The University of Kent, Canterbury Tizard Centre

Mad, bad or sad: the police overuse of Section 136 of the Mental Health Act 1983.

A thesis submitted to the University of Kent's School of Social Policy, Sociology and Social Research.

For the degree of:

Doctor of Philosophy

By

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June 2019

Word count: 91575

Abstract

Section 136 of the Mental Health Act 1983 provides a power for police officers to detain a person found outside their home, who appears to be mentally ill and who presents a risk of harm to themselves or others. The purpose of this detention is to enable an assessment to be made of their need for further treatment under the other provisions of the Act. The number of detentions under Section 136 have risen 6 to 10 fold in the last 30 years whilst over the same period, the treatment rate following detention has fallen from over 95% to less than 20%. The analysis of public data in this thesis also shows a range of other trends in the police engagement with those who are mentally ill.

Four studies are reported here which show that the behaviours which result in detention have also changed over the same period and whilst they were previously violent, abusive, aggressive or sexualised they are now concerned with self-harm 80% or more of the time.

Study 3 shows that whilst part of the increase in detentions relates to reductions in available treatment services, a large part also relates to the development of a 'risk averse' culture within policing which encourages officers to detain people under Section 136 to reduce the potential consequences for them of a 'death following police contact'.

Study 4 shows that detentions and related risks can both be reduced by encouraging officers to use their *discretion* and through more effective partnership working.

Finally, study 4 also shows that the full range of police contacts with those who are mentally ill are not understood, as for every Section 136 type incident there were also eight others which also needed to be managed.

This thesis also includes recommendations for developing policy, practice and research.

Acknowledgements

Thank you to Jacqueline Thomas without whose encouragement I would never have started this project and who kept me on track throughout.

I am also very grateful to Professor Rachel Forrester-Jones and Professor Glynis Murphy who have each helped convert me, at least in part, from a scientist to a sociologist. Without their support and advice, I could never have completed this project.

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1.1 Introduction.

Mental illness is unusual amongst medical conditions for it is one of the few where people can be treated against their will and restrained and deprived of their liberty in order to do so[1]. Within England the legal framework for compulsory treatment lies within the Mental Health Act 1983 (as amended in 2007 and 2017) and the Mental Capacity Act 2005. Most countries in the world have a similar legal or administrative system to manage and oversee this process of detention and treatment and whilst the legal, cultural and medical processes may vary, all seek to balance three distinct sets of interests (Salize, Dreßing & Peitz, 2002). These are:

- The human and other rights of the patient.
- Public safety.
- The efficacious treatment of the patient.

Over the last century the approach of many 'first world' countries to the care of the mentally ill has changed significantly and since the nineteen sixties generally been moving from institutional based provision to more personalised support of individuals in their own communities. Reducing the frequency of their compulsory admission and treatment had been an aim of this change across the world (Curran, 1978). However one perverse outcome has been increasing rates of compulsory treatment in many European countries (Salize, Dreßing & Peitz, 2002, de Stefano, Ducci, 2008) including England (Wall et al. 1999). Whilst one of the intentions of United Kingdom (UK) government policy in moving from institutional to community care was to prevent unnecessary detention and treatment, latterly public fear of the harm that the mentally ill may cause has led to a policy shift which focuses more on public safety (Angermeyer and Matschinger 1995; Holloway 1996; Phelan and Link 1998; Hotopf et al 2000) as seen most recently in the Mental Health Act 2007 (MHA). This introduced supervised community treatment such as Community Treatment Orders (CTOs) which enables a patient to be returned to hospital and

[1] The other current compulsory treatment in the UK is of notifiable diseases such as Tuberculosis and is operated through Sections 37 and 38 of the Public Health (Control of Disease) Act 1984

forcibly medicated if they do not comply with the requirements of their treatment order. It also changed the 'treatability test' for detention which previously required that a treatment must be likely to alleviate or prevent the deterioration of a condition, to an 'appropriate treatment' test which is less stringent in that a "medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations". These changes are more focused on managing the risk presented by patients rather than their treatment. Concerns have been expressed about the consequences of these changes (Mental Health Alliance 2012).

This research is concerned with one small part of the legal framework - Section 136 of the Mental Health Act 1983 - and how it operates. This is the section that empowers the police, to detain someone who appears to them to be mentally disordered where this is necessary for their own or someone else's protection. There has and continues to be significant public disquiet about the operation of this legislation, as manifest through the many reports of regulators and other public bodies (set out in full below), Criticisms focus on how the act has led to unjustified police detentions, rather than balancing the rights of individuals with public safety and their effective treatment.

Examining this issue is the principle motivation for this research.

1.2 Definition of Section 136.

Section 136 of the Mental Health Act 1983 states:

> *(1) If a person appears to a constable 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—*
>
> > *(a) remove the person to a place of safety within the meaning of section 135, or*
> >
> > *(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.*

(1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than—

(a) any house, flat or room where that person, or any other person, is living, or

(b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.

(1B) For the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force.

(1C) Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult—

(a) a registered medical practitioner,

(b) a registered nurse,

(c) an approved mental health professional, or

(d) a person of a description specified in regulations made by the Secretary of State.

(2) A person removed to, or kept at, a place of safety under this section may be detained there for a period not exceeding the permitted period of detention for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

(2A) In subsection (2), "the permitted period of detention" means—

(a) the period of 24 hours beginning with—

(i) in a case where the person is removed to a place of safety, the time when the person arrives at that place;

(ii) in a case where the person is kept at a place of safety, the time when the constable decides to keep the person at that place; or

(b) where an authorisation is given in relation to the person under section 136B, that period of 24 hours and such further period as is specified in the authorisation.

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the permitted period of detention mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the permitted period of detention mentioned in that subsection.

(5) This section is subject to section 136A which makes provision about the removal and taking of persons to a police station, and the keeping of persons at a police station, under this section.

Section 136 has been significantly redrafted through the Policing and Crime Act 2017 and in its present form came into force in December 2017. Prior to this Section 136 of the Mental Health Act stated:

(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from a mental disorder and to be in immediate need of care or control, the constable may, if he thinks it is 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[2]*.*

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a

[2] Section 135 defined a Place of Safety as Social Services residential accommodation, a hospital, a police station or other suitable place the occupier of which was willing to receive the patient.

registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the 72 hours mentioned in that subsection.

The changes introduced through the Policing and Crime Act 2017, whilst significantly affecting the operation of the legislation were not pertinent to the research, reported and set out below. The amendments clarified or altered several aspects of Section 136 including widening the scope of the locations where officers could exercise this power. Previously this was limited to places to which the public had access and included public places and private places where there was permitted access such as shopping centres, football stadia etc. The power did not apply to private places where the public are not permitted such as railway lines, or prohibited areas of tall buildings or structures (where suicidal people might be found). It now applies anywhere apart from peoples' homes. To promote alternatives to detention in police facilities a requirement was introduced for officers to consult Health professionals, usually in the form of a 'Triage Scheme', before exercising this power – "where practical". The time limit for detention was also reduced from 72 hours to 24 hours. This was intended to minimise harm to individuals and focus the attention of partners on speeding up the process of assessment. The use of police custody for children was prohibited and for adults prohibited, save in exceptional circumstances.

The purpose of Section 136 is to enable Health professionals to make an assessment of the detained person to see if they are ill and if so whether they need further detention for assessment and treatment (see Section 2 and 3 of Part II of the MHA 1983). However, at its heart the power for the police to detain remains unchanged.

The operation of the Act is also government by the Code of Practice to it, published by the Department of Health (2015), this is concerned that people should be:

- Treated with the least restriction of their freedoms whilst maximising their independence.
- Empowered and involved in the decision-making process.
- Treated with respect and dignity.
- Treated with purpose and effectiveness and
- Treated with efficiency and equity.

1.3 Definition of Section 135.

Section 136 is concerned with the behaviour of people in public places and specifically not in their own homes. As people who are mentally ill or disordered may be at significant risk of harm in their own homes there is a complimentary police power through Section 135 of the Mental Health Act. This enables police officers on the authority of a Court warrant to enter private dwellings.

> *Section 135. Warrant to search for and remove patients.*
>
> *(1) If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder—*
>
> > *(a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or*
> >
> > *(b)being unable to care for himself, is living alone in any such place,*
>
> *the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.*

In this case the police action is directed by a Court, on the application of a mental health professional and so not on the officer's discretion. The operation of Section 135 is incidental to this study.

1.4 Definition of Mental Disorder.

Mental disorder (as amended by Para 1(2) and 1(3) of The Mental Health Act 2007) means any disorder or disability of the mind. This would not normally include a learning disability "*unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part"* (Para 2A (b) MHA 2007).

The wider clinical definition of mental disorder is provided by two widely recognised authorities which are most recently converging in their definitions. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, uses a common language and standard criteria to define mental disorders. Their definition has recently changed with the publication of DSM 5 which states:

> *"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above" (American Psychiatric Association, 2013).*

The other authority is the International Statistical Classification of Diseases and Related Health Problems (ICD), produced by the World Health Organization (WHO). This takes a wider view of

mental health as a part of general health. The ICD-11.06 states that mental, behavioural or neurodevelopmental disorders are:

> *"…… syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning" (World Health Organisation, 2018).*

In previous versions these two definitions had been quite different but at present they are quite closely aligned. However, given the complexity of the clinical analysis and classification of mental disorder, the definition used in Section 136 seeks to provide a *common place* definition upon which unqualified police officers or others can exercise their discretion. It is a *moot* point how well this works in practice given that so often the police assessment differs from the psychiatrists. As Teplin and Pruett (1992 page 140), pointed out:

> *"Whilst the law provides the legal structure and decrees the police officers' power to intervene, it cannot dictate the police officers' response to that situation. Unlike other professionals the police do not have a body of technical knowledge with respect to psychiatry which they use as a formula in the performance of their role. As with all law enforcement decisions the police must exercise discretion in choosing the most appropriate disposition in a given situation.*
>
> *In mental health cases the situation is further complicated by the nebulous definition of 'mental disorder'. There is a large grey area of behaviour which depending upon cultural values, community context and administrative practices, might be labelled criminal, psychiatric or merely odd."*

Section 136 provides an extraordinary power for the state to intervene in the lives of its citizens. The person need not have committed any crime nor other wrongdoing, rather they are in a public

place and in the opinion of a police officer, are mentally disordered and need to be detained to protect them from themselves or to prevent a risk of harm to others.

There is another issue which besets this type of study and this concerns terminology. There are and have been a wide range of terms used to describe mental disorder. Many of these have changed over time and some may, by present standards, be regarded as offensive or inappropriate. In quoting sources, the original wording is used and this range of terms is taken as forming part of mental impairment for the purposes of his review. Similarly, there is the issue of how to categorise the people who are detained by the police under this or similar provisions. They are generally not criminals and are not under arrest and so they are not prisoners (although technically the term prisoners should only be applied to convicted imprisoned offenders it is much more widely used within the police). Once they are in the care of the Health Authorities then their status become that of a '*patient'*, but that is determinedly not what they are when in the custody of the police, for they receive treatment little or no different from those arrested for criminal offences. Another option is that they are the subject of a process of detention and assessment, in which case they could be described as a '*subject'*, which is a relatively neutral term, however it is relatively obscure and conceals the nature of the process. In the legislation it is specified that a person is detained under Section 136 and so such people can be accurately be described as 'detainees'. This is a term with a wider public currency for it is applied for example to the detention of asylum seekers and many others subject to civil legal processes. As it does not appear offensive and it accurately describes the status of the individuals, for the purposes of this study people detained under Section 136 are referred to as detainees. Where people are detained in similar circumstances in other jurisdictions or historic periods and a specific term is in use to describe them then that term may be used instead.

1.5 Mental health conditions and the criminal justice system.

There is a far wider range of engagement by the police with those who are mentally ill than just through Section 136. It does not feature in this study, but mental disorders or mental illness is far

more prevalent in those people arrested and processed through the criminal justice system than in the general population. The table below shows comparative rates for each.

Table 1.1 Prevalence of mental illness in prison and general populations.

Diagnosis	Prisoners	General population
Personality disorder	66%	5%
Depression or anxiety	45%	14%
Psychosis	8%	0.5%

Data from Singleton et al. (1998) and Singleton et al. (2001), cited by the Centre for Mental Health (2008).

Around ninety percent of prisoners have at least one mental health problem, four times the rate of the wider community, and with multiple problems the comparison is even more stark. Seventy percent of prisoners have two or more problems compared to four percent in the general population whilst psychosis is fifteen to twenty times more common amongst prisoners than in the population at large (Centre for Mental Health 2008).

That people with mental illness are drawn into the criminal justice system is also shown by considering the history of mentally ill patients. In their study of 232 patients with schizophrenia, Hodgins and Müller-Isberner (2004) showed that 77.8% of the *forensic* patients had previous admissions to general psychiatric services whilst 24.3% of the general psychiatric patients had a criminal record. This again demonstrated a high level of involvement of people who are mentally ill with the criminal justice system.

Section 136 is therefore unusual in policing terms for it leads into a patient care pathway rather than into the criminal justice system. For that reason, there is no further reference to the criminal justice system and mental illness in this study.

1.6 The medical context for the operation of Section 136.

To understand the context of Section 136 detention in the wider Health setting it is also useful to understand the other powers of detention and treatment within the MHA 1983. The great majority of the provisions and detentions relate to the civil/medical treatment of the mentally disordered and mentally disordered offenders. These provisions are:

Part II.

- Section 2. This is a civil admission, authorised by two doctors, for the assessment of the condition of the patient and lasts for up to 28 days.
- Section 3. This can follow on from Part II or be used directly where the patient has been assessed already. It is an authority from two doctors to detain the patient for treatment in the first instance for six months, though this can be extended for six months and thereafter for a year at a time.
- Section 4. In urgent or emergency cases, where Section 2 is not practical, a patient can be detained for up to 72 hours for assessment on the application of an Approved Mental Health Practitioner, their nearest relative or their medical practitioner.
- Section 5. This section authorises a doctor or nurse to prevent a voluntary or informal patient from leaving the hospital where informal treatment is no longer practical, and they consider it is necessary for the patients' health and safety or the protection of others. This can last for up to six hours and is an interim measure to allow the operation of Sections 2 or 3.

Part III.

- Section 35. In this Section a Court may remand a person charged with a crime, punishable with imprisonment, to a hospital for an assessment of their mental condition.
- Section 36. Where two medical practitioners determine that the person charged with an offence is suffering from mental disorder and that an appropriate treatment is available for him, then the Crown Court may remand him to hospital rather than to prison.

- Sections 37 and 38. Where a person is convicted of an offence punishable with imprisonment and two medical practitioners determine that the person is suffering from a mental disorder, then the Court may sentence the person to be detained in a mental hospital under the guardianship of the local Social Services. This detention may continue through Interim Hospital Orders.
- Section 41. Where the patient is considered to be high risk then the Crown Court may order special restrictions permitting his release only on the discretion of the Secretary of State. This was formerly known as "detained under his majesties pleasure".
- Section 47. This section, on the recommendation of two medical practitioners, permits the transfer of convicted persons from prison to hospital if appropriate treatment is available there.
- Section 48. This section provides the same powers of transfer but for persons in prison but not convicted for example detained under the Immigration Act or for non-payment of fines.

When, for a person detained under Section 135 or Section 136 further detention is authorised, it is likely to be under Section 2 (or if they had been assessed on a previous admission in hospital, directly under Section 3). A person who was initially arrested for a criminal offence but was subsequently determined to be mentally disordered could be detained for assessment under Sections 2 or 4 (Part II of the MHA), or if charged with an offence, detained under Section 35 and later Sections 36 or 37 (Part III MHA), or once convicted under Sections 38, 41 or 47.

1.7 Comparison of Section 136 with the Mental Capacity Act 2005.

The Mental Capacity Act 2005, which came into force in October 2007, created a power of detention for Health professions (and for the police) which is in some ways similar to Section 136. Compared to Section 136 the MCA is a complex piece of legislation containing powers and safeguards. The Act needs to be considered alongside it's Code of Practice. For the purposes of brevity, the parts relevant to the police are set out below. These will equally apply to the Ambulance Service as first responders.

Section 1 sets out five principles about the capacity of individuals to make decisions relevant to their own health or wellbeing.

Section 1. The principles

The following principles apply for the purposes of this Act.

> *(1) A person must be assumed to have capacity unless it is established that he lacks capacity.*
>
> *(2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.*
>
> *(3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.*
>
> *(4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*
>
> *(5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.*

Whether a person lacks capacity is set out in section 2.

Section 2. People who lack capacity

> *(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.*

This inability to make decisions is further defined.

Section 3. Inability to make decisions

> *(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—*

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

Section 4 gives a qualified power to engage in an act of care of treatment.

Section 5. Concerns acts in connection with care or treatment

(1) If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if—

(a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and

(b) when doing the act, D reasonably believes—

(i) that P lacks capacity in relation to the matter, and

(ii) that it will be in P's best interests for the act to be done.

Section 6 further limits Section 5 powers.

(1) If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless two further conditions are satisfied.

(2) The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P.

(3) The second is that the act is a proportionate response to—

(a) the likelihood of P's suffering harm, and

(b) the seriousness of that harm.

(4) For the purposes of this section D restrains P if he—

(a) uses, or threatens to use, force to secure the doing of an act which P resists, or

(b) restricts P's liberty of movement, whether or not P resists.

Best interest is in turn further qualified by the Code of Practice which states:

5.31 All reasonable steps should be taken to preserve life

5.61 In emergency, saving life or preventing someone suffering serious harm will almost always be in the persons best interests and treatment should be given without delay.

The MCA is a power available for the police to use where Section 136 may not apply. The two most likely circumstances are where they encounter a person in their home (where Section 136 does not apply) who is threatening suicide and no other Health service is present. The other is where they find a person who is at risk of harm through their behaviour but who has lost the capacity to make sensible decisions – for example they suffer from dementia. The police would not wish to take such a person to a POS for an assessment, they would probably wish to return them to their carers, which they can do with the MCA.

1.8 The legal origins of Section 136

The earliest legislation to deal with *dangerous lunatics* was the Justices Commitment Act 1743 which in Section 20 states:

"XX. And whereas there are sometimes Persons, who by Lunacy, or otherwise, are furiously mad, or are so far disordered in their Senses that they may be dangerous to be permitted to go abroad;' Be it therefore enacted by the Authority aforesaid, That it shall and may be lawful for any two or more Justices of the Peace where such Lunatick or mad Person shall be found, by Warrant under their Hands and Seals, directed to the Constables, Church wardens and Overseers of the Poor of the Parish, Town or Place, or some of them, to cause

such Person so to be apprehended, and kept safely locked up in some secure Place, within the County or Precinct where such Parish, Town or Place shall lie, as such Justices shall under their Hands and Seals direct and appoint; and (if such Justices find it necessary) to be there chained, if the last legal Settlement of such Person shall be in any Parish, Town or Place within such County or Precinct; and if such Settlement shall not be there, then such Person shall be sent to the Place of his or her last legal Settlement by a Pass, mutatis mutandis , as aforesaid, and shall be locked up or chained, by Warrant of two Justices of the County or Precinct to which such Person is so sent, in Manner aforesaid; and the reasonable Charges of removing, and of keeping, maintaining and curing such Person during such Restraint (which shall be for and during such Time only as such Lunacy or Madness shall continue) shall be satisfied and paid (such Charges being first proved upon Oath) by Order of two or more Justices of the Peace."

This provided a power to detain people who would be dangerous if allowed to go abroad, i.e. if they had contact with the public. This legislation specifically identifies *potentially* dangerous lunatics and offers a power to detain and restrain them even though they may not have done any harm. It foreshadows later legislation.

Having provided a power of detention it was then necessary to determine who would be a competent authority to judge whether the detained person was lunatic. In the absence of qualified doctors (the Medical Registration Act was passed in 1858), the local and ubiquitous authority was the magistracy who were empowered to so. This was only an extension of their traditional role. Most criminal powers could be exercised by one magistrate but in this section two or more are required. This is clearly a safeguard to prevent people being detained for malicious reasons. The act enables the person to be detained in 'some secure place', which would be a gaol or prison. If the person was not a resident of the parish in which they were detained then they could be transferred to their settled parish. No treatment is offered in the Act rather just restraint whilst the insanity prevails. The act also provides that the costs of such confinement

would in the first instance fall to that individual and their estate and only where there were no such funds, fall upon the parish.

The presumption at the heart of this legislation is that insanity is a 'clear cut' condition which can easily be recognised by the magistrates in detaining the person and that a recovery would be similarly clear cut enabling the person to be released. There are no records to show how well this operated in practice, but it is the first legislation which recognises the insane as a specific class of person who needs to be dealt with outside of the criminal law.

The Criminal Lunatics Act of 1800 formalised the process for dealing with a person who had committed a crime but could not be held responsible for their actions through insanity and were thus acquitted by a jury. Part 1 of the Act stated:

> *"…..That in all Cases where it shall be given in Evidence upon the Trial of any Person charged with Treason, Murder, or Felony, that such Person was insane at the Time of the Commission of such Offence, and such Person shall be acquitted, the Jury shall be required to find specially whether such Person was insane at the Time of the Commission of such Offence, and to declare whether such Person was acquitted by them on account of such Insanity; and if they shall find that such Person was insane at the Time of the committing such Offence, the Court before whom such Trial shall be had, shall order such Person to be kept in first Custody, in such Place and in such Manner as to the Court shall see fit, until his Majesty's Pleasure shall be known……"*

This act also introduced the notion of detention without limit at "his Majesty's pleasure". Part 3 of the act went further and offered a preventative power:

> *"III. 'And, for the better Prevention of Crimes being committed by Persons insane,' be it further enacted, That if any Person shall be discovered and apprehended under Circumstances that denote a Derangement of Mind, and a Purpose of committing some Crime, for which, if committed, such Person would be liable to be indicted, and any of his Majesty's Justices of the Peace before whom such Person may be brought shall think fit to*

> *issue a Warrant for committing him or her as a dangerous Person suspected to be insane, such Cause of Commitment being plainly expressed in the Warrant, the Person so committed shall not be bailed except by two Justices of the Peace, one whereof shall be the Justice who has issued such Warrant, or by the Court of General Quarter Sessions, or by one of the Judges of his Majesty's Courts in Westminster Hall , or by the Lord Chancellor, Lord Keeper, or Commissioners of the Great Seal."*

This was a power to detain someone who was mentally ill or disordered and appeared to be about to commit an indictable crime i.e. triable by a jury. At that time this included a very wide range of crimes many of which would now be regarded as relatively minor.

These provisions form the foundation upon which the present power under Section 136 is built. That there was growing concern about the mentally ill is illustrated by the volume of law.

> *"Parliamentary reports are one index of the growth of concern about lunacy. The number of Bills, reports of Select Committees and inquiries relating to lunacy rose from a mere handful in the 18th century to 71 between the years 1801 and 1844"* (Skultans 1979 page 98).

As set out above this increase in volume of legislation closely parallels that for vagrancy. Having created such a power there was then the need to accommodate those detained by this or other powers. The first legislation to address this was the Lunatics, paupers or criminals act 1808, part II of which stated:

> *And be it further enacted, That the said Justices of the Peace, after such Notice being given as aforesaid, shall at their next General Quarter or General Annual Sessions proceed to take the same into Consideration; and if it shall appear to the major Part of the said Justices being then and there assembled, such major Part not being less in Number than Seven, that it is expedient that a Lunatic Asylum or House for the Reception of Lunatics and other insane Persons should be erected in and for the said County sole, the said Justice shall nominate and appoint such Number of Visiting Justices as they may think fit to*

> *superintend the Building, Erection, and Management of such Lunatic Asylum, and from Time to Time to report the State of their Proceedings to the Court of the General Quarter Sessions.*

This act required the magistrates to hold a vote at their annual or quarterly meeting on whether the County should build an asylum. If agreed, to appoint some of their members to oversee the process and supervise its operation. Such additional expenditure was not a popular proposal and no more than a handful of asylums were built. The law was revised in 1828. In this year the County Lunatics and Asylums Act 1828 (sometimes called the Madhouse Act) again required the magistrates to engage with the public and vote on building an asylum, a simple majority being enough to agree it. Again, very few asylums were built as a result of this change in legislation. This act also repealed the 1774 Act and introduced a requirement for a medical practitioner to attend private madhouses weekly to release any individuals inappropriately detained.

Finally, in 1845 the Lunatics Act, otherwise known as the County Asylums Act was passed. This required every County or Borough that did not have an asylum to build one, to cooperate with neighbouring boroughs or counties if necessary to do so and if provision was too small to enlarge it. So, 40 years after the first attempts to provide adequate provision of asylums and 100 years after the first efforts to regulate asylums, a national provision was created.

There have continued to be developments and refinements ever since. The Lunacy Acts Amendment Act of 1885 defined the circumstances in which lunatics could be brought before a magistrate with a view to detaining them. It stated:

> *2. Where, under the Lunatic Asylums Act, 1853, it shall be the duty of any relieving officer, overseer, or constable to give notice to or lay information before a justice as to any pauper who is or is deemed to be a lunatic, or as to any person wandering at large who is deemed to be a lunatic, or as to any other person deemed to be a lunatic who is not under proper care or control, or is cruelly treated or neglected by any relative or other person having the care or charge of him, or to apprehend and take any such person wandering at large*

> *before a justice, and the relieving officer, overseer, or constable is satisfied that it is necessary for the public safety, or the welfare of the alleged lunatic, that before such notice or information can be given or laid, or the alleged lunatic can be brought before the justice, the alleged lunatic should be placed under care and control, the relieving officer, overseer, or constable may remove the alleged lunatic to the workhouse of the union in which the alleged lunatic is, and the master of the workhouse shall, unless there is no proper accommodation in the workhouse for the alleged lunatic, receive and relieve and detain him therein but no person shall be so detained for more than three days; and before the expiration of that time the relieving officer, overseer, or constable shall give the notice to or lay the information before the justice as to such alleged lunatic, or bring him before the justice, as the said Act requires.*

This is clearly the origin of the modern provision with Section 136. It included provision to detain any pauper who was deemed to be a lunatic, or anyone who was a lunatic wandering at large, for the public safety or for their welfare. They could be detained by a Constable an overseer or a relieving officer. It made provision for them to be securely detained and brought before a magistrate within three days or 72 hours, which was until 2017 the limit on detention prior to a determination of fitness.

Shortly after this the first comprehensive and specific legislation to set out how the mentally ill should be dealt with was the Lunacy (Consolidation) Act of 1890. This made a clear distinction between paupers and other destitute lunatics and those who had the means to pay. The Act covered the process through which family members or friends could testify to the magistrates concerning the illness of the subject and through this have them detained and taken to an asylum. The Act also concerns people in public places who were mentally ill.

Section 15 of the Lunacy Act 1890 stated:

> *(1.) Every constable and relieving officer and every overseer of a parish who has knowledge that any person (whether a pauper or not) wandering at large within the*

> *district or parish of the constable, relieving officer, or overseer is deemed to be a lunatic, shall immediately apprehend and take the alleged lunatic, or cause him to be apprehended and taken, before a justice.*
>
> *(2.) A justice, upon the information upon oath of any person that a person wandering at large within the limits of his jurisdiction is deemed to be a lunatic, may by order require a constable, relieving officer, or overseer of the district or parish where the alleged lunatic is, to apprehend him, and bring him before the justice making the order, or any justice having jurisdiction where the allege lunatic is.*

This refinement of the Lunacy Acts 1885 did away with the distinction between paupers and others and was just concerned with their state of mind. Section 16 went on to detail the examination which for the first time was to be undertaken by a medical practitioner:

> *The justice before whom a pauper alleged to be a lunatic or an alleged lunatic wandering at large is brought under this Act shall call in a medical practitioner, and shall examine the alleged lunatic, and make such inquiries as he thinks advisable, and if upon such examination or other proof the justice is satisfied in the first-mentioned case that the alleged lunatic is a lunatic and a proper person to be detained, and, in the secondly-mentioned case, that the alleged lunatic is a lunatic, and was wandering, at large, and is a proper person to be detained, and if in each of the foregoing cases the medical practitioner who has been called in signs a medical certificate with regard to the lunatic, the justice may by order direct the lunatic to be received and detained in the institution for lunatics named in the order, and the relieving officer, overseer, or constable who brought the lunatic before the justice, or in the case of a lunatic wandering at large, any constable who may by the justice be required so to do, shall forthwith convey the lunatic to such institution.*

Section 22 concerned alternative arrangements to taking the person to an asylum. It stated:

> *In the case of a lunatic as to whom a summary reception order may be made nothing in this Act shall prevent a relation or friend from retaining or taking the lunatic under his own care if a justice having jurisdiction to make the order, or the visitors of the asylum in which the lunatic is or is intended to be placed, shall be satisfied that proper care will be taken of the lunatic.*

This wording, with a few small substitutions, forms the basis of the relevant provision in the Mental Health Act 1959. The main difference is the previous Acts only required that the lunatic was wandering at large, which is very widely defined and could under some circumstances include private property. This became restricted to "*to which the public have access*". This is not as narrow as a public place – which is where the public are permitted to be as of right e.g. a street or footpath, but is wider in that it includes private property which the owner allows the public to have access to the material time e.g. shops, cinemas, football grounds when open etc. The Lunacy and Mental Treatment Act of 1930 also did away with a range of terms: lunatics became patients or persons of unsound mind; paupers became 'rate aided' and asylums became hospitals, and this too is reflected in the wording of the 1959 Act in which Section 136 stated:

> *(1) 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 the last foregoing section.*
>
> *(2) A person removed to a place of safety under this section may be detained there for a period not exceeding seventy-two hours for the purpose of enabling him to be examined by a medical practitioner and to be interviewed by a mental welfare officer and of making any necessary arrangements for his treatment or care.*

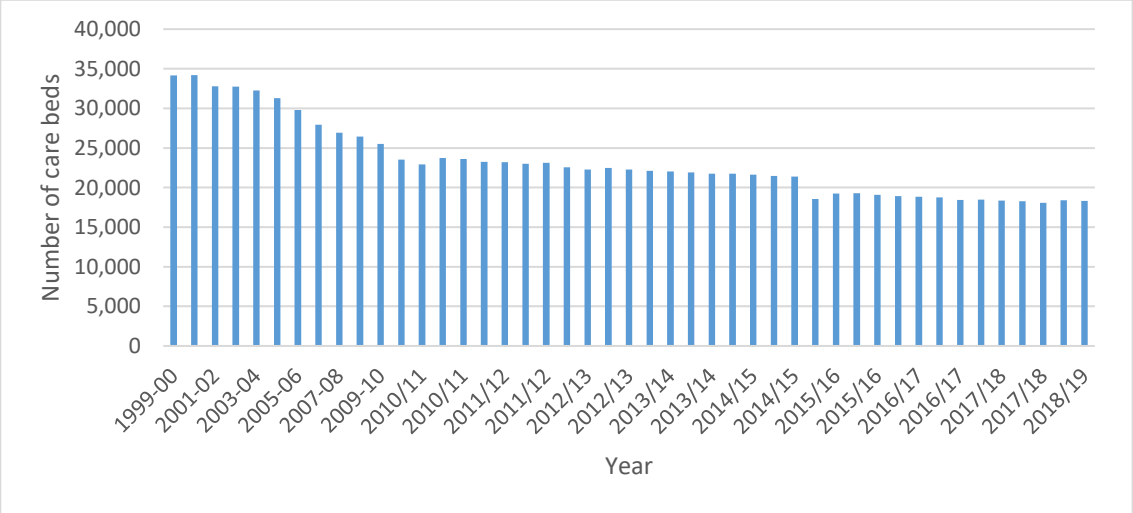
This section was clearly felt to be a successful provision for it was retained word for word in the original drafting of Section 136 of the Mental Health Act of 1983. The original 1983 Act stated:

(1)If a constable finds in a place to which the public have access a person who appears to him to be suffering from a mental disorder and to be in immediate need of care or control, the constable may, if he thinks it is 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.

1.9 Changes in the mental health services context.

Alongside the changes in use of Section 136 have been long and short term changes in the social context of mental health services. The deinstitutionalisation of the mentally ill since the 1950s significantly reduced the number of psychiatric beds available for their treatment from 150,000 in 1955 to 55,000 by 1995 (Hotopf et al., 2000). This number has continued to fall ever since. The figures for 1987 to 2018 are set out below.

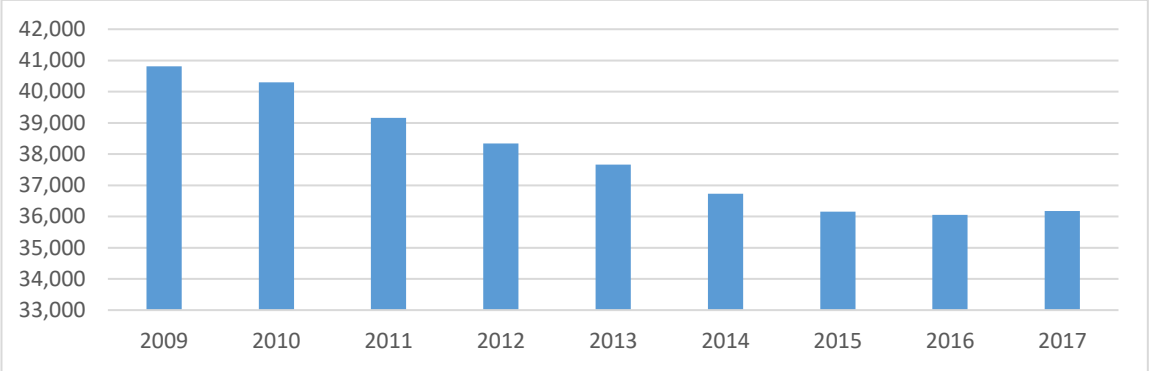
Figure 1.1 Available care beds for mental illness, average per quarter, 1987 to 2018.



Source: [https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/]

Over the last four years from the first quarter of 2014 to the second quarter of 2018 the number of overnight treatment beds has declined from 21,750 to 18,311, a reduction of 16%. As treatment beds declined the number of mental health nurses working in the NHS has also declined but at a slower rate. From 2014 to 2017 the numbers fell by only 1.5%. This is likely to reflect the occupancy rates in treatment units (see below).

Figure 1.2 Total number of mental health nurses in NHS hospitals and Community Health Services (HCHS) in England 2009 to 2017.

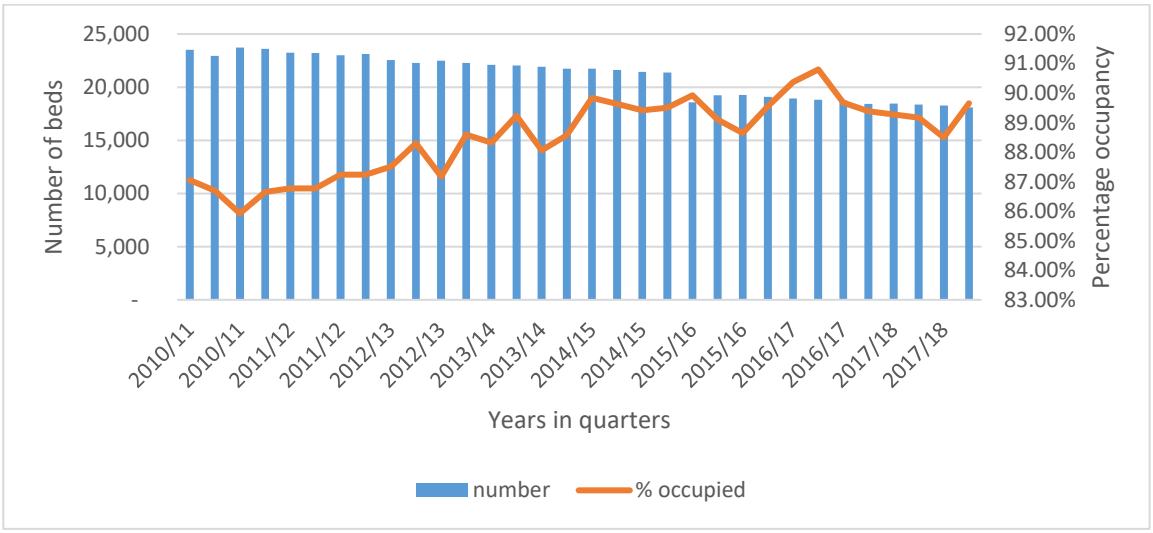


Source: [https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics-october-2017-provisional-statistics-including-experimental-report-on-mental-health-and-learning-disability-workforce-up-until-september-2017]

As the number of treatment beds declined this was accompanied by a rise in the occupancy rate.

The most recent figures are set out in the figure below. These show a short-lived peak in 2016/17.

Figure 1.3 Average number of available over night beds for mental health services in England per quarter and occupancy rate, 2010 to 2017.



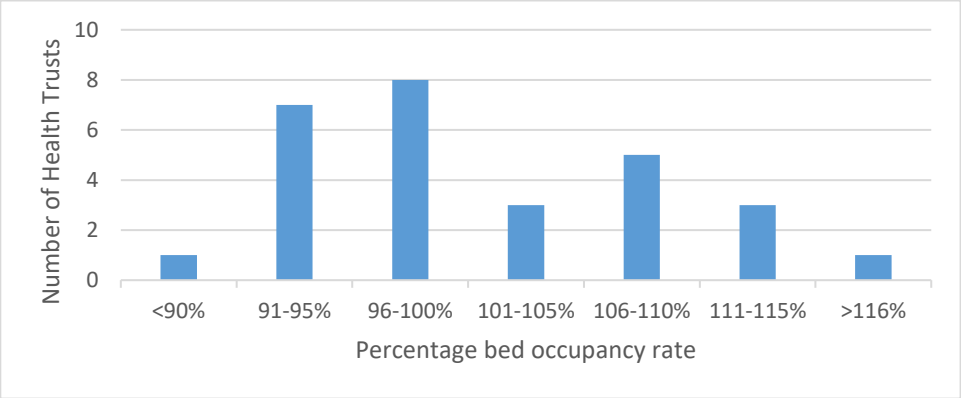
Source: [https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/]

This may be anomalous given that so much else in the data for that year is inaccurate (see Ch.3)

Excluding that peak the average occupancy rate over the last four years has been around 89 to 90%.

These average rates can mask periods of higher admission rates. Following a Freedom of Information request McNicoll (2013) was able to show much higher rates of bed occupancy in the 28 of 55 Health Trusts that responded to his request. This is summarised in figure 2.13 below.

Figure 1.4 Bed occupancy rates in psychiatric units on 1st August 2013 in 28 Health trusts.



Source: [http://www.communitycare.co.uk/2013/10/16/patients-at-risk-as-unsafe-mental-health-services-reach-crisis-point-2/]

The best practice advice from The Royal College of Psychiatrists is for occupancy rates no higher than 85% (The Royal College of Psychiatrists, 2011), clearly these were regularly exceeded in this data.

There are frequent reports in the media about the difficulties caused by the shortage of mental illness beds within the NHS. In an investigation for Community Care magazine it was reported that between 2012 and 2013 there were seven suicides of and one homicide by people waiting for admission (McNicoll, 2014). Following a further FOI request McNicoll (2015) has shown a rise from 3,611 to 4,447 patients (23% increase) sent to hospitals outside their local Trust's catchment area. This follows a doubling in the number of such placements the year before (McNicoll, 2015).

The Care Quality Commission (CQC 2014a) previously reported on this reduction in the number of available beds and the resultant *"local system failures in facilitation of timely and appropriate access to care".* Similarly the Department of Health (2014) identified the difficulties faced by people in crisis, who try and access mental health services through A&E Departments which again lack suitable POS provisions. If people cannot easily access services when they know they need help, then they may present with a more serious illness when they finally gain such access. This

would be supported by the increased rate of compulsory detention amongst patients initially admitted on a voluntary basis (CQC 2014a).

As well as hospital-based care there is also 'care in the community'. This is provided both through Health and through local authorities.

NHS care was designed, in the NHS plan of 2000[3], to provide an extensive framework of care in the community defined as follows:

> *"Crisis resolution*
>
> *14.31 At the moment the only option in many areas is to admit people with an acute mental illness to hospital. Crisis Resolution Teams (CRT) respond quickly to people in crisis, providing assessment and treatment wherever they are:*
>
> - *a total of 335 teams will be established over the next three years*
> - *by 2004, all people in contact with specialist mental health services will be able to access crisis resolution services at any time……."*

In addition to these 335 CRT there was also planned to be Assertive Outreach Teams to manage the more difficult patients living in the community:

> *"Assertive outreach services*
>
> *14.32 There are a small number of people who are difficult to engage. They are very high users of services, and often suffer from a dual diagnosis of substance misuse and serious mental illness. A small proportion also have a history of offending. Services to provide assertive outreach and intensive input seven days a week are required to sustain engagement with services, and to protect patient and public:*

---

3 https://webarchive.nationalarchives.gov.uk/20121102184216/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960. Page 120

> *• a further 50 teams will be established over the next three years in addition to the 170 teams which will be in place by next April*
>
> *• by 2003 all 20,000 people estimated to need assertive outreach will be receiving these services."*

Whilst research by Glover et al., (2006) showed that Crisis Resolution Teams can be effective (at least for some population groups) in reducing hospital admissions, they found no evidence that Assertive Outreach had any such effects. In terms of the effectiveness of CRTs the issue appears to be that they have never been fully resourced. This was illustrated through an FOI request by McNicoll (2015) which revealed that between 2010/11 and 2014/15, in 43 (of 56) Mental Health Trusts, crisis home treatment funding reduced by 8.3% (in real terms) whilst average referrals rose by 18%. Until 2013 the Government published a national annual survey on spending on mental health services, but this was discontinued in that year which has made analysis of resourcing more difficult.

FullFact Org in their review of expenditure on mental health services[4] estimate that funding fell by £34 million between 2017/18 and 2018/19. The NHS patient survey program for 2018[5] offering a view on the experiences of service users concluded that mental health services were in decline. In the Executive Summary (page 2) it states:

> *The report shows that people's experience of mental health services has deteriorated across several areas according to this survey. In some areas, this represents a continued negative trend, with a consistent decline in results since 2014. In other areas, the results declined significantly this year, having remained relatively stable between 2014 and 2017.*

[4] https://fullfact.org/health/mental-health-spending-england/
[5]https://www.cqc.org.uk/sites/default/files/20181122_cmh18_statisticalrelease.pdf

The NHS mental health 5 year forward view dashboard published for Quarter 4 2018/19[6] in Code CR(ii) indicates the spend on crisis resolution home treatments at £342m and rising but these are indicative figures and not actual audited expenditure.

Whilst Community based services can potentially reduce admission into hospital-based crisis care, the evidence, such as it is, indicates that such services have been underfunded through the period of this research.

There is some published academic research to support this view. For Health the reduction in spending on mental health services may have been as high as 32% over the seven years up to 2014, resulting in a treatment gap where up to 75% of people who were mentally ill received no treatment at all (Docherty and Thornicroft, 2015). There has also been a similar reduction in funding for social care through cuts in local authority budgets, resulting in a 48% reduction in the number of adults (aged 18 to 64) receiving social care between 2005 and 2012 (Fernandez, Snell & Wistow, 2013). This situation is unlikely to have improved since then given the state of local authority funding.

There are a range of other reports about the potential problems arising from a lack of treatment beds. These may cause treating physicians to allow the availability of beds to determine or prioritise which patients are admitted, and which turned away rather than allocating beds on the basis of clinical need. This effect was identified by Bindman et al (2002) who speculated that reduction in beds might lead to delays in admission and higher occupancy levels. Weich et al., suggested that this would lead to increased seriousness of illness before admission, 'inpatient units' which were more disturbed and frightening and so patients more reluctance to be admitted (Weich et al., 2012). Wall et al had previously proposed that this would result in early discharge with resultant relapse and readmission (Wall, Churchill & Hotop, 1999). Keown (2011) examined loss of treatment beds and readmission rates and concluded that a 60% reduction in treatment

[6] https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

beds resulted a year later in a 60% rise in involuntary admissions and for every two beds lost, one additional involuntary admission.

In terms of demand for services this is also likely to have risen given that mental illness generally increases in prevalence during economic recessions (Evans-Lacko et al., 2013, Katikireddi, Niedzwiedz & Popham, 2012).

Taken together these effects would predict more people with mental illness, not receiving support or treatment and so more likely to be present in crisis in the community. This would be the most likely explanation for the rise in all MHA detentions and in part at least for the rise in Section 136 detentions. If the rise in detentions was simply 'more of the same' then the reasons why people were detained should remain the same as the volume rose.

1.10 Recognised shortcomings in the operation of Section 136.

Public disquiet about the operation of Section 136 emerged through the publication of a series of reports. These are set out below.

1.10.1 *Metropolitan Police.*

One of the earliest reports was published by the Metropolitan police and the Care Services Improvement Partnership in London. This was the "Review of Section 136 Mental Health Act. Report and Recommendations September 2006" (No longer on-line, copy in data disk Appendix I). This made 12 recommendations specific to the Met police and partners:

- Each police area to hold multi-agency meeting
- Each area to appoint lead officer for each partner agency
- Develop written protocols about the operation of Section 136
- Develop early intervention process to prevent the necessity for later detention
- Develop 'crisis cards' for officers to assist in identification of illness and its management
- Guidance for officers on when to arrest, detain Section 136 or take to A&E

- London Ambulance and police should develop a protocol about the use of ambulances for transport of persons detained
- Department of Health should be asked for clarification and guidance about Acute Behavioural Disturbance
- Health Trusts should identify and designate appropriate premises as POS
- New paperwork should be developed to record details when people are detained under Section 136.
- Set time standards for attendance of partners at Section 136 incidents
- Develop a process of monitoring and evaluating the operation of Section 136.

Whilst a few of these issues are specific to the Metropolitan Police many will emerge again and again in the further reports.

1.10.2 *Independent Police Complaints Commission*

In 2008 the Independent Police Complaints Commission published their report "Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act" (Docking, Grace & Bucke, 2008). This contained a review of the data on the police use of Section 136 up to 2005/06. It made 22 recommendations.

1 and 2 recommended the provision of better POS.

3 and 4 recommended better 'outreach' in the community to prevent detentions.

5 recommended improvements that needed to be made in the coordination of mental health assessments.

6 recommended that where there were long delays in assessments that a mechanism be created to challenge Mental Health Commissioners over them.

7 recommended the need for training be improved for police officers on recognising mental illness.

8 recommended the need for arrangements be made to enable officers to contact other partners to discuss ongoing cases in the community.

9 recommended that police custody staff receive additional training on mental illness.

10 recommended that the police and Mental Health Commissioner review their local arrangements.

11 recommended that better arrangements are made for people who were intoxicated.

12 recommended that the timeliness of attendance of Section 12 doctors be improved.

13 recommended that the quality of records kept on those detained be improved.

14 recommended that the use of police transport for those detained be reduced.

15 recommended that non police transport be provided upon release.

16 recommended that multi-agency groups monitor Section 136 detentions.

17 recommended that the CQC should collate and improve data collection.

18 recommended that the CQC should analyse data to improve the use of the power.

19 recommended that there should be joint training between partner agencies.

20 recommended that information sharing be improved.

21 recommended that further research be undertaken to analyse and understand the disproportionality in the use of Section 136.

22 recommended that further research be undertaken to explore users' experiences of being detained in order to improve services.

Much of the focus concerned improved training for officers, partnership working and data collation and analysis.

1.10.3 *Care Quality Commission*

The Care Quality Commission have produced a series of reports looking both at the MHA 1983 and latterly at Section 136. The CQC published their fourth report to parliament on the operation of the MHA in January 2014. This was entitled – "Monitoring the Mental Health Act in 2012/13 " (CQC, 2014a). It presented observations rather than recommendations about the operation of Section 136. These were:

- *In some areas difficulty in accessing Approved Mental Health Professionals (AMHPs), with waits of over four hours out of hours, being reported.*
- *In 2012/13, there were 21,814 uses of section 136, with over 7,500 estimated to involve the use of a police cell. This is a decrease of 7% on the previous reporting period.*
- *Only 17% of recorded uses of hospital-based places of safety under section 136 resulted in further detention, following assessment by mental health professionals.*
- *In one area police told us that 41 young people had been detained in police cells over the previous year, the youngest of whom was 11. This is unacceptable.*
- *Health-based places of safety are often not staffed at all times. This has led to hospital places of safety lying empty while a patient is taken to police custody*

The CQC also drew attention to the operational difficulties caused by alcohol consumption. Many places of safety operated by Health will not accept detainees who have been drinking or otherwise appear intoxicated. This is on the basis that they will not be able to undertake any assessment until they are sober. This results in such detainees having to be held in police custody. The CQC recommended that a better solution be found for this problem.

A review of Health partners approach to Section 136 was provided early in 2014 when the CQC surveyed Health Based Places of Safety for people detained under Section 136, in their report "A Safer Place to Be" (CQC, 2014b), they reported:

> *Overall CQC's findings suggest that whilst some health-based places of safety are effective, others are less responsive to people's needs and require far reaching improvements.*

Overall, they identified four key findings with related recommendations. The findings were:

> *1. Too many places of safety are turning people away or requiring people to wait for long periods with the police, because they are already full or because there are staffing problems. This raises questions about provision and capacity. A quarter of providers told us that they did not believe that there was enough local provision. We also found that the use of police stations as a place of safety is directly linked to the provision, or lack of, health-based places of safety.*
>
> *2. Too many providers operate policies that exclude young people, people who are intoxicated, and people with disturbed behaviour from all of their places of safety. In many cases, this leaves the police with little choice but to take a vulnerable individual in their care to a cell in a police custody suite.*
>
> *3. Too many commissioners are not adequately fulfilling their responsibilities for maintaining an oversight of the section 136 pathway. This may limit their awareness of key issues that could inform their commissioning decisions.*
>
> *4. Too many providers are not appropriately monitoring their own service provision. Many places of safety could not give us basic information about the use of their service or how often people were turned away, or excluded, and the reasons for this. In addition, not all providers said they collected all the monitoring data required by the MHA Code of Practice. This makes it difficult for those providers and their commissioners to evaluate if provision is meeting the needs of people in their local area.*

All of these issues directly impact upon other partners to the Section 136 process and so were likely to contribute to poor working relationships.

In January 2018 the CQC published another report looking at the operation of the MHA "The rise in the use of the MHA to detain people in England" (CQC, 2018). This was concerned with the increasing use of detention and treatment under the MHA and its conclusions for the reasons for this rise are relevant. These were:

1. The apparent rise in rate of detention since 2010 is in part due to the national data return being more complete or to an increase in duplicate returns.

2. More people are being detained on more than one occasion during a calendar year than was previously the case.

3. As bed numbers have fallen, more people with severe mental health problems are living outside of a hospital setting and so are at greater risk of being detained.

4. Some people are being detained under the MHA who would previously not have been detained. This is because clinicians are applying the criteria for detention differently to people with certain types of disorder (such as dementia or personality disorder). It could also be because more people with mental health problems are coming to the attention of mental health care workers (for example, through schemes that divert people from the criminal justice system).

5. People who need admission and who would previously have agreed to informal admission are now refusing and are being admitted as detained patients.

6. Admissions (some of which would be formal) that could in the past have been prevented are now not being prevented because less restrictive alternatives in the community are not available.

7. There has been an increase in the total size of the population of England and an increase in the size of those sections of the population that are more at risk of detention.

8. There has been an increase in the prevalence of risk factors for detention, such as social exclusion and problematic, untreated drug and alcohol misuse.

1.10.4 The Mental Health Alliance.

The Mental Health Alliance (2012) published a review of the implementation of the Mental Health Act 2007. This included a few recommendations relevant to Section 136:

• Commissioners should ensure that their areas include a range of appropriate places of safety.

• Data on the number of uses of police cells as places of safety should be collected as part of local monitoring, incorporated into the NHS Information Centre's data and monitored by the Care Quality Commission.

• Provider organisations should review their policy and practice in the use of section 136 to ensure they are not turning people away inappropriately.

1.10.5 Adebowale review.

As a result of a series of deaths and injuries in 'police contact' the Metropolitan Police Commissioner set up the Independent Commission on Mental Health and Policing in September 2012. This was chaired by Lord Adebowale (2013). Whilst the remit was much wider than just Section 136 the finding were relevant to understanding the shortcomings within the Metropolitan Police. The findings were:

1. Failure of the Central Communications Command to deal effectively with calls in relation to mental health
2. The lack of mental health awareness amongst staff and officers
3. Frontline police lack of training and policy guidance in suicide prevention,
4. Failure of procedures to provide adequate care to vulnerable people in custody
5. Problems of interagency working
6. The disproportionate use of force and restraint
7. Discriminatory attitudes and behaviour
8. Failures in operational learning
9. A disconnect between policy and practice
10. The internal MPS culture
11. Poor record keeping
12. Failure to communicate with families

The Commission made 28 recommendation, which have been accepted by the Metropolitan Police, and which relate to police leadership, officers working on the frontline and interagency working. On the basis of this report it appeared that the Metropolitan Police had not applied itself to this issue with the same vigour as many other forces worldwide.

1.10.6 House of Commons.

The first observations on Section 136 by Parliament were from the House of Commons Health Committee (2013). "*Post-legislative scrutiny of the Mental Health Act 2007. First Report of Session 2013–14".*

One section of this report directly concerned the operation of Section 136.

> *Para 66. People detained under section 136 are often distressed and can be very vulnerable, and the proportion who are subsequently detained by clinicians is surprisingly low. The Committee notes that the CQC has now been tasked with mapping access to hospital-based places of safety, and welcomes the further trial of street triage whereby nurses join police officers to deal with incidents involving people with mental health problems. The Committee recommends that Health Ministers should work with their Home Office counterparts and police representatives to improve the operation of the place of safety provisions of mental health legislation. Better application of section 136 would relieve pressure on hospital-based places of safety and allow for a reduction in the use of police custody.*

This was followed by a number of other reports such as The House of Commons Home Affairs Committee (2015). "*Policing and Mental Health. Eleventh report of session 2014/15*".

This report was only on the operation of Section 136 of the MHA and made 33 recommendations and conclusions. These can be summarised as:

- Mental illness was impacting too much on police resources.

- The police had reduced the use of police cells for detainees, but Police custody should no longer be listed as a POS, except in exceptional services.
- The NHS does not fund enough POS.
- The NHS should not turn away detainees just because they were intoxicated.
- The range of places where Section 136 could be used should be extended.
- Children should no longer be detained in police custody.
- Street Triage schemes need to be properly evaluated.
- More effort needed to be made to divert people who are mentally ill out of the criminal justice system.
- Police transport should not be used to transport detainees, this should be by ambulance.
- The way that 999 calls from people in mental crisis need to be dealt with more effectively.
- Mental illness needs to be dealt with on a par with physical illnesses.
- The time limit on detention should be reduced to 24 hours.
- Data needs to be collected on what happens to people who are detained if they are not formally or informally admitted to hospital.
- Data collected about Section 136 remains of poor quality and needs to be improved.
- Police training needs to be improved.
- This training should also result in the reduced use of restraint and force against people who are mentally ill.
- There has been an alarming increase in suicides following police custody, vulnerable people need to be identified and their details passed to Health.

Another report by the House of Commons; Home Affairs Committee (2018) "*Policing for the Future Tenth report of the session 2017/19"* made a series of observations about the police engagement with those who were mentally ill. These included:

- Concerns about the police use of restraint against people in a state of extreme emotional distress and the related issue of deaths in police contact.

- A recommendation that police forces adopt as mandatory the College of Policing two-day training course on mental illness and vulnerable people.
- Their satisfaction with progress made through Triage schemes but their disappointment that the police remain the first point of response. They recommended that the NHS should take the lead for this issue.
- The need for the NHS to address the disparity of funding between physical and mental illness so that the police no longer need to bear the costs of caring for people who are ill, which is the responsibility of the NHS.

1.10.7 Her Majesties Inspectorates.

Her Majesties Inspectors of Constabulary (HMIC) and more recently Her Majesties Inspectors of Constabulary and Fire and Rescue Services (HMICFRS) have published two reports on the MHA and Section 136. A major review - "*A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs*" was a joint review by Her Majesty's Inspectorate of Constabulary; Her Majesty's Inspectorate of Prisons; the Care Quality Commission and Healthcare Inspectorate Wales (HMIC, Care Quality Commission, 2013) and examined the extent to which police custody was used as a POS under section 136 of the MHA 1983.

This inspected seven police forces and focused on six areas:

- police use of section 136: why are people detained under section 136, and how often and why is police custody used as a place of safety?
- strategic oversight and direction among partner agencies: how far are oversight and direction ensuring the appropriate use of section 136, and generating better adherence to the Codes of Practice?
- multi-agency working: how effectively are the police service and health partners working together?
- recording and monitoring the use of section 136: how are data collected, used and shared between partners?

- training: are all staff aware of policies and procedures regarding the use of section 136?
- the perspectives of those detained under section 136: what are their views on their time in police custody?

The report made 11 recommendations:

1. *The Codes of Practice should be amended to bring detention times for those detained in police custody under section 136 in line with those in the Police and Criminal Evidence Act 1984, which allows up to 24 hours in police.*
2. *A data field should be added to the Mental Health Minimum Data Set held by the Health and Social Care Information Centre to collect data on each occasion when:*
    - *an individual brought by police to a health-based place of safety is not accepted into that health-based place of safety, stating the reason why he or she remained in police custody; and*
    - *a person under the age of 18 years is brought to and/or received into a health-based place of safety under section 136.*
3. *The College of Policing, The Royal College of Psychiatrists, the College of Social Work, police forces and mental health service providers should work together to develop and deliver joint training to staff.*
4. *Clinical Commissioning Groups and local social services should make sure that they have commissioned sufficient capacity to meet the demand for assessment under section 136, and that multi-agency working is effective.*
5. *NHS England16 and Local Health Boards in Wales should ensure that local commissioning of mental health services is appropriate, and that they provide sufficient capacity and resilience to meet demand.*
6. *Commissioners and providers of social services and health services should ensure that they identify periods of demand for the reception and assessment of persons detained under section 136, and that they effectively manage resources to meet this demand.*

7. *Health and Wellbeing Boards in England should include section 136 provision as part of their Joint Strategic Needs Assessment.*
8. *The Office for Standards in Education, Childrens' Services and Skills (Ofsted), HMIC, CQC, HIW, HMI Probation, HMIP and Her Majesties Crown Prosecution Service Inspectorate (HMCPSI) should examine and highlight as part of their multi-agency inspections of child protection arrangements the inappropriate use of police custody as a place of safety for children under 18 years who are detained under section 136.*
9. *The CQC and HIW should use their combined powers under the Mental Health Act 1983 and the Health and Social Care Act 2012 to develop a robust approach to the regulation of mental health providers.*
10. *Police custody officers should ensure that a full explanation is recorded in the custody record as to why a person detained under section 136 has not been accepted into a health-based place of safety.*
11. *The Mental Health Act 1983 should be amended to remove a police station as a place of safety for those detained under section 136, except on an exceptional basis.*

The second report by the then new HMICFRS (2018) entitled "*Policing and Mental Health: Picking up the pieces"* made further recommendations for police forces:

- The NPCC lead and College of Policing should agree a new national definition of mental ill-health for all forces to adopt. This was intended to standardise the response to incidents and assist in accurately collecting data.
- All forces should carry out a 'snapshot' exercise to assess their mental health-related demand. This was intended to assist forces in understanding their mental illness demand.
- All forces should evaluate their mental health triage services. The evaluation was needed to understand whether they are working well and that partners were contributing to them.

- All forces should review their mental health training programmes. There was a great variation in training for officers and so this recommendation was intended to make sure that training was effective.
- The Crisis Care Concordat steering group should carry out a fundamental review and make proposals for change.

The HMICFRS view was that although the police believed their first four recommendations were achievable, they wouldn't solve the fundamental problems. There needed to be a comprehensive, long-term approach to identifying, assessing and supporting people with mental health problems. This was beyond the remit of the police.

1.10.8 The Royal College of Psychiatrists.

The Royal College of Psychiatrists (2013) prepared a paper "*Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983*". This set out a position statement and its recommendations were that:

1 Police custody suites should be used in exceptional circumstances only.

2 A vehicle supplied by the ambulance provider should be able to attend promptly so that it is used for conveyance unless the person is too disturbed.

3 The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within three hours in all cases where there are not good clinical grounds to delay assessment.

4 The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act.

5 A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases.

6 Commissioners should ensure that there is a multi-agency group meeting to develop, implement and quality assure the agreed policy. This group should review the monitoring data. It should also consider how the need for use of Section 136 might be reduced.

1.10.9 Home Office and Department of Health.

As part of a Government review into Sections 135 and 136 of the MHA the Home Office and Department of Health (2014a) undertook a literature review of both Sections. Based on this review the paper made 12 key findings:

1. The number of people detained using Section 136 had risen considerably and was still rising.
2. The quality of data was poor.
3. No research had been undertaken on people detained other than in police custody or hospital.
4. The use of Section 136 was highly variable even between neighbouring areas.
5. Most detentions were made outside of normal business hours when some services were not available.
6. There was a high prevalence of schizophrenia, personality disorders, mania and drug induced psychosis in individuals detained under Section 136.
7. People detained under Section 136 were often white, single, unemployed young men in their 20s, with a diagnosis of schizophrenia and a previous psychiatric history.
8. Black and Minority Ethnic groups are over-represented in S136 detentions, and across mental health services more generally, and this appears to have been consistent over the past three decades.
9. Although the Code of Practice for England states that police custody should only be used as a POS in 'exceptional' circumstances, in some areas police cells were routinely used as such
10. The operation of Section 136 was poorly monitored with little oversight or accountability.

11. There was little published research on Section 135 of the MHA which has attracted little criticism.
12. Other European and comparable countries have shorter lengths of detention than 72 hours and many make less of a distinction between public and private places.

In addition the Home Office and Department of Health published the findings of their extensive consultation exercise on the operation of Sections 135 and 136 (Home Office and Department of Health, 2014b). In this report many observations and recommendations were made. These can be summarised as follows:

- Police cells as a POS.
    - Half the respondents thought that police cells should never be used as a POS whilst 73% thought they should only be used in exceptional circumstances where the person was very violent (respondents were asked to agree with statements and many agreed twice).
    - There was wide agreement that the use of police cells caused stigma, distress and embarrassment.
    - Two thirds of respondents thought police cells were only used because of lack of capacity in alternative Health based provision.
- The availability of Health Based Places of Safety (HBPOS).
    - There was overwhelming agreement that lack of HBPOS was the barrier to reducing the use of police cells.
    - That HBPOS should be accessible 24 hours a day
    - That intoxication should not be a barrier to entry to a HBPOS.
- Powers for police to respond in peoples' homes.
    - Police powers limited in home
    - Can take a long time to obtain a warrant under Section 135.

    - The police sometimes misuse Section 136 by tricking people into stepping outside their homes so they can be detained or sometimes just detain them in their homes.
    - Mixed views over extending power into peoples' homes.
- Maximum length of detention (72 hours).
    - 86% or respondents said 72 hours was too long.
    - 4 or 24 hours believed to be more suitable
    - Concerns raised that sometimes people are detained in police cells after the assessment whilst a suitable 'bed' is found for the patient.
- Extending powers to other professionals.
    - Two thirds of respondents believed the powers should be extended to other Health professionals but only subject to suitable training and risk assessment.
    - Over 90% or paramedics thought they should have the power again subject to suitable training and risk assessment.
- Transporting patients to and from POS.
    - Two thirds of respondents believed that the wait for an ambulance is usually longer than 30 minutes.
    - 70% of paramedics thought that the use of ambulances where an incident was not life threatening was a por use of resources.
    - Two thirds of respondents said that police vehicles should not be used for transport.
- Other findings.
    - Academic roundtable discussion concluded that use of Section 136 was rising through increase in Personality Disorder (PD) complicated by substance abuse.
    - Most people detained do not go on to receive treatment and so the police are detaining people that Health will not treat.
    - Diversity and equality in detention need further consideration.

Both reports informed the consultation process by the Government on amending Section 136 and lead to the amendments later enacted in December 2017.

1.10.10 *The Mental Health Crisis Care Concordat*

In response to the many public concerns raised a national multi-agency protocol was agreed by a wide range of Health and other public sector organisations. This was the "*Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*" (Department of Health, 2014). It committed parties to improving the care and support for those in crisis. The concordat specifically made reference to the inappropriate use of police cells as POS, the disproportionality by race of those detained and the unacceptable level of injury and death of those in crisis, when in contact with the police. As a specific response to Section 136 the NHS funded a pilot study in nine forces of 'Street Triage' where mental health professionals went on patrol with police officers and could be first responders to situations which involved issues of mental illness.

1.10.11 The *Angiolini Review.*

The "*Independent Review of Deaths and Serious Incidents in Police Custody*" was led by Dame Elish Angiolini (Angiolini 2017). Whilst the review was mostly concerned with deaths in police custody this was clearly connected with Section 136. The review highlighted a series of observations about the use of police custody for people who were mentally ill. These included:

- *lack of effective policies and systems concerning the operation of section 136, for example, there is currently no clear policing process that applies from the moment someone is detained under section 136;*
- *poor training and understanding concerning the application of section 136 powers*
- *the inappropriate use of police stations as suitable 'places of safety'*
- *conflicts and tensions between the NHS and police in the understanding of roles and responsibilities in the operation of section 136*
- *local section 136 policies which fall short of Home Office guidance*

- *overly restrictive local policies by NHS services concerning disturbed and agitated detainees, despite this being a common feature of someone in need of section 136 assistance*
- *shortages of NHS 'places of safety' accommodation provision*
- *lack of joint co-ordination and working between the relevant local agencies including to identify and address any emerging problems around the operation of section 136*

These shortcomings were illustrated by the separate deaths in police custody of Toni Speck; Terry Smith and Leon Briggs. There were two specific recommendations relevant to this review:

> Recommendation 13.
>
> *National policing policy, practice and training must reflect the now widely evident position that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life-threatening risk.*
>
> Recommendation 66
>
> *This report also argues that the use of police custody for children detained under section 136 of the Mental Health Act 1983 should be brought to an end with all NHS Trusts required to make sufficient provision of health-based places of safety to meet this requirement*

1.10.12 *The Government sponsored Independent Review of the MHA.*

The Independent Review (2018) of the Mental Health Act was commissioned by the Government in October 2017 and was specifically intended to examine the growth in detentions under the act and especially the disproportionality by race of those detained for treatment. As part of this it considered the role of the police. The final report made a range of recommendations several of which were relevant to the police and Section 136. These were that:

- *By 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety in the Act and*

ensure that the majority of people detained under police powers should be conveyed to places of safety by ambulance. This is subject to satisfactory and safe alternative health-based places of safety being in place.

- *Ambulance services should establish formal standards for responses to section 136 conveyances and all other mental health crisis calls and ambulance commissioners and ambulance trusts should improve the ambulance fleet, including commissioning bespoke mental health vehicles.*
- *The responsibilities of NHS commissioners under section 140 of the Act must be discharged more consistently and more effectively, so that emergency beds are available.*
- *NHS England should take over the commissioning of health services in police custody*
- *Equality issues, particularly police interactions with people from ethnic minority communities under the MHA, should be monitored and addressed. This should be under the proposed Organisational Competence Framework where possible.*

1.11 *Conclusions*.

The operation of Section 136 has been regular reviewed for the last 12 years by a range of national organisations, regulators and parliament. They have often drawn similar conclusions and in particular some issues appear to have remained constant and problematic over time. These include:

- Poor quality and analysis of data
- Inappropriate use of force, use of police transport and police custody.
- The need for training of officers and partner organisations.
- The problematic effect of intoxication on the process of detention and assessment.
- The timeliness of assessment.
- The disproportionate use of the MHA by race.
- The lack of funding for Mental Health Services both in hospitals and the community.
- Problems in effective partnership working.

In addition to these reviews what insights and observations can academic and other published data make about the operation of Section 136? This question will be considered in the next chapter.

Chapter 2. Systematic literature review.[7]

2.1 Systematic Review. Introduction.

Whilst the many reviews detailed in the previous chapter make it clear that there has been and remains public disquiet about the operation of Section 136 and in particular the growing use of the power; the lack of care for vulnerable people; the inappropriate use of force and restraint; the inappropriate use of police cells as POS; failings in partnership working as well as other issues, these problems appear to be symptoms rather than causes.

A number of reviews were also identified that deal with aspects of Section 136, many of which link into the concerns set out in Chapter 1. One of the earliest and most comprehensive of these was the review by Churchill et al (1999). This large paper consists of a systematic review of the operation of the whole MHA 1983. Of the 220 pages, four were concerned with Sections 135 and 136. This part of the review identified 27 research papers that were examined. The themes that were set out were:

- The characteristics of those detained i.e. diagnosis, behaviours and demographics.
- Whether it was being used appropriately, for whilst there were some issues around inappropriate use in private property, it was largely observed to be well used.
- The impact of poor professional relationships between those involved in its operation. This was identified as a source of many difficulties.

In the same year Costen and Mill (1999) examined the difficulties faced by the police in using Section 136. They summarised these as (page 117):

> *This power is the subject of considerable controversy and this paper examines the difficulties faced by the police when exercising that power: the difficulty in deciding whether somewhere is a public place; the problem if recognising mental disorder in the*

[7] The content of this chapter has been published in a chapter in: McDaniel, J., Moss, K. and Pease, K. eds., 2020 Policing and Mental Health: Theory, Policy and Practice. Published by Routledge. Thomas, A., 2020. *Examining the relationship between policing and section 136 of the Mental Health Act 1983*.

> *absence of any meaningful training; the use if a police station to manage a mentally disturbed detainee; the length time allowed by the law for the two assessments to take place; and, finally, the apparent lack of support received from the other professionals involved in s.136 detentions.*

Both reviews effectively coming to similar conclusions.

Difficulties over the use of Section 136 in public places has more recently emerged in Rix (2016). As part of the Policing and Crime Bill 2016 it was proposed to extend police powers to enter private property to detain persons under Section 136. This review examined all legal aspects around the operation of S136 and opposed the changes, which were not then enacted, but the power has since been extended to permit detention everywhere but in a person's home (See Chapter 1).

The characteristics of those detained was again reviewed by Borschman, Gillard and Turner (2010). The article summarised the range of published literature on the operation of Section 136 and identified a high prevalence of schizophrenia, personality disorders and mania in individuals detained under Section 136 as well as an over-representation of black detainees. It highlighted problems with partnership working and poor levels of understanding by professionals involved in the process. Finally, it also set out the need for research to be undertaken on the experiences and needs of those detained.

Hampson (2011) in his review of the literature identified the overuse of police custody for Section 136 detentions rather than separate Places of Safety, especially where patients were intoxicated. As a result, patients felt criminalised through use of police transport and police cells. He reported delays in the initial assessment of those detained and the need for effective local partnership working to improve performance and the experiences of patients.

The use of appropriate Places of Safety was reported by Apakama (2012) though he took a more nuanced view that what was appropriate depended upon individual circumstances. His conclusions were that cases should be considered on their merits. Police stations should best be

used for those who were violent or intoxicated, Hospital A&E Departments for those injured or in need of medical attention and Mental Health treatment units for those in most serious crisis.

Two reviews looked at the effectiveness of Street Triage. A review by Cummins and Edmondson (2016) was prompted by Lord Adebowale's report (See Chapter 1). The review examined the history and context of police involvement with mental illness and the models for Street Triage in operation. A review by Puntis et al (2018) was a full systematic review of the operation of Street Triage systems in operation in the UK and elsewhere. Twenty six published evaluations were assessed. Overall, it concluded that there was poor design of evaluations and data collection. Street Triage may reduce Section 136 detentions and may be more acceptable to users but there was a lack of clear evidence. In conclusion the researchers stated:

> *"There remains a lack of evidence to evaluate the effectiveness of street triage and the characteristics, experience, and outcomes of service users. There is also wide variation in the implementation of the co-response model, with differences in hours of operation, staffing, and incident response."*

One review attempted to explain the increase in the use of Section 136 (Loughran 2018). This suggested three sets of reasons for the increase, changes in police attitudes, socio-economic factors and reduction in resources. It further identified the need to better manage use of Section 136.

One review looked at the use of force against people who were in distress and often mentally ill (O'Brien and Thom (2014)) and in particular the increasing use of the Taser (an electrical discharge weapon that causes temporary paralysis). Although this was a wider issue, it was connected with Section 136 as many persons who were 'Tasered' were detained under section 136. The paper identified the potential problems with such use but more especially the need for further research.

Finally, three reviews began to extend the range of this research into similar provisions in other countries. In the first Chappell (2008) introduced the notion from the U.S. of "Emotionally

Disturbed Persons" (EDP), which included people who were mentally ill but could also include other crises. He identified a series of challenges in such encounters:

- *The dilemmas of first contact.* Officers generally wanted to help such EDP but they lacked the skills to identify the nature of the crisis and often did not have many options for how to respond.
- *Exercising discretion and the use of force*. This involved balancing the safety of officers and the public against the need to prevent harm by the EDP, whilst at the same time using only the minimum force required.
- *The Scheduling process*. This concerned the need to provide assessment and help in a timely way.
- *Transportation of mentally ill persons*. The involves the recognition that whilst the use of police vehicles was common that they should only have been used in the most extreme circumstances.
- *Detention in police custody.* The inappropriateness of holding EDP in police cells.
- *Training*. The need for improvements in training for officers for many issues including those above.

Chappell and O'Brien (2014) were guest editors in a special edition of the journal "International Journal of Law and Psychiatry" which was concerned with many aspects of the engagement of the police internationally with people who were mentally ill. This included the development of Crisis Intervention Teams in the U.S. as well as police responses in Europe, New Zealand and Australia. Many of these themes are set out in Chapter 3.

Linking to the police use of Tasers (above), Chappell and Ryan (2107) reviewed police interactions with people with mental illness and in particular the data on deaths in police contact or custody. They reviewed the responses to this issue in terms of training but then expressed concerns about the emerging use of Taser against people who were mentally ill.

The public authority reports in Chapter 1 and the range of issues in the reviews set out above indicate that there are many areas of concern around the policing of people who are mentally ill. To discover the range and extent of empirical research on Section 136 and related topics a further review was undertaken.

2.2 Objectives*.*

This search consisted of a *systematic review* which "uses a transparent and systematic process to define a research question, search for studies, assess their quality and synthesize findings qualitatively or quantitatively" (Armstrong et al., 2011).

The research question at the outset was to discover what was known about the operation of Section 136 of the MHA. This included:

- The experiences and views of police officers, health professionals and those detained under this provision.
- Whether efforts had been made to change the way that the power was used and if so, what effect these had.
- Observing changes in patterns of use over time, variations in use by location or through other factors.
- What the outcomes were of the use of this power for all parties involved.
- Whether the reported studies were designed to and had identified factors to account for the trends and deficiencies in the operation of this power.

2.3. Method.

2.3.1 Eligibility.

As Section 136 of the MHA 1983 was identical to Section 136 of the MHA 1959, no start date was set on the age of relevant material.

As Section 136 is a provision that exists in that specific form in England and Wales only English language sources were searched as part of this review.

Articles were eligible for inclusion in this review if they included original research relevant to Section 136. This included those:

- that were specifically about the use, operation, effects or effectiveness of Section 136.
- that were only in part about Section 136.
- concerned with the arrest or detention of people who were mentally ill or disordered, for their own protection or the protection of others - but where no serious crimes were involved.
- concerned with the police involvement in the civil detention of people who were mentally ill or disordered.
- that considered the exercise of police judgement or discretion in dealing with people who were mentally ill or disordered where there was no criminality.
- concerning the use by the police of a 'place of safety'.
- concerning the police management of mental illness in the community.
- on the knowledge or experiences of professionals involved in the operation of Section 136.
- on the diagnosis or treatment of people detained under Section 136.
- on the experiences of people detained using Section 136.

Excluded were articles concerning -

- the treatment of mentally ill or disordered people in the criminal justice system.
- the sentencing or processing of mentally disordered offenders.
- the treatment of the mentally ill or disordered in prison.
- the medical treatment of the mentally ill or disordered.
- the nature of mental illness
- arrests or detentions for criminal offences.
- detention in connection with assessment or treatment under other provisions of the MHA.

- literature reviews, book chapters, editorials and papers other than empirical papers (those included all contained original research and were primary sources).
- Legal “Stated Cases” and other findings arising from the operation of the civil or criminal justice systems and issues relating to civil liberties.

2.3.2 Information sources.

A range of ‘on-line’ data bases were searched as part of this review. Those that provided relevant results were included in this review. These were: Scopus; Pub Med; Web of Science; Sage Journals; Emerald Insight; Academic Search Complete; Springer Link and Criminal Justice Abstracts. The end date of the searches was the 31st December 2018, no start date was set as Section 136 has been in operation since 1959, before most digital data bases hold records.

In addition to the database searches a general library search using the same terms was also employed*.*

2.3.3 The Search.

Articles on Section 136 are a small subset of the wider range on the police, the criminal justice system and mental illness. This can be illustrated through the results of data base searches for example using the Scopus data base.

A search on Scopus to the end of 2018 on the terms “police” and “mental” identified 3,611 articles. On “police” and “detention” identified 636 articles. On “police” and “mental” and “detention” identified 151 articles. Of these 151, 15 included reference to Section 136 in the title and in an additional 5 articles the relevance to Section 136 was clear in the abstract.

A Scopus search for “Section 136 Mental Health Act” identified 49 articles over the same period. Amongst these Section 136 was present in the title of 35 and for an additional 7 the abstract demonstrated that it concerned Section 136.

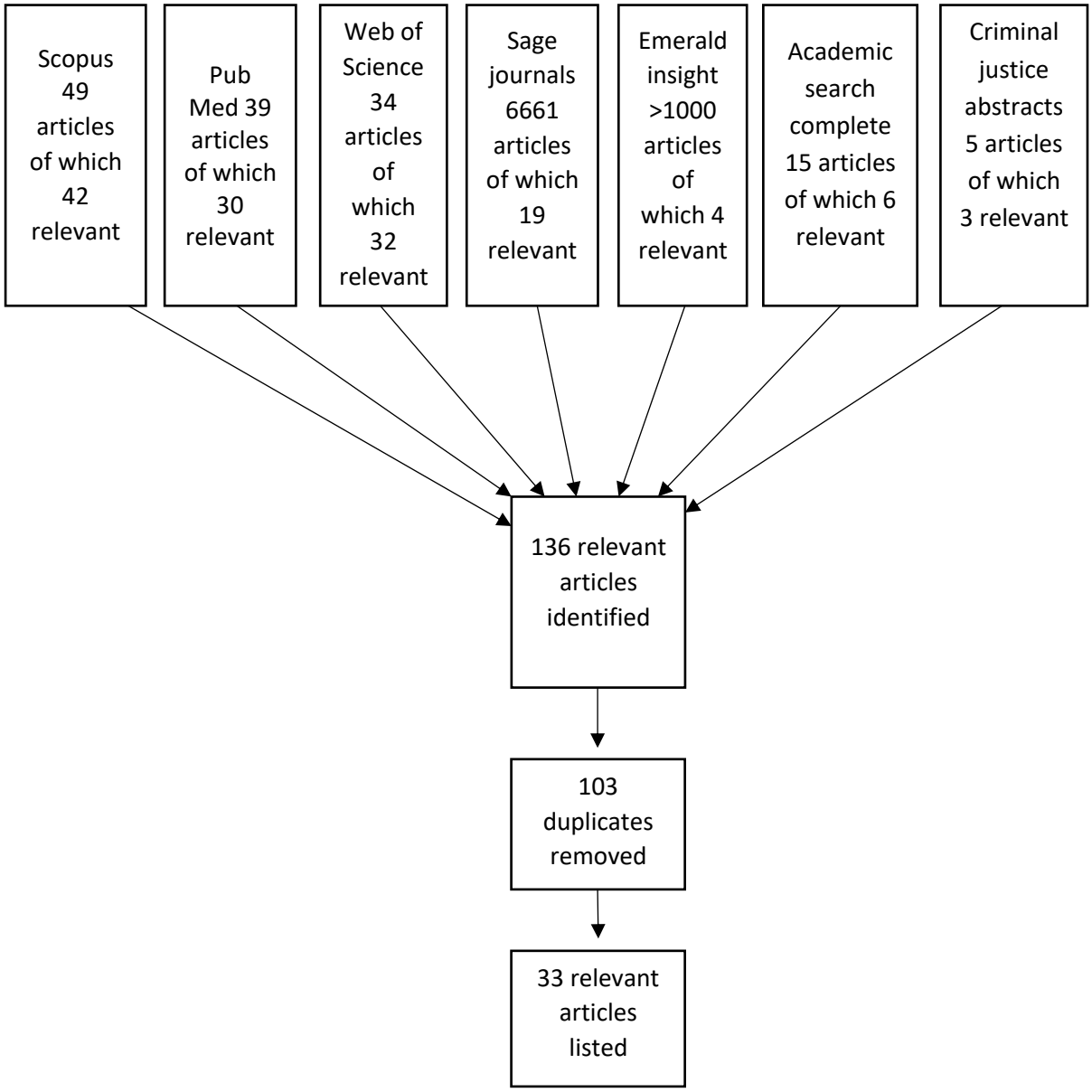
As all of the articles found using the search terms “police”, “mental” and “detention” were present in the set identified through the search term “Section 136 Mental Health Act”, the latter was used as the search term in all further searches.

Some other database searches provided a very large number of possible articles, thus Sage Journals identified 6,489 articles when searched against the term “Section 136 Mental Health Act”. Only 19 of these articles appeared relevant and these were all found in the first 100 articles. The next 200 were inspected but as none were relevant no further articles were inspected. This principle of inspecting the first 300 articles was applied where large numbers of results were presented.

2.4 Systematic review - results.

These results are summarised in the PRISMA diagram, Figure 2.1 below and the relevant publications are listed in the table below that.

Figure 2.1 PRISMA diagram showing results of systematic review.



The Kent University library index was also searched for relevant material using the same search terms and criteria. Nothing additional was discovered. Set out in table 2.1 below is a list and summary of the 33 relevant articles from the review.

All of the publications listed below were research papers presenting original research in the UK. All of those that that undertook analysis of data held by Health, the Police or other agencies suffered from a similar problem in the source data – that of the poor accuracy and quality of the

records held. As a result, there must be a significant 'margin of appreciation' in all their considerations. This is discussed further below.

In addition to the 33 articles in table 2.1, a series of publications were identified which did not meet the criteria above but were relevant. Some referred to similar legal provisions in other countries from which parallels could be drawn about the operation of Section 136. Some related to issues which are now connected with Section 136 but which were not relevant when this research started, such as the use of Taser by the police on people who are mentally ill or the role of the ambulance service in dealing with potential Section 136 detainees. There were also 13 systematic or literature reviews which widened the scope of this research beyond this systematic review. All these are referred to in the chapters that follow.

Table 2. 1 Empirical papers discovered during the systematic review.

Authors and year of publication	Years of research	Aims of study	Sample size and character	Method	Main findings
1. Kelleher and Copeland (1972)	1966	Compared S136 MHA 1959 with other admissions	92 police admissions and 208 others	Quantitative analysis	This was 1959 act and compared the treatment rate of S136 detentions compared to admissions by Doctors (not psychiatrists). Different pattern of diagnosis and behaviours. 42% schizophrenia in S136 against 30% by Drs. 11% depression S136 against 27% by Drs. 20% aggressive S136 against 10% by Drs. Self-harm 7.6% S136 against 12% Drs. However, police were as good as Drs in identifying those in need of treatment.
2. Dunn and Fahy (1990)	1983 to 1985	Police admissions to Psychiatric hospital S136	268 patients	Quantitative analysis	Looked at all detentions, a large and significant sample size. 90% or police referrals needed treatment. Difficulties in estimating populations sizes for minority groups but appeared 15% of local population black but were 33 % of admissions. Black men were over-represented. They were younger and more likely to be given neuroleptics, they were largely diagnosed as schizophrenic or drug induced psychotics at a higher rate than white population. Not clear why. Suggested race was compounding difficulties in identification of MH for officers.
3. Pipe, Matthews and Hampstead (1991)	1996	S136 and race	99 admissions	Quantitative analysis	An influential paper which looked at the over-representation of young Afro/Caribbean men usually under 30 yrs and often repeatedly detained. Overall low rates of treatment, short admission with high rates of readmission, high rates of social disadvantage and poor engagement in follow up and after care.
4. Turner, Ness and Imison (1992)	1985 to 1987	Review of diagnostic and social aspects of S136 detainees	163 cases	Quantitative analysis	Difficulties with quality of records used in study. Suggested that whilst S136 was clinically appropriate it highlighted unmet social and medical needs within community care. Over representation of black residents. Psychotic illness was main cause of detention with schizophrenia and PD increasing, 88% of police detentions

					needed MH treatment so high rate of conversion. 80% had previously been admitted and 24% had 6 or more previous admissions so repeated detention an issue.
5. Mokhtar and Hogbin (1993)	1991	Comparison of S136 patients with severe S2 or S4 admitted patients	39 S136, 18 Section 2 and 11 Section 4 patients.	Quantitative analysis	Previous research suggested that S136 patients had higher levels of illness and came from more disadvantaged background than S2 or S4 admissions. The greater disadvantage is what brought them to the attention of the police and may have prevented their access to service by the usual routes. However, no real differences found, which suggests that the police use same basis as clinicians using S2 and S4. Thus, the police may underuse S136 and so it is a useful safety net to catch those who miss conventional access to treatment.
6. Spence and McPhillips (1995)	1991	PD and S 136 detentions	65 detentions	Quantitative analysis	Retrospective analysis of Section 136 assessments and admissions. Behaviour 'bizarre' in 67% of cases was reason for detention, self-harm in 26%. 66% admitted to hospital. Schizophrenia most common diagnosis at 38.5% and PD second at 37% but PD diagnosed in 87% through repeat detentions. PD least likely to result in admission. MH services have little to offer PD. Small number of assessments, records may not be accurate.
7. Lowe-Ponsford and Begg (1996)	1995	Review of S136 detentions at Gatwick airport	70 adults and 19 children	Quantitative analysis	Looked at S136 detentions in the airport. None of the children and half the adults were examined by a doctor but rather dealt with informally as missing persons. Suggests that future studies should examine whether some S136 detentions are dealt with through such informal means.
8. Latham (1997)	1996	Forces surveyed about S136 and is use by Police Surgeons.	43 police forces	Quantitative analysis	Letters sent to all 43 forces in E&W about S136, for the attention of their Police Surgeons. Asked for numbers of S136 detentions and other returns that should be supplied. Clear that there was an unsatisfactory level of knowledge amongst the surgeons. Recommendations made for improved training and accreditation but now superseded by events.

9. Hotopf et al., (2000)	1984 to 1996	Changes in rate of use of provisions within MHA	National statistics	Quantitative analysis	Formal detentions rose over period from 16,000 to 26,000 a 63% rise, this is despite the loss of treatment beds. Mainly driven by Section 2 and 3 of Part II. Drop in S136 detentions until 1990 and after a rise. Details described and some reasons offered such as changes in psychiatric provisions and under public pressure a move from liberalism to the system become more coercive.
10. Simmons and Hoar (2001)	1995 to 1996	To examine behaviours leading to S136 detention	90 assessments reviewed	Quantitative analysis	An early and influential paper looking at behaviour leading to S136 detention and diagnosis. Average admission rate 82%, lower rate for self-harm. 90% behaviour violent, abusive or aggressive, only 10% self-harm. A very different pattern from later reports. As with many such studies the accuracy of records was problematic and interfered with the analysis.
11. Ogundipe, Oyebode and Knight (2001)	1999	Survey of Section 12 doctors about legal powers within S136	106	Quantitative analysis	Identified widespread confusion about whether a person taken by police to one POS could then be taken to another. Recommendations for changes - which are now in place.
12. Greenberg et al., (2002)	2002	Review timeliness of S136 assessment in rural area	178 assessments over 3 months	Quantitative analysis	Monitoring forms were completed for these detentions taken to 6 different custody centres. Self-harm present in 35% of detentions, Bizarre behaviour in 22%, passive behaviour in 11% and non-specified or not recorded in 21%. Timeliness slower in rural areas. Only 32% admitted, lower than previous studies. Longest delay for arrival of approved social worker. Need for future research to understand why variations in use which could arise from different police or medical procedures.
13. Lynch et al (2002)	2002	Review understanding of S136	179 questionnaires reviewed	Quantitative analysis	Understanding of S136 poor amongst all professionals involved in its use.
14. Greenberg and Haines (2003)	2000	Comparative rate of use S136 in 10 forces	>1800 detentions	Quantitative analysis	Considerable variation in rate of use between 'similar' forces. Devon more than 2.5 times average and 30 times more than the least. Proposed reasons include; lack of training of officers; better care in the community in some force areas; alternative use of POS; different population characteristics; misuse of S136 and

					different local arrangements. As Devon and Cornwall officers did not have to remain with those they detained this may have encouraged its use.
15. Laidlaw et al. (2010)	2002 to 2006	Analysis of S136 detentions	576 detentions reviewed	Quantitative analysis	Looking at detentions in rural area (192 year on average) and compared to the previous reports largely from inner cities. Problems reconciling police data which was likely to be accurate with Health data which was known to be inaccurate. Behaviours leading to detention -Self harm was commonest cause for detention at 55%, violence only 28% and intoxication at 16%. Overall, 34% admitted – which is low compared to previous findings in the 80s. Not clear what happened to those detained under S136 who were not treated. 9% repeat detentions might suggest a problem with that group.
16. Borschman et al. (2010)	2005 to 2008	Examine sample of S136 detentions	887 consecutive detentions	Quantitative analysis	Sample of 3 years consecutive detentions representing a large and significant sample. Black people over-represented, 5% population but 17% detentions. Finding suggest many black people accessing MH services through S136 route. 41% overall not admitted so a waste of resources. 75% detentions out of hours (75% of time is out of hours) causes problems with staffing and accessing suitable resources.
17. Sadiq, Moghal and Mahadun (2011)	2008	Research use of S136 facility	Only 45 assessments examined	Quantitative analysis	Examined use of new S136 facility. Self-harm largest behaviour group at 35%. 22% mood disorders largest diagnostic group. 38% admitted after assessment, which is lower than previous reports but higher than many other reports since. An initial surge in use then a drop in numbers, which implies a behaviour change in officers rather than a change in population base.
18. Riley, et al. (2011a)	2009 to 2010	Examine experiences of being detained under S136	18 detainees and 6 carers semi structured interviews	Qualitative analysis	This was before Health Based Place of Safety (HBPOS) and to inform its design. Detainees found many aspects of police custody dehumanising though the staff were kind. Much dissatisfaction with mental health care too. Identified the difficulties in setting up effective POS as alternative to police custody as MH facilities

					may also have stigma. Real problem with lack of follow-up after release.
19. Riley et al. (2011b)	2010	Review appropriate POS	8 groups of professionals 223 respondents	Quantitative analysis	Postal survey of workers involved in S136. 64% return rate – good. 74% thought Police custody unsuitable, A&E not much better, Psychiatric unit first choice at 58%, however, views rather partisan as MH workers though police custody best. Clearly no consensus about best way forward which could cause problems in the future.
20. Keown (2013)	1984 - 2011	Changes in use of POS orders	Over 7 years	Quantitative analysis	Large scale analysis of public data on mental health treatments over the period. Showed a six fold increase in use of S136 though wide variation in its use by area. Use of other provisions also increased. Whilst rate of use rose, subsequent treatment rate fell. Also appeared to be a shift away from police custody towards hospital-based POS. Looked for correlations between a range of factors, the closest association was population rise with S136 use rising. Maybe a change in the threshold for the use of Section 136 that accounts for the rise.
21. Patil, Mezey and White (2013)	2007 to 2010	Adolescents detained S136	34 patients detained 37 times.	Quantitative analysis	This is one of the very few papers found that examines young people and S136 and compared them to a matched set of adults. A surprise that a ratio 2:1 female to male in both adults and children for adults are usually reported as majority male. Children different from adults in diagnosis - 91% had previous contact with MH services, diagnosis depressive 18% and conduct 15%. 82% presented with self-harm. Only 53% diagnosed as mentally ill at time of detention. Almost half detained at 'home' so officers clearly misunderstood their powers.
22. Menkes, David and Bendelow (2014)	2006 to 2007	Vulnerability and dangerousness	6 focus groups and approx. 30 interviews	Mixed methods	Examined the vulnerability and dangerousness of those subject to Section 136. Range of issues identified, its use depended upon structural, institutional factors, social context and particulars of individuals. PD problematic through repeat presentations, interagency problems especially exclusion through intoxication.

					Nearly all incidents were of self-harm which is a change from previous studies.
23. Dyer, Steer and Biddle (2015)	2015	Review Street Triage (ST) operation	16 interviews plus data collection	Semi structured interviews and data analysis	ST supported by practitioners in interviews. The change in rate of detentions after ST introduced very striking. Of 558 people detained by police without ST 82% not admitted, of 572 assessments by ST only 2 detained and admitted. Police detained 11 against ST advice and none admitted. These results are unusually high and might suggest that assessments for detention were not necessarily being undertaken on the basis of clinical need. It then appeared that people were trying to bypass the ST system as tensions arose between partners over increase in self referrals and repeat referrals.
24. Zisman and O'Brien (2015)	2012	Cohort study on S136 detainees	245 patients	Quantitative analysis	245 people detained 276 times in 6 months. Profile very similar to similar recent reports. Slightly more men than women, May be slight over representation of ethnic minorities. Over half were previously admitted or detained. Commonest cause for detention was self-harm – 45%, which shows increase in this cause over time. 44% were intoxicated which delayed assessment and reduced chance of admission. Just over half were released without further treatment, which shows the rate falling over previous studies. Only included those taken to POS so other detentions missed. Quality of records used for analysis generally good.
25. Pugh and Laidlaw (2016)	2009 to 2013	Effect of opening POS	>2000 detentions reviewed	Quantitative assessment	Examined S136 detentions in the 5 years around opening of HBPOS. Increased detentions by 60%. Formal treatment rate fell from 29 to 18% and over 50% didn't need Health intervention. The implication is that the creation of a HBPOS has changed the behaviour of police officers who favour the HBPOS over custody.
26. Keown et al. (2016)	2014	To examine effect of Triage scheme	12 months detentions	Quantitative analysis	Compared detention rates before and after the introduction of ST. S136 appeared to fall by over 50% Also compared the S136 rate against the availability of ST and found a reverse correlation The greater the latter the lower the former so good correlation,

					but no control of other variables. Illustrated by the treatment rate following detention, being the same for both – which is unexpected. Also, no evidence about the outcome for those that ST deflected from S136. Broadly supportive of ST but some issues unresolved.
27. Heslin et al. (2016)	2014 to 2015	Analysis of relative costs of ST and non ST attendance	194 detentions before and 118 after.	Quantitative analysis	Compared detentions before and after introduction of ST. Significantly fewer detentions with ST and the costs without ST were £1077 as opposed to £1043 with the ST. Since the costs were all 'sunk' costs, this may not have any practical value? The health outcomes under the two schemes were not determined and so no overall cost could be determined.
28. Heslin et al. (2017)	2011	Examine costs of enhancements to treatment	783 incidents	Pathway mapping and costing	The research used pathways and probabilities to examine the costs of 3 recommended enhancements to care pathways. This was for 55 individuals and 783 specific elements. The three options were ST, Mental Health act assessments for all S136 detentions and outreach link custody workers. Any would only marginally change individual-level costs between -8% and +6%. However, did not include client and societal costs which could be significant.
29. Burgess, White and O'Brien (2017)	2012	Follow up review of S 136 detainees over a year.	242 detainees all over 6 month period	Quantitative analysis of outcomes	A previous study (Zisman and O'Brien (2015)) had found half of those detained under S136 were released with no treatment. This research followed up on that half to see if entered treatment later. Research looked at diagnosis. Change in pattern over time, were psychotic but now commonest diagnosis PD or chaotic behaviour. Those with psychosis most likely admitted, PD or substance abuse resulted in multiple detentions. 41 individuals (17%) detained again, 39 between 1 and 4 times but 2 over 10 times. 52% detained for self-harm. To reduce detentions 20% unnecessary detentions could be avoided through better liaison but better care need for those with PD.
30. Jenkins et al (2017)	2014	Compare triage schemes	273 assessments	Quantitative analysis	Compared Street triage and control room-based schemes. ST reduced detentions and increased admissions, control room had

					little effect, however the comparison was of two different geographical areas so no effectively matched sets of data. The authors also recognised that a qualitative analysis from the professionals involved could also help explain the differences.
31. Scantlebury et al. (2017)	2016	Evaluation of MH training and S136 outcomes	249 officers received additional MH training	Quantitative analysis	Training evaluation. Struggled to identify appropriate outcomes to assess trial. Trained officers more reliably identified incidents as MH and this may have identified more people as ill but no reduction or increase in S136 detentions. Too many uncontrolled variables in the method to be sure of much.
32. Eswaravel and O'Brien (2018)	2011 to 2016	Examination of characteristics of under 18s detained S136	85 people 104 admissions	Quantitative analysis	Admissions may be increasing over time, small cohort but no over-representation of black people. Commonest behaviour was self-harm or threats – 83%. Most had previous MH contact. 14 admitted more than once typically in clusters. Typical admission 16 yr. old white female for self-harm. Pattern for under 18th different from adult studies.
33. Sondhi et al. (2018)	2016	Experiences of those detained under S136	54 patients and 4 carers non-probability sample	Qualitative semi structured grounded interviews	3 interwoven issues identified, failings with procedure e.g. journey time to POS, dissatisfaction with the personal engagement with staff and a chaotic non-therapeutic environment. Study may not have been representative, and the recall of subjects may also not be accurate. Researchers were concerned that issues raised would not be addressed by new legislation being implemented.

2.5 Quality appraisal of systematic review papers.

A quality appraisal of the papers identified above was undertaken and the results are set out below. Nearly all the papers concerned were descriptive studies and quantitative analysis, so the CASP qualitative assessment tool was not appropriate. Instead a Mixed Methods Appraisal Tool (MMAT) appeared more appropriate given the nature of the studies. The authors (Hong Q.N, et al. 2018) claim for their MMAT that it is:

- *"Designed for systematic reviews that include qualitative, quantitative and mixed methods studies;*
- *Efficient as it allows to use one tool for concomitantly appraising the most common types of empirical studies;*
- *Addressing the quality of mixed methods studies (appraisal of qualitative, quantitative and mixed methods components);*
- *Based on a constructionist theory and a literature review;*
- *Content validated using feedback from experts and workshops;*
- *Pilot tested for reliability."*

The user guide and mixed methods appraisal tool (MMAT) version 2018 was employed[8]. Each of the papers above was assessed using the algorithm on page 8 of this guide and then set out in the tables below. The criteria numbering is retained from the MMAT guide.

The first and largest assessment group of 29 articles concerned quantitative descriptive studies.

[8] Downloaded from http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

Table 2.2. Quantitative descriptive studies

Methodological quality criteria. **Yes =Y** **No = N** **Can't tell = C**	1. Kelleher and Copeland (1972).	2. Dunn and Fahy (1990)	3. Pipe, Matthews and Hampstead (1991)	4. Turner, Ness and Imison (1992)	5. Mokhtar and Hogbin (1993)	6. Spence and McPhillips (1995)	7. Lowe-Ponsford and Begg (1996)	8. Latham (1997)	9. Hotopf et al. (2000)	10. Simmons and Hoar (2001)	11. Ogundipe, Oyebode and Knight (2001)	12. Greenberg et al. (2002)	13. Lynch et al (2002)	14. Greenberg and Haines (2003)	15. Laidlaw et al. (2010)
1 Is the sampling strategy relevant to address the research question?	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y
2 Is the sample representative of the target population?	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y
3 Are the measurements appropriate?	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y
4 Is the risk of non-response bias low?	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y
5 Is the statistical analysis appropriate to answer the research question?	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y

Methodological quality criteria. **Yes =Y** **No = N** **Can't tell = C**	16. Borschman et al. (2010)	17. Sadiq, Moghal and Mahadun (2011)	19. Riley, et al. (2011b)	20. Keown (2013)	21. Patil, Mezey and White (2013)	24. Zisman and O' Brien (2015)	25. Pugh and Laidlaw (2016)	26. Keown et al. (2016)	27. Heslin et al. (2016)	28. Heslin et al. (2017)	29. Burgess, White and O' Brien (2017)	30. Jenkins et al (2017)	31. Scantlebury et al. (2017)	32. Eswaravel and O' Brien (2018)
1 Is the sampling strategy relevant to address the research question?	y	y	y	y	y	y	y	y	y	y	y	y	y	y
2 Is the sample representative of the target population?	y	y	y	y	y	y	y	y	y	y	y	y	y	y
3 Are the measurements appropriate?	y	y	y	y	y	y	y	y	y	y	y	y	y	y
4 Is the risk of non-response bias low?	y	y	y	y	y	y	y	y	y	y	y	y	y	y
5 Is the statistical analysis appropriate to answer the research question?	y	y	y	y	y	y	y	y	y	y	y	y	y	y

A smaller group of four articles were qualitative studies and so assessed against that those quality criteria within the MMAT framework.

Table 2.3 Qualitative studies.

Methodological quality criteria. Yes =Y. No = N. Can't tell = C	18. Riley et al. (2011a)	22. Menkes, David and Bendelow (2014)	23. Dyer, Steer and Biddle (2015)	33. Sondhi et al. (2018)
1. Is the qualitative approach appropriate to answer the research question?	Y	Y	Y	Y
2. Are the qualitative data collection methods adequate to address the research question?	Y	Y	Y	Y
3. Are the findings adequately derived from the data?	Y	Y	Y	Y
4. Is the interpretation of results sufficiently substantiated by data?	Y	Y	Y	Y
5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Y	Y	Y	Y

The largest part of the papers above were quantitative studies and were non-analytical or descriptive in approach. They appear to score well in the analytical assessment, but this reflects for the most part the fact that they were simple descriptive studies which used arithmetic and basic statistics for comparison purposes. They set limited objectives which they achieved. In sixteen papers the population of people detained under Section 136, which consisted of consecutive sequences of those detained, were described in various terms (1,2,3,4,5,6, 10, 12, 15, 16, 17, 21, 24, 25, 29, 32) This included behaviour, diagnosis, race, timeliness and where detained. Three papers were concerned with the changes in rates of detentions set out through nationally published Health data (9, 14,20). Four papers concerned Street Triage schemes and other alternatives to Section 136 and examined changes in detention rates or costs where ST schemes were employed (26, 27, 28, 30). Four papers were surveys of professionals involved in Section 136 detentions and examined the operation of policy and levels of understanding (8, 11 13, 19). One paper looked at the effects of training upon detention rates (31) and one described the detentions of people at a major airport (7).

All these papers described the operation of Section 136, in different circumstances or locations, but none examined directly mechanisms of cause and effect that could account for the observable differences in operation or changes over time.

There were four papers that reported qualitative studies. Two concerned the experiences of those detained under Section 136 (18, 33). One assessed the operation of a Street Triage Scheme through interviewing staff involved in it (23) and one used similar methods to assess the vulnerability and dangerousness of people detained under Section 136 (22). The studies involved the use of semi structured questionnaires and interviews (18, 23, 33); and once involved both focus groups and interviews (22). They all appeared methodologically sound and appeared to accurately represent the views of those studied.

2.6 Discussion

Section 136 is the very specific legal power that operates within England and Wales with the result that this systematic review only provided a narrow insight into the operation of that specific provision. The many similar provisions in other countries have different tittles and so are hidden in the large numbers of publications concerned more generally with mental illness and policing or the criminal justice system.

More articles were discovered through extensive *source* and *citation* searching (also called ancestor searching). In this all the publications listed above were examined and all the references they refer to were in turn also reviewed. Where articles appeared relevant then both those and other later articles which cited them were also reviewed. Through this means the search was extended into other relevant and related provisions both in England and Wales and especially elsewhere. All the topics discovered by this means are discussed more fully in the following chapter.

Even allowing for the limited range of results of a search using the term “Section 136” the review still identified problems and trends in the operation of Section 136.

There appears to be no doubt that the volume and rate of use of Section 136 has increased in real terms over the last few decades (Keown (2013)), though for most of that period the quality of records of detentions have been very poor (Laidlaw et al (2010)). There are also wide differences between geographical areas (Greenberg and Haines 2000) and the volumes of detention can be greatly affected by changes in the process such as the creation of a Health Based Place of Safety (Sadiq, Moghal and Mahadun (2011), Pugh and Laidlaw (2016)).

There have been changes over time in the diagnosis and behaviour of those detained under this provision. Thirty or more years ago, most people were detained for *bizarre* behaviour arising from psychotic conditions such as schizophrenia, whilst more recently Personality Disorder and self-harm are more common causes (Borschman, Gillard, Turner et al. (2010)). The treatment rate following detention has also declined over time with some individuals detained repeatedly (Burgess, White and O’Brien (2017)).

Over the same period a disproportionality by race has emerged in those detained with black or Afro-Caribbean young men most affected (Pipe, Matthews and Hampstead (1991), Borschman et al. (2010)). Though this may not be the case for young people (Eswaravel and O'Brien (2018)). Whilst there has been much further research to demonstrate the existence of the racial disproportionality in detention and treatment under the MHA., up to the date of this publication there is no accepted research-based explanation.

Many of the articles were concerned with failings in the operation of Section 136. Levels of knowledge of its operation appeared poor (Latham (1997), Lynch et al. (2002)), those detained expressed a high level of dissatisfaction with the processes and facilities (Riley et al. (2011a)), whilst all agreed that police cells were not an appropriate POS (Riley et al. (2011b)).

A recent response to tackle the problems in the operation of Section 136 was the development of various Triage schemes, the evaluation of which appeared in several articles, the most comprehensive being by Puntis et al. (2018). The results of Triage operations appeared mixed though this will hopefully become clearer over time.

It also emerged in the review that there was a potential wealth of research in other countries about equivalent legislation and police interactions with people who were mentally ill (Chappell and O'Brien (2014)). This is explored in the following chapter.

This review revealed surprising aspects in the operation of Section 136 but although it provided some insights and observations, there was no coherent account for what was observed either in this review, or the reports in the previous chapter.

What is lacking in the research so far is a clear analysis and understanding of why the pattern of detentions under Section 136 (and even the MHA) is changing and a critical analysis of the effectiveness of those interventions being adopted, both in the short and longer term.

2.7 Limitations

The main limitation of this review has been the limited range of literature published directly about Section 136 as the provision operating in England and Wales. It has since become clear that similar provisions exist across the *first world* for the police to detain people who are in crisis, but these provisions have many different names and so could not be identified directly through this review. Many of these have been identified and included both through source and citation index searching and more general reading around related topics and are discussed in the following chapters.

A further limitation has been the very recent nature of much of the response to the problems with Section 136 through Street Triage and other similar schemes. Whilst a few publications on Triage were revealed in this review many other articles have been published since this was completed and so have been included later into this thesis.

A final limitation has been that the published research tended to concentrate on specific aspects such as diagnosis. A few papers had considered changes in use either over time or by location but as many of the articles were relatively old none had sought to understand and account for the more recent trends.

For these reasons this review was of limited value in developing the scope of this research.

Chapter 3. Themes from the systematic review, a wider literature review and public data.[9]

3.1 Introduction.

As well as the systematic literature review a review of 'public' data was also undertaken. A large volume of data on mental health and other related issues was available from:

- The Office of National Statistics (ONS)
- Data.gov
- NHS.uk
- NHS Digital
- The Health and Social Care Information Centre (HSCIC)

The HSCIC was the most relevant to this research however the database was closed in 2017 and transferred to NHS Digital as a result of which there is a significant discontinuity in many of the data collections. Much of the data downloaded from the HSCIC is no longer available online and so this has been included in the data disk attached to this thesis (Appendix I). Data from all these sites is included in the analysis that follows.

The systematic review above identified a limited literature base on the operation of Section 136. Over the course of the study many other relevant articles about similar provisions elsewhere or related topics were discovered. This was especially through reading other literature reviews and following up sources and citations from reference lists in relevant articles. It was not practical to conduct a systematic review on every such strand that was identified but rather these were researched through separate key word searches and source and citation indexing.

Whilst all the articles in the systematic review were from England, during this research many articles and reviews were found from elsewhere in the English-speaking world, in particular from the United States, Canada and Australia. The principle issue in reviewing literature from the U.S. is

[9] The content of this chapter has been published in part in a book chapter: Thomas, A., 2020. *Examining the relationship between policing and section 136 of the Mental Health Act 1983.* Policing and Mental Health: Theory, Policy and Practice.

the lack of a comparable legal framework which means that there is a less clear distinction between the criminal justice system and the police involvement in the care for and protection of individuals. In addition, such legislation operates at a local level which concerns the 18,000 law enforcement bodies, half of which possess less than ten employees (Reuland, M., Draper & Norton, 2013). Thus, every jurisdiction has a different legal framework and care needs to be taken to ensure comparisons are meaningful.

Whilst Canadian provinces are, like American states, devolved with regard to law making and have 230 different police organisations, all have mental health acts which permit the police to detain a person who appears to be mentally disordered and likely to cause harm. This is in circumstances where it is not practical to use a physician or a judge to obtain a psychiatric examination (Gray, Shone & Liddle, 2008). This is the most commonly used power to deal with people who are mentally ill but have not committed a crime (Cotton and Coleman, 2013). This power is broadly comparable to Section 136.

The most similar legal framework to England is reported in Australia. Whilst the individual states are relatively devolved and autonomous all have a similar legal framework for mental illness. In Victoria under Section 10 of the Mental Health Act (Victoria) 1986 a police officer may apprehend a person who appears to be mentally ill if they have reasonable grounds for believing that the person has recently attempted suicide or attempted to cause serious harm to themselves or another. Although the Act was amended in 2010 to allow for the detained person to be examined by a registered medical practitioner or a mental health practitioner, in practice the great majority of those detained were taken to the Emergency Department (ED) of a hospital most often in a police van (Al-Khafaji, Loy & Kelly, 2014). In its various guises this legislation is very similar to Section 136.

3.2 Themes from the literature and published data review.

Thematic analysis of the reviewed papers delineated a number of major themes which were then used to inform the subsequent studies. The themes were obtained through reading each paper

and identifying firstly the main area of research that the paper explored, the conclusions drawn but then also the other issues that were touched upon or alluded to. These were all then compared or contrasted with the content of the other papers. From this a list of annotated themes were produced.

The list of themes was then extended over time by the inclusion of others identified through reading more widely around the subject. In particular the literature from the U.S., Australia and Canada were rich in papers on related and informative issues for example the role of the exercise of discretion in the use of police powers. The list of themes relevant to this research has grown over the period of this research and continues to grow up to the present.

The themes developed during this research are listed below and then set out in more detail.

1. *Poor quality of documentation and statistics.*
2. *Increasing frequency of use of Section 136 and other MHA provisions.*
3. *Local variations in use of Section 136.*
4. *Inappropriate use of POS.*
5. *Lack of availability of treatment.*
6. *Reductions in treatment following police detention.*
7. *Diagnosis associated with detention.*
8. *The criminalization of the mentally ill.*
9. *Social Causation or Constructivism in the use of Police discretion and Section 136.*
10. *Homelessness and Section 136.*
11. *Behaviours leading to detention.*
12. *Frequent or repeat presenters.*
13. *The experiences of people who are mentally ill with the police and 'procedural justice'.*
14. *The demographics of those detained and changes over time.*
15. *Problems with partnership working.*
16. *Defensive professional or risk averse cultures.*

17. *Police efforts to improve responses to mentally disordered people.*

18. *Triage schemes in England and Wales.*

3.2.1 Poor quality of documentation and statistics.

An early review is within the Report of the Committee on Mentally Abnormal Offenders (Home Office, 1975). Whilst this is mostly concerned with the treatment of mentally disordered offenders it does consider the use of Section 136 of the MHA 1959. The provision within the 1959 Act was copied exactly into the 1983 Act. The first problem it identified concerned the accuracy of the recorded statistics. The Department of Health and Social Security figures for 1973 (included in the report) recorded that of the 1,555 admissions to hospital under Section 136, 1,376 were in London alone whilst Wales had only ten admissions and the Mersey area only one. The report observed that this arose from different operating and recording practices. In Liverpool and Bootle where the police found a mentally disordered person wandering at large they would summon an ambulance to take them to hospital but did not record such detentions under Section 136. In contrast in London such persons taken to the hospital by the police were recorded under Section 136, whereas if a person was taken to a police station under Section 136 and was then examined and admitted to hospital, such an admission in London would then have been recorded under Part IV (Section 29) of the 1959 Act and not under Section 136.

The Home Office (1975) report also concerned itself with the necessity for the police to have such a power when on the face of it, it was not used in many parts of the country. Their subsequent analysis showed that the power was actually widely used but that the statistics were misleading and the application of the power was widely misunderstood.

These issues have persisted to the present day. Rogers and Faulkener (1987) identified that both data collection and the statistics prepared around Section 136 were poor. Turner, Ness and Imison (1992) identified this in their review of 163 inner city detentions and Latham (1997) again identified shortcomings in the documentation of Section 136. Greenberg and Haines (2003)

similarly identified this issue in their review of rural English police forces and Dearman, Rao and Harrison (2007) raised their concerns in a joint letter stating:

> "*Concerns about variable use, outcome and proper documentation of Section 136 have been raised at least 10 years ago and yet little has apparently changed."*

Problems in the record keeping of Section 136 may also be compounded by the lack of understanding of the legislation by the various parties to it. In a study in Yorkshire the knowledge of hospital staff and police officers was assessed using multiple choice questionnaires (Lynch et al., 2002). This showed deficiencies in knowledge of all parties for example 17% of respondents did not know that the person had to be suffering from a mental disorder and 40% of police officers did not know that Section 136 cannot be used in a person's home. Respondents also had incorrect perceptions of the relative roles of different partner organisations.

Table 3.1 Section 136 detentions from 2005 to 2013.

Year	Section 136 to hospital	Section 136 in police custody	Total Section 136	Percentage in police custody
2005/06	5,495	11,500	16,995	67.70%
2006/07	6,004			
2007/08	7,035			
2008/09	8,495			
2009/10	12,038	7,035	19,073	36.90%
2010/11	14,111			
2011/12	14,902	8,867	23,769	37.30%
2012/13	14,053	7,881	21,934	35.90%
2013/14	17,008	6,028	23,036	26.20%

Source:(Home Office and Department of Health, 2014a)

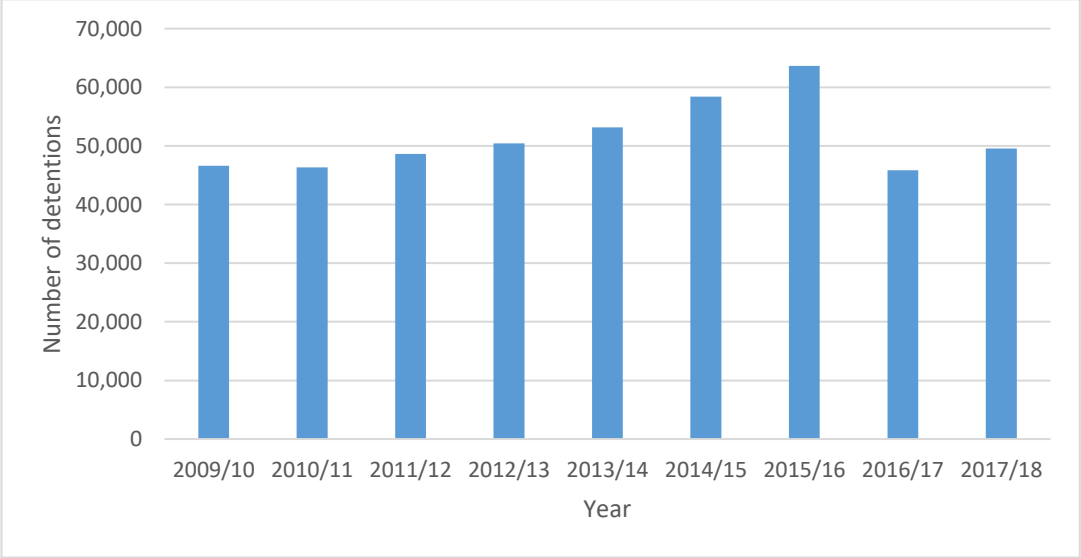
More accurate figures concerning the use of Section 136 have only been available since the financial year 2011/12 (Home Office and Department of Health, 2014a) and a table showing their published data is set out above.

Although there are significant gaps in the data a reduction in the number detainees taken into police station custody is already clear by 2013. However, even to date not all Police data on detentions under Section 136 are accurate (see below).

Data from Health had for several years been consistent and accessible through the HSCIC and much of the data reported below has been obtained from the KP90 report from that source. However, after 2015/16 data collection and processing has been transferred to NHS Digital and unfortunately the data quality has since been inconsistent and so there is no accurate continuity of data between the two. This issue is illustrated in figure 2.2 below. Published with the data is a covering statement which sets out:

> *"Last year, the way we source and produce these statistics changed. Previously these statistics were produced from the KP90 aggregate data collection. They are now produced from the Mental Health Services Data Set (MHSDS). The MHSDS provides a much richer data source for these statistics, allowing for new insights into uses of the Act."*

Figure 3.1. Number of all detentions under the MHA 2009 to 2017.



Source: Mental Health Act Statistics, Annual Figures 2017-18. Published by NHS England 9th October 2018 [https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures]

> *"However, some providers that make use of the Act are not yet submitting data to the MHSDS, or submitting incomplete data. Improvements in data quality have been made over the past year. NHS Digital is working with partners to ensure that all providers are submitting complete data and this publication includes guidance on interpreting these statistics."*

This data shows a drop in all MHA detentions from 2015/16 to 2016/17 of 28%. NHS digital stated in the covering note (at the same web site above) that where they believed the data to be accurate that there had been a 2.4% rise in detentions in the same period, a difference of 30%!

> *"49,551 new detentions under the Mental Health Act were recorded (2016/17), but the overall national totals will be higher as not all providers submitted data. Trend comparisons are also affected by improving data quality. For the subset of providers that submitted good quality detentions data in each of the last three years, we estimate there was an increase in detentions of 2.4 per cent from last year."*

Two separate sources of data have emerged since 2013/14 and these have been from the police - the National Police Chief's Council (NPCC) collected and published data from forces for 2013/14 and 2014/15 and since then the Government has collected the figures as National Statistics (see below). Through these sets of figures a continuing rise in use of Section 136 is still visible each year, but as some data is still shared with the police from Health some inaccuracy may still have arisen.

Table 3.2 Section 136 detentions in England and Wales between 2014 and 2018.

Year	Number detentions E&W
2014/15	21,394
2015/16	23,602
2015/16	28,271
2016/17	26,328
2017/18	29,662

Source: (Home Office and Department of Health, 2014a); [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018] and: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017]- and [https://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf]

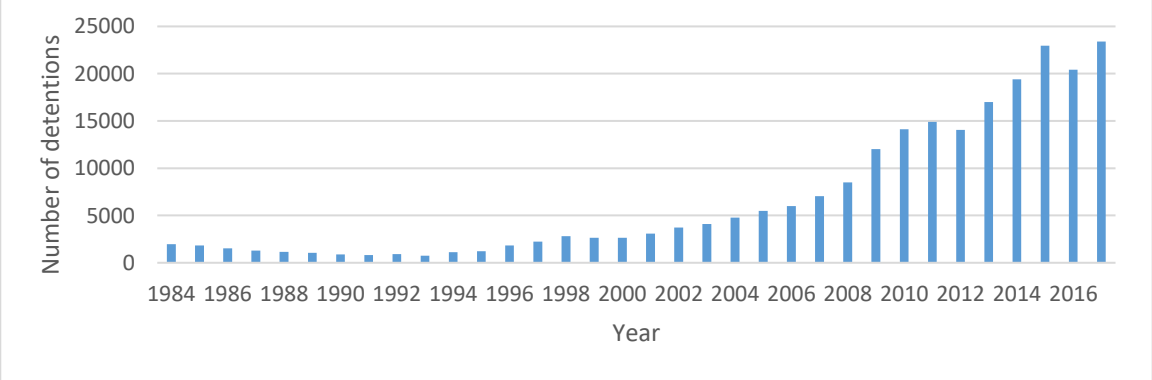
In recent years great efforts have been made to improve the accuracy of the data around the use of Section 136, however this has only been with limited success. Hence there are limits to the analysis that can been made on the basis of this published public data.

3.2.2 Increasing frequency of use of Section 136 and other MHA provisions.

In terms of the use of Section 136, it appeared to have declined in the late 1980s but has risen since then (Hotopf et al., 2000) with 23,569 detentions in 2011/12 (14,902 taken to hospital and 8,667 taken to a police station), a 6% rise over 2010/11 and a 26% rise in use of Section 136 since 2005/06. A study by Keown (2013) made use of all publicly available data to compare the period 1984/5 to 2010/11. This showed a six fold increase in the use of Section 136 in that period, though this is qualified by the difficulties in collecting accurate and comparable data. He observed significant variation in detention rates across the country by region. In the two years 2003/04 and 2005/06 in the South East there were 11.9 detentions per 100,000 population into NHS facilities and 40.3 detentions per 100,000 into police custody. In contrast in the North West in the same years the figures were 14.6 and 5.4 respectively. It is not clear why there were these changing patterns of detention over time and such apparently wide differences between rates of detention in different regions of the country. It appears unlikely that changes in population could account for these, changes in service funding and bed availability could but that data is not readily available.

As Police data was scant the Home Office published data they had collected from within Health showing the number of Section 136 detentions (taken to hospital) per year since 1984. As they recognized and as has been published (above) there are uncertainties about the accuracy of this data. The range of data in figure 3.2 below has been extended using the hospital detentions figures produced in Government statistics, which is still likely to be inaccurate (as above).

Figure 3.2 Number of Section 136 detentions taken to hospital as POS 1984 to 2017.



Source: (Home Office and Department of Health, 2014a) and [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018]

An artifact exaggerates the rise in detentions in the figure below and that is the reduction in the use of police custody as a POS especially in recent years. As fewer people were taken to police custody but instead to hospital, that would have increased the numbers of people appearing in the hospital figures, even if overall detentions remained unchanged. Notwithstanding these concerns this does serve to give an indication of the growth in the use of the power over the last 20 years. Thus from 1996 to 2017 the number of recorded detentions rose nine fold from 1,833 to 23,414, which is an average annual growth rate of 12.9%.

The operation of Section 136 can also be viewed in the wider context of the provision of mental health services and in particular of the involuntary treatment of the mentally ill under the other provisions of the Mental Health Act 1983 in which Section 136 serves a specialist role.

The last 30 years has seen a significant rise in the number of people detained in England for compulsory psychiatric treatment (Keown et al., 2011). The rate of increase in admissions rose sharply by 14% in the five years after the introduction of the Mental Health Act 2007 and more recently in 2010/11 and 2011/12 has risen by 5% per annum (Weich et al., 2014). In 2012/13 the total rose above 50,000 people for the first time (figures from the HSCIC cited by Weich (2014)). In the last year for which data is available (2017-18) the rise was estimated as 2.4% over the previous year (NHS Digital[10]).

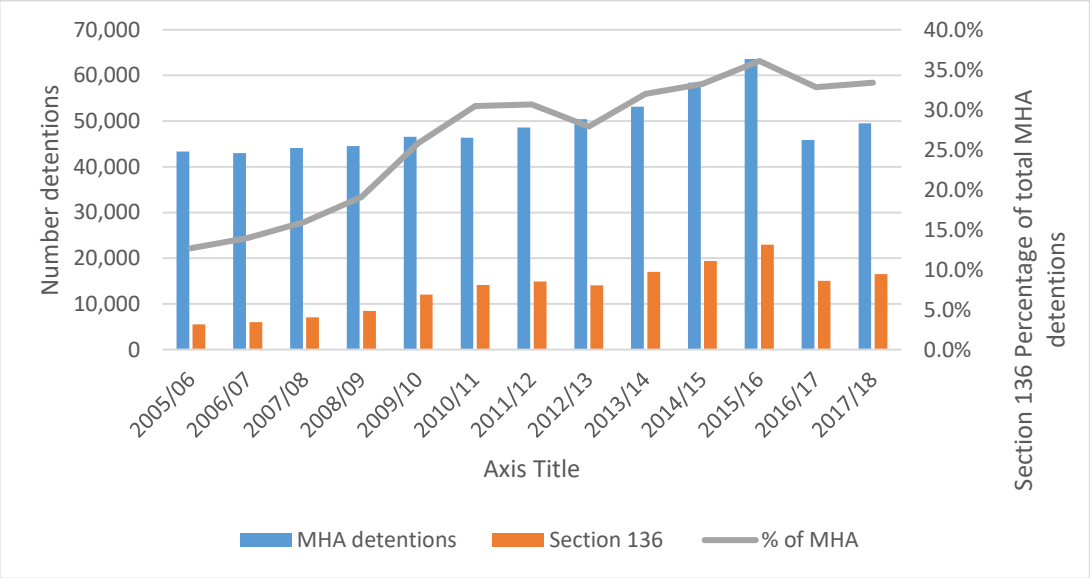
Whilst it is clear that the number of people detained under Section 136 has been rising, is this just because the number of people detained under the other provisions of the MHA have also increased?

Figure 3.3 below compares the numbers of these two sets of detentions and expresses Section 136 detentions as a percentage of the overall MHA detentions. There is a discontinuity in data after 2015/16 (as discussed above). The rise in Section 136 detentions is faster than that of overall

[10] [https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures]

MHA detentions and so the percentage of detentions that relates to Section 136 rose over the period from 10% in 2003/04 to 36% in 2015/16. Thus, whilst it may be the same cause or set of causes making both numbers increase, the effect is disproportionate in terms of Section 136 such that Section 136 is becoming a significant entry point for people who need Health treatment under the MHA.

Figure 3.3 Comparison of all MHA detentions with Section 136 hospital POS detentions, 2005 to 2017.



Source the HSCIC KP90 data return (Copy in data disk Appendix I), Mental Health Act Statistics, Annual Figures 2016/17 - Link: [http://digital.nhs.uk/pubs/mha1617] and Mental Health Act Statistics, Annual Figures 2017-18 - Link: [http://digital.nhs.uk/pubs/mha1617]

Using a combination of data published by the National Police Chief's Council (NPCC) and Government Statistics the data for Section 136 detentions for the last three years can be prepared per police force and region (below).

Apart from the South West where there is clearly an issue with data collection, there are data for all other forces. It appears anomalous that detentions sharply dip in 2016 before rising again in 2017.

Table 3.3. Showing Section 136 detentions by year, force and region 2015 to 2018.

Police force and region	2015/16	2016/17	2017/18	Direction
Cleveland	**180**	**232**	**166**	
Durham	**136**	**170**	**173**	

Northumbria	**222**	**137**	**183**	
North East Region	**538**	**539**	**522**	**Steady**
Cheshire	**215**	**161**	**250**	
Cumbria	**249**	**248**	**296**	
Greater Manchester	**1328**	**1,416**	**1,745**	
Lancashire	**664**	**795**	**711**	
Merseyside	**320**	**341**	**461**	
North West Region	**2776**	**2,961**	**3,463**	**Rising**
Humberside	**81**	**441**	**442**	
North Yorkshire	**310**	**370**	**335**	
South Yorkshire	**791**	**873**	**1,139**	
West Yorkshire	**1341**	**1,198**	**1,207**	
Yorkshire and the Humber Region	**2523**	**2,882**	**3,123**	**Rising**
Derbyshire	**225**	**221**	**136**	
Leicestershire	**88**	**97**	**120**	
Lincolnshire	**368**	**397**	**440**	
Northamptonshire	**426**	**434**	**323**	
Nottinghamshire	**500**	**466**	**397**	
East Midlands Region	**1607**	**1,615**	**1,416**	**Falling**
Staffordshire	**516**	**523**	**592**	
Warwickshire	**250**	**316**	**176**	
West Mercia	**911**	**786**	**853**	
West Midlands	**1021**	**852**	**903**	
West Midlands Region	**2698**	**2,477**	**2,524**	**Steady**
Bedfordshire	**333**	**98**	**101**	
Cambridgeshire	**300**	**376**	**366**	
Essex	**799**	**687**	**580**	
Hertfordshire	**642**	**511**	**409**	
Norfolk	**331**	**336**	**373**	
Suffolk	**358**	**440**	**347**	
East of England Region	**2763**	**2,448**	**2,176**	**Falling**
London, City of	**125**	**167**	**158**	
Metropolitan Police	**3693**	**4,097**	**4,585**	
London Region	**3818**	**4,264**	**4,743**	**Rising**
Hampshire	**692**	**713**	**543**	
Kent	**1026**	**1,340**	**1,528**	
Surrey	**768**	**671**	**562**	
Sussex	**1001**	**894**	**1,066**	
Thames Valley	**1081**	**1,098**	**920**	
South East Region	**4568**	**4,716**	**4,619**	**Steady**

Avon and Somerset	**1262**	**444**	**1,063**	
Devon and Cornwall	**1464**	**..**	**956**	
Dorset	**429**	**75**	**641**	
Gloucestershire	**485**	**224**	**309**	
Wiltshire	**334**	**246**	**237**	
South West Region	**3974**	**989**	**3,206**	**Data issues**
ENGLAND	**25265**	**22,891**	**25,792**	**Steady**
Dyfed-Powys	**226**	**270**	**239**	
Gwent	**266**	**287**	**237**	
North Wales	**323**	**589**	**680**	
South Wales	**710**	**679**	**799**	
WALES	**1525**	**1,825**	**1,955**	**Rising**
British Transport Police	**1481**	**1,612**	**1,915**	**Rising**
ENGLAND AND WALES	**28271**	**26,328**	**29,662**	**Rising**

Source: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018] and [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017] and [https://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf]

As forces are likely to be dependent upon Health for data about hospital and other Health based detentions then this could also have arisen from the data collection issues (above). Whilst there are a few forces such as Nottinghamshire, Essex, Hampshire and Hertfordshire where there appears to be a downward trend in detentions, for the remainder, allowing for missing data, it appears that the number of detentions is continuing to rise.

The growth overall in detentions under all provisions of the MHA and the continuing disproportionate growth in use of Section 136 even after the introduction of Triage schemes (see para 2.3.18) across the country might argue that there are factors other than medical need at play. However, the presence of similar rises in numbers of detentions outside England and Wales makes this assessment less certain. Over this period there has been a substantial rise in the number of detentions for mental illness in Europe as well (Priebe et al. 2005; Salize and Dressing 2004). There are very few publications in English concerning the treatment of the mentally disordered in France and whilst there are similar powers for the police they are managed

differently. The law concerning the involuntary treatment of the mentally ill in France is summarised in the major European Commission review by Salize, Dressing and Peitz (2002) and provided the data below (Jonas, Machu and Kovess 2002). The French Health Authorities - Commission Départementale des Hospitalisations Psychiatriques – (CDHPs) provided statistics which showed that 12.5% of all patients in psychiatric wards were admitted involuntarily – 55,740 hospital admissions via the Hospitalisation à la Demande d'un Tiers (HDT) process (civil admission) and 8,807 via the Hospitalisation d'Office (HO) process (police process). In the six years from 1992 to 1998 admissions through HDT rose from 31,057 to 55,033 – a 77% increase and through HO from 6,631 to 8,817 – a 33% increase in the same period. In 1999 66% of HO admissions were carried out on a temporary order from a mayor on the grounds of imminent danger whilst 34% of HDT admissions were on an emergency basis. The review comments that more and more often these emergencies arise through extreme behaviour under the influence of alcohol or other drugs.

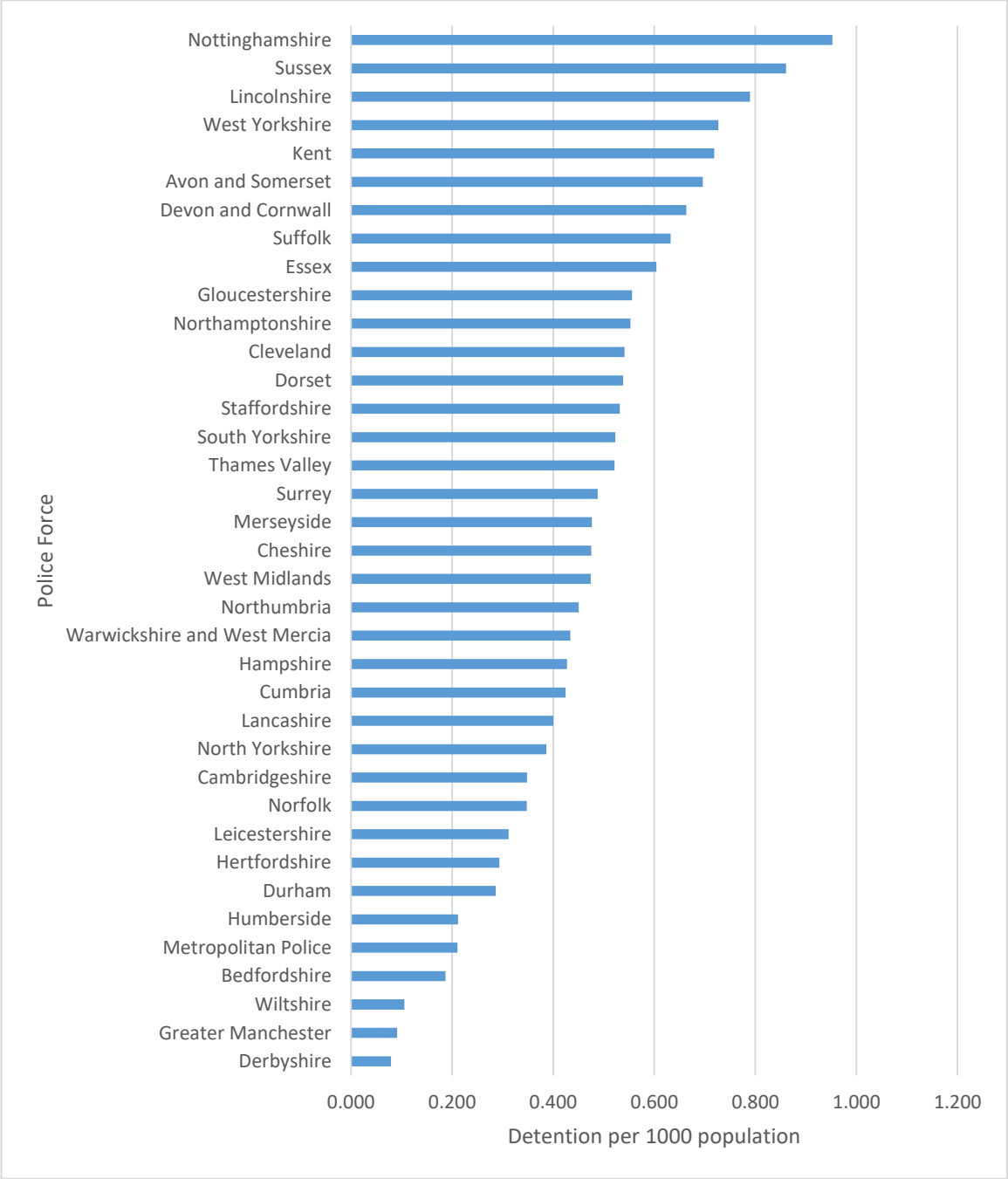
General increases in detentions in other countries might suggest two processes are responsible for the rise in Section 136 detentions. There is a general rise in MHA or equivalent detentions everywhere, but this becomes more variable in impact and extent through more local factors.

3.2.3 Local variations in use of Section 136.

HSCIC data for 2013/14 shows the number of detentions per force per 1,000 residents. British Transport Police and the City of London are excluded as they have either no resident population or very large numbers of visitors compared to their residents.

These figures show a ten fold variation across forces in the rate of detentions. In 2013/14 the top four forces were Nottinghamshire, Sussex, Lincolnshire and West Yorkshire. Nottinghamshire had the highest rate. which is striking as Derbyshire, which is its neighbour and shares many demographic and economic features, finds itself at the opposite and of the table.

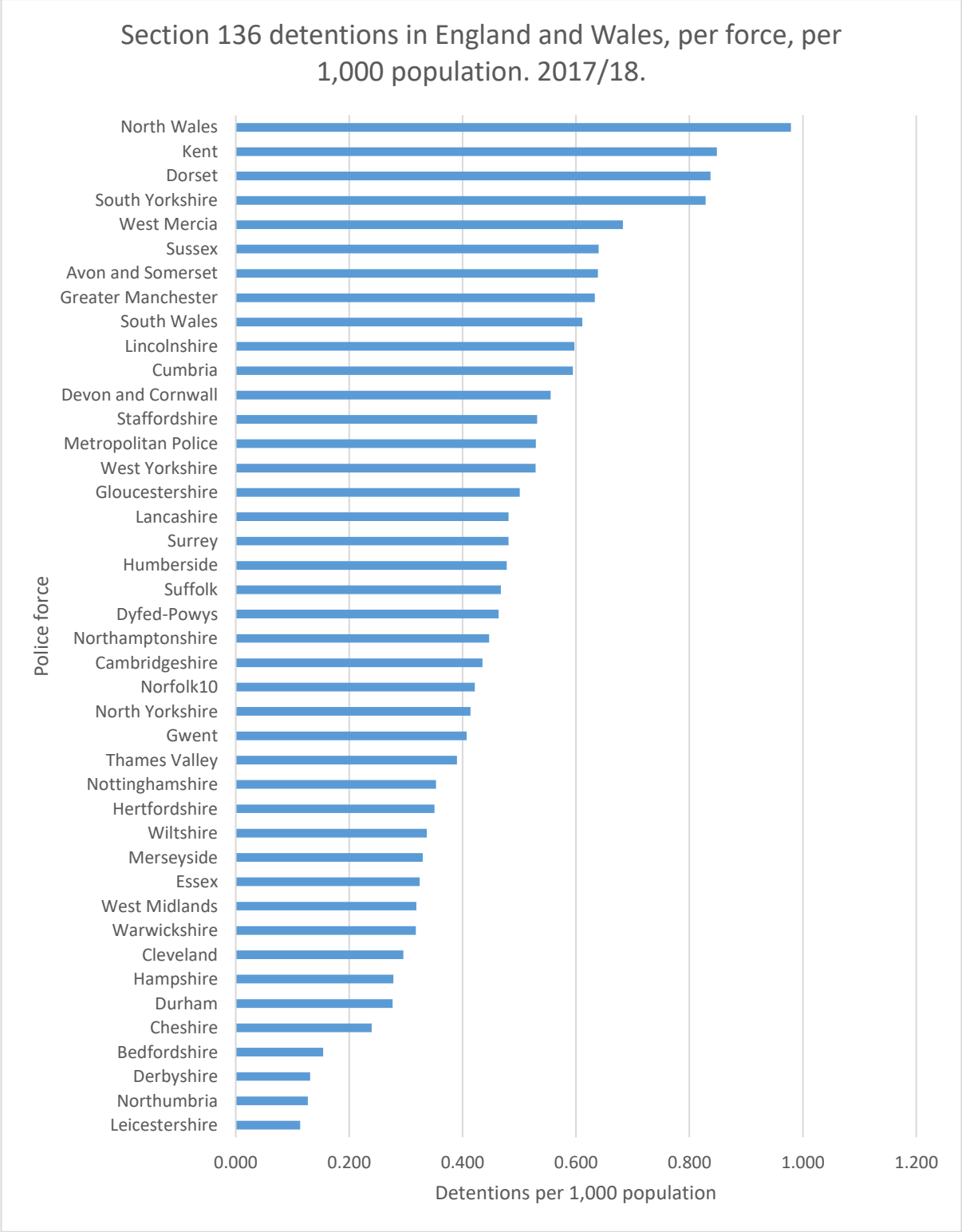
Figure 3.4 Section 136 detentions for each police force per 1000 residents, 2013/14.



Source: [https://www.gov.uk/government/...data/.../pfa-la-pop-house-nos-xls.xls] and HSCIC PUB12503Copy of inp-det-m-h-a-1983-sup-com-eng-13-14-exp-tab-v2.xls in attached disk Appendix I

When redrawn using the data from 2017/18 the variation remains striking. The relative position of individual forces had also changed significantly. Four years later Sussex, West Yorkshire and Lincolnshire remained at the higher range of detentions whilst Nottinghamshire had reduced to the lower half. In 2013/14 Bedfordshire and Derbyshire had low numbers of detention and this remained so in 2017/18 but Greater Manchester which had been low in detentions appeared near the top of the figures in 2017/18. Such variability in the data might imply that other factors,

Figure 3.5 Section 136 detentions for each police force per 1000 residents, 2017/18



Sources: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018] and https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables/current]

perhaps managerial or concerning partnership working may also be influencing these outcomes. It is difficult to conceive that population or sociodemographic effects changed to that degree.

To make comparisons between police forces more meaningful in terms of socio-economic, crime and other factors, the Justice Inspectorates have recently updated their groups of 'most similar forces'[11]. Two of these groups are set out in the two columns below. Each family contains a police force subject of research in studies 1 and 2 (below). Next to each is its ranking in figure 2.5 above.

Table 3.4 Showing two 'most similar forces' groups, ranked by the number of Section 136 detentions per 100,000 residents.

Force Group	Ranking	Force Group	Ranking
Durham	**37**	**Avon & Somerset**	**7**
Gwent	**26**	**Essex**	**32**
Humberside	**19**	**Hampshire**	**36**
Lancashire	**17**	**Hertfordshire**	**29**
Northamptonshire	**22**	**Leicestershire**	**42**
Northumbria	**41**	**Staffordshire**	**13**
South Wales	**9**	**Sussex**	**6**
South Yorkshire	**4**	**Thames Valley**	**27**

These groups of forces are selected for comparison with each other as they have similar socio-economic, demographic and crime characteristics. Again, it is difficult to see any pattern in the number of detentions, they are not 'clustered' but rather spread across the distribution.

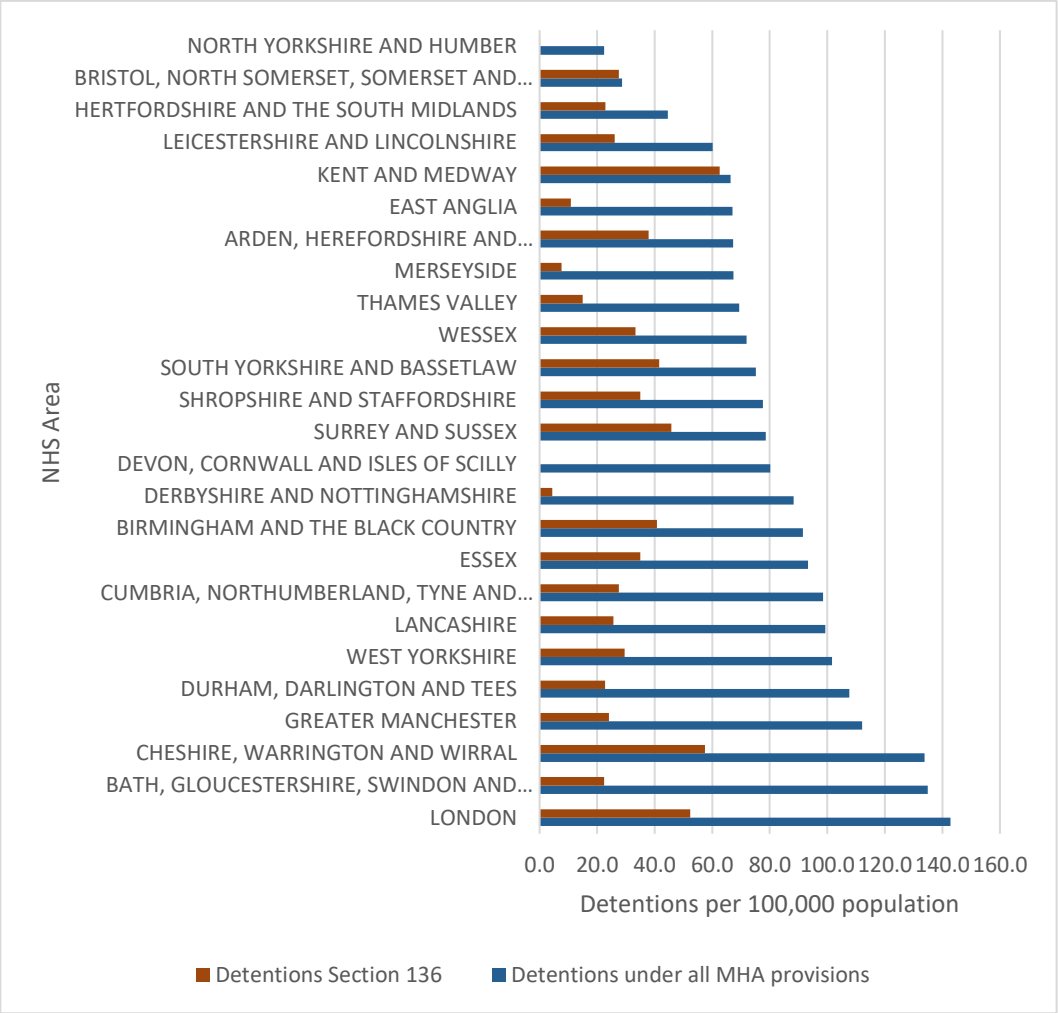
Wide differences in detention and compulsory treatment rates between Strategic Health Authorities have previously been reported (NHS Information Centre Community and Mental Health Team. 2010) cited by Weich et al (2014).

These marked differences between similar areas are even more striking where detention rates for Section 136 and all MHA provisions for police forces and their corresponding Health Authorities are compared. The figure below shows a comparison between detention rates, per 100,000 population, under Section 136 and all other MHA provisions, sorted by order of the volume of all other MHA provisions.

The wide variations in rates of all detentions under the MHA provisions across the country is repeated in the wide rates of Section 136 detentions, but not in the same locations. The range of

[11] *See [https://www.justiceinspectorates.gov.uk/hmicfrs/crime-and-policing-comparator/about-the-data/]*

Figure 3.6 Comparison of Section 136 and all MHA detentions per NHS area per 100,000 residents for 2013/14



Source: HSCIC [*www.hscic.gov.uk/.../inp-det-m-h-a-1983-sup-com-eng-13-14-tab.xls*] copy in data disk Appendix I

detentions under all other MHA provisions extends nearly seven fold from 22 detentions per 100,000 residents in North Yorkshire to 143 per 100,000 in London. For Section 136 the numbers range from 4.4 detentions per 100,000 residents in Nottingham and Derbyshire to 62.6 in Kent and Medway. Whilst Kent and Medway were one of the highest Section 136 detention rates, they had one of the lowest overall MHA detention rates. Again, this strongly argues for something other than medical need or socio-economic factors being the determining factors in the figures.

Weich et al (2014) set out to determine whether these differences in admission and treatment rates could be accounted for by socioeconomic or sociodemographic factors or features of the delivery of local mental health services. To undertake this study, they used multi-level statistical

models to examine the Mental Health Minimum Data Set for the year 2010/11. This included just over 1.2 million patient records. They found that 84% of the variation lay between individuals on the basis of personal factors such as age, gender and race. However, statistically significant variations also arose between local areas and Health Trusts. The authors concluded that different policies and budget levels between Health Authorities may account for a significant part of the differences in detention and treatment rates. It is not clear how such differences influence the actions of officers making Section 136 detentions.

This enormous variability not correlated to social and economic factors, might argue that quality of data collection, managerial or political issues within or between the various partners in the treatment of mental illness, accounts for the variations in overall treatment rates as well as the use of Section 136.

3.2.4 Inappropriate use of POS.

Another area of public disquiet concerns the use of police cells for people detained under Section 136. This was exemplified by the report that during the 11 years between 2004/05 and 2014/15, 47% of those who died in, or following, police custody suffered mental health problems, and 82% had links to drug and alcohol misuse (Angiolini, 2017).

A POS, as defined by Section 135 of the MHA 1983, may be a police station (since November 2017 in more limited circumstances), a hospital, a Social Services residential unit or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient. The detained person can be held at the place of safety for up to 24 hours (previously 72 hours) to enable an assessment to be undertaken. In the original MHA 1983 the first place of safety was the only one that could be used for that detention. This was amended by the Mental Health Act of 2007 such that if a person was detained initially at a police station then they could be taken to another place of safety to be assessed. This change was intended reduce the time spent in police stations. Until recently the Evidence still suggested that police stations were used too often as a place of safety (House of Commons Health Committee,

2013, Riley et al., 2011b, Metropolitan Police, 2006). This was even though the Code of Practice to the MHA published in 2008 stated that the use of a police station should be exceptional and the Royal College of Psychiatrists report on Section 136 recommended that police cells should not be used (The Royal College of Psychiatrists, 2011a). The recent figures from Her Majesty's Inspectorate of Constabulary (HMIC) in their report "A criminal use of police cells" (HMIC, Care Quality Commission, 2013) showed that from 6 to 76% of people detained under Section 136 were taken to police cells and that the average length of time spent in police custody by these people was ten hours.

There have been longstanding disagreements between professionals about the best locations for a place of safety. In 2011 a survey of professionals involved in Section 136 detentions found the rather partisan results that 100% of custody sergeants, 97% of constables, 96% of Approved Mental Health Professional (AMHP) and 87% of police surgeons thought police custody unsuitable as a POS. For A&E doctors and nurses the figures were 75 and 60% respectively whilst for Section 12 doctors and mental health nurses the figures were 56 and 33%. The more likely the respondents were to be an alternative to custody, the less likely they were to support it (Riley, at al. 2011b). Many of these differences arose from the police having wider powers and skills in the use of force and restraint and some concerns from health professionals that there is stigma associated with being admitted to a psychiatric unit (Riley et al. 2011a). Notwithstanding the undesirability of it there is emerging evidence that the reduction in use of police custody for detainees has resulted in increased use of Accident and Emergency Departments (see below).

It is also clear that patients and their carers' experiences of police stations as a place of safety was not satisfactory (Riley et al., 2011a) and that transport of patients to places of safety was all too often in unsuitable police vehicles (Metropolitan Police, 2006). Sondhi et al (2018) undertook an extensive review of the experiences of detainees interviewing 58 patients and carers. They found three sets of issues, the long time it took to arrange for, and transport people detained to a POS; the variable quality of interactions with professionals involved in the process and the often chaotic and non-therapeutic atmosphere in the POS. In addition, the detention and assessment

processes overlapped such that those detained repeatedly had to provide their details and accounts of their circumstances. What Sondhi and her colleagues research illustrated is that the nature of the process of detention and assessment is as important as the physical location of the POS.

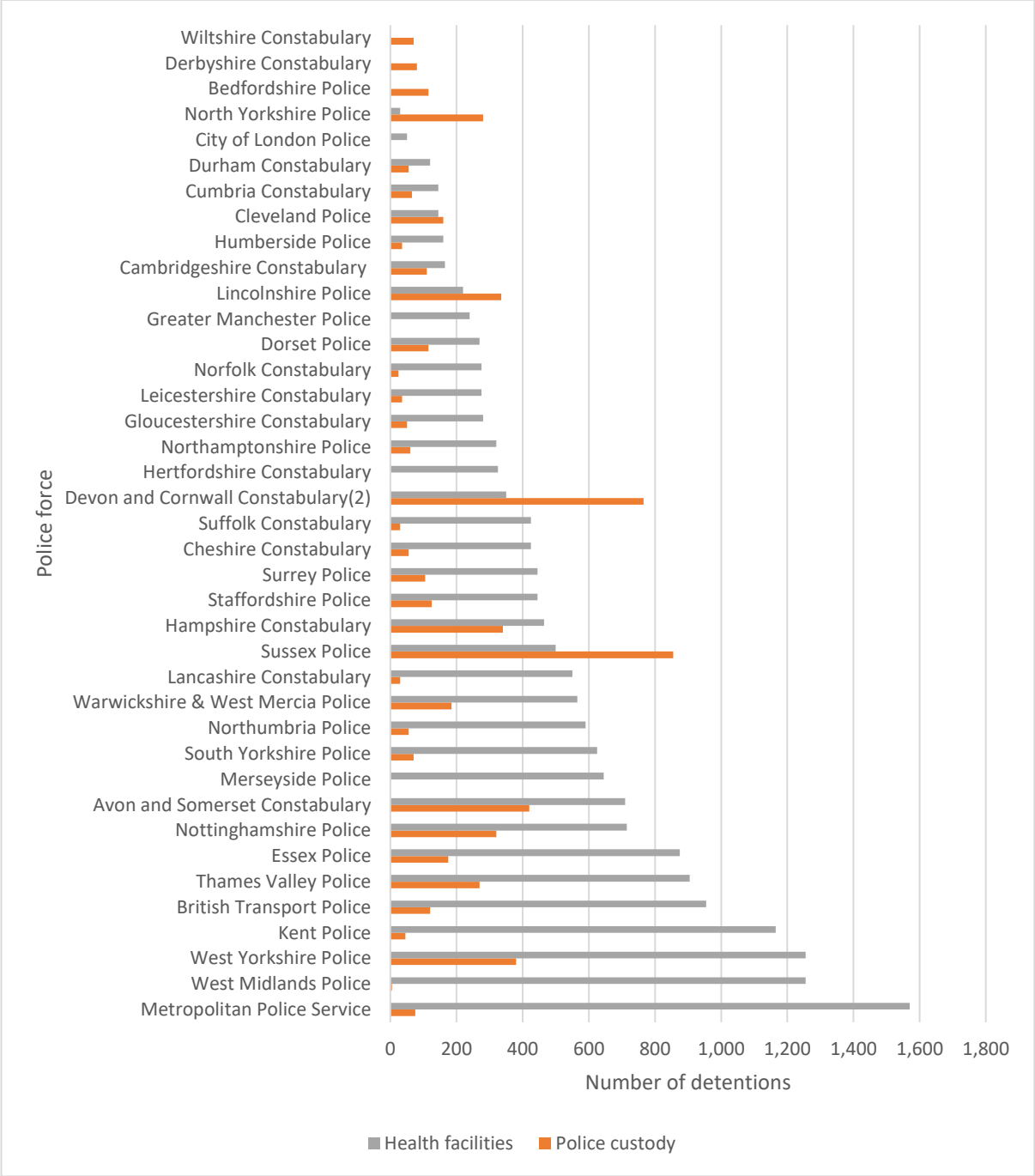
The 2008 Code of Practice to the MHA recommended that there be a range of places of safety available with the one assessed as most suitable being used. This was supported by a review by Apakama (2012) but this did not appear to be common practice.

An editorial in the journal The Lancet summarised the potential harm through the use of police cells:

> *"Detention in police cells conflates mental illness with criminality, increasing stigma and could be particularly problematic in people having their first episode of psychosis, for whom initial negative experiences of mental health care could have lifelong ramifications."(The Lancet, 2013).*

Although there are large gaps in the data it is clear that there had been a significant reduction overall in the number of detainees taken into police custody and this change may account for some of the more recent rise in the number of Section 136 detentions taken to hospital. It is also important to clarify that in this report Hospital is a rather generic term. More recently Health facilities have been divided into Health Based Paces of Safety (HBPOS) which are dedicated for the reception of people in mental distress as opposed to Accident and Emergency Units (A&E), which are not generally seen as suitable for such cases. In figure 3.7 below, it is not possible to determine what sort of hospital premises is recorded. HSCIC data for 2013/14 showed the variations in number of detentions under Section 136 taken to police custody or hospital by Police Force area. The data showed some forces took no (or hardly any) Section 136 detentions into police custody for example Merseyside (0%) or West Midlands (0.4%), whilst others such as Devon and Cornwall (68.6%), North Yorkshire (90.3%) or Sussex (63.1%) took most detentions into police custody. These figures have radically changed through reductions in the use of police custody

Figure 3.7 Section 136 detentions by Force taken to police custody and Health facilities, 2013/14.



Source: [HSCIC PUB12503Copy of inp-det-m-h-a-1983-sup-com-eng-13-14-exp-tab-v2.xls] Copy in data disk Appendix I

(now mandatory) and improvements in quality of data. The data for the last four years from the NPCC and Government Statistics shows this clearly.

The rapid decline in the use of police stations for Section 136 assessments has been matched by the increase in HBPOS. It is also affected by the change in database from HSCIC to NHS digital so the rise in use of HBPOS drops off sharply in 2016/17. This also illustrates that the use of A&E as a

POS has grown rather sharply from the same date. It seems unlikely that this is an artifact, but it may be an underestimate.

Table 3.5 Section 136 detentions from 2013 to 2017 showing POS used.

Table showing Section 136 detentions in England and Wales 2013 to 2017

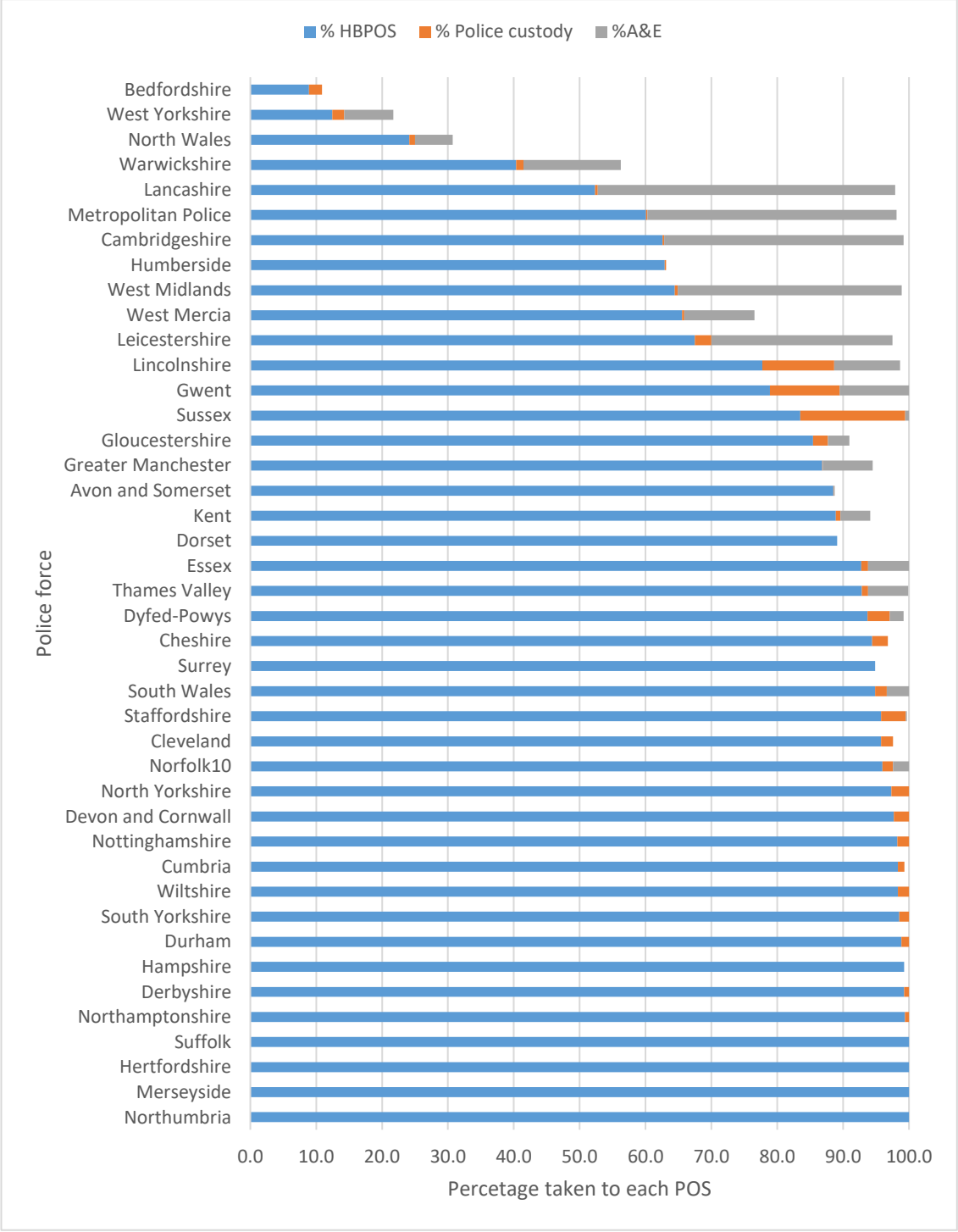
Year	2013/14	2015/16	2016/17	2017/18
Total S136 detentions England and Wales	23602	28271	26328	29662
Detained police station	4537	2100	1029	471
% Police station	19.2%	7.4%	3.9%	1.6%
Health Based Places of Safety	19065	26171	20435	23414
% HBPOS	80.8%	92.6%	77.6%	78.9%
Accident and Emergency			1944	3243
% A&E			7.4%	10.9%
Other			360	453
% Other			1.4%	1.5%
Not Known			2560	2081
% Not Known			9.7%	7.0%

Source: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018] and [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017 and [https://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf]

This more recent use of POS is set out per force in figure 3.7 below. For each bar on the figure the force's use of HBPOS, custody and A&E is shown. Any other space relates to 'other' or 'unknown' uses. The police data is still some way from being complete. However, the figure shows the shift over recent years in where people detained under S136 are taken for assessment. Very few are taken to custody, though there are still gaps in the data.

This growth in use of Accident and Emergency relates to police officers taking Section 136 detainees directly there as a POS. This may well result in the officers having to remain to supervise their detainee until the assessment is complete or even until a suitable bed is found to admit them. The recent advice published by the Royal College of Emergency Medicine (The Royal College of Emergency Medicine, 2017) states that police officers arriving with someone detained under Section 136 should be required to stay with the detainee unless the '*hospital has staff and space to safely take responsibility for detention and agrees to do so'.* The Royal College of

Figure 3.8 POS for Section 136 detentions by force for 2017/18.



Source: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018]

Psychiatrists in their guidance also state that officers may need to remain at the POS for *'a short period'* (The Royal College of Psychiatrists, 2011a). Though in their later guidance the Royal College had set the time limit at 30 minutes (The Royal College of Psychiatrists, 2013). It therefore seems likely that in many cases officers will be required to stay and supervise the person they

detained. When taken to hospital by ambulance the responsibility for supervision would fall on ambulance or hospital staff which in turn could cause significant problems for the NHS as one detainee may require two or even three staff to supervise them whilst in A&E. It is not desirable to take detainees to A&E unless they have a specific facility for as a POS. This was set out long ago in the report of the Royal College of Psychiatrists (the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine, 1996) and expanded upon by Lynch et al. (2002), though lack of capacity may make A&E a POS of last resort.

Whilst the reduction in the use of police stations as POS is an undoubted success there may be an emerging problem if A&E in hospital is being used as an alternative.

3.2.5 Reductions in treatment following police detention.

The earliest figures about diagnosis and treatment under the MHA 1959 were provided to the Committee on Mentally Abnormal Offending by Gibbens (Home Office, 1975), Professor of Forensic Psychiatry at the Institute of Psychiatry. In his sample of 856 detainees under Section 136:

- In 45.4% they reverted after 72 hours to become informal patients
- In 54.6% a formal order for treatment was made
    - 75% left hospital in the normal way but 11.2% absconded
    - 11.2 % were transferred to other hospitals
    - 27% were of no fixed abode

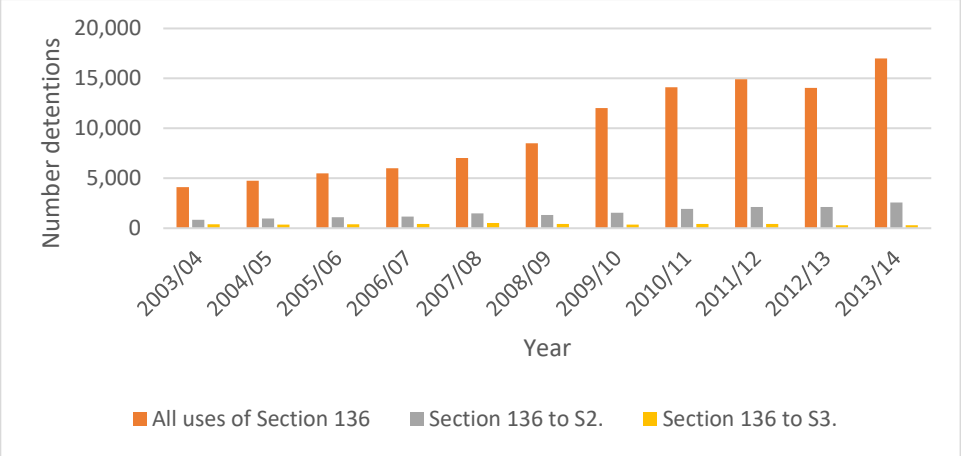
Gibbens concluded that the police hardly ever acted inappropriately in detaining patients. This analysis is certainly different from the most recent reports.

Another investigation of the 1959 Act was undertaken by Twigg (1982) who noted that many people detained under Section 136 had a previous history of treatment and were generally unwilling to comply with treatment and after-care follow up. When they were admitted to hospital they generally stayed only for a short period.

With the MHA 1983 changes in outcome following detention have over recent years become significant. Rogers (1990) reported a 95% agreement between the police and psychiatrists, with only 12% of Section 136 detainees not being admitted after assessment. Between 2003 and 2004 it was reported that in London over 99% of people detained were admitted as informal or formal patients (Mental Health Act Commission, 2007). This convergence in view between the police and psychiatrists resulted in a significant rise in the number of admissions following detention. Between 1995 and 2005 the number of persons admitted as formal patients after Section 136 detention rose from 465 to 3385 (Office National Statistics, 2006). Finally with the severe pressure on beds in mental health units the rate at which detentions under section 136 resulted in formal admissions has fallen to 20% (House of Commons Health Committee, 2013). This may be the result of changes in funding for mental health services and represent a lack of parity of esteem in the provision for mental as opposed to physical illnesses (House of Commons Health Committee, 2013). What is not clear in the published material is whether increases in the number of detentions may have resulted in this decline in treatment rate.

For hospital-based detentions under Section 136, data is available to show the treatment outcomes from assessments, see figure 3.9 below. In 2013/14, 15.2% of detentions were converted into further detention for treatment under Part II Section 2 and 1.7% of Section 136

Figure 3.9 Treatment outcomes from Section 136 hospital detentions.



Source: HSCIC KP90, KH15 and KO37 Returns, Health and Social Care Information Centre (2005/06 onwards and prior to this The Department of Health) Copy on data disk Appendix I.

detentions resulted in treatment under Part II section 3. The percentage figures over this date range are shown in table 3. below.

These figures are perhaps misleading in two regards firstly for the number of detentions only concerns hospital-based POS detentions. Over the date range above, especially in the earlier years, there was a significant number of persons who were detained and assessed in police stations. Whilst they would not appear in the total number of hospital detentions, they would appear in the totals concerning treatment under Sections 2 or 3. If this is so, then the percentage treatments in the early years would be artificially high and only when police custody detentions had dropped away would they be more accurate.

Table 3.6 Conversion rates for Section 136 detentions to treatment, 2003 to 2013.

Year	% treated under Section 2	% treated under Section 3	% treated under S2+3
2003/04	20.9	9.3	30.2
2004/05	20.7	7.6	28.3
2005/06	19.9	7.2	27.1
2006/07	19.4	7.0	26.3
2007/08	21.3	7.4	28.7
2008/09	15.6	5.0	20.6
2009/10	12.9	3.0	16.0
2010/11	13.8	3.0	16.8
2011/12	14.4	3.0	17.3
2012/13	15.2	2.1	17.3
2013/14	15.2	1.7	16.9

Source: HSCIC KP90, KH15 and KO37 Returns, Health and Social Care Information Centre (2005/06 onwards and prior to this The Department of Health) Copy on data disk Appendix I.

This table can be reconstituted over the last few years including all Section 136 detentions in the totals but using the hospital-based treatment figures (Table 3.7 below).

Analysis of the data is further confounded by the discontinuity (discussed above) between 2016/17 and previous years. For the two years that overlap between the two tables – 2012/13 and 2013/14 – the treatments rates under S2 are 6% and 3% lower in the second table. This simply reflects the larger number of overall detentions. The overall trend in the second table is

Table 3.7 Treatment rates following detention under Section 136, 2012 to 2017.

Year	Number of detentions	S136 to S2	S136 to S3	% S136 to S2	% S136 to S3
2012/13	23769	2135	291	8.9%	1.2%
2013/14	21394	2587	295	12.1%	1.4%
2014/15	23602	2882	303	12.2%	1.3%
2015/16	28271	3660	439	12.9%	1.5%
2016/17	26328	2118	227	8%	0.9%
2017/18	29662	2324	245	7.8%	0.8%

Source: Mental Health Act Statistics, Annual Figures 2017-18 Link: [http://digital.nhs.uk/pubs/mha1718] and [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017] and [https://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf]

that the percentage of S2 treatments was slowly rising until 2016, which follows the trend in the last few years in the first table. For S3 treatments in the two overlap years the treatment rates were 0.9 and 0.3% lower in the second table and whilst the rates were falling in the first table, they appear steady in the second. Given all the uncertainties over the data one can only firmly conclude that Section 136 detentions were rising until 2017/18 and treatment rates were certainly less than the 20% reported to Parliament (above).

The second issue is that many people who are detained under Section 136 and assessed as needing treatment 'volunteer' to undergo it. Given a coercive choice between being 'sectioned' and volunteering for treatment, it is not surprising that many people volunteer. They might then come to notice if they wish to leave their treatment against the wishes of their treating clinician as then they may still be sectioned. So, there are a further group of people detained, receiving voluntary treatment, who do not appear in the data and figures above.

The Home Office review of Section 136 (2014b) claimed that the great majority of those not further detained under Sections 2 or 3 nonetheless received treatment 'informally' however, they did not demonstrate the basis on which this claim was made. When the definition of 'informally' was sought from the HSCIC the following response was received:

> *"Informal in this sense means that the person is no longer subject to the Mental Health Act (an informal patient). As you say they could be referred to a community team, they could*

remain an inpatient but informally or they could be discharged completely from the mental health service (Ref. NIV-348177-D4Q6M 21/05/15)."

This indicates that there is no basis upon which to conclude that the great majority of people detained receive some form of treatment. Indeed, it is safer to conclude that treatment rates following Section 136 detention remain low, especially in light of the lack of treatment capacity.

Taken together it is not clear whether the growth in detentions using Section 136 has, through using available capacity for treatment, resulted in the consequent fall in treatment rates. There are alternative explanations, for example it may be that although the people detained are in crisis at that time, once they are detained the crisis passes and they no longer need treatment. It might again be that whilst they are in crisis when they are detained the nature of their illness does not necessitate treatment. These alternatives cannot be explored with this data.

3.2.6 Diagnosis associated with detention.

NHS digital (and HSCIC formerly) publishes data on primary diagnosis for hospital admissions. Example of three character codes are set out in table 3.8 below. These are for 2017/18.There is a wealth of other data included and the classifications below have been chosen to exclude diagnosis of dementia or learning disability.

Table 3.8 Three character primary diagnosis codes for hospital episodes relating to mental illness 2017/18.

3-character code	Primary diagnosis	Finished consultant episodes	Admissions
F10	Mental and behavioural disorders due to use of alcohol	61,203	39,239
F11	Mental and behavioural disorders due to use of opioids	1,605	1,236
F12	Mental and behavioural disorders due to use of cannabinoids	1,627	1,280
F13	Mental and behavioural disorders due to use of sedatives or hypnotics	283	202
F14	Mental and behavioural disorders due to use of cocaine	887	764
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine	725	604
F16	Mental and behavioural disorders due to use of hallucinogens	154	133

F17	Mental and behavioural disorders due to use of tobacco	552	495
F18	Mental and behavioural disorders due to use of volatile solvents	16	15
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	4,714	3,670
F20	Schizophrenia	21,026	13,123
F21	Schizotypal disorder	75	48
F22	Persistent delusional disorders	2,578	1,806
F23	Acute and transient psychotic disorders	4,665	3,373
F24	Induced delusional disorder	16	10
F25	Schizoaffective disorders	6,748	4,338
F28	Other nonorganic psychotic disorders	175	123
F29	Unspecified nonorganic psychosis	5,222	3,720
F30	Manic episode	1,481	1,014
F31	Bipolar affective disorder	12,033	8,117
F32	Depressive episode	13,998	10,760
F33	Recurrent depressive disorder	4,041	3,057
F34	Persistent mood [affective] disorders	135	94
F38	Other mood [affective] disorders	60	47
F39	Unspecified mood [affective] disorder	170	139
F40	Phobic anxiety disorders	707	697
F41	Other anxiety disorders	12,576	10,426
F42	Obsessive-compulsive disorder	553	458
F43	Reaction to severe stress, and adjustment disorders	5,126	4,366
F44	Dissociative [conversion] disorders	3,033	2,105
F45	Somatoform disorders	1,745	1,470
F48	Other neurotic disorders	116	103
F50	Eating disorders	4,431	3,064
F51	Nonorganic sleep disorders	308	301
F52	Sexual dysfunction, not caused by organic disorder or disease	362	357
F53	Mental and behavioural disorders associated with the puerperium, not elsewhere classified	425	367
F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere	55	38
F55	Abuse of non-dependence-producing substances	18	13
F59	Unspecified behavioural syndromes associated with physiological disturbances and physical factors	14	7
F60	Specific personality disorders	12,348	9,819
F61	Mixed and other personality disorders	569	452
F62	Enduring personality changes, not attributable to brain damage and disease	62	44
F63	Habit and impulse disorders	21	18
F64	Gender identity disorders	1,335	1,324
F65	Disorders of sexual preference	4	2
F66	Psychological and behavioural disorders associated with sexual development and orientation	2	2
F68	Other disorders of adult personality and behaviour	82	58
F69	Unspecified disorder of adult personality and behaviour	98	78

NHS digital; hospital episode statistics admission diagnosis 2017/18. Link: [https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2017-18]

In discussions with the HSCIC there was the possibility that the primary (and secondary) diagnosis of people admitted to hospital through mental illnesses – as above – could be compared with the same diagnosis for those admitted through detention under Section 136. This could also be examined over time to examine changing trends in each. However, after extensive discussions it was discovered that the 'quality control' processes on the inputting of the Section 136 admissions was poor, that the margin of appreciation in the data was likely to be large and so the analysis was not undertaken. However, there is a range of research on diagnosis and Section 136.

Spence and McPhillips (1995) in their study of 65 cases in Westminster found 38.5% were diagnosed with Schizophrenia, 12.2% with mania and 29.8% with personality disorder (PD). This last is much higher than previous studies which for example found the figure to be 11% (Dunn and Fahy 1990). Whilst Spence and McPhillips (1995) were cautious that PD may have been masked in other studies, they raised concerns that with a low conversion rate of such detentions into treatment – in their study just 8% - that such individuals would present through Section 136 on multiple occasions. The *round table* discussions which formed part of the Home Office review of Section 136 also indicated that PD was responsible for part of the rise in Section 136 detentions (Home Office and Department of Health 2014b). The treatment of PD within the UK was considered within the Bradley Review (2009) which noted that there were limited PD appropriate services, but that the changes to the Mental Health Act in 2007 to include PD as a mental disorder should have improved the level of treatment. This was examined again by Thomson (2010) who was not confident that the care of patients with PD had improved.

In their follow up cohort study of 242 detainees (Burgess, White and O'Brien, 2017) the classifications above, which formed part of the medical records of the patients, were analysed. Used in this way any uncertainties over the accuracy of data recording could be overcome. The commonest primary diagnosis was schizophrenia and related disorders F20 to E29 above at 21%, whilst PD, F60 to F69, was present in two fewer cases still at 21%. Mental and behavioural disorder due to psychoactive substances, F10 to F19 was present in 20% of cases. Taking primary and secondary diagnosis together 52% had a diagnosis of psychoactive substance abuse, which

clearly overlaps with other disorders. Following detention 24% of patients were admitted formally and 14% informally. During the follow up year there was a significant association between diagnosis and repeat detention under Section 136. 36% of individuals with a primary diagnosis of PD were detained at least once more. For Psychoactive substance abuse this was 27%. In contrast hospital admissions were significantly associated with a primary diagnosis of psychotic disorders, 75% being admitted in the following year whereas 50% of PD were admitted and only 17% of substances abusers.

The factor that is always present in studies of Section 136 detainees concerns substance abuse, whether alcohol or other drugs. Zisman and O'Brien (2015) in their cohort study of 245 Section 136 detainees found that 44% were intoxicated at the time of detention, which delayed their assessment and reduced the likelihood of admission. This appears to be a common level of reported intoxication amongst detainees.

The implication of these observations is that PD (or borderline PD), especially in association with substance abuse has become more prevalent and is contributing to a 'revolving door' detention process where detention is not followed by effective treatment and repeated detention ensues.

The issue of PD is more widely reported outside England and Wales. In a study in Victoria, Australia, Martin and Thomas (2013) analysed the views of police officers concerning their encounters with people who were mentally ill. There was a perception within policing that the number of such encounters had increased (Fisher and Grudzinskas Jr. 2010). In a survey of 3,500 police officers 50% of respondents reported one or two encounters with the mentally ill per week and over a third reporting between three and ten encounters. These occurred in a range of settings, often during times of crisis for the subject (Godfredson et al. 2011). During Martin and Thomas's study (2013) it quickly emerged that officers singled out PD and Borderline Personality Disorder (BPD) as areas of particular concern for them and their communities. It is estimated that PD is present in up to 10% of the population (Sadock and Sadock 2007) and BPD in a further 2% (American Psychiatric Association 2013). In the officers' accounts of their experiences in Victoria

people would often try to harm themselves by running in front of traffic or swallowing tablets, they would be detained under Section 10 (the local equivalent of Section 136) but would be released by the hospitals who would describe them as displaying a behavioural problem - 'attention seeking', rather than being mentally disordered. One officer described it thus (Martin, Thomas, 2015):

> *"Officers see someone who is not right, they take them to the hospital and the hospital goes "no, it's behavioural" or "no, its borderline personality disorder", we don't deal with them. Well what do you do with them? Unless they have committed an offence, we've got to let them go. And where do you let them go to, who is going to look after them? They all get given social workers, but the social worker won't answer the phone after 5pm. Well, at 3 o'clock in the morning – what are you going to do?"*

In reality people with PD or BPD were not excluded from treatment but this view was promoted by mental health professionals and the strict admission criteria often meant that they were released quickly from treatment (Lamb, Weinberger and DeCuir Jr. 2002). In their study Martin and Thomas (2013) concluded that in the absence in Victoria of effective mental health policy and a legal framework for dealing with PD, that police encounters with people with PD were problematic. The population of people affected by PD would continue to fall through the gaps in service provision and remain a cause of considerable concern for the police and public.

A further study in Victoria looked at the outcomes of detentions by the police under Section 10 of the Mental Health Act (Ogloff et al. 2013). It examined 4,798 detentions between December 2009 and November 2010. 90.7% of these arose through some form of crisis, whilst only 2.4% arose through pre-planned contact by the police. The vast majority arose because the person had threatened suicide, attempted suicide, engaged in self-harm, and had been aggressive or damaged property. Most often the police were called by family members (Ogloff et al. 2013). In nearly 80% of these cases the subject was taken to a hospital emergency department, and in the remaining 20% either to a police station or directly to a psychiatric unit. There was a high degree

of convergence in the police and metal health assessment, just over 75% of those detained were either admitted to a unit or were assessed as needing treatment. However, 20% were released because they did not meet the criteria for treatment, though they still showed high rates of PD, substance misuse disorders, intellectual disability or brain injury. In terms of offending rates 51% of those detained had previously been charged with a criminal offence - ten times higher than the population at large whilst 25% had been the perpetrator of family violence – 20 times higher than the population at large (Ogloff et al. 2013). Whilst the process of detention in this study appeared similar to that in England, the outcomes were not the same as those presently in England but rather resemble those from 20 years ago. The implication is that whatever has changed in the process of detention and assessment in England had not yet changed in the same way in Victoria.

Another study is relevant to this section and compared the diagnosis of those detained under Section 136 with those admitted directly to hospital through Sections 2 or 4 of the MHA (Mokhtar, Hogbin, 1993). The premise of the study was that Section 136 detainees would in general be more ill and come from more disadvantaged backgrounds than those detained under Section 2 or 4. This was first observed by Rollin (1965) under the MHA 1959. Mokhtar and Hogbin were surprised to discover that "*there was a remarkable conformity between the two groups*" so rather than overusing Section 136 the police were apparently underusing it. It is not clear whether this still remains the case given the growth in its use since their study.

3.2.7 The criminalization of the mentally ill.

In the 1970s and 1980s the Criminalisation Hypothesis emerged in the US to account for the increasing arrests of the mentally ill. This theory was neatly summarised by Morabito (2007-page 1583):

> *"In the wake of the deinstitutionalisation and the emptying of state mental hospitals, shorter inpatient stays and stricter criteria for civil commitment without matching community health spending, the criminal justice system became responsible for controlling the sometimes deviant behaviour of people with mental illness. Troublesome behaviour*

> *that had previously been addressed in psychiatric institutions was now treated as a legal violation. Scholars have described jails and prisons rather than psychiatric facilities as the de facto institutions responsible for the care of people with mental illness."*

In the United States there have been a number of publications looking at the police engagement with the mentally disordered. It was estimated that 7 to 10% of all police - public contacts in the U.S. involved people with mental disorders and that these resulted in a disproportionate number of arrests, though typically for minor offences (Borum et al. 1997). They are also some of the most complex and time-consuming calls with significant outcomes for the subjects (Teller et al. 2006). It has been estimated that in the U.S. 685,000 people with severe mental illness were jailed each year, which is just less than 1 in 3 of the prison population (Torrey, Stieber and Ezekiel 1998), whilst in Europe 63% of prison inmates met the criteria for a mental disorder (Blaauw, Roesch and Kerkhof 2000).

General social trends in Canada have also replicated those in England and elsewhere with the closure of many psychiatric hospitals and poor government planning of services following this process of de-institutionalisation (Cotton and Coleman 2013). There have also been significant changes to mental health legislation to increase the protections for people involuntarily detained resulting in extremely limited provision of compulsory treatment, applying only to dangerous people (Gray, Shone and Liddle 2008). These have both been compounded by the growth in homelessness and substance abuse (Laird 2007). The overall effect has been to bring more people with mental impairment into contact with the police at a time when the funding for mental health services has fallen behind other areas of health spending (Cotton and Coleman 2013).

Several studies in Canada have been reported which examined the frequency of the use of their equivalent MHA powers. One such in the small town of Belleville, Ontario, suggested 8% of police incidents involved detentions under these powers whilst in Vancouver, a much larger city, it was estimated that between 23% and 49% of calls to the police involved people who were mentally

disordered (Cotton and Coleman 2013). The key findings from the largest study in London, Ontario were that the mentally disordered:

- Had 3.1 times more interactions with the police than the population at large.
- Were twice as likely to become a repeat customer.
- Were twice as likely to be arrested or charged.
- Had a significant impact on the police resources consuming between 3 and 9% of the budget.

There is a consistent theme in the literature that there is a high level of contact between the police and people who are mentally ill. Similarly there is no doubt of the high incidence of mental illness amongst those who appear in the criminal justice system (Bonta and Andrews, 2016) or ultimately in prison (Ogloff, 2006). However, most research has been framed in the context of criminal or antisocial behaviour and it is difficult to equate this with the power to detain under Section 136. The need for police officers to bring an incident to a conclusion – even where the behaviour is merely strange or disturbing -might encourage officers to use Section 136. Therefore, a variation in the criminalization hypothesis might account for the increasing use of Section 136. How officers exercise their discretion in making choices about which powers to use in which circumstances has also been reported upon.

3.2.8 Social Causation or Social Constructivism in the use of Police discretion and Section 136.

Some of the behaviours identified above are criminal conduct and would also convey a criminal power of arrest, but the officer chose to detain for Section 136 (or a similar provision). Others would carry criminal powers, but the officer would still have discretion not to arrest but rather deal with the incident in some other way. Some studies have shown a lack of confidence on the part of police officers dealing with the mentally ill (Cherrett, 1995, Fahy,and Dunn, 1987, Revolving Doors Agency, 1993).There are no published UK studies looking at decision making by officers compared to the behaviours of those detained, but there is a study which compared detention rates in similar police forces. Greenberg and Haines (2003) compared the rate of use of

Section 136 in Devon and Cornwall with seven other similar rural police forces. Within these eight forces Devon and Cornwall officers were two and a half times more likely to use Section 136 than the eight-force average. They were thirty times more likely to use it than the force with the lowest rate. They speculated that this difference arose from different procedures in the forces. In most forces detaining officers would remain with the person they detained until the assessment process was complete. This usually took several hours. In Devon and Cornwall, the detaining officer took the person to police custody where the custody staff supervised them through the process, releasing the officer to return to other duties. Greenberg was prompted to do this study because he had previously observed the very low treatment rate in Devon and Cornwall following detention (Greenberg et al., 2002). Only 32% were admitted for treatment compared to 90% (Rogers and Faulkner 1987) or 66% (Spence and McPhillips 1995) elsewhere. The implication was that officers were more likely to use Section 136 where it was more convenient or less time consuming for them to do so. Thus, in using it more they would detain people who were less ill hence the reduced treatment rate.

A similar insight into officers' motivation was provided by a study in Gloucester. In this study Pugh and Laidlaw (2015) examined the 60% rise in Section 136 detentions following the opening of a HBPOS. This provided an alternative to the use of police custody. They speculated that this rate of rise, higher than then national trend, arose from the convenience for officers of this alternative. Both of these examples imply that the operation of force policies and procedures or changing circumstances could affect the exercise of discretion by officers in the use of Section 136 and significantly affect rates of detention. It is an observation that could account for the different rates of use of Section 136 across England and Wales reported above.

In the United States one of the earliest and most comprehensive attempts to understand the role of the police in arresting the mentally ill was by Bittner (1967). In this he studied arrests by the police in a large west coast U.S. city and in particular the rules and considerations surrounding such emergency apprehensions. He observed that in general the police are reluctant to arrest people who are mentally ill and identified five factors that contribute to this (Bittner, 1967):

- Officers share the public view about what constitutes mental illness but "*they avail themselves of various forms of denial when it comes to doing something about it*" (Bittner, 1967) in particular they are concerned that as they are not experts and that their actions might cause them future embarrassment.
- Officers deal continually with people who are disorientated or incompetent but who seem to lead their lives without aid or intervention. If all such people were to be detained, then the system could not cope with the increase in numbers of arrests.
- Although officers acknowledge that dealing with the mentally ill is an integral part of their work it retains relatively low status compared to crime fighting and other tasks. Spending time arresting such people was not seen as good for career progression.
- Processing someone whom they detain for mental illness is seen as a "*tedious, cumbersome and uncertain procedure*" (Bittner, 1967) and if the hospital does not accept their detention then the officer has the further issue of what to do with the person they arrested.
- Officers also make judgements about the nature and treatment of people who are detained in hospitals and so need to consider whether the person they are dealing with deserves to be confined in such an institution with others who are clearly mentally ill.

These factors would appear consistent with the observations from Devon and Cornwall (above).

Bittner (1967) defined three "*horizons of context*" which account for the factors influencing officers' discretion. These are *scenic*, *temporal* and *manipulative*. Morabito (2007) reviewed and further defined these contexts and factors.

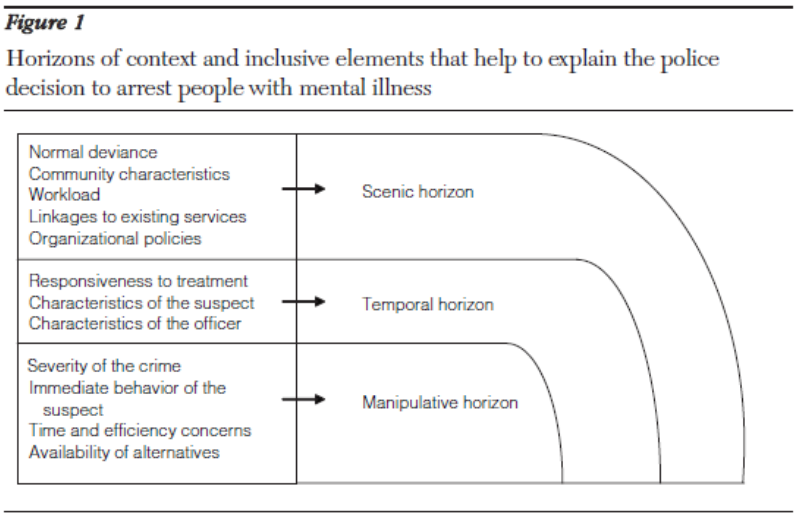
The three horizons of context can in turn be sub-divided into further factors that influence officers when deciding to make such arrests.

The Scenic Horizon. In order to understand the factors influencing an arrest it is necessary to consider more than just the individuals and their actions. The Scenic Horizon describes the wider

environment which informs the officers' decision about whether to arrest. It in turn consists of five elements:

- Normal deviance concerns the background level of antisocial behaviour that officers and the community are willing to accept. It varies from community to community and is influenced by local factors (Klinger, 1997).

Figure 3.10 Horizons of context in the police use of discretion, Morabito (2007).



Reproduced from Morabito (2007) page 1584

- Community characteristics concerns measures of social disorganisation such as disadvantage and mobility. People living in disadvantaged communities rely more upon police assistance as their communities often lack structures of informal social control and have high levels of mobility and so rely upon the police to solve disputes (Black and Black, 1980).
- Workload factors influence decisions about arrest for the busier the officers the less likely that an arrest will be made (Klinger, 1997).
- Linkages to existing services affect outcomes for officers who believe that the mental health service is less effective are less likely to arrest and so use it (Fisher, Silver and Wolff, 2006).

- Organisational policies also affect the behaviour of officers. The exercise of discretion by officers is affected not only by their own values and beliefs but also by the goals, incentives and pressures within their own organisations (Brown, 1981).

The Temporal Horizon. This again concerns a set of factors wider than the behaviour of the suspect but relate to other aspects of the offender or features of the officers.

- Responsiveness to treatment. Where the officer has knowledge of the suspect and knows that they have responded well to previous treatment then they are more likely to deal with them informally (Bittner, 1967). Where the officer knows they have social support networks or access to support services then again they are less likely to arrest (Bittner, 1967).
- Characteristics of the suspect. Officers may be influenced in the exercise of their discretion by the gender, race or appearance of the suspect (Alpert, Dunham & MacDonald, 2004) and in particular where they are transient, officers may informally deal with them by encouraging them to leave the jurisdiction (King, Dunn, 2004).
- Characteristics of the officer. The age, gender, education and experience of the officer may affect the exercise of discretion (Terrill and Reisig 2003) and officers who are empathetic may be less likely to arrest (Muir 1977).

The Manipulative Horizon. This concerns the most immediate factors surrounding the suspect, their circumstances and includes the safety of the community and the officer.

- *Severity of the crime*. The more serious the crime the less discretion officers have in how they deal with the suspect, regardless of their mental health status (Lamb, Weinberger & DeCuir Jr., 2002).
- *Immediate behaviour of the suspect*. Antisocial behaviour arising from substance abuse or from the symptoms of mental disorder may bring the suspect to the attention of the police but may not predict arrest (Terrill, Reisig, 2003). A more reliable predictor of subsequent arrest concerns resisting the officer (Novak and Engel, 2005, Alpert, Dunham

and MacDonald, 2004) or displaying hostility or disrespect (Klinger, 1997). This effect may be compounded as the mentally ill may be more likely to be disrespectful to the police (Novak and Engel, 2005).

- *Time and efficiency concerns*. Taking someone to hospital is more time consuming than a criminal arrest (Steadman et al., 2000) and so officers under pressure of work may prefer to employ more efficient alternatives (Bittner, 1991).
- *Availability of alternatives.* Whilst officers may wish to employ alternatives to arrest for people who are mentally disordered, these can only be used where available and where officers have confidence in them (Appelbaum et al., 1992)

Whilst it is clearly recognised, over recent years, that an increasing number of people who are mentally ill have been arrested by the police the extent to which this represents 'criminalisation' remains unclear and unproven (Morabito, 2007). An alternative hypothesis is that social factors such as poverty, transience and substance abuse may be more responsible than the actions of the police (Morabito, 2007). Further research is needed to determine whether the mentally disordered live in such communities because the higher levels of normal deviance renders them invisible (Draine, 2003) or as homes of last resort.

A comprehensive study of the policing service and the mentally ill in Victoria was reported by Ogloff et al. (2013). Part of the study concerned police officers' attitudes to mental illness given their increased involvement with it. The equivalent power to Section 136 in Victoria was Section 10. To determine whether someone was mentally ill officers used the following resources in decreasing importance:

- Person based information i.e. previous knowledge or behaviour at the scene.
- Police sources i.e. police databases.
- Health information i.e. Health databases.

Their understanding was more likely to be based on personal experiences at work or in their private lives rather than through any formal police training. Officers reported five significant challenges in resolving situations and these were:

- Gaining support from mental health services
- Communicating with the mentally ill.
- Avoiding violence or aggression in such encounters.
- Obtaining cooperation and compliance from the mentally ill person.
- Identifying and understanding mental illness

In a related study just over 300 officers who had previously completed the survey were shown one of three videos intended to elicit the maximum opportunities for officers to exercise discretionary powers. The scenario was identical the differences were in the mental state of the subject. They were portrayed as clearly mentally ill, not mentally ill or in an ambiguous state. The officers were asked how they would resolve each scenario, both in practice and ideally, using the following options:

- Walk away
- Deal with informally
- Call for assistance from the mental health Crisis Team
- Detain under Section 10 of the Mental Health Act
- Arrest

Where the subject was clearly not mentally ill 70% of officers would have dealt with it informally both in practice and ideally. 20% would have arrested and 5% walked away again the same in practice and ideally.

For the other two scenarios there were wide differences between practical and ideal solutions. With a subject in an ambiguous state officers ideally would have called a Crisis Team (40%) or dealt with it informally (35%). In practice they would have called a Crisis Team (10%) or dealt with informally (60%). Where the subject was clearly mentally ill officers ideally would have called a Crisis Team (55%) or detained under Section 10 (30%), in practice officers would have called a Crisis Team (20%) or detained under Section 10 (55%). These wide differences reflect the

obstacles that officers face when dealing with people suffering from mental illness (Ogloff et al., 2013).

There is very little published research from England concerning the operation of the police use of discretion. If the research elsewhere is applicable in England and Wales, then there may be a significant number of factors affecting the exercise of discretion in the use of Section 136.

3.2.9 Homelessness and Section 136.

Another factor that may affect the way that individuals come into contact with the police concerns homelessness. This was recently examined in France (Girard et al. 2014). Homelessness in France is a highly political issue and has featured in various election campaigns with demands for a legal right to housing (Loison-Leruste and Quilgars, 2009). Homelessness is especially significant as the proportion of the homeless who have serious psychiatric disorders has created a serious social problem in French cities (Girard, Estecahandy and Chauvin, 2009). French studies have shown a significant over representation of severe mental disorders amongst the homeless (Laporte, Le Mener and Chauvin, 2010) which is consistent with general findings in Western cities (Fazel et al., 2008) but coupled with high levels of public prejudice against the mentally ill (Caria et al., 2010). In response to these issues more than 60 mental health outreach teams were set up in France between 2005 and 2008 (Mercuel, 2008) including one in France's second city Marseille. That these operate independently of the police is illustrated by Girard who said:

> *"To date, there has been no published research on partnerships or other encounters with the police. More generally, little research has been conducted on any form of collaboration between the police and psychiatry in France."* (Girard et al. 2014 page 377).

Whilst the French police in their public safety role must encounter the mentally ill in their duties the only review of collaboration relates to the outreach project in Marseille (Girard et al. 2014) which was evaluated between 2009 and 2011. Marseille, with a population of 800,000, has the poorest urban centre of any French city and has a large homeless population. The mental health outreach team provided services to 200 homeless people who were routinely charged by the

police with disorderly conduct for nuisance behaviour (Girard et al. 2014). The review was based upon records of encounters made either by the police or outreach workers and the number reviewed over two years at 40, was small. Two key themes emerged from the analysis which included the violent nature of life on the streets and the high proportion of ethnic minorities amongst the detainees. It was also found that the outreach workers and the police often used similar coercive methods to ensure compliance, such that the 'users' were often more fearful of the psychiatrists than the police (Girard et al. 2014). Girard concluded that the study demonstrated the potential for closer working between the two parties to help homeless people who are mentally ill receive care and to reduce inappropriate hospitalisations and arrests.

The relationship between homelessness, mental illness and other disorders is well established.

> *"Homeless people in Western countries are substantially more likely to have alcohol and drug dependence than the age-matched general population in those countries, and the prevalence of psychotic illnesses and personality disorders are higher"* (Fazel et al. 2008 page 1670).

In addition, the UK the homeless have a lower life expectancy; poorer access to health services; higher prevalence of psychosis, depression and personality disorder and are more than 34 times more likely to commit suicide than the resident population (Bhui, Shanahan & Harding, 2006).

The fairness of treatment of the homeless mentally ill in England has also been studied. Reid (1999) interviewed 200 homeless young people in Manchester. He found that 82% had psychological problems but that only 17% had seen a psychiatrist; 51% had not sought treatment for deliberate self-harm; 71% medicated their own symptoms using drugs; and although 77% had a drug problem, only 22.5% were in contact with a drug agency.

Bhui et al. (2003) also raised the issue of the fairness of their treatment and he found that there was a striking lack of data on how to provide services to the homeless with a service focus on physical illnesses or injuries.

Behaviour and lifestyle have a significant influence on the exercise of police powers under Section 136. Violence, self-harm, dangerous and anti-social behaviour are all likely to bring people into contact with the police as will the street 'presence' associated with homelessness. High levels of untreated mental illness in the homeless population may also cause a higher level of abnormal behaviour which again attracts the attention of the police. Little has been published in England in the last 15 years about the prevalence of such behaviours and their outcomes through the actions of police officers. This appears to be a potentially rich area for further study.

3.2.10 Behaviours leading to detention.

There are a range of publications concerned with the behaviours of individuals leading to their detention for mental disorder. Two were prior to the MHA 1983, in one Rollin (1965) found that the majority of unprosecuted male offenders, detained by the police, had behaved in a way which:

> "*had a certain bizarre quality, because of which there could have been little doubt in the minds of the police that they were committed by persons seriously deranged and in need of immediate care and control*". (Rollin 1965 page 832)

George (1972) found that the police used these admissions where the subject was more aggressive – though he expressed the concern that the aggression may have been prompted by the police attendance. This suggestion appears again below.

In their 1991 study Bean el al. (1991) interviewed Metropolitan police officers about 100 incidents (in North East London) where they detained a person under Section 136. In these interviews, they considered the features of the events that precipitated the detention. These are reproduced in the table below. Each incident could demonstrate a number of different features.

Table 3.9 Showing behaviours that resulted in Section 136 detention (Bean et al 1991).

Feature	*Present %*	*Not present %*	*Uncertain or not applicable %*
Odd appearance	35	35	30
Odd behaviour	75	16	9

Physical injury	6	89	5
Violent behaviour to others (not police)	20	69	11
Threat of violent behaviour	14	53	13
Violence towards property	35	58	7
Threat of violence towards property	2	53	10
Self-harm	1	94	5
Threat of self-harm	1	91	8
Attempted suicide	4	92	4
Threat of suicide	3	87	10

Table reproduced from Bean et al. (1991 page 35)

Self-harm, suicide or threats of either were features in 9% of the detentions (assuming no double counting between these four categories) whilst violent behaviour towards others and threats of it were present in 34% of cases and violence towards property of threats were present in 37% of cases. Self-harm or suicide (or attempts at either) were relatively rare as events precipitating detention. In examining suicide or an attempt as a precipitating feature Bean et al. (1991) observed that suicide alone appeared to be sufficient cause for police intervention though it was not necessarily thought to be a sign of mental disorder. Bean et al.'s observations replicate the findings of Bittner (1967) who stated:

> *"where there is evidence that a person has attempted or is attempting suicide he is virtually always taken to the hospital. Occasionally officers have doubts about the genuineness of the attempt, but such doubts do not seem to weigh significantly against making the apprehension." (Bittner 1967 page 283).*

Turner, Ness and Imison (1992) examined Section 136 detentions in the City of London and Hackney Health areas over two years between 1985 and 1987. From the Health records they identified 163 cases which lead to 135 admissions. There were six types of behaviours described by the police leading to detention. These were:

Table 3.10 Showing types of behaviours that resulted in Section 136 detention (Turner, Ness and Imison 1992).

Type of behaviour	***Number of cases***	***Percentage of total***
Causing disturbance	59	34.9
Violence to person	29	17.1
Violence to property	28	16.6

Threatening behaviour	21	12.4
Self-harm suicide	18	10.6
Sexualised behaviour	14	8.3

Data reproduced from Turner, Ness and Imison 1992 page 768

They reported that several behaviours could be displayed by one person and that many behaviours were hard to categorise. Even allowing for this, 80% of conduct leading to detention was violent or threatening and only 10% concerned self-harm.

This was examined again by Simmons and Hoar (2001) who in their study looked at 90 detentions under Section 136 in London in 1996/97. Their analysis of the behaviours leading to detention are reproduced in table 3.11 below.

Table 3.11 Showing types of behaviours that resulted in Section 136 detention (Simmons and Hoar 2001).

Behaviour	*Number of people with specified behaviour (%)*	*Number of people with specified behaviour admitted*	*Percentage of people with specified behaviour admitted*
Violent threats or acts to other or property.	34 (38)	27	79
Abnormalities of streams of speech (not mutism).	29 (32)	27	93
Walking, lying or running in road.	20 (22)	17	85
Hallucinations or delusions.	14 (16)	11	79
Suicidal, self-harm, threats or attempts.	14 (16)	8	57
Agitated or volatile.	8 (9)	8	100
Mute.	7 (8)	7	100
Holding or possessing a weapon.	7 (8)	7	100
Verbally abusive or aggressive (not violent).	7 (8)	6	86
Berserk.	6 (7)	5	83
Confusion or disorientation.	6 (7)	4	67
Wanted to see psychiatrist.	5 (6)	5	100
Naked or partly clothed.	4 (4)	4	100
Depression.	3 (3)	2	67
Other.	23 (26)	18	78
Unknown.	7 (8)	6	86

Numbers do not add up to 100% as more than one behaviour was exhibited per person.
Table reproduced from Simmons and Hoar (2001 page 345)

They found it hard to categorise behaviours, but their 14 types are broadly similar to those above.

The three main reasons for detention were:

- violence – 38% of detention of which 79% were admitted for treatment

- impaired speech or stream of speech (not mutism) – 32% detentions of which 93% admitted
- walking or lying in the road – 22% detentions of which 85% were admitted

Overall, 82% of detentions were admitted for treatment. The category of behaviour on the road was new to his study and may have reflected the widespread use of mobile phones resulting in the more prompt attendance of the police and detention whilst the behaviour was still occurring.

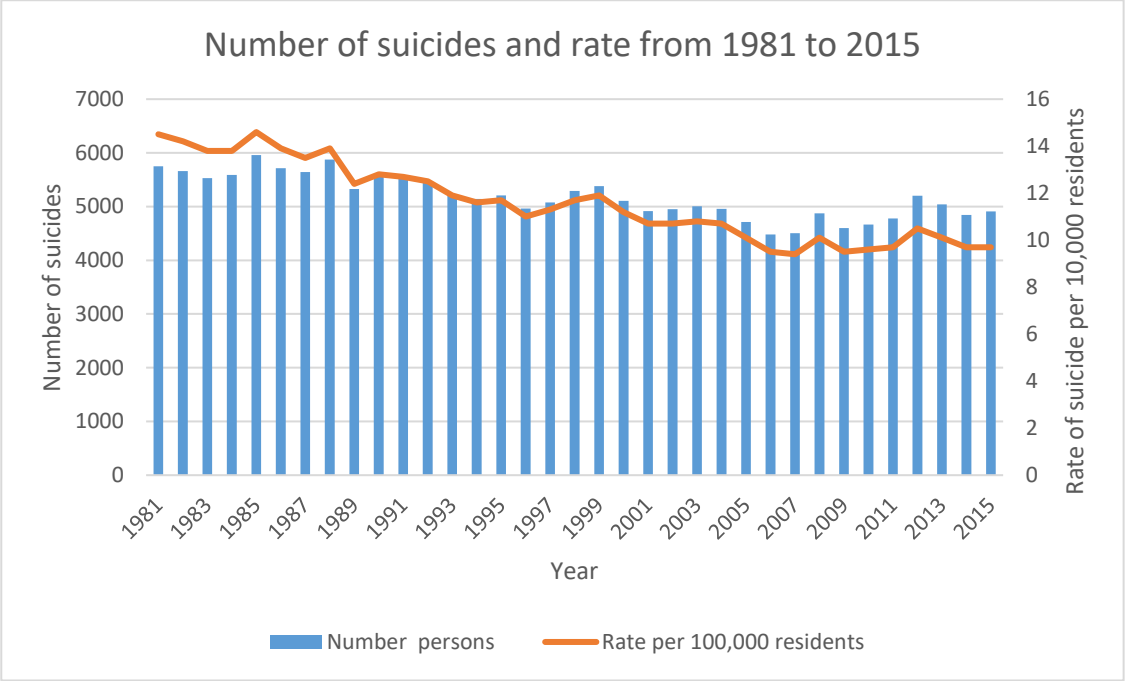
Dunn and Fahy (1990) in their review of 268 Section 136 detentions found violent behaviour in 42% of cases, non-violent often bizarre behaviour in 40% of cases and threats of self-harm in 9% (some data was missing).

Spence and McPhillips (1995) examined diagnosis of Section 136 detainees and described that 67% of the patients they reviewed displayed bizarre behaviour and 26% threatened self-harm.

In rural Gloucestershire Laidlaw et al (2010) examined 576 detentions under Section 136 and found 55% concerned self-harm whilst in Manchester the commonest behaviour was again self-harm at 35% (Sadiq, Moghal and Mahadun 2011). Two years later Zisman and O'Brien (2015) examined the records of 245 Section 136 detainees in London and found the commonest cause for detention was self-harm in 45% of cases.

In contrast to the threat of self-harm the actual suicide rate nationally has been in long term

Figure 3.11 Showing suicide rate between 1985 and 2015



Source: Office National Statistics: [https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations]

decline over this period (see fig 3.11 above). It does not therefore appear that the changing pattern reflects a change in the suicide rate but rather a change in the pattern of behaviour presented to the police.

In interviews with police officers across three police forces examining their use of Section 136 Menkes and Bendelow (2014) noted the compassion of officers, which set them apart from their Health service partners, in particular:

> *their unfailing, and often compassionate, response to the public expression of extreme emotional distress was all too often in conflict with that of the mental healthcare services, which were perceived to be more focused on defining and treating mental illness than managing the associated social disturbance. The overwhelming incidence of police sectioning powers being used in cases of people threatening suicide or engaging in self harm suggests that police interpret the criteria to enforce s136 Mental Health Act very literally, as a suicide prevention strategy". (*Menkes and Bendelow 2014 page 29).

This indicated that Section 136 was used extensively to prevent self-harm.

Outside of England and Wales, in a study of mental health detentions in Victoria (Australia) 197 presentation by 167 patients were examined (Al-Khafaji, Loy and Kelly 2014):

- 58% were male with a median age of 35 years.
- 65% were detained for self-harm and in 61% of cases no sedation or restraint was used.
- 67% were deemed safe for home discharge
- Only 26% were admitted to a psychiatric ward (equally divided between voluntary and involuntary admission).
- The median stay in the Emergency Department (ED equivalent to A&E) was 156 minutes.

This process and the figures appear very similar to the English research reported above. The authors concluded that more work was needed to determine a less restrictive or traumatic process of detention and assessment, again similar to recommendations in England (Al-Khafaji, Loy and Kelly 2014).

If the rise in use of Section 136 is caused by the reductions in treatment available to people who become mentally ill, which is a model of social causation, then the patterns of behaviour resulting in detention may remain the same as the numbers rise. If the behaviours of people detained are different as the numbers rise, then this might imply some external factor, perhaps within policing, is responsible for the rise. Such a mechanism would be socially constructivist rather than socially causative. If a trend is visible in these publications, then it appears that self-harm as a cause of detention has risen over time. This has most recently been confirmed in two reports (Thomas and Forrester-Jones 2018; Eswaravel and O'Brien 2018) which both estimated self-harm as present in over 80% of Section 136 detentions.

3.2.11 Frequent or repeat presenters.

The potential revolving door detention and release of certain kinds of mentally disordered people (referred to above) has also given rise to the concept of Mental Health Frequent Presenters (MHFP) (Baldry, Eileen and Andrews 2013). These are defined by them as people who:

> *"…. are mentally ill or disordered consumers with multiple needs who frequently present to emergency services in mental health crisis. They often fail to have their complex health, social and economic needs recognised or met, relapse quickly and then present repeatedly to emergency services in the midst of mental health crises." (Baldry Dowse and Clarence 2012 page 198).*

The few studies published in the U.S. and Australia on this group indicate that they account for between 15 and 25% of all Emergency Department presentations (Baldry, Eileen and Andrews 2013). In an analysis of the data from NSW police from 2005 showed (Baldry, E., Dowse and Clarence 2012):

- Males were more frequent presenters though females were over-represented in the highest frequency presenters.
- Younger people were more often higher rate presenters.
- Aboriginal persons were over-represented, especially women.
- Whilst MHFPs represented less than 7% of individuals in contact with the police for mental health issues, there were responsible for 23% of volume.
- Their high frequency contacts extend beyond mental health issues and so of the 1010 individuals identified as MHFPs, 80% were known to the police for low level criminal offences or nuisance and 60% as victims of crime.

Some of the individuals concerned had huge numbers of contacts with the police, several had over 200 in less than 20 years. It is Baldry's view that effective interagency case management is the only effective way to manage the interests of these individuals and the risks they present (Baldry and Andrews 2013).

There is evidence of the presence of Frequent Presenters in England and Wales. Turner, Ness and Imison (1992) in their study of 112 cases in London found over two years that:

- 90 people were detained once
- 11 twice
- 4 three times
- 3 four times
- 1 five times
- 1 six times
- 1 seven time
- 1 nine times.

Thus around 20% of people detained under Section 136 were detained more than once over two years.

In their review of a small sample of 65 detentions through Section 136 Spence and McPhillips (1995) observed that in 87.5% of assessments of those detained more than once, the diagnosis was PD. In Zisman and O'Brien's study (2015) of 245 Section 136 detentions 22 patients were repeatedly detained over six months accounting for 19% of all detentions. Therefore, there is good evidence to believe that frequent presenters are also present in England.

3.2.12 The experiences of people who are mentally ill with the police and 'procedural justice'.

An important aspect of the operation of mental health powers and legislation by the police concerns the perceptions of the subjects of the exercise of these powers. A relatively new approach to this field of study relates to procedural justice. Procedural justice concerns the perception of the overall fairness of the process by the subject (or parties). Studies have also shown that where people suffering from mental illness assess a legal process as being high in procedural justice they report feeling less coerced and are more likely to cooperate with the process and outcome (Poythress et al. 2002). It has been identified that there are four components to procedural justice. These consist of two aspects of the procedures and two aspects of the authorities that undertake them. Thus, the four components are: the quality of the decision making within the rules of the process; the quality of the subject's treatment during the

process; then the quality or fairness of the people making the decisions and finally the way that those people treat or deal with the subject (Blader and Tyler 2003).

One way of evaluating or assessing the quality and effectiveness of police engagement with the mentally ill is against a framework of procedural justice. This is the process reported by Watson et al. (2008). In their study they undertook in depth semi-structured interviews with 67 mentally ill people who had had encounters with the police. The circumstances of these encounters were similar to those previously reported in England (above). Police officers initiated 53% of the encounters, participants 13% and third parties 33%. Around 36% of the encounters arose in connection with nuisance or minor criminal behaviour, 18% in connection with minor crime such as shop-theft whilst 9% related to more serious crime such as drug possession. Mental health crises accounted for 18% of encounters, participants requests for police assistance provided 10% and the remainder concerned court processes. The interviews firstly demonstrated the overall fearfulness of the respondents about the police. They were concerned that they would be abused or subject to violence. Notwithstanding these, many had positive experiences to relate in particular where officers had treated them with respect, dignity and concern. In some of the most positive encounters officers treated them with kindness. Even where officers were less engaging with them it was still a good experience for the respondents so long as the officers were “just doing their job”. These positive perceptions fit neatly into the procedural justice framework (Watson et al. 2008). The respondents also reported negative experiences where officers “jumped” or “rushed” them; where they used unnecessary force; physical or verbal abuse; or would not listen to them nor showed them respect. This is again consistent with the procedural justice framework (Watson et al. 2008). This framework appears to offer a template to assist with training officers how to behave in their encounters with those suffering from mental illness (if not the public at large).

There are few reports of studies which examined the experiences of being detained under Section 136. A recent study was reported by Sondhi et al. (2018) which has already been mentioned in Section 2.4.4. They interviewed 54 people who had been detained under Section 136 in London

and four of their carers. Their interviews identified three themes one of which is relevant here. There was stigma in being detained by the police and the experience with the detaining officers was mixed but where it worked well, they were very satisfied. This concerned being offered humane treatment and support which reassured them that their condition was accepted and taken seriously. Many described their arrival at the POS as cold and clinical and part of a 'paper' exercise which continued where they were often repeatedly asked the same questions. The authors of this study did not refer to procedural justice, but their respondents' views clearly reinforce the importance of it.

3.2.13 The demographics of those detained and changes over time.

An early review published by Fahy (1989) was concerned that the program of '*care in the community'* would lead to increased contact between the mentally ill and the police which could result in challenges around the recognition and management of their illness. He believed that the poor and undereducated were most likely to call upon the police to assist with mentally ill relatives. The demographics he found of those detained by the police were broadly white, single unemployed men in their 20s with a history of mental illness. This profile was consolidated through further reviews and so Spence and McPhillips (1995) were able to define the principle profile as young white single men, unemployed; working class; with no registered GP and suffering from psychosis and a previous history of psychosis. This is not the general profile of mental impairment, so it raises the question as to whether there is something about the public behaviour of such people, which rendered them more likely to encounter the police.

However, over the same period there have been a series of reports of the disproportionate use of Section 136 against members of the black and African/Caribbean community. Early reports were by Rogers and Faulkener (1987) and Dunn and Fahy (1990). In the latter whilst 90% of those detained were assessed as suffering from a mental disorder the pattern of diagnosis was different by race. Schizophrenia was the commonest classification for men and women both black and white however black men and women were twice as likely to receive this diagnosis than their

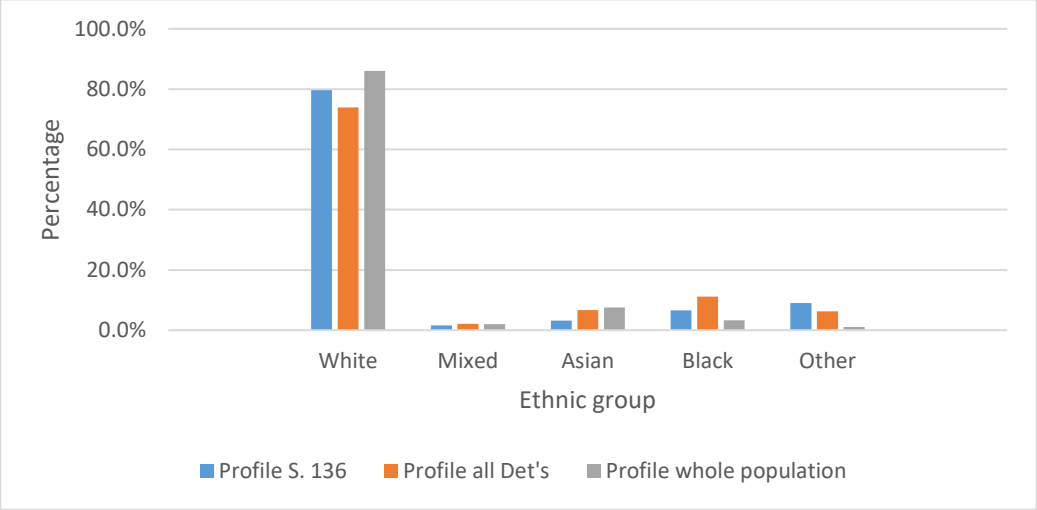
white counterparts. Black men were nearly four times more likely to be diagnosed with drug induced psychosis whilst 20% of white men were diagnosed with alcohol or drug abuse, which was absent amongst black men. Following admission black men were more likely to be treated with psychotropic drugs, likely to be detained longer and released on a further compulsory treatment order. No clear explanation could be offered for these differences.

Reports of this different profile of those subject to Section 136 has continued especially in the inner cities. Pipe, Matthews and Hampstead (1991) found that black people accounted for 21% of Section 136 detentions over a year while only constituting 5.5% of the local population. They also identified that young black men, despite appearing to be less obviously ill and appearing to have greater social stability were still being detained more than their white peers. They raised the possibility of 'institutional racism' and the contribution made by misunderstanding or misinterpretation of communications with racial minorities. Further inner city research (Turner, Ness and Imison 1992) showed that young black men were disproportionately likely to be detained through this section and that as some people were repeatedly detained the mental health services follow up was weak. More recently this racial disproportionality still remains (Borschmann et al. 2010) with Section 136 representing a significant entry point into mental health services for black people, the majority of whom were not formally admitted through the process and for whom it is not clear whether there was any effective follow up. These figures might imply that there is something about the public presence of young black mentally disordered individuals, which brings them into contact with the police in a way to account for this.

As with the disproportion by race in the operation of Section 136, there is a similar disproportion for black people who receive higher rates of compulsory detention and treatment within the general operation of the MHA (Commander et al. 1997; Bhui et al. 2003). Black people were three times more likely to be subject to a compulsory admission than white, the commonest age range was 18 to 35 years which again matches the pattern for Section 136 (Weich et al. 2014). An explanation that may account for both these disproportionalities suggests that it is GPs that are less likely to identify mental illness in their black patients (Shaw et al. 1999) and so they are likely

to follow more complex or adverse pathways into health care (Bhui et al 2003) which can include Section 136.

Figure 3.12 Comparison of the racial profile of Section 136 detentions and all detentions under the MHA.



Source: www.**hscic**.gov.uk/.../inp-det-m-h-a-1983-sup-com-eng-12-13-exp-tab in data disk Appendix I *and [http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/rpt-ethnicity.html]*

The profile of those detained under Section 136 compared to those detained under all MHA provisions and the population at large for 2012/13 is set out above.

This figure shows that the findings published above still hold true for MHA treatments. The white population are relatively underrepresented in Section 136 detentions and more so for other MHA provisions. Asians are underrepresented in other MHA provisions and more so for Section 136 detentions whilst Black people are over represented in both Section 136 and other MHA detentions. Whatever the cultural or other explanations for the differences between ethnic groups in general MHA treatments, there are also differences in the operation of Section 136 by ethnicity, which have yet to be explained.

It is not possible to update this data for the last few years because of a divergence between the classification of race in the Section 136 and general population data. The Section 136 data in HSCIC *detentions-mental-health-act-police-powers-procedures-mar18-hosb2418-tables*. Classifies race as:

1. White European
2. Dark European
3. Black
4. Asian
5. Chinese/Japanese/southeast Asian
6. Other
7. Not known

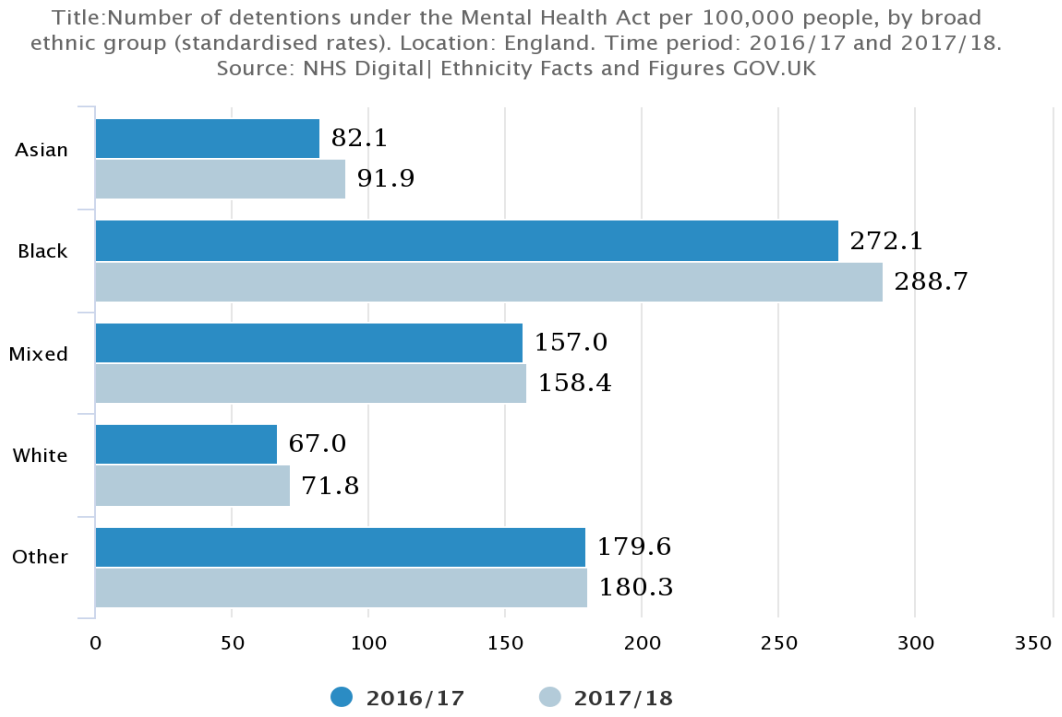
The HSCIC data is no longer published and the NHS Digital mental health statistics[12]– classifies race (where known) into 18 categories.

1. White
    a. White British
    b. White Irish
    c. Any Other White Background
    d. Gypsy or Irish Traveller
2. Mixed
    a. White and Black Caribbean
    b. White and Black African
    c. White and Asian
    d. Any Other Mixed Background
3. Asian or Asian British
    a. Indian
    b. Pakistani
    c. Bangladeshi
    d. Any Other Asian Background
4. Black or Black British
    a. African
    b. Caribbean
    c. Any Other Black Background
5. Other Ethnic Groups
    a. Chinese
    b. Any Other Ethnic Group
    c. Arab

The data is published in broad groups per 100,000 residents in figure 3.13 below but even these groups are different from the Section 136 data categories.

[12] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures

Figure 3.13 Detentions under the MHA per 100,000 people by broad ethnic groups, 2016 and 2017.



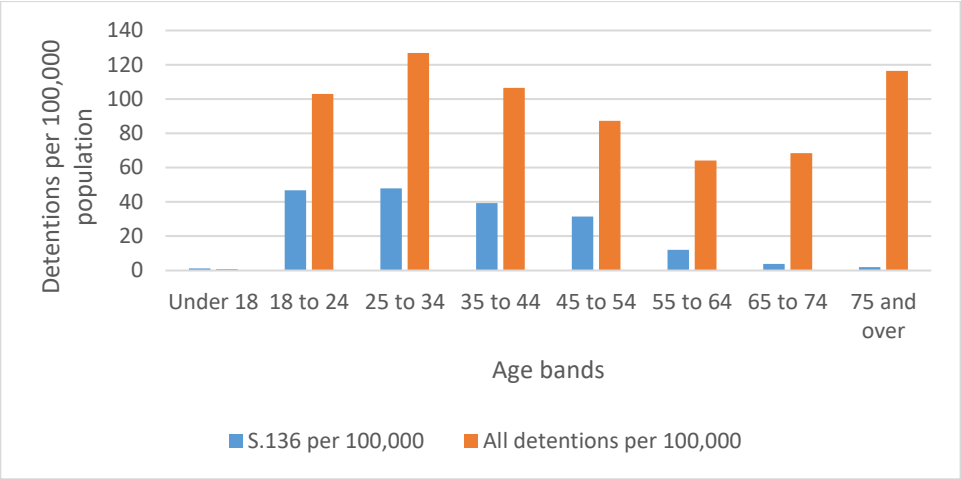
Source: [https://www.ethnicity-facts-figures.service.gov.uk/health/access-to-treatment/detentions-under-the-mental-health-act/latest#by-ethnicity-5-ethnic-groups]

It is clear that up to the present day that there is a disproportionality by race in the treatment of mental illness in England and Wales. In the figure above black people remain four times more likely to be detained. This disproportionality is also then manifest in the operation of Section 136. There must be cultural differences that are at least in part responsible for this and whilst it is possible to speculate upon them, there is no conclusive published research about the causes of this in the operation of Section 136.

In terms of the age profile of people detained under Section 136, this data was publicly available. The figure below, prepared at the start of this research, showed the age profiles of MHA detentions. This clearly showed that for all mental health detentions there was a double peak, the later 'old age' peak presumably corresponding to age related mental illnesses such as dementia. This double peak is not present for Section 136 which would suggest that relatively few older people with such illnesses are detained by the police under this section. They would more appropriately be detained under the MCA 2005. The peak age for Section 136 detentions is in the

late teens or early 20s, which has been consistent over time, though the proportionality by race in some areas has changed. The figure cannot be updated as the recent published Section 136 data on age only uses two classifications, under 18 and over 18.

Figure 3.14 Male Section 136 detentions in England, by age band per 10,000 population, 2013/14.



Source: www.hscic.gov.uk/.../inp-det-m-h-a-1983-sup-com-eng-12-13-exp-tab attached Appendix I and [http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/rpt-ethnicity.html]

3.2.14 Problems with partnership working.

For many years it was reported that there were poor relationships and a general level of mistrust between police, psychiatrists and social workers (Bean et al. 1991; Fahy and Dunn 1987; Revolving Doors Agency 1993). Such difficulties appear to have continued as reported by the IPCC in their review (Docking, Grace and Bucke 2008)

Menkes and Bendelow (2014) undertook research with officers across three regions of England and Wales. In their research they concluded the decision to detain under Section 136 depended upon institutional and structural factors, as well as on social context and the details of the individual cases. Officers felt that "*the response to many incidents, especially after hours, was that the mental health services were disorganised, poorly resourced or frankly unavailable*" (Menkes and Bendelow 2014 page 80). More examples of poor partnership working are cited in Chapter 1.

3.2.15 Defensive professional or risk averse cultures.

A study of the Queensland model (Australia) has cast a new light on some of the operational difficulties within in it (Bronitt and Gath 2013). The issue concerned the relationship between the police and the ambulance service. As part of the Mental Health Improvement Plan (MHIP) it was agreed that the ambulance service would be first responders to mental health incidents in the community if this appeared safe for their staff. This would provide a more dignified and less intrusive response to individuals which would reduce the need for people to receive involuntary medical care. However defensive practices in operational decision making, driven by uncertainty over legal rights and litigation has had a perverse effect (Bronitt and Gath 2013). The number of occasions where people were taken under emergency orders to hospital (EEOs) rose by 18% in a single year and 72% over five years. Of those detained over 50% either did not need treatment or would volunteer for it (Queensland, Department, of, Health. 2010). Given the choice between making decisions to support the care and dignity of patients or risking exposing themselves civil charges of professional negligence, front line ambulance staff and police regularly chose the latter (Shaban 2009). This was summed up by Bronitt and Gath (2013 page 242):

> *The Queensland case study reveals how a defensive professional culture can trump patients' rights and the statutory principles that have been adopted (ostensibly) to uphold and maximise protection of those rights under the Mental Health Act 2000, including the presumption that persons with mental illness have the capacity to make and should be encouraged to take part in, decisions about assessment and treatment, unless proven otherwise. The increasing number of EEOs issued by police and ambulance officers suggest a professional culture dictated by defensive rather than therapeutic imperatives for managing people with mental health problems. This trend in EEOs is at odds with the growing community awareness of the importance of patient autonomy and the legal precedents that underscore the fundamental importance of respecting patient autonomy and self-determination.*

They go on to say that in the absence of adequate funding for acute or crisis services the burden for dealing with these individuals falls unfairly upon frontline services such as the police or ambulance (Bronitt and Gath 2013).

The presence of a risk averse or defensive culture has also been identified within mental health services. This was set out by Hotopf et al (2000 page 484):

> *Increasing public concern about the threats posed by the mentally ill, and the extraordinary impact made by, and resources devoted to, inquiries that follow undesirable incidents (Muijen 1997), lead to a defensive practice of psychiatry. Such practice is increasingly dominated by risk management and increasing reluctance to accept risk taking and uncertainty (Holloway 1996). The net result may be a steady increase in the use of coercion, but increasingly fewer resources for this purpose.*

Risk aversion potentially offers an explanation for both the general increase in MHA detentions and the rise in use of Section 136.

3.2.16 Police efforts to improve responses to mentally disordered people.

The widest range of efforts to improve the police response to mental illness is reported from the United States. Within the US it was proposed that in part the propensity to arrest arises from police officers' perceptions that they lack viable alternatives – such as diversion into mental health teams (Borum et al. 1998). To provide alternatives a range of initiatives have been developed to divert mentally ill or disordered people away from arrest and the criminal justice process. A 1998 survey of police based diversionary schemes in 194 US cities with a population of 100,000 or more showed that 55% had no specialised response whilst the 45% that did fell into three types: a police-based specialized police response (3%); a police-based specialized mental health response (12%); and a mental-health-based specialized mental health response (30%). There is some work to show that the last of these – a health based mobile response – was seen as most effective (Geller, Fisher and McDermeit 1995) but this review lacked empirical evidence.

Since this review many more US police forces have changed their response to mentally disordered people. Following the fatal shooting by the Memphis Police Department in 1988 of an emotionally disturbed person (EDP) armed only with a knife, Memphis Police set up a Crisis Intervention Team (CIT) program which has since been adopted by more than 1000 police forces in the U.S (Lord et al. 2011) and more widely in Canada (Reuland 2010) and Australia (Donohue 2013). This program developed in partnership with the National Alliance on Mental Illness (NAMI) delivers 40 hours of specialist training to a team of officers so that at least two are on each shift and at least one is available 24 hours a day. These officers are there to provide immediate and effective crisis de-escalation for the mentally ill (Reuland 2010). This represents a police based specialised police response. This original program also included an agreement with the local Health Authority that there would be a 'no refusal' drop-off facility and a mobile crisis team to support officers (Lord et al. 2011).

An early review of the effectiveness of CIT programs in the U.S. looked at four dimensions: meeting the needs of the subject; preventing them from being arrested; reducing police time spent on such Incidents; and maintaining community safety. In all these areas officers who were part of CITs and officers who were not, rated the CIT as more effective than other programs including a mobile mental health response team (Borum et al. 1998). Another review in the U.S. looked at comparative arrest rates between different responses to mentally disordered people in crisis, it transpired that the arrest rate for the CIT was lower than in the other responses – 2% against 5% and 13% (Steadman et al. 2000). In a slightly different approach Franz and Borum (2011) analysed the number of arrests, again in the U.S., prevented through the operation of a CIT. They compared arrest rates per incident over the period before its introduction and the five years following. Whilst they could not control for other variables the reduction in arrests after contact with a CIT was striking. The projected number over the five years would have been 342 from 1539 incidents (22.2%) whilst the actual number was 52 (3.4%) (Franz and Borum 2011). In Chicago similar positive outcomes were determined through interviewing officers (Canada, Angell and Watson 2010) and a more detailed study of officers' views by Bonfine, Ritter and Munetz

(2014) showed three major benefits; firstly improved officer and community safety; secondly improved access to health services and thirdly through enhanced officers' skills, improved confidence and preparedness in dealing with incidents.

Not all research casts a favourable light on the use of CITs. In their review Fisher and Grudzinskas (2010) in the U.S. highlighted the lack of evidence based research to support its use. They wrote:

> *"….but the CIT based model enjoys no such support. Indeed, there have been few systematic studies using valid research designs that can support the claim that police speciality units surpass other approaches to managing psychiatric emergencies, that they are necessary, that they are universally workable, or that they warrant the costs associated with their adoption and maintenance".* (Fisher and Grudzinskas 2010 page 59).

They proposed that the desirable outcomes of the creation of CITs:

- Improved use of emergency mental health services.
- Reduced use of arrest for misdemeanour offences.
- Greater use of on-site resolutions.
- Decrease in rates of injury for officers and subjects.

Could be achieved through improved partnership working and better general training for all officers, thus avoiding the costs associated with the creation of specialist teams. This is the approach reported as taken by New York police (Fisher, W. H. and Grudzinskas Jr. 2010).

At the same time that the Memphis CIT program was being developed, communities in Los Angeles became concerned about the frequency with which mentally ill people who were in contact with the police did not engage in follow up services or treatment. The police were seen to provide only short-term solutions for the problems they dealt with. The innovation in Los Angeles was to provide Co-responder teams which paired police officers with mental health professionals to respond directly to calls from the public. This model has also been widely adopted elsewhere in the United States and outside the US (Reuland, M., Draper and Norton 2013). There is some evidence to suggest that either the CIT or Co-responder model (Specialised Police Response) can

be effective in improving outcomes for all parties (Reuland, Melissa, Schwarzfeld and Draper 2009). However Reuland points out that either CIT or Co-responder programs need to be tailored to the community in which they operate to meet both the needs of the community and the partner organisations (Reuland, Draper and Norton 2013).

New South Wales, Australia, after extensive research adopted the CIT model from Memphis (Donohue 2013). A trial of the new model – Mental Health Intervention Project (MHIP) - was evaluated over 18 months (Herrington et al. 2009) and a number of strengths and weaknesses were identified. The strengths included: better working relationships between practitioners; increased use of de-escalation techniques; better data sharing between partners; better understanding by officers with improved confidence and a self-reported reduction in time spent on such incidents. The weaknesses included: it appeared to have made little difference at a strategic level to the operation of partners; it had not resulted in the police desired changes in legislation and it has not affected the allocation of resources so for example police vehicles continue to be used to transport detainees. The MHIP is a police led solution and these findings may be consistent with a lack of commitment from other partners. Notwithstanding any shortcomings the model has since been adopted throughout New South Wales. A very similar model has also been introduced in Queensland, Australia (Queensland Police Service. 2013).

Canadian police forces are encouraged to tailor local solutions to the issue of how they respond to people with mental impairment and as a result there is variation across the country, however the predominant model concerns mobile crisis teams which consist of police officers and mental health workers jointly responding to people in crisis. The CIT model so common in the US is relatively rare in Canada (Cotton and Coleman 2013). There is relatively little evidence of the effectiveness of these specialist programmes, especially given their expense. A recent ‘before and after’ evaluation undertaken in Nov Scotia was able to demonstrate the anticipated results in terms of increased service utilisation by patients and families; decreased time spent per call by the police and greater engagement by patients in treatments (Kisely et al. 2010).

All the interventions outlined above seek to reduce arrests through training or improved access to clinical services but none seek to address the underlying socioeconomic causes of the involvement of the mentally disordered with criminal justice agencies (Morabito 2007). The implication is that engagement with the mentally disordered is just being transferred from one agency to another.

3.2.17 Triage Schemes in England and Wales.

The model so far adopted by most forces in England is largely the Co-responder model, however in its set up it appears to lack some of the core requirements set out by Reuland above. In England and Wales this takes the form of a 'Triage' or 'Street Triage' (ST) scheme.

As an initial response to concerns about Section 136 the NHS, in 2012, funded a pilot study of street triage in Cleveland and Leicestershire and then rolled this out to a further nine forces in 2013 (Dyer, Steer and Biddle 2015). In this trial mental health professionals went on patrol with police officers (co-responder model) and could be first responders to situations which involved issues of mental impairment. The first published assessment of a ST service was that employed by Cleveland Police (Dyer, Steer and Biddle 2015). This study compared the number of Section 136 detentions and their outcomes when the ST team was not working with those referrals that they dealt with. When the ST was not working the police made 558 Section 136 detentions – 82% of which were not admitted for hospital treatment. The ST team dealt with 572 referrals of which they referred two cases to hospital and were admitted. This is less than 0.5% of referrals. There does appear to be something extra-ordinary in this methodology for the police alone Section 136 referrals resulted in 18% admissions to hospital whilst the ST team referrals were less than 0.5% i.e. they were 40 times less likely to admit patients than the Health team making the parallel assessments for the police directly.

The way that the review presents the success of the ST pilot is also interesting. Rather than the figures above, the report (Dyer, Steer and Biddle 2015) highlights that without the ST during the review period the police made 572 detentions from 15,937 'concern for safety' incidents recorded

on their command control system. This is a rate of 4%. With the ST available the rate of referrals they record as 13 Section 136 detentions from 15,937 incidents, which is 0.08%, a reduction of 80%. However, of the 13 detentions, 11 were made against the advice of the ST and none of these 11 were admitted so more properly there were only two detentions recommended by the ST which is a rate of 0.012%. A reduction of over 99%! This is in contrast with another evaluation of the Leicestershire scheme which claims a reduction of 40% in detentions through street triage (MIND 2015) though in this case the methodology is not reported.

Two issues of concern were raised in the evaluation (Dyer, Steer and Biddle 2015), during the trial there appeared to have been a growth in 'self-referral' where patients on their own or transported by police officers, by-passed the ST and presented directly for admission at hospital. Secondly there may have been an increase in repeat presenters. The 572 ST cases related to 490 individuals of which 58 presented more than once. One person presented six times; five people four times; nine people three times and 43 people twice.

Since then there have been a number of other reported evaluations. The Thames Valley Strategic Clinical Network published their evaluation of the Oxford trial scheme which concluded in December 2014[13]. This listed a range of benefits improving the outcomes for service users; reducing the number of Section 136 detentions by 20%; early intervention reducing repeat detentions by 44% as well as financial savings for all public sector participants.

An evaluation of the Northumberland, Tyne and Wear scheme was reported by Keown et al. (2016). This consisted of an analysis of data from the Police, Health and the Local Authorities. In this the rate of operation of the ST scheme was compared with the detention rate. The two showed a linear relationship in that the detention rate declined conversely with the presence locally of the ST scheme. The actual rate fell from 60 per 100,000 residents per year to 26 per 100,000. This equated to 50 less detentions per month.

[13] report at *http://tinyurl.com/z3hck5a*

The evaluation of the Scarborough Scheme from 2014 was undertaken through the University of York[14] and employed mixed methods with interviews with staff and a small amount of data collection. The views of staff were very positive about the operation of the scheme, but it was less clear that any detentions were prevented, rather it suggested that some patients were diverted away from NHS mental health services.

An anonymous two force evaluation was reported by Kane and Evans (2018). This compared ST with a control room based triage and a custody based liaison and diversion scheme. None of the schemes appeared to reduce the number of Section 136 detentions but they were all strongly supported by the staff who worked with them.

An overall evaluation of all nine trial Triage schemes was undertaken by Reveruzzi (2016). Of the nine, for one no data was available, for two there was no change and for six schemes there was a reduction on average of 21% in Section 136 detentions. The review also made recommendations about such schemes including how to promote effective partnership working; information sharing; data collections and a timely response. A systematic review of co-responder street triage models was also published recently (Puntis et al. 2018). This identified that the previous reviews had lacked structure with no randomised trials and so there was a lack of evidence on which to judge their effectiveness and outcomes. Notwithstanding this the schemes did appear to reduce detentions.

The findings from the reviews of ST schemes appear very variable and coupled with the data (above) which shows that nationally Section 136 detentions continue to rise, notwithstanding the widespread presence in nearly all forces of ST schemes, perhaps what is being observed are the short term 'Hawthorne' effects[15]. Thus, when ST schemes are introduced, with the attendant publicity, detention rates fall but over time they rise again.

3.3 Footnote.

[14] report at *http://eprints.whiterose.ac.uk/94059/1/STRfinalreport.pdf*
[15] https://en.wikipedia.org/wiki/Hawthorne_effect

As a footnote to this review and leaving aside Section 136, it is worth reflecting that the issues raised about the care of people suffering from mental illness reflects many personal tragedies. This is made especially poignant given the long period over which these issues have been manifest. Rollin wrote of the Mental Health Act 1959 in a letter to the British Medical Journal on the 17th September 1966:

> *In London in particular with its vast, shifting, multi-racial, multi-lingual masses, it is by no means uncommon for discharged patients to belong nowhere and to be thrust back on their own resources, which, by virtue of their psychosis, are slender indeed. The problem of this rootless variety of chronic schizophrenics, and, indeed, of others belonging to the poorly integrated social groups cannot be solved by sweeping it out of the mental hospitals and under the social mat. Unless and until the community makes adequate provision for the ex-hospital chronic schizophrenics in their midst, they will continue to erupt in a variety of ways. Some undoubtedly will find their way back into hospital, some less fortunate perhaps, will swell the ranks of the unemployed and unemployable. Others will join the army of vagrants and will elbow each other off the park benches or lengthen the queues outside the doss houses. Others will embarrass the courts and prisons where their crimes, usually petty and purposeless, unless interpreted as a plea for care and protection, have landed them.*

Rollin (1965) in turn quoted John Atkin the C18th hospital reformer:

> *Amidst the universal diffusion of this amiable spirit, one thing appears wanting to complete the wishes of humanity; and that is that a proper direction of the means should accompany the well-meant intention of doing good.*

3.4 Discussion and Conclusions from the systematic and public data reviews.

From the systematic review and the consideration of published data what can be established about the operation of Section 136 of the Mental Health Act 1983 and how did this inform the direction of the research

- The use of this police power has increased over time and the rate of increase in use has risen over the last 20 years. The quality of data upon which to make such a judgement was poor, but in recent years appears more accurate.
- These changes in the use of Section 136 are reflected in changes in the use of similar provisions in other English-speaking countries such as Australia, Canada and America.
- There are considerable variations in the rate of use of Section 136 in England by Region, Health Commissioning Authority or Police Force.
- The formal medical treatment of people following their detention under Section 136 has declined from over 90% to less than 20% in the last 20 years.
- The informal treatment following detention also appears to have fallen but as national data is not collated on these it is hard to estimate numbers.
- The prevalence of mental illness or disorder, as measured through all detentions under the MHA, has increased in society over the same period but the use of Section 136 has risen faster than other provisions for the treatment of the mentally ill.
- The operation of Section 136 and all other provisions under the MHA operates disproportionate by race and class.
- Partnership working between the Police, Health and Social services in the operation of Section 136 is widely reported as ineffective.
- The number of treatment beds for people who are mentally ill has been in long term decline and continues to fall in the most recent published data.
- The funding for community-based treatments for the mentally ill has also decreased over the last few years.

As well as these facts about its operation there are a range of consequences that may have arisen from these changes and have been reported in journals. These include:

- As the availability of treatment for the mentally ill has become more restricted then people are generally more ill before they can access treatment.

- The average length of treatment has reduced suggesting that treatment may be less effective and that patients may finish treatment before they are fully recovered.
- People are more likely to suffer a relapse in these circumstances.
- As the severity of illness in treatment units increases, they become less pleasant places and so people with experience of them may be more reluctant to seek admission and so become more ill before they do so. They may also be less attractive places for staff to work.
- As a result, either more people find themselves in 'crisis' in the community or some people find themselves more frequently in 'crisis'.
- The rising prevalence of mental illness or disorder could arise from several sources; changing definitions or diagnosis within Health; increasing demands for service by patients; increasing demands for services by family, friends or carers or through a real increase caused by poverty, economic or other factors.

There are a range of possible mechanisms or explanations which could give rise to these increases in the use of Section 136. These include:

- Changes in society which have caused more people to become mentally ill. These could include:
    - Breakdown in families or communities resulting in social isolation, despair or similar causes of mental illness.
    - Increases in unemployment and/or poverty which resulted in more mental illness.
    - Higher levels of substance abuse through alcohol or other drugs resulting in an increased level of mental illness.
- As the number of people in 'crisis' in the community increased then their contact with the police increased. This could have then resulted in a higher use of Section 136 through:
    - The simple increase in volume of contacts, all other factors remained the same.
    - Increased extreme/unacceptable behaviour which resulted in the police being called.

  - Increased self-harm or destructive behaviour which resulted in the police being called.
  - Families, friends or carers were unable to cope and so called for help from the police.
  - Communities may have become less tolerant of extreme behaviour and so were more likely to call the police.
  - Changes in technology such as mobile phones had made it easier to contact the police.
  - Increased numbers of people in 'crisis' out of hours, called upon the police for help.
  - Increased prevalence of homelessness or other factors amongst the mentally ill may have brought them more frequently into contact with the police.
- Alternatively, there may have been changes in the nature of the encounters between the police and the mentally ill or disordered which gave rise to an increased likelihood that Section 136 would be used. These could have arisen through:
  - A reduced tolerance for certain kinds of behaviour.
  - Changes in the demographics, outlook or experience levels over time within the police, which resulted in different outcomes from such encounters.
  - Organisational pressures within the police which affected the exercise of discretion by officers in deciding whether to use Section 136 or other disposals. These in turn could have included:
    - Changes in organisational cultures over time.
    - Changes in organisational processes and procedures over time that offered different incentives or disincentives to use Section 136.
    - Changes in performance frameworks and other managerial pressures.
    - Changes in 'risk' appetite by officers which influenced their decision making.

It appears that there are most probably at least two sets of process responsible for the increases in use of Section 136. The first set are those general process which have resulted in increased detentions overall, under all the provisions of the MHA. Then there are a second set which account for the faster increase in the use of Section 136 than the MHA overall. This second set may have some aspects which are specific to the police and which can be seen and assessed within the police. Thus, research within the police may be a fruitful starting point in understanding this. As nearly all the mechanisms listed above could influence the police, an open ended 'thematic' approach appears most likely to identify which from this disparate list are responsible.

Two sets of data are likely to be accessible which could identify possible mechanisms. Individual police force data concerning the number and types of incidents that they deal with and the views, experiences and opinions of officers. It was determined that these would form the basis of the initial research.

Chapter 4. Analysis of police attendance at incidents concerning mental illness.[16]

4.1 Study 1. Introduction.

Chapters One, two and three identified a range of shortcomings in the way that Section 136 has operated over recent years. Many of these shortcomings appear rather more as symptoms of underlying or more fundamental causes. As a first attempt to understand what these may be the intention of this study was to look closely at the available data on Section 136 detentions in one police force. To understand the use of Section 136 it is also helpful to examine it in the context of other incidents involving mental illness where Section 136 is not employed. Data to support such an analysis is generally available from police force Command Control systems.

All Police forces all have computerised Command and Control systems which they use to manage telephone calls from the public, the dispatch of police officers and staff to incidents and to record the outcomes. As well as the details of the people involved in incidents there is also a description of the nature of the initial call and then an outcome – usually provided by the officer attending. Incidents concerning mental illness were identified in two main ways. On the Command Control system operators were asked to 'flag' any incident they recognised as concerning mental illness. These can then be searched on that system over periods of time using the flag. The second method involved a member of staff undertaking a 'manual' search using 'key word' terms such as 'hospitals' or 'mental' or 'disorder'. These identified additional incidents not flagged by operators. Through these means this force was able to identify those incidents that related to mental illness. They were also able to copy the text relating to the initial record of the incident and the outcome recorded for the system and paste these into an Excel spreadsheet. This provided the researcher with the anonymised details of mental health incidents.

4.2 Study 1. The aims of this study

[16] The research in this chapter was published in: Thomas, A. and Forrester-Jones, R. (2018). Understanding the Changing Patterns of Behaviour Leading to Increased Detentions by the Police under Section 136 of the Mental Health Act 1983. Policing: A Journal of Policy and Practice. 13(2) pp 134 -146.

These were to:

- To collect and analyse anonymised incident records, recorded by the force, which related to mental illness.
- To analyse these to understand the basis upon which the police attended these incidents.

4.3. Study 1. The objectives of this study.

These were to:

- To compare the grounds for the police attendance at these incidents with those previously reported and published elsewhere.
- To identify if there has been an increase in police involvement with people who are mentally ill and in particular why there has been an increase in the use of Section 136.
- To identify what measures might be available to reduce such contacts.

4.4. Study 1. Method.

4.4.1. *Study 1. Strategy and Research design*

This was exploratory research concerned with the categorisation of types of incidents using the wording from the incident records created by the police. The analysis was largely quantitative and consisted of the categorisation of incident types and then a numeric analysis of the numbers of each. The descriptions of incidents allowed for a small amount of qualitative judgement about the categorisation (discussed more fully below).

4.4.2. *Study 1. Setting.*

In order to find a police force willing to engage in this research a list of Mental Health co-ordinators for police forces in England and Wales was obtained from the National Police College. All were contacted setting out the intended research and four forces expressed an interest. However, after discussions with each about their IT systems, the availability of data and the proposed time scales - only one police force appeared suitable. This was a small provincial force. It covers five local authority areas, which are a mixture of rural and post-industrial communities.

In terms of Section 136 detentions the rate per 100,000 residents places this force in the middle of the table set out in Figure 3.4, Chapter 3.

4.4.3. *Study 1. Institutional approval.*

Agreement was sought for collaboration in this research through the Chief Constable of the force and a senior manager was given delegated authority to oversee the research (see Appendix A).

4.4.4. *Study 1. Legal Compliance.*

For research to take place, police forces require compliance with the Data Protection Act and Human Rights Act. Different forces adopt different approaches and so far, cooperating forces have agreed these on the basis of undertakings made in the exchange of correspondence above.

4.4.5. *Study 1. Ethics.*

An opinion was obtained from the chair of the University of Kent Ethics Committee that in this case as the research only concerned anonymised records of incidents which were wholly numeric and did not involve interviews with participants, that ethical approval was not required.

4.4.6 *Study 1. Procedure.*

The data was presented to the researcher in an Excel spreadsheet and consisted of the text initially used to describe the incident and then the text used at the conclusion of incident to summarise it. Whilst the initial caller remained anonymous the type of caller was indicated i.e. a member of the public (MoP) or the ambulance service. Finally, an outcome of the incident was also recorded for example if Section 136 was used.

The incident details were read through and a rough categorisation of the incidents was made using the caller types, descriptions of incidents and outcomes. The incidents were then read again, and each was classified into the categories devised above and through a process of iteration the classifications were refined until they appeared consistent. This created seven types of incidents.

Through a separate and parallel process, the lead officer for mental health for the force had also undertaken a process to categorise the incidents and then the two sets of categories were compared and found to be the same seven types.

The classification of each incident was then compared and nearly all were found to be the same. The six incidents where the classification differed were discussed and a final classification agreed. This high level of agreement is not surprising given that many of the categorisations were very clear cut.

Through adding filters to the spreadsheet, the analysis of the incidents could be undertaken.

4.4.7. *Study 1. Participants.*

Between 1st Jan and 31st July 2015, the Force identified 660 incidents where mental illness or disorder was a significant factor. The Force also accepted that the 660 incidents were unlikely to be a comprehensive record of police encounters.

4.5. Study 1. Results.

4.5.1. *Study 1. Incident data recorded by the force.*

In the time that the force identified the 660 incidents involving mental illness they received a total of 104,418 calls from the public. This is slightly over half of one percent of calls. General estimates of the level of contact between the police with people who are mentally ill or disordered ranges from 2 to 40% overall (House of Commons Home Affairs Committee, 2015, College of Policing, 2015). This level of contact appears low in this context.

The 660 incidents (which would print out on 68 pages are not included in this text for reasons of space, but they are included in the data disk at Appendix I) were identified as falling into one of seven mutually exclusive categories. These were:

1. Absconders from treatment. These calls related to people who were being detained for treatment under the MHA and who absconded from hospital or had left a hospital whilst

informally receiving assessment or treatment and were considered to be at risk. These were all reported to the police by various Health organisations.

2. Requests for assistance. These were requests from other public authorities for assistance from the police over an issue concerning mental health. They included assisting Health staff to restrain patients, requests to transport patients to care facilities or requests to visits patients' home addresses where there were concerns for their welfare.
3. Section 135. These related to the use of a Warrant, by Health or Social Services, to search for and detain a person in their home where they needed treatment.
4. Concerns for safety. These related to calls from the public where it was believed that a person had or was likely to harm themselves. In this period one suicide was also recorded.
5. Section 136. These concerned incidents where a person was detained under Section 136.
6. Crime related. These are incidents where violence was used or threatened, either against people or property and the offender was suspected of being mentally ill. Many concern violence within the family.
7. Other. These included a range of incidents that did not fall into the other categories but still appeared to relate to mental illness. They included calls relating to people with dementia or mental illness who were confused or delusional. One call concerned the behaviour of a person with Asperger's Syndrome and others related to neighbour disputes where one or more parties were mentally ill.

These seven categories were chosen based on the initial presentation of the incident – except for Section 136 which is an outcome and different from the other categories. This is explained more fully below. Some categories were clear cut, thus 'absconders from treatment' were calls to the police which were easy to identify through the wording of the requests, as were Section 135 requests. All the other categories had the potential to overlap and examples of this are discussed in the tables below.

Representative examples of each type of incident are set out below. The text is copied from the force Command and Control system and contains spelling and grammar errors which have not

been corrected. Text in brackets are substitute names to anonymise locations. Abbreviations are explained below each table. Absconders from treatment or assessment are *unlawfully at large* and can be arrested by the police who have a legal duty to search for them. Most absconders are reported with a risk assessment concerning potential harm to themselves (or occasionally others). These are Low, Medium or High risk. The last is the one of most concern to the police and can become very time-consuming incidents.

Table 4.1 Showing examples of Absconder incidents.

Initial call summary	Outcome	Incident type
(Hospital) absconder..female left before assessment. Repeat female	Officers located her. Taken to (unit) hospital.	Absconder
(Hospital)…absconder..sec 3 patient. Left 3 hrs earlier. Mediuim grade	Returned of his own accord	Absconder
(Hospital) absconder…	Female returned before officer allocation. Was in the grounds	Absconder
(Hospital) absconder…no risk assessment	Located by officers in (Town) and returned	Absconder
(Hospital) absconder psychotic/disorientated and not coherent. Was waiting to see a psychiatrist..HR	Officers allocated. Female eventuallylocated in (Y). Taken voluntarily by police/ family members to (Hospital)	Absconder
(Hospital)…absconder…sec 3 patient. Refused to give risk assessment. Said it's not their place!	Officers allocated. Located by officers in (City) 10 hrs later	Absconder
(Hospital)….absconder..sec 3 patient. MR	Officers allocated but returned of own accord 6hrs later	Absconder
(Hospital) absconder….HR.came in with OD	Male turned up at A!. taken back to (Hospital)	Absconder

HR is High Risk. MR is Medium Risk. OD is Over Dose. A is home address

Table 4.2 Table showing examples of Requests for Assistance incidents.

Initial call summary	Outcome	Incident type
(Care home)..asking police to help restrain a patient (82 yrs old)	Police did not attend and staff sedated him	Assistance Request
(Hospital) reporting a patient is being restrained having tried to take her life 3 times overnight	Hospital want to transport her back to (unit) who can deal with her MH. Advised to contact Amb to do this. No amb available. Police ended up transporting. Patient was calm	Assistance Request
Male in sheltered accommodation pulled his cord and was threatening to stab himself	Taser officers allocated. Male had a knife and was threatening to stab himself. Disarmed but in need of MH intervention. Amb have no one to send and no ETA. Officer had to remain with him but got called away to an emergency. Amb eventually arrived and took him NHH	Assistance Request
Request from Health Care to transport a woman from (Hospital) back to (Home town). she was becoming aggressive	Officers allocated and transported her as requested	Assistance Request
AMHP requesting assistance to transport patient detained at home under MHA. Becoming increasingly hostile	No ambulances available. Officer transported detainee to (Unit) and then back to (Hospital) at the request of the AMHP. Detainee was calm	Assistance Request
(hospital)…reporting irate sec 3 patient. Assistance requested	Irate male being held by 2 staff members. Clear MH issues and hospital staff were attempting to sedate him. Calm when officers left	Assistance Request

Amb is ambulance. AMPH is Approved Mental Health Practitioner. MH is Mental Health.

This category includes a wide range of requests from help with violent patients through to the more mundane transport of patients. All appear to be more suitable to be dealt with within health services.

Table 4.3 Table showing examples of Section 135 incidents.

Initial call summary	Outcome	Incident type
Social services requesting assistance with a sec 135 warrant. Female previously needing restraint	Police attended and female was sectioned but transferred by police to (Hospital)	S135 MHA
Sec 135 warrant…(Z) AMHP	5 officers with taser dispatched (warning markers). Male taken to (Hospital). No issues	S135 MHA
Sec 135 warrant…(Location).	Short time notice. Difficulties with getting officers there on time due to high demand levels. Officers eventually dispatched from (Z) but subject went with the MH team voluntarily in the end.	S135 MHA
(Hospital) advising mother of ex patient is concerned about his deteriorating MH state. Wants police to attend. Not sending any medical assistance!	GOOD EXAMPLE OF POLICE BEING USED INAPPROPRIATELY. Caller wanting police to do a welfare check! Mother spoken to who states she is having no assistance from (Hospital) or GP. Police allocated to safety plan mother and ensure MH services are involved. Sec 135 eventually obtained	S135 MHA
Sec 135 warrant….	Officers attended but huge delay in amb attendance. DCC authorised officers to transport	S135 MHA
Sec 135 warrant.	Officers allocated but decision made not to execute warrant. Male left at home	S135 MHA

Warning markers are Health and Safety notes on file for the advice of officers, in this case for violent conduct hence the deployment of Taser equipped officers. DCC is Deputy Chief Constable.

Most cases in this category concern initial requests from Health or Social Services for the police to attend an address to assist with the execution of a warrant to detain a person under the MHA. In the fourth example the incident started as a concern for safety but became a Section 135 incident. In the last incident a decision was made, presumably by Health, not to execute the warrant and detain the patient.

Table 4.4 Table showing examples of Concern for Safety incidents.

Initial call summary	Outcome	Incident type
Request from (Unit) staff that police conduct a welfare check on a male they saw earlier in the day. Male was told by them that would carry out an assessment on him the following day which he was happy with. Nevertheless, still requesting welfare check because he had earlier indicated suicidal thoughts	Officers attended his H/A and he was arrested (not known what for)	Concern for Safety
Amb…reporting a suicidal 16 yr. old female but they can't locate her.	Police attended and located the female at home. She is known to police. No issues.	Concern for Safety
Drs Surgery (Y)…patient with known MH issues attended surgery that morning and had left documents about psychopaths and suicide. Caller concerned he may be danger to himself or others	Officers attended his address for a "welfare check". He seemed fine	Concern for Safety
Male concerned about his suicidal cousin (general feelings not immediate). Had called the GP but they told him to call police	Dr refused to attend. Police attended and found male has app with his GP that afternoon.	Concern for Safety
Housing support worker rec'd call from client threatening suicide (police markers for suicide/ brain damage)	Located by police at his home address. (guest house) Appeared in good spirits. Told officers he didn't feel suicidal but was lonely. Caller also attended and made urgent referral to deal with his homelessness issue. Left in care of his father	Concern for Safety
Call from CMHT concerned about one of their clients who has contacted them stating her " can't cope". History of attempt suicide. Caller requesting a "welfare check". Caller also sending staff	CMHT in attendance . no further police action reqd	Concern for Safety

CMHT is Crisis Mental Health Team.

Most of these examples concern direct or indirect threats of self-harm. The first example indicates that the person was arrested, this was not a Section 136 detention but in the absence of an indication of the grounds has not been recorded as a crime.

Table 4.5 Table showing examples of Section 136 incidents.

Initial call summary	Outcome	Incident type
Officer detaining someone under sec 136	Taken to (Hospital). originally officers were staying with the detainee until FIM got involved and instructed them to leave as he posed no threat	S136 MHA
Officer located female with MH problem. Arrested on sec 136	Taken to (Hospital)…	S136 MHA
MOP reporting concerns for female with MH problems who has left a suicide note under her door	Located in another town having arrived by bus. Arrested on a sec 136 (5th time in recent months)	S136 MHA
Mother reporting her son wants to die. Diagnosed with MH problems but refusing to go to hospital	Male being restrained by family members to prevent him from leaving. Officers attended address but male ran off. Numerous resources allocate to search for him. Located hours later and arrested for sec 136. Taken to (Hospital)	S136 MHA
(Hospital) patient threatening to leave and kill himself. Being restrained	police attended and arrested him for sec 136	S136 MHA
Officer... detained one for sec 136. Located wrong side of bridge railings with rope and noose in his possession	Taken to (Hospital)	S136 MHA
(Unit)…female threatening partner and members of the public. Female has MH problems. Been taken to another room to get her from the public	Police attended and arrested under sec 136. Taken to (Hospital) and sectioned	S136 MHA
Amb…assistance reqd to a call to a 23yr od with chest pain. Being aggressive	Officers attended and detained male for sec 136. Paranoid and suicidal	S136 MHA

FIM Force Incident Manager (supervising Inspector). MOP is Member of Public

In this category, sometimes an officer directly encounters the person they detain – as with the second and sixth example above. Often the incident arises from a call from the public – as with the third and fourth examples. Sometimes, as with the fifth and seventh example above, it is Health (even a MH Unit) that contacts the police to report and incident which results in the use of Section 136. The last example relates to the Ambulance service calling for assistance.

Table 4.6 Table showing examples of Crime Related incidents.

Initial call summary	Outcome	Incident type
Mother reporting her son with MH problems going mad in the house	Upon police attendance, no MH problems determined. Arrested to prevent BOP	Crime Related
Nursing home (Town)..same patient as previous incident. Lighting fires in the hospital and threatening staff	Staff want her removed from the home as they are unable to deal with her (sectioned patient!!). Was arrested by officers	Crime Related
Sister reporting concerns for her brother who was threatening suicide. Brother still in the house with her mother. Now calm	Male arrested	Crime Related
(Hospital)..female trying the self harm. Being held down by security	Arrested for being D and D after treatment	Crime Related
(Hospital)…known patient turned up threatening with a knife. Has previously disclosed intention to kill a police officer	Full firearms authority. Numerous officers. Male arrested later for offensive weapon	Crime Related
(Hospital)…patient has been discharged 20 mins ago from them but is now saying that he wants to go and fire bomb his uncles house. Caller has told officers to consider sec 136 if found!!		Crime Related
(Social) housing raising concerns for a client walking around in an erratic manner with a machete strapped to his back	Numerous officer and FE units allocated with taser. Male later arrested outside his home address for possession of offensive weapon	Crime Related
(Hospital)…police assistance. Patient with large piece of glass threatening others	Female arrested by police	Crime Related

FE is a Unit of armed officers.

The fourth, fifth, sixth and eight examples here all concern threats of violence reported by Health. These could be viewed as requests for assistance but the criminal aspect (serious threats) appears to take primacy. The seventh concerns a client of a Housing Association and is probably delusional behaviour but with the scale of the response appears, in terms of resources, to be more appropriately recorded as a crime. The third might appear to be a 'concern for safety' but though the details are lacking he was arrested and booked into custody.

Table 4.7 Table showing examples of Other incidents.

Initial call summary	Outcome	Incident type
Father reporting domestic with his daughter who has MH problems.	No crime but the incident was seemingly caused by the daughter not taking her meds for MH issues.	Other
(Hospital)..male has barricaded himself into his room	Stood down by hospital as they had the situation under control	Other
Elderly caller, called several times. Reporting being threatened by neighbours.		Other
Female attended ( ) police station. Asked for officers to walk her home. Clearly had MH issues		Other
Caller reporting her father who has dementia is shouting and slamming doors at her house	CO unit allocated. Caller stated her father has not been sleeping well and had lost his teeth in the night making him upset. VA form submitted	Other
Call from careline who have taken call from elderly female reporting her husband is getting violent	Police attended address. Male with dementia had pushed his wife. Va1 submitted. Daughter in attendance	Other
Male reporting a rape (but spiritually not physically)	Officer allocated to confirm no criminal matter. VA1 submitted	Other
MOP reporting locating confused elderly female in street	Police attended and req amb. Female's carer also in attendance	Other
Female with known MH issues reporting persons in her attic	No persons in attic. Female is paranoid and has MH issues. Referrals submitted	Other
Male reporting that everyone at ( ) hospital are all out to get him.	Officer allocated and spoke with male. He suffers from paranoia and mh issues. No issues	Other
Elderly female phoned to say there were 4 strangers in her house (one in the bath). Known MH problems	PCSO allocated for a welfare check	Other

CO is Community Officer. VA form is a referral form to Social Services.

The 'other' category appears to be a mixture of delusional behaviour and dementia.

4.5.2 *Study 1 Analysis of incident data.*

The classification of incidents into these seven categories is relatively subjective. Fewer categories could be used but then the following analysis loses the differentiation. With more categories, the numbers become very small when factors are cross referenced. These seven categories appear to support a useful level of comparison. The figure and table below show the number of these incidents for each category and the percentage of the total that this represents.

Figure 4.1 showing categories of mental health incidents recorded by the police.

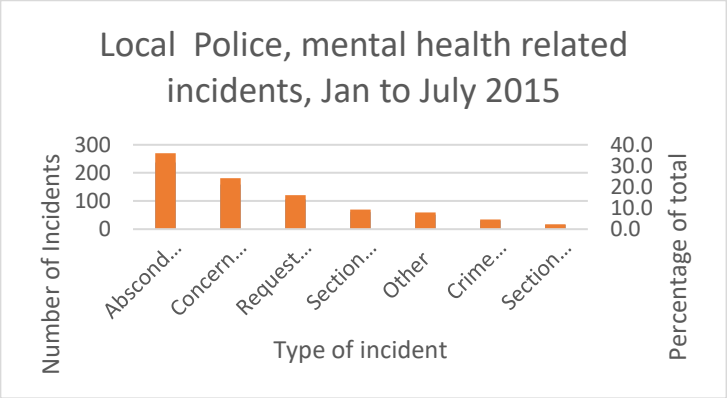


Table 4.8 Showing the number and percentage of incident types

Call type	Number	Percentage
Absconders from treatment	237	36
Concerns for safety	159	24.1
Requests for assistance	106	16.1
Section 136 incidents	61	9.3
Other	52	7.9
Crime related	30	4.6
Section 135 incidents	15	2.3
Total	**660**	**100.2**

The most striking feature of this data is that the largest part of the demands on police time arose from Health and other partner organisations. The categories shown as 'Requests for Assistance', 'Absconder' or 'Section 135' involved approaches from these partners. They were 358 of the 660 incidents, which is 54.2 % of the total. Previous research looking only at Section 136 and its outcomes has not identified the nature or scale of this demand.

The remaining 302 incidents are those in which the police were in direct contact with the public. These have one of two outcomes. In most the person was not detained under Section 136, this was in 241 of the 302 incidents (80%). In the other 61 incidents the person was detained under section 136 (20%). For both of these groups there were three types of incidents. For those not detained:

- **Concern for Safety** There were such 159 (66%). There would appear to be considerable scope for different outcomes from these depending upon the views and actions of the officers. Many would appear to meet the criteria for the use of Section 136 but are dealt with by other means.
- **Crime related.** There were 30 incidents in this category (12%).
- **Other**. There were 52 incidents in this category (22%).

For Section 136 incidents these 61 incidents represented less than 10% of the overall number of 660 but 20.2% of the public facing incidents. They can be divided into the same three categories and then these two groups of incidents can then be compared. This is set out below.

Table 4.9 Showing breakdown of police incidents and Section 136 detentions by type.

Incident type	*Not detained S136*	*S 136 detentions*
Concern for safety	159 (66%)	50 (81%)
Crime related	30 (12%)	6 (10.3%)
Other	52 (22%)	5 (8.6%)

Using a chi-square test to compare those detained or not detained, the Chi-squared statistic is 6.6948. The p-value is 0.035175 and the result is significant at $p<0.05$. Thus, it is more than 95% certain that the categories of those detained are different from those not detained.

The Section 136 table excludes the three detentions where the behaviour was not recorded. In the Section 136 data all the detentions for crime concerned damage to property or threats to people. Thus, for those detained by the police 'crime' appears to relate principally to violence. This would not be surprising as officers would be expected to take action where violence is present. All the 'other' detentions concerned delusional behaviour. These are very difficult to categorise in the brief text recorded about the incidents but around 15 of the 660 overall

incidents appear to describe delusional behaviour, which would be 2.2% overall and so delusional behaviour appears to prompt a greater likelihood of detention by the police. The clearest prompt for police action appears to be threat of self-harm which are 25% higher in the S136 detentions than in the incidents overall. Those least likely to be detained are the 'other' categories but given that many of these relate to dementia, this is not surprising as the Mental Capacity Act is a more appropriate piece of legislation (see below).

For the 61, Section 136 detentions above the outcomes of the mental health assessment were provided to the police by Health as part of their data sharing agreement. The outcomes after assessment were:

- 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 nine cases were 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 as they are not admissions for treatment. There is no way to determine the outcome of these referrals or indeed whether any follow up contact is made. On that basis 30% of these Section 136 detentions result in some form of formal or informal treatment and 70% result in a release back into the community either with no further action or a community referral. This was higher than the national average which, when last published (above), was around 20% of assessments resulting in 'in patient' treatment.

These two sets of data about behaviours and outcomes can also be cross referred. At this level of analysis, the behaviours can be more closely defined. All the concerns for safety are about self-harm; all the crime concerns violent conduct and all the others are delusional behaviour – shown in brackets in the table below.

With a sample size of 61, the numbers when cross referred are small and so it may not be accurate to draw detailed conclusions however, violence prior to detention appears to indicate a higher rate of admission for treatment than other behaviours. This provides an interesting differential between partners, the police appear more likely to detain someone who threatens self-harm whom Health are less likely to treat, whilst the police detain fewer people who are violent under Section 136 in proportion to their overall presence, whilst Health are more likely to detain these people for treatment.

Table 4.10 Showing Health outcome against behaviour leading to Section 136 detention.

		Outcome		
Behaviour	**Formal/Informal admission**	**Follow up in community**	**NFA**	**NK**
Concern safety (Self-Harm)	22.2%	24.4%	37.8%	15.5%
Crime (Violence)	50%	16.7%	33.3%	-
Other (Delusional)	20%	20%	40%	20%
NK			33.3%	66.6%

4.5.3 *Study 1. Comparison of Health and Police data.*

The purpose of a Section 136 detention is to allow Health Services to assess whether the detained person is ill and in need of treatment. This assessment is 'invisible' to the police who don't hold records on the outcome but rather share in the data held by Health. The Health data is provided as tables of anonymised data which cannot be analysed further nor cross-referenced to the police data.

The Health data allows a comparison to be made with the volume of police Section 136 data by location of residence, which may differ from place of detention. The figures are set out below. The corrected column is the percentage recalculated after removing those from outside the Force area and those of no fixed abode, which are around 8% of the total. The combined figure of 36% for Y and Z is lower than the 44% proportion from the police data alone, from overall incidents and crimes.

It is impossible to say which method is more accurate but using the force's data it is possible to estimate that there were 127 incidents relating to Y and Z. Of these 66 concerned requests from other agencies and 61 were officer encounters with members of the public who appeared to be mentally ill or disordered. As 44% of incidents occur in the data collection area then on average around 27 such incidents occurred in the data collection location and period.

Table 4.11 Showing home Borough of Health Section 136 detentions.

Home Borough of detainee	*Number*	*Percentage*	*Corrected %*
A	11	10	11
B	27	26	28
Z	8	8	8
Y	27	26	28
C	24	23	25
Out of Force	4	4	
No fixed abode	4	4	
Total	**105**	**101**	**100**

10 incidents were reported to the researcher in Study 1a, one of which fell out of the reporting period and so a total of nine reports were made. Of these nine, only six were recorded or identified by the force and so, whilst these numbers are small, around 30% of officer encounters with the public were not formally recorded by the force. The six incidents that were recorded represent around 22% of the possible encounters. This appears, to the surprise of the researcher, to be a good response rate but is still a small number on which to base an analysis.

This separate set of Health data also holds information on the behaviour of the detained persons which can be compared with the police data. In the four months from April to August 2015 105 detentions were recorded. This was 26 per month whilst the Force data above records about eight per month. This is a very significant difference and the Police accepts that their Control Room did not at that time accurately identify all incidents involving mental illness. However, if the pattern of behaviours within the Health data was similar to the Force data then it may be that the omissions in the force data are random and the Force figures may still be representative of the data overall.

In terms of the behaviours leading to their detention, there are two classifications in the Health data: conduct and behaviour. Each are set out in the tables below. The classifications are not the same as the police data but 80% of detentions presented for assessment appeared to relate to self-harm or threats of self-harm. This is very similar to the 79% of Section 136 detentions relating to self-harm in the force data.

Table 4.12 Showing Health 'conduct' of person leading to Section 136 detention.

Conduct	***Number of instances***	***Percentage of total***
Harming others	3	3
Harming self	17	16
Threats to harm self	67	64
Difficult to manage	17	16

Table 4.13 Showing Health 'behaviour' of person leading to Section 136 detention.

Behaviour	***Number of instances***	***Percentage of total***
Violent	5	5
Aggressive	9	9
Abusive	2	2
Irrational	84	80
Other	4	4

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

The Health figures also showed that 68% of detainees went directly to hospital for assessment and 32% to a police station whilst 40% were recorded as under the influence of drink, drugs or both. This corroborates the view expressed by officers in interview that Health will not accept Section 136 detentions where they are in any way intoxicated.

Another area for direct comparison concerns the outcome of the Health detentions. These are set out in the table below. In this Health data 36% of detainees were formally sectioned under the MHA or informally admitted to hospital for treatment. In the Force data 30% of detainees were admitted, which again is a similar proportion. The police data percentages are shown in brackets.

Table 4.14 Showing 'disposals' of persons detained under Section 136.

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
Total	**103**	**100 (100)**

On the basis of these comparisons of Section 136 data the Force and Health figures were similar, notwithstanding that the rate of detention in the Health figures was three times higher than the Force's recorded rate. The implication is that the force significantly under records/identifies incidents involving mental illness. Thus, officers' contacts with people who were mentally ill could have been three times higher than the force's recorded figures. On the basis of this comparison it does appear that the under recording by the police is 'random' in that there are no disparities in the proportions of type of incidents between police and Health figures.

4.5.4 *Study 1. Outcomes of Section 136 detentions.*

For those people who were detained by the police under Section 136 the force was able to say for most, on the basis of data supplied by Health, what the outcome was following their mental health assessment. Returning to the Force's data there were 61 Section 136 detentions in the review period. For 13 the outcome was not known. Of the remaining 48, five resulted in the patients being sectioned and the summaries are set out below.

Table 4.15 Showing detentions resulting in compulsory admissions.

Description	Outcome	Incident type
Mother reporting her son wants to die. Diagnosed with MH problems but refusing to go to hospital	Male being restrained by family members to prevent him from leaving. Officers attended address but male ran off. Numerous resources allocate to search for him. Located hours later and arrested for sec 136. Taken to (Hospital)	S136 MHA
Officer detained one for sec 136. Located wrong side of bridge railings with rope and noose in his possession	Taken to (Hospital)	S136 MHA
(Unit)…female threatening partner and members of the public. Female has MH problems. Been taken to another room to get her from the public	Police attended and arrested under sec 136. Taken to (Hospital) and sectioned	S136 MHA
Amb…assistance reqd to a call to a 23yr old with chest pain. Being aggressive	Officers attended and detained male for sec 136. Paranoid and suicidal	S136 MHA
Caller reporting male on scooter punching and hitting himself	Officers allocated and male detained under sec 136	S136 MHA

Table 4.16 Showing detentions resulting in informal admissions.

Description	Outcome	Incident type
Mother reporting daughter has just ran out of (Hospital). Now threatening suicide	Officers allocated but female returned to (Hospital) of her own accord. However ran off on 2 separate occasions. Eventually detained under sec 136	S136 MHA
(Y) city homes…male presented as homeless but left saying he was suicidal	Detained sec 136	S136 MHA
concern for male possibly suicidal. Has left house	male located threatening to throw himself under an HGV. Detained sec 136. amb attended to convey	S136 MHA
caller concerned about a man outside her building saying he can hear voices in his head and afraid he may harm himself or others	detained under sec 136. taken to (Hospital)	S136 MHA
mother concerned for her son. Armed with a knife but suicidal	officers attended (taser), male calm and complaint but very upset. Taken to GP who was very dismissive and told officers to detain on a sec 136!!! (complaint made by me about this). Refused access to (Hospital). Taken to ( ) custody	S136 MHA
female trying to jump off (Y) bridge	detained under sec 136. mother and detainee taken to (Hospital)	S136 MHA
carer….client is refusing to get in car. LD and MH problems.	detained under sec 136	S136 MHA
HGV company concerned for employee who has abandoned his lorry and text them indicating suicide	located by police and detained under sec 136. taken to (Unit)	S136 MHA
foster daughter being aggressive/ smashing plates….	upon arrival child had been self-harming and had continuous thoughts to do so. Detained under a sec 136 taken to (Hospital) as (Hospital) was full. Left in ward overnight (with the paperwork)	S136 MHA

HGV is Heavy Goods Vehicle i.e. lorry company.

Ten of the Section 136 detentions were *Informally admitted* for treatment. Of these nine, six concern self-harm, one concerns violence, one delusional behaviour and one related to an uncooperative person with LD. Given the small numbers, these appears to be very consistent with the behaviours leading to being sectioned. Their details are set out in the table above.

Table 4.17 Showing detentions resulting in a Community referral.

Description	Outcome	Incident type
Female saying she can't get through to (Hospital) and if she doesn't get help she is going to harm herself or someone else	Officer attended and detained her under sec 136	S136 MHA
MOP reporting concerns for female with MH problems who has left a suicide note under her door	Located in another town having arrived by bus. Arrested on a sec 136 (5th time in recent months)	S136 MHA
MOP reporting female in PJs walking away from (Unit)	Female arrested for sec 136	S136 MHA
Male threatening suicide by jumping off bridge	Detained by police and taken to custody (presumably for a sec 136)	S136 MHA
Female difficult to understand. Upset.	Located by police banging her head on ground. Detained under sec 136	S136 MHA
Officers come across a male about to jump off bridge.	Detained under sec 136	S136 MHA
Mother concerned about her son shouting in the street and hallucinating	Detained under sec 136..log does not indicate where he went	S136 MHA
school calling..13 yr old assaulting master and self-harming	detained under sec 136. mother and detainee taken to (Hospital)	S136 MHA
male saying his g/friend has hit him with a bottle. Male now gone missing. Possibly indicating suicidal tendencies	male located and detained under sec 136	S136 MHA
Amb…male threatening to jump off bridge	detained on sec 136	S136 MHA
female being restrained to stop her jumping off a bridge	detained under sec 136	S136 MHA
male detained under sec 136 threatening to jump of bridge. Very aggressive/ unpredictable	taken to (Unit)	S136 MHA
partner is psychotic. Has left house saying he is going to kill himself. Has a knife with him	originally detained for Off weapon…then sec 136!	S136 MHA

For the 13 cases where the patient was released with a referral to a community-based health team, 10 cases appear to concern self-harm, one concerns violence, one delusional behaviour and one odd behaviour. These figures are broadly similar to the previous two categories. With such small numbers and such limited details of their behaviour it is hard to draw a general conclusion but the types and frequencies of behaviours in each of these groups appears to be very similar.

Table 4.18 Showing detentions resulting in No Further Action.

Husband reporting concerns for wife. Missing. Has diagnosed MH issues and was upset	Located by officers and returned home initially but then arrested on sec 136	S136 MHA
MOP reporting a male sat on wrong side of bridge	Numerous officers/ negotiator / fire/ ambulance allocated. Male eventually on right side and arrested for sec 136	S136 MHA
Female raising concerns for father who may be suicidal	Male eventually located and detained under sec 136	S136 MHA
Female attended (police station) advising she had OD.	Detained under a sec 136 and taken to (hospital) for treatment prior to PoS. later taken to (unit) by officers	S136 MHA
Daughter reporting father with MH probs on railway station with a knife. Scared of people coming towards him.	Male located. No making any threats. Detained under sec 136. Dealt with by BTP	S136 MHA
MOP reporting male on wrong side of bridge	Police fire attending. Detained under a sec 136	S136 MHA
concern for intoxicated male sat on ledge. Seemingly has MH problems	detained under sec 136 taken to (Hospital)	S136 MHA
Amb en route to another call saw a male (possibly a jumper) on Chartist bridge	located by police and detained under a sec 136	S136 MHA
concern for suicidal female in his taxi	female had gone into KFC. Driver concerned. Located and detained under sec 136	S136 MHA
caller concerned for friend who has crashed his car and now left scene. Believe he may be intending to self-harm	located and detained under sec 136. no evidence to prove he had been driving. Male is suicidal. Taken to (Hospital) (head injury) then to (Unit) for assessment	S136 MHA
son is threatening to jump off a bridge. Struggling to restrain him	male detained on sec 136. taken to (Hospital) via ambulance	S136 MHA
call from crisis team. Male suicidal. Stated he has taken a quantity of tablets.	located at home address. Originally agreed to go to PCH with ambulance but then refused. Was detained under as sec 136 (seemingly outside house in ambulance) taken to (police) custody	S136 MHA
male going off on one in a nearby field.	detained under sec 136. threatening suicide. Taken to (police) custody (intoxicated)	S136 MHA
MOP reporting suicidal female	female located nr to river. Detained under sec 136	S136 MHA
Amb…call from (Town) GP. Patient has just returned home covered in blood carrying a knife	male eventually located. Officers satisfied no offences but detained under a sec 136 clearly mentally unwell	S136 MHA

husband is having some kind of MH breakdown	located in vehicle, locked in car. Negotiator etc. eventually detained under sec 136	S136 MHA
caller hearing voices saying to kill himself	known to local officers. Located and detained under sec 136	S136 MHA
concern for male possibly suicidal. Has left house.	located but made off from officers. Was very aggressive and was self-harming. Detained under sec 136	S136 MHA
male smashing up car.	upon police arrival male suffering MH found smashing up his own car. Detained under sec 136	S136 MHA
male detained under sec 136. circs u.k.	taken to (Hospital)	S136 MHA
female lying in the middle of the road	detained under sec 136. St Cadocs full. FIM told officer to take detainee to NHH!! NHH wouldn't deal with her	S136 MHA

BTP is British Transport Police

In 21 of the Section 136 detentions No Further Action was taken. 17 incidents related to self-harm, one to violence, two to delusional behaviour and one is not clear. Again, there is little to distinguish these NFA outcome incidents from the other categories.

In terms of gender, 16 of the 59 detentions concerned females and 42 males (1 unknown). This is 27.6 % female and 72.4% males (The Local Health figures showed 35% female and 65% male). The national figures for 2013/14 show the ratio of detentions to be 41.5 % female and 58.5 % male [17]

4.6 Study 1. Discussion.

The difficulty in distinguishing how the behaviours led to the different outcomes following Section 136 detention and assessment, probably reflects the small number of cases and the non-clinical nature of the police descriptions. However there remain differences between the behaviours and the decisions to detain by police. How does this data compare to previously reported studies?

This study indicated a high rate of transfer of incidents from local Health partners to the Police. Excluding those, the pattern of behaviours leading to detention through Section 136 appeared to

[17] HSCIC. Report on "In-patients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual figures, England 2013/14"

have changed significantly from the 1990s. Whilst in previous studies (set out in paras 3.2.10) in the 1990s, the behaviours were aggressive; abusive; violent or disturbing, the behaviour was beginning to change and by the early 2000s self-harm was becoming more common. In this study the behaviours appear overwhelmingly to relate self-harm.

Most mental health incidents where the police directly engage with the public concern threats or self-harm and self-harm more than any other type of behaviour results in detention under Section 136. Whilst self-harm (described as concern for welfare) was present in 66% of all mental health incidents it was present in 81% of Section 136 detentions. In terms of the outcomes after assessment: four out of five of those sectioned were detained for self-harm (80%); 17 out of 21 released with NFA were detained for self-harm (81%); 10 of the 13 released with a recommendation for Follow Up Action (77%) were initially detained for self-harm whereas only six of the 10 (60%) who were Informally Admitted were detained for self-harm. Whilst self-harm influences police actions it does not appear to affect the mental health assessment outcome.

In contrast the most significant factor in determining which detainees are treated after detention by Health appears to be the level of violence they display and not the apparent level of threat of self-harm. This is not necessarily what the wording of Section 1 of part II of the MHA intends, for this states:

> *(2) An application for admission for assessment may be made in respect of a patient on the grounds that—*
>
> > *(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and*
> >
> > *(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.*

It may be that given the limited capacity within treatment units that admission operates more on the basis of risk to others rather than self-harm, or it could be that much of the self-harm displayed to the police is not thought to be credible during the assessment process.

All these issues are explored in more detail in the following chapters.

4.7 Study 1. Limitations.

Whilst there was easy access to data concerning mental health incidents limitations remained. One was the distance between the researcher and the primary data. The force used their own business processes to identify which incidents related to mental illness and this contained several uncertainties. At each stage of the recording and deployment process the record in the Command and Control system was completed by a person remote from the incident and reliant upon the account provided by the initial caller or later by the officer attending. If such call handlers were often very busy there would have been a temptation to abbreviate the details of incidents, a possibility that is supported by the often 'scrappy' nature of the records made. There were clearly opportunities for call handlers to make assumptions about the nature of the incident and allow those to influence their records and even where an officer attended, they may have been an incentive to present their account in a way that supports their actions rather than offering an objective account.

These factors must go some way to account for the large difference in recorded rates both for mental health incidents between this and other police forces and Section 136 detentions between the police and Health records. As the local 0.6% of all incidents relating to mental illness is much lower than the nationally estimated rate of between 2 and 40%, there is a good indication that many incidents are not identified. The Health records must also be more accurate as the assessment and outcome is their primary purpose, whilst the identification of incidents involving mental illness or Section 136 detentions must be an ancillary purpose in the police recording system.

This apparent disparity leaves an unresolved issue of whether there are fewer mental health incidents in this force or whether they have just not been identified by the force's management processes. The latter appears more likely.

Chapter 5. Study 2. The experiences and motivations of officers when dealing with people who are mentally ill.[18]

5.1 Study 2. Introduction.

In the previous studies and chapters, it has become clear that the behaviours which lead to detentions under Section 136 have changed over time. The rise in use of Section 136 appears to correspond to an increase in threats of self-harm. In study 1 it appeared that a large proportion of incidents involving people who were mentally ill were transferred to the police by other public sector partners. These could have arisen from circumstances beyond the control of officers or it may be that the changes have been generated by changes in behaviour of officers. In order to explore these possibilities semi-structured interviews were undertaken with volunteer officers. This allowed for an in-depth account of these issues with additional themes being delineated.

5.2 Study 2. Aims and objectives.

5.2.1 Study 2. The aims of this study.

These were to:

- Map the demographic data on the police to identify their level of experience and understanding of mental disorder.
- Explore how and in what ways the police perceive and/or socially construct behaviours likely to lead to the detention of members of the public.
- Analyse the factors that influence the exercise of police discretion in their use of Section 136 MHA.

5.2.2 Study 2. The objectives of this study.

[18] The research in this chapter was published in: Thomas, A. and Forrester-Jones, R. (2018). Understanding the Changing Patterns of Behaviour Leading to Increased Detentions by the Police under Section 136 of the Mental Health Act 1983. Policing: A Journal of Policy and Practice. 13(2) pp 134 -146.

These were to:

- Determine possible ways to improve the outcomes of encounters between the police and the mentally disordered and in so doing move towards improving the operation of Section 136.

- Identify possible opportunities for the wider range of Agencies and partners who support the mentally disordered to benefit from an improved operation of Section 136 which would ultimately lead to improving outcomes for the mentally disordered.

5.3 Study 2. Methods.

5.3.1 Study 2. Strategy and research design.

In considering the objectives set out above, the philosophy underpinning this research is post-positivist in its approach. In part it collects quantitative data which is numeric and categorised, for example concerning numbers and classification of incident types. For these, scientific and statistical methods can be employed. However, the way that incidents are resolved is the outcome of the exercise of individual discretion influenced by a wide range of factors relating to the personal experiences and beliefs of officers as well as cultural and managerial pressures. There is also an interplay between the officers and those who they consider to be mentally disordered in which the latter may exercise significant control on the behaviour of the former. Whilst officers may believe that they are engaged in a rational or logical process of decision making, many factors both conscious and unconscious may be affecting the actions they take. All these factors are qualitative in nature and therefore qualitative methods need to be employed.

The design was primarily explorative and used mixed methods. Qualitative interviews included open-ended questions using a topic guide to allow participants maximum freedom to describe and elaborate on their experiences (see Miles and Huberman, 1994; and Sandelowski 2000) and for an iterative process of themes to emerge from the data, as described by Charmaz (2014). In addition, numeric data concerning the types of incidents helped to refine the analysis and identify a range of possible factors causing the change in use of Section 136.

5.3.2 Study 2. Setting, institutional approval and legal compliance.

The additional face to face interviews were agreed through correspondence with the Force, who then facilitated access to potential participants. The force reviewed the research in terms of compliance with relevant legislation and force policies.

5.3.3 Study 2. Ethics.

A favourable ethical opinion was obtained from the University of Kent Ethics Committee (Appendix C) for this part of the study. Potential participants were constables, out of their probationary period and sergeants. The research was again compliant with the four ethical principles of research (see para 3.4.5).

5.3.4 Study 2. Procedure.

In the circumstances of this research the most practical and effective way to find a sample of officers to interview was through a *convenient, non-probability, volunteer sample*. This is defined by Vehovar et al (2016 page 330) as:

> *Volunteer sampling- a type of convenience sampling where the decision to participate strongly relies on respondents due to the non-individualised nature of invitations (e.g. general plea for participants appears in media posters leaflets web etc).*

That is to say that officers were motivated to volunteer and at that time it was not known whether they were *representative* of the workforce as a whole.

The lead Inspector for mental health issues agreed to canvass for potential volunteers and send them the information pack and consent forms (examples at Appendix B). This request was disseminated through the force's internal briefing and communications system and so was widely received across the force. Potential volunteers were provided by the inspector with a list of dates when the interviews were taking place and it was negotiated with them and their supervisors for them to attend on specific dates and times. There were more potential volunteers than actual

interviews because some officers were not available on the interview dates through days off or other commitments.

It was necessary for the inspector to organise the interviews as the researcher did not know the range of locations where they could be held, arrange his own access to them or negotiate with supervisors for officers to be available. In addition, he had no access to their shift patterns to see when they would be working.

Since the officer participants were working whilst data collection took place, they needed to continue to monitor their radios during the face to face interviews as there was a possibility that they would have to cut short the interview in order to attend incidents if required. This did not happen in any of the interviews.

The subsequent interview records and transcripts had all identifying details removed from them.

5.3.5 Study 2. Participants.

A three day period was agreed for the interviews and the inspector contacted the volunteers and arranged suitable times for those available on those dates. Eighteen interviews were initially arranged, two officers dropped out at the last minute through personal and *operational* commitments, but a further volunteer came forward so seventeen interviews were conducted.

5.3.6 Study 2. Measures.

The interviews were semi structured, and tape recorded with the consent of the participants. The format of the questions are set out in Appendix B. As the interviews were conducted over three days there was no opportunity to transcribe and analyse each interview before the next so the interview formats could not be adjusted as they progressed. The most effective use of the process was to interview officers with the same questions on some topics and then explore their views as broadly as possible with open ended questions on a range of further topics. The topics were:

- Officers' experiences in dealing with people who were mentally ill.
- Behaviour and accountability of officers.

- Officers' skills, values and beliefs.
- Issues with public sector partners.
- Societal or environmental context.

With their agreement some personal data about the officers' age, length of service and experiences were also obtained.

5.3.7. Study 2. Thematic analysis.

The content of the interviews was subject to thematic analysis in order to identify all the issues that the respondents raised about its operation and their experiences of it. These themes were identified using the six-step process set out by Braun and Clarke (2006). The six steps are:

1. Familiarisation with data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

These stages were followed during this thematic review and the findings are set out below.

5.4 Study 2. Results.

5.4.1 Study 2. Participant characteristics.

Through a Freedom of Information request the following details were obtained about the demographic profile of the force on the 31st March 2015. The request and response is attached at Appendix D. These are compared with the profile of the interviewees.

Table 5.1 Showing FOI response and Force gender breakdown.

Rank	No. Female (%)	No. Male (%)
Constable	248 (33%)	508 (67%)
Sergeant	25 (17%)	124 (83%)

In the interviews 15 of the 17 officers were male (88%) and two were female (12%) and so female officers were underrepresented in the interviewees.

15 were constables and two were sergeants, both the sergeants were male. 17% of the sergeants in the force were female (1 in 6) but with only two sergeants interviewed, this is not unrepresentative.

Of the combined constables and sergeants in the force 84% were constables and 16% sergeants, in the interviews 88% were constables and 12% sergeants, which appears similar.

Amongst the participants the mean average age was 38.9 years and the median average age was 38 years. In length of service the mean average was 14 years and the median average length of service was 11 years.

Table 5.2 Showing FOI response and length of police service.

Rank	Average of Length of Service - Years
Constable	11
Sergeant	16

The force mean average constable length of service (excluding officers in training – which were excluded from the research as well) was 11 years which was similar to that of the respondents 14 years.

All the participants declared their ethnic origin as white European. 2% of the force strength declare themselves as belonging to an ethnic minority group. The participants appear to be representative.

Table 5.3 Showing FOI response and ethnic diversity.

	White (%)	Ethnic (%)	Not Stated (%)
Constables	727 (97%)	18 (2%)	11 (1%)
Sergeants	147 (99%)	1 (<1%)	1 (<1%)

The demographic profile of the interview participants was therefore similar to the force profile save that female officers were under-represented. Eight of the officers reported personal

experiences, away from work, of mental illness, either their own or that of close family members. It is difficult to judge whether this figure of nearly 50% having experience is representative of the workforce or population at large. The charity Mind reports that around 25% of the population experience a mental illness in a year [19], so 50% could be representative of the population at large, but then it is not clear whether mental illness within the police reflects the population as a whole.

5.4.2. Study 2. Thematic analysis.

5.4.2.1. Familiarisation with data.

The 17 interviews were transcribed in full. Although the interviews all followed a similar format the length and content varied considerably from 40 to 90 minutes. This is illustrated by table 5.4 below

Table 5.4 Showing number of pages and word-count of interview transcripts

Officer	Number of pages	Number of words		Officer	Number of pages	Number of words
1	13	5,775		10	10	4,419
2	13	6,282		11	7	2,855
3	11	5,197		12	10	4,673
4	10	4,670		13	13	6,981
5	17	8,394		14	12	6,526
6	11	5,397		15	12	5,602
7	14	6,987		16	13	6,985
8	17	12,332		17	14	7,947
9	9	4,136		Total	205	105,158

which shows the length and word count of each. The full typed transcripts are not included in this thesis for reasons of space however one is included for illustrative purposes, interview 8, at Appendix E.

All the transcripts are included in the data disk attached in the rear of this thesis, Appendix I.

[19] [https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#.XNWSEI5KjIU]

5.4.2.2. Generating initial codes.

Each interview transcript was then read through several times and analysed to identify the statements of text that captured the views and opinions expressed. These statements were coded, with the codes then listed at the bottom of each transcript together with relevant quotations from the text which illustrated each code clearly. An example of this process is provided using interview 8 at Appendix E.

5.4.2.3. Searching for themes.

This process created a large number of codes many of which were similar to or variations of the same theme. Such similar codes were then consolidated together into a smaller number of groups of themes. Each interview then had every theme within it listed. A small section of this data table is set out below in table 5.5 as an example.

Table 5.5 Showing example of themes appearing in interviews.

Interview	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Self-harm most frequent incident type	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y
Dementia another common incident type	y	y			y		y					y				y	y
Other behaviours rare	y																
Mental illness increasing					n	y	n	y	y		y	y	y	y			n
Section 136 used to be very rare												y					
Use of Section 136 gone down in recent years															y		

The table also included the demographic details of the interviewed officers and so it was possible to compare the coding of themes with age, gender, length of service and rank.

The full set of interview themes against participants and their demographic details is set out in Appendix F

Participants agreement with a theme statement is shown as a 'y' or disagreement with that theme as a 'n'. Where no view was recorded this is shown as a 'blank'. Coding statements could be phrased as a positive or negative statement. In the example below one statement was "Section 136 used to be very rare" whilst this is opposed by the following statement "Use of Section 136 gone down in recent years". Thus, the analysis set out to capture disagreements as well as agreements.

To check the reliability of coding and themes, three transcripts were provided to the researcher's supervisor who followed the process and agreed the codes and themes.

5.4.2.4. Reviewing themes.

As the interviews were semi-structured all the participants were asked a set of the same questions but in addition, they were encouraged through *open ended* questions to set out whatever they felt was important or relevant. The result of this is that there are clusters of themes around the structured questions, but the other themes were quite diverse. Some themes contained disagreements such as whether mental illness was increasing (in table above) where seven respondents believed it was whilst three did not. In other cases, the disagreements were on smaller scales, for example respondent 12 felt that Section 136 used to be used rarely (and by implication had gone up more recently) but was contradicted by respondent 15 who believed that the use of Section 136 had gone down in recent years. As well as some divergence in views there were many codes or themes which were only expressed by one or two officers. This was an inevitable consequence of the conduct of the interviews for they were held over a short period of time and there was no opportunity to adjust the questions to follow specific themes as they emerged. Even if this were possible themes emerged at different points in the series of interviews and so those that had been interviewed before could not be asked about themes that

emerged after their interview. For example, the issues above about frequency of use of Section 136 were only raised in the twelfth and fifteenth interviews.

Thus, for many of the statements that arose from the open-ended questions other officers may not have been asked about them and so no response could be recorded. Opinions were also offered by officers which were not relevant to this research, these were not represented in the codes or themes, though they were usually recorded in the transcripts, for example officers mentioned changes to pension regulation and other working conditions. Some officers described their own personal experiences concerning mental illness and these were not recorded as statements, but such officers were identified as having such experiences. It was also clear in the analysis of the interviews that some officers spoke with compassion and empathy about their dealings with mental illness, whilst others took a more pragmatic view that such incidents were just one of a variety of things that they dealt with. This division between officers was also recorded, though it was very difficult to assess it on anything other than a rather subjective impression.

5.4.2.5. Defining themes.

Just as the many of the codes could be condensed or clustered into themes, so many of the themes could be grouped or clustered together to create the three main themes.

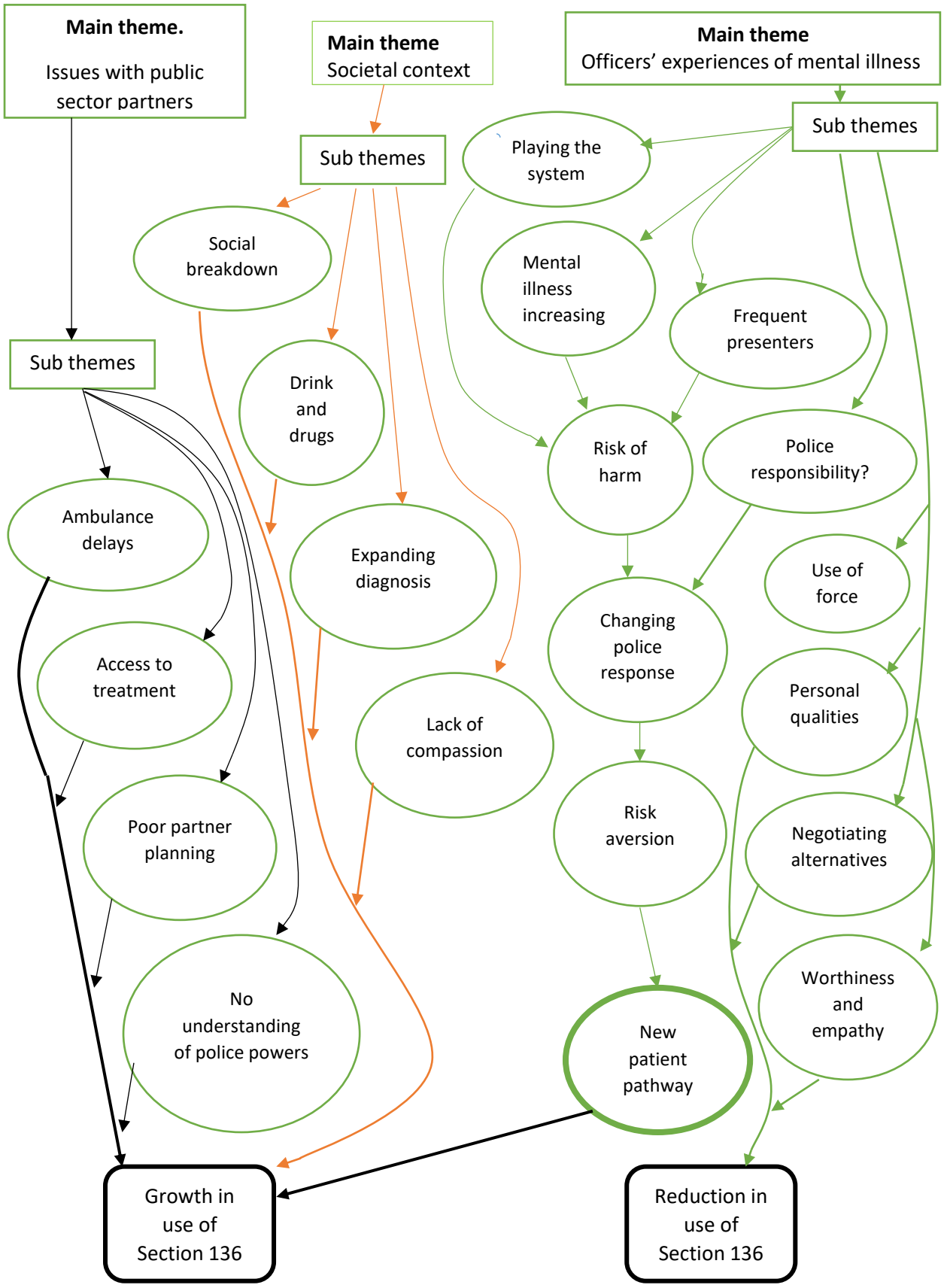
To quality assure this process it was independently undertaken by both the researcher and his academic supervisor and the results were then compared to ensure consistency. This process provided a high degree of thematic inter-rater reliability.

The themes are set out in figure 4.1 below. For ease of viewing each theme is colour coded in black, red or green. To illustrate the effects of each theme there are two outcomes shown at the bottom of the figure, one denotes an increase in the use of Section 136, the other a reduction. As is illustrated most of the themes tend to result in an increase in the use of Section 136, some would tend to reduce the use, but appear overall to have relatively little effect, and one theme appears to be neutral in terms of the rate of use of Section 136.

5.4.2.6. Producing the report.

in line with the six stage ‘TA’ the qualitative findings are reported from para 6.5. below

Figure 5.1 Thematic map showing drivers for change in rate of use of Section 136.



5.5. Study 2. Qualitative findings – Main theme: Officers' experiences in dealing with people who were mentally ill.

As in the diagram above there are a series of sub-themes that link together to create a mechanism of cause and effect for the changes in use of Section 136. These are set out immediately below.

5.5.1 *Study 2. Mental illness increasing.*

Seven officers believed that mental illness in their communities was increasing, two disagreed with this and there are no views from the other six. This increase is not linked to the increase in dementia nor was the view linked to any particular age or length of service of officers. Officer 6 pointed to a general decline in mental health.

> *I think people in general their mental health seems to have decreased dramatically over the last few years, a lot of people we deal with now, that seems to be a factor, one way, either in a small way or quite a big way.*

Officer 12 believed the increase was across the force but might have arisen through the police being called more often to it:

> *Hmmm I think it is probably the same everywhere. I don't think it is specific for (…..). I think it's a massive increase everywhere. Mainly because we have been everybody's broom, haven't we, now we are trying to fight back but I think it's probably a bit too late.*

Officer 8 had experienced a rise in calls but was unsure whether this was because of the local hospital creating the increase in demand.

I think certainly looking back on the amount of times I was called to deal with someone who had mental health problems it is more often now but is that because of where I am working or is that because the fact that it is more prevalent… So, I would say here, because you have got the hospital it is different from elsewhere…

Officer 7 believed that they were less calls in connection with mental illness than 10 years ago.

I would say that I deal with people like them a lot less in the last couple of years than I would have, I have been in the job 11 years. In my first eight or nine years there seemed to be a marked reduction, I don't know whether that's because they are being. When we get the call, they are being outsourced to ambulance correctly I don't know.

It seems that the commonest view amongst officers was that mental illness was increasing in the communities in which they worked.

5.5.2 *Study 2. Frequent presenters.*

12 of the 17 officers interviewed believed that a significant proportion of incidents arose from a relatively small number of *frequent presenters.* This was described by a sergeant, Officer 15, as most demand from a few people:

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

Officer 9 set out the challenges of dealing with the same person again and again.

Yes, it is about sometimes you do go to that same person for the 20th time that week and you do get that feeling- crikey! here we go again – we will have lots of paperwork, lots of

my time just sat with this person. Trying to talk them through but at the same time then, we don't know what's going on in their head, you don't know why they are in crisis, you don't know the background so you have got to. As hard as it can be sometimes, got to treat it like it's the first time you ever met them, so yea, mixed feelings, yes it can be frustrating sometimes but personally you have got to treat them… do as much as you can for them.

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

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

Estimates of the proportion of mental disorder incidents relating to frequent presenters varied from 'most' above to half as with Officer 12:

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

A few officers did not see frequent presenters as an issue such as Officer 17:

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

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

Some officers were clear that the frequent presenters were just attention seeking because the behaviour could be stopped. Officer 8 recounted this story:

> *R We have people, you asked earlier on whether we have repeat callers, for want of a better word, yes, we do, we have a gent is alcoholic who … he will constantly phone 999 when he has had a few drinks, and he will make all sorts of allegations about what he has done, he has never done it but used to go through the motions with him. There was never any justification for what we were doing, and it was attention seeking. In the end one of our officers turned around to him and gave him a fixed penalty notice for wasting police time.*
>
> *Q It was a brave thing to do (issuing a fixed penalty notice to a repeat caller)?*
>
> *R It was a very brave thing to do and it ended the problem because he didn't need us and it was better for him because it broke this cycle of gratification behaviour, it was like obsessive compulsive disorder for him, in a broader sense in as much as he had the drink inside him, his demons surrounded him. It was all to do with the breakup with a girl when he was a young man, he was a man in his 70s, and his inability to form new relationships due to the alcoholism. So, he would phone up, it was almost like a naughty boy syndrome, he wanted somebody to come along and deal with him. When that happened and they took £80 out of his back pocket so he couldn't spend that on the alcohol, it was a very sobering moment for him, excuse the pun, and it actually improved him.*

This example raises the possibility that a significant proportion of the calls that officers dealt with could have been avoided. Officer 3 pointed out that Section 136 is a 'last resort' and a lot of mental health calls are from peoples' homes where it does not apply:

> *No. obviously 136 is a last, last, resort to be fair, a lot of the calls we get are in relation to people in their own homes so 136 wouldn't apply there anyway. So, we can't use that, when it is exercised, then maybe once every set or once every two sets, the powers are actually used.*

The problem of calls to peoples' homes and the lack of police powers was raised regularly. Officer 3:

> *I think, the dwelling element needs to or could be looked at and the whole 135, 136 area could be far clearer for officers to put things into perspective or to make things clearer, I went to a call a couple of weeks ago, a gent I know has mental health problems and drink problems. He initially said he was going to self-harm, we called the ambulance, then he said no I didn't, he was happy to sign disclaimers for the ambulance, they were the ones, they were the experts as it were, and so it's that element then I would prefer then to get him help, he is in his house and he won't come out and what can you do, what can you do?*

5.5.3 *Study 2. Playing the system.*

There were several statements that are similar in content and may be linked to the issue of frequent presenters. These included "*people manoeuvre the police into taking action*" 11 officers supported this statement; "*attention seeking behaviour to engage the police*" three officers; "*a distinction between attention seeking people and people really in need*" two officers; "*gratification of attention seeking behaviour by the police*" two officers and *"self-harmers playing the system*" one officer. In all 12 officers supporting the notion that some of the people who contacted the police were not really in need of medical help but rather wanted the police to meet their need for

attention. Many people were lonely or unhappy and in crisis. Officer 6 set out 'attention seeking' behaviour thus:

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

Officer 14 expressed the abuse of the system thus:

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

Officer 5 observed that many people who have received treatment for a mental health condition have become 'institutionalised' and want to return into such 'care'.

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

The notion of playing the system does not just apply to people who are mentally ill as Officer 17 explained:

> *They want the attention. Typically, half hour ago we brought this person in, we went to the Costa Coffee, she is an alcoholic from what I gather, and she told me she does take heroin, she wanted to go in for a warm and a coffee but she had no money and she was wet through. To get arrested obviously public order demands that other people call us "Fucking Cunts". My colleague said say that again and you will get arrested, so she was arrested. So, she has come into the desk by there, and they have gone through the check list, any injuries, ailments? Oh yes, I have got pain in the mouth, I have got an enlarged heart and the list of ailments comes out and she is now 'one to one' (supervision) and we are going to get the doctor down as I thought. People clearly come into us because they clearly know what they are going to get, some people.*

Taken together the officers believe that many people who are in crisis abuse the Section 136 system to get attention from the police, who are more accessible and perhaps sympathetic or certainly responsive than other services.

5.5.4 *Study 2. Risk of harm.*

All the participant officers agreed that self-harm and threats of self-harm were the most common type of incident that they dealt with involving people whom they considered to be mentally ill. This is in accord with the force level data presented previously.

Seven of the seventeen officers interviewed identified the second most common kind of incident as dementia in its various forms, manifest as 'missing persons' or finding people in a confused or disorientated state. This appeared to be very localised to the more established and settled communities with an aging population. A few Officers identified that there were emerging operational challenges arising from dementia such as Officer 1:

R. He had a bit of a walking stick and he was threatening staff, to us it was quite funny because he couldn't hurt a fly, honest to god, but to that staff it was like, we don't know what to do with him. What do you expect us to do with a 70-year-old guy, we will talk to him, if you think we are going to whack him, handcuff him and bundle him in the back of a police vehicle and take him to the police station, you are sorely wrong, we are not going to do that unless he is showing so extreme form of violence? People just don't seem to...

Q. But then these are girls or women on the minimum wage?

R. Yes, yes, I get that, again why are we the police getting involved with elderly people that are not well, it doesn't sit right with me.

Thus, for a mental impairment rather than mental illness, the police may also be asked to respond to difficult to manage patients.

5.5.5 *Study 2. The police respond differently now.*

It may be that frequent presenters have emerged because the police have changed the way that they deal with vulnerable people. Officer 8 offered this view:

I think that what's happened is vulnerable groups, that lobbying for people who are telling us as police officers or telling the police service the way that we are dealing with vulnerable groups has altered. There is far more pressure on the police to do the right thing when it comes to dealing with people with mental health issues, the same as with domestics in the bad old days where it would be like "you pop around your mother's mate", "pop the kettle love", we are not going to do anything with this. I think what has happened is that we have become more adept at understanding the need for us to be involved professionally in these incidents that we go to rather than its only old George again, "calm yourself down George we will take you home". Because I remember in my

early career if you dealt with somebody who was a suicidal missing person who would have the mental health aspect of that incident, I don't ever remember those people being taken to (Unit) or anywhere like that, to be honest with you I don't, and the facility to do it was different as well.

Such a change in approach could account for the increasing use of Section 136.

5.5.6 *Study 2. Risk aversion and the creation of a new 'patient pathway'.*

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

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

The overwhelmingly strong view shared by fifteen of the seventeen participants (and recognised by the other two) is that officers operate in fear of a 'death following police contact' which results in highly risk averse behaviour and a high degree of compliance with force policy, even where the officers judge this is inappropriate. When asked about the consequences if an incident 'went wrong' Officer 7 stated:

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

Officer 17 stated:

> *You would lose your job. You would be sacked. As you are probably fully aware officers do get sacked for neglect of duty……*

Officer 9 stated:

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

Officer 5 set out why this is more serious than other failings:

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

Two participants nearing 30 years' service reflected upon the changes over time. Officer 12 stated:

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

Whilst Officer 13 stated:

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

Once an officer has become involved in an incident where there is a threat to life, then the only way they can discharge their accountability is to pass the responsibility to someone else. In the past, this may have been custody, but with the reduction in the number of people taken there, it appeared to be a Health professional, whether to a hospital or an ambulance - Officer 1:

> *We know what the consequences would be, we would be in a world of trouble, we are in a catch 22 situation we can't take that risk…. As I say if they suggest that they have taken tablets, whether or not they have taken them, if they tell the ambulance service, when they eventually turn up, that they are fine and the ambulance says they are fine, thank you very much. That is a different set of circumstances.*

It appears based on these interviews and the analysis of data that the police have inadvertently created a new 'patient pathway' which provides direct access for people in crisis to health services and to a mental health assessment. This can operate either formally through Section 136 or informally with consent. Officer 13 describes the informal process:

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

Whilst Officer 12 describes the formal process:

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

5 officers identified that there was a tension between "*conscientiousness and risk aversion*" whilst another three officers put it more strongly the other way around being "*more concerned to do the right thing than follow policy*".

All officers appeared to be aware of the tension between doing the right thing and doing the professionally safest thing. Whilst most opted for the latter a few felt passionately about the tension this caused, such as officer 8 who stated:

> *Whilst I am dealing with this person that doesn't actually need me, the person is on the other side of the parapet and there is no one to send. So what am I going to do when I am driving somebody as a taxi service to a hospital they don't need to attend to gum up the hospital services that they don't need to go to, when that person who has never come to our attention before, who something has happened to, something has broken inside them on that day, needs somebody there who can say the right thing at the right time or do the*

> *right thing at the right time, to stop them from being the one who does step off the parapet. That would bother me more.*

5 officers believed in "*changing behaviour of officers over time*" whilst one did not. It was not possible to show that this view was linked to length of police service for whilst four of these officers had 11 or more years of service, one had only 5. Officer one felt very strongly that officers' behaviour had changed over time and officer 12 described it thus:

> *Experience maybe. Over the years there is….. you haven't not dealt with something, I don't care where you have worked most things you will have come across at least once, no matter what it is, and then I guess, thinking back to the way I used to deal with it rather than with policies that they do now. Touch wood it hasn't gone wrong yet……. Then I think with the new ones coming in because there is all policy grounded, like decision making has been taken out for a lot of bobbies, in my opinion, they basically run like robots, this happens you deal with it this way – bang – bang – bang. It's not really the best way for the public and it's not always the best way for the police either. Unfortunately, that's where we have gone.*

However, data to systematically support or contradict this view was not collected.

The tendency for risk averse behaviour was compounded by police computer systems which were quick to record that someone was mentally ill but never verified that status. Officer 13 described this more fully:

> *Absolutely, and you create an issue in regard to it because of all the forms that we put in, the referral forms, you make sure that it is on the system, you flag the person, I suppose it's now become what would have been the old beat bobbies' knowledge, I know who the people are…. You would have your duty book, your station book that people could look through to see what had been going on for the last ….. but now everything is*

computerized, you have got flags on people, you have got referrals forms that get put in, the problem is you get sent to a call and the operator will tell you that there is a flag on this address - the person at that address suffers from mental illness. It doesn't have a whole wide thing saying since this initial flag they have been assessed by the community mental health team and by doctors and they have a personality disorder that cannot be solved by blah, blah, blah. You go there and you are already thinking that they are flagged as mental health, I have got to do something about it. That as you say, that treadmill creates that because once you have said this person has got mental health, every person that goes there is told, the address is flagged up mental health, you go there with a predisposition to deal with it that the person has got mental health issues and when they are there saying I feel depressed and I want to take tablets then – come on you are coming with me.

Officer 15 expressed frustration that the police just had one level of assessment of risk:

But then within (the force), there is a big thing, as soon as someone self-harms no matter whether that is just a few cuts on the forearms to really going down exposing tissue and muscle and things like that, it's all got to be treated the same. An alarm goes off and the person needs everything thrown at them…….

A more effective assessment of level of risk is an obvious route to reducing the number of detentions. This perhaps is the role of the various Triage schemes.

Only one officer, Sergeant 16, took a different view about the responsibility of officers in managing risk. This he set out very clearly in the context of a less than credible attempt at self-harm:

Okay, however what I would say to that is, and this is where common sense does come into it, if someone is telling you that they have taken an overdose you have a duty of care,

which is inherent in everything we do to protect life, you have got information which says that person's life is in jeopardy and you have nothing to say that it isn't. So, you assume that what they are telling you is correct and you would mitigate against them dying by going to the hospital. Officers are well aware of policies and procedures now, but those policies and procedures are there purely to protect the public, not to protect officers, they give officers clear instruction on what to do and that's your policy. However, it's not to cover your back its because it's the right thing to do so for example, and we are going off the point a little bit now, but domestic violence, you don't make an arrest of a suspect because to cover your back, you do it because it's the right thing to do. Not covering your back, so there is a different philosophy there all together, with mental health you deal with people not to cover your back but because that person needs that care from the information that you have got at that time. It really is that simple. One of the main principles of what we do now is protecting people to the best of your ability, then there is no repercussion, there are the policies and procedures that give you guidance, but you need to use the national decision model to evidence why you have done something, or why you haven't done something. I do try and instil confidence in the officers, this is how it is not confronting officers, it is empowering them to feel more at ease with what they do on a day to day basis. Don't do it to cover your back, get rid of the phrase for ever.

However strongly he felt, it was not a view expressed by others.

As well as the series of linked sub-themes above, there were also more isolated sub themes that are still relevant to understanding the use of the police use of Section 136.

5.5.7 *Study 2. Should the police be involved?*

Officers had mixed views on the necessity for them to be dealing at all with people who were mentally ill. All believed that sometimes the police need to be involved, as Officer 2 put it:

I have thought about this a lot, over the years, yes there is a function for the police in dealing with this as far as we have got them to a safe place…….. if they are out on the street with a knife in each hand screaming and wailing and clearly emotionally disturbed as opposed to committing offences then there is a role for the police. But in an ideal world a response from the NHS with a well-equipped mental health team that doesn't have to be amassed from various places over a period of four hours, a team who will go and assess each case on its merits and who are qualified to say, "you are fine go and see your doctor in the morning"

Herein lies the mixed feelings for Health should have a suitable response as well. The confusion about the need for the police to be involved also extends to the public. Officer 3 explained this:

Public perception is a strange one, I can understand why we are called, I think if somebody has got a broken leg and a member of the public comes across that person with a broken leg, they would naturally expect an ambulance to turn up and deal with it... If somebody is threatening suicide, then a member of the public phones the police first rather than an ambulance or a doctor. So, I think that's a strange one to grasp, the public's perception. I can understand why we are called… We are there to preserve life, but that can only ever mean in my view grabbing someone to stop them going over the bridge, that very immediate element ... Likewise, we call an ambulance and there is not always one available. We will always attend various calls, we are the service of last call.

5.5.8 *Study 2. Negotiating alternatives.*

Whilst all officers felt obliged to act to manage the risk of harm for some there was still scope for finding alternative resolutions to the incident. Officer 6 stated this as:

Because I have been able to... They have been able to go to hospital – voluntary basis – when you talk to them, this is what you need, this is the best thing for you, cells are not

the best place for you, so the people I have dealt with have voluntarily gone or they have been taken by us and taken to the hospital, and waited until they have been seen there.

Officer 15 set out the sliding scale of risk and response:

Yes, yes treat them all seriously, definitely, because there is still that safeguarding element where we need to make sure that person is safeguarded from future harm whether we think they do want to kill themselves or whether they are doing it just for attention ,whatever, if there is that possibility that they are going to go on and do something even, it may be that they have taken five paracetamols, which is not going to cause them much harm, but we need to make sure that we put something in place. Now that something in place is obviously on a massive sliding scale so, someone on the wrong side of a bridge we are never going to take home and leave with a family member, but someone who has taken five paracetamol we may, probably the outcome would be the safeguard would be to put them with a family member or friend, someone who could look after them until... and give them some sort of guidance, you need to go and see a doctor in the morning... That sort of thing with regards to having a mental health check.

5.5 9 *Study 2. Worthiness and empathy.*

Whatever the personal motives of the person contacting the police, many participants believed that the outcome of the incident was being managed by what people said or did and officers were thus not in control of the outcome. This frustrated some officers as they viewed some of the people they dealt with as more 'worthy' than others. four officers believed that the worthiness of the person affected the way that they dealt with them and one did not. This was reflected in their personal feelings about them. Officer 15, a sergeant, observed:

So, if you have got an 18 year old boy who is totally out of it on legal highs and something like that, then the empathy that we would give somebody like that with regards to their

current mental health condition would be totally different from maybe someone with bi-polar who has struggled for years and years… somebody who is self-inflicted through alcohol or drugs then... I definitely have less sympathy, I would say that that probably goes for many officers. But yes, I certainly do.

A few participants such as Officer 9 took a more nuanced view:

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

It was clear that many officers had considered these issues carefully but realised how hard a fair resolution was. Officer 6 stated:

Yes, in a way and it's not self-induced either. Whereas for some people their schizophrenia is blatantly drug induced and you just think well OK so you made bad choices, you probably didn't realise you were going to end up with schizophrenia at the end of it but you think who is more deserving then? The person who has worked 27 years and then suddenly become ill or the person who has never worked but has drugged themselves into a coma most days and doesn't really want help anyway, who would you give it to first. The

trouble is there is no way of filtering out who deserves and who doesn't deserve it. If there is only a small percentage of help available should there not be more of a criteria, then or you have got to do something to try and help yourself first.

The dispassionate view was set out by Officer 9:

I guess that's just a little bit of being about a bit and seen a little bit. I am ex forces and so I have seen some… life has been pretty grim there so at the end of the day I do my job every day and every night I go home and see my family.

Q. You count your lucky stars.

I do, when I was in the forces they could take anything away from me at the drop of a hat so I am here I get paid so as long as I go home at the end of the day I don't mind. If I have got to be sympathetic to somebody or I have got to be kind to somebody …

Clearly the officer presented as 'professional' even if not sympathetic.

Whilst officers often made judgements about those suffering from mental illness with dementia the sufferers appeared to be blameless. Officer 5 talked about this different view:

Yes… my experience people missing suffering with dementia, that's the one we deal with most, that doesn't even cross my mind, at that point my mind is the case that we have got an elderly vulnerable person who we need to find, I only say elderly because that's likely to be what it is. But as I say that doesn't cross my mind in any way shape or form. It's a simple case that I need to find this person because they need our help. Come back down to bread and butter policing, this is somebody that needs my help therefore I am going to do everything to find them.

5.5.10 *Study 2. Personal qualities.*

Officers also had views about the personal skills and qualities needed to deal with those who are mentally ill. Four officers spoke of the importance of "*keeping the dialogue going*" or being "*patient calm and polite".* two officers made the point that some of their colleagues actively avoided "*calls to deal with mentally ill people".*

In both sets of interviews, it has been clear that officers are divided in their approach to those who are mentally ill and that they fall into one of two roughly equal sized 'camps'. Those with a high degree of empathy or understanding and those who are more dispassionate in their approach. This empathy can also present as distress at not being able to help people as Officer 4 put it:

> *It keeps you on your toes, I have 11 years in the job, and you do come across, you get used to it or you become accustomed to how people respond and how people…. What people are like. You not too surprised as much as what it was in your first two years in the job when everything is very new experiences. You do get kind of seasoned quickly and hardened regarding what comes up in front of you. It's frustrating, you mentioned mental health regarding the elderly and whatnot, you want to get them help that they need, you think oh crikey your breathing is not too clever but they are still saying I want to remain in my house, you just think Oh what can we do?*

It is not clear whether this difference has any effect on the police management of Section 136 incidents, especially given that risk aversion appears to be a more powerful motive than the exercise of discretion. It would certainly be interesting to look at this further especially in light of other issues such as the police overuse of Section 136 by race, or the police overuse of the Taser against mentally ill people (O'Brien, Thom, 2014).

5.5.11 *Study 2. Use of Force.*

In some interviews the issue of the police use of force was raised, this is especially relevant given that people who are mentally ill or distressed are five times more likely to be 'Tasered'[20] (O'Brien, Thom, 2014). On that subject Officer one offered these views:

> *It's a not a torture method and that's the issue but, I can understand why officers use it because I have been in situations where people have been threatening to self-harm, they have had knives to their throat, and they have been tasered to stop them self-harming, however, and that wasn't myself, I don't agree that that is what we should be doing.*

> *If I have to go to deal with someone in a different scenario who has got an extremely bad cold, I am not going to Taser them because they have got a bad cold, you're not are you because we forget that mental illness is an illness, it's like having a broken leg or a cold or the flu, it's an illness and that's what…. The problem is that we are left sometimes with very little alternative. Whether it's the right alternative, I don't suggest it is, because anybody that is ill, sorry but sometimes we have to use force on them sometimes to stop them hurting themselves but that's not right really, but it's the only way we can do it, isn't it?*

The officer clearly identified that high risk behaviour can arise from illness and as a result is reluctant to use force but believes that sometimes this is necessary and inevitable.

5.6. Study 2. Qualitative findings – Main theme; Officers' perceptions of problems with public sector partners.

[20] Defined by OED as "A weapon firing barbs attached by wires to batteries, causing temporary paralysis."

During the course of the interviews all of the officers identified one or more shortcomings with their dealings with public sector partners. This is hardly surprising given that over half the incidents involving mental illness were passed to the police from such partners.

5.6.1 *Study 2. Long delays in ambulance attendance.*

The most common complaint concerned ambulance delays, six officers raised this. Officer 17 was typical:

> *One of the other areas is calling for an ambulance, right, absolutely waiting time is horrendous, especially if they know you are there for you are a first aider and you are bottom of the pecking order. Obviously, our bosses don't like us conveying any hospital related stuff, we do…*

2 other officers related that the ambulance service used the police as a 'Triage'. Because the police are first aide trained if they are in attendance then *high priority* ambulance calls, which they have performance targets to attend, can be downgraded so that attendance at the police incident then goes to the bottom of their list.

Officer 2 set this issue out:

> *Absolutely. It is a medical issue all the way, to be battled out between the mental health teams and our immediate concerns about whether someone has taken an overdose or self-harmed themselves. My view about why we are out there every time? It's because we get there faster, because when we arrive at an incident the ambulance clock stops and so their response time isn't affected. Ambulance haven't got enough crews to be able to deal with it immediately, I don't think ambulance crews are aware or willing to use the powers that they have got under the Mental Capacity Act in relation to people. Their view is still*

that if you have got somebody who is a threat to themselves then it's the police's job to instigate Section 136 powers.

Another officer identified that the problem for the ambulance service is that they cannot discharge their patients at hospital and that ultimately is the source of the delays.

Some of the issues with partners are more complex. In an effort to force the Ambulance service to take responsibility for their patients force senior managers have placed a prohibition of transporting people to hospital, perhaps with unfortunate consequences. Officer 2 set this out:

R. Yes, so it would be a phone call to the unit they could go to, if they are willing to go in. Mental Health services love using voluntary admissions, they hate using any sort of powers. If they can get that person to agree to go, and normally they would want to if they are genuinely feeling ill. That would be straight forward.

Q. That would be negotiating them to volunteer, would you take them there if they were volunteering to go, or might they make their own way.

R. Up until recently yes. We would go because logistically it made sense.

Q. And it is quicker presumably

R. Yes it is, five minutes down the road, straight in, job done, compliant, happy, want to go there and we are simply a taxi but unfortunately it has turned into a bun fight between the police and mental health services whereby protocol is now that ambulance has to be used to transport, regardless of where they are and regardless of common sense.

5.6.2 *Study 2. Access to treatment.*

5 officers identified that a significant problem with Health was a lack of consistency in the outcome of assessment. People were detained under Section 136 and usually not treated but there was inconsistency. Four officers raised the issue that if there was a trace of drink on the person detained that they would not be assessed and have to be kept in police custody until completely sober. Officer one set this out:

> *……they actually have a breathalyser device...(Q at the hospital?) Yes, because we will say that they have not been drinking, they will do it, we say have you had a drink and they will say no, we don't breathalyse them but they will put them on a little intoxaliser machine to see if they have had any alcohol... we know why because if there is – Oh sorry we aren't going to see them, take them to the police station and we are sat looking at them like this until it is all out of their body…*

Some officers felt very strongly that this approach by health was wrong, drawing the parallel of what it would look like if the police adopted the same approach. Officer 8:

> *Absolutely yes. A lot of people with mental health problems will also self-medicate with alcohol and other drugs anyway, we know this, so if I was to go down there and somebody wanted to be awkward I would be thinking hang on, what is actually your job, aren't you here to support people with mental health problems not do your best to sleeve it? It's a bit like me going to a robbery and saying do you know what, you left the door open I am not going to take anything... I am not accepting of that, I appreciate that they have their own policies and I appreciate that they don't want to take somebody in there that has additional things, however I think there has to be a common sense approach including us, there cannot be this carte blanche they have had alcohol they are not coming in. It's not the Salvation Army for god's sake. It's a mental health institution... so when somebody comes in to report a crime to me, I don't sit there with my arms folded going convince me*

that you are worthy of my time as a policer officer. Have you been drinking? Because I don't think they would be very happy if I spoke to them like that.

Officer 9 pointed out that for alcoholics to function at all they often need to have some drink:

Yes, so you are not really getting how they are feeling because when they have had a drink sometimes that is when they start to open up. When they sober up, they clam up and so it's only when they have a drink that they begin to talk... I know alcoholics who can't function until they have had a drink so it makes no sense that they can't deal with them until they are sober, and they can't function. That would be my big issue.

Officer 13 raised the difficulty that some people are clearly ill, but Health do not share that view:

We look at it and say that person is 'barking' and take them in and a mental health worker looks at them, or the doctor sits down with them or whatever else and they might have been having a depressive moment or a psychotic episode, and that medical person decides they are treatable and they need to go and see the community mental health nurse or they need to go and see their GP, and look at some sort of medication and I think there is that position where the police are now getting to the stage of – we have got to do something about it, we can't leave that person wandering around the streets, looking dazed and confused or standing on the bridge parapet, but when they get to the doctor they say it's a personality disorder – it can't be treated, it's just something they have got. I think that has certainly caused that problem in that as police we are dragging more and more people in, but then putting them into medical services who are saying there is nothing we can do for them.

Officer 14 described how some frequent presenters eventually get arrested and put into the criminal justice system as a device to get them treatment, but then he had to struggle to get them out of that system to get the care that was needed:

... in the end you end up arresting them for a criminal offence of some kind, you still would get them assessed even though they had been arrested for an offence, and then the assessment would still come back that it is behavioural issues, they will be released with a caution or a fixed penalty ticket at the lower level, then they will go out and do the same things and keep on doing it and we go through spates of that where you have a person who comes to our attention on every shift, so from A relief to E relief will deal with that person…. For the whole like month they will just keep on coming in, like that person has been locked up again, it's a one to one in custody, every shift you come into this… That person has been dealt with by somebody else and everybody gets to know then straight away, until something were to happen where their... Somebody gives in somewhere and gives them a different sort of help. I had a chap who we dealt with every day, similar sort of circumstances and in our opinion and again we are not trained, but in our opinion, he was mentally unwell and in the end I arrested him, I detained him numerous times, I saved him from jumping off a bridge, he jumped over the bridge and I caught him and pulled him back, so on my part he was a genuine sort of attempt, I had him in here and then later in the day he was detained, arrested for quite a vast amount of criminal damage to a flat he was renting, it was £40,000... It was a lot of money, he destroyed the flat, my whole criminal case against him for that criminal damage, the landlord, although he gave me a statement he wasn't worried about it because he understood the mental health side of it. I battled for a long time whilst he was in (Hospital), then to get the case dropped against him because he was, I believe, mentally unwell and not criminal, and it went right to Court where eventually he wouldn't turn up, he didn't turn up because he was still in (Hospital), and in the end, he ended up in a hospital in (City), where he was to my knowledge still there being treated.

Out of hours services was a regular source of friction as set out by Officer 17:

Another incident, we got a call about three years ago now, went to a house, this couple had a problem with their son, mid 20s a drug user. And in the garden, he had a Rottweiler dog and he is lying in the garden with this dog. He has got sunglasses on this dog and a blanket around her. It's obvious that things aren't right and he clearly needs help. He is well known and having help and all that, but it was a Friday afternoon. You try phoning Social Services on a Friday afternoon at 5 o'clock to get help! Many a time I can be with someone for four or five hours until a doctor or health professional turns out, obviously they are short staffed as well, a lot of my week gets tied up with mental health, it does.

5.6.3 *Study 2. Poor planning by partners.*

A number of different examples were presented where poor planning by partners in Health presented the police with additional work or responsibilities. two officers identified that poor resource planning within mental health units at night "*passes the problem to the police".* Officer 15, a sergeant, explained about his discussions with a local unit:

…the default position cannot be as soon as the wheel comes off that you call the police. If say your minimum staffing is four people on a night shift regardless of whatever, that isn't right because your employer needs to be assessing what sort of risk you have in that hospital at that very time and if it says that you should have four to one for one patient then you need to have more people working. It is like banging your head against a brick wall.

Officer 8 set out what for him was a regular instance:

….from my perspective as well I find it very reprehensible that we criminalize mental health by our involvement beyond what it needs to be, we are, I get that there are times where the situation is so volatile or dangerous that you have got to send the police in the first instance, but there have been times in the past where I have had, not shouting

matches, but certainly very robust conversations with mental health teams where I am not putting a mentally ill person in the back of a cage to take them to (custody) because you can't be bothered to arrange for an ambulance. It happens, what happened regularly when I was temporary sergeant, we had a young man just up the road who suffered from a kind of psychosis there was a team there to section him, they had already decided in conjunction with the family that he was going to go to a certain location, and he was comfortable with that, he was a very unwell young man, he was only young, two officers had gone out there simply to be present to prevent a breach of the peace during the sectioning process. Just in case. They were there for an hour and then they asked me to go out there and you had god knows how many people out there, there was a section 12 doctor there, there was two AMPs and they were outside arguing the toss over what was going on, and of course they then said about us transporting this chap and the only place that they could find for him was (unit). They hadn't bothered to see if the place that they had agreed to was free to take him. It really got to the stage where …the finality of it was that I said you have got 30 minutes, if you haven't made a decision on what you are going to do in 30 minutes we are leaving. I am not criminalizing his young man and traumatizing him.

Lack of availability of services drew the police into involvement with those who were ill, as Officer one described:

That's the analogy I was going to use, if your house is flooded you don't want a butcher and we get that a lot. People will ring the ambulance and they haven't got an ambulance to send so they ring the police or the ambulance will ring us.

5.6.4 *Study 2. Partners don't understand or abuse police powers.*

5 officers had examples of where Health staff had not understood police powers and were mistaken in the beliefs about what the police could do. Officer 5 explained this:

> *The only other thing I find with 136 we do have a big problem with is… in terms of the mental health teams social services, that sort of side of it. They seem to have a very… Either a lack of understanding of our powers and abilities or they chose to ignore it… we do still get that phone call at 4 o'clock on a Friday afternoon, we are concerned with somebody's mental health within their house, they are at home at the moment. We are the mental health team in (Town), well hold on a second, this is your remit not ours, you know we can't do anything in a house, surely you can just pop around and check that they are alright, because they know that once we get there, that's it. We have to deal with it one way or another.*

Officer 15 described Health partners regularly calling upon the police to detain their own patients:

> *We had a paramedic and a doctor, I think they were called an Alpha car, so like a first responder car, had a call the other day for a mental health matter and they phone us to turn up to arrest this woman for S 136. So, there is a Doctor there a paramedic phoning the police to turn up because they had phoned (Hospital) and said what shall we do with this woman and they said phone the police to arrest her for 136, which of course didn't happen… I had a relevant patient the other day, someone who has had secondary services within the two years and they were referred from (Hospital 1) to (Hospital 2), (Hospital 2) accepted this patient, the patient then started being a nuisance and so they called us to take her away.*

5.6.5 *Study 2. Lack of compassion.*

Some officers had the impression that the police were the only service that cared enough to try and help people and that much of the time partners spent trying to avoid engagement. Officer 8:

The ones that we come across that are just in need of help, when I turn up in this uniform, I am utterly convinced that there is very little that I can do to help them, because it is not a lack of desire because I really want to help this person because there but for the grace of god go I, but I can because I seem to be the only person who is prepared to take responsibility for this person. Everybody else in the mental health chain in my opinion and experience generally will do everything in their power not to become involved in this person's care. There is no "let's get out there and help this guy!" its Oh we can't bring him in here. It's that default position of you having to convince them to take somebody in that you genuinely believe is mentally unwell, it shouldn't feel like that.

5.7. Study 2. Qualitative findings. Main theme: Officers' perceptions of societal or environmental context.

5.7.1 *Study 2. Breakdown in communities.*

Several officers spoke about the breakdown of communities and the social isolation that makes peoples' illnesses worse. Officer 2 stated it thus:

A compliant person who doesn't really want to harm themselves, who has told a family member or has told a friend, will normally be taken to their GP by that family friend or by that family member or if it's out of hours taken to casualty and we wouldn't be involved. Its only people who are sort of isolated. Anybody that doesn't fall inside the normal box then comes the police.

Officer 12 cited this as a cause for the rise in dementia related incidents as well:

So, they are either living in a house on their own or in a home possibly, but if they are living in a house on their own then they are up and wandering. I think there is breakdown

of families coming to that with these elderly people or people who would be looked after by family or friends, they are now somebody else's problem.

Officer 17 described the downward spiral for some young people:

Yes. Young people where perhaps life hasn't been good to them or perhaps they have been in the drugs or alcohol scene and then obviously in your 20s then, you become homeless, or you get your children taken away…. things are always a pattern of events, we can see them because we deal with them on a regular basis, with them, the people we deal with, they slip into a lifestyle I suppose, especially with the drugs thing when they don't care, then your family becomes less and less important and then perhaps you have a wakeup call and then that's when you get all then depressing side of it I would have thought.

5.7.2 *Study 2. Drink and drugs as cause.*

As well as the breakdown in communities and perhaps connected with it, drink and drugs are seen by officers as a contributory factor to mental illness. Officer 5 stated:

I think that drugs is a massive contributor to a lot of peoples' issues and drink. You know, if you took the drug and drink induced mental health issues out of there and you just dealt with people who have got mental health issue because that's just genetics then there would probably be a tiny percentage here and a massive percentage over there. I think personally that mental health is directly related to the drugs and drink.

Officer 17 spoke of the harm of the then 'legal highs':

… I think that is mainly legal highs, which buggers young people up basically. I have gone to parks around here and there are young lads and they are absolutely stoned out of their heads and they are just sitting there and they have taken legal highs. Again, they are the

20s age group. I don't know if it's the 'in' think to take stuff or it's just that its available, it's for sale basically. You just see people destroying themselves really.

Officer 15 took the long view:

The demands on police officers now are completely different to 20 years ago. There are a lot more social problems now from life styles than there were 20 years ago, in such a short period of time, the new psychoactive substances, that's just come on us in the last five years and we were completely unprepared for how that was going to cause problems for us. There is a bigger increase in the misuse of drugs and alcohol, which causes … Self-harm, the lack of self-worth, and a much more competitive society now where the large employers are gone, so the educational requirements for jobs and things like that…

5.7.3 *Study 2. Increased diagnosis.*

Other officers described the increasing diagnosis of mental illness and in particular the medicalisation of poor behaviour. Officer 13 stated:

… I think there has definitely been an increase in the number of people who claim to be mentally ill, there has definitely been a rise in the number of calls we get where we are told to deal with a person we believe to be mentally ill, and I think it's a society linked thing from the percentage of people who will now quite happily tell you – I have been diagnosed, I am mentally ill, and I think there is an increase in all that. I think we used to deal with people 28 years ago who were more than likely looking back now, were more than likely mentally ill but it either wasn't called that or you didn't see them , they weren't out in the community, they weren't being cared for in the community, they didn't have their own flats, or warden controlled developments or with regular visitors, it's probably fair to say I just about caught the end of, not asylums as such but the fact that you didn't see people in the community, they weren't there, or they were the homeless guy you knew

with clear mental health and we were looking after them. They were just getting on with it and dealing with it themselves whereas now it's sort of – I am mentally ill – the Doctor has told me I am mentally ill, I have noticed that more, that has definitely increased particularly the two I would suggest specifically is ADHD in youngsters and bi-polar, certainly from my understanding if you speak to a doctor bi-polar seems to cover a massive range of behavioural conditions rather than mental health, that anybody gets told they are bi-polar and they are quite happy – I am bi-polar – because I smashed my bedroom up.

For some people it is a mixture of everything that brings them to a crisis where they call the police. Officer 17:

I have been to a house, I can see it now, double crewed on nights, someone was feeling down, they were crying, they wanted help, it was 2 in the morning. You have got to stay with them and I remember talking and you end up having a decent conversation from half hour later you are having a laugh and a joke. A lot of people with mental health tend to live by themselves, and they are lonely. Many a time I have gone to houses talking about life I suppose. Alcohol always seems to be involved or they have taken their medication then they are taking illegal drugs on top and so it's just everything…. It's just a cycle, is everything too freely available.

5.8 Study 2. Discussion.

The interviews present two kinds of responses and views. For those where the same questions were asked of all officers, then quantitative assessments can be made of their answers. For the less structured parts of the interviews, issues emerged but it is not possible to produce a similar quantitative analysis.

Both the force data and the interviews confirm that the most common type of incident which officers dealt with involving those they suspected to be mentally ill concerned self-harm and threats of self-harm. Thus, it appears certain that the types of behaviour leading to detention by the police under Section 136 have changed over the last 20 years from violent, abusive and aggressive behaviours to self-harm. This trend has been visible over time through a series of publications (para 3.2.10) but the connection with the rising Section 136 detention rate has not been made. In contrast to the threat of self-harm the actual suicide rate nationally has been in long term decline over this period Figure 3.11). It does not therefore appear that the changing pattern reflects a change in the suicide rate but rather a change in the pattern of behaviour presented to the police.

The increased use of detention for people threatening self-harm appears in turn to have arisen from a 'risk averse' culture that has emerged within the police over more recent years. This culture seeks to avoid any risk of harm to people in contact with the police where there are significant professional and personal liabilities. It is striking how this fear of the consequences of death or injury following police contact was shared so strongly by 16 of the 17 respondents. Though the data were limited, there was a view amongst longer serving officers that this change in attitude had happened during their service and so in less than the last 30 years.

Deaths following police contact are recorded and investigated by the Independent Office for Police Conduct (the successor of the Independent Police Complaints Commission). Their figures indicate why officers would be so concerned about deaths following police contact especially of those who are mentally ill. Their most recent report (Independent Office for Police Conduct, 2018) identified five categories of deaths following police contact resulting in 283 deaths. There were:

- 29 road traffic fatalities
- 4 fatal police shootings
- 23 deaths in or following police custody
- 57 apparent suicides following police custody

- 170 other deaths following police contact that were independently investigated

Two of these categories are relevant in this study. Deaths following police custody concerns the death of any person who has been arrested or detained (such as under the MHA) whilst being taken to custody (or a POS), whilst being detained or immediately after their release. Of the 23 deaths in this category 12 were identified as having mental health concerns whilst four of these concerned people detained under the Section 136. Whilst mental health appears to be a small proportion of these, it does illustrate the point that detaining a person does not eliminate all the risk of a death following police contact.

The largest group were 170 deaths following police contact which the IOPC investigated because of the circumstances. Almost three quarters of these deaths (120) related to people with mental health concerns whilst in half (93) of the deaths the person was intoxicated with drink or drugs. In 146 of the 170 deaths the reason for police contact was a concern for the welfare of the individual. Of these 45 related to missing persons and 43 were specific concerns about self-harm. These are the most common causes of deaths following police contact and are the incidents that appear to cause officers most concern about risk. It appears that their concerns are well founded.

The changes in peoples' behaviour together with the risk averse culture appears to offer a mechanism of cause and effect to account for the growth in use of Section 136 and the reduction in treatment following detention. Officers appear to understand that those they detain were most often not formally treated by Health but nonetheless repeatedly detain them both from fear of professional consequences but also to try and help those in distress. A few officers were still willing to exercise their professional discretion to try to identify better solutions for those they dealt with, but detention overall appeared to be the preferred course of action.

This process of detention and subsequent presentation for assessment appears to have created a new patient pathway for people who would otherwise find it difficult to access the rather limited mental health services.

Officers all appeared to be aware of the limitations on the use of Section 136 i.e. that they could not use it in peoples' homes but also, with one exception appeared unaware of their possible powers under the Mental Capacity Act to detain people who had lost the capacity to make decisions that placed them at risk. It also appeared that the ambulance service was also either unaware of these powers or unwilling to use them. This is an area which is worthy of further study for there can only be increased contact between the police and an aging population suffering increasingly from loss of capacity.

A majority of officers believed that mental illness was increasing in their communities, and this appeared to arise from several sources. The commonest explanation was that it was promoted through the use of drink, drugs and the then legal highs (now illegal). The role of alcohol is supported through the 3-character code diagnosis figures in para 2.2.7 above. In these "F10 - mental and behavioural disorders due to the use of alcohol" was recorded as responsible for over 61,000 hospital assessments resulting in 39,000 admissions, which was by far the largest category. In comparison cannabis use "F12" resulted in 1.627 assessments (1,280 admissions) and multiple drug use "F19" 4.714 assessments (3,670 admissions). It is possible that alcohol may be more prominent in hospital admissions whilst other substance abuse is more present in Section 136 detentions because the police are more involved in the latter. Whilst the relative proportions are not clear the overall influence of substance abuse is clear.

Social break down in communities was also blamed and one officer identified that the loss of local unskilled employment had left many youngsters with few if any prospects. Several officers identified a 'spiral' of decline through self-destructive behaviour but there were mixed views about the nature of the mental illness. Two officers directly attributed mental illness to the use of drugs, but more officers identified that many of their incidents related to people who were lonely and distressed. Taken together they described many of their incidents as involving emotionally or behaviourally distressed people and those suffering from drink or drug induced psychosis. When these are detained, they are either not treated or, in the case of alcohol, not even assessed until they are sober. This difference in view between the officers and Health appeared to be a

significant source of friction but appeared to arise from their different perspectives. Officers were trying to resolve crises and so minimise risk or help people in distress whilst Health were restricting access to services to those who met the clinical criteria. It is difficult to see how this difference in perspective can be resolved.

This then leads into several related issues. The first concerns frequent presenters. It appears that many people remain in crisis over some time and so continually contact or come to the notice of the police. The police repeatedly detain them, but they are released by Health without their issues being addressed for they then come back to the notice of the police and the cycle is repeated. The impression is given that there are people in crisis, who don't meet the criteria for services from Health, Social Services or others and so who then present to the police as the readily accessible service of last resort. Several officers recognised that the people they dealt with were playing the system, knowing what to say to the police to force them to act and give them the attention they wanted, though this was not just limited to those who were mentally ill.

The existence of frequent presenters both in the UK and abroad was set out in para 3.2.11. It is not clear in this research what the nature of the mental illness was for those presenting at high frequency. Spence and McPhillips (1995) observed that PD could be a cause and whilst there are studies that look at behaviours leading to detention under Section 136 and other studies that look at diagnosis after detention (see Chapter 3), there are no reported studies that compare behaviour with diagnosis, so the issues remains unresolved.

Given all these issues how do officers respond emotionally to the distress that they encounter? It is perhaps not surprising that many officers make judgements about frequent presenters and others and consider that they are less worthy than other people that they encounter or serve. Police officers making judgements about whether people are responsible for their mental illness have previously been reported by Watson et al. (2004) in the U.S. Whilst Godfedson et al (2011) in Australia observed that officers based such judgments on several factors surrounding the incident. Hansson and Markström (2014) have suggested that such stigma or negative judgements

about mental illness can be changed through appropriate training but they did not comment on whether empathy or sympathy can also be developed.

One study sought to examine the role of empathy in police engagement with the mentally ill (Compton et al., 2011). In this officers volunteering for CIT training were assessed for levels of empathy and psychological mindedness and compared to those assigned to the training and others not engaged in it. This was to test the theory that people who volunteer for such training might have higher levels of empathy. The results showed no difference in levels of empathy between any of the groups. The only difference was that volunteers for CIT training had more exposure to incidents of mental illness than the others and so were presumably motivated by wanting more insight into this illness.

It was noticeable during the interviews that some officers appeared to display more empathy towards people with mental illness than others. There was no diagnostic test in the study to properly assess this, but the researcher was nonetheless left with an impression that five of the officers interviewed displayed a high level of empathy or understanding for people suffering from mental illness. Of these three had personal experiences of mental illness whilst two did not. On the basis of this casual observation it does not appear that empathy is only present where there is experience of mental illness or *visa versa*.

Perhaps half the officers in this study were quite dispassionate and 'remote' from mentally ill people, but the other half displayed high levels of engagement, which in turn appeared to cause some concerns about the best outcome for those they dealt with. This connects with the study by Menkes and Bendelow (2014) in which they commented on the officers' "…..u*nfailing and often compassionate response to the public expression of extreme emotional distress*…. "(para 3.2.12 above). There is an interesting issue here about how officers deal with conflicting priorities where they wish to deliver the best outcome to the person who is ill but feel constrained to detain them in order to reduce their personal risk.

The performance of other public sector partners was the other areas where officers' views were quite consistent. There was a high level of criticism of the ambulance service for their poor response times which often left officers supervising people who were ill over extended periods. Ambulance and other Health partners often expected officers to detain people using Section 136 even when they were already receiving treatment from them. Two officers identified that the problems for ambulances lay elsewhere in that they could not unload their patients at hospitals and were thus not available.

Whilst this research offers a clear explanation for the changing pattern of use of Section 136 the range of other issues revealed illustrates the difficulties that this force will have to overcome to reduce police detentions and improve the experiences both of those detained and of officers.

In order to confirm the findings about the high incidence of self-harm leading to detention under Section 136 and the proposed explanation through risk averse behaviour by officers, it would be useful to examine data from another force. Ideally this would be a force with a significantly lower or higher rate of detentions, where there may be differences in the data. With the emergence of Triage schemes across England and Wales it might also be possible to see if, as proposed, Triage schemes specifically reduce potential detentions arising from threats of self-harm.

Several forces with lower rates of detention were contacted to ask if they would participate in this research and Hampshire Constabulary were willing to do so. This will be the subject of the next study (see Chapter 7).

5.9. Study 2. Limitations.

There are a range of factors that had the potential to limit this study. These fall into two major groups, issues with the participants and with the effectiveness of the researcher.

In terms of the participants, however demographically representative the group may appear compared with the force as a whole, those that volunteer may be quite different from those who chose not to. There is a huge field of published research on volunteering, much of it is concerned

with altruistic or *prosocial behaviour*. This latter is defined by Hinde and Groebel (1991 page 54) as “voluntary behaviour designed to benefit another”. This could clearly be a motive to take part for those who wish to improve the way that mentally ill people are dealt with but conversely, would not inspire those who have no such interest. Such differences in motivation could result in different views between those who took part and those who did not. Aside from prosocial behaviour there could be a range of other motivations for example someone might wish to ‘show off’ their knowledge or expertise; if they view their work as mundane they might appreciate the opportunity to engage in something different; conversely someone lacking confidence might be too anxious to volunteer irrespective of their knowledge or other motivations.

The issue of the representativeness of the interviewed officers is not easily resolved. If a group of officers were randomly selected from the workforce, some would have to be compelled to take part if they would not volunteer and this would certainly have a significant effect upon their engagement, responses and the general applicability of the findings. Understanding the potential differences in views and responses between those that volunteered and those that did not would be a significant research project in itself. However for the purpose of this research it is not unreasonable to conclude that the people who volunteered to take part in this study were most likely to have been motivated to do so by a degree of interest in or sympathy in research in general or this research in particular. This in turn may mean that their views and responses were different from those who are not motivated to take part. Where questions were factual, such as about the volume of mental illness they encountered, there does not appear to be any reason why accounts would differ. Thus, all respondents agreed that threats of self-harm were the commonest manifestation of mental illness. However, where the question related to opinions or experiences then responses might differ between those who volunteer and those who do not. A principle finding is that officers were fearful of a death following police contact and that this influenced their exercise of discretion in their use of Section 136. If the officers that volunteered for the research were, by and large, more interested in mental illness or sympathetic to people who were mentally ill, then they may have been more likely to wish to help people in that

condition. If their fearfulness of consequences is such that it is stronger than their desire to do the best for the person they are dealing with, then it is likely that officers who were not interested in mental illness or insensitive to that condition would be even more fearful of an adverse outcome. Given that all the constables in this study shared the same view about this risk, then it is likely that this view could be stronger in the force as a whole.

Where there is less consistency in view between the officers then it is possible that these more diverse views may not have been representative of the views of the majority of officers in the force. The only safeguard against this was that most of the interviewed officers were asked directly about the views of their colleagues. Their responses indicated that they thought (in nearly all cases) that their views were representative of the majority. The interviews in this study and study 2 indicated that some officers sought to avoid attending incidents involving mental illness. Different views were offered as to why, it may be because they were more time consuming; they did not meet the officers' expectation about their role, i.e. not about crime fighting; or they did not like the level of emotion present in the incidents. None of the participants appeared to avoid dealing with mental health incidents so that separates them from this other group of officers. This is a limitation of this method, but it does not appear to affect the principle findings of this research.

The notion of the degree to which officers needed empathy to deal effectively with mental health incidents was raised a number of times during the study but this study had no means to analyse this issue. The researcher gained an impression that the participants differed in their levels of empathy, but a different methodology would be needed to examine this.

The other issue concerned the researcher who was a retired police officer. Whether or not it was publicised to the volunteers that the researcher was a retired police officer it would have been easy to find out through Google or other means. In any case it appears that there are so many verbal and nonverbal cues that enable people in professions to recognise this in each other that the researcher would quickly have been identified as a former officer. This raised the notion of

subjectivity and reflexivity in research. These are issues that can interfere with the process of collecting and analysing qualitative data and relate to the subjectivity or objectivity of the researcher. Any researcher cannot but help to introduce their own ideas, values and beliefs into their understanding of any issue they observe. This was set out in the much quoted comment from Kreiger who was studying the relationship between Pueblo potters and their work. In this she observed (kreiger 1991 page 89):

> *The pot carries its maker's thoughts, feelings and spirit. To overlook this fact is to miss a crucial truth, whether in clay, story or science.*

This notion was set out more fully by Finlay (2002 page 531) as:

> *Our behaviour will always affect participants' responses, thereby influencing the direction of findings. Meanings are seen to be negotiated between researcher and researched within a particular social context so that another researcher in a different relationship will unfold a different story.*

There is also the issue of the researcher as an *insider* or *outsider*. When Rabe (2003) set out her views on this issue it was as a white female researcher examining the views of black African miners on fatherhood. The notion is that there are advantages and disadvantages to being either an insider or an outsider. Rabe (2003) identified three concepts to manage in this context. The first is the *power* relationship between the interviewer and interviewee. In this case did the interviewer exercise authority over the officers he interviewed. This appears unlikely as the researcher had been retired for ten years and had never worked in the researched police force or anywhere nearby. The second concerns *knowledge*. The advantages of the researcher being an ex-police officer are that he may have better understood the operational setting and cultural framework of the officers he interviewed. The disadvantages are that he may unknowingly impose his own views on the officers he interviews by either how he framed his questions or how he interpreted their answers. This was managed through the use of open-ended questions which did not seek to lead the officers in their responses. The responses could also be triangulated

against other forms of data available both in the force and nationally, which offered further independent verification of findings. The third strand can be considered in the context of an anthropological study. If the researcher is from a completely different cultural background, then they may have the benefit of an independence of view which might produce new or different insights. This remained a potential danger for the researcher who may not have had sufficient independence of view to find original insights in the research. However, as the principal findings were so consistent amongst the officers this was perhaps not an issue.

Finally, these potential problems are compounded by the reconstructive nature of memory first proposed by Bartlett (1932) and now with many amendments and adaptations, widely accepted. In this he rejected the notion that memory is like a tape recording of events which can afterwards be replayed in exactly the same order and format in which it occurred, but rather memory is stored and replayed in a form that accords with our views and experiences of the world. Thus, memories can lack accuracy and objectivity and can change over time. This was managed by the researcher through audio recording the interviews and transcribing them in full. Thus, no data depended upon memory and interviews could be reflected upon in the *cold light of day*.

Chapter 6. Identifying the full range of contacts between the police and people who are mentally ill.[21]

6.1 Study 3. Introduction.

The original intention of this study had been to examine the operation of Section 136 in another police force. However, it proved impossible to engage with any local Health partners and so the focus of the research was changed. Whilst there are a range of publications concerned with Section 136 it is clear from studies 1 and 2 that the use of this power reflects but a small proportion of the overall engagement that the police have with people who are mentally ill. Much of this engagement appears so far to be relatively unreported. In this study, an examination is made of this broad range of police contacts across a whole force, to show how and why calls are classified as mental health related and how/why they are acted upon.

As with most police forces the great majority of public contacts were through the telephone network. These were received at a centralised Force Control Room (FCR). The process of such call handling was mapped and analysed to assess both the quality and accuracy of the data on mental health incidents (set out below).

The potential benefits of such a mapping exercise included the ability to examine all calls to the police including those which either officers did not attend, or where little or no action was taken by the police. The calls reported in studies 1 and 2 related to incidents where a police response was part of the outcome. The purpose of this more detailed examination was to analyse the types of behaviours reported in the incidents and the alternative ways in which the force responded to them compared to these later studies. This more detailed account also provided an opportunity to corroborate the reported findings concerning the change in proportion of calls that related to self-harm.

[21] This chapter was published in: Thomas. A., Forrester-Jones, R. and Hunt, P. (2019) Exploring the growth in Police engagement with those who are mentally ill and the developing use of the Mental Capacity Act as an alternative to Section 136 of the Mental Health Act. Policing: a Journal of Policy and Practice.

6.2 Study 3. Aims and Objectives

6.2.1 *Study 3. The aims of this study were:*

- to analyse the behaviours of the Force Control Room (FCR) staff, police officers and the public in incidents involving mental illness and relate these to how the police were involved and the outcome.

- to explore how and in what ways the police perceived and/or socially constructed behaviours likely to lead to the classification of incidents are relating to mental illness.

- to explore how and in what ways the police perceived and/or socially constructed behaviours which identified such individuals as in need of care.

- to describe and analyse possible influencing factors on the exercise of police discretion in how they dealt with people who appeared to be mentally ill and in need of care or protection.

6.2.2 *Study 3. The objectives of this study were:*

- to determine possible ways to improve the outcomes of encounters between the police and mentally disordered people and in so doing offer insights into improving the way that the police deal with people who are mentally ill and in particular the way that Section 136 operates.

- to identify possible opportunities for the wider range of Agencies and partners who support mentally disordered people to benefit from an improved approach to dealing with and supporting those who are mentally ill and in particular the operation of Section 136 and alternative approached to it. These could ultimately lead to improving outcomes for people who are mentally ill.

6.3 Study 3. Method.

6.3.1 *Study 3. Strategy and research design.*

As this study concerned a relatively poorly understood area of police work it was exploratory by nature. The research was based on data and the analysis of data held on a police computer system and so was relatively objective and positivist. There was however a margin of appreciation in the categorisation of incident types, so a degree of subjective assessment had to be managed.

6.3.2 *Study 3. Setting*.

This study took place within Hampshire Constabulary - a large provincial police force in England with over 5000 police officers and staff. It consists of two urban areas which are Unitary authorities, Southampton and Portsmouth; the Unitary Authority of the Isle of Wight (IOW) and the two-tier County of Hampshire including principal towns such as Winchester; Basingstoke, Andover and Aldershot. Whilst the police areas are co-terminous with one or more local government boundaries, the Health Trust boundaries are not, except on the IOW, which is unique in England, as all Health, Ambulance, local government and police boundaries are the same.

There is a range of data publicly available about Hampshire Constabulary and its neighbouring forces. It is displayed here as it is only applicable to this study. Most of it is concerned with the operation of Section 136 but it remains relevant to the results of this study.

For the use of Section 136, in 2013/14 Hampshire Constabulary detained 42.7 people per 100,000 residents per year but by 2017/18 this number had fallen to 27.29 per 100,000. This gave

Table 6.1 showing Section 136 detentions in the South East forces in 2016/17.

Police force	Number S136 detentions	Population	S136 detentions per 100,000
Hampshire	713	1953700	36.49
Kent	1,340	1801200	74.39
Surrey	671	1168800	57.41
Sussex	894	1665600	53.67
Thames Valley	1,098	2358600	46.55
South East Region	4,716	8947900	52.71

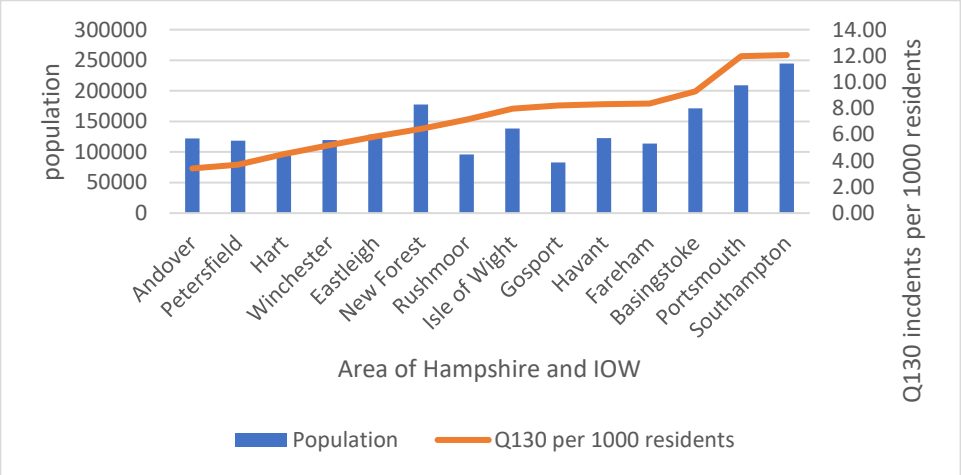
Population data from:
[https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables/current] and S136] and: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017]

Hampshire the seventh from lowest rate. The lowest rate of any police force that year was Leicestershire at 11.36 per 100,000 and the highest was North Wales at 97.71 per 100,000[22].

Set out in table 6 .1 above are the figures for Section 136 detentions per 100,000 residents for forces in the South East Region, which includes Hampshire.

Significant variation was found between forces in the same region with Hampshire having half the detentions of Kent. This is less than the 10-fold difference in rate across the whole country (paragraph 3.2.3 above). Given this variability in detention rates between forces, was there any difference in rates within a force? This is examined in the fig 6.1 below. The classification of incidents in Hampshire is set out fully in paragraph 6.3.6 below but for this illustration the code Q130 is taken as a 'proxy' measure for all mental illness incidents.

Figure 6.1 Comparison of Q130 closing codes per District Council area per 1000 residents for 2016.



Section 136 detentions per District from Hampshire data. Population data source: Hampshire County Environment Department's 2016 based Small Area Population Forecasts [https://www.hants.gov.uk/landplanningandenvironment/facts-figures/population/estimates-forecasts]

Within one police force, with operational policing policy operated through one central control It is not immediately clear how to interpret this data. There is a four fold variation across the districts in the rate of Q130 incidents from three per 1000 in Andover to 12 per 1000 in Southampton. It

[22] Source: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018]

was suggested by Officers in Study 2 that urban areas tend to draw in people from neighbouring communities who wish to seek better access to mental health care. This is consistent with the higher rates of Q130 incidents in Southampton and Portsmouth. However, Gosport, Havant and Fareham are all on the outskirts of Portsmouth, but they have high rates too, whereas Eastleigh on the outskirts of Southampton has a lower rate.

room, if detention rates differ by district then something other than policing may be responsible. One candidate concerns the local community-based partnerships that operate across the force to manage people in mental health crisis and in particular frequent presenters. These partnerships provide care plans for named individuals, which offer advice about their mental illness and specific actions to be taken when dealing with them. Variations in the quality of such local care plans may also influence the actions of officers by District. As the variation between forces is then reflected by variation within forces (or at least this force) this might argue that such variation is a two-part process. The provision of mental health services sets a level of funding in a local community (and care planning) which would leave differing amounts of 'unmet' care needs and then the risk aversion of officers (and other processes) would convert this into a local detention rate. This could account for the range of rates between and within forces.

Arguing against this are the boundaries of the mental health Clinical Commissioning Groups (CCGs). Whilst Southampton and the Isle of Wight were largely coterminous with the unitary authorities, Portsmouth included Havant; Gosport and Fareham were linked; Eastleigh and the New Forest were linked; Aldershot and Rushmoor were linked with part of Surrey; and Andover, Basingstoke, Hart, Petersfield and Winchester were combined. Treatment Units also provided services across CCG boundaries. Thus, there was no practical way to compare to compare the per capita funding per resident of a CCG area, with the rate of detention per 1,000 residents using Section 136. Whilst the differences in detention rates within a force may in part be the result of differences in funding, it is not possible to test this.

As well as rates of detention there is also data about how Section 136 detainees were transported to a POS. This is set out in table 6.2 below for the SE forces.

There is significant variation between forces on the issue of how they transport detainees. For the use of ambulances for transport the highest proportion was in Surrey at 70% with nearly all the others being through police vehicles. The lowest use of ambulances was in the neighbouring force of Sussex at 8.9% with 75% being in police vehicles and the rest in unspecified 'other'. The average use of ambulances across the region was 38.8%.

Table 6.2 Showing means of transport to POS SE Region of forces.

Police force	Hampshire	Kent	Surrey	Sussex	Thames Valley	South East
Ambulance	84	486	475	80	707	1832
% ambulance	11.8	36.3	70.8	8.9	64.4	38.8
Police Vehicle	245	812	180	673	281	2191
% police vehicle	34.4	60.6	26.8	75.3	25.6	46.5
Other health vehicle	271	2	2	0	0	275
% other health vehicle	38.0	0.1	0.3	0.0	0.0	5.8
Other	2	10	7	141	2	162
% other	0.3	0.7	1.0	15.8	0.2	3.4
None (Already at a place of safety)	0	16	7	0	25	48
% none	0	1.2	1.0	0.0	2.3	1.0
Not known	111	14	0	0	83	208
% not known	15.6	1.0	0.0	0.0	7.6	4.4
Total	**713**	**1340**	**671**	**894**	**1098**	**4716**

Source: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017]

Hampshire had a low use of ambulances at 11.8%, however they had a contract with a private ambulance company to provide transport to a POS for those detained under Section 136[23] and used these private ambulances 38% of the time. Thus, this table is slightly misleading for where it records ambulances, for Hampshire this is a mixture of their private contract ambulances and NHS ambulances. The reasons why police vehicles were used are set out in the table below.

In Hampshire nearly 70% of those cases where the police transported detainees the cause was ambulance delay. It is not clear which ambulance was delayed but in many if not most cases it must be the private ambulance. This would not be surprising as there would generally only be one private ambulance available in the force area with consequently longer response times.

Table 6.3 Showing use of ambulance services SE Region of forces.

Police force	Hampshire	Kent	Surrey	Sussex	Thames Valley	South East
Ambulance not available 30 mins.	170	303	99	198	180	950
% Ambulance not available 30 mins	69.4	37.3	55.0	29.4	64.1	43.4
Ambulance not requested	15	186	24	456	41	722
% ambulance not requested	6.1	22.9	13.3	67.8	14.6	33.0
Risk assessment - behaviour	3	239	25	19	48	334
% risk assessment - behaviour	1.2	29.4	13.9	2.8	17.1	15.2
Ambulance refused	0	3	2	0	6	11
% ambulance refused	0.0	0.4	1.1	0.0	2.1	0.5

Source: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017]

[23] At that time Hampshire Constabulary had a contract with MEDISEC, to take all Section 136 detentions to a POS. The contractor has since changed but a private ambulance service is still employed.

Ambulance refusal through risk assessment relates to violent conduct by the detainee. This is very low for Hampshire because the contracted private ambulance staff are trained in 'control and restraint' techniques and their vehicles are more suited to such circumstances. The final data concerns the use of POS.

These uses of POS were before the changes to the MHA in 2017 which largely prohibited the use of police custody as a POS. Most forces in the table above used custody relatively rarely and it appeared that Hampshire used it most. However, the large 'not known' figure arises because the use of a private ambulance service meant that the FCR did not know where the patient was taken by the ambulance after detention. Adding that figure in brings Hampshire closer to the other forces, but it was still then on the higher end of the use of police custody.

Table 6.4 Showing POS used SE Region of forces 2016/17.

Police Force	Hampshire	Kent	Surrey	Sussex	Thames Valley	South East
HBPOS	448	1234	643	679	1003	4007
% HBPOS	62.8	92.1	95.8	76.0	91.3	85.0
Police station	80	53	3	215	41	392
% Police Station	11.2	4.0	0.4	24.0	3.7	8.3
A&E used as POS	0	41	0	0	4	45
% A&E as POS	0.0	3.1	0.0	0.0	0.4	1.0
Private home	2	1	0	0	0	3
% Private home	0.3	0.1	0.0	0.0	0.0	0.1
Other	59	10	25	0	44	138
% other	8.27	0.75	3.73	0.00	4.01	2.93
Not known	124	1	0	0	6	131
% not known	17.4	0.1	0.0	0.0	0.5	2.8
Total	**713**	**1340**	**671**	**894**	**1098**	**4716**

HBPOS is a Health Based Place of Safety
Source: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017]

To consider Hampshire Constabulary in context of the SE Region, they had the lowest rate of detention and were unique in that they had a private ambulance service to take detained persons to a suitable POS. This may have skewed the data slightly as for the other forces the data only referred to NHS ambulances but for Hampshire it was most often a contracted service. That might be why there was a higher rate of non-availability within 30 minutes but a very low rate of ambulance refusal; ambulance declined on the basis of risk assessment; or ambulance tasked to other calls. In other regards Hampshire did not appear to be an 'outlier' in its performance.

6.3.3 *Study 3. Institutional approval.*

Written consent was obtained from the force for the collection of this data. In addition, the force was proud of their efforts in managing Section 136 detentions and wanted any published findings not to be anonymous (Appendix A).

6.3.4 *Study 3. Legal compliance.*

At that time many police forces did not operate an ethical approval process for applications for data collection for research. Rather they sought compliance with the Data Protection and Human Rights Act. Hampshire Constabulary agreed to this research through an exchange of correspondence (Appendix A). More recently forces have been encouraged to set up an Ethics 'body' to consider the ethical implications of force policies and practices and such research projects.

6.3.5 *Study 3. Ethical considerations.*

This study collected anonymised data on incidents from the FCR computer system. This method of collecting and processing such data had previously obtained a favourable opinion from the University of Kent Ethics Committee and on advice (attached at Appendix C), no further approval was required.

6.3.6 *Study 3. Procedure*.

Contact with the police can be in person at Police Stations, directly with officers in the street, or by phone through the emergency 999 or non-urgent '101' telephone system. In this study less than 1% of reported incidents arose through members of the public contacting police stations in person or by direct contact with officers. The overwhelming majority of incidents were generated as a result of a telephone call through either system.

After passing through the police switchboard calls were handled by the call takers within the FCR where in principle every phone contact was recorded and created a record. This was not always practical. Some incidents such as collisions on the motorways may have generated hundreds of calls with the result that for repeat calls containing no new information, a record of the caller may not have been created. Other calls were forwarded to other units such as crime management units and so a record was not made in the FCR. For the purposes of calls relating to mental health, it was most likely that a record would be created within the FCR.

When an incident is created the call-handler is led through a process of completing a record on the force 'command and control' system. This includes details of the caller, a description of the incident and if the caller or location is recorded on an existing record then this is drawn to the attention of the call handler. This links together potentially related incidents. The call handling staff are 'qualified' through National Vocational Qualifications in their roles and are subject to close supervision as well as quality assurance 'dip sampling' checks. Given all this, the researcher concluded that the typed records of incidents were likely to be accurate enough for the purposes of this study.

For each incident record an 'incident type' is attached to it which takes the form of an opening code and describes the key feature of the call. For example, a call about a burglary would trigger the opening "BURINC" – burglary incident.

The incident may require no further action by the force; some action by the force on the phone, for example notifying another party of the content of the call or may require an officer or Police and Community Support Officer (PCSO) to attend. The record of the incident also contains this

outcome from the person who resolved it and then a 'closing code' or codes which again classify the incident. The closing codes may be different from the opening code. The closing code is generally seen as a more accurate record of the type of incident as it is based on a more detailed and complete analysis.

In discussion with FCR managers four codes were identified as likely to be relevant in research about contact from or about people who were mentally ill. The opening code of "VUNBLEINC" referred to an incident concerning a person who was *vulnerable*. The opening code "CONWELF" identified an incident which raised concerns about the welfare or wellbeing of an individual. The closing codes of Q130 (Mental illness) or Q115 (Persistent caller) were also reported as relevant.

At the time of the study in 2016, the only mental health Triage Scheme in Hampshire Constabulary was a scheme on the IOW. In this scheme a mental health worker attended police incidents – when available. A small number of Incidents dealt with in this way and were identified through reference in the incident record to the scheme. Most outcomes were also recorded there too.

In choosing the period in which the data was to be collected there were several considerations. Data could be examined on the *live* command and control system which would make it as current as possible but as it would take some time to collect and analyse data and the collection period would need to be *fixed* otherwise new data would continually be added.

If the data were collected from the then current year the live command and control system had very limited functionality to undertake data collection and analysis. There was also the danger that any such analysis would interfere with the operation of the live system, which was old and slow and coming to the end of its operational life. This would clearly be unacceptable. If data were collected from the previous year – 2016 - then a whole year's worth of data could be downloaded to an analytical program "Business Objects" which was designed for such analysis and which would not then interfere with the live system. On this basis it was agreed that the dataset from 2016 would be analysed.

In 2015 Hampshire Constabulary had appointed a small team to manage their internal and multi-agency approach to mental illness. One of their first actions had been to improve the accuracy of the identification of such incidents on their Command Control system. This is illustrated by the change in the numbers of incidents with mental illness codes (table 6.5 below). Q135 relates to Section 135 MHA warrants and Q136 relates to Section 136 detentions.

This revealed a three fold increase in use of the Q130 code (Mental illness) and the identification of Section 135 and 136 incidents previously unrecorded. The operational policy was that for mental illness incidents an opening code of 'Vulnerable' would be used coupled with a closing code of Q130 or Q115. In 2016 Hampshire Constabulary generated 433,261 command and control

Table 6.5 Showing mental illness closing codes in 2015/16 and 2016/17

	Reporting Year 2015/16	**Reporting Year 2016/17**
Q130	3604	11805
Q135	0	58
Q136	0	110

logs overall which resulted in the creation of 401,645 unique incidents. Using the search criteria of opening with Vulnerable and closing with Q130 or Q115, 15,409 of these incidents were identified as relating to mental illness. However, the researcher discovered that operators were often opening with vulnerable but not closing with Q130 or *visa-versa.* When all permutations of the codes were included 18,320 incidents were identified. This represented a rate of 4.6% of all incidents that were concerned with mental illness. This is higher than the 0.6% reported by Thomas and Forrester-Jones (2018) but that report was only concerned with incidents where officers attended (see para 4.1 above). The College of Policing estimated demand from mental illness as 2% (College of Policing, 2015) whilst HMICFRS estimated 2.4% of crimes and 2.8% of incidents were concerned with people who were mentally ill (HMICFRS, 2018), though they reported that these were likely to be under-reported figures. The Metropolitan Police have

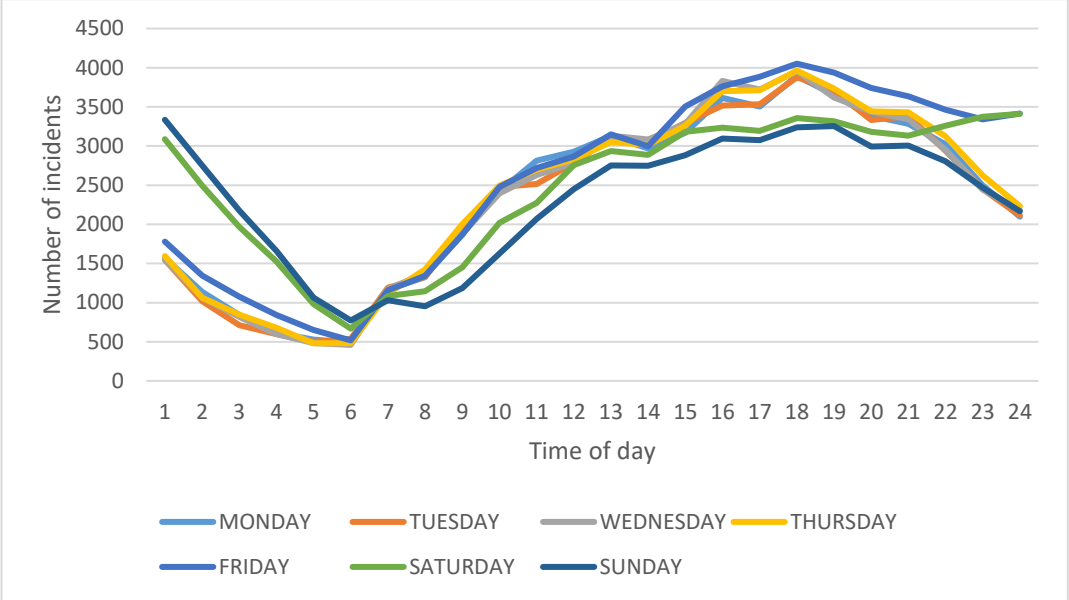
estimated the level of demand as much higher at 15 to 20% of workload (College of Policing, 2015).

To formally test the reliability of the recording of police incidents a two-part process was employed. The first part assessed the researcher's accuracy in classifying incidents. To do this 200 consecutive incidents were assessed on one day and 202 on another. These were all types of incidents and not limited to mental health. The researcher and a senior officer from the force (the second rater), skilled in the use of the computer system each read and reviewed half the incidents and then read and reviewed the half that had already been checked by the other. This ensured consistency and accuracy in the review process. Of the 402 incidents there was only one where there was a difference in view, and this was quickly resolved. This gave an acceptable agreement rate of 99.75% between the researcher and the second rater.

The second part of the assessment was to look at the accuracy of the force's classification process upon which the later research would rely. Of the 402 incidents reviewed above, the first set revealed nine mental health incidents: six were VUNBLEINC opening codes of which five were Q130 on closing, three others were Q130 on closing. In the second batch six incidents were identified of which two were opened as VUNBLEINC of which one was closed as Q130 and three other incidents were identified as Q130 on closing. All these seventeen incidents were correctly identified by the force staff during the recording process. In addition, three other incidents could have been classified as Q130 on closing. Both reviewers shared this judgement which was then referred to the FCR Inspector (supervisor) present on those days. The Inspector agreed that the three had been mis-classified. This represents an accuracy rate of over 99%, which is a satisfactory rate for the study.

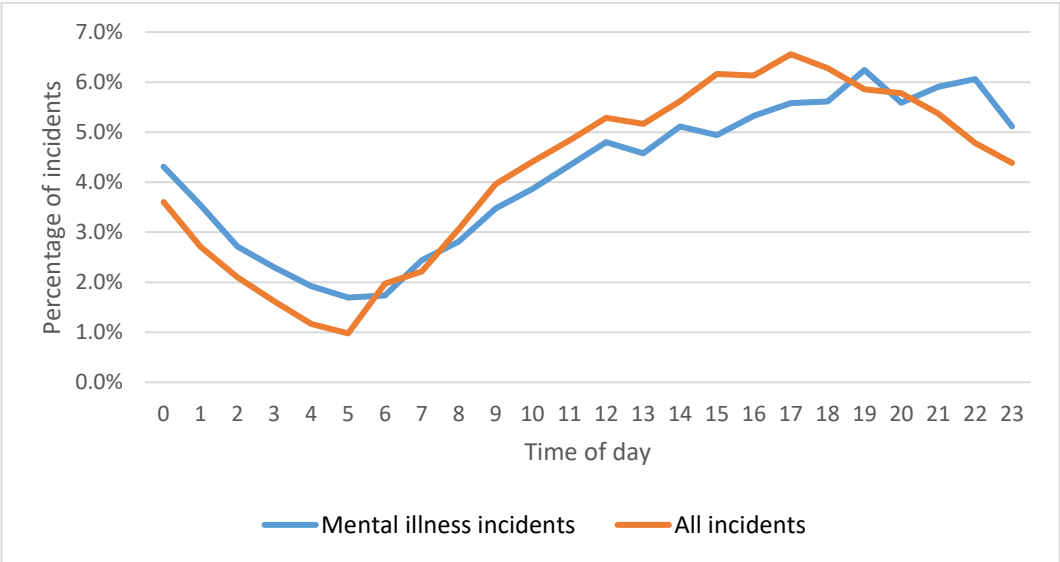
To determine how best to sample incidents for these codes an analysis was undertaken comparing the number of incidents reported by time of day, day of week and month of the year. All incidents by time of day and day of the week for 2016 are set out in the figure below. To read the figure it is necessary to understand that the day of the week changes at 24.00 to the following

Figure 6.2 All FCR incidents by time of day and day of the week for 2016.



day. Thus, the light blue line that is Friday after 24.00 becomes the green line that is Saturday at 01.00. Bearing that in mind Sunday to Thursday have a very consistent pattern of incidents, the lowest number is between 05.00 and 06.00 in the morning after which it rises until about 18.00 then falls back down to the low number overnight. For Friday to Saturday and Saturday to Sunday nights the numbers remain higher overnight, consistent with the higher level of socialising overnight on the weekend.

Figure 6.3 Percentage of all incidents and Q130 closing codes by time of day for 2016.



To compare the pattern for mental illness incidents the percentage by hour of the day for all incidents can be compared with the percentage by hour of the day for mental illness incidents. This is set out in figure 6.3 above. Using percentages overcomes the difficulties caused by the disparity in numbers. It is perhaps not surprising to see that the police involvement with mental illness is lower than overall incidents during office hours and higher outside office hours. It might be expected that those who are in crisis out of hours will then tend to call on the police.

The implication is that by sampling whole days any time of the day effects can be eliminated and by sampling a whole week, day of the week effects can be minimised. Thus, it was determined to analyse all the incidents relating to mental illness from one week in the first quarter of 2016. Those incidents which were largely dealt with on the seventh day but concluded on the eighth were also included in the data.

6.3.7 *Study 3. Dataset.*

Searching using permutations of the four codes identified 444 incidents during one week. The anonymized data about these incidents including the codes, the opening and closing description and the outcomes, where known, were entered into an Excel spreadsheet where they were analysed using filters.

The whole spreadsheet would print onto 171 A4 pages and so is not included in this thesis however it is available in the data disk (Appendix I).

For illustrative purposes a small sample of 25 consecutive incidents is included in table 7.6 below. This sample has also had several columns removed in order to fit it onto the page.

The analysis of the data operated as follows, each incident was represented by a row in the spreadsheet. In this row are the details of the incident, the date, the time, a summary and a number of ‘codes’. A filter can be applied to each set of codes to identify just the incidents containing that code. For example, there are 25 listed opening codes. Applying a filter to these produces a list of all these codes, some or all of which can be selected. When selected, only

incidents containing those codes appear in the table and so if “dominc” (domestic incident) is selected then the three incidents opened with that code appear in the table.

Some codes were those applied by the force and so adopted by the researcher without further analysis. In table 7.6 below the initial code and closing codes are of this type. The correct classification is an assessment but has been quality assured as part of this process (above). Whether there is a deployment formed part of the computer record and who was deployed was listed in the text and so was easily recorded.

The incident was described using a summary containing as much of the original text as possible. To analyse the data the content of each incident was assessed, and a range of codes were attached to each. Through an iterative process the thematic assessments and codes were refined until consistent results were obtained. It was not practical to employ two independent assessments of all the subjective behavioural codes because it took up too much time for the senior officer involved. However, it was possible for both assessors to check 100 incident records and to agree on the coding for those, which then formed the basis of the remainder of the analysis.

The ‘style’ column related to the nature of their apparent mental condition e.g. del = delusions; dem = dementia; irrat = irrational. For dementia, the diagnosis was always part of the incident record and usually was something that the call takers were told by the callers about the subject officers were told by others at the scene. Thus, dementia was an accurate assessment of when the description was applied, but it is not possible to be certain about its accuracy as a diagnosis. Delusions referred to the caller who expressed delusional views or beliefs (see table 6.6). Irrational could either be a description of the caller or the behaviour of another described by the caller. It concerned distress, anger or unreasonableness. As can be seen in table 6.6 these last two classifications can be very clear cut.

The next column indicated if they were a regular caller, which was again generated by the computer on the basis of the call history.

The next column shows the type of behaviour e.g. Misper = missing person; Beh = unmanageable or disturbing behaviour; dist = distressed and self = self-harm. This was separated from the style column above so that more than one code could be used. Thus, in table 7.6 there is the combination of delusional and behavioural and irrational and behavioural.

Learning disability and Autism like dementia was a diagnosis shared with the police usually by the caller who was contacting the police about them. It was therefore an accurate record of the description offered but could not be independently verified.

The last column indicated what sort of premises or other partner agency contacted the police. Amb = ambulance; care = care home; hosp = hospital and police = other police force. This enables an assessment to be made of the transfer of work between partner agencies as a comparison with study 1.

There is manifestly a limited value in the subjective assessments for they are based on a few words recorded on a computer system by a busy member of staff who is interpreting something that is being described to them 'second hand'. It is a *descriptive* element and included as it illustrates or indicates the potential for further research into the behaviours of those who are mentally ill or impaired and who come into contact with the police.

Having linked the codes to the incident records it was then possible to search for combinations of codes, present or absent. This searching took the form of a 'decision tree'. A simple example is set out below.

- 444 incidents – select code for "correctly classified" = 436 incidents.
    - Select code for dementia "dem" = 54 incidents
    - Select deployment " yes" = 25 or non deployment "no" = 29 incidents
        - Select deployment "yes" and "police" = 22
        - Select deployment and "yes" and "police then ambulance" = 2
        - Select deployment and "yes" and "111" phone system = 1.

In the sample of the spreadsheet below the first three columns show the initial and closing codes. Next is the confirmation of a correct classification followed by whether there was a deployment to the incident. If there was, the next column shows which service attended.

Table 6.6 showing sample of incident database on Excel spreadsheet

Abbreviations. Amb = ambulance; Dom = domestic dispute; Inf = informant and MOP = member of public.

Initial code	closing code	closing code	Correct class	Deployment	Who	Description	style	reg	type	aut/LD	premises
vul	Q130		☑	No		caller had annoyed partner by putting shit on his grave and since then he has been bothering her through TV. Him and her husband both at it. Regular caller.	del	reg			
vul	Q130		☑	No		female caller in hospital saying it is under siege, series of different calls from different locations. No action. Several calls.	del	reg			
conwelf	Q130		☑	Yes	Police and ambulance	MOP found woman who had tried to take life in river and with overdose. They called ambulance. Taken to hospital. Officers making enquiries for family.			self		

conwelf	Q130	Q125	☑	Yes	Police	Call saying that her neighbour is banging and crashing and is now in garden with torch. Second call about naked man in garden with a torch. Male says he went walking as someone after him. MH problems. Long delay on ambulance officers took to hospital for paranoia.	del		
vul	Q130	Q125	☑	Yes	Police and ambulance	Caller from care home to say that being forced to take Medication. Home rang to say patient out of control threatening self-harm, locked himself in room	del		care
dominc	Q130		☑	Yes	Police	Inf is with her elderly mother who has dementia and is being aggressive and trying to leave house. Scared for mum's safety. Inf called 111 who would not deploy. Officer attended contacted 111 and a doctor will attend.	dem		
conwelf	Q130		☑	Yes	Police	Officers found woman walking in road, she stated that she was all set for a campsite but appears to have MH problems. Will take her to camp site. No answer at campsite so took to hotel in Salisbury and made sure she was booked in.			
vul	Q130		☑	No		Rang asking for royal pardon, felt sorry for the police, disappointed for judge who recently dealt with him. Regular caller	del		
mispinc	Q130		☑	Yes	Police	Inf son walked off from home, never done it before, in drink, Bi-polar and had just disclosed historic rape. Tracked down by officer. Not missing, failed to communicate with family.		misp	

vul	Q130		X	No		Handle fell off door and man trapped in office				
vul				No		Patient in hospital rang to report murder, hospital contacted, patient refusing treatment.				
vul			☑	No		Patient rang from hospital to report murder, hospital contacted and patient had refused to take medication and rang police.	del			hosp
vul	Q130	Q115	☑	No		Neighbours squirting dirty water at roof. Regular caller.	del	reg		
conwelf	Q130	Q125	☑	Yes	Police	Call from swimming pool, male has arrived by taxi and is very odd, claims he is being followed by people and needs to hide. Clearly paranoid. He was recently released from hospital and has been taken after to A&E where they would not admit him. Officers with him, very paranoid, delay on amb, officers Section 136 Medisec called.	del			
vul	Q130		☑	No		Call from care home, male shouting needs police assistance to stop doctor assaulting him. Call from staff to say problems with caller who has behavioural issues.	del		beh	care

vul	Q130	Q115	☑	No		Regular caller stating that she has injected someone with her blood to give them cancer and aids. Regular MH caller.	del	reg			
burinc	Q130		☑	Yes	Police	Male caller stated that o/n his flat had been broken into, clothes strewn about and some taken. Officers report MH issues, nothing stolen no entry	del				
conwelf	Q130	Q125	☑	Yes	Police	Call from Surrey DC, victim in his case of sex assault has found out case discontinued. She has range of MH issues. He on way to see her but has puncture. Phoned her and she indicates self-harm. Officers attended with amb and she taken to hospital.			self		police
vul	Q130		☑	No		Regular caller reported that assaulted but didn't know by whom, she was asleep when happened in her locked room, high volume caller, care plan in place including non deployment.	del	reg			
pubord	Q130		☑	No		Ex member of staff has returned to claim that she is owed wages, has caused problems harassing staff. She is not owed pay and this is not the wages department. They asked that police make record as she is very volatile with HM issues. She then left.	irrat				
conwelf	Q130		☑	Yes	Police	Retail security guard called in at police station, autistic customer in shop has become distressed as she could not buy something. Officers attended and helped carer persuade her to get into car.			dist	autism	

vul		☑	No		Info concerning neighbour's behaviour, pretending to defecate in garden and on street, pretending to fire pistol at passing cars, referred to partner agency.	irrat	beh		
conwelf	Q130	☑	Yes	Police Ambulance	Call from amb, female jumped in pond to try and drown, now out and standing in road to get run over. Now turned up at home discharged from trying to get in. Now back in river. Officers arrived with her, called for amb. Detained by amb Mental Capacity Act, taken to hospital.		self	amb	
dominc	Q130	☑	Yes	Police	Mother reporting domestic dispute at her son's house. Previous reports of MH issues for mum. Son visited and confirmed no dom, MH problems with mum.	del			

6.5 Study 3. Results

6.5.1 *Study 3. Incident data in the sample*

Of the 444 incidents, eight appeared to be mis-classified. However, one related to a man who rang to say that the door handle had come off his door and he was locked in his office. The call taker, thinking that the man might be mentally ill, classified him as Vulnerable, but indeed the handle had fallen off the door trapping a perfectly sane man inside. Another call was about a man who was reported as hanging off a roof and possibly suicidal and so coded as Vulnerable. It turned out that he was a 'free runner' who was taking a rest so again an understandable classification. Three were classified as Q115 (persistent caller) but they related to '*take-aways'* which were frequent callers because of anti-social behaviour not mental illness and three were family disputes and appeared to be in error. This would give an error rate of around 1.8%. A fairer estimate might be to accept that the first two did appear to relate to mental illness or vulnerability and so the error rate should properly be six out of 444 which equates to 1.3%. This error rate is low and similar to that reported above.

Table 6.7 Showing FCR incident opening codes and numbers in sample.

Incident opening code	Number of incidents
Arson	1
Assault	16
Burglary	9
Concern for welfare	66
Crime other	1
Damage	1
Dispute	1
Domestic dispute	16
Drunkenness	2
General police duties	5
Injury illness	10
Malicious comms	2
Missing Person	13
Nuisance	3
Prevent Breach of Peace	1
Public order	4
Rape	2
Suspicious incident	10
Telephone abandon	4
Threat to life	2
Vehicle drunk in charge	1
Vulnerable	261
Weapon incident	5
Total	436

6.5.2 *Study 3. Types of incidents present in sample.*

These incidents shared twenty-five different opening codes. The two largest by volume are Concern for Welfare and Vulnerable. Reviewing the incidents these two categories appear very similar. Though sometimes interchangeable, the main difference

appeared to be that Vulnerable concerned a person who contacted the police themselves and appeared to vulnerable or at risk. Concern for Welfare generally concerned a person ringing about someone else who they believed was in some way at risk. The Concern for Welfare sometime included an element of the person not being contactable, which was the basis of the concern. In its most direct form such incidents were reported as a Missing Person. There were only 13 such reports which is a small but significant proportion – 20% - of the larger group of Concerns for Welfare.

These opening codes can be aggregated as:

- **Concerns for someone's welfare** including: Vulnerable (261); concerns for welfare (66); injury illness (10) and missing person (13) - 352 incidents = 80% (of 436).
- **Crime** including crimes; public order; drink related offending and driving and suspicious incidents- 60 = 14%.
- **Domestic disputes** - 17 = 4%.
- **Other** including General policing enquiries and abandoned 999 phone calls - 10 = 2%

The great majority of incidents reported to the police, shown here as "concerns for someone's welfare", concerned the prospect of harm to individuals. These could be reported directly by individuals or by third parties.

6.5.3 *Study 3. Types of incidents which received a police attendance or deployment.*

193 of the 436 (44%) of these incidents had an officer or PCSO deployed to it and of these deployments:

- 155 (78%) were by the police,
- 24 (12%) were initially the police who handed the incident over to an ambulance.
- 11 (5%) were deployed to by ambulance alone (but the police were notified).
- 8 (4%) started with the ambulance but was passed to the police.

- 1 (0.5%) incident was passed from the police to NHS direct on 111.

Whilst this list reflects the 'cross-over' between the police and ambulance services, there would also have been a number of calls to the ambulance service alone, concerning crises of mental illness, which are not recorded here. Police handing incidents to the ambulance service was not observed in a previous study though incidents passed from ambulance to police through delays in ambulance attendance was observed (Thomas and Forrester-Jones, 2018).

243 (56%) of the incidents were dealt with by no deployment, either through the initial conversation by the call taker or a follow up conversation on the telephone with that person or someone else. If this is representative of the eighteen thousand recorded mental health incidents, then the rate of deployment to such incidents falls to 2.5% which is more consistent with previous estimates of demand upon the police (above).

74 (17%) of the calls came from other public sector partners such as the ambulance service, care homes, hospitals or doctors. This is significantly lower than the fifty percent reported previously (Thomas and Forrester-Jones, 2018). In the deployed incidents only 32 were from other public sector partners, which represents 16%. Differences in such partnership working is likely to account for some if not most of the variation between force in the use of Section 136.

6.5.4 *Study 3. Section 136 'type' incidents.*

46 (10%) of the calls appeared to meet the criteria for the use of Section 136 in that at the conclusion of the incident the subject was passed into the care or custody of another party. Thus, either Section 136 was used, the ambulance service took the person away for assessment or the person was passed into the care of family friends or another authority. In terms of the level of threat arising from the behaviour of the individuals:

- In 34 of the incidents there were threats of self-harm;
- in five the subject appeared to be having a psychotic episode;
- In four through their behaviour they appeared very vulnerable to harm;
- In two the subject appeared extremely distressed;

- In one the subject exhibited irrational violent and aggressive behaviour.

Thus in 38 (83%) of these incidents the person was threatening self-harm or otherwise appeared likely to come to harm. This figure is consistent with the 81% of behaviour leading to Section 136 detention concerning self-harm (Thomas and Forrester-Jones, 2018).

In terms of outcomes:

- Officers detained people under Section 136 on ten occasions (but in one the ambulance agreed to take the person detained to hospital).
- On ten occasions an ambulance took the person to hospital using their powers under Section 4 and 5 of the Mental Capacity Act
- On five the police left the subject with family members waiting for an ambulance
- On eleven occasions the person was left with family members to care for them
- On one the police returned a patient to his treatment unit
- On one the family took the person to hospital
- On one occasion police officers took the person to hospital
- On four occasions the IOW Triage Scheme dealt with the person (one taken home; one no further action; one an appointment made and the fourth not known)
- One person was arrested on a criminal warrant
- One was handed to the military authorities to care for them
- One was referred to their GP
- One person was dealt with informally (taken to a hotel and booked in overnight)

The outcomes can thus be summarised as:

- No detentions were taken into police custody.
- Nine Section 136 detentions by the police were taken to a Health Based Place of Safety using a private secure ambulance service.
- Eighteen detentions went to hospital directly. Sixteen by ambulance, one taken by family and one directly by police officers.

- Eleven individuals were cared for by family members.
- Two were dealt with by other Health bodies.
- Two were passed to other responsible authorities.
- One was dealt with informally
- One was No Further Action (through IOW Triage Scheme).
- One not known (through IOW Triage Scheme)

6.5.5 *Study 3. Missing persons as a special case of risk management.*

The 13 missing persons represent an unusual set of incidents. They consist of:

- Three children absent from school
- Three people who absconded from mental health care or assessment
- Six people reported missing by families and
- One report that arose from a misunderstanding.

The first six were reported as part of a legal duty to report them missing because of the high level of risk associated – at least in general - with their absence. The children either were distressed when missing or had LD. The adults were mentally ill or suspected to be so. It is not clear in the incident records what the outcomes were, but they were all found unharmed and returned safely.

Of the six reported missing by their families one was vulnerable but not for reasons of mental health and one was suffering from dementia. They were both taken home when found, one by the police and one by members of the public. Of the remaining four, three were detained under Section 136 and the fourth was taken to hospital by his family.

What appears clear from the review of the incidents is that Missing Persons are a special case of high-risk incident and are therefore prioritised. No other incident type had a detention rate under Section 136 as high as Missing Persons. Excluding the six from schools and hospitals and the one in error, four of the remaining six missing persons incidents were Section 136 type (66%) and three (50%) were actual section 136 detentions. This compares with 27 Section 136 type incidents amongst the 66 Concern for Welfare incidents (41%).

6.5.6 *Study 3. The MCA and the growth in use of A&E as a POS.*

Whilst 20% of these detentions went to a mental health unit for assessment, 41% went to A&E in hospital – usually by ambulance. Detentions by ambulance staff taken to hospital would not appear in the police figures quoted above but an increase in police Section 136 detentions going to A&E appears to be an emerging trend across England and Wales.

Table 6.8 Section 136 detentions in England and Wales 2013 to 2017 and POS.

Year	2014/15	2015/16	2016/17	2017/18
Total S136 detentions England and Wales	23602	28271	26328	29662
Detained police station	4537	2100	1029	471
% Police station	19.2	7.4	3.9	1.6
Health Based Places of Safety	19065	26171	20435	23414
% HBPOS	80.8	92.6	77.6	78.9
Accident and Emergency			1944	3243
% A&E			7.4	10.9
Other			360	453
% Other			1.4	1.5
Not Known			2560	2081
% Not Known			9.7	7.0

Source:[https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018]: [https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017] and []https://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf]

The growth in use of Accident and Emergency in table 6.8 relates to police officers taking detainees there. This may well result in the officers having to remain to supervise their detainee until the assessment is complete or even until a suitable bed is found to admit them. The recent advice published by the Royal College of Emergency Medicine (The Royal College of Emergency Medicine, 2017) states that police officers arriving with someone detained under Section 136 should be required to stay with the detainee unless the '*hospital has staff and space to safely take responsibility for detention and agrees to do so.'* The Royal College of Psychiatrists in their guidance also state that officers may need to remain at the POS for *'a short period'* (The Royal College of Psychiatrists, 2011a), though in their later guidance the Royal College had set the time limit at 30 minutes (The Royal College of Psychiatrists, 2013). It therefore seems likely that in many cases officers will be required to stay and supervise the person they detained. When taken

to hospital by ambulance the responsibility for supervision would fall on ambulance or hospital staff which in turn could cause significant problems for Health as one detainee may require two or even three staff to supervise them whilst in A&E. It is not desirable to take detainees to A&E unless they have a specific facility as a POS. This was set out in the report of the Royal College of Psychiatrists (the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine, 1996) and expanded upon by Lynch (2002), though lack of capacity may still make A&E a POS of last resort.

6.5.7 *Study 3. Mental health incidents that the police deployed to which were not Section 136 'type'.*

In addition to the 46 Section 136 'type' incidents there were 147 other mental health incidents that officers were deployed to. The behaviour in these two types of deployment were quite different. Whilst eighty nine percent of the Section 136 incidents related to threat of self-harm, this was only present in only fifty five percent of other deployments. This was reversed for crime and domestic disputes which were thirty one and eleven percent of other deployments and only nine and two percent of Section 136 type deployments. This is the established pattern that self-harm is the causal factor for Section 136 type incidents.

It is possible based on the descriptions in the police records to further categorise the incidents. This analysis is more *cautious* given that it is based on a summary account recorded in the control room, from an assessment provided from the scene by an 'unqualified' person and the numbers are quite small. For the 46 Section 136 type incidents, removing the level of threat and concentrating on the apparent state of mind of the individuals, these can be described as:

- **Suicidal**. 23 (50%) An attempt or direct threat of suicide.
- **Delusional**. 6 (13%) Where the perception of reality appears disturbed or distorted.[24]
- **Distressed**. 9 (20%) Where they are described as very distressed.

[24] The Royal College of Psychiatry defines the term as the term 'delusion' to denote a pathology in which a belief held with unshakeable conviction runs counter to the prevailing cultural norm.

- **Irrational**. 5 (11%) Where their behaviour is described as irrational.
- **Attention seeking.** 2 (4%) Where their purpose appears to be to get attention from the police.
- **Behaviour.** 2 (2%) Difficult or uncooperative behaviour. In most cases this concerned requests from other organisations or carers for assistance.

For the 147 other deployments the state of mind can be assessed in the same way, but the pattern was different.

- **Suicidal**. 13 (9%).
- **Delusional**. 24 (16%).
- **Distressed**. 28 (19%).
- **Irrational**. 19 (13%).
- **Behaviour**. 28 (19%) and in addition
- **Dementia**. 25 (17%) Where the person was identified as suffering from dementia.
- **Absconders**. 6 (4%) These were absconders from assessment or treatment by Health.
- **Assistance**. 4 (3%) Other requests for assistance from partners.

This remains an imperfect analysis because some categories relate to threats of action whilst others are about behaviours. Whilst the behaviours in ‘distressed’ or ‘irrational’ can be described it is impossible to say what the underlying state of mind of the subject was. In contrast in the absence of these behaviours the delusional nature of the subject can often easily be seen. Nonetheless there are a strong similarities and differences. Delusional, distressed and irrational behaviour together, was present in 44% of Section 136 tyre incidents and 48% of other deployed incidents. A similar percentage, which implies that when present these behaviours were not material in the decision as to whether the person was detained under Section 136. That decision was mostly determined by the level of risk of self-harm. Thus, suicide was threatened in 50% of Section 136 incidents and only 9% of other deployments.

Dementia resulted in deployments but none that appeared to be suitable for detention under Section 136. A lack of mental capacity through dementia would be more suitably dealt with using Sections 4 and 5 of the MCA.

6.5.8 *Study 3. Comparison of deployed and non-deployed mental health incidents.*

In 243 incidents (56%) there was no police or other attendance. These can be divided into two principle categories: single callers and frequent callers and then the same categories as above. This comparison is set out below in table 6.9 below.

Table 6.9 Comparison of mental incident types for deployed and non-deployed incidents.

Behaviour	Section 136 type incidents n=46	Other deployments not Section 136 n=147	Non-deployment frequent callers n=113	Non-deployment single callers n=130
Suicidal	23 (50%)	13 (9%)		1 (1%)
Delusional	6 (13%)	24 (16%)	64 (56%)	39 (30%)
Distressed	9 (20%)	28 (19%)	15 (13%)	20 (15%)
Irrational	5 (11%)	19 (13%)	20 (18%)	29 (22%)
Attention seeking	2 (4%)		9 (8%)	5 (4%)
Behaviour	1 (2%)	28 (19%)		7 (5%)
Dementia		25 (17%)	5 (4%)	24 (18%)
Absconders		6 (4%)		
Assistance		4 (3%)		
Other				5 (4%)

The non-deployed suicidal incident was exceptional and arose when a member of the public rang to say her friend was distressed and suicidal but that she had calmed her down and would look after her. Apart from that case, threats of suicide were deployed to by the police and high-risk cases were detained or left in the care of other agencies or family members. Delusional callers who appeared 'low risk' were most often not deployed to – this is in accordance with clinical advice received by Hampshire Constabulary.

Distress or irrationality appear equally often in deployed and non-deployed incidents and so these behaviours do not appear to affect police actions and outcomes.

Requests for assistance from carers because of behaviour most often related to Learning Disability or Autism and is a small but growing area of police work as was reported previously (Thomas and, Forrester-Jones, 2018). Similarly calls relating to dementia must be set to grow in volume and were around half of a percent of Hampshire Constabulary incidents in this study.

6.5.9 *Study 3. High frequency callers to the police.*

There has also been publicity about high frequency callers to police and other emergency services[25] and this is equally true for Hampshire Constabulary. The top ten callers in 2016 made 6,131 calls, the top caller alone made 2,636 calls. This caller fitted the pattern of delusional calls. There were few if any deployments to this caller, but it is noticeable that the staff taking the calls were kind and courteous, which may reinforce the behaviour. The force has local partnership meetings to discuss the care and management of such high frequency callers living in the community, but it is reported that it is very difficult to limit such calls.

In the sample period it was possible to follow the progress of an emerging frequent presenter. The history of calls from the individual are set out below:

Table 6.10 Showing pattern of calls from an emerging frequent caller.

Incident number	Date	Description of incident
259	Day 1	Man called claiming that people were standing outside his window listening to him. He said police had attended twice but now police had gone people had returned. No markers on address so officers deployed. Nothing found.
263	Day 1	Same caller as 259. Complaining that men outside his house, he is under threat. Repeated calls – nine in all, distressed, several police attendances, no persons found.
279	Day 1	Caller claims he can hear people outside his house planning to break in and get him. Frequent caller. No Further Action.
291	Day 2	Regular caller stated that there are people outside his house saying that they are going to break in, however this time he also claimed that his car had been damaged. Even with previous history officers dispatched. Area Search No Trace, caller phoned again to say police have not attended and people still there. Series of calls to same effect. NFA.

[25] https://www.bbc.co.uk/news/uk-england-43293581

Over two days this young man, who was clearly suffering a psychotic episode, hearing voices and other delusions, contacted the police over a dozen times. Having deployed officers several times and linking all the incidents together, quite quickly a policy decision was made not to attend such calls. For the last call, with a new allegation of criminal damage to his car officers were deployed but again the call was seen to be 'false'. The force has a process of identification for such mental health crises with a referral to community-based health services. It is not clear what happened in this case for there were no further calls in the sample period. Perhaps the caller referred himself for help or family or friends did so, two days would be a very rapid intervention for a partnership-based approach.

For other callers their contact with the police continued unabated through the sample period indeed in many cases across the whole year. Through the analytical software it was possible to identify frequent callers and the number of calls and incidents that they generated. Apart from genuine high-volume calls from businesses such as British Telecom concerning the '999' system, the individual high-volume callers are listed below.

6.11 Table showing total calls and incidents from high frequency callers for 2016.

Anonymous Caller identifier	**Number of telephone calls**	**Number of incidents generated (% all calls)**	**Nature of calls**
AA	3038	980 (32%)	Mental Health
BB	893	284 (32%)	Mental Health
CC	500	185 (37%)	Most Mental Health some Domestic disputes
DD	328	118 (36%)	Mental Health
EE	324	104 (32%)	Mental Health
FF	281	93 (33%)	Mental Health
GG	270	96 (35%)	Mental Health
HH	262	97 (37%)	Mental Health

It is striking that the conversion rate of calls to incidents remains very consistent amongst these high frequency callers. There is no obvious explanation for why that should be the case.

The highest frequency caller, AA, made 14 calls during this data collection period which would equate to a total of 728 incidents in a year. This is slightly less than the 980 incidents actually created by her.

The calls could be listed to illustrate their nature but placed in the public domain, she might be identified by people who know something of her and her condition. This would constitute a potential breach of the Data Protection Act and the Human Rights Act.

Her calls have a certain bizarre quality. The greater number concern a relative from many years ago whom she claims steals her property, interferes with her life and harasses her telepathically. Reviewing a wider sample, her calls cover a wider range of topics such as her health and medication, other people stealing her property or strange things she has seen or heard. In a sample of over 50 additional incidents there was not a single deployment. AA is the subject of a locally based multi-agency management group and whilst she does live in the community with support, it has never been possible to prevent her from calling the police.

In contrast to AA, BB made no calls during the data collection period. A sample of her calls were examined and they all concern her being stalked by men, sometimes in public and sometimes in her own home. Usually the calls concerned threats but sometimes she claimed actual assaults. There is a care plan in place on the command and control system from the local multi-agency group which includes a diagnosis of paranoid schizophrenia and lists her usual beliefs and behaviours. Her pattern of calls is more clustered with many over a few days and then gaps where there are no calls. This probably accounts for her not appearing in the data sample. With clear identification of her condition the force policy is not to attend her calls but rather to refer them to her care workers. Thus, there were no deployments to any of her calls that were reviewed.

The third most frequent caller CC is unusual as her calls to the police are identified as more mixed and not solely concerned with mental illness. In the data collection period she only made two calls. CC regularly called the police in connection with her neighbours or passers-by and

complained about how they looked at her or behaved. There was a care plan in place and she was diagnosed with learning disabilities and paranoid schizophrenia with fluctuating capacity.

Another high frequency caller, FF, was present in the data sample. FF's calls are consistent over the year and concerns infections through various means or allegations of sexual assaults – usually against health professionals. She was subject of a multi-agency care plan, but it was not possible to prevent her calls to the police, hardly any of which are deployed to.

For these callers with the highest frequencies of contact the force did not appear to have prosecuted or taken other sanctions against them, rather they attempted to manage their behaviour through partnership working. However, further down the list and still with over 200 calls there were cases where the callers were identified as mentally ill, but the calls were abusive and took up significant time on the '999' system. In these cases Criminal Behaviour Orders were sought to prevent them from abusing the phone system.

Thus, the force makes a clear distinction in how it responds to frequent callers who present as low risk. Where their conduct is not criminal i.e. abusive threatening or wasting the time of the 999 system, a multi-agency approach is employed to reduce their volume of calls. Where criminal behaviour is present criminal sanctions are sought and calls are often quickly terminated.

6.5.10 *Study 3. Use of MCA by the police – an FOI request.*

In Hampshire it did not appear that police officers ever used their powers to detain under the MCA, but the ambulance service did, often instead of the police using Section 136. To start to explore the potential use of the MCA by the police a Freedom of Information request was sent to all police forces in England and Wales. This was intended to see if forces had records of their officers using the MCA and whether they had specific policies on its potential use. The request is included at Appendix D.

34 of 43 police forces responded and they did so in a range of ways which makes it difficult to precisely compare their answers.

- 12 forces stated that they did not hold records on the use of the MCA by their officers.
- 8 forces stated that it would be too expensive to extract the data from their systems to find out if it is used and if so, how often. This related to the need to manually inspect a large number of records on their command and control system.
- 7 forces accepted that their officers may have used the MCA to detain people but either had no practical means to determine how often or believed that it was too expensive to find out, as above.
- 1 force stated that only the ambulance service would use that power (in their force area)
- 6 forces had some records of the use of the MCA by officers. These were:
    - British Transport Police (BTP) recorded 15 detentions by their officers in 2017 and 25 detentions in the same year by non BTP police officers on railway property. In 2018 they recorded 14 detentions by BTP officers and 20 detentions on railway property by non BTP officers.
    - Cambridgeshire recorded eight uses of the power by their officers between September 2016 to March 2017. They held no other records and so this appeared to have arisen from a specific data capture to examine at the issue.
    - Derbyshire recorded eight uses in 2016/17; 10 in 2017/18 and four in 2018 (to November)
    - Essex in the three years from April 2016 to December 2018 recorded 20 detentions by officers using the MCA.
    - Lincolnshire recorded 25 uses between September 2016 and November 2018.
    - The Metropolitan police in calendar years recorded 356 detentions in 2016; 353 in 2017 and 370 in 2018.

To simplify the police responses further, 21 forces didn't appear to know whether their officers used their power of detention under the MCA and had no easy way to find out (One force thought the power could only be used by the ambulance service and so probably didn't know whether their officers used it). 13 forces knew or suspected that their officers used this power but only six

could access any data on its use. Of those six forces BTP and the Metropolitan Police appeared to have the best understanding of and data about its use. The Metropolitan Police had published specific guidance for their officers on the use of the MCA while all other forces that answered this part of the request stated that they relied upon the Guidance from the National College of Policing. This is included at Appendix G. This guidance is a simplified form of the legislation with two stated cases for illustration purposes.

However even 370 detention in a year is a tiny proportion of the 120,000 arrests made by the Metropolitan Police[26]. Though in terms of Section 136 detentions in London it becomes a higher proportion. In 2017 there were 4256 Section 136 detentions in London[27] of which the 353 MCA detentions would equate to 8%, a small but significant proportion.

6.6 Study 3 Discussion.

In Hampshire Constabulary the number of recorded Section 136 detentions are falling. In 2015/16 there were 692, in 2016/17 there were 713, whilst in 2017/18 there were 543. The projection for 2018/19 was 366. Expressed per 100,000 residents even in 2016/17 Hampshire had the lowest detention rate in the South East. Although the detention rate is falling in a few forces, for most the numbers detained have continued to rise. This study identifies a number of factors that may contribute to these changes.

One surprise in the force data was the four-fold variation in detention rate by local authority District. There is no obvious explanation for this. The likely candidates are either that the level of care by mental health services differs by district (which was too difficult for this study to assess); that in some way the level of police resourcing between districts caused this effect, though there was no obvious urban/rural divide; or that people in mental crisis are attracted to particular districts because of their condition, where they then come to the notice of the police. It may be

[26] https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/policing/number-of-arrests/latest
[27] https://www.london.gov.uk/questions/2018/0559

that the only way to understand the cause of this variation would be to interview people detained under Section 136. It remains a significant source of unaccounted for variation.

When this data was collected the only operational Triage Scheme in Hampshire was a 'Street Triage' scheme on the Isle of Wight whilst now, they are more extensive and operate in partnership with the ambulance service. Clearly the development of a more extensive triage scheme may have contributed to the falling numbers but as the fall predates the introduction of a force wide Triage scheme it seems likely that the scheme was only in part responsible. Detentions under Section 136 of the MHA continue to rise nationally and as nearly all force have triage schemes it does not appear that the presence of a Triage Scheme alone is sufficient to reduce the numbers of detentions. A useful further study would be to examine similar data on detentions in a force with a high rate of use of Section 136.

In reviewing the data on Section 136 detentions it has not previously been clear that these form part of a much larger group of incidents. When people contact the police about those who are mentally ill and appear to be in crisis. There are a range of outcomes:

- The police do nothing - most cases.
- The police do something that doesn't involve attending – for example they tell another organisation.
- The police attend and deal with it informally by taking limited action - offering advice or telling another organisation.
- The person is in such a set of circumstances that the police officer cannot leave them without doing something to reduce the immediate risk.

This last set of circumstances resulted in studies 1 and 2 in the police detaining people under Section 136 and indeed detaining people referred to them by partners, under S136.

In Hampshire they did not detain people under S136 in many of these S136 type incidents. Rather they passed them to the care of someone else, friends, families, neighbours, the ambulance

service etc. As a result, there were fewer S136 detentions though the number of S136 type incidents remained higher.

Thus, in the 46 Section 136 type incidents officers only made ten detentions, the other 36 or 78%, were dealt with by other means. This represents a significant difference with study 1, where it appeared the police would have detained all or nearly all of those 46. A second difference is that in study 1 the police had in addition been passed detentions by the ambulance service and other Health partners. In this case eleven of the 46 people were passed to the ambulance service to deal with, which they did either with consent or using their powers under the MCA. This represents a significant difference in working practices which could easily account for different rates of detention between forces.

Hampshire have published policies which encourage officers and staff to use their discretion in dealing with such (and other) incidents and they believe they have effective arrangements in their partnership with the Ambulance Service which has resulted in them taking responsibility for a larger proportion of mental health emergencies. The latter certainly appears to be the case but to determine if the former is correct it would be necessary to interview their police officers.

Another insight from this study concerns the difference between Section 136 type incidents and other mental health incidents that the police were deployed to. Police attended 193 of the 436 incidents. 46 were Section 136 type incidents and 147 were not and it was possible to identify that it was only the level of threat of harm that separated the two. Delusional, distressed or irrational behaviour was present in 44% of the former and 48% of the latter whilst direct threats of suicide were present in 50% of the former and 9% of the latter. Both study 1 and 2 show that the main determinant of whether Section 136 is used is the level of threat of self-harm.

In a similar way it is possible to compare incidents with deployment against incidents which were recorded but not deployed to. Thus, there were:

- 36 of 193 deployed to incidents related to suicide (20%) and one of 243 non deployed incidents related to suicide (<0.5%). The non-deployed suicide appeared to be an exceptional case.
- 30 *delusional* deployed incidents (16%) and 103 delusional non deployed incidents (42%), amongst the frequent callers this rose to 56%. Delusional behaviour was between three and four times more common in non-deployed incidents.
- 37 *distressed* deployed incidents (19%) and 35 distressed non deployed incidents (14%), with similar rates in frequent and single callers. The similarity between deployed and non-deployed perhaps reflecting a higher level of risk associated with distress.
- 24 *irrational* deployed incidents (12%) and 49 irrational non deployed incidents (20%), again with similar rates between frequent and single callers. There were almost twice the rate of irrational callers in non-deployed incidents.

The delusional incidents appear to be low risk and are more often not deployed to and amongst the high-volume frequent callers are hardly ever deployed to. The example cited in the study showed how a caller could quickly become both a frequent caller and not deployed to. Li et al. (2018), reporting from New Zealand, analysed their increase in demand through mental illness calls. They found a similar rise in high risk threats of suicide calls but also a disproportionately large rise in non-deployment 'low risk' calls. Their study over nine years, supports and compliments this work showing the growth in calls disproportionally arises through low risk calls. They are undertaking 'content analysis' of the calls to see if they can categorise them (personal communication).

It is not clear whether there has been a large rise in low risk non-deployment calls in England and Wales. It has only been since the HMICFRS (2018) report that forces have started to collate increases in calls arising from mental illness, though newspaper headlines indicate that the numbers of calls have risen by a third since 2012[28]. Looking at changes in numbers of calls will be

[28] https://www.theguardian.com/society/2017/aug/28/police-phone-calls-mental-health-nhs

handicapped by poor record keeping but this is an interesting area for future research. This study indicates that there could be significant future growth in low risk non-deployed calls.

Another part of the study indicates a future problem for the NHS arising from the recent changes to the MHA. The prohibition on the use of police custody for Section 136 detentions has resulted, only for some forces so far, in an increase in the use of A&E as a POS. This is undesirable for all parties concerned. It is not suitable for those in distress, it is time consuming for the police and is likely to cause capacity problems within A&E Departments because of the high levels of supervision required for such patients. If there is not suitable financial provision for POS, then A&E may be the POS of last resort.

One issue that stands out from this study concerns the emerging use by both the police and the ambulance service of the MCA to detain people in mental distress or loss of capacity. In Hampshire the partnership arrangements had resulted in the ambulance service detaining as many people, using the MCA, who were suicidal or in mental distress as the police detained using Section 136. The invisibility of police officers use of the MCA, save in one or two forces such as the Metropolitan Police and BTP, is another issue that will surely come to prominence in the coming years. Its use is bound to increase with an aging population and the growth in the population of people with dementia. What is not clear at present is under what circumstances police officers are detaining people using their powers under the MCA. It could be confused or disorientated people in public places who are at risk through their lack of capacity, or it may be mentally distressed or suicidal people in their own homes where Section 136 powers do not apply. This would be another interesting area for future study.

The evidence of this thesis is that there is a continuing rise of mental illness and distress in the population at large. This growth has not yet been capped or reduced by the much-publicised Government increases in funding for mental health services.

The creation of Triage schemes in forces does not in itself appear to be sufficient to reduce the contact between the police and those who are mentally ill and in distress. The risk that officers

fear of a ‘death following police contact’ will continue to press them into taking action where there is a threat of harm and this will often be manifest through the use of Section 136.

It appears that Section 136 detention provides people in distress with a faster ‘patient pathway’, giving access to a mental health assessment and treatment. The various Triage schemes were intended to prevent this but for the present they are not having a significant effect. This may reflect the lack of community-based services into which the Triage schemes can deflect people in crisis.

6.7 Study 3 Limitations.

Whilst this study looked in more detail at the records made about incidents in the FCR, there were limitations to the approach in that the digital audio recordings made of incoming phone calls were not listened to, to compare with the typed FCR record. This would have been too time consuming and would have required a different ethical approval. Whilst this limitation may have resulted in some disparities being overlooked between the conversations that occurred and records made, the force’s quality control processes should have limited this effect.

To explore the influence of the level of perceived risk on the actions of staff in the FCR and others attending incidents it would have been useful to have conducted semi-structured interviews. This was not possible because as there was insufficient time left in the research project. In the absence of such corroboration the conclusions remain based upon deductions and inferences drawn from the incident records and the quantitative analysis.

The clearest analysis of changes in the use of Section 136 and the changing pattern of contact from those who are mentally ill, could best be obtained by interviewing people who were mentally ill and in contact with the police. Such research cannot be contemplated without a willing Health partner to co-sponsor the necessary ethical approval and the potential access to present and former patients. So far this has not proved practical.

There were also limitations to this study which derived from the qualitative nature of descriptions of some incident outcomes. Whilst many aspects of incidents were clearly and quantitatively identified and recorded, where behaviours were described there was far more scope for interpretation. For example, it was common in Concern for Welfare incidents for it to be reported that a person was harming themselves, often cutting with a knife. The police and ambulance would attend and the final outcome would be that the person was taken to hospital. It was not always clear whether this was for the act of self-harm i.e. for their mental condition, or for treatment to the injuries caused. Indeed, taking someone to hospital for the latter would enable the former to be considered as part of their care. Such circumstances were only included in the Section 136 type incidents where it was clear that the ambulance had detained them because of their mental condition, not where the grounds may have been either. The consequence of this was to deliberately underestimate the number of incidents where ambulances took mentally ill people to hospital. The actual volume of such treatments must be higher than reported in study 3 and worthy of further research.

Where analysis around delusions, irrationality or other criteria were concerned there must also be limited value to any conclusions drawn. The process of creating the detail in incident logs by police staff, often second hand and at a distance, must introduce more uncertainty than for more clear-cut categories. In addition the process of checking the accuracy of the researcher's classification of incidents took place at the start of the data collection and analysis whilst the most detailed classification took place later when it was not possible to use the second rater to quality assure the process. The must mean that some of the last classifications could be less objective and for that reason there would be benefit in repeating this element of the research. The value of the research described here is to identify that this may be a useful area of future research with an improved methodology.

Finally, because officers were able to manage the risk of harm present in Section 136 *type* incidents by means other than Section 136 detentions, i.e. by passing the person into the care of other responsible parties, the actual number of Section 136 detentions was small. This resulted in

relatively small numbers for each individual type of outcomes. To have more confidence in the numbers concerned, a larger sample of Section 136 type incidents and Section 136 detentions would have been useful.

Chapter 7. Findings from studies with recommendations for policy practice and future research.

7.1 Introduction.

For over a thousand years, through the common law and then legislation, people who were mentally ill could be detained to protect them or others. Starting with the Justices' Commitment Act of 1743, this power concerned those who were *furiously insane* or *dangerous lunatics* and was refined until it eventually developed into the current legislation, Section 136 of the MHA 1983 (as amended).

Since the C18th when records of mental illness became more accessible, there have been continual increases both in the number of those who were identified as mentally ill and the numbers incarcerated under various mental health acts. Initially this growth was accommodated through expansion in the number of asylums. Problems have most recently become manifest since the emergence of *care in the community*, the closure of asylums from the 1960s, culminating in the Community Care Act 1990 closing/reducing the size of many of those remaining hospitals.

In terms of the numbers of Section 136 detentions, the poor quality of the records has made accurate comparisons over time difficult, but it is clear that there has been a very significant increase in its use over recent years.

The power to detain was never expressly concerned with suicide (or self-harm) which was considered both a *mortal sin*[29] (in many religions) and a crime (until repealed by the Suicide Act of 1961). Indeed, the first research into the behaviour leading to detention under Section 136 (of the 1959 MHA) showed that it "*had a certain bizarre quality"* (Rollin 1965 page 832) and that it mostly concerned violent, disturbing or threatening behaviour (Turner, Ness and Imison 1992).

[29] See [https://www.catholiceducation.org/en/culture/catholic-contributions/the-sin-of-suicide.html]

Most of the previously reported literature has concentrated on describing aspects of the operation of Section 136 and related powers. Thus, there are many descriptive reports on the racial disproportionality of its use or the changing diagnosis or behaviour leading to detention. The studies and literature review set out in Chapters 2 and 3 aimed to further our understanding of the underlying factors that are responsible for the changing patterns of use. It is surely only through understanding such factors that successful interventions to reduce or more effectively manage its use can be made. Below are summaries of these factors. These are followed by suggestions for further research.

7.2 Summary of key findings.

Since Section 136 of the MHA 1959 was introduced there have been recognised shortcomings in the operation of the provision. From an early stage it was clear that police forces did not adopt a consistent approach to its use and the services provided by Health Services, after the closure of most mental hospitals, did not meet the level and nature of demand from those in distress.

These and many problems continued after the introduction of Section 136 of the MHA 1983. The many reports issued after enquiries by public authorities (Paragraph 1.10 onwards) repeatedly identified the same issues:

- Failures in partnership working including disagreements about the use of police or ambulance resources.
- Lack of training or understanding about powers and procedures on the part of professionals involved in the process.
- Inappropriate use of police cells and transport for those detained and a shortage of appropriate alternative ‘Places of Safety’ (especially for young people).
- Inappropriate use of force and restraint on those detained.
- Disproportionality by race of those detained.
- Lack of standardisation of systems to collect and oversee data on detentions, diagnosis and treatment of those detained (and lack of oversight by public authorities).

- Lack of 'outreach' into communities to prevent detentions.
- Difficulties in manging those who were intoxicated and mentally ill.
- Delays in timely attendance of those involved in assessment and treatment of those detained.
- Lack of 'follow up' of those detained upon release, especially where detained on multiple occasions.
- Wide variations in the use of Section 136 between apparently similar areas[30] (see paragraph 3.2.3 above).

The systematic review (Chapter 2) and other published literature (Chapters 1 and 3) on the use of Section 136 and similar provisions in other countries found many of the same problems and others in addition. These included:

- The large increase in the use of detention powers under all provisions of the MHA 1983 as well as under Section 136.
- Changes in patterns of diagnosis in those detained using Section 136; in particular an increase in the presence of Personality Disorder and Borderline Personality Disorder.
- Changes in the behaviour of people leading to their detention under Section 136 in particular an increase in the proportion of people presenting as self-harming.
- A very significant reduction in treatment rates following detention. Over 30 years the rate had fallen from over 90% to around 20% (House of Commons Health Committee, 2013).

All of these problems in the operation of Section 136 are set out more fully in Chapter 3.

The studies set out in Chapters 4, 5 and 6 offer an explanation which in part may account for the changing patterns in the use of Section 136.

Study 1 reported in Chapter 4 indicated that whilst the volume of detentions under Section 136 had increased over time, the pattern of behaviours leading to detention had also changed, with self-harm becoming by far the commonest ground for detention. The treatment rate for

[30] As defined by HM Inspectorates at: https://www.justiceinspectorates.gov.uk/hmicfrs/police-forces/data/

detentions arising from threats of self-harm was also lower than for all other grounds. This raised the possibility that the rise in rates of detention, the change in grounds for detention and the decline in treatment rates were all connected.

Study 2 reported in Chapter 5 explored in more detail the experiences and motivations of police officers. The principal finding in this research was the emergence amongst police officers of a 'risk averse' culture where they were fearful of the personal consequences should any harm befall someone that they had dealt with. This was manifest through their desire to prevent such harm through whatever means were available to them, which in practice meant detaining someone under Section 136 where there was a prospect of harm, for example where a threat of self-harm was made. This change in officers' behaviour could link together the change in rate of detention, the change in behaviours leading to detention and the reduction in treatment rates.

Study 3 in Chapter 6 investigated the wider range of contacts between the police and those who are mentally ill and have come to notice in the community. This was undertaken in a police force which had a low rate of Section 136 detentions and where this number was continuing to decline. The principal finding in this study was that people who were mentally ill, in distress and in need of care were common in this force too. However, through the apparent exercise of discretion, officers found alternatives to detention under Section 136. These included passing them to the care of the ambulance service and friends and relatives. Through this means, the types of incidents which gave rise to detentions in Studies 1 and 2 were dealt with by other means. This appeared to be the origin of the different rates of detention between the two forces and perhaps more widely in the police service.

7.3 Changes in behaviour and future research.

Over the last 30 years the increase in the use of Section 136 has been accompanied by changes in behaviour leading to detention. The studies in this thesis and other research (Eswaravel and O'Brien 2018) shows that at present 80% or more of the behaviours leading to detention concern self-harm.

Again, over the same period the funding for mental illness services has declined in real terms with the loss of treatment beds, services and funding for care in the community services. As a direct result of this the number of people detained for treatment under all provisions of the MHA has risen sharply over recent years. The implication is that there are more people who are more ill living in the community and that it is harder for them to access treatment services. Whilst detentions relating to treatment for mental illness have risen rapidly over recent years the rate of increase of Section 136 detentions has risen even faster. This implies that there was something else, other than the decline in accessibility of services, that was contributing to the increased Section 136 detention rate.

As both the number of Section 136 detentions and the proportion that relate to self-harm have risen, the treatment rate following detention has declined from close to 100% to 20% or less at present. This too must relate, at least in part, to the reduced access to treatment services.

Over the same period of the last 30 years, public disquiet has grown over the number of people who have died either in the custody of the police or in contact with them. These people were disproportionately young, from the black or minority ethnic population and were mentally ill or both. In response to these public concerns the Independent Police Complaints Commission was set up in 2003 with powers and duties defined under the Police Reform Act 2002. Subsequently, in 2018, this was replaced by the more powerful Independent Office for Police Conduct. Both organisations had at their core the need to investigate deaths following police contact with a view either to the prosecution of wrongdoing or using the police discipline regulations to deal with it.

The research set out in this thesis proposes that all these changes are linked and have caused the changes observed in the use of Section 136.

Police officers were found to be fearful of the personal and professional consequences of a death following their contact with a member of the public. Where a person presented as being at risk of harm or self-harm either through their conduct or their expressed intent, officers needed to find a resolution to their engagement with the person which passed the responsibility for the individual

to another. This was described in this research as *risk averse* behaviour. In study 1 and 2 their options were very limited as it was difficult for officers to access the ambulance service or mental health treatment services, so overwhelmingly, they detained such people under Section 136 as this discharged their liabilities. This detention under Section 136 provided the individuals so detained with prompt access to mental health assessment and services, notwithstanding that most often they were turned away from treatment. The process had created a new *patient pathway* to access services.

One issue that remained unresolved through the study is whether the people who were detained had learned that by threatening self-harm they could better access services. Certainly, for those who regularly called upon the police – *frequent presenters* – it could easily be a learned behaviour, reinforced through experience.

Most officers encountered during this research were compassionate and caring and wished to do their best for the people they were dealing with. With encouragement to use their discretion, within appropriate guidance, better care and support could be offered to individuals in mental health crisis. This could balance the risk averse culture present in the police force in studies 1 and 2 and was a clear contrast with the force in study 3, where many alternatives to the use of Section 136 were demonstrated. For this to be more widespread other forces would need to review the way that they encourage officers to use their discretion.

7.3.1 *Recommendations. Investigate use of police discretion.*

The culture of fear derives from the IOPC's intention to rigorously investigate all deaths following police contact. The response of officers is usually to comply as closely as possible with force policies and policies are generally prescriptive and do not for example require that officers do "what seems sensible to you". That one force appears to have succeeded in encouraging the use of discretion offers an opportunity to undertake a more detailed review of how this was achieved.

7.3.1.1 Further study in Hampshire Constabulary.

To determine whether the reduction in Section 136 detentions in Hampshire is a result of the use of discretion by officers, interviews with officers and their supervisors could be undertaken along the lines of those in Study 4. This could be very easily accomplished.

7.3.1.2 Studies in other forces with falling rates of detentions.

There are two or three other forces who appear to have reduced the numbers of Section 136 detentions. This may be through the same apparent mechanism or through something entirely different. An analysis of their FCR incident logs would give an indication of whether a similar mechanism was responsible. Interviews with their officers could also demonstrate the actual mechanism. It is not clear how cooperative these other forces would be.

7.3.2 Recommendation. R*eview of the quality, accuracy and effect of 'mental' markers on police IT systems*.

The interviews in study 3 indicated that officers were told in advance when dealing with an incident if it involved someone with mental health issues. This was through *markers* on the police IT systems and that these predisposed them to deal with such incidents as such. Officers also indicated that such markers were easy to put onto police systems but were hardly ever removed. This contrasted with study 4 where in the FCR many such markers appeared to be linked to care plans, provided by Health, which described the diagnosis of the individual, their likely behaviour and set out the actions officers should take when dealing with them. However even in Hampshire not all Health Trusts placed these care plans on the police IT system. Given a risk averse culture within policing, if there are many *unfounded* markers indicating mental illness, then this may result in too many detentions under Section 136. An initial review of the accuracy of such markers would indicate the scale and nature of any such problem. Such research would be difficult as it would require someone with access to medical records to compare those with the same individuals on the police IT system. Proving that entries on the two systems relate to the same person is also problematic and may be part of the reason why this issue has not already been addressed.

7.4 The transfer of responsibility for the mentally ill between police, ambulance and other Health services.

Whilst the focus within policing has been around the use of triage schemes to reduce the level of Section 136 detentions, the likely conversion of any reduction in police detentions to an increase in ambulance attendances needs to be examined. The contrast between Study 1 and 3 shows how significantly the balance of workload between police forces and ambulance services can vary. These differences could account in part for the different rates of use of Section 136 between forces.

7.4.1 *Recommendation. To examine the balance of workload between the police and ambulance services in caring for people who are mentally ill and in crisis.*

A wider examination of the relative rates of engagement between the police and ambulance services locally, could determine the extent to which this factor alone is responsible for the different police force rates of use of Section 136. However, there is no easy way to access this data. Police and ambulance boundaries are hardly ever co-terminous and different authorities operate different policies and practices. It is however work that could be undertaken on a local basis through effective partnership working.

7.4.2 Recommendation. *Investigate use of hospital A&E departments as POS.*

In study 3 officers had more opportunities to pass responsibility for people to partners such as the ambulance service or to use their discretion in caring for such individuals and so leave them with family members. As a result, officers were significantly less likely to use Section 136 and indeed the rate of use in that police force was falling and has fallen further since. This success in reducing Section 136 detentions appeared however to have resulted in the ambulance service taking more people in crisis to Hospital A&E departments. Some were taken as they had injuries requiring treatment because of their self-harm. Others were taken because of their mental illness, either through consent or using ambulance staff powers under the MCA.

As police stations are now practically prohibited as POS and as in many areas there is not enough provision for HBPOS, it is not surprising more generally to see hospital A&E departments increasingly used as a POS for Section 136 detentions. It is easy to monitor the nationally published data on use of POS which provides an indication of which police forces experience the highest rate of use. Those forces would be worthy of investigation. The FCR incident records in such forces would offer an explanation for why detainees were transferred to hospital. The reasons why there was insufficient capacity within HBPOS could then be examined.

7.5 The operation of mental health triage schemes.

The Department of Health response to the problems with Section 136 was to introduce Street Triage trials in eleven initial forces (paragraph 3.2.17). Since then such schemes have been extended across England and Wales. In the rush to deliver these they lacked proper evaluation and may not have been the most effective method for reducing Section 136 detentions. This was most recently reviewed by Rogers et al. (2019) who state in their conclusion:

> *Most published evidence that aims to describe and evaluate various models of street triage interventions is limited in scope and methodologically weak. Several systematic reviews and recent studies have called for a prospective, comprehensive and streamlined collection of a wider variety of data to evaluate the impact of these interventions.*

They go on to say that future evaluations should include outcomes other than Section 136 and include the short, medium- and long-term outcomes for the individuals involved. Qualitative studies should capture dissenting views as well as those of supporters. The need for a clear and methodologically sound review of Triage schemes remains.

There has been no attempt to consider if any of the alternative interventions employed in other parts of the English speaking world might be more effective than Triage. Whilst in the published evaluations of Triage schemes over half resulted in a reduction in the use of Section 136, now the schemes are in place across the country, the number of detentions continues to rise overall. The evaluations suggest that the Triage schemes were intended to have several benefits. They could

improve partnership working by increasing the understanding in partner organisations of the respective roles of other partners. This in turn could lead to more effective local initiatives to tackle issues with Section 136. They were principally intended to direct people in crisis into more appropriate services which could be arranged in *slow time*. Given the lack of available services, the alternative view would be that they were a way to restrict access into these services. For some schemes this was manifestly the case (see paragraph 3.2.17 above). In practice by taking responsibility for the care of the person in crisis away from the police officer, then their risk averse decision making, and Section 136 detentions could be avoided. However, as the number of detentions still appears to be rising, perhaps risk averse decision making is also present within the Triage teams?

In informal discussions with police managers responsible for Triage schemes the problem with Street Triage is that it can be defeated by *geography*. Whilst in urban areas the volume of incidents and the short distances travelled between them may be cost effective, in more dispersed rural areas the travel times to incidents may render the scheme much less effective. In Hampshire for example it can take over an hour to drive from the South West to the North East of the police force (or *visa versa*). This accounts for the range of schemes in Hampshire (at the time of study 3) where there were two street triage schemes in the cities, a phone triage in the county and an on-call triage on the IOW. Within a year Hampshire had moved to a single telephone triage scheme, which they considered to be a more cost effective and timely way to provide advice to officers dealing with incidents.

Though not part of study 3, since then the ambulance service in Hampshire initially shared the telephone triage service that the police used and they have subsequently taken it over and now operate it both for the police and ambulance. This is an obvious additional area of research, for the implication is that the transfer of work from the police to the ambulance service resulted in the same sort of risk averse decisions by the ambulance service resulting in far more people being taken to A&E. This effect had previously been reported in Australia (Bronitt and Gath 2013). An increase in volume of people taken to A&E was likely to cause further problems in those

overstretched hospital departments. The implication of the Ambulance Service taking over the telephone triage service was that they were using the same mechanism that the police had used to prevent the unnecessary detention of people who appeared to be mentally ill and in crisis. This would be likely to be a combination of referring some people to more appropriate slow time services and for others it could just be turning them away.

7.5.1 *Recommendation. Review the operation of the Hampshire shared ambulance and police telephone triage service.*

A freedom of information request to all police forces should provide an indication of whether the shared telephone triage model service operates elsewhere. If not, a study could be undertaken in Hampshire to examine the FCR incidents logs for the police and the call logs for the ambulance service to examine if and how the volume of mental health related calls has been reduced. The researcher is presently involved in a similar police/ambulance evaluation in Kent to assess the operation of a crisis café operating in Folkestone.

7.6 *Finding alternatives to Triage.*

The problem in this area of public policy is that there is insufficient capacity within health services to meet the apparent need of those in crisis. If people find it difficult to access the services, they feel that they need through their GPs or other service providers, then the police may represent an alternative route to care and services. If the police have trouble accessing HBPOS then they may start to take those they detain to hospital. If access is restricted through the police by triage or other means, then people may contact the ambulance service (or be transferred to them by the police) and again end up at hospital. They could present themselves directly at A&E but with delays in being seen, this may be less attractive or practical.

This describes a system where those in need are shuffled between different partners or they find their own route to the care that they seek. All the *themes* (in Chapter 3) that tend to drive up the use of Section 136 will also drive up the demand for mental health services in general. Whether

the police succeed in reducing their engagement with those who are mentally ill and in crisis, this problem of excess demand will remain and indeed expand into other health services.

Perhaps the solution to managing people in crisis without assessing them for hospital admission lies in alternatives such as the Safe Haven Café in Aldershot[31]. This café is open for people in crisis to drop in between 6pm and 11pm Mondays to Fridays and 12.30pm to 11pm weekends and bank holidays Although clinicians are available on a more restricted basis, the café is operated by volunteers who have experience of mental illness and so can relate directly to the problems of their clients. It is operated by the NHS Surrey and Borders partnership who claim that it reduced mental health hospital admissions by a third in its first seven months of operation[32]. They quote one of the café clients as explaining:

> "I've never felt so supported, listened to and appropriately cared for. Definitely since I've been coming here there are probably six or maybe seven occasions where I've come here instead of where I would have gone to A&E or ended up spiralling out of control in this crisis and ended up doing something stupid."

In many of the interviews with officers in Study 2, it appeared that unhappiness amongst the public as much as mental illness was responsible for their distress. Often people just wanted someone to talk to, to pay attention to them, and the police were easy to contact. The Aldershot café model could provide an alternative to engagement with the police. Hampshire Constabulary believe that this model has made a contribution to their reduction in detentions in the North East of their police force area, though they have no figures to say how much. An evaluation of this initiative is an obvious area for further research for whilst the conventional assessment and treatment model appears to endlessly generate additional demand for services, this sort of facility may be able to reduce demand.

7.6.1 Recommendation. To undertake a*n academic evaluation of a crisis café.*

[31] https://www.sabp.nhs.uk/our-services/mental-health/safe-havens/SafeHavenAldershot
[32] See [https://www.england.nhs.uk/mental-health/case-studies/aldershot/]

There are a range of informal evaluations of such facilities[33] and many more are proposed or have been set up[34]. There does not appear yet to be any academic reviews of their effectiveness. An evaluation of such a Haven in Folkestone is presently being undertaken by the author.

7.7 Understanding why the police are contacted by those who are mentally ill.

Where Hampshire Constabulary are focused on the management of risk in their call handling and deployment processes, their responses to people who are mentally ill and who are not reporting a crime fall into three categories which in turn define three types of mental illness.

1. They receive calls from or about people who appear to be mentally ill and at high risk of harm. For these Section 136 'type' incidents they deploy officers and resolve them by either detaining the person or passing them into the care of another responsible party.
2. They receive calls from or about people who appear to be mentally ill and whose behaviour is such as to cause concerns about their welfare or that of others. These calls are deployed to but result in no further action at the time, though referrals may be made to other agencies later.
3. They receive calls from or about people who appear to be mentally ill but because they most often appear to be delusional and at no immediate risk of harm, no action is taken in response to the call.

The ratio in Hampshire of such calls, in descending order above, is 1:3:5. Whilst there has been much focus nationally on category one above (Section 136), there are eight times more calls in the other categories and it may reasonably be assumed that reductions in mental health services are likely to cause these numbers to rise. Understanding the full range of non-crime engagements between the police and those who are mentally ill living in the community appears to be an essential area for further research.

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[33] https://www.dorsetccg.nhs.uk/wp-content/uploads/2018/07/Annex-9-Aldershot-safe-haven-evaluation-report.pdf https://www.nhft.nhs.uk/crisis-cafe https://www.healthwatchsurrey.co.uk/wp-content/uploads/2017/06/Safe-Haven-Surrey-Health-Report-Final-for-web.pdf

[34] https://purepotentialscotland.co.uk/wp-content/uploads/2017/10/Proposal-for-an-Out-of-Hours-Crisis-Cafe-NE-Glasgow-1ST.pdf

7.7.1 *Recommendation. Research to identify the diagnosis linked to high frequency non-deployment police incidents in order to reduce the volume of contact.*

To understand why some people call with such a high frequency and how best to deal with them, it would be useful to understand their clinical diagnosis and link this to their pattern of calls. In Hampshire, though the care plan linked to an individual might reduce unnecessary deployments there didn't appear to be a mechanism for preventing those calls. There were local multi-agency management groups to discuss the care of individual cases, but these tended to concentrate on those in crisis and at risk. In discussion with the ambulance service in Kent, they had implemented a process of ringing high volume callers at regular times, for example first thing in the morning, to discuss their condition and ask about their welfare. This was a way of preventing less timely calls later in the day. A review of these high volume non deployed callers could offer this and other solutions to minimise their use of services.

7.7.2 Recommendation. *Research to understand the motives and expectations of those contacting the police.*

Much of the published research on Section 136 concerns the diagnosis of people who were detained, to a lesser extent their behaviours and for some the experiences of being detained. Study 2 implied that for some of those that the police dealt with it was desperation for attention that motivated their calls. The motive for ringing the police has never been studied and in trying to reduce the number of people detained it would be useful to understand why they contacted the police, what their expectations were and what alternatives they considered. This would involve interviewing people who had been detained under Section 136, especially frequent presenters. There would be many practical difficulties in such research, but it could be helpful in reducing detentions and would link into other research for example around Triage and crisis cafes.

7.8 The pervasive effects of police officers' *empathy* on services.

There is a set of issues that formed a connected strand through this research. These link together:

- Officers' discretion in the exercise of their powers
- The way that officers and those they deal with perceive their interaction through the framework of *procedural justice*
- The degree to which officers feel empathy or sympathy for those they deal with
- Their use of force.

What appears to link these all together concerns the way that officers view the people they deal with and certainly those who are mentally ill. Where officers appeared to have a high degree of empathy, they tended to wish to serve the best interests of the individuals they dealt with. They wished to find the least distressing and best outcome from an incident and wished to use their discretion to negotiate this. In practice in study 2 the risk averse behaviour limited their scope to do so, whilst in study 3 officers appeared to exercise their discretion more freely.

High levels of procedural justice are found in incidents where officers treat those they deal with courteously and in compliance with the *rules* and where possible allow them to express their views or wishes. Low levels are found where officers are brusque or discourteous and bring incidents to a conclusion without apparently allowing the other person a fair hearing.

The use of force by the police is a huge research project in itself and for the discussion here a very abridged description is set out. For the police use of force to be lawful, it has to be proportionate and necessary and used in pursuit of a lawful objective[35]. In practice officers are trained to manage people through conversation and persuasion; then escalating to direct or more aggressive instructions; then threatening the use of force such as with a baton, pepper spray or a taser and then finally using force. The use of force is to ensure compliance with instructions which most often concerns desisting from a course of conduct or surrendering to arrest. Police training on the use of force is concerned both with escalating the use of force and de-escalating it.

[35] Relevant legislation: Section 3 Criminal Law Act 1967 and Section 117 Police and Criminal Evidence Act 1984.

In practice in potentially violent situations it is much easier for officers to escalate than de-escalate their use of force. Though this is not a proposition supported here by evidence, if it is accepted as a principle for the sake of argument, then a clear linkage can be drawn between discretion, procedural justice, empathy and the use of force, which is especially relevant in police dealings with those who are mentally ill.

Although the researcher did not set out to examine it, the influence of empathy upon an officer's conduct became clear during study 2. An officer who has empathy for and is interested in the welfare of a mentally ill person that they are dealing with, is more likely to engage them in conversation, to try to negotiate the best outcome for them and to exercise their discretion to this end. An officer with little or no empathy may wish to bring the encounter to a speedy conclusion, may be less inclined to engage in conversation and more likely to escalate their use of force to ensure compliance with their instructions about how to conclude the incident.

If this hypothesis is valid then the explanation for many of the issues in the police handling of incidents involving those who are mentally ill may have far more to do with the state of mind or personality of the officer than the condition of the person they are dealing with.

7.8.1 *Recommendation. Research to analyse the disproportionate use of force, in particular Taser, on people who are mentally ill and in crisis.*

Given the disproportionality in the use of the Taser in incidents where the police deal with people who are mentally ill, to analyse such incidents would provide an unique insight into the motives of officers and in particular the interplay between risk aversion, empathy and other factors. The author is engaged in discussions with the Metropolitan police to undertake such research using the video recordings from body worn cameras at assess behaviours.

7.9 Reflections and limitations.

Looking back over six years the researcher concludes that the research has been enjoyable and challenging in equal measure. The main difficulties have been in finding willing partners to the

research. Perhaps because of the researcher's background in the police, it proved easier to find partners from the police and as a result the research has concentrated on that aspect of Section 136. However even engaging with the police was problematic. Some forces were keen to engage but lacked IT systems that would support the research, others appeared keen but then turnover of staff would introduce new managers who were less keen. The Metropolitan Police were a strong prospect but after several months of negotiation and form filling, their research department was significantly reduced as part of a savings program and further progress was blocked. The most enjoyable part was visiting forces to conduct the research. Officers and their colleagues were kind, courteous and endlessly interesting for their range and depth of views and experiences – though transcribing interviews was hardly the most enjoyable aspect!

The main limitation was not being able to connect the police experience more directly with their partners. This was especially frustrating for study 3 in Hampshire where it initially appeared that such a connection, to evaluate their various triage schemes would be possible. The complex structure in Health and perhaps a lack of enthusiasm by some, resulted in the researcher being passed 'from pillar to post' until he ended up back where he started.

Finally on the topic of the research, so much of the mental distress that the police and others encountered appeared to derive from loneliness or unhappiness which in turn reflected wider changes in society that has left more people isolated, damaged and perhaps with fewer prospects. Personally, for the researcher, this observation that arose in study 2, that changes in society underpinned the rising rate of mental illness, was the most striking of the thesis.

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