APPG on Mental Health

Inquiry into Parity of Esteem: Improving Emergency Mental Health Care

House of Commons, Committee Room 14

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Witnesses:

Rt Hon Damian Green MP  Minister for Policing, Criminal Justice and Victims
Sue Goddard  Expert by experience
Vicky Skeldon  Area Manager for Making Space of Crisis Services across Lincolnshire
Dr Ann Hicks  Emergency Department Consultant and Trust lead for Mental Health and Liaison services
Robert Cole  Head of Clinical Services at West Midlands Ambulance Service and Mental Health Lead
Commander Christine Jones  Metropolitan Police lead for mental health

*Transcriber's note - Some parts of the discussion were difficult to hear due to the quality of the recording

James Morris MP (Halesowen & Rowley Regis) (Con): Okay, well thanks very much for coming along and sorry for starting late in getting underway. This is the second session of the All Party Parliamentary Group on Mental Health's inquiry into parity of esteem for mental health and today we're going to be looking at the quality of mental health emergency care. And I'm delighted that we have Damian Green MP, who is Minister for Policing, and Damian, if you'd like to talk to us.

The Minister of State for Policing, Criminal Justice and Victims (Mr Damien Green): Thanks very much James, thank you all for struggling through the increased security to get here and because we were delayed I will stick to the main purposes of what we're trying to do. We start with the principle that we want to see mental health receiving parity of esteem with physical health, which we all know it hasn’t really in the past, and that includes when dealing with emergency situations, which is obviously where I come in as a police concern. And it's because in an emergency when the person is suffering a mental health crisis the police are often the first to arrive on the scene and need to be able to recognise mental health issues and deal with them appropriately. And while the police can't and shouldn't provide the necessary medical support and treatment, they do have a key role to play in identifying the vulnerabilities among people they come in to contact with. We know that the high numbers of people who have mental health problems come in to contact with the police, and it's
important to understand in each case how and why some people who've committed a crime or are arrested on suspicion of having committed a crime might also be suffering from mental health problems, and it's essential in those circumstances that we strike the right balance between bringing defendants to justice and helping people access appropriate treatment. But there are also those who come in to contact with the police because a member of the public has concerns for their safety or the safety of others, but in a situation where no crime has been committed, and this includes those who've been reported missing. Four out of five adults who go missing are suffering mental health issues and we're keen to ensure that they too get the best possible response when they come in to contact with the police.

So let me move on to what we've been doing. There have been a number of reports over the years that have highlighted the various problems, the Adebowale Report and reports by criminal justice and health inspectorates. And there's a pattern in those reports, they raise concerns about training, about identification and about screening, as well as the general treatment of offenders with mental health issues. And we are making progress in these areas and have been able to respond to the many criticisms in these various reports. Funding has been made available by the Department of Health for liaison and diversion services, with the aim of having these services available in all of these stations and in courts across the country within three years. Now these liaison and diversion schemes will ensure that offender's health needs, including mental health problems, are identified and assessed and the appropriate referral is completed at the point of entry to the criminal justice system.

We're currently working with more than 100 adult and youth liaison and diversion schemes nationally and in January we announced ten schemes that will receive additional funding and will operate to the core service specification and be part of an evaluation of how they're working. And those schemes are operating out of police custody suites and courts and custody staff and police officers will be able to refer the people they suspect have more complex mental health needs for screening, assessment and referral for appropriate treatment. And nearly 50 police custody suites will be covered within the rollout of these ten schemes and obviously after the evaluation we will see what works and that will be the basis of the national rollout over the next three years.

And at the same time our officials in the Home Office are working closely with the policing needs around the country, particularly the Met and the College of Policing, to develop effective training and screening tools to enable the police to identify people with mental health problems and other vulnerabilities and for these to be rolled out to all forces. We're also reviewing the training available to police officers on identification of vulnerabilities, surveying the take up of and the adherence to the training that's available and suggesting improvements to the police curriculum. And it's good that the police forces in England are making arrangements to transfer their custody healthcare conditions to NHS England, having the NHS commission police custody healthcare will improve the health needs of detainees while in custody and provide better links to GPs, community healthcare services and treatment providers. And I saw myself, I visited the Bethnal Green custody suite in January when we launched this programme and the custody sergeant there, who was a classic custody
sergeant who'd been doing the job for a long time, said that finally he felt he had someone there who when he could see this type of problem literally on his desk he had someone to turn to who would know and was properly trained what to do. And interestingly the nurse, who is now there full time, said that the great thing that she discovered she provided to the police was that she had access to NHS records, which the police, of course, don't have. So when somebody turns up it's a matter of saying, okay, it's him, he's on these kind of drugs, this is his GP, this is the treatment. And in the past that was just not available to police officers who would do their best but who neither had the training or the information to do what was necessary. So I think that will be taking a good step forward.

But let me also talk about deaths in custody, which is obviously one of the most sensitive areas of this whole area because some people who die in police custody have had mental health issues and obviously every death in custody is a tragedy. So this is a priority area for the government, and that's why the Home Secretary has commissioned HMIC, Her Majesty's Inspectorate of Constabulary, to undertake in 2014/15 a specific thematic inspection of vulnerable people in custody. This will obviously include individuals with mental health issues and learning difficulties because we want to use the HMIC report come out of this as the basis for how we can improve police performance in this area as well. And obviously we're also continuing to monitor the existing work under the oversight of the ministerial council on deaths in custody and its independent advisory group, and that's not only working on deaths in police custody but also Section 136 of the Mental Health Act, race and diversity monitoring and the IPCC's, Independent Police Complaints Commission's review on how it investigates death in custody because how each one was investigated is also important as well.

So let me move on to non-offenders, the people who come in to contact with the police not when they've committed a crime but specifically because they're in crisis and need help. As everyone in this room knows the Mental Health Act provides the police with powers under Section 135 and 136 the act to detain individuals and take them to a place of safety for a medical assessment. This is clearly a vital power, but the problem is that all too often police cells are used as a place of safety and this shouldn't happen unless there's an overriding need to do so. Then last year's report by (unintelligible - 24:20) inspectorates, the HMIC and its prisons' inspectorate, the Care Quality Commission and the Healthcare Inspectorate Wales found that in a number of areas the use of police cells remains unacceptably high. And we know that during 2012/13 nearly 8,000 Section 136 orders that were made where a police station was a place of safety, that's more than a third of the overall total number of detentions under the section. And that's unacceptable, these people are ill, they need and deserve proper care and support in a hospital environment where they can receive care and medically qualified professionals. We all know being locked up in a police cell may well just make matters worse.

And on top of that too often the police are relied on to transport people who would better be transported by an ambulance. And I'm told, this is anecdotal evidence but it's what I hear from response officers in particular, that a higher and higher proportion of people being taken to hospital for assessment travel in a police car rather than an ambulance, and this is also not
acceptable. And of course we have a further problem that some health based places of safety will turn away people because they are intoxicated, for instance like drink or drugs. So there is a raft of issues here that we need to grip and that's why we've been working to produce an agreement across the board on the response that should be provided to people in this situation and that's why we've published the Crisis Care Concordat, which is a concordat between 20 national organisations, agencies and departments and it provides for the first time a national leadership by setting out the standard of response that people suffering mental health crisis and crime (unintelligible - 26:14) care should expect, and the key principles around which local health and criminal justice partners should be organised, I know you heard from Norman Lamb in your first session, didn’t you, sir?

**Mr Morris:** We did.

**The Minister of State for Policing, Criminal Justice and Victims (Mr Damien Green):** It is, to a large extent it's Norman's document even though that talked about it. But it does leave agencies, both the criminal justice agencies and health agencies, in no doubt about what's expected of them. The concordat states it's essential that health based places of safety are available and they're equipped to meet local demand and police officers shouldn’t have to consider using police custody as an alternative just because there's a lack of local mental health provision or unavailability at certain times of day or night.

So the concordat asks all localities to bring together their various professionals across the blue light services and indeed the mental health service to review what's happening and agree to work together to reduce the number of times police custody was used in their areas. Our aim is to halve the number of people who are detained in police cells because they're mentally ill. And it's also clear in the concordat that people in crisis who need to be supported in a health based place of safety will not be excluded on the grounds of intoxication or a previous history of offending or violence. The Care Quality Commission is carrying out a review of the quality of health based places of safety across England and it will be reporting by the end of this month.

The concordat also stipulates that commissioners and providers should ensure that people who are in distress owing to a mental health condition and who need a formal assessment receive a proper response from the appropriate health professionals so that arrangements for their care support and treatment are put in place in a timely manner. And it also says that police vehicles shouldn’t be used to transport individuals detained under Section 135 and 136 to places of safety or between hospital units.

Now we published the concordat and said clearly the most important thing now is to ensure that it has an impact locally in each area. And the Department of Health is working with Mind to develop the infrastructure for local crisis declarations and it's planning four regional events to encourage the delivery of the concordat principles across England. They're offering local support to signatories and encouraging sign up to local declarations, so everybody in each area knows that this big change should be happening. And we'll be obviously
monitoring the delivery of those local declarations through local meetings and through annual sub meetings, which will be of great interest not just to the public health but to those of us in the home office who are dealing with this as well.

Moving on from the concordat we're also reviewing mental health legislation working jointly between the Home Office and public health, the operations Sections 135 and 136 to ensure that they're fit for purpose and the Department of Health is leading the review of the supporting Code of Practice for the 1983 Act in England. And one other player I should mention, which are Police and Crime Commissioners, many of them are already playing a pivotal role in encouraging agencies to come together to address the issues. There's a lot of good work being done by Martyn Underhill, the PCC for Dorset, who's leading a group of PCCs who are pushing for the improvement in this area.

And one last specific area I want to talk about was street triage, because we're beginning to see good results from the nine mental health street triage teams being funded by the Department of Health. The nine pilot areas are using different models, the first was launched in Sussex in October and we've seen the number of persons taken in to custody reduce significantly between October and January compared with the same period last year, there were 37 to 15. And the team also believes that potentially of 38 Section 136 detentions have been avoided in the same period, which is very encouraging and as well as the nine that are being funded centrally there are a number, I know, of locally funded triage schemes, including the recently successful bid to the Home Office's police innovation fund (unintelligible - 30:56) police and indeed one in my own county of Kent where they, again, so they've only been running it a few months but they said they've basically halved the number of Section 136 detentions since they started doing it. I spent Saturday night with the team that was doing it and go away impressed by the good work that's being done and by the diversion of people away from detention in to proper treatment.

So we believe and the police believe the pilots have improved the experience, the outcomes and the access in to health service for individuals at the point of crisis. They're freeing police time, allowing the police to get on with the job we want them to do, which is to fight crime. It's also led to better mental health awareness of, in the police officers involved themselves and therefore I hope over time will spread through those particular forces.

So a lot has happened over the past few months but, of course, we still face big challenges. Lord Adebowale's Report last May made it clear that there still needs to be more effective interagency working between the police and between health agencies as well. I know this report was just about London, but I think the issues raised in that report are applicable across the country. So we need to ensure that the police and the other agencies receive the right to training. I'm not saying that police officers need to be trained fully in mental health assessment or to be able to diagnose, that's not what they're for, it's not what most of their training will be about, we can't expect them to become mental health professionals, but they do need to know who to go to when this is required and they do need to have the confidence that when they turn to someone that someone is there, so the whole system needs to work
together. So the police are one of many partners in this area, and that's why the College of Policing is working with many other agencies and medical profession to develop the most effective approach.

One other important aspect of the Adebowale Report was about collection and sharing of data by police and health agencies. All agencies, including the police, including ambulance staff, have a duty to share essential need to know information for the good of a patients so professionals or service dealing with the crisis know what's needed to manage that crisis. And this is mentioned in the concordat but my experience, and I suspect the experience of many people here today, is that there's still considerable work to do to make this a reality. And I'm as keen on data protection as anyone else, but actually you can find inappropriate uses of data protection and unwillingness of a professional agency to allow other people to have access to their data when all they are trying to do is help somebody who's having a crisis. So there needs to be a certain amount of cultural change there and of course there needs to be in place adequate A&E and mental health services to provide continuing treatment and support for people with mental health problems.

So in summary, we have come a long way since Lord Bradley's report was published, we are beginning to see some tangible results and I think the Crisis Care Concordat will be a very significant step forward. But if I can reach back in to the midst of time in to the New Labour era, they had a phrase that said 'a lot done, a lot more to do', and I think that's true about our use of services dealing with mental health emergencies and so we will try and do that a lot more in the future. Thank you very much.

[Applause]

Mr Morris: Well thank you, Damian. What I'd like to do now is just open up the floor to questions to Damian. If you've got a question please can you say who you are and what organisation you represent, and the lady here first.

Krishna James, Rethink Mental Illness: Me? Okay, thank you. I'm from Rethink Mental Illness and I'd like to ask a question particularly pertinent what's going on at the ground level at the moment. How will the government make sure that those experiencing a mental health emergency know where to go when in need of help and a crisis? And I will say to you I'm sitting here just about having been through some harrowing stuff, my older brother is asking to be taken to Switzerland, he's that ill, and a good friend has tried twice to go in to A&E, eventually she ended up taking overdose and the door had to be broken down. Now I am absolutely gutted, you know, I've made every effort to come here today because I feel so strongly about this subject.

Mr Morris: Sure yes. So your question would be?

Krishna James: My question is what is the government going to do immediately to remedy the situation on the ground, how to meet the crisis that people face. When people face crisis
they need emergency treatment, just like any other physical illness. If it was heart attack people will be taken in, why not when they're having a breakdown? Thank you.

**Mr Green:**
Quite right, of course, that the National Health Service should apply to mental health as well as physical health, many people have identified a discrepancy, and that's what lies absolutely at the heart of the principles of the Concordat, that you deserve emergency treatment. I mean, you asked specifically about where people should go. People will go in that circumstance to a variety of routes, they might go to their GP, they might turn up at A&E. This crisis might hit them in the street, in which case somebody else may well call the police, that's what happens in reality. And what we're trying to do is to ensure that whatever route you go through, that you rapidly are put in touch with a mental health professional who knows what to do. That's what hasn't happened frankly anything like enough in the past with this specific problem from the police angle. But that is at the heart of what we're trying to do with this concordat, to make sure the structures and systems are in place at a local level. So where you are in the country and whatever emergency service you come in to contact with, you rapidly get triaged and given the appropriate treatment.

**Mr Morris:** Lady here and then the lady in the front.

**Member of London Clinical Senate:** My name's Jenny (unintelligible - 37:52), I'm a health and social care manager and I'm currently involved with the London Clinical Senate, who are looking at powerful ways to engage, particularly for people who services don't seem to serve very well. But my question really, I was very encouraged by what you've said but you mentioned medically qualified professionals and in my experience a lot of time is taken and a lot of difficulty encountered because there's a lack of wraparound services to support medical professionals. And so we tend to, in mental health, I've worked in criminal justice services in prison, in probation and homeless services, and I see this repeatedly, that issues of housing benefits, occupational health and so on tend to take up all the time and make it more difficult. So my question is really what can be done to address the imbalance between expertise, between inpatient services and services in the community so that there's a balance of professional mental health services balanced by the other services supported by things like advocacy, peer support and so on.

**Mr Morris:** Thanks very much

**Lara Carmona, Rethink Mental Illness:** My name is Lara Carmona and I'm from Rethink Mental Illness, I'm Head of Campaigns. The Crisis Concordat, which we hugely welcome and we're in staunch support of, we're really delighted that Mind is going to support the government and the various bodies to help implement it. But at the end of the day there's an agreement of principles and it would be really helpful, Minister, if you could explain what levers there are to genuinely drive this change on the ground. Because while we're delighted by a lot of the content in there, as Krishna has described we have limited assurances that
progress will be made and swiftly, which is what matters most to people who are experiencing a crisis.

**Mr Morris:** Sure thanks for that. Do you want to address those?

**Mr Green:** Okay, fine.

**Mr Morris:** It's slightly outside your remit.

**Mr Green:** It is slightly, yes, but in terms of provision of health services, obviously that's part of a question you'd have to address to a Health Minister, but it's a very important one, particularly about all the other advice that needs to go to the people who are in a particular vulnerable, particularly vulnerable situation. And in terms of prison, offenders who've been in prison and then coming out on probation, part of the rehabilitation revolution that we're bringing in is precisely so that anyone who may well have been sentenced to a short prison sentence, 12 months or below, will actually get all of that, will get that mentoring from, before they come out, so they don't suddenly come out in to a world where they haven't got anywhere to live or they don't know where their next meal is coming from and all of that. And I know that's a small subset of the total of people we're talking about with this type of crisis, but that's precisely what we're trying to address there.

And I think that again the whole principles of the Concordat are to make sure and to make sure in each area that those sort of background services that you described are available, because you're right, unless you treat all the problems at the same time then they'll just recur. There's no point giving people the best medical treatment if the rest of their life is so chaotic that this place will drive them in to another crisis, which leads me on to the second question of what levers do we have to make that Concordat a reality. Well, that's one of the reasons why Norman Lamb and I are sort of trailing the country making sure that people are signing local concordats and making a fuss locally about that. So it's not just a one off event that happens somewhere distant, but that actually in your area there will be local Concordat. And the thing is it's signed, as I said, by over 20 bodies, so there are national bodies with local arms, each of whom has agreed to do this. So fingers can be pointed if necessary, but actually people have taken responsibility for implementing this, to make it a reality on the ground and not just a sort of working set of principles. So there are, each of the individual bodies who will have something to do to provide the full wrap around care is committed to it, it's not just a government document, that's why it's a Concordat and not a white paper or anything like that, it's actually people signing to agree to do it.

**Mr Morris:** Okay. The lady at the front and then the lady at the back.

**Alex Stirzaker, Avon and Wiltshire Mental Health Partnership NHS Trust:** My name's Alex Stirzaker, I'm national advisor on improving access to psychological therapies development and with a specific reference to personality disorder. So when we're talking about people who potentially end up in emergency care, there's clearly a group there that are
often served by emergency services. I'm very keen to urge that we consider this not as individual isolated situations in terms of emergency care, but to look at the system as a whole. We need to be moving more towards, I think, providing evidence based treatments, and that's clearly something that at the moment we're quite interested in, understanding what helps people change their lives. I mean, I absolutely take the point we need to think about the wider system in terms of housing, employment and various aspects to it, but also to look at what it is that we deliver in mental health. Because I am concerned, I note from some of the results of the survey, there are people are asking for treatments that are evidence based, one of which, of course, is psychological therapies. So I'd be very keen that we don't look at this in isolation but across the whole system.

Mr Morris: The lady half way back.

Paula Peters, Disabled People Against Cuts: My name's Paula Peters and I'm from Disabled People Against Cuts and the Mental Health Assistance Network. One of the concerns we've got is the great impact (unintelligible - 44:13) in place. We're having more people come on to social media, and we had four today, who are threatening to take their own lives. They're coming on to Facebook, they're coming on to Twitter and threatening to take their own lives and we can't get hold of people. Now, I've been to the police with two cases saying what is the actual policy in social media when we have someone in crisis who's threatening to take their own lives? We can't get hold of them because it's putting people who are managing pages, who are themselves under terrible distress as well when people are coming on and saying we want to, you know… they've just had their benefits cut, they've got no money, they're starving and they're about to do something here. Like I said I had four people who threatened to do that before I came here that I was having to, I had to call the police and everything and contact the emergency services. And nine times out of ten the crisis support is pretty much non-existent. They've tried to speak to a crisis line to be told to have a hot cup of tea, have a bath, everything will be all right in the morning, and it's not. What do we do? What is the social media policy? Because this has happened quite a lot.

Mr Green: Okay, it's a good question, a very good question.

Sue Goddard, Expert by experience: Yes, my name's Sue Goddard, I'm here with someone who has lived the experience and the reference to Switzerland I very much understand. I'm interested in what you're saying about the triage within custody suites and whether having an NHS professional there is the way to try and legitimately access medical information or shared information, because there is a real problem. And quite rightly so, people's information shouldn't be shared and the NHS isn't great at respecting confidentiality sometimes. I've had experience of the police who say have you got a crisis card or something? To be quite honest, when you're very unwell you're not likely to be carrying one, and they'll try to try and get information. And I'm wondering if this is a way (unintelligible - 46:23) legitimately (unintelligible - 46:24) so that information is shared. And if that
trust of the triage, being in police custody suites for the very quick access.

Mr Green: Yes, the point about treating the whole story and (unintelligible 46.50) the actual treatment being clearly at the heart of it, I think overall I agree, clearly that's an essential place to start. And in the individual case, in the individual assessments of people who are in crisis, a lot of that will be about speed of access to the appropriate treatment and a lot of that is about data to see it sort of come together, that if people, specifically custody suites or street triage, if you've got someone there who can quickly work out what information is required to make sure they're getting the appropriate treatment as fast as possible, then that treatment is likely to be a bit more effective than it would be otherwise.

And of course, treatment should be evidence based and in fact the more information that's shared around the more likely it is that, different people will require different treatment and that the individual will be getting the right sort of treatment. You're asking is it at the heart of the triage system, it's not, the heart of the triage system is, as I already explained to an earlier question, the thought that if you're in an emergency, as fast as possible the system should deliver you in front of somebody who can make some kind of sensible medical assessment rather than a police officer who is not trained to do that. They will absolutely do their best but will not be trained to do that to the extent that you would want, so that's at the heart of it. But, as I say, I observed myself that one of the side benefits is the possibility of access to the sort of information that allows the right treatment to be given as soon as possible.

In terms of social media and how to report it, I'd be interested to hear if there are crisis lines that are not providing appropriate advice as clearly, that shouldn't be happening and it may well be that in some circumstances is that people phone the police because they're the most immediately available emergency service, whether or not they're the most appropriate ones.

And the whole purpose of what we're doing is to ensure that whatever emergency service is called in, whether it's the police or anything else, that you start off with appropriate treatment as fast as possible, that's the best way to deal with that. I think the whole point about the capacity of people to communicate or indeed be witness to people who communicate on social media where they may not be able to otherwise is a very good one, which I suspect, I mean, I know the police are grappling with the use of social media and I'm sure health professionals are as well.

Mr Morris: I think we've just got time for one more round of questions, this lady here the lady there, there's a gentleman there and I think I saw a man there. So take all four together then that should just be all.

Observer: Thanks a lot. My name's (unintelligible - 49:55) and I very much welcome your article this week on diversity, ethnicity and crisis care, which is really relevant. And one of the things I would like to say though is that the data does show that other minorities have lower detention rates under the Mental Health Act than the host population, but as far as crisis
care goes sadly the UK's Afro Caribbean communities are really disproportionately represented. And I don't know how it's possible for the community based agencies who have a really good working relationship with people in crisis to then be factored in or (unintelligible - 50:36) partnership working with this group, because they have an understanding of this group's needs, their cultural competency is really sound. Because policing, as you say, when (unintelligible - 50:48), even though they did want to assist with people in crisis (unintelligible - 50:53) and also just to give you a copy of our coverage on your response levels.

**Dr Ann Hicks, Emergency Department Consultant, Plymouth Hospitals:** Mine's just brief information and question. Ann Hicks from emergency medicines, there's a unit in Bristol which has been researching the social media and thinking about putting the equivalent of a sort of nurse in to the environment particularly a lot of adolescents and teenagers are using. So I don't know the details of it but there's quite a lot of work goes on there.

**Paula Peters:** It's not just adolescents and teenagers.

**Dr Hicks:** No, no, it's not.

**Paula Peters:** It's across the board here, we want proper protocol put in place to save lives, because if something's not done who's liable? That's all we want to know.

**Mr Morris:** Okay, well, maybe if we can pick up that point when we come to talk about those issues. Gentleman there.

**Thomas Bell, Rethink Mental Illness:** Yeah, I'm representing Rethink and my name's Thomas Bell. It says on this report that there is no clear access point for emergency care, I could probably argue against that. The crisis team, that's where the problem lies. I'm a service user and I've gone through them dark times myself and you ring the crisis team and they are dismissive, they hang the phone up on you or they tell you to ring the police or… that's where the problem lies. It needs more funding because there's lack of staff in the crisis team. It needs more funding there. And you say about your access points, that's where it needs…

**Mr Morris:** No, that's a really important, a very important point. That's exactly why we’ve been trying to address this issue.

**Tim Campbell, George Kendall Legacy Mental Health Charity:** Hi, my name's Tim Campbell, I am a consultant in mental health advocacy and my experience includes running the Broadmoor advocacy service, and what I'm wondering is whether there may be an opportunity for independent advocacy to be funded to enable it to work within emergency settings. For example to go in to police stations or to go in to emergency departments and being able to support service users directly there and then and if they're having problems getting help from the services. And I just wonder if that might be a more efficient use of money to sort of speed these processes up actually on the front line.
Mr Morris: This is maybe slightly outside of your remit…

Mr Green: Sure. I mean, (unintelligible - 53:47) community based agencies, that's really quite interesting and given that a lot of the funding now goes through Police and Crime Commissioners at a more local level may well be that's a good point of contact for specific community based agencies to go to. If a crisis team's dismissive then of course they shouldn’t be and, as James said, the whole purpose of this and other exercises is to ensure that at the first point of contact the right response is given. Advocacy service funding is an interesting one, always very interested in more efficient ways of spending money in the current climate or indeed in any climate. Let's take a look at that, there is a case to be made, the best way to, you know, what the style, what expertise, what skills you want available in any situation. So we will take that away and think about it, that's an interesting idea.

Mr Morris: Okay, great. Thanks very much, Damian, for coming to talk to the group, I think that was a very productive Q&A session airing a lot of issues that, I'm sure we'll pick up in the subsequent discussion that we have. So thank you very much for coming along, show our appreciation for Damian.

[Applause]

Mr Morris: Right, let's move on to the main body of the session now. I'd just like to introduce the panel, if you could just maybe, if we went through the panel, if you just want to introduce yourself and say which organisation you're from before start off, so.


Commander Christine Jones, Metropolitan Police: Christine Jones, I'm a Commander in the Metropolitan Police and I have responsibility for mental health in London but I also man the national remit for mental health and policing.

Ann Hicks: I'm Ann Hicks, I'm a Consultant in Emergency Medicines, that's A&E, and I work down in Plymouth, which is why I was invited today, to represent the college for all things mental health and I sit on the Psyche Liaison Accreditation Network Committee.

Sue Goddard, Expert by experience: I'm Sue Goddard, I'm here as a person with lived experience and probably am meant to be engaging with the services.

Vicky Skeldon, Making Space: My name's Vicky Skeldon and I'm an area manager for a voluntary organisation called Making Space.
Mr Morris: Okay, great. So Christine, if you could just kick us off, just conscious this room is quite echoey so I think if you could just raise your voice slightly as you speak that might be helpful, it's quite an echoey room, so Christine.

Christine Jones: Okay. First of all thank you very much for the invitation to come this afternoon, I do think it's pretty critical because ultimately 40% at least of policing time is devoted to people who are vulnerable as a result of mental ill health. So anybody who says this isn't core business for policing doesn't understand policing in the modern context. So first of all let's be absolutely clear that police and leadership (unintelligible - 56:45). I think there's a couple of things that I want to pick up that really kind of form the basis of some of our thinking in policing and with partners is that we're dealing with a health act from 1983 where I think the social context around the expectation for people who were mentally ill was very much that they would be regarded as dangerous, not to be treated lightly and probably the police was the best response in many cases where people were suffering crisis. And I think really what's happened is we've kind of drifted along with that kind of thinking between ourselves and other agencies and ended up with the police taking perhaps far too big a role in how we deal with crisis. And I really do welcome the support of government, certainly Norman Lamb, who's been absolutely brilliant around understanding some of the complexities of this and helping us to device concordat. But also Damian Green, because again you can hear from what the minister said earlier on, he does absolutely understand the position the policing find themselves.

All of that said when people turn to the police in crisis you have to expect that you get a reasonable service from the police that make you feel less vulnerable and directs you to the service that you need. So underpinning all of this is we have a job to do to keep people safe and some of that will be outside policing responsibility. But frankly if we come across people, members of the public, who need help then we've got to have a process that ensures that people are referred to the right service in the right way. And I think part of the problem for us is that we have very little relationship between ourselves and health at the front line, so that when my officers turn up to somebody who appears to be in distress in the street, what is the officer to do if they cannot access knowledge around who holds this person's care plan? Who their local carer is or named carer? Perhaps what their background is around what crisis commencement looks like? And therefore make a proper assessment as to whether or not this person needs emergency care or otherwise.

In that way we can make some far more sensible decisions about the use of Section 136, because ultimately for me and my aim for London and nationally is that the use of Section 136 will be regarded by not only ourselves, but also our health partners, as a critical incident in service failure, because it's very rare, it's very rare that we come across somebody who needs the exercise of 136 without having had some contact with them in the past.

The other point about mental ill health, of course, is that it makes people much more vulnerable either to crime or to committing crime, and there are lots of circumstances that we can describe people who have been living with a mental ill health vulnerability or a learning
disability or a personality disorder, where their homes have been taken over by drug dealers and drug users, etc, etc. Our vulnerability assessment of that person has not been efficient and not been effective enough to divert them from the criminal justice processes. So one of the things that we're teaching our officers is to assess vulnerability more effectively by the vulnerability assessment framework, because as you heard the minister say earlier on it is not realistic to imagine a police officer can in any way reflect the sort of complexity of training and the years of commitment that it takes to be a mental health professional and in any way to be able to differentiate between somebody who has a learning disability potentially and somebody who is living with a personality disorder. Particularly if those two people are in crisis and even more so if they are unfortunately using drugs and alcohol. I don't want that for my officers but what I do want is to make sure that in every occasion we meet with a member of the public, we apply a consistent framework, which enables us to assess their vulnerability and then to act on it.

And that brings me to the next issue, which is around the sort of data sets and information that we share with partners. When some of the clinical commissioning decisions were made this year they weren't always made on the basis of information that came from the police because we weren't asked for it and frankly didn't collect it. We've got to get very sensible here about how we describe the depth and breadth of demands at a local level and at a national level for different services, so that if we have an accurate record of the types of people who are coming through custody with mental ill health needs and therefore the possibility of liaison and diversion pathways out of it, we can make an assessment as to what level of resourcing needs to go in to that.

But more importantly there is a business case behind this. The business case is that acute care and unplanned care costs the country an absolute fortune. Whereas actually if we go and look at the opportunities to intervene upstream and provide people with the support they need that avoids those sorts of crisis, then it's in everybody's interest that we get that right, and the police have a huge role to play in that. So the argument of not exchanging information on the basis that it's uncomfortable frankly just doesn't stand scrutiny. And I would much rather that my officers, who are encountering John Smith on the street who has a propensity for going in to crisis, but actually we can access information that says his mother, his carer, his named worker is on this telephone number and can be accessed 24/7 etc, etc. Therefore avoiding fear and ignominy that often takes place when people are taken from the streets in to mental health environments necessarily, as a result of no alternative, is to be avoided and I think there's a good business decision behind that.

There are other issues that I think are pertinent to public confidence and that is that the police have a role to play to support those who are vulnerable. What I don't want is for people who are ill to be placed in the back of a police vehicle, transported to a place of safety where they feel nothing more than that they have been arrested, they've been ill treated and that they haven't been cared for in the way that they need. We're working nationally with colleagues to make sure that that does not happen and I know that certainly my colleagues around the table, and nationally, have achieved a really fantastic improvement in the number of cases that are
transported from the streets to places of safety through ambulances. I cannot say the same for London yet, but we are working very hard with colleagues in health and criminal justice process to remedy that situation for London.

Finally the issue for me is about - so what difference should this make to communities and to help people feel safe? And I think what's really important about the liaison and diversion processes, but more importantly triage, is that it gives the public and the police an opportunity for a different outcome that doesn't involve necessarily being restrained. It doesn't involve being placed in a police vehicle, but it does involve the sort of care that people would expect to have if they went to an emergency department. And I think this is the point with policing, it is that we have a role but we need to be very clear about what that role is.

What's really encouraging about the concordat is it's a way for all public services to hold one another to account so that if my officers failed to recognise vulnerability and failed to refer someone to the right pathway, then I think it's right and proper that we should be held to account. In the same way that if health partners failed to manage bed space and don't provide transportation and don't support that pathway. Again, we need to hold each other to account, and Norman Lamb's concordat absolutely provides the framework for that. And of course there's governance in London that is being reflected elsewhere across the country and through the Mental Health Partnership Board and other user groups and other strategic groups, which will make sure the principles of concordat don't stay as a strategic intention, but actually do change activity at ground floor level.

Mr Morris: Thanks very much, Christine. We'll move straight on to Robert and the West Midlands Ambulance Service.

Robert Cole: Yes, absolutely. I'm talking on behalf of West Midlands and then a little bit on nationally, an ambulance service point of view. About three years ago we recognised from an ambulance service point of view that mental health didn’t have the parity of esteem it absolutely should do. I'm very clear on this, the Section 136 is a medical emergency until proven otherwise. No police officer can rule out an underlying medical condition, they don't do hypoglycaemic checks, they don't do toxicity checks, they're not medical professionals. We recognised that three years ago in the West Midlands and as a result of this we make sure that every request for Section 136 from our four police forces have an emergency blue light paramedic response within, the agreed targets are 8 to 20 minutes, that's a standard emergency response.

We've been doing that for three years and that basically means that, to echo Christine, we take very few people in the West Midlands in to custody. Patients are assessed, they are red flag screened. If it's appropriate that they go to an Emergency Department, then that's great, I've got no issues, other than that they're to go to a health based place of safety. We've got them in all of our areas in the West Midlands and at the very last resort, and it might occasionally be appropriate that a patient does need to be managed by the police in custody, but it's an absolute rarity and that's certainly how it is in the West Midlands. Just to add to that that is
going to be national policy from the 1st April that all ambulance services in England will attend Section 136s as a blue light emergency for a clinical screening, that's on the 1st April 2014.

We went one step further, we said Mental Health Act conveyance needs to be robust. People are in crisis and they need an appropriate and timely response and waiting four, five, six hours while police, ambulance, mental health and AMHPs decide how to convey is frankly unacceptable. We have a conveyance (unintelligible - 1:06:18), we've had it for three years. The headline points are any patient in mental health crisis where police are managed it's a blue light emergency, you get a blue light emergency response, you get a blue light ambulance and the patient is removed to the place where they'll need to be treated. Those patients who don't need the police, we look at their cases on an individual basis. We have to recognise we have limited resources and we have to recognise that ambulances need to be available for all. But absolutely if the police are involved in the management of a mental health person in crisis, that is an absolute emergency. So Section 2, 3 and 4s and 136s are all dealt with as blue lights within the West Midlands for those patients. We're trying to push that nationally as well.

We've got a mental health triage pilot, as the Minister has stated, and in the West Midlands we're the only area that is looking at the process of having a police officer, a mental health nurse and a paramedic in one a vehicle. It's an unmarked vehicle, it provides dignity and respect, it does have blue lights but it's covert, it's dual deployed by ambulance and police. Initially it was scoped to deal with street triage, but we've moved that one step further. I'm a big believer that street triage, street crisis exists because we don't manage the patients in the home correctly. So we said no, we go to everybody and 70% of our work, of course, is now in patient's homes.

We have got police officers, they are dedicated teams, they're absolutely brilliant and they're very sensitive and dignified in dealing with patients. We have dedicated mental health nurses. At the moment, if I'm honest, we have paramedics who are only as on an adhoc basis. The Jury is out as to how I think we should move forward with that, I personally believe we need paramedics for health screening, but I think we need another dedicated resource, people who are trained to a higher level. It's not standard paramedic work, it's a totally different genre, it needs additional training and it needs a different approach, but I think, we can provide the health based screening.

In the West Midlands we've done over 400 contacts within the first two months, we've had very few Section 136s and out of those that have been detained with a Section 136, in excess of 90% have been further detained under the Mental Health Act, proving to us that those who are detained are appropriately detained. The national average we know was somewhere around about the 18% mark so we're really pleased with that. And of course, also, the final thing on that is we convey patients in the car, it's absolutely undignified to convey people in mental health crisis in a bright yellow, 3.7 ton emergency ambulance, why would you ever do that? What is dignified is a car - there's nothing wrong with these people's legs, they need to
be managed in a dignified manner and conveyed in an unmarked vehicle and that's exactly what we're doing. So that's for Section 135, 136, 2, 3 and 4.

I thought the point around intoxication is really, really interesting. I know that when you turn up at hospital having a heart attack, if you're intoxicated you don't get turned away and I know that if you have a broken leg and you're under the influence of alcohol you still get managed. I fail to understand why that's different in the world of mental health, especially when a lot of people are forced in to intoxication as a result of factors.

I'm a big believer that no person should attend A&E as a result of no appropriate health based place of safety, places not being stamped or not been able to accept more than one person. Plus A&E should accept patients who are appropriate for A&E custody at the absolute last resort and other patients with the provision to go to a health based places of safety. From an ambulance's point of view we've got a national mental health leads group, we deal with it on a very, very senior basis. The Association of Ambulance Chief Executives are basically all over this, they have a designated lead and we're really engaged to make sure that it's given the parity of esteem that it holding have.

My final just few points, what do I think we need to do? I think we need improved training even further for ambulance staff and it needs to consider further triage, but not just street triage, we need general liaison diversion in the home, dedicated staff from all areas with advanced training. Pathways, I can't echo enough about pathways. Crisis intervention care is not commissioned as an emergency service and four hours for somebody in crisis is not good enough. Why do people call treble nine? Because quite often every other route has failed. But actually that's not a resort for calling treble nine because we're a service who doesn't say no when we turn up and we're quite polite. We also then get stuck with where can we signpost these patients to? We also struggle to get involved in crisis and pathways and we end up then being forced to take people to hospital. It's not appropriate, it's not fair on the hospitals, it's not fair on the patient, it's not fair on the ambulance staff either. We need proper pathways in to proper services and that's one thing the triage pilot has absolutely done, it's given us access to that mental health 24/7 and that's fantastic.

Appropriate transport I've said, I think appropriate commissioning is absolutely vital. You have to look at some of your commissioning contracts, they're out of date, they're not fit for purpose, they don't do what they need to do. We need to commission appropriate services. And also, my final thing is 136 legislation, this might be a curveball but the Mental Capacity Act allows for other persons other than the police to detain people, to act reasonably and proportionately, to use restraint where appropriate. It's a postcode lottery, if somebody looks out the door and they call the police, actually they may get an appropriate pathway, they may get a Section 136, an ambulance in timely fashion and conveyed to a health based place of safety. If they call an ambulance they get taken to A&E, that can't be right. So consider 136 powers may be for ambulance staff as well. Thank you.

Mr Morris: Thanks very much, moving on to Vicky.
Vicky Skeldon: Hi, I work for a voluntary organisation called Making Space who have been working to support people with mental health conditions for 30 years. We, as an organisation, work with the commissioners and service users in mental health services in Lincolnshire to implement the crisis houses within the county and to design a service model. The Haven in Lincoln opened on the 8th June 2009 and it's a six bedroomed house, four bedrooms allocated to guests including a downstairs room with a full wet room and one sleeping room for staff. And each house has one spare room in case one is out of use. Each house will support four guests at a time. The service is staffed 24 hours a day, seven days a week, 365 days a year. The other service Collyhurst and Spalding followed in October 2010 and is exactly the same model. We are funded through the CCG and for the first few years a fifth of our funding came from public health. However we had our funding reduced by £90,000 across services when Public Health made the decision to withdraw their part of funding. Public health, however, still hold the contract and complete all the contract monitoring.

When we first opened the service the only pathway in to the houses was a referral from the crisis teams, however we worked very closely with the community teams and the commissioners to ensure that the referral process is as stress free as possible for the guest. And we started by opening up the pathway to the recovery teams in 2011 and in 2012 we opened it up to include all community mental health teams, meaning that the guests would now only have to have one assessment rather than two. We also take referral from the 136 suite in Lincoln from A&E and have been used as a step down service for those who have been on the acute ward for some time. And we actually aim to get people in to the service within four hours of referral.

When we first opened the occupancy levels were low, however we now average between 85% and 95% occupancy, our highest being 98.2%. We support a wide range of individuals for many different reasons and they are able to come and stay in the service for up to seven nights. We also work with the commissioners so that we now have a tool to have an extension of stay built in, which means that somebody can stay for a maximum of ten nights. People get referred to us for many different reasons and what constitutes a crisis is totally individual. We are not averse to working with people with high risk, but ensure that we're able to manage any risk before acceptance of referral. During the admission process a comprehensive risk assessment is completed and any risk management is discussed and agreed. During a person’s stay, a person centred support plan is also completed and we work very much in a way of co-production, a do with and not for approach. We refer on to many other different services by way as a signposting.

To the end of December 2013 the crisis houses across the county support 1,163 people, with a high percentage of these having a positive outcome. There have been times when the service has been unsuitable or the person's mental health has deteriorated, therefore the risk becoming unmanageable resulting in a reassessment and a hospital admission, however this currently stands at 7%. The feedback we get from both referring agencies and the people that have used the service is very positive and we pride ourselves on delivering a first rate service.
Mr Morris: Thanks very much. Dr Hicks.

Ann Hicks: Thank you very much for inviting us lot from accident and emergency or emergency medicine, as we call ourselves. If I just take it back to the grass roots, if we have a bloke called Bob who comes in, he's 32, he's got pneumonia, I've explained to him what's wrong with him, I can explain to his family what's going to happen to him and I can pretty much now guarantee that I'll get him on to a hospital bed, what his care will be, we'll start his treatment. I can look at my staff and the family and the patient in the eye and feel that I'm doing a good job. Often if I have a guy in called Bob who's 32, he's got a primary mental health issue, you might suddenly take a sharp intake of breath. I have to ask him where his GP is, where he lives. The hospital where I work, we have three different patches, one is over a great big river called the Tamar, which is as wide as the Atlantic when it comes to trying to engage with people to get him back. And I can't tell the relative what the pathway is going to be and I can't tell the patient how long the wait's going to be or what's going to happen. And I've done that talk for ten years using the same picture, trying to say this isn't right. So I really welcome the concordat because I think it's a massive step forward in trying to do something about it.

There are loads of patients who should be in an emergency department, there's no question of that, and we're trained for that, so as a consultant in emergency medicine, my membership and fellowship exams, have mental health representatives right across the board. If you take our nurses, they have 22 hours training a year, it's largely around mandatory retraining, which is basic life support, manual handling and things like that. And for all the specialist areas they often come in on their days off to come (and maybe we should say that mental health training isn't a specialist area) so it's got to get a quantum leap in terms of how we fund nurse training so that we can address their trainees.

I think there's probably a few zones of access to us, one is someone, quite rightly, sees a red light outside our door, it's meant to be somewhere for emergency and they come in and they try and get help. We frequently have GPs who are just frustrated that they can't access service for their patients when they come through. We also often have carers who, or family members or friends, just going “please look after our friend”, and they can't access other places because they can't phone a place on behalf of someone else. And sometimes it's the police going please can you help us, we don't know what to do either. And so out of that there comes a disconnect of people who are going to emergency departments, they're rubbish, they're horrid, they don't give us the treatment that we need and all that sort of thing. There are also an awful lot of people who are going “do you know what, that was fantastic, they were great, they were really nice”. And part of it is because the frustration is, it's really difficult being a professional to navigate your way out for the patient's benefit.

The danger of the mental health concordat is it does address mental health. And the slightly tricky problem is not all patients remember have only one thing wrong. And also for us a mental health patient isn't just a mental health patient, it might be a mother, someone who's
working, all the rest of it and so what we need to do is just be a bit more grown up about how we approach patient's needs. And that's what the parity of esteem document is about.

Someone might come in all guns blazing, mental health crisis, took an overdose or doing self harm. They might come in because they're just complete physical neglect and their side order is mental health. It might be they've got medically unexplained symptoms, or their mental health, stress comes out through physical symptoms and they go round various departments in the hospital and everyone's going “oh, I don't know what's wrong with them”. The other thing is they might come in with a broken leg and actually their mental health is a side order and they need help for that through there.

So what do we need to do? It might be a forensic need, it might be their life chaos ends up with the sort of police or for the police and us and for the paramedics it's just a system of failure and so all of us are trying to do the best we can. So what do we need to do? There are some really positive things going on, there's a mental health toolkit that was published last year on the College of Emergency Medicine website. Interestingly it's our fastest downloaded document ever, I think it was 524 overnight before it was published. There are only 200 departments, emergency departments (unintelligible - 1:20:22). We had a college CPD day last year, which was our fastest selling out CPD day just about mental health. There's loads of evidence of why liaison services, liaison embedded in mental health and acute hospitals why that benefits the patient, for all the reasons that I've just said.

We're massively underfunded and we have to find the money and we have to train more liaison psychiatrists. We have to accept that the nursing teams, those specialist mental health teams, there are acute hospitals big enough to serve their hospital. And then the other thing we need to try and do is try and think of how we provide a safe environment for people to have, I don't know what the right phrase is and I don't want to offend anyone, maybe a mini crisis. So sometimes people are intoxicated, everything feels awful, once the alcohol wears off they're okay. Now those people might need help with their use of alcohol, they might have serious mental health issues and they need to get liaison psychiatrist, but it might just be down to housing and benefits or whatever. But the only way we can address those needs is to put them all together and the right place for that isn't the emergency department, it's definitely not a police cell, so we have to work out how we're going to provide that.

And so what are the blocks? I sat on the accreditation committee, the room in the emergency department, we just want it to be safe and nice for patients and staff, and do you know what? People can't get the funding for that. So one of the things this year will be the College of Emergency Medicine audit and it'll be the first time, they have one every year, the CPC look at them, this year it will be the first mental health one. And one of the points of that will be the room, which reinforces loads of other areas, because we've got to get the environment safe so that people feel they can talk, that we can look after people when they're out of the sort of main helm of the main emergency department.
We have to try and get over, there's got to be a quantum change in commissioning. So I went to our local mental health concordat meeting last week, and there were tons of people there. There was a bit of me that felt overwhelmingly optimistic, but then a bit of me thought that they're still talking about commissioning things in pockets, and we can't solve the patchy commissioning of mental health, that will never meet the acute trusts or police patches if it stays the same. So we've got to try and get rid of bewildering numbers of services, an ICE team, a crisis team, a home treatment team, I'm in the biz and I get confused. So we need to sort of really try and clear the way so it's simpler for both staff and patients. So I hope that we can get through some of the blocks with training.

And I'd just like to say two last things, one is data sharing. There's one powerful one locally and the family gave me permission to use it, which was the police didn't tell us why they'd brought someone to the department, we didn't tell them all that we knew about the patient, they went on custody and they went to prison and there was a very sad outcome for that patient. If we had just said do you know what, this is what I know, what we need to know, and we've learnt locally that we've all got to learn from that. And the last thing is the most powerful thing, which is why you've maybe left our best guest speaker till last, is our expert patient that's being used for our CPD day, she stunned the room in to silence because not only was it her perception of going to an emergency department, but it was also a lot of the emergency department nurses were trying to say things that helped and yet they completely clashed and clanged with what was going to help. And so we have to embrace that for both our educational needs but also to shape the service. Sorry for overrunning.

Mr Morris: That's all right, fantastic, thank you very much for that, it was very interesting.

Sue.

Sue Goddard: Okay, I think, first all this is the first time I've disclosed my struggles in an open environment, okay, so bear with me, and I apologise to anyone that it might be triggering in any way. I have to make comment on the availability of crisis teams because there's an assumption out there that if someone has a mental health crisis there is a crisis team that you ring up out of hours and things, there is not, I don't think, I think in this room everyone will know that, to the general public the idea that out of hours, if you're lucky you'll get a five minute phone call with a discussion about lavender baths and telling you to go to A&E, okay. So that is, I think, a shared experience and as I suspect across the country.

I think what I want to say is really to try and illustrate how hard it is to access services even when you know what is out there, okay. I had a (unintelligible - 1:25:33) input for about the last ten years, not so much the last two years, of mental health services in Camden. What I'm going to describe to you is not an isolated event, because often what happens is that, you know, something happens (unintelligible - 1:25:50). This is a pattern that happens with people regularly, I just happen to be able to talk about it today.

There's a slight run up to this, I had community care services (unintelligible - 1:26:06), which was probably about three or four contacts a week with care professionals, psychiatrists I'd
seen for seven years and medication. Cuts or reorganisation, as it's called, happened and that, without planning, stopped with no follow up, which meant not only did I lose all the support I had also it meant my medication stopped dead okay, because my GP had never been involved in my mental health, okay, so we've got to get there.

I have bipolar symptoms, I've been very unwell and quite elated actually all over the place and then had quite a psychotic presentation I was absolutely terrified of the world, absolutely, I can't even explain what that means. A lot of voices, a lot of things I hadn't experienced to that extent before, I was completely without support. I shut down to people, I wandered around the country basically, I'd gone down to London, (unintelligible - 1:27:15) country. I was reasonably well presented, presumably like this, so I didn't flag up, you know, all the stereotypes necessarily (unintelligible - 1:27:28), but I was very, very unwell. I was detained under Section 136 in Wales, I have very little memory around this, I was admitted for about six days in Wales and discharged in the care of a friend, okay. No follow up from any mental health service.

By this time I'd actually deregistered myself from my GP, not for any reason the fault of the GP, just because these are the sorts of things you do when you're thinking straight, she alerted mental health services, so at this point I also had no GP as well. So there was no follow up on those occasions. I then wandered down and in Cornwall twice on rail tracks, I get detained under Section 136. I get admitted to, the first time I get admitted to A&E unit, discharged, no mental health assessment at all. I don't know why, it's Cornwall, (unintelligible - 1:28:27) and I don't, and I wasn't very well. Within 24 hours I was detained again on police tracks because this was part of what was going on in my head, taken to the 136 suite, had a Mental Health Act assessment. For some reason they didn't admit me, they discharged me with an alert to Cornwall and Devon police that I was a high risk suicide, a suicide risk, okay.

I'm in Cornwall, I'm aiming to get back home to London, disorientated, still not very well, still no medication. British Transport Police, give them their due, actually then escorted me on a train back to London, okay. They, and I have to say, I mean, this is all credit to the police, for me the police have turned to be the emergency service. I arrive back in London, still no contact from any mental health professionals at this point who now know I'm a service user that they've known ten years, so they know that I'm not very well, they know I'm someone who doesn't ask for help very easily and someone who has a history of being actually compliant and not resistant or combative, no need to restrain, no history of violence, with a history of suicide attempts, okay.

British Transport Police phoned me to see that I'd got home okay, pick up that I'm not very well and that no one's come round, they come round to my home, they're there for several hours, call the ambulance service. They call, ask, contact the crisis team and the mental health, the AMHPs service and ask for a mental health assessment. About three or four hours go by, no one turns up, they have to leave, okay, I'm left on my own. The next day they follow up again and they say this is ridiculous, they make a complaint, well, a telephone call, they come round, again they're with me again with the ambulance service for several hours,
make the same call, mental health services say they can't turn up, don't turn up, whatever, they leave again.

The Met then do two welfare checks the next day because obviously British Transport Police and the Met have coordinated, despite the fact mental health services aren't, and I don't come up on a police national computer but I've been a missing person a number of times and I certainly have a flag of some sort, okay. And the second time of the evening they come round and they persuade me to be taken to A&E, not my local A&E (unintelligible - 1:31:13). I'm there for about an hour and a half and discharged with not seeing a psychiatrist, no Mental Health Act assessment.

I'm now extremely unwell and having extreme voices, intrusive thoughts, I mean, really at the most self destructive nature you could get. I then attempt to jump in front of a tube train, restrained from doing so, detained by the Section 136, finally admitted to hospital under section 2. When, and that settled me for a bit and I was prescribed new medication. At the end of that stay, of course at this point I have very little faith in mental health services, I don't see them fit for purpose however psychotic I am, that's still (unintelligible - 1:32:06), I feel that now and I felt that then. I'm discharged from hospital with no crisis plan, no community referral, this is on my discharge plan, I've got no GP remember and an agreement to buy my newly anti psychotics online, okay.

Now I had the capacity probably by then to make the decision, that's a real statement on the position of what most people think is meant to be a high functioning mental health trust, okay. And I think all credit to the clinical team on the ward, they had to make a decision, I'd be bed blocking otherwise, I'm quite stable by then and they're making a decision that horrified other people, although I was quite pleased with it because it got me out the ward, so.

Now this year, this is about 15 months ago, this year I become unwell again, although you wouldn't have recognised it.

I've got support from a GP and an independent advocate from a charity, that's my support, and I use the Samaritans, who are absolutely excellent, absolutely excellent. But I become high, elated, medication becomes an issue, it's very difficult. My GP now has no one to refer to because I have no community team so she has no one to talk to. I've become very unwell, extremely psychotic, barricade myself in my home. The mental health services apparently, I've learnt since, were alerted many times, I wouldn't have approached them, I couldn't see, you just don't. I think that's what people don't understand, why wouldn't you approach them? When you're very unwell sometimes you don't know you need help and other times your experience has been so bad that it's a real risk to approach them and to be turned away, it's almost like a suicide trigger in itself, if you are suicidal and ask for help and those people basically say no, for whatever reason, then the outcome can be very poor. And on that occasion I'd actually, I had been very unwell but we tried to manage it, but I dialled NHS 111 to try and speak to a duty doctor about psychiatric medication, I was having problems taking it, and I think a lot of people do, okay. I couldn't get past the contact centre on NHS 111,
they asked the mental health questions, within three minutes the police arrived first and then the ambulance service, because the arrangement in the Met, and you can correct me here, is the LAS request, London Ambulance Service, request police attendance. They don't know what they're going to, I mean, they must be quite amused to see my cowering in the corner, and then come in force. But for me that is terrifying, absolutely terrifying.

So on this occasion they come round, because I'd been ill I'd sort of deconstructed my bedroom in a way that would cause alarm, they were the first people to come to my house for months. I was taking care of myself in other ways you see, all those other flags didn't come up, but I can acknowledge now that I represented as not being particularly well. Again they ring the crisis team, apparently tell them to ask for an assessment under the Mental Health Act, they ring the AMHP service, don't come out at all. Eventually after four hours, three police officers and two LAS staff which are in my house, eventually a friend comes round, I'm left in the care of them, I send the friend away, I disappear. I'm too frightened to go back home because I think these people are going to come and lock me up and I'm thinking I'm at the end of a crisis and trying to manage and it just feels so threatening.

I'm quite clearly becoming more suicidal because, not just because, but having that situation just can tip the balance. The police are then concerned enough to report me as a missing, high risk missing person, Manchester police spent a lot of time looking for me as well. They all notify the trust that I'm under, well, I'm not under the care of because I don't have a team, but alert the people who you'd expect to be alerted. I think, they stuck a note through the door and reckon I would come back home about a week later, they'd stuck a note through the door showing that they'd turned up 14 hours later and a note saying if you need to talk to someone ring the crisis team or your GP, which is actually what I tried to do in the first place, rung my GP. So that is, that is how it is as a lived experience. And I'm someone who's worked really hard to try and work with services, I'm not someone, I get frightened and I withdraw, but I don't have any of the other issues that may complicate the picture and even with that it doesn't work.

**Mr Morris:** Okay, well, thank you very much, Sue, for sharing that with us, it's an extremely powerful example of precisely why we are doing the work we're doing on this enquiry, so thank you very much for having the courage to do that. I just want to open it now to questions, some of my parliamentary colleagues might have questions which you'd like to start off with.

**Mike Thornton MP (Eastleigh) (Lib Dem):** Well I'd very much like to ask Dr Ann Hicks as an emergency expert. When one goes to an emergency for a physical thing, very often you get quite a good assessment process for physical illnesses, which happened to my mother, but her mental assessment, because she had dementia, was not very good. But it was very good and then it got better, but it was very good at Winchester hospital, very good assessment centre where she got very well treated. Now, it just surprises me that there is so little, they're very good at all sort of physical illnesses but why not mental, there's no requirement for a
mentally health trained nurse there? You said they had their 22 hours but should there not be actually a fully qualified mental health nurse nearby or trained or something like that?

**Dr Ann Hicks:** Last year there was a rewriting of the joint document about liaison services in acute hospitals. So what we should have is we should have liaison services (mental health), so there are trained mental health nurses and doctors who work in parallel with the acute trust from the front door to the back door. Emergency medicine nurses do know about mental health and will do assessments and do all that but it's all very well us doing the sort of assessment at the front but the other half is, the starting of treatment is working out where the pathway is and all that sort of stuff. So I think there are loads and loads of emergency medicine nurses who are very good mental nurses, it's a huge amount of our time.

If you think that the major trauma networks and how much has been put in to major trauma, that's less than 1% of my job, okay. About 10% to 15% of my job is mental health, the overt mental health as opposed to the covert you mentioned earlier. So we are trained in mental health but lots of people say why don't they have more training? Why aren't they trained in restraint? Why aren't they trained in this? Well, a) we look after a huge variety of conditions in emergency medicine by its very nature, but also we just try to free up people to have their individual training, it's something that isn't championed and looked at. So they do have some training in mental health but I think every time we do a little bit of training it's like throwing water on a dry sponge.

**Mr Thornton:** Yes, I've had loads of compliments about the police in my constituency about how they deal with it, especially since the liaison started and how effective it's been, and they're not trained in any kind of medical procedures at all except resuscitation. So it just seems well if they can be that effective there, is it just that I'm getting it wrong or is it just lesson, why isn't it as effective in A&E or is it just that it doesn't continue?

**Dr Ann Hicks:** It is effective, it's just not provided.

**Mr Thornton:** It doesn't continue.

**Dr Ann Hicks:** So the emergency medicine nurses (unintelligible - 1:41:21) we get an awful lot of complements about the impact of emergency nurses on patients with mental health, but the thing that's not there is the funding float and that's because of the historical barriers of commissioning. So you either ask mental health trusts and it's not going to be their priority because they've got all the rest of mental health to commission, whereas the acute trust are going “really, is it our job to provide that?” I got my local commissioners to top slice off all of their health community to start providing our liaison services, but that is pretty unique in the country. But that's the problem and, no, we know that having mental health trained specialist nurses in the emergency department is only (unintelligible - 1:42:08) for good, it's just common sense, and there is research to back that up as well.

**Chair:** Thank you.
Dr Ann Hicks: But it's just not resourced.

Chair: Baroness Hollins (unintelligible - 1:42:13)

Baroness Hollins, of Wimbledon: Yes, I'm a crossbencher here but I'm also a former psychiatrist, retired psychiatrist, put it like that. Shouldn't the acute hospital actually be employing psychiatrists and nurses, not as liaison professionals but actually as people who are responsible for the pathway, so they're actually employed, not just leaving it to the mental health trust. And I'll explain what I mean about that and I want to thank all of the speakers and to apologise for being late, I was at a learning disability (unintelligible - 1:42:46) parliamentary group. I was very moved, Sue, by your condition and shocked by it. But I think it really highlights what to me seems to be the difficulties that we have a system which is reactive, you have to know where to go and then having gone there somebody has got to take responsibility. And what you found and what other people have talked about is that it was the police who took responsibly.

Sue Goddard: All the way through, yes.

Baroness Hollins: That must mean that things aren't being commissioned properly, which is the point that several people have made. So if we feel they have parity of expectation, we've got to have parity of response and that response has got to be joined up. And so it brings me back to my feeling that actually until we start having consultant psychiatrists and consultant specialist nurses working in acute hospitals, employed by acute hospitals, who'd have to take responsibility for the pathway so that you know when the patient comes in, aged 32, with pneumonia that they're going to that pathway.

But you also know what happens when somebody comes in with bipolar trouble and you know what the pathway is there too because you're actually going to take responsibility for it, you are going to sort of somehow wonder where out there it's going to happen to work. And I just think that we're sticking to the, what I always see as Virginia Bottomly's mistake, which was by separating our mental health and our physical health, as if somehow we weren't held equal, we were people who could either have one diagnosis or another but they'd got nothing to do with each other.

Mr Morris: Anybody want to just reflect on that?

Dr Ann Hicks: The current major block to that is every acute trust in the country is being asked to spend less money so they're looking at essential services and to reduce their bed base.

Baroness Hollins: But it would save them money if they actually treated people's health equally.
Dr Ann Hicks: Yes, but when you take that to an acute trust they can't realise that saving without employing people from other, it's all divided up in to service lines. All of the commissioning structure at the moment is against innovation and it's, I'm agreeing with you, I think it's fantastic but it's almost impossible to do in the current commissioning environment.

Mr Morris: Before I bring other people in, Charles [Walker] would like to ask a specific question.

Charles Walker MP (Broxbourne) (Con): Nice to see you Assistant Chief Constable.

Christine Jones: Ah ha, yes, Commander, same thing.

Mr Walker: Assistant Chief Constable, Christine Jones, we met in Wolverhampton.

Christine Jones: We did.

Mr Walker: Christine, I think the Metropolitan Police is doing a lot of pretty interesting stuff around this and we've heard of those pilots with mental health nurses going out with the police officers. What further support, I mean obviously there's a huge amount of further support that could be made available, is there access, for example, for officers to a 24 hour line where they can call in and seek advice whilst they're on duty or whatever “look we've got a situation here, how do we handle this?” Does that exist or not?

Christine Jones: Well, the London triage is very different from what's happening in the rest of the country, I think you've hit the nail on the head because I think the idea of having joint patrols is fantastic, but frankly utterly unsustainable. And I think the problem with that is that we are fixing with a sticking plaster what is a broader issue, which is a failure of access at every level, be it from the other emergency services or from the public or from concerned relatives or whoever to 24 hour crisis advice, care, support and then pathway. And what we're doing in London with the triage, it starts on the 24th, is we are looking at the highest demands, if you like, at the mental health trust area. The reason it's highest demand we're not sure about yet, and it may well be that we are using 136 inappropriately because we don't have enough information about pathways, etc. But we are using it in one specific area in London firstly to find out does this give people the right and quick access in to the type of care environment that they need at the time of crisis? So it will be accessible to police officers. Our hope is that it would also become accessible to London, and I know that the mayor for London is very interested in seeing the outcome of the pilot that we're running.

But the other piece for me is about those that come through the criminal justice process, so those who come repeatedly in to custody who perhaps are regularly being arrested every two or three months for pretty crime, who are quite clearly suffering from mental ill health, who don't get the support from a particular trust because they're not in crisis. They may be homeless and all the other issues that potentially surrounds somebody's life collapse that brings them in that revolving door process through criminal justice.
But what I would say is that NHS England are investing £3.5 million in liaison and diversion schemes across the country, they're working alongside of us and in London we've got 70% of customer suites now covered and all courts in London, so this is a really big step forward. The issue again though is continuing the funding and making sure that the processes that we're using for pathway development are evaluated and they are put against the reduced cost to the criminal justice process to urgent care and everything else, because whilst we look at demand reduction in one point, it's like standing on a balloon, isn't it? It comes up elsewhere.

So we need to be really clear about how flexible government departments are about moving budgets, because that's what it comes down to. We can be the most efficient and effective commissioners in the world, but if the money's not there, the money's not there and although we can work together to be more efficient, ultimately the demand needs to be met and it needs to be met not just now but in five or ten years time. And it's a similar argument to early years intervention with young people.

Mr Walker: Who's running the pilot, are you running the pilot or is the trust running the pilot?

Christine Jones: We're running it between us, it's…

Mr Walker: The trust (unintelligible - 1:48:49)

Christine Jones: Well, the money is being held by MOPAC, not the Metropolitan Police, and this is being given to the NHS to use in order to provide the service to policing. So it's quite independent in the way that it's being managed.

Mr Walker: Which part of London is being run in?

Christine Jones: It's run in south London.

Mr Walker: South London.

Christine Jones: Yes.

Mr Morris: Okay, I think I'm now going to open it up, is there anybody who didn’t contribute a question in the first round when the Policing Minister was here or does anybody else want to make a comment? Gentleman at the back and the gentleman there. Can you just say who you are.

Male: Yeah, I'm (unintelligible - 1:49:28) I'm a carer (unintelligible - 1:49:30) A couple of observations (unintelligible - 1:49:34) really, one is this concept of having some mental health expertise on hand with the emergency services, which we know (unintelligible - 1:49:42). And I've seen it in situations, one fairly recently, where there was a case (unintelligible -
1:49:49) for a crisis. But there's not enough treated (unintelligible - 1:49:56) they need the mental health assessments. And the mental health (unintelligible - 1:50:01) qualified party wasn't at that particular place (unintelligible - 1:50:03) they actually treated him for self harm and they (unintelligible - 1:50:11) special crisis unit. The hospital that could take them couldn’t (unintelligible - 1:50:15) mental health assessment. They had to go to a (unintelligible - 1:50:21) hospital to get that assessment before they moved over. There was a wait in this hospital for four hours before he got that assessment, which took four hours, he had a carer there (unintelligible - 1:50:31) they wanted their treatment straightaway. Why was (unintelligible - 1:50:38) to a crisis unit in a further location. His level of anxiety was so high that it was another problem to deal with, not just one, (unintelligible - 1:50:48). And the point I was going to make, it's a question really, if there's someone gets admitted to an emergency service and most of the practitioners know him very well in my experience of my disability, if there's a carer there and (unintelligible - 1:51:04) procedure has to be taken (unintelligible - 1:51:06) discretion, can professionals not use some discretion to take the word and advice of the carer who knows far more about (unintelligible - 1:51:16) that particular case, far more, and if that person (unintelligible - 1:51:19) come in with the carer, can they not do that to sort of short circuit it made make it more easier (unintelligible - 1:51:24) some people are traumatised (unintelligible - 1:51:27), keep their anxiety low made actually gets to their (unintelligible - 1:51:31) much more quickly without causing them a problem. So please where possible could the (unintelligible - 1:51:37) exercise the carers who can (unintelligible - 1:51:39).

Mr Morris: It's a good point, I'll just take the point or question from the gentleman.

Tim Reeves, Care Quality Commission: Tim Reeves, Care Quality Commission. I'd just like to say as one of the signatories of the Crisis Care Concordat we support the work of the (unintelligible - 1:51:55) on these issues specifically. And also just to say that the Care Quality Commission is also launching a major programme of work in to mental health crisis care and specifically people's experiences of a mental health crisis in accessing help and support. But also I just really wanted to sort of ask the panel really, as so many of these issues cut cross different agencies, different responsibilities, areas which the Care Quality Commission has regulatory responsibility and also with the police where we have monitoring responsibilities under the Mental Health Act and areas which we have (unintelligible - 1:52:37) regulate or (unintelligible - 1:52:38) at all, where does the panel feel their CQC would best kind of position itself to help on this issue?

Mr Morris: I don't know whether the panel want to address the point about carers and the CQC point. Robert, you haven't had an opportunity to speak, have you got any views on that?

Robert Cole: To be honest the view I was going to make actually was just a bit of word of caution again around mental health telephony support, and I just think we need to be careful about commissioning a service that's (unintelligible - 1:53:15) something that the person couldn't get in the first place. And that's one of the biggest issues around telephony support, it just advises that they need crisis intervention. Well, they tried that four hours earlier and it's
actually not the commission of the telephone support, it's commission of the service in the first place to provide that, because if you had that in the first place you wouldn't need the latter. I guess that was my point.

Dr Ann Hicks: There's been a thing about carers, I know with the national suicide strategy last year (unintelligible - 1:53:46) is quite strongly worded that because of this whole confidentiality and carer thing, and often one of the key people who could intervene or help or support when people feel suicidal is their carer. So I think there's a lot can be done there and people, it is certainly the training bit and we do a lot more much better to make carers, and one way that we've done in driving that through is through the plan accreditation, because a whole section of that is what the carers say, what's the carer's feedback, what information the carer is given. Particularly for older patients where dementia is heavier than in the young, that's really important not to say it's any less.

Sue Goddard: To the CQC there. I think, I mean, I understand your remit's changing and hopefully will change further, personally I'd like to see (unintelligible - 1:54:43) CQC because it's something that's been a huge problem. (Unintelligible - 1:54:50) how you might be able to extract that data (1:54:56), you have an influence over what happens. (Unintelligible - 1:55:01) historical issues that we're all aware of. I think that, as well, your remit seems to be about looking at people who are receiving the services, what about those, including myself, who don't? In the area I live in the rates for people being assessed under the Mental Health Act who are known to services but don't have a team are 22 to 30%, covers two areas, (unintelligible - 1:55:37), okay, 22 to 30%. Now 80% being assessed under the Mental Health Act are detained, if you don't have a team it's going to be 100%. To have 30% of people detained under the Mental Health Act in an area who aren't receiving services is an appalling reflection on community services, which I will refer to as cuts because I cannot bear to call them reorganisation. (Unintelligible - 1:56:05) completely outside the remit of the CQC. I've looked at what (unintelligible - 1:56:09) at the moment and the form about (unintelligible - 1:56:13) at looking at crisis care, for example, has very little inclusion on the police involvement, there's about one box in one section. It makes an assumption, and I understand that you don't regulate the police, but if you don't collect that data you don't have it. I know I've been told a million times probably, or heard a million times (unintelligible - 1:56:39) individual complaints, we collect the data to inform services, but if you don't look at the complaints you're losing the data. But my (unintelligible - 1:56:49) concerns is you don't address those who aren't receiving the services. I, despite what I described, don't receive a service. So it doesn't address a lot of people.

Mr Morris: Okay. I'm just conscious of time, we've probably got about five minutes left so what I'm going to do is, I think there was a number of people who wanted to make points but (unintelligible - 1:57:08) and then we can then maybe just address them (unintelligible - 1:57:12). The lady here.

Krishna James: I just wanted to say that with, following the CQC and as Sue has said, it's absolutely imperative that there are more provision of beds. I have actually talked to
professionals where, what I was describing earlier, and I walked in to the service unit and see
them running around like madness, I'm talking about Harrow in particular. And one of the
things that really worries me is that like Sue, again, quoting you, is people who work. I'm one
of those so called former service users, so I'm not, I'm on medication now. But all, everybody
was just discharged without a letter or anything and this particular community is actually, the
best picture that comes to my mind is like a raft, everybody's holding on to each other. And
then consequently the people, including myself this morning - I'm surprised the way I'm
feeling and I've actually made it - if you imagine a container, a glass jar, cracking up, that's
basically what happens to people, that's the visual image if you can imagine that.

The community actually in my part of London is just barely holding on to each other, you
know, it's a sea and they're trying to hold on and swimming together. So please I say there's
people who are Care Quality Commission and other people and the Baroness, please take that
with you, the visual picture of what is actually happening out there. And I've nearly lost my
dear friend and thanks to the police that she survived and I'm sitting here not in another form,
so I'm very sort of honest about what I feel, so thank you to the police.

Mr Morris: Thank you. The lady here.

Member of the London Clinical Senate: Thank you. I'm (unintelligible - 1:59:30) among
other things a patient carer, sit on the London Clinical Senate (unintelligible - 1:59:35). I
think the case that is most apposite to this discussion on crisis is exemplified by a client of
mine who made the concerted attempt to commit suicide and was saved by one of my staff
and taken to hospital at 6.30 in the evening. She was discharged to the street at 3am and then
the staff tried to get a crisis carer intervention and she was told there was no place for her.

Now her note that she'd left said “I don't feel there's any place for me in this world”. So that
was particularly poignant, the staff rallied round and we did a lot of things and Anna is doing
well today, although she wouldn't be able to ask for this, I think commissioning is part of
the answer. We need standards based commissioning and we need to stop the wreckage that
occurs over a three year commissioning cycle.

These mental health problems often are cyclic longer than three years. If, for example, you
suffer a brain injury, and a brain injury often involves criminal justice service because of
violence that it induces, the waiting time for treatment can be 18 months for a brain injury.
What we need is advocacy, services that liaise with the save the neighbourhood teams, I ran a
service for that. That had a very great commissioning cycle of five years but the funding
eventually stopped, luckily we self funded the service and there were clients graduating from
college six years in to that service who were supported throughout by the same member. If
we lose staff every three years it damages the service, and it's a more expensive way to buys
services. So this point about responsibility, I think buying as part of the service, the
responsibility to a particular standard is very important. Thank you.

Mr Morris: Gentleman here.
Thomas Bell: I'm just wondering, I'm hearing training for this, training for that, why can't you guys employ people like for the crisis teams who answer the phones who have had experience, personal experience, of mental health, mental illness? You can have all the training out there in the world but if you haven't experienced it firsthand I don't think you can fully understand it.

Mr Morris: That's a very good point. Sue?

Sue Goddard: (Unintelligible - 2:02:27) a couple of things on that. I use the Samaritans, the Samaritans are actually a face to face service, which I think people aren't aware of, and in central London they have an enhanced service for people they feel are completely vulnerable. So I get to see a counsellor every couple of weeks, which is quite a unique service. I think (unintelligible - 2:02:46) to make sure we (unintelligible - 2:02:47). But we need to talk about increasing crisis teams, people coming out at night, doubling the amount of AMHPs mental health professionals, coming out, coming out, coming out. We're talking about the other end of the scale before we're talking about crisis houses, safe places where people can just go and hang out, (unintelligible - 2:03:05) and get supported, that hasn't entered the discussion.

But at the other end of the discussion we're talking about what happens particularly if the police are involved in these high risk emergency situations, you can have all those people but if you don't have beds there is nowhere to put them. And that is why AMHPs don't come out and assess because they cannot legally detain someone under the Mental Health Act unless there is an identified bed in an identified hospital. And if they do anything else in between time it gets in to potential litigation and the legal attention, respective friends here will know exactly what that means so, and that is the pressure on the system. You cut community certainly and you increase crisis. We can talk about recovery if we want, it's very, very important, you won't get to recovery if you don't get out of your crisis. But you can have all these extra people and extra training, but it is the pressure of a system of having no beds and it brings up all sorts of other things, as you're well aware, about people getting sectioned who doesn't have any conditions. But that's the pressure, so commission the beds and end this (unintelligible - 2:04:19), it's not either or.

Mr Morris: Final question.

Paula Peters: I'm from Bromley and my name's Paula Peters from Disabled People Against Cuts. We're about to lose 45 of our beds. We're going to have one unit with four boroughs in southeast London, one unit, not even 50 beds, if they build it. And we were told by the trust, which is Oxleas, if they build that unit the jobs in the (unintelligible - 2:04:45) community will go. My friend, okay, she went to the psychiatrist in crisis, said she was suicidal, I asked her to go, she's only jumped in front a train. Before that she phoned up the crisis line, the Oxleas crisis line, (unintelligible - 2:05:09), they told her to go and have a hot cup of tea, a hot bath and everything will be all right. The British Transport Police knocked on my friend's
husband's door, 3am, she jumped to her death from a train from a bridge (unintelligible - 2:05:27) station. She left behind three small children. And I've only got one thing to say, the mental health services are failing, they're failing (unintelligible - 2:05:39), they're failing carers, they're failing professionals and it's all due to lack of money. You're cutting care beds, you're cutting crisis teams, you're cutting police officers, it's all down to money. What the government needs to look at is the money because we need support. And you're discharging people back to GPs who should not be referred back to a GP, again, lack of GP training, because I know people who've been referred back to a GP where a GP's giving general injections who haven't got the training, they're ending up in crisis in A&E and a lot of the welfare reforms, I'm sorry to bring this up again.

**Female:** But I know time and again (unintelligible - 2:06:29) where they're coming in to A&E with no support because there is no support after 5 o'clock at night and on weekends. The lack of support at night time and during the weekends seriously needs to be addressed and addressed today.

**Mr Morris:** Okay, well, thanks very much for your contribution today, it's a very important point. I'd just like to thank you all for coming along. I think we've had a really, really good in-depth session and I particularly like to thank the panel for coming along to give their contribution, so I'd just like to show our appreciation to the panel.

[Applause]

**Mr Morris:** If anybody wants to send in further evidence to submit to the enquiry that is still very much open and I look forward to seeing you at our next session, which is in May. Thank you very much for coming.

[End]

**Attendee list:**

**Members of Parliament:**

James Morris MP
Charles Walker MP
Mike Thornton MP

**House of Lords:**

Baroness Sheila Hollins

**Observers:**

Laura Able
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<td>Andy Bell</td>
<td>Centre for Mental Health</td>
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<td>Thomas Bell</td>
<td>Rethink Mental Illness</td>
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Jamie Woodward  British Association for Counselling and Psychotherapy  
Emily Wright  CQC  
Simon Yu Tan  Little Portion Community Project  

**Secretariat Organisations:**  
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**About us:** The secretariat for the APPG on Mental Health is coordinated by Rethink Mental Illness, Mind and the Royal College of Psychiatrists, who provide administrative support and expert advice.