Title

Exploring the growth in Police engagement with those who are mentally ill and the use of the Mental Capacity Act as an alternative to Section 136 of the Mental Health Act.

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Abstract

Despite efforts of Parliament; the Home Office; police forces and health practitioners, the number of people detained under Section 136 of the Mental Health Act 1983 continues to rise.

By analysing quantitative data from Hampshire Constabulary this study describes in detail police engagement with the mentally ill.

Findings showed how people in mental crisis were increasingly detained by the ambulance service using the Mental Capacity Act and taken to A&E Departments. Nationally Police officers were also found to be increasingly taking Section 136 detainees to A&E.

The majority of people contacting Hampshire displayed delusions which were unlikely to result in a police response and may disproportionately account for the overall growth in contact with the police.

The data suggests that 'Triage' schemes alone will not be effective in reducing detentions. Hampshire's partnership and discretionary approach is successful in reducing detentions.

Recommendations for policy, practice and further research are provided.

Introduction.

Mental illness is unusual amongst medical conditions for it is one of the few where people can be

treated against their will and restrained and deprived of their liberty in order to do so[i]. Most countries

have a legal or administrative system to manage and oversee such processes of detention and treatment and whilst the legal, cultural and medical processes vary, all seek to balance three distinct sets of interests (Salize, Dreßing and Peitz 2002). These are:

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

Over the last century the approach of many 'first world' countries to the care of the mentally ill has changed significantly and dramatically since the nineteen sixties, generally moving from institutional based provision to more personalised support of individuals in their own communities. Reducing the frequency of their compulsory admission and treatment had been an aim of this change across the world (Curran 1978). However one perverse outcome has been increasing rates of compulsory treatment in many European countries (Salize, Dreßing and Peitz 2002; de Stefano and Ducci 2008) including England (Wall et al. 1999). Whilst one of the intentions of United Kingdom (UK) government policy in moving from institutional to community care was to prevent unnecessary detention and treatment, latterly public fear of the harm that the mentally ill may cause has led to a policy shift which focuses more on public safety (Angermeyer and Matschinger 1995; Phelan and Link 1998) as seen most recently in the Mental Health Act 2007 (MHA)[ii]. This introduced supervised community treatment such as Community Treatment Orders (CTOs) which enables a patient to be returned to hospital and forcibly medicated if they do not comply with the requirements of their treatment order. It also changed the '*treatability test'* for detention which previously required that a treatment must be likely to alleviate or prevent a deterioration of condition to an '*appropriate treatment'* test which is less stringent in that a "*medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations*". These changes are more focused on managing the risk of

harm that could be caused by patients, rather than their treatment. Concerns have been expressed about the consequences of these changes (Mental Health Alliance 2012).

Within England and Wales the legal framework for compulsory treatment lies within the MHA 1983 (as amended) and the Mental Capacity Act (MCA) 2005. This paper is concerned with the detention of members of the public under Section 136 of the MHA 1983.

Section 136 of the MHA 1983 states:

> *(1) If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—*
>
> > *(a) remove the person to a place of safety within the meaning of section 135, or*
> >
> > *(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.*
>
> *(1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than—*
>
> > *(a) any house, flat or room where that person, or any other person, is living, or*
> >
> > *(b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.*

This amended version of Section 136 of the MHA which was introduced in December 2017 clarified or altered several aspects of the Act including widening the scope of the locations where officers could exercise this power. Previously this was limited to places to which the public had access and included

public places and private places where there was permitted access such as shopping centres, football stadia etc. The power did not apply to private places where the public are not permitted such as railway lines, or prohibited areas of tall buildings or structures (where suicidal people might be found). It now applies anywhere apart from peoples' homes. To promote alternatives to detention in police facilities a requirement was introduced for officers to consult Health professionals, usually in the form of a 'Triage Scheme', before exercising this power – "*where practical*". Triage schemes operate by allowing a police officer who is considering using Section 136 to speak to a mental health professional (either by phone or in person) who can offer them advice about whether they need to make a detention. The details of such schemes are set out in an evaluation of nine trial Triage schemes undertaken by Reveruzzi (2016).

The purpose of Section 136 is to enable Health professionals to make an assessment of the detained person to see if they are ill and if so, whether they need further detention for assessment and treatment (see Section 2 or 3 of Part II of the MHA 1983). The time limit for detention was also reduced from 72 hours to 24 hours. This was intended to minimise harm to individuals and focus the attention of partners on speeding up the process of assessment. However, at its heart the power for police to detain remains.

There is a longstanding significant public disquiet about the operation of Section 136, especially around the rising rate of detentions and the low treatment rates that follow. A study by Keown (2013) using publicly available data to compare the period 1984/5 to 2010/11, showed a six fold increase in the use of Section 136 in that period. More recent public data, (see table 1), shows a continuing rise of thirty nine percent over five years. This is perhaps more surprising when Her Majesties Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) reports that forty two of the forty three police forces in England and Wales have some form of Triage Scheme in place to prevent such detentions (HMICFRS 2018).

Table one.

Empirical research has indicated that the growth in police use of Section 136 has also been accompanied by a change in the pattern of behaviours of those who are subsequently detained. Thirty years ago the majority of behaviours resulting in detention were violent, abusive, aggressive or disturbing (Bean et al. 1991; Turner, Ness and Imison 1992; Simmons and Hoar 2001) whilst most recently the majority of behaviours resulting in detention has concerned threats of self-harm (Thomas and Forrester-Jones 2018). These changes in both the volume of detention and in behaviour leading to detention have also appeared to coincide with a decline in treatment rates following detention. It is proposed by Thomas and Forrester-Jones (2018) that all three effects were caused by the emergence of a 'risk averse' culture amongst police officers which resulted in them detaining people to prevent any possibility of blame for harm attaching to officers.

Wide differences in the rate of detention and treatment by Health Authority area have also been reported, most recently through NHS Digital (NHS Digital 2018). In this the rate varied from 6 to 116 detentions per 100,000 residents. Weich et al. (2014) set out to determine whether these differences in admission and treatment rates could be accounted for by socioeconomic or sociodemographic factors or features of the delivery of local mental health services. Using multi-level statistical models to examine the Mental Health Minimum Data Set for the year 2010/11, which included just over 1.2 million patient records, they found that 84% of the variation lay between individuals on the basis of personal factors such as age, gender and race. However, statistically significant variations also arose between local areas and Health Trusts. The authors concluded that different policies and budget levels between Health Authorities may account for a significant part of the differences in detention and treatment rates. It is not clear how such differences influence the actions of officers making Section 136 detentions.

The rate of Section 136 detention per 100,000 residents for Forces in England and Wales is shown in Fig 1 below[iii]. There is a tenfold difference between the highest and lowest values and even allowing for inaccuracies in the data, this still represents significant variation. It is also noticeable that whilst some

neighbouring forces, which presumably share social and demographic factors, are near each other in the chart such as Cambridgeshire, Norfolk and Suffolk or Avon and Somerset and Devon and Cornwall, other forces that are neighbours are widely separated such as Kent and Essex, or Dorset and Wiltshire. Even in the Police groupings of most similar forces[iv] the spread is wide e.g. In one such group the rankings are Kent 2nd; Sussex 6th; Avon and Somerset 7th; Essex 11th; Staffordshire 12th; Hertfordshire 29th; Hampshire 35th and Derbyshire 39th. It is not clear why or how such variations arise and differences in NHS structures and models of policing may also play a part. The aim of this study was therefore to investigate in more detail the police engagement with people who are mentally ill to further understand the origins of such differences. Within available resources a single force study was most practical and Hampshire Constabulary agreed to participate.

Figure one.

A favourable ethical opinion for the research was obtained through the Ethics Committee of the School of Social Policy, Sociology and Social Science at the University of Kent. And the study was undertaken with the cooperation and written consent of the Hampshire Constabulary. The research was also compliant with the General Data Protection Regulations and other Force policies of Hampshire Constabulary.

Method.

The study took place within Hampshire Constabulary a large provincial police force in England. It consists of two urban areas which are Unitary authorities, Southampton and Portsmouth. The two-tier County of Hampshire and the Unitary authority of the Isle of Wight (IOW).

This research used quantative methods to analyse Force Control Room (FCR) data. The data was collected in 2017 and records from the full year of 2016 were analysed. The study was in two parts. In the first the Force classification of incidents was examined. These classifications are very general and

provided a limited opportunity for analysis. In the second, analysis of the content of the incident records was employed. On this basis a more detailed analysis could be undertaken, however there are limitations to this approach given the uncertain process by which the record is derived from the actual incident. Each incident was summarised and categorised using an Excel spreadsheet and the analysis undertaken using filters and formulas.

In this study less than 1% of reported incidents arose through members of the public contacting police stations in person or by direct contact with patrolling police officers. The overwhelming majority of incidents were generated as a result of a telephone call.

Calls to the police can arrive through the 999 system or through non urgent contact numbers such as '101'. After passing through the switchboard the calls are handled by the call takers within the FCR. Here in principle every phone contact is recorded and creates a record. In practice this is not always so. Some incidents such as collisions on the motorways may generate hundreds of calls with the result that for repeat calls containing no new information, a record of the caller may not be created. Other calls may be forwarded to other units such as the crime management units and so a record will not be made in the FCR.

When an incident is created the call-handler is led through a process of completing a record on the force 'command and control' system. This includes details of the caller, a description of the incident and if the caller or location is recorded on an existing record then this is drawn to the attention of the call handler. This links together potentially related incidents. In addition, an 'incident type' is attached to it which takes the form of an opening code and describes the key feature of the call. There are a wide range of these for example it could be about a burglary, so the opening code would be "BURINC".

The incident may require no further action by the force; some action by the force on the phone for example notifying another party of the content of the call or may require an officer or PCSO to attend

the incident. The record of the incident also contains this outcome from the person who resolved it and then a 'closing code' or codes which classify the incident. The closing codes may be different from the opening code. The closing code is generally seen as a more accurate record of the type of incident.

Four codes were identified as likely to be relevant in research about contact from or about people who were mentally ill. The opening code of "VUNBLEINC" which is used to denote an incident concerning a person who is *vulnerable*. The opening code "CONWELF" identifies an incident which raises concerns about the welfare or wellbeing of an individual. The closing codes of Q130 (Mental illness) or Q115 (Persistent caller) were also reported as relevant.

At the time of this study the only mental health Triage Scheme in Hampshire Constabulary was a scheme on the IOW. The Isle of Wight uniquely has a single Health trust which provides all NHS services on the island including the ambulance service. In this scheme a mental health worker attended police incidents – when available. A small number of Incidents dealt with this way and were identified through reference in the incident record to the scheme. Most outcomes were also recorded there too.

Results and discussion.

In 2016 Hampshire Constabulary generated 433,261 command and control logs which resulted in the creation of 401,645 unique incidents.

Of these, 18,320 incidents related to one or more of those first four codes. This represented a rate of 4.6% of incidents that were concerned with mental illness. This is higher than the 0.6% reported by Thomas and Forrester-Jones (2018) but that report was only concerned with incidents where officers attended (This is further discussed below). The College of Policing estimated demand from mental illness as 2% (College of Policing 2015) whilst HMICFRS estimated 2.4% of crimes and 2.8% of incidents were concerned with people who were mentally ill (HMICFRS 2018), though they reported that these were

likely to be under-reported figures. The Metropolitan Police have estimated the level of demand as much higher at 15 to 20% of workload (College of Policing 2015).

To check the accuracy with which the incidents were coded, two hundred and two consecutive incidents on one day and two hundred or another were examined. The first set revealed nine incidents: six were VUNBLEINC opening codes of which five were Q130 on closing, three others were Q130 on closing. In the second batch six incidents were identified of which two were opened as VUNBLEINC of which one was closed as Q130 and three other incidents were identified as Q130 on closing. All these seventeen incidents were correctly identified. In addition, three other incidents could have been classified as Q130 on closing. This is a judgement, but it was supported by the FCR supervisor present on the days. This represents a potential error rate of around three quarters of one percent, which is a satisfactory rate of accuracy for the study.

To determine how best to sample incidents for these codes an analysis was undertaken comparing the number of incidents reported by time of day, day of week and month of the year. There are no significant differences in reporting rates of overall and mental health incidents by day of week or month of year. There are a similar pattern of incidents by time of the day, as in Fig. two below.

Figure two

This shows proportionately more calls out of hours than during the day, but otherwise a similar distribution. The implication is that by sampling whole days any time of the day effects can be eliminated. It was determined to analyse all the incidents relating to mental illness from one week in the first quarter of 2016. Those incidents which started on the seventh day but concluded on the eight were also included in the data

Searching using the four codes identified 444 incidents. The anonymized data about these incidents including the codes, the opening and closing description and the outcomes, where known, were entered into an Excel spreadsheet where they were analysed using filters and formulas.

Of the 444, eight appeared to be mis-classified. However, one related to a man who rang to say that the door handle had come off his door and he was locked in his office. The call taker though he might be mentally ill, classified him as Vulnerable, but indeed the handle had fallen off trapping him. In a second a man was reported as hanging off a roof, possibly suicidal and so coded as Vulnerable, but he was a 'free runner' who was talking a rest so again an understandable classification. Three were classified as Q115 (persistent caller) but they related to '*take-aways'* which were frequent callers because of anti-social behaviour not mental illness and three were family disputes and appeared to be in error. This would give an error rate of around 1.8%. A fairer estimate might be to accept that the first two did appear to relate to mental illness or vulnerability and so the error rate should properly be six out of 444 which equates to 1.3%. This error rate is low and similar to that reported above.

These incidents shared twenty-five different opening codes. These and the numbers of each can be aggregated as:

- **Concerns for someone's welfare** including: Vulnerable (263); concerns for welfare (67); injury illness (10) and missing person (13) - 352 incidents = 81% (of 437).
- **Crime** including crimes; public order; drink related offending and driving and suspicious incidents- 57 = 13%.
- **Domestic disputes** - 17 = 4%.
- **Other** including General policing enquiries and abandoned 999 phone calls - 10 = 2%

The great majority of incidents reported to the police, shown here as “concerns for someone’s welfare”, concerned the prospect of harm to individuals. These could be reported directly by individuals or by third parties.

One hundred and ninety three (44%) of these incidents had an officer or PCSO deployed to it and of these deployments:

- 155 (78%) were by the police,
- 24 (12%) were initially the police who handed the incident over to an ambulance.
- 11 (5%) were deployed to by ambulance alone (but the police were notified).
- 8 (4%) started with the ambulance but was passed to the police.
- 1 (0.5%) incident was passed from the police to NHS direct on 111.

Whilst this list reflects the ‘cross-over’ between the police and ambulance services, there would also have been a number of calls to the ambulance service alone, concerning crises of mental illness, which are not reported here. Police handing incidents to the ambulance service was not observed in a previous study though incidents passed from ambulance to police through delays in ambulance attendance was observed (Thomas and Forrester-Jones 2018).

Two hundred and forty three (56%) of incidents were dealt with no deployment, either through the initial conversation by the call taker or a follow up conversation on the telephone with that person or someone else. If this is representative of the eighteen thousand recorded mental health incidents, then the rate of deployment to such incidents falls to 2.5% which is more consistent with previous estimates of demand upon the police (above).

Seventy four (17%) of the calls came from other public sector partners such as the ambulance service, care homes, hospitals or doctors. This is significantly lower than the fifty percent reported previously (Thomas and Forrester-Jones 2018). In the deployed incidents only thirty two were from other public

sector partners, which represents sixteen percent. Differences in such partnership working is likely to account for some if not most of the variation in the operation use of Section 136 between forces.

Forty six (10%) of the calls appeared to meet the criteria for the use of Section 136 in that at the conclusion of the incident the subject was passed into the care or custody of another party. Thus, either Section 136 was used, the ambulance service took the person away for assessment or the person was passed into the care of family friends or another authority. In terms of the behaviour of the individual:

- In thirty four of the incidents there were threats of self-harm;
- in five the subject appeared to be having a psychotic episode;
- In four through their behaviour they appeared very vulnerable to harm;
- In two the subject appeared extremely distressed;
- In one the subject exhibited irrational violent and aggressive behaviour.

Thus in 83% of these incidents the person was threatening self-harm or otherwise appeared likely to come to harm. This figure is consistent with the 81% of behaviour leading to Section 136 detention concerning self-harm (Thomas and Forrester-Jones 2018).

In terms of outcomes:

- Officers detained people under Section 136 on ten occasions (but in one the ambulance agreed to take the person detained to hospital).
- On ten occasions an ambulance took the person to hospital using their powers under Section 4 and 5 of the Mental Capacity Act
- On five the police left the subject with family members waiting for an ambulance
- On eleven occasions the person was left with family members to care for them
- On one the police returned a patient to his treatment unit
- On one the family took the person to hospital

- On one occasion police officers took the person to hospital
- On four occasions the IOW Triage Scheme dealt with the person (one taken home; one no further action; one an appointment made and the forth not know)
- One person was arrested on a criminal warrant
- One was handed to the military authorities to care for them
- One was referred to their GP
- One person was dealt with informally (taken to a hotel and booked in overnight)

The outcomes can thus be summarised as:

- No detentions were taken into police custody.
- Nine Section 136 detentions by the police were taken to a Health Based Place of Safety using a private secure ambulance service.[v]
- Eighteen detentions went to hospital directly. Sixteen by ambulance, one taken by family and one directly by police officers.
- Eleven individuals were cared for by family members.
- Two were dealt with by other Health bodies.
- Two were passed to other responsible authorities.
- One was dealt with informally
- One was No Further Action (through IOW Triage Scheme).
- One not known (through IOW Triage Scheme)

So, whilst twenty percent of these detentions went to a mental health unit for assessment, forty one percent went to A&E in hospital – usually by ambulance. Detentions by ambulance staff taken to hospital would not appear in the police figures quoted above but an increase in police Section 136 detentions going to A&E appears to be an emerging trend across England and Wales.

Table two.

The growth in use of Accident and Emergency in table two relates to police officers taking detainees there. This may well result in the officers having to remain to supervise their detainee until the assessment is complete or even until a suitable bed is found to admit them. The recent advice published by the Royal College of Emergency Medicine (The Royal College of Emergency Medicine 2017) states that police officers arriving with someone detained under Section 136 should be required to stay with the detainee unless the '*hospital has staff and space to safely take responsibility for detention and agrees to do so'* The Royal College of Psychiatrists in their guidance also state that officers may need to remain at the POS for *'a short period'* (The Royal College of Psychiatrists 2011). Though in their later guidance the Royal College had set the time limit at 30 minutes (The Royal College of Psychiatrists 2013) It therefore seems likely that in many cases officers will be required to stay and supervise the person they detained. When taken to hospital by ambulance the responsibility for supervision would fall on ambulance or hospital staff which in turn could cause significant problems for Health as one detainee may require two or even three staff to supervise them whilst in A&E. It is not desirable to take detainees to A&E unless they have a specific facility for as a POS. This was set out in the report of the Royal College of Psychiatrists (the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine 1996) and expanded upon by Lynch (2002), though lack of capacity may make A&E a POS of last resort.

In Hampshire Constabulary the number of recorded Section 136 detentions are falling. In 2015/16 there were 692, in 2016/17 there were 713, whilst in 2017/18 there were 543. The projection for 2018/19 is 366. This may arise from a number of sources. When this data was collected the only operational Triage Scheme was a 'Street Triage' scheme on the Isle of Wight whilst now, they are more extensive and operate in partnership with the ambulance service. As the fall in number of detentions predates the introduction of a force wide Triage scheme it seems likely that the scheme was only in part responsible

for the fall. The Force has published policies which encourage officers and staff to use their discretion in dealing with such (and other) incidents and they state they have effective arrangements in their partnership with the Ambulance Service which has resulted in them taking responsibility for a larger proportion of such mental health emergencies. As most forces have Triage Schemes in place and yet the number of detentions nationally continue to rise, the implication is that Triage Schemes in themselves are not sufficient to reduce the number of Section 136 detentions. Triage Schemes in combination with better working practices with ambulance services and other Health partners and more discretion exercised by officers especially in involving family and friends in caring for those in crisis appear to offer the best prospects.

In addition to the 46 Section 136 'type' incidents there were 147 other mental health incidents that officers were deployed to. The behaviour in these two types of deployment were quite different. Whilst eighty nine percent of the Section 136 incidents related to threat of self-harm, this was only present in only fifty five percent of other deployments. This was reversed for crime and domestic disputes which were thirty one and eleven percent of other deployments and only nine and two percent of Section 136 type deployments. This is the established pattern that self-harm is the causal factor for Section 136 type incidents.

It is possible on the basis of the descriptions in the police records to further categorise the incidents. This analysis is more *cautious* given that it is based on a summary account recorded in the control room, from an assessment provided from the scene by an 'unqualified' person and the numbers are quite small. For the forty six Section 136 type incidents these can be described thus:

- **Suicidal**. 23 (50%) An attempting or direct threat of suicide.
- **Delusional**. 6 (13%) Where the perception of reality appears disturbed or distorted.[vi]
- **Distressed**. 9 (20%) Where they are described as very distressed.
- **Irrational**. 5 (11%) Where their behaviour is described as irrational.

- **Attention seeking.** 2 (4%) Where their purpose appears to be to get attention from the police.
- **Behaviour.** 1 (2%) Difficult or uncooperative behaviour. In most cases this concerned requests from other organisations or carers for assistance.

For the 147 other deployments the pattern was different.

- **Suicidal**. 13 (9%).
- **Delusional**. 24 (16%).
- **Distressed**. 28 (19%).
- **Irrational**. 19 (13%).
- **Behaviour**. 28 (19%) and in addition
- **Dementia**. 25 (17%) Where the person was identified as suffering from dementia.
- **Absconders**. 6 (4%) These were absconders from assessment or treatment by Health.
- **Assistance**. 4 (3%) Other requests for assistance from partners.

Whilst the behaviours in 'distressed' or 'irrational' can be described it is impossible to say what the underlying state of mind of the subject was. In contrast in the absence of these behaviours the delusional nature of the subject can often easily be seen. Taken together with delusional behaviour they constituted forty four and forty eight percent of incidents. A similar percentage which implies that these behaviours were not material in the decision as to whether the person was detained under Section 136. That decisions was mostly determined by the level of risk of self-harm.

Dementia resulted in deployments but none that appeared to be suitable for detention under Section 136. A lack of mental capacity through dementia would be more suitably dealt with using Sections 4 and 5 of the MCA.

In two hundred and forty three incidents (56%) there was no police or other attendance. These can be divided into two principle categories: single callers and frequent callers and then the same categories as above. This comparison is set out below in table 3.

Table 3.

The non-deployed suicidal incident was exceptional and arose when a member of the public rang to say her friend was distressed and suicidal but that she had calmed her down and would look after her. Apart from that case, threats of suicide were deployed to by the police and high-risk cases were detained or often left in the care of other agencies or family members. Delusional callers who appeared 'low risk' were most often not deployed to – this is in accordance with clinical advice received by Hampshire Constabulary. Li et al. (2018), reporting from New Zealand, analysed their increase in demand through mental illness. They found a similar rise in high risk threats of suicide calls but also a disproportionately large rise in non-deployment 'low risk' calls. Their study over nine years, supports and compliments this work showing the growth in calls disproportionally arises through low risk calls.

Distress or irrationality appear equally often in deployed and non-deployed incidents and so these behaviours do not appear to affect police actions and outcomes.

Requests for assistance from carers because of poor behaviour most often related to Learning Disability or Autism and is a small but growing area of police work as was reported previously (Thomas and Forrester-Jones 2018). Similarly calls relating to dementia must be set to grow in volume and were around half of a percent of Hampshire Constabulary incidents in this study.

Finally, there has been recent publicity about high frequency callers to police and other emergency services (https://www.bbc.co.uk/news/uk-england-43293581). This is equally true for Hampshire Constabulary. The top ten callers in 2016 made 6,131 calls, the top caller alone made 2,636 calls. This caller fitted the pattern of delusional calls, not deployed to. There were few if any deployments to this

caller, but it is noticeable that the staff taking the calls were kind and courteous which may reinforce the behaviour. The force has local partnership meetings to discuss the care and management of such high frequency callers living in the community, but it is reported that it is very difficult to limit such calls.

Conclusions.

Detentions under Section 136 of the MHA continue to rise nationally though there are forces such as Hampshire Constabulary where numbers are falling. It does not appear that the presence of a Triage Scheme alone is sufficient to reduce the numbers of detentions. This requires effective partnership working, which is dependent upon the willingness of partners, and the more effective use of discretion by officers. The latter is under the control of forces but requires them to manage the often risk-averse behaviour of their own officers and staff. A useful further study would be to examine the same data in a force with a high detention rate using Section 136.

The evidence in this paper offers a way for forces to assess their use of Section 136 and the effectiveness of their partnership working. This in turn sets out priorities for future action to reduce the use of Section 136 and avoid the 'pitfalls' above.

The prohibition on the use of Police custody facilities for Section 136 detentions has resulted in an increase in detained persons being taken by officers to hospital A&E departments – presumably as a POS of last resort. This may become problematic and time consuming for officers and forces may wish to address this before the problem gets worse.

Where the number of police detentions fall the individuals in crisis are often detained instead by the ambulance service, which in turn is likely to cause significant problems for them and elsewhere within Health such as in A&E.

Detention, whether under Section 136 or the MCA in most cases arose from an assessment of a high risk of self-harm. Other behaviours or symptoms of illness such as distress, irrationality or delusions may

have prompted police attendance but more often than not did not cause detention. It appears likely that a disproportionate part of the growth in calls to the police over recent years concerns people who would generally be described as at low risk of harm to themselves or others and who most commonly display delusional behaviour. High frequency callers most often exhibited delusional behaviour alone and were least likely to experience a police attendance. The example from Hampshire shows that careful assessment of risk can minimise the real time response from the police to many calls, whilst facilitating the multiagency management of mentally ill people in the community.

Further research on the impact of the MCA, as used by the ambulance service and the police, and its effect on potential Section 136 detentions would be useful in informing public policy.

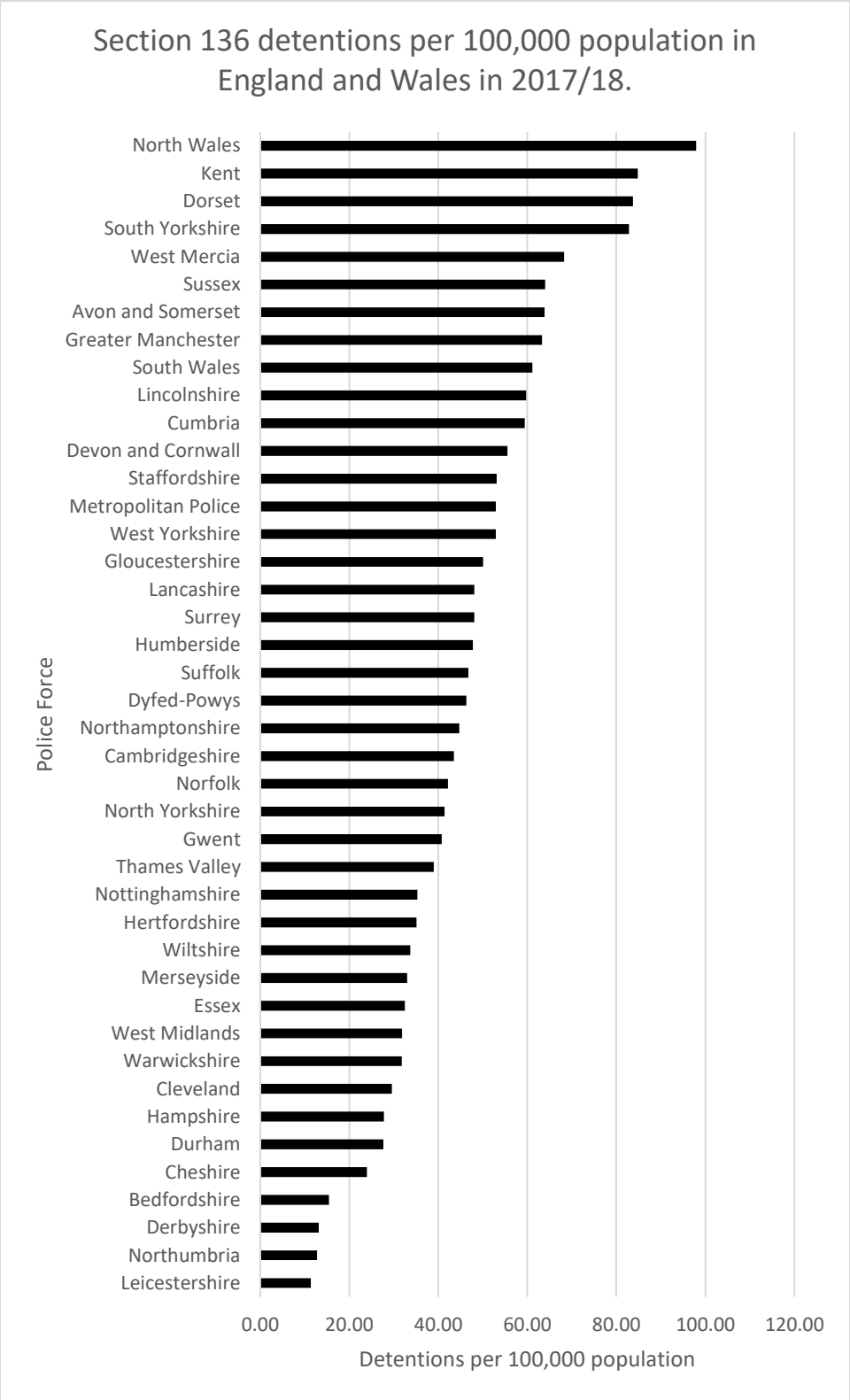
Table 1

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

Year	Number detentions E&W
2013/14	21,394
2014/15	23,602
2015/16	28,271
2016/17	26,328
2017/18	29,662

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

Figure 1.



Source: As per table 1 and in addition from:
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables/current

Figure 2.

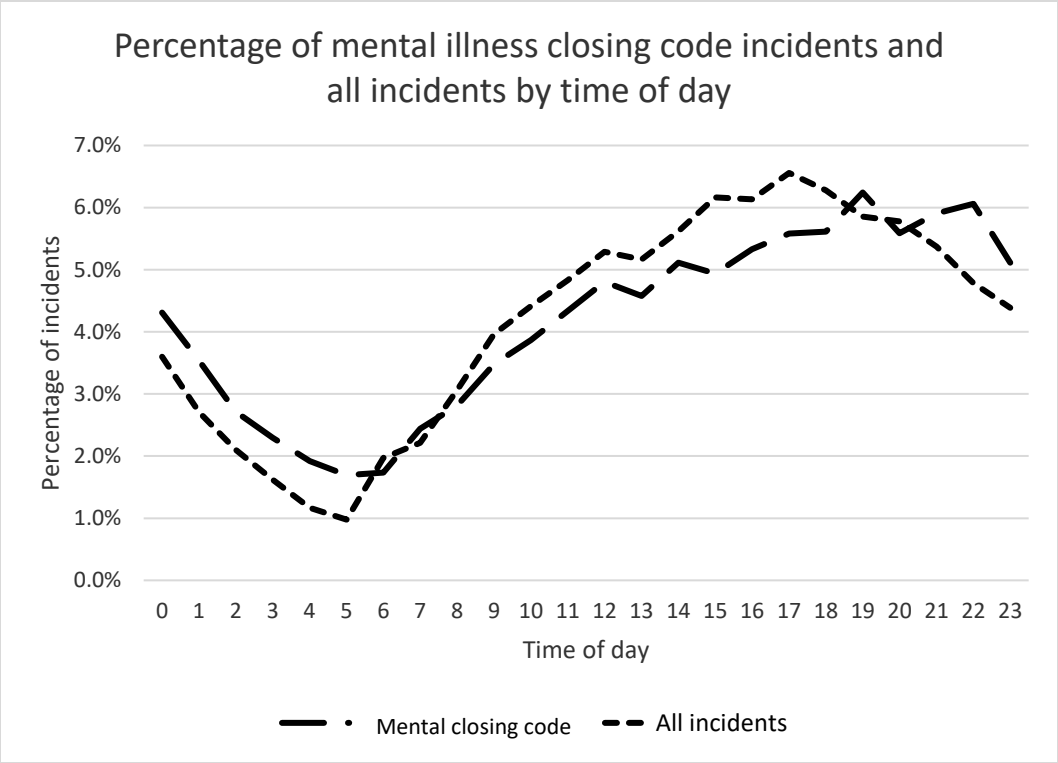


Table 2

Section 136 detentions in England and Wales 2013 to 2017 and places of safety.

Year	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Total S136 detentions England and Wales	23602	28271	26328	29662
Detained police station	4537	2100	1029	471
% Police station	19.2	7.4	3.9	1.6
Health Based Places of Safety	19065	26171	20435	23414
% HBPOS	80.8	92.6	77.6	78.9
Accident and Emergency			1944	3243
% A&E			7.4	10.9
Other			360	453
% Other			1.4	1.5
Not Known			2560	2081
% Not Known			9.7	7.0

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

Table 3.

Comparison of mental incident types for deployed and non-deployed incidents.

Behaviour	Section 136 type incidents n=46	Other deployments not Section 136 n=147	Non-deployment frequent callers n=113	Non-deployment single callers n=130
Suicidal	50%	9%		2%
Delusional	13%	16%	56%	29%
Distressed	20%	19%	13%	15%
Irrational	11%	13%	18%	22%
Attention seeking	4%		8%	4%
Behaviour	2%	19%		5%
Dementia		17%	4%	18%
Absconders		4%		
Assistance		3%		
Other				4%

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[i] The other illness subject to compulsory treatment in the UK is Tuberculosis and is through Sections 37 and 38 of the Public Health (Control of Disease) Act 1984

[ii] Only applies in England and Wales

[iii] Excludes the City of London and British Transport Police where comparisons of resident populations are meaningless.

[iv] For full lists see https://www.justiceinspectorates.gov.uk/hmicfrs/crime-and-policing-comparator/about-the-data/

[v] At that time Hampshire Constabulary had a contract with MEDISEC, a private ambulance company to take all Section 136 detentions to a POS. The contractor has since changed but a private ambulance service is still employed.

[vi] The Royal College of Psychiatry defines the term as the term 'delusion' to denote a pathology in which a belief held with unshakeable conviction runs counter to the prevailing cultural norm.