The Criminalisation of Mental Distress:

An Exploration of S136 Detention Processes

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‘There’re two crisis teams in this area: there’s the official one by the Trust, and then there’s the police’ (Adult with Experience 5)

Abstract

In England and Wales, the increase in adult Section 136 (S136) police detentions under the Mental Health Act is well established; however, there are equally concerning rises in detentions of children and young people (CYP): 753 detentions in the year ending March 2014 (Home Affairs Committee, 2015), rising to 1,561 detentions in the year to March 2020 (Home Office, 2020a).

This rise in police interaction with people who experience mental distress (MD) in public spaces suggests a failure in health and social care support provision, places greater demands upon police resources and raises concerns about the impact that police involvement has on people who are experiencing MD. This thesis explores whether the current reliance on police to assist in situations of acute MD is criminalising.

This mixed-methods research analyses primary and secondary data pertaining to S136 detentions of adults and CYP. It hears the perspective of front-line police officers (n=12) and adults with experience of S136 detentions (n=5) and analyses an NHS administrative dataset (n=4,211) containing all S136 detentions over a 40-month period (December 2017 to April 2021) in one county in the North of England.

I found that police officers play a significant role in the care of persons experiencing an episode of MD and that this is perceived and experienced as criminalising. The lack of available inpatient beds is key: correlation is found between discharge after a bed request fails to result in admission and repeated detention, and that S136 suites being rendered inaccessible due to detainees awaiting admission results in an overuse of Accident and Emergency departments, where detained persons are supervised and controlled by police officers. There is no parity of service provision for CYP. Proportionally, CYP have less access to S136 suites, experience more repeated detentions and spend longer under police supervision and control than adults do.

Contents

List of Tables

List of Figures

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Declaration

This thesis is the result of my own work and has not been submitted for the award of a higher degree elsewhere.

Chapter 1: Introduction

In England and Wales, there were 34,243 Section 136[1] (S136) police detentions under the Mental Health Act (MHA) in the year ending March 2020 (Home Office, 2020a)[2]. This was a 2% increase compared with the previous year (ibid) and a concerning rise since 2014 when there were just over 17,000 S136 detentions (DoH and Home Office, 2014; Home Office, 2020a). The doubling of detention rates over this time period is also seen for children and young people (CYP): in 2013–14 there were 753 detentions (Home Affairs Committee, 2015), rising to 1,561 detentions in the year ending March 2020 (Home Office, 2020a).

The ongoing increase in detentions is seen by stakeholders and academics as morally and financially unsustainable (Bendelow et al., 2019a) and is suggestive of structural failure to support people who are vulnerable to episodes of mental distress. As outlined in the MHA, police officers are obliged to take a person to a place of safety (POS) if they think that the person poses a risk to themselves or other people due to an episode of mental distress. This thesis explores the disturbing increased association between policing and mental distress.

In this first chapter I discuss the language of mental distress before offering an overview of S136 legislation. After positioning mental distress within three extant models, I then explore areas of concern regarding the current application of S136 detentions. I move on to present this project's aims and three substantive research questions. The chapter closes with a presentation of the thesis structure.

Nomenclature

The language used to describe episodes of mental distress and the people who experience it has evolved over time (Scull, 2020). Some words have been used, and are often still used, to medically classify, stigmatise and create a damaging othering within society (Foucault, 1965; Goffman, 1963). In

[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 […], or (b) if the person is already at a place of safety, keep the person at that place […] or remove the person to another place of safety. […] Before deciding to remove a person to, or to keep a person at, a place of safety, […] the constable must, if it is practicable to do so, consult [a medical, nursing or approved mental health practitioner (AMHP)]. […] A person may be detained […] for a period not exceeding 24-hours for the purpose of enabling him to be examined by a [doctor] and to be interviewed by an [AMHP]" (GOV.UK, 1983, p. npn).

[2] Accurate recording of S136 detentions is problematic and so these numbers are known to under-represent fact. See the Methodology chapter for an in-depth discussion on sources of S136 data.

the field of mental distress, language has evolved with the complex history of deviance (Gove, 1982) and the associated marginalisation and medicalised labelling of symptoms (Foucault, 1965; Rogers and Pilgrim, 2014; Scull, 2020). Consequently, nomenclature in this field has been particularly problematic.

With the development of the social model of mental distress (explored later within this chapter) there has been the evolution of a more inclusive language that places the person before any behaviour or health condition (Rogers and Pilgrim, 2014). As a sociologist, throughout this work I use the phrase 'mental distress' (abbreviated henceforth to 'MD') or 'an episode of MD'. This phrasing incorporates all forms of MD with no discrimination. The trigger, should there be one, and the level of distress experienced are entirely subjective but are still equally significant to the person who experiences the distress (Cummins, 2019). Furthermore, it is important that the language used acknowledges the ability to recover[3] for persons who experience MD. By using 'MD' throughout this work, no distinction is made between the person who experiences a single, isolated episode and the person who lives with recurring episodes of MD.

Further on nomenclature, this work refers to 'the police' as meaning the institution that is the police forces of England and Wales, for these two countries share the same legislation. Where hypothetical or participant police officers are referred to, the term 'police', 'officer/s' or 'police officer/s' is used. Where the police force within the geographical location of the project is mentioned, this is written as 'the Force' or 'the Constabulary'. Likewise, the National Health Service (NHS) trust within the geographical area of the project is referred to as 'the Trust'.

Finally, there is reference made to 'members of the public' in regard to bystanders within public spaces or in Accident and Emergency (A&E) departments. To differentiate between members of the public and detained persons, they are occasionally described thus. In no way is this intended to 'other' detained persons; it is merely phrasing to illustrate to whom I am referring.

Overview of Current Mental Health Legislation

Under the terms of S136 of the 1983 MHA, as amended by the Policing and Crime Act 2017 (PCA) (GOV.UK, 2017a), the only professional who is able to assist a person in a place other than a home or associated garden who, as a result of what is thought to be an episode of MD, is deemed to pose a

[3] The notion of 'recovery' from mental distress is contested and problematic in itself (Morrow and Weisser, 2012; Slade and Longden, 2015). 'Recovery' here is to say that persons are able to return to whatever state of being that recovery means for the individual, rather than what it means from a medical perspective; a state of being that does not restrict their ability to participate, to whichever level is meaningful to them, in society.

risk to either themselves or other people, is the police. Hereafter, the area from which persons can be detained under S136 will be referred to as 'a public space', although I acknowledge that this includes private spaces including workplaces, transport networks and within institutions, including police stations and hospital buildings. Under the terms of S136, the police have the power to take persons to a POS, where they are required to have a mental health (MH) assessment. There is no age restriction placed upon S136 legislation and thus detentions of children occur.

As will be explained in this work, the POS has moved away from police cells towards health-based places of safety (HBPOS). Nevertheless, in this introduction I explain the use of police cells in order to position current S136 practices.

Under the terms of the MHA (GOV.UK, 2007), the person detained by police under S136 must only be detained for a period of up to 24 hours from their arrival at the POS; it should be noted that prior to the December 2017 changes brought in by the PCA (GOV.UK, 2017a), the period allowed for assessment was 72 hours. Since 2017, an extension of up to 12 hours may be applied for by a medical officer, *only* if the condition of the person means that it is not possible to complete the assessment within 24 hours; and extension cannot be granted for other reasons, such as staffing problems preventing a timely assessment. In the absence of admission to an acute MH bed, where another section of the MHA may be applied, there is no legal framework that enables a person to be detained under S136 for longer than 36 hours[4]. In summary, since December 2017, any detention which extends beyond 36 hours is unlawful.

Under the terms of the MHA, assessment of detained persons must be performed by two medical physicians and an approved mental health practitioner (AMHP), who is often a social worker who has undertaken additional training (GOV.UK, 1983). For CYP, at least one of the physicians should specialise in CYP psychiatry, and usually works for Child and Adolescent Mental Health Services (CAMHS). The two-pronged assessment, that involves specialists from health and social care professions, aims to consider not just the health-based reasons for distress but also MD from the social perspective. The assessment must be completed and the detained person either admitted to a secure MH ward or released from detention and allowed to leave within 24 hours of their arrival at the POS (ibid).

[4] A further amendment to the lawful length of detention occurred during the writing of this work. Under the terms of the Coronavirus Act (GOV.UK, 2020a), which received Royal Assent on 25 March 2020, a person may be detained for up to 36 hours without the requirement of an extension. This amendment was to account for the expected increased pressure on the NHS; however, it was not effectuated within the geographical location of this project and was therefore disregarded.

The POS in which to keep a person safe whilst they await an MH assessment is mainly limited to three options: police cells, S136 detention suites at psychiatric units and A&E departments at general hospitals. If the owner and other occupiers agree, a POS can also be the detained person's home, the home of another person or a care home; however, these options are not used by the Constabulary and I could find no published material on whether they are used by other police forces.

Police Cells as Place of Safety

Previous to the 2017 amendments to the MHA, the use of police cells as places of safety for people already experiencing MD was concerning due to the association of police cells with criminality (Cole, 2008; Riley et al., 2011; Her Majesty's Inspectorate of Constabulary et al., 2013). There were statistically more CYP than adults detained in police cells owing to the lack of POS that were able to accept persons under the age of 18 years (Home Affairs Committee, 2015).

The 2017 amendment to the terms of S136 detentions forbade the use of police cells as a POS for CYP under the age of 18 years and stated that police cells must only be used for adults 'in very limited circumstances' (DoH and Home Office, 2017, p. 17). Since 2017 police cells are only to be used where there is an absence of any physical health concerns, where detaining officers perceive that the behaviour of the detained person poses an active risk to other persons and where access to a healthcare professional is present and available throughout the duration of the detention.

S136 Suites as Place of Safety

Psychiatric hospitals and some A&E departments within general hospitals have an 'S136 suite', which is the ideal and preferred POS (Bendelow et al., 2019a) since these rooms are purpose-built to keep the detained person safe and under the care of trained MH staff. Some such suites are dedicated to the use of CYP only and are staffed by paediatric MH trained staff. Whether for adults or CYP, these suites usually have one or two individual, lockable rooms that contain, for the safety and comfort of those using them, only a soft sofa or bed and toilet facilities.

In the absence of any active attempts to self-harm, an S136 suite enables a person to be released from police physical control and/or restraint and contains them safely until an assessment of their MH has been completed. On arrival to an S136 suite a risk assessment is completed and, if both professions agree, police officers can leave the detained person in the care of the MH nurses and officers can return to other policing duties (REDACTED).

Whilst S136 suites are purpose-built and, as their name suggests, designated to be used for S136 detentions, in the area of study they are often unavailable for use (MH Lead, 2019). This lack of availability is likely a result of two principle causes: firstly, detained persons might remain in suites beyond their assessment whilst an inpatient bed is found for them, thereby 'blocking' the suite to subsequent detainees (CQC, 2020, 2014); and secondly, inadequate staffing levels prevent their use (Menkes and Bendelow, 2014). S136 suites are sometimes incorrectly used to hold persons beyond the term of their detention whilst an acute MH bed is found (CQC, 2020, 2014). The ideal situation is that once admission has been deemed necessary, the person is moved immediately from the S136 suite into an acute admission bed. If unwilling to comply with admission, persons can be detained under either Section 2 or Section 3 of the MHA, both of which allow detention, ongoing assessment and treatment to be administered for specified lengths of time. This process complies with the terms of the MHA and ensures that the S136 suite is available to accept the next person who requires assessment.

Accident and Emergency Departments as Place of Safety

Assuming that there is no justification for the use of police cells, should an S136 suite be unavailable, an A&E department is the only other option for a POS within the study location. A&E departments are sometimes required if there is a physical health need, since this takes priority over MH needs (Royal College of Emergency Medicine, 2017); although, with 2017 legislative changes removing the option of police cells as POS, the Care Quality Commission (CQC) predicted that the use of A&E as a POS would increase (CQC, 2017).

Where A&E is used as a POS, there must be at least two officers to ensure continuous close supervision in order to keep the person safe and avoid absconsion. Where there is a high or active risk of absconding or violence, the detaining officers might, with regard to their National Decision Making Model (NDM) (CoP, 2014), deem handcuffs to be required. For more severe forms of MD, it is not uncommon to require multiple officers, leg restraints, handcuffs and spit/bite hoods to keep the detaining staff and detained person safe (MH Lead, 2019).

A&E departments are public spaces with notoriously long waiting times and are recognised as being very difficult places for persons in MD to be in whilst they await MH assessment (HSIB, 2018; Riley et al., 2011). Bearing in mind that the person requiring assessment is in the company of two police officers, the arrival of such a group of people captures the attention of a bored audience who, with the police being seen primarily as law enforcers, might assume that the detained person has

committed some kind of offence for which they are in trouble (Riley et al., 2011). Taking into consideration that the person has been detained because of MD, such a public environment under the gaze of others can do nothing to alleviate any distress (Riley et al., 2011). Furthermore, disordered thinking that can be associated with MD can often present as paranoia, further complicating this situation of being under the gaze and curiosity of others. Often assessment or treatment cubicles within A&E are divided by curtains as opposed to individual walls, and so the distressed person and detaining officers are under continuous visual or auditory public observation in the hospital environment (HSIB, 2018). One must also consider the dangers that are present in A&E departments with the large number of potentially dangerous pieces of moveable equipment that are to hand for persons experiencing thoughts of self-harm.

The National Institute for Health and Care Excellence (NICE) produced guidelines for the care of persons in A&E departments who have self-harmed (NICE, 2011) and, as most people are detained under S136 because of the risk they pose to themselves rather than other people (Bendelow et al., 2019a; Menkes and Bendelow, 2014; Warrington, 2019), it is reasonable to consider these guidelines regarding the situations of MD under discussion here. Although persons under an S136 detention remain with police officers, NICE provide clear guidelines that: persons should be treated with the care and respect shown to persons presenting with physical illness; persons should be monitored frequently; people presenting with repeated self-harm injuries 'should have each episode treated in its own right' (ibid, p. npn); a quiet room should be provided which is away from the rest of the department; and, in regard to CYP, they should be 'treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department' (ibid, p. npn). Despite NICE guidelines, A&E departments tend not to have secure rooms in which a detained person can await an MH assessment (HSIB, 2018).

Problems with the S136 Detentions Process

Given the above overview, in particular the public nature of A&E departments, the use of A&E as a POS is concerning. The CQC forewarned that the loss of police cells as a POS would place greater pressures on the small numbers of S136 suites that are available and that there would be an increased use of A&E as a POS (CQC, 2017). At the time, research already showed increases in MH referrals for people attending A&E (Beck et al., 2017). As police must remain with detained persons in A&E, it is likely that detained persons are spending an inordinate time under the supervision and control of detaining police officers.

There is a known crisis within MH services (GOV.UK, 2014) that, among other problems, has seen a lack of acute MH beds (Moore, 2018; Galante, Humphreys and Molodynski, 2019) and insufficient CAMHS services to meet the ever-growing demand (Crenna-Jennings and Hutchinson, 2018). The CQC (2020) noted that there are unlawful breaches in the terms of S136 detentions whilst beds are sought for people deemed by their MH assessment to require one. Persons in this situation are being detained in breach of Article 5 of the HRA, regarding the right to liberty (GOV.UK, 1998). As police officers are often required to remain with detained persons whilst they are at the POS, officers become complicit in unlawful detentions.

Cuts to public services since austerity measures commenced in 2010 saw the loss of 20,000 serving officers in England and Wales (Hales, 2020) and a drastic reduction in MH beds and MH nurses, as well as a loss of many community-based support services (McManus et al., 2016; McCartney, 2019). People with enduring MH conditions are disproportionately affected by austerity measures (Cummins, 2018) and a further blow was caused by the COVID-19 pandemic. Social restriction policy (SRP) has been central to the government's attempts to control the spread of the coronavirus and has resulted in isolation and loneliness, in addition to the closure of face-to-face MH services, reducing access to support. SRP has severely impacted the MH of people in England and Wales (Molodynski et al., 2020; Zavlis et al., 2021), with CYP being those who have been most adversely affected (Children's Commissioner, 2020a).

There is an ongoing increase in S136 detentions (Bendelow et al., 2019a; Cummins, 2012; Home Office, 2020a; O'Brien et al., 2018; Scantlebury et al., 2017), which suggests a structural increased reliance upon the police to attend to people who are experiencing MD; indeed, it is almost 30 years ago since the emerging rise in S136 detentions was suggested to be a signal of 'unmet social and medical needs' (Turner et al., 1992, p. 765). Police officers are more traditionally known for their role as law enforcement officers and so I suggest in this work that persons seen by others to be detained and under police control could be labelled as 'criminal' by members of the public who witness the detention process.

Positioning this Work in Models of Mental Distress

In order to illuminate the causes of the increasing S136 detentions that are evident today, and to position my thinking regarding the criminalisation of MD, in this section I offer an overview of three extant models of MD.

Each of the models represent the three institutions that are involved in S136 detentions. The police represent the criminal model due to their active involvement with law enforcement and the fact that they are the only professionals permitted by law to remove people from a public place who are considered to be a risk to themselves or to other people as the result of an episode of MD. Once detained, people are assessed by medical staff as well as AMHPs, who epitomise medical and social care institutions respectively, thus representing the medical and social perspectives of MD.

Criminal Model

The criminal model of MD has its origins in the 1500s when people with MD were removed from society in order to maintain social order (Foucault, 1965; Scull, 2020). The Vagrancy Acts of 1714 and 1744 were designed to clear the streets of people who did not fit with the desired norm of behaviours (Scull, 2020) and it was left to the police to determine those who were experiencing MD from those considered to be vagrants. This police role is considered to be the historic emergence of what was to become the S136 detentions of today (Loughran, 2018).

The police remained the institution which delivered people thought to be experiencing MD into medical care throughout the centuries, until the MHA of 1959 specified the conditions surrounding this practice. S136 detentions first appeared within this 1959 Act (Morris, 1958) and the wording of the terms under which a 'constable' (GOV.UK, 1959, p. 71) may detain a person and remove them to a POS for a duration 'not exceeding 72 hours' (GOV.UK, 1959, p. 72) remained unchanged until the aforementioned 2017 amendments.

As previously noted, since 2017 the number of S136 detentions has maintained an upward trajectory (Thomas et al., 2020; Thomas and Forrester-Jones, 2019). With the aforementioned misuse of S136 suites meaning that they are often not available for a detained person to be contained safely and out of public gaze, and with the use of police cells being forbidden unless there are specific safety reasons present, the use of A&E departments as places of safety has increased (CQC, 2020).

Historically, people who tried to take their own life were committing a crime for which they could be prosecuted and imprisoned (Royal College of Psychiatrists, 2021). This only changed with the Suicide Act 1961 (GOV.UK, 1961), after which persons who were experiencing suicidality were considered to be in need of medical care rather than punishment. It is worth noting that since then no laws pertaining to MD specifically comment on suicidality, which stands as the primary reason for detentions under S136 (Menkes and Bendelow, 2014; Warrington, 2019). Nevertheless, the language

of suicide retains nomenclature which is usually reserved for crime; for example, commit, attempt, threaten.

Previous academic writing on the criminalisation of MD arose following deinstitutionalisation. First coined by Abramson (1972), criminalisation was considered to refer to the increased incarceration of persons vulnerable to episodes of MD in prisons following legislative changes in the US which reduced access to long-term psychiatric care. In a literature review, Teplin (1983), referring to the situation in the US, explored the claims that in areas where psychiatric hospitals had closed, the prison population increased. Whilst Teplin (1983, p. 55) found research which both supported or disputed this hypothesis, it was clear that the police had come to be seen 'as a major mental health resource within the community', as the numbers of MD related incidences which they attended to increased. Teplin evidenced that research was suggesting disgruntlement among police officers who had decreased dispersal options open to them in which to resolve situations which involved MD. With the loss of MH beds and stricter criteria of levels of MD which required admission, Teplin (1983, p. 55) observed that police officers 'might consider arrest to be a less cumbersome and more reliable way of handling situations'.

Teplin joined with Pruett (1992) to explore the decision making of police officers who were attending situations which involved MD. The authors noted the complexity faced by officers in determining which behaviours were suggestive of a MH problem. It was explained that behaviours vary both situationally and culturally meaning that officers were making judgments on behaviours which contravene societal norms of conduct and that officers were, in effect, becoming 'street corner psychiatrists' (Teplin and Pruett, 1992, p. 139). In this research Teplin and Pruett evidence increased police involvement in MD post deinstitutionalisation, and that a lack of options for dispersal means that persons formally considered to warrant care were entering criminal justice systems.

An undeveloped aspect of Teplin's (1983) early work was her observation that post deinstitutionalisation community care led to increased legislative control of persons vulnerable to MD which she deemed as being criminalising. This criminalising aspect of MD was seen within the UK's MHA which was amended in 2007 to force compliance to community care orders under the threat of hospitalisation, and long-term incarceration in secure psychiatric hospitals for persons who were deemed to be a threat to others should they be released. This is explored further in the Medical Model section of this work.

Teplin (1983) and Teplin and Pruett's (1992) work showing the increase in arrest and incarceration of persons vulnerable to MD compared with others was disputed by later work by Engel and Silver (2001)

who, controlling for more variables associated with decisions to arrest, found no increase in the arrest of persons vulnerable to MD. In their work Engels and Silver reconsidered the criminalisation hypothesis, but this was still very much centred on the involvement of the criminal justice system rather than being seen more broadly.

Other published materials claiming the criminalisation of MD has centred around the use of police cells which, together with concerns regarding the lack of access to medical care, was seen as criminalising already-distressed persons (Cole, 2008; Docking, 2009; Her Majesty's Inspectorate of Constabulary et al., 2013; Riley et al., 2011; Wise, 2013). Owing to the lack of urgent care provision for CYP experiencing MD, the numbers of CYP being taken to police cells was greater than for adults (Home Affairs Committee, 2015). The 2017 amendment sought to address this concern; it forbade the use of police cells as a POS for under 18-year-olds and stated that police cells may only be used when an adult 'poses an imminent risk of serious injury or death to [themselves], or to another person' (GOV.UK, 2017b, p. 2). This caveat to the terms of S136 detentions has retained the ability for people experiencing extreme distress to be treated the same as people who have committed a crime. Furthermore, it juxtaposes advice that persons in unrelenting extreme distress are at increased risk of death owing to the intense associated physical response and such cases should be treated as a medical emergency (College of Paramedics, 2018; CoP, 2021; Takeuchi et al., 2011).

Criminalisation has historically been associated with the evolution of behaviours that were once seen as socially acceptable transitioning to being viewed as deviant and punishable by emerging legislation (Chadwick and Little, 1987; Muncie, 2008; Tannenbaum, 1938). Aside from legislation, Becker (1963) identified that it was the reaction of onlookers which determined whether actions or behaviours were deviant. Via a process of labelling what onlookers witnessed, persons who are perceived by others to be criminal are subsequently labelled as such, which is highly problematic in situations where a person under an S136 detention is witnessed by others as under police control, such as within A&E departments. Labelling theory also posits that people internalise the label ascribed to them.

Becker's labelling theory can be seen in the aforementioned work done to prevent the use of police cells as POS (Cole, 2008; Docking, 2009; Her Majesty's Inspectorate of Constabulary et al., 2013; Riley et al., 2011; Wise, 2013). Here the use of police cells was deemed to be criminalising for persons who were experiencing acute MD; however, unlike Teplin's work (Teplin, 1983; Teplin and Pruett, 1992), this more recent writing does not suggest that persons being held in cells for the purpose of a MH assessment were actually entering the criminal justice systems. Rather, the issue was they were being treated as though they had committed a crime and that this was experienced by them as being criminalised. In other words, the loss of liberty and the associated processes undertaken by police

officers during an S136 detention, which were akin to those used for persons who have committed an offence, 'effectively criminalise[d detained person's] behaviour' (Docking, 2009, p. 44).

Following the 2017 legislative changes, and building from extant work, this work now considers whether S136 process remain criminalising. I suggest that, for a person in acute MD, to be under police control might be *experienced* as criminalising as well as being *seen* by others as being criminalising.

There is a distinct difference between criminalisation and criminal law breaking. This has not been formally explored by scholars, like Teplin and Pruett, who sought to expose the increase in the use of prisons to house persons vulnerable to MD post deinstitutionalisation, or even by those opposing the use of police cells as POS. Criminalisation is the perception of a person as deviant; criminal law breaking pertains to the act of contravening agreed legislation (Harding, 2020). Nevertheless, although a situation of MD in itself does not breach any laws, it is not independent of legal frameworks since legislation exists which enables police intervention. I posit that the use of police to assist persons experiencing an episode of MD and the connected process have ramifications that are likely to be seen and experienced as criminalising.

With the problems associated with the use of A&E as a POS already established, the association with criminality, as highlighted in regard to the use of police cells, remains relevant. Although there is an absence of research specifically pertaining to this, narrative accounts which mention feelings of being criminalised are evident in existing literature (Goodall et al., 2019; Sondhi et al., 2018).

Medical Model

This model sees MD as an anomaly of the mind that requires correction via medical treatment. There has always been an intersection of the medical model and the criminal model as mental health legislation evolved to incorporate the medical model whilst retaining provision for the involvement of police officers. The medical model's roots were also planted centuries ago: people who exhibited signs of MD were removed from society, triggering the growth of asylums in which to house them, and slowly there developed an approach to care for and treat these people (Scull, 2020).

The medical model centres on the labelling of conditions and behaviours and, subsequently, the nomenclature to describe MD and persons who live with conditions which cause recurrent episodes has been closely aligned with the medical categorisation of conditions which are viewed as illnesses (Scull, 2020).

The growth to the contemporary dominance of the medical model to describe MD is grounded in the development of medical understanding and treatments. Historically, asylums became overcrowded in conditions far from conducive to easing MD and MD was reduced with the development of an array of intrusive treatments, including psychosurgery and electric treatments (Rogers and Pilgrim, 2014; Scull, 2020). The development of psychotropic medications[5] in the early 1950s began to change the approach to treating MD (Soares et al., 2013); however, side effects were severe and a new form of endurance was asked of people to whom they were prescribed. In fact, despite the further advances in pharmacology, and contrary to the belief that people with MD pose a risk to the public, significantly more people die as a result of taking psychiatric medications than are killed by people experiencing MD (Bartlett, 2011).

With the development of drug therapies there was less requirement for long-term institutionalised care for persons vulnerable to episodes of MD and, after several high-profile scandals regarding mistreatment within poorly staffed, crumbling buildings, the 1980s Conservative government pushed through the Care in the Community (CC) policy which had first been mooted in the 1950s (Morris, 1958). Hallam (2002) suggests that it was the lure of the financial gain to be achieved by selling the land on which old psychiatric hospitals stood, as well as the perceived saving on delivering care in the community, which finally pushed through this move towards the social care of MD.

The CC policy did not transition well, with insufficient social care provision in place to support people as hospitals closed and MH beds were lost (Turner et al., 1992). The media coverage of a small number of incidents where persons, unsupported within the community, harmed others led to coercive amendments to the MHA in 2007 (Cutcliffe and Hannigan, 2001). The amendments made long-term detention possible for people for whom no treatment can improve their symptoms and favoured public protection over the care of people who lived with enduring psychiatric conditions (Szmukler, 2001; Szmukler and Holloway, 1998). The change towards the long-term incarceration of people who are deemed to be dangerous and untreatable was described by Miller (1993) as contributing to the now chronic shortage of MH beds in America post-deinstitutionalisation. Miller states that resources are being diverted away from those people who could benefit from treatment in favour of public protection. I suggest that in considering the 'paternalistic' (Shah, 2009, p. 60) changes to the UK's MHA in 2007 and the drastic reduction in acute MH beds (Keown et al., 2011), the same situation is occurring in the UK.

[5] These drugs alter mood by affecting the body's dopamine receptors. They are associated with significant unpleasant side effects such as weight gain, apathy, the development of Parkinson's disease symptoms and blood disorders, among many others (Rogers and Pilgrim, 2014).

Further concerning the lack of MH beds, there is growing concern about persons, especially CYP, being moved many miles from home in order to access available beds (Moore, 2018; Galante, Humphreys and Molodynski, 2019). In spite of the chronic shortage of MH beds, the coercive nature of the current MHA has meant that the number of involuntary detentions have trebled since the 1980s and doubled since the 1990s (Keown et al., 2018, 2011). Beds are only available to those who are in greatest need of care and thus those who are well enough to *want* to be in hospital are often denied inpatient care (McCartney, 2017). This point was illuminated by a person with experience of several admissions in a CQC report:

> 'I very rarely get admitted to hospital as an informal patient because when I am unwell to the point of professionals wanting to admit me to hospital, I am no longer able to consent' (CQC, 2020, p. 15)

Such application of coercive legislation, especially when a situation might have been avoided by earlier admission for specialist help, is highly concerning. In spite of there being a known MH bed crisis, there is also concern regarding available support for people attempting to access support for MD, with unacceptable waits to access primary care support (Gregory, 2019; Mind, 2013; RCPSYCH, 2020).

Aside from S136 detentions, which rely on the police to assist persons experiencing MD in a public space, the medical model approach also calls on police intervention to assist with MHA detentions for MD in people's homes under Section 135 (S135)[6]. Furthermore, there is evidence of an increasing reliance on police to assist with disturbances in hospital settings (Cummins, 2012; Hayden and Shalev-Greene, 2018), with the absconsion from secure health-based settings of persons classed as 'high-risk' and transfer between hospitals needed for people in MD (Hayden and Shalev-Greene, 2018).

Outside of S136, the UK's MHA, including its amendments, leaves decision making to medical staff, who are obliged through legislation to consider public safety, thereby perpetuating the association of MD and violence. In such circumstances, hospital beds are retained for those people who are considered to pose a danger and consequently, in the current climate of an extreme lack of acute MH beds (Moore, 2018; Galante, Humphreys and Molodynski, 2019), there is a barrier to accessing help for the much larger group of people who experience distress but do not pose a risk to other people. This is highly concerning considering that there is an ongoing rise in suicide in England and Wales, with the greatest increases seen in people aged 10 to 24 years and middle-aged men (ONS, 2020a).

[6] S135 requires a magistrate's order to enable a multi-agency removal of a person from their own home for the purpose of an MH assessment.

Social Model

The social model of MD is two-dimensional; it recognises social causes of MD, such as abusive relationships and poverty, whilst also recognising the ameliorating aspects of society, such as cohesive communities with strong social and familial groups (Cummins, 2019). No amount of medication can remove the social cause of MD; medication merely numbs the effects and renders the person passive to their situation. It is only by tackling the deleterious aspects of society and strengthening social networks and integration that will enable these social qualities to support mental wellbeing (Cummins, 2010). A benefit to the social model of distress is that rather than exert social control over people who challenge the expected social norms, the model seeks inclusion and integration that reduces the stigmatisation that is strongly felt by people who experience MD (Cummins, 2019; Rogers and Pilgrim, 2014; Scull, 2020).

An antipsychiatry movement grew in the 1960s in objection to medicine's treatment of persons vulnerable to MD behind asylum walls (Scull, 2020). Antipsychiatry activists were outsiders to the medical profession, such as sociologists Erving Goffman (1968) and Michel Foucault (1965), as well as psychiatrists from within, notably Thomas Szasz (1979). Much of the antipsychiatry movement centred on medicine's failure to recognise the social causation of MD (Cummins, 2010) and this crusade was joined by a movement of people who had been treated according to the medical model and describe themselves as psychiatric survivors (Rogers and Pilgrim, 2014). Psychiatric survivors describe the social roots of their distress, for example, unaddressed childhood trauma can manifest itself as heard voices that the medical model would call 'auditory hallucinations', a symptom that can contribute to a diagnosis of schizophrenia. Whilst accepting that some people gain relief from medication, rather than resort to the long-term commitment of psychotropic medications that eradicate voices to the expense of the soporific side effects that render the person incapable of contributing to family life and society in a meaningful way (Crawford, 2011), Sapey and Bullimore (2013) promote an approach that assists the voice hearer to engage with and understand the voices so that they become less intrusive and controlling to the person. In the absence of strong medication with its dangerous side effects, people who manage their heard voices using this alternative method are able to partake in society in a way that was unachievable to them with medication (Crawford, 2011).

The 1980s CC policy appeared to be the first steps towards a social approach to help those experiencing episodes of MD. In principle, the move to integrate people into the community should have been an excellent social model option; however, Langan (1990) highlighted that the policy was forced through in spite of a decade of rising unemployment, declining housing and increasing poverty. Furthermore, there had been a lack of provision and planning to properly support people within the

community (Knapp et al., 1997; Langan, 1990). Since the start of the CC policy, as well as the rise in S136 detentions, the number of people who live with recurrent bouts of MD have risen within the homeless population (Craig and Timms, 1992) as well as within prisons (Earley, 2006). Furthermore, Cummins observes that the failings of the policy had a 'profound influence' (2010, p. 27) on the paternalistic, coercive 2007 amendments to the MHA; indeed, from 2008 there was 'rapid period of increased rates' (Keown et al., 2018, p. 598) of involuntary hospitalisation under either Section 2 or Section 3 of the MHA.

A further assault to a successful move away from the medical model towards a model which required police input was the commencement of austerity measures in 2010. Financial hardship caused by reduced public spending and slashes to welfare support benefits has been described as a 'war on the poor' (Cummins, 2018, p. 1145), and people vulnerable to experiencing episodes of MD are disproportionately represented within the sectors of society that are most adversely affected by austerity measures. The closure of support charities through their own financial hardship caused a 25% reduction in people with MH difficulties being able to access social care (Elliott, 2016). A further assault has been COVID-19 and SRP, which prevented access to support charities. The effects that this has had on levels of MD are now emerging, with an increase in MD associated with anxiety and loneliness seen (Molodynski et al., 2020; Zavlis et al., 2021). CYP are highlighted as being disproportionately affected by COVID-19 and SRP (Children's Commissioner, 2020a; O'Sullivan et al., 2021).

There are recognised benefits of short-term inpatient care in a model of MD that bridges the social and medical models (Rogers and Pilgrim, 2014), especially for people who live with enduring MH conditions (Keown et al., 2018). Psychiatrist Tyrer (2011) warned at the beginning of the austerity policy that a minimum of 30,000 acute MH beds were required in the UK and yet, in a growing population, there were just 18,730 NHS MH beds available in 2017 (McCartney, 2019). Furthermore, a consequence of demand for beds is hasty discharge, resulting in high suicide rates soon after discharge (Osborne, 2014). Other research shows concerning percentages of persons dying by suicide within the first three months post-discharge (Appleby et al., 1997; Culatto et al., 2021), with Appleby (1997) observing an association between suicide and inpatient admissions of a duration below one week. This increase in suicidality is certainly part of the reason for the current rise in S136 detentions, for it is police interruption of suicide intention which causes a large portion of them. More S136 detentions are due to risk to self rather than to other persons, whereas the dominant reason for S136 detentions 30 years ago was risk posed to others (Turner et al., 1992).

Whilst the social model is valuable in that it recognises a person's social circumstances as both a potential trigger to and alleviation of MD, the success of this approach is severely hampered by government policy. This has been demonstrated by: deinstitutionalisation, which occurred before the social support infrastructure was in place; austerity, which saw the loss of charitable support organisations; and, recently, SRP. Furthermore, paternalistic and coercive MH legislation, particularly the 2007 amendments to the MHA, leave little room for a favourable move towards a more inclusive, destigmatising approach to MD.

Model Intersections

There are intersections between the models. Aspects of the medical profession are recognising the social influences on episodes of MD, with talking therapies aiming to reduce reliance upon medications (Loewenthal, 2012); nevertheless, waiting times for such therapies are known to be lengthy (Gregory, 2019; Mind, 2013; RCPSYCH, 2020), thereby failing to provide timely support and relief of symptoms. Social prescribing, which sees gym memberships and social activities funded by the NHS, is another evolving alternative to medication (Abernethy, 2011). This holistic approach takes account of the social influences of a person's struggles and strengths, and connects them with community-based organisations with the aim of building stronger social networks.

As mentioned, the social model accepts the ameliorating effects of some medications and the benefit of short-term hospitalisation; however, adequate community-based support needs to be in place, and the chronic shortage of acute MH beds does not offer care in a timely manner, often failing to prevent crisis point. Under current legislation, the only profession able to assist a person in MD in a public space is the police, and even if urgent intervention for acute MD is required in a person's home, police involvement is still required under S135 of the MHA.

There are also many intersections between the criminal model and the medical model. Legislation pertaining to MD includes powers only awarded to police officers. There is also a concerning use of police officers to assist with situations of MD within hospital settings, with some hospital policies instructing healthcare staff to call police to assist with disturbances on hospital wards (Hayden and Shalev-Greene, 2018). Nevertheless, crucial to this work is the increased reliance on police to remain with persons they detain under S136, even after the person has been delivered to a POS and where persons experiencing acute MD can be expected to be under the care of healthcare staff.

A more positive intersection between the models is that of Street Triage (ST), which sees dedicated teams of MH professionals (either social care or medical care) and police officers deployed together

to respond to situations of MD in dedicated vehicles. These initiatives have been shown to reduce the number of S136 detentions (Jenkins et al., 2017; Keown et al., 2016; Wondemaghen, 2021). The geographical area of this study has one such ST team and is available to the one area of the county which is known to see the greatest number of S136 detentions. The ST team are only able to attend one incident at a time and can become engaged with single incidences for many hours until their resolution (MH Lead, 2019); a fact which, for a while, caused a halt to the service in the geographical area of study for it was seen to be an expensive way of assisting too few people (MH Lead, 2019). It is an unfortunate reality that effective services such as ST are limited by the number of people who they can assist. Efficiency is too often marked by cost effectiveness rather than the positive impact that the service has on an albeit small number of persons. ST has been shown to reduce S136 detentions (Jenkins et al., 2017; Keown et al., 2016; Wondemaghen, 2021) and provides another point of contact and advice to other officers who might be attending to separate situations of MD.

A further initiative which was shown to reduce police demand is one which was focused on persons who experience multiple detentions. A programme assigning multi-agency (including police) mentors to persons known to be frequently detained under S136 was developed and is known as Serenity Integrated Mentoring (SIM). Regular contact between professionals and the person vulnerable to detention enabled the exploration of alternative coping strategies, established triggers and highlighted alternative options to S136 that were particular to the person. The aim was to reduce demand on emergency services but it also enabled person-specific packages of care to assist the person to manage episodes of MD more effectively. A small pilot study showed the model to be highly effective at reducing the number of S136 detentions (Jennings and Matheson-Monnet, 2017). Such was national concern regarding the number of repeated S136 detentions for the same persons that this programme, formed into the High Intensity Network (HIN), was rolled out across 23 NHS trusts and 18 police forces (ACPUK, 2021). However, in 2021 a social media campaign fronted by the hashtag #stopSIM (StopSIM, 2021), which carried the strap line of ‘Mental Health is not a crime’, raised concerns about denying emergency care to people in MD and that such action breached the HRA (GOV.UK, 1998) and Equality Act (GOV.UK, 2010). This campaign triggered statements by several professional governing bodies including the British Association of Social Workers (BASW) (BASW, 2021), the Association of Clinical Psychologists (ACPUK, 2021) and the Royal College of Nursing (RCN, 2021). Each organisation advised their members to be cautious about further delivery of SIM and involvement in HIN, and BASW called for a public, independent investigation into the operation of HIN. HIN had grown so quickly that the monitoring of evolving approaches to SIM was impossible and some persons had care plans drawn which denied their access to life-saving medical interventions. What was intended to be a much-needed opportunity to offer persons vulnerable to repeated S136

detentions a tailored package of care and support, as well as avoid the imposition of criminal charges for their repeated calls for police assistance regarding MD[7] (Jennings, 2020), appears to have become unmanageable on a large scale, thereby failing persons vulnerable to MD. In response, and whilst not offering a solution, the Royal College of Psychiatrists (RCPSYCH) noted that concerns raised by the StopSIM consortium were:

> 'just one highly difficult area related to the interface between policing and mental health, including how to best respond to mental health emergencies and care models for preventing mental health crises' (RCN, 2021, p. npn)

When considered together, police involvement with situations of MD permeates all models presented here through which to approach and explain MD. Despite decades of medical development with treatments and drug therapies, there is still no 'cure' for MD, just an amelioration of symptoms. The use of the police, in legislation and local policy, still exists. The social model, whilst being increasingly recognised by some aspects of medicine, is unable to be utilised to its full potential due to the oppressive nature of government policy: the failure to correctly initiate and fund CC, austerity and, latterly, SRP. In the context of limited resources, and attitudes towards MD in civil society, the inability of the social model to adequately support persons within communities means that police involvement is required in situations of MD. To this end, the criminal model of MD remains visible owing to the reliance on police to intervene with situations of MD; distress which has not been ameliorated or prevented by medical or social care models. It is under this understanding that I conduct this research.

Mental Health in Crisis

Above, I have reported the loss of MH beds post-deinstitutionalisation and the deleterious impact that austerity has had on the MH of persons who have been worst hit by the cuts to public spending. With the addition of the COVID-19 pandemic and associated SRP, I suggest that the MH crisis in England and Wales is more severe now than it has ever been.

Within the duration of this research, the RCPSYCH said that the waiting times for MH support were 'simply [not] good enough' (RCPSYCH, 2020, p. npn), with 23% of people waiting more than three months and 11% waiting in excess of six months for an appointment after their initial assessment. 38% of respondents said that delays in accessing support had led to calls to emergency or crisis services and 39% reported deterioration of their MH during this time. The RCPYCH warned that the deleterious

[7] There have been several incidences where people have been prosecuted for repeated threats to jump from bridges due to the chaos caused to road networks (Brown, 2013).

MH impact of the pandemic and associated financial hardship was going to worsen an already overwhelmed MH service and called on the government to take 'decisive … action on workforce, infrastructure and funding' (RCPSYCH, 2020, p. npn).

There is a particular crisis for CYP access to age-appropriate MH services. The second wave of a longitudinal survey found an increase which was statistically significant in probable MH disorders for both genders in CYP aged 6 to 16 years in 2021 compared with 2017 (NHS Digital, 2021). Again calling for government action to reverse the poor state of CYP MH provision, the RCPSYCH state that between April and December 2020 there was a 28% increase in CYP referrals to MH services and an 18% increase in urgent or emergency crisis care, compared with the same period in 2019 (RCPSYCH, 2021). Claiming that CYP have been the people worst hit by the pandemic and associated SRP, the president of the RCPSYCH said that the current MH crisis is 'terrifying' and warned that 'services are at a very real risk of being overrun by the sheer volume of people needing help with their mental illness' (RCPSYCH, 2021, p. npn). Elsewhere, Stowell, a manager for a CYP crisis team, suggested that CYP MH service provision is in place structurally but that services are 'chronically understaffed' (Stowell, 2021, p. npn); furthermore, ascribing medical diagnoses to CYP and the associated increase in the use of medication rather than considering the wider, contextual reasons for MD is contributing to the increase in sustained CYP MD. Stowell's observations offer a rare inside critique to the medical model and, indeed, the aforementioned longitudinal survey assesses MH via the use of the Strengths and Difficulty Questionnaire, when such validated instruments have been criticised for their nomenclature and focus upon the medical labelling of CYP (Fledderjohann et al., 2021).

In response to the ongoing claims of crises within MH service provision, the UK government release a steady stream of promises with little evidence of these coming to fruition. The government's 2016 Five Year Forward View for Mental Health (Independent Mental Health Taskforce, 2016) recommended that a service should exist that provides urgent community-based care 24 hours a day, 7 days a week. It also claimed that in developing this provision, there should be provision for CYP on an equivalent basis. At the time of writing the report, 64% of MH care providers reported that they did not have intensive community outreach services (CAMHS Tier 4 Steering Group, 2014). Again, in 2019 the government announced 10-year targets with further promises of ring-fenced MH provisions and plans to bridge existing gaps in MD care provision, including the creation of 'crisis cafes' and other such urgent care provision (NHS, 2019). The Long Term Plan also promises that CYP will have access to MD crisis services via the NHS 111 telephone line, which will 'reduce pressures on A&E [and] paediatric wards' (NHS, 2019, p. 50).

In response to promises set out in the Long Term Plan, in 2021 the NHS announced the intention to ensure that persons in MD are seen by crisis teams within 24 hours and that MH liaison services will be available within A&E departments (NHS, 2021). Whilst it remains to be seen if these promises are realised, gaps remain in services and it is important to note that the crisis teams which these plans rely upon lack research validation. There is some evidence that crisis teams reduce hospital admissions (Johnson et al., 2005; Lloyd-Evans et al., 2020), although most crisis teams were found not to follow government guidance, thereby failing to deliver desired service (Lloyd-Evans et al., 2018). Some studies found low patient satisfaction (Chilman et al., 2021; Lloyd-Evans et al., 2020), whilst another presented tentative findings of patient satisfaction (Johnson et al., 2005).

Amidst all of the promises, urgent MH services, including those for CYP, are woefully inadequate. In a 2020 report, the CQC again stressed their concern regarding inadequate community support and the lack of hospital beds meaning that people are dying after having been assessed as requiring admission (CQC, 2020). In short, there can be no doubt that the MH provision in the UK is in crisis, with inadequate access to support and intervention available to prevent episodes of MD within the community, to which a police response is required.

Project Aims

MH provision in the UK is in crisis. This work aims to explore whether the contemporary involvement of police in cases of MD and the processes involved are criminalising and, if it is, the extent to which it is perceived so. Criminalisation, per se, has not been explored since the removal of police custody as an accessible POS. This work centralises the voices with experience of detention, namely detaining police officers and adults with experience of detention. In doing this alongside the support of secondary quantitative data, it aims to document the characteristics of detention processes for adults and CYP to gain an understanding of contemporary processes. The overarching aim is to highlight similarities and differences of S136 detentions for adults and CYP, to fill research knowledge gaps, and to highlight where improvements could be made.

The research project takes a mixed-methods approach to explore S136 detentions and their application. Since the commencement of this research, this approach has been noted as having the best impact on promoting policy change (Boulton et al., 2021). The research concentrates on one geographical area in the North of England which covers the majority of one county, with a population close to 1.5 million. This area is policed by one constabulary, subdivided into three divisions. There is one dominant NHS trust which contains four large A&E departments and six sites which contain a total

of eight S136 suites. The area comprises several clinical commissioning groups (CCGs), which determine the allocation of funding to physical health and MH service provision.

Quantitative material used in this project is administrative data collected by the Trust. It contains anonymised details of every S136 detention in the geographic area of the study between December 2017 and the end of April 2021. For this project, the dataset is used to assess numbers, processes and patterns of detentions.

By way of groundwork for this thesis, I observed MH training that was delivered to new police recruits and had access to a restricted blog post that one police officer had started on the Constabulary's intranet. This post was written out of frustration at there not being a suitable POS for an individual experiencing extreme MD who was under S136 detention, and it garnered several responses from other police officers of varying ranks. In addition to my research with the Constabulary, I met with senior medical and social care staff from within the Trust.

From a qualitative perspective, I then collected primary data from police officers from the Force and they provided accounts of their experiences of detaining adults and CYP under S136. They have shared their observations of the detention process prior to and after arrival at the various POS available. Additionally, I gathered the opinions of adults with experience of having been detained by police under S136; these participants are henceforth referred to as AWEs. Owing to the difficulty of finding these 'experts by experience', some participants are from outside of the geographical area of study. These valuable testimonies are crucial to understanding detained persons' perspectives of the detention processes.

Research Questions

In order to understand the characteristics of detention processes, this project seeks answers to three substantive questions:

1. Within contemporary policy and approaches to MH, what is the nature of police involvement in the urgent care of persons who are mentally distressed?
2. Are there differences in the urgent care of mentally distressed CYP compared with adults?
3. Are policing practices and police involvement with mentally distressed persons seen and experienced as criminalising?

These questions are explored by considering the experiences of CYP and adults throughout the detention process. Commencing with initial police contact and decision making, this thesis moves

through the experiences in different POS, experiences of being under police control, duration of detention and, finally, outcomes of detentions. Each section is explored within separate chapters.

Thesis Structure

The thesis continues with Chapter 2, which offers a review of literature pertaining to the S136 detention process, aided by the use of a flow diagram. In this chapter I also consider legislation which intersects with the MHA.

I provide a description and justification of my philosophical and methodological approach in Chapter 3. Here I give an account of my standpoint and my sociological, human rights–based approach to the project and explain the process of data collection and analysis.

To respond to the overarching research questions, Chapter 4 explores the characteristics of detentions – who is detained, when are they detained and for how long – and it explores the outcome of detentions. Qualitative data here expands upon quantitative findings. Differences and similarities between adult and CYP detentions are highlighted, and temporal analysis highlights any changes since the implementation of SRP.

Chapter 5 explores police decision making with regard to invoking S136, and then analyses quantitative and qualitative data concerning the initial POS, transfers and final POS. Again, differences in adult and CYP detentions are highlighted.

Chapter 6 presents data findings regarding perceptions of police officers and police practices. From the point of detention and throughout the duration of the S136 detention, the police role and associated practices are explored through qualitative and some quantitative data analysis.

With findings having been discussed in the previous three chapters, Chapter 7 responds to the three research questions regarding police involvement in CYP and adults who experience an episode of MD. This final chapter then explores the strengths and limitations of the research and makes a series of recommendations for policy and practice amendments as well as identifying gaps in research.

Chapter 2: Literature Review

This chapter explores existing literature on S136 detention processes. By way of structure, I present a flow diagram of the intended police involvement with S136 detentions and the detention process. I then give an overview of published literature, including reports and research literature on S136 detentions with a focus on the timing and duration of detentions, the POS used and the detention of CYP. I give an overview of perceptions of detention from the perspective of police officers, the public and persons with experience of detention, including the use of control practices such as the use of physical and mechanical restraint, which are synonymous with policing.

The chapter finishes with an overview of UK legislation which intersects with the MHA and I highlight how this impacts the application of S136 detentions.

The Role of Police

The purpose and role of the police has long since been the topic of opinion and debate. In the late 1960s, Bittner (1967a) identified two distinct areas of police work, the first being that of law enforcement. This area of policing evolves as legislation changes, and as society faces new threats and challenges. For instance, there were 29 new classifications of crime in 1998, which contributed to the recording of 750,000 new offences in 2005/06 (Committee, 2008); more recently, the COVID-19 crisis and subsequent Coronavirus Act (GOV.UK, 2020a) also significantly added to the role of the police as they enforced laws preventing public gatherings and non-essential journeys (Reicher and Stott, 2020).

The second of Bittner's (1967a) police role is that of keeping the peace. Whilst there are intersections with law enforcement, there are close connections to public safety. It is this aspect of police role which is most open to change as society adapts, often in response to government policy. Despite the age, much of Bittner's writing (for example, 1970, 1967a, 1967b) speaks directly to breadth of the police role and police involvement in the management of persons in acute MD and other social care situations.

In the late 1980s, the increasing demand on police officers to assist in situations of MD mid deinstitutionalisation, at least in part, triggered a review into the structure, role and responsibility of the police. In the early 1990s the Sheehy Inquiry (Sheehy, 1993) reviewed the UK police force and their associated responsibilities. The Inquiry's definition of the police role was adopted by the police service and stands as:

> ‘to uphold the law fairly and firmly; to prevent crime; to pursue and bring to justice those who break the law; to keep the Queen’s peace; to protect, help and reassure the community and to do all of this with integrity, common sense and sound judgement’ (Committee, 2008, p. 9)

Just before the 2010 commencement of austerity policy, the Seventh Report (2008) found that the increased pressures and expectations placed on the police were much broader since the last review. As well as technical advances and increased mobility creating new forms of criminality, the increased multi-agency working towards improving public protection had increased police work and blurred the division of each agency. A quote from the Association of Chief Police Officers (ACPO) evidenced the challenge that the changes have brought:

> ‘The service is grappling with an expanding, yet imprecise, mission … In 2008 the police service in England and Wales can be characterised as having a mission that is wider than ever before and having a lack of shared clarity amongst stakeholders about what is expected of it in relation to the breadth of the challenge.’ (Committee, 2008, p. 11)

The multi-agency work that the police are involved in was found to be an area of frustration and affected the quality-of-service delivery. The committee heard from the ACPO that:

> ‘greater efforts to hold partnerships to account for the mutual provision of service could motivate all those involved in delivery to take responsibility’ (Committee, 2008, p. 11).

A prime example of this multi-agency working is that which pertains to situations of MD, where policing intersects with medical and social care professions.

In the same year that austerity measures were announced, the Home Secretary, Theresa May, was clear that the role of the police was ‘to cut crime, no more no less’ (Easton, 2012, p. npn). Later in her address to the Police Federation Annual Conference in 2013, May reiterated this in direct relation to the use of police to attend to people experiencing MD: ‘police officers have many skills, but they are not in a position to be psychiatrists diagnosing and treating mental illness – nor are [they] meant to be social workers or ambulance drivers’ (May, 2014a, p. npn). Despite the insistence that the additional burdens on police that take them away from more ‘traditional’ police work would be reduced, the numbers of S136 detentions continued to rise exponentially in light of austerity measures (Cummins, 2018).

May recognised that the demand on the police could only be reduced 'when there are full and effective mental health services and fully-staffed mental health centres' (2014a, p. npn), but again, such services have failed to materialise. In a police report *Picking Up the Pieces* (HMICFRS, 2018), it is claimed that the lack of access to MD emergency care, akin to A&E being unavailable for physical health emergencies, means that there is an 'untenable' (2018, p. 8) reliance on the '24/7 availability of the police' (2018, p. 3).

The use of police as having a 'pivotal role in mental health resource[s]' was noted almost 30 years ago, post-deinstitutionalisation (Teplin and Pruett, 1992, p. 155). Now, police receive calls for assistance for people experiencing MD from places of care as well as community spaces (Hayden and Shalev-Greene, 2018; Thomas and Forrester-Jones, 2019). The Metropolitan Police receive 13,000 calls per year (equivalent to one call every forty minutes) from organisations which care for people who experience MD (HMICFRS, 2018). A study, from the North of England, looking at police demand found that 'incidences most typically associated with traditional police work' were the smallest category of calls for police assistance (Boulton et al., 2017, p. 82). Furthermore, 20.5% (n=245) of calls which came from statutory bodies, including a 'central hospital which generated a large number of calls', were regarding concern for welfare (Boulton et al., 2017, p. 76). These figures demonstrate NHS reliance on police intervention in the management of people who experience MD and that draws concern regarding existing work regarding police intervention being experienced as criminalising (Cole, 2008; Docking, 2009; Her Majesty's Inspectorate of Constabulary et al., 2013; Riley et al., 2011; Wise, 2013).

With a fall in the number of reported crimes (Boulton et al., 2017; College of Policing, 2015), a large part of policing pertains to 'non-traditional police business [that requires] the use of skills such as mediation and social service' (Boulton et al., 2017, p. 79). Policing is now likened to the role of social workers, whose role also includes upholding and applying law and, to quote again from the accepted police role, 'to protect, help and reassure the community' (Committee, 2008, p. 9). Despite this, there is a lack of published material that considers the police to be in a 'caring' role; the role which they are increasingly called to perform. Nevertheless, case law has established that the police do have a duty to care for people with whom they come into contact (Heaton, 2011).

Older literature shows that police officers felt greater job satisfaction when their role involved law enforcement rather than incidences that require an approach that is more akin to social or healthcare professionals (Magenau and Hunt, 1996). Over half of participants in a study disagreed that dealing with people expressing suicidality was a police matter (Fry et al., 2002). More recent research evidences the ongoing tensions between policing and health and social care systems (Leese and Russell, 2017; Wondemaghen, 2021) as police become increasingly frustrated by what they see as

shortfalls in these service provisions (Loftus, 2010); indeed, the *Picking Up the Pieces* report acknowledges this expanded policing role (HMICFRS, 2018).

The juxtaposed law enforcement and social care roles demand very different approaches. The 'warrior mindset' adopted when confronted with criminal public disorder is the complete antithesis of the 'guardianship', caring role that is required when approaching a person in MD (Baker and Pillinger, 2020, p. 109; Rahr and Rice, 2015). Commenting on perspectives within America, Rahr and Rice (2015) note the public preference of police as guardians and suggest that it is an existing police culture which favours the 'traditional' warrior role; a role which is resistant to the emergence of the guardian policing role. There is also evidence that police culture regarding attitudes to MD and what is seen as the role of police permeates within the UK (McDaniel, 2019).

Rahr and Rice (2015) suggest that changing police education will evolve the police culture into one where officers see themselves as guardians, and a dramatic change in police education is currently underway in the UK. Policing in the UK is currently being professionalised with degree programmes incorporated into training and an increased drive towards evidence-based approaches which take account of sociological and criminological theories (CoP, 2020a). This is timely as the shift in societal expectations from the police is evident. In research carried out in the North of England just prior to the commencement of this work, analysis of calls for police assistance show that 'the majority' of incidences are those which were not formally seen as 'traditional police business' (Boulton et al., 2017, p. 81). Whilst there is frustration at the shortfall of MH provision and reliance upon police officers (McDaniel, 2019), the recent research appears to show a reluctant acceptance by police officers of the expansion of their role towards that of safeguarding people who are classed as vulnerable.

To apply Goode's (1960) strain theory to the role in regard to acute MD and the role of police compared to that of social and healthcare is helpful. Goode described how expanding, competing roles that individuals personally manage affect their overall performance, and that society relies upon each societal member making decisions and prioritising conflicting roles in order to maintain societal stability. To transpose this, each of the three systems (policing, health and social care) each make decisions based upon externally initiated strains; for instance, deinstitutionalisation policy followed by a decade of austerity measures. Each system is making decisions based upon the available resources and giving priority as is seen fit. To a degree, there is flexibility within health and social care, with each prioritising high-risk cases and being more creative with available budgets; for instance, with the creation of integrated care initiatives (Goodwin, 2016). However, the low priority afforded to MH over physical health provision is documented (Independent Commission, 2013; McCartney, 2017; Moore, 2018). Policing also makes decisions based upon risk and need, and, as established above,

continuously adjusts according to the evolution of crimes and national security threat. Nevertheless, police must still attend calls where there is risk to a person or persons, and this remains a priority. Risk cannot be ignored and demand regarding threat to life, even if that is risk-to-self, must be prioritised. Consequently, for as long as health and social care designate people prone to episodes of MD as low priority, this will exist as a role expansion and strain upon policing.

Expansions to Goode's work speak to the scarcity theory (Marks, 1977): individuals have a limited reservoir of energy with which to maintain their allotted and competing role allocation. When stretched beyond their capacity and having exhausted scarce energy resources – and chronically so, for instance, through the financial instability – a crisis point is reached. This can be transposed to the police force, to the crisis point that is seen in the UK's approach to MH care in light of the scarcity of funding resources (GOV.UK, 2014), just as it can to people who experience MD in public spaces.

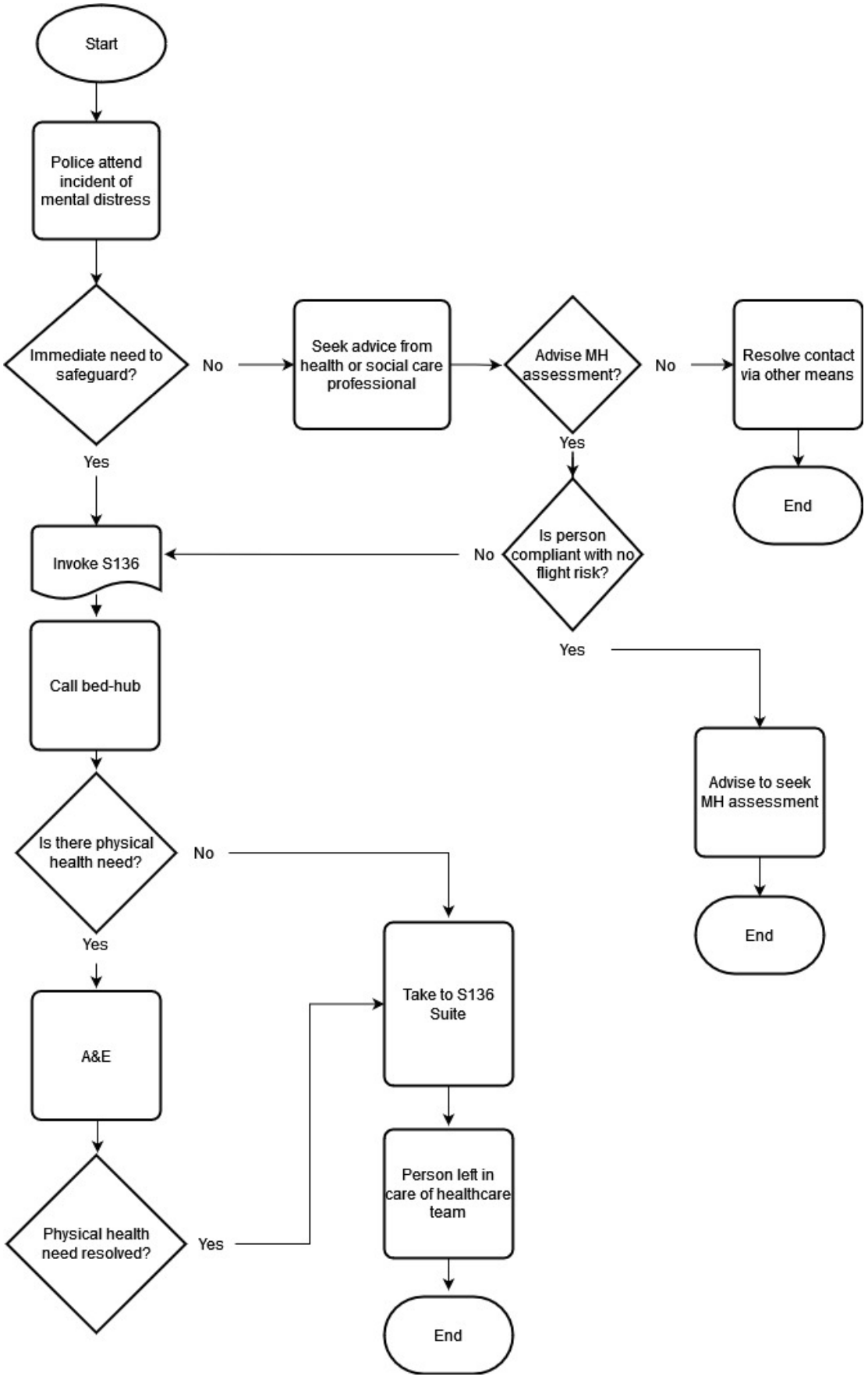
There is no doubt that the role of the police is expanding to incorporate social care responsibilities and that there is reliance on the police by the NHS; however, there is a dearth of material to explain the public perception of the police role. The number of calls to police from the public regarding situations of MD, to be discussed in the next section, suggest that there is an awareness of their role as 'protector', but there is nothing published regarding the perceptions of persons under police supervision and control.

In conclusion to this section, it is clear that the role the police is one which evolves and, indeed, has evolved to increasingly incorporate the care of persons who are deemed to be vulnerable, including those who experience MD. Historically, officers have resented the social care side of their role in preference to what they have viewed as 'proper' policing; an attitude which is noted to be linked to police culture. Nevertheless, this attitude is seen to be slowing changing: there is a reluctant acceptance of the role expansion towards assisting with vulnerability and this is predicted to be strengthened by the professionalisation of policing via new approaches to training new officers.

Section 136 Detention Process

To consider the police role in attending to calls regarding a person experiencing MD, the flow diagram shown in Figure 1 elucidates the process using conventional shapes to indicate the start, process steps, decisions, application of MH legislation (where I use the document symbol) and endpoints of the process. The following sections present existing literature regarding police response to each step in the S136 process as shown in the flow diagram.

Figure 1. The S136 process.



Calls Regarding Situations of Mental Distress

Looking at the first stage of the flow diagram, pertaining to police attendance to a call regarding MD: national data on the volume of calls to police concerning situations of MD ranges from 2% to 20% of all calls per constabulary (College of Policing, 2015). Inconsistencies are noted as being mainly due to varying MH qualifiers and the 'flagging' of calls to these qualifiers by call handlers (ibid). The Metropolitan Police reportedly receive an MH-related call every four minutes and deploy an officer to such a call every 12 minutes (HMICFRS, 2018). Recent qualitative research evidences police officer opinions that between 20% and 40% of police contact relates to MH concerns (Wondemaghen, 2021). Analysis of calls for police assistance in a study conducted in the North of England show that almost 19% of calls over 1 year pertained to concerns for welfare, a category which included 'concern for safety, collapse/illness/injury, missing from home [and] truancy' (Boulton et al., 2017, p. 75). In the research by Bouton et al. (2017), calls for assistance were broken down to show demand from various sources, including statutory bodies, which comprised healthcare and social care providers, and children's services, which comprised schools and care homes. For both groups, concern for welfare was the highest-coded category, requesting a police response at 20.5% and 40.81% of calls, respectively, thereby evidencing a reliance on police by other welfare providers. Some calls for police assistance from healthcare settings regard patients who are admitted (Hayden and Shalev-Greene, 2018); unless they have absconded and are classed as a vulnerable missing person, these are unlikely to result in an S136 detention. However, under the 2017 expansion of the terms of S136 detentions, such detentions are permitted within healthcare settings; for instance, where a person is deemed to be at risk of absconding from A&E after voluntarily presenting with MD.

As well as members of the public who report concerns regarding the safety or behaviour of people, there are also persons who request police assistance with their own MD (Wondemaghen, 2021). Warrington's (2019) research participants, who had each experienced multiple S136 detentions, spoke of their experiences of contacting the police themselves: feeling unable to engage with support services and considering themselves a burden to family and friends, they felt that the police were the only service to offer a reliable response to their MD.

There is a lack of literature pertaining to calls regarding concern for welfare and situations of MD to which police were called and which did not result in an S136 detention. Because of this, the following subsections pertain to literature regarding people who have been detained.

Decision Making

Once officers arrive at the scene of a situation of MD there is a need to determine if there is an immediate need to safeguard the person. In England and Wales, police officers use the National Decision Model (NDM) to guide their decision making (CoP, 2014). The terms of S136 note the 'immediate need for care and control' (GOV.UK, 2017b) of persons. Where there is immediate need to protect life, S136 detentions permit an officer to intervene to prevent harm.

Bendelow et al. (2019a, p. 97) found that with most detentions being for self-harm or suicide ideation, S136 detention was being 'widely used as a suicide-prevention measure', and Laidlaw et al. (2010) found that 55% of detentions in their study were for self-harming behaviours. These findings are contrary to the use of other detentions under the MHA: I highlighted earlier that risk posed to others was the dominant reason for Section 2 and Section 3 detentions (Keown et al., 2018, 2011; McCartney, 2017). Faced with a person verbalising suicide intent, even though this is not an indication of 'mental illness' (Wondemaghen, 2021), officers face a difficult safeguarding decision for which no amount of MH training would prepare them (ibid). Recent literature evidences that police decisions regarding whether or not to evoke S136 detentions remain rooted in the consequences that they would face should they not detain and the person were to subsequently cause harm to themselves or other people (McDaniel, 2019; Wondemaghen, 2021).

Decision making is more complex where immediate need is not present. Moving to the right of Figure 1, S136 calls for police, where possible, to liaise with health or social care professionals prior to invoking S136. As mentioned earlier, ST exists across many police forces to provide a multi-agency response to MD, and where the decision to detain is shared with other MH-trained staff, there has been a reduction is S136 detentions (Jenkins et al., 2017; Keown et al., 2016; Wondemaghen, 2021). Where ST does not exist, the 2017 legislation requires local stakeholders to ensure that a system exists whereby officers can seek telephone advice from MH professionals. Whilst the decision can be informed by an MH-trained professional, the final decision of whether to detain remains with the attending officer, who ought to use the NDM to justify their decision making. As well as guiding all policing decisions, the NDM is also the tool via which officers reflect on their practice with supervisors and through which they must justify their decisions should their practice be called into question in a subsequent Independent Office for Police Conduct (IOPC) investigation.

There is evidence of disquiet between police officers and healthcare staff as MH nurses were found to blame unnecessary police detentions for 'clog[ging] up huge parts of the mental-health system' (Wondemaghen, 2021, p. 269). Wondemaghen's (2021) work acknowledges that police officers

cannot be expected to diagnose MH conditions and that the only reasonable way to avoid risk-averse decision making is to improve collaborative working between partner agencies.

Moving to the right of the decision-making section of the flow diagram (Figure 1), should there be a joint decision that a formal MH assessment is required, a further decision must then be made regarding any flight risk that is posed by the person. For instance, the ST team could take the person to a POS informally to have an MH assessment, but should they subsequently threaten to leave, or actually leave (thereby becoming a vulnerable missing person), this would trigger a further call for police assistance. Where a flight risk is established, invoking S136 is the only option available to the police officer, whether an ST team is present or not.

There is another outcome to calls for police responses to situations of MD and this has been described as the 'gray zone' (sic) (Wood et al., 2017). Grey zones refer to areas of policing which do not require application of legislative detention or arrest but rather they require an appreciation of alternative options available to the officer. Moving through Figure 1, here the grey zone refers to situations where no MH assessment requirement is identified and the person is deemed not to be a flight risk. Here, police knowledge of local support agencies to which they can signpost a person for support is required, and this forms part of the expanded role of policing which was described earlier in this chapter. The grey area constitutes police discretion as part of decision making, which has been a long-established key feature in policing practices (McDaniel, 2019). Where this referral to other agencies is possible, this would be the end of police involvement, save for logging the encounter and documenting decision-making processes.

Police participants in Wondemaghen's (2021) research show their use of discretion in decision making by claiming that they try to avoid S136 detentions and prefer to end encounters without invoking them. McDaniel (2019) suggests that the current wording of S136 detentions offers limited guidance to police officers regarding decision making, thereby forcing them to rely upon their discretion; however, there are few alternatives to S136 open to police offers owing to 'partners … struggling for resources' (Wondemaghen, 2021, p. 269) and the numbers of detentions occurring out of hours (OOH) when services are unavailable (ibid). An officer might decide in the absence of an MH-trained professional that an S136 detention is not required; however, in the absence of OOH support for situations of MD, there are limited alternative options that can ensure the safety of a person expressing suicidality.

Police officer decision making at this early part of the S136 detention process is key to the number of detentions seen and to the experience of detainees and their access to MH support services. Whilst

there is evidence that multi-agency approaches, such as ST, reduce the number of detentions, in the absence of such an approach, officers continue to practise risk-averse decision making for fear of the adverse consequences of not detaining a person. There is no published literature on decision making regarding the detention of CYP.

Invoking Section 136

After the decision has been made that an MH assessment is required and an S136 detention has been invoked, the detention process commences and the POS is decided upon. Prior to decision making regarding the POS, this section explores literature pertaining to who is detained, how often and when detentions occur.

Who is Detained?

Adults over 18 years account for 95% of all S136 detentions (Home Office, 2020a), with males accounting for more than 55% of detainees (Bendelow et al., 2019a; Home Office, 2020a; Laidlaw et al., 2010). In a retrospective look at people detained aged over 18 years (mean=38 years), in Suffolk during 2012, Bendelow et al. (2019a) found that 5% were aged 18 to 20 years and 6% were over 60 years old.

Figures for CYP detentions are uncertain owing to national inconsistencies in the recording of S136 detentions. Home Office data (2020a) offers the best indicator of S136 detentions and suggests that there were 1,561 detentions of persons aged below 18 years; this was an increase on the previous 12 months where there were 1,438 detentions (Home Office, 2019), and again on the year ending March 2018 where there were 1,345 detentions (Home Office, 2018). Whilst Laidlaw et al. (2010) noted that the age range of detainees in their dataset on S136 detentions began at 14 years, they made no comment on these CYP. Persons aged 15 to 20 years accounted for 11.8% of detentions in a research study, although there was no further analysis of this younger age group (Burgess et al., 2017). The two pieces of research on CYP detainees show that 67.6% were female with a mean age of 15.9 years (range 13 to 17 years) (Patil et al., 2013), and in the only other study of CYP detainees, 60% were female with a mean age of 15.69 years (range 8 to 17 years) (Eswaravel and O'Brien, 2018).

People from Black, Asian and minority ethnic (BAME) communities are reported as being overrepresented in S136 data within small geographical areas of study (Independent Commission, 2013; Laidlaw et al., 2010; Turner et al., 1992); however, more recently, national Home Office data (2020a) shows that 86% of detained people were white, which is only marginally below the 2011

Census figures (GOV.UK, 2020b) which show that 87% of UK citizens identify as white. Regarding CYP, available research, notably both from London which does have higher percentages of ethnic diversity than other areas of England and Wales (Office for National Statistics, 2012), there is an over-representation of BAME CYP: the Eswaravel and O'Brien (2018) research of 104 detainees described 78.8% of detained CYP as 'white', compared to 76.5% in the Patil et al. (2013) study of 40 detained CYP.

Regarding CYP, the Eswaravel and O'Brien (2018) research identified that 25.9% of those detained where looked after and under local authority care. The Patil et al. (2013) study described 20.6% as having a Child Protection Plan in place. These figures show an over-representation of CYP within 'the care system'; in 2013/14, a mid-point in the Eswaravel and O'Brien data collection, 0.6% of children in the UK were looked-after (DfE, 2014), and the average percentage of children in England with a Child Protection Plan during the Patil et al. data collection period was 0.3% (Royal College of Paediatrics and Child Health, 2021).

Repeated Detentions

Few studies offered quantitative findings regarding repeated detentions of the same individuals. The Bendelow et al. (2019a) study saw 142 people being detained 422 times, accounting for one-third of all detentions. Elsewhere, Jennings and Matheson-Monet (2017) found that 69 persons were detained 165 times. Of these, 8 females with complex MH histories 'caused' (2017, p. 107) 54 incidents which comprised 32% of the multiple detention figures. A study from 2010 declared that 9% of detainees had been previously detained (Laidlaw et al., 2010).

Warrington's (2019) research into multiple detentions of the same persons found a link to suicidality and lack of faith in services which failed to meet the level of support that was needed by her participants. The police were identified as the singular reliable source of support in a crisis situation; the inconsistent approaches by healthcare staff meant that participants were reluctant to seek help for fear of rejection that would worsen their MD.

Females account for the greater number of detentions of the same person (Jennings and Matheson-Monnet, 2017; Warrington, 2019). Males made up 57% of people who had been detained twice, but it was females who experienced the higher frequencies of multiple detentions and accounted for 55% of all multiple detentions (Warrington, 2019).

I could find no published analyses on individual CYP who are detained on multiple occasions, although there is mention of discounting subsequent detentions in the analysis for both of the existing studies

of CYP (Eswaravel and O'Brien, 2018; Patil et al., 2013). The Patil et al. (2013) study, which used data from before 2010, mentions the exclusion of data from second detentions of three individual CYP.

Timing and Duration

An Inspector of Constabulary (HMICFRS) report on police demand regarding MH showed that peak demand for MH calls was 3pm to 6pm during weekdays and between 5pm and 10pm during the weekend (HMICFRS, 2018). The report points to a gap in service provision since these times represent when primary care services are either closing or closed. Research found that 81% of S136 detentions occurred OOH (Bendelow et al., 2019a), whilst another published paper suggested that two-thirds of detentions occurred in either the evening or overnight, with the authors theorising that S136 detentions are used as a 'safety net' OOH when there were no crisis services open (Laidlaw et al., 2010, p. 32). Research by Thomas et al. (2021) shows the pattern of calls to police regarding MD within one county in the South of England: the research evidenced the steady rise in calls from a low at 05:00 to a high at 19:00. Calls regarding MD remained relatively elevated until midnight, when there was a fall to the 05:00 low (ibid).

Regarding the day of the week when most detentions occur, Bendelow et al. (2019a) found that Fridays and Sundays saw most detentions, whilst Laidlaw et al. (2010) found Wednesday to be the busiest day.

Regarding the time of year when most detentions occur, there is little information, although 'a slight dip' in detention numbers was observed in the first quarter of the year in one study (Laidlaw et al., 2010, p. 30).

To summarise this section regarding who is detained, adults appear to comprise 95% of detainees; more than half of these people are male, whereas for CYP, more are female. Nationally, the ethnicity of adults who are detained appears to be in proportion to the population; however, existing research for CYP suggests and overrepresentation of the detention of non-white CYP. CYP who are classed as looked-after or who have Child Protection Orders are overrepresented in detention figures. There are no data on repeated detentions of CYP, however, there is evidence that some female adults experience many detentions whereas, while some males encounter a second detention, males tend not to feature in data regarding the higher numbers of detentions. Most detentions occur OOH, with connections made within literature to a lack of available services during this time.

There are gaps in available literature, particularly regarding the detention of CYP. Literature on CYP detentions exists only from older data. The Patil et al. (2013) study used data from between 2007 and

2010 and the Eswaravel and O'Brien (2018) research used data from between 2011 and 2016, meaning that both pieces of research use detentions from before the 2017 legislative changes. Little is known about the characteristics of CYP who might experience subsequent detentions and there is a dearth of recent material on the detentions of CYP.

Physical Health Need?

Referring to Figure 1, after the invocation of S136 the policy in the geographical area of study is that detaining police officers must telephone a central Bed Hub provided by the Trust who then inform officers to which POS they should take the detained person. If there is a physical health need, for instance, if the person has self-harmed, is intoxicated or has breathing problems, then they must be taken to an A&E department for assessment prior to an MH assessment.

The ability of police officers to recognise a physical health concern has garnered scant research interest. Health screening tools are used by custody sergeants in an attempt to reduce deaths in police custody suites (McKinnon and Grubin, 2010, 2013); however, despite there being high proportions of persons under police detention who have existing physical health concerns (McKinnon and Grubin, 2013), and the presence of dual diagnoses[8] being overrepresented in persons who have died in police custody (Best et al., 2004), decision making regarding a physical health concern at the point of S136 detention is an under-researched area.

If there is no physical health need identified and the person only requires an MH assessment, police officers should be advised to take the person to an S136 suite, in other words, an HBPOS[9]. In the geographical area of study, the policy is that after a handover and where risk assessment is agreed, police officers are to leave the detained person in the care of MH-trained medical staff, but I am aware that officers in other trusts are required to remain with detained persons whilst they are within the S136 suites.

Transport

Although not included in Figure 1, there is a clear need for persons to be transported from the place where they were detained to the allocated POS. There are occasions when people are detained within hospital buildings; this is usually A&E departments where someone who is considered to pose a risk

[8] That is, those people who have both existing physical health and MH concerns.
[9] Literature regarding the various POS are included in the following sections.

to themselves or others has presented voluntarily but is later considered to be at risk of leaving the department. In such situations, transportation would be required to transfer the person to an S136 suite.

Despite ambulances being the prescribed form of transport from the place of detention to a POS (CoP, 2020b; DoH, 2014), a Home Office (2020a) report suggests that ambulances were only used for 45% of detentions. In this report, most detainees (51%) were transported in police vehicles and the remaining percentages were accounted for by detentions occurring at a POS, as outlined above. In the same report, the dominant reasons for non-transportation via ambulance were recorded as an ambulance not being timely available (38%), risk assessment ruling that an ambulance was not appropriate (34%), and that no ambulance was requested (25%).

Thomas et al. (2021) report that most of their participants were transported to hospital via ambulance, with some persons being transported by 'a private secure ambulance service' (ibid, p. 643) which held a contract with the Trust in question. A study by Morgan and Paterson (2019) which sought opinions of police officers found frustration among officers regarding the waiting time for ambulances to arrive; participants reported having to wait for several hours and it was felt to be in the detained person's best interest to transport them via police vehicle rather than have them under public gaze on a roadside for that period of time. Morgan and Paterson had a participant refer to transportation via police vehicle as 'stigmatising [detained people] as criminals' (2019, p. 130), thereby referencing the criminal model of MD.

Further literature regarding transportation can be extracted from qualitative data within CQC reports regarding experiences of detention where people describe feeling criminalised and confused as to why they are being transported and restrained within cages in the back of police vans (CQC, 2020). There are no data, neither qualitative nor quantitative, available on the transportation methods of detained CYP.

Places of Safety

Returning to Figure 1, this section explores the POS to which detained persons are taken. Although persons might be transferred from an A&E department to an S136 suite, the POS is where MH assessments take place and where S136 detentions are revoked, and so this is the final section of the flow diagram. This section explores S136 detention experiences in A&E departments before it moves to research regarding S136 suites.

This section does not explore police custody suites as, following the 2017 legislative changes, there has been a dramatic drop in the use of police cells as a POS (Home Office, 2019, 2020a). Here it is only relevant to comment on the percentage of detained persons being taken to police cells, which, for two consecutive years, Home Office data reports as being 0.5% of all detained persons (Home Office, 2019, 2020a). Despite the 2017 legislative changes forbidding the use of police cells for CYP under 18 years, it is of note that 0.5% of CYP detainees were taken to police custody suites as a POS, which is marginally more than adult detainees (0.4%) (Home Office, 2020a).

There is no expectation in legislation that police officers are to remain with detained persons once they have arrived at the POS. The Crisis Care Concordat (2014) recommends that NHS staff take over the care of detained persons as soon as possible, and the RCPSYCH (2011), recognising the need for sufficient assessment staff and resources available to relieve police of the responsibility of caring for persons in MD, set the standard that 30 minutes should be an adequate amount of time for officers to hand over care of the person to medical staff. In conjunction with the RCPSYCH, The College of Policing (CoP) state that the requirement for police officers to remain at the POS should not exceed 1 hour, which is judged to be sufficient time to enable handover and for the POS to arrange appropriate staffing levels (CoP, 2020b). Nevertheless, the Royal College of Emergency Medicine (RCEM) (2017), who represent A&E staff and guide A&E policy, outline that police must remain in attendance within A&E departments unless there are staff and resources to ensure that the detained person is unable to leave the department prior to the completion of the MH assessment.

A 2016 survey carried out by the RCEM (Royal College of Emergency Medicine, 2016) which assessed the quality of care of persons experiencing MD within A&E departments sought opinions from the College's fellows. The report highlighted that the experience of CYP attending A&E for an episode of MD was worse than that of adults: 31% of respondents thought that the overall care to persons in MD had improved, whereas only 7% thought there were improvements in the overall care of CYP experiencing MD. When asked if overall care for persons in MD had got worse, 26% of respondents thought it had, with 49% opining that the overall care of CYP in MD had got worse, which is greater than the previous year's percentage of 36%. The RCEM recommended that CCGs should ensure that S136 suites are always available and properly resourced to accommodate persons in MD, and that emergency MH beds must be available to CYP since 'admitting a child to an emergency department observation ward or acute paediatric ward can worsen and prolong the crisis' (Royal College of Emergency Medicine, 2016, p. 5).

There appears to be a rise in the use of A&E as a POS. In the year ending March 2020, A&E was the POS for 21% of detentions, an increase from 17% in the previous year (Home Office, 2020a). Research

by Thomas et al. (2021) identified that 41% of detentions in their study used A&E as a POS. Above I have outlined the need for A&E should a physical health assessment be required, but consideration specifically of the relationship between physical health and the use of A&E as a POS for the sole purpose of an MH assessment is not made in available literature.

Research participants have spoken of a lack of understanding of MH conditions by police and A&E staff, with a comment of 'oh not you again' (Riley et al., 2011, p. 166) having been made towards a detained person attending A&E due to injuries caused by self-harm. Other research by Sondhi et al. (2018) suggests that the experience of being with police in the 'chaotic' A&E environment is a 'frightening and traumatic experience with potentially long-lasting consequences' (ibid, p. 160). Recognising A&E departments as potentially making MD worse, Sondhi et al. (2018) offers a quotation from one of their participants who described the fear that they experienced in hearing screams of physical pain whilst they were awaiting an MH assessment. Other participants in this research refer to concern regarding their confidentiality and of being seen in A&E whilst wearing handcuffs and under police control.

Supporting academic research findings regarding negative experiences in A&E departments, a CQC (2015) report found that less than 40% of respondents had positive experiences in A&E during an episode of MD, with more positive experiences noted from interactions with police, GPs and ambulance staff. Respondents to the CQC call for evidence, which formed the 2015 report, noted that the medical professionals' responses to those experiencing MD can have a profound effect on the person, and one person felt that their MH needs came secondary to persons who present with physical health needs. The RCEM made clear, prior to the 2017 legislative changes, that A&E was not the place for persons experiencing MD:

> '[A&E] is only used for [S]136 patients who have an acute healthcare need. Otherwise mental health services should provide an assessment suite, or where necessary the patient should be taken into police custody.' (Royal College of Emergency Medicine, 2013, p. 12)

This approach, which favours persons in MD being treated in the same way as persons who have committed a criminal offense rather than provided access to a physical healthcare environment, clearly sets a precedent for A&E staff responses; nevertheless, it cannot be assumed that all staff are unwelcoming to persons in MD. Of 316 participants giving feedback on their experience of A&E when experiencing an 'MH crisis', 37% felt listened to and had their concerns taken seriously, 34% were 'treated with warmth and compassion' and 33% felt that they were not judged (CQC, 2015, p. 7).

Research by Akther et al. (2019) recognised that A&E staff lacked the skills in how to assist persons experiencing MD and suggested that this could be why some people in MD felt that staff were dismissive towards them.

Although not explicitly clear, research and available reports suggest that A&E is becoming used as a POS to which persons are taken for an MH assessment rather than for a medical assessment. In the absence of improved HBPOS, by which they mean S136 suites, and with strict guidance regarding police cells, the CQC (2017) predicted that there would be an increase in the use of A&E as a POS. This is somewhat frustrating as research from a decade ago highlighted the need for a suitable POS that was neither police cells or an A&E department (Riley et al., 2011).

In an echo of the previous discussion, with no mention of physical health concerns, the Home Office annual report on the use of police powers noted a decrease in the use of S136 suites as a POS from 81% to 73% between 2019 and 2020 (Home Office, 2020a). The percentage discrepancy in these years is not due to the changing rules regarding the use of police cells; the percentage of detained persons being taken to police cells was consistent over this period at 0.5% of detentions, as previously noted. What this appears to suggest is a change in the availability of S136 suites. There is no reported reduction in the number of S136 suites, in fact, a CQC report recommended that more suites were to be made available to meet the demand of S136 detention numbers (CQC, 2014). It is more likely that the mismanagement of available suites, noted in the aforementioned report, has been maintained and to such a degree as to impact on A&E departments.

The main reason for the disproportionate number of CYP being detained in police cells pre-2017 pertained to the absence of CYP-specific S136 suites and CYP not being able to access adult suites (Home Affairs Committee, 2015). There have since been calls for parity between mental and physical healthcare as well as CYP access to MH provision being on a par to that which is available to adults (HSIB, 2018; Rosa, 2018). Rather than resort to A&E, in Gloucestershire, a multi-agency policy guidance document states that where the adult S136 suite is unable to accept a CYP, the CYP's home, in the first instance, ought to be considered as a POS. Under such circumstances, the police are to remain with the CYP in their home until after MH assessment or until a suitable S136 suite becomes available (Gloucestershire 2gether, 2018). Under Gloucestershire's guidance document, A&E should only be used as a POS for CYP and adults in 'limited circumstances' (Gloucestershire 2gether, 2018, p. 22).

Access to S136 suites can be problematic. Substance and alcohol dependency feature prominently among those detained (Laidlaw et al., 2010; Riley et al., 2011; Wondemaghen, 2021) and this is known to be a barrier to S136 suites since intoxication is viewed as a medical health concern which requires

monitoring in A&E (Wondemaghen, 2021). Furthermore, the CQC report mentioned earlier in this section identified that persons in MD were 'being turned away or forced to wait for long periods because [the S136 suites] were already full, or there were staffing problems' (CQC, 2015, p. 11).

A succession of CQC reports have identified a shortfall in emergency provision for persons experiencing MD (CQC, 2020, 2017, 2015, 2014), some with mention of the shortfall in provision for CYP (CQC, 2018, 2014), but there appears to be no resolution to concerns. A CQC (REDACTED) report in the Trust highlighted many concerns regarding urgent MD provision, blockages throughout the system and breaches in the duration of detentions. Furthermore, the local report noted that there was an absence of 'effective local arrangements for young people who were detained under [S136]' (REDACTED).

I have referred to many reports regarding different POS and the increasing use of A&E as a POS but the experiences of detained persons within either S136 suites or A&E departments is somewhat lacking. Prior to the 2017 legislative changes, much was written about the inappropriateness of police cells for persons in MD, with the idea that a hospital environment was more appropriate (Cole, 2008; Docking, 2009; Her Majesty's Inspectorate of Constabulary et al., 2013); however, there is a lack of empirical evidence since 2017 regarding experience of these POS. The voices of experience such as exist in the primary data are represented in the next section. As is becoming a theme in this literature review, the number of and experiences of detained CYP are absent from reports and any available published research.

This section has been the final element to the flow diagram in Figure 1, for, as is local policy, as soon as the detained person has entered an S136 suite, police can withdraw if a risk assessment deems this to be safe. Similarly, once MH assessment has occurred and the detained person is either released from detention or admitted for further assessment or treatment, the detention is revoked and officers can withdraw. This final section has evidenced that the S136 detention process is more complicated than legislation suggests, for there is a requirement on police officers beyond the removal of persons from a public space and to a POS. Indeed, with the increasing use of A&E and the requirement for police officers to remain with the detained person whilst they are within an A&E department, police officers are required to remain with detained persons throughout the entirety of the detention.

Perceptions of Detention

Aside from the detention process, it is important to explore material pertaining to detained persons' perceptions of detention. There is a consensus that the S136 detention process is harrowing and a

frightening experience (Bendelow et al., 2019b; Laidlaw et al., 2010; O'Brien et al., 2018; Riley et al., 2011; Sondhi et al., 2018; Warrington, 2019). Studies mention feelings of shame for being seen under the control of police by people they know (Akther et al., 2019), and the use of handcuffs, police vehicles and restraint are perceived as being criminalising and dehumanising (Akther et al., 2019; Goodall et al., 2019; Livingston et al., 2014; Riley et al., 2011). Furthermore, literature shows that police are seen as 'enforcers' (Goodall et al., 2019, p. 200) who have a role to protect the public and deal with persons who challenge the status quo or pose a risk, and in this role police were perceived as being used to guard persons under detention whilst they await an MH assessment within hospital environments (Riley et al., 2011). Nevertheless, there is evidence that detained persons appreciate the care and compassion shown to them by the police, with reference made to this surpassing that shown to them by healthcare staff (Bendelow et al., 2019b; CQC, 2014; Warrington, 2019).

Personal experiences of healthcare staff are reported as negative (Akther et al., 2019; Bendelow et al., 2019b; Riley et al., 2011; Warrington, 2019), with a lack of trust, inconsistent approaches and feelings of being seen as a nuisance compounding feelings of MD and dissuading persons approaching an episode of MD from seeking help. Nevertheless, each piece of research does offer some examples of good practice which supported a person in MD; for example, Akther et al. (2019) identified how personal approaches which showed a sincere concern were valued by detained persons.

Persons who have experienced multiple detentions are reported to feel rejected by MH services and found no support through community MH crisis support services; this lack of useful support compounding their sense of worthlessness (Warrington, 2019). In the same study, the police were seen as the service who always respond to crises and, whilst the detention process was 'harrowing' (Warrington, 2019, p. 10), there was a sense of gratefulness that the police cared enough to respond.

It is clear here that although detained persons feel afraid by detention processes and criminalised by being managed by police officers, there are problems in the care provided by healthcare staff. Persons vulnerable to repeated detentions are shown to resist seeking help due to fearing rejection or an unsympathetic response which increases their despair. In contrast, despite the connotations of criminality, police officers are perceived as caring and do not dismiss an episode of MD. In line with the rest of this chapter, there is an absence of empirical data on the perspectives of CYP who have experienced detention.

Intersecting Legislation

The web of intersecting legislation is complex and so it is important to consider where separate legislations pertaining to the detention of persons experiencing MD merge and interact with one another. Here I explore the often-competing intersections between the MHA and other legislation governing England and Wales, as well as legislation to which the UK is ratified and therefore ought to abide.

Mental Capacity Act

The Mental Capacity Act (MCA) (GOV.UK, 2005) applies to persons over the age of 16 years and is designed to assess a person's situation-specific decision-making capacity (DMC). Where a person lacks the ability to make a decision and is at risk to themselves or others, the frameworks provided by the MCA enable professionals to make 'best interest' and 'least restrictive' decisions on their behalf. The fact that the framework of protection offered by the act is not available to CYP was described as 'concerning' by the Children's Commissioner (2020b, p. 41). The MCA, following five principles, comprises of two stages: the functional test assesses the ability of a person to make a situation-specific decision, and the second stage guides professionals to make a best-interest, least-restrictive decision on behalf of a person who lacks capacity.

The MCA is complex, and there have been criticisms that persons under psychiatric care are discriminated against in that their DMC and the least-restrictive options offered by the MCA are overruled by the paternalistic nature of the MHA (Szmukler, 2010; Szmukler et al., 2014). It is not within the aims of this thesis to explore this further; it is sufficient to comment that it has been ruled in court that the MCA is not a police power. The ruling, by judges Pitchford and Supperstone (2011), involved a female removed from her home and who was subsequently detained under Section 2 of the MHA. Her admission for further assessment evidences that the officers were right in their concern that she was experiencing an episode of MD (Williams and Jones, 2012); however, the judges' ruling was clear that the only powers available to officers where there is a concern regarding MH are either S135 or S136 of the MHA, and not powers under the MCA.

Recent research by Thomas et al. (2021) considered decision making after multi-agency responses to calls regarding MD via triage schemes. A reduction in S136 detentions were due to a small number of cases being resolved via powers provided by the MCA and bestowed by healthcare professionals; however, the authors suggest that these pertained to older people who lacked capacity through dementia rather than other forms of MD.

The Human Rights Act

Incorporating rights set out by the European Convention on Human Rights, the Human Rights Act (HRA) of England and Wales outlines 14 'fundamental rights and freedoms that everyone in the UK is entitled to' (Equality and Human Rights Commission, 2018a, p. npn). Each right or freedom is described within 14 articles, and crucial to this work are Article 5: Right to Liberty and Security, and Article 3: Freedom from Torture and Inhuman or Degrading Treatment. There are limited writings specific to S136 detentions and the HRA (notable exceptions: Cummins and Edmondson, 2016; Morgan and Paterson, 2019); however, in research seeking the opinions of persons detained as inpatients under different sections of the MHA, participants commented that they felt that their human rights had been violated (Akther et al., 2019).

Under Article 5, everyone has a right to liberty unless they are deprived of that liberty due to lawful arrest or detention. When a person remains under detention for a time exceeding that which is stated in law (24 hours or 36 hours if there is an extension when pertaining to S136), they are held in breach of the HRA. Under the terms of Article 5, any person whose liberty has been unlawfully withheld is entitled to 'an enforceable right to compensation' (Equality and Human Rights Commission, 2021a NPN). Despite CQC (2020) comments confirming that there are S136 detentions which exceed the lawfully permitted time, there is an apparent lack of concern regarding the fact that these are unlawful detentions for which compensation could, and should, be sought. Enabling 'loopholes', the HRA outlines 'soft law' which enables a person's right to liberty to be breached in specific situations. There must be medical evidence to suggest that the person is of 'unsound mind', that there is an ongoing MH condition and that the detention is appropriate with regard to risk posed to the person or others if the person was to be released (Equality and Human Rights Commission, 2019). The only research specific to human rights and S136 (Cummins and Edmondson, 2016; Morgan and Paterson, 2019) pertain to detention processes and so do not provide data on excessive duration times.

Article 3, which offers freedom from torture and inhuman or degrading treatment, also has intersections with S136 detentions. S136 permits police officers to restrain detained persons, and this can continue after arrival at the POS, which can be under the public gaze in an A&E department. The definition of 'torture' includes 'cruel or barbaric conditions or restrains', whilst 'degrading' is considered to be treatment that is 'extremely humiliating and undignified' (Equality and Human Rights Commission, 2021b, p. npn). Guidance states that a lack of resources cannot be used to justify an authority denying persons' freedoms outlined under Article 3 and that 'the right not to be … treated in an inhuman or degrading way is absolute' (Equality and Human Rights Commission, 2021b, p. npn). Morgan and Paterson (2019) refer to the use of restraint and police vehicles during MD as being an

infraction to the person's right to freedom from inhumane and degrading treatment. Nevertheless, officers, whilst aware of the criminalising and stigmatising impact of the use of police vehicles, found it less of an infringement of the person's rights than to have them at the roadside waiting several hours for an ambulance. As with Article 5, soft laws in regard to Article 3 exist. A document (Council of Europe, 2017) outlines the circumstances in which restraint may be used; it states that restraint must not be applied because of staff shortages or convenience, in front of other patients, and only for a minimal time (minutes, not hours) under ongoing review.

There is no independent person overseeing an S136 detention. During a criminal arrest, people are entitled to legal representation, children and 'vulnerable' adults are provided with advocates and there is a custody sergeant overseeing detentions; however, persons detained under S136 are at the mercy of those detaining them. Presumably owing to the supposedly short duration of the detention, and perhaps because they are in the care of representatives from three professional bodies, there is no provision under S136 for an advocate to be appointed and no recourse to appeal the detention.

In summary, soft law pertaining to the HRA enables medical professionals to detain persons beyond the terms laid out by the MHA; in these circumstances, there is no legislative framework, advocacy or recourse to appeal. Furthermore, although restraint is permitted, this must be proportional, under review and out of the public gaze. Situations in which the freedoms and rights set out by the HRA can be infringed and how this occurs in practice are considered within this work.

United Nations Convention on the Rights of Persons with Disabilities

The MHA also intersects with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which recognises conditions which cause recurrent episodes of acute MD as a disability. The UNCRPD passed in 2006 and was ratified by the UK in 2009. The document does not form part of UK law itself but is incorporated into the HRA. The UNCRPD highlights areas where extra considerations are required to ensure that people with long-term health conditions can expect the same rights that are granted to others in society.

There has been concern expressed by academics as well as by medical and social care staff regarding the intersection between the MHA and the UNCRPD (Dawson, 2015; Gosney and Bartlett, 2020; Kelly, 2014; Szmukler et al., 2014). In particular, Article 14 of the UNCRPD, which pertains to Liberty and Security, states that a person should not be deprived of their liberty because of a disability, and yet the MHA, which is specifically in place to manage persons with a disability, allows the enforced detention of persons either suspected or diagnosed as having an MH condition.

Proponents of the UNCRPD call for its full implementation and an end, or at least a revision, to the MHA, that enables forced detention and treatment without consent (Gosney and Bartlett, 2020). Bartlett (Gosney and Bartlett, 2020) asserts that the exclusion of and prejudice against people who experience MD is entrenched in society and that the MHA reflects the outdated thinking of segregation and enforced treatments. Meanwhile, Gosney (Gosney and Bartlett, 2020) calls for the reversal of the UK's ratification of the UNCRPD until it has been amended on the issue of enforced detention. Gosney insists that a continuation of the compulsory detention of people in severe MD is essential and considers the possibility that the UK ratified the UNCRPD 'without intention to act on it' (Gosney and Bartlett, 2020, p. 297).

The last review of the UK's application of the UNCRPD, performed in 2017, (Equality and Human Rights Commission, 2018b) highlighted shortfalls in several areas. Specific to this work are the negative attitudes and prejudices towards disabled people; regarding Article 13 (Access to Justice), the UN Committee highlighted concern at police officers' 'low awareness of disabled persons rights' (2018b, p. 16). Considering concern regarding S136 detentions exceeding the lawful detention duration, the report mentions that 'people with mental health conditions do not always receive the right support to access justice' (2018b, p. 16). Furthermore, the involuntary detention of disabled people that is permissible under UK law was also of concern to the committee under Article 14 (Liberty and Security of the Person), as was the use of restraint, including the tasering of people in MD, that contravenes UNCRPD's Article 15: Freedom from Torture and Cruel, Inhuman or Degrading Treatment of Punishment.

A second UN report on progress made by the UK in view of the 2017 review was published in October 2018 (Equality and Human Rights Commission, 2018c). Although the second report does not specifically comment on the aforementioned areas, the language used by the committee evidences their alarm. Notably, the second report highlights the 'continued reluctance from the UK government to accept the conclusions of the report: 'the most recent evidence … remains deeply concerning' and the impact of continued austerity has caused 'social protections [to be] reduced and disabled people and their families continue to be some of the hardest hit' (Equality and Human Rights Commission, 2018c, p. 7).

The Children Act 1989

The Children Act (CA) (GOV.UK, 1989) is a significant, large piece of legislation with various intersections with the MHA. The overarching aim of the CA is to ensure the safety and wellbeing of

children by placing the child's needs first and giving due consideration to the wishes of the child, through independent advocacy if required.

Section 46 (S46) of the CA enables a CYP under the age of 18 years who is considered to be at risk of significant harm to be taken into police protection via a police protection order (PPO). To avoid a CYP being 'institutionalised or stigmatised', the CoP recommend that a PPO is used in preference to an S136 detention (CoP, 2020b). PPOs last for 72 hours, and the CoP suggest that this is sufficient time to enable any MH or social care assessments to be conducted. Under Section 47 of the CA, social workers are obliged to make enquiries to establish what is needed to ensure the ongoing safety of the CYP, during which time the CYP would be placed in an emergency social care provision, or with relatives if risk allows.

Something that differs from the experience of adults is that S46 of the CA enables a CYP to be detained from within their home under a PPO (CoP, 2020b). This means that where there is a concern for safety regarding MD, police officers have the power to remove a CYP and take them for an MH assessment. A S135 warrant must be sought prior to the forcible removal of an adult or a CYP from their home for the purpose of an MH assessment under the MHA; however, S46 under the CA would bypass a multi-agency decision and associated delays. This means that, in cases of MD, police officers have increased powers to detain CYP from their homes than they have for detaining adults.

I found no national data on the number of PPOs invoked and they do not appear in the annual Police Powers and Procedures documents which report the number and temporal patterns of S136 detentions. It is curious that the CoP consider CYP detention under the MHA to be more stigmatising than placement in social care whilst an investigation is conducted into their ongoing safety. As with other aspects of S136 detentions of CYP, there are no available literature on this. The MH lead (2021) for the Constabulary reports that S46 detentions are rarely used for the purpose of MD, although this legislation was recently used to enable a more thorough assessment for a CYP who had been subjected to several S136 detentions.

United Nations Convention on the Rights of the Child

The United Nations Convention of the Rights of the Child (UNCRC) (UNICEF, 1989) features heavily within the CA guidance (for example, DfE, 2015). However, the UNCRC also intersects with MH legislation. Article 3 calls for 'the best interests of the child to be a primary consideration' (UNICEF, 1989, p. 4); Article 12 demands that the views of the child, offered through an advocacy service where appropriate, should be considered; and Article 37 offers protection against inhuman and degrading

treatment and unlawful deprivation of liberty. Where a child is deprived of their liberty, it should be for the shortest time possible and they should be held separately from adults 'unless it is considered in the child's best interest not to do so' (UNICEF, 1989, p. 11).

A report by the Children's Commissioner (2019) noted that more work is required in regard to the UNCRC since statutory requirements and professional processes often take priority over the UNCRC principle which is primarily to protect CYP from harm. Furthermore, the Commissioner noted that there are further challenges to upholding the UNCRC where there are multiple professionals involved; this occurs in S136 detentions, which involve police, healthcare professionals and AMHPs. Like adults, CYP who are detained under other sections of the MHA are entitled to an advocate; however, due to the urgency and supposedly short duration of an S136 detention, advocacy services are not sought, although there is an absence of literature pertaining to this. With no representation, detained CYP are entirely under the decision making of people detaining them.[10] Tomasi (2014) asserts that it is the responsibility of individual professionals to abide by the principles of their professional body and place the needs of the CYP at the forefront of their practice and decision making, and to ensure that legislation is followed and human rights are upheld.

As with adults, there are exceptions to the rights and freedoms that CYP can expect, therefore the United Nations have a document (United Nations, 1990) outlining rules regarding the care of under 18-year-olds who are deprived of their liberty. Within this document is guidance on the use of restraint and force:

> 'Instruments of restraint and force can only be used in exceptional cases where all other control methods have been exhausted and failed … [they] should be used restrictively and only for the shortest possible period of time … in order to prevent the juvenile from inflicting self-injury, injuries to others or serious destruction to property. In such incidences, the director should at once consult with medical and other relevant personnel and report to the higher administrative authority.' (United Nations, 1990, p. 8)

In the case of police detentions under S136, this suggests that mechanical restraints such as handcuffs can be used for short periods of time, but this should be immediately brought to the attention of the

[10] In communication with the National Youth Advocacy Service, an organisation with contracts to advocate for CYP throughout England and Wales, I was told that despite having an advocate being a statutory right for CYP wishing to pursue a complaint against Health, they have received less than one request per year for this service.

staff due to conduct the MH assessment and the use of restraints on CYP should be reported to senior police personnel.

As with all situations within this literature review, there is an absence of articles relating to the application of the UNCRC and children detained under S136; nevertheless, it is clear from research published regarding CYP rights that these are as restricted as adults' rights are within MH services (Cave, 2013; Damodaran and Sherlock, 2013).

To summarise this section, the literature shows that there are many intersections between the MHA and other legislation and, that persons held under the MHA are denied the protections that legislation provides to others in society. As most sections of the MHA contain powers provided to psychiatric care professionals, this evidences the control that the medical model has over persons to whom it ascribes a psychiatric label. Pertaining to S136 detentions, the MCA cannot be considered as an alternative way to seek help for a person experiencing MD, for DMC is disregarded under the MHA. Whilst the HRA and the UNCRPD legislation highlight rights and standards that persons can expect, there are situations which fall under soft law; this means that authority can be held over persons experiencing MD, meaning that these additional pieces are superseded by the MHA.

As with all areas of this literature review, research regarding CYP and the intersections between the relevant legislation that they experience is lacking. There are clearly situations where England and Wales fail to uphold the rights of CYP in their treatment during detention, and 'soft law' exists, which means that medical professionals can justify their actions as long as they are able to create a case that justifies a need relating to the safety of the CYP or other people.

Concluding Remarks

This chapter has considered existing literature on the process of S136 detentions. I explored the role of police officers, showing an increasing requirement of police to attend situations of MD and that this reliance on police officers is attributed to failings within health and social care provision. Police culture was known to favour the warrior (Rahr and Rice, 2015) aspect of their role and, although through education there is a suggestion that officers are beginning to accept their guardianship role, research has yet to confirm this in light of transitions towards evidence-based policing and the professionalisation of policing through degree programmes.

Figure 1 demonstrates the S136 process as prescribed by the terms of the MHA. At the point of detention, there is an increasing multi-agency response by way of triage initiatives, such as ST;

however, police officers make the final decision of whether to detain and this is often constrained by the fear of an adverse outcome should they not detain. Once detained, a person remains under police supervision and control until they can be passed into the care of medical professionals and held in a secure environment, such as an S136 suite. However, research suggests that the use of S136 suites is declining whilst the use of A&E departments is increasing. There is no clear understanding as to why this is occurring and there is associated concern regarding the increased time that persons are remaining under police supervision and control within these relatively public spaces.

This review of the detention process highlighted the connotations with criminality and is suggestive of a move towards the criminal model of MD; this is due to the presence of police supervision, the practices associated with policing and the duration of time that persons spend under police control. Research suggests that police officers can have a caring approach to detained persons, with the suggestion that the police approach is more consistent than that which is offered by healthcare staff; this situation has been linked to the reluctance of people accessing healthcare support that could have prevented later police involvement.

Research on the perceptions of persons detained under S136 is scant, as is that regarding the thoughts of police officers regarding S136 detentions. However, research on the experiences of CYP is absent from contemporary research. Official reports suggest that the detention of CYP is increasing but there are no reasons in the reports offered for this. Following the 2017 legislative changes which forbade the use of police cells, there is no research which evidences the detention processes for CYP. It is not known which POS are used nor how long CYP are under the supervision and control of police officers.

A review of legislation which intersects with the MHA evidences the dominance of the medical model and its power, aided by the MHA, in restricting access to protective legislation for detained persons. I am chiefly concerned regarding the potential loss of human rights for persons detained under S136, particularly regarding the duration of detentions and the protection of persons from inhuman and degrading treatment when they are under the supervision and control of police officers within A&E departments.

The subsequent chapters of this thesis seek to address the gaps in available literature. The research questions outlined at the end of Chapter 1 mean that, firstly, this research seeks to understand the role of police officers in the care of persons who are experiencing MD. Secondly, the work will compare the experiences of adults and CYP who are detained under S136, and finally the work will consider if the evident increase in police involvement in MD does constitute the criminalisation of MD.

Chapter 3: Methodology

Recognising the standpoint and positionality from which the researcher approaches a project is important to the transparency and validity of the findings (Harding, 1992; Holmes, 2020), and so this chapter begins with an account of my professional background. This section ends with using the unique perspective that my careers have given me to justify my decision to use both quantitative and qualitative data to analyse S136 detentions.

After briefly explaining the ethics applications and permissions, the chapter introduces the types of data that were used in this project. It explains existing sources of data and introduces the analytic strategy.

Epistemological Positioning

With a general nursing background followed by a social work professional degree, professions which encompass two of the three disciplines involved with S136 detentions, I had a unique set of skills and perspectives with which to approach this research project.

My nurse training in the late 1980s involved an 8-week placement on an acute psychiatric ward within a large psychiatric hospital in rural Lincolnshire. Despite seeing efficacious results of safely administered ECT and drug therapies that reduced symptoms of MD, I was concerned that such treatments could be given to patients detained under the MHA without their consent. Although very junior within a medical setting, I was aware of the apotheotic powers of the MHA and the associated lack of autonomy to which anyone in society could fall prey to – views that exist among critics of the Act (Dyer, 2007).

My medical career did not follow an MH nursing path and it was not until a career change to social work twenty-five years later that I encountered the MHA again. Preferring to consider the social forces which cause episodes of MD, I engage with the branch of social work which sees MD through a social lens, which critiques medical terminology, labels and treatments. The social model prefers to consider that persons sometimes experience an episode of MD and that this is often in response to adverse experiences, and thus social aetiology of MD requires consideration in any 'treatment' plan. I mark the word 'treatment' since this is synonymous with drug therapy, which staunch advocates of the social model consider to merely anaesthetise the person to their form of social oppression.

As well as being critical of the medicalisation of MD, social workers are advocates of maintaining human rights and of anti-oppressive approaches to care, and question the construction and

application of legislation. This research is therefore very much framed with the human rights of persons and the correct application of existing laws in mind.

Throughout the project I drew on personal and professional skills that I developed throughout my careers and training:

- Respect for the anonymity of my human participants.
- Acknowledgement that each entry to the dataset represented an account of extreme MD, attention to detail and a secure understanding of legislation – all of which were crucial whilst working with quantitative data.
- Skills of working with people, not pathologizing them, respectfully hearing their narratives and recognising my privilege and responsibility to ensure that their contribution creates change for others.
- Skills of communication, gaining and respecting the trust of my participants, listening and hearing accounts of distress whilst ensuring that, by contributing to the project, no harm came to the narrator, and respectfully analysing personal stories whilst maintaining my emotional intelligence.
- In remaining accountable to both my responsibilities as a researcher and to my social work professional body, I was required to act in an analytical and reflexive manner.

Methodological Justification – Mixed Methods

With my professional interest in approaches to MD, I chose a mixed-methods approach for this project in order to quantify the extent of police involvement with situations of MD whilst also understanding and hearing the human impact of detentions. A mixed-methods approach is recognised as being ideal in research which seeks to ensure social justice (Denzin, 2012; Fusch et al., 2018) since the triangulation that this offers gives improved understanding of the situation. Furthermore, Boulton et al. (2021) note that research in policing practices which use mixed-methods approaches are those which have the greatest likelihood of changing practice and policy.

A full understanding of S136 detentions cannot be established without the analysis of an administrative dataset and so I gained access to one of the most comprehensive datasets compiled on S136 detentions within a single police force. This was analysed as secondary data; nevertheless, an administrative dataset is only half of the story in regard to the detentions of people.

As well as analysing secondary data in the form of an administrative dataset, this work benefits from analysis of primary, qualitative data. People who have personal experience of detention by police due to an episode of MD each have their own stories of what brought them to the point of detention, their prior and subsequent interactions with professionals and the processes that they encountered whilst detained. Likewise, police officers provide valuable insight into their use of the power of S136 that is awarded only to them under the MHA. From the point of decision making to their observation of how a detained person experiences healthcare professionals, their contribution to research in this area is essential.

Sources of Quantitative Data

The accurate recording of S136 detentions has been inconsistent and incomplete (Her Majesty's Inspectorate of Constabulary et al., 2013; Sadiq et al., 2011), and thus establishing temporal changes in detentions is difficult. Sadiq et al. (2011) suggest that the inaccurate recording of S136 data is, at least in part, because of the multidisciplinary and multisectoral nature of S136 detentions as opposed to other detentions under the MHA.

Problems with the reliability of data have long since been established, which lead to this cynical observation:

> 'one might argue that the lack of data on this issue reflects the relative value that society and governments' place on mental healthcare and people with mental health issues – gathering data about an issue is typically a precursor to doing something about it' (Baker and Pillinger, 2020, p. 108).

Inconsistencies were first noted in the 1980s when researcher interest in police detentions under MH legislation began (Turner et al., 1992). Over 20 years later, Laidlaw et al. (2010) found discrepancies between data on S136 detentions held by police compared with those recorded by MH services. These researchers suggested that MH service data captures only 50% of overall detentions.

Despite police data being seen as more accurate than MH services data, in 2014 the Home Secretary called for increased transparency and improved recording of police detentions under the MHA (May, 2014a). At the time, S136 detentions were collected by the National Police Chiefs' Council (NPCC). Since the call for improvement, annual data collection has formed part of an existing Police Powers and Procedures (PPP) report, which lists data on the use of all police powers, such as stop and search and driving offences. Initially piloted in 2016, with just 15 of the 43 police forces submitting numbers

of S136 detentions (Home Office, 2020b) and therefore not including data from every force within England and Wales, this annual report is the best indicator by which to monitor S136 detention numbers.

It is a requirement that the specifics of each S136 detention are recorded on an S136 Monitoring Form. This form follows the detained person throughout the detention to the revoking of S136, rather than remain in police hands. With many forms not finding their way to an MHA administrator for analysis, this method of data collection is estimated locally to only capture 60% of detentions (MH Lead, 2019), which is comparable to research elsewhere claiming that such methods only capture 50% of detentions (Laidlaw et al., 2010). Whilst additional ways of monitoring and recording S136 detentions are improving the capture rate of detentions in some regions, including within the geographical location of this research, for many forces across England and Wales, S136 Monitoring Forms remain the best record of S136 detentions and will be their source of data submitted annually to the Home Office. Considering the aforementioned problems of this paper trail, and despite the PPP report being the best way to monitor temporal changes in S136 detentions, many incidences of S136 detentions across England and Wales remain uncounted via the S136 Monitoring Forms.

This research is unique in that it analyses an administrative dataset of S136 detentions which, unlike the S136 Monitoring Forms, captures all detentions[11]. The administrative dataset is compiled by the local NHS trust based upon data initially provided by the detaining police officers. When police officers attend an incident of MD, where practical and in accordance with the terms of the MHA, they seek advice from an MH professional prior to invoking an S136. Where an S136 has occurred or is advised by medical professionals to be invoked, an entry is made into the administrative dataset by the trust's 'Bed Hub', who advise detaining police officers to which POS the detained person should be taken. Variables are then populated throughout the detention process. These data are shared with the police force and enable a comprehensive understanding of S136 detentions within the region. Whilst the S136 Monitoring Forms are still compiled, this dataset is seen as the most complete record.

Ethics

Ethical approval for accessing and analysing police-held data and interviewing police officers and persons with experience of detention was awarded by the University's Research and Ethics Committee (REC) (Reference Number: 18021). Amendments were applied for and granted (Reference Numbers:

[11] It is accepted that there may be 'a few detentions each year' (MH Lead, 2019) which are not recorded on the dataset.

19082 & 19140) to ensure that changes made to data collection methods to meet the government's SRP during COVID-19 remained compliant to REC approval.

An Integrated Research Application System (IRAS) application was submitted to acquire access to the Trust-compiled administrative dataset used in the quantitative part of this research. Satisfying the IRAS REC committee and gaining their approval (Reference Number: 283249) to use the data enabled my ongoing, full access to this important administrative dataset.

The Quantitative Data

The administrative dataset began in December 2017 when the terms of S136 detentions were altered to align with the Policing and Crime Act, and now has details of several years' worth of S136 detentions, enabling analysis of temporal trends in detentions.

The data were anonymised by a member of the Senior Management Board at the Trust, who established a unique identifier from each detained person's NHS Number so that occasions of multiple detentions of the same person could be identified. The age of each detained person was established prior to the deletion of their date of birth and any mention of the person's name was removed from free-text variables before I obtained the data.

Arriving to me in a pseudonymised format, the dataset comprised 4,978 police detentions under the MHA within the Trust over the 40-month period from December 2017 to the end of April 2021. In the latter months of the dataset, the Trust expanded into the territory of a different police force. As this thesis considers S136 detentions from one police force, the 239 detentions outside of the Force's area were dropped, leaving 4,739 detentions.

The dataset also included S135 detentions – planned multi-agency detentions that require a magistrate's order to enable professionals to enter a person's home to take them for an MH assessment. There were 272 such detentions, which were removed from the dataset, leaving 4,467 S136 detentions. Owing to inconsistencies with populating the dataset when it was first established, there are 196 missing data for the variable regarding whether a person was detained under S135 or S136. Although it is reasonable to consider that the detentions are most likely to have been S136 detentions, for transparency, these missing items were dropped, leaving 4,271 detentions.

As the age of detainees is crucial to this thesis which compares the detentions of adults with those of CYP, detentions where age is missing (n=60) were dropped, leaving a total sample size of 4,211 detentions.

Some individuals were detained multiple times. For each case, I gave each entry a sequential detention number to enable ongoing identification of each individual detention.

Missing Data

There is item missingness in early entries into the dataset which I believe to be due to administrative staff becoming familiar with the new system of recording detentions; for instance, a variable regarding whether the person was detained under S135 or S136 is only sporadically populated in the first month of the dataset. Other item missingness relates to the evolution of dataset. For instance, it was not until December 2018 that gender was routinely recorded, thereby leaving 1,206 incidences of missing data for this variable. Likewise, over time and as the purpose of the administrative data expanded, additional variables were added, leaving prior detentions unpopulated with data on these specific variables.

Other than to preserve data by correcting obvious typographic errors in date and time variables via cleaning and coding processes, I did not conduct imputation: available data were analysed as they appear. To enable as thorough an analysis as possible, data under analysis are presented within descriptive statistical charts in Chapters 4, 5 and 6, and each individual analysis table presents the sample size of complete data for each of the variables under examination. For this reason, the sample sizes under analysis vary throughout the findings chapters.

Variables

Age is provided in years. Extremes in age such as 2 years and ages above 100 years were assumed to be out-of-range values and, as such, I coded them as missing. The youngest detention age of 9 years was confirmed as accurate by the MH lead within the police force. After cleaning, there were valid data for 4,211 detentions. I coded categorically to capture CYP by age, although ages 9 to 13 years are grouped due to low cell numbers. Adults were grouped by stage of early adulthood (19 to 24 years and 25 to 30 years), and older adults were grouped in 10-year intervals until 50 years. The final group, determined by cell size in comparison to other age categories, is 51 years plus. Early adulthood represents two groups since this is known to be a time of high incidence of mental distress (Audini and Lelliott, 2002; Carr et al., 2016).

The age at which a CYP becomes an adult is arbitrary and socially constructed (Sawyer et al., 2018), with Uprichard (2008) noting that the transition from childhood into adulthood is situation specific. CYP access NHS adult physical health services after the age of 16 years (LTHNHSFT, 2020); for MH care,

CYP remain under CAMHS care until the age of 18 years (Appleton et al., 2019). Financial support by way of Child Benefit and Child Tax Credits is available until a young person reaches the age of 19 years (Kennedy, 2005), and in social care, young people are enabled to remain in foster or residential care until the age of 21 years (GOV.UK, 2011). From a police and criminal justice perspective: 10 years is the age of criminal responsibility (CPS, 2019); parents or carers must be informed of the arrest of a 17-year-old and they must be treated as a child is rather than an adult (GOV.UK, 2017a); and there is ongoing discussion about the complexity of maturity of persons up to the age of 25 years regarding the suitability of adult prisons for this age group (Justice Committee, 2018).

In light of conflicting concepts of childhood, adolescence and adulthood, I chose the upper age of 18 years for CYP, as this is the absolute upper age limit for which CYP can remain in contact with CAMHS services (Appleton et al., 2019) and is recognised by the UNCRC (UNICEF, 1989). In addition, socially this age signifies the transition from secondary school to adult education and the point at which government financial support to raise children ceases. To this end, I created a separate, dichotomous variable to determine if the detained person was a CYP of up to and including 18 years.

Gender is recorded as a binary of male and female. Free-text variables demonstrate that some detained persons were involved in gender transition but analysis of anything outside of a gender binary is not possible due to the dichotomous recording in the dataset as received from the Trust. Gender is routinely recorded only from December 2018 and was added only after my recommendation to police supervisors.

A four-category variable labelled ‘referrer’ indicates whether the professional body making the request for police attendance was purely police led or followed calls from AMHPs, health professionals, or community-based organisations (including a triage team, the Criminal Justice Liaison Team who assess persons in police custody and other health-based community MH teams).

There is a dichotomous variable (yes=1) for whether police officers called the ‘mental health access line’ for advice from an MH professional prior to detention.

The dataset contains four date and time variables for: police detention, arrival at POS, transfer, and the revoking of the detention. These exist as day, month, year and in 24-hour clock format. Where obvious typographic errors could be identified by comparison to other date and time data (typically at the change of year or over midnight), I coded to preserve data that would otherwise have been lost.

I used date data to create additional variables for the day of the week as well as the month and year of detentions. After coding time variables as whole hour, I created a dichotomous variable evidencing

whether the time was within or outside the standard office hours of 09:00 to 17:00, Monday to Friday (OOH=1).

Using date and time variables I coded dichotomous variables (Yes=1) to show detentions which exceed the permitted 24 hours and those which exceed 36 hours, the latter being the maximum lawful period of detention should a 12-hour extension have been applied.

To code detentions which occurred after the initiation of SRP, the date of the government's first call to 'stay at home' was established as 16 March 2020 (GOV.UK, 2020c). I calculated how many days exist to the end of the dataset and then calculated this same distance prior to 16 March 2020. I then made a variable for whether detentions occurred equidistant prior to and beyond 16 March 2020 as a dichotomous variable (Post-SRP=1). This dichotomous variable then allowed me to compare the characteristics of detentions in the same time period pre- and post-SRP.

A dichotomous variable indicates officers' perceived existence of 'physical health needs, drug use or intoxication' in the detained person. Physical health needs always take priority over MH needs and so must be dealt with prior to any MH assessment. An affirmative response here would mean that the detained person must attend A&E for a physical health assessment prior to an MH assessment.

For a dichotomous variable regarding the availability of an S136 suite, I coded entries of N/A as missing data (n=37). This is an example of administrative data being populated in an arbitrary fashion. It is assumed that an MH assessment in an A&E department resulted in release from detention or immediate admission to hospital, but even then, as S136 suites are the preferred POS when someone is detained under S136, there can never be an occasion where the availability of a designated suite is 'not applicable'.

A categorical variable indicating the reason why an S136 suite is unavailable was rarely populated until March 2018. Here, many of the 2,452 entries of N/A are likely to indicate that a suite is available. To enable analysis, I coded N/A as missing and other data according to three dominant categories: Occupied, Staffing Issues and Not Medically Fit. The person not being medically well enough to be cared for in an S136 suite is the only valid reason for the non-use of a suite, from a detained person's perspective.

The initial POS used is a categorical variable that has the geographic location and type of POS. As previously stated, detentions outside of the geographical reach of the Constabulary were dropped and this was done using this variable. Aside from this, the specific location within the geographical area of this research is not under analysis here and so this portion of the data were disregarded. I created a categorical variable of S136 suites, A&E departments and police custody suites.

A categorical variable contains the location of the S136 suite that a detained person is transferred to if their current location or first POS is anything other than an S136 suite. Again, data on location were disregarded as these are not under analysis; however, the other data were used to create three separate variables. Firstly, I created a dichotomous variable for if a transfer occurred. Here, I combined data from an existing dichotomous variable in the administrative dataset regarding whether a transfer occurred, thereby capturing any missingness from this variable. Next, I created a categorical variable to describe the final (or 'end') POS where the S136 detention will have been revoked: A&E, S136 suite or police custody. Finally, using the same process together with the aforementioned dichotomous variable that determines if the detained person was a CYP, I created a categorical variable for if the end POS for a CYP is an A&E department, an adult S136 suite or a CYP S136 suite. Of note, there was one entry where police custody was the end POS of a CYP; however, exploration of open-end variables showed this to be an administrative error. Consequently, this entry was coded as missing.

A dichotomous variable (yes=1) indicated whether a request was made for an inpatient bed.

A dichotomous variable indicates whether a lapse in the lawful detention duration occurred (yes=1), with entries of N/A coded as missing. There were two additional responses (totalling four detentions) in this variable that are subjective: 'No 12 hr ext' and 'Yes 12 hr ext'. The first could be read as 'no, there was no lapse as there was a 12-hour extension granted', or 'no, there was no 12-hour extension' – the latter possibility I feel is unlikely as it would just be marked as 'yes', thereby indicating that a lapse did occur. However, it is not so obvious with the second response as this could be interpreted as 'yes, there was a 12-hour extension' or 'yes, there was a 12-hour extension and a lapse still occurred'. Despite there being no other reference to 12-hour extensions within the dataset, these four entries were coded as missing data. To enable comparison, from date and time variables I created dichotomous variables (yes=1) to indicate if detentions had exceeded 24 hours.

The dataset has a variable noting the reasons why any lapse in the lawful detention duration occurred. Whilst this late addition to the dataset has a high percentage missing, it offers an insight into the reasons for unlawful detentions. I coded this variable categorically according to common themes: bed availability, transport and awaiting assessment.

I coded the outcome of each S136 detention into four categories: Admitted – Detained, Admitted – Informal, Discharged with No Follow-Up, Discharge with Follow-Up. I also created a dichotomous variable where Admitted=1.

For CYP, I hand-coded variables based on free-text variables. I ordered data according to age and read free-text entries for all detentions up to and including 18-year-olds. I created dichotomous variables

for risk to self, risk to others, type of self-harm the CYP engaged in, if restraint was used and any mention of the CYP being in local authority care. Risk to self was determined if text suggested any suicidality or self-harming behaviours; risk to others included mention of any aggression or heard voices suggesting that the CYP should harm other people[12]. The free-text data were merely a brief comment on the reasons or circumstances of the MD that lead to the detention and so coding should be viewed as an underrepresentation of the actual facts.

Owing to the large number of adults represented in the data, it was not time-efficient to repeat the above for these detainees. The notion of risk to self or others was determined using the 'find' facility in Microsoft Excel, using search terms and a wildcard signifier to capture variations of words of interest; for example, harm, violen*, ligature, cut*. The mention of the use of restraint or disabling method was established using search terms such as restrain*, handcuffs/cuffs, leg, taser/tazer and spray. Dichotomous variables were made for each form of restraint and disabling method and a further dichotomous variable (Yes=1) comprised any mention of any of the police methods of restraint used. There is no literature available to suggest that adults in local authority care experience S136 detentions, and if this does occur, the chance of capturing the likely small numbers via search terms was so small, given the aforesaid underrepresentation of incidences, that being under local authority care was not analysed for adults.

Once I had created dichotomous variables on risk in Excel, they were merged to the data for analysis in Stata.

The Qualitative Data

To understand what leads to S136 detentions and how the processes were experienced, it is essential to hear the narratives of people who have lived experience of S136 detentions. Likewise, hearing police officer narratives and their perspectives on the processes of detention and MH assessments is invaluable to this project.

The current situation of increasing detention rates is a serious concern (Bendelow et al., 2019b; HMICFRS, 2018), and people who have been detained, as well as the officers who detain them, have a lived experience that is valuable to illicit change. By empowering my participants to assist in that change, it is hoped to give them a sense of wellbeing.

[12] It is important to note that there was mention of several CYP and adults actively seeking help because of heard voices telling them to harm others.

Recruitment – People with Experience of Detention

People with lived experience of S136 detentions have been described as vulnerable and hard to reach (Smith and Thorpe, 2015), and for this reason the recruitment of these participants was not restricted to the geographical area of study. This group of participants were recruited via one of three means: posters in the geographical area of study, Twitter or through local and national organisations who support people vulnerable to repeated episodes of MD.

Posters (Appendix 1) inviting people to participate were displayed throughout the area of study. During recruitment, SRP restricted access to public and charitable buildings; nevertheless, 60 posters were placed in supermarkets, police stations and foodbanks throughout the region. One participant was recruited in this way after they saw the poster in a supermarket.

Charitable organisations throughout the geographical area of study were contacted via email, as SRP prevented any in-person meetings. The email contained an overview of the project and the recruitment poster was attached, with a request for the email to be forwarded to colleagues who support persons who might be interested in participating. A total of 21 emails were sent; responses offering to forward the information were received from four, two of which included my work in their newsletter. One such response also 'tweeted' about the project.

Three waves of calls for participants were posted to Twitter, with four people contacting me via this method. I also used Twitter to find persons working with people with experience of detention. I contacted one such professional, who was in contact with an organisation which supported persons who experience multiple detentions, and through this contact an additional participant was found.

For the five people who responded via Twitter, I sent an email reply introducing myself and attached the participant information sheet (PIS) (Appendix 1) and consent form (Appendix 1). After email confirmation that they wished to proceed, I telephoned[13] each participant at a time convenient to them. At this point one person requested for me to call back at a later, agreed time. Two subsequent calls to this person were unanswered and a follow-up email inviting the person to contact me if they wished to progress with participation went unanswered. Respecting their right to decline to proceed, I made no further contact.

Contact with the participant who was sourced via the support organisation was assisted by their support workers. They video-called me during their bi-weekly face-to-face meeting and I was introduced to the person. With their support workers present, I read through and explained the PIS

[13] A phone dedicated to my research was used, not my personal telephone.

and consent forms. I responded to all questions asked by the person and their workers and I agreed a time to telephone the person for a private one-to-one conversation.

Initially I had hoped to recruit around eight people with experience of an S136 detention, but SRP hampered the recruitment of people who are already recognised as difficult to reach. Nevertheless, of the five participants, three had experienced two or more S136 detentions (with the participant who I had been introduced to via video-call having experienced an indeterminable number of detentions) and the generosity of all participants gave me a rich data.

Of the five participants, four were female and one was male. As previously mentioned, more than half had experience of more than one detention. Two participants were from the geographical area of study and the other three were living in different parts of England.

Recruitment – Police Officers

Serving police officers from the Constabulary were initially recruited from a list of officers who had undergone additional training in MH. Invitations to participate were sent to officers by the MH lead on the Force who had delivered this training.

To hear the perspectives of officers who had not received additional MH training, weekly posts inviting participation in this research project were placed onto the Force's intranet over a period of two months. The posts were placed by a contact within the Force using a poster (Appendix 1) that I provided.

After the officers interested in participating made email contact with me, I replied via an email containing attachments of the PIS and consent form (Appendix 1). Consent forms were completed and returned, and I telephoned police officers at an agreed time.

A total of 14 servicing police officers from across the region contacted me and interviews were conducted with 12 officers: eight males and four females; nine were constables, two were sergeants and one was an inspector. The two officers who were not recruited failed to respond to two follow-up emails. Again, out of respect for persons declining to participate, I made no further contact. Participating officers came from throughout the geographical reach of the Constabulary, thereby offering insights from throughout the region.

Data Collection

Qualitative data were collected from all participants via audio-recorded one-to-one telephone interviews. The possibility of data collection via focus groups was considered but dismissed, largely due to SRP preventing group gatherings and associated pressures on policing (Reicher and Stott, 2020), but also due to the practicalities of coordinating geographically disperse participants (Robinson, 2020). Furthermore, regarding persons with experience of S136 detentions, expecting persons with ongoing vulnerabilities to share personal accounts of distress in focus groups is highly complex (Owen, 2001). One-to-one interviews enable the private sharing of personal experiences and opinions without peer impairment or influence, which is seen as a limitation of focus groups (Robinson, 2020). Whilst face-to-face interviews would have enabled conveyance of non-verbal feedback cues (Etherington, 2004), the quality of data from telephone interviews is acknowledged to be comparable to that gained from face-to-face interviews (Musselwhite et al., 2007; Sturges and Hanrahan, 2004); my initial friendly but professional email communications forged trust, and my verbal communication skills, which responded appropriately to participants speech, enabled productive interactions. Furthermore, although this protocol was largely forced by SRP, the additional anonymity offered to my participants through telephone interview was effective in eliciting rich data, as is recognised by Sturges and Hanrahan (2004).

I began each interview by checking that participants were feeling well, were comfortable, were content for me to audio-record the interview and were somewhere private where they could speak freely. Likewise, I reassured participants that I was alone and would not be overheard or interrupted during the conversation. I used prompt sheets to ensure that all areas of interest were covered. As noted earlier, as the data collection and early quantitative data analysis progressed, the prompt sheets were supplemented to elicit additional data on emerging themes. The final prompt sheets are found in Appendix 2.

Interviews with persons with experience of detention/s were of narrative enquiry, with me inviting participants to share their experiences and observations in a way that was not constrained by my questions (Etherington, 2004). I opened by inviting participants to share what happened to bring them to a point of MD that drew police attention and then participants were prompted to talk me through the processes of their detentions. Where participants had experienced more than one detention, they were invited either to talk me through each of them or to highlight differences in experiences between the detentions. In the instance where there were more than two detentions, the participant shared memorable detentions and gave accounts of positive and negative experiences of the different

detention processes. Owing to the narrative approach, interviews with participants ranged from 28- to 78-minutes duration.

Interviews with police officers were semi-structured to cover the detention process from start to completion. However, once I had posed a question or prompted an area of discussion, I enabled a free narrative reply that was not interrupted until the participant had completed their response.

With all participants, ensuring that they were not adversely affected by their participation in this project was of paramount importance to me. Several police officers recalled S136 detentions that they had been involved in with minute detail, which suggested that officers were troubled by what they had witnessed. Just as for persons with experience of having been detained, it was equally important that police participants were unharmed by this research process. To this end, throughout all interviews there were timely reminders to only share information to a level that the participant felt comfortable with and that they were at liberty to decline to answer any question that made them uncomfortable and to stop the interview at any point that they wished. The participant with experience of multiple detentions had clearly benefitted from our previous video-link introduction in the presence of their known and trusted support workers. With that participant, and indeed all participants, I drew on my social work training to ensure participants' wellbeing: I closed interviews with thanks, some light conversation and an enquiry as to how they felt having shared their experiences. Had it been necessary, I would have directed participants to the sources of support that were available on the PIS form. For the person with experience of multiple detentions, it had already been established with the participant that I was to contact their support workers if I was at all concerned about their wellbeing; however, this was not necessary, and their workers reported back to me that the participant had very much enjoyed speaking to me.

In accordance with ethical approval, participants with experience of detention were offered £10 by way of thanks for their participation and time given to the interview. Sadly, this offer was missed for one participant due to my forgetfulness. Of the other participants, two declined the offer, with one requesting that I donate the money to a police charity in acknowledgment of the kindness and respect shown to them by their detaining officers, and two participants accepted the recompense.

The iterative nature of my cleaning and coding of data as it was acquired demonstrated to me that with 12 police officers and 5 persons with experience, I had data which were rich in detail, there were no further emerging themes and I had reached saturation point.

Coding

Qualitative data were gathered over a period of three months with all audio-recordings being transcribed by me within two days of the interviews. This second hearing of the data enabled my clear understanding and recognition of emerging and repeating themes, thereby assisting in a rounded methodology which gained rich data on all areas of interest.

Data were entered into NVivo within three days of the interviews whilst the narratives and identified themes were fresh in my mind. Each transcription was entered under the 'case classification' of 'person' and details of each participant were entered. Details included an identifier code of either PO (police officer) or AWE (adult with experience) followed by a number unique to that participant, the gender of the participant, location and either the number of detentions for persons with experience or rank for police officers.

NVivo enables the coding of data into 'nodes' which represent each theme or area of interest. Transcriptions were read in NVivo and text were 'dropped' in whichever node/s they were deemed to correspond. A total of 29 nodes were created. These were then grouped into hierarchies of broader themes; for instance, any data which related to A&E departments or S136 suites were dropped into thus named nodes and these nodes were later placed into a higher node labelled Places of Safety. This can be seen in the Table 1 below. This separating and then grouping of data enables close analyses.

Table 1. Qualitative Data Coding Process and Results.

Node	Participants Included n=	Individual Data n=	Higher Node	Individual Data n=
S13 suites	16	50	POS	207
A&E	17	131		
Police cells	9	26		
Children	10	64	Children	83
Children in Care	5	19		
Communication (police/detained person)	7	28	Experience of detention	298
Bystanders	15	44		
Experience of Police	11	61		
Experience of Health/social care staff	8	38		
Distress	13	41		
Duration of Detention	15	60		
Frequent Callers	11	26		

Social Care	3	26	Support/care	171
NHS mention	6	45		
What happened prior to detention	6	17		
Outcome/aftercare	7	38		
What is needed	11	45		
Restraint	15	60	Criminalisation	149
Transport	15	37		
Criminalising	16	52		
Relationship police & health/social care	14	47	Policing	402
Frequency of Detentions	11	19		
Risk	11	62		
Decision Making	14	135		
Personal Impact on Officers	6	48		
Role of Police	15	71		
Training	4	7		
Historic Approaches	8	13		
COVID mentions	10	22		

Note: 'Participants Included n=' refers to the number of participants (police officer and persons with experience) who comment on the subject of each node. 'Individual Data n=' refers to the total number of quotations which relate to each node.

Mixed-Methods Analysis

Simple analysis as soon as the quantitative data were cleaned and coded enabled an understanding of the extent of S136 detentions under examination. These early findings informed the qualitative data collection methods and early thematic analysis of these data, which in turn fed back into further analyses of the quantitative data.

For qualitative data, in NVivo coded nodes were analysed using matrices enabling cross-sectional association between nodes. This demonstrated meaningful associations and highlighted intersections that were of use when comparing qualitative and quantitative findings.

There was no dominant priority given to either the quantitative or qualitative data. Whilst initial quantitative data were secured early in the project, more data were acquired to enable temporal

analyses and to investigate any changes in detention rates during the COVID-19 pandemic. Thus, the gathering of both forms of data became concomitant, enabling an iterative approach. For example, early exploratory analyses of quantitative data were loosely based upon existing knowledge of S136 detentions and these informed the structure of early qualitative interviews; however, emerging themes within qualitative data, such as the detention of looked-after children, encouraged further analysis of the quantitative data.

Taking the perspective of Gorard and Siddiqui (2018), my approach to the research was not constrained by the force of methodological labels; rather, it was cyclical and required ongoing reflexive adaptations as were appropriate to the subject, the data and the human participants. This flexibility, more commonly seen in qualitative research, enabled the work to evolve and adapt to emerging themes (Davies et al., 2011), such as the social change caused by the COVID-19 pandemic which prompted my acquisition of further quantitative data. This cyclical approach enabled a freedom for the evolution of this unique social research that ensured data collection remained appropriate to the research questions (Gorard and Siddiqui, 2018) and permitted recognition of the multidimensional phenomena that is classic of social research with human participants (Bazeley, 2010) in rapidly changing social conditions.

To answer my research questions, I used qualitative and quantitative data to critique the standard process of detention. Quantitative data informed detention time, arrival at POS, type of POS, any transfer, duration of detention, discharge time and outcome. I began with an examination and some bivariate analyses of the variables to understand the data and the S136 process in the project's geographical area; for instance, how many detentions occur and how many detainees are taken to A&E compared with S136 suites. Comparing emerging findings with qualitative data, I then examined correlations between variables. I built models to understand specific areas of interest based upon the qualitative data, such as the duration of police contact with detained persons. Using bivariate analyses and drawing on appropriate categorical or dichotomous variables, I explored to seek empirical correlations to test hypotheses of association between variables. Throughout I compared the detention processes for adults and CYP and tested differences in findings for significance using Pearson's chi-squared or *z*-test as appropriate.

Each findings chapter describes specific analyses methods, and variables under examination are presented. Results are displayed within tables and are illustrated with figures, including bar charts and Sankey diagrams, to aid understanding and impact.

Throughout, quantitative and qualitative analyses were performed in parallel, with findings being presented concurrently to enable illumination.

Chapter 4: Characteristics of Detentions

This chapter displays results of quantitative and qualitative data analyses regarding who is detained and how often, including the age and gender of detainees. These are essential results to understand who police are assisting and where gaps in MH provision could be failing detained individuals. The chapter responds to the first two research questions regarding the extent and nature of police involvement in MD and differences in adult and CYP detentions.

The chapter contains analyses on the temporal nature of S136 detentions and the outcomes of detentions. Again, temporal understanding demonstrates where demand for acute MD provision is, and the outcomes of detentions are valuable for understanding how health and social care services respond to people who are presented by police after an episode of MD.

Table 2 presents descriptive statistics for both detentions and for unique detained individuals, who may appear more than once in the data. For both detentions and detained individuals, data are first presented as the full sample and then two subsamples of adults and CYP. Owing to missing data within the administrative dataset, the number of available data are provided in bold alongside each variable presented. Total sample sizes in each table of analysis throughout the chapter will vary owing to the high levels of missing data; for instance, gender was absent from the dataset until 2019. All available data for each variable are presented in Table 2; however, analysis only occurs on valid data pertaining to the particular variables under examination.

Data on month, year and hour of detentions are presented within the text of the chapter. Owing to administrative typographic error in the dataset, there are item missingness within date and time variables. Analysis is only performed on valid, complete data across variables and so, again, sample sizes do vary throughout this chapter. Timing variables are presented only for detentions rather than for detained individuals as the aim of these analyses is to determine how detention numbers and processes differ at different times, and multiple detentions of the same individuals remains relevant to these findings.

Each section of the chapter offers data analyses for all detentions. Subsequently, the sections are disaggregated into children and adults. Summary analysis to demonstrate differences between findings are presented throughout the chapter.

Coverage starts in December 2017 when the amendments to S136 detentions occurred; however, owing to excluded data described in Chapter 3, data remaining do not begin until January 2018. There are only 2 and 8 detentions for January and February 2018, respectively, which is due to missingness

in the variable regarding which section a person was detained under. As patterned missingness would skew results, January and February 2018 are excluded from temporal analyses within this chapter.

Table 2. Descriptive statistics of Trust administrative data.

	All Detentions (n=4,211)			Adult Detentions (n=3,911; 92.88%)			CYP Detentions (n=300; 7.12%)			All Individuals (n=2,696)			Individual Adults (n=2,509; 93.06%)			Individual CYP (n=187; 6.93%)		
	n	% Mean	SD	n	% Mean	SD	n	% Mean	SD	n	% Mean	SD	n	% Mean	SD	n	% Mean	SD
Age	**4,211**	33.85	12.6	**3,911**	35.17	12.13	**300**	16.57	1.48	**2,696**	35.27	13.04	**2, 509**	36.67	12.41	**187**	16.46	1.55
Age Group	**4,211**			**3,911**			**300**			**2,696**			**2,509**			**187**		
9–13yrs	14	0.33					14	4.67		9	0.33					9	4.81	
14 years	20	0.47					20	6.67		16	0.59					16	8.56	
15 years	24	0.57					24	8.0		15	0.56					15	8.02	
16 years	48	1.14					48	16.0		34	1.26					34	18.18	
17 years	103	2.45					103	34.33		59	2.19					59	31.55	
18 years	91	2.16					91	30.33		54	2.0					54	28.88	
19–24 yrs	865	20.54		865	22.12					438	16.25		438	17.46				
25–30 yrs	833	19.78		833	21.3					490	18.18		490	19.53				
31–40 yrs	1,023	24.29		1,023	26.16					721	26.74		721	28.74				
41–50 yrs	717	17.03		717	18.33					510	18.92		510	20.33				
51–98 yrs	473	11.23		473	12.09					350	12.98		350	13.95				
Gender	**3,244**			**2,985**			**259**			**2,069**			**1,914**			**155**		
Male	1,817	56.01		1,722	56.69		95	36.68		1,305	63.07		1,243	64.94		62	40.0	
Female	1,427	43.99		1,263	42.31		164	63.32		764	36.93		671	35.06		93	60.0	
Detentions per Person										**2,696**			**2,509**			**187**		
1										2,105	78.08		1,964	78.28		141	75.40	
2										343	12.72		320	12.75		23	12.3	

3										101	3.75		90	3.59		11	5.88		
>4										147	5.45		135	5.38		12	6.42		
Call Advice Line	**3,697**			**3,439**			**258**			**2,371**			**2,215**			**156**			
No	2,153	58.24		2,004	58.27		149	57.75		1,381	58.25		1,288	58.15		93	59.62		
Yes	1,544	41.76		1,435	41.73		109	42.25		990	41.75		927	41.85		63	40.38		
Referring Agency	**4,190**			**3,892**			**298**						**2,493**			**185**			
Police	3,576	85.35		3.316	85.2		260	8.25					2,131	85.48		155	83.78		
Health	257	6.13		242	6.22		15	5.03					155	6.22		11	5.95		
Community MHT	260	6.21		242	6.22		18	6.04					147	5.9		15	8.11		
Social Care	97	2.32		92	2.36		5	1.68					60	2.41		4	2.16		
LA Detainees	**300**			**0**			**300**			**187**			**0**			**187**			
LAC not mentioned	248	82.67					248	82.67		155	82.89					155	82.89		
LAC mentioned	52	17.33					52	17.33		32	17.11					32	17.11		
Gender L.A Care	**47**			**0**			**47**			**29**			**0**			**29**			
Male	12	60.85					12	60.85		9	31.03					9	31.03		
Female	35	74.47					35	74.47		20	68.97					20	68.97		
COVID-19	**3,040**			**2,792**			**248**			**1,961**			**1,812**			**149**			
Detained 31.01.2019 - 15.03.2020	1,512	49.74		1,439	51.54		73	29.44		960	48.95		911	50.28		49	32.89		
Detained 16.03.2020 - 30.04.2021	1,528	50.26		1,353	48.46		175	70.56		1,001	51.05		901	49.72		100	67.11		
Day Detained	**4,186**			**3,887**			**299**												

Sunday	648	15.48		595	15.31		53	17.73											
Monday	572	13.66		533	13.71		39	13.04											
Tuesday	593	14.17		548	14.10		45	15.05											
Wednesday	600	14.33		563	14.48		37	12.37											
Thursday	580	13.86		537	13.82		43	14.38											
Friday	572	13.66		531	13.66		41	13.71											
Saturday	621	14.84		580	14.92		41	13.71											
Detention OOH	**4,186**			**3,887**			**299**												
No	906	21.64		854	21.97		52	17.39											
Yes	3,280	78.36		3,033	78.03		247	82.61											
Rescinded OOH	**4,016**			**3,732**			**284**												
No	1,563	38.92		1,430	38.32		133	46.83											
Yes	2,453	61.08		2,302	61.68		151	53.17											
Duration of Detention	**3,924**	25.12	47.92	**3,644**	25.79	49.47	**280**	16.47	15.63										
< 24 hours	2,983	76.02		2,741	75.22		242	86.43											
< 36 hours	356	9.07		337	9.25		19	6.79											
<= 48 hours	150	3.82		141	3.87		9	3.21											
<= 72 hours	161	4.10		155	4.25		6	2.14											
<= 96 hours	85	2.17		83	2.28		2	0.71											
<= 120 hours	57	1.45		56	1.54		1	0.36											
<= 144 hours	38	0.97		38	1.04		1	0.36											
<= 168 hours	31	0.79		30	0.82														

<= 192 hours	17	0.43		17	0.47													
> 216 hours	46	1.12		46	1.26													
Detention Outcome	**3,535**			**3,276**			**259**			**2,254**			**2,100**			**154**		
Admitted Detained	893	25.26		845	25.79		48	18.63		606	26.89		584	27.81		22	14.29	
Admitted Informal	342	9.67		329	10.04		13	5.02		209	9.27		202	9.62		7	4.55	
Discharge No F-U	569	16.10		543	16.58		26	10.06		400	17.75		381	18.14		19	12.34	
Discharge With F-U	1,516	42.89		1,349	41.18		167	64.48		922	40.91		818	38.95		104	67.53	
Other	215	6.08		210	6.41		5	1.93		117	5.19		115	5.48		<5	1.3	
Bed Request	**4,178**			**3,881**			**297**			**2,678**			**2,495**			**183**		
No	2,632	63.00		2,377	61.25		255	85.86		1,706	63.70		1,540	61.72		166	90.71	
Yes	1546	37.00		1,504	38.75		42	14.14		972	36.30		955	38.28		17	9.29	
n = Number; SD = Standard Deviation; MHT = Mental Health Team; LAC = Local Authority Care; OOH = Out of Hours (external to Mon–Fri, 9am–5pm); FU = Follow-Up Care																		

Who is Detained and How Often?

As per the secondary data presented in Table 2, of the 4,211 S136 detentions under analysis from the Force over a 40-month period, 300 (7.12%) are CYP between the ages of 9 and 18 years (mean 16.57; SD 1.48) with the remaining 3,911 (92.88%) being adults between the ages of 19 and 98 years (mean 33.85; SD 12.6). These 4,211 detentions are of 2,696 unique detained individual persons comprising 2,509 individual adults and 187 individual CYP.

According to the Office for National Statistics (ONS, 2020b), the sample of detained individuals under investigation here represents 0.25% of the population: 0.26% of adults and 0.13% of CYP. CYP represent 12.8% of the area population of people and 6.93% of detained individuals, whereas adults represent 87.2% of the area population and 93.06% of detained individuals; therefore, proportional to the area population, more adults are detained than CYP.

In primary, interview data, most police participants (n=11) stressed how MD is a large part of their daily work, with many calls to police regarding self-harming and suicide intention:

> 'It happens on a daily basis; I don't know if you and the public understand how many calls we get a day regarding people who are threatening self-harming or feeling suicidal. It has become very, very common to us now.' (PO1)

Police officers also spoke of the increase in S136 detentions. When asked how many S136 detentions they had invoked, one officer replied:

> 'In the earliest part of my career, not many at all. I'd say in the last 5 years, despite being in different departments and not always on response, plenty, at least 30, and they are ones I've [invoked] directly. Those that I've been involved with, where I have been at scene, you are talking hundreds and hundreds where someone has been 136'd.' (PO2)

Secondary, administrative data show that half (50.01%) of all detentions are of persons who have been detained on more than one occasion. The sample of 4,211 S136 detentions comprises just 2,696 detained individuals, with 591 (21.92%) detained individuals accounting for 2,106 all detentions. The 300 CYP detentions in the sample include 187 detained individuals. Of those detained individuals, 75.4% (n=141) were detained once, meaning one quarter of detained individual CYP experience subsequent detentions. 12.3% (n=23) were detained twice, 5.88% (n=11) were detained three times and 6.42% (n=12) were detained between four and 12 times. For CYP, 53% of all detentions are second

or subsequent detentions of the same detained individual. Of detained individual CYP, the mean age is 16.46 years (SD 1.55 years).

In interviews, most police participants (n=11) commented on their frustration of dealing with CYP on multiple occasions:

> 'A couple of times a week, [we would be called to] a young [person] … [we] would end up wrestling this teenager, in the buff out in the street. It was such a drain on police resources as once you have detained [them] it would need at least two of you because [they were someone] that you would have to sit on for the entire shift before [they] got assessed. And then [the assessment team] would turn around and say, "sorry there is nothing wrong, it's behavioural."' (PO8)

Secondary data show that for adults, 49.78% (n=1,947) of all detentions are second or subsequent detentions of the same detained individual. Of detained individual adults, the mean age is 36.67 years (SD 12.41 years). The 3,911 adult detentions in the sample includes 2,509 detained individuals; of these people, 78.28% (n=1,964) were detained once, meaning that over one-fifth of detained individual adults experienced multiple detentions. 12.75% (n=320) of detained individual adults were detained twice, 3.59% (n=90) were detained three times and 5.38% (n=135) were detained between four and 31 times.

Although police officers find themselves repeatedly detaining the same individuals, most of these police participants shared that it is the system they are frustrated with, not the people in MD:

> 'It's really frustrating, especially with cases when they are detained every week. They go to the hospital and they are looked at and then they are released, and then you are going back the next week and you are doing the same and it is really, really frustrating, and very difficult. The system frustrates me. You can't blame it on the people that you are detaining because they are poorly; they really are. I mean, sometimes you get a bit frustrated if you are dealing with the same person time and time again, but that's a frustration at the fact that there is nothing else in your policing role that gets done.' (PO12)

The same officer spoke of another case where they felt that the person was denied support which resulted in the person dying:

> 'The sad thing is we were dealing with [them] every week … we kept 136ing [them] and [the hospital] kept releasing [them] … [they] ended up seriously harming. They

> are clearly poorly and clearly need help […] in front of my colleagues and as a result [they have] died.' (PO12)

The adult participant with experience of repeated detentions spoke of their experience and what brought them to the point of MD that drew police attention:

> 'The majority of the time a member of the public has seen me on a bridge, or I have contacted the crisis team for support; they have not given me the right support and I have made threats to harm myself. I couldn't tell you how many times I have been detained. It must be at least 20. It does still happen, but it is not frequent because now there's plans in place so for me [sic] … there are other options that are more helpful towards my recovery.' (AWE4)

Specific only to CYP detentions, being looked after in local authority care was mentioned for 52 (17.33%) of the detentions which comprise 32 detained individual CYP. As only 3% of CYP in England and Wales are classed as looked after (Ofsted, 2021), there is an overrepresentation of looked-after CYP being detained under S136.

Five police participants spoke of S136 detentions of looked-after CYP. One police officer participant shared that looked-after CYP are placed within the region so that they are geographically distanced from dangers within their home location. These CYP might not appreciate the move, attempt to return home and then become vulnerable missing persons who, when found, are sometimes detained under an S136 owing to threats to harm themselves:

> 'Children in care who are involved in drugs or grooming – anything where they are being exploited – are moved [away from their home area] and then the more involved [they are], the further away [social services] move them. That just means they go missing a lot more because they are trying to get home.' (PO5)

While S136 detentions of CYP comprise little over 7% of total S136 detentions, there are 300 detentions of CYP aged between 9 and 18 years over a 40-month period, with looked-after CYP being overrepresented. The high percentage of the same individuals being detained multiple times calls into question the quality of support in place to prevent further police contact regarding their MD.

Total CYP detentions are comprised of proportionally more repeated detentions than total adult detentions are (53% vs 49.78%). When considering detained individuals, 75% of detained individual CYP are detained once compared with 78.28% of detained individual adults being detained once, meaning that CYP are marginally more likely to be detained more than once compared with adults.

Similar proportions of CYP and adults were detained on two occasions (12.30% vs 12.75%) but more CYP were detained three times than adults were (5.88% vs 3.59%) and, despite the maximum number of recorded detentions for detained individual children being 12 (compared with 31 for adults), proportionally more children are detained in excess of four times compared with adults (6.42% vs 5.38%). An independent samples *t*-test showed no statistical significance (p=0.64), so although there is a difference noted in repeated detentions, this is not a disproportionate difference between individual detained CYP and adults.

To summarise, one-quarter of CYP and over one-fifth of adults experiencing repeated detentions suggests a failure in the ongoing care of individuals who are vulnerable to repeated episodes of MD, with a particular deficiency in the ongoing care of CYP who have experienced an episode of MD that has brought them to police attention.

Age and Gender

Figure 2 shows the data pertaining to the age of all CYP detentions and detained individual CYP (age at first detention) by percentage of the total detentions and detained individuals. Likewise, Figure 3 shows the data pertaining to the total adult detainees and detained individual adults (age at first detention). It is important to present the two figures separately as the larger percentages of adult detentions dilute the visibility of the equally important CYP detentions.

The blue bars represent the total number of detentions for each age group, whilst the orange bars represent the total numbers of detained individuals in each age group.

Figure 2. Percentage of CYP detentions by age.

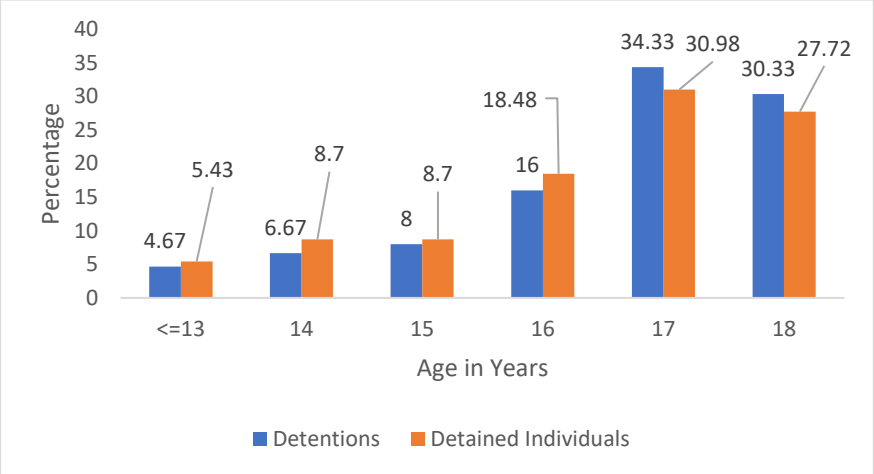
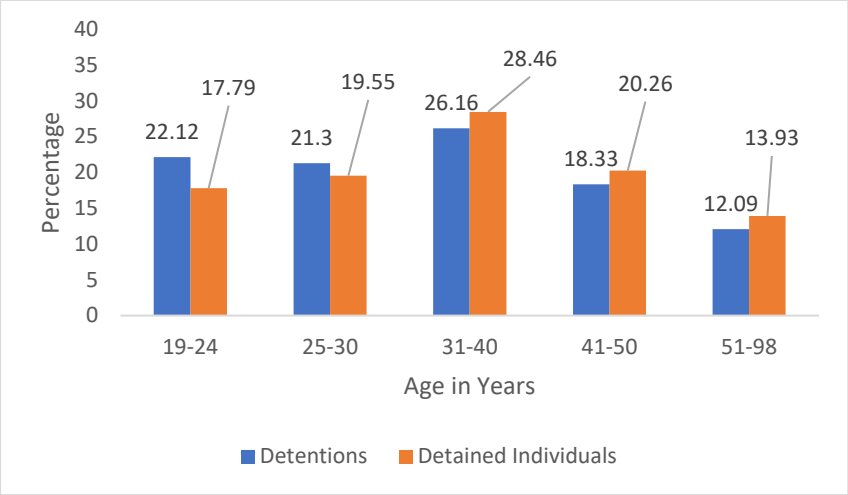


Figure 3. Percentage of adult detentions by age.



For CYP, the greatest percentage of detentions (34.33%) is for 17-year-olds, and this age also comprises the greatest percentage of detained CYP individuals (30.98%). Although Figure 2 shows data which evidences that older CYP experience more detentions, the youngest CYP age group (9 to 13 years) still comprise 5% of CYP detentions.

The greatest percentage of adult detentions (26.16%) are in the 31-to-40 category, which is where we also see the greatest percentage of detained adult individuals (28.46%). The younger adults experience greater percentages of detentions than older adults, with ages 19 to 24 years and 25 to 30 years comprising over 22% and 21% of adult detentions, respectively.

The data in the graphs show that ages 17 to 30 years have higher numbers of detentions (blue bars) than detained individuals (orange bars), showing that, in these data, people of these ages are those more likely than the other age groups to experience more than one detention.

Most CYP detentions occur in the 17-year age category, but what is not seen in Figure 2 is that the 103 detentions comprise just 59 detained individuals. Likewise for adults (Figure 3), 438 detained individuals were detained a total of 865 times. To explore this further, data regarding the average number of detentions for each age are shown in Figure 4.

Figure 4. Average number of detentions by age.

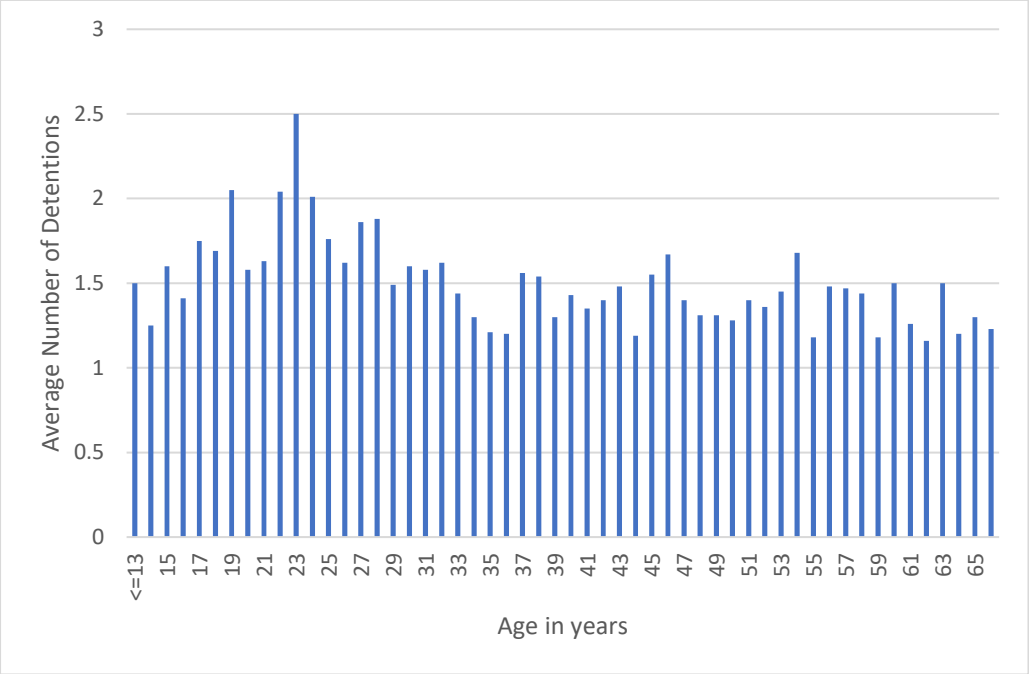


Figure 4 presents data regarding the average number of detentions for each age, with the lower (<=13 years) and upper ages (>=66 years) grouped. Proportionately more detentions per person occur in the young adult years, where the ages of 19 and 21 to 24 years each see an average of over two detentions per person, with 23-year-olds having an average of 2.5 detentions per person. Whilst one detained individual can skew averages by being subjected to many detentions, Figures 2 and 3 evidence that the percentages are comprised of multiple detained individuals.

Of CYP, 17-year-olds represent the age which features most commonly within data, with an average of 1.75 detentions per person. School examination pressure has been linked to CYP distress, especially for females (Fortune et al., 2008); however, formal examination times also affect CYP who are aged 16 and 18 years, so this cannot be accredited to the comparatively high detentions of 17-year-olds.

It is not clear why 17-year-olds experience more detentions than 18-year-olds. 10 police participants spoke of the number of CYP detentions. One police participant, who has dealt with many situations regarding CYP, offered their views as to why so many CYP experience acute MD:

> ‘There are so many malicious communications between children and there is no teaching of how to cope with that. No wonder kids are growing into adults and being stressed to high heaven and they don’t know how to cope with things.
>
> ‘All the social media and phone use puts a very different element of stress on society than the [Second World War] rations did. Kids are being encouraged to commit suicide

on an app on their phone. Stress levels have changed but there is still no intervention for how to deal with that or how to stop idiots encouraging people to commit suicide. [Intervention] would reduce the pressures on services.' (PO10)

Although detention numbers of CYP are greater with the higher ages (103 detentions of 17-year-olds and 91 detentions of 18-year-olds), there is a sharp rise in detentions of young adults, with 865 detentions across the 5 years between ages 19 and 24 years, meaning that this age group is that which is most vulnerable to episodes of MD that result in police detention. Further of note regarding adult detentions, there are 1,023 detentions of adults in the 10 years between 31 to 40 years; this number of detentions is comprised of 721 detained individual adults who account for only 29.52% of the total number of detentions. After the younger adult categories, this age group remains vulnerable to MD which draws police intervention.

As presented in Table 2, across all detentions where data are available (n=3,244), more males are detained than females (n=1,817; 56.01% and n=1,427; 43.99%, respectively); however, there is a relationship between gender and age. For instance, for detained CYP, there are more females (n=164; 63.32%) than males (n=95; 36.68%), whereas for detained adults there are more males (n=1,722; 56.69%) than females (n=1,263; 42.31%). A chi-squared test was applied (Table 3), showing that the difference in gender for both CYP and adults is statistically significant ($\chi2=42.69$; $p=<0.001$).

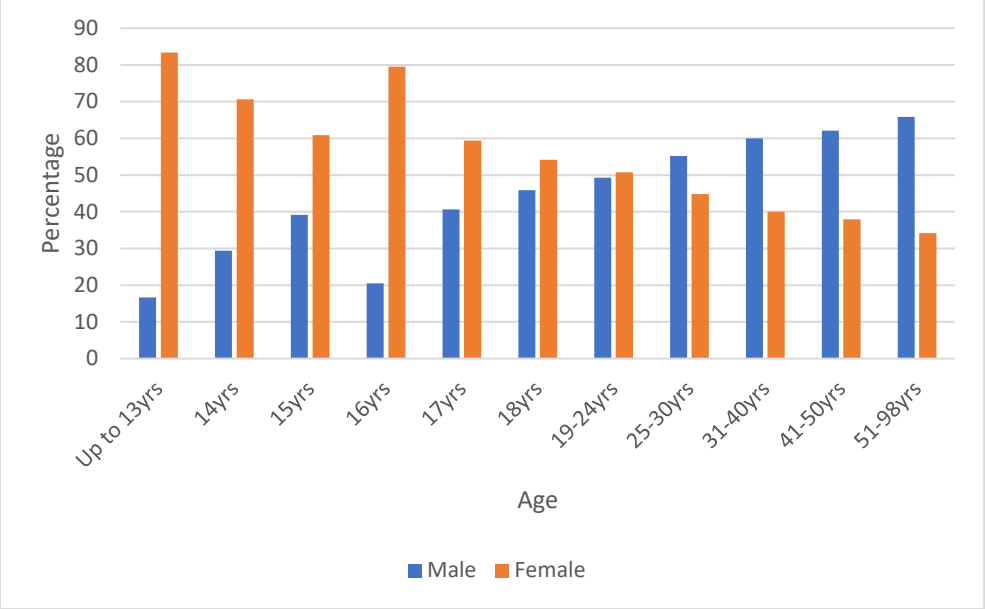
Table 3. Number of CYP and adult detentions by gender.

	Male	Female	Total
CYP	95 36.68%	164 63.32%	259 100%
Adult	1,722 57.69%	1,263 42.31%	2,985 100%
Total	1,817 56.01%	1,427 43.99%	3,244 100%

Notes: Frequencies and percentages given; $\chi2=42.6926$; $p=0.000$.

Tabulation of age groups and gender reveals results which are displayed in Figure 5. Here there is a clear inverse association. The greatest gender split is in the lowest age group of CYP aged 9 to 13 years, where 83.33% are female, followed by 16-year-olds, where 79.55% are female.

Figure 5. Age and gender of detained persons shown as percent.



For young adults aged 19 to 24 years, there are marginally more females (50.75%) than males (49.25%) detained; however, for all other age groups, there are more males than females, with the greatest divide being in the oldest age category where 65.85% of detentions are male.

Gender was available for 29 of the 32 looked-after detained individual CYP and showed that almost 69% (n=20) were female. Owing to several cell counts below five, these data are neither shown nor explored in any greater detail. Nevertheless, the gender division of looked-after detained individual CYP is higher in females than is seen for other detained individual CYP (68.96% vs 60%). A chi-squared test was applied (Table 4) and the results show no statistical significance in the gender of detained individual CYP who are looked after and those who are not ($\chi 2=1.19$; $p=0.27$).

Table 4. Number of looked-after CYP compared with CYP not looked after.

	Male	Female	Total
Care Not Mentioned	53	73	126
	42.06%	57.94%	100%
Care Mentioned	9	20	29
	31.03%	68.97%	100%
Total	62	93	155
	40.00%	60.00%	100%

Notes: Frequencies and percentages given; $\chi 2=1.1948$; $p=0.274$

To summarise this section, young adults of 19 to 24 years are those most at risk of being detained multiple times, but there are higher percentages of detentions comprised of the same detained individuals throughout mid-teens to the end of the twenties. Whilst this is the age range where the onset of most MH conditions are diagnosed (Kessler et al., 2007), social causes must not be dismissed. This age-band suffers increased societal pressures regarding higher education and careers, long-term relationship building and the transition into adulthood and towards independent living.

There is a clear need for increased individualised care and support plans targeted at people within the age groups which are highlighted here as being those people who are most vulnerable to repeated detentions. In particular, with more than 35% of CYP detentions being comprised of the same detained individuals across five of the six CYP age categories, there is a clear deficit of adequate MH support post-S136 detention to prevent subsequent detentions of the youngest people in society.

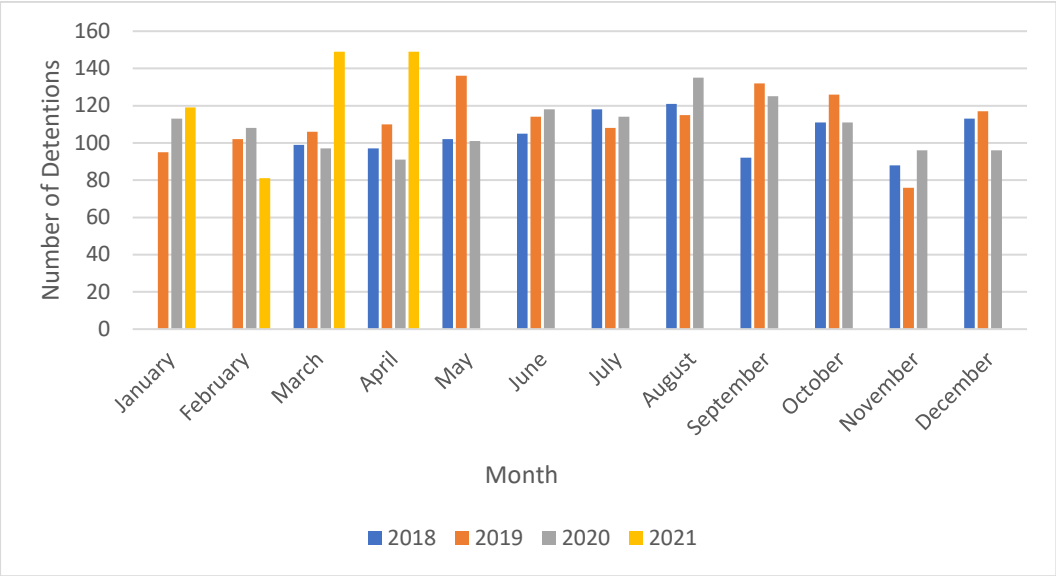
Self-harming practices occur more commonly in young females (Chandler and Simopoulou, 2021) and this tends to subside with maturity (Carr et al., 2016), which is possibly why most detentions of younger people are of females. Likewise, middle-aged men are the age group most likely to die by suicide (Struszczyk et al., 2019) and this would explain why males are overrepresented in the adult detention numbers.

Temporal Nature of Detentions

This section excludes January and February 2018 as previously explained.

Figure 6 shows data regarding the number of S136 detentions by month and year. Each year can be seen to follow a seasonal pattern of rises and falls in detention numbers. Peak detentions are seen through summer months, starting in May, peaking in August (mean=123.6) and then falling until the consistent annual low in November (mean=86.6). Detention numbers rise again to a second, albeit lower, peak in January (mean=109) before a second low over the spring months of March (mean=100.6, excluding March 2021) and April (mean=99.3, excluding April 2021). However, March and April 2021 both saw an unusual peak of 149 detentions for both months, to be explored later in this chapter.

Figure 6. Total number of S136 detentions by month and year.



According to the qualitative data, police participants felt that there had been a decrease in adult detentions and an increase in CYP detentions since COVID-19 SRP; this is supported in the quantitative data.

As shown in Table 2, detention numbers in the 13.5 months prior to SRP were almost equal to detention numbers in the 13.5 months since SRP (mean[14] =111.92; n=1,512; 49.74% vs mean=112.59; n=1,528; 50.26%). However, for detained adults there were marginally fewer detentions since SRP (mean=99.6; n=1,345; 48.33%) than prior to SRP (mean =106.51; n=1,438; 51.54%), whereas there were more CYP detained since SRP compared with the 13.5 months prior to SRP, a difference which is statistically significant (mean =12.96; n=175; 70.56% vs mean=5.4; n=74; 29.44% ($\chi2$=44.51; p=<0.001. See Table 5)).

Table 5. Detention numbers of CYP before and after SRP.

Detention Date	Aged > 18	Age <= 18	Total
13.5 months pre-SRP	1,439	73	1,512
	51.54%	29.44%	49.74%
13.5 months post-SRP	1,353	175	1,528
	48.46%	70.56%	50.26%
Total	2,792	248	3,040
	100%	100%	100%

Notes: Frequencies and percentages given; $\chi2$=44.5176; p=0.000.

The 13.5 months either side of SRP comprised 39 of the 52 CYP for whom being looked after was mentioned. With mean detentions per month being 2.88 since SRP compared with 0.59 per month

[14] Mean number of detentions per month

pre-SRP, a chi-squared test was applied to test for significance. The test excluded incomplete data for age, gender, date and looked-after status. The results are shown in Table 6 and reveal that since SRP, there is a marginally significant difference in the detention of looked-after children compared with those who are not in local authority care ($\chi 2 = 4.30$; $p=0.03$).

Table 6. Looked-after CYP detentions before and after SRP.

Detention Date	Care not Mentioned	Looked-After CYP	Total
13.5 months pre-SRP	65	8	73
	89.04%	10.96%	100%
13.5 months post-SRP	136	39	175
	77.71%	22.29%	100%
Total	201	47	248
	81.05%	18.95%	100%

Notes: Frequencies and percentages given; $\chi 2=4.3026$; p0.038

Figure 7. During SRP, adult detentions by month and year.

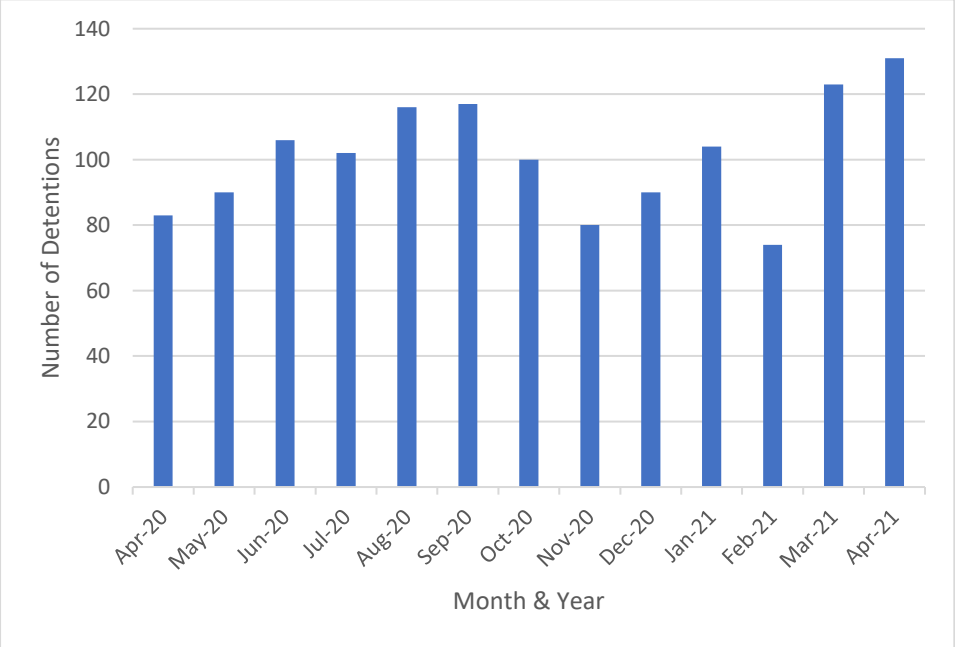


Figure 7 shows the data pertaining to the number of adult detentions in the months since SRP. As with previous years, there is an oscillation of monthly detention numbers; however, during SRP these oscillations were amplified, and the change was accurately noted by one police officer participant who related them to the social impact of the easing and tightening of social restrictions:

> ‘In the first lockdown, everything that we [as officers] do changed dramatically. Demand went down. We didn’t deal with much mental health, which is really surprising as we thought we would. As we came out of lockdown [in summer 2020] it was like it had an impact on anyone who was mentally ill. All of a sudden, we went from everyone being at home to people appearing […] we got loads of mental health type calls with people wanting to kill themselves, needing help, in crisis. Then we went through the next lockdown [in November 2020] and we saw a decline. This lockdown [since January 2021] has been much worse. Part of it is that it is cold, and people are stuck in their house. So, we are getting a lot of mental health calls that probably wouldn’t have come to light if it hadn’t been for this latest lockdown. People have lost their jobs, relationships have split up because people have maybe been together all the time and so [detentions have] increased dramatically, I think. Now whether as we reach the warmer weather that decreases slightly, we will have to see, but currently (March 2021) there are quite a lot [of detentions] and this is putting a massive strain on policing because detentions are long-winded; you are dealing with someone for hours after they are detained.’ (PO12)

Annual detention numbers were analysed for the same time periods of May to April 2018 to 2021. These months were selected to enable the most recent detention numbers of April 2021 to be used. For all detentions, in the year to end April 2020 there was a 5.54% increase and in the year to end April 2021 there was a 4.57% increase. For adult detentions, in the year to end April 2020 there was a 4.82% increase and in the year to end April 2021 there was a 2.14% decrease. However, for CYP, in the year to end April 2020 there was a 19.67% increase in detentions and in the year to end April 2021 there was a 120.54% increase in detentions.

Figures 8 and 9 show adult and CYP monthly detention numbers from March 2018 to April 2021.

Figure 8. Adult detentions by month and year.

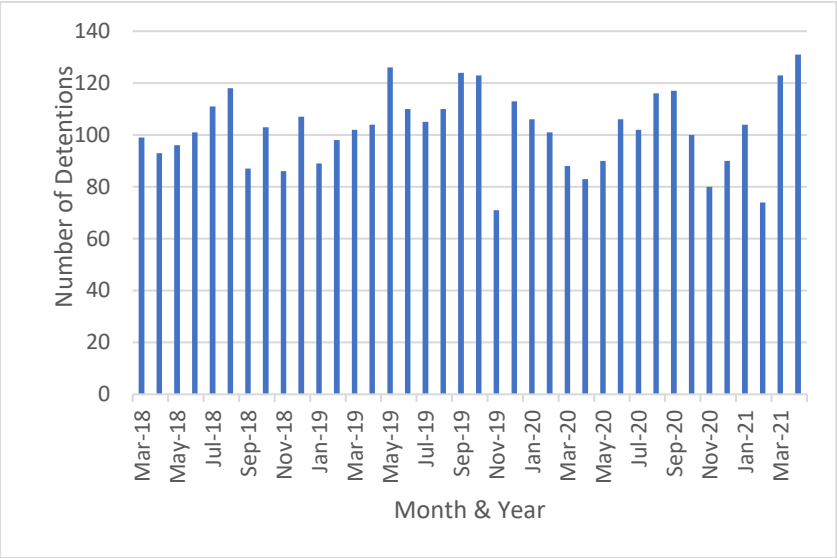
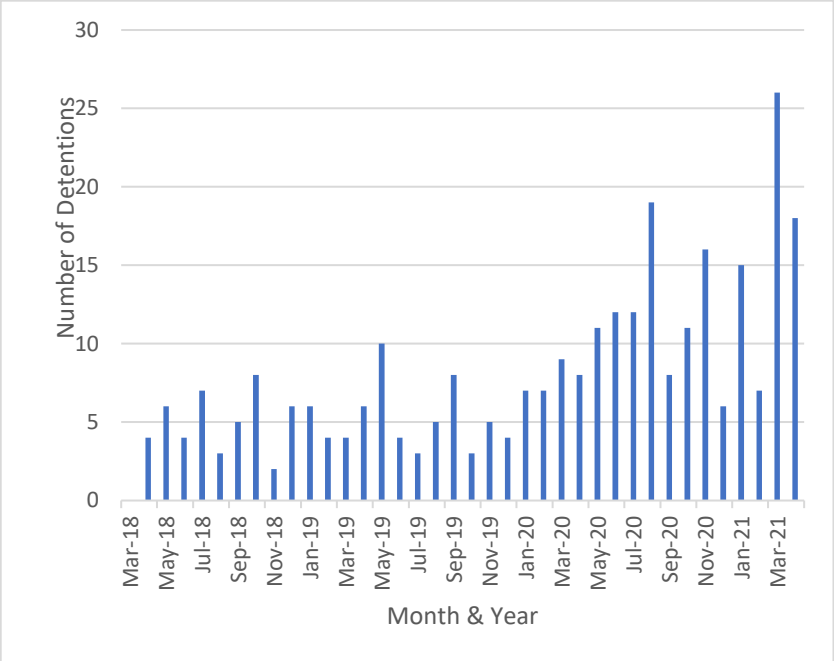


Figure 9. CYP detentions by month and year.



Together, data regarding the yearly percentage variations and data displayed in Figure 9 clearly show that SRP increased the number of CYP experiencing MD who came to police attention. This was not seen in adult detentions, which reduced during SRP. Nevertheless, the disproportionate increase in adult detention numbers in March and April 2021 (Figure 8) suggest an emerging change in adult detention numbers that cannot be explored within this work.

Overall, there is an increase in police involvement with MD in CYP, which has previously not been commented upon in stakeholder reports nor published research. The increase in adult detentions that

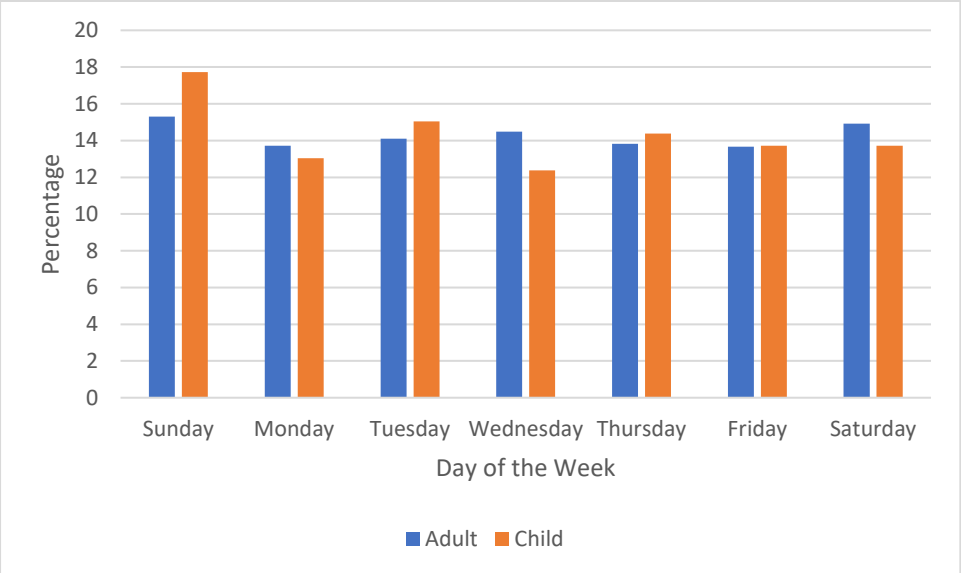
are widely reported in literature are not seen in these figures. However, it could be that the reduction in adult detention figures have falsely suggested a levelling out of adult detentions, which could return to the increasing numbers post-SRP.

Days of the Week

Establishing when episodes of MD draw a police response is important to theorise why there are times and days when MD and police demand is greatest. Table 2 shows the data regarding the number of detentions per day of the week. More detentions occur on Sundays, which saw 648 (15.48%) detentions. Saturday saw the next highest detention figure at 621 (14.84%) detentions, meaning that weekends see more detentions than weekdays. The fewest detentions were seen on Mondays and Fridays, which each saw 572 (13.66%) detentions.

Figure 10 shows the data regarding the percentages of adult and CYP detentions by day of the week.

Figure 10. Percentage of adult and CYP detentions by day of the week.



Sundays see the highest percentages of detentions of both CYP (17.73%) and adults (15.31%). For CYP, Tuesday was the second highest detention day (15.50%), whilst for adults Saturday was the second highest (14.92%). Wednesday has the lowest percentage of detentions of CYP (12.37%) and Friday has the lowest percentage of adult detentions (13.66%), closely followed by Monday (13.71%).

The pattern of detentions per day of the week is largely an accurate summary of detentions of CYP and adults. Sunday is the day which sees most detentions across the ages. The overall high incidence

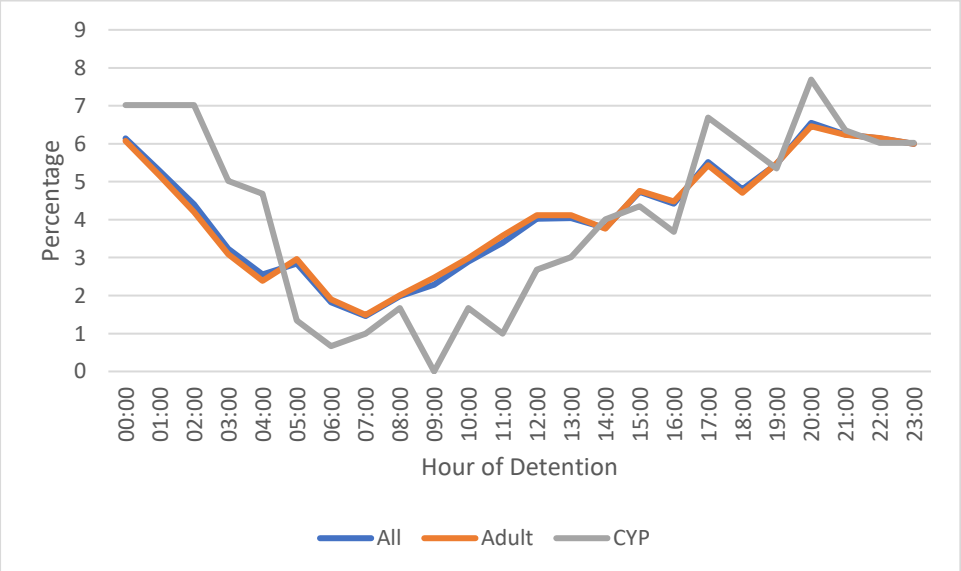
of Saturday detentions (14.48%, Table 2) is due to adult detentions, which means that adults are proportionally more vulnerable to MD which draws police involvement during weekends. For adults, weekdays, especially Mondays and Fridays, have proportionally lower detention numbers than other days – a pattern which is not seen in CYP. With no obvious sociological reason, other than it being a school day at the beginning of the week when maybe the hope that the week will be better did not come to fruition, Tuesday is the second highest detention day for CYP.

Of note is that support for acute MD from both charitable organisations and primary and secondary care medical practitioners is not readily available at weekends. Sociologically, weekends are noted for increases in household stresses as, for example, external pressures impact work strain recovery (Fritz et al., 2010) and weekend sporting features raise incidences of domestic abuse (Kirby et al., 2014). This inability to find calm and security within a home environment increases emotional pressure when external support is unavailable, which could account for the increased call for police intervention for incidences of MD.

Hour of Detention and End of Detention

Figure 11 gives a visual representation of the data regarding the percentage of detentions by hour of the day. Three lines represent all, adult and CYP detentions, which enable visualisation of highly comparable trends in the times of adult and CYP detentions.

Figure 11. Whole hour of detention for all, adult and CYP detentions.



After rising throughout the latter afternoon, detentions for both adults and CYP peak at 20:00 and remain relatively high until midnight for adults and 02:00 for CYP, when they then tail off to a low of 07:00 for adults and 09:00 for CYP. This pattern results in more detentions occurring OOH[15] than during the day. 78.36% (n=3,280) of all detentions occur OOH, meaning that only 21.64% (n=906) occur during a regular working day.

There is a proportionally higher percentage of CYP detained OOH than adults (82.61% vs 78.03%). Three police participants spoke of the lack of available staff with skills to assess a child's MH, meaning that CYP who are detained OOH often spend a long and uncomfortable night in A&E under the direct supervision and control of police officers.

> 'There is always an argument about who's going to come and assess that child: are we going to wait for CAMHS in the morning or are we going to do it overnight with the normal process with social workers and doctors? It's always about waiting for CAMHS, so it is always a long-term detention. Usually it is that they need to bed the child down for the night and CAMHS will come out in the morning.' (PO7)

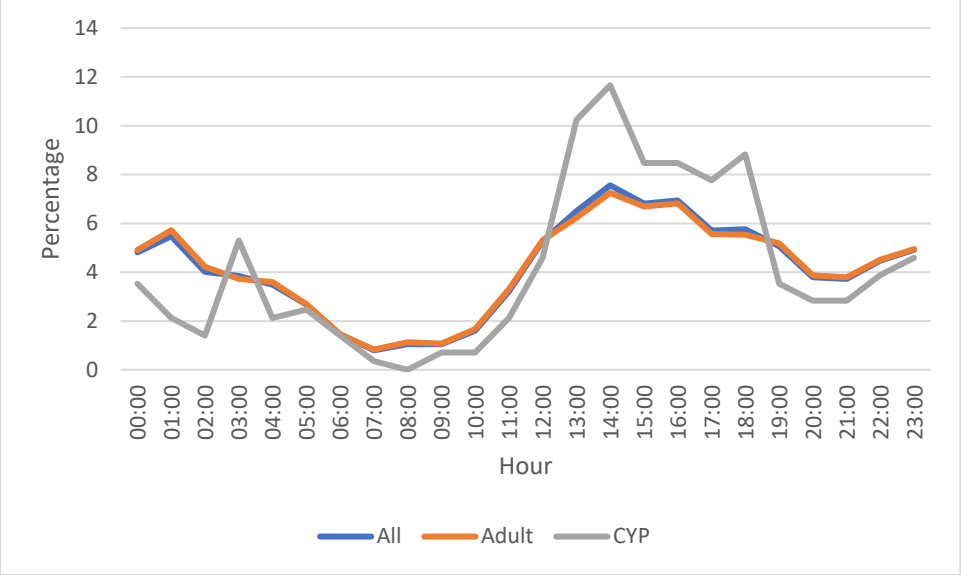
> 'The assessment is between an AMHP and two doctors and we will try to get at least one of the doctors who has got experience in child psychiatry. Invariably they are not available during the evening or night. So, you may end up with someone who has been detained at 6pm in the evening. If that assessment hasn't been able to take place because of the lack of a consultant, then it then gets passed to the day team and it would be dinner time at the earliest. So, you could have that young person there, under the detention and watch of police officers, for way in excess of 12 hours because of the lack of out-of-hours provision.' (PO11)

> 'I had a 17-year-old on [an S136 detention] and [they were] asleep on the floor in the corner, and I thought "this is absolutely ridiculous; this is awful", but there is nothing I could do about it.' (PO5)

Conversely, police participants report more efficient OOH S136 detention processes for adults. With no clinical responsibilities such as out-patient clinics, dedicated 'on call' doctors and AMHPs are generally able to complete timely MH assessments. Evidence of this can be seen in Figure 12, which gives a visual representation of the data regarding the whole hour when S136 detentions are rescinded.

[15] A working day is judged to be 09:00 to 17:00, Monday to Friday.

Figure 12. Whole hour of when S136 is rescinded for all, adult and CYP detentions by percentage.



Whilst the rescindment of S136 detentions of CYP is comparable to adults throughout the day, the discrepancy sharply rises in the early evening. Further analysis of this showed that proportionately more adults have an MH assessment and their S136 detention rescinded OOH than CYP do (61.68% vs 53.17%). The rise in CYP detentions at 03:00 was explored further to reveal that 73.33% (n=11) of these CYP were aged either 17 or 18 years. From the NHS perspective, these CYP are classed as adults, meaning that they did not have to be assessed by CAMHS-trained medical staff.

To explore CYP OOH release from S136 further, bivariate analysis was performed between age groups and hour of S136 being rescinded. Owing to small cell numbers, CYP were grouped to <=15 years as the first category. The results can be seen in Table 7 where the results of the data analysis show that for CYP <=15 years and 16-year-olds, most detentions (59.62% and 56.25%, respectively) occur during office hours (DOH) when CAMHS specialists are available. After the age of 17 years, when detainees are medically classed as adults, most detentions (minimum across age groups = 56.41%) occur OOH.

Table 7. Number of rescinded S136 detentions DOH and OOH by age group.

Age Category	DOH	OOH	Total
<=15 years	31	21	52
	59.62%	40.38%	100%
16 years	27	21	48
	56.25%	43.75%	100%
17 years	40	56	96
	41.67%	58.33%	100%
18 years	35	53	88
	39.77%	60.23%	100%
19 to 24 years	311	509	820
	37.93%	62.07%	100%
25 to 30 years	292	507	799
	36.55%	63.45%	100%
31 to 40 years	374	604	978
	38.24%	61.76%	100%
41 to 50 years	299	387	686
	43.59%	56.41%	100%
>51 years	154	295	449
	34.30%	65.70%	100%
Total	1,563	2,453	4,016
	38.92%	61.08%	100%

Note: Frequencies and percentage shown.

DOH=During Office Hours (09:00–16:59); OOH=Out of Office Hours (17:00-08:59)

The fact that there is no access to paediatric-trained psychiatrists overnight means that CYP must wait until regular working hours to have an MH assessment. Proportionally more CYP are detained OOH than adults are (82.61% vs 78.03%) but more adults than CYP have their S136 detentions rescinded OOH (61.68% vs 53.17%). A greater percentage of the youngest CYP have their assessment DOH than OOH. This clear failure to provide OOH urgent healthcare for acute MD in the youngest members of society means that children remain under police supervision and control within A&E departments overnight. This will be discussed further in the next chapter.

Duration of Detentions

Whilst 76% (n=2,983; 76.06%) of detentions were revoked within the lawful 24 hours, 9% (n=356; 9.07%) took up to 36 hours before they were revoked. 12-hour extensions may only be applied if the person's condition prevents assessment within 24 hours. There is no variable on the application of

extensions that has the longevity to enable useful analysis and so, with police officer participants stating that extensions are 'rare' (PO2; PO4), I hesitantly consider these 356 detentions to be lawful. Detentions in excess of 36 hours are unlawful. Almost 4% (n=150; 3.82%) of detentions took up to 48 hours and over 4% (n=161; 4.10%) took up to 3 days (72 hours) to be revoked. The data suggest that 46 (1.17%) detentions exceeded 9 days (216 hours). Although some of these excessive detention durations could be due to administrative error, CQC inspection reports have noted detentions which have lasted in excess of 1 week (REDACTED) and the peer-review report also noted that extended stays in the S136 suites 'were the norm and not the rare occasion' (REDACTED), and so, for transparency, analysis will be presented as factually accurate to the data available.

For all detentions, the mean S136 duration time is 25.12 hours, which exceeds the lawful 24 hours. Owing to the 46 incidences of detentions exceeding 9 days (216 hours), this mean has a large standard deviation of 47.92 hours.

For CYP, mean detention time is 16.47 hours (SD=15.63) and therefore within the lawfully permitted time. Despite the previous concerns regarding overnight waits for MH assessments, most (86.43%; n=242) S136 detentions of CYP are revoked within 24 hours. Almost 7% (n=19; 6.79%) lasted for up to 36 hours and could have had lawful detention extensions applied. Nevertheless, over 3% (n=9; 3.21%) of CYP detentions took up to 48 hours to be revoked, and almost 4% (n=10; 3.57%) took up to 6 days (144 hours) to be revoked.

For adults, mean detention duration is 25.79 hours (SD=49.47), thereby exceeding the lawful 24 hours. Only three-quarters (75.22%; n=2,741) of adult detentions are revoked within the lawfully intended 24 hours. Over 9% (n=337; 9.25%) of adult detentions last for up to 36 hours and will be considered here to have had a lawful extension applied. Nevertheless, almost 4% (n=141; 3.87%) of detentions take up to 48 hours to resolve, over 4% (n=155; 4.25%) take up to 3 days (72 hours) to be revoked and 6.15% (n=224) take between 4 and 8 days (96 to 192 hours) to be revoked. Over 1% (n=46; 1.26%) of detained adults remain under S136 detention in excess of 9 days (216 hours).

All police officer participants (n=12) suggest that excessive waiting times for assessments to be completed contribute to detentions exceeding 24 hours:

> 'I have been home and come back multiple times and they are still sat there, and you think "what on earth is going on? How can it take so long?" It could be an exaggeration [that they were there for 48 hours]. I just know that I have been home and had 11 hours off and come back in and they are still sat there. So maybe it wasn't over 24 hours, but it would have been 23:59 that they have been sat there.' (PO5)

> ‘Things have changed slightly now, but there were particular problems with massive wait times and bed space, and it could be 24 hours plus. There were a number of occasions where it did go over that 24-hour period and we were detaining people without that legal justification.’ (PO4)

For persons who have experience of being detained under S136, the waiting times were sometimes unbearable and contributed to their MD:

> ‘You are just waiting. There is nothing to distract you: no medication, nothing. You are just sat in this room waiting. I was aggressive; I was mad from waiting so long.
>
> Ages ago [maximum detention time] used to be 72 hours and that was extended for me once. I was in [an S136] suite waiting for a Section 2 bed.’ (AWE4)

Whilst proportionately more CYP detentions are resolved within 24 hours than adult detentions (86.43% vs 75.26%), over 13% (n=38) of CYP are detained beyond 24 hours.

The excessive detention times are longer for adults than children, with proportionally more adult than CYP detentions exceeding 36 hours (15.53% vs 6.79%).

Detentions beyond 24 hours, or 36 hours with an extension, mean that there is no legal framework under which detained people are protected. Detainees have no recourse to advocacy and are unable to appeal their detention. Medical and social care staff who choose to continue to detain a person under no legal framework for this duration carry a burden of responsibility to act in a way that they are able to legally defend, should they be challenged through court.

As will be seen in the coming chapters, CYP spend more time under the control of police officers for the duration of their S136 detention than adults. One police participant shared that there are systems in place to escalate detentions which are at risk of breaching the lawful 24 hours:

> ‘Our inspector will make frequent calls to us to determine where we are in the assessment process and if we are making any progress. If it gets to, I think, 12 or 16 hours then it gets escalated higher up. It’s not in anyone’s benefit to get close to the 24 hours.’ (PO6)

Thus, due to CYP spending more time under police control, it is entirely probable that this escalation of assessment times hastens the revoking of S136 and this, at least in part, accounts for the mean detention time being lower for CYP than for adults.

Outcomes of Detentions

Most people (62.01%) who are detained by police under S136 are discharged after MH assessment. Two police officers participants spoke of how few people that they detain end up being admitted and it is a consideration when attending an incident of MD. One officer said:

> 'Probably less than 10% of people I have 136'd have been admitted under Section 2 or 3. You almost know when you are doing it. Certainly in the early days I was just taking them to be assessed and be released. And you're having that conversation with them at the time: "Look, I'll take you to the hospital to see a doctor who will ask these questions and then I'll give you a lift home when you're done". You know that's going to happen. If ever I go down that route of thinking, then I will stop myself and reconsider an S136.' (PO2)

Actually, 25.25% of all S136 detentions progress to a formal detention for ongoing assessment and/or treatment under either Section 2 or 3 of the MHA. Only 9.67% of S136 detentions resolve with an informal admission. The fact that almost three times as many people are forcibly detained as are admitted voluntarily confirms opinion in Chapter 2 that pressure on reduced psychiatric beds mean that admission is reserved for people who require Section 2 or 3 detentions (McCartney, 2017).

Proportionately more S136-detained adults are admitted, either formally or informally, than S136-detained CYP (35.83% vs 23.65%). 25.79% (n=845) of adult S136 detentions result in a compulsory hospital admission compared with 18.63% (n=48) of CYP S136 detentions, and 10.04% (n=329) of adult S136 detentions end in informal admission compared with 5.02% (n=13) CYP detentions. With such pressure on acute psychiatric beds (especially CYP beds, with many CYP being sent to available beds out of area (CQC, 2018)), the admission versus discharge decision made by medical staff is unlikely to be based purely on clinical need.

The most common outcome of an S136 detention is discharge (62.01%; n=2,192): 16.10% (n=569) of people detained under S136 were discharged with no follow-up care in place. At 17.75%, the percentage of detainees discharged without follow-up care provision was higher in people who went on to experience subsequent detentions. As there had been previous writing regarding the amount of people discharged without follow-up care, including those with active suicidality (REDACTED), I compared pre- and post-SRP data as an analysis of how practice might have changed since the 2019 report. Of detentions resulting in discharge, pre-SRP 32.58% were without follow-up care provision whereas post-SRP this had reduced to 20.85%. An independent samples *t*-test was applied, which showed that this was statistically significant (p=<0.001).

Proportionately more CYP are discharged with follow-up care provision than adults are (64.48% vs 41.18%). This could be a result of the lack of available beds to enable admission, although one would think that support would be put in place for anyone whose MD had resulted in police intervention. Nevertheless, over 10% (10.06%; n=26) of CYP (16.58%; n=543 of adult detentions) were discharged from S136 police detention with no follow-up care provision in place. When comparing pre- and post-SRP discharge with and without follow-up care provision for adults and CYP, there is a reduction in the percentage of those discharged with no follow-up care provision for both adults and CYP (33.28% vs 22.38% for adults, and 18.31% vs 11.11% for CYP). Independent samples *t*-test for each showed statistical significance for the reduction in adults discharged with no follow-up care provision ($p<.001$), but no statistical significance for the reduction of CYP discharged with no follow-up care provision ($p=0.15$).

Whilst tabulation between S136 outcome (binary: admitted or discharged) and bed requests revealed that 14.32% (n=323) of people were admitted when no bed request had been documented, almost 20% of people were discharged after a bed request was made. This suggests that MH assessment judged that the detained person would benefit from hospital admission, but they were subsequently discharged. Bed request was then tabulated against detailed outcomes, revealing that 2.31% (n=29) of adults (0% of CYP) were discharged with no follow-up care provision in place after a bed request had been made.

Marginally more bed requests were made for people who went on to have multiple detentions than were not (50.78% vs 49.22%). A chi-squared test was applied to test the significance of a person being discharged after a bed request was made for persons experiencing multiple detentions. The results, as presented in Table 8, shows that there is a chance that a person will experience multiple detentions if they are discharged after a bed request has been made, and this difference is statistically significant ($\chi2=9.73$; $p=0.002$).

Table 8. Bed request and multiple detentions in people who were discharged.

	One Detention	Multiple Detentions	Total
No Bed Request Made	976 50.49%	957 49.51%	1,933 100%
Bed Request Submitted	96 39.83%	145 60.17%	241 100%
Total	1,072 49.31%	1,102 50.69%	2,174 100%

Notes: Frequencies and percentages given; $\chi2=9.7373$; $p=0.002$

The fact that so many people are discharged after a bed request has been logged has a positive association to repeated detention and is evidence that the reduced number of acute psychiatric inpatient beds has increased the number of S136 detentions. Hospital admission is not always the preferred response to MD, but the ability to enable inpatient stays when required is becoming a forgotten aspect of the CC policy (Tyrer et al., 2017). The number of repeated detentions also suggests an absence of effective community-based support services. This evident failure of medical and social care support inevitably transfers the onus onto police to manage acute MD.

Four police participants commented on the delays in finding inpatient beds as contributing to excessive delays in detention duration as well as increased time under the supervision and control of police officers. One officer said:

> 'The reality is that on any given day there could be 30+ individuals waiting for admission to a mental health bed and there are simply not enough beds to go around … individuals can be waiting for prolonged periods of time in S136 suites, which creates a bottleneck, and any new detentions are directed to A&E.' (PO11)

A chi-squared test was performed to test for the significance of detentions exceeding 24 hours where the detained person being admitted rather than discharged home. Results can be seen in Table 9, which reveals that there is a difference which is statistically significant in detentions exceeding 24 hours regarding the outcome of the detention ($\chi 2=406.62$; $p<0.001$).

Table 9. S136 detentions exceeding 24 hours and their outcomes.

	Discharged	Admitted	Total
Detention <24 hours	1,864 71.01%	761 28.99%	2,625 100%
Detention >24 hours	225 30.32%	517 69.68%	742 100%
Total	2,089 62.04%	1,278 37.96%	3,367 100%

Notes: Frequencies and percentages given; $\chi 2=406.62$; $p=0.000$.

The extended duration of S136 detentions is therefore connected to the process of finding a bed for the detained person to be admitted. The fact that 30% of detentions which exceed 24 hours result in discharge supports earlier findings regarding discharge after a bed request had been made.

Chapter Summary

This chapter has outlined the characteristics of persons detained by police after an episode of MD and has elucidated when S136 detentions occur as well as the duration and outcome of these detentions.

The number of S136 detentions under analysis represents 0.25% of the geographical population, with adults being marginally more represented than CYP. Adults have autonomy for their own care and where there is an expressed intention to harm themselves, that autonomy is more likely to be removed by the invoking of S136 than it is for CYP, who are passed back into the care of adults (i.e. their parents or carers).

There is a high number of repeated detentions of the same persons, with 22% of detained individuals accounting for half of all S136 detentions. CYP are proportionally more likely to experience multiple detentions than adults are, with one-quarter of detained individual CYP and one-fifth of detained individual adults experiencing subsequent detentions. These facts suggest a failure within health and social care services to support persons who have already shown themselves to experience levels of MD that bring them to the attention of police officers. Health and social care service failures are greater for CYP than they are for adults.

Within the data, the age of people experiencing S136 detentions is between 9 and 98 years. For CYP, most detentions occur in the 17-year-old age category, which is also the category which sees the most repeated detentions of the same detained individuals. For adults, the highest number of detentions is seen within the category of 31 to 40 years; however, younger adults between 19 and 30 years of age experience greater incidences of repeated detentions of the same detained individuals.

Regarding gender, there are more detentions of males than females, although this varies between adult and CYP, for which there is a statistically significant difference. More CYP detentions are of females, especially detentions of looked-after CYP, whereas more adult detentions are of males.

These facts evidence the characteristics of those persons who police detain under S136. Young females are particularly at risk of MD which requires police intervention. The number of detentions and repeated detentions of detained individuals, particularly of females, remains comparatively high throughout early adulthood, before more males than females are detained from mid- to late-twenties onwards. Once this early adulthood passes, males between the ages of 31 and 40 years are the people who are most represented within S136 detention numbers. These findings suggest where health and social care needs require improvement, or at least offer an awareness of the age and gender of those who are most at risk of MD which requires police intervention. Considering that S136 detentions occur most commonly for ‘risk to self’ rather than ‘risk to others’ (Bendelow et al., 2019b; Thomas and

Forrester-Jones, 2019), the findings here align with existing research which shows that self-harm practices are most common among young females than young males (for example, Beckman et al., 2019) and that middle-aged men are overrepresented within suicide figures (ONS, 2019).

Regarding when detentions occur, the data show a seasonal variation, with summer months and January seeing a higher number of detentions. This changed with COVID-19 SRP. When comparing detention numbers an equidistance time either side of the commencement of SRP, there was a statistically significant reduction in adult S136 detentions and a rise in CYP detentions after SRP commenced. Also, there has been increased police involvement with looked-after CYP who experience MD since the start of SRP, a difference which is statistically significant. SRP caused increased MH challenges to CYP who were isolated from peers whilst still being expected to continue with schoolwork (O'Sullivan et al., 2021), were unable to access in-person support and were more vulnerable to abuse within the home (Storz, 2020). For CYP who were looked after, there was the added trauma of having reduced contact with their families (Simmonds and Sims, 2020).

Towards the end of the time period of the data, there was a marked increase in S136 detentions of adults, with police participants noting the rise and attributing it to lockdown measures over the shorter days of winter and overwhelming relationship strains and financial concerns.

Despite previous research regarding the rise in adult S136 detentions (Cresswell, 2020; Loughran, 2018), and a rise in detention numbers since SRP (Sam and Kelbrick, 2021) (although this was thought to be in line with the previous rises in detention numbers), this was not seen within the data here. Within this research, there was a 2.14% decrease in adult detentions in the year ending April 2021. Nevertheless, SRP could have masked adult detention trends which, as suggested by the latter data, could be returning to pre-COVID figures. There is limited research on CYP S136 detentions; however, a marked increase in 'clinically significant' MH conditions among CYP has been attributed to the pandemic (Mahase, 2021). This thesis shows a rise in CYP detention numbers in both the previous two years, showing 19.67% and 120.54%, respectively.

Weekends see higher numbers of S136 detentions than during the week. It is unclear why CYP detentions increase on Tuesdays, although school pressures as a trigger cannot be ignored. High detention numbers at weekends can be linked to social causes, since family pressures are greater, and to structural changes, since access of primary and secondary support services is reduced. The police are the only service which is guaranteed to be available 24 hours a day, 7 days a week, and so it is police officers who are called to assist when other services are inaccessible.

The importance of structural services from which to access support is further seen by the fact that most detentions occur OOH. There is a close association between service opening hours and the percentage of detentions of both adults and CYP, with an increase in detentions through the later afternoons, peaking in the evening and remaining high though to the early hours of the morning, before falling to a low just before the start of the working day.

Whilst proportionally more CYP than adults are detained OOH, proportionally more adults than CYP have their S136 rescinded OOH. There is a lack of OOH services for younger CYP who require paediatric MH–specialist assessment, and access to a child-appropriate S136 suite is dependent on the CCG area in which the CYP resides.

A quarter of all detentions exceed the lawful 24-hour duration. The data does not provide evidence of correctly applied 12-hour extensions, although almost 1 in 10 detentions last up to 36 hours. I have evidenced the numbers of CYP and adult detentions which exceed 36 hours.

Most people are discharged following S136 detention, some with no follow-up care provision in place. Following previous concern regarding this occurrence within the Trust (REDACTED), there has been a reduction in the number of persons discharged with no follow-up care provision; however, of detainees discharged, over 22% of adults and over 11% of CYP still have no follow-up care provision in place. Of the detentions which result in admission, most are formal admissions under either Section 2 or Section 3 of the MHA. There is a statistically significant rise in detentions exceeding 24 hours if the person goes on to be admitted. Qualitative data suggest that delays in finding an appropriate bed cause a 'blocking' of S136 suite access for other detained persons, as people remain within them whilst awaiting a bed to be found. Where S136 suites are blocked, detained persons must remain under police supervision and control within A&E departments until either an S136 suite becomes available or the S136 is rescinded after an MH assessment has been performed within A&E. This will be explored in more detail in the next chapter.

Owing to the shortage of acute MH beds, some people are assessed as requiring admission but are then discharged, and for some this discharge pathway does not include aftercare and support provision. There is a chance, which is statistically significant, that a person will experience multiple detentions if they are discharged after a bed request has been made.

In short, shortfalls in health and social care provision increase police contact with persons experiencing MD to the point where there is a reliance on policing to bridge gaps and to safeguard people who are at risk of future episodes of acute MD. The high incidences of repeated detentions of the same detained individuals, suggestive of a lack of effective ongoing care and support provision,

places the onus of care back onto police officers, who must intervene to protect life. Of note is the shortage of MH beds, which means that people who have been assessed as requiring an inpatient bed are then discharged into the community; a practice which is correlated to repeated incidences of MD leading to further police intervention. Furthermore, police supervision and control are required if a detained person is unable to access an S136 suite; this also relates to CYP, for whom there is limited OOH provision despite most CYP detentions occurring OOH.

The use of the different places of safety available for detained persons to be taken and the nature of police involvement in these areas is discussed in the next chapter.

Chapter 5: Decision Making and Places of Safety

Chapter 4 explored the characteristics of persons subjected to S136 detentions. It highlighted inequality in OOH service provision where, although proportionally more CYP are detained OOH than adults, proportionally more adults are discharged from their detention OOH than CYP. High OOH detention numbers were linked to an absence of OOH support services, meaning the police were the only available intervention in situations of MD. The chapter also presented findings showing a correlation between discharge after a bed request was made and repeated detentions, and a blockage of S136 suites whilst inpatient beds are found; a situation which extends the time that detained persons remain under police supervision and control. These factors show that police involvement in MD is increased due to the lack of MH service provision.

This chapter explores the process of S136 detentions, including transfers, using quantitative data, whilst empirical qualitative data provides personal experience of the different POS. Firstly, however, given the high numbers of detentions under discussion in Chapter 4, to investigate the suggestion that officers are indiscriminately invoking S136 detentions, I explore decision-making processes as expressed by police participants. This includes assessment of risk, data gathering, officer experience and how S136 processes dissuade officers from invoking S136. Requests for assistance from health and social care representatives are explored in regard to how they influence decision making, and finally how the fear of incorrect decision-making impacts on decisions to invoke S136.

This chapter considers the nature of detentions rather than detained individuals. Variables under scrutiny are displayed at the appropriate place within the chapter. Some variables described in Table 2 are used in subsequent analysis – in particular regarding demographics and duration of detention. As with Chapter 4, the sample sizes do vary with each analysis as on each occasion I only analyse complete data across the variables under scrutiny. As explained in Chapter 3, this decision was made to enable the maximum analysis from the dataset.

This chapter feeds into the first research question, which concerns the nature of police involvement in MD, as well as the second question, regarding the differences in detention processes and experiences of detained adults and CYP.

Decision Making

Regarding the level of police involvement with MD, it is important to consider decision making since anecdotal evidence from medical professionals suggests blame towards police officers for

indiscriminate invoking of S136 detentions, and that alcohol-fuelled emotional distress can lead to officers invoking S136. Certainly, in primary research data, the presence of mind-altering substances such as drugs and alcohol does impact officers' decision making. One police participant shared:

> 'Some people in mental health crisis might appear that they are drunk as well, and you have to figure out is this person just being drunk and disorderly and crying because they have split with a partner and are really upset, or is it something more than that; are they having a mental health crisis? So, you have to weigh it up and get to the bottom of it. How can you help this person?' (PO3)

The presence of drugs or alcohol can complicate police decision-making processes. The use of drugs and alcohol are recognised as a sign of vulnerability as substances can be used as a way to block or build resilience to adverse experiences (Rudzinski et al., 2017). The Home Secretary speech to a Policing and Mental Health Summit cautioned that the presence of drugs and alcohol use 'should never be a barrier to treatment' (May, 2014b), and so, although the presence of intoxicants confuses the presentation, they must not prevent the consideration of the need of an MH assessment and this is one such occasion where further evidence must be gathered to inform decision making.

Data Gathering and Experience

Since the 2017 amendments to S136, 'the constable must, if it is practicable to do so' (GOV.UK, 2017c, p. npn) consult with a medical or social care professional prior to invoking S136. The 'if practicable' clause in the amended act recognises that it is not always possible to seek advice if the risk posed by a situation demands an immediate response. Five participant officers shared their experiences of measuring risk and responding with what they deem to be appropriate, proportional force to preserve life. The first example involves a looked-after CYP; the second involves an adult.

> 'We had to run in front of a train and grab [them] off the line. I remember [the] school uniform. [The care worker] called [999] and [they] called us [as British Transport Police]. We got through to Network Rail, but we just couldn't stop the trains in time.' (PO10)

> 'We're trained to react to a situation. If we feel that any violence is perceived towards us or that person then we have to react quickly because if we wait, that person could be hurt, we could be hurt or a member of the public, so it's best to deal with it there and then. We had reports of a [person] on the bridge … this is a very busy motorway;

> [it] was rush hour as well. We pulled up and [they were] right next to the bridge so for [their] safety I just had to use force, get [them] into handcuffs and get [them] into the back of my car. For all I know [they] could have jumped over the bridge or into the motorway and put [themselves] and other road users at risk; and myself.' (PO1)

In the geographical area of this project, the route via which to seek advice exists as a 'mental health access line' that officers attending an incident of MD are to call. Table 10 shows the secondary, quantitative data regarding the use of this helpline.

Table 10. Calls to MH access line for all detentions, adults and CYP.

	All Detentions	Adults	CYP
No Call to Access Line	2,153 58.24%	2,004 58.27%	149 57.75%
Call Made to Access Line	1,544 41.76%	1,435 41.73%	109 42.25%
Total	3,697 100%	3,439 100%	259 100%

Note: Frequencies and percentages given.

The data presented in Table 10 show that no calls are made to the advice line in almost 60% of cases. Marginally more calls are made regarding CYP (42.25%) than regarding adults (41.76%). The utilisation of the advice line is low, although there are other routes through which advice is sought, such as through community MH support staff and paramedics (MH Lead, 2021), which are not recorded in this variable. Additionally, primary data reveals that officers make use of their own intelligence systems to weigh risk and inform their decision making:

> 'Before we even go to a job we get, hopefully, all the details of the person. We run through our system to see if we have previous calls regarding that name.' (PO1)

Assessing what is already known about a person can highlight areas of risk, how previous incidences regarding the person have been managed (and the outcome of these), and what support by way of family or services might be available to assist with the situation, all of which assists the attending officer in their decision making. A problem arises with CYP who are placed in care homes that are away from their hometowns. A government report suggests that 44% (n=4,080) of looked-after children are placed more than 20 miles from their home (Foster, 2021). As mentioned in Chapter 4, there are a disproportionate number of looked-after CYP detained under S136 with five police participants mentioning this. Three of these participants suggest that this is in part due to CYP threats to harm

themselves when attempts are made to return them back to care after they have been reported as a vulnerable missing person. One officer shared:

> 'Children in care are moved around the country and come under different NHS trusts … [the trusts] don't talk to each other, so obviously [if] we've got someone from London in a care home [locally] and they go missing, then you find them and they threaten to kill themselves … we have nothing on our records.' (PO5)

With inconsistent information to hand, where the decision to detain is not forced by urgent circumstances it is down to attending officers to decide on the most appropriate course of action. The NDM, described in Chapter 2, was only mentioned by one participant; this was when they shared that they had used the NDM to justify their actions during an IOPC investigation into the death of a person with whom the officer had had contact. The officer reported that they were confident that they had made the correct decision, despite the poor outcome, and they were exonerated by the investigation. Nevertheless, the process was described as traumatic and it was many months until the officer heard that they had been cleared of any wrongdoing.

Although MH education for officers has increased after gaps were highlighted in their training (MH Lead, 2021), they cannot be considered as MH experts. The MHA recognises officers' role in taking a person who 'appears to him [sic] to be suffering from mental disorder and to be in immediate need of care and control' (GOV.UK, 2017c) to a POS. Decision making here is naturally subjective and it was clear in qualitative data, with comments from three police participants, that 'on-the-job' experience increases confidence and informs decision making. Officers who are early in their careers are viewed by their colleagues as being risk averse and more likely to invoke S136 than explore alternative actions, whereas experience and increasing confidence in the role enables more of a positive risk-taking approach. This is noteworthy as, in the current climate of evidence-based policing, which is aligned to the drive to professionalise the police, it has been noted that there is an overreliance on 'experience' rather than decision making being supported by a secure research and evidence base (Selby-Fell, 2020). Officers said:

> 'In the earlier days [of being a police officer], and you see it all the time, especially with younger police officers, as soon as [the person] say[s], "I'm going to kill myself", that's it. They do [an S136 detention] all the time.' (PO2)

> 'I feel like I've got the experience now. I can take positive risks and say "actually, based on this rationale and speaking to this person, and based on the information we've got

> on the police system, I think we can leave this person and just put in a referral to mental health services." I do that more often, but so many police officers don't.' (PO7)

Additionally, experience gained from previous employment or life experiences outside of policing also informs decision making. One officer shared:

> 'I have experience of people who are genuinely unwell and to the point of being in hospital […] I feel that I can read between the lines a bit more and I have a bit of knowledge.' (PO6)

Attending situations where a person in MD is verbalising that they wish to die appears to be frequent, especially with CYP, where expressions of suicide are so frequently heard that officers can view them as empty threats. There was disagreement from officers about how best to manage a situation where a CYP is threatening harm. 10 police participants commented of the detention of CYP. One officer stated:

> 'A lot them say ["I will kill myself"] but no one wants to risk the child's life so it's all hands on deck. But a lot of the time children in care seem to say it because it's a threat if they can't go home.' (PO5)

Other officers will try to take an alternative approach in an attempt to avoid invoking S136, with one officer sharing:

> 'They are saying that they will kill themselves because they are trying to emotionally blackmail you into doing whatever it is they want you to do. I don't ever remember a job like that where I think "ah shit, this child is actually going to kill themselves". You often hear kids say that. It's just a maladjusted coping strategy: "ah well, I'll just kill myself then". They don't mean it; they have no intention of doing it. They might have heard mum or dad saying it if they had mental health problems and they threatened suicide, so they think that that is what you say when you are distressed and not coping. Unless, they have a history of attempted suicide or significant, serious self-harm. You see, even if they have a history of self-harm, if it is superficial and just their coping strategy, then that won't force me down the road of [an S136 detention].' (PO7)

PO7 refers here to what three participants intimated as a binary of 'genuine' or 'not genuine' MD: that which poses an active risk to the person or other people, and that which is viewed as help-seeking to satiate an emotional need. What constitutes genuine MD appears to be of personal opinion, as my

observation of the MH training that new officers receive made no such distinction. Whilst the training gave an overview of the differing causes of MD, which included enduring conditions such as those which can lead to a diagnosis of schizophrenia, there was no insinuation that these conditions were more worthy of police assistance in a 'mental health crisis' than those crises which present as suicide ideation, which is what some participants suggested. Whilst some interventions by police officers interrupt almost-completed suicides, as with AWE2, who was cut down when unconscious from hanging, participant police officers reported incidences where officers are having a conversation with a person exhibiting suicide ideation where they are not viewed as being genuinely at risk of taking their own life. This interpretation of risk was linked to occasions where the person experiencing MD have themselves called for police intervention. One officer shared their experience of dealing with situations where there has not been the suicide ideation conversation:

> 'I've been to so many incidences where high-risk missing persons have been reported … and they've just gone off and hung themselves, or however they've done it. You don't get that phone call; you don't get that alert. My experience is that the people who are high-risk and are going to kill themselves are the ones who just go and do it. We don't get that phone call to say "I'm going to kill myself". They just go and do it.' (PO2)

Experienced officers are aware of the limitations of emergency healthcare provision and seek alternatives to S136 detention for persons who they view as being at lesser risk of 'genuinely' intending to end their lives. This particularly applies to the situation regarding emergency OOH provision for CYP, as was discussed in Chapter 4. In an attempt to avoid invoking S136, officers will try to return a child to the care of parents or carers with advice to seek urgent medical help the following morning when services are available. This approach is used to prevent the officer from sitting with a CYP when the parent or carer already has that duty of care. Nevertheless, for looked-after CYP, should damage to property or assault of care staff occur as a result of MD, there can be criminalising consequences to MD which CYP who live with their parents would not have to face. One officer commented on this:

> 'That time that I am sat with them, [parents and carers] can do that. If they try to jump out of the window, then [the parents or carers can] stop them. [When a child is in care,] I will always put the onus back onto the care staff: "Look you are being paid to care for this child. If that means that you have to sit up all night and watch them then that is what happens, and then you need to access the doctor, the social worker, CAMHS, whoever that child is engaging with." But to me, detaining them [under S136]

> isn't the right course of action. I will always take them back to the care home and do it that way. More often than not we don't get a call back. They just manage it. We might go back a couple of times, but once that child realises that they are not getting what they want, they just bed down for the night. Obviously, if it gets to the point that they can't control them, well at that point the kid then starts committing offences, assaulting staff, *etcetera* … then we can arrest them for assault and look at it from that route.' (PO7)

Decision making is complex, especially given restricted outcome options, level of experience and the consequences should harm occur due to actions or inactions. Here, PO11, whilst mentioning the consequences should things go wrong, recognised that decision making is not straightforward, even for MH-trained medical staff:

> 'I think you'd find that lots of mental health professionals will struggle justifying not [detaining] people in some circumstances … I suppose that is why we see people admitted to hospital … they cannot guarantee their safety when they leave hospital [and] there is nothing between the choice of admission or going home. Police officers find themselves in that dilemma on a daily basis – we're there as un-mental-health-trained [sic] professionals having to make decisions on a person's safety, and the public's safety potentially. If we can't guarantee that safety then there is always that level of risk recorded, but there is always that aspect in the back of an officer's mind … [if] they go home and take their own life then there is probably going to be a degree of investigation into the decision making.' (PO11)

Documenting an account of contact with persons is essential to providing evidence should officers face an IOPC investigation into their actions or inactions. Such documentation is recognised as a way to evidence decision making and avoid risk-averse policing, as described by PO2:

> '[There are] lots of times where I have not [detained someone under S136], but I am always conscious, and I put a full rationale on the log as to why I haven't. I'll only ever do it if I am completely comfortable that I can justify my rationale and I'll always document on the log that that is my risk assessment, my interpretation of the risk at that time. All I can do is judge the risk based on what is presented to me at that time. That individual could get a phone call from a partner saying they are going to end a relationship 5 minutes after I walk out the door and they go on [to] kill themselves. I

> can't control that, but as long as my justification is sound at the time then I sleep easy and I don't worry about it, because it's about positive risk taking, isn't it?' (PO2)

The decision to detain or not, whilst informed by circumstances and other professionals, lies with the attending officer; however, S136 detentions require a multi-disciplinary response. The broader consequences regarding public expense and the additional workload created by risk-averse decision making are recognised by one officer:

> 'We [as police officers] think "yeah, we're now going to sit for 8 hours with this person at [A&E], but at least it covers us." We should think about the inconvenience to A&E, the inconvenience to the patient, the fact that we've got to call out two doctors who are probably on call duty and cost a fortune to do [an S136 detention]. The amount of money that is used for us to cover our back – it's just a nonsense.' (PO2)

To summarise this section, where situations allow, officers have access to telephone advice from MH professionals who can inform of past incidences of MD and offer advice on how to proceed. Officers also utilise their own intelligence services. Decision making is more complex with regard to CYP as data is often missing for CYP who are looked after. Nevertheless, for CYP there is the option for officers to return them into the care of parents or carers, who have a legal duty to protect CYP from harm. However, in these circumstances, looked-after CYP risk criminal prosecution should damage to property or assault occur as a result of their MD.

As much as the decision making is informed by the seriousness of the incident that they are attending and advice from healthcare professionals, decision making is also informed by officers' own experiences and is weighed by the knowledge of the detention process which lies ahead. Officers recognise the responsibility held by them in the decision-making process. Should there be an adverse outcome, being able to justify their decisions appears to be at the heart of the process.

Health and Social Care Referrals

The secondary data show that almost 15% of detentions arise as a result of referrals made by healthcare, social care or members of the MH community team (Table 11). There is little of note regarding differences in the referrals of adults compared with CYP. The marginal difference of referrals from healthcare regarding CYP compared with adults (5.03% vs 6.22%) is likely to be due to parent or carer accompaniment of CYP attending A&E departments, which lessens their absconsion risk. Absconsion would raise a vulnerable missing person's alert, to be discussed further below.

Table 11. Source of initial referral to police for all detentions, adults and CYP.

	All Detentions	Adults	CYP
Public Calls to Police	3,576 85.35%	3,316 85.2%	260 87.25%
Health	257 6.13%	242 6.22%	15 5.03%
Community MH Team	260 6.21%	242 6.22%	18 6.04%
Social Care	97 2.32%	92 2.36%	5 1.68%
Total	**4,190** **100%**	**3,892** **100%**	**298** **100%**

Note: Frequencies and percentages given.

Primary data show that referrals from other agencies are a source of frustration for police officers. Officers feel that rather than manage concerns for welfare themselves, the responsibility is passed from these other agencies to police, as the latter are a 24-hour service and can pick up concern for welfare and enable social care staff to leave work on time. An increase in calls to police on Friday afternoons was noted in research by Marsden et al. (2020) and is mirrored in the first example by PO4, below. The other examples below evidence police frustration regarding people leaving A&E departments. Improved care and observation in A&E could prevent people who attend seeking assistance from leaving the department as they could not endure the waiting time.

> 'At 5 to 5 we generally get an upsurge in calls from partners to say, "you need to go and check on this person because they have expressed some intention that we don't like, or there are risks around them that are cause for concern". The conversation is "well, why are you telling us at 5 to 5?" "Well, because I'm going home, because I've sat on this all day and haven't done anything about it. I have made a phone call. But now I am going home, and I need to offload it onto someone, so it's you."' (PO4)

> 'Maybe they have been assessed [in A&E] and there is an element of risk around them, but nobody has sat with them to safeguard them and now they are missing. Then it gets rung through to us that … they are a missing person.' (PO11)

> '[Voluntary patients will say] "I don't want to be here anymore because I've been sat here for 8 hours and I'm bored, and I just want to go home."' (PO4)

The latter two examples above offer an insight into the difficulty of waiting in A&E for persons who attend A&E voluntarily. One adult with experience of S136 detention demonstrates an additional difficulty of waiting in A&E after seeking help for an episode of MD. In their state of distress, interactions with staff upset the participant and they left A&E only to then be reported to police as a high-risk missing person:

> 'Sometimes I do [manage to wait in A&E] but there have been times when I took myself up and the nurse was dead rude to me, so I just took myself out.' (AWE4)

Whilst invoking an S136 detention is entirely the duty of the attending officer, referrals from other agencies create an added pressure on the decision to detain. Where there is documented risk to a person, there is added onus on officers to detain. One officer shared:

> 'When we do find [a person classed as "vulnerable" who absconded from A&E], it puts officers in a really difficult position. We have got another agency telling us that there is such a high risk around this person who has proved that they cannot wait in hospital where they were hopefully going to get some support, and the risks around suicide and self-harm are there and have been documented and passed on to the police. So, we are now with the individual and have to make a decision on how best to safely manage them.' (PO11)

Whether a person is likely to abscond from A&E after agreeing to attend as a voluntary person also adds complexity to the officer's decision of whether to detain. Officers consider this risk as part of their decision making and two officers spoke of opting to invoke an S136 rather than receive a call to find the person if they leave the A&E department. One of these officers said:

> 'We try to encourage them to go to hospital to get a mental health assessment, but if they say they might not stay and say that they can't ensure that they will keep themselves safe while waiting, then that in turn would lead to a high-risk missing person. We would rather know where they are and so have an officer with them. And whilst that is not ideal, it is better than having a high-risk missing person.' (PO6)

Referrals from health and social care professionals create a frustration for police officers who feel that timely interventions or improved facilities to care for and safeguard persons attending A&E as voluntary patients would reduce a reliance on police intervention. Part of the decision-making process includes officers pre-empting later calls regarding high-risk missing persons by invoking S136 to ensure that detained persons who are considered a flight risk remain in A&E until they have had an MH assessment.

Consequences of Wrong Decision Making

There have been incidences within the Force which demonstrate that things can go wrong. Two officers spoke of their experiences in this area:

> 'Police were called for concern for welfare and instead of [detaining under S136], took him as a voluntary patient to the casualty department. He was not obligated to stay as he was not [detained under S136] and so [he] left, but he went on the railway and committed suicide.' (PO10)

> 'We've had adverse circumstances where people have raised a concern for welfare, we haven't attended and then somebody has ended up dying. Not because of something we have done, but we haven't attended and that person has ended up dying.' (PO4)

Police decision making, actions and inactions are heavily scrutinised by IOPC, to whom such incidences are referred for independent investigation. IOPC investigations are a stressful process that all officers seek to avoid. Because of this, incidences such as those described above have impact on future decision making:

> '[After the incident where the person left A&E and took his own life,] it was almost installed [sic] that if anybody said "I'm feeling really down; I feel like committing suicide" then that is it, they are [detained under S136]. There's no alternative, no other option – you just have to do it. And in a way, you are also protecting your own job, because if you don't, and like what happened, then you are in the shit basically. There is no alternative but to [invoke S136].' (PO10)

Above, PO10 reflects the individual, arbitrary nature of police decision making regarding S136. Each officer must weigh their confidence in their decision making and reconcile this with direction from their seniors. Here there was clearly a directive to adopt a risk-averse approach, which inevitably has an impact on the number of S136 detentions and does offer some support to the perceived indiscriminate invoking of S136 detentions. However, PO10 spoke with the experience of having worked for British Transport Police, where there are immediate risks when a person makes threats to access railway lines. They went on:

> 'I think [I've] probably [detained under S136] more people than [I've] attended fatalities, I'm quite sure of that; but obviously, in fatalities, I am still in double figures'. (PO10)

The personal impact of dealing with deaths on railway lines inevitably, of course, has an impact on future decision making. This stands as a reminder that police officers are human, and when dealing with situations of MD, an area for which they have limited training, their job demands decisions with which they must be personally at peace. For this officer, after dealing with so many completed suicides, being able to prevent a death was paramount.

Decisions being made based upon previous human experience is probably what reconciles these somewhat contrary data, given the earlier evidence that officers attempt to avoid invoking S136. I suggest that the decision of whether to detain is rooted in common sense regarding the level of vulnerability (Wood et al., 2017) as well as the 'gut-feeling' or 'hunch' that police officers utilise to drive their decision making (Lerner, 2006; Pinizzotto et al., 2004). This police intuition is formed of experience and reflective practice (Pinizzotto et al., 2004), as was shown with PO2 who, as an advocate of positive risk-taking, showed confidence in their ability to defend actions and decisions should they be later investigated.

During my research work within police headquarters, I heard more than one comment that healthcare decisions which result in persons completing suicide do not have the same level of investigation to which police officers are subjected should it occur as a result of their decision making; a situation which was highlighted by both police and MH nurse participants in Wandemaghen's research (2021). For example, in Chapter 4 I quoted PO12's experience of detaining a person multiple times before an episode of MD resulted in completed suicide. That person was 'clearly poorly and clearly need[ing] help' (PO12). There was an IOPC investigation into the incident which resulted in confirmation of the person's death as it occurred in the presence of police officers, but PO12 informed me that there was no such investigation into why, in the officer's view, the person was failed by healthcare professionals who denied treatment for MD owing to regular substance use. As described earlier, police officers are told not to prevent access to treatment for MD on the basis of drug and alcohol misuse, but a barrier appears to exist in accessing healthcare.

In responding to adverse incidences, PO4, one of the more senior participants, refers below to the ever-expanding role of policing as the public protection element encroaches on territory which used to be the preserve of social workers:

> 'If something goes wrong and there is criticism that comes our way, we will then harden to that and we will say "right, we're not taking risks in that area anymore". So, our policy going forward is that we will attend [when there is concern for welfare]. And that doesn't massively affect the running of our organisation, but it's the drip of

> incident after incident after incident … there is a weight then of things that have gone wrong in this area and so we need to be more conscious.' (PO4)

In 2017, frontline social care support services were described as being 'in crisis' (Stevenson, 2017, p. npn) due to austerity cuts disproportionately affecting those people who are most in need. In the absence of effective social and MH care, persons in MD will inevitably access whatever services are available, as recognised by the UN Special Rapporteur who said that the situation is pushing people 'towards … services which can't turn them away' (Alston, 2019, p. 15). Although Alston (2019) was referring to A&E departments, I suggest that this also applies to the police force as despite also receiving harsh cuts to resources, the police remain as the 24-hour response service who have expanded their role to plug the gaps in care left by other services.

The police role in S136 detentions is limited to identifying risks that could be associated with MD and to take the person for an MH assessment. This section has explored factors involved in the associated decision making, revealing that the consequences of adverse outcomes to police actions or inactions are heavily criticised in a way that healthcare decisions possibly are not. Data from police officers is at times contrary. Some officers, especially those with experience and/or increased confidence in their decision making seek to avoid S136 detentions. Conversely, fear of harm resulting from decision making prompts other officers, especially following incidences where harm has been attributed to police action or inaction, to be risk averse.

First Place of Safety

Having explored what drives police officers to invoke S136 detentions and that the availability of OOH provision impacts decision making, this section considers the POS to which detained persons are first taken.

In this section, I examine the quantitative data regarding the initial POS, looking first at A&E, then S136 suites and finally at police custody suites. I highlight differences between adult and CYP detentions throughout the following sections. Unless otherwise stated, I use *z*-test to test for significance. Table 12 presents the relevant variables within the data regarding first POS.

Table 12. First POS for all detentions, adults and CYP.

	All Detentions	Adults	CYP
First POS = A&E	2,922 70.51%	2,703 70.21%	219 74.49%
First POS = S136 Suite	1,131 27.29%	1,058 27.48%	73 24.83%
First POS = Custody	91 2.20%	89 2.31%	<5 0.68%
Total	**4,144** **100%**	**3,850** **100%**	**294** **100%**

Note: Frequencies and percentages given.

S136 Suite

The data, presented in Table 12, show that just 27% of detainees are taken directly to an S136 suite as their first POS. Fewer CYP are taken to an S136 suite than adults (24.83% vs 27.48%); this difference is not statistically significant (p=0.32).

S136 suites exist as places to which detained persons can be taken as a POS and where they can have an MH assessment, and it is noteworthy that little over one-quarter of detained people are being taken to an S136 suite. Quantitative data regarding the availability of an S136 suite and reason for unavailability is displayed in Table 13. These data show that there is an available S136 suite for just over half of detentions (52.80%). Discrepancy between available suites and the proportion of detainees who are taken directly to the suites is not clear, although it could be, at least in part, due to whether detained persons require medical attention for physical health concerns, which is also considered in the table.

Table 13. S136 suite availability and reasons for unavailability for all detentions, adults and CYP.

	All Detentions	Adults	CYP
Suite Available = No	1,965 47.20%	1,829 47.30%	136 45.95%
Suite Available = Yes	2,198 52.80%	2,038 52.70%	160 54.05%
Total	**4,163** **100%**	**3,867** **100%**	**296** **100%**
Reason Unavailable = Occupied	1,340 78.23%	1,280 79.45%	60 58.82%
Reason Unavailable = Staffing	129 7.53%	115 7.14%	14 13.73%
Reason Unavailable = Not Medically Fit	244 14.24%	216 13.41%	28 27.45%
Total	**1,713** **100%**	**1,611** **100%**	**102** **100%**

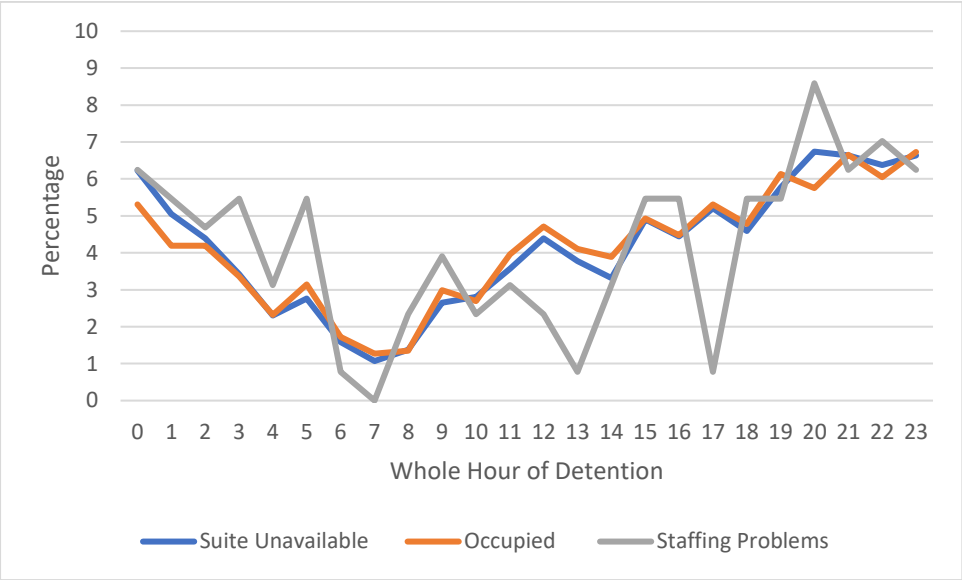
Notes: (i) Frequencies and column percentages given. (ii) The discrepancy between 'Suite Available = No' and 'Reason Unavailable' is due to item missingness in 'Reason Unavailable' variable.

When first detained, the reason why detained persons were unable to go directly to an S136 suite was largely due to the suites being already occupied (78.23%). When comparing adult and CYP detentions, proportionately more adults than CYP were unable to access an S136 suite due to it being occupied (79.45% vs 58.82%); this difference is statistically significant ($p<0.001$). This finding supports qualitative data from the previous section regarding S136 suites being occupied by persons awaiting an MH bed.

Staffing issues prevented access for 7.53% of detentions that went directly to A&E. Specialist staff being redeployed to the CYP S136 suite when it is required probably accounts for the fact that staffing issues prevent proportionally more CYP than adults from accessing S136 suites; this difference is statistically significant (13.73% vs 7.14%; $p<0.001$).

I further explored these two reasons for a detained person not being able to access an S136 suite, as they are both problems with the S136 process rather than because of a reason to do with the detainee. There was little of note for adults and CYP separately, so here I present the findings of the total number of detentions in Figure 13. Data here show the percentage of total detentions which were not taken directly to an S136 suite due to unavailability and the suite being occupied, or due to staffing problems, by hour of detention, thereby highlighting issues with the process that are not connected to the detainee.

Figure 13. Percentages of S136 suite unavailability by time of day.



The blue line in Figure 13 represents, hour by hour, the percentage of detainees who could not be taken directly to an S136 suite because of suite unavailability. The orange line represents unavailability due to the suite being already occupied. Unsurprisingly, this line closely resembles the percentage per hour of admissions, which falls to a low at 07:00 and peaks at 21:00, as presented in Figure 11 in the previous chapter. In Figure 13, the grey line, representing staffing problems being the reason why an S136 suite was inaccessible, is less regular (owing to the smaller numbers involved), although some similarity to the other lines can be seen. There could be several reasons why staffing prevents access to an S136 suite, for example, shift changes; however, there is no empirical evidence available here to explore this further.

The previous chapter evidenced that almost 80% of S136 detentions occur OOH. On the following page, Table 14 presents data regarding access to S136 suites as the first POS for all, adult and CYP detentions by DOH and OOH.

Table 14. First place of safety by DOH and OOH detentions for all detentions, adults and CYP.

	All Detentions		Adults		CYP	
	DOH	**OOH**	**DOH**	**OOH**	**DOH**	**OOH**
A&E	580 67.36%	2,336 73.48%	541 66.79%	2,156 73.38%	39 76.47%	180 74.69%
S136 Suite	281 32.64%	843 26.52%	269 33.21%	782 26.62%	12 23.53%	61 25.31%
Total	861 100%	3,179 100%	810 100%	2,938 100%	51 100%	241 100%

Notes: Cells contain n and column percentage. DOH = During Office Hours; OOH = Out of Hours.[16]

Data presented in Table 14 show that, of all detentions, more detentions invoked DOH are taken to S136 suites than those invoked OOH (32.64% vs 26.52%; $p<0.001$). This difference, which is statistically significant, could be due to the assessment and bed finding being more efficient DOH than OOH, meaning that S136 suites become available, thereby enabling access for new detainees. This higher proportion of DOH than OOH detentions accessing S136 suites remains for adult detentions (33.21% vs 26.62%; $p<0.001$); however, it is different for CYP detentions. Although not statistically significant, more CYP access S136 suites OOH than DOH (25.31% vs 23.53%; $p=0.789$). This seems contrary to qualitative data, which evidences that access to S136 suites for CYP OOH is difficult, and in some areas, access to a CYP S136 suite is not possible due to CCG not funding OOH emergency MH provision for CYP (as mentioned earlier in this work).

To explore the conflicting evidence, I conducted further analysis to show the different ages of CYP accessing S136 suites DOH and OOH, and I applied a chi-squared test to assess the significance. Results, displayed in Table 15, show that over 80% of CYP detentions going first to an S136 suite occur OOH, although this percentage is lower for those CYP aged up to 15 years and those 18 years old (50% and 60.23%, respectively). This was not statistically significant ($\chi 2=7.00$; $p=0.072$).

[16] Police custody as a first POS is not shown here due to reliability issues, which are explored later in the chapter.

Table 15. Numbers of CYP to S136 suites DOH and OOH by age group.

Age Category	DOH	OOH	Total
<=15 years	<5	<5	<5
	50.00%	50.00%	100%
16 years	<5	9	11
	18.18%	81.82%	100%
17 years	6	24	30
	20.00%	80.00%	100%
18 years	<5	26	28
	39.77%	60.23%	100%
Total	12	61	73
	16.44%	83.56%	100%

Notes: Frequencies and percentages given. DOH = During Office Hours (09:00–16:59); OOH = Out of Office Hours 17:00–08:59) $\chi 2=7.000$; p=0.07.

I also looked at whether the S136 suite was a CYP or adult suite by the age of CYP detentions. To preserve anonymity, I am not presenting the findings; nevertheless, six of the seven detentions to a CYP S136 suite occurred OOH, with five of these being within the older CYP age range. These CYP are able to access adult S136 suites, as is explained below.

In summary, whilst the quantitative data do seem contrary to qualitative data regarding access to CYP S136 suites OOH, the difference in the quantitative data is not statistically significant and, as the numbers are in single figures, the sample size is too low to draw any firm conclusions. What is clear from the data is that the youngest detained CYP do not gain access to CYP S136 suites. Occasions where CYP remain in extreme MD under police supervision and control because of lack of commissioning is particularly noteworthy to officers, and this is inevitably why these qualitative data were provided to this research. As with the quantitative data, there is little qualitative data pertaining to this issue; however, that is not to diminish the impact that the lack of provision available to distressed CYP has on the individual CYP and on the attending police officers.

Returning to Table 12, not being medically fit means that there is a physical health need which requires a general health assessment, and this takes priority over an MH assessment. This variable is populated according to police response to the Bed Hub questions at the point of the S136 detention being invoked; it could be informed by medical personnel on scene, such as ambulance staff. If there is a current history of overdose, intoxication, cutting or other self-injurious behaviour, such as hanging or near drowning, then A&E rather than an S136 suite is required. What is being displayed in this variable is the availability of an S136 suite and so the presence of a physical health need is presented as

secondary to whether there is an S136 suite available. A suite might be available, *but* the person has a physical health need and so is unable to access it.

A detainee requiring A&E due to them not being medically fit to go directly to an S136 suite is the only reason, from the detainee's perspective, for why the detained person cannot be taken directly to an S136 suite. Not being medically fit accounted for 14.24% of detentions, and more CYP than adult detentions, which is statistically significant (27.45% vs 13.41%; $p<0.001$). Nevertheless, these figures do not account for why three-quarters of all detainees do not have an S136 suite as their first POS. Data are not available for the reason why more CYP than adults require a physical health assessment; one reason as to why could be that self-harm by cutting and ingestion are more common in young people, as well as more common in females than males (Hawton et al., 2012; Moran et al., 2012). As data presented in Table 16 show, there is a greater percentage of female to male CYP (64.97% vs 35.03%; $\chi2=0.126$, $p=0.639$) than female to male adults (43.50% vs 56.50%; $\chi2=0.126$, $p=0.723$) having A&E as their first POS.

Table 16. First POS by gender.

	All Detentions			Adults			CYP		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
First POS = S136 Suite	632 56.63%	484 43.37%	1,116 100%	596 57.39%	435 42.61%	1,021 100%	28 37.33%	47 62.67%	75 100%
First POS = A&E	1,200 54.55%	1,000 45.45%	2,200 100%	1,117 56.50%	860 43.50%	1,977 100%	69 35.03%	128 64.97%	197 100%

Note: Frequencies and percentages given.

Despite not being the dominant initial POS (Table 11), S136 suites are the preferred POS for anyone detained under S136, for this is where the person has access to MH care rather than remain under police supervision and control. In the qualitative data, five polices officers spoke of a smoother process when an S136 suite is used as the initial POS, which is less traumatic for the distressed person and less time-consuming for the police. PO1 also suggests that in these instances, police vehicles are the standard method of transportation:

> 'We literally just fill out the paperwork, transport them to the mental health team and leave them with them. It's minimal contact, minimal distress for them and it's minimal impact on our force capability.' (PO1)

> 'We can go to the [S136 suite] and as long as they have availability, [we] will hand them over … As long as that person isn't violent and that they haven't got any medical

needs, for example, they are not intoxicated or they are needing any medication, then the officers are relieved, and we are allowed to go.' (PO10)

S136 suites are particularly valued for CYP as child-appropriate S136 suites have specialist staff trained in paediatric MD and access to the suites prevents CYP in MD from remaining under police supervision and control for extended periods of time:

'[It was a] much smoother process; there was a specialist nurse who came down from the paediatric team and it was the right way to do it.' (PO7)

Nevertheless, some areas of the county are no longer able to access this specialist suite for CYP aged 16 years and under because of a change in the CCG commissioning. For CYP who experience ongoing MD after detention, four police officers expressed the need for peace and privacy for the detained CYP that an S136 suite can offer:

'…otherwise I am fighting with them in hospital for 12 hours. It just baffles me why we don't have some specialist suite intervention where these children can go.' (PO7)

Where the facility exists but is unavailable due to staffing, it is frustrating for the police:

'You just get told there's no staff for there, which seems crazy when you are the other side of the hospital with a juvenile.' (PO3)

To bypass the issue of no nursing staff to enable the suite to be opened, officers have tried to access the S136 facilities so that they might care for the CYP there rather than in a public A&E department:

'I have made suggestions in the past around opening the suite so that we can get in there … so we are not holding the person in the A&E department. If that could happen then at least the young person is not distressed in an A&E department. We'd [still] be with them, but at least we could get them in the suite and in a different environment.' (PO11)

In summary, S136 suites are the preferrable POS as this is where persons can be placed under the care and protection of healthcare staff who are trained in the care of people who are experiencing MD, and police officers can withdraw from the situation. Nevertheless, barely 27% of detainees are placed in an S136 suite as their first POS. For almost half of all detentions (47.20%), an S136 suite is unavailable; in over 78% of occasions this is because they are already occupied. More S136 suites are unavailable to adults due to them already being occupied than for CYP (79.45% vs 58.82%).

Staffing problems preventing access to an S136 suite is more of an issue for CYP suites than it is for adult suites; this will be because CYP suites are staffed on a need-only basis. Being able to staff a CYP suite relies on there being two suitably trained paediatric staff elsewhere in the hospital who can be redeployed to the suite.

More CYP detainees require medical assessment for a physical concern than adult detainees, which necessitates the use of A&E rather than an S136 suite as the first POS. Where a suite is unavailable throughout the duration of a detention, a situation which is more common for CYP than it is adults, detainees must remain under police supervision and control within A&E, which is discussed in the next section.

S136 suites being unavailable for detained persons to be cared for by medical staff increases the demand on police services and means that detained persons must remain under police supervision and control. This section has shown that suites, overall, are unavailable more frequently OOH, increasing demand on police officers overnight and placing detained persons in A&E, where there are no sleeping facilities.

Accident and Emergency Department

Data presented in Table 11 shows that over 70% of detainees are taken to A&E as the first POS. Proportionally, slightly more CYP are taken to A&E than adults (74.49% vs 70.21%; p=0.12).

Despite the high percentage of detainees going directly to A&E departments, all police officer participants (n=12) are fiercely against their use as a POS, with one police officer stating that they are:

> 'wholly, wholly inappropriate. That place is like a zoo … it's the most chaotic environment you can imagine … it's a nightmare. A lot of people we take there are vulnerable, scared, paranoid, intimidated.' (PO2)

Of note is the fact that PO2 was speaking of the county's busiest A&E department, which happens to be where the local CCG does not fund OOH CYP S136 suites, thereby preventing transfers out of the A&E environment for CYP.

Prior to the next section, it is helpful if I explain the nomenclature used within the administrative dataset (previously mentioned within Chapter 3) which has the potential to cause confusion. There exists a dichotomous variable regarding the presence of a 'physical health need' – this would be where there is a health concern, such as self-harm wounds, ingestion or a more general health concern such

as breathlessness or chest pain, which requires medical healthcare assessment/treatment. This information is given by police when they first alert the Trust to the fact that they have invoked an S136 detention, and it is used to determine the POS to which the person is taken. The term 'not medically fit' is used to justify why a person was unable to access an S136 suite; the variable in which this wording was used was analysed in a previous section.

In regard to why people are taken to A&E, earlier I showed that 'not being medically fit' was the reason given for only 14% of persons who were denied access to an S136 suite (Table 12). Here, Table 17 presents a variable for if there is a physical health need as reported by police in the initial call to the Bed Hub. Having a physical health need would justify the use of A&E as an appropriate first POS.

Data presented in Table 17 show that just over 36% of all detainees had a physical health need. Contrary to the previous data, which show more CYP than adults were unable to access an S136 suite due to being medically unfit, a difference which was shown to be statistically significant, here presence of a physical health need is greater for adults than CYP, a change which is also statistically significant (37.31% vs 25.75%; $p<0.001$). This demonstrates that despite CYP having proportionally less physical health concerns, such concerns are more likely to prevent access to S136 suites.

Table 17. Physical health needs identified in detained persons shown for all detentions, adults and CYP.

	All Detentions	Adults	CYP
Physical Health Need = No	2,668 63.51%	2,446 62.69%	222 74.25%
Physical Health Need = Yes	1,533 36.49%	1,456 37.31%	77 25.75%
Total	**4,201** **100%**	**3,902** **100%**	**299** **100%**

Note: Frequencies and percentages given.

The results of a tabulation between A&E as a first POS and the administrative data variable, presented in Table 17, are shown in Table 18. The results show that over 57% of detainees taken to A&E had no physical health need and an S136 suite would have been more appropriate. This percentage is greater for CYP than it is for adults, a difference which is statistically significant (68.86% vs 56.35%; $p<0.001$), evidencing that the inappropriate use of A&E as a POS is greater for CYP than it is for adults. To be clear here, the choice of the POS is made by healthcare representatives within the Bed Hub and not detaining police officers; although, officers can state if they believe that there is a physical health concern which requires A&E. Again, this points towards a lack of suitable S136 suite provision for CYP.

Nevertheless, there are still almost 60% of adult detainees unnecessarily being taken to A&E, evidencing a shortage of S136 suites for adults too.

Table 18. Tabulation of physical health needs and A&E as first POS.

	All Detentions	Adults	CYP
Health Need = No	1,674	1,521	153
	57.37%	56.35%	68.86%
Health Need = Yes	1,244	1,178	66
	42.63%	43.65%	30.14%
Total	**2,918**	**2,699**	**293**
	100%	**100%**	**100%**

Notes: (i) Frequencies and percentages given. (ii) Frequencies here differ slightly to those in Table 17 owing to missing data in the comparison variable.

Once any physical health need has been attended to, prompt transfer to an S136 suite ought to occur so that the detained person is under medical rather than police supervision and control. A&E departments are designed to treat urgent physical health conditions and a report on the Trust's approach to urgent MH care noted that 'little compassion' is awarded to people in MD from A&E staff (REDACTED). My participants also report a lack of tolerance on behalf of A&E staff for people with MD presenting in A&E. One person with experience of frequent S136 detentions told me of their A&E experiences:

> 'At reception … because I'm known it's "Oh my God, she's here again". [Or] if they don't know me, they will read my diagnosis and they'll go, "oh, it's that disorder, these people are always up here, they are always taking up time". It's that attitude, and it just makes you feel even shitter.' (AWE4)

A further problem with the use of A&E as a POS is that detainees become known to A&E staff for having episodes of MD. Although highly inappropriate, this creates a barrier to accessing help for physical health conditions which are unrelated to MD:

> 'I went to A&E with stomach pains, and I got the same attitude problem: "What are you doing here?"' (AWE4)

Police officer participants were clear that MH assessments in A&E are not ideal as these often occur behind curtains owing to an absence or lack of doored cubicles:

> 'They can't even find room to do the assessment … so the patient can talk privately. They are sometimes just in a bay with a curtain. This person may be disclosing historic

> child sex abuse. They are not going to do that when the only sound barrier is a curtain.' (PO2)

Police officer participants were particularly concerned about the insecure nature of A&E departments. Persons detained under S136 must always be under surveillance and control to prevent them from absconding, which necessitates the presence of at least two police officers. One participant shared their experience of very challenging situations within A&E:

> 'The worse one we've had is someone who is extremely violent who also needs medical attention, so we've had to take them to A&E and they've been restrained for a number of hours. The mental health team will not assess them until they have been deemed medically fit. Again, we've had ones that have been detained for over 30 hours and we are up at the hospital with them. It was a massive issue 2 or 3 years ago, but lately it's been a lot better.' (PO1)

This officer was not the only participant who confirmed that the situation of adult detentions in A&E has improved over time. However, this was not the case for CYP detentions. Despite the rise in S136 detentions of CYP, which more often occur OOH (as evidenced in the previous chapter), S136 pathways for CYP have declined following alteration to CCG commissioning, which has caused a loss of access to specialist S136 suites.

Police officers report CYP under the age of 16, who cannot access adult S136 suites, being detained and taken to A&E in the early evening but there being no MH assessment available until the following morning when CAMHS staff are available. PO3 was concerned about the process of S136 detentions and the conditions in which CYP are spending the night:

> '[We were] stuck in an A&E corridor … there was nowhere to take [them] so [they] had to stay in A&E, and it took nearly 13 hours for someone to come out, and they did the assessment there … I tried to get [them] somewhere to rest, such as [an S136] suite, but there wasn't one. It's frustrating.' (PO3)

Where the CYP is unable to access an S136 suite, whether through commissioning or lack of staff, an alternative to the CYP remaining in A&E is for them to be transferred to a paediatric ward for the night. There are no data available for how often this occurs. This short-term solution is reported to work well if the detained CYP is no longer experiencing acute MD. However, where there is ongoing distress, being on a children's ward is not ideal:

> ‘You have got [physically] poorly children who are then being disturbed and frightened by the behaviour of another child on the ward …. that was for 9 hours [overnight] on a children’s ward with other very poorly children … for the other children, and the child you have detained, that is horrific.’ (PO7)

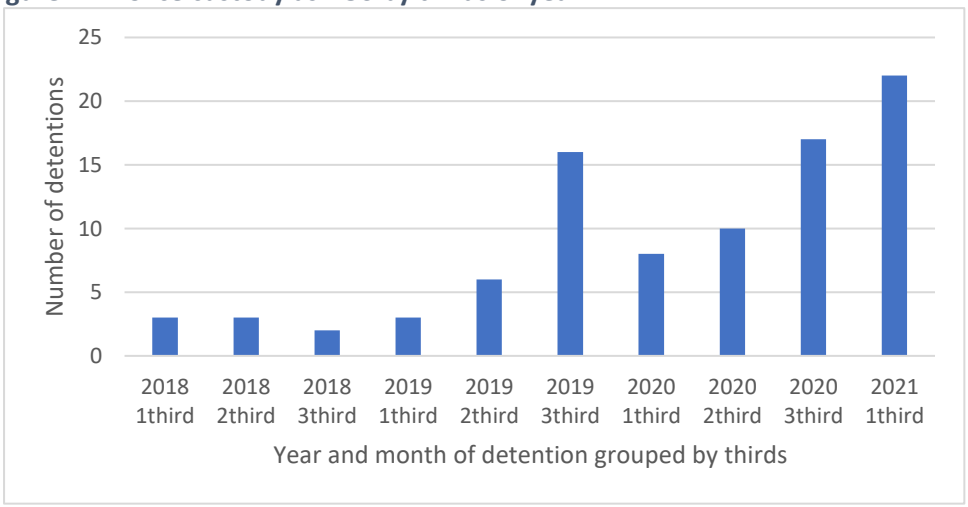
Despite participants evidencing A&E departments as inappropriate for S136 detentions, they exist as the dominant first POS for detained persons. Participants report little compassion from A&E staff, police officers must remain with detained persons where active MD must be contained with restraint and there is no privacy during MH assessments. The use of A&E as a POS exceeds any physical health need and inappropriate use of A&E is more common for CYP than it is for adult detentions; this difference is statistically significant. CYP who live within the reach of some CCGs are unable to access S136 suites OOH and therefore spend the night with no sleeping facilities within A&E or are transferred to a general paediatric ward where any ongoing MD is managed by attending police officers.

Police Custody

Data analysis presented in Table 11 shows that 2% of detainees are taken to custody at a police station. Detainees already in or taken to police custody involved less than 1% of CYP detentions, compared with 2.31% of adult detentions. This was not statistically significant (p=0.06).

Despite being limited to adults and only in circumstances where there is active risk to others, 91 (2.2%) detentions have police custody suites recorded as the first POS. Further analysis was performed. Figure 14 presents analysis of data regarding the use of police custody suites by year and 4-monthly intervals, owing to cell counts below 5.

Figure 14. Police custody as POS by thirds of year.



I was surprised by this increase in use, which is statistically significant ($\chi 2=7.970$; $p=0.005$), as PO9 had shared with me that a request to use a custody suite for a volatile person detained under S136 had flatly been denied by the custody sergeant.

To explore this further, I spoke to the MH lead for the Constabulary regarding the accuracy of the data. They had also noted the increase in custody as a POS in the Trust's data and consequently had explored the cases individually via police records as in their understanding only 'one or two' (MH Lead, 2021, p. npn) detainees were taken to custody per year. The MH lead illustrated the rarity of the use of police custody as a POS by recounting that after access had been initially denied, they had recently 'fought' to gain access to a police custody suite for an 'incredibly violent' detainee who had been unable to access an S136 suite due to them being occupied. A detaining officer had suffered a fracture and the person was being held in the back of a police van as A&E was unsuitable. Considering this, access to a police custody suite was granted, where the MH assessment was performed and where the person subsequently remained for criminal charges which occurred prior to the S136 detention.

It was confirmed that the vast majority of detentions listed as having police custody suites as the first POS were, in fact, S136 detentions invoked on persons already in police custody for whom there was concern regarding their MH.

Considering the above, further quantitative analysis of the use of police custody suites (for instance, if there has been a rise in the detention of people who are already in police custody) would be invalidated due to the inconsistent recording of this variable within the administrative dataset.

Nonetheless, despite the legislation restricting the use of custody suites to only the most volatile of detainees, two police participants see benefit in their use over the use of A&E departments:

> '[Custody suites] would be more suitable because they are secluded from the general public. We've always got a health practitioner on site to take care of any health concerns. We've got cameras so we can keep an eye on them and document anything that happens. We've got control of the environment.' (PO6)

> '[We] can keep the door open the entire time and watch them. They've got access to a bed, a toilet, a shower, a nurse on site, books, hot food, hot drinks, water, exercise yard. You've got access to everything you need, and you can do it in a controlled environment. I think provided the patient was able to understand why they were going to a police station and you could take the time to explain it to them, I think it's a far better place.' (PO2)

Participants and the MH lead for the Constabulary see the benefit of police custody suites where an S136 suite is unavailable and A&E is the only alternative. Persons who are able to understand the reason for using the suite can be supported in a private and more comfortable environment, and persons who are resistant to restraint can be managed more safely in the security offered by a locked room rather than undergo ongoing restraint within A&E. Nevertheless, in line with the MHA, custody suites are infrequently used, and participants reported that gatekeeping custody sergeants oppose requests by detaining police officers.

Transfers and Final Place of Safety

Having established which POS detainees are first taken to, this final section of the chapter considers transfers and the final POS. The final POS is where the detention is revoked and is generally where the MH assessment will have taken place; although, if an assessment in A&E establishes that admission is required, the detained person may be transferred to an S136 suite, where they will remain until an inpatient bed is found.

Administrative data on transfers and the end POS can be seen in Table 19 below.

Table 19. Transfers and end POS shown for all detentions, adults and CYP.

	All Detentions	Adults	CYP
Transferred = No	2,087	1,948	139
	50.75%	51.05%	46.96%
Transferred = Yes	2,025	1,868	157
	49.25%	48.95%	53.04%
Total	**4,112**	**3,816**	**296**
	100%	**100%**	**100%**
End POS = A&E	1,488	1,361	127
	35.75%	35.02%	43.05%
End POS = S136 Suite	2,661	2,494	167
	63.94%	64.51%	56.61%
End POS = Custody	13	12	<5
	0.31%	0.31%	0.34%
Total	**4,162**	**3,867**	**295**
	100%	**100%**	**100%**

Note: Frequencies and percentages given.

Table 19 shows quantitative data regarding transfers from the first POS to a final POS, and the numbers and percentages of persons within the different POS when their detention was revoked.

There were 2,025 transfers of detained persons, which impacts half (49.25%) of all S136 detentions. In itself, this looks like a large demand on the ambulance service, but all AWEs (n=5) informed me that police officers were responsible for transporting them to the S136 suite:

> 'I was taken to the [psychiatric hospital] in a police van. It would have been an ambulance, but it was a couple of hours wait and to save time I was taken in a police van. [The officers] asked if I minded and it was fine by me.' (AWE2)

> 'Once they had finished with me at the hospital, the officers again took me to a different hospital with an S136 suite.' (AWE3)

There are no data within the administrative dataset on the mode of transport for detained persons, which would have enabled closer analysis, although qualitative data suggest that police vehicles are frequently used in order to hasten transfer. Transport is discussed in more detail in the next chapter.

The data presented In Table 19 show that proportionally, but not statistically significantly, more CYP detainees are transferred between POS than adult detainees (53.04% vs 48.95%; p=0.09).

Of CYP detainees initially taken to an A&E department prior to a transfer, 34.38% were transferred to a specialist CYP S136 suite (mean age=16.13; SD=1.45; range 13 to 18 years), with 65.63% of CYP being transferred to an adult S136 suite (mean age=17.2; SD=0.78; range 15 to 18 years). Further analysis explored the absence of transfers of CYP below the age of 13 years within these ranges.

I performed tabulations between age (Table 2) and initial POS (Table 11), and between age and the POS from which the S136 was revoked (Table 19). The results are displayed in Table 20.

Table 20. Tabulation of first and final POS for all detentions, adults and CYP.

	All Detentions (n=4,129)				Adults (n=3,835)				CYP (n=294)			
	End POS = A&E	End POS= S136 Suite	End POS= Custody	**Total**	End POS = A&E	End POS= S136 Suite	End POS= Custody	**Total**	End POS = A&E	End POS= S136 Suite	End POS= Custody	**Total**
First POS = A&E	1,481 50.99%	1,429 49.11%	0 0%	**2,910** **100%**	1,354 50.32%	1,337 49.68%	0 0%	**2,619** **100%**	127 57.99%	92 42.01%	0 0%	**219** **100%**
First POS = S136 Suite	0 0%	1,129 100%	0 0%	**1,129** **100%**	0 0%	1,056 100%	0 0%	**1,056** **100%**	0 0%	73 100%	0 0%	**73** **100%**
First POS= Custody	<5 5.56%	72 80%	13 14.44%	**88** **100%**	<5 5.68%	71 80.68%	12 13.64%	**86** **100%**	0 0%	<5 50.00%	<5 50.00%	**<5** **100%**

Note: Frequencies and percentages given.

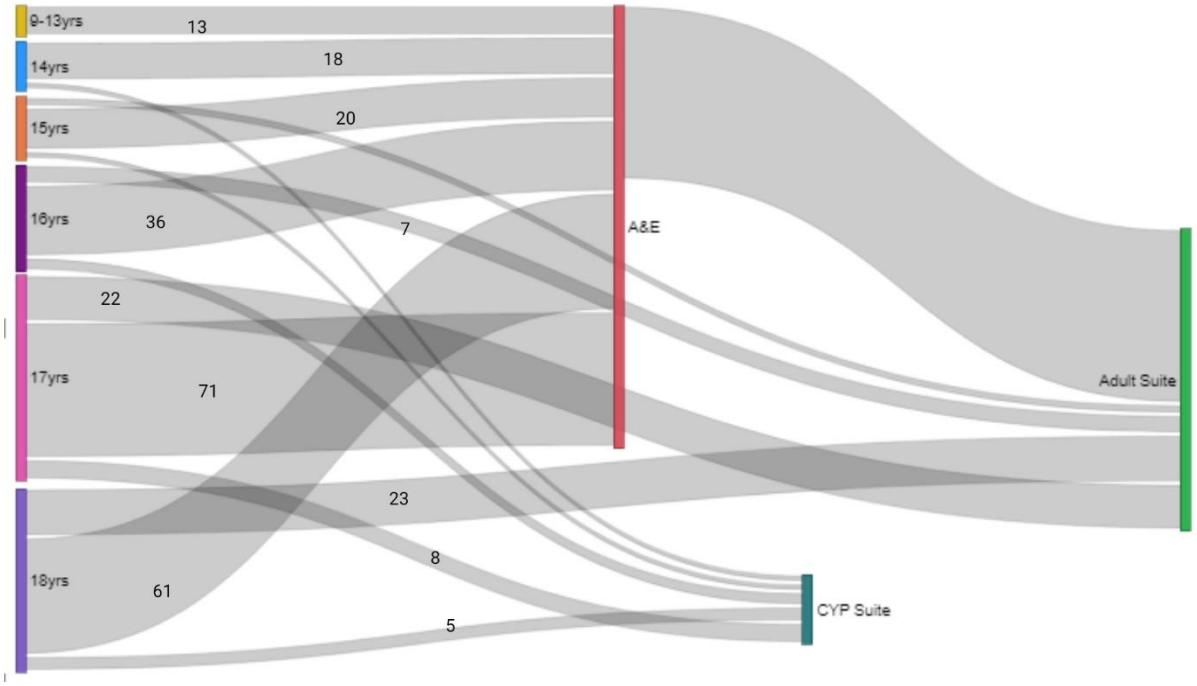
Data analysis presented in Table 20 show that slightly over half of all persons who are first taken to an A&E department end their detention there rather than being transferred to an S136 suite. The

percentage of CYP ending their detention in A&E is greater than it is for adults, a difference which is statistically significant (57.99% vs 50.32%; p=0.29).

Data in Table 20 also show that where an S136 suite was the first POS, there were no transfers to a second POS. Owing to the aforementioned inconsistencies in the recording of detentions in or to police custody, caution is retained in the interpretation of these data. Nevertheless, it can be seen that 80% of detainees reported to have been in police custody suites are transferred directly to S136 suites, which far exceeds transfers from A&E to S136 suites (80.00% vs 49.11%; p<0.001). It could be the higher ranking of the custody sergeants who request a POS which secures an S136 suite; other S136 detentions are likely to be invoked by frontline police constables. The number of CYP in police custody suites is too low to warrant useful analysis, in addition to earlier comment regarding data reliability.

To demonstrate the nuance of CYP detentions in age and the use of adult and specialist CYP S136 suites as first and final POS, I performed tabulations to demonstrate these. To illustrate the results, I produced two Sankey diagrams. Firstly, to show the movement of CYP through the various POS, Figure 15 shows 'nodes' of age of CYP on the left and the POS that they were taken to. The size of each node represents the proportional 'weight' of each node in comparison with others. Between each node are threads which show the pathway of each age group to the initial POS and any subsequent transfers to a second POS. The weight of these threads relates to the number of detainees that they represent. Numbers of detainees are given for those greater than 5.

Figure 15. Sankey diagram of detention pathways for ages of CYP.



As discussed earlier in this chapter, it can be seen that A&E is the first POS for the greater proportion of detainees across all age groups. Apart from the youngest CYP of 9 to 13 years, a small number across all age groups go directly to a CYP S136 suite. With no transfers out of A&E to a CYP S136 suite, this means that none of the youngest detained CYP access the specialist care for MD that these suites offer. Just under one-quarter of this youngest group (n=<5; 23.08% (Table 19)) were transferred to an adult S136 suite; with each of these being 13 years old, these CYP are at the upper end of this youngest age group. These transfers of 13-year-olds occur despite police officer participants saying that when access to adult suites is requested to be able to remove a young CYP from an A&E environment, access is denied as adult suites are deemed unsuitable for CYP.

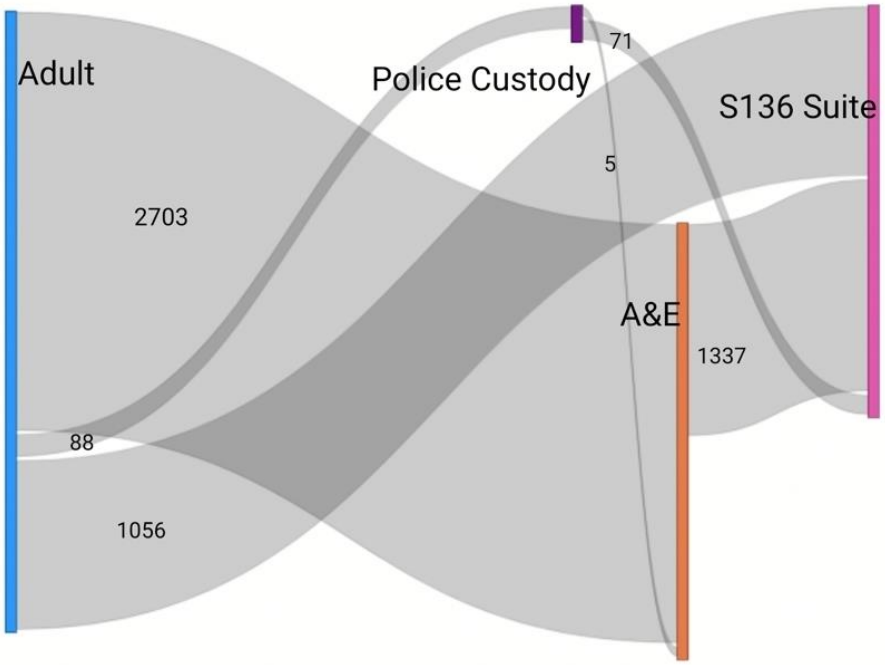
Further regarding the previous point is the weight of the older CYP who access the CYP S136 suites. Of the 19 uses of CYP S136 suites, 13 of the detainees were either 17 or 18 years old. At these ages, CYP are seen by the NHS as adults. The lack of available adult suites has already been established and so it can be understood that available suites ought to be used for these young detainees; nevertheless, such practice then renders the CYP suite unavailable for younger CYP.

The underuse of CYP S136 suites, especially for the youngest detainees, is noteworthy. Less than five CYP aged 9 to 15 years and zero 1 to 11-year-olds go directly to an S136 suite, with as many going to an adult suite as to a CYP suite; all other CYP go directly to A&E. The underuse of S136 suites for the youngest detained CYP means that the majority begin and end their detention in A&E, a pattern which is not seen in older CYP. As the reason for detention is an MH assessment, this means that a high proportion of assessments for CYP are completed within A&E departments and CYP are denied care by paediatric MH-trained healthcare staff, instead remaining under the supervision and control of police officers for the duration of their detention[17].

Turning to adult detentions, I created a similar Sankey diagram using the results of the tabulation displayed in Table 18. Figure 16 is similar to Figure 15, but the left-hand node represents adult detentions and the threads show adult detention pathways to the first POS and subsequent transfers to a second POS.

[17] As described above, police officer participants report that some CYP who are unable to access an S136 suite are transferred to a children's ward, although this is not recorded in the dataset. Nevertheless, CYP remain under the supervision and control of police rather than specialist MH-trained paediatric staff.

Figure 16. Sankey diagram showing the S136 detention pathway of adults.



The majority of adult detainees are taken to A&E as their first POS, with approximately half of those being transferred to S136 suites (49.68% (Table 20)). There are no transfers out of an S136 suite. With the addition of transfers from A&E, S136 suites are the dominant end POS for adults, with 64.51% (Table 19) of detentions ending here.

The data presented in Figure 16 shows that of the 88 detainees who are recorded as having police custody as their first POS, many more detainees are transferred from police custody to S136 suites than are transferred to A&E (71 vs 5).

The data in Figure 16 also shows that a high proportion of adult detentions are first taken to A&E, from which there were no transfers to S136 suites.

Data presented in Table 17 suggest that 13 detainees (one of these a CYP) remained in police custody for the duration of their detention. Examination of available free-text variables suggests inaccuracies within the dataset, as at least two detainees (one being the CYP) were transferred to an S136 suite, but these transfers had not been recorded in the appropriate variable. Consequently, there may be inaccurate recording regarding other transfers, thereby slightly altering the data.

To consider the final POS more clearly, I refer back to Table 19. Date presented here shows that of all detainees, 35.59% (n=1,481) had their detention revoked in A&E. CYP are overrepresented here, with over 43% of CYP detentions ending in A&E compared with 35% of adult detentions. This difference is statistically significant (p=0.005).

Of course, with proportionally more CYP than adults remaining in A&E, more adults than CYP are able to access and consequently to end their detention in S136 suites; this difference is statistically significant (64.51% vs 56.61%; p=0.006) (Table 19).

In short, half of all detentions which are first taken to an A&E department are subsequently transferred to an S136 suite. Access to a specialist CYP S136 suite is denied to the youngest CYP and only very small numbers of CYP access these suites as a first POS. Once a CYP has arrived at A&E, there are no transfers to a CYP S136 suite. Although a large proportion of adults are not transferred out of A&E, the small number of transfers of CYP to adult suites mean that more CYP than adults have their detentions revoked in A&E departments. Detentions ending in A&E departments mean that persons in MD are under the supervision and control of police officers and MH assessments are performed in A&E under conditions which were described earlier as having minimal privacy.

As Chapter 4 highlighted, detentions exceed 24 and 36 hours, and I performed a two-way analysis between the duration of detentions and the different POS where S136 was revoked. Data presented in Table 21 show the final POS and the detentions below and above 24 hours[18]. 77.14% of detentions exceeding 24 hours have a final POS of an S136 suite, whilst 22.86% are within A&E departments. The chi-squared test shows this difference to be statistically significant ($\chi2=71.94$; $p<0.001$).

Table 21. Detentions exceeding 24 hours and final POS.

	A&E	S136 Suite	Total
Detention <24 hours	1,118 37.98%	1,826 62.02%	2,944 100%
Detention >24 hours	214 22.86%	722 77.14%	926 100%
Total	**1,332** **34.33%**	**2,548** **65.67%**	**3,880** **100%**

Notes: Frequencies and percentages given; $\chi2=71.9453$; $p=0.000$.

As 12-hour extensions to S136 detentions can be granted to persons whose condition prevents an assessment within 24 hours, thereby justifying an extended stay within A&E departments, further analysis was performed to highlight detentions exceeding 36 hours, which is the absolute maximum lawful S136 detention period. Results can be seen in Table 22.

[18] Missing time data mean that numbers in Table 21 do not match those in earlier tables.

Table 22. S136 detentions exceeding 36 hours and final POS.

	A&E	S136 Suite	Total
Detention <36 hours	1,254 38.05%	2,042 61.95%	3,296 100%
Detention >36 hours	78 13.36%	506 86.64%	584 100%
Total	**1,332** **34.33%**	**2,548** **65.67%**	**3,880** **100%**

Notes: Frequencies and percentages given; $\chi 2=134.1432$; $p=0.000$.

Data analysis presented in Table 22 show that a majority (86.64%) of people detained beyond the absolute maximum lawful duration were held within S136 suites. A chi-squared test shows the difference to be statistically significant ($\chi 2=134.14$; $p<0.001$). Nevertheless, over 13% of detentions which became unlawful occurred within A&E. It must be highlighted again that the duration of detentions at this time is beyond the control of police officers; however, their presence makes them complicit in the unlawful detention.

Police participants explained that most of the delays in A&E were due to waiting for the assessing team to arrive but that the extended delays are caused by pressure on the number of beds. S136 suites become blocked by persons awaiting an inpatient bed to be found, thereby explaining the high proportion of breaches in detention duration where the final POS is an S136 suite. The potential for access to S136 suites being prevented by other people was noted by the CQC, who caution against S136 suites being used as 'swing beds' in which to detain a person in the absence of a suitable inpatient bed unless there were 'contingency plans' for when another person requires the S136 suite (CQC, 2020, p. 30). The issue of an S136 suite being unavailable is reduced if they are used only to detain a person until they have been assessed, which is what their intended use is; however, such practice relies on sufficient acute MH beds being available in which to transfer people in a timely fashion.

Despite A&E being what PO2 earlier described as 'wholly, wholly inappropriate', 35.59% of detainees remained in A&E departments throughout the duration of their detention.

With no S136 suite available, detained persons must be taken to A&E and if admission is assessed to be required then the person must remain there. One officer shared:

> 'We have found that … as the pressure on beds mounted up, as you can see in the breaches, then people would spend longer than the 24 hours in [an S136] suite, which then passes those other detentions to the A&E department ... [People] have no

> physical need to be there but because [S136 suites] are full, then they end up in an A&E department ... What we were finding was that multiple detentions hit that 24 hours, or 36 if they have been extended, and the police are in the position of "they have been assessed, they need a bed, but there is no bed."' (PO11)

PO11 here explains the difficult position that officers are placed in: they are unable to release the person from an expired S136 detention as they have been assessed as presenting such a risk to self or others that they require hospital admission. Consequently, there is no alternative but to safeguard them and keep them under supervision and control until a bed, or at least an S136 suite that removes the necessity of police officers, can be found.

I performed further tabulations, with results of these displayed in Table 23, to show the final POS and detentions exceeding 24 and 36 hours to compare CYP with adult detentions. Of detentions exceeding 24 hours, more CYP remain in A&E under police supervision and control than adults do; a difference which is statistically significant (44.74% vs 21.94%; p=0.001).

Table 23. Final POS by S136 detentions less than and exceeding 24 hours for adults and CYP.

	Adults				**CYP**			
	A&E	S136 Suite	Custody	**Total**	A&E	S136 Suite	Custody[19]	**Total**
Detained <24 hours	1,018 37.54%	1,689 62.28%	5 0.18%	**2,712** **100%**	100 42.02%	137 57.56%	<5 0.42%	**238** **100%**
Detained >24 hours	197 21.94%	701 78.06%	0 0.00%	**898** **100%**	17 44.74%	21 55.26%	0 0.00%	**38** **100%**
Total	1,215 33.66%	2,390 66.20%	5 0.14%	**3,610** **100%**	117 42.39%	158 57.25%	<5 0.36%	**276** **100%**

Note: Cells contain frequencies and percentages

Data presented in Table 24 show the final POS for detentions of adults and CYP which exceed the maximum lawful duration of 36 hours. Proportionally more CYP S136 detentions were in A&E beyond 36 hours than adult S136 detentions, but this was not statistically significant (26.32% vs 12.92%; p=0.09).

[19] Note the presence of the CYP recorded as remaining in police custody, which was earlier identified to be an administrative error.

Table 24. Final POS by S136 detentions less than and exceeding 36 hours for adults and CYP.

	Adults				CYP			
	A&E	S136 Suite	Custody	**Total**	A&E	S136 Suite	Custody	**Total**
Detained <36 hours	1,142 37.50%	1,898 62.33%	5 0.16%	**3,045** **100%**	112 43.58%	144 56.03%	<5 0.39%	**257** **100%**
Detained >36 hours	73 12.92%	492 87.08%	0 0.00%	**565** **100%**	5 26.32%	14 73.68%	0 0.00%	**19** **100%**
Total	1,215 33.66%	2,390 66.20%	5 0.14%	**3,610** **100%**	117 42.39%	158 57.25%	<5 0.36%	**276** **100%**

Note: Cells contain frequencies and percentages.

Although the majority of the 584 detentions exceeding 36 hours were in S136 suites, therefore under medical rather than police supervision and control[20], with no legal framework in place it must not be ignored that people held in such circumstances have no recourse to advocacy and appeal.

Whilst outliers of single detentions could be dismissed as administrative error, it is harder to dismiss greater numbers, such as the 584 detentions which are listed as exceeding 36 hours. Police participants informed me that as detentions approach 24 hours, senior staff escalate concerns to hasten a resolve to the situation and remove officers. It is therefore unlikely that the Constabulary would provide relief to officers to detain persons in A&E for over 9 days (n=4), as exists within the data, and so these and probably several other excessive detention durations could be seen as administrative error. However, larger numbers of excessive detention durations within S136 suites either suggest a significant administrative error or they represent accurate data; the latter people are detained for up to 4 days, and 59 people are detained for more than 7 days. These data would be concerning as these are clear breaches in S136 legislation and violations in persons' human rights. PO11's narrative quoted earlier explained that beyond assessment, people only remain in A&E if they require a bed and one is not available, and the S136 suites are occupied. PO11's data and the fact that 78 people remained in A&E beyond 36 hours, and assuming that no S136 suite became available in that time, supports the notion of a lack of MH inpatient beds, implying that many of the data regarding numerous days spent in S136 suites are accurate.

[20] Police sometimes do remain within S136 suites to assist medical staff in situations where MD continues to pose an active risk of self-harm.

Whilst this section has uncovered areas where there are likely to be administrative errors in the recording of the data, qualitative accounts of police presence with persons detained in A&E beyond the lawfully permitted time suggest that much of these quantitative data are accurate.

Following S136 detention, proportionally (although not statistically significantly) more CYP are taken to A&E than adults (74.49% vs 70.21%). A visit to A&E is often required to ensure that there are no physical health concerns (for example, from self-harm or poison ingestion) prior to an MH assessment; nevertheless, the higher proportion of CYP not going directly to an S136 suite suggests that the lack of available provision is more acute for CYP than it is for adults.

A transfer to a second POS happens for almost half of detentions and more CYP end their detentions within A&E than adults (43.05% vs 35.02%). Consequently, over 40% of detained CYP are under the supervision and control of police officers for the duration of their detention, rather than paediatric medical staff who are trained in the care of CYP in MD. Alarmingly, only 3.64% of CYP below 15 years of age end their detentions in specialist S136 suites, and zero CYP of up to and including 13 years do so.

Proportionally more CYP remain in A&E and under police supervision beyond the 24 hours than adults, a difference which is statistically significant. Furthermore, proportionally more CYP are detained beyond the 36-hour duration permitted by the MHA than adults.

Chapter Summary

This chapter has highlighted the complex decision making that occurs prior to police officers invoking an S136 detention. Officers try to avoid invoking S136, citing an awareness of the S136 process that lies ahead and the implications of detentions for the detained person, themselves as officers and other professionals as factors informing decision making. Officers attempt to place persons in distress into the care of family members; this is particularly the case for CYP, especially in the knowledge of the lack of OOH provision for CYP.

There are occasions where officers invoke an S136 because of the consequences should harm occur if they do not. Officers cited their inexperience, distressed CYP, believing that a distressed person would be unable to tolerate a voluntary attendance to A&E for assessment, and when referrals come directly from health or social care as reasons why they might be more inclined to invoke S136.

Purpose-built S136 suites are designed to meet the MH needs of detained persons and yet there is an overuse of A&E departments as a POS. The use of A&E is driven by the Trust's management regarding the use of S136 suites despite strong concerns by police officers regarding the suitability of the A&E environment for a distressed person. For both adults and CYP, more detainees are taken to A&E than to an S136 suite as their first POS. A&E is required if there is a physical health concern as these must be addressed prior to assessment, and yet over 35% of detainees had their detentions revoked there; 1,481 MH assessments occurred within A&E departments, a place where police officers highlight a lack of private rooms in which detained persons can talk about highly personal experiences.

There is a statistically significant relationship between age and access to S136 suites, with none of the youngest detainees going directly to an S136 suite; this is possibly due, at least in part, to the lack of OOH MH provision for CYP due to CCG commissioning.

Older CYP of 17 and 18 years comprise over 68% of CYP who access S136 suites and 13-year-olds have been shown to access adult suites. Nevertheless, considering evidence regarding the experiences of detainees in A&E, any S136 suite is likely to be preferrable to none. A CQC report (2014), whilst considering the findings that adult units are sometimes unsuitable environments, cautioned against excluding some groups of people, including CYP, from access to specialist health services. Despite the aforementioned rise in CYP detentions, which is statistically significant, S136 detentions of CYP are relatively infrequent, with 300 detentions over the 40 months of this research. Considering this, the occasional use of available spaces by persons who can access adult suites is likely to have minimal impact on other detentions; it is prolonged stays that increase the risk of suites being inaccessible to subsequent detainees.

The lack of inpatient beds in which to accommodate persons who have been assessed as requiring admission means that S136 suites become blocked for subsequent detainees. As well as this meaning that more persons must go to A&E, where they are under the public gaze under police supervision and control, should they require admission, in the absence of available MH beds and with S136 suites already full, they sometimes remain under this supervision beyond the lawful duration of S136. More CYP are held beyond 24 hours in A&E than adults, a difference which is statistically significant, and proportionally more CYP are held in this way beyond 36 hours than adults.

Despite the administrative data suggesting that there is a statistically significant increase in the use of police custody as a POS since SRP, this was shown to be an inaccurate recording within the dataset. The MH lead for the Constabulary gave testament that it is very difficult to gain access to custody suites, even for extremely volatile persons, when S136 suites are unavailable. Aside from detainees

who pose an active risk of harm to others, police officers prefer the use of police custody as a POS over A&E departments; this is due to the controlled environment and the privacy and facilities that custody suites offer that are not available within A&E.

This chapter has evidenced that there is a lack of suitable places in which to take CYP. Prior to the 2017 amendments to S136 detentions, there was concern that the use of police custody suites was criminalising, especially for CYP where there was no alternative POS, and yet now CYP are taken to A&E departments where they remain under police supervision and control rather than to an S136 suite.

With over 35% of detentions being revoked in A&E, this chapter has shown that too many detained persons remain under police supervision and control rather than being supported through their MD by MH-trained medical professionals. The next chapter expands upon qualitative data regarding S136 processes within A&E departments and considers whether this practice is criminalising.

Chapter 6: Detention Process and Policing Practices

The previous chapter highlighted the extensive time that detained persons spend under police supervision and control once they have arrived at the POS. Over 35% of detained persons end their detentions within A&E departments, where they are required to stay with detaining police officers rather than be under the care of healthcare staff who are trained in the support of persons experiencing MD.

This chapter explores the intersection between policing practices and MD and considers if there is a connotation of criminalisation. Using participant narratives, how the detention process is experienced and perceived by police officers and adults with experience of S136 detention/s is explored at different stages of the detention process. Police and AWE participant accounts of interactions with members of the public during the detention process and the perceived perceptions of the public are also presented.

Police officers' objection to the use of A&E departments has been explored in previous chapters. Here I illustrate why there is such discomfort with this POS by using qualitative data from police and AWE participants.

Quantitative data is included to support qualitative data regarding the use of physical and mechanical restraint, and this is presented in Table 25. As explained in Chapter 3, these variables were established from any mention of a method of restraint or the use of an incapacitant, such as a taser or PAVA spray[21], within free-text variables in the dataset by using the Microsoft 'Find' function. Whilst accounting for typographic errors (for example, the spelling 'tazer' appeared four times), this method possibly missed some incidences of restraint use. Furthermore, these quantitative results only count the detentions where there was mention of restraint within the dataset's free-text variables. As the population of the free-text variable is not structured, these data can only be considered as a guide and are accepted to be an indeterminable underrepresentation of restraint practices.

Owing to the coding of restraint practices, there are no item missingness here; however, where analysis considers restraint in various POS the sample sizes do vary owing to missing data within the administrative dataset variables.

The first section of this chapter explores police involvement at the point of detention. Public perception of police officers is considered, as is the method of transportation to the POS. Police

[21] A spray consisting of pelargonic acid vanillylamide which causes short-term pain and stinging to the eyes, thereby acting as an incapacitant.

involvement at the POS is explored next, with consideration to policing practices, from communication to the use of restraints and incapacitants. Any similarities or differences in the experiences of adults and CYP are highlighted.

This chapter relates to all three research questions: Question 1 concerning the nature of police involvement, Question 2 pertaining to differences in the processes and experiences of the detention of adults and CYP and Question 3 regarding police practices and whether these are seen and experienced as criminalising.

Owing to the nature of the content under analysis, this chapter does contain accounts of distress.

Table 25. Restraint methods used by police officers during S136 detentions.

	All Detentions (n=4,211)		Adults (n=3,911; 92.88%)		CYP (n=300; 7.12%)	
	n	%	n	%	n	%
Restraint Methods Used	**4,211**		**3,911**		**300**	
No	4,092	97.17	3,817	97.60	275	91.67
Yes	119	2.83	94	2.40	25	8.33
Handcuffs Mentioned	**4,211**		**3,911**		**300**	
No	4,142	98.36	3,853	98.49	290	96.67
Yes	69	1.64	59	1.51	10	3.33
Limb Restraint Mentioned	**4,211**		**3,911**		**300**	
No	4,198	99.69	3,898	99.67	300	100
Yes	13	0.31	13	0.33	0	0
Head Guard Mentioned	**4,211**		**3,911**		**300**	
No	4,203	99.81	3,903	99.80	300	100
Yes	8	0.19	8	0.20	0	0
Spray Mentioned	**4,211**		**3,911**		**300**	
No	4,197	99.67	3,898	99.67	299	99.67
Yes	14	0.33	13	0.33	1	0.33
Taser Mentioned	**4,211**		**3,911**		**300**	
No	4,187	99.43	3,899	99.44	298	99.33
Yes	24	0.57	22	0.56	2	0.67

Note: The variable 'Policing Methods Used' includes any mention of one of the other methods of restraint.

At the Point of Detention and the Perception of Police Officers

Despite the expanding role of police officers, they remain the face of authority, those who uphold and oversee legislation and those who bring people who flout the law to the attention of the criminal justice service. This ongoing view of the police was confirmed by one participant:

> '[The] public perception is still that our role is to fight criminality.' (PO6)

The power of the uniform is recognised (Bickman, 1974) and the obedience with which law-abiding persons view the authority of police officers was summarised by an AWE of two S136 detentions:

> 'Without actually intending to, they make it very hard to say "no" to. And, without actually realising, they can actually really intimidate – it's not quite intimidation, but you're not able to say "no" to them because you don't feel you can, and that can be quite frightening. So, you feel worthless, you feel disempowered, you feel, you know, you're frightened because you feel "if I say 'no', something adverse is going to happen". I think they'd be horrified if you actually told them that.' (AWE5)

All AWEs commented that they were attended to by multiple officers; in one incident more than eight officers had been in attendance. Considering the intimidation felt by AWE5, it is reasonable to imagine that feeling being increased with multiple officers in attendance.

When attending a call regarding someone experiencing MD, although their first job is to preserve life, officers commented that they recognise that people can be wary of their attendance and that they attempt to reassure the person that they are there to help them. When their role to uphold the law intersects with MD, participants demonstrated an awareness of ensuring that the person's health takes priority over any criminal processes. One officer shared:

> 'We just have to go in with empathy and tell them we are not there to arrest them and they are not in any trouble … If someone is actively wanting to end their life, or if they are actively harming themselves, or they have swallowed a load of tablets, we have a job to try to get them the help they need. Sometimes it can be difficult if someone is committing a crime, but they are also having a mental health episode … A young person set fire to the kitchen as they wanted to kill themselves, so I had to consider that as an arson … [they] had put others at risk, but [they were] having a crisis and [were] so distressed we had to prioritise [their] mental health needs before we could move onto the criminal side of things. What would it benefit [them] in that crisis when [they were] hysterical to put [them] in a custody cell? We had to meet [their] needs and also keep in mind the seriousness of what [they] had done.' (PO3)

Despite all police participants (n=12) mentioning their efforts to reassure persons, not all AWE encounters with police officers were positive:

> ‘When the police arrived … I was in [a] calm state because some time had passed since the initial intervention by the security [guards]. But … they immediately asked a few questions to the security guards in private and then came to me and [were] like, “we’re detaining you under S136” [and] they put me in handcuffs. They took my things … in my bag I had a suicide note … the two who were reading the note were standing right in front of me reading it amongst themselves and made no effort to be discrete about it … I was getting really agitated. I was like “please, stop reading that because it’s personal” … it felt like I was being taunted. I start[ed] to shout and get restless and agitated and really upset at what they were doing, and so I was trying to get up … Immediately I had three officers on me putting me in leg restraints. So, I am now in handcuffs and leg restraints with three officers pinning me down while two other officers were reading out a very private suicide note. So, the whole thing was really traumatic; it was really traumatic.’ (AWE1)

That quote, from an AWE outside of the research geographical area, was the most concerning account of police interaction shared with me. Within the geographical area of study, the use of restraint, handcuffs and limb restraints were mentioned in the dataset (in 2.83%, 1.64% and 0.31% of detentions, respectively); however, most police participants mentioned the use of handcuffs during S136 detentions, and so their use in just 1.64% of detentions is likely to be an underestimation of reality.

Whilst AWE1 described a highly traumatic experience of detention, three of the five AWEs, including AWE1, have experience of more than one S136 detention, and every AWE volunteered positive interactions with officers. Three of the five AWEs volunteered that the care afforded by officers surpassed that experienced by healthcare professionals. For example:

> ‘I woke up and there was a huge copper over me. He had every reason to be worried by me as I was in shock – I didn’t expect to wake up again – but he was brilliant with me. [Two officers] stayed with me and let me ramble on. Not once did they look down on me or judge me …. or make me feel like I was wasting their time. The police were brilliant; I can’t say the same for the healthcare people.’ (AWE2)

Previous research has hinted that persons in crisis call for police assistance as they know that they will receive kindness and compassion that they do not get from MH support services (Bendelow et al., 2019b; Warrington, 2019), and this is supported by my findings. The fact that the police do respond to calls when people are in crisis, with several of my participants reporting that they display empathy

and compassion, could well contribute to the number of repeat calls to police for assistance. One officer recalled a conversation that they had with a person who had experienced multiple detentions. The officer was concerned about accidental falling as the person would position themselves on the wrong side of bridge railings as an expression of their need for assistance with their MD:

> 'I had a long conversation with [them]. I asked what [their] perception of it was and [they] said "I like the police because when I call them, they come, they take me seriously, and when they sit with me in the A&E department, they make sure I get a brew. But when I am just [in A&E] on my own, nobody gives two hoots, nobody speaks to me and I just get left to my own devices. And … I start getting anxious because I think nobody cares."' (PO4)

Most of the AWEs who I spoke to had access to telephone crisis care provision provided by their local NHS trust but there were no positive comments about the service. One person (AWE5) reported that they received an S136 detention as officers had no alternative after the refusal to engage with crisis care. There were expressions of frustration from three AWE participants that support workers are often unable to attend in person[22] and that the service is not tailored to individual needs but has prescriptive responses, which aggravate rather than alleviate MD. One participant said:

> 'I would rather them be like "do you want to talk about it; what's bothering you?" I need to talk about what's bothering me as then it gets it all out, instead of saying "have a cup of tea". Because when someone says, "have a cup of tea", I think they are being sarcastic. "Are you taking the piss?" Do you know what I mean? Like, "I feel suicidal", "Have a fucking cup of tea".' (AWE4)

Whether the person has called the police themselves, been referred from health or social care professionals or from concerned members of the public, by their nature, S136 detentions are invoked in public places and consequently members of the public can be in attendance. Many officers reported that the public will try to assist in situations of MD, certainly until the police arrive; however, with smartphones increasingly being used to record police responses and interactions (Ariel et al., 2018), video recording of incidences of MD was a noteworthy finding within the qualitative data. Here I present two accounts: the first by AWE1, who earlier described their traumatic police interaction, and the second from a police participant, who is aware of smartphone usage but did not offer narrative regarding the perspective of the person in MD.

[22] These comments were unrelated to SRP.

> ‘I was in a public place. It was very demoralising and humiliating. At one point somebody walked past and took out their phone and started recording. At that point I couldn’t even put my hands up to cover my face because I was handcuffed. I literally couldn’t do anything and the officers who were around didn’t do anything to move that person on.’ (AWE1)

> ‘You are constantly being watched and phones are recording you. It could be that someone is having some kind of mental health episode: shouting, swearing. If they are running into traffic or taking their clothing off, you have to get hold of them and use force to keep them safe to protect others. [A member of the public hears] a commotion and that will lead to them getting their phone out. So, we do have to keep in mind that we are constantly being watched. However, if you just do your job with honesty and integrity and you are always accountable for what you do, it doesn’t matter what it looks like to other people.’ (PO3)

Two officers commented on how they reassure members of the public without disclosing details of the person in MD. They reported that members of the public are generally aware that the police are trying to assist the person; however, that is difficult to uphold when police vehicles are used to convey a person away from a scene. One officer said:

> ‘If you’ve got someone on a bridge or on a carpark roof and the police turn up to manage the situation, then the public understand that. I think what the public would like to see is that they go into the back of an ambulance rather than in the back of a police van, because then the perception is that they are going to someone who can help them.’ (PO4)

Legislative and local policy guidance states that wherever possible, detained persons should be conveyed to a POS by ambulance; however, PO9 told me that 60–70% of the time detained persons are transported in police vans due to the length of time they would have to wait for an ambulance. Police can raise the category of need for a more rapid ambulance response time but officers report that this has had little effect; especially during SRP, when an already-stretched ambulance service experienced additional pressure. The delay in ambulance attendance was confirmed by all other police participants, who stated that police vans, despite the cages in the back, were preferrable to remaining on a roadside with persons in MD for several hours until an ambulance could attend. Of note is that the use of police cars for the conveyance of anyone detained is forbidden in the geographical area of study due to risk to officers. Despite the regularity, officers are not comfortable with the use of police

vans: five officers used a variant of the term 'criminal' when describing the use of police vehicles to convey persons in MD. For example:

> 'They are coming out of the back of a police van and they are just criminalised straight away ... everyone there is thinking "oh, I wonder what he's done". In everyone else's mind, and quite often including the nurses and doctors, they are not patients, they are prisoners. They are prisoners with the police.' (PO2)

> '[Detained] people think they are being treated as a criminal and I can fully sympathise with that.' (PO6)

From AWE participants' perspectives, most reported that they had been in the back of a police van during at least one detention and, despite accounts from police officers who had recounted the distress of some persons who were being conveyed in this way, these AWEs had not objected; the difference could be their ability to understand the time-saving reasons for the use of police vans, whereas persons experiencing delusions might not be able to comprehend. AWE1, who was in handcuffs and leg restraints, reported spending four or five hours with the officers in that distressed state whilst awaiting an ambulance. Their second detention involved a police van:

> '[It was] very quick. [The officers] were quite efficient in the sense that they didn't do the whole process of waiting for an ambulance. They were already in the van so they just took me to hospital in the police van.' (AWE1)

There is evidence here that the police continue to be seen as the service which enforces the law and one which instils obedience in law-abiding members of the public. Although not all accounts of police intervention in situations of MD are positive, all AWE participants had positive experiences of police intervention, which surpassed some care received by healthcare staff. AWEs have little faith in the telephone crisis care service, which leads to increased reliance upon police to intervene in situations of MD. There is evidence here that police officers are seen by persons with experience of multiple detentions as the compassionate service who always attend and listen.

To summarise, police participants voice care and empathy towards persons who experience MD and say that the wellbeing of the person takes precedence over any criminal matters with which they might be connected. Caged police vans are used out of necessity due to delays in accessing ambulances for conveyance to the POS. Although AWE participants here had no objection to their use, police participants were not comfortable with this owing to the impression given to members of the public and additional distress their use causes some persons. Whilst members of the public are reported to be helpful in alerting police to 'concern for welfare' situations, there is a noteworthy use

of smartphones to record incidences of MD; this is highly distressing for the person experiencing MD, with no evidence here that police officers fully appreciate the traumatising impact.

Policing in the Place of Safety

There is nothing within the MHA that suggests that it is a police role to remain with the detained person beyond delivering them to the POS. Nevertheless, even where the POS is an S136 suite, if a joint risk assessment by healthcare and detaining officers suggests that risk remains to either the detained person or others, police officers will remain in attendance. One participant spoke of having to remain with a person who was trying to reopen self-harm wounds:

> 'We couldn't have left because [they were] so difficult, but they didn't have the staff to manage [them].' (PO12)

This suggests a reliance on police presence due to a lack of staff rather than the requirement of police restraint practices. Whilst some participants could see the need for their ongoing attendance, PO12 pointed out that the use of police officers was not cost effective:

> 'The way I look at it, I am not the person to be doing that … Surely there is a more economical, cost-saving way to do it than pay a police officer; a top PC who gets 40, 42 grand a year to sit with somebody in hospital. I think there should be more staff at the suite where you drop them off … almost like babysitters, and I know that sounds bad, but I just don't think it is value for money that we have to sit there.' (PO12)

The most senior of police participants pointed out that the MHA terms of police involvement do not extend beyond delivering the person into the care of healthcare staff within the POS:

> 'The Act is very specific to that "immediate need of care and control" and I think that's a good guide as to where we fit into [the] puzzle. If there's an immediate need to save life and an immediate risk to life, an immediate need to intervene, then yes, we will get the person off that bridge and do what we need to get them to a place of safety, but … it's then somebody else's responsibility for that person's longer-term care.' (PO4)

Chapter 5 evidenced that 57% of persons who are taken to A&E have no physical health concerns; nevertheless, where there is concern regarding physical health that requires assessment, it has become a police responsibility to remain with the detained person within A&E, and even this could be

said to extend beyond the role of police. Officers remain in A&E because of an absence of acute MH care facilities, including staff and secure rooms, and since persons are under a detention due to a perceived risk, they must not be allowed to leave until after an MH assessment. This expanded role of police officers to meet the shortfalls in health and social care systems is resented by police officers who continue to see their role as that of 'proper policing' (Loftus, 2010, p. 5)where people who commit crime are removed from the streets.

Participants explained the problem of safely containing someone who is detained under S136 within an open A&E environment. It is preferrable to have two officers in attendance for their own welfare as well as ensuring the safety of the detained person, as they must be accompanied to prevent the possibility of them harming themselves or absconding from detention. The requirement to enforce control of the detained person, which 11 police participants spoke of conflicts with the empathy for the person's situation which was evident earlier. One officer commented:

> 'There are risks that we have to manage. If someone [detained under] Section 136 escapes from you and goes on to harm themselves, then you are in a lot of trouble. If they want a cigarette, you've got to handcuff them because you've got to mitigate that risk. Trying to get them contained within a room is a nightmare. There is never a room available so they are just in open areas. You are having to control them like a prisoner but trying to treat them like a patient. It's very difficult to get that balance.' (PO2)

A&E departments are busy areas where members of the public can await assessment and treatment for many hours. The public are therefore a captive, bored audience and, as police are best known for their role in upholding the law, their presence with a person under their direct supervision and control draws speculation. Three police participants spoke of restraint practices during detention being viewed by others as criminalising. One officer commented:

> 'The public see someone walking between two police officers and they think they are under arrest or they're in trouble.' (PO1)

Officers report a lack of available private rooms, which leaves the detained person and police officers within sight of other people. Officers expressed understanding of speculation about what was happening and agreed that in the same situation they would be equally curious. Officers are sensitive to the plight of the person who they are detaining and it is this that causes officer concern about the use of A&E as a POS:

> ‘It is really distressing for people who had never previously had contact with the police, and then you are stood there saying “you’re not going anywhere because you might harm yourself”. And I know it’s awful, but you are in a busy A&E corridor [and] people [are] staring. Whether it’s a young person or adult … [we]’re stood there with them and they might see someone who they know. You look like a criminal when you are stood with two police officers with you. And if they are in handcuffs, if they are quite agitated *etcetera*, we might have to carry on using restraint, and it can be quite distressing for people.’ (PO3)

An AWE confirmed the distress that the environment caused them:

> ‘The corridor, it was absolutely heaving and obviously I was with the police. I was actually trying to stand in the corner facing a wall as I felt that I was under scrutiny.’ (AWE3)

Four police participants recounted many incidences where distressed persons were under the gaze of members of the public. One officer said:

> ‘People can be held visibly in the waiting room. I dealt with one [person] last year who wanted to walk around, and I had to walk [around] with [them] all evening. It was quite clear that [they were] mentally poorly, and [they were] on display to everyone. It was horrible. It’s not nice. I think they should be out of view; not to hide them but to hide the embarrassment for them, because at some point they will be better again, and they might walk down the street and see someone who was in that waiting room at that time. I think it is too public.’ (PO12)

Prolonged police presence creates an added trauma for persons who experience persecutory delusions where they feel, as reported to me in the case below, that the government are seeking them. As police are government employees they are agents of the government:

> ‘I felt so sorry for this [person] … [They were] so paranoid [they] thought we were there to kill [them]. We had [them] handcuffed for so long because [they were] trying to escape continually. [They] thought we’d taken [them] there to kill [them] so, rightly so, [they were] trying to escape. We had [them] in A&E for, I think, 10 hours and we were just battling with [them] the entire time. Everyone was staring at [them] and [they were] staring at everyone else because [they] thought they were a risk to [them] … in a waiting area, in [their] head [they were] waiting for us to kill [them]. It was just awful.’ (PO2)

With no safe place in which to contain distressed persons, after arrival at A&E, an officer reported the use of a police van, as this had been deemed the safest option to contain a CYP. Within the data, this is the second use of a police van to contain distressed persons when an S136 suite is not available and when the level of distress makes containment in A&E departments unsafe. As with the other account relayed in the previous chapter, the use of police vans is recognised by officers as poor practice; however, officers are left with few options when there is no safe POS available within the Trust:

> 'I was there with a 13- or 14-year-old … it was really horrendous. [They were] so violent that [they were] having to be taken out of A&E and put in the back of a police van.' (PO4)

Ongoing MD within an A&E department where there is no private room in which to contain a person leaves the distress and containment in view of other members of the public. Many officers spoke of the trauma caused either to the detained person or to members of the public when they were each sharing the same space. Hearing sounds of pain from persons with injuries who are experiencing an acute physical health crisis can be just as traumatic to anxious, detained persons as seeing levels of MD that require police intervention can be to persons who are physically unwell.

Four officers recognised that healthcare staff were extremely busy in their roles and that they were clearly frustrated by the number of persons brought to A&E suffering MD. For one AWE, frustrated comments about their MD contributed to their distress:

> 'I've had leg restraints on and handcuffs to the back and I've had coppers sit on me for about 4 hours in A&E where everybody else could see me. On top of that, you have got the nurses going "this is an A&E department, not a police station" and shit like that, making comments like that. I've kicked off before in A&E and they have gone "this is A&E, not a prison" to a police officer, and it was horrible.' (AWE4)

Such comments as heard by AWE4 suggest that persons under police control are viewed by healthcare staff as criminals rather than noting MD as the source of the distress.

There was frustration from police participants that the care of persons in ongoing distress was left to them. PO2 spoke of finding food and drink for persons under their control as there had been no acknowledgement from healthcare staff that this would be required. Another officer (PO3) found an unused resuscitation room that, whilst full of equipment, was preferrable to a communal area for a neurodiverse CYP who was at risk of being overwhelmed.

Aside from the comfort of detained persons, participants spoke of situations of enduring distress where police officers were unsupported by healthcare staff within general rather than psychiatric care settings. As an MH assessment was not available until the following morning, PO7 and police colleagues spent a night managing a CYP on a children's ward, where they had been transferred as an alternative to being in A&E. Whilst restraints were removed whenever possible, handcuffs, leg restraints and spit hoods were repeatedly applied to safely manage the distressed CYP. PO7 reported feeling very uncomfortable with the situation and felt that the CYP was not getting the care that they required. On enquiring what healthcare staff did to assist the CYP in their enduring distress, I was told:

> 'They will come and do their [observations] as they are obliged to do, but we are left to deal with it while they concentrate on the other children on the ward. We are a hindrance to them … I get it, I understand why. But we are left as police officers to manage that situation. There is very, very little medical intervention with any [S136 detention]. Once they are medically cleared and we are waiting for the assessment, there is zero medical intervention.' (PO7)

Another officer told me that they had previously advocated for persons within A&E departments. To prevent a person from biting themselves, officers had been restraining them for a prolonged period of time whilst they awaited the MH assessment. PO10 recognised the physical strain on the body caused by being forcibly restrained for many hours:

> 'We made representation to the medical staff to say "look, we cannot keep restraining [them]" because that puts [their] body under significant physical pressure. Whether or not [they were experiencing] excited delirium … physically restraining somebody puts significant physical strain on them. We were very conscious of that, so we had to ask for [them] to be helped.
>
> 'It gets to a point where you just cannot keep [restraining them]. It's not you as a bobby who can't do it, you just can't keep on physically restraining somebody. It's not fair; they get exhausted. We have to say … "you have to help them; this is not fair."' (PO10)

This section has provided some evidence of the reliance on police officers beyond the delivery of detained persons to the POS. S136 suites are unable to provide care to persons whose MD causes ongoing risk and there is no provision within A&E that would enable police to withdraw. Aside from MH legislation drawing on the police to intervene when there is an immediate risk in a public space, there is an ongoing reliance upon police officers. Where the place of safety is A&E, there is a

requirement for police to take on a caring and advocacy role in the absence of available healthcare, as well as their policing supervisory and control role.

Furthermore, this section has reiterated A&E as a 'wholly inappropriate' environment in which to contain detained, distressed persons whilst they await an MH assessment. Whether passive to the presence of officers or actively resisting detention, persons are under the gaze of members of the public and all involved parties can be traumatised by the situation.

Police participants have again shown compassion and care towards detained persons. They ensure that basic human rights to food and drink are upheld and attempt to find appropriate shelter in which to manage situations of MD comfortably and safely, even if that is using police vehicles. Despite being left to manage detained persons with no medical intervention, there is evidence that officers understand the dangers of prolonged restraint and advocate for detained persons by requesting medical assistance.

Use of Policing Practices and Restraint

The previous section has evidenced that practices such as control and restraint, which are more commonly associated with policing than healthcare, are used during S136 detentions. Even if the person does not experience the use of physical restraint or police vehicle transportation, the fact that they are under the supervision and control of detaining police officers means that they have significant interactions with attending officers and so experience policing practices. UK police officers are not routinely armed and, as of September 2019, less than 20% carry tasers (NPCC, 2020). As such, UK policing practices have relied upon secure de-escalation skills which, as far as possible, rely upon advanced communication skills. One officer (PO6) shared that they had received training on how to talk to persons in distress and how to approach them, not as criminals, but as vulnerable persons in need of care. Two AWEs who had experience of more than one detention recounted detentions where they felt ill-informed about proceedings. During AWE1's first detention, there was minimal conversation with attending officers who invoked S136 and placed AWE1 in handcuffs without speaking to them at all. Officers then spoke amongst themselves and AWE1 was only aware of what was happening from overheard conversations. The authoritarian perception of police, together with the disempowering consequences of having liberty removed to then be compounded by the disrespect of poor communication, is understandably traumatising for persons already experiencing MD.

Aside from these experiences, the qualitative data contain many examples, from both police and AWEs, where officers have conversed with detained persons in positive ways; for example, AWE2 highly praised the officers who attended to them. Four police participants shared how they attempt to converse with detained persons. PO2 stressed how they always introduce themselves to detained persons and explain the detention process and progress. From AWE4's experience, the officers were speaking generally to help pass the time:

> 'At the hospital the police were just talking to me about the gym and stuff.' (AWE4)

Nevertheless, some detained people are unable or unwilling to converse with officers and some levels of distress cause fear of the attending officers:

> 'No matter how we try to reassure them, in their distressed state they might not have the capacity to be able to understand that they are not in trouble.' (PO6)

It is a reality that the worse the level of distress, the greater the need for police to rely upon other police practices, such as restraint, to manage the situation as safely as possible for all concerned. Where MD presents as psychosis, where disordered thought alters the perception of reality, restraint intensifies distress, thereby creating a perpetual cycle of worsening distress necessitating increased restraint. During police intervention with persons experiencing persecutory delusions, PO1 acknowledges that visible police 'tools' exacerbate the situation:

> 'If you have someone who is suffering from hallucinations, who is thinking that the authorities are after people, then us turning up with tasers and batons is not an ideal thing. But unfortunately, that's the way it is at the moment.' (PO1)

As there are several testimonies within this work regarding cycles of extreme distress, PO1 is correct in their summary of the current approach to care for persons experiencing these extreme forms of MD.

Returning to Table 25, I performed a tabulation on mentions of restraint and the first POS to which detained persons are taken. Results of this tabulation can be seen in Table 26.

Table 26. Methods of restraint and first POS.

	A&E	S136 Suite	Police Custody	Total
Any Restraint Method	99 79.84%	23 18.55%	3 1.61%	**124** **100%**
Handcuffs	52 80.00%	11 16.92%	2 3.08%	**65** **100%**
Limb Restraints	11 84.62%	2 27.29%	0 0%	**13** **100%**
Headguard	6 75.00%	1 12.50%	1 12.50%	**8** **100%**

Note: Frequency and row percentage given.

It is clear from Table 25 that most mentions of restraint are regarding detained persons in A&E departments, thereby intersecting with the previous section of this chapter.

Where mentioned, almost 80% of police control methods, 80% of handcuff uses, almost 85% of limb restraint uses and 75% of headguard uses occur within A&E departments. Headguards were mentioned several times by police participants for severely distressed, restrained detainees, including CYP. They protect officers from persons spitting but they are also used to minimise the damage caused through biting. The qualitative data include several accounts of officers attempting to prevent further severe self-harm through distressed persons biting themselves.

Whilst neither are recorded as having been used on many occasions, the use of incapacitant sprays is recorded less frequently than the use of tasers (0.57%; n=24 vs 0.33%; n=14 (Table 25)). A person must be medically assessed after being tasered (CoP, 2021), thereby increasing the likelihood of it being mentioned. Nevertheless, the fact that these incapacitants were used is not in doubt and this evidences that persons experiencing MD can be subjected to the full range of standard policing practices. Indeed, AWE4 disclosed that they had experienced 'pepper spray' and had a taser drawn on them during an episode of MD.

The use of incapacitant spray in situations of MD was not mentioned by police participants other than it being listed as a police practice which ought to be documented in case of future investigation into an incident. Closer analysis of free-text variables reveals that PAVA spray was used because of resistance to restraint, aggression, active attack on police officers or because of risk posed by threats to self and others with a sharp/bladed weapon. Police guidance on the use of incapacitant spray approves its use as a temporary incapacitant in order for the officer to gain control when 'faced with violence or the threat of violence' (NPCC, 2012, p. 8). The guidance recommends that when attending a situation of MD and where the situation allows, MH professionals or family members or friends ought to be consulted on alternative de-escalation techniques which might work; nevertheless, the

decision to use an incapacitant spray belongs to the officer, who must be able to justify this use of force.

One participant (PO8) identified themselves as being 'taser trained'. When asked about this, they said that they had never actually discharged the taser; the threat of its visible presence or appearance of the red dots as the taser is aimed has always been intimidating enough for the person to desist in whatever risk they are threatening or engaging in. PO8 is aware of the power of the visibility of the yellow taser on their uniform:

> 'It isn't always the best way, and it could make them worse. But at the same time in the back of your mind is that you have to keep them safe and to keep you [as a police officer] safe.' (PO8)

Free text in the dataset for detentions where tasers had been discharged evidence that each occasion concerned a sharp weapon which was either being used to actively self-harm or as an advancing threat towards detaining officers.

The variable 'Restraint Methods Used' includes physical or mechanical control and captures any mention of words derived from 'restraint' or reference to incapacitants or mechanical restraint. Mention of restraint methods used applied to 2.84% (n=119) of all detentions. I tabulated to compare mention of the use of restraint methods in A&E and S136 suites as the initial POS. Police custody data were not included owing to the problem of the reliability of this data, which was noted in the previous chapter. The results, displayed in Table 27, show greater mention of police restraint methods where A&E is the initial POS rather than an S136 suite, which is statistically significant (2.19% vs 1.77%; p=0.003). This pattern of increased mention of restraint methods exists for adult detentions (1.96% vs 1.61%; p=0.013) and CYP detentions (5.02% vs 4.11%; p=0.177), although the sample under analysis regarding CYP is small.

Table 27. Tabulation of first POS and mention of restraint methods for all detentions, adults and CYP.

	All Detentions (n=4,144)			**Adults (n=3,850)**			**CYP (n=294)**		
	Restraint = No	Restraint = Yes	**Total**	Restraint = No	Restraint = Yes	**Total**	Restraint = No	Restraint = Yes	**Total**
First POS = A&E	2,858 97.81%	64 2.19%	**2,922** **100%**	2,650 98.04%	53 1.96%	**2,703** **100%**	208 94.98%	11 5.02%	**219** **100%**
First POS = S136 Suite	1,111 98.23%	20 1.77%	**1,131** **100%**	1,041 98.39%	17 1.61%	**1,058** **100%**	70 95.89%	<5 4.11%	**73** **100%**

Note: Frequency and row percentage given.

Whilst there was no statistically significant difference in the mention of restraint practices for CYP in A&E compared with S136 suites, there is greater increase in the mention of restraint practices for CYP detentions than adult detentions (Table 25), and this is statistically significant ($\chi2=30.71$; $p=<0.001$) as determined by a chi-squared test shown in Table 28.

Table 28. Mention of control methods used by adult and CYP detentions.

	Restraint Method = No	Restraint Method = Yes	Total
Adult	3,808	103	3,911
	97.37%	2.63%	100%
CYP	275	25	300
	91.67%	8.33%	100%
Total	**62**	**93**	**4,211**
	96.96%	**3.04%**	**100%**

Notes: Frequencies and percentages given; $\chi2=30.7124$; $p=0.000$.

Cross tabulations were applied to explore gender difference in the use of restraint methods for all detentions, and then adult and CYP detentions. The results can be seen in Table 29, which shows that mention of restraint methods occurs more in males than females (64.15% vs 35.85%), although again a difference is seen in adult detentions compared with CYP detentions. For adult detentions, more male than female detentions mention the use of restraint methods (70.93% vs 29.07%), whereas for CYP detentions, bearing in mind the small numbers under examination here, more female than male detentions mention restraint methods (65% vs 35%). A chi-squared test reveals that detentions of female CYP are more likely to mention the use of police control methods than any other group, a difference which is statistically significant ($\chi2=9.10$; $p=0.003$ (Fisher's exact $p=0.004$)). It could be that the use of police restraint methods used on a CYP in MD, especially a female CYP, is considered emotive and therefore is more noteworthy than the use of restraint methods on an adult or a male CYP. Likewise, the use of restraint on adult males could be noted by way of emphasising a perceived dangerousness of adult males and this being greater when combined with MD.

Table 29. Police restraint methods used by gender and adults and CYP.

	Adults	CYP	Total
Male	61	7	68
	89.71%	10.29%	100%
	70.93%	35.00%	64.15%
Female	25	13	38
	65.79%	34.21%	100%
	29.07%	65.00%	35.85%
Total	86	20	106
	81.13%	18.87%	100%
	100%	100%	100%

Notes: Frequency row percentage and column percentage given; $\chi 2=9.1088$; $p=0.003$.

'Restraint Methods Used' was disaggregated to reveal mentions of multiple forms of restraint used on the same persons. With several cell count below five, these cannot be expanded upon to protect anonymity. However, almost one quarter (24.63%; n=17) of detentions which mention the use of handcuffs also mention at least one other form of restraint listed in Table 25. Having the highest percentage of all restraint methods listed (1.64%), handcuffs were mentioned in 57.98% (n=69) of occasions when control methods were used.

As alluded to earlier in the chapter, the quantitative data here do not align with the qualitative data. Whilst police participants report differing levels of handcuff usage for S136 detentions, even the more cautious estimates of between 5 and 10% of cases (PO12) far exceed the usage evidenced within the dataset. Several police participants told me that handcuffs are used 'quite often' (for example, PO3), and two of the five AWE participants had experience of being handcuffed during S136 detention/s, with AWE4, who has experienced multiple detentions, estimating that 8 out of 10 of their detention experiences involved handcuffs. A third AWE told me:

> 'I had been perfectly calm and compliant, but [the officer] did say along the lines of "all the while that you are calm, then we won't put the handcuffs on". When I thought about that later I thought "ok, so you have threatened me with handcuffs". In fact, that would have been an awful thing if they had done that to me as I was quite stressed anyway. It is those subtle [kind] of things that have an impact.' (AWE3)

Police participants recognised the escalating potential that handcuffs can have on someone who is already experiencing MD. Again, picking up on the concept of 'genuine' MD, PO5 offers insight into the dilemma:

> ‘Obviously we have handcuffs but for me personally, for people who are genuinely in a mental health crisis, force is the worst thing you can use on them because there are consequences for them. But there are risks if you’ve got someone who is trying to hit you or assault the nurses or try [to] get out the room and escape. You have to weigh it up; if saving their life outweighs the use of force.’ (PO5)

One officer, who operates in the one area of the county where it seems common to have only one officer in attendance with a detained person in A&E, commented that they personally use handcuffs ‘more often than not’ (PO3) owing to their small stature. Size, age, demeanour and perceived fitness level of persons being detained features in many police narratives regarding the use of handcuff restraint. Here, PO8 gives an overview of their risk assessment when weighing the use of handcuffs:

> ‘In A&E, where I have spent many an hour, it depends how much of a risk they are if they got away; how much of a risk they are to themselves or other people. Do [I] reckon [I] could catch them? If it’s an old bloke who’s sat there, I might be able to catch him. If it’s a young lad in his Nike Air Max then there is no way I’m going to be able to catch [him]. And the circumstances when they were brought in: Were they aggressive and violent to the bobbies who detained them? I would think about that.’ (PO8)

Whilst used less frequently than handcuffs, there are nonetheless 13 mentions of the use of limb restraints. Two of the five AWE participants reported experience of the use of limb restraints: AWE1 was in a public space, where they were videoed by a member of the public, and AWE4 experienced this form of restraint in an A&E department. Where police participants mentioned the use of limb restraints, both incidences were outside of S136 suites: PO7’s experience of restraining a CYP overnight on a children’s ward has already been mentioned; here, PO6 also explains uses of limb restraints within an A&E department:

> ‘When you have got someone who is hostile and aggressive, there are some times when we have to restrain that person. It’s got to the point where we have had to use limb restraints before and we are doing that in the middle of a busy A&E environment, where you have got people who are unwell. It’s not suitable or practicable.’ (PO6)

This section has evidenced that the full arsenal of policing practice is used during S136 detentions within the data. AWE participants shared some negative experiences of policing communication, and this served to increase MD and feelings of disempowerment. Nevertheless, without meaning to diminish the personal traumatic experience of such incidences, there were many positive encounters

with police which brought comfort and helped to pass the time whilst awaiting MH assessment. Police officers are aware that persons in MD require an approach which recognises their vulnerability; however, the requirement to prevent harm appears to often necessitate the use of force. This is particularly evident in A&E departments, a POS which previous chapters have evidenced as being over-used owing to a lack of available alternatives where persons would be under the care of healthcare staff.

A noteworthy finding here is that persons who experience more severe forms of MD are those who are more likely to experience police restraint methods and incapacitant tools. Furthermore, people who are detained in A&E are more likely to experience these forceful policing practices since the incidence must be contained within the busy and open department. For members of the public, witnessing forceful policing practice is potentially traumatising to them, as well as it being highly inappropriate for the detained person's distress to be viewed by others.

Chapter Summary

This chapter has explored qualitative and quantitative data on the process of S136 detentions and the policing practices which are used.

Despite the expanding role of the police, officers are still viewed by law-abiding people as an authority to be respected and obeyed. People seen to be under police control, especially where restraint is used, illicit speculation of criminal wrongdoings by members of the public. Furthermore, people who experience MD who are approached by police officers are understandably fearful.

Conversely, a lack of confidence in crisis care access lines causes persons who are vulnerable to distress to be drawn towards police officers for care and compassion. Although there is evidence that this is not always the case, officers appear to be effective communicators, and this serves to alleviate MD and brings comfort to persons who are able to understand their situation. As victims of their own successes, police officers' compassion towards those people experiencing MD increases the demand on police officers to assist with MD.

Not all people experiencing MD are able to comprehend their situation or position themselves within other people's reality; this is especially the case for persons who experience a psychotic episode. People who experience persecutory delusions appear to be those who are most likely to experience forceful policing practices as their fear increases their attempts to escape from detention.

There is a reliance upon police officers to remain with detained persons when they arrive at the POS. A lack of staff and an absence of healthcare staff trained in restraint practices to ensure the safety of distressed persons under their care means that there is a reliance upon police within MH care settings. Additionally, A&E as a POS is highly reliant on police presence. This chapter has evidenced multiple situations of MD within A&E departments, where police officers must use prolonged restraint practices to ensure the safety of distressed persons and other people. Officers are frustrated by the apparent lack of medical care and sometimes have to request medical intervention to alleviate distress that requires prolonged restraint which is known to have adverse physical health implications.

In their role in law enforcement, police officers are trained in an array of practices with which to manage incidences safely. Where communication alone cannot mitigate risk to the detained person or other people or where there is a risk of the detained person absconding from detention, alternative policing practices are used. This chapter has evidenced that all restraint and incapacitants carried by police constables are used in S136 detentions.

How CYP are managed by police is no different to how adults are managed for it is risk that triggers escalation in policing practices. There is evidence that CYP experience the whole arsenal of police restraint methods in the same way as adults do. Whilst the dataset suggests that CYP experience proportionately more restraint and control practices than adults, this does not align with qualitative data.

Police officers are sensitive to the plight of those who they forcible detain. They understand the fear and recognise that the detained person is not getting the treatment that they require and deserve but the absence of alternative detention processes necessitate their ongoing presence and intervention.

Connotations of criminality, and thus criminalisation, occur from the point of detention in a public space and throughout the detention process. This is particularly the case where caged police vans are used to transport detained persons as well as where A&E is used as a POS as persons under police control and restraint are visible to members of the public. Where persons in MD are within sight of members of the public, this can have longer-term connotations of criminality. Officers have expressed concern that persons under their control will see people who they know or will later be recognised by people who witnessed their distress in an A&E department. An alarming finding within this chapter is the use of smartphones, which have been used to video distressed persons under police control. The contemporary use of social media sites on which to share smartphone video recordings creates an additional level of concern regarding criminalisation for, as mentioned earlier, it is the perception of

persons rather than actual law breaking which creates the notion of criminalisation. In this research, there was no evidence that police officers appreciate the seriousness of this contemporary problem.

Chapter 7: Conclusion

As each finding was discussed throughout the previous three chapters, this final chapter will firstly return to the three substantive research questions. Taking each in turn, here I use evidence laid out in the three previous chapters to respond to the questions established at the outset of this work and I contextualise them within the wider available research.

Secondly, I present the strengths of this work and how it contributes to the broader understanding of S136 detentions and associated policing practices, as well as my contributions to the understanding of MD through a criminalising lens. After this, I acknowledge the limitations of my research.

Based upon the findings of this work, I move on to make recommendations of how policing and healthcare professionals can adapt their practice and procedures to improve the experience of detention and, hopefully, reduce the number of S136 detentions. There are inevitably policy implications here and the need for a clearer understanding of the role of the police in S136 detentions; these are included after recommendations to the professionals who are involved in the detention process.

In the writing of this work, I have discovered several areas which deserve further research, and these are presented in the penultimate section.

Finally, I close this chapter and thesis with concluding comments.

Responses to Research Questions

Throughout the previous three chapters I have summarised the findings from this research and the analyses. The findings are not repeated here; instead, taking each question in turn, I respond to the three research questions presented at the outset of this work, which sought to understand S136 processes in light of the 2017 amendments.

Question One: Within contemporary policy and approaches to mental health, what is the nature of police involvement in the urgent care of persons who are mentally distressed?

In line with existing literature, I have shown an ongoing reliance on police to intervene and assist persons who are experiencing MD in community spaces. Whereas some of the earlier research suggests that police officers object to this aspect of their role (for example, Magenau and Hunt, 1996), my police participants saw assisting people in acute MD as very much their responsibility. Officers

voiced care and compassion and advocated to medical staff on behalf of persons in MD. What officers did object to is the ongoing reliance of the NHS on officers to remain with persons until they have an MH assessment; they were frustrated at the lack of facilities and resources to care for persons in MD. This is particularly true of persons who are detained multiple times, where there is a clear lack of effective, person-centred support in place to reduce episodes of MD which require police intervention.

An important addition to previous research that I have shown is the unacceptable time that detained persons remain under police supervision and control after they have arrived at the POS. Legislation requires police to deliver persons thought to be in MD to a POS, not continue the ongoing care of people after they arrive at the POS. As predicted by the CQC, the use of A&E has risen and now stands as the dominant POS for both adults and CYP. Of note is that at this POS, police officers are left to manage MD in both adults and CYP with minimal input from medical staff. In A&E departments and on general wards, *id est*, those wards which are for physical health rather than MH concerns, the management and care of detainees is viewed by healthcare staff as a police role. This is particularly important and noteworthy when persons remain in distress which requires ongoing restraint by police officers, for such situations have been linked to death through hyperthermia, metabolic acidosis and exhausted cardiovascular systems (Takeuchi et al., 2011). Situations of extreme distress where a person continues to resist restraint are viewed as medical emergencies (Royal College of Emergency Medicine, 2019), and thus there is a clear requirement for medical management and care from MH professionals rather than police officers.

Many detentions result in discharge and some of these people leave hospital with no follow-up care provision in place. This research has established an increased chance of repeated S136 detention in people who are discharged after a bed request had been made but where no bed was available; this increased likelihood is statistically significant and evidences that a lack of NHS bed resources increases police involvement in the urgent care of persons in MD. The lack of MH beds is an ongoing result of deinstitutionalisation policy and the desire for MH provision to be provided within the community (Tyrer and Johnson, 2011). There is a clear failure of this policy to meet the needs of distressed persons and yet the policy of reducing MH beds persists despite professional calls for its review (Goh, 2017; McCartney, 2016; Tyrer et al., 2017; Tyrer and Johnson, 2011).

Police officers felt that the NHS relies upon them to plug the gaps within health and social care services. I found frustration among both police officers and AWEs of multiple detentions regarding a lack of suitable provision when persons are vulnerable to repeated detentions. Targeted care provision which meets specific individual needs and which does not exclude those who have become

alcohol or substance dependent is seen by officers as important and has been shown, in the case of AWE4, as effective in reducing MD which results in police intervention.

With no AWE speaking positively about NHS crisis team support services, some saw the police as an important source of support for situations of MD, whereas others were surprised at police involvement in their MD. Some AWEs spoke of experiences of police interactions where they felt humiliated by officers, where they were not protected from the public gaze and where they felt criminalised. Nevertheless, each AWE did have some positive experiences of police intervention, with two participants claiming that the care shown to them by detaining officers exceeded that offered by A&E staff; this is to be discussed further in the 'Recommendations' section of this work.

In summary, the lack of suitable resources, including effective social and crisis care support, secure POS, staff and MH beds means that the reliance on police to assist in situations of MD is firmly embedded into the care provision for persons vulnerable to MD. However, police officers remain as authority figures who uphold the law and bring persons before the criminal justice system and therefore persons seen to be under the supervision and control of police officers are perceived by members of the public as being criminal, thereby criminalising the detained person, and detention practices which are akin to the management of persons who have committed a crime are experienced as criminalising.

Question Two: Are there differences in the urgent care of mentally distressed CYP compared with adults?

Whilst CYP comprise only 7% of all detentions within this administrative dataset, analysis has shown that, on average, their S136 journey is more complex than that of adults. CYP are proportionally more likely to experience multiple detentions than adults, have less access to OOH assessments and the youngest detainees do not access S136 suites, thereby evidencing that CYP OOH provision is not equal to that afforded to adults as was recommended by Healthcare Safety Investigation Branch in 2018 (HSIB, 2018).

No CYP was taken directly to an S136 suite; none of the youngest CYP, and less than 4% of those in the mid age range of CYP were transferred to an S136 suite. These findings mean that most CYP had A&E as their only POS, although small indeterminate numbers were transferred to general paediatric wards, where they remained under police supervision and control.

Officers with experience of how poor OOH provision is for CYP make attempts to avoid S136 detention; this includes placing CYP back into the care of adults responsible for their safety. In the case of looked-

after CYP, who are overrepresented within the data, this means that there is a chance of criminal charges should their level of MD subsequently result in damage to property or assault of care staff.

In summary, despite insufficient NHS provision to enable adults who are detained under S136 to be cared for by medical staff rather than police officers, urgent MH provision for CYP is worse. This is particularly the case within several areas of the country where the governing CCGs have not funded OOH provision and rely on police intervention for the care of CYP experiencing an episode of MD. As there are similarities in experiences here to the findings of previous writings on the use of police cells as a POS (Bendelow et al., 2019b; Cole, 2008; Docking, 2009; Her Majesty's Inspectorate of Constabulary et al., 2013), it can be considered that this process is both seen by others and experienced by detained persons as criminalising.

Question Three: Are policing practices and police involvement with mentally distressed persons seen and experienced as criminalising?

This work has evidenced that police involvement with situations of MD is perceived by police and members of the public and experienced by detained persons as criminalising.

Early writing on the criminalisation of MD centred on the increase on persons vulnerable to MD entering the criminal justice system post deinstitutionalisation (Engel and Silver, 2001; Teplin, 1983; Teplin and Pruett, 1992). The most recent writing on the criminalisation of MD was in response to the use of police cells as a POS and how this was perceived as being criminalising (Bendelow et al., 2019b; Cole, 2008; Docking, 2009; Her Majesty's Inspectorate of Constabulary et al., 2013), particularly for CYP owing to a lack of suitable emergency provision. This practice has all but ceased since the 2017 amendments; nevertheless, gaps in urgent care provision, for adults and especially CYP, has merely moved the previously viewed criminalising practices from within police cells to public A&E departments.

Advancing the work of previous scholars, this work has shown that detained persons feel criminalised owing to being in the presence of police officers. The power of the uniform remains as an indicator of the authority held by the police and of their role as law enforcement officers. The use of police vehicles and restraint practices reinforces this role, no matter how compassionately and empathetic officers' approaches are to the person in MD. Indeed, police officers also recognise that the practices involved in S136 detentions are seen and experienced as criminalising. Officers voiced concern at the public visibility of MD within A&E departments and the adversarial approach they have had to take,

particularly with ongoing extreme distress in adults and where young CYP have required repeated restraint techniques over prolonged periods of time whilst within hospital settings.

Of note, and something which has not been researched to date, are the disturbing instances of the use of smartphones to record incidences of MD where persons are under the control of police officers. The fact that such recordings could be posted on social media is problematic; indeed, the recent case of police officers sharing images on social media of themselves at a murder scene illustrates the serious impact that such actions can have on victims, their families and wider society (Lucraft, 2021). Police participants did not verbally acknowledge the impact that the recording of situations of MD can have on detained people.

In summary, police involvement in MD is seen by others and experienced by detainees as criminalising.

Strengths and Limitations

Firstly, whilst the many findings presented in the previous three chapters evidence the value of this work to the understanding of current S136 process and the impact that SRP had on this, this section highlights a unique aspect of this research: the analysis of S136 detentions of CYP. There follows an overview of the strengths of the methodological approach. Finally, this section discusses the limitations of this research.

Strengths

What has been unique about this work is its exploration of S136 detentions of CYP. I have exposed the current lack of urgent MH care provision and the experiences of CYP. The only previous research on CYP detentions (Eswaravel and O'Brien, 2018; Patil et al., 2013) was conducted within MH assessment units before the 2017 legislative changes. No research has been performed to understand the experienced of CYP since legislation prevented the use of police custody suites as a POS, and even before then, in published material CYP received only a passing mention; usually just a note regarding how many detentions there were of persons below a certain age (for example, Docking, 2009). It was known that custody suites were used due to a lack of NHS urgent MH care provision for CYP (Docking, 2009; Her Majesty's Inspectorate of Constabulary et al., 2013) but there has been no research to understand the contemporary situation. Maybe it is owing to the seemingly small number of cases or the perceived ethical obstacles which must be overcome to research this vulnerable community; obstacles which have prevented previous research. However, owing to their existence within the

administrative dataset and an additional level of permission granted by the IRAS for me to analyse these data, this research has exposed the deleterious impact that the lack of urgent MH service provision is having on CYP.

Of importance is the contribution to theory that this thesis has made. The fact that the criminal model is gaining a dominant position in the response to acute MD within England and Wales is valuable to scholarly understanding in this area. Consideration that the response to MD is criminalising has been absent since the 2017 legislative changes ceased the use of police cells as a POS. This work has established that police detentions under the MHA continue to be criminalising through the overreliance of health services on the police and the application of police practices to people in MD. This work gives important weight to broader theorisation of responses to MD and the (in)appropriateness of the use of police officers to meet the shortfall in more appropriate support services.

In addition, this research has offered insight into police officers as carers. The changing role of officers is noted within existing research (Boulton et al., 2017; Millie, 2013; Millie and Bullock, 2013) but police as carers in society is not explored elsewhere. This view of police officers is juxtaposed to the contemporary rhetoric of police culture in regard to racism (MacPherson, 1999; Rowe, 2004) and misogyny (IOPC, 2019; Police Professional, 2021).

The mixed-methods nature of this research enabled the triangulated approach, advocated by Denzin (2012) and Fusch et al. (2018), to understand the processes connected to S136 detentions and, importantly, how these are experienced by detained persons. Previous mixed-methods research on S136 detentions (for example, Bendelow et al., 2019b) did not use such a large dataset and often concentrated on a single aspect of adult detentions; for example, adults who experience repeated detention (Warrington, 2019).

The administrative dataset that was used was, at the time of its creation, probably one of the best and most comprehensive accounts of S136 detentions in one geographical location[23]. Prior to this, the auditing of S136 detentions was largely based on returned S136 Monitoring Forms (as discussed in Chapter 3) or on NHS or policing data, which rarely matched up. The dataset which I have used captures all persons detained under S136 throughout the study period and contains data provided by detaining police officers, date and time stamps for each part of the detention process and the outcome

[23] It is acknowledged within the Home Office monitoring of S136 detentions that the Constabulary's data could not be compared with their previous years' as the way in which data are now recorded is so superior that it invalidates comparison (Home Office, 2019).

of the detention. This dataset illuminates the details of over 4,000 detentions and thus has acted as a rich source of data for this project.

How the S136 detention process is experienced by AWEs and how police officers perceive detentions to be experienced by those who are detained and viewed by bystanders has been essential to understanding whether or not police involvement is criminalising MD. These narratives have enriched this work; they have given human voice to the quantitative data and together have uncovered concerning observations on contemporary S136 detentions and the management of people requiring urgent access to MH services.

The impact from this work has broad potential. I have already submitted data regarding the detention of looked-after CYP to a government call for evidence regarding the criminalisation of CYP within children's homes (Erlam, 2021) (Appendix 3). Furthermore, I contributed to a report by the Northern Health Science Alliance and N8 Research Partnership regarding the impact of COVID-19 on Northern children (Broadhurst et al., 2021). Within this report I presented a summary of my quantitative and qualitative data regarding the rise in S136 detentions of CYP during SRP and the lack of OOH urgent MH provision for CYP. I am preparing a manuscript for publication regarding S136 detentions of CYP with the aim of highlighting my findings in this alarmingly under-researched and under-reported area. There are a number of other research articles to come from this work; for example, the psychological impact that S136 detentions have on detaining police officers, the overuse of A&E departments as a POS and the associated criminalisation of MD, and the impact that bed shortages have on the S136 detention process.

Limitations

As with all research, there are several limitations to this study.

Firstly, regarding the quantitative data, data only exists for incidences where police made the decision to detain persons. I could not analyse data regarding where decisions were made not to detain a person and the outcomes and associated experiences of such decisions. Had the available data included situations of MD where alternative solutions to S136 detention were found, this would have enabled comparison of these outcomes with S136 detentions and could have informed future policing practice.

The administrative dataset exists as an excellent account of S136 detentions in the geographical area of study and, as it was newly created following legislative changes in December 2017, it has evolved over the duration of the research. This means that newer and valuable variables have many

occurrences of missingness; for example, gender was not recorded until after I first accessed the data via the regional police headquarters in December 2018, at which time I recommended that it ought to be added to enable important analysis. Gender as a variable now exists but only as a binary, thereby erasing the detention experiences of nonbinary and transgendered persons. It is known that there are many detentions attributed to MD caused by gender identity or gender transition as there are several mentions of this within the free-text variables; to only record gender as a binary erases the experiences of persons of this marginalised group who are overrepresented in suicide figures (Bailey et al., 2014).

Further on the quantitative data, there is no record of ethnicity. As discussed earlier in this work, research exists evidencing that BAME people are overrepresented in S136 detentions. Representation within research, especially that which explores the use of police powers and access to services such as this work does, is important, and yet I was unable to conduct analysis of this. Had these data been available, I could have drawn some conclusions regarding systematic bias regarding access to MH services and/or policing practices; this would have been particularly useful with data regarding the decision to detain or opt for an alternative solution in situations of MD.

I noted many errors in the administrative dataset. Whilst cleaning and coding of data enabled the preservation of data which would otherwise have been lost, there were data which could not be analysed and many of these pertained to the duration of detentions. Further inaccuracies pertained to the number of people recorded as having ended their detention within police custody suites, which I uncovered as being inaccurate following consultation with the MH lead for the Constabulary. Whilst inaccuracies do call into question the precision of other variables, throughout the findings chapters in this thesis I offer my opinion regarding the accuracy and limitations of findings. Where there has been any doubt, I opted for a downward bias.

Finally on the administrative dataset, I was unable to establish the application of 12-hour extensions as no variable exists regarding this and thus this stands as a recommendation for change in the future. To enable analysis on the duration of detentions, I was forced to assume that 12-hour extensions were applied and, as previously noted, this is a generous assumption to make. The lack of data and my decision here inevitably erased incidences of breaches in the duration of detentions, including detentions of CYP and particularly where the POS remained as an A&E department to which MH staff and AMHPs must travel in order to conduct MH assessments. This decision most likely introduced a downward bias in my findings regarding breaches of legislation.

Through pragmatic necessity I had to make a decision regarding the maximum age where I would consider a detained person to be categorised as a CYP. As explained in Chapter 4, the determinates regarding childhood and adulthood are arbitrary and largely specific to each situation. To this end, in Chapter 4 I justify my reasons regarding the inclusion of 18-year-olds as CYP. Had I chosen a different upper age, the proportion of detained persons would, of course, differ. I tried to mitigate the impact of this decision by, where necessary, analysing CYP detentions as smaller age groups to compare the experience of those who are below 15 years of age and those aged 16 to 18 years inclusive, who the NHS view as able to access adult services.

Further regarding pragmatic necessity, in order to understand the impact of SRP I had to establish a date for its commencement. I established 16 March 2020, the day that the Prime Minister instructed people to stay at home (GOV.UK, 2020c); however, findings that I attributed to SRP could be viewed as arbitrary. It is likely that the effects of the pandemic that many persons previously unaffected by episodes of MD have experienced were already being felt by persons who are vulnerable to MD prior to SRP. Equally, there is no evidence to suggest that detentions during SRP were directly linked to the COVID-19 pandemic, nor that occurrences such as the rise in adult detentions in the final two months of the data were a sign of a return to pre-SRP levels of detention. Nevertheless, measuring social response to a pandemic has been an interesting exercise and it would have been amiss of me to not explore it in this work.

Further regarding the pandemic, the added workload that it placed upon health and social care staff caused me to redact the initial plans to recruit participants from these professions from my IRAS application. I gathered data from police and AWEs as well as from a comprehensive NHS administrative dataset, but the voice of health and social care representatives is absent. It is possible that, despite my social work registration and previous nursing career, I may be incorrect in my interpretation of processes within these systems. Where I felt that secure understanding was crucial to analysis, I was able to seek advice from a member of the Trust's senior management team; nevertheless, I wholeheartedly apologise if I have misrepresented the Trust and social care provision in this work.

The final comments on the limitations of this research relate to selection and social desirability bias and the strength of my qualitative findings. My recruitment methods, particularly the call for police participants which invited participants from all fields of policing work rather than target officers with additional MH training, ensured that all police officers had an equal opportunity to participate in this research; indeed, officers of all ranks throughout the region participated. Nevertheless, I could not avoid selection bias as the officers who approached me to participate had opinions about S136

detentions which were so strong that they were willing to give up their free time to participate. A short survey method could have extended reach and might have elicited alternative perspectives, allowing for the different forms of data that such an alternative research method would provide.

For AWEs, participants were sourced from a number of routes, as explained within Chapter 3, and I was reliant upon their generosity to contact me and agree to participate in my research. For two participants, their reason to contact me was made clear from the outset of the interviews; one participant wanted to lavishly praise police for the care shown during their detention and, for a second participant, their aim was to heavily criticise police for their harsh handling of the situation, which caused additional distress to the person. Whilst the first participant had only experienced one detention, the second participant had experience of two detentions and their testimony regarding the second detention juxtaposed the previous detention, going someway to mitigate bias. As with the recruitment of police participants, there is an inevitable selection bias here as these AWEs felt sufficiently strongly about their experience. The pandemic impacted on my ability to access a larger pool of AWE participants; nevertheless, and in addition to the aforesaid selection bias of AWEs, the narrative imparted gave this work a valuable insight into the personal experiences of S136 detainees.

Personal narratives are valuable data (Etherington, 2004; Pepper and Wildy, 2009) and whilst I accept that a person's experience and truth might not be shared with everyone, that in no way invalidates the narrative. I believe that the risk of social desirability bias was mitigated firstly by telephone interviewing, which, although forced by SRP, enabled a further layer of anonymity for the participants (including police participants) thereby permitting honest responses. Secondly, the narrative approach in the interviews enabled free speech with minimal input by myself; I spoke only to structure the narrative rather than ask direct questions and therefore reduced the chance of participants responding in a way that they felt that I wished (Etherington, 2004). There was only one interview with a police officer where I felt I was not receiving honest, heartfelt responses; their responses were short, factual and devoid of the richness of other police participant narratives. Consequently, whilst their data were coded, I have not included any of it in this work.

Reflection before, during and after each interview, as advocated by Etherington (2004), enabled flexibility and reflexivity in my approach, particularly when ensuring that AWEs were safeguarded in the sharing of their narratives. For example, on one occasion what I had intended as an utterance of supportive encouragement was met with an outpouring of similar examples on the same theme and thus, I felt my interjection was perceived as being encouragement to provide more, similar narrative. On that occasion I amended my verbal responses to avoid any further researcher interference with the narrative.

Finally on bias, I am aware that my approach was partial, particularly towards AWEs. I battled with the impact that this could have on my research for several weeks, which led to my writing of the epistemological positioning (located in Chapter 3) for this work. I make no apology here for partiality regarding access to appropriate, person-centred care and for the lawful application to legislation. At times I am aware that this could have implied a kinship towards police officers rather than to NHS and social care staff for it is the police who appear to be meeting the shortfall in NHS provision. I wholeheartedly accept that NHS and social care staff are usually not directly to blame for the shortfall in provisions but my frustrations on behalf of persons experiencing MD must stand as a limitation to this work.

Recommendations

This section firstly gives recommendations to policing practice. As police officers' practices are often constrained by the availability of health and social care resources, recommendations such as transportation of detained persons are covered in the second section, which outlines recommendations to health and social care organisations.

Policing

Police participants within this study have largely shown themselves to be sensitive, empathetic and caring towards persons experiencing MD, although, owing to the methodological limitations outlined above, I cannot surmise that this means that all police officers afford detained persons the same level of care. In line with their Code of Ethics (College of Policing, 2014), police officers must remain sensitive to the distress experienced by persons who find themselves under their care; indeed, the police officer role must be classed as that of 'carer' despite the legislative duty to maintain control of the detention. Officers must treat detained persons with respect and remain sensitive to the impact that their expressions, actions and interactions with fellow officers can have on the detained person.

For as long as the detained person is safe and poses no risk to others, whilst, of course, being aware of risk and with consideration to the NDM (CoP, 2014), officers must avoid the use and/or threat of handcuffs and other forms of restraint. Restraint is experienced as criminalising and negatively impacts on the level of MD. Avoiding restraint should particularly be the case for persons who are experiencing extreme forms of distress which is linked with disordered perceptions of reality. Restraint in such cases accelerates the level of distress and results in an increasing use of force that continues until there is medical intervention. There is evidence of this within this research but it is also shown in

the many coroners' reports (for example, Lynch, 2013; Whitting, 2021) into the deaths of persons following police restraint during an episode of MD.

To help evade such situations, there ought to be a strategic plan to move towards a well-defined police role to avoid the evolving reliance upon the police force to plug gaps in other services. Nevertheless, whilst there are frustrations regarding the ongoing reliance upon police once detained persons reach the POS, officers must not allow this hindrance to be evident to detained persons. AWE participants voiced their appreciation of police patience and the impression given that their distress was not an inconvenience to officers, and this must remain at the forefront of policing attitudes and approaches.

Police participants voiced that they advocated to NHS staff on behalf of detained persons; this must form part of every detention. Where the POS is an A&E department, access to private areas away from public gaze is paramount and must be demanded by officers. To give weight to their demands, officers should reference Article 3 of the HRA regarding the absolute right to freedom from degrading treatment. A policy of recording and reporting when this right is breached would support demands for change in urgent MH provision.

Health

The most pressing change which is needed from a health-based perspective is the management of the use of S136 suites. In 78% of instances where a suite is unavailable to newly detained persons it is because the suites are already occupied. Further analysis on the use of suites is required to establish if this is due to an insufficient number of suites or if suites are being misused due to bed unavailability.

The availability of acute MH beds is an additional priority that requires improvement. This work has shown a noteworthy number of occasions where persons who were assessed as requiring a bed were later discharged and this has been shown to increase the likelihood of future S136 detentions; this increase is statistically significant. Furthermore, the lack of available MH beds is the main reason for breaches in the lawful duration of detentions.

The transportation of persons in MD requires review. The current, almost standardised, use of police vehicles is unacceptable and against legislative guidelines. There should be a vehicle dedicated to the transportation of persons who are experiencing MD where they can be safely conveyed without the need for criminalising police vans.

Previously I have called for the increased availability of crisis care units that would be akin to A&E departments. In the absence of these, and until S136 suite management is improved, A&E staff must

receive training in the care of persons who present to their departments in MD. It is unacceptable that persons who present voluntarily to A&E seeking help with their MH experience negative remarks and attitudes, which have been presented both here and elsewhere (Riley et al., 2011; Wondemaghen, 2021). This research has heard, from both AWE and police participants, that if staff within A&E departments showed more care and compassion towards persons who are experiencing MD, persons would be more able to endure the wait for assessment rather than leave the department and subsequently be classed as a 'high-risk missing person' requiring a police response.

Whilst this work acknowledges some inaccuracy in the recording of the end of S136 detentions, it is clear that there are a number of occasions where people are being held under no legal framework and the lack of acute MH beds suggests that they are also being denied the healthcare which they require. These detentions are in breach of the HRA: Article 5 regarding unlawful detention and Article 3 regarding access to treatment and care which is neither humiliating nor degrading (European Court of Human Rights, 2018). The Trust is currently relying upon the grey area of legislation which gives the option for professionals to justify their unlawful practices on account of perceived risk and clinical need. This is fragile ground, and I would suggest that, given the numbers here, a case taken before the European Court of Human Rights would not be found in favour of the Trust.

The administrative dataset exists as an excellent and comprehensive record of S136 detentions within the geographical area of study; however, there are some changes which should be made to this to improve accuracy and inclusivity:

1. Gender ought to be expanded beyond the binary to avoid misgendering persons and to enable the MD of nonbinary and transgendered persons to be understood.
2. Ethnicity should be recorded to ensure the needs and experiences of BAME persons are visible and to ensure equality of access to services. There is already a requirement for police to record ethnicity in their records and so the inclusion of this data, accessed during the initial phone call, would be straightforward.
3. The accuracy of recording the date and time variable requires improvement, particularly regarding the revoking of detentions. Drop-down date and time facilities within variables would avoid typographical errors. Improved communication, and possibly monitoring, regarding detention progress would enable the accurate recording of the date and time of when detentions are revoked.
4. There is a need to record when a 12-hour extension has been applied and the reason/s for the extension to monitor excessive detention durations.

5. The mode of transport to and between POS ought to be recorded to enable the demand on the ambulance service and their ability to respond to be monitored.
6. There needs to be improvement in the nomenclature within some variables. Currently, the variable regarding the legal status of persons detained beyond the legislative framework is problematic to the point that analysis of one variable was deemed unviable. Current phrases currently include: 'Held in Best Interest – No Capacity', 'Member of the Public – Capacity' and 'No Capacity – Not Objecting – Held Due to Clinical Risk'. Firstly, the nonsensical nature of 'member of the public' implies that persons without capacity cease to hold such a status; furthermore, such statements as these examples bear no resemblance to legal status. Persons held beyond the lawfully permitted duration of detention fall under a grey area of legislation and, in such cases, professionals continuing to detain a person under no legislative framework must be able to justify their decision to avoid prosecution should the case be taken before the European Court of Human Rights. The wording of categories within this important variable therefore requires review.

Policy

If MH truly was a government and NHS priority, there would be more resources in place to prevent the deterioration of persons' MH which then creates situations of MD. Earlier in this work I evidenced that currently there are unacceptable waiting times to access community-based support; this creates a situation where persons' MH deteriorates. There is nowhere people can access support and thus, they find themselves in crisis where the only service available to support them is the police.

The terms of police officer involvement in S136 detentions requires review. There ought to be the ability for medical and social care staff to enable an MH assessment without police involvement. Nevertheless, as it stands, legislation only requires officers to take a person to a POS, not for them to remain for the duration of detentions, as this research has shown to occur frequently. Where there is a medical health concern, there is a clear need for medical rather than psychiatric assessment and currently this is only available to detained persons within an A&E department; however, the presence of a medical health concern does not justify ongoing police involvement. Detained persons under such circumstances should be under the care of healthcare staff and facilities ought to be available where they can be kept securely, thereby negating the ongoing presence of police officers. Likewise, the ongoing presence of police officers where there is MD is vastly inappropriate once the person arrives at a healthcare setting.

There is a requirement for community-based MH care as well as specialist units that can offer immediate support to people who feel that they are approaching a situation of MD. These units would be in keeping with the current NHS drive towards integrated care systems which seek to create person-centred, collaborate and integrative health, social and local authority care to persons when it is required (NHS England, 2021). Specialist units for adults do exist in some areas, such as in West Glamorgan, Wales (Swansea Bay University Health Board, 2020), and there was a recent call by the Children's Commissioner for Wales for similar places to be available for CYP (Holland, 2021). The units I call for are akin to A&E departments, which exist to treat physical health emergencies; they should be staffed by social care as well as medical care staff and charitable support organisations could also be based there, thereby giving an array or resources within one area. Such units would likely reduce police involvement in MD as persons would have a place to go which can meet their immediate needs. The unit would be a POS and so where police do become involved in MD and invoke an S136, the detained person could be placed into the care of the staff, enabling police to withdraw.

Despite calls that 24-hour access to urgent medical care is made available (Independent Mental Health Taskforce, 2016; NHS England, 2021) and that there should be a parity between services for CYP and adults (HSIB, 2018), this is not the case in several CCGs within the geographical area of study. This has meant that CYP who present in MD OOH have no access to paediatric MH care support and must remain under police supervision and control until an assessment can be conducted DOH. Whilst it is accepted that S136 detentions are infrequent, there are times within this study period where monthly numbers have reached in excess of 20 across the county. With the majority of CYP detentions occurring OOH, the infrequency of their occurrence should not prevent the availability of an adequate MH response for situations of CYP in MD being restrained by police officers over multiple hours with no healthcare input. This must not be allowed to continue.

Thirdly, the number of persons being detained beyond the lawfully permitted time must be addressed as a matter of urgency. Despite previous CQC reports and peer review highlighting these concerns, breaches in the lawful duration of detentions still occur. The delay in ending an S136 detention appears to be mainly due to the lack of available MH beds to which to admit the person. Persons in this position are held under no legal framework and, as the majority of breaches in the terms of the MHA occur in an S136 suite, persons are at the mercy of medical and social care staff, with no recourse to independent advocacy or appeal. It is only a matter of time before a person who has been unlawfully detained under S136 accesses legal advice and brings a case against the Trust regarding a breach of their human right to liberty and/or appropriate access to healthcare.

There is clear evidence presented in this work that some people are assessed as requiring an MH bed but are discharged back into the community because a bed is not available. This practice results in repeated S136 detentions by police, an increase which is statistically significant.

An observation within this work, which was also noted by Wondemaghen (2021), is that when there is an adverse outcome to interactions with a person in MD, such as death by suicide, decisions made by healthcare staff do not come under the same scrutiny as those made by police officers. Whilst IOPC investigations are stressful for police officers, and to date all IOPC investigations regarding death due to MD after police contact have ruled as no fault of officers (MH Lead, 2021), that is not to say that there should not be an independent assessment of the situation, for there are always lessons to be learnt to improve future practice. To ensure transparency and to improve practice and provisions, when there is a death following contact with MH provision, healthcare decisions ought to come under the same scrutiny as police decisions. There is a recommendation by the Independent Mental Health Task Force Strategy (2016) that the NHS should learn from past events in order to improve future practice and that this information should be brought to the attention of CQC inspection teams. An independent organisation does exist which investigates NHS care, although the summary of their approach is that they do not apportion 'blame or liability' (HSIB, 2021, p. npn), which is somewhat different to the approach of the IOPC. The Healthcare Safety Investigation Branch did produce a report into the death of a woman who had presented at A&E three times before she absconded on the last occasion and later took her own life (HSIB, 2018). The report suggests that opportunities were missed to prevent her death and recommends 24-hour access to MH liaison services for A&E departments and commitment to the parity of esteem between physical and mental healthcare provided in A&E as recommended by the CQC. There is clear evidence in this work that parity is not achieved within A&E departments in the same way as parity in the MH provision of adults and CYP is not available.

Future Research

This research uncovered several occasions where smartphones had been used to record incidences of MD. In contemporary western society the use of social media has encouraged the recording of events, which are then posted online for others to see (Van Dijck, 2013); this is of concern when the subject of the footage is experiencing a crisis, whether than be through injury or MD. Police officers will be aware of the use of smartphone recordings as such material has been used as evidence against officers in high-profile deaths, such as that of George Floyd in the USA (Ristovska, 2021). However, there is a need for research to uncover the effects that being a protagonist within such videos has on the individual to improve police response to the recording of video footage.

This research has been important in highlighting contemporary experiences of CYP who are subject to S136 detentions. More research in this area is required as it is an area which has received no attention since the legislative amendments forbade the use of police cells as a POS. Further work is required to understand the lack of CYP S136 suites and to ensure that the plight of CYP being cared for by police officers rather than health or social care staff is addressed.

The fact that I have uncovered a statistically significant rise in the detention of CYP must be explored further to establish whether this is an effect of SRP and the pandemic, or if it is an ongoing pattern that confirms my belief that CYP MD that draws police attention is due to failings within MH provision for CYP. The impact of CCG commissioning and the nonexistence of OOH service provision for CYP requires more exploration to establish the links between these and the number of S136 detentions of CYP in under-resourced geographical areas.

There is evidence within this work that some police officers try to avoid invoking S136 detentions. Research on the outcomes of such decisions would be a valuable comparison to occasions where S136 was invoked. Such data could have the ability to validate alternatives to S136 detentions. Data on this will exist within police databases, although it will not be stored in an easily accessible way.

Gender differences have featured within this research, such as the increased percentage of female to male detained CYP, which is transposed in adults. Further work on gender and age would aid the understanding of triggers of MD and if gender affects decision making regarding the invocation of S136. Likewise, a more nuanced look at the opinions of S136 detentions across gender and ages would illuminate another aspect of S136 detentions.

Partnership work between police and MH services deserves more research, in addition to the recent work by Wondemaghen (2021) which sought to understand conflicts between police officers and healthcare staff. Despite early positive research regarding multi-agency mentoring of persons who experience multiple detentions (Jennings and Matheson-Monnet, 2017), the collapse of HIN following the StopSIM campaign has inevitably had a deleterious effect on such programmes. Within the geographical area of this research there is evidence that mentoring has positive effects for both the person (one of whom took part in this research) and on reducing demand on police and emergency services' resources; however, there is no formal audit or research to support this. To recover faith from the public and professional bodies in such programmes in light of the StopSIM campaign, robust research is required in this area so that this important support work can continue.

This thesis was unable to cover important areas such as the personal impact of S136 detentions on police officers; this was particularly apparent in my work on decision making and how seeing suicide

deaths on the railway network affects future police practice. This is certainly an area which demands further work out of respect for my generous participants.

Finally, the use of S136 suites requires more analysis to enable better management of these resources. It is clear within this research that adult suites become blocked by persons awaiting MH beds, which increases the use of A&E departments as POS and forces ongoing police supervision and control of persons in MD.

Final Conclusions

This research has enabled a contemporary overview of the S136 process since the 2017 legislative changes. I have completed a thorough review of an important and comprehensive administrative dataset on S136 detentions in one county in the North of England. These data have been supported by the voices of police officers and AWEs; groups which are classed as experts by experience.

I have offered a unique overview of the process of S136 detentions and illuminated the impact that a global pandemic has had upon this. Advancing previous work in this area, I have shown that S136 detentions for an episode of MD are experienced and viewed as criminalising, and this is largely due to the lack of, or mismanagement of, NHS resources. For instance, had crisis care hotlines met the needs of persons vulnerable to distress, and had the NHS and social care services been able to intervene and keep persons who declared that they were experiencing MD safe (especially those people who present voluntarily at A&E departments), the number of S136 detentions would be reduced as police officers would not have to meet the gaps in existing provision. Furthermore, there is a lack of available provision once detained persons are taken to a POS. Data suggests that it is the lack of acute MH beds which prevents the availability of S136 suites, meaning that a large number of people are unnecessarily taken to or remain in A&E, where they must stay under police supervision and control.

The CQC prediction that there would be an increased demand on A&E departments as a POS after police cells became inaccessible as a POS has come to fruition; this is largely due to an absence of available S136 suites. Despite calls for CYP provision for urgent MD to be aligned to that available to adults, this research has shown that this is not the case. The experience of a CYP S136 detention is, on average, worse than that of adults, which still is too often below the standard demanded by legislation.

Appendix

1.Ethics forms

Research participants required for a study looking at Police Detentions under the Mental Health Act

I would like to interview people who have previously been detained by police under the Mental Health Act.

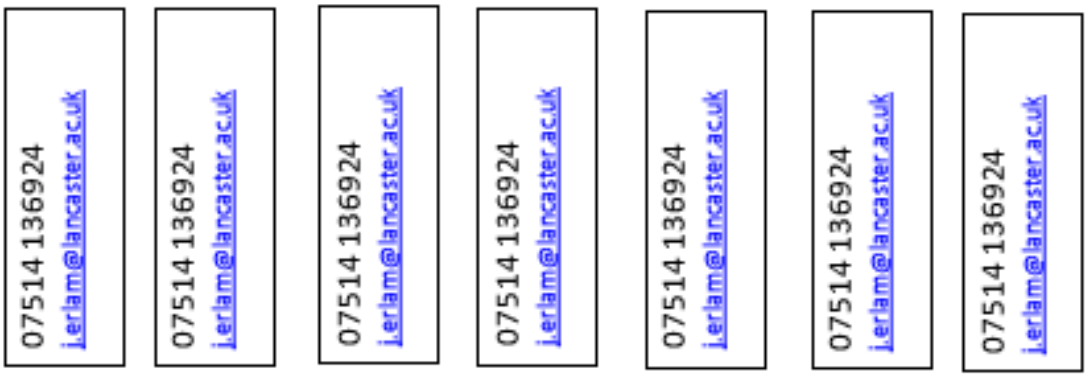
Participation would involve a one-to-one conversation about your views and experience.

Your participation is entirely voluntary, and your responses will be kept confidential.

In appreciation of your time, you will receive £10 as a small token of thanks

Contact Jayne: mob. 07514 136924
j.erlam@lancaster.ac.uk for more information

This study is funded by the Economic and Social Research Council and has been approved by Lancaster University Research Ethics Board



Participant information sheet – Interviews

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

I am a PhD student at Lancaster University, and I am undertaking research into the increased reliance upon the police to assist people experiencing mental distress.
Please take time to read the following information carefully before you decide whether or not you wish to take part in this interview.

What is the study about?
This study aims to explore the involvement of police in the detention and care of persons who experience mental distress.

Why have I been invited?
You have been invited to participate in this research because you have said that you have previously been detained by police under Section 136 of the Mental Health Act.
Your experience and thoughts about the role of the police in this area of health care are valuable to my research.
I would be very grateful if you would agree to take part in this study, but your participation is strictly voluntary.

What will I be asked to do if I take part?
If you decided to participate, this would involve taking part in a short audio recorded telephone interview. You will be asked a series of questions that will invite you to share your experience and thoughts. How much detail about your experience that you want to share will be entirely up to you. You can remain in control of the situation and are free to say if you do not want to answer a question, or to stop the interview at any time.

What are the possible benefits from taking part?
The increased numbers of S136 detentions has been highlighted as a cause for concern. By taking part in this study will allow you to share your experience and this could help my research to suggest changes in how the current system helps people who experience an episode of mental distress.

Do I have to take part?
No. It's completely up to you; your participation is voluntary.

What if I change my mind?
If you change your mind, you are free to stop the interview at any time. After the interview has occurred, you have 2 weeks in which you may contact me to request for your contribution to this research to be withdrawn. After this time, anonymisation and coding will have occurred that will make your contribution difficult to identify to enable its removal.

What are the possible disadvantages and risks of taking part?
Talking about difficult or upsetting times can resurface painful memories that you had previously managed to suppress.

Will my data be identifiable?
After the interview, transcriptions of the audio-recording will be performed by me, and I will remove any personal information from the written record of your contribution. Only I as the researcher conducting this study will know the complete story that you offer. My supervisors at the university, will know parts of what you share with me, but your identity and any specifics of your experience that could enable deductive disclosure will not be shared.

How will we use the information you have shared with us and what will happen to the results of the research study?
I will use the information you have shared with me for research purposes only. It is likely to form part of my PhD thesis and be used in conference presentations and publications such as journal articles.
When writing up the findings from this study, I would like to reproduce some of the things you shared with me. I will only use anonymised quotes so, although I will use your exact words you cannot be identified in any publications.
If something that you tell me suggests that you or somebody else might be at risk of harm, I will be obliged to share this information with my supervisors for guidance. If possible, I will inform you of this breach of confidentiality.

How my data will be stored
Audio transcriptions will be deleted as soon as transcriptions are saved. Your data will be stored in encrypted files (that is no-one other than me, the researcher, will be able to access them) and on a password-protected computer. No hard copies of any data are held. I will keep data that can identify you separately from non-personal information (e.g. your views on a specific topic). In accordance with University guidelines, I will keep the data securely for a minimum of ten years.
This study is funded by the Economic and Social Research Council. The funder expects me to make my coded data available for future use by other researchers. No complete transcriptions will be offered, and I will exclude all personal data from archiving.

What if I have a question or concern?
If you have any queries or if you are unhappy with anything that happens concerning your participation in the study, please contact myself, Jayne Erlam (j.erlam@lancaster.ac.uk), or my supervisor Jasmine Fledderjohann (j.fledderjohann@lancaster.ac.uk). If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact Imogen Tyler who is Head of Sociology at Lancaster University (i.tyler@lancaster.ac.uk).

Sources of support
Mind - www.mind.org.uk/information-support/
Samaritans - 116 123
The Cove - 01524 550360
Community Mental Health Team - https://www.lscft.nhs.uk/cmht-adult

This study has been reviewed and approved by the Faculty of Arts and Social Sciences and Lancaster Management School's Research Ethics Committee.

Project Title: Mental health in austere times: The increasing role of police intervention in cases of mental distress

Lancaster University

Name of Researcher: Jayne Erlam
Email: j.erlam@lancaster.ac.uk

Please tick each box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study and within 2 weeks after I took part in the study, without giving any reason. If I withdraw within 2 weeks of taking part in the study, my data will be removed.	☐
3. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher, but my personal information will not be included, and I will not be identifiable. Fully anonymised, coded data will be made available to my funders, ESRC, and Lancaster University, and may be made available to other researchers for re-analysis for a period of 10 years.	☐
4. I understand that my name will not appear in any reports, articles or presentations.	☐
5. I understand that if there is a disclosure to suggests that a person may be at risk of harm, then confidentiality might be compromised in order to ensure safety.	☐
6. I understand that any interviews will be audio-recorded with my permission and transcribed, and that data will be protected on encrypted devices and kept secure.	☐
7. I agree to take part in the above study.	☐

_____ _____ _____
Name of Participant Date Signature

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher taking the consent _____ Date _____

Research participants required for a PhD study looking at S136 Detentions under the Mental Health Act

I would like to interview police officers who have experience of S136 detentions.
The handover process at the place of safety and the detention of children are particular areas of interest.

Participation would involve a half hour telephone conversation about your views and experience.

Your participation is entirely voluntary, and your responses will be kept confidential.

For more information, contact Jayne:
07514 136924

j.erlam@lancaster.ac.uk

This research is funded by the Economic and Social Research Council and has been approved by Lancaster University Research Ethics Board.

Participant information sheet – Interviews

I am a PhD student at Lancaster University, and I am undertaking research into the increased reliance upon the police to assist people experiencing mental distress.

Please take time to read the following information carefully before you agree to participate in an interview for my research.

What is the study about?
This study aims to explore what factors contribute to a person's detention under S136 of the Mental Health Act. I am interested in issues that police officers face in establishing a place of safety and while caring for the person throughout the assessment process and until discharge or admission.

What will I be asked to do?
I am interested in your work and to understand how you manage incidents where mental health is a factor. I am mostly interested in the processes that occur surrounding S136 detentions.
You are invited to take part in a 30-minute audio recorded telephone interview where you will be asked to share your thoughts and experiences with this aspect of police work.

What are the possible benefits from taking part?
Taking part in this study will allow you to share your experiences of policing and mental health. There is an increased reliance on police to assist those who experience mental distress, and this might not be in the best interest of either the police or the person experiencing distress. Taking part in this study is an opportunity for you to have your voice heard in research that aims to highlight problems in the system and offer suggestions for improvement.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part.
I am happy to discuss any questions or concerns that you might have.

What if I change my mind?
If you change your mind, you are free to withdraw your participation in this study. If you want to withdraw, please let me know, and I will extract any ideas or information you contributed to the study and destroy them.
However, it is difficult and often impossible to take out data from one specific participant when this has already been anonymised or pooled together with other people's data. Therefore, you can only withdraw up to 4 weeks after taking part in the study.

Will my data be identifiable?
After the interview, only I, the researcher conducting this study and my university supervisors will have access to the information and ideas you share with me. The project as a whole will be discussed with Andrew McGuinty (Mental Health lead), although the source of specific

information will not be divulged, save for strictly limited circumstances, but this would be discussed with you first.
I will keep all personal information about you (e.g. your name and other information that can identify you) confidential. I will remove any personal information from the written record of your contribution.

How will you use the information I have shared with you and what will happen to the results of the research study?
I will use the information you have shared with me for research purposes only. It is hoped that this research will highlight problems with current policy, and it is my intention to present my findings at conferences and in publications such as journal articles, as well as use it for my PhD thesis.
When writing up the findings from this study, I would like to reproduce some of the views and ideas you shared with me. I will only use anonymised quotes so, although I will use your exact words, you cannot be identified in any publications.
Fully anonymised data will be made available to my funders, ESRC, Lancaster University, and may be made available to other researchers for re-analysis for a period of 10 years.
If something that you tell me suggests that you or somebody else might be at risk of harm, I will be obliged to share this information with my supervisors for guidance. Where possible, I will inform you prior to this breach of confidentiality.

How my data will be stored
Your data will be stored in encrypted files within password protected University servers and no-one other than me, the researcher, will be able to access them. I will store hard copies of any data securely in locked cabinets in my office. I will keep data that can identify you separately from non-personal information (e.g. your views on a specific topic). In accordance with University guidelines, I will keep the data securely for a minimum of ten years.
This study is funded by the Economic and Social Research Council. The funder expects me to make my data available for future use by other researchers. I will exclude all personal data from archiving.

What if I have a question or concern?
If you have any queries or if you are unhappy with anything that happens concerning your participation in the study, please contact myself, Jayne Erlam (j.erlam@lancaster.ac.uk), or my supervisors, Jasmine Fledderjohann (j.fledderjohann@lancaster.ac.uk) and Les Humphries (l.humphreys@lancaster.ac.uk
If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact Imogen Tyler who is Head of Sociology at Lancaster University (i.tyler@lancaster.ac.uk).

Sources of support
Mind - www.mind.org.uk/information-support/police/
PFOA - Tel: 01354 669749 www.pfoa.co.uk/support/welfare-support-programme
Police Federation WSP - www.polfed.org/fedatwork/Welfare_Support_Programme.aspx
Samaritans - Tel: 116 123 www.samaritans.org

This study has been reviewed and approved by the Faculty of Arts and Social Sciences Research Ethics Committee.

CONSENT FORM – Interview

Project Title: Mental health in austere times: The increasing role of police intervention in cases of mental distress

Name of Researchers: Jayne Erlam
Email: j.erlam@lancaster.ac.uk

Please tick each box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study and within 4 weeks after I took part in the study, without giving any reason. If I withdraw within 4 weeks of taking part in the study, my data will be removed.	☐
3. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher, but my personal information will not be included, and I will not be identifiable. Fully anonymised data will be made available to my funders, ESRC, and Lancaster University, and may be made available to other researchers for re-analysis for a period of 10 years.	☐
4. I understand that my name will not appear in any reports, articles or presentations.	☐
5. I understand that if there is a disclosure to suggests that a person may be at risk of harm, then confidentiality might be compromised in order to ensure safety.	☐
6. I understand that any interviews will be audio-recorded with my permission and transcribed, and that data will be protected on encrypted devices and kept secure.	☐
7. I agree to take part in the above study.	☐

Name of Participant _____ Date _____ Signature _____

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher taking the consent _____ Date _____ Day/month/year

2. Interview Prompt Sheets

AREAS TO COVER IN AN INTERVIEW WITH A PERSON PREVIOUSLY DETAINED UNDER S136

Ensure consent to record the interview.

Age. Gender. Location

Ensure private area for both persons where not overheard or will be disturbed.

Enquire how the person is feeling and check that they are feeling strong enough to think back over their experience of mental distress.

Invite them to tell me what happened before professionals became involved. This will hopefully begin a narrative account of events, or use the areas to be covered, as listed below, to offer a more structured interview if this is required.

Use prompts to maintain focus, while remaining respectful of the flow of their narrative.

Were you surprised at police involvement?

What was the police approach?

What did onlookers do?

A&E experience – approach of staff, other patients

Guide the narrative to cover thoughts and feelings, experiences, time, which professionals were involved, what was helpful and what was not helpful, and what happened after the police left the situation.

End the interview by asking how they are doing now and what support they are receiving. In case this is required, direct to a list of places that they could go to for support that are specific to their area.

By way of some debrief from the interview, ask them **how they are feeling after speaking about their experiences and will seek to highlight positive areas that have been mentioned in our time together.**

Invite the person to contact me if they think of anything else that they would like to add, before thanking them for their time and departing.

Police Prompt Sheet

Gender, Age, Rank, Years in role, Experience of S136 detentions

What do you see as the role of police?

In line with your expectations?

What drives your decision making?

How do people respond to police intervention in their distress?

Do you get the sense that they feel criminalized?

Use of restraint

Bystanders

Transport

Thoughts of A&E:

Time spent in company of detained people
Other people in A&E
Attitudes of staff

Thoughts of the people who are detained

Detention of children

Places of safety
Particular difficulties
Children in care

Coronavirus legislation

An example of a smooth/good/appropriate detention and an example of badly managed/frustrating/awful detention

Thoughts of the MH system

What would make it better?

Anything you would like to add – what area should I be giving priority to?

3. Evidence Submitted to Education Committee: Criminalisation in Children's Homes

Introduction

I am an ESRC funded PhD student based at Lancaster University. My thesis looks at the increasing number of Section 136 (S136) detentions by police under the Mental Health Act. The work is mixed methods project using anonymised NHS administrative data on S136 detentions within one county in the Northwest of England, and hears the perspectives of police officers via interview.

Evidence is submitted owing to the disproportionate representation of children in care within the data.

Key Points:

- Looked-after children account for 15.3% of children detained by police under the MHA, when less than 1% of children are in local authority (LA) care
- 65.85% of these children were detained since the onset of the COVID-19 pandemic
- Mentally distressed children who are looked after in care homes are at risk of a criminal record if their distress causes them to damage property

Under Section 136 (S136) the Mental Health Act (MHA) police can detain a person in a public space who poses as a risk to themselves or to other people and take them to a place of safety to have a mental health assessment.

Analysis of 37 months (December 2017 to end of January 2021) of administrative data show that there were 268 S136 detentions of children, aged 9 to 18 years. The data contain a free-text variable of a brief reason for detention. Coding of this variable reveals that 15.3% (n=41) of children detained under S136 were children looked after in local authority (LA) care. This is an over-representation considering that less than 1% of children in England are classed as looked after (GOV.UK, 2021). Owing to the unstructured nature of the free-text variable, this figure is likely to underrepresent the true picture of S136 detentions of looked-after children.

Logistic regression reveals that there is a statistically significant ($p=<0.001$) rise in S136 detention of children compared to the detention of adults since the start of social restriction policy to control the spread of COVID-19. A chi-squared test was carried out to determine if the rise in S136 detentions of children was different for looked-after children compared with children not in LA care, with the null hypothesis being that there would be no difference. The chi-square test showed $p=0.031$ on 1 degree of freedom thereby providing evidence to reject the null hypothesis and accept the alternative

hypothesis that the rise in S136 detentions of children during social restriction policy was greater for children looked after by LA.

A simple tabulation demonstrated that of the looked-after children detained in one county over 37 months, 65.85% (n=27) of the detentions occurred in the 10 months after the commencement of social restriction policy triggered by COVID-19.

Interviews with police officers with experience of detentions of children reveal that there are several areas of the county where CCGs have funded no provision for children who experience mental distress outside of normal working hours. In such areas, children detained under S136 must remain under the control of police officers in hospital, often in an accident and emergency department where there are no sleeping facilities, until they can be assessed by day staff. As this is not ideal, police officers try to avoid S136 detentions by returning children to their homes with advice to parents or carers to keep the child safe, restrained if necessary, until medical advice can be sought in the next working day. Police participants told me that, for looked-after children, they are sometimes called back to care homes if the child's mental distress has caused them to damage property, in which case charges for criminal damage are considered. This is something that police do not see in children who live with their parents.

There is limited research on S136 detentions of children, and these findings for one county in the Northwest of England suggest that there is an overrepresentation of looked-after children being detained. Looked-after children can have a challenging relationship with police officers and the fact that police intervention is required when children are already experiencing mental distress is particularly noteworthy. Of additional concern is the resulting possibility that looked-after children might be criminalised because of the lack of emergency provision for children experiencing mental distress, which is contrary to the government's framework to reduce the criminalisation of looked-after children (DfE et al., 2018).

Abbreviations

A&E – Accident and Emergency

AMHP – Approved Mental Health Practitioner

AWE – Adult with Experience

BAME – Black, Asian and minority ethnic

CA – Children Act 1989

CAMHS – Child and Adolescent Mental Health Services

CoP – College of Policing

CQC – Care Quality Commission

CYP – Children and Young People

DMC – Decision Making Capacity

HBPOS – Health-Based Place of Safety

HIN – High Intensity Network

HMICFRS – Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services

HRA – Human Rights Act 1998

IOPC – Independent Office for Police Conduct

IRAS – Integrated Research Application System

MD – Mental Distress

MH – Mental Health

MHA – Mental Health Act 1983

N/A – Not Applicable

NHS – National Health Service

POS – Place/s of Safety

PPO – Police Protection Order

PPP – Police Powers and Procedures Report

RCEM – Royal College of Emergency Medicine

RCPSYCH – Royal College of Psychiatrists

REC – Research and Ethics Committee

SIM – Serenity Integrated Mentoring

SRP – Social Restriction Policy

ST – Street Triage

UK – United Kingdom

UN – United Nations

UNCRC – The United Nations Convention of the Rights of the Child

UNCRPD – United Nations Convention on the Rights of Persons with Disabilities

USA – United States of America

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