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## Introduction.

The police in England and Wales possess a power under Section 136 of the Mental Health Act 1983 (MHA) to detain people who they believe are mentally ill. This section states:

*If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.*

Whilst this section has recently been amended, during this study this detention enabled the police to take the person to the appropriate Health Authority to assess whether they were ill and in need of further detention and treatment.

The number of people detained by the police using this power has risen by as much as 6 fold over recent years (Keown 2013), this rise has been the source of much public disquiet. In parallel to the increase in detentions the subsequent rate of treatment by Health Authorities has declined. Thirty years ago, over ninety percent of people detained received treatment either formally or informally (Rogers 1990), whereas recently the figure was closer to twenty percent (House of Commons Health Committee 2013).

Over the last 30 years the number of people detained for compulsory treatment under all provisions of the Mental Health Act 1983 has also increased from 40,000 in 2003/04 to over 63,000 in 2015/16<sup>i</sup>. The causes for this rise include changes in social support networks;

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2  
3 treatment and bed shortages; reductions in 'care in the community'; increased use of  
4  
5 compulsory treatment for patients initially admitted voluntarily; increased severity of illness  
6  
7 before admission and early discharge resulting in relapse and early admission (Weich et al.  
8  
9 2014).

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11  
12  
13 There have been significant efforts between public sector partners and the police to reduce the  
14  
15 number of people detained under Section 136. Those reported upon such as street or  
16  
17 telephone triage appear to operate by bringing forward the decisions about treatment to the  
18  
19 stage before the officer detains a person (Dyer, Steer and Biddle 2015; Keown et al. 2016;  
20  
21 Reveruzzi and Pilling 2016) thus reducing unnecessary detentions. Whilst the focus has been  
22  
23 upon reducing detentions, there have however been no reported studies which have examined  
24  
25 why the number of police detentions have risen. The implication from the reductions in  
26  
27 treatment and care may be that there are a larger number of mentally ill people living in the  
28  
29 community who come more often into contact with the police, resulting in the rise in  
30  
31 detentions. In the past there have been reported studies which have examined in detail the  
32  
33 behaviours of people which led to their detention (Bean et al 1991, Turner et al 1992, Simmons  
34  
35 and Hoar 2001). In these the great majority of reported behaviour was violent, abusive, or  
36  
37 disturbing - the sorts of behaviour that might be expected to result in the use of this power.  
38  
39 This research set out to re-examine the types of behaviours leading to detention and to  
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41 examine the circumstances and factors which caused officers to use their power of detention.  
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## 50 51 **Method.**

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3 The research for this study was undertaken in a small provincial police force, which contains  
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5 post-industrial communities as well as relatively wealthy rural areas. A mixed-methods  
6  
7 approach was undertaken, using both quantitative and qualitative methods and analyses.  
8  
9

10  
11 Quantative data.

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13  
14 *Police records of mental illness.*

15  
16  
17 Two sets of quantitative data were analyzed. The first was data from the control room system.

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19  
20 To collect data about mental illness operators are requested to 'flag' incidents which they  
21  
22 believe involve mental illness. These can then be selected from the main volume of incidents.

23  
24  
25 Each incident usually consists of two sets of anonymous text descriptors, an initial account,  
26  
27 usually from the operator taking a telephone call and a closing account, most often provided by  
28  
29 the officer or PCSO who attended.  
30

31  
32  
33 The incident descriptors were read through several times and a number of categories were  
34  
35 devised. Each time the incidents were assessed the descriptions of the categories were  
36  
37 amended until they were consistent with each other and the number of categories were  
38  
39 sufficiently large to support cross referenced analysis. The incident types were sorted into  
40  
41 categories and the numbers obtained.  
42  
43

44  
45 *Health Trust data.*

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47  
48 The second set of data concerned the Health assessments made of people presented to Health  
49  
50 by the force, after a detention under Section 136. This data is collected by all Trusts and  
51  
52 collated and reported nationally. In this case it was provided such that the data was co-  
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3 terminous with the force boundary. It was in a tabulated, cross referenced and anonymized  
4  
5 form and was not capable of further analysis.  
6  
7

8  
9 Qualitative analysis: Police views and experiences of people with mental illness

10  
11 Following on from the quantitative analysis a series of semi-structured interviews were  
12  
13 undertaken with police officers. Using an ethnographic approach, the transcribed interviews  
14  
15 produced a narrative of the informant's views and experiences in their own words providing  
16  
17 their own subjective reality of their actions when dealing with people who were mentally ill.  
18  
19 This method is phenomenologically orientated and accepts different realities for different  
20  
21 informants and is regarded as "no less real than the objectively defined and measured reality"  
22  
23 (Fetterman 1989 p. 11). A latent thematic analysis (Morse and Field, 1996; Glaser and Strauss,  
24  
25 1967) was carried out on the transcribed data. Text was systematically reviewed to identify and  
26  
27 code major significant theoretical categories and themes. Comparative methods of Glaser  
28  
29 (1992) were used in this process. The emerging framework was tested and retested by the  
30  
31 second author to ensure a high degree of agreement about the themes. This inductive,  
32  
33 analytical process (Glaser and Strauss, 1967) enabled a theoretical framework to be developed  
34  
35 to explain the actions of officers and the data previously analyzed. 17 officers (15 uniformed  
36  
37 constables and 2 uniformed sergeants) were interviewed for an average 40 minutes each.  
38  
39 Participants were recruited by an appeal for volunteers through the force's internal  
40  
41 communications system. It was not possible to select volunteers who were demographically  
42  
43 representative of the workforce.  
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46  
47 The structured framework of questions in all interviews concerned the following:  
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- The frequency of encounters with people who are mentally ill or disordered.
- The behaviours they engage in to come to notice.
- Considerations when deciding how to deal with them.
- Differences in dealing with mentally disordered offenders compared with those under Section 136.
- Essential skills in dealing with people who are mentally disordered.
- The necessity for the police to deal with people who are mentally disordered.
- Views of colleagues about dealing with mentally disordered people.
- Personal experiences of mental disorder.
- Desirable changes to police engagement with people who are mentally disordered.

The interviews also allowed for any other issues or concerns by participants to be raised.

## **Results and discussion.**

Command and Control data.

Between 1st Jan and 31st July 2015, the force identified 660 incidents, which officers were sent to, where mental illness or disorder was a principle concern. Over that seven-month period the force recorded 104,418 calls from the public. Given that several calls could relate to one incident and many calls may not illicit a police response, it is not possible to be exact, but that indicates around 0.6% of calls directly related to mental illness. This figure is low compared to the College of Policing (2015) estimate that 2% of demand arises from mental illness and the Metropolitan Police estimate in the same report, that 15 to 20% of demand relates to mental illness. This is discussed below.

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3 These 660 calls were classified into 8 categories. These were:  
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- 6 • Absconders from treatment. These calls related to people who were being detained for  
7 treatment under the MHA and who absconded from hospital, or had left a hospital whilst  
8 informally receiving assessment or treatment and were considered to be at risk. These were all  
9 reported to the police by Health organisations.  
10  
11
- 12 • Requests for assistance. These were requests from other public authorities for  
13 assistance from the police over an issue concerning mental health. They included assisting  
14 Health staff to restrain patients, requests to transport patients to care facilities or requests to  
15 visits patients' home addresses where there were concerns for their welfare.  
16  
17
- 18 • Section 135. These related to the use of a Warrant, by Health or Social Services, to  
19 search for and detain a person in their home, where they were believed to be in need of  
20 treatment.  
21  
22
- 23 • Concerns for safety. These related to calls from the public where it was believed that a  
24 person had or was likely to harm themselves. In this period one suicide occurred.  
25  
26
- 27 • Crime related. These are incidents where violence was used or threatened, either  
28 against people or property and the offender was suspected of being mentally ill. Many incidents  
29 concerned violence within the family.  
30  
31
- 32 • Other. These included a range of incidents that did not fall into the other categories but  
33 still appeared to relate to mental illness or incapacity. They included calls relating to people  
34 with dementia or mental illness who were confused or delusional. One call concerned the  
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3 behaviour of a person with Asperger's Syndrome and others related to neighbour disputes  
4  
5 where one or more parties were mentally ill.  
6

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8  
9 • Section 136. These concerned incidents where a person was detained by a police officer  
10  
11 under Section 136. This is a different category from the other seven as it is an 'outcome' and  
12  
13 not a type of behaviour. Contained within this group are some of the categories above. The  
14  
15 numbers in each category are set out in Table 1 below.  
16  
17

18  
19 Table 1.  
20

21  
22 The most striking feature of this data is that the largest part of the demands on police time  
23  
24 arose from Health and other partner organisations. The categories shown as 'Requests for  
25  
26 Assistance', 'Absconder' or 'Section 135' are relatively clearly defined in their categorization for  
27  
28 they were incidents involving approaches from these partners. This concerned 334 of the 660  
29  
30 incidents, which is 50.6 % of the total. Previous research looking only at Section 136 and its  
31  
32 outcomes has not identified the scale of this demand, which other ongoing research suggests  
33  
34 varies considerably from force to force (unpublished data).  
35  
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40 The remaining 326 incidents are those concerning direct police and public encounters. These  
41  
42 consist of three categories of calls and an outcome – detention under Section 136.  
43  
44

45 • Concern for Safety. There were 190 such incidents. There would appear to be  
46  
47 considerable scope for different outcomes from these depending upon the views and actions of  
48  
49 the officers. Many would appear to meet the criteria for the use of Section 136 but are dealt  
50  
51 with by other means.  
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- Crime related. There were 34 incidents in this category.
- Other. There were 43 incidents in this category.

There were 61 Section 136 detentions. They can be divided into the same behavioural categories above and consisted of 42 incidents of concern for safety. Seven incidents which were 'crime related' i.e. violence against persons or property. There were seven incidents which would be classified as 'other' above but in this case, they all concerned delusional behaviour. Finally, there were three incidents where the behaviour was not recorded. A comparison of all public/police mental health incidents compared with Section 136 incidents is set out in table 2 below. The three Section 136 incidents where the behaviour is not known are excluded.

Table 2.

On the numerical values it appears that Section 136 detentions arise more often from threats of self-harm.

For these Section 136 detentions the final outcomes after assessment by Health were as follows:

- |  |     |
|--|-----|
| • No further action  | 44% |
| • Released with recommended follow up such as from community teams | 26% |
| • Informal admission to hospital                                   | 20% |
| • 'Sectioned' for treatment  | 10% |

These results exclude the 9 cases where no result was recorded.

The national figures for the outcomes from Section 136 detentions do not include informal referrals to community based teams as these are not recorded in NHS data because they are not admissions for treatment. There is no way to determine the outcome of these referrals or

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2  
3 indeed whether any follow up contact is made. On that basis 30% of these Section 136  
4  
5 detentions resulted in some form of formal or informal treatment and 70% resulted in a release  
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7  
8 back into the community either with no further action or a community referral.  
9

10  
11 These two sets of data about behaviours and outcomes can also be cross referred and at this  
12  
13 level of analysis, the behaviours can be more precisely defined. All the concerns for safety are  
14  
15 about self-harm; all the crime concerns violent conduct and all the others are delusional  
16  
17  
18 behaviour see table 3 below.  
19

### 20 21 Table 3

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23  
24 With a sample size of 58, the numbers when cross referred are small however, violence prior to  
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26  
27 detention appears to indicate a higher rate of admission for treatment than other behaviours.  
28  
29 This provides an interesting differential between partners, the police appear disproportionately  
30  
31 likely to detain someone who threatens self-harm whom Health are less likely to treat, whilst  
32  
33  
34 the police proportionately detain people who are violent-, whilst Health are more likely to  
35  
36  
37 detain these people for treatment.  
38

### 39 Health data.

40  
41  
42 The other set of data concerns Section 136 detentions presented to Health for assessment. In  
43  
44 the four months from April to August 2015 105 detentions were recorded. In terms of the  
45  
46 behaviours leading to their detention, there are two classifications in the Health data: conduct  
47  
48 and behaviour. These classifications are not the same as in the police data but 80% of  
49  
50  
51 detentions presented for assessment appeared to relate to self-harm or threats of self-harm.  
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53  
54 This is the same as the 79% of Section 136 detentions relating to self-harm in the force data.  
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3 For 'conduct' there were four types:  
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- 6 • Harming others - 3%
- 7 • Harming self – 16%
- 8 • Threats to harm self – 64%
- 9 • Difficult to manage – 16%

10  
11  
12 For behaviours there five types:  
13  
14

- 15 • Violent – 5%
- 16 • Aggressive – 9%
- 17 • Abusive – 2%
- 18 • Irrational – 80%
- 19 • Other – 4%

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23  
24 In terms of behaviour, 16% of Health instances related to violent, abusive or aggressive  
25  
26 behaviour. This appeared to correspond to the 'criminal' classification in the Force data, which  
27  
28 constituted 10% of Section 136 detentions (and 15% of overall incidents). Again, the two sets of  
29  
30 figures are similar.  
31  
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34  
35 Another area for direct comparison concerns the outcome of the Health detentions. These are  
36  
37 set out in table 4 below. In the Health data 36% of detainees were formally sectioned under the  
38  
39 MHA or informally admitted to hospital for treatment. In the Force data 30% of detainees were  
40  
41 admitted, which again is a similar proportion. The police data percentages are shown in  
42  
43 brackets.  
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47  
48 Table 4  
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51 Based on these comparisons of Section 136 data the Force and Health figures were similar,  
52  
53 notwithstanding that the rate of detention in the Health figures was three times higher than  
54  
55 the Force's recorded rate (26 per month for Health compared to eight per month for the police  
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3 data). There are a range of possible reasons why reviewing police command and control data  
4  
5 does not identify a significant proportion of incidents involving officers' contacts with people  
6  
7 who were mentally ill. However, if the force was only identifying one third of incidents then the  
8  
9 actual rate of incidents at 1.8% would be closer to the College of Policing estimate (2015). On  
10  
11 the basis of this comparison it also appears that the under recording by the police relating to  
12  
13 Section 136 is 'random' as there are no differences between police and Health categories and  
14  
15 outcomes.  
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21 Whilst there are few recent reports in England and Wales on the proportion of police demand  
22  
23 arising from mental illness, in the U.S. it is reported that seven to ten percent of police contacts  
24  
25 involved people who were mentally disordered (Borum et al. 1997), whilst in Canada this varied  
26  
27 between 8% in a small rural town to between 23 and 47% in Vancouver (Cotton and Coleman  
28  
29 2013). Understanding the complete volume and nature of police contacts with the mentally ill is  
30  
31 the subject of ongoing research.  
32  
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35

36 How does this study compare to those previously reported? In their 1991 study Bean et al.  
37  
38 (1991) interviewed Metropolitan police officers about 100 incidents where they detained a  
39  
40 person under Section 136. In these interviews, they considered the features of the events that  
41  
42 precipitated the detention. Self-harm, suicide or threats of either were features in 9% of the  
43  
44 detentions whilst violent behaviour towards others and threats of it were present in 34% of  
45  
46 cases and violence towards property or threats were present in 37% of cases. Thus, self-harm  
47  
48 or suicide (or attempts at either) were relatively rare as events precipitating detention. In  
49  
50 examining suicide or an attempt as a precipitating feature Bean et al. (1991) observed that  
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3 suicide alone appeared to be sufficient cause for police intervention though it was not  
4  
5 necessarily thought to be a sign of mental disorder.  
6

7  
8 Turner at al. ( 1992) examined Section 136 detentions in the City of London and Hackney Health  
9  
10 areas over two years between 1985 and 1987. From the Health records they identified 163  
11  
12 cases which led to 135 admissions. 90% of conduct leading to detention was violent or  
13  
14 threatening and only 10% concerned self-harm.  
15  
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17  
18 This was examined again by Simmons and Hoar ( 2001) who in their study looked at 90  
19  
20 detentions under Section 136 in London in 1996/97. In this study excluding the 'other' and  
21  
22 'unknown' categories, self-harming behaviour was exhibited 14 times whilst violent or  
23  
24 disorderly behaviours were expressed 153 times. These latter behaviours were ten times more  
25  
26 likely. In addition, whilst overall 82% of the 90 individuals were admitted for treatment  
27  
28 following detention, only 57% of those self-harming were admitted. This was the lowest rate  
29  
30 for any behaviour. For all others, the rate was between 79 and 100%.  
31  
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34  
35 Whilst these results only relate to one police force, the difference in behaviour leading to  
36  
37 detention is most striking. The great majority of incidents that the police in this study engaged  
38  
39 in directly with the public, concerned threats of suicide or self-harm. The violent or disorderly  
40  
41 behaviours that were previously so prominent now represented a small minority. Given the rise  
42  
43 in use of Section 136 over time, could it be that this rise is largely made up of the growth in  
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45 incidents involving self-harm?  
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52 Qualitative findings – police response to mental illness.  
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3 Officers' responses could be broadly classified into 3 categories; those within the police, those  
4 concerning public sector partners and societal or environmental issues. In this paper only the  
5 police issues are presented. Five themes important to officers were derived from the  
6 interviews. Each is described below and exemplified by substantive quotations.  
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9

#### 10 11 12 13 *Self-harm.*

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15  
16 All the participant officers agreed that self-harm and threats of self-harm were the most  
17 common type of incident that they dealt with involving people whom they considered to be  
18 mentally ill. This is entirely in accord with the data presented above.  
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23  
24 Seven of the seventeen officers interviewed identified the second most common kind of  
25 incident as dementia in its various forms, manifest as 'missing persons' or finding people in a  
26 confused or disorientated state. This appeared to be very localised to the more established and  
27 settled communities with an aging population.  
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#### 33 34 35 *Frequent presenters.*

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38 Twelve of the seventeen officers interviewed believed that a significant proportion of incidents  
39 arose from a relatively small number of 'frequent presenters'. This was described by a sergeant,  
40  
41  
42  
43 Research participant 15, as most demand from a few people:  
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45

46  
47 It's like with most policing, we get sort of a nucleus of 6 people and they give us all our  
48 business, they are the ones who are repeat callers, who are the biggest users of our  
49 resource.  
50

51 Research participant 9 set out the challenges of dealing with the same person again and again.  
52  
53

54  
55 Yes, it is about sometimes you do go to that same person for the 20<sup>th</sup> time that week  
56 and you do get that feeling- crikey! here we go again – we will have lots of paperwork,  
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3 lots of my time just sat with this person. Trying to talk them through but at the same  
4 time then, we don't know what's going on in their head, you don't know why they are in  
5 crisis, you don't know the background so you have got to.... As hard as it can be  
6 sometimes, got to treat it like it's the first time you ever met them, so yea, mixed  
7 feelings, yes it can be frustrating sometimes but personally you have got to treat them...  
8 do as much as you can for them.  
9  
10

11 Research participant 14 identified repeat callers and the disparity in assessment between the  
12 police and Health as to whether the detained people were mentally ill:  
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14

15  
16  
17 It would be the same people over and over. Mostly, you do get people that you meet for  
18 a first time and they are given the right care and straight off the bat, but we go through  
19 periods of time where a person will come to our attention and they will be arrested or  
20 detained for 136, continually every day the same thing, every day assessed, assessed,  
21 assessed, keep being told that it is behavioural issues not mental illness and we will  
22 continue to detain them and getting them assessed.....  
23  
24

25 Estimates of the proportion of mental disorder incidents relating to frequent presenters varied  
26 from 'most' above to half as with research participant 12:  
27  
28

29  
30  
31 Probably half and half. There are certain re-occurers shall we say, a couple are one off  
32 episodes, because of their circumstances they just lose it and come into our contact.  
33

34 A few officers did not see frequent presenters as an issue such as research participant 17:  
35  
36

37 I would say that there is quite a variety of people. Sometimes they are not from this  
38 area, they might even catch a train here or something like that, they do all sort of things.  
39  
40

41 Such views appeared to be very specific to location, in this case an urban centre which the  
42 officer believed drew people in from a wider area.  
43  
44

#### 45 46 *Issues about diagnosis.* 47

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49 The repeated process of assessment and release by Health mentioned above introduced  
50 another set of issues raised by officers and this relates to whether people in contact the police  
51 are mentally ill.  
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3 Research participant 14 expressed it thus:  
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6 That's where we seem to be fighting these losing battles all the time. We are just, it's  
7 never a waste of time to help someone but it feels at the time when you are sat there  
8 with someone that you know isn't in dire need of mental health care, that you are  
9 wasting your time..... I would say why the mental health act was brought in, Section  
10 136, was for the genuine cases where we come across somebody in the street who is  
11 clearly unwell and we take them to a place of safety where they are then assessed.  
12  
13

14 The most common view amongst officers was that many people were lonely or unhappy, in  
15 crisis and wanted attention. Research participant 6 set out 'attention seeking' behaviour thus:  
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19  
20 Oh yea, I have gone to ones, both very recently, where you sit down and have a chat  
21 with them, they say it's nice just to have a chat with somebody as well. You can certainly  
22 sit down and engage with somebody who is genuinely in need but then there is also that  
23 person who will take advantage of saying that they have taken an overdose or whatever  
24 to get a bit of attention and to get what they want. It's like a toddler tantrum.  
25  
26

27 Research participant 5 observed that many people who have received treatment for a mental  
28 health condition have become 'institutionalised' and want to return into such 'care'.  
29  
30

31  
32  
33 Yes, I think the one problem that I seem to notice is that people who are already in the  
34 mental health system, they get released from the hospital and it's almost like they have  
35 been institutionalized once they got into the hospital, so that they are afraid of the  
36 outside world, so therefore they do what they can to get back, so they tend to go to  
37 places like a hospital or to family, say whatever they can or do what they can in order to  
38 think that they will get back into the system.  
39  
40

41 *Worthiness and empathy.*  
42  
43

44 Whatever the personal motives of the person contacting the police, many participants believed  
45 that the outcome of the incident was being managed by what people said or did and officers  
46 were thus not in control of the outcome. This frustrated some officers as they viewed some of  
47 the people they dealt with as more 'worthy' than others. This was reflected in their personal  
48 feelings about them. Research participant 15, a sergeant, observed:  
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3 So, if you have got an 18 year old boy who is totally out of it on legal highs and  
4 something like that, then the empathy that we would give somebody like that with  
5 regards to their current mental health condition would be totally different from maybe  
6 someone with bi-polar who has struggled for years and years..... somebody who is self-  
7 inflicted through alcohol or drugs then..... I definitely have less sympathy, I would say  
8 that that probably goes for many officers. But yes, I certainly do.  
9  
10

11 A few participants such as participant 9 took a more nuanced view:  
12  
13

14 I do recognize that, I would say that sometimes you do have those feelings but I would  
15 also say that there is always something that perhaps you don't know, that's there is  
16 always perhaps a back story whether it be in their upbringing or whether it be in their  
17 previous relationships to make them that like that. You might not know that, it might be  
18 that that made them abuse. It might not be the case at all, it might be the case that they  
19 are just one of those people on self-destruct and they like taking drugs and getting  
20 drunk all the time. But do you ever really know and I think that is the tragedy that  
21 sometimes there are genuinely people that come into contact with us who aren't very  
22 nice, who are wild but they are a subject of their upbringing or something that  
23 happened in their life and that's the reason for being like it. Of course, it can be quite  
24 hard when they are shouting and bawling in your face and being violent .....  
25  
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27  
28

29 Police officers making judgements about whether people are responsible for their mental  
30 illness have previously been reported by Watson et al. (2004) in the U.S. Whilst Godfredson et al  
31 (2011) in Australia observed that officers based such judgments on several factors surrounding  
32 the incident. Hansson and Markström have suggested that such stigma or negative judgements  
33 about mental illness can be changed through appropriate training.  
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41 *Risk aversion and the creation of a new 'patient pathway'.*  
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43  
44

45 It is perhaps surprising given the widespread view that many people are wasting police time,  
46 that the police respond in such an attentive way but the reason for this is very clear. Research  
47 participant 6 introduced the notion:  
48  
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50

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52  
53 No because if you made a decision that you were going to leave that one person and say  
54 I am sorry you are clearly manipulating us we are not doing anything for you, that could  
55 be the person that is lying on the road dead, so it's not worth taking the risk of that one  
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3 person, that you know for a fact is taking advantage , it is still not worth taking the risk  
4 of not going through the process of taking them to hospital waiting 6 hours for the  
5 ambulance to arrive.  
6

7  
8 The overwhelmingly strong view shared by fifteen of the seventeen participants (and  
9  
10 recognised by the other two) is that officers operate in fear of a 'death in police contact' which  
11  
12 results in highly risk averse behaviour and a high degree of compliance with force policy, even  
13  
14 where the officers judge this is inappropriate. When asked about the consequences if an  
15  
16 incident 'went wrong' Research participant 7 stated:  
17  
18

19  
20  
21 I would lose my job! If something happened to her and I had had contact with her and it  
22 turned out that she had self-harmed I would be a bit worried and a bit concerned that  
23 they would be looking at a death following police contact.  
24

25 Research participant 17 stated:  
26

27  
28 You would lose your job. You would be sacked. As you are probably fully aware officers  
29 do get sacked for neglect of duty.....  
30

31  
32 Research participant 9 stated:  
33

34  
35 It is. I would say mostly it is about consequences, for me personally, I have got a young  
36 family, I have got a mortgage and bills to pay, I don't want to be on the receiving end of  
37 a phone call saying such and such has died because you did not do your job properly.  
38

39  
40 Research participant 5 set out why this is more serious than other failings:  
41

42  
43 It's not, however mental health can be more extreme because if we have taken the  
44 wrong decision in mental health it can lead to something somebody seriously ill, life  
45 changing or death that's the sort of thing where effectively we are looking at losing our  
46 jobs whereas not investigating something properly or dealing with something properly is  
47 more likely just to put marks on your record rather than anything else.  
48  
49

50 Two participants nearing 30 years' service reflected upon the changes over time. Research  
51  
52 participant 12 stated:  
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3 No, it's a cover all isn't it. If they mention that they are going to kill themselves they are  
4 coming in – full stop. Why? Because I have got 18 months to go (laughs).... Whereas  
5 before we could quite happily make our own decisions, we are directed by policies, by  
6 them above.....Whereas now it is come on, for if they jump or if they are hurt and there  
7 is police contact, any police contact, then we are the ones that get the blame.  
8  
9

10 Whilst research participant 13 stated:

11  
12  
13 I think, in this day and age, it would be fair to say that you are looking at losing your job,  
14 because it's a hell of a decision to make and I know it goes back to, taking things back to  
15 a bygone era was that that decision about taking the drunk out of the town, taking them  
16 home, opening their door for them and leaving them there. We did it and we did it time  
17 and time again, because it was easier than having a drunk and incapable in the cells  
18 overnight. You pushed them in through the door and as long as they didn't die  
19 everything was OK. But it's now got to the stage where you are looking at what  
20 happened, I came across this person, they said they had taken tablets, couldn't see any,  
21 found his address and so took him home, they die of an overdose overnight. I think in  
22 this day and age its goodbye.  
23  
24  
25

26  
27 Once an officer has become involved in an incident where there is a threat to life, then the only  
28 way they can discharge their accountability is to pass the responsibility to someone else. In the  
29 past, this may have been custody, but with the reduction in the number of people taken there,  
30 it appears to be a Health professional, whether to a hospital or an ambulance - Research  
31 participant 1:  
32  
33  
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38  
39 We know what the consequences would be, we would be in a world of trouble, we are  
40 in a catch 22 situation we can't take that risk.... As I say if they suggest that they have  
41 taken tablets, whether or not they have taken them, if they tell the ambulance service,  
42 when they eventually turn up, that they are fine and the ambulance says they are fine,  
43 thank you very much. That is a different set of circumstances.  
44  
45

46  
47 It appears based on these interviews and the analysis of data that the police have inadvertently  
48 created a new 'patient pathway' which provides direct access for people in crisis to health  
49 services and to a mental health assessment. This can operate either formally through Section  
50 136 or informally with consent. Research participant 13 describes the informal process:  
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3 They can refer themselves back in..... we have created pathways for people to get  
4 referred and we have got arrangements in place and I am sure other colleagues have  
5 told you that now you can ring up the mental health ward and say I have got so and so  
6 person, they are not drunk, they haven't taken drugs, they are saying that they want to  
7 kill themselves, right bring them up. And we take them straight up and we have created  
8 pathways but we haven't created beds, we haven't created staff...  
9  
10

11 Whilst Research participant 12 describes the formal process:  
12  
13

14 .....but we have created maybe a shortcut for them into the services, I don't know,  
15 because we have set out what we are going to do with them, we take them to custody,  
16 over the years they have been assessed by the nurse or what have you, and then the  
17 next thing they know they are maybe on a mental health assessment. Whereas their GP  
18 is just a referral after referral, whether or not it's a quick shortcut that we made I don't  
19 know.  
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## 26 **Conclusions.**

27  
28

29 Whilst this study concerns one small force, informal focus group discussions in another larger  
30 force and management interviews in two other forces support these findings. Thus the rise in  
31 police detentions over the last 20 years and the corresponding decline in treatment rates arises  
32 from two sources. The patterns of behaviours leading to detention were formerly violent,  
33 abusive or aggressive and only infrequently related to self-harm, now the great majority of  
34 police contacts relate to self-harm and few to the former.  
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44 Secondly, police officers' detention of people threatening self-harm appears to be part of a new  
45 'risk averse' culture which fears deaths following police contact. This prevents officers from  
46 exercising their discretion and finding other ways to deal with those in distress or crisis and  
47 makes detentions inevitable. The police as a result appear to have inadvertently created a new  
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3 'patient pathway' which provides access to Health Services that would otherwise be difficult or  
4  
5 restricted. To use this a person only has to threaten self-harm.  
6  
7

8  
9 The treatment rates for people detained in connection with self-harm were previously low and  
10  
11 they remain so, if not even lower. Taken together this suggests that the mechanism by which  
12  
13 Triage interventions reduce detentions relates to a specific reduction in those cases involving  
14  
15 self-harm (This is the subject of ongoing research).  
16  
17  
18

19 The implication of this and the recent changes to Section 136 in the Policing and Crime Act  
20  
21 2017, which, where possible, requires engagement by officers with a Triage scheme, is that the  
22  
23 number of police detention will decline but in the absence of access to alternative support for  
24  
25 those in crisis, the level of engagement by the police with those who are mentally ill may  
26  
27 continue to rise.  
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38 Table 1.  
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Category of incident	Number of incidents	Percentage of total
Absconders from treatment	232	35.2%
Concern for safety	190	28.8%
Requests for assistance	87	13.2%
Section 136 detentions	59	9.0%
Other	43	6.5%
Crime related	34	5.2%
Section 135 warrants	15	2.3%

51  
52  
53  
54 Table 2.  
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59  
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		Overall incidents	Section 136 detentions
Type of behaviour	Concern for Safety	159 of 241 = 66%	47 of 58 = 81%
	Crime related	30 of 241 = 12.5%	6 of 58 = 10.3%
	Other	52 of 241 = 21.5%	5 of 58 = 8.6%

Table 3

Behaviour		Outcome			
		Formal/informal admission	Follow up in community	No further Action	Not known
	Concern for safety (self-harm)	22.2%	24.4%	37.8%	15.5%
	Crime (violence)	50.0%	16.7%	33.3%	-
	Other (delusional behaviour)	20.0%	20.0%	40.0%	20.0%
	Not Known			33.3%	66.6%

“Not Known” consists of 3 cases.

Table 4

Disposal	Number of instances	Percentage of total
Sectioned under the MHA	13	13 (10)
Informal admission to hospital	25	24 (20)
Follow up action recommended	29	28 (26)
Released - no further action	36	35 (44)
Released - criminal charge	0	0 (0)

The percentages of disposals using police data are shown in brackets.

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<sup>i</sup> Data obtained from the Health and Social Care Information Centre (HSCIC) and NHS Digital KP90 reports.

## Introduction.

The police in England and Wales possess a power under Section 136 of the Mental Health Act 1983 (MHA) to detain people who they believe are mentally ill. This section states:

*If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.*

Whilst this section has recently been amended, during this study this detention enabled the police to take the person to the appropriate Health Authority to assess whether they were ill and in need of further detention and treatment.

The number of people detained by the police using this power has risen by as much as 6 fold over recent years (Keown 2013), this rise has been the source of much public disquiet. In parallel to the increase in detentions the subsequent rate of treatment by Health Authorities has declined. Thirty years ago, over ninety percent of people detained received treatment either formally or informally (Rogers 1990), whereas recently the figure was closer to twenty percent (House of Commons Health Committee 2013).

Over the last 30 years the number of people detained for compulsory treatment under all provisions of the Mental Health Act 1983 has also increased from 40,000 in 2003/04 to over 63,000 in 2015/16<sup>i</sup>. The causes for this rise include changes in social support networks;

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2  
3 treatment and bed shortages; reductions in 'care in the community'; increased use of  
4  
5 compulsory treatment for patients initially admitted voluntarily; increased severity of illness  
6  
7 before admission and early discharge resulting in relapse and early admission (Weich et al.  
8  
9 2014).

10  
11  
12  
13 There have been significant efforts between public sector partners and the police to reduce the  
14  
15 number of people detained under Section 136. Those reported upon such as street or  
16  
17 telephone triage appear to operate by bringing forward the decisions about treatment to the  
18  
19 stage before the officer detains a person (Dyer, Steer and Biddle 2015; Keown et al. 2016;  
20  
21 Reveruzzi and Pilling 2016) thus reducing unnecessary detentions. Whilst the focus has been  
22  
23 upon reducing detentions, there have however been no reported studies which have examined  
24  
25 why the number of police detentions have risen. The implication from the reductions in  
26  
27 treatment and care may be that there are a larger number of mentally ill people living in the  
28  
29 community who come more often into contact with the police, resulting in the rise in  
30  
31 detentions. In the past there have been reported studies which have examined in detail the  
32  
33 behaviours of people which led to their detention (Bean et al 1991, Turner et al 1992, Simmons  
34  
35 and Hoar 2001). In these the great majority of reported behaviour was violent, abusive, or  
36  
37 disturbing - the sorts of behaviour that might be expected to result in the use of this power.  
38  
39 This research set out to re-examine the types of behaviours leading to detention and to  
40  
41 examine the circumstances and factors which caused officers to use their power of detention.  
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51 **Method.**  
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3 The research for this study was undertaken in a small provincial police force, which contains  
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5 post-industrial communities as well as relatively wealthy rural areas. A mixed-methods  
6  
7 approach was undertaken, using both quantitative and qualitative methods and analyses.  
8  
9

10  
11 Quantative data.

12  
13  
14 *Police records of mental illness.*

15  
16  
17 Two sets of quantitative data were analyzed. The first was data from the control room system.

18  
19  
20 To collect data about mental illness operators are requested to 'flag' incidents which they  
21  
22 believe involve mental illness. These can then be selected from the main volume of incidents.

23  
24 Each incident usually consists of two sets of anonymous text descriptors, an initial account,  
25  
26 usually from the operator taking a telephone call and a closing account, most often provided by  
27  
28 the officer or PCSO who attended.  
29  
30

31  
32 The incident descriptors were read through several times and a number of categories were  
33  
34 devised. Each time the incidents were assessed the descriptions of the categories were  
35  
36 amended until they were consistent with each other and the number of categories were  
37  
38 sufficiently large to support cross referenced analysis. The incident types were sorted into  
39  
40 categories and the numbers obtained.  
41  
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43

44  
45 *Health Trust data.*

46  
47  
48 The second set of data concerned the Health assessments made of people presented to Health  
49  
50 by the force, after a detention under Section 136. This data is collected by all Trusts and  
51  
52 collated and reported nationally. In this case it was provided such that the data was co-  
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3 terminous with the force boundary. It was in a tabulated, cross referenced and anonymized  
4  
5 form and was not capable of further analysis.  
6  
7

8  
9 Qualitative analysis: Police views and experiences of people with mental illness  
10

11  
12 Following on from the quantitative analysis a series of semi-structured interviews were  
13  
14 undertaken with police officers. Using an ethnographic approach, the transcribed interviews  
15  
16 produced a narrative of the informant's views and experiences in their own words providing  
17  
18 their own subjective reality of their actions when dealing with people who were mentally ill.  
19  
20 This method is phenomenologically orientated and accepts different realities for different  
21  
22 informants and is regarded as "no less real than the objectively defined and measured reality"  
23  
24 (Fetterman 1989 p. 11). A latent thematic analysis (Morse and Field, 1996; Glaser and Strauss,  
25  
26 1967) was carried out on the transcribed data. Text was systematically reviewed to identify and  
27  
28 code major significant theoretical categories and themes. Comparative methods of Glaser  
29  
30 (1992) were used in this process. The emerging framework was tested and retested by the  
31  
32 second author to ensure a high degree of agreement about the themes. This inductive,  
33  
34 analytical process (Glaser and Strauss, 1967) enabled a theoretical framework to be developed  
35  
36 to explain the actions of officers and the data previously analyzed. 17 officers (15 uniformed  
37  
38 constables and 2 uniformed sergeants) were interviewed for an average 40 minutes each.  
39  
40 Participants were recruited by an appeal for volunteers through the force's internal  
41  
42 communications system. It was not possible to select volunteers who were demographically  
43  
44 representative of the workforce.  
45  
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54 The structured framework of questions in all interviews concerned the following:  
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60

- The frequency of encounters with people who are mentally ill or disordered.
- The behaviours they engage in to come to notice.
- Considerations when deciding how to deal with them.
- Differences in dealing with mentally disordered offenders compared with those under Section 136.
- Essential skills in dealing with people who are mentally disordered.
- The necessity for the police to deal with people who are mentally disordered.
- Views of colleagues about dealing with mentally disordered people.
- Personal experiences of mental disorder.
- Desirable changes to police engagement with people who are mentally disordered.

The interviews also allowed for any other issues or concerns by participants to be raised.

## **Results and discussion.**

Command and Control data.

Between 1st Jan and 31st July 2015, the force identified 660 incidents, which officers were sent to, where mental illness or disorder was a principle concern. Over that seven-month period the force recorded 104,418 calls from the public. Given that several calls could relate to one incident and many calls may not illicit a police response, it is not possible to be exact, but that indicates around 0.6% of calls directly related to mental illness. This figure is low compared to the College of Policing (2015) estimate that 2% of demand arises from mental illness and the Metropolitan Police estimate in the same report, that 15 to 20% of demand relates to mental illness. This is discussed below.

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2  
3 These 660 calls were classified into 8 categories. These were:  
4  
5

- 6 • Absconders from treatment. These calls related to people who were being detained for  
7 treatment under the MHA and who absconded from hospital, or had left a hospital whilst  
8 informally receiving assessment or treatment and were considered to be at risk. These were all  
9 reported to the police by Health organisations.  
10  
11
- 12 • Requests for assistance. These were requests from other public authorities for  
13 assistance from the police over an issue concerning mental health. They included assisting  
14 Health staff to restrain patients, requests to transport patients to care facilities or requests to  
15 visits patients' home addresses where there were concerns for their welfare.  
16  
17
- 18 • Section 135. These related to the use of a Warrant, by Health or Social Services, to  
19 search for and detain a person in their home, where they were believed to be in need of  
20 treatment.  
21  
22
- 23 • Concerns for safety. These related to calls from the public where it was believed that a  
24 person had or was likely to harm themselves. In this period one suicide occurred.  
25  
26
- 27 • Crime related. These are incidents where violence was used or threatened, either  
28 against people or property and the offender was suspected of being mentally ill. Many incidents  
29 concerned violence within the family.  
30  
31
- 32 • Other. These included a range of incidents that did not fall into the other categories but  
33 still appeared to relate to mental illness or incapacity. They included calls relating to people  
34 with dementia or mental illness who were confused or delusional. One call concerned the  
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3 behaviour of a person with Asperger's Syndrome and others related to neighbour disputes  
4  
5 where one or more parties were mentally ill.  
6

7  
8  
9 • Section 136. These concerned incidents where a person was detained by a police officer  
10  
11 under Section 136. This is a different category from the other seven as it is an 'outcome' and  
12  
13 not a type of behaviour. Contained within this group are some of the categories above. The  
14  
15 numbers in each category are set out in Table 1 below.  
16  
17

18  
19 Table 1.  
20

21  
22 The most striking feature of this data is that the largest part of the demands on police time  
23  
24 arose from Health and other partner organisations. The categories shown as 'Requests for  
25  
26 Assistance', 'Absconder' or 'Section 135' are relatively clearly defined in their categorization for  
27  
28 they were incidents involving approaches from these partners. This concerned 334 of the 660  
29  
30 incidents, which is 50.6 % of the total. Previous research looking only at Section 136 and its  
31  
32 outcomes has not identified the scale of this demand, which other ongoing research suggests  
33  
34 varies considerably from force to force (unpublished data).  
35  
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37

38  
39  
40 The remaining 326 incidents are those concerning direct police and public encounters. These  
41  
42 consist of three categories of calls and an outcome – detention under Section 136.  
43  
44

45 • Concern for Safety. There were 190 such incidents. There would appear to be  
46  
47 considerable scope for different outcomes from these depending upon the views and actions of  
48  
49 the officers. Many would appear to meet the criteria for the use of Section 136 but are dealt  
50  
51 with by other means.  
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- Crime related. There were 34 incidents in this category.
- Other. There were 43 incidents in this category.

There were 61 Section 136 detentions. They can be divided into the same behavioural categories above and consisted of 42 incidents of concern for safety. Seven incidents which were 'crime related' i.e. violence against persons or property. There were seven incidents which would be classified as 'other' above but in this case, they all concerned delusional behaviour. Finally, there were three incidents where the behaviour was not recorded. A comparison of all public/police mental health incidents compared with Section 136 incidents is set out in table 2 below. The three Section 136 incidents where the behaviour is not known are excluded.

#### Table 2.

On the numerical values it appears that Section 136 detentions arise more often from threats of self-harm.

For these Section 136 detentions the final outcomes after assessment by Health were as follows:

- |  |     |
|--|-----|
| • No further action  | 44% |
| • Released with recommended follow up such as from community teams | 26% |
| • Informal admission to hospital                                   | 20% |
| • 'Sectioned' for treatment  | 10% |

These results exclude the 9 cases where no result was recorded.

The national figures for the outcomes from Section 136 detentions do not include informal referrals to community based teams as these are not recorded in NHS data because they are not admissions for treatment. There is no way to determine the outcome of these referrals or

1  
2  
3 indeed whether any follow up contact is made. On that basis 30% of these Section 136  
4  
5 detentions resulted in some form of formal or informal treatment and 70% resulted in a release  
6  
7  
8 back into the community either with no further action or a community referral.  
9

10  
11 These two sets of data about behaviours and outcomes can also be cross referred and at this  
12  
13 level of analysis, the behaviours can be more precisely defined. All the concerns for safety are  
14  
15 about self-harm; all the crime concerns violent conduct and all the others are delusional  
16  
17  
18 behaviour see table 3 below.  
19

### 20 21 Table 3

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24 With a sample size of 58, the numbers when cross referred are small however, violence prior to  
25  
26  
27 detention appears to indicate a higher rate of admission for treatment than other behaviours.  
28

29  
30 This provides an interesting differential between partners, the police appear ~~more~~  
31  
32 disproportionately likely to detain someone who threatens self-harm whom Health are less  
33  
34 likely to treat, whilst the police proportionately detain people who are violent ~~under Section~~  
35  
36 ~~136 in proportion to their overall presence~~, whilst Health are more likely to detain these people  
37  
38  
39 for treatment.  
40

41  
42 Health data.

43  
44 The other set of data concerns Section 136 detentions presented to Health for assessment. In  
45  
46  
47 the four months from April to August 2015 105 detentions were recorded. In terms of the  
48  
49 behaviours leading to their detention, there are two classifications in the Health data: conduct  
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51  
52 and behaviour. These classifications are not the same as in the police data but 80% of  
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3 detentions presented for assessment appeared to relate to self-harm or threats of self-harm.

4  
5 This is the same as the 79% of Section 136 detentions relating to self-harm in the force data.

6  
7  
8 For 'conduct' there were four types:

- 9  
10  
11
- 12 • Harming others - 3%
  - 13 • Harming self – 16%
  - 14 • Threats to harm self – 64%
  - 15 • Difficult to manage – 16%
- 16  
17

18 For behaviours there five types:

- 19  
20
- 21 • Violent – 5%
  - 22 • Aggressive – 9%
  - 23 • Abusive – 2%
  - 24 • Irrational – 80%
  - 25 • Other – 4%
- 26  
27  
28  
29

30 In terms of behaviour, 16% of Health instances related to violent, abusive or aggressive  
31 behaviour. This appeared to correspond to the 'criminal' classification in the Force data, which  
32 constituted 10% of Section 136 detentions (and 15% of overall incidents). Again, the two sets of  
33 figures are similar.  
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39

40 Another area for direct comparison concerns the outcome of the Health detentions. These are  
41 set out in table 4 below. In the Health data 36% of detainees were formally sectioned under the  
42 MHA or informally admitted to hospital for treatment. In the Force data 30% of detainees were  
43 admitted, which again is a similar proportion. The police data percentages are shown in  
44 brackets.  
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53 Table 4  
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3 Based on these comparisons of Section 136 data the Force and Health figures were similar,  
4  
5 notwithstanding that the rate of detention in the Health figures was three times higher than  
6  
7 the Force's recorded rate (26 per month for Health compared to eight per month for the police  
8  
9 data). There are a range of possible reasons why reviewing police command and control data  
10  
11 does not identify a significant proportion of incidents involving officers' contacts with people  
12  
13 who were mentally ill. However, if the force was only identifying one third of incidents then the  
14  
15 actual rate of incidents at 1.8% would be closer to the College of Policing estimate (2015). On  
16  
17 the basis of this comparison it also appears that the under recording by the police relating to  
18  
19 Section 136 is 'random' as there are no differences between police and Health categories and  
20  
21 outcomes.  
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27  
28 Whilst there are few recent reports in England and Wales on the proportion of police demand  
29  
30 arising from mental illness, in the U.S. it is reported that seven to ten percent of police contacts  
31  
32 involved people who were mentally disordered (Borum et al. 1997), whilst in Canada this varied  
33  
34 between 8% in a small rural town to between 23 and 47% in Vancouver (Cotton and Coleman  
35  
36 2013). Understanding the complete volume and nature of police contacts with the mentally ill is  
37  
38 the subject of ongoing research.  
39  
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41  
42

43 How does this study compare to those previously reported? In their 1991 study Bean et al.  
44  
45 (1991) interviewed Metropolitan police officers about 100 incidents where they detained a  
46  
47 person under Section 136. In these interviews, they considered the features of the events that  
48  
49 precipitated the detention. Self-harm, suicide or threats of either were features in 9% of the  
50  
51 detentions whilst violent behaviour towards others and threats of it were present in 34% of  
52  
53 cases and violence towards property of threats were present in 37% of cases. Thus, self-harm  
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3 or suicide (or attempts at either) were relatively rare as events precipitating detention. In  
4  
5 examining suicide or an attempt as a precipitating feature Bean et al. ( 1991) observed that  
6  
7 suicide alone appeared to be sufficient cause for police intervention though it was not  
8  
9 necessarily thought to be a sign of mental disorder.  
10  
11

12  
13 Turner at al. ( 1992) examined Section 136 detentions in the City of London and Hackney Health  
14  
15 areas over two years between 1985 and 1987. From the Health records they identified 163  
16  
17 cases which led to 135 admissions. 90% of conduct leading to detention was violent or  
18  
19 threatening and only 10% concerned self-harm.  
20  
21

22  
23 This was examined again by Simmons and Hoar ( 2001) who in their study looked at 90  
24  
25 detentions under Section 136 in London in 1996/97. In this study excluding the 'other' and  
26  
27 'unknown' categories, self-harming behaviour was exhibited 14 times whilst violent or  
28  
29 disorderly behaviours were expressed 153 times. These latter behaviours were ten times more  
30  
31 likely. In addition, whilst overall 82% of the 90 individuals were admitted for treatment  
32  
33 following detention, only 57% of those self-harming were admitted. This was the lowest rate  
34  
35 for any behaviour. For all others, the rate was between 79 and 100%.  
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37  
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41  
42 Whilst these results only relate to one police force, the difference in behaviour leading to  
43  
44 detention is most striking. The great majority of incidents that the police in this study engaged  
45  
46 in directly with the public, concerned threats of suicide or self-harm. The violent or disorderly  
47  
48 behaviours that were previously so prominent now represented a small minority. Given the rise  
49  
50 in use of Section 136 over time, could it be that this rise is largely made up of the growth in  
51  
52 incidents involving self-harm?  
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3 Qualitative findings – police response to mental illness.  
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5

6 Officers' responses could be broadly classified into 3 categories; those within the police, those  
7  
8 concerning public sector partners and societal or environmental issues. In this paper only the  
9  
10 police issues are presented. Five themes important to officers were derived from the  
11  
12 interviews. Each is described below and exemplified by substantive quotations.  
13  
14  
15

16 *Self-harm.*  
17  
18

19  
20 All the participant officers agreed that self-harm and threats of self-harm were the most  
21  
22 common type of incident that they dealt with involving people whom they considered to be  
23  
24 mentally ill. This is entirely in accord with the data presented above.  
25  
26

27  
28 Seven of the seventeen officers interviewed identified the second most common kind of  
29  
30 incident as dementia in its various forms, manifest as 'missing persons' or finding people in a  
31  
32 confused or disorientated state. This appeared to be very localised to the more established and  
33  
34 settled communities with an aging population.  
35  
36

37  
38 *Frequent presenters.*  
39  
40

41  
42 Twelve of the seventeen officers interviewed believed that a significant proportion of incidents  
43  
44 arose from a relatively small number of 'frequent presenters'. This was described by a sergeant,  
45

46 Research participant 15, as most demand from a few people:  
47  
48

49           It's like with most policing, we get sort of a nucleus of 6 people and they give us all our  
50           business, they are the ones who are repeat callers, who are the biggest users of our  
51           resource.  
52  
53

54 Research participant 9 set out the challenges of dealing with the same person again and again.  
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3 Yes, it is about sometimes you do go to that same person for the 20<sup>th</sup> time that week  
4 and you do get that feeling- crikey! here we go again – we will have lots of paperwork,  
5 lots of my time just sat with this person. Trying to talk them through but at the same  
6 time then, we don't know what's going on in their head, you don't know why they are in  
7 crisis, you don't know the background so you have got to.... As hard as it can be  
8 sometimes, got to treat it like it's the first time you ever met them, so yea, mixed  
9 feelings, yes it can be frustrating sometimes but personally you have got to treat them...  
10 do as much as you can for them.  
11  
12

13  
14 Research participant 14 identified repeat callers and the disparity in assessment between the  
15  
16 police and Health as to whether the detained people were mentally ill:  
17

18  
19 It would be the same people over and over. Mostly, you do get people that you meet for  
20 a first time and they are given the right care and straight off the bat, but we go through  
21 periods of time where a person will come to our attention and they will be arrested or  
22 detained for 136, continually every day the same thing, every day assessed, assessed,  
23 assessed, keep being told that it is behavioural issues not mental illness and we will  
24 continue to detain them and getting them assessed.....  
25  
26

27  
28 Estimates of the proportion of mental disorder incidents relating to frequent presenters varied  
29  
30 from 'most' above to half as with research participant 12:  
31

32  
33 Probably half and half. There are certain re-occurers shall we say, a couple are one off  
34 episodes, because of their circumstances they just lose it and come into our contact.  
35

36  
37 A few officers did not see frequent presenters as an issue such as research participant 17:  
38

39  
40 I would say that there is quite a variety of people. Sometimes they are not from this  
41 area, they might even catch a train here or something like that, they do all sort of things.  
42

43 Such views appeared to be very specific to location, in this case an urban centre which the  
44  
45 officer believed drew people in from a wider area.  
46

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48  
49 *Issues about diagnosis.*  
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3 The repeated process of assessment and release by Health mentioned above introduced  
4  
5 another set of issues raised by officers and this relates to whether people in contact the police  
6  
7 are mentally ill.  
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9

10  
11 Research participant 14 expressed it thus:  
12  
13

14 That's where we seem to be fighting these losing battles all the time. We are just, it's  
15 never a waste of time to help someone but it feels at the time when you are sat there  
16 with someone that you know isn't in dire need of mental health care, that you are  
17 wasting your time..... I would say why the mental health act was brought in, Section  
18 136, was for the genuine cases where we come across somebody in the street who is  
19 clearly unwell and we take them to a place of safety where they are then assessed.  
20  
21

22 The most common view amongst officers was that many people were lonely or unhappy, in  
23 crisis and wanted attention. Research participant 6 set out 'attention seeking' behaviour thus:  
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25

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27  
28 Oh yea, I have gone to ones, both very recently, where you sit down and have a chat  
29 with them, they say it's nice just to have a chat with somebody as well. You can certainly  
30 sit down and engage with somebody who is genuinely in need but then there is also that  
31 person who will take advantage of saying that they have taken an overdose or whatever  
32 to get a bit of attention and to get what they want. It's like a toddler tantrum.  
33  
34

35 Research participant 5 observed that many people who have received treatment for a mental  
36 health condition have become 'institutionalised' and want to return into such 'care'.  
37  
38

39  
40  
41 Yes, I think the one problem that I seem to notice is that people who are already in the  
42 mental health system, they get released from the hospital and it's almost like they have  
43 been institutionalized once they got into the hospital, so that they are afraid of the  
44 outside world, so therefore they do what they can to get back, so they tend to go to  
45 places like a hospital or to family, say whatever they can or do what they can in order to  
46 think that they will get back into the system.  
47  
48

49 *Worthiness and empathy.*  
50  
51

52 Whatever the personal motives of the person contacting the police, many participants believed  
53 that the outcome of the incident was being managed by what people said or did and officers  
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3 were thus not in control of the outcome. This frustrated some officers as they viewed some of  
4  
5 the people they dealt with as more 'worthy' than others. This was reflected in their personal  
6  
7 feelings about them. Research participant 15, a sergeant, observed:  
8  
9

10  
11 So, if you have got an 18 year old boy who is totally out of it on legal highs and  
12 something like that, then the empathy that we would give somebody like that with  
13 regards to their current mental health condition would be totally different from maybe  
14 someone with bi-polar who has struggled for years and years..... somebody who is self-  
15 inflicted through alcohol or drugs then..... I definitely have less sympathy, I would say  
16 that that probably goes for many officers. But yes, I certainly do.  
17  
18

19  
20 A few participants such as participant 9 took a more nuanced view:  
21

22  
23 I do recognize that, I would say that sometimes you do have those feelings but I would  
24 also say that there is always something that perhaps you don't know, that's there is  
25 always perhaps a back story whether it be in their upbringing or whether it be in their  
26 previous relationships to make them that like that. You might not know that, it might be  
27 that that made them abuse. It might not be the case at all, it might be the case that they  
28 are just one of those people on self-destruct and they like taking drugs and getting  
29 drunk all the time. But do you ever really know and I think that is the tragedy that  
30 sometimes there are genuinely people that come into contact with us who aren't very  
31 nice, who are wild but they are a subject of their upbringing or something that  
32 happened in their life and that's the reason for being like it. Of course, it can be quite  
33 hard when they are shouting and bawling in your face and being violent .....  
34  
35  
36

37 Police officers making judgements about whether people are responsible for their mental  
38 illness have previously been reported by Watson et al. (2004) in the U.S. Whilst Godfredson et al  
39 (2011) in Australia observed that officers based such judgments on several factors surrounding  
40 the incident. Hansson and Markström have suggested that such stigma or negative judgements  
41 about mental illness can be changed through appropriate training.  
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50 *Risk aversion and the creation of a new 'patient pathway'.*  
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3 It is perhaps surprising given the widespread view that many people are wasting police time,  
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5 that the police respond in such an attentive way but the reason for this is very clear. Research  
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7  
8 participant 6 introduced the notion:  
9

10  
11 No because if you made a decision that you were going to leave that one person and say  
12 I am sorry you are clearly manipulating us we are not doing anything for you, that could  
13 be the person that is lying on the road dead, so it's not worth taking the risk of that one  
14 person, that you know for a fact is taking advantage , it is still not worth taking the risk  
15 of not going through the process of taking them to hospital waiting 6 hours for the  
16 ambulance to arrive.  
17  
18

19  
20 The overwhelmingly strong view shared by fifteen of the seventeen participants (and  
21  
22 recognised by the other two) is that officers operate in fear of a 'death in police contact' which  
23  
24 results in highly risk averse behaviour and a high degree of compliance with force policy, even  
25  
26 where the officers judge this is inappropriate. When asked about the consequences if an  
27  
28 incident 'went wrong' Research participant 7 stated:  
29  
30

31  
32 I would lose my job! If something happened to her and I had had contact with her and it  
33 turned out that she had self-harmed I would be a bit worried and a bit concerned that  
34 they would be looking at a death following police contact.  
35  
36

37 Research participant 17 stated:  
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39

40 You would lose your job. You would be sacked. As you are probably fully aware officers  
41 do get sacked for neglect of duty.....  
42  
43

44 Research participant 9 stated:  
45  
46

47 It is. I would say mostly it is about consequences, for me personally, I have got a young  
48 family, I have got a mortgage and bills to pay, I don't want to be on the receiving end of  
49 a phone call saying such and such has died because you did not do your job properly.  
50

51 Research participant 5 set out why this is more serious than other failings:  
52  
53

54 It's not, however mental health can be more extreme because if we have taken the  
55 wrong decision in mental health it can lead to something somebody seriously ill, life  
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3 changing or death that's the sort of thing where effectively we are looking at losing our  
4 jobs whereas not investigating something properly or dealing with something properly is  
5 more likely just to put marks on your record rather than anything else.  
6

7  
8 Two participants nearing 30 years' service reflected upon the changes over time. Research  
9  
10 participant 12 stated:

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12  
13 No, it's a cover all isn't it. If they mention that they are going to kill themselves they are  
14 coming in – full stop. Why? Because I have got 18 months to go (laughs)..... Whereas  
15 before we could quite happily make our own decisions, we are directed by policies, by  
16 them above.....Whereas now it is come on, for if they jump or if they are hurt and there  
17 is police contact, any police contact, then we are the ones that get the blame.  
18  
19

20  
21 Whilst research participant 13 stated:

22  
23  
24 I think, in this day and age, it would be fair to say that you are looking at losing your job,  
25 because it's a hell of a decision to make and I know it goes back to, taking things back to  
26 a bygone era was that that decision about taking the drunk out of the town, taking them  
27 home, opening their door for them and leaving them there. We did it and we did it time  
28 and time again, because it was easier than having a drunk and incapable in the cells  
29 overnight. You pushed them in through the door and as long as they didn't die  
30 everything was OK. But it's now got to the stage where you are looking at what  
31 happened, I came across this person, they said they had taken tablets, couldn't see any,  
32 found his address and so took him home, they die of an overdose overnight. I think in  
33 this day and age its goodbye.  
34  
35

36  
37 Once an officer has become involved in an incident where there is a threat to life, then the only  
38  
39 way they can discharge their accountability is to pass the responsibility to someone else. In the  
40  
41 past, this may have been custody, but with the reduction in the number of people taken there,  
42  
43 it appears to be a Health professional, whether to a hospital or an ambulance - Research  
44  
45 participant 1:  
46  
47

48  
49 We know what the consequences would be, we would be in a world of trouble, we are  
50 in a catch 22 situation we can't take that risk.... As I say if they suggest that they have  
51 taken tablets, whether or not they have taken them, if they tell the ambulance service,  
52 when they eventually turn up, that they are fine and the ambulance says they are fine,  
53 thank you very much. That is a different set of circumstances.  
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3 It appears based on these interviews and the analysis of data that the police have inadvertently  
4  
5 created a new 'patient pathway' which provides direct access for people in crisis to health  
6  
7 services and to a mental health assessment. This can operate either formally through Section  
8  
9 136 or informally with consent. Research participant 13 describes the informal process:  
10  
11

12  
13 They can refer themselves back in..... we have created pathways for people to get  
14 referred and we have got arrangements in place and I am sure other colleagues have  
15 told you that now you can ring up the mental health ward and say I have got so and so  
16 person, they are not drunk, they haven't taken drugs, they are saying that they want to  
17 kill themselves, right bring them up. And we take them straight up and we have created  
18 pathways but we haven't created beds, we haven't created staff...  
19  
20  
21

22 Whilst Research participant 12 describes the formal process:  
23  
24

25 .....but we have created maybe a shortcut for them into the services, I don't know,  
26 because we have set out what we are going to do with them, we take them to custody,  
27 over the years they have been assessed by the nurse or what have you, and then the  
28 next thing they know they are maybe on a mental health assessment. Whereas their GP  
29 is just a referral after referral, whether or not it's a quick shortcut that we made I don't  
30 know.  
31  
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## 37 Conclusions.

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40 Whilst this study concerns one small force, informal focus group discussions in another larger  
41 force and management interviews in two other forces support these findings.  
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43

44  
45 ~~This study indicates that~~ Thus the rise in police detentions over the last 20 years and the  
46  
47 corresponding decline in treatment rates arises from two sources. The patterns of behaviours  
48  
49 leading to detention were formerly violent, abusive or aggressive and only infrequently related  
50  
51 to self-harm, now the great majority of police contacts relate to self-harm and few to the  
52  
53 former.  
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3 Secondly, police officers' detention of people threatening self-harm appears to be part of a new  
4  
5 'risk averse' culture which fears deaths following police contact. This prevents officers from  
6  
7 exercising their discretion and finding other ways to deal with those in distress or crisis and  
8  
9 makes detentions inevitable. The police as a result appear to have inadvertently created a new  
10  
11 'patient pathway' which provides access to Health Services that would otherwise be difficult or  
12  
13 restricted. To use this a person only has to threaten self-harm.  
14  
15  
16  
17

18 The treatment rates for people detained in connection with self-harm were previously low and  
19  
20 they remain so, if not even lower. Taken together this suggests that the mechanism by which  
21  
22 Triage interventions reduce detentions relates to a specific reduction in those cases involving  
23  
24 self-harm (This is the subject of ongoing research).  
25  
26  
27  
28

29 The implication of this and the recent changes to Section 136 in the Policing and Crime Act  
30  
31 2017, which, where possible, requires engagement by officers with a Triage scheme, is that the  
32  
33 number of police detention will decline but in the absence of access to alternative support for  
34  
35 those in crisis, the level of engagement by the police with those who are mentally ill may  
36  
37 continue to rise.  
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48 Table 1.  
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Category of incident	Number of incidents	Percentage of total
Absconders from treatment	232	35.2%
Concern for safety	190	28.8%
Requests for assistance	87	13.2%
Section 136 detentions	59	9.0%

Other	43	6.5%
Crime related	34	5.2%
Section 135 warrants	15	2.3%

Table 2.

		Overall incidents	Section 136 detentions
Type of behaviour	Concern for Safety	159 of 241 = 66%	47 of 58 = 81%
	Crime related	30 of 241 = 12.5%	6 of 58 = 10.3%
	Other	52 of 241 = 21.5%	5 of 58 = 8.6%

Table 3

Behaviour		Outcome			
		Formal/informal admission	Follow up in community	No further Action	Not known
	Concern for safety (self-harm)	22.2%	24.4%	37.8%	15.5%
	Crime (violence)	50.0%	16.7%	33.3%	-
	Other (delusional behaviour)	20.0%	20.0%	40.0%	20.0%
	Not Known			33.3%	66.6%

"Not Known" consists of 3 cases.

Table 4

Disposal	Number of instances	Percentage of total
Sectioned under the MHA	13	13 (10)
Informal admission to hospital	25	24 (20)
Follow up action recommended	29	28 (26)

Released - no further action	36	35 (44)
Released - criminal charge	0	0 (0)

The percentages of disposals using police data are shown in brackets.

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<sup>i</sup> Data obtained from the Health and Social Care Information Centre (HSCIC) and NHS Digital KP90 reports.