting on suicidal intent.
- Where the individual was potentially a source of immediate harm to others e.g. by running out in front of oncoming traffic.
- Where the individual's behaviour was so odd or irrational or they were so distressed that they should not be left alone.
- Where the person was dangerously intoxicated, and there was no-one available to care for that individual.
- Where this was the second incident in a short time and the situation had escalated.
- Where they had been alerted to the individual's mental state by another UK police authority.
- The individual was actively unwilling to consider help or going to hospital for assessment.

- Where the individual was unable or unwilling to engage in discussion about going for assessment/treatment or refusing to give information: '*was not willing to speak, uncommunicative, agitated, would only respond to a direct question'* Quote from police officer.
- The person was irrational or not making sense.
- Where the individual had run away from the police prior to this incident.
- Where the individual had already run away from hospital before being assessed.
- Police needed to use physical force or restraint to remove the individual from the situation.

Where available, the views of medical professionals were taken into account.

In some areas, mental health community triage nurses were available to support police decision making.

When considering a Place of Safety it was standard practice in some localities for officers to call ahead to the intended receiving hospital.

Any suspicion of a crime

We asked officers whether the incident involved a crime or offence, not of a minor nature, or whether there were any concerns about a potential offence.

In almost all cases there was no crime at all involved; however in a third (14) of cases, officers talked of actively *considering* whether an actual or potential crime might be involved.

The police immediately carried out all checks required where two individuals said they had harmed another person, but these statements were quickly found to be untrue and part of the individual's delusional thinking. In advance of arriving at the scene officers based on information already known, might consider whether the incident potentially would come under 'breach of the peace' (for shouting in the street etc) or potential s38 Criminal Justice and Licencing (Scotland) Act (for threatening or abusive behaviour, or placing people in a state of fear and alarm). A search would be undertaken where an individual was acting suspiciously or there was a suspicion that drugs were involved.

Ultimately, at the scene of all these incidents police decided that the individual's mental health needs took priority, and therefore moved to a s297.

In two cases, after s297 being used first, and the person being released from hospital, the person was then arrested.

Outcome

In just over half (23) the cases where we interviewed police officers, individuals were discharged from hospital following assessment; three were then taken to police cells. About one in three (14) were admitted, six detained, four voluntarily, four where formal/voluntary status was not known. Four more were being kept for assessment and police did not know the outcome. At least two were known to be released from hospital later the same day or the next day. Three went to police cells, one immediately and the other two after hospital assessment.

Of those discharged following assessment, police transported half (12) or more back to the person's own home or to a relative (5) or other informal support (2).

"Police drove him back to his home a few minutes walk from where he was picked up. En route went to a supermarket and man went in to get some shopping so he had some food. Police took him to his own front door and chatted for five minutes, then he was happy to take himself in. By this time he almost seemed a different person from who we met initially, much calmer and more relaxed." Quote from police officer.

Police were aware of community psychiatric nurse (CPN) or community mental health team follow up arranged for three cases and in one instance a social worker took the individual home.

"Police drove her home, sat outside with her while she had a cigarette. Watched her go inside. By then she had calmed down a lot, no ramblings. PC thought she had a follow up appointment the next day with her CPN or doctor." Quote from police officer.

Police commonly spoke of the individual being much 'calmer' at the point of discharge. In at least two cases it seemed the effects of intoxication by drugs or alcohol had worn off.

Improvements or issues

We asked officers if anything would have improved the situation.

For almost half the incidents (20), officers felt there was nothing that would have improved the situation; and half of these (11) described the incident as 'routine' 'typical' 'straightforward' 'run of the mill' or going 'smoothly'. These latter incidents included three cases of being on or near a bridge/water with suicidal intent, five near a home-like environment and two from a public road.

Several officers commented on some mental health services refusing to assess someone who had drunk alcohol even though the officers felt the person was able to be assessed.

Our overwhelming sense from the interviews was one of compassion from the police officers.

Psychiatric Emergency Plans

We received the plans from all but one health board. They all specified a hospital setting as the Place of Safety, but varied in how often they had been reviewed. Some had not been reviewed since 2012. We believe these plans are important to co-ordinate the response to someone in a mental health crisis and should be reviewed on a regular basis.

The views of individuals

We asked for the views of people who had been taken for assessment by the police through service user and carer organisations. We spoke to 13 individuals and five groups. We do not know if formal Place of Safety powers were used.

Common themes were:

Lack of community support for people in crisis.

People with borderline personality disorder and suicidal ideation not being admitted.

Generally positive comments about the police, words like calm, caring, nice and reassuring were frequently used.

Comments from individuals who had been taken for assessment:

"The police took me to the place of safety both times and they were nice."

"I have been very lucky with the police, I have no record, but there were at least a dozen times they could have arrested me. They dealt with the situation well and were calm and professional, they seemed to have my safety as their first concern."

"They were lovely and were very nice, I felt very confused, they weren't judgemental."

"I know most of my local officers and the local sergeant says he is terrified that he will send his officers round and they will find me dead one day."

"People do not know who to phone in crisis, generally all people know is to phone the police."

Summary

The current system results in the police having to make very difficult and potentially risky decisions about individuals who may be at serious risk of self harm. The police should not be expected to do this without proper support from health and social care professionals. The levels of distress they were dealing with was significant and there should be a joined-up response from services to this. The care, compassion and professionalism shown by police officers in dealing with very difficult situations was obvious.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