Examining and understanding the use of the police custody as a "place of safety" under section 136 of the Mental Health Act

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Examining and Explaining the Use of Police Custody as a "Place of Safety" under Section 136 of the Mental Health Act

A thesis submitted for a Doctorate of Law

King's College London, School of Law, 2013

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Abstract

This thesis describes the use of police custody as a 'place of safety' and examines the deaths of those detained under the power to explain how they might best be prevented. The police are often the first agency to be called and attend difficult and potentially confrontational situations. They may have to deal with vulnerable, disturbed, distressed individuals behaving in bizarre or aggressive ways. However, police officers generally do not have the skills and understanding to deal with these people. There is currently very little evidence about the nature and extent to which police custody is used as a 'place of safety' under Section 136 of the Mental Health Act 1983 or the details of those detained. Many deaths in police custody involve people with mental health problems and deaths in custody remain a highly contentious issue. This is particularly the case for Black and Minority Ethnic (BME) communities who have experienced some of the most controversial deaths and where trust and confidence in the police have traditionally been lower.

This thesis explains why variations in the use of Section 136 of the Mental Health Act 1983 occur by exploring the data gathered from police forces. In particular it explores the possibility that variation in the use of Section 136 may be linked to differences in police cultural knowledge or 'habitus', with some forces having more positive working relationships with health and social care than others, and differences in the wider 'field' with the availability of alternatives to police custody varying greatly across police force areas. The relationship between the 'field' and 'habitus' cannot be underestimated, with the availability and prioritisation of resources and cultural knowledge of the police and other agencies influencing and impacting on each other. In

turn, this can be affected by a number of issues such as police leadership, training, law and policy.

Acknowledgements

The empirical research for this thesis was conducted while I was working as a Senior Research Officer at the Independent Police Complaints Commission (IPCC). The IPCC kindly gave me permission to use the data on which this thesis has drawn. The data were collected for two separate studies; the first was published in September 2008[1] and the second in 2010[2]. I am grateful for the assistance and support of the other researchers who worked on these projects and helped to collect and analyse the data. In particular I would like to thank Kerry Grace who helped to conduct the interviews for research into Section 136 and assisted in analysing the qualitative and quantitative data for this study. I would also like to thank Tom Bucke for editing the IPCC report on Section 136, for his support and encouragement and for helping to secure IPCC funding for me to study for this thesis. The methodology chapter explains in greater depth how this thesis builds upon and deviates from the IPCC studies and the roles of the individuals named as authors on the IPCC reports. I am also grateful for 'Way with Words' who professionally transcribed the interviews, and 'Eurodata' who inputted the quantitative data on deaths in custody into SPSS for analysis. All 43 Home Office police forces provided data for this research and several gave their time to participate in qualitative work, without their support and co-operation this thesis would not have been possible. Anonymity prevents me from thanking individuals.

[1] Docking, M., Grace, K. and Bucke, T. (2008): *Police Custody as a "Place of Safety": Examining the use of Section 136 of the Mental Health Act 1983*. IPCC Research and Statistics Series: Paper 11. IPCC: London

[2] Hannan, M., Hearden, I., Grace, K. and Bucke, T. (2010): *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09*. IPCC Research Series Paper: 17. IPCC: London

Thanks to my supervisor Ben Bowling who encouraged me to try to reach my academic potential and has remained patient throughout. Thanks also to Genevra Richardson for acting as my second supervisor and for offering helpful and constructive criticism.

Finally, I would like to thank my parents and granddad for always believing in me, and Guy for his never ending support, patience and generous tea making.

Disclaimer

Except where specified all work in this thesis is my own.

This thesis does not reflect IPCC policy or views and any errors or omissions are my own.

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Introduction

> People who are picked up in public places by the police in an emergency are highly vulnerable. A police station is never the best place for such people to be kept for as many as three days. As the government has acknowledged, holding someone in a police station can give them the false impression they have committed a crime. Police officers are rarely trained to manage the needs of people in a mental health crisis. Police stations lack the facilities to cater for people who need urgent health care and they can be distressing environments to be kept in. Statistics show that half of people who die in police custody have mental health problems (Angela Greatley, Chief Executive of Sainsbury's Centre for Mental Health, *The Guardian*, May 2008).

The police are often the first agency to attend difficult and complex incidents which may involve some of the most vulnerable members of society. However, they may not have the understanding, knowledge or resources available to them to be able to deal effectively with some such situations and people. Dealing with mentally ill people is one such example. In addition the police have a large amount of discretion in terms of how they can choose to exercise their powers, particularly at street level. Police discretion is necessary in order for officers to make decisions appropriate to the situations they are dealing with but it has been shown to have problems in its application. For example, research has shown that police discretion has led to disproportionality in the way in which their powers are used and the groups upon whom the resources are focused.

This thesis examines the use of police custody to detain individuals in a 'place of safety' under Section 136 of the Mental Health Act 1983 (hereafter the Act). Section 136 detainees are individuals who are deemed to be 'in need of care or control' and may be exhibiting a variety of symptoms of potential mental illness such as acting in a bizarre, aggressive or irritable manner,

experiencing hallucinations, delusions or paranoid ideas, and having extreme high or low moods. For people experiencing these issues a police cell is therefore an unsuitable environment which may exacerbate their symptoms and lead to a feeling of being stigmatised. However, there is little existing research on the use of this power, particularly outside of London, so this study will contribute to the evidence in this area. This thesis analyses the existing literature on the use of this power as well as using empirical research to produce primary data on Section 136 and identify variations in its use across England and Wales. It seeks to provide possible explanations for this variation by examining it within the wider context of law, policy, research knowledge, and theoretical literature on police occupational culture. The intention is to identify the main drivers for police practice and to think about the ways in which change may occur.

It is likely that the way in which the police deal with the mentally vulnerable people they encounter under this power is dependent on the attitudes and training of the individual officers, their senior command team and the leadership they provide, as well as the resources available in the police force area. Having legislation and policy to set out the ways of working across forces in England and Wales does not necessarily lead to consistent practice. Occupational culture, training and education, and strong leadership can also impact on operational practice on the ground.

Chapter one sets out the history of police powers to detain, the safeguards placed around these powers, and examines the specific legislation and official policy governing the area. It argues that the safeguards established in law are sometimes flawed in practice. It highlights the contradictions and debates about the way in which mentally disordered offenders should be

treated; whether to divert them away from the criminal justice system or to detain them to 'protect the public'. It suggests a greater need for multi-agency working in this area, better training and improved information sharing. It also draws attention to the large gap in knowledge around the extent to which police custody is used as a place of safety.

Chapter two then moves on from the legislation and policy governing Section 136 to discuss wider theories of policing and the drivers for their actions and ethos. It argues that the law and policy alone do not drive the police and that police occupational culture in particular could influence the way in which the police operated on the ground. Leadership can help to shape and change operational practice and can be harnessed for good. Chan's (1997) theories of changing police culture offer a useful insight into how police culture and therefore practice in the use of on Section 136 can be improved; by changing both the 'habitus' (or cultural knowledge) of the police and the wider 'field' in which they work. In this context this means effective working relationships with health and social care agencies which can lead to greater provision of alternative places of safety. The change to the field would also require greater societal changes with mental health being seen as an important area for funding for government and a worthwhile use of tax payers' money.

The chapter then looks at the existing empirical and statistical evidence on the use of police custody and the detention of mentally disordered offenders and Section 136 detainees, as well as examining deaths in police custody. There is a lack of reliable evidence on the extent to which people are detained by the police who have mental health needs. The available evidence suggests that those who are detained are vulnerable and often have complex needs. These needs are

frequently not met due to a lack of a co-ordinated approach by a range of agencies. There is empirical evidence which shows that the safeguards to protect people sometimes fail. And in the most tragic cases this can lead to deaths in or following police custody.

Chapter three sets out the methodology for this thesis describing the aims and objectives for the research and makes an argument for a mixed methods approach to addressing these. **The overall aim of this thesis is to examine the extent and use of police custody as a place of safety under Section 136 of the Act, the nature of police contact with mentally disordered individuals, and the deaths that arise from these incidents.** Within this overarching objective there is a desire to examine how and why police practice varied, using the available evidence and theories of policing to explain any differences. The research used quantitative data to paint a picture at a national level and qualitative data to examine the issues in more depth in specific localities. It acknowledges the possible impact of my role as a researcher at the IPCC in the research process, the contributions of other IPCC researchers and the relationship between the IPCC studies and this thesis, as well as the steps that I took to limit the effect of my IPCC role. It also highlights the limitations of the scope of the research and the continuing gap in our knowledge from the perspective of service users.

The remainder of the thesis examines the empirical evidence I gathered for this thesis and draws conclusions from this research in light of the wider body of research literature. The empirical evidence is split into three chapters; chapter four focuses on the quantitative evidence on the prevalence of Section 136 detentions in police custody and the make up of those who are detained. However, it also explores the decision to detain individuals, the training that police

officers receive on Section 136 and it discusses why the use of Section 136 detentions in police custody might vary across England and Wales. In particular it explores the possibility that variation in the use of this power may be linked to differences in police cultural knowledge or 'habitus', with some forces having more positive working relationships with health and social care than others, and differences in the wider 'field' with the availability of alternatives to police custody varying greatly across police force areas. The relationship between the 'field' and 'habitus' cannot be underestimated with, for example, the availability and prioritisation of resources and cultural knowledge of the police and other agencies influencing and impacting on each other.

Chapter five looks at the care detainees receive while in police custody under Section 136, examines any deaths which have occurred while individuals have been detained and how they might best have been prevented and, looks at what happens to other individuals when they are released from custody. It looks at the failure of the safeguards around Section 136 detentions in some tragic cases, and the variation of practice across different forces. Again this appears to be related to both the 'habitus' and 'field' rather than legislation or local policies that are in place. Given that the legislation is consistent across England and Wales differences in how it is applied and interpreted appear to be linked to the cultural knowledge and beliefs of the police within different forces in terms of how they prioritise and treat individuals, as well as different resources that are made available to them and the working relationships and practices of the agencies on the ground.

Chapter six goes onto explore working relationships in more detail and examines multi-agency working within the context of Section 136 detentions and mental disorder more generally. It looks at the various types of multi-agency working and the levers for driving good practice and positive changes on the ground. It examines the differences between what is set out in local policies and the practice on the ground in some of these police force areas. It looks at the positive effect that multi-agency working can have on police occupational culture and how this can translate into a gradual shift in the 'habitus' leading to an improved 'field' within which Section 136 detainees can be cared for appropriately. By working with other agencies with differing perspectives and training the police culture can adapt to one in which the care and appropriate treatment of Section 136 detainees is at the forefront of officers minds. This in turn can lead to a shift in the prioritisation of resources and greater impetus to work collaboratively. In chapter seven, the findings and conclusions from both my own empirical research and the wider literature are brought together to highlight the key issues and suggests ways in which the use of Section 136 can be better understood and how practice might be improved in the future.

1. Police Powers to Detain, the Mentally Disordered and Safeguards in Detention

> *For as long as the police have had powers of detention for the purposes of questioning there have been concerns about the treatment and welfare of people in custody in police stations* (Newburn and Hayman, 2002: pg. 3).

Introduction

This chapter outlines the history and development of police powers to detain people and the safeguards which exist to try and protect those in custody and ensure their wellbeing. It will then examine the specific legislation and policy which allows the detention of people with mental health needs. This chapter therefore provides an overview of the relevant background on police powers to detain and the legal protection that should be afforded to detainees. It aims to set the context for the following chapters where theories of policing and the research evidence on actual police practice in this area is explored to examine how the reality of policing may differ from the position set down by legislation and policy.

History of police powers to detain

Locke set out a justification for governmental authority which is known as contract theory; in simple terms it means "the exchange of complete freedom for some measure of protection by the state" (Bowling and Foster, 2002: pg. 982). This theory which balances the interests of security and liberty, has dominated contemporary explanations of policing (Kleinig, 1996). The police have the power to arrest, detain and charge suspects and are in a unique position of being able to use reasonable force against civilians in some situations, but at the same time have the duty to

protect us. However, contract theory does not provide a complete explanation of policing and the scope of police powers, as police practice is highly complex and subject to high levels of discretion (Bowling and Foster, 2002). It is therefore vital that there are sufficient safeguards and accountability mechanisms to ensure that these powers are used fairly, legitimately and justly.

When people are taken into police custody the safeguards surrounding their care are key for the protection of the detainees. Until the early 1980s police powers were governed by 'Judges' Rules', a set of principles and practices which provided the police with guidance on what they were allowed to do when seeking to find offenders (Brown, 1997; Newburn and Hayman, 2002). The 1970s saw an increase in concern over police powers and accountability (Newburn and Hayman, 2002; Reiner, 2000). There were high profile miscarriages of justice such as the Guildford Four and Birmingham Six which also led to a rise in fear of abuse of police powers, and the lack of safeguards to protect the rights of those detained in police custody (Brown, 1997; Newburn and Hayman, 2002).

In 1977 the Royal Commission on Criminal Procedure (RCCP) was announced to Parliament, by the then Prime Minister, James Callaghan (Reiner, 2000). This was set up to report on the use of police powers and an extensive programme of research to assess police powers and safeguards were undertaken. Alongside this, the early 1980s saw large scale urban rioting which led to the Scarman Report; investigating the Brixton riots. The Scarman Report (1981) was critical of the police relationship with the Black community and made recommendations for change. In particular it highlighted the need for an independent oversight mechanism of the police

complaints system in order to monitor potential abuses of police powers. The RCCP also reported in 1981 and placed great weight on a balance between police powers and suspects rights stating that they were required to "have regard both to the interests of the community in bringing offenders to justice and to the rights and liberties of persons suspected or accused of crime…" (RCCP, 1981: pg. iv).

The first version of the Police and Criminal Evidence Bill was published by the then Home Secretary, William Whitelaw, in 1982 (Reiner, 2000). The Bill drew on the RCCP report but in a one-sided way; incorporating the proposals for greater police powers but omitting many of the safeguards (Reiner, 2000). The Bill therefore faced a great deal of criticism when passing through parliament and as a result a revised version was introduced in 1983 (Reiner, 2000). In 1984 the Police and Criminal Evidence Act (PACE) came into place and fundamentally reformed the law relating to the investigation of crime (Brown, 1997). PACE echoed the RCCP call for balance between suspects' rights and police powers and the Act's provisions were designed around three key criteria – fairness, openness and workability (Brown, 1997). Reiner (2000) describes PACE as "the single most significant landmark in the modern development of police powers" (pg. 176) and suggests that overall, it "seems to have had a profound effect on the nature and outcomes of police handling of suspects" (pg. 180). Whilst PACE is likely to have had an enormous impact on police practice, it is important to note the complexity of the relationship between the police and the law; this will be discussed in later in this chapter and in the subsequent chapters.

PACE and PACE Codes of Practice; safeguards for those held in police custody

PACE sets out the powers the police have to stop and search individuals, to enter a property, search and seize property, to arrest and detain individuals, and to question suspects. The accompanying PACE Codes of Practice set the standards for police practice within the law and must be adhered to by police officers. Although, Fielding (2005b) notes that "breach [of the Codes] does not occasion criminal proceedings, but internal disciplinary action" (pg. 69). PACE and its Codes of Practice also provide for safeguards on the use of these powers. The powers set down by PACE are therefore wide ranging but for the purpose of this thesis I will focus on the powers of arrest and detention as those are the most relevant.

Section 26 of PACE allows the police to arrest an individual and Section 32 permits them to search an individual considered to be in need of police intervention. Section 117 of PACE allows the police to use reasonable force in the exercise of their powers, and Section 30 requires the police to take a person arrested for an offence to a police station as soon as practicable after the arrest. Once the person arrives at the police station the custody officer should decide whether there is sufficient evidence to charge the individual for an offence under Section 37. An individual can be held at a police station for 24 hours before they have to be charged with an offence or released under Section 42, except where the alleged offence is an indictable one, where the maximum is 36 hours. From January 2004, new powers were introduced which enabled an officer of Superintendent rank or above to authorise continued detention for up to 36 hours for all arrestable offences. Additionally, the police can apply to magistrates for warrants of

further detention, extending the maximum detention period to 96 hours. With effect from January 2006 the offence coverage was revised to include all indictable offences (Povey et al, 2011).

PACE created a new role of a 'custody officer' (usually a sergeant), who is responsible for protecting the rights of suspects and is independent of the investigation of the crime (Newburn and Hayman, 2002). The custody officer has responsibility for the prisoners in their care, to let them know their rights, and look after their welfare. They are assisted by a 'gaoler', who was traditionally a constable, and completes the custody record (Newburn and Hayman, 2002). However, the Police Reform Act 2002 introduced Designated Detention Officers (DDO) into the custody environment and they are civilian members of staff. DDOs should be appropriately trained to assist the custody sergeant. It has become more common for forces to recruit DDOs to work in custody suites as they are cheaper to employ than warranted police officers.

Newburn and Hayman (2002) note that the role of a custody officer is an unusual one in the police service, as in principle it involves being an independent arbiter between the suspects held in custody and police colleagues who may wish to interview them (pg. 55). This puts them in a difficult and pressured position, as there is a strong sense of solidarity within police culture, a sense of 'us vs. them' in terms of the police against the criminals which has been discussed at length in the literature on police culture (Reiner, 2000) and this will be explored in chapter two. They may therefore be expected to support their police colleagues above the detainees entering custody.

There are also additional pressures placed on custody officers such as workloads and expectations of other professionals. Newburn and Hayman (2002) interviewed a number of custody sergeants and 'gaolers' for their research and found that they "most frequently spoke about the pressures of their work and being undervalued", they quote one officer as saying "'…in a very busy suite there should be better management. I am forced to break Codes (PACE Codes of Practice) continually to allow the job to work '" (pg. 58). The researchers found that:

> Officers are expected to adhere to high standards of professionalism, while coping with staff shortages, working in an ill-designed custody suite, facing distressed and sometimes abusive detainees, as well as coping with the professional demands of other such as solicitors and doctors (pg. 58).

Once detained in a police station, the detention of individuals is governed by PACE Code of Practice C. The Code of Practice has been amended several times (most recently in 2008), with the most significant changes occurring in 2003 when attempts were made to help strengthen the risk assessment of detainees. Code C of the Codes of Practice covers the 'detention, treatment and questioning of persons by police officers' (Home Office, 2008). The Code sets out the conditions in which detention should occur in the police station. This includes setting out the basic standards of physical comfort that should be expected, the use of reasonable force, the detention of vulnerable individuals such as juveniles and those suffering from mental illness, the need for regular checks on cells to ensure physical wellbeing – particularly where someone is intoxicated, and the provision of food and water. When an arrested suspect arrives in police custody they should be 'booked in' by a custody officer, and must be informed of their rights, both orally and by giving them a notice in writing (Code C, 3). Information pertaining to their arrest should be fully documented on the custody record for the individual by the custody officer.

The custody officer should then ask the detainee if they would like someone to be informed of their detention and whether they would like legal advice (Code C, 3.5). They should also seek to determine whether the detainee is or might be in need of medical treatment, needs an appropriate adult (see below), an interpreter or other help to check documentation (Code C, 3.5).

Appropriate adults

Under PACE there is a requirement for an 'appropriate adult' to be with vulnerable suspects during interview and set the length and timing of interviews. Appropriate adults are required to give support to juveniles and both mentally disordered or mentally vulnerable detainees. An appropriate adult in the case of a juvenile is:

- the parent, guardian or, if the juvenile is in local authority or voluntary organisation care, or is otherwise being looked after under the Children Act 1989, a person representing that authority or organisation;

- a social worker of a local authority social services department;

- failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police (Code C, 1.7 (a) (i-iii)).

In the case of a person who is mentally disordered or mentally vulnerable, an appropriate adult should be:

- a relative, guardian, or other person responsible for their care or custody;

- someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police;

- failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police (Code C, 1.7 (b) (i-iii).

A person should not be an appropriate adult if they are involved in the offence in any way; this includes a parent or guardian (Code C, 1B). Solicitors and independent custody visitors should also not be appropriate adults (Code C, 1F). The custody officer must advise the detainee that the role of an appropriate adult is to assist the detainee and advise them whilst they're in custody and that they can therefore meet in private if they want (Code C, 3.18). If an interview is conducted the appropriate adult should be told of their role to advise the suspect and observe that the interview is conducted properly (Bucke and Brown, 1997).

The Code of Practice, as set out above, provides a very wide definition of who can be an appropriate adult, and essentially means that in a situation where someone with responsibility for the detainee, or experience in dealing with vulnerable people is not available any other adult can be a substitute. Appropriate adults are there to provide vulnerable individuals with support which

may include giving advice, ensuring police interviews are conducted properly, and facilitating communication between the police officers and the detainee (Bucke and Brown, 1997).

Cherryman and Bull (1996) point out that when interviewing a vulnerable person the onus is on the police to identify when an appropriate adult is necessary and it is for them to then identify that person. McKenzie (1993) states that it is not always an easy task for the police to determine which adults in their custody fall into the 'vulnerable' category. Jenkins (1993) therefore recommended that custody officers and Forensic Physicians (FPs will be explained in more detail later in this chapter) should receive training in identifying mental illness and judging whether someone should be deemed fit for interview.

Bucke and Brown's (1997) study found that appropriate adults attended the police station in two thirds of cases involving mentally disordered patients – much lower than for juveniles. In terms of the reasons for not attending; there were a small number of cases where a social worker or parent refused, but in the majority of cases a doctor recommended that an appropriate adult was not required or that the detainee was fit to be kept in custody and interviewed. However, the requirement for an appropriate adult is separate from that of a doctor. Six out of ten appropriate adults in cases involving mentally disordered or mentally vulnerable detainees were social workers; friends or neighbours, and parents or guardians made up most of the remaining appropriate adults (Bucke and Brown, 1997). Of particular relevance to this thesis, Hodgson (1997) notes that:

> in instances of suspects with a mental illness, there is an additional conflict of interest where an approved social worker acts as an appropriate adult and is then involved in making a psychiatric

> assessment of the suspect for the purposes of removing the suspect to a place of safety under the Mental Health Act 1983 (pg. 791).

Gudjonsson et al (1993) found that twenty-five (15%) of their sample were considered by the researchers to need an appropriate adult to be called for their police interview. Of these 12 (7%) needed an appropriate adult because of a mental illness, four (three per cent) because of a mental handicap, and nine (15 %) for other reasons. An appropriate adult was requested in four (33%) of the 12 cases. Appropriate adults were called by the police in seven cases (4%). The researchers therefore argued that the police only called an appropriate adult in exceptional circumstances where they were fully satisfied that detainee had mental problems. However, the researchers also believed that the police were able to identify the most vulnerable detainees and take the necessary action to call an appropriate adult.

In Bucke and Brown's (1997) study the level of instruction given to appropriate adults was limited – 29% of family members received some form of explanation regarding the role and only 4% of social workers. This may be because officers assumed that social workers knew their role as appropriate adults, although previous research demonstrates that this is not always the case (Palmer and Hart, 1996). Family members may also have attended the station previously so that might be the reason why officers fail to talk them through the role, but again the knowledge should not be assumed. Only 5% of family members and 2% of social workers asked for an explanation of the appropriate adult role (Bucke and Brown, 1997). Hodgson (1997) states that "…once an appropriate adult has been secured, there is a great deal of evidence to demonstrate that most, whether parents or social workers, do not appreciate the nature of their role" (pg. 789).

She goes on to state that "whoever attends, the police do not encourage them to take an active role" (pg. 790). Littlechild (1995) states that:

> The reality is that the police station is very much the police's territory; they are very familiar with its physical layout, routines and processes. The appropriate adults can feel disempowered, and experience procedures and events moving along at a pace which leaves them feeling unable to take any control (pg. 542).

In addition to this, Newburn and Hayman (2002) point to a lack of understanding by the detainee regarding the role of the appropriate adult. They found that the detainees in their study did not necessarily understand that the information they disclose to an appropriate adult is not privileged and may be revealed to the police. Newburn and Hayman (2002) also found that it often takes a considerable amount of time for an appropriate adult to come to the station, particularly when a parent or guardian is unable or refuses to attend. This meant that people in their sample who needed the support often spent a disproportionately long period of time in police custody waiting for an appropriate adult to arrive; because vulnerable detainees cannot be interviewed, provide or sign a written statement, be intimately or strip-searched, or be cautioned or charged without the presence of an appropriate adult. There were occasions when officers had to resort to bringing in people off the street to act as an appropriate adult when detainees had been in custody for a lengthy period. As Hodgson (1997) puts it:

> It may be a simple case of who the police can find to come to the police station. In some instances, the person will be neither an adult, nor appropriate (pg: 789).

The dangers of using an appropriate adult where it is very unlikely that they will be familiar with the task and what is required of them have been discussed above. Given the importance of this role, the fact that they could essentially be someone without experience of dealing with vulnerable individuals or police custody, diminishes the effectiveness of the safeguard. Therefore in an ideal world:

> …An appropriate adult should have a greater understanding of the suspect's vulnerabilities (especially in the case of mental illness and learning disabilities) and suggestibility….there is much work to be done in raising awareness of the appropriate adult role, providing training and organising and funding reliable service provision (Hodgson, 1997; pg: 794).

Littlechild (1995) suggests that:

> To ensure that the appropriate adult role is being carried out effectively, in the manner intended, there is an obvious need to co-ordinate the quality of provision of such a service. Social Services departments would be best placed to undertake this role as they currently have responsibilities for all vulnerable groups (pg. 545).

Appropriate adults are an important safeguard provided by PACE, but the evidence in this section has shown that they are rendered less effective due to a lack of adequate provision, training and information. This means that those who most need them are not always given access to an appropriate adult, or at least one who is adequately informed or trained. Having a properly resourced appropriate adult service provided by a professional service such as social services would help improve this situation.

Risk assessments

Given the vulnerability of many people being held in custody, it is important that their needs are appropriately assessed as well as identifying any risks that they might present to themselves or others. PACE Code of Practice C Para. 3.6 states that:

> When determining these needs [the detainees' needs] the custody officer is responsible for initiating an assessment to consider whether the detainee is likely to present specific risks to custody staff or themselves. Such assessments should always include a check on the Police National Computer, to be carried out as soon as practicable, to identify any risks highlighted in relation to the detainee.

It is the responsibility of Chief Officers within the force to ensure that proper and effective risk assessments are implemented in their area (Code C, 3.7). Risk assessments must follow a structured process and the results must be recorded onto the custody record, with the custody officer ensuring that those responsible for the detainees' care are fully briefed on the detainees' needs (Code C, 3.8). The custody officer is responsible for taking any appropriate action following on from the risk assessment, for example trying to prevent self harm (by removing potentially harmful clothing or property), calling a healthcare professional, or increasing the levels of observation (Code C, 3.9). Risk assessment should be an ongoing process which is subject to review (Code C, 3.10). The Association of Chief Police Officers (ACPO) published "Guidance on the Safer Detention and Handling of Persons in Police Custody" (2006) which sets out more detail on risk assessment as well as the detention and care of individuals in police custody and this will also be referred to where appropriate throughout this thesis.

Under Para 9.3 of the Code, all detainees should be visited at least every hour, and if no "reasonably foreseeable risk was identified in a risk assessment there is no need to wake a sleeping detainee". For those who are "suspected of being intoxicated through drink or drugs, or having swallowed drugs…or whose level of consciousness causes concern must, subject to any clinical directions given by the appropriate health care professional…be visited and roused at least every half hour, have their condition assessed as in Annex H, and clinical treatment arranged if appropriate". Annex H of PACE Code C sets out an observation check list for officer to follow when checking and rousing detainees in their care is it set out in Box 1.1 below:

Box 1.1: Annex H PACE Code C detained person observation list

1. If any detainee fails to meet any of the following criteria, an appropriate health care professional or an ambulance must be called.

2. When assessing the level of rousability, consider:

Rousability – can they be woken?

• go into the cell

• call their name

• shake gently

Response to questions – can they give appropriate answers to questions such as:

• What's your name?

• Where do you live?

• Where do you think you are? *Response to commands* – can they respond appropriately to commands such as: • Open your eyes! • Lift one arm, now the other arm! 3. Remember to take into account the possibility or presence of other illnesses, injury, or mental condition, a person who is drowsy and smells of alcohol may also have the following: • Diabetes • Epilepsy • Head injury • Drug intoxication or overdose • Stroke

Source: Home Office (2008) *Police and Criminal Evidence Act 1984 (PACE). Code C: Code of Practice for the Detention, Questioning and Treatment of Persons by Police Officers*. Pg: 84

Forensic Physicians

If a detainee "appears to be suffering from physical illness; or is injured; or appears to be suffering from mental disorder; or appears to need clinical attention" (Code C, 9.5) the custody officer should ensure that they receive appropriate clinical attention as soon as reasonably practicable. If the need for medical attention is more urgent the custody officer should call a health care professional or ambulance immediately. A health care professional in a police

custody setting will generally be a FP (formally known as Forensic Medical Examiners or Police Surgeons) although some police forces are beginning to use custody nurses for this purpose. The Bradley report (2009) found that:

> Health services in police custody are not currently commissioned by the NHS, but by each individual police force. There have been studies looking at different models of such provision that found that they broadly fall into one of, or a mix of, the following categories:
>
> - Traditional Forensic Medical Examiner (FME) [FP] services
> - Privately provided services
> - Directly employed custody nurses
> - Liaison schemes (pg. 47).

Kelly et al (1993) point out that the FP role is of vital importance to the work of custody officers as they determine someone's fitness to be detained and fitness to be interviewed. They have a role to play in balancing the welfare of the detainee and the need for a swift investigative process, and not least in protecting the suspect's rights (pg. 160). Brown (1989) and Robertson (1992) found that the provisions relating to the FP had the effect of substantially increasing the proportion of cases in which FPs were called, though there were considerable variations between police stations. A detainee may also request attention and if they do an appropriate health care professional should be called as soon as practicable (Code C, 9.8).

Kelly et al (1993) reported on primary research on FPs consisting of a national postal survey and qualitative interviewers with a smaller sample from across different policing areas, as well as a

study in the Metropolitan Police Service on their FP service (pg. 161). They found that (at that time) the majority of FPs were general practitioners (91%) and that this meant that the role had developed in an ad hoc fashion with no central co-ordination of their services (pg. 161). This meant that there were inconsistencies across forces in terms of the recruitment and training of FPs, and in some cases may have had serious implications in that the FP did not understand the potential importance of their work within the context of the criminal justice system (pg. 163).

Their research also found that FPs faced challenges in balancing the skills they required for this specialist role and in balancing their variety of responsibilities as well as inter-agency co-operation (Kelly et al, 1993; pg. 168). Some of the FPs stated that they would like to see the role professionalised and some police officers also agreed that they would like to see FPs with a more specialist skill set (pg. 168). Problems were acknowledged by both police officers and FPs in terms of the difficulties in balancing their role as a general practitioner as well as a FP, and the fact that this meant that they were not always available to conduct FP work (pg. 169). In rural areas there was the added complication of some FPs seeing their own patients in custody and the need to be clear about the capacity in which they were seeing the individual and ensuring that was clear to the person (pg. 170).

Since Kelly et al's (1993) research was conducted, the Faculty of Forensic and Legal Medicine was formed in 2006 with an aim of promoting forensic medicine, developing good practice and establishing a training pathway for practitioners[3]. However, whilst there may have been some improvements, Wall (2008) indicates that around 30% of FPs may not have been appropriately

[3] See http://fflm.ac.uk/faculty/ for more information.

trained. The need for a professional service who are appropriately trained is important in order to maintain what Kelly et al (1993) see as a balance between the caring and medical role and forensic side of the role. They suggest that it is the tension between these two roles that is sometimes difficult as welfare decisions can affect investigative actions and investigative procedures can exacerbate the difficulties of maintaining a caring approach (pg. 164).

Kelly et al (1993) suggest that there are two aspects to the police and FP role in the mental health context: the assessment of suspects' mental health and the assessment of those individuals brought to the police station as a 'place of safety' under Section 136 of the Act (pg. 166). Their research found that police officers in the Metropolitan Police Service were sometimes concerned that the FP would pass responsibility to a psychiatric hospital, were too cautious in their recommendations about a suspect, and were concerned about the level of qualification of FPs in their area (pg.167).

Gudjonsson et al (1993) found that a FP was called out by the police prior to interview in 26 cases (16% of their sample). They found that a FP was typically called in when the police suspected or noted physical rather than mental health problems. In Bucke and Brown's (1997) research fourteen per cent of those in custody received medical attention. However, this varied widely between the police stations the research looked at, with one quarter of detainees at one station compared to 7% at another receiving attention. This may be due to the location of the station, for example in the town centre police station more people were treated due to drunkenness, but it could also be due to differences in informal policies of custody officers. Of those receiving medical attention in their sample 58% were for physical injuries, 23% for

drunkenness, 14% for a suspected medical condition, 12% for suspected drug addiction, 12% for a suspected mental disorder, and 3% for other illnesses. Following the medical assessment; 74% were deemed fit to be detained, 27% fit to be interviewed, 15% were allowed medication, 7% were to go to hospital, 7% did not require an appropriate adult, 4% did require an appropriate adult, and regular checks were advised for a further 4%.

In Newburn and Hayman's (2002) sample almost half (47%) were seen by a FP. This is a much higher figure than that found by the Gudjonsson et al (1993), Bucke and Brown (1997) and by Brown (1997) who found that a doctor was called in up to 7% of cases. However, this difference can be explained in part by the difference in the police station the sample was taken from. Brown (1997) found that the highest call out rates of FPs were in the Metropolitan Police (where Newburn and Hayman conducted their research) and also found that the most common reason for the callout was drunkenness. In Newburn and Hayman's research 44% of people seen by the FP were deemed to be 'unfit through drink', 12% were addicted to drugs and nearly 8% had mental health problems. They found that the possibility of being seen, or needing to be seen, by a FP increased with age. In addition, "proportionately, over twice as many women as men had attempted self-harm' and women were more likely to have mental health problems, and less likely to be unfit through alcohol" (Newburn and Hayman, 2002: pg. 47).

Bucke and Brown (1997) found in their sample that a doctor attended in just over three quarters of cases where the detainee had mental health problems (this is a requirement under PACE). While such medical attention focused on the nature and extent of any mental problems; a small number of cases also concerned other matters including physical injuries, drunkenness, drug

addiction and medical conditions. Where the doctor had attended the recommendation in over a third of cases was for an appropriate adult to attend (37%), an appropriate adult was not required in just under a third (30%), in 30% of cases the detainee was found to be fit to remain in custody and 13% were also deemed fit to be interviewed, only 9% were recommended for hospital attention and 4% for regular checks. Newburn and Hayman (2002) found that the data they collected did not allow an accurate account of how frequently the cells were checked, they did however establish that the major imperative seemed to be uniform checks rather than checking according to individual detainee's needs.

The research therefore shows that FPs are regularly called to assess detainees in police custody but that in the case of those with mental health problems this is not as robust as it could be. This could be due to custody officers not initially recognising a mental illness, and/or may be due to other factors such as how seriously they treat people with mental health needs and the importance they place on their care. Where a FP did attend there was a low rate of people deemed to require hospital attention. Whilst this might be perfectly correct, it could also indicate the need for more specialist training for FPs and custody officers in recognising mental illness, as suggested by Gudjonsson et al (1993). As Newburn and Hayman (2002) note

> Officers are not medically trained and rely heavily on their own instincts as to a person's state of mind and the information provided by detainees when [the risk assessment form] is being completed at the booking-in stage (pg. 85-86).

More recently, Lord Bradley (2009) reported on the role of FPs in assessing individuals for mental health problems. It examined how well placed FPs were to deal with the high levels of

mental health problems within the police custody population. Bradley (2009) found that the role of the FP tends to be focused on "making judgements in terms of 'fitness to be detained' and 'fitness to be interviewed'" (Pg. 132). Whereas he thought that community psychiatric nurses who were sometimes based at police stations, were potentially more effective at identifying whether someone needed hospital admission than FPs, given their links to mainstream mental health services.

Bradley (2009) points out that police custody is the only stage in the criminal justice system where NHS commissioned care is not available. This means that there may be difficulties in sharing information about an individual and that the quality of the care they receive may be inconsistent (pg. 48). He therefore recommends to the Department of Health that:

> The NHS and the police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity (pg. 48).

This recommendation has yet to be implemented but the Home Office and Department for Health are exploring the possibility of transferring the commissioning of healthcare in police custody to the NHS (Hannan et al, 2010). This has followed a pilot in one police area reported on by Viggiani et al (2010).

> Overall it is hoped that, with the health service commissioning the provision of healthcare in custody directly, the level of medical care provided will improve, and there will be increased provision available on a 24-hour basis. It may also help to join up the work of various agencies, but in particular the police and health service, increase communication and information sharing… (Hannan et al, 2010; pg. 89).

Other safeguards – CCTV in custody suites

In October 1998 the Police Complaints Authority (PCA) held a conference entitled: 'Deaths in Police Custody: Reducing the Risks' and later published a report in the same name setting out the recommendations from the conference (PCA, 1999). The conference highlighted some key areas of concern: suicide and self-harm, drug and alcohol misuse and restraint issues, and led to calls for the expansion of CCTV in custody suites to include observation cells for particularly vulnerable detainees. They suggested that:

> CCTV coverage of custody suites should be expanded to include one or two observation cells for particularly vulnerable detainees (pg. 17).

On drugs and alcohol misuse the PCA recommended greater clarity and revisions in the PACE Codes of Practice to improve the rousing of intoxicated detainees, improved training for FPs and the use of a 'scale of consciousness' to aid decisions on detainees, and training for custody officers on intoxicated detainees. This detail has been added to later versions of the Code – specifically several changes were made in 2003.

Newburn and Hayman (2002) state that in response to the PCA suggestions police forces gradually began introducing CCTV to cells for particularly vulnerable or 'at risk' detainees. Prior to this CCTV had generally been limited to the booking area and corridors, if it was available at all. The authors felt that the PCA recommendation that some cells should have CCTV for vulnerable people rather than all cells placed the burden on officers to decide who the high risk

detainees are. In a busy station there might be competing demands on these cells with officers unable to tell which detainees are most at risk. The officers who the researchers spoke to felt that by only having some cells with CCTV this increased the likelihood of allegations of negligence if they failed to put someone in one of those cells who later self-harmed (Newburn and Hayman, 2002). The view of the officers was therefore, that it was better to have CCTV in all cells or none at all.

In the late 1990s the Metropolitan Police and some other police forces began to introduce CCTV to booking areas in custody suites and into some cells (Newburn and Hayman, 2002). The Metropolitan Police conducted some small scale evaluations of the CCTV and found that officers working in the stations thought that the cameras had improved their professional behaviour, provided additional safeguards for officers and suspects and reduced complaints against officers (Metropolitan Police Service, 1997: Cited in Newburn and Hayman, 2002).

Newburn and Hayman's (2002) research showed the potential impact CCTV could have on possible discrimination by police officers in custody suits. A total of 12% of detainees in their research were strip searched while in custody. They found that there were significant differences in the ethnicity of detainees who were strip searched. Afro-Caribbeans were significantly more likely to be stripped searched (17%) compared to White detainees (8%). This could be explained in part by the type of offences that Afro-Caribbeans were likely to have been arrested for, for example 46% of drug arrests resulted in strip searches and Afro-Caribbean detainees were more concentrated in these offence figures (Newburn and Hayman, 2002). However, this fails to fully explain the disproportionality, as when drug offences were looked at as a separate sample of

cases 41% of White European detainees were strip searched compared to 52% of Afro-Caribbean detainees.

The researchers note that the disproportionality identified in the data chimes with allegations of discrimination that were brought to their attention through interviews with people from the local community (Newburn and Hayman, 2002). The installation of CCTV into the station and cells seemed to lead to a 30% reduction in the use of strip searches across the various ethnic groups, perhaps therefore holding the officers to account for their actions more thoroughly.

In terms of detainees with mental health problems Newburn and Hayman (2002) found that officers thought that the cameras were a great help as they enabled staff to monitor unpredictable behaviour. However, the authors note that whilst the use of CCTV can have many benefits and for many detainees may provide reassurance, "those with mental health problems might see the cameras as a malign means of observation" (pg. 54). This has the potential to worsen some mental health problems as it may cause them to be stressed or paranoid, although it is clearly very useful in monitoring and preventing self-harm and suicide.

Mental disorder and policing

Before going on to discuss mentally disordered offenders it is important to note that many of the people described in this thesis are not actually 'offenders'. The majority of people who are detained under Section 136 of the Act have not committed any crime but instead have come to the attention of the police due to their behaviour. For example, they may be acting in a disturbed

manner and threatening to harm themselves or others. However, as will be seen later in this thesis, due to the large amount of discretion the police have available to them some of these people are actually arrested for offences such as breach of the peace rather than being detained under Section 136, therefore becoming 'mentally disordered offenders'. Other individuals might have actually committed a crime but be suffering from a mental disorder. The Police Foundation (2009) state that there are generally considered to be three types of mentally disordered offender:

> 1. People who have an existing mental disorder, and who have committed an offence (but not necessarily been convicted); 2. People who have been convicted of an offence or are on remand and subsequently develop a mental disorder. 3. People with a mental disorder serious enough to prevent them from making a valid plea when brought to trial, or who may be found 'not guilty' for the same reason (pg. 1-2).

The first category is likely to consist of individuals who have committed minor offences and some of these individuals will probably not be charged by the police, the second category might include people who have been diverted from prison to hospital following an appropriate diagnosis, and the third category are likely to have committed more serious offences prompting the police to consider prosecution – however this last group are much smaller in number (Police Foundation, 2009). Following the implementation of 'care in the community' in the early 1990s and the closure of many psychiatric institutions the police have become more likely to attend to people with mental health problems who are in crisis (Lynch et al, 2002; Police Foundation, 2009), and statistics on mentally disordered offenders have shown a rise in their numbers (Ministry of Justice, 2010).

Peay (2008) notes that mentally disordered offenders present a challenge to health, criminal justice personnel and criminologists, in deciding and agreeing within whose remit they should fall. They are not 'exclusively ill nor uncomplicatedly bad' (Peay, 2008: pg: 746) and as such there has been an incoherence in the approach that the law, practitioners and policy makers have taken towards trying to deal with them. Home Office Circular 66/90 promoted the diversion of the mentally ill away from the criminal justice system where possible so that they should receive health treatment instead of being placed in custody. The Richardson Committee (1999) in their report on the scope of mental health legislation kept with this principle of dealing with mentally disordered offenders in terms of their mental disorder. However, as the decade wore on and the fear of crime became widespread, the public responded amicably to what Bottoms (1995) terms 'populist punitiveness' in the attitude of politicians and the media towards those deemed to be 'dangerous' (Ashworth and Hough, 1996), and this has included the mentally disordered.

Changes in the law have pushed mental health law into the direction of 'penal law' and illustrate a growing shift in the desire to maintain penal control over mentally disordered offenders (Peay, 2008). However, it is important to note that despite some high profile media coverage of controversial cases, people with mental health problems are more likely to be victims of crime than perpetrators (Hall et al, 1998 and Teplin et al, 2005). The policy context for mentally disordered offenders is therefore one of contract and contradiction, calling for diversion from the potentially harmful effects of the criminal justice system for these offenders, but then at the same time showing a distrust for therapeutic disposals for mentally disordered offenders – particularly for more serious offenders (Peay, 2008). It is against this backdrop that I will now examine the law and policy applicable to the main focus of this thesis: those detained under Section 136 of

the Act who tend to be at the less serious end of offending (if they have offended at all) but yet are still being drawn into the criminal justice system.

Section 136 of the Mental Health Act 1983[4]

A key pathway into police custody for those with mental disorders is via Section 136 of the Act.

> The power of the police to detain mentally ill people dates back to the Vagrancy Acts of 1714 and 1744, which allowed a constable on the order of two magistrates to lock up a 'lunatic pauper' in a secure place". Unlike the earlier acts, which permitted the constable to apprehend a mentally disturbed person anywhere, the Mental Health Act 1959 restricted the power to persons found in a 'place to which the public have access'. Section 136 of the Mental Health Act 1983 is identical to that of the 1959 Act (Lynch et al, 2002; pg: 297).

The Section states:

> (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.
> (2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an [approved mental health professional[5]] and of making any necessary arrangements for his treatment or care.
> (3)A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in

[4] The fieldwork for this thesis was completed prior to the implementation of the Mental Health Act 2007 and as such uses the definitions and terminology from the 1983 Act.

[5] This is the wording as of the changes made by the 2007 Act.

> subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety[6].
>
> (4)A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection

Borschmann et al (2010) states that "Section 136 is the only section of the Act whereby one person – acting without medical evidence or training – has the authority to deprive another person of his or her personal liberty" (pg: 34). It should be noted that whilst Section 136 detentions generally do not involve any offences being committed, for the purposes of PACE they are treated as an 'arrest' and the individual can therefore be searched and subject to risk assessment etc like other detainees. However the length of time they can be held for is subject to the Act rather than PACE.

Section 136 likely to be used after the police have received phone calls from members of the public who may be worried about an individual's welfare or after officers encounter someone who they feel is in need of immediate care. The Act defines mental disorder as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind…."[7] It goes on to describe 'mentally disordered' as being either: "severe

[6] This is the wording as of the changes made by the 2007 Act which allowed transfer between places of safety, prior to that it was not explicitly permissible.

[7] The Mental Health Act 2007 amends this definition so that a single definition applies throughout the Act and abolishes references to categories of disorder. However, the Act had not come into effect at the time of fieldwork for this thesis so I have quoted the original definition.

mental impairment"[8], "mental impairment"[9], or "psychopathic disorder".[10] This definition does not include dependency on drugs or alcohol.

The Mental Health Act 2007 broadened the definition of mental disorder to include 'any disorder or disability of the mind', which potentially widens the net of people who may be deemed to have a mental disorder to include those for whom their mental health problems may be temporary. Peay (2011a) states that this new definition is "…seemingly so broad, as to include the world at large. Indeed, it includes many who might consider themselves, and who might be considered by others, to be mentally healthy" (pg. 1). This broader definition was introduced subsequently to the fieldwork conducted for this thesis and therefore was not applicable at the time. Police officers may have problems interpreting the definition of "mental disorder" and in correctly identifying mental disorder as opposed to other possible conditions, such as drug or alcohol dependency (it should be noted that problems with interpreting 'mental disorder' is a general one and not specific to the 2007 Act).

[8] "Severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly.

[9] "Mental impairment" means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "mentally impaired" shall be construed accordingly.

[10] "Psychopathic disorder" means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

Some individuals may have problems arising from both alcohol/drug use and mental health problems, these individuals can be termed as needing 'dual diagnosis' and as such require help and treatment from different service providers. A review of the literature by Afuwape (2003) found that prevalence of dual diagnosis amongst those with mental health problems ranged from 16-52% (pg: 8). Traditionally the focus has been on addressing either the alcohol/drug use *or* mental health problems and then trying to tackle the other issue separately, rather than acknowledging that both problems may be mutually interactive and therefore require an holistic approach. The responsibility often rests with the service user to communicate between the differing agencies which can also be problematic (Afuwape, 2003). The Department of Health (2002) issued a good practice guide for dual diagnosis, which states that:

> Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care. **This should be delivered with mental health services** (pg. 4, original emphasis).

The Revolving Doors Agency (2000) found that people who have multiple needs are less likely to gain access to appropriate health and social care services and are therefore more likely to become victims of the 'revolving door syndrome' i.e. end up coming into frequent contact with the police due to a failure to address their underlying issues or problems.

A place of safety is defined under Section 135 of the Act as a "hospital, police station, mental nursing home or residential home or any other suitable place". The police may also be required to assist in entering premises under Section 135 of the Act and returning patients to hospital, who have absconded. Section 135 of the Act enables a magistrate to issue a warrant authorising a

police officer, accompanied by a doctor and an Approved Social Worker (ASW now known as Approved Mental Health Practitioner[11]), to enter premises to remove someone to a "place of safety" if there is reasonable cause to believe that they are suffering from a mental disorder, and they are being ill-treated, neglected or not under proper control, or live alone and are unable to care for themselves.

In addition to the provisions and safeguards set out by PACE and the Codes of Practice set out above, the Code also highlights the need for the custody officer to be aware of the particular needs of 'vulnerable prisoners' such as mentally vulnerable and mentally disordered, to juveniles in general and to those for whom English is not a first language (Code C, 3 (b)). The Code states that:

> It is imperative a mentally disordered or otherwise mentally vulnerable person detained under the Mental Health Act 1983, Section 136, be assessed as soon as possible. If that assessment is to take place at the police station, an approved social worker and a registered medical practitioner shall be called to the station as soon as possible in order to interview and examine the detainee. Once the detainee has been interviewed, examined and suitable arrangements made for their treatment or care, they can no longer be detained under Section 136 if a registered medical practitioner, having examined them, concludes they are not mentally disordered within the meaning of the Act (Code C, 3.16).

In terms of their rights, Section 136 detainees:

[11] The Mental Health Act 2007 revised the terminology and role to change it from an approved social worker to an approved mental health practitioner or AMHP. However, as with some of the earlier definitions, because my fieldwork was completed at a time when practitioners were still called ASWs that is how they are sometimes referred to in this thesis.

> …should be cautioned and their rights explained as it is deemed to be an 'arrest' for the purposes of the Police and Criminal Evidence Act 1984. Where a person has been removed to a place of safety by the police under Section 136 the person is entitled to have another person of their choice informed of their removal and whereabouts and access to legal advice should be facilitated whenever requested. Where the hospital is used as a place of safety, the hospital managers must ensure that the provisions of Section 132 (giving information) are complied with… (Lynch et al, 2002; pg: 299).

If detained under Section 136 of the Mental Health Act 1983, the custody officer should seek to arrange the mental health assessment as soon as possible, but the law allows the detainee to be held at the place of safety for up to 72 hours until a medical examination by a doctor approved under Section 12 (2) of the Act[12] and interview with an Approved Mental Health Practitioner (AMHP) can be arranged. The two different terms are used in this thesis as the fieldwork took place before the introduction of AMHPs and therefore interviewees are referred to as ASWs. Seventy-two hours is a very lengthy period of time to be held in a place of safety, particularly if that place of safety is a police cell. There have been attempts to reduce the period of detention which have failed, and the British Medical Association considered that four hours should be sufficient, whilst the National Council for Civil Liberties and MIND have suggested a period of 24 hours (Roger and Faulkner, 1987). An ASW or AMHP is an individual who has been specially trained and approved to apply the sections of the Act. As a result of these assessments, the person may be:

- Released from the place of safety.

- Admitted to hospital of their own free will.

[12] This will generally be a psychiatrist but some general practitioners can also be approved under the Section. This means that they have expertise in mental disorder and are trained on the details of the Act.

- Admitted to hospital against their will under another Section of the Act (Sainsbury's Centre for Mental Health, leaflet).

The Royal College of Psychiatrists (1997) state that the most common facilities used as places of safety in the UK are hospital Accident and Emergency (A&E) departments, police stations and psychiatric units. They go on to state that:

> Police stations are often poorly designed for the reception and observation of those who might not be just restless or over excited as a result of mental disorder, but unpredictably suicidal. Staff in police stations are rarely trained to deal with this situation. There is a widespread feeling among the police, among users and carers' groups, and among social workers, that the use of police stations…is inappropriate for the management even of the disturbed mentally ill (Royal Society of Psychiatrists, 1997).

There is also some official recognition that police stations are an inappropriate place of safety for people with mental health problems. Home Office Circular 66/90 'Provision for Mentally Disordered Offenders' (1990) states that "it is desirable that, whenever possible, the place of safety…should be a hospital and not a police station*"* (pg. 2). This was reiterated in the joint Home Office and Department of Health (1992) review of social services for mentally disordered offenders which suggested that police stations should rarely, if ever, be used as a place of safety. The Code of Practice to accompany the Act published in 1999 stated that "it is **preferable** for a person…to be detained in a hospital rather than a police station" (Para. 10.5). This has been strengthened in the recently revised Code of Practice (2008), which states that *"*a police station should be used as a place of safety only on an **exceptional** basis*"* (10.21). It goes on to state that

"it may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or users of a healthcare setting". However, the Code says "it is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting where mental health services are provided (subject, of course, to any urgent physical healthcare needs they may have)" (Para. 10.21).

The ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody, states that "police cells are not suitable places for detaining people with mental health problems, and a person's condition can sometimes be exacerbated by being held in such conditions" (Para 3.4.1). The Guidance states that "being in a police cell can have an adverse effect on a person's condition if they are already suffering from mental illness. In particular, isolation and the noise in a busy custody suite can be aggravating factors" (Para 2.4.5). Accident and Emergency Departments of General Hospitals are also not ideal facilities for detaining people under Section 136 given that they are busy environments where individuals may have to wait for long periods of time to be assessed. However, they do have the advantage of avoiding the stigmatisation of being held in a facility designed for individuals who have committed a crime and are staffed by individuals trained to deal with people from a healthcare perspective.

It is widely accepted that police cells are not a suitable place to hold people who are mentally disordered; it can exacerbate their symptoms by heightening their levels of stress and anxiety. Taking someone with mental health needs into custody also has the effect of criminalising and stigmatising their behaviour, particularly when transported in a police vehicle. This is because from the perspective of the detainee it will feel like an arrest and as Cummins (2012) states it is

de facto an arrest since the person will often be detained using forced, restrained using handcuffs, searched and placed in a cell under PACE. The most tragic outcome in these cases can be a death in police custody with the individual potentially committing suicide in custody. Although broader than just Section 136 detentions, around 50% of deaths in police custody involve someone with mental health needs highlighting their vulnerability (PCA, 2003). The Mental Health Act Code of Practice (2008) acknowledges some of these potential issues and states that:

> In identifying the most appropriate place of safety for an individual, consideration should be given to the impact that the proposed place of safety (and the journey to it) may have on the person and on their examination and interview. It should always be borne in mind that the use of a police station can give the impression that the person detained is suspected of having committed a crime. This may cause distress and anxiety to the person concerned and may affect their co-operation with, and therefore the effectiveness of, the assessment process (Para. 1024).

Multi-agency working and developing alternative places of safety

Whilst not specifically about the policing of people with mental illness, it is important to consider the wider context of multi-agency or partnership working. Since the 1980s there has been encouragement from central government for the police to work with other agencies on crime prevention strategies (Fielding, 2005b; pg. 22). The Morgan Report (1991) also tried to promote the need for partnership working between the police and local authorities, but it was not until New Labour took office in 1997, that the principles of the Morgan Report were enacted in the Crime and Disorder Act 1998 (Fielding, 2005b). The Police Reform Act 2002 also set out that policing functions were carried out by many different agencies. Fielding (2005b) describes

the thinking that the police should "…work alongside other agencies and institutions on the premise that most enduring social problems are multi-causal and multi-dimensional" (pg .23).

> The Crime and Disorder Act 1998 promoted inter-agency work with a partnership approach. The outcome was a legal requirement to set up 'crime and disorder' partnerships…police were required to partner local social work, education, housing and health services. They had to consult local communities on their priorities and take advice on tactics to deal with them (Fielding, 2005b; pg 127).

It is therefore not surprising that the police have also been asked to work with other relevant agencies to implement policies on some non-crime related matters, and with particular relevance to this thesis, the detention of people under the Act. As Section 136 detainees are suffering from a health problem and are being detained by the police so they can be taken to a 'place of safety' it is imperative that the police are joined up with healthcare providers in ensuring that these people are suitably cared for. The Home Office Circular (1990) suggests that the police service agrees with local health authorities and social services departments, suitable arrangements for the detention and assessment of mentally disordered people. This may involve the use of social services accommodation or hospitals, depending on availability and on whether the person is likely to require hospital treatment. The ACPO Guidance (2006) takes this further and states that forces must develop and agree with Mental Healthcare Trusts and Primary Care Trusts protocols identifying a first choice place of safety, and the criteria for their use (Para 3.4.1), and the Mental Health Act Code of Practice (2008) states that there should be locally agreed policies in place for all aspects of Sections 135 and 136 (Para 10.16), although this was not in place at the time of the empirical research of this thesis.

In cases where the use of police stations cannot be avoided, for example in relation to the investigation of serious offences or where the individual is being violent, it may also be advantageous for each police force to consider developing a policy on the use of specific, identified police stations for the detention of mentally disordered people where arrangements can be established for their speedy assessment by a mental health professional (Home Office and Department of Health, 1995). The Code of Practice for the Act (Department of Health, 1999) states:

> The identification of preferred places of safety is a matter for local agreement. However, as a general rule it is preferable for a person thought to be suffering from mental disorder to be detained in a hospital rather than a police station. Regard should be had to any impact different types of place of safety may have on the person held and hence on the outcome of an assessment. Once the person has been removed to a particular place of safety, they cannot be transferred to a different place of safety (Para 10.5).

This has since been amended by Section 44 of the Mental Health Act 2007, which allows people to be transferred between one place of safety and another, a move welcomed by the Royal College of Psychiatrists (2008). The most recent version of the Mental Health Act Code of Practice (2008) states that:

> A police station should not be assumed to be the automatic second choice if the first choice place of safety is not immediately available. Other available options, such as a residential care home or the home of a relative or friend of the person who is willing to accept them temporarily, should also be considered (Para 10.22).

And:

> If a police station is used, health and social care agencies should work with the police in arranging, where appropriate, the transfer of the person to a more suitable place of safety (Para 10.23).

This amendment to allow the transfer of detainees between places of safety came into force after the fieldwork for this thesis was complete and it remains to be seen whether it will have any significant impact on working practices. But the inability to be able to transfer between places of safety at the time of the fieldwork for this thesis might have meant that those who were taken into police care remained there for an unnecessary period of time. This is discussed further when presenting the empirical evidence in the later chapters. It should also be noted that there was some lack of clarity around the legality of transferred detainees between places of safety prior to the new Act. This has been explored in some of the academic literature (see for example Ogundipe et al, 2001 and Lynch et al, 2002).

> There is no direct reference in the 1983 Act itself about a transfer of a person from one place of safety to another more suitable place of safety but the Codes of Practice discourage it. However, the Codes of Practice to the Police and Criminal Evidence Act 1984 (revised 1999) advise police officers not to 'delay the transfer of a person to a place of safety under Section 136 of the MHA 1983 where that is applicable (Ogundipe et al, 2001; pg: 388).

The most recent Code of Practice (2008) on the Act provides detailed guidance on local policies for the detention of Section 136 detainees and sets out ways in which the police and healthcare agencies should work together and what their roles and responsibilities should be. Box 1.2 below summarises this guidance:

Box 1.2: Mental Health Act Code of Practice (2008) guidance on local policies for Section 136 detainees

It is important to ensure that a jointly agreed local policy is in place governing all aspects of the use of Sections 135 and 136. Good practice depends on a number of factors. For example:

- LSSAs [local social service authorities], hospitals, NHS commissioners, police forces and ambulance services should ensure that they have a clear and jointly agreed policy for use of the powers under Sections 135 and 136, as well as the operation of agreed places of safety within their localities;

- all professionals involved in implementation of the powers should understand them and their purpose, and the roles and responsibilities of other people involved, and should follow the local policy;

- professionals involved in implementation of the powers should receive the necessary training; and

- the parties to the local policy should meet regularly to discuss its effectiveness in the light of experience (Para 10.16).

The policy should define responsibilities for:

- commissioning and providing secure places of safety in healthcare settings;

- identifying and agreeing the most appropriate place of safety in individual cases;

- providing prompt assessment and, where appropriate, admission to hospital for further assessment or treatment;

- securing the attendance of police officers, where appropriate for the patient's health or safety or the protection of others;

- the safe, timely and appropriate conveyance of the person to and between places of safety (bearing in mind that hospital or ambulance transport will generally be preferable to police transport, which

should be used exceptionally, such as in cases of extreme urgency or where there is a risk of violence);

- deciding whether it is appropriate to transfer the person from the place of safety to which they have been taken to another place of safety (see **paragraphs 10.34-10.39**);

- dealing with people who are also under the effects of alcohol or drugs;

- dealing with people who are behaving, or have behaved, violently;

- arranging access to a hospital accident and emergency department for assessment, where necessary;

- record keeping (see **paragraphs 10.40-10.41**) and monitoring (see **paragraphs 10.42-10.44**) and audit of practice against policy; and

- the release, transport and follow-up of people assessed under section 135 or 136 who are not then admitted to hospital or immediately accommodated elsewhere [original emphasis] (Para 10.17).

Responsibilities should be allocated to those who are best placed to discharge them, bearing in mind the different purposes for which health and social services and the police service exist. Local policies should ensure that police officers know whom to contact prior to the removal of a person to a place of safety under Section 136 (Para 10.18).

Such policies may be best maintained by the establishment of a liaison committee, which might also take responsibility for examining the processes in place for other multi-agency tasks, such as conveyance of persons under the Act and policies in respect of patients who go absent without leave (Para 10.19).

In defining responsibility for providing a prompt assessment, the locally agreed policy should set out the time within which it would be reasonable to expect the appropriate health and social care professionals to attend the police station to assess the person or to assist in arranging to transfer them (Para 10.23).

Lord Bradley's (2009) report to the Department of Health on offender healthcare also has an entire chapter devoted to 'delivering change through partnership', and specifically states that

"the use of Section 136 is a prime example of why the police and health services need to work so closely together. Even once a person has been removed to a place of safety; the speed of assessments is further determined by the resources and willingness of local health and social services to attend within suitable timeframes" (pg. 46). There is therefore clear guidance in place as to how agencies should work together on Section 136 detentions, and although the Code referred to in the previous paragraphs was published subsequently to the fieldwork undertaken for this thesis, there has been guidance to the effect that multi-agency working in this area is desirable for some time.

However, in there is evidence that there are problems with the way in which multi-agency co-operation actually works and varies in practice (this will be explored further in chapter six). Bradley (2009) found that there were problems in partnership working and agreeing a way forward with the police and achieving consistency because of

> the different approaches of the 43 separate police forces, serving 603 custody suites; huge regional and local variations in resources, priorities, protocols and service provision in the different police force areas; and geographical boundaries not being co-terminous with those of NHS organisations (primary care trusts/mental health trusts/strategic health authorities) who will have different sets of priorities and budgets (pg. 54).

There are other specific problems for developing alternative places of safety outside of police custody. For example, whilst it is preferably to use places of safety other than police stations in the majority of cases, evidence suggests that A&E departments are rarely equipped to deal with patients detained under the Act and psychiatric units may also have problems in providing a suitable place of safety (Royal College of Psychiatrists, 1997). The Royal College of

Psychiatrists (2008) states that an "emergency department should only be used as the place of safety where medical problems require urgent assessment and management"[13] (pg. 5). Churchill et al (1999) argued that neither police stations nor hospitals should be considered places of safety and suggested that there should be special facilities for places of safety which are in easy reach of medical facilities and are secure and provide the necessary multi-disciplinary assessment. In many areas it is therefore a police station that is the first and not the last resort as a place of safety under the Act (IPCC, 2004; NACRO, 2005). However, there is a lack of data and evidence on the extent to which police custody is used as a place of safety.

The Mental Health Act Commission (2003) in its biennial report states that the current statistics on places of safety detentions "do not include such detentions in police stations and are therefore substantially incomplete…[it is] a serious lack in mental health statistics that there are no total figures available for the uses of these powers" (pg. 103). This lack of evidence in the use of police custody as a place of safety is something that this thesis seeks to address, as it is a fundamental gap in our current knowledge of police custody and mental health.

I have highlighted the wide ranging powers that police officers hold to detain people in their care, and have discussed the safeguards that exist to try and protect those held in police custody. However, I've also drawn attention to the evidence that safeguards such as appropriate adults, the availability of FPs and risk assessing detainees do not always offer adequate protection and are not always deployed as they should be. Furthermore, custody is not a suitable environment for individuals with mental health needs, particularly for those who have committed no criminal

[13] It should be noted that the Royal College Standards apply only to England as there is a separate Mental Health Code of Practice for Wales which was not published at the time of this quote.

offences, such as many Section 136 detainees. It should not be considered a 'place of safety' because it may exacerbate their condition. To this end the police and the health service have been encouraged to work together to develop alternative places of safety. Before concluding this chapter I will briefly cover some other important aspects of multi-agency working – training of police officers in mental health issues, information sharing and criminal justice liaison schemes (and a little on diversion more broadly).

Training on mental health

In his report Lord Bradley (2009) stated that "despite the potential high level of contact between the police and people with mental health problems, the police currently receive very little specific training in mental health awareness" (pg. 37). He identified some specific areas of good practice but states that these are particular examples and that the training is not widespread. Probation constables receive some training in mental health but the scope and length of this training varies across forces, and longer serving officers did not necessarily receive this. Custody officers received training in mental health as part of their custody course, but again the scope varied, as did how it was provided with some receiving joint training with other agencies or input from service users and others not. Bradley (2009) therefore makes the following recommendations:

> Community support officers and police officers should link with local mental health services to develop joint training packages for mental health awareness and learning disability issues (pg. 36).

And:

> Mental health awareness and learning disabilities should be a key component in the police training programme (pg. 53).

In terms of specific training on Section 136, Lynch et al (2002) found that "the level of training received by both A&E [accident and emergency] staff and police was inadequate and unsatisfactory. This needs to be tackled as a matter of urgency by a series of in house training programmes and joint meetings between A&E staff and police" (pg. 299). Since the Bradley Report (2010) was published the National Police Improvement Agency (NPIA) in collaboration with the Department of Health and ACPO, have published "Guidance on Responding to People with Mental Ill Health or Learning Disabilities" (2010) for police officers. The document provides detailed guidance (208 pages) and is intended to be used in conjunction with training packages within police forces, and the NPIA also produced an on-line training package to accompany the guidance (NPIA Mental Ill Health Learning Programme). The findings from the IPCC study into police custody as a place of safety upon which this thesis is based also fed into this guidance.

The guidance provides advice on the police response to a variety of situations involving people with mental health needs or learning disabilities both in the criminal justice system and in a healthcare capacity. It also sets out to debunk some of the myths about people with mental health needs and improve how the police deal with them by ensuring that officers are aware of their vulnerability and needs.

It also points out that having "appropriate support at a senior level is essential to the development of effective responses to people with mental ill health or learning disabilities, both within the Police Service and in partnership with other agencies" (NPIA, 2010: Para 8.2.1). It therefore suggests the need for forces to appoint an ACPO rank officer to lead on this area, as well as having a force mental health and learning disabilities liaison officer. At Para 8.3 the Guidance discuses training for police officers and staff, and states:

> It is not the role of training to provide police officers with clinical skills, but rather to provide sufficient knowledge and awareness to respond confidently to situations involving mental ill health or learning disabilities. Training should include:
>
> - generic training;
> - specialist training in accordance with particular roles;
> - joint training involving staff from health and social care agencies to promote more effective collaboration between the police and staff from these different agencies (NPIA, 2010).

This means that they expect all officers to have some foundation training in mental health and those with more specialist roles to have further training. On joint training it highlights the particular benefits of minimising effort and gaining the experience of a range of practitioners (Para 8.3.3). The document therefore provides a very useful framework for training and guidance to officers but whether forces adopt this approach is likely to depend on the resources they have available and the weight they place on the treatment of the mentally ill. NPIA guidance is just that 'guidance' and therefore not mandatory and NPIA itself is undergoing significant changes as part of the current government's austerity measures. Therefore the Guidance may fail to have the impact it could otherwise deliver to officer training.

Information Sharing

In his 2009 report Lord Bradley found that that:

> A single, consistent theme has been apparent throughout [this] review, regardless of organisation, activity and environment, which is the importance of managing information effectively. Appropriate information sharing is key to ensuring continuity of care and delivery of services throughout the criminal justice system and on release back into the community. In addition, sharing data between health and criminal justice practitioners and organisations is vital for ensuring the protection of both the public and the offender (pg. 135).

However, despite the importance of effective information sharing Bradley (2009) highlights potential barriers such as legislative requirements, different organisational cultures and issues relating to confidentiality. There are good practice guides available on information sharing concerned with mentally disordered offenders. These include guidance by NACRO published in 2004 and by the Royal College of Psychiatrists in 2006 (see bibliography for details of both) which set out the legal rules for sharing information, the benefits of information sharing and the parameters and principles which allow different agencies to share information on individuals. And importantly the need for agencies to have agreed written protocols which sets out how and in what circumstances they will share information. Despite this there is evidence to suggest that effective information sharing does not occur consistently and Bradley calls on "practitioners to implement the existing frameworks much more effectively and collaboratively" (pg. 135). Bradley (2009) draws on the Information Commissioner's guidance which states that

"unfortunately, some organisations continue to use the Data Protection Act 1998 as an excuse not to do something" (pg. 135).

Bradley (2009) highlights the Multi Agency Public Protection Arrangements (MAPPA) as a good example of different agencies working together and sharing information. He goes on to state that "…stakeholders often cited this as an example of how information sharing can work between these particular agencies, and stressed that there was a need for something similar for less serious offenders as well…" (pg. 135). Bradley (2009) recommends that "a responsibility of the Criminal Justice Mental Health Teams will be to ensure that appropriate information is shared between all the agencies that are responsible for caring for an offender with mental health problems or learning disabilities" (pg. 137).

Criminal Justice Liaison and Diversion Schemes

Home Office Circular 66/90 requires diversion of mentally disordered offenders away from the criminal justice system to be considered before a decision on whether to charge them is made. It also states that wherever possible mentally disordered offenders should receive health and social care as an alternative to be taken through the criminal justice system. However, there have been moves away from this view of mentally disordered offenders towards a system that may be more likely to punish them in order to manage potential risk; this was explored earlier in this chapter. Despite these competing aims of the system, there are diversion schemes still in place across England and Wales so it is worth considering them.

The NPIA Guidance on responding to people with mental ill health (2010) states that "there is no agreed definition of what constitutes a liaison or diversion scheme as the services they offer can vary. Not all geographical areas are supported by such services or teams and there is no national list of such schemes at the moment" (Para 7.4.3). They say that there are four main type of schemes; those focusing on assessment at an early stage to minimise the need for assessment if they are remanded into prison; those focused on liaison who offer support and guidance to individuals and other agencies; those focused on diversion to identify mental health problems and transfer (where appropriate) individuals to hospital; and those focused on bringing together a range of agencies onto a panel to agree a coordinated approach to caring for individuals with mental health needs (Para 7.4.3). The schemes can operate in both police stations and courts.

Box 1.3: Lord Bradley (2009) recommendations for criminal justice liaison schemes based at police stations

Schemes: could provide significant benefits by:

- identifying and assessing mental health or learning disability needs swiftly and effectively after arrest;
- ensuring that the police can make a fully informed risk assessment of the offender;
- identifying the need for the attendance of an Appropriate Adult;
- ensuring that those arrestees with serious mental health problems can be referred to mental health facilities before reaching court, which may have necessitated a period spent in custody on remand;
- providing information for the police and CPS on charging and prosecution;

- providing information and advice for solicitors at the police station;

- ensuring that people with mental health problems who would not necessarily progress to court stage are signposted to mental health services rather than just dropping out of the system; and

- providing information for court services about individuals' mental health or learning disabilities. This will help to inform decisions about the need for psychiatric reports at an earlier stage, about where an offender should be remanded and about sentencing (pg. 53).

Therefore:

All police custody suites should have access to liaison and diversion services. These services would include improved screening and identification of individuals with mental health problems or learning disabilities, providing information to police and prosecutors to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system, and signposting to local health and social care services as appropriate (pg 53).

Conclusions

This chapter has examined the powers that the police have to detain individuals and the context in which they developed; it has outlined the legal safeguards to help protect those that are in police custody. It has also highlighted some of the research evidence, which shows that there are flaws in the system and gaps between the intention of the law and the reality of practice on the ground. For example, the use of appropriate adults and FPs in practice means that vulnerable individuals do not always receive the best protection due to inadequate training and resources for these services.

The chapter then discussed mentally disordered people coming into contact with police, the legal and policy contradictions towards the way in which this group should be treated i.e. diverted from the criminal justice system or incarcerated in order to 'protect' the public. It then focused on the law and policy governing the detention of individuals under Section 136 of the Act and outlined the unsuitability of police custody as a place of safety. The custody environment can exacerbate an individual's fragile mental state and has the effect of stigmatising their behaviour by effectively treating them as a criminal. Finally, the chapter highlighted the lack of knowledge regarding the extent of detentions in police custody under this power, and the need for multi-agency working, training and information sharing and the development of alternative places of safety.

2. Explaining Police Practice and its relationship to police custody and mental disorder

> …the police officer's own presumption that s/he lacks expertise in diagnosing mental illness, or by beliefs among police officers that dealing with the mentally ill does not constitute real police work, or that seeking the appropriate medical help can be time consuming and often futile (Borschmann et al, 2010: pg. 35).

Introduction

The police are often described as being the gateway to the criminal justice system. They have a large amount of power, discretion and influence to decide what becomes a crime and what doesn't, which sectors of society are portrayed as 'dangerous' and to which groups they afford greater protection (Bowling and Foster 2002). They carry out multiple roles including "crime prevention, detection, peace keeping, public order maintenance, and the preservation of state security" (Reiner, 1994: pg. 753-4). However, Reiner (2000) argues that the principal function of the police is order maintenance, irrespective of what the function *ought* to be (an argument derived from Bittner, 1967). The function of order maintenance, and the ability of the police to portray certain sections of society in potential negative ways, offers little protection to those individuals who may need assistance from the police or who may be vulnerable and come into contact with them, such as those suffering from mental health problems. Additionally some officers may have joined because they see the role as one of primarily 'fighting crime' and therefore do not want to take on, and perhaps resent the social work aspect of the role (Reiner, 2000). This chapter moves beyond legislation and policy to consider the wider issue of police accountability and will examine the drivers for the way the police actually act looking at the role

of police culture and discretion. It will then set out the empirical evidence on who is detained in police custody, the identification of mental disorder by police officers. It will look at who is detained under the Act, and the vulnerability of those detained. Finally, it will examine deaths in custody and the link to mental health.

Theories of police practice

As set out in the previous chapter, the police are in a unique position in society in terms of the legal powers to detain people, but also in the powers they have to use legitimate force. Due to the strength of police powers, there needs to be an effective mechanism for holding them to account and ensuring that their powers are not used disproportionately or excessively. The use of police powers needs to be open and transparent so they can be effectively scrutinized. This is particularly important when considering how these powers are applied to those who are among the most vulnerable in society such as people who have mental health needs. These individuals may not be best placed to protect themselves and therefore it is important that there are adequate safeguards placed around the powers the police have to ensure they are held to account and do not misuse their powers.

In England and Wales police accountability has traditionally been characterised as having three 'pillars': accountability to the law, accountability to police authorities, and accountability through the police complaints system (Reiner, 2000). The previous chapter set out the legal powers that the police hold to detain people in general and specifically under Section 136 of the Act. It also outlined the policies and safeguards that exist to guide the police on how to apply the law and

protect those that are detained. I will now examine the theoretical basis of how the police exercise their power in practice and how they are held to account.

'Legal-bureaucratic' theories and police discretion

'Legalist-bureaucratic' theories of policing rest on the belief that law is the major determinant of policy activity and practice (Grimshaw and Jefferson, 1987; Dixon, 1997). Grimshaw and Jefferson (1987) describe it as the 'machine model' in which individuals within an organisation simply execute the directives of a superior authority (pg. 6). Dixon (1997) states that in a policing context this means that 'senior officers are able to direct the activities of their subordinates by means of training, policy statements, and internal regulation' (pg. 1). In this respect it is very similar to individual theories of policing because it argues that if the machine does not work, it must be due to a faulty component in the system, it takes for granted the idea that the police will adhere to the law, policies and training.

An additional consideration is highlighted by Kappeler et al (1993) who argue that:

> The law is created in a political forum with its character and effect being determined by power differences that exist in society. Different segments of society can alter the character of law and thus shape its effect on citizens. Law serves as a tool that supports existing social arrangements and relations and preserves the distribution of power in society (Chambliss & Seidman, 1971; Turk, 1976). Therefore, the law serves the interests of those most likely to influence its creation. It regulates behaviour, economic arrangements, and social relations to the benefit of the dominant segments of society (pg. 79).

This is important because even if we accept that the police simply uphold the law, this may still result in discriminatory or unfavourable treatment of some sections of society. The law in itself, however, only serves a symbolic function in society; it must be turned into action to be effective as social control.

Dixon (1997) states that the police have used their subordination to the law to claim legitimacy and argues that policy makers and legislators have seen problems in policing as arising from gaps in the law. An attractive benefit of this theory for the police is that they can blame the law for any problems, while policy makers and legislators can "promise that their interventions will be effective and efficient" (Dixon, 1997: pg. 2). Legal-bureaucratic theories can therefore be criticised for "[taking] the efficacy of law for granted" (Dixon, 1997: pg. 7) and for describing how the "organisation 'ought' to work rather than how it actually does in practice" (Bowling, 1998: pg. 239).

Bowling (1998) argues that "law and administration do not determine police practice but do exert a specific degree of influence in specific circumstances" (pg. 239). Dixon (1997) argues that police officers attitudes towards the law are complex, for example they will uphold and enforce some laws vigorously where they agree with them or where the law works in their favour, whereas when the reverse is true they may choose to exercise their discretion and not enforce the law. Furthermore, Kappeler et al (1993) argue that "the law is often written and can be interpreted in ways that give the police sufficient latitude to deviate in their pursuit of legitimate goals" (pg. 62). They go on to say that "not only do the police use the law selectively to maintain

or create social order; they also use it as an instrument of coercion to achieve organisational and personal objectives" (pg. 63).

Fielding (2005b) states that "the exercise of discretion is inevitable in a society where resources are limited" and that the "police have to decide priorities, and that is, of course, a question of politics" (pg. 5). Fielding (2005b) also argues that the demands made by the organisation for high arrest rates encourage "corner-cutting forms of occupational deviance, reinforced by the self-generated nature of the work and the virtual invisibility of frontline policing to supervisors" (pg. 81-82). Lustgarten (1986) argues that the nature of police discretion which allows a range of permissible choices in different situations means that "to say therefore that [a police officer] must uphold the law, or is responsible to the law, is in practical terms meaningless" (pg. 11). There is some evidence to suggest that police discretion can be curbed in certain circumstances. For example, Rowe (2007) found that a positive arrest policy in cases of domestic violence was able to limit or shape the level of discretion officers had at street level. Although interestingly complainants often called for the police to have more unfettered discretion when the policy in place prevented the police from taking into account the complainant's wishes.

One of the most commonly cited examples of how police discretion can result in an unequal application of the law is that of stop and search. There are several powers under which someone can be stopped and searched, with the majority of people being stopped and/or searched under Section 1 of PACE which requires the police to have 'reasonable suspicion' in order to stop someone. Statistics from 2008/09 show that "there were over seven times more stop and searches of Black people per head of population than of White people, and over twice as many stop and

searches per head of population of Asian people and people of Mixed ethnicity" (Ministry of Justice, 2010c; pg: 9). Possible reasons for the disproportionality in the use of stop and search have been explored extensively in the literature and include the possibility that Black people, in particular, are over-policed due to discrimination, that people from BME groups are younger and poorer and are therefore more likely to be on the street and available to be stopped and searched (therefore explaining some disproportionality by comparing rates of stop and search to the available population rather than the resident population), and varying crime rates amongst different ethnic groups (see for example Quinton et al, 2000; MVA and Miller, 2000; FitzGerald et al, 2002; Bowling and Philips, 2007; Waddington et al, 2004).

The application of stop and search is a good illustration of how much scope the police have in applying the law and in choosing who to apply the law to. As Fielding (2005b) states "the 'law' is supplanted by considerations of the worthiness of those involved, public feeling, seriousness, or the costs and benefits of various sanctions" (pg. 101). Kappeler et al (1993) believe that the "…police are directed by the law and are trained to target the criminality of those who have the least power in society and are the least likely to complain or be heard" (pg. 80).

The safeguards that PACE introduced to protect those in police custody were outlined in the previous chapter and the empirical evidence on police practice in detaining people in custody and in particular the detention of people with mental health problems will be discussed in greater detail below. Other theories of policing also shed light onto the relationship between the laws and policies, such as the PACE safeguards in Code C, and how policing actually works in practice.

Structural theories

Dixon (1997: pg 20-48) identifies a number of variants of structural theories of policing. The first is Kinsey and Baldwin's work which provides an account of policing structured by legal and situational factors with the limits and possibilities of police rules being their primary focus. They point out that the "effect of rules will be significantly influenced by their context: being realistic about legal rules and policing…means looking to particular aspects of police activity and judging their amenability to legal controls" (Dixon, 1997: pg. 22). In the case of police custody, and in particular the detention of vulnerable individuals this argument would mean that the rules may be limited given the relative lack of power of the individuals being detained and the potential lack of independent oversight of how the police use their powers to detain.

Grimshaw and Jefferson (1987) identify the doctrine of constabulary independence as the key to understanding English policing. They argue that this doctrine negates attempts to control policing, leaving a vacuum which is filled by police culture (cultural theories will be explored later in this chapter), structuring the choices which discretion makes necessary. Law is the problem but also the solution, they believe that legal regulation coupled with the "promotion of principles of justice to guide the exercise of discretion will help create an accountable police service" (cited in Dixon, 1997: pg 26). Therefore, for Grimshaw and Jefferson "law is theorised as the determining but not necessarily dominant structure in policing" (Dixon 1997, pg. 27).

Grimshaw and Jefferson also describe the '*class functionalist model'* which prioritises analysis of the way in which policing impacts on the working class and other marginalized groups (Bowling, 1998: pg. 241). This would include the policing of those with mental health problems. They argue that the Marxist paradigm is 'simplistic and reductive', and that policing needs to be considered as a combination of structures – they build on the sociological concepts of formal structure, working practices, and environmental contexts, taking account of the importance of law, work and the community in influencing police work (Bowling, 1998: pg. 242).

A form of this is known as the *'environmental model'* of policing, as the environment shapes police behaviour but works within an underdeveloped conception of the environment (Bowling, 1998: pg. 243). Grimshaw and Jefferson argue that where the law is permissive or limited this enables police work related values to prevail, so that operational and related matters are open to this. The greater discretion the police have the more this is possible, they go on to state that the effectiveness of supervision is related to the task (Bowling, 1998: pg. 243). In terms of the detention of people with mental health problems in police custody, the summary of the relevant laws and Codes of Practice set out in the previous chapter that attempts have been made to limit police discretion. However, the police still have enormous discretion in deciding when to use their powers, who they choose to bring into custody and under what powers they choose to apply. An example of this with the most relevance to this thesis would be an officer making a choice as to whether to detain someone under Section 136 of the Act or for a 'breach of the peace' or criminal damage (depending on the circumstances of the case) under the Public Order Act 1988. This will be an example I return to later in this thesis.

Training of officers can also play a part in this and influence the approach that officers might take in differing situations or their understanding and knowledge of which laws to apply. Mokhtar and Hogbin (1993) argue that a lack of training could lead to underuse of Section 136 by police officers. Bradley (2009) called for greater training in mental health for police officers, as stated in chapter 1 the training that officers receive on mental health is varied, with probationer constables receiving some input on mental health (of varying length and quality) but longer serving officers may not have received any training. Cummins (2007) also found that many officers receive little training on mental health issues. In the later chapters where the empirical data is discussed it will be shown that refresher training on mental health was also uncommon and that the mental health training that custody officers receive as part of their custody officers course also varied in quality and quantity with some receiving detailed joint training with input from other agencies, and others scant classroom based training of a few hours. Cummins and Jones (2010) studied mental health awareness training in one police force area which was delivered jointly with health and social care and input from service users. They found that:

> To challenge the stigma attached to mental health issues, professionals need to take account of and learn from the experiences of service users. Finally, sound inter-professional practice is based not only on a recognition of and respect for the skills of your fellow workers, but also of the organisational and other pressures that they face (pg. 18).

In 2010 the NPIA published Guidance for police officers on dealing with mental health and learning disabilities alongside an online training package. The Guidance is very detailed and includes specific references to the use of Section 136 so may assist in its appropriate application. However, the NPIA guidance is not mandatory and the NPIA itself is undergoing significant

changes meaning that the implementation of such training is likely to be varied across police forces.

The '*environmental model'* lies somewhere between the legalistic-bureaucratic and sub-cultural models, "it shows that managerial strategies and constraints imposed by the 'community' can affect at least some areas of police behaviour some of the time" (Bowling, 1998: pg. 240). McBarnet's work critically examines the nature of the law itself (Dixon, 1997: pg. 28). She argues that the most accepted accounts of criminal justice are actually based on false dichotomies with a stark contrast between the reality of legal rules and their practical application and the rhetoric of legality (McBarnet, 1983). McBarnet (1979) states that if "we bring due process down from the dizzy heights of abstraction and subject it to empirical scrutiny, the conclusion must be that due process is *for* crime control" (pg, 39). She therefore believes that the traditional opposition of crime control and due process breaks down within the law itself which provides procedural rules allowing the police to pursue crime control through due process. However she has faced criticism for failing to take into account the different kinds of rules that the police are subjected to (Dixon, 1997; pg. 31).

McBarnet's work was about 'ordinary crime' rather than crime involving mental health issues or the police interaction with individuals with mental health issues per se. However, if it were to be applied to the use of Section 136 we can see that the scope of the law is incredibly wide and open to interpretation with someone being found 'in need of immediate care and control' by the police (which is open to subjective judgement) liable to being held for up to 72 hours while waiting for assessment – far longer than the 24 hours routinely permitted for a PACE arrest.

If structural theories were applied to police custody and the detention of those with mental health problems we would have to be realistic about the limits of the law as an influence on police practice and acknowledge that for the law to have an impact on policing, the amount of police discretion needs either to be curbed or supervised to a greater extent, making them more accountable to the community. There is currently a failure to adequately monitor the police powers to detain people in custody under the Mental Health Act and as such little is known about the extent or use of these powers, it is therefore not currently possible to hold them to account or to know how their discretion may be being used inappropriately. The methodology chapter later in this thesis explains how we gathered empirical evidence to address this current knowledge gap.

Community policing – theories

Fielding (2005a) cites Weatheritt to state that community policing "can stand for: (i) an alternative to rapid response, enforcement-oriented policing, involving long-term beat assignment so police are closer to the community; (ii) a process by which crime control is shared with the public, as in Neighbourhood Watch, or (iii) a means of developing communication with the public, for example, consultation meetings" (pg. 460). However, he summarises it to be, at its broadest, a style of policing whereby the police are close to the public and act on their wishes. He points out the difficulty with this: it assumes a large degree on consensus when in fact communities are likely to be diverse in their make up and in their priorities for policing. In England and Wales all police forces are engaged in community policing and the Crime and

Disorder Act 1998 "created a statutory requirement for police/community partnership and mandated community consultation" (Fielding, 2005a; pg. 461). Fielding (2005a) states that "the principal force-level programmes are Crime and Disorder Reduction Partnerships which bring together police and other agencies from the public sector (for example, health service, probation service), private sector (via business forums), and voluntary sector. The Police Reform Act 2002 put community policing at its heart, and Home Office objectives reinforce it" (pg. 461).

Community policing has been subject to a plethora of research which has tended to be policy-orientated or an evaluation (Fielding, 2002: pg: 151) and Fielding (2002) highlights the lack of theoretical discussion and basis applied to research on this specific type of policing. Fielding (2002) draws on general systems theory and structuration theory to explore a theoretical basis which can be successfully applied to community policing. He does this using the differing perspectives of action and structure in terms of policing. He argues that the "two key perspectives in the field, structure and action, have moved together, to a point where it is routinely accepted that a coherent account of phenomena in the policing field should involve them both" (Fielding, 2002; pg: 153). Fielding (2002) states that "for a study of a social institution like policing, which is so centrally about both power and the interactional competencies of officers, the system theory approach has real merit" (pg: 157). However, Fielding (2002) highlights the problem with the classic systems approach when applied to community policing in that it appears to make everything relevant. "The alternative is to pursue an analysis that works from a theory providing a rationale for selecting a smaller number of elements and has reason to assign particular weightings to them" (Fielding, 2002; pg: 158).

Fielding (2002) comes to the conclusion that the approach should be one of seeing policing as a system, and that a change in one part of the system can affect another part which is not directly related to it (pg: 161). He goes on to state that "research needs to attend to these connections, which are exposed in the interrelational of action and structure" (pg: 161). Some programmes of work on community policing may be working within their own terms or conditions, but other programmes may alter or rebalance their effects (Fielding, 2002; pg: 161). Therefore by dedicating more resources into understanding the theoretical framework of community policing, a better understanding of the empirical research can be reached (Fielding, 2002; pg: 161).

Cultural theories

Inspired by Michael Banton's (1964) early work in this area, '(sub)-culturalist theories' have often been based on observational studies of the police, predominantly of the rank and file, who are seen as the "primary determinant of policing where it really counts: on the street" (Reiner, 2000: pg. 86). Reiner (2000) describes cop culture as "a patterned set of understandings that help officers to cope with and adjust to the pressures and tensions confronting the police" (pg. 87). Reiner (2000) goes on to discuss Skolnick's classic study of the police 'working personality' which is "a response to a unique combination of facets of the police role: 'two principal variables, danger and authority, which should be interpreted in the light of a constant pressure to appear efficient"' (pg. 88). Reiner (2000) provides a full and detailed description of the core characteristics of cop culture which he sees as: a sense of mission and a desire for action, cynicism, pessimism, suspicion, isolation and solidarity – viewing crimes and people in different

categories of importance, conservatism, machismo, pragmatism, and racial prejudice[14]. Kappeler et al (1998) point out that many interactions between the police and individual members of the public occur out of view from the wider public, allowing some police actions to go unnoticed (pg. 68). Furthermore, Kappeler et al state that:

> It is also possible for the police to choose the settings in which encounters occur and to select weak victims for particular types of deviance. Citizens who live on the margin of society are particularly vulnerable to victimisation by the police. The opportunity for deviance is greatly enhanced by the relative lack of supervision of the police (pg. 68).

These aspects of police culture are important to consider when looking at the detention of people in police custody under Mental Health Act powers, as they will influence the way in which officers see these individuals and decide how to treat them. The handling of people with mental health problems is unlikely to be a priority for an officer with a 'desire for action' and they are likely to view dealing with these individuals as a lower priority than 'fighting crime'. Reiner (2001) suggests that some groups are seen as 'police property' in that they are over policed and more likely to have adversarial contact with the police. This includes people from Black and minority ethnic (BME) groups and other marginalised groups in society. There is little literature specifically on the treatment of individuals who have mental health problems and/or who are also from BME groups but it seems reasonable to suggest that they may be treated less favourably due to these negative aspects of police culture and potential racial prejudice. This is particularly the case when considering the empirical evidence which will be presented later in this chapter which shows the disproportionality in the use of the Mental Health Act powers against those from BME groups and the role of the police in this process, with them frequently being the

[14] For full details and discussion see Reiner (2000) pg. 87-101.

agents of power who initiate the process. Possibly because the police are more likely to be called by members of the public concerned about the behaviour of BME individuals in comparison to White individuals due to racial prejudice or stereotyping on their part, or that the police are more likely to detain these individuals when called, or both. The literature on police culture has explored the potential racial prejudice of police officers to a greater extent than potential prejudice towards people with mental health problems and therefore the discussion below focuses on this prejudice. It serves as a useful benchmark for how police culture may affect attitudes towards people with mental health problems, as they are also a marginalised group.

There are two views relating to this aspect of the culture; on the one hand some researchers such as Holdaway (1995) argue that so-called 'canteen culture' impacts directly onto police behaviour and action towards BME groups. Others such as Waddington (1999) argue that there is a gap between what officers say and what they actually do, so whilst a police officer may hold racist views this will not affect their interaction with someone from a BME background.

Kappeler et al (1998) suggest that the police often have very different values to that found in other sections of society (pg. 15). They go on to state that because of the unique role and powers that the police hold, their views and beliefs can "sometimes conflict with the formal rules of social interaction" (pg. 15). They also highlight that accepted behaviour and beliefs might also vary depending on the area they are policing or the type of policing they are conducting. The behaviour expected of the police needs an understanding of the "differences in norms as they are expressed at the legal, organisational, and sub-cultural levels" (pg. 16). Rules which govern police practice and conduct may develop externally or internally by the police occupation

(Kappeler et al, 1998). The external rules come from legislation and official policy, whereas the internal rules include local force policies and practices. Police forces ascribe values and set out the behaviour it expects from its officers. If an officer's behaviour falls short of what is expected of him or her there may be sanctions brought against that officer. Kappeler et al (1993) state that "social responses to police deviant behaviours depend on who discovers the deviance, the perception of the severity of the deviation, the restraints placed on social control agents, and the effect of sanctioning of police deviance" (pg.16).

Sanctions taken against an officer following misconduct may depend on who discovers behaviour i.e. if it is discovered by a supervisor they may not take any formal action as they may not want to draw attention to their unit, whereas if it is discovered by a journalist and exposed to the public then they may receive a different social response and be pressured into taking some action (Kappeler et al, 1993; pg. 16-17). An added complexity to police behaviour is where an officer may deviate from accepted practices set out by the dominating police culture. Where this occurs officers may find themselves sanctioned by their fellow officers (pg. 17).

"One of the most powerful constructions about the police is the administrative and political promotion of the myth of the 'rotten [or bad] apple'" (Sherman, 1974 cited in Kappeler et al, 1993; pg. 67). This promotes a myth of a single officer acting alone and as Bowling and Philips (2002) point out it is appealing "because the obvious solution is to ferret out the 'bad apples' who have sneaked into the barrel and prevent any more from getting in" (pg. 156). It also provides the public with the necessary assurance that the "police do not engage in significant systematic deviance" and that such behaviour is not condoned by the organisation (Keppeler et

al, 1998; pg. 67). However, it fails to take sufficient account of the extent to which these views, practices or actions are shared within the wider police culture, society or to consider the structural context within which policing exists (Bowling and Philips, 2002; pg. 156).

Kapeller et al (1998) also discuss the importance of supervision of officers, or more pertinently the lack of supervision, in allowing misconduct to occur and helping to perpetuate the 'bad apple myth' by claiming ignorance as and when misconduct is uncovered (pg. 71-72). When incidents of deviance are detected, this ignorance provides the organisation and its ranking officials with the cover necessary to support the "rotten apple myth" – again supporting the public perception of limited organised deviance. The supervisor officer may also be acting inappropriately and know that their subordinates are aware of their behaviour so that they are faced with a choice or concealing their inappropriate practices or drawing in their subordinates to prevent themselves being exposed (pg. 72).

The motivations of police behaviour will also differ depending on the nature of the actions. Barker and Carter (1994) identify two different types of police wrongdoing. The first has an external source leading to an 'abuse of authority' "because the behaviour is inconsistent with law and/or policy" (pg. 9). Whereas, occupational deviance has an internal source because it breaches rules set down by the organisation or the trust placed in the individual. Barker and Carter (1994) therefore believe that "…abuse of authority is largely motivated by the officer's intent to accomplish a direct to peripheral police goal; occupational deviance is largely prompted by the personal benefit, gratification, or convenience of the individual officer" (pg. 9). This is an

important distinction as the first type of wrongdoing is unlikely to be challenged or changed significantly unless the wider societal views and beliefs change.

Changing Police Culture and Practice

Police culture can be presented as a relatively negative phenomenon; however it is also seen to be "functional to the survival of police officers in an occupation considered to be dangerous, unpredictable and alienating" (Chan, 1997; pg: 45). Others have argued that police culture can be harnessed and utilised in a positive manner. Goldsmith (1990) argues that the police should be involved in negotiating the rules and ethics that they have to abide by as this would mean that they would be more likely to follow them. He suggests having both internal and external accountability based around Braithwaite's positive shaming concept, which requires organisations to accept responsibility for their problems and rectification to avoid abuses of this power. This might be based on a restorative justice model, which would bring officers who are only minor offenders of the rules back into the organisation after successfully challenging their behaviour. Goldsmith (1990) also suggests the possibility of having the public involved in the negotiating the rules as this would possible increase confidence and also subject the police to alternative points of view.

Dixon (1997) argues that "police organisations must become as adept at identifying good practice and rewarding officers…as they are at creating disciplinary rules and punishing officers for breaking them" (pg. 316). In a study and comparison of two inner city police stations Foster (1987) found that leadership, management and training could have a large impact on attitudes

and approaches of police officers. One station had successfully altered the culture of the officers in line with the expectations of the Scarman Report due to the commitment and backing of the whole management hierarchy. Fielding (2005b) points to the way in which chief constables conceive different crimes as "accounting for considerable variation when similar cases are compared across jurisdictions" (pg. 102). He references empirical work on the way in which both young offenders and people committing drug offences are dealt with in different police forces and concludes that differences in attitudes and approaches within the forces to these offenders (supported by the chief officers) will make a difference in terms of how they are dealt with (Fielding, 2005b; pg. 101). Cummings (1992) also argues that having a leadership that promotes strong role models, positive stories of action, positive symbols and rituals within the police force can lead to cultural change. In the context of Section 136 detentions this could mean that if there was strong leadership within the force on the matter, more action would be taken in ensuring that these individuals were not taken to police custody, and this in turn could lead to pressure for greater provision of alternative places of safety for these individuals.

Brogden et al (1988) distinguish between two main ways to hold the police to account (touched on above): changing the culture of police organisations or tightening the rules in order to curb their level of discretion. Tightening the rules of how the police operate might involve drawing up internal standards or codes of practice, or trying to improve the transparency of police work, or it could involve external rule tightening which might consist of further legislation, seeking independent feedback from those who have had contact with the police, monitoring schemes, changes to the complaints procedures or establishing other types of auditing of the police (pg:

120-121). Chan (1997) states that "disillusionment with rule-tightening as a way of reforming the police leads to a growing interest in the [other] approach: changing police culture" (pg: 55).

Changing police culture (in the context of tackling police racism), according to Chan (1997) has traditionally seen the police undertake training and/or try to address the recruitment of new officers to encourage a wider variety of people to join the force (and specifically BME officers) (pg: 56 – 58). Bowling (1998) also states that police culture has traditionally been tackled through changes in policing policy, namely 'race relations' training. Brogden and Shearing (1993) suggest that the impact of changes to recruitment policies is unlikely to be successful in changing police culture, as it is likely that minority groups within the force such as woman and people from BME groups will tend to accept or adopt elements of the overriding culture in order to integrate within the organisation. Equally training is also likely to fail in "changing deviant cultural practice unless the nature and structure of police work are substantially transformed" (Chan, 1997; pg: 61).

Another way of trying to change police culture involves "the building of direct links between the police and the community" (Chan, 1997; pg: 56). It is thought that ongoing contact with the community may help to change attitudes and views represented by the dominant police culture, as well as helping the community to hold the police to account. However, "in spite of its attractive rhetoric, community policing is more often talked about than practised" (Chan, 1997; pg: 60). There is also likely to be a problem in terms of defining what kind of policing the public want (as mentioned earlier), as Smith (1987) argues that there are many publics with "conflicting demands" (pg: 63-64).

Training and initiatives such as community policing show the importance of frontline officers and the role they play in addition to the importance of police leadership and management as discussed above. Police discretion has been discussed earlier in this thesis and as highlighted above Mokhtar and Hogbin (1993) found that a lack of training in Section 136 led to officers under-using the power. It will be shown later in this thesis when discussing the empirical evidence, that officers' knowledge and attitudes towards the law make a difference to how it is used and applied. For example, in forces where it was seen as more acceptable and/or less bureaucratic/time-consuming to use breach of the peace to arrest an individual rather than detain them under Section 136 this power was used instead, whereas in other forces the reverse was true. In addition, officers' will interpret the actual power differently in terms of how they determine the threshold of whether an individual is 'in need of immediate care or control' and their belief as to whether this threshold is met or not. This may be influenced by the experience and attitudes of the individual officers as well as the culture surrounding them, advice they receive from colleagues and the quality and quantity of training in mental health they have received. It will also be seen later in this thesis that officers may apply Section 136 differently to individuals depending on their own characteristics and/or the type of mental disorder they are exhibiting. With personality disorders being viewed as more problematic to deal with by many officers (under the 1983 Act particularly as opposed to the changed definition under the 2007 Act) due to it being a 'non-treatable' illness, and with a disproportionate number of Black people being detained – the possible reasons for this will be discussed later in this thesis.

Chan (1997) has four major criticisms of how police culture has traditionally been constructed; firstly that it fails to "account for internal differentiation and jurisdictional differences" (pg: 65); secondly that it implies "passivity of police officers in the acculturation process" (pg: 66) whereas "a sound theory of police culture should recognise the interpretive and active role of officers in structuring their understanding of the organisation and its environment" (pg: 66-67). The third criticism is "its apparent insularity from the social, political, legal and organisational context of policing" (pg: 67), and the final criticism is related to all of the previous three "an all-powerful, homogeneous and deterministic conception of the police culture insulated from the external environment leaves little scope for a cultural change" (pg: 67). Kappeler et al (1998) also highlight some of these issues, pointing out that different cultures exist within the police and that "these different stands of conduct may conflict with one another" (pg. 17). They also state that "police deviance does not exist within a political, economic, or social vacuum" and that "structures outside the police such as the law and the wider society contribute to the actions and views of the police" (pg. 79).

Given these criticisms Chan (1997) draws on theories developed by Sackmann to explain the existence of many different cultures, Chan (1996) describes how Sackmann's model accounts for and recognises various forms of cultural models and:

> …classifies cultural knowledge in organisation into four dimensions: (1) *dictionary knowledge*, which provides definitions and labels of things and events within an organisation; (2) *directory knowledge*, which contains descriptions about 'how things are done' generally in the organisation; (3) *recipe knowledge*, which prescribes what should or should not be done in specific situations; and (4*) axiomatic knowledge*, which represents the fundamental assumptions about' why things are done the way they are' in an organisation. Axiomatic knowledge, often

> held by top management, constitutes the foundation for the shape and future of the organisation. These may be adjusted or revised from time to time as a result of critical evaluations of growing experience (pg. 113, original emphasis).

Chan (1996) therefore points out that this allows for various cultures to exist within the same organisation and for this to be different to the axiomatic knowledge held by senior management as it might depend on the dictionary and recipe knowledge of those with differing levels of responsibility at different positions within the hierarchy of an organisation (pg. 113). Chan (1997) also draws on Shearing and Ericson's work on the role of individuals within the force to shape culture; and Bourdieu's relational theory to explain "cultural practice as the result of interaction between cultural dispositions ('habitus') and structural positions (field), [which] situates culture in the social and political context of police work" (pg: 67). Chan (1996) states that "for Bourdieu, society is constituted by an ensemble of relatively autonomous fields. A field is a social space of conflict and competition, where participants struggle to establish control over specific power and authority, and, in the course of the struggle modify the structure of the field itself" (pg. 114). Chan (1997) explains that in terms of police work on the streets, the 'field' might "consist of the historical relationships between certain social groups and the police, anchored in the legal powers and discretion that police are authorised to exercise and the distribution of power and material resources in the community" (pg: 71). By contrast, the 'habitus' is the cultural knowledge of the police, the 'policing skills' or what officers might refer to as 'commonsense' which allows them to cope with the varying circumstances of job (Chan, 1997; pg: 71). Chan (1996) expands on this to state that 'habitus' is:

> …closer to what has…been described as cultural knowledge. It is a system of 'dispositions', which integrate past experience and enable individuals to cope with a diversity of unforeseen

> situations (cites Wacquant, 1992: 18). Instead of seeing culture as a 'thing', e.g. a set of values, rules, or an informal structure operating on actors in an organisation, Bourdieu argues for the primacy of relations, so that habitus and field function fully only in relation to each other. Habitus generates strategies which are coherent and systematic, but they are also 'ad hoc because they are "triggered" by the encounter with a particular field' (cites, Wacquant, 1992: 19)…habitus allows for creation and innovation within the field of police work. It is a 'feel for the game', it enables an infinite number of 'moves' to be made in an infinite number of situations (pg. 115).

Chan (1996) goes on to state that the police therefore have an "interpretative and active role…in relating policing skills to the social and political context of policing" and that the theory allows for numerous cultures to exist because "different organisational positions operate under different sets of field and habitus" (pg. 115).

Using these various perspectives Chan suggests that the key to changing police culture lies in being able to change both "the field, that is, the social, economic, legal and political sites in which policing takes place" and the 'habitus' or cultural knowledge within the police service (pg. 92-3). She highlights the importance of the police themselves in this process as they are not merely passive participants but have a role in changing and shaping the culture (Chan, 1997; pg: 73-74). Culture cannot be seen as purely internalised rules or values that are independent from the conditions of policing (Chan, 1997). She believes that unless the pressures generating the traditional cultural attitudes change as a result of more profound changes in the societal structural context of police work, changes in the selection and training of individual officers can't achieve much (Chan, 1997). Chan (1996) uses the analogy of sports, suggesting that if the rules are changed (the field) a player may adapt quickly without necessarily altering their performance (the equivalent would be the rules governing policing) (pg. 131). Whereas changes to the 'habitus' also affect practice (this relates to the objectives of policing), but unless the changes are

supported by the field then the new "…'habitus' itself may revert to its old dispositions" (pg. 131). Finally she states that:

> It may be that tightening the law is easier to achieve than changing police culture, but the results of both can be unpredictable. Moreover, changing the field can be just as difficult as changing the habitus when the distribution of power and resources is the target of change (Chan, 1996: pg. 131).

This will be seen and discussed in more detail later in this thesis as the application of Section 136 and changes to where individuals are held as a place of safety require changes to the resources available and for changes in ways of working across agencies.

Fielding (2005b) has also argued along similar lines that "critics of police institutionalised racism do not generally go far enough", he states that "such criticism fixes at the level of occupational culture ('canteen culture'); but it is doubtful that the key players can be identified in a personified form. Institutionalised discrimination is a product of decisions taken in several settings, in Parliament, in the courts, in the administrative settings of the state, whose consequences may be unforeseen and unintended" (pg. 6).

Similarly, Morgan (1996) argues that accountability is multi-faceted concept and mechanism and that the chain of accountability is as strong as its weakest managerial link (pg. 25). He therefore believes that effective accountability has *political, legal, managerial* and *operational* dimensions and that one dimension is unlikely to work without the other. Law alone is not enough since (as we have observed above) there is often a gap between the law and its application. Senior managers ensure that certain standards are met and criteria followed, as well as establishing

whether instructions were followed and taking appropriate action if not, thereby providing political accountability. Operational accountability ensures that service delivery is transparent. Using the example of custody, Morgan argues that while much has been done to provide greater transparency in custody (via PACE), ultimately the provision of adequate standards in custody, and the development of a caring environment within them will depend on integrating the services provided in the community (the essence of normalisation) and by developing high standards of professionalism among custodial staff (pg. 26).

In the context of this thesis this means that a crucial source of police prejudice towards the mentally ill is societal prejudice which leads to discrimination and stigmatisation of the mentally unwell (see for example Read and Baker, 1996; Sainsbury Centre for Mental Health, 2002; Social Exclusion Unit, 2004; Thornicroft, 2006). This may affect their treatment of these individuals who may be disturbed and distressed, coupled with possible racial prejudice on the part of the police this could affect who they decide to detain, and more generally this could lead to a lack of determination and drive to push for change in the way in which Section 136 detainees are held. Chan's (1997) account of the failure of attempts to change the police culture in Australian reform attempts underline the limited possibilities in the absence of fundamental transformation of the police role.

Changes to the field would involve greater resources being allocated to the care of the mentally ill, the availability of alternatives places of safety for Section 136 detainees, greater accountability of the police, and less discretion which in turn means greater auditing of how they use their powers. "Changing police culture requires changes in the field at both management and

street levels" (Chan, 1997; pg 232). A variety of tools are therefore needed to change police practice such as strong leadership and management, challenging negative beliefs and attitudes both within the police force (at all levels) and wider society, and ensuring that the police are properly accountable to the communities they police.

I have set out the drivers for how the police work and the parameters within which they operate i.e. law, policy, discretion, structure, and police culture, and have examined how positive changes to police practice and culture might be made. I will therefore now turn to the existing empirical evidence to look at actual police practice on the ground in terms of the prevalence of those detained in police custody and their make up, the prevalence of deaths in custody and other deaths under the Act and the demographics of these people.

Detention in custody and detention of people with mental health problems

The police are often the first agency to be called and attend difficult and potentially confrontational situations where they may be have to deal with violent, intoxicated, mentally ill and vulnerable individuals. They "are frequently the only 24-hour service agency available to respond to those in need" (Morgan and Newburn, 1997: pg. 79). These instances may or may not involve an actual offence but will often require the police officer to manage and diffuse the situation. As set out earlier, this 'social work' function of the police service has long been recognised as an aspect that many officers do not see as an important or worthy part of their job and yet it takes up much of their time (Reiner, 2000; Fielding, 2005b; pg: 96 and 139). Singer (2001) studied how officers spent their time and found that only 23% was spent 'attending

incidents' and 9% doing 'crime related' work (pg. 14) which means that only around a third of their time is actually spent in work related to crime, with the remainder conducting a range of other various functions. Fielding (2005b) points out that regarding the social work side of the job as 'secondary' has been reinforced by "police efforts to get citizens to report 'non-urgent' matters to special call centres or via the internet and email" (pg. 96). Fielding (2005b) highlights the different criteria which the police and the public use to evaluate the success of the police, with the public being interested in how they perform as 'helpers or comforters' whereas the police assess themselves against their effectiveness in crime fighting (pg. 139).

The functions and powers of the police service have continued to increase and officers are expected to deal with an ever-expanding variety of problems (Police Foundation and Policy Studies Institute, 1996). However, they may not always have the training and understanding they need to help them deal with particularly vulnerable individuals that have multiple needs such as alcohol and drug dependency in addition to mental illness. In addition to this, research has shown that certain groups tend to be treated as 'police property', meaning that due to their 'low status' and lack of power the police are able to treat them as they wish (Reiner, 2000). These groups include people who are homeless, those with drug and alcohol problems, the young and people from BME groups. It is also likely to include many individuals with mental health needs. This is because the evidence suggests that many people with mental health needs also have other problems such as alcohol and/or drug addiction and that people with multiple needs are less likely to gain access to appropriate health and social care services and are therefore more likely to come into frequent contact with the police (Revolving Doors Agency, 2000). There is also evidence to suggest that BME people, and in particular Black people, are overrepresented within

detentions under the Act (Audini and Lelliot, 2002; Singh et al, 2007; Care Quality Commission, 2011). I will now consider the evidence about those who are detained in police custody more generally before looking at those detained with mental health needs.

Official statistics – police custody population

There are currently no national data on the total police custody population for England and Wales. The closest available data are figures published annually by the Home Office on the number of arrests for 'notifiable offences' This data underestimates the total number of police held in custody as it excludes most summary offences and instead primarily consists of indictable or triable either way offences (Povey et al, 2011). The notifiable arrest data does not therefore include offences such as being drunk and disorderly. Section 136 detentions are also not included in the figures since they are not technically 'offences'. To provide an approximation of the difference between notifiable arrests and the total custody population it is useful to consider data collected from police forces by the Department of Health and the Home Office (2010). This showed that there were around two million people detained in police custody in 2008/09 whereas the notifiable arrest data for the same period showed that there were just under 1.5 million people detained (Povey et al, 2010). This is a fairly large difference and suggests that around half a million people per year are detained in police custody for relatively minor offences. However, despite the limitations of the notifiable arrest data, they still provide the most accurate portrait of people detained in police custody for any given year.

The most recent statistics available for notifiable arrests are from 2009/10 (Povey et al, 2011). They show that the number of persons arrested for recorded crime (notifiable offences) fell by five per cent between 2008/09 and 2009/10, to 1,386,030 (a fall of 76,109). There was a continued fall in arrests for offences of violence against the person, and arrests of young people (10 – 17 years old) fell by 12% in 2009/10 to 241,737. The offences with the three largest percentage decreases recorded were for criminal damage, a fall of 12%, theft and handling stolen goods down 10%, and 'other offences' also down 10% (Povey et al, 2011). In contrast, arrests for sexual offences increased, and showed the largest percentage increase in 2009/10 at 9% (Povey et al, 2011). Although it is thought that this is likely to reflect an increased willingness on the part of victims to report these crimes following steps by ACPO and forces to encourage and promote this. Arrests for drug offences have continued to increase for a number of years and rose again in 2009/10. Finally, arrests for property offences (burglary, theft, fraud and forgery, and criminal damage) accounted for 39% of all arrests for recorded crime offences in 2009/10, down from 41% of arrests in 2008/09 (Povey et al, 2011).

For forces who were able to provide this data, the overall number of persons detained for more than 24 hours (up to a maximum of 96 hours) under PACE and subsequently released without charge was 4,224 (Povey et al, 2011). Where compared to the same selected forces for the previous year, this represents a 4% fall. Ninety-four per cent of those detained for more than 24 hours during 2009/10 were released within 36 hours, up from 88 per cent in 2008/09 (Povey et al, 2011). Warrants of further detention (issued by magistrates) under PACE, which authorise detention without charge, were applied for on 582 occasions during 2009/10. Sixty-six per cent

of those detained under warrant were charged, a fall of five percentage points on the previous year (Povey et al, 2011).

In terms of the demographic make up of those arrested for notifiable offences, in 2009/10, 83 per cent were male, the same proportion as the previous four years (Povey et al, 2011). In recent years, arrests for violence against the person have exceeded those for theft, for both men and women. Eighty per cent of those arrested in 2009/10 defined themselves as White (Povey et al, 2011). Eight per cent defined themselves as Black or Black British, and 9% Asian or Asian British. The Office of National Statistics estimate the make up of the general population of England and Wales, the latest figures which include a breakdown of ethnicity are for 2007. This data estimates that males make up 49% of the population and females 51% (ONS, 2007), meaning that men are overrepresented in the custody population. The ethnic breakdown of England and Wales is estimated to be 89% White, 5% Asian, 3% Black, 2% Mixed, and 1% Chinese/Other ethnic group (ONS, 2007). Therefore people from BME groups, and particularly Black people, are also overrepresented in the custody population. This might be linked to earlier discussions on police discretion and culture and how the law is not applied equally to all groups, leading to over-policing of some groups, and disproportionality in terms of the ethnicity and class of those entering the criminal justice system.

As might be expected due to the differences in both their size and the populations they police, different police forces represented different proportions of the overall notifiable arrests figures. In 2009/10 nine police forces recorded increases in the number of arrests for recorded crime offences while 34 recorded decreases (Povey et al, 2011). The largest percentage increases

reported were in Wiltshire (up 12%), followed by the Metropolitan Police (up 6%) and Humberside (up 5%). Whereas the largest percentage falls were recorded in the West Midlands (down 18%), followed by Gloucestershire and West Mercia (both down 17%). Due to their different sizes, it is more meaningful to look at arrest rates by population at police force area level. This shows that the rates range from 13 per 1,000 population in Surrey to 38 per 1,000 in Cleveland, with the rate for England and Wales as a whole being 25 per 1,000 population (Povey et al, 2011).

Official statistics – mentally disordered offenders

The Ministry of Justice publishes data annually on mentally disordered offenders; this used to be a separate publication (Ministry of Justice, 2010a) but has now been combined into annual statistics on offender caseloads (Ministry of Justice, 2010b). The Act enables mentally disordered offenders to be detained in hospital for treatment and to be managed on the basis of their clinical condition and the risk they pose rather than any element of punishment via the criminal justice system (Ministry of Justice, 2010b). Offenders may be detained in hospital as restricted or unrestricted patients. Unrestricted patients remain in hospital for as long as their mental disorder requires treatment and this is a matter of clinical judgement for the patients' doctors, although this is subject to review by the Mental Health Tribunal (Ministry of Justice, 2010b).

Restricted patients are generally offenders found by the sentencing court to pose a risk of serious harm to others (Ministry of Justice, 2010b). A restriction order means that the offender cannot be

discharged, transferred from one hospital to another or allowed leave in the community without the consent of the Secretary of State (Ministry of Justice, 2010b). This is based on the principle that the Secretary of State is protecting the public from someone who is potentially 'dangerous' which was discussed in chapter 1. However, restricted patients can be discharged by a Mental Health Tribunal if it is not satisfied that the criteria for detention continue to be met (Ministry of Justice, 2010b). The Act is also used to detain prisoners who have been given prison sentences and if the court or the Secretary of State directs a prisoner to be detained in hospital under the Act, the prisoner will be managed subject to restrictions. They cannot be discharged into the community during the term of their prison sentence and will be returned to prison once treatment is complete (Ministry of Justice, 2010b).

These statistics provide information on all mentally disordered offenders who are in hospital under a restriction order and will not therefore include information on those whose mental illness is not serious enough for them to be under a restriction order in hospital but who have still been held in police custody for some period and who have some mental health problems. In 2009 there were 4,300 restricted patients, an increase of 8% on 3,900 in 2008 (Ministry of Justice, 2010b). Of these patients, 87% were male and 13% female (Ministry of Justice, 2010b). The proportion who were female was therefore more than twice the proportion of females in the general prison population – 5% (Ministry of Justice, 2010b). Restricted patients also had an older age profile than the general prison population, with 8% aged 60 or more compared to 3% in the general prison population (Ministry of Justice, 2010b). Data on the ethnicity of mentally disordered offenders is not published which seems to be an omission given the overrepresentation of BME groups both within the criminal justice system and among the

detentions under the Act. The evidence on disproportionality in terms of the ethnicity of those detained under the Act is discussed in more detail later in this chapter. Briefly, the evidence suggests that detentions under the Act vary by ethnic group with individuals from Afro-Caribbean backgrounds in particular being more likely to be detained. However, this does not necessarily mean that the incidence of mental illness is higher among BME groups as the reasons for the detentions are complex and could include racial discrimination both within society and within health and social care and the criminal justice system, as well as cultural issues meaning that they do not access mental health services at an early stage (Chakraborty and McKenzie, 2002). This could mean that people from BME groups are more likely to come into contact with the police and therefore enter the criminal justice system, both because of the way the public view their behaviour and perceive a potential threat – thereby alerting the police, and because of the way the police may interpret their behaviour and perceived 'dangerousness', and because they may not have received adequate treatment or accessed mental health services at all.

Whilst some prisoners are transferred from prison to hospital under the Act as set out above, others remain in a prison setting. The last large survey of prisoners to assess their mental health was conducted in 1997 by the Office for National Statistics (ONS) on behalf of the Department for Health and reported in 1998 (Singleton et al, 1998). It found that 64% of male sentenced prisoners and 50% of female sentenced prisoners had a personality disorder (Singleton et al, 1998). With a personality disorder defined as "patterns of behaviour or experience resulting from a person's particular personality characteristics which differ from those excepted by society" (Singleton et al, 1998; pg: 10). This compares to only 5% of men and 3% of women in the general population (Singleton et al, 2000). The Survey also found that 7% of male sentenced

prisoners and 14% of female sentenced prisoners had some form of psychosis (Singleton et al, 1998).

Other studies have also found high levels of mental disorder among prisoners, for example Gunn et al (1991) found that 37% of prisoners had a diagnosable mental disorder. Whereas Brooke et al (1996) found that 63% of prisoners on remand had a mental disorder and 5% were suffering from psychosis. Because the police act as the gateway to the criminal justice system these individuals would therefore all have been detained at some point in police custody, giving an indication of the high levels of mental disorder the police experience in their custody population.

Official statistics – people detained under the Act

The National Health Service (NHS) and individual primary care trusts monitor people who are held in hospital under the various provisions of the Mental Health Act 1983, including those who are held under Section 136 as a place of safety - other than those held in police custody (The NHS Information Centre, 2010). The Act allows for the detention of people in hospital either for their own safety or for the protection of other people. Since November 2008 detained patients can be discharged from hospital by means of a Community Treatment Order (CTO), subject to the possibility of recall to hospital if necessary (The NHS Information Centre, 2010). This is known as supervised community treatment (SCT). Data is published by the NHS annually on 'in-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment' (The NHS Information Centre, 2010). These statistics are for

England only (not Wales) and cover detention under the following parts of the Act (for detentions in hospital), as well as CTOs:

- civil detentions made under Part 2 of the Act,

- court disposals and prison transfers made under Part 3 of the Act and relating to patients detained by direction of the court while on remand, or after conviction, or transferred from prison under warrant from the Secretary of State for Justice,

- Place of Safety Orders made under Part 10 of the Act which allows temporary detention while assessment is made.

These statistics show that in 2009/10 the total number of formal detentions in hospital rose by 3.5% from 2008/09, to a total of 49,417 detentions, including all formal admissions, as well as detentions subsequent to admission and detentions following use of Section 136 (The NHS Information Centre, 2010). There were 30,774 formal admissions which is the largest annual increase in formal admissions for four years (The NHS Information Centre, 2010). There were a total of 4,103 CTOs in 2009/10 which is an increase of 92.3% from the previous year, however this is likely to be due to the previous year's only covering a 5 month period and being the first time these figures were collated (The NHS Information Centre, 2010). Of the 6,237 CTOs made since November 2008 only 1,965 (31.5%) have been ended. The report therefore suggests that there is emerging evidence of some people being kept on CTOs for long periods of time (The NHS Information Centre, 2010). It also shows a continuing rising trend in the number of people

detained in hospital at which it suggests, if taken together with the number of people on CTOs suggest that increasing numbers of people are being subject to restrictions under the Act (The NHS Information Centre, 2010). It also shows a link between the wider evidence on the increasing trend for 'care in the community' of people who are mentally ill (Peay, 2008) and therefore they face an increased likelihood of coming into contact with the police, and depending on their behaviour potentially being detained under Section 136 of the Act.

The statistics report on 'Place of Safety Orders' under Section 135 (where a warrant is obtained to detain someone for their safety from a private premise) and 136 (where an individual is detained in a public place because they are in 'need of care and control'). In 2009/10 there was a steep increase in the number of Place of Safety Orders involving assessment in hospital, rising by 40% to 12,300 (The NHS Information Centre, 2010). This appears to be a continuing trend in with the data showing that place of safety detentions in hospital have increased each year since 2005/06. When comparing the number of place of safety detentions in 2005/06 to those in 2009/10, they have more than doubled (The NHS Information Centre, 2010). However, because the report only contains data on detentions in hospital and not police custody, it is not clear to what extent the increase in Place of Safety Orders is due to an overall increase or the effect of greater use of hospitals rather than police stations as places of safety (The NHS Information Centre, 2010). There could also be additional reasons such as improved recording and monitoring by NHS staff. The majority of place of safety detentions in hospital involved males, although the detention of females appears to be increasing (The NHS Information Centre, 2010). The report found that the number of Place of Safety Orders that did not result in a formal detention (under Section 2 or 3 of the Act) increased at a similar rate to the number of Section

136 orders (The NHS Information Centre, 2010). The data therefore suggests that although increasing numbers of people are brought to hospital under a Place of Safety Order, in most cases this does not result in a formal detention (The NHS Information Centre, 2010). The data does not show all of the outcomes of the order so it is not possible to know what proportion of patients are discharged or how many remain in hospital voluntarily. The data does show that orders under Section 135 of the Act are rarer, and only make up 2.1% of all place of safety detentions in 2009/10 (The NHS Information Centre, 2010).

Rogers and Faulkner (1987) recommended the need for closer monitoring of the use of Section 136 and suggested that there should be a "standardised monitoring system whereby the police make a record of all the people they detain at the point of detention" (pg. 47). This has still not been implemented and as stated in chapter 1, others such as the Mental Health Act Commission (now replaced by the Care Quality Commission) have also called for Place of Safety detentions in *police stations* to be recorded.

Empirical evidence on detentions in police custody

In addition to the official statistics set out above there have also been several studies which have looked at police custody and the use of police powers to detain (Brown, 1989, Brown, 1997, Brown and Bucke, 1997, Hayman and Newburn, 2002). Brown's (1989) research looked at how detention in police custody was working under PACE. He used custody records from ten police forces, with quota samples of records taken from three or four stations in each force. The forces ranged from the mainly rural to metropolitan and the stations within the forces were chosen to

reflect a variety of workloads. In total the research looked at just over 5,000 custody records for a one year period.

The study therefore had a large quantitative dataset from which to draw its conclusions and was able to look at the entire process from someone entering custody, the advice and contact they received, the identification of those detainees that were sick and/or vulnerable, to how crimes were investigated and the disposal of people leaving custody. The number and range of police forces and stations within those sites that were used helped to overcome some of the problems of previous studies which had focused on a small number of case study sites and whose findings could therefore not be seen to be typical in any sense. Brown (1989) was also aware, when designing the study, or the problem in establishing comparable pre-PACE data, as the equivalent provisions often did not exist, the aim of the study was therefore not primarily intended as a comparison with pre-PACE practice. Instead the study hoped to set a baseline on the operation of PACE which could be used to inform policy makers, the police and other stakeholders.

The research succeeded in collecting extensive data which was analysed in great detail and shed much light on detention in police custody. However, as Brown (1989) himself acknowledged, as the research was based on mainly quantitative data it can say very little about the "underlying processes or the attitudes and motivations of those whose activities are being measured" (pg. 73). He suggested, and I would agree, that there is a need for additional qualitative research using observation and interview, this could explore and account for some of the variations that Brown (1989) discovered and provide a fuller picture of custody practices.

Brown (1997) is a large scale review of the literature and research undertaken on the different aspects of PACE and brings together a wealth of evidence in one report under various themes. It provides a useful analysis of secondary data sources and draws together all of the available evidence to try and address "whether PACE produced a satisfactory balance in the investigative process between the public interest in bringing offenders to trial and the rights and liberties of the suspect" (pg. 243). It concludes that there is further work to be done before PACE can be said to have adequately struck this balance. Finally it also identifies the gaps in the research material and areas where a lack of clarity remains.

Bucke and Brown's (1997) study assessed the changes to the PACE Codes of Practice and their impact on police powers and the rights of those detained in police custody. They sought to examine any changes the new provisions had brought, in comparison to previous research, and to provide information on the effectiveness of PACE in regulating police practice in detaining people. The study employed a mixed methods approach, using observation of suspects and detainees in custody areas, analysis of custody records, questionnaires to investigating officers, and a number of interviews conducted with officers responsible for identification procedures. As with Brown's (1989) earlier study, the research was conducted in ten different police force sites which included county and metropolitan forces. A total of 25 police stations within these ten different forces were used for the research which were a mixture of city centre, inner-city and large town stations (Bucke and Brown, 1997).

Bucke and Brown's (1997) research, therefore, much like Brown's (1989) earlier study was designed in order to obtain information from a range of police force sites in order that the

findings could be assumed to be more typical of police practice across England and Wales. However, unlike Brown's (1989) earlier work the research used a variety of data sources to gain a more detailed picture of the workings of police practice in custody. The researchers acknowledged the possible problems with observational research, in that those being observed, the police officers, may change their everyday routine because they are aware that they are being observed (Bucke and Brown, 1997). This is particularly relevant in this study as the research was being conducted by the Home Office and the officers might have therefore wanted to be seen to be following the rules. This issue will be explored in more depth in chapter three when critically appraising the methodology I employed for the empirical data gathered for this thesis.

However, the researchers believe that this 'observer practice' was unlikely to have been significant as the fieldworkers were present in each of the sites for three weeks (a total of 4,095 hours across 13 police stations). This lengthy time period coupled with the fact that the research was generally not seen as a threat by the officers as they realised over time that the focus of the research was not on individual performance but on the general implementation of the new provisions; meant that officers were unlikely to significantly change their behaviour. The questionnaires were given to a total of 3,950 officers and had a 90% response rate, providing a large dataset of officers. A total of 12,500 custody records were analysed from 25 police stations, 13 of which were the same as the observation sites. Additional data was also collected on a number of issues such as legal advice, appropriate adults, searches, body samples, and bail and case outcomes.

The use of custody records in Bucke and Brown's (1997) study provided an effective means of collecting data on a large number of police detainees and due to the large sample they were able to look at relatively rare procedures such as the taking of body samples. Whilst the data they collected was reliant on the information provided by others (i.e. the custody officers, via the questions asked of the detainees) and therefore subject to their interpretation this was somewhat overcome by using observational research in order to assess the practices and the make-up of the detainees for themselves. The research is also strengthened by its mixed methods approach which allows generalisations to be drawn from the quantitative data but for the procedures to be explained in more detail from the qualitative analysis.

Newburn and Hayman's (2002) research differed in that it sought to look at a specific issue within police custody: the use of CCTV to monitor suspects and detainees. The research therefore monitored and evaluated a pilot site in a north London police station. The researchers used custody records covering a year and a half period (7,962, with about 4% having missing data which were therefore not analysed), interviews with custody staff and members of the local community, and observational research to judge the usefulness of CCTV in protecting both the police and the detainees. They placed their research within the context of wider custody issues such as deaths in custody, mistrust of the police, vulnerable detainees and the legal procedures that govern custody. The research is only based on one case study site and the findings cannot therefore be generalised beyond that, especially as it is a Metropolitan police station which is likely to have a very different custody population to that of a rural police station. However, the methods employed were entirely suitable in meeting the aims of the research i.e. evaluating a

pilot study into the potential of CCTV and provides a useful summary of the issues that need to be considered before expanding such pilots.

Newburn and Hayman (2002) found that the custody records which they analysed showed that just over 90% of detainees were male, nearly 50% were under 27 years of age, and a third were under 21 years old (pg. 42). The age of detainees ranged from 10 to 82 years old. Detainees identified by the police as being White European and by the researchers as being Irish made up 45% of the total number; this was very similar to the make-up of the local population which according to police data had a non-White population of approximately 54% (pg. 42-43). Forty-one per cent of detainees were identified by the police as being Afro-Caribbean, 6% Asian, 5% 'Mediterranean', 1% 'Oriental', and 2% 'Arabic' (these are the police ethnicity classifications based on the officers' interpretation of the individuals' ethnicity and not the Census self classification codes). Again this is likely to be reflective of the local area which had a very diverse community.

The researchers found that the main reasons for arrest were public order offences (22%), theft/handling offences (16%), drug offences (12%) and violence (12%) (pg. 44). There were some key differences in the reason for arrest by ethnicity; White people were more likely to be arrested for public order offences, Afro-Caribbean and Asian people were more likely to be arrested for theft/handling and drugs offences. There may be many reasons why these differences occurred, including differences in the way in which the police used their discretion to decide when to arrest and what to arrest for (Lustgarten, 1986) which might be influenced by police culture and more negative views or attitudes towards ethnic minority groups which were

discussed earlier in this thesis (Reiner, 2000). Just over two-fifths of detainees in Newburn and Hayman's (2002) study were held at the station for no more than four hours and approximately three-fifths were detained for six hours or less. Of those arrested and taken to the station, just over one-fifth (23%) were held overnight and overall three per cent were held for more than 36 hours (pg 45).

Bucke and Brown (1997) describe the three main options that a custody officer has when a suspect's detention is no longer justified:

- if there is sufficient evidence the officer may charge the suspect or in less serious cases where the suspect has admitted the offence they may administer a caution;

- the second option involves the police releasing the suspect and closing the case with no further action (NFA). This occurs when officers find no evidence against a suspect or where evidence exists but the officers decide that charging would serve no useful purpose.

- The third option is to delay making a decision; officers may want more time in order to make further enquiries, may want to arrange an identification parade, or may be satisfied about a suspect's involvement in an offence but may be unsure whether to proceed with a charge. In these cases the suspect might be bailed to return to the station on a specific date, or may be told that the facts of the case will be reported with a view to prosecution and that they may receive a summons (pg. 59).

In Bucke and Brown's (1997) sample just over half of all suspects were charged (53%), 15% were cautioned, 19% NFA'ed, and the remaining 13% transferred or released. The researchers found wide variations in the pattern of disposals across the stations the research looked at, although cautioning rates were more consistent. In Newburn and Hayman's (2002) sample, the majority of detainees were released back into the community (83%), almost a third (32%) were bailed to return to the station, 13% were taken to court, and the remaining 4% were sent to prison, deported, or sent to secure accommodation under the Act or to hospital.

Empirical evidence on detentions of the mentally ill in police custody

The studies outlined above looked at police custody more generally but all touched on the issue of vulnerable detainees such as juveniles and the mentally ill, who were recognised in each of the studies as representing an important issue for the use of police custody. However, several research studies have sought to examine the specific issue of police custody and mental health and have employed differing methods to that of more general studies.

Irving (1980) and Irving and Mckenzie (1989) (both cited in Gudjonsson et al 1993) carried out observation studies of suspects who were being interviewed by the police. They carried out three studies in total in 1979, 1987 and 1988. The first study found that 25 (42%) of suspects were in some way mentally disturbed during the police interview. The number of suspects who were judged to be in an 'abnormal' mental state dropped to 21 people (31%) in the second study, and to nine people (13%) in the final study. The main reason the researchers gave for the improvement related to far fewer suspects being interviewed when they were visibly under the

influence of alcohol. This may relate to improvements being introduced by PACE. For the total number of 196 suspects in all three studies only one (0.5%) was judged to be of low IQ or mentally vulnerable.

Bucke and Brown (1997) found that in their study, 2% of detainees were treated as being mentally disordered or mentally vulnerable. However, they point out that other research has suggested that this proportion might be higher as detainees with mental health problems are not always identified as such by custody officers and therefore did not appear on the custody records. In terms of the demographics of those detained, Bucke and Brown (1997) found that compared to other detainees in their sample, those with mental health problems tended to be older and were more likely to be female. Forty-three per cent were over 30 years of age compared to 27% of other detainees, whiles 24% were women compared to 15% of the whole sample. Four out of ten of these detainees were in custody as a place of safety under Section 136 of the Act; the remainder had been arrested for a wide range of crimes, with theft, criminal damage and public order offences the most common.

Gudjonsson et al (1993) sought to build on earlier observational research of suspects being interviewed by the police, where the researchers aimed to judge if the suspects were intoxicated and/or mentally ill. Rather than use observational research or records compiled by officers in the custody suite which they believed significantly underestimated the extent of those who were mentally ill or mentally vulnerable, Gudjonsson et al (1993) decided to assess the suspects psychologically. The study aimed to identify the type and extent of potential vulnerabilities prior

to police interview, and to assess how easily suspects' mental vulnerabilities could be identified by superficial observation.

The study involved three clinical psychologists attending two police stations in inner and outer London. The study focused on those over 17 years of age, those being detained for the purpose of an interview in connection with a criminal offence (as opposed to those being detained under the Act), and people that were not intoxicated or potentially violent to such an extent that it would be unsafe to assess them. Each assessment had to be agreed by the custody officer, and the suspect had to agree and sign a consent form. Each assessment lasted for up to an hour and consisted of intelligence testing and questions about the individuals' background and mental state. The aim of the assessments was to determine the individual's mental state and ability including intelligence and IQ to determine their overall vulnerability.

The researchers were able to complete a total of 156 psychological assessments, which is relatively small sample, especially for analysis is to be conducted on smaller subgroups such as ethnicity, age or particular offences. The research was only conducted in two police stations and two-thirds of the assessments were conducted in the inner-London station meaning that the respondents cannot be seen to be representative of mentally vulnerable detainees in other police force areas. The custody officers had the potential to bias the sample by only allowing the researchers' access to certain individuals; however the authors felt that this was not a problem. The research also limits itself to those held for potential offences and not others held in custody under the Act which might have been a useful comparison group.

However, due to its specialist and technical nature the research does provide valuable information and shows that many mentally vulnerable people are not identified by police officers and therefore will be not identifiable from custody records. The nature of a research project such as this limits its scale, as it would simply not be feasible or desirable to psychologically assess every detainee in police custody, due to the resource implications and the delays it would cause to processing people through the custody suite.

Gudjonsson et al (1993) found that 12 suspects (7%) were deemed to be mentally ill (the primary diagnoses being schizophrenia and depression), four (3%) mentally vulnerable, two (1%) intoxicated, 12% drugged. Furthermore, their IQ tests showed that a large number of detainees suffered from a significant intellectual impairment.

Of the 7% of suspects who were suffering from mental illness, most were not identified by the police as being mentally ill (Gudjonsson et al, 1993). This illustrates the limitations of only using custody records to monitor those in police custody with mental illness, as highlighted by Bucke and Brown (1997). The schizophrenic suspects in Gudjonsson et al's (1993) study were most readily identified by the police. It was the depressed suspects, some of whom were clearly actively suicidal but whom the police most commonly failed to identify as vulnerable. This is an important point as it is this group that might be likely to self-harm in custody and therefore pose a high risk. The researchers stated that the majority of the remaining suspects would not have been readily identified as mentally ill without a brief clinical interview – something the police could not be expected to carry out.

Gudjonsson et al (1993) go on to state that proper identification of people with a mild mental handicap, even by trained clinicians, is a difficult task. They give three main reasons why there are problems in identification:

- many people with significant intellectual impairment have reasonable social functioning which may disguise their intellectual limitation;

- some people with mental handicap see it as a private matter and wouldn't tell the police and may deliberately disguise it if they are able; and

- even when social functioning is significantly impaired, it may not be easy to assess on brief acquaintance.

Gudjonsson et al (1993) made several recommendations in light of their research findings. They suggested that there is a need for an operational definition of mental disorder and vulnerability, and that all police officers should be provided with basic training to assist them in more readily identifying vulnerable individuals. This leads me to believe that the difficultly the police may have in recognising people in custody with mental illness and problems and the vulnerability of these people only strengthens the argument that police custody is not a suitable place for them to be. This argument is even more persuasive when an individual has only committed a minor offence, or in the case of a detainee under Section 136 of the Act, may not have committed any offence. I believe that police custody is an unsuitable environment for someone with mental

illness and may make their condition worse, particularly if they are not dealt with quickly and appropriate and receive the care they need.

Empirical evidence on use of police custody as a 'place of safety' under the Act

As discussed earlier in this thesis, there are no national statistics available on the use of police custody as a place of safety under the Act, only on the use of hospitals. Furthermore, there is little empirical evidence and the research that does exist has largely focused on London (Borschmann et al, 2010) or other urban areas where the experience and issues may be different to that of a rural environment. "Despite the London-centric nature of the literature, studies from outside of London do indicate that Section 136 is inconsistently implemented and monitored across the UK and that differences exist between rural and urban areas" (Borschmann et al, 2010; pg: 38). Much of the evidence is several years old but some of the main studies will be examined here.

Rogers and Faulkner (1987) and looked at the procedural variations in Section 136 of the Act in London. They investigated procedures and modes of assessment that operated at different places of safety and how the place of safety chosen for providing assessments affects the way in which the police use Section 136, the nature of any assessment provided by mental health professionals and the disposal following the assessment (pg. 11). The study also sought to examine the characteristics and psychiatric history of those detained under Section 136. The research examined case records of people referred by the police to three places of safety in London over a two-year period. The places of safety were a psychiatric hospital, a police station and an

Emergency and Assessment Unit (an emergency psychiatric facility), which were selected as being broadly representative of the different services used to deal with police referrals. It should be noted that this might be different in other areas where Accident and Emergency (A&E) departments are also used.

The study only included cases where the police had initiated the referral themselves and not simply assisted other professionals. The data was collected from the notes of the referred patients and the accompanying police records, the information was then coded. The study is reliant on data which was collected by the police and other professionals and may therefore be incomplete or biased and should be considered in that light. It is also a purely quantitative study (it was the first stage of a larger project) and was therefore not able to explore some of the issues that it raised in any more detail. The study was also based in one area of London and it is therefore difficult to know if the findings would be similar elsewhere in England and Wales. However, it does provide data on the use of Section 136 detentions by the police, both to the police station and to hospital and psychiatric settings. Finally, it also managed to explore the extent to which the police work with other agencies such as social services on Section 136 referrals, although it does not examine the nature of this work.

The study found that over a two year period "273 people were referred by the police to the three places of safety on a total of 326 occasions, with 34 people being referred more than once" (Rogers and Faulkner, 1987; pg. 15). Of these people 53%[15] were aged 17-35, 43% were aged 36-79 and the age of 4% were missing (pg. 15). Sixty-one per cent were male and 39% female

[15] I have rounded all of the percentages cited in this thesis, except those less than 1%.

(pg. 16). The authors note that this is different to the gender make up of psychiatric admissions more generally, where woman make up the majority, and suggest that this may be due to the behaviour of mentally disturbed men potentially being viewed as more aggressive and therefore attracting the attention of the police (pg. 16). The sample were more commonly from lower socio-economic groups and the majority were unemployed (61%), unmarried (77%), 17% were of no fixed abode and only 63% were registered with a general practitioner (much lower than the national average of that time of 97%), showing the social disadvantage in this population (pg. 17-18).

In terms of the ethnicity of their sample, Roger and Faulkner (1987) found that 69% were White, 18% Afro-Caribbean, 4% Asian and 2% 'Other' (pg. 19). The authors therefore note that "the Black population is over-represented in comparison with its proportion in the general population as indicated by the Census…" (pg. 19). They were unable to conduct a more detailed analysis of the ethnicity of their population due to missing data or small samples (pg. 19). However, they note that when compared to other types of psychiatric referrals "…Afro-Caribbeans are more likely to be admitted under compulsory sections than their White counterparts, and…the proportions subject to Section 136 is greater still" (pg. 20).

> The results also show ethnic differences with regard to the type of outcome received after assessment under Section 136. For example, 22% of the Afro-Caribbean referrals at the Emergency and Assessment Unit were discharged immediately following assessment by the psychiatrist, compared to 37% of the White referrals. Additionally, 7% of the White referrals were admitted under Section 2 or 4 of the Mental Health Act compared to 12% of the Afro-Caribbean group (Rogers and Faulkner, 1987; pg. 20).

Rogers and Faulkner (1987) discuss possible reasons for the over-representation of Black people in police referrals under Section 136 (pg 39-41). They suggest that there are a number of possible explanations; it may be that the

> …mentally disordered behaviour demonstrated by Black people is more overtly expressed than by White people and is therefore more likely to draw the attention of the police; the public in general may be more ready to call the police when a Black person is behaving 'oddly' than when a White person is doing so; it has been suggested, for example, that Afro-Caribbeans are not as likely as other groups to be referred from GPs…because there is a reluctance to seek help because of a distrust of establishment services (pg. 40).

Finally, they also touch on the wider context of the more frequent and adversarial contact between Black people and the police that has been discussed earlier in this chapter (pg. 40).

Rogers and Faulkner (1987) found that most of their sample of Section 136 detainees had previous psychiatric treatment (80%), and 71% had previously been admitted to hospital, 33% on three or more occasions (pg. 21). Much of the previous psychiatric treatment or contact had been recent with 36% having been seen by the same psychiatric services within the previous six months (pg. 22). In addition, "13% were referred on more than one occasion during the study period, which shows that a core group of people consistently come to the attention of the psychiatric services through the police" (pg. 22). The authors note that more women than men had a history of psychiatric referral and treatment, and that Afro-Caribbeans had less history of such treatment than other ethnic groups (pg. 21-220). Although they suggest that this latter difference may be due to more Afro-Caribbeans being from a younger age group (pg. 22). In terms of diagnosis, schizophrenia and mania/manic depression were the most common (14% and

15% respectively), and just under a quarter (23%) were not given a specific diagnosis but were thought to be mentally ill, whereas 10% were not thought to be mentally ill (pg. 26).

There were differences in the diagnosis of Afro-Caribbean and White groups: "the two most frequent diagnoses for Afro-Caribbean men were drug induced illness (24%) and unspecified psychosis (26%), whereas schizophrenia (22%) and manic depression (21%) predominate for White males" (pg. 27). It was not possible from their data to explore explanations for this difference. Rogers and Faulkner (1987) note that of the police referrals only 10% were considered by the psychiatrist to not be mentally ill, indicating that the ability of the police to recognise mental disorder is reliable (pg. 32). Of those taken to a police station as a place of safety, 29% were discharged and 39% were admitted formally (pg. 36).

Rogers (1990) built on the report by Rogers and Faulkner (1987) and included the findings of interviews with 160 officers, observational research, interviews with psychiatrists and examination of administrative police records (pg. 227). The aims of the research were to find out in what circumstances the police invoked their powers; the way in which they dealt with and made decisions about the people they detained; and the nature of professional relations between the police and psychiatrists in dealing with this shared client group (pg. 227). The article uses the research to challenge the premise on which the police role in Section 136 detentions had been previously evaluated and the role of the police criticised.

The inclusion of the observation research evidence and the qualitative interviews brings greater depth to there research that was not achieved in the report by Rogers and Faulkner (1987) and

some of the issues such as the over-representation of Black people within the sample, are discussed and conclusions reached which could not have been evidenced without the addition of the qualitative data. However, the research was still based on data collected in only one police force area and it would have been useful to have at least one comparison site in a different type of police force. The Metropolitan Police Service is the largest force in England and Wales and has a uniquely diverse population and different policing issues to other forces. It would therefore have been useful to look at a smaller urban police force and a rural police force with different policing styles and techniques and cultures to identify a range of issues.

Rogers (1990) found that:

> Undoubtedly, the study revealed evidence of considerable discretion on the part of individual officers. For example, the ability for the police to be discriminating in their decisions was indicated by one finding that showed that over a one year period 48% of the arrests at one station involving mental disorder and minor crime did not result in the use of Section 136. However, an examination of the processing of individual cases also suggests that the dominant role of the police has been exaggerated and misconstrued. At the same time the social content of policing and the role of other organisations and social actors have been under-acknowledged (pg. 228).

This highlights both the importance of police discretion and the role of police occupational culture discussed earlier in this chapter, as well as the importance of Chan's theories on the need to change both the 'habitus' and field in order to successfully alter police culture and practice in detaining people under Section 136.

Rogers (1990) found that "in most cases **members of the public** called on the police for assistance" (pg. 228, original emphasis). Individuals contacting the police in such circumstances

were not necessarily concerned with the mental health of the person, but were more often worried about a perceived threat of violence. Very few cases (5%) involved the officers coming across the incidents themselves without being called and in 64% of cases officers stated that they had no warning that the case involved mental health (pg. 228). Officers therefore have very little prior information to base their judgement and actions on (pg. 229).

In terms of their decision whether or not to arrest someone, Rogers (1990) identifies different contributory factors.

> …Whether an officer thought an incident was likely to continue if no action was taken (89%)…Secondly, officer's discretion was influenced by certain contingencies. Informal action would sometimes be tried, and only after this had failed would police make an apprehension…Similarly, the presence of vulnerable people (elderly people or children) made police more likely to consider arrest, whilst cues of potential support such as the presence of a relative or neighbour appeared to have the opposite effect (pg. 229).

Once at the police station Rogers (1990) notes that the police then held the power to decide whether the individual entered the criminal justice system or was treated in a psychiatric setting. When deciding which route to send someone, officers considered both the "practicalities of pressing charges and the perceived seriousness of an individual's mental state vis a vis their 'crime'" (pg. 231). To help make these decisions officers considered the extent to which they thought the crime was intentional and how far the person could be considered responsible for their actions. Another factor in the route individuals were sent down, or indeed whether officers decided to deal with them formally at all could be the other tasks that they were dealing with or that they became aware of over the radio while with the individual. Reiner (2000) describes the

drive of some officers for action and crime fighting and therefore there is a possibility that some officers may be influenced by a more 'exciting' or 'proper' crime if one arose during the incident. Furthermore, as will be seen later in this thesis, depending on the facilities available to be used as a place of safety and the perceived bureaucracy associated with these, the officers may choose to use one over the other depending on which was most likely to lead to them being quickly back on duty.

However, Rogers (1990) also highlights the importance of the influence and policy of the local courts and psychiatric services (pg. 231). For example, Rogers (1990) found that the rate of Section 136 detentions was higher in one police station where the perception was that the local magistrate did not want the police to bring mentally disordered offenders before them (pg. 231). They also weighed up their views on the particular hospital, such as whether the hospital was reluctant to take referrals, how far away it was, and whether it was time consuming (pg. 231). The police also faced problems in gaining a psychiatric assessment in 20% of cases due to reasons such as use of the catchment area criteria by psychiatrists (Rogers, 1990; pg. 232). The relationship between psychiatrists and the police was generally considered to be poor with only 15% of officers rating the "attitude of psychiatrist towards them as positive" (pg. 232).

Rogers (1990) found that the police were relatively good at identifying mental disorder as only 12% of the referrals were not admitted to hospital (pg. 232). However, as with other research in this field, Rogers (1990) found over-representation of Black people within Section 136 referrals, with 39% of referrals she looked at involving Afro-Caribbean people compared to 18% of the local population (pg. 233). However, Rogers (1990) claims that the process of this discrimination

differs in some ways to how it has previously been presented (pg. 233). She cites the importance of how Afro-Caribbean people came to the attention of the police, with:

> …Afro-Caribbean people…found to be less frequently referred by their relatives or neighbours and **more** frequently by strangers or passersby. This together with the high number of Black referrals implies a process of 'transmitted discrimination' (cites Reiner, 1986). This entails the police acting as a 'conveyor belt' for community prejudices due to public perceptions of Black people's deviant behaviour constituting a threat to public law and order (Rogers, 1990; pg. 233, original emphasis).

Rogers (1990) goes on to note that there were variations in the way in which the police and psychiatrists viewed the 'dangerousness' of Black people compared to other groups (pg. 233). The police rated the dangerous of Black people and other groups similarly (although there is other evidence to dispute this which will be discussed when examining restraint related deaths below). However, psychiatrists more frequently rated Black people as a 'serious or moderate danger to others' than other ethnic groups (pg. 234). Rogers (1990) therefore argues for the importance of both the public and psychiatrists "in the way in which Black people come to be labelled by the psychiatric system as [well as] the perceptions of the police" (pg. 234).

Again this highlights the importance of Chan's theory of changing both the 'habitus' and the 'field' to successfully change the practice of detaining people under Section 136 of the Act. Trying to change police practice and culture in isolation will not work, wider societal changes are needed, both in terms of the other agencies involved in the process and the views of the wider public. As Rogers (1990) says:

> Thus, any legal reforms directed at police action in arresting and detaining people are likely to be relatively ineffective…an evaluation of Section 136 as a socially constructed process seems more relevant in both conceptualising the process relevant to Section 136 and seeking more effective and sensitive social policy changes in relation to psychiatric emergencies dealt with by the police and others. From this conceptual position, officers' decisions are not considered as if they take place in isolation, but as part of a wide system which is influenced by the courts, hospitals, and professional interests (pg. 234-235).

Other research studies into Section 136 have had similar findings to those summarised above. Borshmann et al (2010) undertook a systematic literature review of Section 136 research including literature reviews, population and demographic studies, surveys of police officers and mental health professionals, and qualitative studies; in total they reviewed 42 papers for their article. Of the four main literature reviews they identified which were published between 1989 and 1999 they highlight several consistent findings. Findings such as Section 136 detainees were often:

> white, single, unemployed men in their 20s with a diagnosis of schizophrenia and a previous psychiatric history…an over-representation of ethnic minority groups, particularly Black men, postulating that a combination of clinician or police bias, presentation of illness and socio-economic status may have contributed to this…such individuals were frequently disorganised and unsupported, they had a high absconding and self-discharge rate, few were registered with a general practitioner and they were unlikely to attend follow-up (pg. 35).

The literature also suggests that:

> …the police officer's own presumption that s/he lacks expertise in diagnosing mental illness, or by beliefs among police officers that dealing with the mentally ill does not constitute real police work, or that seeking the appropriate medical help can be time consuming and often futile (pg. 35).

Borschmann et al (2010) also report similar findings from the literature to those discussed above in terms of the "high correlation between police officers' assessments of mental illness and subsequent hospitalisation by psychiatrists" (pg. 35). They also noted that police officers and psychiatrists tended to suggest a lack of involvement by ASWs (pg. 35). Borschmann et al's (2010) review of the population and demographic studies on Section 136, also reported similar findings to those discussed above, with Section 136 detainees being diagnosed with "schizophrenia, mania, personality disorder and drug induced psychosis" (pg. 36). The social disadvantage of this group is highlighted again with many having no fixed abode, not being registered with a GP, a previous psychiatric history, being unemployed, unmarried, misusing drugs or alcohol, having been previously detained under Section 136, and having a mean age of "between 32 and 41 years, with some variation among different ethnic groups…Black individuals were, on average, significantly younger than their White counterparts…" (pg. 36).

From their systematic review of surveys of police officers and mental health professionals Borschmann et al (2010) find, as reported on earlier, that professionals involved in Section 136 have inadequate knowledge and training. They also identified problems in the working relationships between the police and other agencies, a lack of approved social workers, and delay in obtaining assessments (pg. 36). Poor recording and monitoring of Section 136 detentions by both the police and the health service has been highlighted by professionals (for example see Dearman, 2007). A service user's perspective was scarce amongst the research Borshcmann et al (2010) reviewed suggesting a need for more research into this area, but they did examine one peer reviewed paper. This paper by Jones and Mason (2002) found "…a general dissatisfaction

with the quality of care and treatment from both police and professionals, but with the former being viewed as acceptable whilst the latter was considered unacceptable" (pg. 73). Exploring this further the authors note that whilst the respondents' views

> Were generally negative, they were closely related to the patients' anticipated perceptions of police and mental health professionals prior to contact. Whilst they expected police to be antagonistic to them, when they showed concern and compassion this was perceived very positively by the offenders. However, this had the effect of exacerbating the negativity felt during hospital admission. This enhanced negative perception resulted from an anticipated positive response being frustrated by poor professional interaction (pg. 80).

In addition to the need for research into detainees perspectives of Section 136, Borshmann et al (2010) conclude that further qualitative research is needed into "…mental health professional and police officer experiences of Section 136 that would inform improvements in interagency practice for the benefit of all detainees" (pg. 38). This thesis has not been able to look at Section 136 from the perspective of those who are detained but it does seek to address the other research gap that Borschmann et al (2010) highlight by undertaking qualitative interviews with police officers and mental health professionals. This is discussed in the next chapter on methodology and the proceeding chapters on my empirical findings.

Detaining in a 'public place'

An issue which merits some further attention is the inappropriate use of Section 136 by the police to detain people who are not in a 'public place' as set out by the Act. Lynch et al (2002) found in a survey of A&E staff and police officers that "55% of A&E staff and 14% of police

thought that a person could be placed on a Section 136 in their own home while 25% of A&E staff and 16% of police constables did not know that this section could only be enacted in a public place" (pg. 297). Rogers and Faulkner (1987) found that 17% of their sample of Section 136 detainees "…had been arrested from places to which the public do not have access" (pg. 30).

> The reasons for this unlawful action raises interesting questions for further explanation…it may, for example, be possible that the police blatantly misuse Section 136 or that there is some misunderstanding of the law on their part. Alternatively it could well be that when the police are faced with a psychiatric crisis, procedures for the detention of mentally disordered people from private premises are deficient because of difficulties in contacting the mental health professionals and that Section 136 is used because it is more expedient to do so (Rogers and Faulkner, 1990; pg. 41).

Rogers (1990) found that "…a substantial minority (19%) [of Section 136 detentions] were not made from public places" (pg. 230). "…In only 2 out of 28 instances did officers claim they were unaware of the legal requirements to arrest someone from a public place. A more common reason was perceived ineffectiveness or inefficiency of the alternative designated procedures for dealing with mental health crises which take place in private places" (pg. 230).

The case of *Seal v Chief Constable South Wales Police*[16] raised the question of what constitutes a 'public place' and where it is lawful for the police to detain people. Mr Seal had been detained whilst at his mother's house; he was taken to a police station and then spent a week in hospital for assessment. When he was released he claimed that he had been falsely imprisoned by the police as they had no power to detain him under the Act. However, the Lords decided that "no claim will be upheld unless it can be shown that there has been bad faith or a lack of reasonable

[16] [2007] UKHL31

care. And permission has to be obtained first from a High Court Judge" (Cragg, 2007). Therefore leaving the position of the law on what constitutes a 'public place' open to the judgement of the courts if it could be proven that the intention behind the detention was 'bad' or that the care provided was poor. The Mental Health Act Commission (2008) have also highlighted their concerns about people being detained under Section 136 who have been asked or made to step outside their home. Churchill et al (1999) suggest that Section 136 should be revised so that it would be legal to implement it on private premises.

However, the Care Quality Commission (2010) report that "in the debates over the 2007 amending Bill, Parliament rejected an attempt to insert into the Act broader powers of entry to private property" (pg. 31). They also point out that:

> Police officers may enter or remain on private premises and, if necessary, search those premises, for the purpose of saving 'life or limb' or preventing serious damage to property under section 17 of the Police and Criminal Evidence Act 1984. The case of Baker v CPS[17] confirmed that Section 17 of PACE does cover protecting someone from themselves, as well as from someone else, where the officer believes that serious bodily injury is imminent. This could, therefore, be used to authorise police officers to remain on private property with a person whom they think is actively suicidal. However, this power of entry has no clear procedure for any subsequent action where the police involvement is solely one of preventing suicide, and no arrestable offence has been committed. Police could be left waiting for a civil assessment to be arranged at the person's home (including, presumably, waiting for an AMHP to obtain a warrant), and there would be no clear authority for them to remain on the property. In practice, these situations are often resolved by police inviting (or indeed forcing) the person to accompany them outside onto public property and, once there, using section 136 to detain them (pg. 31-32).

[17] (2009) EWHC 299 (admin).

Given the potential misuse of this power and the lack of alternatives in some circumstances it is important that its use is monitored so that the police can be held to account for their actions. The Care Quality Commission (2010) therefore suggest that:

> A vital role of the multi-agency Section 136 groups should be to monitor local section 136 detentions for such examples, both as a training issue for police, but also to consider how mental health services could provide practical support to police in the field and so avoid such misuse of legal power (pg. 33).

Deaths in police custody

When examining the use of police custody to detain mentally vulnerable individuals, it is important to consider the worst possible outcome for someone who has been detained in police custody (including those detained under Section 136) – that they die during their detention. Understandably, deaths in police custody have been a controversial area of policing for some time and cause both public concern and media attention. Deaths in police custody are usually construed more widely than just those who die in the actual police station or cell. Morgan (1996) points out that:

> PACE provisions concern custody from the moment of arrest (or what other jurisdictions call 'apprehension'), custody should therefore be construed as a condition rather than a location. By custody means restraint of liberty and submission to authority of the state and this condition begins before the person in custody arrives at a designated institution. This is important as individuals may not be taken to designated places of custody straight away… (pg. 7).

Morgan (1996) goes on to state that:

> Persons in custody are peculiarly vulnerable and dependant…because they are in the hands of the state, because the state exercises complete control over them, it follows that the state should take responsibility for them and owes a correlative duty for their care (pg. 23).

Concern amongst professionals and the community at large over vulnerable people being held in police custody has been linked to deaths which have occurred whilst in police custody. In their Memorandum of evidence to the Joint Committee on Human Rights Inquiry into Human Rights and Deaths in Custody (2003) the Police Complaints Authority analysed all deaths in custody from April 1998 to March 2003. They found that just over 50 per cent of the cases for which information was available had a prior indication of mental health problems.

The Police Reform Act 2002 placed a statutory duty on police forces in England and Wales[18] to refer all deaths and serious injuries arising from police contact to the Independent Police Complaints Commission (IPCC)[19]. All deaths during or following police contact are recorded and reported on annually by the IPCC. They are broken down into four main categories, including deaths during or following police custody which is defined in Box 2.1 below.

Box 2.1: IPCC definition of death in or following police custody

Deaths in or following police custody includes deaths of people who have been arrested or otherwise detained by the police. It includes deaths which occur whilst a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

[18] Since 2006 the IPCC has also been responsible for reporting on fatalities which are referred to it from Her Majesty's Revenue and Customs and the Serious Organised Crime Agency, and since April 2007 the UK Boarder Agency.

[19] Or a complaint alleging that police conduct has resulted in a death or serious injury. Paragraph 4 (1) (a) and 13 (1) (a), Schedule 3, Part 1, Police Reform Act 2002, as amended by the Serious Organised Crime Agency (SOCA) and Police Act 2005 Schedule 12.

This would include the following:

- Deaths which occur during or following police custody where injuries which contributed to the death were sustained during the period of detention.

- Deaths which occur in or on the way to hospital (or other medical premises) following or during transfer from police custody.

- Deaths which occur as a result of injuries or other medical problems which are identified or develop while a person is in custody.

- Deaths which occur while a person is in police custody having been detained under Section 136 of the Mental Health Act 1983 or other legislation.

This would not include the following:

- Deaths (including suicides) which occur after a person has been released from police custody, except where they meet the criteria outlined above.

- Deaths of individuals who have been transferred to the care of another agency and subsequently die while in their care (Source: Grace, 2010: pg. 2).

The empirical evidence on deaths in custody, including data on the number of individuals who died previously to 2009/10 is explored later in this chapter and the deaths of people who died in police custody but who had been detained under Section 136 are examined in more depth in chapter five. The latest available statistics for 2009/10 show that 17 people died in or following police custody (Grace, 2010). Sixteen of those who died were White and male, one person was of Mixed ethnicity (Grace, 2010). The ages of the individuals ranged from 19 to 73 years old, with an average age of 47 years old. Most people were declared dead in hospital (14), although 12 of these people were found to be unwell when still in custody or in a police vehicle (Grace,

2010). The most common reason for arrest was for driving offences and four people were found to have mental health issues – two of whom had been detained under Section 136 of the Act (Grace, 2010). "All of the deceased had a link to alcohol or drugs in that they had recently consumed, were intoxicated from, or were in possession of drugs or alcohol at the time of their arrest. In eight of these cases alcohol or drugs were related to the cause of death" (Grace, 2010; pg. 4).

As highlighted by Table 2.1 below the most common causes of death were injuries, natural causes and alcohol and/or drug related and accidental drug overdoses.

Table 2.1: Deaths in or following police custody by cause of death 2009/10

Cause of death	Deaths in or following police custody
Injuries	4
Natural causes and alcohol and/or drug related	4
Natural causes	3
Overdose accidental – drugs	2
Alcohol and/or drugs	1
Head injury and natural causes	1
Alcohol and/or drugs while restrained*	1
Awaited	1
Total fatalities	**17**

Source: Grace (2010)
* From the post mortem it is not possible to determine whether the restraint was a direct causal link to the death

In addition to those who were recorded as deaths during or following police custody in 2009/10, there were an additional 54 apparent suicides which occurred within two days of release from police custody or there was something about the period of police custody which may have been relevant to the subsequent death (Grace, 2010, pg: 7).

> Fifty of the 54 apparent suicides occurred within two days of release from police custody, with 15 of these occurring on the same day of release…Twenty-two people were reported to have known mental health issues and three of them had been detained under the Mental Health Act 1983 (pg. 7).

In addition to official statistics on deaths in police custody, there have also been some empirical studies which have examined the subject both in England and Wales and in other similar jurisdictions. Leigh et al (1998) studied all deaths in custody between 1990 and 1996 except those where the role of police was considered tangential; this came to a total of 227 deaths. They estimate that between 1990 and 1997 there were approximately 3.2 deaths per 100,000 arrests for notifiable arrest, meaning that the number of deaths as a proportion of the total number of people passing through police custody would be lower. Leigh et al (1998) found that of the deaths they looked at the majority of people were White (87%), male (92%) and aged between 20 and 50 (74%). The authors believe that this reflects the general make-up of police custody (although no official data on this was available). Most of the detainees had been arrested for relatively minor offences: 49% for being drunk, 11% for theft, and 9% on a warrant, a place of safety order or under the Mental Health Act 1983. They grouped the causes of death into three categories:

- those resulting from the deceased's own actions (63%);
- those resulting from the deceased's medical condition (29%); and
- those in which 'another person's actions may have been associated' with the death (8%).

In the 'deceased's own actions' group deliberate self-harm either in or pre-custody made up the largest group of deaths (34% of all deaths). The researchers analysed the data to establish whether there were any differences in the nature of deaths by the ethnicity of the detainees. The numbers were too small to find any statistically significant differences but there were some differences which were noted:

- a smaller proportion of Black than White detainees were arrested for alcohol-related offences;

- a larger proportion of Black than White detainees were arrested for drug-related offences;

- a greater proportion of White than Black detainees die from in-custody deliberate self-harm or from medical conditions; and

- over one-third of cases in which a Black detainee died occurred in circumstances in which police actions may have been a factor (the proportion rises to almost one-half if the cases of accidental death where the police were present are added) – this compared with only 4% of cases where the detainee was white.

This last point is relevant to the widespread concern of deaths in custody of ethnic minority suspects which has been an issue that has troubled BME communities for sometime and has been highlighted as an area which contributes to a lack of trust in the police (Macpherson, 1999; Bowling and Phillips, 2002). There have been many high profile deaths in or following police

custody, of Black men in particular, which have caused understandable anger and grief within BME communities (Bowling and Phillips, 2002). There are concerns regarding the relationship of the negative characteristics of police culture, such as racial prejudice, and the potential this has to influence police practice and lead to deaths in custody (or at the very least fail to prevent them). This was explored in greater depth earlier in this chapter. Some of these deaths also involved individuals who were mentally vulnerable; examples of these cases will be discussed below in the section on restraint related deaths.

The concern over people from minority groups dying in police custody has also been explored in other jurisdictions. For example, in the early 1990s the Royal Commission into Aboriginal Deaths (1991) in Australia published its report. The Commission examined the deaths of 99 Indigenous people in police or prison custody over a nine year period. The Royal Commission (1991) found that "their Aboriginality played a significant and in most cases a dominant role in their being in custody and dying in custody" (pg. 1). Morgan (1996) states that:

> What the Royal Commission analysis revealed is that the large numbers of Aboriginal deaths in custody was primarily the consequence of the over-representation of Aboriginals in custody. Both in relation to the Australian data and the situation elsewhere, we should remember that for a substantial minority of persons, perennial custody is a feature of their impoverished lives. The revolving door between hostel life, rootlessness and rooflessness, police custody, prison custody and, often, mental hospital. For many of the persons whose deaths in custody the Royal Commission individually investigated, custody was a regular, distressing and depressing part of the downwards spiral of their lives. The same is true in England and Wales (pg. 21).

This shows similar issues to those discussed above in terms of the vulnerability of people held in custody as a place of safety under Section 136, and the vulnerability of people who are in police

custody more generally. Many will be frequently held in custody and have a range of issues which are not being adequately addressed by the various agencies, in part due to a failing of the different agencies to work more effectively together to provide a holistic service.

The most recent research on deaths in police custody in England and Wales was published by Hannan et al in 2010[20]. Hannan et al (2010) analysed all deaths in or following police custody over an eleven year period from 1998/99 (financial year) to 2008/09. They found that during this period 333 people died and that the number of deaths fell from 49 in the first year of the study to 15 in the final year (pg. vi). When using the 'notifiable arrest data' (accepting the limitations of this data which were discussed earlier), the authors found that the "overall rate of deaths was 2.2 per 100,000 notifiable arrests across a ten year period" (Hannan et al, 2010; pg. 10). Deaths in custody are therefore rare events. However, there is a cost to every life that is lost in or following police custody; both to the individual concerned and their family and to the wider community who may have concerns about police practice and this can impact on overall trust and public confidence in the police. There are also some differences across police force areas:

> The highest number of deaths – in the Metropolitan Police Service area (71 deaths – 21%) and the Greater Manchester area (20 deaths – 6%) can perhaps be explained by the fact that these large forces have the highest number of notifiable arrests. However, other forces had slightly more deaths than may have been expected for their size. For example, Northumbria had 15 deaths (5%) and South Wales had 14 deaths (4%) (pg.11).

[20] It should be noted that I was the lead researcher and author of this report, some of the data I gathered during that study on deaths of people detained in police custody as a place of safety will be examined later in this thesis.

Hannan et al (2010) found that ninety per cent of the deceased were male, "…76% were White, 7% were Black, 5% were Asian, 2% were Mixed race, and 1% were Chinese/Other ethnicity (the ethnicity of 9% of the sample was not stated)" (pg. vi). "The ethnic breakdown of deaths in custody appears therefore to be broadly in line with the make-up of detainees more generally" (Hannan et al, 2010; pg. 13). "However, Black people in particular are over-represented in the custody population, and there are complex reasons for this, such as the potential for over-policing of this group. This will therefore not provide complete reassurance to people from these communities" (pg. 84-85). The research also found some differences in the cause of death by ethnic group with "White people [being] more likely to die of natural causes (not statistically significant) and significantly more likely to commit suicide than people from BME groups, and people from BME groups were more likely to overdose (not statistically significant)" (pg. 18).

> …BME people…were more likely to be restrained compared to White people, and…this was statistically significant. However, this restraint was not necessarily related to the death…restraint was related to the death in 16 cases (5% of the sample). Of these deaths 12 people were White, three were Black and one was Asian (pg. 86).

The research also found that "although making up 7% of all cases, the cases involving Black detainees accounted for seven of the 13 recommendations for prosecution of police officers" (pg. 88). Perhaps indicating that cases involving the death of Black detainees were more likely to have involved the use of force or neglect of the detainee by the police.

There were some indicators of vulnerability for some of the people who died within Hannan et al's (2010) sample as 16% had no fixed abode, their ages ranged from 14 to 77 years old (pg. 13), nearly three quarters (72%) were linked to alcohol and/or drugs, 39 people were identified

as having possible mental health needs, a further 17 were being detained under Section 136, two were detained under other Sections of the Act, another 11 were identified as being a possible suicide/self-harm risk, and 26 individuals were not identified as having any propensity to commit suicide or mental health needs but did successfully commit suicide (pg. vii). Of the 17 people who were detained under Section 136, nine were taken to police custody as a place of safety, six to hospital and two died at the scene of the arrest (pg. 51). The report found that there were also an additional "two detainees who were arrested for public order offences [but] were actually dealt with under Section 136 of the Mental Health Act once they were taken to custody*"* (pg. 54). These data from this study relating to these deaths are analysed in greater detail in chapter five.

Hannan et al (2010) found that:

> Most were arrested for relatively minor offences which were often linked to intoxication such as being drunk and incapable/disorderly, public order offences, and driving offences. Of the 87 arrests for being drunk and incapable/disorderly, 60 were not arrested for any other offences but were taken to custody (this included one person who was also being detained under Section 136 of the Mental Health Act). This raises questions about why some of these individuals were taken to custody (pg. 85).

The research also found issues in terms of the risk assessment of detainees not being done adequately, and checks and rousing of individuals' not adhering to the PACE Code of Practice (pg. 87). This is explored in greater depth when considering how to minimise the risk of deaths in custody below. Ultimately the research found that those who die in police custody have complex problems and needs and that the medical provision in custody was often inadequate in

terms of dealing with these issues. There was a need for healthcare provision in police custody to improve and for the ACPO Guidance on Safer Detention (2006) and PACE Code of Practice C (2008) to be adhered to (Hannan et al, 2010; pg; 89).

Restraint related deaths

An issue of particular controversy is the link between some deaths involving people who been restrained by the police and subsequently die, particularly those involving people with mental health problems and/or from a BME background. The Police Complaints Authority (PCA, 2002a) stated that "…a disproportionate number of people who die in custody or specifically following restraint are from minority ethnic groups, which inevitably leads to allegations of racism" (pg. 5).

Under Section 3 of the Criminal Law Act 1967, a police officer has the authority to use reasonable force to make a lawful arrest or to counter a genuine threat of assault whether on themselves or an another person (PCA, 2002a). Reasonable force should be proportionate, necessary and reasonable in relation to what the officer is seeking to prevent. Article 2 of the European Convention on Human Rights (ECHR) sets out the right to life and places a positive duty on the state to protect the lives of everyone in its jurisdiction and that any force used must be 'no more than absolutely necessary'. The case of *McCann and Others v. the United Kingdom*[21] in the European Court of Human Rights ruled on the Article 2 of the Convention of Human Rights the 'right to life' and made it clear that police forces were under a duty to improve

[21] 21 ECHR 97 GC.

systems that have failed to protect life in the past, and that forces failing to do so or to provide adequate training for officers, systems and medical care for the preservation of life of incapacitated prisoners may be exposed to legal action under the Human Rights Act (PCA, 2000).

If an individual is trying to resist or escape arrest, or if they become violent or attempt to self-harm whilst in police custody; then police officers are allowed to restrain them (under Section 117 of PACE). The restraint may involve manual restraint, batons, CS spray, hand-cuffs and other equipment (e.g. firearms in extreme cases) or a combination of these (PCA, 2002a). Detainees who have taken drugs and/or alcohol, or have some physical, medical or psychiatric condition are more vulnerable to the impact of restraint than others (PCA, 2002a). APCO Guidance (2006) provides detailed advice to officers on how and when to restrain detainees in order to ensure it is safe and minimises risk. However, in reality, as with most aspects of policing, officers operate within wide parameters and have considerable discretion to decide when and how to restrain an individual.

"There is a lack of consensus among pathologists and other medical practitioners as to the precise cause of death in many restraint-related cases" (PCA, 2002a: pg. 10). One of the most controversial conditions is 'positional asphyxia' – where the death results from a body position which restricts a person's ability to breathe. Some forms of police restraint may increase the risk of asphyxiation, the degree of risk associated with different holds is not clear but neck holds have been strongly discouraged (PCA, 2002a, also see Davis, 1999).

Another condition related to restraint deaths is 'excited delirium' or 'acute exhaustive mania'. There are many possible causes including head injury, brain tumours, delirium from high temperature, heat exhaustion and endocrine disorder such as high blood sugar or low blood sugar and thyroid disease, anti-psychotic and other drugs such as cocaine can also precipitate these episodes (PCA, 2002b). Someone suffering from this condition may ignore pain and continue to struggle against restraint beyond the normal point of exhaustion (PCA, 2002a). The main features of excited delirium are a period of agitation, excitability, paranoia, great strength, aggression and non-pain compliance; sudden collapse and death may follow (PCA, 2002b, see also Di Maio and Di Maio, 2005). The "PCA believes that restraining someone… particularly for any length of time, can pose severe risks as can leaving a detainee unattended in any position that might restrict their breathing" (PCA, 2002a: pg. 10). A more recent study found that:

> Excited delirium has proved a contentious topic. Many contend that death in such cases is the result of confrontation, abuse and inappropriate use of force, rather than the effects of drugs. The psychological stress of being confronted with this aggression, they argue, results in further psychological reactions. It is only relatively recently that they existence of excited delirium has become more widely accepted in the USA. This followed a September 2009 report by the American College of Emergency Physicians (ACEP), which classified excited delirium as a syndrome in its own right. The Faculty of Forensic and Legal Medicine, which aims to develop and maintain the highest possible standards of competence and professional integrity amongst FPs, has now recognised excited delirium (as a form of acute behavioural disorder) (Hannan et al, 2010; pg 23).

Some of deaths in custody that are restraint related have caused the most concern and have the highest profile e.g. Joy Gardner, Brian Douglas, Shiji Lapite, Richard O'Brien, Wayne Douglas and Ibrahima Sey (PCA, 2002a: pg. 9). Between 1991 and 1995 Inquest records six deaths within the prison service from control and restraint; 5 out of the 6 deaths were Black people. Between

1985 and 1998 the Institute of Race Relations records the deaths of 15 Black people in psychiatric hospitals – six of whom died after injections and one after being restrained (both reports cited in PCA, 2002a).

Hannan et al (2010) also examined restraint related deaths in police custody between 1998/99 and 2008/09. They found that of their sample of 333 people, 87 were restrained at any point during their detention by the police (this was physical restraint rather then simply being handcuffed) (pg. 26). "…People who had been arrested for drug offences [were] significantly more likely to be restrained" (Hannan et al, 2010; pg. 26). "…Black people, and those of Mixed ethnicity… formed a greater proportion of those restrained than they did of the entire sample, while the opposite was true of White people. When BME groups were combined for analysis, people from BME groups were significantly more likely to be restrained than White people" (pg. 27).

Perhaps the one of the most high profile recent case is the death of Roger Sylvester who died in 1999 after being restrained by officers from the Metropolitan Police Service, after he was detained under Section 136 of the Mental Health Act 1983. Another young Black man, David 'Rocky' Bennett died in 1998 during his detention under the Act (although not under Section 136) whilst being restrained, although this time by National Health Service staff. The PCA (2002a) argued that restraint is used more frequently where an individual's mental state or what is known as 'acute behavioural disturbance' is a factor. Following David Bennett's death a public inquiry took place which found an over- representation of young Black men in sectioning, an over-representation in being restrained, and an over-representation in death during restraint

(Stone, 2004). The Inquiry recommended a time limit of 3 minutes for restraint of patients face down on the floor (Stone, 2004) but this has not been implemented by the NHS or the police service.

Following some of these high profile deaths, the state organisations stereotyped Black men as aggressive, threatening and violent (Bowling and Phillips, 2002), which has been interpreted by many as attempting to blame the victims for their own deaths (PCA, 2002a, Inquest 2003a). David 'Rocky' Bennet was described by nurses as 'big', 'excessively strong' and 'animalistic' (PCA, 2002a: pg. 10). Roger Sylvester was described as a 'mentally ill drug user' (Inquest, 2003a). These cases would seem to show a link between so-called 'canteen culture' discussed earlier in this chapter and the way in which officers view and treat the people they come into contact with.

There has been a lack of satisfaction amongst families with the investigation of these deaths and this has continued to impact on wider public confidence of the police and statutory organisations (PCA, 2002a). Research found that some senior officers in the MPS saw the potential of CCTV in cells as a possible way of improving public confidence, particularly amongst BME communities that had suffered deaths in custody and viewed the police with some suspicion (Newburn and Hayman, 2002).

This issue is likely to remain a concern as some argue that the new Mental Health Act 2007 will increase police contact with people suffering from mental illness because the new Act provides for the greater use of compulsory powers in relation to patients living in the community. There

will therefore be situations where these people will be forcibly removed to institutional care by the police and physical restraint must be used to do so (IPCC, 2004):

> The IPCC envisages complaints concerning police involvement to be likely to follow such incidents and, indeed, for these to pose a high risk of harm where the physical resistance to action is sustained and police training or resources deficient (IPCC, 2004).

Research evidence discussed earlier in this chapter has shown that the police have tended to use their discretionary powers such as stop and search to target people from BME groups (Bowling and Phillips, 2002) and there is concern that these powers could be used in a similar way. The area of mental health and police custody is therefore likely to remain a contentious one, which could contribute to a lack of public (and particularly BME) confidence in the police.

Reducing the risks of deaths in custody

The PCA (1999) recommended that safe restraint procedures and positions should be reinforced to officers in training, and that where officers are involved in the detention of someone under the Act there should be a professional or family member known to the person (where possible) to assist in moving the person to hospital or elsewhere. In terms of suicide they recommended improving risk assessments when 'booking in' detainees, reducing the possibility of ligatures being used, improving the availability of custody nurses to undertake assessments, increased availability of CCTV cells for vulnerable people, and 'at risk' detainees to be kept under constant supervision. They suggested that "CCTV coverage of custody suites should be expanded to include one or two observation cells for particularly vulnerable detainees" (PCA, 2002: pg.17).

Leigh et al (1998) made many recommendations including medical training for civilian and officer custody staff, and the use of detoxification and 'drying-out' facilities for intoxicated detainees rather than police custody. Finally, they also recommended the careful examination of the use of CCTV in police cells for particularly at risk detainees. On drugs and alcohol misuse the PCA (1999) recommended greater clarity and revisions in the PACE Codes of Practice to improve the rousing of intoxicated detainees, improved training for FME and the use of a 'scale of consciousness' to aid decisions on detainees, and training for custody officers on intoxicated detainees.

In the late 1990s the Metropolitan Police along with other forces began modernising their cells to make them safer for detainees, this included removing potential ligature points and increasing the use of FPs they also proposed a new custody officer course which emphasised the care of prisoners and the identification of vulnerable detainees (Newburn and Hayman, 2002). As highlighted in chapter 1, in 2003 there were revisions to PACE Code C in terms of providing greater clarity and guidance to officers on the risk assessment, checks and rousing of detainees to ensure their safety and well being. And in 2006 ACPO published its Guidance on the Safer Detention and Handling of Persons in Police Custody, which also provided detailed guidance on the care of detainees in police custody.

Yet despite all of the recommendations and changes to legislation and policy, recent research suggests that some key problems remain. Hannan et al (2010) found that:

> All detainees are supposed to be risk assessed on entry to custody. However, of the 247 detainees who were booked into custody, only just under half were risk assessed. A detainee's level of intoxication was by far the most common reason given for why no risk assessment was carried out. It is likely that a lack of risk assessment would have played some part in the circumstances leading to some of these deaths. Furthermore, the inability to conduct a proper assessment should have been recognised as a significant warning of potential risk (pg. 86).

Although it should also be noted that the research also found a fall in the number of suicides across the eleven year period they examined, suggesting that "this would indicate an improvement in cell conditions and a removal of possible ligature points across the custody estate to make it a safer environment…" (pg. 16). This does suggest that there have been at least some physical changes which help prevent some deaths in custody.

Morgan (1996) suggests the need for much broader changes to police and practice to minimise deaths in custody:

> …all deaths in custody will best be avoided by our employing the minimum use of custody: employing summons rather than arrest, providing community care rather than institutional settings for the mentally disordered; granting bail, conditional or unconditional, more generously; using community penalties rather than imprisonment. It may also mean decriminalising certain offences….It was not sufficient to decriminalise drunkenness – indeed in some states that measure alone actually served to increase the use of police stations on grounds of personal protection without the need to complete paperwork. What was needed were alternative facilities, detoxification centres, shelters and so on… (pg. 22 -23).

The same applies with regard to minimising the deaths in custody of people detained in police custody as a place of safety – there is a need for alternative places of safety and for greater provision of mental health care and better working between the various agencies. In order to

change police practice in this area it is necessary to change wider societal views on how these people should be treated.

Conclusion

There is currently a lack of evidence regarding the use of police custody to detain people with mental health problems, how these powers are used and who they are used to detain, why variations in their use occur and the factors that influence that. The empirical and theoretical evidence explored in this chapter has shown the there are numerous laws, policies and Codes of Practice which seek to provide safeguards to protect those detained in police custody, and in particular those that are vulnerable. However, there is also evidence which shows that deaths in custody still occur and that these individuals are some of the most vulnerable people in our society with a range of complex needs.

The literature on theories of policing shows that law and policy alone do not govern police practice, and that the nature of their role is subject to high levels of discretion. How the police employ their powers is influenced by various cultural and structural factors in addition to the law and policy that is set down. The negative aspects of police practice may be curbed by strong leadership and tighter supervision, and a culture which challenges the negative views of certain sections of society. But ultimately police practice and culture can only be successfully changed, and the experience of those detained under Section 136 improved, if we change both what Chan (1997) calls the 'habitus' and field so that all of the relevant actors in the process work together positively and effectively.

3. Methodology

> To carry out high quality research, it is important to work with a methodology and methods that are appropriate to both the area of enquiry and the researcher's own way of seeing the world (Somekh and Lewin, 2011; pg. xix).

Introduction

The previous chapters have examined the literature on the policing of people with mental health needs, the legislation and policy which governs the area more generally and in particular the use of police custody as a place of safety. They have also outlined the different theoretical perspectives on drivers for police practice and how it can be changed. Finally, they considered what previous research was available on the use of police custody as a place of safety and any official statistics on the use of this power as well as the evidence on deaths in custody.

What the literature has shown is a gap in knowledge around the use of police custody as a place of safety under Section 136 of the Act, particularly at a national level. This includes the need to establish the extent to which the power is used, whether there is any variation across different police force areas (and if so why this variation occurs), and the makeup of those who are detained under this power. In addition there is a need to examine the deaths in custody which arise from these detentions as they demonstrate vividly why it is so important to understand the use of this power and the people who are detained. In explaining any variation in the use of the power it will be important to consider a range of factors in addition to local force policy such as culture on the ground and ways of working at an operational and strategic level.

This chapter defines the methodology for this thesis, setting out the aims and objectives of the research and justifying the methods used. It explains how the research tools were chosen, piloted and developed, as well as considering the strengths and weaknesses of the research methodology within the context of wider theoretical literature on methods and the role of the researcher. It provides detail about the IPCC studies during which the empirical data for this thesis was collected, how the thesis builds upon and deviates from those studies and the roles of the individual researchers concerned. The chapter also sets out some of the findings from the pilot work.

Researching the police

Brown (1996) argues that:

> The case for conducting research into police and policing rests on a number of claims. As a public service engaged in maintaining order, sometimes using force, and paid for by citizens' taxes, research performs an important accountability function in describing the constitutional position of the police (pg. 177).

Brown describes the history of police research and how it "…is required by police managers and operational officers for the service to function efficiently, effectively and economically" (pg. 177). "For research to be informative and applicable it needs to be rigorous, having valid and reliable measurement" (Hibberd, 1990 cited in Brown, 1996; pg. 177). Brown (1996) describes how studies of policing gradually began to have more of a critical edge and addressed issues such as the conduct of officers and public trust and confidence in the police, as well as some of

the studies which explored police occupational culture that were discussed in the previous chapter. Brown (1996) believes that police research has gone through various stages of 'conflict', 'contradictory studies' and 'confrontational studies' (pg. 178-179).

Brown (1996) identifies four different types of 'research investigators' into the police; 'inside insiders', 'outside insiders', 'inside outsiders' and 'out outsiders'. 'Inside insiders' are police officers working on research in-house (pg. 180). The research is often felt to be of poor quality and "is done to legitimate some activity" (pg. 180).

Whereas 'outside insiders' are police officers turned academics, who have tackled issues such as occupational culture and discrimination within the police, and they may be able to overcome some of the access issues to the police that other academics may face but equally they are faced with "suspicion because of the public nature of research activity. To publish accounts of police conduct is to break the solidarity and secrecy of a culture which seeks to keep the washing of dirty laundry private. There may also be a finite 'shelf life', beyond which an insider's knowledge becomes out of date*"* (pg. 182). Another type of 'outside insiders' are police officers who are seconded to the Home Office to work for Her Majesty's Inspectorate of Constabulary or within a Home Office research unit (Brown, 1996; pg. 182).

'Inside outsiders' are "…academically qualified civilians working within police forces' own internal research departments" (Brown, 1996; pg. 183). Or alternatively may be that police forces buy in research expertise on a consultancy basis with a variety of researchers (pg. 183). 'Outside outsiders' are:

> External commentators on matters of police and policing include local government, academics and independent organisations such as the Policy Studies Institute (PSI), Police Foundation and the increasingly influential Audit Commission (Brown, 1996; pg. 184).

Brown (1996) finishes her description of researcher types by stating that:

> Rather than perceive the differing perspectives as contentious there are perhaps useful creative tensions between researcher types that can push the boundaries of inquiry further than any one constituency left to its own devices. Understanding can only be enhanced if there is a greater degree of crossover between the theoretical and applied domains and a suspension of hostility between them (pg. 190).

I see Brown's latter statement as providing useful context to my role as a researcher for this thesis and what I have aimed to do. This thesis draws on data from two projects conducted in my capacity (at the time) as a Senior Research Officer at the IPCC. I therefore conducted the research of behalf of the IPCC, designed the research specifications, managed and conducted the bulk of the fieldwork, analysis and wrote the research findings up. I was also supported by research colleagues under my supervision. As I conducted the research in my role as a Senior Researcher at the IPCC it is important to examine my role in that process. As Somekh and Lewin (2011) argue:

> A crucial aspect of the researcher as data gatherer is the capacity to question him/herself through a reflexive approach that takes account of the role of the self as a research instrument. In order to interpret meaning, researchers need to take careful account of the context in which the data were collected or recorded, and the effects of interactions (pg. 112).

Using Brown's (1996) descriptions of police researchers, I consider myself to be somewhere between an 'outsider insider' and an 'insider outsider'. I have many years experience of working as a Government Social Researcher and researching the police, both within the Home Office and then at the IPCC. I therefore have a good working knowledge of the police from the research I have conducted but also have an academic background which allows me to consider their behaviour and actions in a different context. As I conducted the empirical work within my capacity as an IPCC researcher, this gave me greater and easier access to police forces than I would have achieved purely as a research student.

The IPCC gave me their permission to draw on the findings of the research for this thesis and access to police forces was gained via my role within the IPCC. This thesis therefore builds on the data collected for the projects I conducted for the IPCC, but seeks to take the research further by exploring the information in greater depth than would be possible within a policy focused research project and placing it within a broader substantive theoretical and policy context. This thesis aims to utilise the wider empirical and theoretical material set out in the first two chapters to examine the data and explain why police practice differs, and how the negative elements of police practice might be minimised rather than simply describing operational practice. It should be noted that I have also published the empirical findings in this thesis as both IPCC reports and a peer reviewed academic journal article.[22]

[22] Docking, M., Grace, K. and Bucke, T. (2008): *Police Custody as a 'Place of Safety': examining the Use of Section 136 of the Mental Health Act 1983*. IPCC Research and Statistics Series, Paper 11. IPCC: London
Docking, M. (2009): 'The Use of Section 136 to Detain People in Police Custody'*, Journal of Mental Health Law*, Spring 2009; pg 33 – 44
Hannan, M., Hearnden, I., Grace, K. and Bucke, T. (2010*): Deaths in or following police custody: an examination of the cases 1998/99-2008/09*. IPCC Research and Statistics Series, paper 17. IPCC: London.

To be clear about the roles of the authors named on the published IPCC reports as well as how this thesis deviates from the published material it is useful to set this out in more detail. The 2008 IPCC report into police custody as a place of safety has three authors – Kerry Grace, Tom Bucke and me (lead author). As stated earlier I designed the research and research tools, conducted the bulk of the analysis and drafted the final report for publication. The IPCC had two Commissioners who led on mental health issues and they were interested in Section 136 as they had overseen a number of investigations involving detentions under this power. However, the scope and nature of the research was left to the research team to define and I took the lead role in this process, developing the research specification and questions.

Kerry Grace and I jointly conducted the qualitative interviews – telephone and face-to-face (more information on the specifics of the methodology is provided below) – taking in turns to interview and take notes (in addition to recording the interviews), but as the lead researcher I trained Kerry and gave her guidance and instructions on how to conduct the interviews. Kerry also assisted with arranging interviews, the analysis of the interviews and some of the quantitative data– again under my supervision and guidance and using a thematic matrix I had designed. By civil service convention, Tom Bucke as Head of Research at the IPCC was listed as an author of this report through his role in supervising the study and editing the final report.

As I wrote the report, parts of it are reproduced for the empirical chapters which follow this chapter but therefore refer to ‘we’ and ‘our’ because the original report was jointly authored. The thesis attempts to develop this work by setting it within a broader body of literature and theory

and therefore developing the conclusions more thoroughly. It also includes some further empirical data published in a separate IPCC study on deaths in custody.

The IPCC has a strong interest in deaths in or following police custody as it has responsibility for investigating many of these cases and for collating and publishing annual statistics on them. The Chair and other Commissioners were therefore interested in some research which could examine the issues raised by these cases in more depth. However, as with the study into Section 136, the scope and nature of the research was left to the research team to define and as the lead researcher I had responsibility for designing the specification and setting out the research questions. Therefore for the 2010 report on deaths in police custody, I was again the lead author and designed research tools but due to the size of the project the analysis and write up of the data was split between Kerry Grace, Ian Hearnden and I more evenly, with Tom Bucke again acting as an editor for the final report. Therefore parts of this report which are quoted within this thesis are attributed normally as they might be to any other literature that is being quoted. However, I was the sole author of a chapter within this report (chapter 5) which examined deaths involving mental health and specifically those detained under Section 136. Data from that chapter has therefore been included in the empirical chapters to build upon the Section 136 study and the parts which are new have not been attributed to in the same format.

A short timeline of the empirical research and the relationship to this thesis is set out below for the sake of clarity (further information on the details of the methodology follows):

1. A questionnaire was designed in the summer of 2005 (see Appendix A) and sent to relevant contacts in different police forces as well as the Mental Health Commission (now the Care Quality Commission), but was not used as it was not an appropriate method to collect the necessary data (no covering letter was therefore ever drafted).
2. I began my PhD at King's College London in September 2005.
3. A data collection sheet (see Appendix B) was piloted to gather data from 7 police forces on their Section 136 detentions in the winter of 2005 for the financial year 2004/05. This was arranged over the telephone and the force contacts were informed of my intention to also use the data for my PhD and asked if they had any objections (none were received). The spreadsheet was then sent electronically. The data were cleaned, coded and analysed.
4. During the summer and autumn of 2006 data were requested and obtained from the 43 Home Office forces for their Section 136 rates for the financial year of 2005/06. This involved an email to a named contact in each force with the data collection sheet. It was explained that the data would be used and published for an IPCC study as well as for my PhD (again no objections were received). The data were then cleaned, coded and analysed with forces being grouped into those with high, low and medium usage of Section 136 detentions and these groupings were used for the next phase of the research.
5. I sought and gained ethical approval for the research from King's College London for the telephone and face to face interviews.
6. From May 2007 telephone interviews were undertaken with 18 police forces (Kerry Grace and I conducted the interviews). Consent was gained when arranging the interviews, including consent to record them and a discussion was had about the data also being used for my PhD as well as the IPCC study (no objections were raised).

7. In the summer and autumn of 2007, face-to-face interviews within 6 police force areas chosen as case study sites were undertaken (33 interviews in total with a variety of police officers and health and social care staff). Consent was gained when arranging the interviews but also at the beginning of each interview when respondents were asked if the interview could be recorded, and were given an information sheet about the research, which included some information about the fact that the research was also being used for my PhD. As stated above, the interviews were conducted jointly by Kerry Grace and me. Kerry also assisted with the subsequent analysis of the interviews.
8. The research was concluded and published in 2008; I drafted the IPCC report which was edited by Tom Bucke.
9. Between 2008 and 2010 I led on a large study which examined deaths in custody over an 11 year period using investigation reports (there were no human participants in this study so it did not raise the same ethical issues of informed consent). The report was published in 2010 and included a chapter written solely by me on deaths involving individuals with mental health issues and those detained under Section 136 who died. Parts of this chapter have therefore also been included within this thesis with the permission of the IPCC.

The IPCC have given me permission to reproduce parts of the two studies that were written solely by me within this thesis.

The IPCC is independent of the police and has no power to compel forces to participate in its research or to provide specific information. Forces and individual participants therefore chose to take part. However, due to the nature and role of the organisation, police forces may have been

more willing to participate and keen to be seen to be 'helpful' to the organisation and provide the data and access I requested. I explained to participants the dual use of the data for the IPCC study and my thesis and did not encounter any objections or problems. This may be because they saw that the data would be published as an IPCC report and therefore did not see any great problems with it also being used as a thesis. There is a possibility that this power balance may also have meant that officers wanted to impart a good impression to me during my fieldwork and this is an important consideration when assessing the data. I do not believe that this affected the quality of the information that was provided in this study as respondents were given anonymity and asked to speak freely. Furthermore, the issue of Section 136 in police custody was one that respondents generally felt quite strongly about and were happy to discuss. Many of the interviewees were not police officers but were health service staff and therefore some of these issues would not apply to them. However, I will return to these issues and how I attempted to address them below when examining the methods used.

Research design for this study

As discussed in chapter two, there is currently very little research evidence specifically on the use of police custody as a place of safety under the Act. There are also no national statistics on the extent to which these powers are currently used by the police across England and Wales and how this varies across police force areas. Very little is therefore known about the individuals who are detained under these powers or how long they are detained for. There is also likely to be a large number of people who may have committed relatively minor offences such as breach of the peace, and are therefore arrested and taken to police custody where it becomes apparent that

they have mental health needs. These people may then be disposed of using the Act, but again little is known about the extent to which this happens or the demographics of those it happens to across England and Wales. The evidence that does exist tends to focus on a few metropolitan areas, and in particular London, and does not provide a picture of the evidence across the country in different policing environments.

In addition to the gaps in the official data, there is a greater understanding needed of how the police work with other agencies such as social services, Mental Health Trusts, Primary Care Trusts, and local voluntary agencies when they have mentally vulnerable detainees. The nature and extent of the relationships and agreements at a local level may impact on the number of people coming into police custody as a place of safety instead of being taken to a psychiatric facility. This will be linked to the occupational culture within the individual force, and the need to examine both the 'habitus' and field in terms of understanding how all the different components and actors in the process of Section 136 detentions work together, in order to assess what needs to change to improve things in this area. There may be other issues which also affect the rate of Section 136 detentions in police custody, in terms of the variation of health care provision across different areas of England and Wales.

Finally, deaths in custody, particularly of people from BME groups, have been an issue of controversy for some time. Previous research evidence has found that over 50 per cent of deaths in police custody involved people with mental health problems (PCA, 2003). Given that stark finding it is important to understand more about those coming into police custody with mental

health problems more generally as well as considering those recent deaths in police custody involving people who have been detained under Section 136 of the Act.

Somekh and Lewin (2011) highlight the importance of adopting an appropriate methodology for the subject area to be explored and the way in which the researcher sees the world (pg. xix). With this in mind, my aim was to gather data at a national level to establish the extent of the use of Section 136 and explore the reasons for variation in its use. This thesis used a mixed methods approach to gather empirical evidence on the use of police custody as a place of safety, and deaths in custody involving Section 136 detainees. It gathered quantitative data from all 43 Home Office police forces to examine usage across England and Wales and then used qualitative data, gathered via in-depth interviews in different case study areas, to explore why variations in police practice occur and how the use of police custody as a place of safety might be minimised.

Finally, it used both quantitative and qualitative evidence collected from completed investigation reports into deaths in police custody of those detained under Section 136 to look at the causes of the deaths, any patterns or trends, identify any failures in police practice and to discuss why these might have occurred. All of the evidence is examined and explored within the context of the legislation and policy governing this area as well as the theoretical perspectives of policing and police practice as discussed in the first two chapters of this thesis, in particular the role of police occupational culture and leadership. The sections below will explore the aims and objectives of the research in more detail, as well as setting out the details of the methodology and identifying the strengths and limitations of my approach.

Aims and objectives

This research sought to examine the extent and use of police stations as places of safety under Section 136 of the Act, the nature of police contact with people suffering from mental health problems, and the deaths in or following police custody that involve people who were held there as a place of safety. In meeting this overarching aim the study sought to do the following:

- Provide data on the number of detentions under Section 136 in police stations and examine the data for any disproportionality in the make-up of detainees.

- Calculate a rate of Section 136 detentions per 1,000 people held in police custody for each police force.

- Examine the variation in the extent and nature of the use of Section 136 across police forces in England and Wales and try to establish why these variations occur.

- Explore how police officer training and understanding of mental health problems varied in different areas, and seek to explain why these variations occur.

- Explain how the police service works with other agencies and examine the agreements and protocols that exist between the police and other statutory bodies on handling people with mental health problems.

- Examine how multi-agency working varies in different police force areas and explain why this differs and how things might be improved.

- Explore deaths in custody that have involved mental health; specifically those that involved people detained under Section 136, and identify any trends and patterns.

- Examine why the deaths occurred, identify any failures in police practice and look at how, if at all, the deaths might have been prevented.

Finally, it attempts to identify any good practice and lessons that can be learnt to prevent future deaths in custody and minimise the use of Section 136 to detain people in police custody. It does this by considering the empirical evidence within the wider context of the existing literature and theories of police practice. The different theories of policing were explored in greater detail in the previous chapter, and will be vital in explaining why the variations in police practice identified by this study occurred. Given that the law and Codes of Practice apply equally to all police forces across England and Wales, it seemed likely that variations in how these powers were used and how differently officers treat those in their custody could be explained in part by the differences in the culture and structure within the force that officers operate within. The theoretical literature will help to draw conclusions from the data.

Methodology - Pilot work

"As no national data is currently collected or reported on the use of Section 136 to hold people in police custody as a place a safety, we did not know what type of data police forces held on the

use of this power" (Docking et al, 2008, pg. 6) and how consistent this might be across police force areas. Piper and Simons (2011) note the importance of piloting methodologies. "The first stage of the project was therefore to assess the type and quality of data we could obtain from forces relating to Section 136" (Docking et al, 2008: pg. 6). Initially a questionnaire was designed which could be sent to a single contact in each of the 43 Home Office police forces in England and Wales, namely the 'custody lead' in each force. It was thought that this would be the most effective and simple method of gathering data and an overview of force policy.

The questionnaire (see Appendix A) began by asking for detailed information on the number of Section 136 detentions, the demographics of those detained and the length of time they were held in custody, in addition to data on other people detained with mental health problems. It then went on to ask about training, multi-agency working and good practice. Drafts of the questionnaire were sent to police force representatives in a rural and urban police force, to IPCC staff and commissioners, and to a representative of Mental Health Act Commission (now replaced by the Care Quality Commission). The nature of the questions and the type of data requested were thought to be sensible and some minor amendments and suggestions were made.

However, it transpired through liaison with police force representatives that "the data required would need to be extracted from individual police force custody IT systems and would then need to be manipulated in order to meet our requirements. It would therefore not be readily available to the force custody lead in each police force" (Docking et al, 2008: pg. 6) who may not have the technical ability to extract and manipulate data. "The custody lead would, however, still be the appropriate person to ask about the force policies on training, and protocols on multi-agency

working. If the questionnaire was therefore sent to a single point of contact in each force this would place the onus on them to liaise with another member of their force to obtain the data required. This meant that there was the potential for this to become a lengthy procedure which may not have resulted in adequate, accurate or consistent data collection. The decision was therefore taken to collect the data as a first step and to then carry out further research on the additional information such as training and multi-agency working" Docking et al, 2008: pg. 6).

I approached each force and asked who would be best placed to be able to provide the information required and was informed that the force 'performance data analysts' would be able to obtain the information required. In order to design a datasheet which could be completed accurately by the data analysts I spoke to an analyst from West Midlands police force (chosen as the force held the ACPO mental health portfolio at that time and as such were supportive of the research) describing the type of information I was going to request and asked if this was in-line with the type of information that was generally available on their custody system.

I then finalised an Excel spreadsheet (see Appendix B) which was blank except for the column headings and sent this sheet with instructions on how I would like it to be populated, to a single contact in each force (force analysts). This method meant that the data was dependent on the quality of information provided by another source and was therefore limited to the information they were able to provide. As noted in chapter two, previous research has shown that the police custody records may underestimate the number of detainees with mental health problems due to them not being identified by the custody staff (Bucke and Brown, 1997; Gudjonsson et al, 1993). However, despite this potential limitation this was the only way to gather data on this issue

nationally, and if Section 136 was the primary ground for the detention I was confident that I would, at the very least, obtain information for all those that were held under that power (as opposed to those who were detained for suspected offences but then found to have mental health issues, or who were arrested for suspected criminal offences *and* detained under Section 136).

"Seven police forces were chosen and approached to take part in a pilot data collection exercise. The forces were a mixture of rural and urban areas, and forces with large and small BME populations based on Census data" (Docking et al, 2008: pg. 47). This was because I wanted to capture forces with different policing conditions so that some would have large numbers of people entering and leaving their custody, whilst others had small numbers. Having some forces with a higher number of people from BME backgrounds was also important due to the over-representation of people from BME backgrounds held under the Act, including Section 136, which was discussed in chapter two. "Forces were approached for data during the winter of 2005 and data was therefore collected for the 2004/05 financial year. The police forces that supplied data were:

- Cambridgeshire
- Cleveland
- Cumbria
- Greater Manchester

- Leicestershire

- Metropolitan Police Service

- West Midlands" (Docking et al, 2008: pg. 47)

Pilot data cleaning

"Throughout the data collection and collation period there was a large amount of liaison with the police force contacts to clarify the data provided, as it often consisted of force acronyms which were unfamiliar and despite providing a standard template for the spreadsheet, some of the forces sent the data back in the format it appeared on their own custody system" (Docking et al, 2008; pg. 47).

"Once a spreadsheet had been received from each force an additional column was added to each with the force name inserted so that all the data could eventually be merged into one large database. Some forces were able to identify individuals in their custody records who were arrested for criminal offences but were disposed of using mental health powers. In some cases, for instance Greater Manchester Police, these were returned as two separate datasheets and therefore needed to be checked for any possible duplicates before being combined with additional force datasets. This was possible as forces provided a unique custody reference number for each detainee" (Docking et al, 2008: pg. 47).

"We asked forces for data on the length of time in custody in the following format" (Docking et al, 2008: pg. 48):

Custody Arrival Date/ Time	**Release Date/ Time**	**Hours in custody**
Dd/mm/yyyy hh:mm:ss	***dd/mm/yyyy hh:mm:ss***	***[hh]:mm***
06/08/2004 10:00	07/08/2004 18:43	32.43

"However, forces provided this information in a variety of formats, for instance, West Midlands had very detailed data on the time in and out of custody:

Ref	**Date In**	**Time In**	**Date Out**	**Time Out**	**Hours in Custody**
DA035532004	31/7/2004	17:10	2/8/2004	20:21	51:10
DA035542004	02/08/2004	19:30	2/8/2004	21:54	2:24

This was problematic as the formatting of the cells needed to be consistent in order to calculate the time held in custody and examine average times for each force and nationally. The cells were therefore reformatted and merged where necessary; in some cases this involved having to re-type the information by hand. There were additional problems with the length of time in custody information as forces recorded the length of time in custody in different ways. For example, if someone was released and then rearrested within a very short space of time this might be counted as one detention in some forces and two in others. These types of discrepancies were checked with the force and the data was rectified to try and ensure as much consistency and accuracy between force datasets as possible" (Docking et al, 2008: pg. 48).

"The forces were asked to provide information on whether the detainees had a fixed abode or not (in order to examine their potential vulnerability). Some of the forces provided the detainees actual address information which needed to be removed from the dataset for data protection reasons. The address information was therefore recoded into one of the following options:

- Yes - has fixed address
- No fixed abode
- Refused
- Unknown" (Docking et al, 2008: pg. 48).

"The data collection sheet asked for the ethnicity of the detainees using both the Census '16+1' self-classification data and police 'Phoenix Classifications'. We requested both types of information were as some individuals may refuse to self-classify their ethnicity and others may not be asked by the police officers. By asking for both types of ethnicity data we therefore hoped to reduce the amount of final missing data. For purposes of analysis, an additional variable of 'ethnic group' was created for each of the force data sets. This was then populated using the 'Five Point Classification' scale (Home Office, 2006):

- White

- Mixed

- Black

- Asian

- Chinese or Other Ethnic

- Not Stated (Docking et al, 2008: pg. 48)

"Where it was provided the self classification data was used (16+1 ethnicity) and where it was not available Phoenix classification data was used. If no ethnicity data was available it was classed as 'not stated'. Table 3.1 below shows how the new 'ethnic group' variable was populated (Docking et al, 2008: pg. 48):

Table 3.1: Ethnicity Re-grouping Information

Visual Identification Census (standard Home Office) 4 point classification 4+1	**Phoenix Classification**	**Self-Classification Census (standard Home Office) 5 Point classification**	**16+1 Classification**
White 1	White European Dark European	White	White British Irish Any other White
		Mixed	Mixed White and Black Caribbean
Black 2	Afro-Caribbean	Black or Black British	Black or Black British Caribbean African Any other Black
Asian 3	Asian	Asian or Asian British	Asian or Asian British Indian Pakistani Bangladeshi Any other Asian
Other 4	Oriental Arab	Chinese or Other ethnic group	Chinese or Other Ethnic group Chinese Other
Unknown	Unknown	Not stated	

Source: Home Office: 2006

As started earlier, in addition to detentions under Section 136 of the Act, some forces were able to provide information on individuals who had *also* been arrested on suspicion of committing an offence (all forces were asked to provide this data but not all were able as this information was not recorded on their system in an easily accessible manner). In some cases information was also available on detainees arrested for a variety of reasons and disposed of using powers under the Act. "The data therefore included a vast range of 'arrest reason' codes. It was decided that for the main study the arrest reasons would be recoded into a smaller group of offences in order to create sample sizes that were statistically more easily manipulated (See Appendix C). However, due to the work required it was decided not to recode the data for the pilot, and analysis of this variable was therefore not conducted (Docking et al, 2008: pg. 48).

"Forces were asked to provide information on how detainees were disposed of from police custody (release codes). Overarching categories of disposal were proposed in the dataset as follows:

- No Further Action (NFA)
- Hospital/Care/MHA (Mental Health Act)
- Cautioned
- Bailed
- Charged
- Summonsed
- Custody
- Penalty Notice
- Other" (Docking et al, 2008: pg. 48-49).

"However, forces inevitably provided data using a massive variety of release codes, which for the purpose of analysis therefore needed to be recoded into a smaller number of categories" Docking et al, 2008: pg 49). The release codes that were provided in the data and how they were recoded are shown in Appendix D.

The pilot study provided insight into the possible problems and quality of data which were submitted for the main phase of the study. Although there was some missing data from some forces in the main phase of the research, the data received still provides an understanding of the use of police cells as places of safety and how this varies across England and Wales. The pilot allowed me to identify the problems that could arise in the data and prepare possible solutions where necessary, for example the reformatting of the time and date data in order to provide analyses, and the arrest and release codes that were used for recoding the data.

Methodology - main study

As set out above this study aimed to look at both the extent of detentions under Section 136 of the Act in police cells across England and Wales (quantitative data) and the reasons for any variation (qualitative data). "…Practical decisions about design and method should be steered by the demands of the context or by the requirements of the substantive constructs being studied" (Greene et al, 2011; pg: 261). Therefore, this research uses a mixed methods approach with two main phases involving both quantitative and qualitative data, as well as a review of the available literature and research evidence which ran alongside both phases. Final, separate analysis of deaths in custody involving people detained under Section 136 of the Act was undertaken at a

later stage to the original data collected for this thesis but the findings have been integrated into this research.

> Mixed methods approaches to social inquiry are uniquely able to generate better understanding in many contexts than studies bounded by a single methodological tradition (Greene et al, 2011; pg. 260).

Greene et al (2011) identifies five different forms of 'better understanding' that a mixed methods approach offers; 'triangulation' which seeks to validate results using different methods 'complementarity' which by using differing methods enables a more detailed understanding of "complex social phenomena"; 'development' where the results from one method help to inform another, for example developing a research instrument; 'initiation' where different results are found from different methods and explored; and 'expansion' to extend the scope of the research through a range of methods and traditions to extend the focus of the work (pg. 260). Greene et al (2011) state that "because practice is characteristically quite a bit more complex than theory, many mixed methods studies incorporate several of these purposes within a given set of methods" (pg. 260).

The early roots of taking a mixed methods approach was about the concept of triangulation (Denzin, 1970), which involved using multiple methods to help overcome some of the limitations of using just one source of data. My research seeks a better understanding of the issue through 'triangulation': by gathering data from different sources to examine the use of police custody as a place of safety, 'complementarity': by using similar data sources to build on each other and create greater understanding of the issue, for example comparing the quantitative data

from police forces to national statistics for the health service use of Section 136, and by interviewing both police officers and health service staff, and 'development': by using the pilot described above to inform the quantitative data collection for the main study, and by using telephone interviews to inform the interview guide for further in-depth qualitative interviews. All of this will be explained in greater detail below.

When designing a mixed methods study there are several key elements which should be considered:

> One is whether the methods and data sets are integrated throughout the study or rather kept separate until the end, at which point conclusions and inferences are compared or connected. In an integrated design, data from various methods can inform the design of a particular instrument or the sampling plan for another, and data of different types can be iteratively merged or blended in analysis, yielding a unique set of results and inferences in which the different data forms are possibly no longer distinct. In a component design, data retain their original form and character throughout, and conclusions and inferences seek harmony and connection rather than full blending or integration…A second important design dimension is whether the different methods involved are considered of relatively equal importance and weight or one methodology is dominant and the other less dominant. Third, different methods can be implemented concurrently or sequentially, either for important conceptual reasons or for reasons of practicality (Greene et al, 2011; pg. 261)

In this study I decided that the quantitative data would be collected first to gather a picture of police custody as a place of safety across England and Wales, and this data would then be used to inform and develop the qualitative data collection. The different data sources were analysed separately but are written up in this thesis together so as to seek a complete picture of police custody as a place of safety.

Phase 1 - quantitative data to provide a national picture

Data was collected from all 43 police forces in England and Wales on the use of police custody as a place of safety during 2005/06. This included data on the following:

- the total number of detainees in custody for any reasons for 2005/06[23];

- the age, gender, ethnicity of detainees;

- whether the detainees had a fixed abode;

- the length of time each detainee spent in custody;

- whether they were arrested for additional reasons, and if so what these offences were (where it was possible for the force to provide this information);

- methods of disposal/release for detainees (where it was possible for the force to provide this information); and

- an attempt was made to determine if there were people who had been repeatedly held under Section 136.

[23] This is because, as noted in chapter two, notifiable arrest data is not equivalent to the total custody population and it was this that is required to calculate a rate of detention.

An Excel spreadsheet was sent to each force which consisted of a standard template asking for the data set out above with instructions on how to provide the data. This was sent to a named contact in each force. A database of force contacts was identified for this purpose, after speaking to each force and identifying a contact – generally an analyst who dealt with force performance data and could therefore access the police force custody IT system. The force was given a period of six weeks to complete the spreadsheet and return it. During this period regular liaison took place between the force contacts and the researchers, with any questions or queries addressed and regular reminders sent. Any forces who did not return data by the specified time was contacted to establish if they were able to return any data and negotiate a new date for the data return.

Initially 42 of the 43 Home Office police forces in England and Wales provided data. Hertfordshire did not provide any data; stating that they had very good arrangements in place with their local Primary Care Trusts and therefore did not use police custody as a place of safety *at all*. As such they had removed the option of recording Section 136 detentions from their custody IT system. Whilst it is laudable that Hertfordshire were working with the health service in their area to reduce the number of people held in police custody under Section 136, there would still be a need in exceptional circumstances for people to be taken to custody, for example if someone was violent.

The Royal College of Psychiatrists (2008) state that:

> The advantage of the police station is that it should provide a safe environment for those with seriously disturbed and aggressive behaviour, owing to the facilities and staff trained in the management of such behaviour (pg. 28).

This meant that there were likely to be a small number of people who were still being held in police custody in Hertfordshire under Section 136, but were not being captured on any recording system and the care they received was therefore not being monitored. As a result of this an interview took place in Hertfordshire with the force custody lead officer (see below for more details on the interviews) and this led to the force being able to provide some data by integrating their IT system further and carrying out 'free text' searches. This meant that data was collected from all 43 Home Office police forces.

Some police forces were able to provide more information than others depending on their custody system e.g. some were only able to provide overall numbers without any data on demographics. Once all of the data was received a significant amount of data cleaning took place, as highlighted by the pilot work set out above. This was done systematically with copies of all of the original datasets left untouched. The cleaning and recoding of data was double checked to ensure consistency and accuracy. Once the data had been fully cleaned and recoded to ensure its consistency, and a new variable of 'police force' was added to each spreadsheet, the data sets were imported into a Statistical Package for Social Scientists (SPSS) dataset. SPSS is a more appropriate software package than Excel for the purposes of analysis given the size of the completed dataset and it enabled greater analysis.

Analysis of the data was then conducted using SPSS, descriptive statistics were produced on the demographics of detainees, the reasons for arrest and the length of time spent in custody. A rate of Section 136 detentions per 1,000 detentions in custody by each police force was calculated, as well as rates in terms of the ethnicity of those held under Section 136 compared to the ethnicity of those in the population of each police force, using Census population data. In order to compare police forces, Her Majesty's Inspectorate of Constabulary (HMIC) Most Similar Force (MSF) and 'force family' information was used.

Phase 2 – qualitative data and case study sites to gain depth

Using the data collected in phase one, a rate of Section 136 detentions per 10,000 people held in custody for each police force was calculated. These rates were then used to select a smaller number of forces to act as case study sites where I undertook further qualitative research to explore why Section 136 usage varies.

> …Case study is an 'approach' to research which seeks to engage with and report the complexity of social…activity, in order to represent the meanings that individual social actors bring to those settings and manufacture in them. Case study assumes that 'social reality' is created through social interaction, albeit situated in particular contexts and histories, and seeks to identify and describe before trying to analyse and theorise – i.e. it places description before explanation (Chadderton and Torrance, 2011; pg: 53).

Case studies can be of institutions or programmes or they can examine policies and "…aspire to tell-it-like-it-is from the participants' point of view, as well as hold policy to account in terms of the complex realities of implementation and the unintended consequences of policy in action"

(Chadderton and Torrance, 2011; pg: 54). Case studies are often criticised as it is not possible to generalise from a small number of cases to the whole population but they can claim to "illuminate more general issues" (Chadderton and Torrance, 2011; pg: 54). However, this thesis has attempted to overcome this criticism by also having data on the national picture as a supplement to the detail of the case studies. Methods traditionally employed in case study research include interviews, observation and analysis of documents. As applied research and evaluation became more prevalent the balance between interviews and observation:

> …had to be radically altered because evaluative case studies had to be completed in weeks, rather than months (or years), and because the researchers had a substantive interest in the particular professional dilemmas and problems of participants. Thus interviewing became widely used to gather data, rather than observation, and the validity of the findings were based on comparing and contrasting across multiple cases and respondent validation of draft reports, rather than just the researcher's long-term observations and interpretations. Key features of such an approach are intensive, interview-based 'condensed fieldwork' and 'multi-case study' (Chadderton and Torrance, 2011; pg: 55).

Chadderton and Torrance (2011) highlight that a key issue in terms of case studies is 'depth versus coverage' and suggest that depth is the recommended approach but that if possible it is also helpful to compare and contrast across different case studies (pg. 56). They go on to say that criticisms of an 'overly empiricist analysis' which can be aimed at research which relies heavily on interview data, can be overcome by also ensuring appropriate attention to the relevant literature. With these possible limitations of case studies in mind I sought to achieve a good range of police forces and have been careful to consider the wider literature and theories when examining my data. A spread of police forces across England and Wales was achieved using the (HMIC) force family data (data which groups police forces together using key characteristics), to

ensure there were forces with different types of populations and policing environments e.g. urban, rural and suburban areas (a Welsh force was also included as there are different Mental Health Codes of Practice for England and for Wales). The qualitative work sought to examine the issues for police forces and mental health services in those areas; and tried to identify ways in which practice could be improved. The case studies sought to:

- provide an overview of operational practice;

- examine training police officers received in relation to mental health issues;

- identify and assess any innovative practice on the ground; and

- assess the existing protocols and information sharing arrangements between the police and other agencies such as Primary Care Trusts and Mental Health Trusts.

The spread and number of force types mean that the findings from the case study sites will be more typical for forces generally than using one or two case study sites of similar police force areas. However, as noted earlier qualitative work by its nature is not meant to provide findings which can be inferred across the population due to the small sample size and the desire to obtain depth in the data collected.

Six police forces were chosen as case study sites, and I then used HMIC force family information to identify the two 'most similar forces' for each of these six forces. This gave a

total of 18 police forces (including the six actual case study sites) for initial telephone interviews. A spread of Section 136 rates within the sample was also achieved:

• six forces with low rates of Section 136 detentions in police custody;

• six forces with high rates; and

• six forces with medium rates.

"Telephone interviews were conducted with the force custody lead or the force mental health liaison officer in these 18 police forces" (Docking et al, 2008: pg. 7). As stated above, Hertfordshire "was unable to provide any data during the first phase of the study so we also conducted an interview with the leads in that force which has been included in the analysis" (Docking et al, 2008: pg. 7). This gave a total of 19 interviews with force leads on custody mental health. "We were subsequently able to obtain quantitative data from [Hertfordshire], which has been included in the analysis.

The interviewees were asked:

- about the levels of Section 136 detentions in their force and why they thought they might have a high/low/medium rate of detention;

- what could be done to minimise the use of police custody as a place of safety;

- what training existed for custody staff and other frontline staff in their force on mental health and how, if at all, this could be improved;

- how they felt their force worked with other agencies on Section 136 detentions in police custody and the mental health of detainees more generally;

- funding for places of safety in their area;

- good practice in their areas; and

- any other issues that they felt may be pertinent in relation to the use of police custody as a place of safety" (Docking et al, 2008: pg. 7).

"The interviews also allowed some comparisons to be made between forces in terms of differences in their Section 136 procedures, multi-agency working and how these relate to each other" (Docking et al, 2008: pg. 7). Telephone interviews are more cost and time effective than face to face interviews but have some limitations: they could exclude certain groups such as the poor (though this wasn't an issue for this study) and because it can be more difficult to engage with the interviewee and build a rapport it is important to ensure that the training of the interviewers is thorough – "interviewers cannot interpret the reactions of the interviewee by observation so they must learn to present questions clearly and listen carefully for any signals that might indicate lack of understanding. A further problem concerns concentration; if the

interview is not pre-arranged, the interviewer may not get the full attention of the interviewee" (Newell, 1998: pg. 98). Every effort was therefore made to minimise these issues by ensuring that the interviews were arranged in advance so that the interviewee has enough time, that they were somewhere quiet and I tried to build a rapport during my initial contact with the interviewees. The reliability and validity of data obtained by telephone interviews can therefore be enhanced by "giving careful attention to the planning and execution of the research project" (Newell, 1998: pg 98).

"The telephone interviews lasted around 30 to 45 minutes. The interviews were recorded and notes were made by the researchers. The recording and the notes were then typed onto a simple proforma for each interview (Appendix E has the telephone interview questions), which was then coded and added to a larger thematic matrix and analysed" (Docking et al, 2008: pg. 7). The themes and issues that arose from this analysis were fed into the development of a semi-structured topic guide used for face-to-face interviews with custody sergeants and health and social care staff (a different topic guide for the police and health interviewees, see Appendix F and G respectively) in the case study sites. It is good practice to "pilot any potential methodological tools (e.g. questionnaire or interview schedule) to ensure questions are unobtrusive (though do not equate this with non-challenging) as well as cultural, gender and age sensitive" (Piper and Simons, 2011; pg: 28).

> Many studies begin with 'pilot interviews', to gather basic information about the field before imposing more precise, and inflexible methods; this is why interviews have their claim to be the most often used research methods (Fielding, 1997a; pg: 137).

The telephone interviews therefore acted as a useful piloting exercise for the scope and nature of the questions to be asked in the face to face interviews in the case study sites and helped me to develop the topic guides to be used. "Face-to-face interviews were conducted at six police forces chosen to be case study sites. We chose:

- two forces with low rates of Section 136 detentions;

- two with high rates; and

- two with medium rates" (Docking et al, 2008: pg. 7).

Barbour and Schostak (2011) suggest that there are keys concepts to consider about interviews (and focus groups) are:

> …the power structures that are the context to the exchange taking place…the relative positions of the actors involved in the interview… the value that the 'information' has…trust – given all the vulnerabilities, the desire to make a good impression, the desire to conceal shady dimensions…the meaning heard by one individual may not be the same as that intended by the speaker…if there are multiple meanings, then interpretation is critical…uncertainty – with multiple meanings and multiple interpretations a stable resting place may be difficult, even impossible, to find (pg. 62).

Some of these concepts are particularly important when considered in the context of my role in the research process as I was interviewing them as a member of IPCC staff and, at least for the police interviewees, they may have felt that they wanted to present a good impression of

operational practice. Barbour and Schostak (2011) highlight different strategies for getting the 'real' data (pg. 62). One of these is an

> impositional [strategy which] begin[s] with a list of themes, issues, problems, questions to be covered. These may be drawn from a review of the literature, the imagination, or an 'expert group'. Once identified they are generally tested with small groups, to reduce ambiguity and identify questions that produce the most useful spread of information, as a way of standardising the questions that can be applied across a large sample…some flexibility may be built in by including some 'open ended' questions, thus generating semi-structured interviews. These enable the interviewer to capture unexpected issues and information (pg. 62).

Barbour and Schostak (2011) also highlight the importance of the interviewer adopting the pose of a listener "in this way, the possibility is increased that the views of the interviewee will **emerge** as their voices are freed from the impositional power of the research. This would mean that the data collected and the analyses that follow would be **grounded** in the experiences of the interviewee rather than grounded in the demands of the research" (pg. 63, original emphasis). Fielding (1997a) highlights some other potential issues with in-depth interviews; the potential for respondents to be overly polite, shy or anxious, or generally trying to please the interviewer (pg. 139). He therefore stresses the importance of the 'manner of the interviewer' in putting the respondent at ease, one tactic he suggests is to try and "personalise the discussion to get [to] underlying attitudes. For example, do not simply talk about 'police policy' in the abstract, ask respondents to tell you about their experiences with the police" (Fielding, 1997a; pg: 139).

When conducting my interviews I tried to reassure respondents that their comments would be non-attributable and when interviewing I, along with the other researcher, always tried to adopt a non-confrontational approach that tried to convey as much as possible that we were listening and

interested in their honest views and experiences, and were not there to make judgements or cast aspersions.

"The relevant custody leads in the six case study police forces were asked to assist in the identification of individuals in their forces and health and social care representatives for interview. We asked for two custody sergeants and two health and social care representatives in each force to participate in the interviews. We requested that one health and social care representative should be operationally focused and the other should have a more strategic role. Following discussions with the force contacts we also spoke to the mental health liaison officer in the force, if one was in place. Some force contacts arranged additional interviews with police and health and social care contacts that they felt would be useful to the study" (Docking et al, 2008: pg. 7). This meant that a total of 33 interviews face-to-face across the six case study sites were conducted. Appendix H contains a detailed list of the various participants by role and case study area.

> Two principles inform research interviews. First, the questioning should be as open-ended as possible, in order to gain spontaneous information about attitudes and actions, rather than a rehearsed position. Second, the questioning techniques should encourage respondents to communicate their underlying attitudes, beliefs and values, rather than a glib or easy answer. The objective is that the discussion be as frank as possible (Fielding, 1997a; pg: 138).

"The combination of telephone and face-to-face interviews allowed us to identify and focus on the key issues" (Docking et al, 2008: pg. 7). "The case study interviews built on the themes of the telephone interviews, but sought to gain more in-depth knowledge and examine practice on the ground and relationships between practitioners in addition to the strategic overview gained

by the telephone interviews. The work carried out at the case study sites aimed to establish why variations occur in the use of Section 136. It examined the issues for police forces and mental health services in those areas and sought to identify ways to improve practice. This in-depth work therefore provides an insight into a range of issues in different police forces areas" (Docking et al, 2008: pg. 7-8. The in-depth interviews took place face-to-face in police stations for the police officers and some health and social care staff, and in other places of work for the remaining health and social care staff.

Newell (1998) notes the importance of distinguishing between "…an interview schedule and an interview guide" (pg. 97). He states that a schedule sets out questions in a specific order which is then adhered to in each interview, whereas a guide has a list of areas to be covered while leaving the actual wording of the questions to the interviewer (pg. 97). In a semi-standardised interview "…the interviewer asks certain, major questions the same way each time, but is free to alter their sequence and to probe for more information. The interviewer is thus able to adapt the research instrument to the level of comprehension and articulacy of the respondent, and to handle the fact that in responding to a question, people often also provide answers to questions we were going to ask later" (Fielding, 1997a; pg: 136).

I designed an interview guide which the other researcher and I used as a tool for semi-structured interviews. In some of the interviews the questions were asked in a different order, which was in line with the general flow of the conversation, but there was some standardisation in the sense that each interviewee was asked the same questions overall even if they were asked in a different

sequence. Prompts and probes were also set out on the interview guide to assist with the interview where an interviewee may not have given as full a response as required:

> Prompting involves encouraging the respondent to produce an answer…probing involves follow-up questioning to get a fuller response; it may be non-verbal or verbal…the probe should be neutral as possible…probing is a key interviewing skill. It is all about encouraging the respondent to give an answer and as full a response as the format allows. The interviewer's task is to draw out all relevant responses, to encourage the inarticulate or shy, to be neutral towards the topic under discussion while displaying interest. Probing needs skill, because it can so easily lead to bias (Fielding, 1997a; pg: 140-141).

The interviews lasted approximately 30 to 60 minutes and were recorded using a specialist digital recorder. As Fielding (1997b) explains "in order to make comparisons you will have to access your data and organise it into categories or instances of occurrence. You will have to 'code' your data, be it a survey questionnaire or an interview transcript (pg: 219). The recordings were therefore sent for professional transcription and were then analysed using a coding framework and a thematic matrix which I designed.

As most of the interviews took place in police stations, there was often the opportunity to spend some time visiting the custody suites, looking around the cells and on occasion observing people being 'booked in' to custody, and on one occasion observing someone being held in a cell and being monitored on the CCTV (the detainee was identified as having mental health needs and being vulnerable), this detention is explored in more detail in chapter four. This provided useful context and aided my understanding of the area and police practice on the ground.

Ethical Approval

I sought and gained ethical approval for the research from the King's College Ethics Committee (see Appendix I for the ethical approval application and the information sheet which respondents were provided with). There are several common ethical concepts which should be considered when undertaking empirical research. Firstly "…most writers of social science ethnics adhere to a concept of informed consent. This means that those interviewed or observed should give permission in full knowledge of the purpose of the research and the consequences for them of taking part" (Piper and Simon, 2011; pg.26).

Piper and Simons (2011) discuss how a written consent form is often used, but how that in some circumstances this may not be possible or desirable. Where this is the case they state that "a more appropriate concept is 'rolling informed consent' or 'process consent', that is, renegotiating informed consent, thought the research, attentive to the risks in the field and how participants perceive these at every stage" (pg. 26). As highlighted earlier in this chapter, given the nature of the IPCC's work, there was the potential that police forces and officers may have felt compelled to participate in the research (this is less likely for the health and social care organisation representatives). As such the researchers endeavoured to reassure the participants that this research did not form part of an IPCC investigation into their force and that there was no obligation to take part in the research.

A formal consent form was not used for this research as my previous experience of interviewing police officers found that this approach can be off putting for the participants as it may amount to

a ‘caution’ in their minds. Instead I gained their informed consent for participating in the research (including providing a copy of the information sheet). To do this I asked them to take part and obtained their agreement by email/telephone which implied tacit consent. In addition when interviewing the individuals at the beginning of the interview they were asked to state that they had consented to participate and that they were happy for the interview to be recorded which also provided tacit consent.

“The second common assumption in ethical social science practice is confidentiality in the process of conducting the research and anonymisation of individuals in reporting” (Piper and Simons, 2011; pg: 26). For this research I did not ask for respondents to give their name or personal details on the recording of the interviews. The data was stored at the IPCC on a secure server. A transcription company was used which conducts a lot of work for Government and as such has secure data storage and adheres to the provisions of the Data Protection Act. The data was anonymised with any personal information removed and individual numbers given to each interview transcript. All paper copies were stored securely at the IPCC in locked cabinets and all electronic data was password protected. Individual police forces who were case studies for the research were not identified in the final report for the IPCC or in this thesis.

Phase 3 - qualitative and quantitative data on Section 136 deaths in police custody

I undertook a separate project in my role at the IPCC which examined deaths in police custody in an eleven year period after completing the analysis detailed above. This study identified all deaths in or following police custody (see chapter two for a fuller definition) between 1998/99

and 2008/09. I gathered completed investigation reports, inquest verdicts and misconduct recommendations for each of these cases and designed a data collection proforma which a team of researchers completed using the information from these various sources. The possibility of using coroners' reports was also explored, as a possible criticism of the investigation reports (particularly those written by the individual relevant police force) is that they may represent a particular perspective of the incident. However, this posed numerous logistical problems such as the number of coroners in England and Wales (116) and the need to convince each of them that the IPCC was a 'properly interested person'[24]. This would have impacted significantly on the size and length of the project and therefore this data was not used. By using inquest verdicts in addition to the investigation report I hope to have overcome some of these limitations.

In addition qualitative information was gathered on some of the details of the cases, in particular any practice or cases that were considered worthy of further examination. For example, cases which strongly illustrated certain breaches of PACE Codes of Practice. The data was inputted

[24] "This can be:

- a parent, spouse, child, civil partner or partner and any personal representative of the deceased;
- any beneficiary of a life insurance policy on the deceased;
- any insurer having issued such a policy;
- a representative from a Trade Union to whom the deceased belonged at the time of death (if the death arose in connection with the person's employment or was due to industrial disease);
- anyone whose action or failure to act may, in the coroner's view, have contributed to the death;
- the Chief Officer of Police (who may only ask witnesses questions through a lawyer);
- any person appointed as an inspector or a representative of an enforcing authority or a person appointed by a Government Department to attend the inquest; or
- anyone else who the coroner may decide also has a proper interest.

It is the coroner who decides who will be given properly interested person status" (paragraphs 21.1 and 21.2, Ministry of Justice, 2010d)

and analysed using SPSS and the qualitative data was inputted into Excel and examined on a thematic basis by me as lead researcher.

The research sought to examine trends in these cases over time, the characteristics of the deceased and the causes of their deaths, the location and timing of the deaths, the investigation and its outcome, the use of restraint and the role of positional asphyxia and 'excited delirium', mental health and suicide, and alcohol and drug use. It examined these issues in the context of the legislation and policy governing police custody as well as the guidance for custody officers and staff and sought to identity lessons that could be learnt to prevent further deaths as well as examining whether the nature and circumstances of the deaths had changed over time. Further details of the study can be found in Hannan et al (2010). This thesis looks specifically at the small number of deaths identified by this study where the individual had either been detained under Section 136 and taken to police custody as a place of safety and subsequently died, or where they had been arrested for an offence and taken to custody but after being booked into custody they were then dealt with under Section 136 and subsequently died. The purpose of including these cases within this thesis is to examine the dangers of using custody as a place of safety, and to demonstrate using real examples the most tragic outcome as a reason why the use of police custody as a place of safety should be avoided.

Limitations of the research

The research for this thesis will hopefully provide a strong evidence base for examining how police custody is used as a place of safety under the Act, how this varies across England and

Wales and the reasons for this variation. However, the quantitative data provides a snapshot of the extent to which police custody was used at a certain time – in this case 2005/06 – and without annual statistics being collated and analysed on an ongoing basis it is not possible to know what if anything has changed since then. As highlighted in chapter two the latest statistics on detention in hospital under Section 136 show a large increase since 2005/06 but the reasons for this increase are not available so if is not possible to know whether this reflects a decrease in the use of police custody as a place of safety. Ideally it would have been beneficial to collect national statistics for other years following 2005/06 to examine the trends in the data and see how, if at all, practice was changing. Depending on what the data showed, it might then have been useful to conduct further qualitative work to see what progress had been made on the ground sometime after the initial data collection.

This research also looks at the working relationships between the health service and the police in terms of the use of Section 136 but the limitations of case study research were explored above, clearly there are limits to how far I can generalise about practice in England and Wales from these case study sites. Although, by picking a range of case studies, representing different police force area types, it is hoped that this limitation will be overcome to some extent and it is for the reader to judge whether the data provides a robust picture. The possible impact of my role in the research was also explored above; there is the potential given my role at the time, as an IPCC employee, that this may have influenced some of the police participants and that they would have provided a more positive picture of practice in their interviews as a result. However, I tried to mitigate this as much as possible by assuring their anonymity and trying to get them to speak about their own experiences. The health and social care staff interviewees were generally

identified by the lead police force contact in each case study site, so there is a risk that they may have selected individuals who would provide a certain perspective on practice. However, the information that participants gave in their interviews does not suggest that this was the case, as they were on the whole very forthcoming.

As well as the potential to carry out further collation and analysis of quantitative data from more recent years, further research into this area could also benefit from gathering the perspective of those who have been detained under Section 136 to examine their experiences (service users). Their voice has been missing from much of the research and this is an area which future research could focus on. In a similar vein, whilst I was able to observe some practice in custody suites, it would have been useful to have carried out a greater number of hours conducted observation research in custody to see whether the practice on the ground reflected the descriptions of the interviewees.

In terms of the research into deaths in or following police custody of people detained under Section 136, it would also have been useful to examine other evidence sources if time had allowed, such as coroners' reports and potentially interviewing the deceased's family/friends/legal representative. There is a risk that by using the official investigation reports that some evidence may have been downplayed or not thoroughly considered, particularly for older cases which were often investigated by the police force where the death occurred rather than an independent body. A comparison with deaths of those detained under Section 136 in a hospital setting would also have offered an interesting contrast to see how the care the individuals received varied and whether the causes of death were different.

Finally, whilst the research examines issues such as disproportionality in the use of Section 136 and suggests possible reasons for this, it cannot offer a definitive reason for the difference in the use of the power. Again it may be beneficial for future research to examine this given that this appears to be an issue running throughout the different detentions under the Act.

Conclusions

This chapter has set out the research design and methodology for this thesis. It has explained why a mixed methods approach to the research was chosen to gather both a quantitative picture of the national use of Section 136 and more qualitative information to provide depth of understanding to what these statistics tell us and why variations in the use of Section 136 occur. In addition deaths in or following police custody involving people who were detained under Section 136 will be examined to highlight the most tragic outcome of these detentions. I have reflected on my role in the research process, in particular the fact that the data was gathered in my role as a researcher at the IPCC and the impact that this may have had on the respondents and the research as a whole, and the actions I sought to take to mitigate this. Finally, it set out the limitations of the research and made suggestions for areas which future research might seek to focus on.

4. Deciding to detain and prevalence of detentions under Section 136

> …it's the man walking round the railway line with no clothes on and acting daft that will get the actual dead obvious 136. You go to the town square and there's a man there talking to himself, trying to jump in front of traffic and things like that, there's no alcohol, they...are the ones where you think it's quite obvious to everyone this man needs help (custody sergeant 1, low rate force 1).

Introduction

There are no official statistics currently available on the use of police custody as a 'place of safety' for mentally disordered people. This chapter therefore aims to increase knowledge in this area by providing data on: the number of Section 136 detentions across England and Wales; the characteristics of those detained; additional reasons for detention and related recording issues. This chapter analyses the quantitative data from forces collated from the pilot work and phase one of the main study, both of which are described in more detail in chapter three. It explores the decision to detain individuals under Section 136 by police officers; their training and knowledge; the prevalence of detentions across police forces in England and Wales and why variations in its use occur. Finally, it considers the inappropriate and potentially illegal use of the power.

Analysis of pilot data

Number of detentions

In chapter three I explained the need and purpose for piloting the quantitative data collection aspect of this thesis before asking all forces to provide data. Seven forces were therefore asked to provide data on Section 136 detentions and data on those who were detained for suspected offences but who were subsequently disposed of under the Act for 2004/05 using the Excel spreadsheet provided. The data received from the forces varied, as some forces were only able to provide data on people who were detained under Section 136 of the Act. Whereas others (for example Greater Manchester Police) included people arrested for other reasons but who were subsequently disposed of under the Act. Table 4.1 shows the total number of mental health detentions compared to the total number of detentions for any offence by force.

Table 4.1: Total number of detentions per force and number of mental health detentions, 2004/05

	Total number of detentions	Total number of MH detentions*	Rate MH detentions per 10,000 arrests
Cambridgeshire	21,696	351	162
Cleveland	N/A	216	N/A
Cumbria	18,281	55	30
Greater Manchester	112,682	215	19
Leicestershire	33,941	225	66
Metropolitan	289,035	152	5
West Midlands	89,698	1,355	151
Total	**565,333**	**2,569**	**42^**

*This number represents the total number of different cases that each force submitted so will therefore include the number of people arrested under the Act and people who were arrested for another reason but subsequently disposed of under the Act.
^ Excludes number of detentions in Cleveland due to total number of detentions being unavailable.

"The figures for mental health detentions in the Metropolitan Police were relatively low compared to the other forces. There are several reasons why this may be the case. The

Metropolitan Police have agreements and protocols in place with primary care trusts in their force so that unless someone is perceived to be violent or there are no available beds, police cells should not be being used as places of safety. The Metropolitan Police are therefore likely to have a lower number of Section 136 detainees if this policy was being followed. In addition to this, the Metropolitan Police have stated that if an individual had been arrested for an additional reason, as well as Section 136 of the Act, then the additional arrest reason would generally be entered onto their system (instead of the Section 136 detention). This means that the figure they provided is likely to be an underestimate as they are possibly failing to capture people who have been detained under Section 136 *and* committed another offence" (Docking et al, 2008: pg. 49). This is something that will be explored further when discussing the data from the main stage of the project below.

Characteristics of the detainees

"The majority of those detained or released under the Act were male (men: 67%, women 32%, missing data: 1%). The average age of detainees across seven forces was 34 years old. The ethnicity was regrouped into the Census 5 point classification; White, Mixed, Black, Asian, Chinese or Other ethnic group, as described in chapter three. Across all forces the highest proportion of detainees was White. The West Midlands had the largest number of Asian detainees (15%) and the Metropolitan Police had the largest number of Black detainees (20%) under Section 136 of the Act. White people made up the largest proportion of detainees, accounting for nearly three quarters (73%) of all detainees. Black and Asian people made up 11% per cent and 10% of the detainee population respectively" (Docking et al, 2008: pg. 50).

"In order to assess the data the police forces had provided in terms of the proportionality of the ethnicity of those detained under Section 136, comparisons needed to be made between the ethnicity of the people held in custody under Section 136 and the ethnic breakdown of the force area population. We therefore had to use the Census 4 point classification, as the population data is only available under the four groups of White, Black, Asian and Other. We therefore had to exclude the 'Mixed' ethnic category. The population data we used grouped all 'Mixed' categories where Black is mentioned as 'Black', as does the 'Asian' category; 'Other' includes Chinese and all other categories not already specified. This means that the Black and Asian categories in the population data we used are therefore larger than the categories we are comparing them to" (Docking et al, 2008: pg. 50).

"In comparing the population data to the makeup of detainees, it might therefore have been expected that potential levels of disproportionality were underestimated given that the 'Mixed' people had been removed from our detainee population but included in the total population. However, as highlighted by [Table 4.2 below], the data still showed an overrepresentation of Black detainees in the majority of forces, with differences in the figures from Greater Manchester (12% of all detainees), West Midlands (15%) and the Metropolitan Police (20%). Black people make up 2%, 5% and 12% of the total population for these three forces respectively. This mirrors findings from previous research, which also pointed to an over-representation of Black people being detained using Section 136 powers (Rogers and Faulkner, 1987; Rogers, 1990)" (Docking et al, 2008: pg. 50-51). This will be examined in more depth below when exploring the data from main study.

"In comparison White people were underrepresented in the detainee figures, particularly by the forces highlighted above when compared with the make-up of the force area populations. Asian people were also underrepresented in Section 136 detainees in Greater Manchester (3% of detainees compared to 6% of the population), Leicestershire (8% compared to 12% of the population), and the Metropolitan Police (2% compared to 13% of the population)" (Docking et al, 2008: pg. 51).

Table 4.2. Ethnicity of Section 136 detainees compared to ethnic breakdown of police force area population

	Section 136 detainees by ethnicity				Force Population by ethnicity			
Police Force	**White**	**Black**	**Asian**	**Chinese /Other**	**White**	**Black**	**Asian**	**Chinese /Other**
Cheshire	87%	4%	3%	3%	95%	1%	3%	1%
Cleveland	96%	0%	2%	1%	97%	0%	2%	0%
Cumbria	98%	2%	0%	0%	99%	0%	0%	0%
Greater Manchester	80%	12%	3%	0%	91%	2%	6%	1%
Lancashire	84%	4%	8%	3%	85%	2%	12%	1%
Metropolitan	66%	20%	2%	6%	71%	12%	13%	4%
West Midlands	64%	15%	15%	1%	80%	5%	14%	1%

Percentages are rounded and may not add up to 100%
Force area population data taken from the Section 95 'Race and the Criminal Justice System: An overview to the complete statistics 2003-2004', Appendix A1 Estimated population aged 10 and over by ethnic origin and police force area, mid-2003

"The majority of detainees had a permanent address (68%) but a quarter had no fixed abode. Cambridgeshire and the Metropolitan Police had the highest proportion of the 'Unknown' information as this information was not captured by their IT systems" (Docking et al, 2008: pg. 51).

Release from custody

"The majority of detainees were sent to hospital, placed in care or sectioned under the Act (46%), or there was no further action (NFA) (41%). However, it is important to note that many forces may give NFA as the release code for anyone that was not charged or sent to court, so this figure may also include people who had actually been taken to hospital. The Metropolitan Police did not capture this information on their system" (Docking et al, 2008: pg. 51).

Average time in custody

"This was difficult to calculate due to problems with formulae and formatting in Excel because of the way in which some forces provided the data [as detailed in chapter three]. This problem [was overcome for the main study and therefore the analysis of the quantitative from phase one includes] average times in custody for each force where data was provided. However, at the time of the pilot analysis it was only possible to calculate the average length of time spent in custody" (Docking et al, 2008: pg. 51) for four of the seven police forces who provided data. Table 4.3 below shows that the average time in custody varied by over four hours between the longest time and shortest time, although it will be important to compare this for a larger range of forces, particularly as one force only had a very small number of cases where this information was available.

Table 4.3: Average length of time in custody by police force

Police Force	Average length of time
Greater Manchester	10hrs 3mins
Leicestershire	7hrs 32mins[25]
Cumbria[26]	8hrs 44mins
Cleveland	5hrs 45mins

Main study phase one – Prevalence of Section 136 detentions during 2005/06

Data was collected from all 43 Home Office police forces in England and Wales. As discussed in chapter three, Hertfordshire initially stated that they were unable to provide data on number of detentions as they had removed this as an option from their custody system because they believed that the protocols they had in place meant that no-one should be detained in custody as a place of safety. However, this seemed to me to be a mistake on the part of the force, as it is likely that there would always be some individuals who may have to be taken to police custody if they were perceived to be very violent. Furthermore, following enquiries with the force it was discovered that the protocol was actually still in draft form so the decision to remove the recording of Section 136 from the custody system was premature. An interview was arranged with the force custody lead and following their assistance data was eventually provided from the force which has been included in the analysis (this was possible by performing free text searches of their data to identify cases).

From the data collected it was estimated that "a total of 11,517 people were detained under Section 136 across the 43 police forces during 2005/06. This means that despite a clear consensus across the police and psychiatric professions that this should be avoided whenever

[25] The Leicestershire data had two extreme outliers which have been excluded as they skewed the data.

[26] Only 8 cases had this information so this should be treated with caution.

possible many thousands of people are held in police detention each year under Section 136. Furthermore, compared to hospital, police cells are *by far the most common* place of safety. A total of 5,900 people were detained in a hospital setting for the same time period for a 'place of safety order involving assessment' (Department of Health, 2007). This means that twice as many people were held in a police cell as a place of safety compared to a hospital" (Docking et al, 2008: pg. 10).

"Our estimates are supported by another survey on the use of Section 136. This was conducted by ACPO during 2007. They received responses from 27 of the 43 forces in England and Wales. Of these 27 forces, 11 were able to provide some estimated figures on Section 136 use (ACPO, 2007). The 11 forces detained a total of 9,071 individuals under Section 136 over a period ranging from nine to 12 months. Some forces were able to provide further information and this stated that 6,984 people were taken to a police station and 2,087 were taken to a hospital. While the response rate to the survey was relatively poor, it provides some support to our findings in terms of the number of people detained each year and the proportion of people placed in police custody compared to a hospital" (Docking et al, 2008: pg. 10), with a much larger proportion of Section 136 detainees being held in police custody. It is interesting that this data was a later time period than the data collected for this thesis but there seemed to have been little improvement in terms of the ration of people being held in custody rather than a hospital setting.

Because the data is not collated and published on Section 136 detentions in police annually for England and Wales it is not possible look at the trends over time since I collected this data or to establish whether things have changed and improved. However, in 2009/10 place of safety

detentions in hospital rose by 40%, in what appears to be a continuing trend since 2005/06 (The NHS Information Centre, 2010). There were a total of 12,300 detentions under Section 136 in hospital in 2009/10 which is more than double the number of 5,900 in 2005/06. It is not possible to know the cause of the increase of hospital detentions, because of the lack of data for police custody detentions. There could be several different factors which explain this increase: better recording, an actual increase in the total number of people being detained, less use of police custody and greater use of hospitals as a place of safety, or a combination of these factors.

Police force comparisons

"We asked forces were asked to provide figures on the total number of people held in custody in their force for 2005/06, as well as those detained specifically under Section 136. This enabled us to calculate of Section 136 detentions for each force per 10,000 people held in custody. Table [4.4] below shows the number of detentions by police forces, the total custody population for 2005/06 and the rate of detentions. Section 136 rates varied from one to 277 per 10,000 people in custody. The rate of detentions across police forces in England and Wales was 57 per 10,000 people in custody" (Docking et al, 2008: pg. 10).

"Nine police forces were unable to provide us with figures for their custody population. It was therefore not possible to calculate rates of Section 136 detentions in the same way as the other forces. Instead we estimated their total custody population using the arrest population for notifiable arrests for each of the forces (Ministry of Justice, 2007). To do this, we looked at the

most similar forces[27] for each individual force without total custody population data. We calculated the percentage difference between the number of notifiable arrests and the total number of people held in custody for each force[28]. We then calculated the average percentage difference between the two figures and used this to estimate the total custody population for these forces" (Docking et al, 2008: pg. 10).

"Table [4.4] categorises forces into four groups – those with low, medium and high rates of Section 136 detentions, and those where the rates had to be estimated as the custody figures were unavailable. The table shows that the forces with the lowest rates of Section 136 detentions were:

- Cheshire;
- Merseyside; and the
- Metropolitan Police.

The forces with the highest rates were:

- Sussex;

[27] Using HMIC most similar force information.

[28] The one exception was the City of London police force, which does not have any similar forces. I therefore used the average percentage differences for the other forces to calculate an overall average percentage difference and used this to calculate the City of London total custody population.

- Devon and Cornwall; and

- Avon and Somerset" (Docking et al, 2008: pg. 10-12).

"The table shows large differences in the number of detentions between forces that might be expected to have similar figures. The second phase of this study looked at why these rates varied by examining practice in a smaller number of police forces and, for example, the availability of alternative places of safety to police custody" (Docking et al, 2008: pg. 12). This evidence is explored later in this chapter as well as the chapters five and six.

Table 4.4: Section 136 detentions, custody populations and Section 136 rates by police force 2005/06

Force	Number of Section 136 detentions	Number of people held in custody	Rate of Section 136 detentions per 10,000 people in custody
Low-rate forces			
Cheshire	2	28,262	1
Merseyside	8	55,222	1
Metropolitan Police Service	76	301,302	3
Kent	41	54,127	8
Northumbria	86	90,879	9
Greater Manchester Police	131	113,431	12
Lancashire	90	72,522	12
South Yorkshire	61	52,940	12
Humberside	40	30,952	13
Bedfordshire	31	22,339	14
Norfolk	28	18,729	15
Medium-rate forces			
North Wales	68	28,233	24
Surrey	66	25,232	26
South Wales	174	51,957	33
Dorset	79	23,470	34
Leicestershire	125	36,701	34
Cumbria	65	17,830	36
Suffolk	71	18,741	38
Northamptonshire	96	21,593	44
Durham	139	26,000	53
Thames Valley	423	77,740	54
Nottinghamshire	316	49,055	64
High-rate forces			
Cleveland	267	32,054	83
Lincolnshire	156	18,780	83
Dyfed- Powys	167	19,649	85
West Midlands	986	106,846	92
Gloucestershire	203	19,325	105
North Yorkshire	271	25,906	105
West Yorkshire	1,503	136,714	110
Hampshire	771	62,486	123
West Mercia	477	33,684	142
Avon and Somerset	732	50,827	144
Devon and Cornwall	891	51,194	174
Sussex	1,384	49,920	277
Forces with rates based on estimated custody population			
Hertfordshire	8	27,743	3
City of London	2	5,418	4
Essex	51	33,482	15
Derbyshire	184	27,656	67
Staffordshire	251	29,804	84
Warwickshire	130	12,145	107
Cambridgeshire	317	23,601	134
Wiltshire	162	11,836	137
Gwent	380	19,490	195
Total for England and Wales	**11,517**	**2,015,817**	**57**
Total Section 136 detentions for forces able to provide custody population for England and Wales	**10,024**	**1,824,642**	**55**

Characteristics of those detained under Section 136

"Two police forces – City of London and Hampshire – were unable to provide further information about the characteristics of those detained in their force under Section 136. They were also unable to provide any details relating to the length of detention or how the detainees were disposed of when leaving custody. The analysis below therefore draws on data from the remaining 41 police forces and consists of a total of 10,736 detentions. Thirty-four per cent of those detained were female and 61% were male. The gender of 6% of detainees was unknown" (Docking et al, 2008: pg. 12).

This is similar to the findings of Rogers and Faulkner (1987) whose sample of Section 136 detainees were 61% male and 39% female. "There were no great differences in the gender spread across the police forces. The average age of the detainees was 36 years old, and the ages ranged from 12 to 89 years old. Figure 4.1 below shows that 30% percent of the people were aged between 35 to 44 years, 26% were 25 to 34 years old and 17% were aged between 18 to 24 years old. Four per cent (420 people) of detainees were aged 17 years and under" (Docking et al, 2008: pg. 12). There were four detainees who were only 12 years old. Those at either end of the age spectrum would clearly be even more vulnerable than most Section 136 detainees, and there is an even stronger argument for not detaining them in police custody. It was not possible to examine ages across police force because the numbers become too small to conduct meaningful analysis. Some respondents in phase two of the research were, however, concerned about the age of some of their detainees and seemed to relate this to a lack of alternative care:

> My most worrying trend is the number of young people that are detained under 136. Yes, 13, 14, 15, and that brings up a whole problem are of its own, because if you get them in on a 136, we can't just phone up the ASW and say, I need a consultant psychologist... it's a child psychologist. And if you think it is difficult getting an adult psychologist, you try and get a child psychologist to come out. We don't want these kids in our Custody units, yet the parents are desperate. I review why they were actually arrested in the first place, and it was clear why they needed to be arrested and detained, but it's the infrastructure and the backup behind it. A couple of them were [to do with drug use] but some of them weren't. It was obviously behaviour. You get personality disorder, ADHD, all comes into this, but basically if somebody is going off on one, they're going off on one and it's very difficult, whether it be family or whatever. We've had youngsters that have actually gone missing from homes, hospitals, whatever, and then have to deal with them afterwards, so that is a worrying trend. (Mental Health Liaison officer, high rate force 1).

This is also supported by evidence from the Mental Health Act Commission (2005) who found that:

> One particularly stark example of the dangers inherent in having too limited choices for places of safety was the admittance during this period of a child to a police cell due to concerns at the appropriateness of the available adult psychiatric facility. It could be that children's services, in particular, could usefully be approached as alternative venues for appropriate cases. We have heard anecdotally of at least two examples of the detention of young children (aged eight and twelve) under s.136 in the last two years (pg. 287).

Figure 4.1: Percentage of Section 136 detainees' age ranges

NB: The age of 758 detainees was unknown (7% of total sample) these have been removed from this sample so the percentages are based on those for whom age was known.

"Fifty-two per cent of detainees had a permanent address and 5% had no fixed abode. However, this should be treated with some caution as information was missing in 43% of cases and eight people refused to provide this information" (Docking et al, 2008: pg. 12). Borschmann et al (2010) found in their systematic literature review of the evidence on Section 136 that many detainees had no fixed abode, Rogers and Faulkner (1987) found that 17% had no fixed abode, and within my pilot data a quarter were homeless. Therefore many more of the 43% where this information was missing in my data may actually have been homeless. The largest ethnic group of detainees were White people (78%), followed by Black people (4%), Asian people (3%), Chinese/Other ethnic group (1%) and then people of Mixed ethnicity (1%). Information about detainees' ethnic background was unknown/not stated in 14% of cases.

Previous research has shown disproportionality in the ethnic make-up of those detained under sections of the Act (Browne, 1990 and 1997; Audini and Lelliot, 2002; Singh et al, 2007; Care

Quality Commission, 2011). This is particularly the case with Black people who were six times more likely to be detained than White people under Part II of the Act (Audini and Lelliot, 2002), and three times more likely than White people to be an inpatient in any mental health service in England and Wales (Healthcare Commission, 2007).

"[Table 4.5 below] shows the rates of Section 136 detainees in this research per 10,000 in the population by ethnic group. It shows that across England and Wales, Black people were almost twice as likely as White people (1.7 times) to be detained and held in police custody under Section 136 of the Act. This is consistent with some of the previous research evidence highlighted above" (Docking et al, 2008: pg. 12), as well as some of the specific research into Section 136 such as Rogers (1990). "People listed as being from 'Other' ethnic groups were 1.5 times more likely to be detained than White people. In comparison, there was little difference in the rates of detention for White and Asian people. Police forces in more rural locations tended to have the greatest potential disproportionate rates, particularly for *Black* detainees (not of all detainees), such as Avon and Somerset, Cambridgeshire, Cleveland and Warwickshire. This may be linked to these forces having generally high rates of Section 136 detentions in police custody" (Docking et al, 2008: pg. 14).

It could also be due to other factors, Rogers and Faulkner (1987) suggest that "the public in general may be more ready to call the police when a Black person is behaving 'oddly' than a White person doing so" (pg. 40). This may be exacerbated in a rural area where ethnic minorities make up a much smaller proportion of the population and are therefore perhaps more likely to be viewed with suspicion and as outsiders (Chakraborti and Garland, 2004).

Table 4.5: Section 136 detainees' rate per 10,000 people in population by ethnic group

Police force	White	Black	Asian	Other	Total rate
Avon and Somerset	5.0	21.2	7.3	5.7	**5.4**
Bedfordshire	0.6	1.5	0.0	0.0	**0.6**
Cambridgeshire	4.4	21.0	6.3	11.5	**4.9**
Cheshire	0.0	0.0	0.0	0.0	**0.0**
Cleveland	5.2	22.2	10.4	15.1	**5.5**
Cumbria	1.5	0.0	0.0	0.0	**1.5**
Derbyshire	0.0	0.0	0.0	0.0	**2.1**
Devon and Cornwall	6.0	16.7	8.5	4.7	**6.1**
Dorset	1.2	0.0	2.4	4.3	**1.3**
Durham	2.6	0.0	0.0	9.6	**2.6**
Dyfed- Powys	3.8	0.0	0.0	0.0	**3.7**
Essex	N/A	N/A	N/A	N/A	**0.4**
Gloucestershire	3.8	7.6	4.9	16.4	**4.0**
Greater Manchester Police	0.6	1.9	0.5	0.0	**0.6**
Gwent	N/A	N/A	N/A	N/A	**7.8**
Hertfordshire	0.1	0	0	0	**0.1**
Humberside	0.5	0.0	2.7	5.6	**0.5**
Kent	0.3	1.0	0.0	0.0	**0.3**
Lancashire	0.7	1.6	0.4	0.0	**0.7**
Leicestershire	1.4	6.2	1.2	1.4	**1.5**
Lincolnshire	2.5	8.4	0.0	7.9	**2.6**
Merseyside	0.1	0.8	1.0	0.0	**0.1**
Metropolitan Police	0.1	0.2	0.1	0.2	**0.1**
Norfolk	0.4	0.0	0.0	0.0	**0.4**
North Wales	1.1	7.2	4.0	0.0	**1.1**
North Yorkshire	3.9	9.6	14.9	6.0	**4.0**
Northamptonshire	1.4	2.9	3.9	0.0	**1.7**
Northumbria	0.7	2.2	1.0	0.0	**0.7**
Nottinghamshire	3.0	14.0	8.7	3.9	**3.4**
South Wales	1.6	5.5	0.0	1.2	**1.6**
South Yorkshire	0.5	2.0	0.3	1.3	**0.5**
Staffordshire	2.5	4.5	0.0	0.0	**2.7**
Suffolk	0.8	2.8	0.0	0.0	**1.2**
Surrey	0.7	1.2	0.8	0.7	**0.7**
Sussex	6.9	16.1	3.5	45.4	**10.3**
Thames Valley	2.2	5.2	1.5	3.6	**2.3**
Warwickshire	2.6	21.9	1.4	7.5	**2.8**
West Mercia	4.5	14.6	4.8	0.0	**4.6**
West Midlands	3.8	14.1	3.8	7.9	**4.4**
West Yorkshire	7.0	18.9	4.8	10.2	**8.1**
Wiltshire	0.9	2.4	1.6	0.0	**2.9**
Total for England and Wales	**1.9**	**3.3**	**1.6**	**2.8**	**2.3**

NB: 'Unknown/not stated' ethnicity data has been included in this table when calculating the total rates by population.

In addition to the possible issues regarding disproportionality and racism in more rural areas there are other possible explanations for disproportionality more generally. The evidence discussed earlier in this thesis suggests that there could be multiple reasons – Black people in particular may be culturally less likely to access mental health services at an early stage, meaning that their health issues become more entrenched, racism within the health service and police force means that people from Black backgrounds may be stereotyped and assumed to be 'mad or bad' and wider societal racism may mean (as mentioned above) that members of the public are more likely to notice or judge people from BME groups they view to be acting strangely and report them to the police bringing them into contact with the criminal justice system and mental health services.

Both the disproportionality in the use of Section 136 to detain greater number of Black people and the evidence suggesting that children are being increasingly detained under Section 136, once more demonstrate the need to address both the wider 'field' as well as the 'habitus' in order to effect change. The law alone is not enough to effect change given the scope of police discretion to apply the law and the strong influence of police culture. The potential discriminatory use of Section 136 can only be truly addressed if wider societal racism and other forms of discrimination are tackled and this in turn will have an impact on the 'habitus', or cultural knowledge, of the police. Without suitable alternative facilities to police custody children and other individuals will continue to be held there as a 'place of safety'. This therefore shows the need for positive changes in the wider 'field' in terms of the social environment in

which policing of Section 136 detainees takes place with changes required to wider societal views.

Additional reasons for detention

"While the primary reason for the detention of the 10,736 people in this sample was Section 136 of the Act, there were additional reasons for why some individuals had been brought into police custody" (Docking et al, 2008: pg. 14). This research allowed for up to two additional reasons for detention to be recorded. "Table [4.6] below shows that a total of 387 additional reasons were given" (Docking et al, 2008: pg. 14). These figures are likely to underestimate the total number of additional reasons due to the way in which detentions are recorded by police forces. "The most common additional reasons given for detention were:

- breach of peace (29%);
- threats to harm self (16%); and
- 'other offences' (13%).

These offences are perhaps the most likely to be associated with someone who is being detained under Section 136 and the table shows that more serious offences are few in number" (Docking et al, 2008: pg. 14).

Table 4.6: Additional reasons for detention

	N	Percentage
Breach of peace offences	113	29
Threats to harm self	60	16
Other offences	49	13
Criminal damage	23	6
Assault (ABH)	21	5
'Other' assaults	21	5
Alcohol offences	18	5
Harassment, alarm or distress	13	3
Warrant/bail offences	13	3
Drug offences	11	3
Other public order offences	10	3
Theft offences	10	3
Sexual offences	9	2
More serious violence	6	2
Other Sections of Mental Health Act 1983	5	1
Burglary/robbery	5	1
Total	**387**	**100**

Percentages are rounded.
The arrests were re-coded into these categories from a larger number of categories (see Appendix C for more details).

Recording of Section 136

"Recording of Section 136 was an issue that was highlighted across the different forces regardless of their rate of detention. Some forces only record the primary reason for arrest which would be a substantive arrest if one had taken place, although most could also note concerns about someone's mental health on the custody system. It was therefore recognised that figures on Section 136 detentions, and the number of detainees with mental health problems more generally, were likely to underestimate the number of individuals held in many force custody suites as there were likely to be many individuals who had been arrested for minor offences whose mental disorder may not be identified by the custody record" (Docking et al, 2008: pg. 14).

There were 24 of the 43 Home Office police forces who were able to provide additional data on the number of people held in custody that had been arrested for criminal offences but were identified as having mental health issues when in custody. There were an additional 1,573 people who were identified as having mental health issues across the 24 police forces who were able to provide this information. This is therefore likely to be a large underestimate of the amount of people actually detained in police custody who have some form of mental health problems, as many police forces cannot capture this on their custody IT systems. Those that can record it may still underestimate the number of detainees, as this relies on custody officers/staff members identifying any mental health needs. In their research Gudjonsson et al (1993) found that 7% of suspects in police custody were mentally ill and most were not identified by the police.

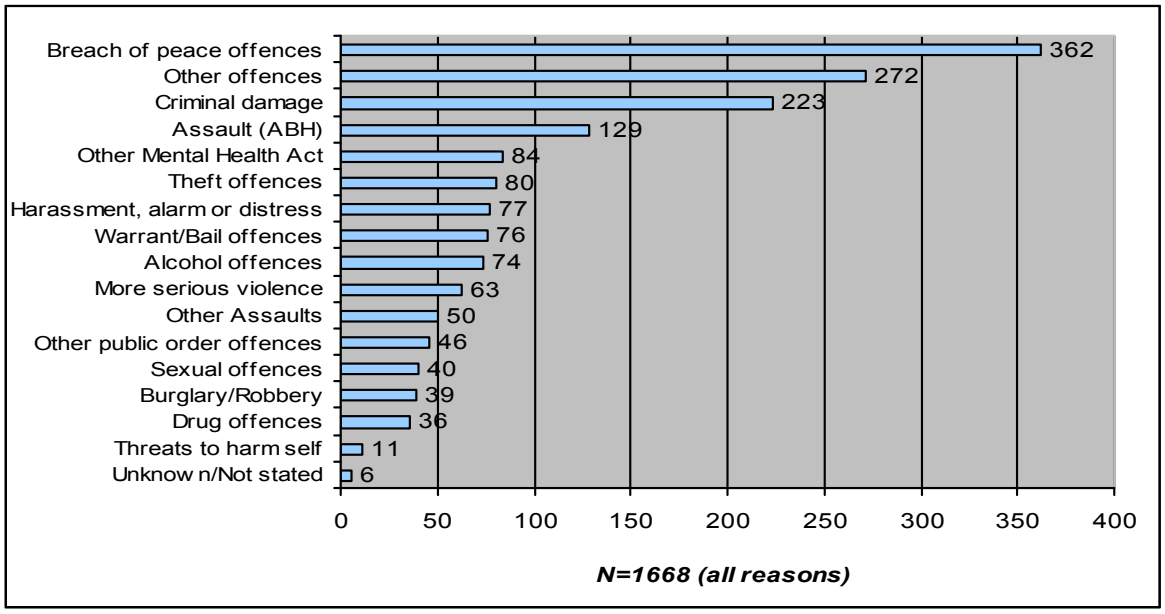
The demographic makeup of this group was different to that of those detained under Section 136. Twenty-six per cent of those detained were female and 74% were male (meaning that a higher proportion were male). The average age of the detainees was 35 years old, and the ages ranged from 12 to 88 years old. Twenty-seven percent of the people were aged between 25-34 years, 27% were 35-44 years old and 18% were aged between 18-24 years old. Five per cent (72 people) of detainees were aged 17 years and under. Fifty-seven per cent of detainees had a permanent address and 5% had no fixed abode. However, this information was missing in 39% of cases and one person refused to state this information. No firm conclusions can therefore be drawn from this data.

The largest ethnic group of detainees were White people (73%), followed by Black people (9%), Asian people (7%), Chinese/Other ethnic group (2%) and then people of Mixed ethnicity (2%).

This information was unknown for 8% of cases. This means that Black and Asian people made up a larger proportion of this sample than those held under Section 136 initially which could imply that the police may have been more likely to arrest people from BME groups for an offence where they had mental health needs than White people. This is supported by evidence from other areas, for example there is evidence to suggest that the police are more inclined to charge BME people with offences rather than caution them in comparison to White offenders even where the evidence is insufficient (Mhlanga, 1999). The discretionary nature of policing and a lack of supervision mean that officers are able to apply the law differently to different individuals in similar circumstances. They may make decisions based on the prevalent culture and attitudes towards different socio-economic groups.

Figure 4.2 shows the total number of reasons for arrest; each individual could have up to three reasons for arrest. Therefore the figures show the total number of arrests not the number of people. The three most common reasons for arrest were breach of the peace offences (22%), followed by 'other' offences (16%) and then criminal damage (13%).

Figure 4.2: All reasons for arrest



Detaining people under Section 136

The remainder of this chapter "looks at the geographical features of different forces and issues around service provision. It examines the process of an individual being detained under Section 136 and the potential problems that officers may face in identifying mental disorder. It assesses the use of Section 136 across forces and examines whether this explains differences in the rates of detention across forces. Finally, it focuses on the availability of alternative places of safety and the factors that affect an officer's decision when determining what place of safety will be used" (Docking et al, 2008: pg. 16).

Geographical features and service provision

"The perceptions of our interviewees broadly reflected the figures we obtained from their police forces. Respondents from higher rate forces tended to view Section 136 detentions as a larger issue for their area than those in lower rate forces. We tried to explore whether particular issues or problems might contribute to the varying rates in the individual forces. Two high rate forces felt that particular geographical features in their areas might contribute to their high numbers of Section 136 detentions. The features were strikingly similar in the two areas and included:

- Local cliff-top 'suicide spots'.

- The areas having holiday locations with a transient population, including people who became distressed or suicidal during their stay. Linked to this was the perceived high use of drugs and alcohol in some towns in the two police forces.

- Towns that were at the end of train lines where people in a distressed state may find themselves.

- High levels of deprivation in some areas of the forces with many homeless people, high unemployment, poverty, probation hostels, and higher levels of mental disorder amongst the population more generally.

- Large airports in the area, where people had suffered from some form of psychotic breakdown necessitating the use of Section 136" (Docking et al, 2008: pg. 16).

"In one of the high rate forces there was also a particular issue relating to the fact that the force covered two separate counties. There were two custody suites near the border of the two counties, one on either side. The fact that Section 136 detainees were sometimes placed outside their resident county led to problems with primary care trust staff having to visit patients from outside their trust area. This does not affect the number of detentions but impacts on the assessment process (Docking et al, 2008: pg. 16).

"Neither of these forces had any alternative places of safety apart from police custody[29] and officers from both forces stated that the custody suites were already very busy and that Section 136 detentions exacerbated this. One officer felt that some of the blame for this could be placed on the local health service. The officer felt that they were quick to suggest custody rather than considering other alternative places of safety:

> [Health] will say, take them to [name of town] custody as it's a place of safety. It's a secure environment (custody sergeant 2, high-rate force 1)" (Docking et al, 2008: pg. 16).
>
> We do have alternative places of safety but always very difficult and time consuming to persuade our partners to get involved as they are the ones who can provide the service (custody policy lead, high rate force 1).

[29] This was the situation at the time of the fieldwork although we were informed that one of these forces has subsequently opened two new dedicated places of safety and will eventually have a total of five dedicated places of safety.

"The two low rate forces described problems with alcohol and drug abuse. Mental health problems were also described among the local population. Some people had frequent contact with officers on patrol. However, some respondents thought that the potential advantage of having a lot of these problems was that professionals become more familiar with how to deal with them. Interestingly (and in contrast to the views expressed by high rate forces) a health representative stated that they could not think of any examples where Section 136 had been used to detain people who should not have been detained. They also stated that Section 136 detainees were likely to be people who were not known to the service because in general they tried to be proactive and take preventative action" (Docking et al, 2008: pg. 16). This is an example of changing the wider 'field' in which the police operate and the effect that this practice can have on the use of Section 136. It demonstrates the importance of multi-agency working and the impact that differing occupational cultures can have on each other leading to positive changes in the treatment of the mentally vulnerable by changing the policing 'habitus'.

Identification of mental disorder by officers on the street

"One factor that may explain different rates of detention across forces is the different application of this power by operational officers. Previous research has suggested that officers can sometimes regard certain types of calls and people who are difficult to deal with as 'rubbish' or not 'real police work' (Reiner, 2000). They may therefore be reluctant to use their powers to detain someone under Section 136 in the first instance and perhaps try instead to move them on" (Docking et al, 2008: pg. 17).

"Officers have the discretion to detain an individual under the powers that seem to be most appropriate at the time and this will inevitably be linked to their individual knowledge, understanding and training" (Docking et al, 2008: pg. 17). Fielding (2005b) has stated that "the 'law' is supplanted by considerations of the worthiness of those involved, public feeling, seriousness, or the costs and benefits of various sanctions" (pg. 101). "It is therefore possible that similar situations may be dealt with in different ways, with some individuals being detained under Section 136 and others being arrested for minor offences" (Docking et al, 2008: pg. 17), depending on the resources and demands available and the policies of the individual police force. "Officers and health and social care representatives across the case study sites seemed to have a good understanding of how Section 136 detentions should occur. However, various respondents said that officers on the street sometimes have problems in identifying mental disorder correctly, and examples were given of ways in which forces were seeking to improve their practice" (Docking et al, 2008: pg. 17).

"In terms of identifying someone with a possible mental disorder, police respondents in high rate forces referred to the Act's description of an officer encountering someone on the street who they decide is 'in need of immediate care or control'. Alternatively, the force may receive a call from a member of the public, or a friend or family member of an individual believed to have a mental disorder and deploy officers. Those officers at the scene will then have to make a judgement as to whether the person appears to have a mental disorder. The most common examples of these cases were felt to involve individuals who were threatening self-harm or suicide, or perhaps acting in a strange manner that disturbed or frightened other members of the

public, such as making threats" (Docking et al, 2008: pg 17), as illustrated by the quote at the beginning of this chapter and repeated here:

> …it's the man walking round the railway line with no clothes on and acting daft that will get the actual dead obvious 136. You go to the town square and there's a man there talking to himself, trying to jump in front of traffic and things like that, there's no alcohol, they...are the ones where you think it's quite obvious to everyone this man needs help (custody sergeant, low rate force 1).

"Some issues make it difficult for officers to decide if a person is suffering from a mental disorder or has some other problems. These included the use of drugs and alcohol, and being diabetic and having hypoglycemia. In circumstances like this, officers may detain an individual for a variety of reasons that are not actually related to any mental disorder. Equally, some people may be detained for being 'drunk and disorderly' and subsequent assessment shows that they are suffering from a mental disorder" (Docking et al, 2008: pg 17). In chapter one I highlighted the evidence which suggests that officers received very little training in mental health awareness (Bradley, 2009; Lynch et al, 2002). The evidence from my research would support the position that officers sometimes struggled to identify mental disorder and would benefit from greater training in this area and that "appropriate support at a senior level is essential to the development of effective responses to people with mental ill health or learning disabilities, both with the police service and in partnership with other agencies" (NPIA, 2010; Para 8.2.1). This is also supported by some of the theoretical literature which suggests that leadership and the influence of senior officers can affect the issues which are prioritised by officers on the ground, and the need to change the 'field' at both a management and street level.

"Some forces had developed practices to try to ensure more accurate identification of mental disorder by officers on the street. In one low rate force, officers were expected to call the control room to check if there was any information on the potential Section 136 detainee or call doctors at the local hospital and ask if the individual's potential mental disorder seemed likely. To help them make a decision officers had also been issued with an aide memoire which listed factors that may lead to a Section 136 detention (Docking et al, 2008: pg. 17) (please see Appendix J).

"In a high rate force custody officers stated that they had a card pinned to the custody suite wall setting out the criteria for detaining someone under Section 136. The custody staff would then talk the arresting officer through this list when they phoned to inform them that they were bringing in a Section 136 detainee. The criteria included whether the person was considered to be a danger to themselves or to the public, whether they were able to look after themselves, and whether their behaviour led the officer to suspect a mental disorder. There was also a pilot scheme in one area of the force where police officers could contact the 'on-call' ASW and ask their advice about a particular individual's behaviour" (Docking et al, 2008: pg. 17).

"If it was decided that the person needed to be detained for their safety, this should be explained to them and they should then be taken to the agreed place of safety in the force. An officer from a low rate force stated that under their force policy the detaining officer should consider the possibility that the individual may be drunk or have taken drugs and they should conduct a risk assessment of the potential dangers to themselves and others. Another custody sergeant in a high rate force highlighted the importance of searching a person when handcuffing them and

searching them again when they arrive in custody[30] (Docking et al, 2008: pg. 18) to remove any items that could be used to self harm.

Inappropriate use of Section 136

"We asked respondents questions about the use of Section 136 and many provided examples of how it was sometimes used inappropriately. In particular, high and medium rate forces spoke about Section 136 being used 'unlawfully' and 'inappropriately' to detain individuals. Section 136 only allows for detention in a public place, however, examples were given in some of the high and medium rate police forces of officers carrying out 'unlawful' Section 136 detentions by detaining people in private premises. Other interviewees talked about individuals who had been 'enticed' out of a private premise and then detained under Section 136. It was stated that this was generally done because officers were either:

- concerned about the welfare of the individual;

- did not feel they had time to wait for a warrant to be obtained under Section 135 of the Act (in order to lawfully detain someone in a private premise); and

- did not feel they had any alternative options for detaining the individual (Docking et al, 2008: pg. 18).

[30] Officers can do both of these searches using their powers under the Police and Criminal Evidence Act (PACE) 1984.

In their study Rogers and Faulkner (1987) found that 17% of the Section 136 detainees in their sample had been detained from a private premise, this rose to 19% in a study by Rogers (1990). The Care Quality Commission (2010) have suggested that local multi-agency Section 136 groups[31] have an important role to play in monitoring detentions for "…such examples, both as a training issue for the police, but also to consider how mental health services could provide practical support to police in the field and so avoid such misuse of legal power" (pg. 33).

"Officers in case study forces with medium rates of detention also gave examples of the powers being used inappropriately to detain people who were described as 'drunk' and 'morose' rather than mentally disordered. It was also stated that the legality of Section 136 detentions which involved people being taken to hospital emergency departments as a place of safety were not checked and that it would be beneficial to improve the supervision of these cases. In one high rate force a health and social care representative estimated that 'only 17%' of Section 136 detentions in police cells led to the person being taken to hospital, and they therefore thought that some detentions were inappropriate" (Docking et al, 2008: pg. 18). The Mental Health Act Commission (2008) has suggested that a possible solution could be for officers to have a dedicated telephone number to contact approved social workers to trigger an assessment. Again this illustrates that the law alone is not enough to govern police practice on the ground. Instead a co-ordinated approach is needed involving multi-agency working and responses, with adequate resources and skills available in the wider 'field' and the effect of differing occupational cultures making positive changes to the 'habitus' of the police.

[31] The role of these groups will be explored in more detail in chapter six.

Use of Section 136 vs. breach of the peace

"We explored whether differences in rates of Section 136 use could be due, in part, to forces using different powers to detain people" (Docking et al, 2008: pg. 18). In particular we were interested in the common law offence of breach of the peace. The data from phase one of the research showed that the most common additional reason for detention for Section 136 detainees and, perhaps more importantly, for those who were arrested for offences but who had mental health needs were breach of the peace offences. Therefore we wanted to examine the extent to which officers were making arrests using the common law power of preventing a breach of the peace as an alternative way of dealing with these situations. "Could forces with lower rates of Section 136 detentions be encouraging officers to use such alternative powers of detention?" (Docking et al, 2008: pg. 18). Or were there other reasons for officers using their discretion to detain for a breach of the peace rather than Section 136? "We therefore asked respondents whether frontline officers received any training or instructions about dealing with people who had perhaps committed minor offences, but where it was clear that this was due to a mental disorder. The respondents reported a mixed picture. None believed that officers received specific instructions regarding breach of the peace, but they believed that there would still be situations where officers used this power. Examples of this included:

- situations where an individual needed to be detained in a private premise where Section 136 does not apply; and

- situations involving the arrest of an individual causing a disturbance on a psychiatric ward where this may be the only option" (Docking et al, 2008: pg. 18).

Respondents from these areas explained the situation:

> I wouldn't go as far as instructions, each officer giving training, perhaps we need to look at what further training…there are clear examples when we could use other powers e.g. a person who is highly intoxicated and wants to throw themselves off a bridge could be a drunk and disorderly rather than a 136. We tend to find that officers are quite comfortable using breach of the peace when it's not in a public place as they know the difference in the legislation, so if there is someone in a private house when someone's trying to harm themselves, perhaps breach of the peace maybe helpful, I don't think our officers are completely blinkered that it has to be 136 (custody policy lead, high rate force 1).

> It varies and you may see somebody on a 136 and you could see somebody with a similar presentation being brought in on a breach of the peace, so there are differences, I guess (health and social care staff, medium rate force 1).

"Respondents across the case study sites stated that officers were generally discouraged from using breach of the peace to detain individuals. However, respondents from forces with medium and low rates of detention reported more frequent occurrences of detainees being held in custody for breach of the peace who perhaps could have been detained under Section 136 than respondents in high rate forces" (Docking et al, 2008: pg. 18).

> Older officers use breach of the peace. The younger officers don't. I don't know if some are even aware of its existence. It's not taught in training school. Breach of the peace is the old fallback, the common law power. They are now encouraged not to use breach of the peace from the force as a directive…You've seen it evolve probably over the last 10 years. Before breach of the peace

> was such a common arrest… It's very rare we get breach of the peace now (custody sergeant 2, high rate force 1).
>
> …breach of the peace is kind of discouraged, I think, in the new police powers or there seems to be little need to use the breach of the peace. It was always fallen back on when you've just completely run out of ideas of if you didn't wish to issue a criminal line (strategic inspector, medium rate force 2).

"The potentially higher number of people being detained for breach of the peace in low rate forces compared to high rate forces could help to explain some of the variation in the rate of Section 136 detentions. However, this reason alone does not provide a strong enough explanation for the different rates. Instead, it is likely to be one of several potential reasons" (Docking et al, 2008: pg. 19 such as the occupational culture which is linked to the leadership of senior officers in the force and the importance that Section 136 cases were given as well as the culture at street level and the influence of this on the use of officers' discretion and this may vary across individual police forces. Fielding (2005b) states that the way in which Chief Constables conceive crimes can affect the application of the law and account for variations in the frequency of charges for different offences. "It is also important to note that when interpreting differences in the rates of Section 136 detentions, some differences could be the result of differences in the recording practices of forces and the poor quality of recording more generally" (Docking et al, 2008: pg 19) that was discussed above. The next section considers the use of other powers of arrest rather than detaining someone under Section 136.

Arresting individuals who have mental health issues for criminal offences

"We asked respondents about people who may have mental health problems being detained for offences other than breach of the peace. It seemed that in these situations officers in high rate forces still tended to use Section 136 to detain people, whereas officers in low rate forces would generally arrest for the offence. This is likely to be another contributory factor to the differing rates of Section 136 detentions. Officers from forces with varying rates of Section 136 detentions stated that the force view was to encourage officers to make an arrest for a substantive offence when one had taken place. One high rate force proved to be an exception to this. Here a respondent stated that if there was a situation where an officer could arrest someone for a minor offence or detain the individual under Section 136 they should do the latter" (Docking et al, 2008: pg. 19).

> There is a force policy about Section 136 and it doesn't talk about alternative powers of arrest. If you believe that it was a mental problem; there always has been the discretion thing (strategic inspector, medium rate force 2).

"While officers were generally encouraged to arrest individuals for possible offences, this practice appeared to vary across the different rate forces" (Docking et al, 2008: pg. 19). In chapter two I argued that the law and policy are not the only driving forces of police practice and that occupational culture has a strong role to play in how the police chose to exercise their powers and can vary across and within police forces depending on the cultural knowledge or 'habitus' and the 'field' in which the policing of Section 136 detainees takes place (Chan, 1997).

For example, variations in the availability of alternative places of safety and the presence of effective multi-agency working on occupational cultures may affect the use of Section 136.

"In high rate forces some interviewees said that officers on the street were reluctant to arrest people acting in mentally disordered or disturbed ways for offences and tended to use Section 136. This is because the process was simpler and less bureaucratic, compared to processing someone for a criminal offence. Whereas, in low rate forces the reverse was suggested with respondents believing that it was less bureaucratic and required less resources for officers to arrest an individual displaying signs of mental disorder for an offence rather than under Section 136. Some respondents said that it would be easier for the officers to take an individual into police custody and get the custody sergeant to arrange a mental health assessment rather than spending a long time waiting at the hospital, particularly at a hospital emergency department, for an assessment:

> I would say that frontline police officers may well shy away from arrests under 136 unless there is an expert or supervisor or someone with some knowledge, if that's the case, they normally go to hospital…if you put mental health in for a 136 for statistics on our custody records, I'd be surprised if you got very many. It's always another offence and then we deal with it [the mental health aspect] (custody sergeant 1, low rate force 1)" (Docking et al, 2008: pg. 19).

> I think sometimes, and this may be a bit unkind to some officers on the street, but I think sometimes they see arrest as an easier option rather than…Because it's a difficult position on the street as well. They're dealing with an incident there. This person, they irrationally kick off in front of them, cause a big disturbance or whatever, and it's totally out of character for what's happening on the street. So what are they going to do? This person's clearly disturbed in some way. Do I think it's a mental health issue or not? It then becomes a bigger problem for the officer, and I think that's why sometimes they use the easy powers, like breach of the peace or public order issues to bring these people into custody and have the assessment done whilst in custody (custody sergeant 2, low rate force 1).

"Some officers reinforced this view by stating that it was better to process someone who had a mental disorder and who had been arrested for an offence than to detain them under Section 136. This avoided the possibility of the detainee simply being intoxicated and a lot of time being wasted" (Docking et al, 2008: pg. 19). Kappeler et al (1998) suggest that a lack of supervision leads to greater use of discretion among officers on the street.

When visiting a custody suite in a low rate force in order to conduct some of the qualitative interviews for this research, we were able to observe the custody suite for a period of around 30 minutes. Before our arrival a man had been arrested and detained in the custody suite for suspected criminal damage after he had allegedly damaged his neighbour's fence. He had been in a cell for around 2 hours at that point and the custody staff had removed all of his clothes because they were concerned that he would try to self-harm. He had been assessed by the custody sergeant as having mental health problems and was awaiting assessment under the Act. When describing his arrest it was obvious that the man had been extremely agitated and distressed and that this had continued in his time in custody, he was in a cell which was monitored by CCTV and we were allowed to watch the feed. He was pacing up and down in his cell in a distressed manner, completely naked having refused a blanket he was given (it was on the floor). It seemed that neither the custody sergeant nor the arresting officers had considered that this man could have been detained under Section 136 instead because they accepted the need to arrest for an offence of criminal damage. It was suggested that due to delays getting an ASW and approved doctor the man may have had to wait several more hours in the cell before he would be assessed.

"The picture in medium rate forces was a mixture of that in the high and low rate forces with no clear consensus of views" (Docking et al, 2008: pg. 19).

Other research has also discussed the use of powers of arrest rather than detaining under Section 136. Kelly et al (1993) state that

> The tension between the need to provide assessment and care, to protect the individual and/or the public, coupled with the difficulties of hospital admission, result in net widening. Since such individuals are sometimes brought in due to breach of the peace or criminal damage, some [FPs] in provincial areas feel that in order to get an adequate psychiatric assessment, and to ensure that people who are ill receive treatment, it is necessary to advise the police to charge the individual concerned…Individuals are, therefore, being drawn in to the criminal justice system as a result of their mental disorder. Control is thus seen by some [FPs] as the only way of circumventing system problems in providing the necessary care for some mentally ill individuals. System problems include the lack of availability of approved social workers and the inter-professional relationship between some [FPs] and local psychiatrists regarding assessment and hospital admissions (pg. 167).

Rogers (1990) identified other pressures that meant that officers detained individuals under the criminal law rather than Section 136:

> Indications were that courts act punitively towards officers who bring mentally disordered people before them, which may result in an increase referral to the health service. Similarly, time consuming, cumbersome, procedures on the part of hospitals might well increase court disposals for mentally disordered people who have committed trivial offences, whether it is desirable to opt for a criminalisation vs. psychiatrisation policy in relation to public disorder involving mentally disordered people is a complicated issue with no easy solutions. However, what is clear is that local agencies need to acknowledge these aspects and their own influence in arrangements that are made about the implementation of Section 136 (pg. 235).

"It may be that, as with the differences in the use of breach of peace, officers in low rate forces may be more likely to arrest for other minor offences due to the perceived bureaucracy associated with Section 136 detentions. In high rate forces the reverse seemed to be true, as officers found it easier to process people for Section 136 than for minor offences. This differing practice could help to explain some of variations in the use of police custody as a place of safety. However, it is not possible to determine this from the data available" (Docking et al, 2008: pg. 19) as the best available official statistics on the custody population (the notifiable arrest data) do not include arrests for summary offences such as breach of the peace.

Availability of alternative places of safety

As set out in chapter one, the Code of Practice for the Act (2008) and other policies such as the ACPO (2006) policy on safer detention, state that "the use of police custody as a place of safety should ideally be limited to exceptional circumstances with most detainees being taken to hospital instead. However, this decision can be based on several different factors" (Docking et al, 2008: pg. 19) which were set out in chapter two, in addition to the legislation and national policy, the local force policy will play a role as will the 'habitus' of the officers, influenced in part by the leadership in the force and working relationships with other agencies, and the wider 'field' affecting the force such as the resources available in the area. This difference in where someone is held as a place of safety "is important as it may affect the length of time the person is held and the type of professionals that care for them" (Docking et al, 2008: pg. 19). In addition, it has

been argued that the use of police custody may exacerbate an individual's mental health needs given that they may be vulnerable and distressed, and unnecessarily criminalise their behaviour.

"A key factor in determining where a Section 136 detainee is taken is the availability of non-police custody places of safety, and it was this that perhaps varied the most between the different rate forces. Alternative places of safety to police custody were more readily available and more commonly used in the medium and low rate forces than in the high rate forces. We asked the 18 forces we conducted telephone interviews with whether their force had any alternative places of safety to police custody.[32] We found that:

- Of the six low rate forces all of them stated that they use hospital environments (emergency departments and psychiatric units) as places of safety unless the individual was perceived to be violent. Two forces also had diversion schemes in their areas.

- Of the six medium rate forces;

  - Two used hospital environments unless the detainee was violent *or* drunk.

  - One stated that they used hospital environments but that this could sometimes involve travelling long distances, so custody was also used.

  - Two stated that they used both hospital and custody environments depending on how busy they were and the resources it would involve.

[32] Some caution should be exercised in these findings as it was not always clear whether the places of safety were available in 2005/06 when the data was collected.

- One stated that at the time our data was collected they were using police custody (however, this force was using a hospital emergency department as an interim measure at the time the interview took place, while building a dedicated place of safety).

- Of the six high rate forces, five stated that custody was the only place of safety available at the time of the data collection, but three were in the process of developing alternatives at the time of the interview. One stated that they had some alternative places of safety, but only in some areas of the force" (Docking et al, 2008: pg. 20).

"It would therefore appear that the majority of 'high rate' forces took their detainees to police custody in all circumstances because there was no alternative. In medium and low rate forces detainees were generally taken to either hospital emergency departments or psychiatric facilities unless there were reasons for taking the individual to police custody. There is therefore a strong association between the rates of Section 136 detentions in police custody shown and the availability of alternative places of safety, which in turn seems to be linked to having good multi-agency relationships and agreements" (Docking et al, 2008: pg 20). This is an important point as it appears to demonstrate that the statistical data on Section 136 detentions which we collected are a real reflection of practice on the ground and not just due to other factors such as recording issues. In order to minimise the use of police custody a place of safety, it is therefore important to make changes to the 'field' by increasing the amount of alternative facilities to hold Section 136 detainees. This in turn is linked to the need to change the 'habitus' in order for Section 136 to be treated as a serious issue and as a high priority by the force and the health and social care

agencies at a senior level changing the management culture, which then needs to filter down to operational practice.

"Multi-agency relationships and agreements appear to be the strongest reason behind the differences in the use of police custody as a place of safety. This serves to highlight the importance of building multi-agency relationships in order to develop alternatives to police custody and minimise the use of police cells as a place of safety" (Docking et al, 2008: pg. 20). Multi-agency working is explored in more detail in chapter six.

Deciding the type of place of safety to be used

"Assuming that there was an alternative place of safety to police custody; respondents stated that a series of factors were considered when deciding where a person should be taken. These were:

- whether the Section 136 detainee was **violent**;
- whether the detainee was **intoxicated** through alcohol and/or drugs;
- whether the detainee had committed an **offence**;
- whether the detainee required **medical assistance**/ had physical injuries;
- if the detainee was attempting to **self-harm**;
- which facilities might be able to process and assess the person more **quickly**; and
- whether it might be easier to obtain a **hospital bed** for a detainee following the assessment.

Some of these factors are explained in more detail below" (Docking et al 2008: pg 20).

"It was generally accepted that if an individual was seen to be **violent** they would be taken to police custody rather than any alternative place of safety. Some respondents stated that this would also be the case where the individual simply had a *history* of violence. This was because it was felt that it was easier to restrain someone in police custody rather than in a hospital environment where other patients were around who would also need to be protected. It was also stated that it would be unfair to expect medical staff to be able to deal with violent individuals and they would feel uncomfortable having to assess someone who was handcuffed. In contrast, one health and social care representative stated that they were aware of violent individuals being taken to hospital rather than custody and it then not being possible to transfer them to police custody.[33]

The issue of **intoxication** was slightly more complicated with some forces stating that if someone had consumed alcohol and/or drugs they would be taken to police custody, and others stating that this would only be the case if the individual was severely intoxicated and could therefore not be assessed until they were sober. Some respondents felt that having severely intoxicated people in police custody could be dangerous from a health point of view and that they would therefore still prefer to see them taken to hospital" (Docking et al, 2008: pg. 20-21). This concern is supported by the wider evidence was has shown a strong link between deaths in or following police custody and the use of alcohol and/or drugs (Hannan et al, 2010). "The issue of intoxication was felt to be particularly difficult in one medium rate force where the preferred places of safety were the local psychiatric units. Respondents reported that the units would

[33] Section 44 of the Mental Health Act 2007 came into effect on 30 April 2008 and amended Sections 135 and 136 of the Mental Health Act 1983. Transfer between places of safety is now permissible.

generally refuse to take Section 136 detainees who were intoxicated from alcohol and/or drugs and were apparently very strict in their interpretation of what they classed as 'intoxicated'. Several respondents said that the hospitals 'breathalysed' detainees and refused to take them if they had consumed a single alcoholic drink" (Docking et al, 2008: pg. 21).

> …which is our local hospital for mental health patients, would automatically say, oh, they've had a drink; no, we won't take them. They'll breathalyse them, and they won't take them. So, the officers do try that, first off, and it's my belief, if they'd gone to the hospital, that is a place of safety, the hospital have no right in turning them away. And they shouldn't turn them away, you know. A police station is not a place for anybody with mental health issues, and it aggravates it. …I find, frequently, that if the hospital doesn't have a bed, then, all of a sudden, that person doesn't have mental health problems (custody sergeant 2, medium rate force 1).

"Officers reportedly found this frustrating and would often resort to taking a Section 136 detainee straight to custody rather than even trying the hospital.

If the detainee was attempting to **self-harm**, they were generally taken to police custody. The feeling was that it was easier to restrain people and prevent any self-harm in this environment, particularly where the alternative place of safety was a hospital emergency department where the physical environment made this particularly difficult" (Docking et al, 2008: pg. 21). However, as highlighted in chapter two there have also been some controversial deaths in or following police custody involving people with mental health needs who have been restrained by the police, so even in a police station there are significant risks around the restraint of individuals by the police.

"As mentioned above some respondents reported that it was time consuming for officers to wait with Section 136 detainees at hospital (particularly at hospital emergency departments). It was therefore sometimes tempting for officers to take the person to police custody instead. Some argued that the detainee might actually be assessed more **quickly** once in a custody suite as they were seen as a greater priority. For the same reason it could sometimes prove quicker to obtain a **hospital bed** for someone needing admission to a psychiatric unit if they were in police custody rather than a hospital environment" (Docking et al, 2008: pg. 21). This was linked to a wider perception shared by many respondents across forces with different rates of Section 136 detentions, that there was a lack of hospital beds for mental health patients, which led to delays and problems in finding care for Section 136 detainees, as illustrated by the following quotation:

> Of course, the other delay from us is that if someone needs a bed, and sometimes it's a security and we have problems with our resources, there may be a long delay waiting for a suitable bed (health and social care worker, high rate force 2).

Conclusion

This chapter has discussed the prevalence of Section 136 detentions in police custody, as well as the makeup of those detained and variations in its use. It has found that police custody was used twice as much as hospitals to detain people under Section 136 in 2005/06. Black people were twice as likely to be detained as White people and this disproportionality was worse in more rural forces. There were large variations in the use of Section 136 in police custody across police force areas. This variation in the use of the power seemed to be linked to differences in police cultural knowledge or 'habitus' (discussed in the theoretical literature examined in chapter two),

with some forces having different policies and working relationships with health and social care organisations than others and this influenced the culture and changed operational practice. Leadership is also important to these differences with the attitudes and priorities of senior officers and health and social care staff leading to differences in practices and culture on the ground. This will be demonstrated further in the coming chapters but in brief where senior leaders in both the police and health and social care organisations prioritised and drove through the agenda of Section 136 detentions there was evidence to suggest that this lead to alternative places of safety being provided and for more collaborative working between differing agencies to improve the experience of those detained under the power.

In addition there were wide variations in the availability of alternative places of safety. In some areas hospitals were able to take the majority of detainees including those who were drunk but not perceived to be violent, in others they were able to take detainees unless they were drunk or violent but in the remaining areas the only available 'places of safety' were custody suites. The wide variation in recorded detainees shown by the national statistics therefore seems to be largely 'real' difference due to the availability of places of safety and working arrangements on the ground. This means that there is a need to change the 'field' in which the policing of Section 136 exists with greater healthcare resources being dedicated to people needing to be detained, and this is linked back to changing the 'habitus' through strong leadership both within the police and in health and social care organisations and the need for closer partnership working. Pressure from senior leaders can lead to improvements in the resources that are made available or how they are used by ensuring that they are a priority. However, recording practices and police discretion also appear to help explain the statistical picture because in some areas other means

were used to manage and control this difficult population. This involved using other offences such as ‘breach of the peace’ to detain individuals rather than Section 136. The need to change both the ‘field’ and ‘habitus’ continue to be explored in the next two chapters. Chapter 5 examines the care of detainees once they have been taken to a police station as a place of safety.

5. Care of detainees, release following detention and deaths in custody

> The needs of distressed and disoriented users detained under Section 136 are for a safe environment where the crisis can be de-escalated, restrictions minimised over the period that an assessment may take and where all basic human needs can be addressed (Royal College of Psychiatrists, 2008: pg. 22).

Introduction

It is widely agreed that police custody is not a suitable 'place of safety' (Home Office, 1990; Department of Health and Home Office, 1992; ACPO, 2006). "However, the data we collected in phase one of this study shows that it is used for a significant number of people. If it is inevitable that police custody *will* be used as a place of safety then the next objective is to minimise the length of time a person spends there and to ensure that appropriate care and attention is received at the earliest possible stage" (Docking et al, 2008: pg. 23).

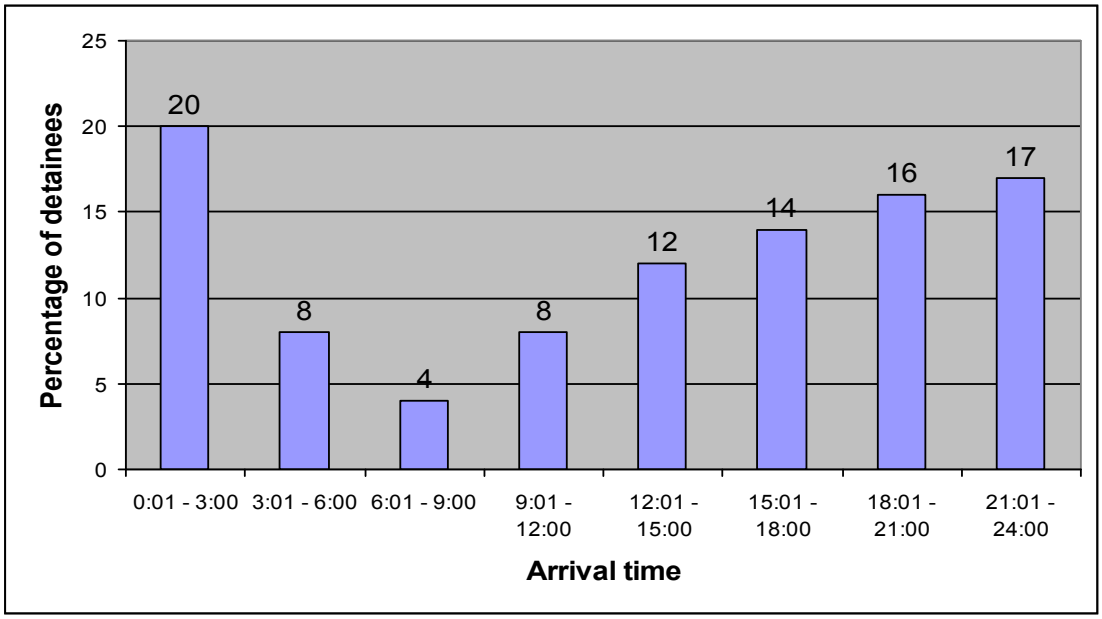
This chapter considers the evidence from our research on what happens to Section 136 detainees once they are 'arrested' by the police, the care they receive in custody including how they are processed and risk assessed. It examines the length of time they spend in custody, their assessment under the Act and any problems and delay associated with this as well as what happens to them following assessment. It also examines these issues for individuals who were arrested for other offences but who were found to have mental health needs (where this

information was available). It discusses the training and knowledge of custody officers and staff. Finally, it looks at cases where a Section 136 detainee has died in or following police custody in order to demonstrate why the care of these individuals is so important. It examines the reasons and causes of their death to see whether there are lessons that can be learnt to prevent further deaths.

Arrival in custody

"Figure [5.1] below shows the most common times for Section 136 detainees to arrive in police custody – between midnight and 3am (20% of detainees), followed by 9pm to midnight (17%) and 6pm to 9pm (16%). This means that 53% of people detained under Section 136 were brought into police custody as a place of safety between 6pm and 3am. This may indicate a lack of alternative places of safety that are able to accept people outside normal office hours. There were no clear trends in terms of the days of the week or the time of year that people were brought into custody under this power" (Docking et al, 2008: pg. 23). Borschmann et al (2010) state that "several studies have also published findings stating that a majority of incidents involving Section 136 typically occur outside of standard business hours, with as many as 77% of cases taking place between 18:00 and 09:00 h the following morning" (pg. 37).

Figure 5.1: Arrival time into police custody for Section 136 detainees



NB: The arrival time of 1,032 people was unknown. These cases have been excluded from this analysis.

Risk assessment and checks on detainees

"All individuals held in custody should be risk assessed to ensure their safety. This includes individuals who are detained under Section 136 – once they are taken to custody, officers should adhere to the PACE 1984" (Docking et al, 2008: pg. 23). As set out in chapter one, PACE Code of Practice C Para 3.6 states that "when determining these needs the custody officer is responsible for initiating an assessment to consider whether the detainee is likely to present specific risks to custody staff or themselves". "The ACPO Safer Detention Guidelines (2006) provide a checklist for the assessment of detainees (pg. 67). The Guidelines set out four levels of observation that can be applied to a detainee depending on the level risk" (Docking et al, 2008: pg 23). In addition to the ACPO Safer Detention Guidelines (2006), Home Office Circular (32/2000) "Detainee Risk Assessment and Revised Prisoner Escort (PER) Form", provides

forces with a risk assessment form. Annex H of PACE Code of Practice C sets out a detained person observation list for officers to use.

"Officers across all case study forces stated that they used a standard risk assessment form, which they completed for everyone entering custody" (Docking et al, 2008: pg 23). An officer explained the process of using the form:

> When they come in the sergeant will do an individual risk assessment on them. And when they book the individual in our local crime information system will throw up if there are markers on them; so it might be they're violent, it might be they've got mental health issues, or last time they came in the doctor said they had behavioural issues or whatever (custody police lead, 'estimated rate' force 1).

"This form was felt to be a comprehensive and useful tool. The risk assessment asked questions about a range of issues including:

- The individual's general medical health such as any allergies they may have or medication they are taking.

- The details of their doctor and next of kin.

- Whether they had ever self-harmed or tried to commit suicide or if they felt that they were likely to harm themselves.

- Questions to try and assess their past and present mental health.

- Any learning difficulties they may have.

- Their use of drugs and alcohol.

- Any possible physical injuries or illnesses (some officers mentioned the possibility of marking any injuries on a 'body map' diagram, which could be kept with the individual's details)" (Docking et al, 2008: pg. 23).

In relation to assessments of whether the individual is likely to try and self-harm, custody officers are permitted to remove items of clothing from the detainee if they could be used to injure the detainee. "The ACPO Safer Detention Guidelines (2006) state:

> The decision to remove [items of clothing] should be made after conducting a risk assessment and the custody officer must balance any risk with the need to treat detainees with dignity. If a detainee is believed to be at risk of suicide or self-harm, the seizure and exchange of clothing may not remove the risk but may increase the distress caused to the detainee and, therefore, increase the risk of the detainee self-harming. Leaving a detainee in their own clothing may help to normalise their situation (7.8.1, pg. 86).

However, officers thought it was quite common to remove items of clothing or jewellery to prevent the individual from harming themselves. It was recognised that this was potentially humiliating and de-humanising for the individual and could worsen their mental state particularly as many of the individuals were already in a distressed state, but respondents said that officers tried to ensure that the custody environment was as risk averse as possible" (Docking et al, 2008:

pg. 24). It is important to note the potential limitations of this data, as stated in chapter three, whilst every effort was made to try and ensure that respondents were open and frank in their observations, there is a risk that due to our roles as IPCC researchers some respondents may have tried to paint a picture of practice in their force in the best possible light. For other officers it may simply have been easier to choose the 'safe' option of removing individuals' clothes. In a study examining 'near misses' or near deaths in custody, Bucke et al (2008) found that

> While PACE allows Custody Officers to withhold clothing and personal effects if they think they will be used to cause harm, some of the [FPs] in our study felt that identifying risk among detainees was difficult. This led them to suggest that the removal of shoe laces and belts from all detainees would greatly reduce opportunities to self-harm. Officers responsible for custody policy in the MPS thought that this would be difficult to defend legally in terms of the rights of detainees (pg. 37).

This demonstrates the difficult balance custody officers and staff face in trying to minimise the risk of harm to detainees whilst ensuring that the individual is treated humanely and with compassion. Where officers make the wrong decision or fail to adequately risk assess a detainee, tragedies sometimes occur. Hannan et al (2010) found that of 247 detainees taken and "…booked into custody, just under half (121; 49%) were risk assessed" (pg. 35). Both Hannan et al (2010) and Bucke et al (2008) found that a common reason for failing to risk assess detainees was due to their level of intoxication.

> In the vast majority of these cases alcohol intoxication was the main reason why an assessment could not be conducted, with a smaller proportion of cases relating to mental health needs. [FPs] felt that intoxicated detainees were overlooked too readily and that the danger in such cases was to place the detainee in a cell and conduct a risk assessment when they were in a fitter state (Bucke et al, 2008: pg. 37).

In their study of near deaths in custody Bucke et al (2008) found that:

> Nearly half of the near misses in this study involved self-harm or a suicide attempt. The incidents involved a wide range of items, but in some instances these included food containers and implements left in cells by previous occupants. This raises the importance of checking and clearing cells between occupancies, as well as being clear what detainees should be allowed to take into cells (pg. 37).

Bucke et al (2008) also found that:

> Forensic Medical Examiners [FPs] identified attempted suicide/self-harm as the main cause of 56 incidents. Thirty-four incidents involved self-strangulation using a piece of clothing, shoe laces, belts or cords from tracksuit bottoms, blankets or paper suits issued in custody (pg. iv).

The evidence demonstrates the importance of conducting an appropriate risk assessment of detainees', especially for vulnerable detainees such as individuals being held under Section 136. It requires a careful balancing of human rights and requires custody staff to be suitably trained in order to make this assessment effectively. The training and knowledge of custody staff will be explored later in this chapter. The importance placed on training of officers needs to be linked to changes in the wider occupational culture, with changes at both a strategic and operational level to ensure that legislation and guidance in this area is adhered to. There may be other additional pressures such as resource issues which can also lead to inadequate risk assessments:

> Even more of a strain for your PFI [Private Finance Initiative] contractor if your custody sergeant says that this person is on constant supervision or half hour visits then the contractor in our case has to comply with that risk assessment…problem then reduces ability to deliver demands across

> the custody department…comes at a price if you treat one person specially, in less of a position to treat/ operate normally with other people…when all cells are full and you also have a mentally ill person that's when it becomes a strain on resources… it impacts on operational policing (custody policy lead, low rate force 1).

In addition to the importance of the initial risk assessment is the care of detainees and a core part of this is the level of checks and observation they receive while waiting in custody to be assessed under the Act. The ACPO Guidelines on Safer Detention (2006) sets out different levels of observation for detainees depending on the level of risk identified for the individual (pg. 83). This recommends that where an individual had been identified as having a propensity to self-harm officers would need to check on them more frequently and where appropriate place the individual under constant supervision. Officers in our interviews stated that "Section 136 detainees would generally receive checks more regularly than some other detainees. Depending on their potential risk level these checks would be every 15, 30 or 60 minutes. Alternatively, they might be subject to 'constant supervision', which involves someone sitting with the person either in the cell or outside the cell with the door open" (Docking et al, 2008: pg. 24).

Again as with the respondents' observations on risk assessment above, it may be that some interviewees were keen to provide the impression that they followed the appropriate guidance. However, there is evidence to suggest that officers do not always follow PACE and ACPO Guidance (2006) when caring for detainees (Hannan et al, 2010), and this will be explored later in this chapter when examining deaths in custody involving Section 136 detainees.

Length of time in police detention

"The PACE Code of Practice C states that:

> It is imperative a mentally disordered or otherwise mentally vulnerable person detained under the Mental Health Act 1983, Section 136, be assessed as soon as possible. If that assessment is to take place at the police station, an approved social worker and a registered medical practitioner shall be called to the station as soon as possible in order to interview and examine the detainee. Once the detainee has been interviewed, examined and suitable arrangements made for their treatment or care, they can no longer be detained under Section 136 if a registered medical practitioner, having examined them, concludes they are not mentally disordered within the meaning of the Act (Para 3.16).

Under Section 136 of the Act detainees are allowed to be detained for a period of up 72 hours for the purpose of conducting a mental health assessment. Some respondents in our study felt that this was a very long time to hold someone and stated that it might mean that these cases had not been prioritised effectively. They hoped that most people would be dealt with substantially quicker than this" (Docking et al, 2008: pg. 24). There have been attempts to reduce the period of detention, with the British Medical Association suggesting that four hours should be sufficient and MIND suggesting a period of 24 hours (Rogers and Faulkner, 1987).

"We were able to calculate the length of time spent in custody by Section 136 detainees for 34 of the 43 police forces. Table [5.1] below shows that by far the majority of detainees were dealt with within 72 hours. The majority of people (70%) spent 12 hours or less in police custody, with just over half of these people being detained for six hours or less. However, while the legal limit for detention is 72 hours our sample shows that ten individuals were detained for longer

than this. These cases were spread across six police forces with medium and high rates of Section 136 detentions. Evidence from our interviews suggest that people can be detained for longer than the legal limit due to delays in beginning an assessment (perhaps due to the individual being intoxicated as highlighted earlier, but also due to a shortage of ASWs and FPs – see below), and problems in finding a hospital bed as mentioned" (Docking et al, 2008: pg. 24) in chapter four.

"The average length of time spent in custody for Section 136 detainees was nine hours and 36 minutes. Police forces[34] with the highest average length of time were:

- Sussex (13 hours 55 minutes);
- Nottinghamshire (10 hours 51 minutes); and
- Staffordshire (10 hours 25 minutes).

Police forces[35] with the lowest average length of time in custody were:

- North Yorkshire (5 hours 55 minutes);

[34] Forces with less than 50 cases where this information was available were not included in this analysis as the results could be misleading.

[35] Forces with less than 50 cases where this information was available were not included in this analysis as the results could be misleading.

- Cleveland (6 hours 41 minutes); and

- Cambridgeshire (6 hours 42 minutes)" (Docking et al, 2008: pg. 24-25).

Table 5.1: Length of time detained in custody[36]

	N	Percentage
Hours up to 6	3,601	39
6:01 - 12:00	2,876	31
12:01 - 18:00	1,700	18
18:01 - 24:00	686	7
24:01 - 30:00	158	2
30:01 - 36:00	75	1
36:01 - 42:00	47	1
42:01 - 48:00	20	0
48:01 - 54:00	13	0
54:01 - 60:00	8	0
60:01 - 66:00	4	0
66:01 - 72:00	4	0
72:01 - 78:00	2	0
78:01 - 84:00	3	0
84:01 - 90:00	3	0
90:01 - 99:00	2	0
Total	9,202	100

NB: the length of time spent in custody was not known for 1,534 cases. These have been removed from the sample.

For individuals who were arrested for offences but found to have mental health needs, the average length of time held in custody for those where the information was available was 13 hours; around three and half hours longer than for individuals detained under Section 136. This may be due to delays in recognising their mental health needs and therefore having to wait for longer for a FP to come and assess them.

[36] There were 46 cases where the individual was detained for longer than 99 hours. However, we confirmed with the relevant police forces that this was due to they way in which the release time was recorded on their system and did not reflect the length of time in custody. These cases were therefore excluded from the analysis.

Explaining length of detention times

"Once an individual arrives at a place of safety under Section 136 of the Act a formal assessment of their suspected mental disorder needs to be conducted to decide what treatment, if any, they require. This should be carried out by a doctor approved under Section 12 (2) of the Act[37] and an ASW[38]. Once a detainee is in custody a doctor known as a FP[39] will be called to conduct an initial assessment to determine whether a full mental health assessment is required or whether the person's behaviour can be explained by any physical injuries, illness or intoxication. Forces who had custody nurses tended to ask them to examine the detainee and establish whether they were fit to be detained in custody and if they were fit to be seen for an assessment – for example, whether they were too intoxicated to be assessed. If it was decided that the detainee did not need a full assessment as there was no mental disorder, the normal practice would be to release the individual following a consultation with an ASW over the telephone[40]. If following the initial

[37] Section 12 (2) of the Mental Health Act 1983 states: "Of the medical recommendations given for the purposes of any such application, one shall be given by a practitioner approved for the purposes of this section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder; and unless that practitioner has previous acquaintance with the patient, the other such recommendation shall, if practicable, be given by a registered medical practitioner who has such previous acquaintance".

[38] The Mental Health Act 2007 changes the formal wording to approved mental health professionals (AMHP), but as this research was conducted under when the 1983 Act was still in place we refer to the previous terminology of ASW.

[39] A number of FPs are also approved under Section 12 of the Mental Health Act 1983, which can expedite matters somewhat. However, in my study there seemed to be a lack of Section 12 approved FPs in several areas.

[40] The ACPO Safer Detention Guidelines (2006) state that "ordinarily, neither a hospital nor the police should discharge a person detained under Section 135 (3) or 136 (2) before the end of the 72-hour period without the required assessments being completed by a doctor and an ASW. The exception is where, having examined the

assessment it is decided that an individual needs to have a mental health assessment, an ASW and a Section 12 approved doctor (a doctor qualified to assess someone's mental health) will be called to examine the individual. They will decide whether the person needs to be admitted to hospital, with the agreement of a second doctor who may be the FP (which is why FPs should ideally be Section 12 approved). Respondents from our case study forces commented on their frustrations at the length of time it often took to complete a Section 136 assessment. This was the case both within the custody environment and at alternative places of safety, when they were available. Delays in the assessment process were generally blamed on:

- a shortage of doctors approved under Section 12 of the Act;

- the availability of FPs and ASWs; particularly outside of normal office hours when the number of people on-call is limited; and

- the need for intoxicated detainees to become sober before they can be assessed" (Docking et al, 2008: pg. 25-26).

Kelly et al (1993) reported that only 9.5% of FPs are approved under Section 12 of the Act as having special experience in the diagnosis and treatment of mental disorder. They also highlight the problems with trying to assess a Section 136 detainee in a custody environment:

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individual, the doctor concludes that he or she is not mentally disordered within the terms of the Act; the detainee can no longer be detained under this section and must be immediately discharged from detention" (3.4.2 pg. 45).

> In many provincial areas the police station is used as a place of safety under Section 136 of Mental Health Act 1983. [FPs] face a number of problems in assessing such individuals, not least of which is the unsuitability of police accommodation for such assessments and the cooperation of psychiatrists and approved social workers. [The authors quote practitioners as saying:] '…need to make an assessment with an approved social worker – very difficult to get at nights or weekends as there's only two on duty for the whole of the county. The police station on Saturday nights is a hopeless place to do a mental health assessment'.'…the police station is not suitable but there are no alternatives for many. The local hospital refuses to accept them' (pg. 167).

As stated earlier in this thesis there was also a perceived shortage of secure beds. "The majority of case study forces also mentioned delays in finding available beds for individuals who needed to be taken to a psychiatric facility following their assessment" (Docking et al, 2008: pg. 26). Peay (2008) highlights how the "…shift to community care, combined with the lack of reality of that care and support, brings more mentally disordered people into contact with the criminal justice system" (pg. 757). When examining the transfer of prisoners to hospital for mental health treatment Bradley (2009) also describes a shortage of beds:

> Historically, transferring prisoners to hospital for treatment of an acute mental illness has been problematic, and prisoners have had to endure lengthy waits. For example, in 2006 London in-reach teams reported difficulties in locating NHS secure beds for prisoners with marked mental health problems, and also in finding acute psychiatric beds where these were deemed appropriate. Participants said that there were not enough appropriate secure beds available…The lack of availability of specialist beds and the absence of timely provider assessments accounted for two-thirds of the delays [in transferring prisoners] (pg. 105).

Aside from the issues around the availability of hospital beds, "it seemed that low rate forces (forces with low rates of Section 136 detainees per 10,000 people held in custody) compared to other forces had attempted to overcome issues in assessing Section 136 detainees and reported

fewer problems with the availability and response of FPs, Section 12 approved doctors and ASWs. In low rate forces the availability of Section 12 approved doctors was felt to be less of an issue for a variety of reasons, including:

- the fact that the different organisations had discussed and changed their protocols to improve working practice;

- the setting of target times (the shortest of any of the forces) for attendance at the place of safety[41];

- ASWs arranging for them to attend, developing better working relationships with them thus improving the response; and

- the fact that there was less of an issue in terms of provision, perhaps because more of the force FPs were Section 12 approved" (Docking et al, 2008: pg. 26).

These factors highlight the importance of effective multi-agency working which will be explored in the next chapter. "When comparing data for the six case study sites the average length of time that detainees spent in custody under Section 136 was shorter in the low rate forces than in the medium and high rate forces. This would seem to indicate that their problem solving may have successfully reduced the delays experienced in the assessment process. However, the low and medium rate forces that used hospital emergency departments in particular, and psychiatric

[41] While it was acknowledged that the targets were not always met they seemed to have contributed to the timeliness of the relevant practitioners and were generally met during normal office hours.

wards to a lesser extent, as a place of safety often reported long delays in the time taken for individuals to be assessed, particularly at busy times. This could mean police officers spending a significant amount of time at a hospital. Because of this, one low rate force had in place a protocol that allowed the police to leave before the mental health assessment was completed if all concerned agreed that the person was not likely to abscond and was not a risk to themselves or others. Higher rate forces in large rural areas stated that some doctors were reluctant to do assessments at night due to the long travelling distances involved. It was also said that some Section 12 approved doctors did not see Section 136 assessments as part of the contractual duties to their primary care trust. Finally, it was sometimes difficult for a doctor to arrive in a timely manner if they were running their own surgery or clinic at the same time" (Docking et al, 2008: pg. 26).

Many FPs were General Practitioners and as such had their own surgeries to run. Kelly et al (1993) also found that FPs had difficulties in balancing these two roles which sometimes impacted on their ability to conduct FP work (pg. 170). There is also evidence to suggest that a large proportion of FPs are not appropriately trained to conduct their role (Wall, 2008) and may not have any specialist mental health training. Bradley (2009) found that:

> There was a widely held belief that [FPs] needed more specialist training in mental health issues in order to cope with the high prevalence of mental health and learning disability problems in custody…In addition to these concerns, police custody is now the only major stage in the criminal justice system where primary NHS-commissioned care is not available, which means a break in the continuity of an individual's care and can cause difficulty in accessing information from NHS sources. Further, the quality of care in custody is therefore not subject to the same governance and performance measures as NHS services. All these issues have led to the suggestion that

> responsibility for health services in police custody suites should be transferred from the police to the NHS (pg. 48).

Again this links back to the importance of what Chan (1997) terms as the wider 'field' in which the police operate and the need to make positive changes in this broader sphere in order to ensure that Section 136 detainees receive the care they deserve. In this case by ensuring that there are enough adequately trained professionals to assess detainees, changes to the structural dimension of the 'field'. The police have some power to influence this as many FPs were, and continue to be, employed via PFI contracts with the police and the police can therefore request doctors with particular skills within their contractual arrangements. Therefore if the PFI provider fails to provide appropriate training to the doctors they employ (in this instance mental health training and ensuring they were Section 12 approved) the force could look to a different provider. If the NHS took on this role (of commissioning and providing healthcare directly) then pressure would need to be exerted at senior levels to highlight the importance of appropriate training for staff in these roles.

"The availability of ASWs was generally only felt to be an issue across the forces outside normal office hours. This seemed to be less of a problem in other medium and low rate forces where different initiatives meant that staff from health and social care were available to co-ordinate and arrange the assessments rather than the custody officers, and make those more timely. In one force this involved a psychiatric nurse being based in a force custody suite and in another a criminal justice liaison team of community psychiatric nurses (CPNs), based in the local courts, provided an outreach service to police custody. The criminal justice liaison team, of the type described in chapter one, also improved the timeliness of the assessment by beginning to arrange

the process prior to the arrival of a FP if they knew the individual being assessed" (Docking et al, 2008: pg. 26). The Royal College of Psychiatrists (2008) recommend that:

> The local implementation group must ensure that there are adequate approved mental health professionals and doctors approved under Section 12 of the Mental Health Act to enable joint assessments to begin within 3 hours currently, with an expectation that, in the longer term, the target will become 2 hours (pg. 8).

Impact on police custody of Section 136 detentions

"Where police custody was used a place of safety, this was felt to place quite a strain on resources. Section 136 detainees tended to need greater supervision than other detainees, which was particularly problematic for custody staff at busier times of the day and week. In forces where the custody officer had to take responsibility for organising the assessment, this could also be a lengthy procedure. Where it was decided that a Section 136 detainee required 'constant supervision', many forces took an officer from other duties and brought them into police custody to sit with the detainee. This obviously affected the resources available for a particular division conducting patrols and response" (Docking et al, 2008: pg. 27). Similar problems were also raised in some areas where accident and emergency departments were used as a place of safety, one interviewee stated that:

> I got involved in mental health, I guess because of a frustration amongst staff about the length of time it was taking to deal with mental health issues. The facilities in force that exist, don't serve us very well because the distances that are travelling…what I found was there's no specific statistics to say how long it takes to get through the system…but certainly from the experiences of officers sending it to me, frustrations are just the length of time it takes, first of all just to get into

> the hospital, get through the first stage of medical assessment, and then the next problem being, there has to ASWs and the FMEs, trying to get them there in a timely manner. The issues…for us really, with resilience being not quite what it used to be on the streets, having two officers away is quite a significant chunk out of my staff. Secondly, they're with a vehicle… (Operational inspector, medium rate force 2).

"In one high rate force they relied on their custody staff to provide this supervision, which had led to closure of the custody suite and further detainees being refused:

> It's a huge drain on our detention officer time, continually monitoring them. That's got to the point of closing before. When we got to five we closed, and I think we had nine prisoners in at the time and we've got 25 cells, but they are so demanding and require so much care and attention, we shut, which means that people who are travelling from [X] to [Y] with other prisoners and detainees…which is an hour from here… (custody inspector, high rate force 1)" (Docking et al, 2008: pg. 27).

Training and knowledge of custody staff

"It would be unrealistic to expect police custody officers and staff to be experts in mental health. But given that police custody is still often used as a place of safety appropriate training is required. We asked the respondents about training and knowledge of custody staff in their force. Views on the quality and scope of the training varied across forces with no clear consensus among the different rate forces. The general view was that custody officers were better trained in relation to Section 136 and mental health issues than frontline officers. This training was generally provided as part of the overall custody officer course. However, some custody officers were concerned that they might overlook some mental disorders or may not be able to deal with them as well as they would like:

> …we as custody sergeants don't have…the training and insight [into] mental health problems… [compared to] doctors and nurses, so [what] we're looking for [when risk assessing individuals is] perhaps very different to what maybe we should be looking for (custody sergeant 2, low rate force 1).

There was an awareness that, despite any training officers may receive; they were not a substitute for medical practitioners. Respondents thought that training could be improved and officers could benefit from more regular refresher training (or indeed *any* refresher training in some forces). However, this was sometimes difficult due to the large number of officers involved, the competing training needs, limited time available and cost implications" (Docking et al, 2008: pg. 27). Bradley (2009) and Lynch et al (2002) highlight the need for police officers to have appropriate training in mental health and in 2010 the NPIA published guidance for police officers for responding to people with mental health needs, but it is not known what the take up of this guidance and training has been. The future of NPIA is uncertain and funding cuts have meant that training is frequently being delivered as an online package.

"The majority of case study forces received some input into the training from external agencies and other individuals with more knowledge in healthcare. Some forces went further than having an input into the custody course from external agencies and had joint training with other agencies. Joint training was thought to allow the different agencies the chance to develop a better understanding of the different roles and the barriers they each faced. Some felt it had the potential to improve multi-agency co-operation. Joint training may help the differing occupational cultures of the various organisations to shape and influence each other for the better. Other suggestions for improving training courses included:

- Improving the ability of custody officers and staff to recognise possible signs and indicators of the potential for suicide and self-harm.

- Increasing levels of understanding of the service user's perspective (two high rate forces were seeking to involve service users in future training).

- Training on new policies and practices once they were established – for example, when a new place of safety opened.

- Simplifying the terminology used on courses so that it was less about medical information and more about practical information on how people should be treated and how to avoid having an adverse impact on their mental state" (Docking et al, 2008: pg. 27).

As mentioned above, NPIA have issued Guidance for the police on mental health since this fieldwork was conducted but given the current state of NPIA and its uncertain future, it is not possible for them to deliver the training, the Guidance and training available nationally is therefore an e-learning package. Individual forces would have to make the decision to provide training with other agencies; this may be less likely in a climate of mass funding cuts.

What happens to detainees following a mental health assessment?

"Following a mental health assessment of a Section 136 detainee the person can be detained under the Act and taken to hospital. Alternatively, they can be released back into the community, with the possibility of further treatments or follow-up action. If the person had also committed an offence, depending on the outcome of the assessment and the likelihood of prosecution the force may decide to charge, caution or release them. We asked all forces in England and Wales for data on what happened to those held in custody under Section 136 upon their release. However, there were major problems with the data we received due to recording problems in police forces. As many of these individuals will not have been charged with an offence, police forces often recorded the 'disposal method' as NFA even though they may in fact have been taken into hospital care under the Act. Some police forces also used an 'other' option to include all those people who were sectioned under the Act but combined this with other methods of disposals such as NFA, which made it impossible to differentiate between the different outcomes" (Docking et al 2008, pg. 28). As the data is of poor quality it should be treated with caution and all the findings as indicative.

This data is therefore problematic and the number of people who were dealt with by NFA is likely to be an overestimate and those taken to hospital/care/Mental Health Act (MHA) is likely to be an underestimate. Table 5.2 below shows that the most common method of disposal from police custody was NFA (47% of detainees), followed by hospital/care/MHA (19% of detainees), and 'other' (16% of detainees).

Table 5.2: Method of disposal from custody

	N	Percentage
NFA	5082	47
Hospital/Care/MHA	2077	19
Other	1744	16
Unknown/Not stated	1183	11
Custody	281	3
Summonsed	124	1
Bailed	92	1
Charged	74	1
Cautioned	52	0
Penalty notice	19	0
Total	**10728**	**100**

The 'Other' reason for disposal for one force included all those who were disposed of under Act or taken to another place of care. However, it also included 'other' methods of disposal such as NFA and it was not possible to differentiate between these cases and those involving the Act, they have therefore been coded as 'other'

Table 5.3 shows that for White people (49%) and Chinese/'other' people (51%) the most common method of disposal was NFA. In comparison the most common method of disposal for Black people (39%), Asian people (31%) and Mixed race people (35%) was to be taken in hospital/care/MHA. This shows that Black people were more than twice as likely to be taken to hospital/care/MHA than White people. For detainees arrested for criminal offences but found to have mental health needs, Table 5.4 shows that 85% of Black detainees were released to hospital/care or under the Act compared to 44% of White detainees. Twenty-three per cent of White people were also NFA'ed compared to only 6% of Black people. This means that Black people were almost twice as likely as White people to be taken into hospital/care/MHA when arrested for criminal offences and White people were almost 4 times as likely to be NFA'ed than Black people. It is difficult to conclude the reasons for this disproportionality from the evidence available in this thesis. However, the evidence regarding the disproportionality of Black people, in particular in detentions under the Act, was discussed earlier in this thesis.

The poor quality of the data raises major issues as we do not know with any certainty what percentage of "Section 136 detainees are released into the community or taken to hospital, which could provide an insight into how appropriately the power is used and how this varies by police force. This highlights the importance of consistent and accurate recording of Section 136 detentions and their outcomes by all police forces in England and Wales" (Docking et al, 2008: pg. 28).

Table 5.3: Method of disposal from custody by ethnic group for Section 136 detainees

	NFA	Hospital/ care/ MHA	Penalty Notice	Summonsed	Bailed	Cautioned	Charged	Custody	Other	Unknown/ not stated	N
Asian	27%	31%	1%	2%	1%	0%	0%	3%	24%	11%	**331**
Black	27%	39%	0%	2%	1%	0%	1%	3%	14%	14%	**376**
Chinese/Other	51%	27%	0%	0%	0%	0%	0%	2%	13%	6%	**124**
Mixed	27%	35%	0%	4%	1%	1%	1%	0%	16%	15%	**98**
White	49%	17%	0%	1%	1%	1%	1%	3%	17%	11%	**8321**
Unknown	51%	22%	0%	0%	1%	0%	0%	1%	13%	11%	**1478**

Percentages are rounded and therefore may not add up to 100

Table 5.4: Method of disposal from custody by ethnic group for detainees arrested for offences and found to have mental health problems

	NFA	Hospital/ care/ MHA	Penalty Notice	Summonsed	Bailed	Cautioned	Charged	Custody	Other	Unknown/ not stated	N
Asian	8%	78%	0%	2%	5%	3%	0%	1%	3%	1%	**109**
Black	6%	85%	0%	0%	2%	2%	1%	1%	2%	1%	**136**
Chinese/Other	8%	63%	0%	0%	4%	4%	4%	0%	8%	8%	**24**
Mixed	7%	73%	0%	3%	10%	0%	0%	0%	0%	7%	**30**
White	23%	44%	2%	5%	7%	4%	6%	1%	5%	2%	**1156**
Unknown	5%	87%	0%	0%	1%	0%	2%	0%	5%	0%	**118**

Percentages are rounded and therefore may not add up to 10

Section 136 detainees with personality disorder or requiring dual diagnosis

In chapter one the issue of individuals who suffer from both mental health problems and alcohol and/or drug misuse was discussed. Individuals requiring dual diagnosis need a more holistic approach to their problems, and the evidence suggests that this often does not happen, leading to these people coming into frequent contact with the police (Revolving Doors Agency, 2000). "Respondents told us of individuals who were repeat Section 136 detainees and as such were part of the 'revolving doors syndrome' of frequently being detained and released without their problems being addressed. The first group of people that were commonly mentioned were those with a 'personality disorder' who respondents felt were not 'treatable' and were therefore not detained any further under the Act. The issue of 'treatability' for people with personality disorders caused particular frustration among police officers, and some health and social care staff. There was felt to be a gap in terms of the way in which these people were dealt with and the need for them to receive appropriate care" (Docking et al, 2008: pg. 28).

> …most of them you will find have only got personality disorders. Very few of them will be admissions (custody manager 2, medium rate force 2).

Peay (2011a) notes that "…they…make considerable demands on primary services, as any GP who has a double-slot booked at the end of the day by a familiar patient will testify" (pg. 26). She goes on to say

> Why specialist services have not similarly grappled with large number of personality disordered patients is not clear: is it an inability or unwillingness where such people do not have a co-occurring mental illness, or because such people do not seek out services, whether because they don't experience the distress attributed to them, or because the services are not obviously accessible or available? But their confused status as 'mentally disordered' is evident, not least in the recent history of policy initiatives and legislative reform in the UK (pg. 26).

"The Act (prior to the amendments of the 2007 Act) describes "mentally disordered" as being either "severe mental impairment", "mental impairment", or "psychopathic disorder". It does not specifically mention personality disorder, but this could be encompassed by the general definition of mental disorder which includes "any other disorder or disability of mind". The distinction is important because a psychopathic disorder needs to be treatable for the use of Section 3 of the Act to admit someone to hospital for treatment (for six months, then renewable for another six months, and then for one year at a time). The 'treatability test' does not apply for Sections 2 and 4 of the Act (admission for assessment for 28 days, and admission for assessment in an emergency for 72 hours respectively), where only a mental disorder is required. It would therefore appear that while the individuals could be detained under Sections 2 or 4 of the Act because they could not be detained for longer periods under Section 3 they were often simply released. The Mental Health Act 2007 removes the treatability test and simplifies the definition of mental disorder which may help to overcome this perception and reluctance to use the Act to detain these individuals. Furthermore, the new Mental Health Code of Practice 2008 gives specific advice regarding the detention and treatment of individuals with personality disorder. Police officers and health and social care staff need to be aware of the extended definition of mental disorder and realise that it

embraces some of those who may previously have been seen as being more difficult to deal with" (Docking et al, 2008: pg. 28) (this came into force subsequently to our fieldwork).

The second group were people who had a mental disorder and a drug and/or alcohol dependency that required treatment. There was also felt to be a lack of services to address both of these problems, which would require dual diagnosis. The result was that individuals in this second group would also not receive any further treatment.

"One low rate force had an initiative to try and reach individuals in these more challenging groups. They had established a scheme in which general practitioners could promote mental health services and help people to access the system and the treatment they might need. This type of initiative could potentially reach people before they need to be detained under Section 136" (Docking et al, 2008: pg. 28). As highlighted earlier this type of initiative shows the importance of trying to make changes to what Chan (1997) sees as the 'field' and through these wider changes there is the potential to change the 'habitus' due to the experiences of officers changing as well as the influence of other occupational cultures, thereby improving police practice.

Transportation

Once someone has been detained under Section 136 they need to be physically taken to a place of safety. The mode of transport used for this purpose is important both for the

safety and mental wellbeing of the individual. “The ACPO Safer Detention Guidelines (2006) state that:

> The police may be asked to assist in transporting a violent or potentially violent person to a mental health establishment after they have been sectioned under the Mental Health Act 1983. The individual and circumstances of the situation should be assessed to determine the safest method of transportation. Options include:
>
> - First, an ambulance with police personnel present to assist the ambulance staff and any mental health staff;
>
> - Second, in a police vehicle with mental health staff present to monitor and assist in communicating with the detainee.
>
> The guidelines go on to state that
>
> > forces should establish procedures for dealing with requests for the transportation of detainees with mental health conditions (Para 5.6.3; pg. 58-59)

Transportation was a problem in all of the forces, with the police generally providing the transportation for detainees from custody to hospital when it had been decided that further psychiatric care was needed. This was more understandable in the low and medium rate forces where alternative places of safety were used more frequently. In these areas individuals who were detained in police custody were often seen to be too violent or intoxicated to be taken to an alternative place of safety so the ambulance service were reluctant to take them or would require a police escort:

> If they're violent the ambulance service will not touch them, and then you could be waiting for hours for the ambulance because it would be a non-emergency…So very often to get them out of custody we will then arrange for our colleagues to come and take them (custody sergeant 2, high rate force 1).

In the high rate forces where police custody was more routinely used a place of safety, the police were generally still responsible for transportation despite having protocols on multi-agency conveyance policies, which had been signed by the police, the ambulance service, the primary care trust or other NHS commissioner and the local authority" (Docking et al, 2008: pg. 28-29). This demonstrates the ineffectiveness of law or policy alone, without adequate changes in the wider 'habitus' and 'field'. There needs to be an improvement in the relationship between agencies in order to help change the 'field', in this instance proper ownership of the transportation of 136 detainees by the ambulance service with appropriate provision of services. This will only occur if the attitudes and beliefs are changed to accept that it is a shared problem requiring a shared response. Agencies need to work more collaboratively together and take sensible approaches with reference to what is best for the individual detainee. Learning across agencies and from service users themselves could help to shape attitudes and in turn occupational culture of organisations to help change the 'habitus' and 'field' and ensure that the intentions of the policy are carried out in practice.

"The protocols stated that unless a risk assessment suggested otherwise, an ambulance should be used for transportation. However, this routinely failed to happen because:

- There were often long delays getting an ambulance, particularly at night as it was not seen as an emergency, which led to a target time for completion of six hours.

- If a police escort was required this could be difficult to co-ordinate as they would not have an estimated time of arrival from the ambulance service.

Where individuals were held in hospital emergency departments, there were also delays in obtaining an ambulance and the police had to provide the transport instead" (Docking et al, 2008: pg. 29).

> There is normally a big delay before we can get an ambulance there, but we can get a police van and a couple of officers quite quickly to take him down anyway (custody sergeant, medium rate force 2).

"However, if the police had already left the emergency department they could be reluctant to return. Respondents in different forces raised concerns about who was responsible for paying for taxi costs where they were incurred. Many were seeking agreement about this issue as part of their wider agreements on any new facilities that were being developed. Examples of the police having to transport an individual to a bed hundreds of miles away from their area were given in all forces and, although rare, clearly placed a burden on the police and had a negative impact on the person being transported. When someone had been held in custody (or in a hospital emergency department) under Section 136 and they were being released, the police recognised that they still owed the individual a duty of care. They would generally ensure that they were

able to get home safely. This could involve checking with the person and with the ASW to establish how he/she was getting home and where they were actually going. They may contact a family member or friend to come and collect them, they may be provided with a taxi home or the ASW or officers may occasionally take them back" (Docking et al, 2008: pg. 29).

Whilst this could be seen as an issue of contrasting resources available to differing agencies and the impact on practice, the interviews also indicated that it was related to 'habitus' since some of the officers and health and social care staff went beyond what might be expected of them to ensure the wellbeing of the individual. This was linked to how much of a duty of care they felt was owed to the individual and whose responsibility this was felt to be (in terms of which agency). The relationships across agencies and between individuals also played a role in shaping the 'field'.

Deaths in or following police custody of Section 136 detainees

In some of the most tragic Section 136 detentions in police custody individuals have died while being detained. These cases are fortunately relatively rate but custody officers were acutely aware of the risk of a death in custody involving a Section 136 detainee:

> The statistics show that when somebody comes in with mental health issues into custody, they're at higher risk of self-harm, and possibly fatalities...as we used to bring them into the police station, you've then got an increased risk, and you've got to mitigate and manage that risk, and any death in custody is a big problem (custody manager 2, medium rate force 2).

As described in chapter three I undertook a study (with support from other researchers) in my capacity as a Senior Researcher at the IPCC which examined all deaths in or following police custody over an eleven year period from 1998/99 – 2008/09. We used data gathered from completed investigation reports for this research. I will now examine the cases where the individual was detained under Section 136 and taken to police custody.

Between 1998/99 – 2008/09 "there were 17 people who were detained under Section 136 and died during or following the detention" (Hannan et al, 2010: pg. 50), an average of 0.6 (or 1) deaths per year. "They ranged from 19 to 71 years of age. Thirteen were British (four not stated), 15 were male and 12 were White (four people were from BME groups and one was not stated)" (Docking et al, 2008: pg. 50). This means that 24% were from a BME background compared to 8% of the general population based on the 2001 Census – 3 times the number. "Most were detained in a public place (nine people) but six were detained in their own home" (Hannan et al, 2010: pg. 50). This supports the evidence presented earlier in this chapter that this power is sometimes breached and used to detain people from private premises rather than in a public place as set out in the legislation. "For five people the time of arrest was not stated, but of the remaining 12 individuals, seven were detained between 6pm and 6am. This supports [the evidence from our quantitative data] that Section 136 detentions at police stations may be more likely to occur outside of normal office hours when alternative resources are not available" (Hannan et al, 2010: pg 50).

"Investigators' reports described the detention as involving either a struggle or some violence in ten cases (it was not stated in a further three cases). This led to eight people being physically restrained (as opposed to simply being handcuffed) by officers; two of whom were restrained using specialist equipment (such as leg restraints). Five of the individuals appeared to be intoxicated through alcohol at the point of detention and three through drugs. The dangers associated with restraint were touched upon in chapter two, in particular restraining people who are under the influence of drugs and/or alcohol. Two people had physical injuries that were identified on the point of detention and two people had medical conditions. Two other factors were noted at the point of arrest for two individuals – one had a propensity to violence and one was noted to be a suicide/self-harm risk. Despite the official policy on places of safety, of the 17 individuals nine were taken to custody as a place of safety; six were taken to hospital and two people died at the scene of detention. When looking at how these cases are spread across the financial years [the police hold the data by financial year and it is therefore reported on in this way] the numbers become very small, although five deaths occurred in 1998/99. However, there does still seem to be an issue with detainees being taken to police custody and subsequently dying as the most recent death following detention in police custody occurred in 2007/08 and every year prior to that had at least one death where the person had been detained in custody (as opposed to an alternative place of safety)" (Hannan et al, 2010: pg 50-51.

The case studies in this chapter are summaries of the incidents as described in the investigators reports. These were written by IPCC or police investigators and are based on a variety of evidence such as witness statements, forensic evidence, medical examinations etc. The methodology is described in more detail in chapter 3. Box 5.1 below highlights a case study which demonstrates the need for alternative places of safety to be available and used rather than police custody.

Box 5.1: Case study on lack of alternative places of safety for Section 136 detainee

An ambulance had been called to help a woman who appeared to be mentally unwell. She was apparently acting violently and trying to smash windows on the street. The ambulance crew were unable to get the woman into the ambulance and so called the police for assistance. The police officers decided to detain her under Section 136 of the Act and she was conveyed to the custody suite as there were no alternative places of safety in the force. She was calm in the police car and was not restrained.

On arrival to the police station it was noticed that she was very yellow and an officer recognised that she was possibly suffering from jaundice. As she arrived she became incontinent and urinated on the floor. She then slipped in the urine and struck her head on the floor. Enquiries in the intervening period had revealed that the woman had mental health, drug and alcohol problems. A FP was already present and advised that she be taken to hospital as she was clearly suffering from jaundice, possibly liver/alcohol related and suggested that the injury to her head could be serious because of her general health problems. The woman was conveyed to hospital by ambulance in a serious condition, and was later declared to be brain stem dead. She died the next day.

The investigation report referred to a similar incident in the force and recommended that custody should not be used as a place of safety, that an urgent review should be held of the signatory bodies (of the Section 136 policy) to find, and if necessary establish, suitable alternative 24 hour facilities at a Mental Health Unit. At the inquest into the death the coroner stated that if the deceased had been taken to an alternative facility she may not have died.

Box 5.2 below describes a case study which shows the failings in the working relationships between the police and the health service, as well as failure by the officers involved in the case to adhere to PACE in caring for the detainee.

Box 5.2: Case study on individual and organisational failings resulting in the suicide in custody of a Section 136 detainee

The deceased was suffering from a 'severe bereavement reaction' characterised by panic attacks and suicidal thoughts, had a 'depressive illness secondary to her bereavement' and was prescribed anti-psychotic medication. She was detained under Section 3 of the Act and made numerous attempts to self-harm and commit suicide. She was described by her doctors as being at a 'high risk of death from her impulses'. Immediately prior to her arrest, the deceased made recurring attempts to self harm and was eventually restrained by psychiatric staff and placed under constant supervision. Due to her increasing levels of violence, the psychiatric staff threatened to call the police. It appears that this statement was simply meant as a threat rather than to be acted upon, but due to some confusion the police were called and attended the scene. They arrested the deceased, placed her in handcuffs and took her to the police station.

The psychiatric staff shared very limited information about the deceased with the police but did inform them that she had been trying to put objects/ clothing into her mouth to try and commit suicide. At the police station, a risk assessment was conducted but the deceased made very limited responses. The officers did not attempt to gain any further information from other sources to aid the risk assessment. The deceased was placed in a normal cell as the video monitoring cell for 'at risk' detainees was closed due to repairs. The custody sergeant responsible for deceased left without informing the other staff coming onto duty of the circumstances surrounding the deceased's detention. The final check on the deceased occurred 80 minutes before it was discovered that she had committed suicide by suffocating on toilet tissue in the cell. The investigator of the case stated that in his view the deceased was "an extremely vulnerable patient who needed a high level of care. The deceased should not have been arrested. The officers had ample opportunity to obtain information from hospital staff. From the evidence it is clear that the deceased was treated as a suspect rather than as an extremely vulnerable patient".

There were numerous examples of breaches of PACE Code C with no evidence of cell visits being recording except for the first two checks which occurred at 30 minute intervals. If all of the relevant information about the deceased's behaviour had been shared between the agencies, it would have been recognised that the deceased needed constant supervision as a minimum. Following the conclusion of the inquest into this death, the IPCC press release stated: "…there was a need for protocols to be put in place between the police and local health care services to outline respective actions when dealing with such incidents".

As discussed earlier in this chapter, the mode of transportation following detention under Section 136 is important for the detainees' mental wellbeing given that they may be disorientated and disturbed and being taken in a police vehicle can add to the sense of stigmatisation. "The Mental Health Code of Practice (2008) states the ambulance service should generally transport Section 136 detainees rather than the police. Most of the Section 136 detainees in this sample were taken to the place of safety in a police vehicle (12 people), two were taken by ambulance and it was not stated how the remaining individual was transported. Of the five individuals who were taken to hospital, one had taken an overdose and one had breathing problems. As with the arrest time, for those who the information was available most arrived in custody or hospital between 6pm and 6am. The length of detention was not stated or not applicable for 11 of the 17 people, four people were held for 3 hours or less, one person was held between three and six hours, and one person was held for between 36 and 48 hours. Again, two individuals were reported as struggling with officers or being violent in hospital/custody and were therefore restrained by officers holding them down, and one was also restrained using a specialist restraint device. Of the nine people who were taken to custody, three had a risk assessment conducted on them, two did not because they were too intoxicated, and two did not for other reasons. Five of the deceased were treated as vulnerable detainees"

(Hannan et al, 2010, pg. 51-52) and three were placed in cells for vulnerable/at risk individuals – two of which had CCTV and two had special low beds. Four detainees had clothing or property removed, including belts/ drawstring/ shoelaces, cash/ credit-debit cards, lighters/ matches, all of their clothing, wallet/ ID, and a shirt/ blouse/ top. The person who had all of their clothing removed was issued with a 'safety suit/special clothing'.

"By asking the risk assessment questions, custody officers identified additional concerns about the deceased. This included being a suicide/ self-harm risk, suffering from epilepsy, having a propensity to violence, domestic issues/ problems, and intoxication from alcohol and drugs[42]. The custody officers can also check the custody system for any markers against individuals' names. This revealed some of the factors that had already been identified from the risk assessment, but in addition highlighted that two of the individuals needed an appropriate adult (an appropriate adult was called for one of the deceased)" (Hannan et al, 2010: pg. 52).

For those whom it was applicable, information stated that it was decided that one person should be roused by custody staff. In terms of the checks that they should have, two people should have been checked on every 30 minutes, and one person should have been constantly supervised. This information was not stated or not applicable for the other detained individuals. More information was provided on the checks the detainees actually received, with two people being roused by custody staff, two people being checked on

[42] Each person could have up to eight risk concerns so these concerns may be associated with one or more individuals.

every half an hour, one person every 15 minutes, one person between 40 and 60 minutes, and a further two people receiving irregular/inconsistent checks. "The investigator was critical of the lack of regular checks in two cases" (Hannan et al, 2010: pg. 52).

Information on the outcome of Section 136 assessments was not available for people who had been taken to hospital for assessment. As discussed earlier in this thesis, "some FPs may have the relevant training to be approved under Section 12 of the Act, but many will not, so it may be that the detainee needs to be seen by a FP and a specially trained doctor. A FP was called out for six individuals by custody officers/staff" (Hannan et al, 2010: pg. 52). On two of these occasions they were called out on arrival to custody, three were called within an hour of arriving in custody and one between one and four hours.

"Four people were actually assessed by the FP and it was advised that three people should be taken to hospital and one should be seen by an approved mental health practitioner/ASW[43]. Four people had a mental health assessment in custody prior to their death with three of them being seen by an approved doctor and all of them being seen by an approved mental health practitioner/ASW. Two were then 'sectioned' and sent to hospital and one was to be released into the community for treatment. On being taken ill, ten people were given first aid at the scene (this was not stated for three people)" (Hannan et al, 2010: pg. 52). First aid was given by different people – the arresting officers or officers/staff at the scene of the person being taken ill, custody officers/staff and paramedics. "An ambulance was called for 11 people (this was not stated for two

[43] This would be necessary anyway for the mental health assessment and prior to 2007 transfer from one place of safety to another was not permitted unless they had emergency medical needs.

people)" (Hannan et al, 2010: pg. 52) and information was not available for all these cases, but four ambulances arrived within five minutes and one between 11 and 15 minutes. "Table [5.5] below shows that two of the deceased were pronounced dead in custody, two at the scene of the arrest and the remainder in hospital" (Hannan et al, 2010: pg. 53).

Table 5.5: Where the deceased was pronounced dead

	N	Percent
In custody	2	**12**
In public place during arrest	2	**12**
In hospital (from arrest)	6	**35**
In hospital (from custody)	6	**35**
In hospital (following release from custody)	1	**6**
Total	**17**	**100**

"Table [5.6] shows the primary and secondary cause of death for the Section 136 detainees. It shows that despite others being aware of their vulnerability three people were still able to commit suicide, and two people overdosed (one of these deaths was also related to the restraint)" (Hannan et al, 2010: pg. 53). The Australian Commission into Aboriginal Deaths in Custody records the causes of deaths in a slightly different way and figures are only available for those held in custody more generally and not people deemed to be mentally vulnerable so comparisons cannot be easily drawn.

Table 5.6: Primary and secondary causes of death for Section 136 detainees

Primary cause \ Secondary cause	No secondary cause	Drug related	Head injury	Alcohol and drug related	Restraint related	Not stated	Total
Natural causes – heart related	4	0	0	0	0	0	**4**
Unascertained/ inconclusive	2	0	0	1	0	0	**3**
Injuries received prior to detention	0	0	1	0	0	1	**2**
Overdose accidental – drugs related	0	0	0	0	1	0	**1**
Injuries sustained during detention	0	0	1	0	0	0	**1**
Alcohol and drug related	1	0	0	0	0	0	**1**
Overdose intentionality unknown	0	1	0	0	0	0	**1**
Suicide – hanging	1	0	0	0	0	0	**1**
Suicide – overdose	0	1	0	0	0	0	**1**
Suicide – poisoning/substance	1	0	0	0	0	0	**1**
Not stated	1	0	0	0	0	0	**1**
Total	**10**	**2**	**2**	**1**	**1**	**1**	**17**

There were also 39 people who died in or following police custody who were arrested for suspected criminal offences and then found to have possible mental health needs during the arrest or once in police custody. "The most common reason for arrest for these individuals was public order offences which included breach of the peace. This was followed by criminal damage and assault. It may be that some of these people could perhaps have been detained under Section 136 instead, but were arrested for minor offences" (Hannan et al, 2010: pg. 54). As discussed earlier in this chapter the evidence from my research suggests that officers in different forces exercise their discretion and that some forces encourage officers to use Section 136 whereas others encourage them to arrest the individual for an offence if possible.

"It appears that two detainees who were arrested for public order offences were actually dealt with under Section 136 of the Act once they were taken to custody…The two

detainees were therefore assessed by an Approved Mental Health Practitioner/ASW and a suitably qualified doctor and it was decided that both should be subsequently sectioned to hospital" (Hannan et al, 2010: pg. 55). This demonstrates that the data we collated is likely to underestimate the number of people held in custody and dealt with under Section 136 of the Act, and the number of people who are arrested for offences but who have mental health needs.

Conclusions

This chapter has examined the processing of Section 136 detainees, their arrival into custody, risk assessment and checks of detainees, the length of time they spend in custody, the impact of detaining people under Section 136 on police custody, the training and knowledge of custody staff, what happens to detainees following a mental health assessment, detainees with personality disorder or requiring dual diagnosis, the transportation of Section 136 detainees, and finally deaths in or following police custody of Section 136 detainees.

It has been found that individuals were most commonly taken to police custody as a place of safety outside of normal office hours indicating that there may be a lack of alternative facilities for outside of these hours. While many of the respondents in my study seemed to be very risk adverse, other evidence has suggested that custody staff do not always conduct adequate risk assessments on detainees, and there is a difficult balance between protecting an individual from harm and ensuring they are treated humanely.

Most people were detained for less than ten hours but some detainees were held for much longer. The length of detention depended on several factors such as the time of the detention and delays in qualified doctors and ASWs arriving in custody (particularly at night), as well as having to wait for some individuals to sober up before they could be assessed. There were also delays if someone needed to be sectioned due to a perceived shortage of hospital beds. Strong multi-agency working was thought to be effective in addressing some of these issues in the lower rate forces. Issues were raised about FPs not always having the necessary skills and training to adequately carry out their duties. Section 136 detainees frequently required a higher level of supervision than other detainees and as such the potential impact on resources in the police custody suite is large.

The data on disposals following detention under Section 136 was of poor quality and therefore represents a gap in the knowledge of this area. What data there was suggested that there were differences in disposal by ethnicity with people from BME groups, and in particular Black people, being more likely to be taken to hospital for further treatment. In contrast to the official guidance, police vehicles were frequently used to transport Section 136 detainees rather than ambulances. The result of this is to further stigmatise their detention, but was often felt to be necessary due to long delays in ambulance attendance. Finally, the deaths of individuals who had been detained under Section 136 demonstrated the unsuitability of police custody as a place of safety, the failings in multi-agency relationships, and the lack of adherence to PACE and the ACPO Safer Detention

Guidelines (2006) in some of these cases which could have helped to prevent some of these deaths.

These findings therefore support my argument that the law and policy alone do not completely govern or change police practice on the ground. Instead the external rules and processes that are in place are interpreted and applied by officers using their cultural knowledge ('habitus') which can be seen as a set of internal rules and practices which govern how they work, their policing skills or 'commonsense' as discussed in chapter two. In the context of this discussion this would mean how police officers understand mental health and the way in which they possibly incorporate stereotypes and bias into their handling of those detained under Section 136. The police occupational culture, and therefore practice, can be changed and influenced via a variety of methods including the influence of other agencies and their occupational cultures, the impact of strong leaders (especially given how hierarchal the police force is), as well as changes to what Chan describes as the wider 'field' which could include the law, the views of wider society and resources which are made available.

It is therefore important for multi-agency working to be in place and to be effective. Fielding (2005b) found that differing occupational cultures can impact and influence each other, potentially for the better. Therefore it could be argued, and some of the evidence from my fieldwork suggests, that when differing agencies work together through multi-agency working this can lead to positive changes in occupational cultures as organisations influence and learn from each other. Closer inter-agency working on

Section 136 can lead to more appropriate resources being made available to ensure that Section 136 detainees have the care they need as the issue is prioritised and existing resources are reallocated and made available – changes to the wider 'field'. For multi-agency working to happen effectively changes in the 'field' need to occur at both the street and managerial level (Chan, 1997). This is more likely to occur if there is strong and effective leadership in both the police service and health and social care agencies, this then can filter down to operational resources. The next chapter explores multi-agency working in more detail.

6. Multi-agency working

> The formalisation of partnership work, furthered by the National Intelligence Model and a general drive for 'joined up government' requires police to engage more fully with social welfare concerns and mandates them to work with social agencies that have very different working practices and occupational ideologies. The police sense of mission and their instinctive preference for action runs at odds with agencies that are less well-resourced, deal in deeper, longer-term responses to social problems, and work more closely to local government requirements (Fielding, 2005b: pg: 130).

Introduction

The previous chapter set out the importance of multi-agency working for developing alternative places of safety to police custody, for ensuring effective and timely assessments of individuals, and for sharing appropriate information to ensure that the detainees receive the best possible care. These relationships are vital and when they work effectively can help to divert people away from the criminal justice system and prevent deaths in custody.

As discussed in chapter two and in the previous chapter, the occupational culture is a set of rules, beliefs or attitudes that influence police practice and the way in which they apply the law. The law and policy alone do not govern practice on the ground. Instead the police have developed an occupational culture which can influence how they prioritise their work and how they treat individuals. For example, in relation to Section 136 detainees depending on the prevailing culture of the individual force, or particular division or rank of officers they may see them as less worthy of their time and attention

than ‘real crime’ and therefore try to process them as quickly as possible. This may lead to individuals not receiving or accessing the treatment they need. Conversely if the occupational culture was one in which the social work function was valued more highly and individuals with mental health problems treated sympathetically then greater levels of care might be given to ensure that these individuals were treated appropriately.

Addressing and changing the occupational culture of the police where it has a negative impact is therefore an important part of changing police practice on the ground. As stated in the previous chapter there are differing ways in which the occupational culture can be influenced and changed, this includes strong leadership, the law, working with other agencies with differing occupational cultures and changes to the wider ‘field’ in which the police operate – for example changes to resources that are available or wider societal views on particular issues and the effect this can have on the views of officers. If an issue or group in society is seen to be a priority for police resources or seen to be something that can be considered a problem for the force to deal with more generally (and therefore legitimate ‘police work’), particularly by senior officers (given the hierarchal nature of the force) this can impact on the importance that the rank and file place on it. The motives of the rank and file in terms of how they spend their time can be influenced by how important they judge differing tasks to be and how worthy the individuals are, in addition to how much supervision they have and whether they think their response will be monitored. Therefore is it is known that an issue, in this case Section 136 detentions, is being taken seriously by senior management in the force and that detentions are being monitored, this could affect the way in which they deal with the detentions.

This chapter focuses on the influence of other agencies via multi-agency working to change police occupational culture and therefore police practice. It also looks at how multi-agency working can be related to leadership and the relationship between different ways of working and what Chan (1997) calls the 'habitus' and 'field'. By working with other agencies the police occupational culture can be influenced and changed by the occupational cultures of the other agencies (Fielding, 2005b). As Chan (1997) says the police are not passive participants in the occupational culture around them but can influence and change it themselves. Therefore working with other agencies who offer different perspectives on issues, in this case the treatment of people with mental health issues, can impact on the culture and practice of the police.

Multi-agency working also helps to affect the wider 'field' in which the policing of Section 136 detentions occur as by having effective and joined up working arrangements the treatment of Section 136 detainees will improve and the availability of alternative places of safety to police custody will increase. However, effective multi-agency working cannot occur purely at an operational level, but needs strong leadership both within the police and health and social care in order to drive through change. Leadership in itself can impact and change police practice on the ground, potentially for the better (Cummings, 1992).

This chapter therefore examines multi-agency working on Section 136, and mental disorder more generally, in greater depth. It looks at types of multi-agency working both

at a strategic and operational level and how this varied in the case study sites with differing rates of Section 136 detentions. It examines any protocols and agreements that were in place in the case study forces and compares them to the reality of practice on the ground. It considers the role of law, policy and occupational culture in helping to shape multi-agency relationships. Finally, it examines the impact of these relationships on the provision and funding of alternative places of safety to police custody.

Types of multi-agency working

"Over the past two decades there has been recognition amongst statutory bodies and government departments, that some entrenched social problems require the involvement of more than one agency to address them. This thinking has led to the development of 'multi-agency' partnership working (Bowling and Foster, 2002). The growth of multi-agency working has seen the police work with other agencies on shared problems in the belief that they can be more successful in tackling them together" (Docking et al, 2008: pg. 31. The Morgan Report (1991) on crime prevention sought to promote the idea of all sectors of the community to fight against crime. The main focus of multi-agency working therefore continues to be on crime prevention. Crawford (1998) states that "crime prevention lies somewhere between the narrow craft of 'policing' and the elephantine and somewhat amorphous process of 'social control'. The debates as to precisely where along this path crime prevention should be situated are reflected in the complex history of activity associated with the term and its organisational location" (pg. 8). Crawford (1998) goes on to discuss how crime prevention has been talked about in terms of 'community safety' and that this term "...has come to imply the need for interventions to be delivered

through a ‘partnership’ approach, drawing together a variety of relevant organisations – in the public, voluntary, and private sectors – as well as community groups” (pg. 9). He states:

> A multi-agency or ‘partnership’ approach is favoured in that it affords a holistic approach to crime which is problem orientated rather than organisationally led (Crawford, 1998; pg. 9-10).

Gilling (1994) also talks about the important of multi-agency working for crime prevention and the need for multi-agency groups, he says:

> At present, many crime prevention initiatives are encouraged to begin with a multi-agency steering group. This forces social and situational prevention together at the outset and breaks the first rule, that initiatives should be problem- and not practice-focused, with other agencies being brought in only when their specific contributions can be determined (pg. 245).

In addition to crime prevention, multi-agency working has also been used to try and address low level or anti-social behaviour and more recently for ‘neighbourhood policing’ initiatives. O’Neil and McCarthy (2012) conducted research into partnership working in this context. In contrast to previous literature which examined multi-agency working when it was a newer concept, the authors discovered that the police officers involved in the work found it a positive experience and viewed it as useful. They found that rather than conflicting with aspects of police culture that their pragmatism helped to enhance partnership working:

> …consistent examples of the police working collaboratively with professionals such as youth workers, neighbourhood wardens, social workers and similar professionals, as well as in some instances realigning their organizational structures to adopt a mandate which was more akin to support-based preventive working (pg. 2).

O'Neil and McCarthy (2012) also found that "over and over again, [their] projects uncovered widespread acceptance that partnership work 'made sense' and was 'the way forward' for police forces. This does not suggest that there were no problems encountered in partnership working, but recognizes that these problems did not significantly impinge on overall inter-agency relations. It became clear that the advantages of this method of working were seen to outweigh the shortcomings. This shows a marked departure from much of the existing literature which suggests that partnership working is treated as a burden by police officers…" (pg.5). With relevance to the subject matter of this thesis, O'Neil and McCarthy (2012) found that "while the police tended to act as the lynchpin partner agency in terms of controlling the partnership, such as structuring resources, data and deploying officers, this was often *supported* by other agencies especially those struggling to provide services in the wake of cut-backs to their organization. One notable finding was the level of support from social welfare agencies for the police, especially their willingness to engage with 'soft' policing functions" (pg.10). As will be seen later in this chapter this mirrors my findings in that social services were positive of their working relationship with the police in some areas where multi-agency working was strong and were as supportive as they could be. Finally, as I have suggested in this thesis O'Neil and McCarthy (2012) found evidence to support Chan's (1997) theory that police culture can be changed:

> What we have shown here is that the way the police predicament is interpreted and managed is significantly different in the partnership work we studied than in other areas of the police organization (as described by the existing body of work on police culture), to the extent that over time, police culture became a facilitator in partnership working, rather than a barrier as had been the case in previous studies of partnership. As Chan (1997) has suggested, police culture is indeed open to change under the right conditions and with sufficient time to adapt (pg. 14).

Multi-agency working and groups are also very important in relation to issues such as Section 136 detentions "since this involves police officers working with health and social care staff to ensure that when individuals are detained they are assessed quickly and obtain any appropriate treatment. Multi-agency working offers the possibility of diverting Section 136 detainees away from police custody and improving the level of care they receive. Multi-agency working can involve a variety of agencies during the actual process of a Section 136 detention. It can also involve agreeing working practices to try to ensure that Section 136 detentions run smoothly and make the best use of the resources available. There may therefore be different aspects to the multi-agency working, with the different agencies working together at different levels and on different issues" (Docking et al, 2008: pg 31). Taking examples from other areas of policing, Fielding (2005b) states that:

> Although the emphasis may vary, senior police have subsequently sought a growing, proactive involvement in the community. The fruits of a growing involvement with community organisations include the prioritisation of a more effective response to racial attacks and domestic violence, experiments with multi-agency co-operation in problem estates, and increased co-operation with victims' organisations generally. Ultimately,

> these innovations hinge on the preparedness of the ordinary ranks to work in new ways, and on the development of an effective supervision system with suitable encouragements to do so. Here the organisation, in its sincere efforts to effect change, is trapped by techniques and competencies imposed by the policies of the past (pg 61).

Fielding (2005b) goes on to suggest a more formal approach to 'partnership work' and a 'general drive for joined up government' has meant that the police have been expected to engage with wider concerns about welfare and they are expected to work with other agencies who often have different approaches and outlooks to the work (pg. 130). As noted in the quotation at the start of this chapter, he argues that the police 'sense of mission' and desire for action is at odds with the 'longer-term responses' to social issues that is required at a local level (pg. 130). Pakes and Winstone (2010) note that:

> ...there are differing principles and organisational pressures that underlie how offenders with mental health problems are dealt with in either health or criminal justice. Within health and criminal justice agencies there are different ways in which caseloads and delays are managed. Health agencies tend to emphasise the importance of voluntary participation and may have a restrictive admissions criteria and restricted availability of bed space. In contrast, the police and prisons can hardly pick and choose their clientele and an individual sentenced to prison must be found a space immediately. Because of such differences, health and criminal justice agencies relate very differently to the same individual, including differing views on their entitlements, what constitutes quality service and the importance of certain outcomes (pg. 170).

This has particular resonance for the subject of this thesis as Section 136 detentions require the police to work with health and social care staff for the effective care of these individuals, who are widely acknowledged to have limited resources to carry out their work. Furthermore, our evidence suggests that forces with the lowest rates of Section 136

detentions in custody (per 10,000 people detained in custody generally) tended to have the strongest multi-agency working. This may be linked to positive changes to the police occupational changes in these areas caused by proactive senior police leaders and the influence of the occupational cultures of the other agencies. This will be explored in greater depth when discussing the evidence below.

In these areas of strong partnership working there was a tendency for the police to take the lead role. This has been highlighted by other research in the field. For example, Barton (2002) found that the police were keen to retain control in multi-agency working and try to steer meetings towards their preferred option (pg. 114). Crawford (1998) also found that the police tended to lead in multi-agency meetings.

In her research however, Rogers (1990) suggests that the failure of other agencies to respond sometimes led to the police *having* to take action and resume the role of lead agency in operational situations:

> Some of the accounts leading up to incidents suggested that other community services, such as GPs or social services, had not responded when called upon by relatives or neighbours prior to them contacting the police. Moreover the only response by the mental health services to crises was admission to hospital. There was no evidence of alternative community crises intervention which may have been more effective in some instances. This points to a pressing need for reconceptualising the present crude response to emotional deviance. This not only requires the planning and provision of a wide range of mental health crises services, but ways of lessening the occurrence of such incidents. This implies greater emphasis on social and material support as well as providing services (and professionals) that are more 'user friendly' and which take into consideration people's social networks and the context within which crises arise. Medically orientated

> and hospital based services are not currently in a position to offer such a response (pg. 235).

For Fielding (2005b) "police participation in partnership work is thus from a bounded perspective seeking to protect their independence, autonomy and occupational culture" (pg: 131). He goes on to describe some of its difficulties:

> The focus of partnership policing on the residue of policing that lies outside core business means that partnership work generally addresses the most intractable problems, the problems least likely to be susceptible to 'Action Man'-type interventions, and the problems that all the partner agencies are apt to construe as someone else's responsibility. (Fielding, 2005b; pg: 132).

However, in their research on neighbourhood policing O'Neil and McCarthy (2012) found that "…the police do dominate partnerships in terms of their available resources and personnel to deploy, but mostly *negotiate* these relations with other agencies with degrees of tact and compromise, rather than simply 'dominating' in zero-sum ways" (pg. 14).

In some of the high rate forces Section 136 was sometimes construed as a problem that no one wanted to take responsibility for. In our study we found examples of various different types of multi-agency working with different purposes and representation. There were:

- "strategic groups with senior representatives from the different organisations that set and agree policies and protocols on Sections 136 and 135 of the Act, information sharing, arrangements for alternative places of safety and transportation of detainees;

- groups of operational staff that monitor the use of Section 136 on the ground and identify any issues with particular cases or facilities, such as delays in assessments in particular facilities;

- mentally disordered offender groups that look at issues including but also beyond Section 136, such as diversion from the criminal justice system where necessary, support and risk assessment for mentally disordered offenders leaving prison, and housing issues;

- groups that look at the feasibility and logistics of developing alternative places of safety; and

- joint working on a day-to-day basis, including sharing information about an individual detained under Section 136 to ensure that they receive appropriate care.

The organisations represented at these meetings varied across the forces but could include staff from:

- the police;

- primary care trusts or other NHS commissioners;

- mental health trusts;

- local authorities;

- the ambulance service (although some forces specifically commented that it was difficult to engage them); and

- social services.

- Mentally disordered offender groups – the Crown Prosecution Service, probation, prisons, and magistrates.

Forces did not generally have links with any voluntary agencies; only a couple of respondents mentioned links with mental health charities such as MIND" (Docking et al, 2008: pg. 31).

There is official guidance on how forces should work with other agencies on Section 136. The ACPO Safer Detention Guidance (2006) states that forces must develop and agree with Mental Healthcare Trusts and Primary care Trusts protocols identifying a first choice place of safety and the criteria for their use (Para 3.4.1). The Mental Health Code

of Practice (2008) states that there should be locally agreed policies in place for all aspects of Sections 135 and 136 (Para 10.16). Though this Code had not been published at the time my fieldwork was conducted and as shall be seen below multi-agency working varied across the different police force areas. The most recent Code of Practice (2008) provides some detailed guidance on what the local policies on Section 136 should cover, who should sign up to them, and ways of working, more detail can be found on this in chapter one.

How multi-agency working varied in the different police forces

"Our findings suggest that multi-agency working is a major factor in explaining the low, medium and high rates of Section 136 detentions across forces. Multi-agency relationships that are well-developed and effective were generally associated with low rate and some medium rate forces, compared to high rate forces. Joint working appeared to be more embedded in the low rate forces, with respondents from both the police and health and social care talking about their collective responsibility and positive relationships" (Docking et al, 2008: pg. 31-32).

The qualitative findings seemed to be relatively strong, as this was the case for both of the low rate and both of the medium rate case study sites with police and health and social care respondents talking favourably about multi-agency relationships in their area, and for the majority of the low and medium rate telephone police interviewees. There were specific examples of how it was working well that are given in this chapter – such

as specialist health staff being based in custody suites, joint training, and greater information sharing. Both of the high rate case study forces were trying to implement stronger multi-agency relationships in their areas post the quantitative data on the number of detentions in their area. However, in one of the areas this hadn't been as successful as hoped as whilst alternative places of safety had been developed there were problems with funding for staff (discussed further below).

> There are better working relationships, as well. Again, we talk about ten years ago but changes at this end take that long to come through a process. And in an organisation as big as ourselves or the hospitals, previously, each of us looked at our roles in isolation, it's not down to me, it's your problem. Now, there is a far greater collective responsibility than there ever was, and that is a critical element and it means that everybody is starting to push in the right direction. I think that's the area where we really do have to carry on and move it forward. Without collective responsibility, it's very difficult for an independent organisation, police, NHS, social service, clinical nurses, all these peripheral health care providers, are actually doing it on their own. They can't do it, it's only when everyone is supporting each other that we get close to it (custody policy lead, low rate force 1).

This need for 'collective responsibility' shows a strong association with the need for positive changes to both the 'habitus' and 'field' identified by Chan (1997) to ensure better working practices in Section 136 detentions. In forces with low rates of Section 136 detentions the attitudes of both health and social care staff and police officers were different to that of high rate areas. In low rate areas the different organisations and their staff viewed Section 136 detentions as a shared problem and worked together to try and address it, whereas in high, and to some extent medium rate, areas their appeared to be more divisive relations and practices, admittedly in part due to a lack of resources.

Therefore, change to occupational cultures can lead to changes in operational practice and the sharing of resources can help ensure that the treatment of people being detained under Section 136 is more effective and joined up.

"Some low rate forces had attached greater resources to this area. An example of this was the existence of a criminal justice liaison team of CPNs in one low rate force. The team conducted outreach work in police custody and helped to divert people with mental disorders away from police custody" (Docking et al, 2008: pg. 32). Criminal justice liaison teams and their different functions and make up are discussed in chapter one, and Bradley (2009) suggests that schemes based at a police station such as the one in the low rate force offered numerous potential benefits in caring for people with mental health issues in custody (pg.53). Bradley (2009) therefore recommends that all police custody suites should have access to liaison and diversion schemes (pg. 53), but at the moment the scale of these schemes is not known (NPIA, 2010).

"Respondents from medium rate forces had mixed opinions and identified some problems with the way that agencies worked together. Some respondents identified agencies that they felt worked less well with than others in a partnership context. Some of the high rate forces expressed positive views about their organisation developing alternative places of safety through multi-agency working and improved relationships. However, other high rate forces felt that their relationships with other agencies remained generally negative" (Docking et al, 2008: pg. 32).

> I'd like to say its positive but very often it's not…They almost try to blackmail us into taking them [Section 136 detainees] (custody sergeant 1, high rate force 1).

"One of the key factors in improving multi-agency working and driving it forward to change practice is having the support of senior personnel within both the police service and primary care trusts or other NHS commissioners. Police forces and local primary care trusts/NHS commissioners must recognise that Section 136 is an issue that both parties need to address together. Senior support was longstanding in some of the low and medium rate forces – from senior police officers and chief executives at primary care trusts, filtering down to staff in middle management and at an operational level" (Docking et al, 2008: pg. 32). Foster (1987) found that leadership, management and training could have a large impact on the attitudes and approaches of police officers. Cummings (1992) also argues that leadership can lead to cultural change. This is linked to the need that Chan (1997) identifies to change the 'field' at both management and street levels in order to effect positive changes to practice.

"In one low rate force the Primary Care Trust seemed particularly proactive in addressing some of the issues. Here the Trust requested a police mental health liaison officer and jointly funded the post with the police. A medium rate force also stated that practice had changed when their Deputy Chief Constable took up the issue of Section 136 detentions with their health counterparts and highlighted it as a problem. This was viewed as a strong factor in alternative places of safety being found. The situation was also helped by the fact that the leading consultant in the local hospital emergency department had previously been based in an area within a low rate police force. There, it had long been

accepted that hospital emergency departments could be used as a place of safety" (Docking et al, 2008: pg. 32). An interviewee from the area summed up the changes:

> … We're aiming for April next year to be operational [alternative place of safety]...It very much came from the police I think it's fair to say, and from the Deputy Chief Constable. The history of starting to use Accident & Emergency rather than the police station was driven by the police. They negotiated that with the Accident & Emergency and actually a little way that mental health services joined in on the back of that. Ideally we've planned it in partnership together, but I think the police had got to the point where they were just so fed up with things not changing they began to explore other options. And actually previously the Accident & Emergency Department, the people working there have been saying no, definitely not, but by chance we had a consultant working there who'd worked in [name of low rate force], and just said well, we did that all the time in [name of low rate force], I don't see the problem. So that block came out of the system and it all happened. But yeah, the Deputy Chief Constable had got to the point of issuing ultimatums and things, so that unblocked the system and got things rolling, and it was very positive... (health and social care strategic lead, medium rate force 2).

This demonstrates the potential impact that strong leadership can have on operational practice. In one high rate force, practice on Section 136 had begun to change after the support and commitment of senior personnel within the police and health service was secured. This led to dedicated places of safety being built. The Assistant Chief Constable of their force and the Chief Executive of the local authority and the trust all attended multi-agency meetings and demonstrated real commitment to tackling the issues. The health and social care strategic lead from the area said:

> The Assistant Chief Constable, a Chief Superintendent [name] who is in charge of custody for the whole of [name of high rate force], the three locality Executive Directors, so each of the three areas of the Trust has its Director, [name of mental health liaison

> officer] and me. So, that's this very tight group. Information feeds up from [name of mental health liaison officer] and me into the group, decisions are made, and it is a decision-making, it isn't just a lip service, this is what will be done, this is how I want it done. [Name of mental health liaison officer] and I will then put the policies together to make it operational. That meets three-monthly and it's due to meet in September. [Name of mental health liaison officer] and I will then do an annual report (health and social care strategic lead, high rate force 1).

"However, in another high rate force police respondents continued to believe that there was a lack of commitment from the health side and a failure to recognise that Section 136 was an issue that they should be addressing together. They reported trying to get senior police officers to attend meetings in order to push the issue of Section 136 up the health agenda. In addition to a lack of support from senior staff and officers, other issues were identified as causing problems or tensions with multi-agency working. These were found across all types of forces, but especially those with high rates of detentions and included:

- A lack of health and social care staff to conduct mental health assessments, both within hospitals and in police custody (particularly outside of office hours).

- Poor recording and information gathering on detentions by the various organisations involved. No organisation has overall responsibility for collating the information held on the Section 136 recording form.

- A lack of will and/or ability to share information about individuals.

- Limited police knowledge/training on mental health, which meant that they sometimes called on health and social care staff unnecessarily.

- Delays in assessing people in hospital emergency departments, which was a drain on police time. This sometimes led to officers leaving the individual concerned at the hospital before they were assessed, causing problems for hospital staff if the person needed to be restrained or tried to abscond.

- Difficulties in getting different primary care trusts/NHS commissioners within the same force area to work together.

- A lack of hospital beds leading to delays, frustrations, and tensions between the different organisations and their staff.

- General resourcing issues – the limited budgets of both police and health and social care organisations meant that they could sometimes be unwilling to take on additional responsibilities.

- A general lack of communication at operational and strategic levels leading to a lack of understanding of the difficulties and issues concerning Section 136.

Of all of these issues, information sharing and general communication were felt to be key to improving relationships between the agencies" (Docking et al, 2008: pg 33).

> Yes, because we can't get information about people because of confidentiality, and sometimes that information is vital, you know, to keep people alive or to keep people healthy or whatever (custody sergeant 1, medium rate force 1).

"The extra level of support available in two forces that had access to CPNs was seen as positive and appeared to work well. The CPNs had access to information on their health systems that the police could not access. They shared this information with the police, when appropriate, which made the process run more smoothly and helped to improve the level of care provided to the individual" (Docking et al, 2008: pg. 33). A CPN in one of the areas described his experience of this:

> What we've done is developed relationships. As health trust we've been allowed to come into a criminal justice environments and develop rapport with colleagues like [force custody lead] and probation and the prison and been able to develop relationships with them and use them as part of the care plan for the person that we're seeing. And then, the benefits that has is about access to information, shared practice and access to their environments as well (CPN, criminal justice liaison team, low rate force 2).

"Having links such as specialist mental health nurses based in or available to custody staff could therefore help to improve information sharing and develop better relationships" (Docking et al, 2008: pg. 32), and as stated earlier Bradley (2009) recommended that all police stations should have access to criminal justice liaison teams (which the CPNs were often part of).

"The importance and usefulness of force mental health liaison officers was also highlighted by many respondents from within police forces and from health and social care. Where a single point of contact existed for officers within the force this proved very useful for sharing knowledge, and was also key in terms of providing a link with other agencies and organisations and driving through changes in practice. Respondents thought that it may be possible to have this service out of hours if the posts were funded jointly by the police and the primary care trust/NHS commissioner/local authority. Finally, it was also said that greater dissemination of good practice and more joint training to improve knowledge of the various roles and responsibilities would help to improve multi-agency working" (Docking et al, 2008: pg. 33).

Protocol and agreements

"A key aspect of multi-agency working once established, is the development of agreements and protocols between the various agencies. These should set out the working practices and arrangements to ensure that the roles and responsibilities of all those concerned are clear. If these are adhered to this should lead to fewer tensions between the agencies. A survey of police forces by ACPO (2007) found that 78% of those who responded had service level agreements with their local NHS organisations in relation to Section 136 detentions and 58% stated that a handover protocol was in place for when officers took someone to a health facility.[44] In our study, most forces from across the various rates of [Section 136] detentions [per 10,000 people in custody] stated that they

[44] Twenty-seven of the 43 forces responded.

had agreed protocols with other organisations and that this had been the case for some time. However, forces with high rates of detention tended to have agreed policies more recently than those with low and medium rates, where protocols may have been in place for ten years or more" (Docking et al, 2008: pg. 33).

Of the 18 forces interviewed for this study (6 low rate forces, 6 medium rate forces and 6 high rate forces), all 6 low rate forces had protocols and had them for a number of years, 4 of the medium rate forces had protocols and again had them for a number of years, and 4 of the high rate forces had protocols but two had only signed them recently (within a year of the interview). This perhaps indicates that change is a slow process which involves the gradual shifting of occupational cultures as the agencies influence each other and the 'field' also gradually evolves leading to the greater availability of alternative places of safety.

"The low and medium rate forces were slightly more positive than some of the high rate forces about how well the protocols worked and were adhered to. One high rate force felt that the police saw the agreements as more binding than some of the other agencies involved. However, another high rate force suggested that, following some high profile deaths in custody of people who had been detained under Section 136 (and these were amongst the cases examined in chapter five), new protocols were agreed and there was strong commitment to them among the various agencies. Some forces included Section 136 within policies covering other mental health issues, such as missing patients and transportation. Others had separate policies. The protocols were generally in place

between police forces and primary care trusts/NHS commissioners. Sometimes, local authorities and social services were also included. The issues covered by the protocols included some or all of the following:

- the agreed places of safety outside of police custody, if any were available;

- the circumstances in which different places of safety should be used – for example, where someone is acting violently they should be taken to police custody rather than a hospital for their own safety as well as others;

- the processes for notifying a place of safety that a detainee was being brought there;

- the setting of target times for assessments to be conducted (both in police custody and at an alternative place of safety where available);

- the circumstances under which officers who were waiting with detainees for an assessment in an alternative place of safety may leave the individual; and

- agreements about the transportation of Section 136 detainees (some forces had a separate conveyance policy setting out all of the transportation issues for different patients under the Act).

Some forces also mentioned having policies on Section 135 – detaining in a private place using a warrant. Some agreements dealt with information sharing between different organisations. However, as discussed above this area was most frequently highlighted as being one that needed further development or did not work well in practice. Both police and health and social care respondents felt that there was sometimes a reluctance to share information on an individual and that this hampered the assessment and care of someone detained under Section 136" (Docking et al, 2008: pg. 34).

This is a well reported problem and a general issue that seems to hinder work between the police and health service to prevent many desirable changes. "It seemed that health and social services were able to share information with each other and often had shared IT systems, but the difficulty came with either of these organisations sharing information with the police or vice versa. Respondents said that issues of confidentiality and data protection were often raised, but others stated that if there were health and safety reasons for doing so, for example, if the person was dangerous, it was acceptable to share information. The lack of information sharing was a cause of frustration among respondents, especially as it sometimes seemed to be borne out of fear. Training about what information can be shared would benefit both police officers and health and social care staff" (Docking et al, 2008: pg. 34).

Bradley (2009) also identified information sharing as being vital for the "continuity of care and delivery of services throughout the criminal justice system and on release back in the community" (pg. 135). There are good practice guides on information sharing by

both NACRO (2004) and the Royal College of Psychiatrists (2006) which set out the legal rules for sharing information as well as the benefits and parameters. But Bradley (2009) calls on "practitioners to implement the existing frameworks much more effectively and collaboratively" (pg. 135).

"As stated above, one low rate force had overcome some of these problems as their criminal justice liaison team had access to a wide range of information on Section 136 detainees. Team members could be called upon by custody officers to check whether an individual was known to their service and whether a mental health assessment was likely to be appropriate. Where necessary, they could share information about an individual depending on the risk and the medical need, regardless of whether they had offended" (Docking et al, 2008: pg. 34).

Provision and funding of alternative places of safety

The Mental Health Act Commission (2005) (now replaced by the Care Quality Commission):

> …recognise…that problems in identifying places of safety other than police stations cannot be the fault of the police alone: often the police have great difficulty in handing-over apparently mentally disordered people into the care of medical authorities. When health authorities refuse to accept such patients, the police appear to retain responsible for them by default, even where they are clearly not the best agency to deal with a problem. It is vital that police and other agencies build strong collaborative working partnerships to ensure appropriate and safe care is provided (pg. 287).

"The availability of alternative places of safety to police custody in our study varied in the different police forces. Forces with low and medium rates of detention tended to have more alternative places of safety available. This meant that these forces used police custody as a place of safety less frequently in comparison to high rate forces. The alternative places of safety in low rate forces (and some medium rate forces) were generally more established and had been used for some time. As a result, they were often not dedicated or purpose-built facilities, but instead included hospital emergency departments or mental health units, which had a room that could be used for detaining people under Section 136 while an assessment was arranged. As highlighted earlier, there were some problems in using hospital emergency departments as a place of safety. They did not always provide the most suitable environment for the detainee:

> …in terms of…basic human rights…it is pretty poor [hospital emergency departments]. There are rooms…they've got chairs in but there's nothing else in there. Bare walls, they're not user friendly…you could furnish it in a way that gave a message that says you're important; we're taking this seriously… (Manager of out-of-hours mental health team, low rate force 1)" (Docking et al, 2008: pg. 34).

The Royal College of Psychiatrists (1997) suggest that accident and emergency departments are rarely equipped to deal with patients detained under the Act and in 2008 took this further to state that "an emergency department should only be used as the place of safety where medical problems require urgent assessment and management" (pg. 5).

"There could be long delays in assessing the individual in hospital emergency departments, putting pressure on police resources as two officers needed to wait with the individual, sometimes for several hours" (Docking et al, 2008: pg. 34). This is also a

stressful situation for the person being detained under Section 136 and could serve to exacerbate their mental condition.

"However, most respondents still felt that this environment was more positive than the use of police custody. Mental health units were felt to be a better place of safety than hospital emergency departments, but some respondents thought that they were not always adequately resourced to facilitate assessments. Respondents in one low rate force stated that their primary care trust wanted to stop one of their mental health units from being used as a place of safety. Instead, they wished to use hospital emergency departments, suggesting that taking someone to a mental health facility prejudges the outcome of their assessment. This view was not shared by the respondents in the area who felt that the mental health unit was an appropriate place of safety. Where alternative places of safety were available they were still generally not able to take detainees who were intoxicated or perceived to be violent. The Department of Health had allocated specific funding for improving mental health facilities. The funding included developing Section 136 places of safety, as the Department saw this as a priority (Department of Health, 2006). Primary care trusts/NHS commissioners could bid for funds to build dedicated places of safety. Our study found examples of high and medium rate forces that had received this funding. Once built, dedicated places of safety require funding for staff, which could be an issue as the funding available did not include staffing costs. This was the case in one high rate force where a purpose-built place of safety had been established in an area of the force and had been open for a pilot period of approximately nine months. During this time, staff from a psychiatric ward were reallocated to help cover the extra demand. The

feedback on how well this worked was mixed. Some thought that the system was very good, but others felt that it was not adequately resourced and therefore could not be used by very many people at any one time. However, it was stated that the service user feedback had been good. Unfortunately, the staff were withdrawn at the end of the pilot period and the place of safety had not been used since. Some respondents reported that it was currently being used as a "store cupboard". Respondents from the force stated that this led to their seeking to use hospital emergency departments as a place if safety. In the meantime, the primary care trusts/NHS commissioners had received funding to build further places of safety across the force (six in total, including the existing facility) and there was a concern that because of the lack of revenue funding for staff they would quickly become six "white elephants":

> There's no funding, it really is a tricky situation because they're expecting us to build places without any extra staffing or training for those staff to deal with what, currently, the police are finding quite a difficult group to manage (head of social care, high rate force 1).

Other high and medium rate forces were in the process of building dedicated places of safety with the money they had received from Department of Health funding. Two of these also raised concerns about the lack of additional funding to staff the facilities. One of the forces had decided that they could not afford to permanently staff the unit once it was opened, but would instead draw on their existing staff resources. This was to be primarily from the crisis resolution team who were part of social services and ran a 24-hour service. There were concerns that the crisis team already had a very busy workload and that the impact of this additional work would cause them problems in meeting their

targets. A monitoring group was set up to assess the impact on staff once the unit was opened" (Docking et al, 2008: pg 35). The health and social care strategic lead in the area described the situation as they saw it:

> What that gave us was the capital to provide the units. It doesn't give us the revenue to staff them, so we need to staff from existing monies because the PCTs have indicated that they can't provide us additional staffing. In [name of an area of the high rate force] we included in our bid £127,000 that we saw that we needed for nursing costs for it. We haven't got that. So, we've got to look at changing some of the staffing arrangements. For example, overnight, it may well be that the receiving nurse will be the nurse that's on duty in CRHT. But those nurses currently will go out with a doctor at night into a person's own home to try and support something, so if they're out doing that we've got to look at how we're going to manage the place of safety (health and social care strategic lead, high rate force 2).

Similar arrangements had been made in the other high rate force, which was also planning to use their crisis resolution team – particularly at night – or to use a senior nurse from the psychiatric ward. However, respondents from the force mentioned the possibility of the initial assessment being conducted by a junior doctor. "Their perception was that this could result in the detainee possibly receiving a lower level of service, given that a junior doctor would often have less experience than could be expected of a FP in a custody environment" (Docking et al, 2008: pg. 35).

The Royal College of Psychiatrists (2008) also highlighted the problem of staffing of alternative places of safety:

> Without adequate staffing provision the danger is that either police will be expected to remain in the place of safety, which is an inappropriate use of their time and potentially stigmatising, or the police custody suite will continue to be used excessively. Neither is acceptable. These members of staff can be used to support other teams or wards when not required in the assessment facility, provided that they are available at short notice to return to the unit (pg. 5).

The College (2008) make a series of recommendations about the staffing of places of safety including the following:

> 1. The psychiatric Section 136 facility should ideally have dedicated staffing, or at the very least, a supernumerary post attached to the team responsible for the place of safety.
>
> 2. Staffing levels should be sufficient 24 hours a day to ensure that the police can leave promptly after a handover period, even when the patient is disturbed. There should be no expectation that the police will remain until the assessment is completed, as currently happens in some places. In many areas this will require additional resources.
>
> 3. There should be a clearly identified person in charge of the psychiatric assessment facility at all times. A member of staff should be present to receive the patient on their arrival (pg. 8).

The evidence from our case studies suggests that at least at the time of the fieldwork the alternative places of safety often did not meet the standards set out by the College. Many were understaffed and required the police to wait until the assessment was complete. This caused frustration, particular on the part of the police, and put a strain on the working relationships. It may also have had the effect of making officers think twice about taking a detainee to an alternative place of safety if taking them to custody instead meant that they were able to return to duty more quickly. Particularly given that they may not have

viewed dealing with a Section 136 detention as 'proper police work' and instead wanted to be 'catching criminals'.

"It should be noted that the Department of Health funding was only available for primary care trusts/NHS commissioners in England. At the time of our fieldwork, respondents stated that there was no equivalent funding for Welsh health boards. One respondent from Wales said that they would like to see Section 136 centres with multi-agency staffing and that they were working on a proposal to put to the Welsh Assembly" (Docking et al, 2008: pg. 35). The outcome of this proposal is not known at the time of writing.

The Royal College of Psychiatrists (2008) describe an ideal scenario for the availability of alternative places of safety:

> In identifying alternative options within the hospital to the preferred place of safety, the managers must satisfy themselves that the physical environment is appropriate for that purpose, using the standards set for the usual psychiatric facility as guidance, to ensure the safety of the individual, staff, other users and visitors. The staffing required for the use of these alternatives should be identified with a clear process to ensure that they can be immediately obtained. There should be a clear procedure for the use of these alternatives. It is recommended that the police should contact the person in charge of the psychiatric Section 136 place of safety to jointly agree the most suitable place of safety, unless the individual requires immediate medical assessment and treatment or is so disturbed as to require a custody suite. The person in charge of the place of safety would ensure that the other facility is in a position to accept the individual before they could be taken there. Where a ward is used it must be made clear to all concerned that the person is not at that point admitted to an in-patient bed. The use of these alternative facilities should be carefully monitored (pg. 26).

They go on to state that:

> The ideal situation would be to have a dedicated emergency psychiatric facility for those detained under Section 136 in close proximity to acute admission wards and with dedicated staff attached to the unit who support the admission wards when the assessment facility is empty (pg. 27).

The Royal College have therefore set out very clear guidelines on what they expect the minimum standards for places of safety to look like. However, the evidence I have gathered for this thesis suggests that this is not being achieved in many places across England and Wales, or there are policies in place which try to reflect this guidance but they are not reflected in practice on the ground. Therefore many Section 136 detainees are being held in inappropriate locations where they are not receiving the care they need, compromising their safety and potentially that of the staff in the facilities as well as that of other individuals.

Conclusions

This chapter has shown that multi-agency working can impact on the use of Section 136. Where it works well it can help to minimise the use of police custody as a place of safety. When all parties recognised Section 136 detentions as a joint problem requiring a co-ordinated approach it became more likely that alternative places of safety were developed. It appears that changes in operational practice can occur when driven by senior leadership both within the force and in health and social care organisations. When the differing organisations come together, they come to better understand the problem

and their individual roles in addressing it. This can cause a gradual shift in police occupational culture – a shift in the 'habitus' – and help to cause positive changes in the 'field' by developing better working practices and increasing resources available for Section 136 detentions. These changes for Section 136 primarily relate to an increase in the provision of alternative places of safety and the development of agreements and protocols which govern how they are jointly run and administrated. Linked to this was an improved understanding and provision of places of safety which provided a suitable physical environment with specialist staff along the lines of the minimum standards set out by the Royal College of Psychiatrists (2008) at the end of the previous chapter. It also relates to improved, and in many cases joint training for the police which helps to ensure the safety of all those involved in the detentions, including the detainee.

7. Conclusions

> Any legal reforms directed at police action in arresting and detaining people are likely to be relatively ineffective…an evaluation of Section 136 as a socially constructed process seems more relevant in both conceptualising the process relevant to Section 136 and seeking more effective and sensitive social policy changes in relation to psychiatric emergencies dealt with by the police and others. From this conceptual position, officers' decisions are not considered as if they take place in isolation, but as part of a wide system which is influenced by the courts, hospitals, and professional interests (Rogers, 1990: pg. 234-235).

Introduction

The police have to deal with all kinds of unpredictable and difficult situations and people. Among them are people who are acting in bizarre ways, who may be confused, depressed, distressed, psychotic, talking to themselves, or acting in other ways that people may find threatening or frightening. Members of the public may therefore call for the police to handle the situation and sometimes these individuals may need to be detained for their own safety under Section 136, or at least the police may decide that they need to be detained. A 'place of safety' can include a police cell and this study sought to describe the nature and extent of Section 136 detentions in police custody across England and Wales.

It also tried to identify the reasons why the use of police custody as a place of safety varied in different police forces, and examined the deaths of those who died in police custody while being detained under Section 136. It gathered empirical evidence on each

of these issues and analysed it within the wider context of the research literature and theories of policing. This chapter seeks to bring together my conclusions from this analysis and to argue how I ultimately think police practice in this area can be changed for the better and the care and treatment of those detained under Section 136 improved.

Changes to the Mental Health Act 1983

Before discussing the findings of my research it is useful to set out some important changes to the legislation since our fieldwork was completed. Section 44 of the Mental Health Act 2007 has amended the 1983 Act to allow the transfer of people from one 'place of safety' to another, this came into effect at the end of April 2008. It is difficult to know how this might have affected Section 136 detentions and whether it has changed day-to-day practice due to the lack of reliable statistics on those detained in custody.

As shown in chapter two, more recent statistics show an increase in the number of detentions in hospital but it is not known if detentions in police custody have fallen during this period, or how many of those held in hospital were first held in police custody and transferred to hospital. The power "may reduce the time people spend in police custody, with those people who are no longer considered to be violent being moved to hospital. However, some respondents in our study also thought that it might mean more individuals being taken to custody when they are perceived to be aggressive in hospital. Some other parts of the Mental Health Act 2007 [came] into effect in late 2008 and these could also have an impact on the use of Section 136 and on police custody as a place of

safety. The [Mental Health Act 2007] amends the definition of "mental disorder" so that a single definition applies throughout the Act and abolishes references to different categories of mental disorder. The implications of this in terms of the 2007 Act potentially encompass individuals with personality disorder more readily than before were discussed [in chapter five]" (Docking et al, 2008: pg. 40-41). The extended definition may encompass people who might previously have been considered to be too difficult to deal with.

"While this should make it simpler for practitioners to understand, there is the possibility that this could lead to the over-inclusion of some individuals who do not actually have a mental disorder, but who may have behavioural problems" (Docking et al, 2008: pg. 41, also see Peay, 2011a). "This could lead to an increase in the number of people detained under the Act, including people detained under Section 136. The [Mental Health Act 2007] also introduced 'supervised community treatment', which allows some individuals who have been detained in hospital under the Act to live in the community while subject to specified conditions and while continuing with the medical treatment that they need. The aim of this is to ensure that individuals who are released from hospital continue with their treatment and do not end up back in hospital. It does, however, mean that greater numbers of people will be subject to some level of compulsion of treatment in the community and there will inevitably be situations where these people will be forcibly removed to institutional care and physical restraint may be used (IPCC, 2004)" (Docking et al, 2008: pg. 41).

Community treatment orders "could also mean that more people may potentially be detained under Section 136 if they fail to continue with their medical treatment and are showing signs of mental disorder in a public place. These issues need to be considered by the police and other relevant agencies in order to ensure that the potential impact is realised and addressed" (Docking et al, 2008: pg. 41). However, because there have been no new national statistics since those collated for this research (at the time of writing), it is not possible to assess the impact of these new provisions – this remains a fundamental gap in the evidence.

"Finally, the amended Code of Practice (Department of Health, 2008) that accompanies the Mental Health Act 2007 sets out the importance of jointly agreed local policy on Section 136 (Para 10.16) [as discussed in chapter one]. This should be agreed by social services, hospitals, NHS commissioners, police forces and ambulance services. It goes on to state that the policy agreed locally should include details of the operation of places of safety within the area. It should also set out the roles and responsibilities of the people involved, ensure that assessments are conducted promptly, cover the transportation arrangements for detainees, and describe how to monitor the use of Section 136. The recommendations set out [in Appendix K] cover several of these points and were addressed to the agencies that are responsible for the area" (Docking et al, 2008: pg. 41); they were drafted as policy recommendations in the report written using this material for

the IPCC[45]. The use of local policy groups (where not already established) which are well-placed to tackle some of the issues discussed below should be encouraged.

Prevalence of Section 136 detentions and make up of detainees – defining the 'research problem'

Section 136 detainees are individuals who are deemed to be 'in need of care and/or control' and may be exhibiting a variety of symptoms of potential mental illness such as acting in a bizarre, aggressive or irritable manner, experiencing hallucinations, delusions or paranoid ideas, and having extreme high or low moods. A police cell is therefore an unsuitable environment for these individuals and being held in such facilities may exacerbate their symptoms. There is very little justification for using a police cell where someone is not suspected of committing an offence. The effect of using police custody as a 'place of safety' is to criminalise the individual's behaviour, in that the experience of being detained by the police, generally transported to a place of safety in a police vehicle, sometimes in handcuffs, and then detained in a police cell unable to leave until they have been assessed – up to 72 hours later which is far longer than a normal PACE detention, simply makes the detainee feel like a criminal. Similarly, Bosworth and Guild (2008) wrote about the experience of being detained for immigration purposes and found "...that asylum seekers at any rate interpret their experiences in the framework of crime and

[45] Docking, M., Grace, K. and Bucke, T. (2008): *Police Custody as a 'Place of Safety': examining the Use of Section 136 of the Mental Health Act 1983*. IPCC Research and Statistics Series, Paper 11. IPCC: London

punishment" (pg. 706). They also use Jonathan Simon's (1997) concept of ' governing through crime ' "to describe how metaphors and practices of punishment have spilled over into public spheres beyond the criminal justice system" (pg. 704). Whilst it is not a criminal detention in name, the reality is that for most detainees it will feel as though it is, and in their distressed and potentially confused state this may possibly worsen their physical and emotional wellbeing. Being transported in a marked police vehicle can only add to the sense of stigmatisation experienced by these mentally vulnerable individuals. As the Royal College of Psychiatrists (2008) put it, "…the stigmatising impact of using a police car to convey to a place of safety, [gives] the impression that the person may be a criminal" (pg.21). The whole experience could be confusing, terrifying and extremely distressing to the individual. The Royal College of Psychiatrists (2008) quote a service user's experience of being detained:

> 'Mentally I got worse and worse. I got a delusion from a sign on a billboard. This made me knock a policeman's helmet off – this was the first legal 136 I experienced. I got to the hospital...I was bursting for the toilet. My hands were behind my back, there was dried blood on my hand. I had to release my bowels on the floor in the room. The handcuffs get tighter as you struggle. Blood everywhere. I arrived at that hospital (place of safety facility) at 1.00 am and went to hospital (admission ward) at 7.00 or 8.00 am.' (pg. 22).

This quotation suggests that the experience of being detained by the police is never going to be pleasant, but it is likely to be all the more frightening and disturbing if the individual had been taken into a busy police custody suite.

It has been argued in the context of sentencing that enforcement of mental health law has a 'hybrid' quality in that it combines elements of both treatment and punishment (e.g. Peay, 2011b). The same can be applied to the role of the police in enforcing mental health law. On one hand, Section 136 is intended to provide for the care of mentally ill people, to remove them from situations in which they could be a danger to themselves to a place of safety where their illness can be assessed and, from there, provide a route into treatment. On the other hand, the section provides the police with a mechanism to *control* behaviour that lies on the boundary between illness and criminality. As has been discussed throughout this thesis, people with mental health problems sometimes act in ways that are disturbing, disorderly or even violent and which can be labelled as either as illness or crime. It is clear that police officers often have to make decisions about how these behaviours are defined and the section provides a hybrid category that enables them to pursue pragmatic police-defined goals concerned with order maintenance on the streets.

This hybridity is inherent in the nature of the power. Section 136 is an administrative power to facilitate the care of the mentally ill and yet it is *de facto* an arrest (Cummins, 2012). Like other arrests by the police, it will in many cases result in the person being detained by force, the application of restraints such as handcuffs, being searched, being read their rights under PACE. While in police custody, people detained on Section 136 will have their belt, shoelaces and other items of clothing removed in much the same way as other arrestees. Cummins (2012, pg. 6) argues that the process "creates the impression that the person has been arrested for being mentally ill."

Malcolm Feeley's (1979) idea that the 'process is the punishment' is useful here. The process of detaining someone under the Act can be seen as punishment in two senses. First, it can be said to be punitive when the degree of coercive power, intrusion into liberty and the unpleasantness of the experience are indistinguishable from the same process embarked on for the purposes of enforcing criminal law. Secondly, it is punitive when the effect of detention under Section 136 is to channel the detainee into the criminal justice system. The evidence set out in this thesis suggests that the process of detention is punitive in both senses. In my view, therefore, the effect of sectioning is not merely to stigmatise the detainee but specifically to *criminalise* them through by blurring the boundary between enabling health care to the mentally ill and the control of criminal offenders.

"It is broadly accepted that police custody should only be used as a 'place of safety' in *exceptional* circumstances. Police custody is an unsuitable environment for someone with a mental disorder and may exacerbate their condition, particularly if they are not dealt with quickly and appropriately and if they do not receive the care they need. However, our study has shown that in many areas, custody continues to be used as the *main* 'place of safety' with few or no alternatives being available. Therefore, over a one-year period (2005/06) in England and Wales we found that over 11,500 people were detained in police custody. This compares to 5,900 in hospital environments (Department of Health, 2007) – in other words almost twice as many people were detained in police custody rather than in a hospital environment. Our data showed large variations across police

forces in the use of police custody as a place of safety. Forces with low rates of Section 136 detentions included Cheshire Police and Merseyside Police (both one Section 136 detention per 10,000 people in custody). Forces with high rates included Sussex Police (277 Section 136 detentions per 10,000 people in custody) and Devon and Cornwall (174 Section 136 detentions per 10,000 people in custody)" (Docking et al, 2008: pg. 37).

However, the picture is multi-faceted, with some forces that appear to have low rates of Section 136 usage in custody having examples of good practice such as good working arrangements with their local health care provider. But some of these forces also seemed to have officers who were simply exercising their discretion to arrest individuals for minor offences such as breach of the peace or criminal damage rather than detaining them under Section 136. The advantage of this practice from their perspective was that in their particular force, by arresting for the criminal offence instead they had to adhere to less bureaucratic procedures without as much paperwork to complete, enabling them to return to the street more quickly. The impact on the individual in terms of potentially criminalising their behaviour, from the perspective of the detainee, and adding to their emotional distress was something that was not generally considered in these circumstances since the officers believed that the outcome would be the same anyway. That is, once an apparently disturbed individual was in custody, the custody officer would call a FP to assess them and if any mental health needs were identified they would be dealt with under that process and the criminal charges generally dropped.

I discussed in chapter five the example of this practice which we witnessed in a custody suite in a low rate force. The individual had been detained for criminal damage but was waiting to be assessed for mental health needs. Our quantitative data also showed that the most common offence for both Section 136 detainees and individuals arrested for offences but found to have mental health needs was breach of the peace. This is an offence which can easily be applied to incidents where someone with mental health needs is seen to be causing a disturbance. This means that for people who were not found to have mental health needs following an arrest, they might be formally charged in some police forces, whereas in others they would have been detained under Section 136 and would leave custody without being charged. This leads to potential disparities in the figures and means that it is difficult to estimate the full extent of detention of people with mental health needs.

The role of frontline officers is therefore important in terms of them deciding whether to detain an individual or not, and using their discretion to decide on which power to use. Training can also play a part in this in improving their knowledge of the law, and therefore influencing the approach that officers might take in differing situations or their understanding and knowledge of which laws to apply. Mokhtar and Hogbin (1993) argue that a lack of training could lead to underuse of Section 136 by police officers. Bradley (2009) called for greater training in mental health for police officers, as stated in chapter 1 the training that officers receive on mental health is varied, with probationer constables receiving some input on mental health (of varying length and quality) but longer serving

officers may not have received any training. Cummins (2007) also found that many officers receive little training on mental health issues.

Even with officers receiving appropriate training and initiatives in some forces, described later in this chapter, to help improve officers' knowledge of the law on Section 136, the nature of the law means that discretion will lead to differing interpretations. Section 136 allows an officer to detain an individual they deem to be 'in need of immediate care or control'; officers faced with the same situation might reasonably believe that an individual does or does not need to be detained. Furthermore, as stated above attitudes towards the law varied among officers from differing forces, with some believing that it would be simpler and less bureaucratic to detain for a minor criminal offence instead. This was related to practices in the force but also to the type of individual they were detaining, with those perceived to be more difficult to process perhaps being detained using criminal powers instead. The most common examples given of this were individuals requiring dual diagnosis for alcohol and/or drug issues in addition to mental health problems and those with personality disorders. These groups of individuals were thought to be part of the revolving door scenario and it was therefore sometimes deemed easier or even more appropriate to arrest them for a minor criminal offence such as breach of the peace or criminal damage (in that it could see them diverted out of the criminal justice system and into mental health services and effective treatment in a way that Section 136 would not). This potentially leads to the criminalisation of these types of detainees. Therefore knowledge of the law and attitudes towards it, and related to this

training of officers, make a critical difference to how the law is used and may account for some of the discrepancies in its use.

"The figures also show notable differences in the ethnicity of those detained. Black people in particular were almost twice as likely as White people to be detained in police custody under Section 136 when rates of detention are compared to population data. This reflects a wider issue of high proportions of Black people both within the criminal justice system and detained under the Mental Health Act 1983" (Docking et al, 2008: pg. 37). The former could in part be explained by police racism and the over-policing of this demographic group (Bowling and Phillips, 2002; Rogers and Faulkner, 1987; Audini and Lelliot, 2002; Singh et al, 2007; Care Quality Commission, 2011). The disproportionality in the ethnicity of detainees was more extreme in more rural forces. Rogers (1990) has noted that community prejudice brings the police into contact with BME groups and this could help explain some of this disparity given that other research has highlighted particular issues with rural racism (Chakraborti and Garland, 2004) which mean that members of the public may be more likely to call the police when they see a Black person acting strangely than a White person and that this may be more pronounced in areas with small BME populations. From the evidence examined in this thesis it appears that there are multiple reasons which explain the disproportionality in the number of Black people detained under Section 136 – reasons include Black people not accessing mental health services at an early stage for cultural reasons and therefore becoming more likely to develop more mental health problems which cause them to come into contact with the police, racism among society meaning that the behaviour of Black people is more likely

to be interpreted as potentially threatening or alarming resulting in the police being called, and potential racism and stereotyping of Black people by the police. However, there is a need for more research in this area to explain definitively why disproportionality occurs.

"The Royal College of Psychiatrists and the Mental Health Act Commission (now replaced by the Care Quality Commission) have both called for the better recording of Section 136 detentions across England and Wales. Our research found problems with the way that Section 136 detentions are recorded, both within police custody and in hospital environments. The data we obtained from police forces came from custody IT systems. It highlighted inconsistencies in the way that Section 136 detentions were recorded and the level of detail collected. As a result, it is not possible to secure accurate data on the outcome of Section 136 detentions" (Docking et al, 2008: pg. 39). The data that we do have is problematic in that due to recording issues it overestimates the number of people who were dealt with by NFA and underestimates those who were taken to hospital/care/detained under the Act. The data also showed some disparities in how people from different ethnic groups were disposed of from custody, with it being much more common for White people to be dealt with by NFA than people from BME groups. This seems to be supported from other evidence suggesting that the police are more likely to charge Black people with similar offences to White people (Mhlanga, 1997).

The poor quality of the data raises major issues as we do not know with any certainty what percentage of Section 136 detainees are released into the community or taken to

hospital, and this could provide an important insight into how appropriately the power is used and how this varies among police forces. The figures are also likely to "underestimate the total number of people detained under this power because some custody systems allowed only one reason for arrest to be recorded, which would generally be the offence committed rather than the Section 136 detention" (Docking et al, 2008: pg. 39). This highlights the importance of consistent and accurate recording of Section 136 detentions and their outcomes by all police forces in England and Wales as this could also mask the reasons for variations between forces.

"Given that the use of Section 136 deprives individuals of their liberty and, when held in police custody, effectively criminalises their behaviour [from the perspective of the detainee], it is vital that this is subject to accurate recording to enable any inappropriate or unjustified detentions to be identified. The lack of routinely collected robust data is therefore a situation that needs to be rectified. It could also help focus resources on those geographical areas that need them to minimise the use of police custody as a place of safety. In addition, our work at the case study sites showed that when alternative places of safety are used, the recording of Section 136 detentions often continued to be poor with no individual agency takes complete responsibility for ensuring that the forms are completed and the data is collated and analysed. We therefore support the Royal College of Psychiatrists in their desire to see a national recording form to improve data standards" (Docking et al, 2008: pg. 39).

In July 2011 the College published an updated version of their minimum standards for places of safety which included proposals for monitoring and auditing Section 136 detentions as well as a recording form agreed upon by a working group of key practitioners. They recommend the use of this national form to allow for comparisons across areas, whilst allowing for additional local information to be collated as and where necessary (Royal College of Psychiatrists, 2011: pg. 50). They recommend a list of key data that should be recorded such as the number of times a detention is invoked by the police, where it occurs, the demographic details of the detainee, the place of safety used, the length of detention, how long the assessment took, the outcome of the detention, drug and alcohol use, self-harm and whether restraint was used (pg. 51). The College also suggest that further background information on the detainees could be audited such as their previous psychiatric history and care. They recommend that the local policy should state who should collect this data, but that "the local Mental Health Act office of the nearest service provider may be in a good position to do this" (pg. 52). Finally, they state that "the data should be reviewed locally by the monitoring groups and nationally by the Care Quality Commission for England and Healthcare Inspectorate Wales" (pg. 52).

"More robust monitoring of the data is also needed in order for us to have a better understanding of the nature and extent of Section 136 detentions and how this might vary between different force/primary care trust areas and different places of safety within those areas" (Docking et al, 2008; pg 39). The Royal College of Psychiatrists' (2011) suggestion that the Care Quality Commission should monitor this data would make a big improvement to this area of work and I support this proposal and suggest that such

statistics be published annually. Monitoring and auditing of Section 136 detentions might also help to prevent inappropriate or illegal use of this power and impact upon occupational culture and practices by ensuring greater supervision and scrutiny of frontline officers.

Little information also exists about the experiences of people detained under Section 136; the absence of the voice of service users is a common issue in criminal justice research and one that needs to be addressed. The fieldwork for this study was conducted for an IPCC study and as such focused on police and other agencies involved in the detentions of individuals under Section 136. Due to time and resource constraints it was not possible to conduct additional research with service users. However, such research would offer a valuable perspective and add to our knowledge on Section 136. Qualitative research with service users using one to one interviews would offer an in-depth insight into their experience of being detained under Section 136, how this might vary between different areas, different places of safety or among different social-demographic or ethnic groups. Interviews with research focusing on Section 136 detainees could also help to establish the circumstances in which they are primarily detained – for example, it could tell us whether Section 136 tends to be used at the bottom end of the spectrum in terms of the seriousness of someone's behaviour, or whether there are circumstances in which individuals could have been arrested and charged instead, again it would be useful to look at how this varied across different police force areas.

Research could involve interviewing people who had been detained under Section 136 within the previous year (to ensure accurate recall), they could come from a range of forces with differing rates of Section 136 usage, working practices and availability of alternative places of safety to capture a variety of experiences. It would be useful to have a mixture of respondents who were sectioned or released following the assessment under Section 136 in order to look at the appropriateness of the detention. Depending on the mental health of the respondent some may need to be accompanied by an appropriate adult and the interviewer may need to consider their circumstances and adapt their interview style. Potential interviewees could be identified and recruited via the police – asking for consent when the individual is detained, via mental health services for individuals that have ongoing treatment or via the third sector through organisations that offer support to individuals with mental health issues. It would be important to gain informed consent. The lack of this research represents another key gap in our knowledge. Finding a way to access this information could help to provide a better insight into the provision and care required by Section 136 detainees and potentially lead to differing ways of working for the agencies who care for detainees depending on what the findings suggest.

In addition the fieldwork did not involve any frontline officers who had actually detained individuals (although some of the custody officers who were interviewed had previously detained people under Section 136 when working on the streets prior to specialising in custody, and one interviewee was an inspector in charge of frontline officers). This was due to a proactive decision to focus on the actual detention in custody and less on the

circumstances that led to it in order to complete the research with the time and resources available. However, frontline officers could also offer a useful insight into the application of Section 136 and how decisions are made on the street. As with service users, qualitative interviews would seem the most appropriate method for this research, across a range of police force types with varying rates of Section 136 usage should provide a variety of data on differing practices. The interviews could focus on the decision making of the officers, how they came across the incidents – i.e. reported by the public or found by the officers, whether they considered using alternative powers, and if not why, their knowledge of the law, training in mental health, views of the detainees, views of other agencies and where the individual was detained. This would provide an overview of practices on the ground, variation and reasons for this and the occupational culture of frontline officers and their views of the Section 136 detainees. This could help to highlight ways in which practice could be changed for the better.

In some of the most tragic Section 136 detentions in police custody individuals have died while being detained. These cases are relatively rare but often high profile in their nature. Between 1998/99 – 2008/09 there were 17 people who were detained under Section 136 and died during or following the detention. They ranged from 19 to 71 years of age, 15 were male and 12 were White (four people were from BME groups and one was not stated). Most were arrested in a public place (nine people) but six were arrested in their own home.

Eight of these people were physically restrained by officers. Five of the individuals appeared to be intoxicated through alcohol at the point of detention and three through drugs. The dangers associated with restraint were touched upon in chapter two, in particular restraining people who are under the influence of drugs and/or alcohol. Nine of the 17 individuals were taken to custody as a place of safety; six were taken to hospital and two people died at the scene of detention. There was evidence that some of the detainees were not risk assessed and others did not receive the agreed levels of checks by officers. Two of the deceased were pronounced dead in custody, two at the scene of the arrest and the remainder in hospital. Despite being aware of their vulnerability three people were still able to commit suicide and two people took a drug overdose (one of these deaths was also related to the restraint).

An additional two detainees who died in or following custody were arrested for public order offences but dealt with subsequently under Section 136 once they were taken to custody. The two detainees were therefore assessed by an Approved Mental Health Practitioner/ASW and a suitably qualified doctor and it was decided that both should be subsequently sectioned to hospital. This demonstrates that the data we collated is likely to underestimate the number of people held in custody and dealt with under Section 136 of the Act, and the number of people who are arrested for offences but who have mental health needs. The deaths of Sections 136 detainees in police custody show that the safeguards that PACE put in place to protect detainees are not always adhered to and starkly illustrate the need for alternative places of safety for these vulnerable individuals.

Improving working practices and care of detainees

"We recognise that some forces had specific geographical factors which lead to them detaining a higher number of individuals under Section 136. This included having a high prevalence of drug and alcohol abuse among the local population, high levels of deprivation and unemployment, a transient population, and having well-known local suicide spots. These factors mean that some forces may have to detain more individuals under Section 136. However, other forces have stated that health and social care providers in their areas have tried to be proactive and take preventative action to avoid people getting to the stage where they need to be detained under Section 136. This includes schemes to encourage GPs to take early action and refer individuals for treatment, where appropriate, and making full use of local crisis teams to conduct outreach work. Some preventative action could focus on groups of people who may come in and out of custody and are more difficult to deal with – such as those requiring dual diagnosis for mental disorder and drug and/or alcohol dependency. This could prevent some people from becoming part of the 'revolving door' scenario" (Docking et al, 2008: pg. 38) (i.e. frequently being taken in to police custody due to a failure to adequately treat their multiple needs).

This links back to the quote at the beginning of this chapter which suggests that police decisions and responses should be considered as part of a wider system (Rogers, 1990). As Bradley (2009) recommends, having police access to criminal justice liaison teams

could also have a positive impact in helping the police to provide appropriate care for vulnerable individuals.

Research on the police has found that they do not see their role as one that should put much focus or time into the 'social work' function but instead wish to see themselves engaged in 'crime fighting' (Reiner, 2000; Fielding, 2005b). This perspective was found amongst my respondents in that they thought that they were often left to deal with issues which they perhaps rightly in some cases, saw as the responsibility of health and social care organisations. Some officers with operational responsibilities were resentful of the amount of police time spent on dealing with Section 136 detainees rather than on 'proper police work'. But the picture was more complex than that with custody sergeants concerned about Section 136 detainees being in their care, both due to fears of a potential death in custody and the repercussions arising from such an incident but also due to genuine concerns about their welfare and an understanding of the impact that the custody environment could have on a mentally vulnerable individual. The 'habitus' or cultural knowledge of the police could be changed for the better if all officers accepted their role as not solely one of crime fighting but one which encompasses more of a social work function involving working with other agencies and maintaining order as Reiner (2000) identifies their function to be. O'Neil and McCarthy (2012) found that the 'pragmatism' element of police culture identified by Reiner could actually enhance multi-agency working for neighbourhood policing and that among the officers involved in this work there was an acceptance of the broader role of the police necessitating work with a range

of agencies. They found that the 'habitus' could be changed with the right circumstances and time to adapt.

While it is not realistic to expect police officers to be experts in mental health, "it is important that officers on the street have a basic understanding of possible signs of mental disorder and to know what their powers are under the Act. This will help to ensure that Section 136 is used appropriately and that individuals receive the care that they need. Officers should also know what the local procedures are and where they should take the individual (presuming that there are alternatives to police custody). Our study found examples of initiatives that sought to ensure officers had this knowledge. For example, in one force with a low rate of Section 136 detentions in police custody the primary care trust and the police force had jointly produced an aide memoire card to fit inside officers' pocket books [see Appendix J]. This set out their powers under the [Act]; some examples of symptoms that may indicate mental disorder; questions that they may ask the individual; a summary of the joint policies and procedures for detention, including relevant places of safety; contact telephone numbers of the different agencies; and details of what should happen on arrival at the place of safety. Officers on the street may find it difficult to recognise individuals with a mental disorder – this is particularly the case if someone is suffering from physical injuries, such as head wounds, or illnesses such as diabetes. These people may show similar symptoms to someone with a mental disorder. Equally, if someone is intoxicated it may also be difficult for officers to discern whether they are mentally disordered. This means that some individuals who are *not* mentally disordered may be mistakenly detained by officers and others who *are* mentally

disordered may not get the assessment they need. Some forces had schemes in place that allowed officers to have telephone contact with health and social care professionals to get advice and information about particular situations or individuals. We welcome this type of initiative. Better training for officers on the street in recognising individuals with mental disorder and knowing their powers to detain them and where they should be taken would all be useful ways to improve practice. Some forces with low and medium rates of Section 136 detentions in police custody seemed to use other powers of arrest, such as preventing a breach of the peace, rather than Section 136, as it was seen as less bureaucratic. On the other hand, the reverse seemed to be the case in some high rate forces. Because of the lack of reliable data highlighted above it is difficult to check whether this approach had an impact on the rates of Section 136 detentions – another gap in the knowledge from not having reliable national statistics. More broadly, officers should be encouraged to use the *most appropriate* power of detention rather than focusing on what may be the quickest or simplest for them" (Docking et al, 2008: pg. 40).

Given the discretionary nature of Section 136, the potentially broad interpretation of what constitutes behaviour 'in need of immediate care or control' and the implications for those detained particularly those – up to 72 hours in a custody suite and the feeling or sense of being criminalised by their treatment – there is an argument that it might be best for the power to be abolished and the police deal with the individuals they would have detained under their existing powers. However, it is difficult to see which powers could be used to result in a more positive experience and outcome for the detainees. Low level offences such as breach of the peace could be used to detain individuals (and indeed are

in some forces) with a view to diverting them out of the criminal justice system and referring them to mental health services. However, this would be stigmatising and could be applied inconsistently therefore leading to greater numbers of people with mental health problems entering the criminal justice system, which is already a large problem. Therefore it is preferable to focus on ways in which the use of the existing power can be improved.

"Even where multi-agency working was in place and relationships were fairly good there was still the potential for further improvements in information sharing between agencies on individual detainees. Custody officers and health and social care staff were sometimes reluctant to share information on individuals due to fears about confidentiality and data protection. While some of these concerns might be legitimate, individuals seemed to be uncertain about what could be shared and feared legal repercussions. It would therefore be useful to ensure that custody officers and health and social care staff are clear about what information can be legally shared. There is also the potential for joint training in this area – this would help to shape the understanding of the different organisations about what each can do in terms of information sharing and their wider role in Section 136 detentions. Such training could also draw on the experiences of service users and their carers" (Docking et al, 2008: pg. 40). Training involving multiple agencies and service users as well as ongoing contact between the agencies, can lead to positive changes in occupational culture and improve relationships as well as the views of the agencies dealing with the individuals and their awareness of the impact of the detention on the detainee.

Joint training with other agencies occurs in other areas of police work such as child sexual abuse where the police have joint training with social workers to aid investigation of such cases and assist with the interviewing of the children. Patterson (2004) examined "the effects of joint child abuse training provided by a social worker, skilled in child welfare practice, and experienced police officers. The objective of the…study was to assess whether mandatory child abuse training produced significant differences in the knowledge, skills, and attitudes between recruits who received the training and those who did not" (pg. 275). He found "…recruits in the experimental group reported significantly more positive attitudes of sympathy and caring toward abusive parents, acquired more knowledge about child abuse and neglect, and developed more skills than those in the comparison group" (pg. 278). Moran-Ellis and Fielding (1996) found that it was accepted good practice for joint working on child sexual abuse cases to occur but that "while the great majority of agencies identified themselves as working jointly" there were variations in practice and , "…the adoption of a broad policy of joint investigation is merely the first step in getting to grips with working together" (pg. 355-356). Positive changes can occur from joint training and working but the key is for it to become embedded into routine practice rather than being seen as a novel innovation.

"Our study found that there were often long delays in assessing Section 136 detainees both in custody and at hospital. It is important that detained people are assessed as quickly as possible because their detention, particularly in police custody, is likely to aggravate their condition. It is therefore vital that the specialist staff required for the assessments arrive as soon as possible. The availability of the specialist staff required to

conduct Section 136 assessments was an issue across all the different forces. This was especially the case outside normal office hours, when limited numbers of staff were on duty and the availability Section 12 approved doctors [meaning that they are suitably trained to conduct mental health assessments] seemed to be more of an issue than that of ASWs. Our study showed that 53% of Section 136 detainees arrived in custody between 6pm and 3am (and a total of 65% between 6pm and 9am)" (Docking et al, 2008: pg. 39).

This is supported by other research evidence (Borschmann et al, 2010). "At our case study sites it seemed that there were often only one or two ASWs and Section 12 approved doctors available during this time period. Whilst we recognise the difficulties faced when trying to co-ordinate the services of professionals from across different specialities, our study did find evidence of initiatives that appeared to improve timeliness. This was especially the case when expectations on attendance were written into protocols, and involved target times. Some [FP] providers were also more proactive in giving their doctors the time and opportunity to become Section 12 approved. It is important that there are sufficient numbers of suitably qualified doctors in general, but the added advantage of increasing the number of FPs who are approved under Section 12 is that they may be available outside normal working hours more frequently. The assessment process seemed to run more smoothly and suffer from fewer delays (in police custody) when health or social care staff arranged the process rather than police officers. This is likely to be due to their closer working relationships with those required to conduct the assessment. Two forces demonstrated particular examples of good practice in this area. The first had a criminal justice liaison team of CPNs, which provided outreach

services to people in police custody, the second had a mental health nurse based in one custody suite. Both of these services had developed very good relationships with the police and other agencies, ensuring that the assessment process was carried efficiently and improving the knowledge of custody staff about mental health. The potential exists to improve this service by extending it to cover 'out of hours' situations. This would require further resources but it is an option that primary care trusts/NHS commissioners and police forces should consider funding" (Docking et al, 2008; pg. 39), and as stated above is practice which has been encouraged by official reports (Bradley, 2009).

Developing alternative places of safety

"A number of key organisations have stated clearly that using police custody as a place of safety should be avoided whenever possible. This is because it is felt to be the *least appropriate* environment to hold people and may exacerbate their mental disorder (Home Office, 1990; Department of Health and Home Office, 1992). While hospital emergency departments do not always provide the most ideal setting for Section 136 detentions they still provide a better alternative to police custody. All areas should ultimately work towards improving alternative places of safety, bringing them in line with the standards set out by the Royal College of Psychiatrists (2008)" (Docking et al, 2008: pg. 37) and explained in chapter six.

There was frustration amongst both police officers and health and social care staff in forces with high rates of Section 136 detentions in custody that more was not being done to provide alternative places of safety. A frequent issue was one of resources. "The

availability of alternatives to police custody appeared to be the biggest factor in reducing its use as a place of safety. Our study found that forces with the lowest rates of Section 136 detentions in police custody tended to have a greater number of alternatives to police custody than those with higher rates" (Docking et al, 2008: pg. 38). This therefore suggests that the differences shown by the quantitative data we gathered were 'real' in terms of practice on the ground, although recording issues also contributed to variations.

"Using other facilities as places of safety and building dedicated places of safety also seemed to be related to better multi-agency working. In low rate forces the police, health and social care providers also seemed to have a shared view that Section 136 was a joint issue, to be addressed together. This led to them having stronger working relationships" (Docking et al, 2008: pg. 38). This was also found by O'Neil and McCarthy (2012) in their work on neighbourhood policing. "Improving multi-agency working and encouraging more joint working was driven by establishing the support of senior staff, both in the police and in the health and social care sector. Such staff can use their influence to improve working practices. Having specialists working alongside the police on the ground – for example, CPNs – also helped to build better relationships and increase understanding of the different roles and responsibilities of operational staff" (Docking et al, 2008: pg. 38). Therefore, variations in the use of Section 136 to detain in custody appear to be linked to differences in police cultural knowledge or 'habitus', with some forces having more positive working relationships with health and social care than others, and differences in the wider 'field' with the availability of alternatives to police custody varying greatly across police force areas. The relationship between the 'field'

and ‘habitus’ cannot be underestimated with, for example, the availability and prioritisation of resources and cultural knowledge of the police and other agencies both influencing and impacting on each other.

Whilst different police forces had different policies and procedures which affected the way in which they dealt with individuals under Section 136, the strongest factor seemed to be the leadership and culture of the particular force. Where senior officers had driven the issue forward with their local health care providers, things had begun to change and improve with alternative facilities being found or developed. For example, in one medium rate police force the Deputy Chief Constable decided to personally try to tackle the issue and in the short term alternative facilities were developed within an existing room in an Accident and Emergency department, but in the longer term specialist facilities were built. The officer worked closely with his counter-part of the local Trust and once they had effectively engaged things progressed. This trickled down the command chain in the force and officers adopted the new policy on the ground. This did not prevent it from being disliked by some officers because of its effects but the hierarchal structure of the organisation meant that it was carried out even if begrudgingly. Others such as Foster (2002) have demonstrated that leadership can change practice on the ground and lead to changes in the occupational culture. If something is viewed as strategically important at the top of an organisation this can affect how seriously operational officers take the matter. However, this influence appeared to be driven by particular individuals and it is was by no means certain that this would continue if these individuals moved on or retired. O’Neil and McCarthy (2012) also found that multi-

agency working was reliant on the drive and relationship of individuals, how they viewed each other and what they could contribute. Therefore it is not as simple as protecting good practice via rules being promulgated.

Fielding (2005b) has argued that occupational culture can also be changed through the influence of differing occupational cultures on each other. In the area that this thesis addresses this would be the effect that the differing cultures of the police and health and social care organisations could have on each other; with the culture of health and social care organisations perhaps 'softening' the approach the police take towards Section 136 detainees to ensure that their care is of primary importance and with the 'sense of mission' the police culture encompassing ensuring that health and social care respond more effectively. In their research O'Neil and McCarthy (2012) found that police pragmatism actually enhanced multi-agency working as there was an acceptance of the wider role of the police, beyond simply crime fighting, and the need to work with other agencies in order to successfully tackle issues more strategically for the longer term.

"Finding an alternative to police custody as a place of safety did not signal the end of problems related to Section 136 detentions. Forces that used existing facilities in hospital emergency departments and psychiatric units often faced long delays waiting for detainees to be assessed" (Docking et al, 2008: pg. 38). Resentment was caused by the amount of time that officers had to wait with the Section 136 detainee once they were at a place of safety for the doctor and ASW to arrive and conduct the assessment. This was particularly acute at weekends when officers were very busy and there were long delays

at the A&E. This may have improved when they were instead taking individuals to specialist units, since if the individual was not perceived to be violent they should have been able to leave the person at the unit to await assessment. This would depend on the agreements in place and the resources available to the specialist unit. However, if things did not improve it may be that officers took things into their own hands and used their discretion to arrest individuals for minor offences – most often breach of the peace – in order to avoid being tied up for long periods of time.

"Waiting for long periods may lead to further distress for the detainee, especially in hospital emergency departments where a separate room was not always provided, leaving the person waiting in the main public area accompanied by two police officers. It can also be frustrating for police managers to have officers spending long periods of time waiting in hospital emergency departments. In some cases the detained person may have been assessed more quickly if he or she had been in police custody. But it was generally recognised that being in a medical facility is preferable to being held in police custody, even when delays are taken into account. Even the building of dedicated places of safety did not end all problems. Some interviewees expressed hope that dedicated places of safety will accommodate and assess Section 136 detainees more quickly, but there were concerns about these places of safety given that funding from the Department of Health does not extend to the employment of staff. Our research found that some areas have failed to provide funding for staffing these units from their existing budgets, leading to the newly built facilities being unused. In addition, even with the provision of dedicated places of safety, these facilities will still not generally accept individuals who are

perceived to be violent or severely intoxicated. These people will inevitably end up in police custody" (Docking et al, 2008: pg. 38).

There are also large changes being considered to the provision of healthcare in police custody with Bradley (2009) recommending the possibility of the NHS directly commissioning the healthcare for within police stations. I understand from attending official meetings that the Department of Health and the Home Office are working together to change the provision of healthcare in custody so that it is provided directly by the NHS and have 'ring fenced' the money to provide for this change. This would mean that the NHS provide the service rather than the police commissioning it to private contractors or local GPs. This could have a large impact on healthcare provision in police custody.

In the longer term, senior police officers and health service executives may want to see things changed and alternative facilities developed. But as suggested above it is important to improve the wider 'field', and as Chan (1997) highlights changes need to occur at both street and management level. This requires greater resources for the care of detainees, greater availability of places of safety and less discretion via the effective monitoring and auditing of Section 136 detentions. This may be difficult given the financial problems facing the public sector at the time of writing. Further funding to develop and staff alternative places of safety is unlikely to be forthcoming and this will be coupled with cuts to police numbers placing further pressures on their demands and how they prioritise issues. There are also shortages of resources in the NHS with the outgoing President of

the Royal College of Psychiatrists, Dinesh Bhugra, stating that there is a "dangerous vacuum of help for people with mental health disorders" because "'dangerously few' doctors train as psychiatrists because the specialism suffers from a poor reputation compared with other medical disciplines. 'It is wrongly seen as less scientific'". He went on to say that:

> Given the continued reduction in bed numbers and increased community care over the past decade, inpatient units have become places for crisis stabilisation and are likely to admit only those individuals who are the most disturbed, distressed or unwell. For such people especially, as they are unable to make the choice to leave, the ward is their home (*The Guardian*, 20 June 2011).

This could mean that if individuals are taken to an alternative place of safety this is less likely to be a specialist facility but instead an A&E department which is not ideal and is likely to mean the police having to remain with the individual for some time awaiting an assessment. However, an A&E department whilst not perfect is at least a medical facility and perhaps not the calmest environment but is at least not as stigmatising as being taken into a police custody suite.

Summary

Given the mounting pressures on police resources, it may become more tempting for them to use their discretion to arrest disturbed, distressed and unwell individuals rather than detain them under Section 136, particularly if facing pressure from their superiors (middle management not senior officers). This will allow them to get back onto the

streets more quickly than they might otherwise if taking the individual to a medical facility. The future of the custody environment may also change the perspective of senior officers and their health counter parts.

The Department of Health and the Home Office are working to change the way in which healthcare is provided within the 'custody suite'. They are looking to change the commissioning of these services so that they will be provided directly by the NHS rather than the force commissioning them to a private contractor or to local GPs. The aim of this is to have a more cost effective service. But it is also hoped that it will mean that the health service provision in a custody suite improves. One model may, for example, involve having custody nurses actually based in police stations who are therefore on hand to provide initial assessment of detainees quickly. Where custody nurses are already in police stations they provide a range of medical services as well as helping with these detentions so can be used as an efficient resource. They may also be able to access the individuals' medical records on site and more thoroughly establish their history, risks and needs. An added benefit to this may be that general working relationships between the police and the health service improve, with more effective communication and information sharing. Initiatives to place police officers in hospitals, driven by rising assaults on hospital staff, may also have a similar positive effect on working relationships.

This thesis has argued and attempted to demonstrate through empirical evidence that the law and policy alone do not govern police practice and that therefore tightening or

changing the law will not be enough to alter police practice. The police have enormous discretion and there is often a lack of supervision of officers on the ground (Kappeler et al, 1998). Chan (1997) has suggested that to be successful in changing police culture and therefore police practice both the 'habitus' and 'field' need to be changed. In order to change Section 136 detentions and minimise the use of police custody as a place of safety, the police and health and social care both need strong leaders at a local level who will push the issue forward, to work together taking a partnership approach. If these leaders move on, others need to take their place in order to preserve the momentum.

Fielding (2005b) has noted that the way in which chief constables conceive crimes can account for variations in the use of offences by officers on the ground. Therefore the same could be true of senior officers taking a lead on Section 136 detentions and trying to ensure that people are not held in police cells by seeking other alternatives and building working relationships with other agencies. Furthermore, Fielding (2002) argues that policing can be seen as a system and that changes to one part of the system can affect others that are not directly related to it (pg. 161). By closer inter-agency working at both an operational and strategic level alternative facilities can be developed and the occupational cultures of the different organisations gradually changed for the better over time. This needs to be supported by wider changes to the 'field' which in this context mean improvements to the provision of healthcare for the mentally vulnerable and greater resource.

Changes to the way in which health care is provided in police custody may remove some of the political pressure from the need to detain people at an alternative place of safety. The argument could be made that the care they receive in custody could be provided more quickly and to the same standard as they would receive in a hospital environment. However, this fails to address the potentially stigmatising effect of being driven to a custody suite in a police vehicle and being placed in a cell in an environment which by its very nature can add to individuals' distress. Section 136 detainees may be distressed, disturbed, behaving in bizarre or aggressive ways, and experiencing paranoid or deluded thoughts and extreme moods. They are therefore potentially extremely vulnerable and need to be treated with respect and given the dignity they deserve. Criminalising their behaviour (from the perspective of the detainee), even if this is a route to appropriate medical care, is not the answer. In the longer term there should be adequate resources allocated to address the needs of this vulnerable group of people.

More research also needs to be conducted into the experiences and needs of Section 136 detainees or the 'service users' in order to better understand the impact of detentions upon the people who it affects the most. Their voice is missing from most empirical evidence, including this thesis. Further research is also needed to establish a more up to date picture on Section 136 detentions following on from the period since the data for this thesis was collected to examine what, if anything has changed in terms of practice on the ground – this should include interviews with frontline officers. Finally, research is needed to better understand the nature and reasons for disproportionality in terms of the ethnicity of those detained and disposed of under Section 136 and other parts of the Act.

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Appendix A: Questionnaire originally designed for project

ipcc
independent police complaints commission

Detentions under section 136 of the Mental Health Act 1983 and inter-agency working

Everything on this form is confidential. No individual force will be identified. All questionnaires are stored in compliance with the Data Protection Act 1998. Please refer to covering letter for details about this research.

Your details

1. Please specify your police force. _____

2. What is your current rank? (*categories also include detective roles*)

Constable	☐	*Superintendent*	☐
Sergeant	☐	*Chief Superintendent*	☐
Inspector	☐	*ACPO rank*	☐
Chief Inspector	☐	*Police staff*	☐

3. What is your role in relation to section 136 arrests? _____

_____

4. How long have you been in your current role? _____

Data on arrests or disposals under the Mental Health Act 1983

As stated in the covering letter, the IPCC would like to obtain data from police forces across England and Wales on the number of people arrested under section 136 of the Mental Health Act and held in police custody for any period of time. We are also interested in people who may have been arrested for other reasons and disposed of using the Mental Health Act. An **Excel spreadsheet** has been sent with this questionnaire, could you please forward it to the appropriate staff in your organisation to complete and **return it with this questionnaire**. We would also like to know the **total number of people detained in custody** in your force in 2004/05 so that we can assess custody rates.

Training

5. Do any officers or police staff in your force receive training on handling people with mental health issues?

Yes	☐☐	*No (go to question 22)*	☐☐
Don't know (go to question 22)	☐☐		

6. Who receives this training (categories also include detective roles)? (*Please tick all that apply*)

Constables	☐☐	*Superintendents*	☐☐
Sergeants	☐☐	*Chief Superintendents*	☐☐
Custody sergeants	☐☐	*ACPO ranks*	☐☐
Inspectors	☐☐	*Mental Health liaison officers*	☐☐
Chief inspectors	☐☐	*Police staff*	☐☐
Don't know	☐☐☐		

7. What does the training cover? (*Please tick all that apply*)

Recognising mental illness	☐☐	*Drugs*	☐☐
Alcohol	☐☐	*Personality disorder*	☐☐
Self-harm	☐☐	*Learning disabilities*	☐☐
Managing aggression	☐☐	*Safe control*	☐☐
Restraint	☐☐	*Race and cultural issues*	☐☐
Diversion from custody	☐☐	*Other agencies and resources in the local area*	☐☐
Suicide risk assessment and management	☐☐	*De-escalation techniques*	☐☐
Risk assessment tools/form	☐☐	*Other (please specify)*	_____

_____

_____

8. Is the training done jointly with any other relevant individuals, agencies or organisations?

Yes (please specify) _____

_____

No	☐☐	*Don't know*	☐☐

9. How long is the training? (*Please tick one*)

1-2 hours	☐☐	*2-4 hours*	☐☐	*4- 6 hours*	☐☐	*1-2 days*	☐☐
2-3 days	☐☐	*3-4 days*	☐☐	*5+ days*	☐☐	*Don't know*	☐☐

10. How often do officers and/or police staff receive training? (*If different for different ranks please tick the average length of time)*

Every 6 months	☐☐	*Yearly*	☐☐	*Every 2 years*	☐☐	*Every 3 years*	☐☐
3+ years	☐☐	*Don't know*	☐☐				

11. Do you have any officers or police staff who specialise in mental health e.g. Mental Health Liaison Officers?

Yes *(please detail)* _____

_____

No *(please go to question 25)* ☐☐ Don't know *(please go to question 25)* ☐☐

12. Is this a full time post?

Yes ☐☐ *No* ☐☐

Don't know ☐☐

13. What training do these officers/police staff receive? *(please detail)*

_____

_____

_____

14. Are all detainees entering custody risk assessed?

Yes ☐☐ *No (go to question 30)* ☐☐

Don't know (go to question 30) ☐☐

15. What does this risk assessment ask about? (*please tick all that apply*)

Whether the person is taking medication	☐☐	*Whether they are suffering from any illness or injury*	☐☐
Whether the person has any mental health problems	☐☐	*Whether the person has ever suffered from depression*	☐☐
Whether the person is violent	☐☐	*Whether the person is under the influence of alcohol/drugs*	☐☐
Whether the person has ever self-harmed	☐☐	*Not applicable/ no risk assessment (go to question 28)*	☐☐

Other (please specify) _____

_____

16. Has the risk assessment been developed with other agencies?

Yes (please specify which agencies) _____

_____

No ☐☐ *Don't know* ☐☐

17. Does your force ask Approved Social Workers for a risk assessment before officers will attend a situation under the Mental Health Act?

Yes (please provide details on what it covers and how developed) _____

No ☐☐ *Don't know* ☐☐

18. Does your force have a policy on 'passive resistance'?

Yes (please provide details on what it covers and how developed) _____

No ☐☐ *Don't know* ☐☐

Working in partnership

We realise that arrangements may vary across the BCUs in your force but we would be grateful if you could answer the following questions in terms of the general position across your force

19. Does your force have any agreements with organisations in your area about what facilities can be used as a place of safety (in line with the Mental Health Act 1983 Code of Practice)?

Yes ☐ *No (go to question 34)* ☐

Don't know (go to question 34) ☐

20. Which organisations are part of this agreement? *(Please tick all that apply)*

Social services	☐	*NHS/ Primary Care Trust*	☐
Courts	☐	*Probation*	☐
FME's	☐	*CPS*	☐
Housing authority/association	☐	*Local health board*	☐
Local mental health charities	☐	*Local authorities*	☐
Local mental health team/trust	☐	*Accident and emergency departments*	☐

Other (please specify) _____

21. Does your force have any policies/agreements with other organisations to ensure that you work together to handle people with mental health problems?

Yes ☐ *No* ☐

Don't know ☐

22. Does your force have any policies/agreements with other organisations to ensure that you work together to share relevant information about mentally ill detainees/patients?

Yes ☐ *No* ☐

Don't know ☐

23. **If yes** to either q. 32 or 33, what do these protocols cover? (*please tick all that apply*)

s. 18 – return of missing patients to hospital	☐☐	*s. 135 – assessment on private premises*	☐☐
s. 136 taking people to place of safety for assessments	☐☐	*Minimum standards for time taken to assess and take to place of safety*	☐☐
Diversion from custody	☐☐	*Transportation of mentally ill detainees e.g. from police cell to hospital*	☐☐

Other (please specify) _____

24. Which organisations do you have these protocols/agreements with? (*Please tick all that apply*)

Social services	☐	*NHS/ Primary Care Trust*	☐
Courts	☐	*Probation*	☐
FME's	☐	*CPS*	☐
Housing authority/association	☐	*Local health board*	☐
Local mental health charities	☐	*Local authorities*	☐☐
Local mental health team/trust	☐	*Accident and emergency departments*	☐☐

Other (please specify) _____

_____

25. Were these protocols developed with the other organisations?

Yes (please detail how they were developed) _____

_____

No	☐☐	*Don't know*	☐☐

26. Are there occasions in your force when officers are called for assistance to private premises by Approved Social Workers when someone is suffering from a mental illness **but** a warrant has not been obtained (under s. 135 of the Mental Health Act)?

Yes	☐☐	*No (go to question 39)*	☐☐
Don't know (go to question 39)	☐☐		

27. How, if at all, do officers generally respond in this situation?

Attend the scene and use other powers where appropriate	☐☐	*Attend, assist and explain have no powers to enter premises but enter if invited*	☐☐
Refuse to attend without warrant	☐☐	*Other (please specify)*	_____

_____

_____

28. Are there problems in your force area in terms of moving patients/detainees between different places of safety under s. 136 of the Mental health Act e.g. from a police cell to a psychiatric ward?

Yes (please specify) _____

_____

No	☐☐	*Don't know*	☐☐

29. Is there a mentally disordered offender working party/group in your area?

Yes	☐	*No (go to question 43)*	☐
Don't know (go to question 43)	☐		

30. Which organisations sit on this party/group? (*please tick all that apply*)

Social services	☐	*NHS/ Primary Care Trust*	☐
Courts	☐	*Probation*	☐
FME's	☐	*CPS*	☐
Housing authority/association	☐	*Local health board*	☐
Local mental health charities	☐	*Local authority*	☐☐
Local mental health teams	☐	*Representatives from Accident and emergency departments*	☐☐

Other (please specify) _____

_____

31. Does this or any other group, monitor or audit the use of s.136 across your force area as specified in the Mental Health Act 1983 Code of Practice?

Yes	☐☐	*No*	☐☐
Don't know	☐☐		

32. Do you have a Criminal Justice Liaison Team(s) for mental health in your force area to assist with referrals and risk assessments of detainees?

Yes	☐☐	*No (go to question 45)*	☐☐
Don't know (go to question 45)	☐☐		

33. Which of the following are involved in the Criminal Justice Liaison Team? *(Please tick all that apply)*

Custody sergeants	☐☐	*Psychiatrists*	☐☐
Other custody officers/staff	☐☐	*Psychologists*	☐☐
Approved Social Workers	☐☐	*Learning disability specialists*	☐☐
Community psychiatric nurses/registered mental health nurses	☐☐	*Other (please specify)*	_____

_____

_____

34. Do you have custody nurses in your force?

Yes	☐	*No (go to question 51)*	☐
Don't know (go to question 51)	☐		

35. Are your custody nurses psychiatrically trained?

Yes	☐	*No*	☐
Don't know	☐		

Good practice

36. Are there any policies in your force around diverting people who have mental health problems away from custody? (*Please detail)*

_____

_____

_____

_____

37. Are there any forums in your area for sharing good practice/learning the lessons, for example around recognising mental illness at an early stage? (*Please detail*)

38. Are there any other issues or suggestions that you have encountered which may have either hindered your work in this area or improved good practice e.g. issues around dual diagnosis? (*Please detail*)

39. Do you have any suggestions that would help to improve either the training that officers/police staff receive or the risk assessments that they carry out? (*Please detail*)

40. Finally, is there anything else you would like to add or think that this survey has missed?

Thank you very much for your help. Please check you have answered all questions. Return completed questionnaires and Excel spreadsheet by XXX to maria.docking@ipcc.gsi.gov.uk or the following address: Maria Docking, 90 High Holborn, London WC1V 6BH. If you have any questions about the survey please call Maria Docking on 020 7166 XXXX.

Appendix B: Excel spreadsheet sent to police forces to collect data

THIS IS AN EXAMPLE SPREADSHEET, PLEASE USE THIS FORMAT AND SUGGESTED VARIABLES TO POPULATE SHEET 2 - DATA SHEET.
We would like to gather data from you on all detentions under section 136 of the Mental Health Act and any disposals under the Mental Health Act where an individual may have been arrested for another reason. We would like all details on each detention or disposals for 1 April 2004 - 31 March 2005.
This should be possible by searching your custody system for the relevant variables (e.g. section 136) and free text options.
In order for us to conduct further analysis and assess custody rates, we would be grateful if you would also provide the figure for the total number of people held in custody in your force (i.e. for any reason not just mental health) for 2004/05.
If you have any queries or problems in collating this data, please contact Maria Docking at the IPCC on 020 7166 3138.

Reason for arrest	Custody Arrival Time	Release Date/Time	Hours in custody	Release code	Ethnicity 16+1	Ethnicity PNC cod
s. 136 Mental Health Act	dd mmm yyyy 00:00	dd mmm yyyy 00:00	10.5	NFA	White British/ W1	White European -1
other reason e.g. breach				cautioned	White Irish/ W2	Dark European - 2
of peace, assault etc				bailed	Any other White background/ W9	Afro-Caribbean - 3
				summonsed	White and Black Caribbean/ M1	Asian - 4
				taken to court	White and Black African/ M2	Oriental - 5
				Mental Health Act	White and Asian/ M3	Arab -6
				custody	Any other Mixed background/ M9	Unknown - 0
				other	Indian/ A1	Don't know
					Pakistani/ A2	
					Bangladeshi/ A3	
					Any other Asian background/ A9	
					Caribbean/ B1	
					African / B2	
					Any other Black background/ B9	
					Chinese/ O1	
					Any other ethnic group/ O9	
					Not stated or don't know/ NS	
					Don't know	

Appendix C: Arrest Codes used for recoding the data in phase 1

1. Assault (ABH)
2. Other Assaults
3. More Serious Violence Against the Person
4. Threats to Harm Self
5. S.136 Mental Health Act
6. Other Mental Health Act
7. Alcohol Offences
8. Breach of Peace Offences
9. Other Public Order Offences
10. Criminal Damage
11. Harassment, Alarm or Distress
12. Drug Offences
13. Sexual Offences
14. Burglary/Robbery
15. Theft Offences
16. Motoring Offences
17. Warrant/Bail Offences
18. Other Offences

Appendix D - Release code categories

No Further Action (NFA)

- No further action
- Refused Charged
- No further Breach of Peace
- No longer applies
- Released
- RWOC (released without charge)
- Insufficient Evidence
- Refused Detention
- Arrest Only
- Released from Custody
- Not Mental Health

Hospital/Care/MHA

- Sectioned
- Mental Health Act
- Transferred to hospital/ out
- Local Authority
- To Hospital
- Redcar/ Banksfield Court (Cleveland)
- Voluntary submitted to hospital

- To HGH (Hartlepool General Hospital, (Cleveland)
- Carlton Clinic (Cumbria)
- WCH (hospital, Cumbria)

Cautioned

- Cautioned
- Instant Caution

Bailed

- Police Bail
- Cancel Police Bail
- Charged and Bailed
- Bailed

Charged

- Charged

Summonsed

- Summonsed
- Court
- Court Disposal
- Reported for Summons
- To TMC (Teeside Magistrates Court, Cleveland)

Appendix E: Custody lead telephone interview proforma

Force:
Custody lead name:
Role/position and length of time in post:
Number and rate of section 136 detentions:
Ranking of force – high, low or average:

Introduction

Hi this is [ ] and I'm a researcher working for the Independent Police Complaints Commission (IPCC). My colleague spoke to you previously and arranged for me to call you at this time to conduct a short interview for a study the IPCC are currently undertaking into the use of police custody as a place of safety under section 136 of the Mental Health Act. We are speaking to a number of custody leads in various police forces with differing rates of section 136 usage; we will then visit a smaller number of police forces to conduct face-to-face interviews with officers and mental health agency representatives. All the information that you provide will be treated as confidential and when using quotations no individual names will appear in any reports, so please be open and frank about your views. We will not pass on what you say to anyone in your organisation.

The interview should last about 15 to 20 minutes. I would like to record the interview as this is more accurate than taking notes and will ensure that the interview is quicker, is that all ok?

Questions

Using the figures we've received from your force, we estimate that in 2005/06 there were [ ] section 136 detentions in your police force which gives you a rate of [ ] per 1000 people held in custody. This means that your force has fairly [high/average/low] rates of section 136 usage compared to other police forces. Why do you think this might be? *(If necessary prompt – lack of or good 'other' provision/relationship with health service/other alternatives too far away/good agreements with other agencies etc?)*

What do you think are the key issues with regard to the use of section 136? (If necessary prompt – training for frontline officers/ length of detention/resource intensive/availability of alternatives/can't transfer to another place of safety etc)

How much of an issue is section 136 for you and your colleagues? (Follow-up) Why is that?

What do you think are the key issues in terms of the detention and care of those in custody under section 136? (If necessary prompt – custody unsuitable for people with mental health problems/lack of specialist skills and

understanding of custody staff/lack of time that can be held/availability of FME or custody nurse to assess/cell space/resource issues – using cell space etc)

If you, were given the task of reducing section 136 detentions what would you do? *(If necessary prompt – agreements or protocols with other agencies/training for officers/increased provision of places of safety/operational instructions to officers etc*

What, if any, instructions are given to officers in the use of section 136? For example is it possible that officers may use another power such as breach of the peace rather than section 136 or vice versa? (If necessary prompt – force policy on use of section 136/is there a policy on charging with offence rather than 136 where appropriate/policy on diversions from custody where minor offence etc)

What training current exists for custody staff and other front line staff in your force on mental health? *(If necessary prompt – training on identification of mental health problems/training on law/information on places of safety and relationships with other agencies)*

How, if at all, do you think this training could be improved? *(If necessary prompt – more specific/for additional staff or officers/longer/other agencies involvement)*

How do you feel your force works with other agencies on section 136 detentions in police custody? *(If necessary prompt – information sharing/diversion from custody/protocols/which agencies)*

How do you feel your force works with other agencies on the mental health of detainees more generally? *(If necessary prompt – do you refer detainees to other services/do agencies visit custody suites and provide advice or support?)*

What provision and funding is available, if any, for places of safety in your force area?
(If necessary prompt – where are the places of safety/what type of facilities are they e.g. dedicated/does the health service provide specific funding for this in your force)

Do you have any examples of good practice in terms of section 136 detentions in your force area that you would like to share? *(If necessary prompt – information sharing and protocols/mental health agency staff coming into custody/diversion from custody/provision of specialist places of safety)*

Are there any other issues that you feel may be pertinent in relation to the use of police custody as a place of safety that you haven't mentioned?

Thank you very much for your time it is much appreciated.

Appendix F: Interview topic guide for custody officers

Introduction

My name is [ ] and I'm a researcher working for the Independent Police Complaints Commission (IPCC). I'm part of a team who are currently undertaking some research on the use of police custody as a place of safety under section 136 of the Mental Health Act. All the information that you provide will be treated as confidential and when using quotations no individual or force names will appear in any reports, so please be open and frank about your views. We will not pass on what you say to anyone in your organisation.

The interview should last about one hour and will include a number of questions for you consideration. I would like to record the interview as this is more accurate than taking notes, is that ok?

(If not, ask what their concerns are and try to reassure them. If need to tell them that the tapes will be transcribed and destroyed at the end of the study; tapes will be held securely in the IPCC; IPCC is a professional body; interviews should be covered by the Data Protection Act).

Are there any questions you would like to ask before we start?
Check recorder

Setting the scene
As I have said I will be asking questions about the use of police custody as a place of safety under the Mental Health Act, but I would just like to ask you a few questions about your role to begin with...

1. How long have you been a police officer/staff member?
   - *Current rank*?

2. How long have you been in your current role within the custody suite?

3. Have you ever worked in another force or an agency connected with mental health issues?
   - *Which?*

Use of section 136
Ok I am now going to start by asking you a few general questions about the use of section 136 in your force…

4. We collected data from your force on the number of section 136 detentions in police custody in 2005/06 and found that your force had a high/low/average rate of detentions in comparison to other forces. Why do you think this might be?
   - *Lack of alternative places of safety*
   - *Higher rates of mental health/drug/alcohol use in area*

- *Good arrangements for alternative places of safety*
- *Training of officers*

5. How much of an issue on a day-to-day basis is section 136 and the use of police custody as a place of safety for you and your colleagues?
   - *Why is that?*

6. Does the issue and use of section 136 differ across your force between the various custody suites?
   - *For example is it more of an issue in some areas due to a lack of alternative places of safety than in other parts of the force?*

Detention of people under section 136

I'd now like to ask you about the issues relating to the detention of people in police custody under section 136…

7. Could you talk me through the process of someone being detained on the street under section 136?
   - *How do officers become involved initially?*
   - *How do they then decide where to take them i.e. custody or elsewhere?*

8. What happens when someone being detained under section 136 is taken to and arrives into custody?
   - *How are they processed?*
   - *What details are entered onto the custody records and system?*
   - *Who is informed?*

9. If someone has been detained under section 136 and brought into custody but has also committed an offence how would you record this?
   - *Record both reasons or primary reason?*
   - *How do you make this decision?*

10. How do you feel when someone is brought into custody under section 136?
    - *Worried re their care*
    - *Frustrated at the lack of other places of safety*
    - *Frustrated at the amount of work it will entail*
    - *Worried at how long they might be in custody before assessed etc*

11. Can you describe to me the risk assessment that is conducted upon the detainee's arrival into custody?
    - *Standard form?*
    - *What factors do you assess?*
    - *Items of clothing removed?*
    - *How useful do you find the assessment?*
    - *Where is it recorded?*

12. Once a detainee is placed into a cell, what checks do they receive?
    - *How often are they checked – is there a standard procedure for this?*
    - *CCTV in cell?*

13. Who do you call to carry out the medical assessment of the detainee? A FME or custody nurse?
    - *Does the force have a specific provider of medical care in police custody?*
    - *Are they generally section 12 approved? Is this a problem?*

14. How quickly are section 136 detainees generally assessed once they are placed in a cell?
    - *Does this depend on the time of day or day of the week?*
    - *Is this a problem/cause of frustration?*
    - *Why is this – i.e. a lack of trained doctors?*

15. If following the medical assessment the detainee is found to be suffering from a mental illness what happens next?
    - *Where are they taken and how is this decided?*
    - *How long might they stay in custody for?*
    - *Does the decision re where they go depend on the nature and seriousness of their illness? If so how?*
    - *What, if any, is the police involvement in what happens next?*
    - *If someone is mentally unwell and is being sectioned do the police generally assist in the transportation of detainees to other facilities?*

16. If following the medical assessment the detainee is not found to be suffering from a mental illness what happens next?
    - *Are they released without any further care or do you work with other agencies to help their release into the community?*
    - *Are any risk assessments conducted prior to their release?*

17. Are there issues in terms of transportation of mentally ill detainees and transferring people from places of safety to other facilities?
    - *What are these issues?*
    - *Why is that?*
    - *Will the new Mental Health Act improve things regarding this issue?*

Detention of people for offences who are then detained under section 136 or have mental health issues

I now want to talk to you about individuals who have been arrested for committing an offence but where it also becomes apparent that they have mental health issues…

18. What happens when someone is brought into custody for committing an offence but is clearly showing signs of mental distress or illness?
    - *How is this decision taken – e.g. seriousness of offence and/or seriousness of signs of illness?*

- *Are they generally charged or dealt with using mental health powers?*
- *How is this decision taken – seriousness of offence? What is level of seriousness? Seriousness of mental illness?*

19. What, if any, instructions are given to officers in the use of section 136 for individuals who have committed an offence? For example is it possible that officers may use another power such as breach of the peace rather than section 136 or vice versa?
    - *Would this vary depending on the type and seriousness of the offence?*

20. Do you have a preference about which powers the officers use to arrest someone and bring them into custody? If so, why?
    - *Is one more simple to deal with than the other?*

Training

I'd now like to ask you about the training you receive in terms of mental health…

21. What training have you received on mental health issues and in particular around section 136?
    - *Recognising mental health issues*
    - *How to deal with*
    - *What the procedures are*

22. How long ago did you receive that training?
    - *Do you receive any refresher training or inputs?*

23. Who delivered the training? Was there any input from any other agencies?

24. What did you think of the training? Are they any improvements you think could be made?
    - *Longer, more detail, input from other agencies, more regular?*

Working with other agencies

I'd like to ask you about partnership working with other agencies on section 136 detentions and mental health more generally…

25. Do you have any other contact with other agencies in terms of section 136 detentions?
    - *Liaison re release from custody*
    - *Diversion from custody?*

26. How well do you think this works? Why do you think that?

27. How well do you feel that your force works with other agencies on the mental health of detainees more generally? Why do you think that is?
    - *community support, release from custody*
    - *diversion from custody*

Promising practice
I would like to finish the interview by asking a few questions about what you think might be promising practice…

28. How, if at all, do you think the use of police custody as a place of safety could be minimised in your force?
- *E.g. better provision of alternative places of safety*
- *Closer working with other agencies, improved agreements*
- *Better training/information for officers on ground in terms of issues and alternatives to police custody*

29. Do you have any examples of good practice in this area that you would like to share with us?

30. Finally, is there anything more you would like to add, or anything that you think I have not covered?

Thanks you very much for your time and co-operation, its really appreciated.

Appendix G: Interview topic guide for health and social care staff

Introduction

My name is [ ] and I'm a researcher working for the Independent Police Complaints Commission (IPCC). I'm part of a team who are currently undertaking some research on the use of police custody as a place of safety under section 136 of the Mental Health Act. All the information that you provide will be treated as confidential and when using quotations no individual or organisation names will appear in any reports, so please be open and frank about your views. We will not pass on what you say to anyone in your organisation.

The interview should last about one hour and will include a number of questions for you consideration. I would like to record the interview as this is more accurate than taking notes, is that ok?

(If not, ask what their concerns are and try to reassure them. If need to tell them that the tapes will be transcribed and destroyed at the end of the study; tapes will be held securely in the IPCC; IPCC is a professional body; interviews should be covered by the Data Protection Act).

Are there any questions you would like to ask before we start?
Check recorder

Setting the scene
As I have said I will be asking questions about the use of police custody as a place of safety under the Mental Health Act, but I would just like to ask you a few questions about your role to begin with...

2. What is your current role?
   - *Main responsibilities and how this relates to section 136?*

4. How long have you been in your current role?

Use of section 136
Ok I am now going to start by asking you a few general questions about the use of section 136 in your area…

31. We collected data from your local police force on the number of section 136 detentions in police custody in 2005/06 and found that your police force had a high/low/average rate of detentions in comparison to other forces. Why do you think this might be?

- *Lack of alternative places of safety*
- *Higher rates of mental health/drug/alcohol use in area*
- *Good arrangements for alternative places of safety*
- *Training of officers*

32. How much of an issue is section 136 for you and your colleagues?
    - *Why is that?*
    - *Issue re police custody?*

33. Does the issue and use of section 136 differ across your Trust area?
    - *For example is it more of an issue in some areas due to a lack of alternative places of safety than in other parts of the force?*

34. How much of an issue is mental health more generally in your local area?
    - *Drug/alcohol usage?*

Detention of people under section 136

I'd now like to ask you about the issues relating to the detention of people under section 136…

35. Could you talk me through the process of someone being detained on the street under section 136 and being taken to a place of safety?
    - *What, if any, is your role in this process?*

36. How is the type of place of safety decided upon i.e. a police station or alternative place of safety?
    - *What factors is this based on e.g. drug/alcohol usage, violence?*
    - *Who makes this decision/how is this assessed?*

37. If someone is taken to police custody as a place of safety, what is the process for assessing them in terms of their detention?
    - *What, if any, is your in role in this process?*
    - *Who is generally called out to assess the detainee – FME/custody nurse?*
    - *Are they generally section 12 approved? Is this a problem?*

38. What do you think are the key issues in terms of the detention and care of those in custody under section 136?
    - *Custody unsuitable for people with mental health problems*
    - *lack of specialist skills and understanding of custody staff*
    - *length of time that can be held*

39. How quickly are section 136 detainees generally assessed once they are placed in police custody?
    - *Does this depend on the time of day or day of the week?*
    - *Is this a problem/cause of frustration?*

- *Why is this – i.e. a lack of trained doctors?*

40. What happens when the detainee is released from police custody and taken to hospital?
    - *Are there standard arrangements to facilitate this?*
    - *Do the police generally assist in the transportation of detainees to other facilities?*

41. What happens when the detainee is released from police custody into the community?
    - *Are there standard arrangements to help their release into the community?*
    - *Are any risk assessments conducted prior to their release?*

42. Are there issues in terms of transportation of mentally ill detainees and transferring people from places of safety to other facilities?
    - *What are these issues?*
    - *Why is that?*
    - *Will the new Mental Health Act improve things regarding this issue?*

Funding for places of safety and multi-agency working

I'd like to ask you about funding for places of safety and partnership working with other agencies on section 136 detentions and mental health more generally…

43. What provision and funding is available, if any, for places of safety in your local area?
    - *What exactly does the funding cover?*
    - *How are decisions about funding made and where does the funding come from?*
    - *What are the funding priorities in terms of healthcare in your area and how does mental health feature?*
    - *Has this changed recently and if so why (i.e. pressure applied on Trust?) What was the previous position?*

44. Do you have protocols and agreements with the police and/or other agencies regarding the use of section 136?
    - *If so, what do they cover?*
    - *Information sharing?*
    - *How and when were these agreed?*
    - *If not, are there plans to introduce such agreements?*

45. How well do you think these protocols and agreements work? Have they changed the procedures and relationships?
    - *How could they be improved?*
    - *Why?*

46. Do you have any contact with the police and other agencies in terms of section 136 detentions or the mental health of detainees more generally?
    - *Assessment for detainees*

- *Care and detention of detainees*
- *Liaison re release from custody*
- *Diversion from custody?*

47. (*If appropriate*) How well do you think this works? Why do you think that?

48. How do you think you could work more effectively with the police and other agencies on these issues?
    - *More frequent working?*
    - *More regular contact*
    - *Greater agreements*
    - *Joint training*

Promising practice

I would like to finish the interview by asking a few questions about what you think might be promising practice…

49. How, if at all, do you think the use of police custody as a place of safety could be minimised in your local area?
    - *E.g. better provision of alternative places of safety*
    - *Closer working with other agencies, improved agreements*
    - *Better training/information for officers on ground in terms of issues and alternatives to police custody*

50. Do you have any examples of good practice in this area that you would like to share with us?

51. Finally, is there anything more you would like to add, or anything that you think I have not covered?

Thanks you very much for your time and co-operation, its really appreciated.

Appendix H: List of interviewees by case study area

Low rate force 1

- Locality manager mental health services
- Manager for out of hours mental health service
- Custody sergeant 1
- Custody sergeant 2
- Telephone interview – head of custody

High rate force 1

- Custody sergeant 1
- Custody sergeant 2
- Custody inspector
- Mental health liaison officer
- Mental health ward manager
- Head of social care
- Telephone interview – head of custody

Medium rate force 1

- Custody sergeant
- Custody sergeant 2
- Custody manager
- Operational inspector
- Strategic inspector
- Manager of ASWs

- Social care lead
- Telephone interview – force lead on section 136

Low rate force 2

- Custody sergeant 1
- Custody sergeant 2
- Custody leads – old and new force lead together
- Force mental health liaison officer
- Criminal liaison nurse
- Senior ASW
- Telephone interview – force custody lead

Medium rate force 2

- Custody sergeant 1
- Custody sergeant 2
- Psychiatric nurse based in custody
- Force mental health liaison officer
- FP
- Telephone interview – with force custody lead

High rate force 2

- Custody sergeant 1 (acting custody inspector)
- Custody sergeant 2
- ASW
- Professional head of social care
- Telephone interview – with force mental health liaison officer

Additional telephone interviews

A low rate force – force custody lead

A high rate force – force custody lead

A medium rate force – force custody lead

A medium rate force – force custody lead

A high rate force – force custody lead

A force with an estimated rate (unknown rate at time of interview) – face-to-face interview using telephone topic guide with force custody leads

A low rate force – force lead on s 136 in strategic criminal justice team

A low rate force – force custody lead

A medium rate force – force custody lead

A low rate force – force custody lead

A medium rate force – force custody lead

A high rate force – force custody lead

A high rate force – force custody lead

Appendix I: Research Ethics Approval Application

APPLICATION FOR RESEARCH ETHICS APPROVAL- LAW

KING'S College LONDON
University of London

Joint Schools Research Ethics Sub-Committee for Humanities, Law and Social Science and Public Policy (RESC)

For office use only:

RESC Protocol No:
Date rec'd:

1. APPLICANT DETAILS	
1. Name of Researcher (applicant) including student number if applicable:	Maria Docking 9802202
2. Email:	
3. Contact Address:	
4. Telephone no:	
5. Status	☐ **Undergraduate Dissertation** ☐ **Taught Masters Dissertation** ☐ **Taught Course Component** ■ **MPhil / PhD Dissertation** ☐ **Staff Research**

2. PROJECT DETAILS	
6. Project Title:	Police custody as places of safety under t Health Act 1983
7. Start Date of Project:	1 May 2007
8. Expected Completion Date of Project:	2010/11 academic year
9. Funding or Sponsoring Organisation: (e.g. ESRC, AHRB, EU)	IPCC (my employer)
10.Will the study place the researcher at any risk greater than that encountered in his/her daily life (e.g. interviewing alone or in dangerous circumstances, or data collection outside the UK) If yes, please confirm that	☐ **Yes, I have completed a risk assessı which has been co-signed by Department.** ■ **No**

you have completed a risk assessment .	
11. Does the project involve human participan require ethical approval? **Please note**; it may sometimes be the case tha not involve human participants yet raises other ethical issues with or environmental implications. In this case the research checklist b completed even if the answer to this question is no. If you requ on this matter please consult with the College Research Ethic rec@kcl.ac.uk	■ **Yes** ☐ **No**
12. Is CRB clearance necessary for this projec	☐ **Yes** ■ **No**
12a. If so will clearance be sought before com of the project?	☐ **Yes N/A** ☐ **No**

3. FOR STUDENTS / TAUGHT COURSES ONLY	
13. Course Unit title and number or Departme for MPhil/PhD:	School of Law
14. Course convenor or supervisor's name:	Professor Ben Bowling, and Professor Genevra Richardson

4. RESEARCH CHECKLIST		
	Yes	**No**
a. Does the study involve participants who are particularly vulnerable or informed consent or in a dependent position (e.g. children, people with learning difficultie students, over-researched groups or people in care facilities)? **Please note:** Important special considerations relate to research projects invo please refer to the guidance for researchers produced by the National Children's Bureau, which can be found in the researc	☐	■

NCB Website, www.ncb.org.uk		
b. Will participants be asked to take part in the study without their consent or kr time or will deception of any sort be involved (this might for example be the covert o people in non-public places) ? Please refer to the British Psychological Society Guidelines for furthe www.bps.org.uk	☐	■
c. Will the study involve discussions of sensitive topics affecting individual resp sexual activity, drug use, death or illegal activities)?	☐	■
d. Could the study induce psychological stress or anxiety, or produce humil harm or negative consequences beyond the risks encountered in normal life?	☐	■
e. Are drugs, placebos or other substances (such as food substances or vitamins) administered to the study participants or will the study involve invasive, intrusiv harmful procedures of any kind?	☐	■
f. Will the study involve prolonged or repeated testing?	☐	■
g. Will financial inducements (other than expenses) be offered to participants? If state the amount of financial inducement being offered.	☐	■

5. AIMS AND OBJECTIVES

Please give a brief outline of the principal aims and objectives of your research *in lay language.*

This project seeks to examine the extent and use of police stations as places of safety under section 136 of the Mental Health Act 1983, and the nature of police contact with people suffering from mental health problems. In addition to this overall aim the study will:

- provide data on the number of detentions under section 136 in police stations and will analyse the data for any disproportionality in the make-up of detainees;
- look for variations in the rate of section 136 detentions across police forces and examine why these differences occur;
- assess police officer training and understanding of mental health problems;
- analyse how the police service works with other agencies and look at agreements and protocols on handling people with mental health problems; and
- seek to identify any good practice and lessons that can be learnt to prevent future deaths in custody and minimise the use of section 136 with regard to police custody.

This project is being conducting by the Independent Police Complaints Commission

(IPCC) and I am the lead researcher, managing and conducting the bulk of the research. The project has the support of the Association of Chief Police Officers (ACPO), the Police Federation and the Mental Health Act Commission.

6. DATA COLLECTION AND ANALYSIS

If you will be collecting information from human participants please describe a) who they are b) how they will be recruited c) your method(s) (e.g. interview, questionnaire, field observation, audio/audio-visual recording etc.) and d) where the work will be carried out

Participants:

We will interview police officers and mental health agency representatives. Initially we will interview a custody lead from each of the 43 police forces in England and Wales. We will then do more in-depth interviews with 18 custody sergeants, nine custody leads and 18 mental health agency representatives in nine police force areas. Additional interviews may be conducted in these sites with other relevant police officers or staff depending on the findings from the initial work. The nine police force sites will be identified using the data we have collected from police forces on their section 136 detentions for 2005/06. We will choose three forces with low rates of detentions, three with high rates and three with average rates. We will try to achieve a spread of police forces across England and Wales and using the Her Majesty's Inspectorate of Constabulary (HMIC) force family data.

Recruitment:

We will approach police force custody leads using the police almanac to identify them. Following on from this initial work we will go back to the relevant custody leads in the nine police forces and ask for there assistance in identifying individuals in their forces to interview. We will use our regional offices to help identify mental health agency representatives and will contact primary care trusts, we can also utilise our national stakeholder contacts to identify individuals. We will contact them via telephone or email and arrange interviews.

Method:

The first phase of this study has been the collection of data from police forces on their section 136 detentions. Forty-two of 43 police forces in England and Wales have returned data to the IPCC. We asked for data on the individuals detained (without any information that could identify that individual) such as age, gender, ethnicity, whether they had a permanent address, the length of time they were held in custody and any additional reasons for the arrest. Some forces were able to provide more information than others depending on their custody system e.g. some were only able to provide overall numbers without any data on demographics. The data was received in Excel and has been cleaned and imported into an SPSS database. We are currently in the process of analysing this data, in addition to describing the percentages and averages in the data, we will use Chi Square to test the statistical significance of some of the findings. We will also calculate rates of section 136 detentions per 1,000 detentions in custody by each police force, and rates in terms of the ethnicity of those held under section 136 compared to the ethnicity of

those in the population of each police force. This first quantitative stage has sought to provide evidence on the number of section 136 detentions, the make-up of those detained and variations across police forces in the use of this power.

The second phase of the research will consist of qualitative work in order to find out why these differences occur and what the issues for police forces and mental health services are and identify ways in which practice could be improved. Telephone questionnaires will be conducted with the force custody leads; these will last between 15 and 20 minutes. This will help to shape the topic guides that will be used for the in-depth interviews in the nine police force sites. We will analyse the questionnaires, coding them into SPSS and entering any free text questions into Excel. Following that we will look at themes and issues and develop a semi-structured topic guide to be used for the face-to-face interviews with custody sergeants and mental health agency representatives (a different topic guide for the police and mental health participants). The interviews will last approximately 50 minutes to an hour and will be recorded using a specialist digital recorder. The recordings will be sent to be professionally transcribed and will then be analysed using a thematic matrix designed by the IPCC. Both phases of the research will be written up into a final report for publication by the IPCC and all of the data collected will be used for my PhD.

Location:
The telephone interviews will be conducted by IPCC researchers in the IPCC. The in-depth interviews will take place face-to-face in police stations for the custody sergeants and custody leads, and in places of work for the mental health agency staff.

7. ETHICAL CONSIDERATIONS

Please explain briefly how the ethical risks identified in the research checklist (in section 4) will be addressed

a) Obtaining Informed Consent

Please attach copies of the draft information leaflet or letter for potential respondents and consent form. If you will not be obtaining written consent please explain why and provide information on how consent will be obtained in another way. Please see the Kings College Research Ethics website for further information on informed consent: http://www.kcl.ac.uk/research/ethics /

An information sheet is attached. A formal consent form will not be used as previous experience of interviewing police officers has found that this approach can be off putting for the participants as it may amount to a 'caution' in their minds. Instead it is suggested that informed consent will be gained by explaining the research to them (including providing a copy of the information sheet), asking them to take part and obtaining their agreement by email/telephone which will imply tacit consent. In addition when interviewing the individuals at the beginning of the interview they will be asked to state that they have consented to participate and that they are happy for the interview to be recorded (this will be stated on the recording) which will also provide tacit consent.

b) Right of Withdrawal

Participants will be advised that involvement in the research is entirely voluntary and that they can withdraw from the study at any time up to the point of publication/completion of the PhD, and that there will not be adverse consequences. We will ask the police contacts in each of our sites to recruit willing volunteers and stress that to the individuals that it is not compulsory to take part. It will be stressed that the research does not form part of the IPCC's investigative work, but is about learning and identifying good practice.

c) Confidentiality of Data

Please see the Guidelines on the Kings College Research Ethics website for further information on the Data Protection Act: http://www.kcl.ac.uk/research/ethics/

We will not ask for respondents to give their name or personal details on the recording of the interviews. The data will be stored at the IPCC on our secure server. We have a contract with a transcription company that does a lot of work for government and as such has secure data storage and adheres to the provisions of the Data Protection Act. The data will be anonymised with any personal information removed and individual numbers given to each questionnaire and interview transcript. All paper copies will be stored securely at the IPCC in locked cabinets and all electronic data will be password protected. Individual police forces will not be identified in the final report for the IPCC or in my PhD.

All data will be stored for seven years following completion of the study in line with King's College London policy.

d) Anonymity of Participants

No identifying details will be recorded on the research instruments. Instead a unique identifying number will be allocated to participants and will be written on all forms and electronic copies of the data. The respondents will not be asked to take part in any future research so it will not be necessary to keep information in order to identify the individuals. As it would be possible to identify the custody leads from their relevant police force, this information will also be anonymised using an identification number and the name of the police force will not appear in any reports.

e) Other Ethical Issues (please specify) – including if deception is to be used as part of the research

Given the nature of the IPCC's work, there is the potential that police forces and officers may feel compelled to participate in the research (this is less likely for the mental health agency representatives). As such the researchers will endeavour to reassure the participants that this research does not form part of an IPCC investigation into their force and that there is no obligation to take part in the research. Police participants will also have to be informed that if they reveal professional misconduct in the interviews this will have to be reported to their professional standards department by the IPCC.

8. IS ETHICAL CLEARANCE REQUIRED FROM ANY OTHER ETHICAL COMMITTEE

☐ **Yes**

■ **No**

If yes, please give further details including name and address of the organisation; if approval has already been received please attach clearance authorization.

9. DO YOU INTEND TO MAKE THE NO-FAULT COMPENSATION SCHEME AVAILABLE TO PARTICIPANTS? (SCHEME AVAILABLE IN UK ONLY)

☐ **Yes**

■ **No**

If yes, the following sentence should be inserted into the participant information sheet ''In the event of your suffering any adverse effects as a consequence of your participation in this study, you will be compensated through the King's College London 'No Fault' Compensation Scheme''.

THE NEXT STEP

For students

A single-sided hard copy of the application signed by both the applicant and the supervisor must be sent, along with single-sided hard copies of any supporting documentation, to the secretary of the Research Ethics Panel for Law at the following address: Matt Evans, Centre Manager, Centre of Medical Law and Ethics, L114, School of Law, King's College London, Strand, London WC2R 2LS.

Complete applications must be received by the secretary of the Research Ethics Panel for Law 14 days prior to the date of the meeting. Applications which fail to meet this deadline will not be considered by the Panel.

You and your supervisor will be notified of the outcome of your application.

Approval will be for one year for undergraduate and taught masters students and two years for research degree students.

For staff

If you have answered 'no' to all questions on the checklist at Section 4, a single-sided hard copy of the application signed by the applicant must be sent, along with single-sided

hard copies of any supporting documentation, to the secretary of the Research Ethics Panel for Law at the following address:

Matt Evans, Centre Manager, Centre of Medical Law and Ethics, L114, School of Law, King's College London, Strand, London WC2R 2LS.

Complete applications must be received by the secretary of the Research Ethics Panel for Law 14 days prior to the date of the meeting. Applications which fail to meet this deadline will not be considered by the Panel.

If you have answered 'yes' to any question on the Research checklist at Section 4, the application must be completed electronically and sent as an e-mail attachment to the secretary of the Research Ethics Sub-Committee at the following address: resc@kcl.ac.uk.

15 hard copies (one original and 14 double-sided photocopies) of the application signed by the applicant must be sent, along with single-sided hard copies of any supporting documentation to the secretary of the Research Ethics Sub-Committee at the following address: RESC Secretary, Room 7.21, James Clerk Maxwell Building, Waterloo Campus, King's College London, 57 Waterloo Road, London SE1 8WA.

Complete applications, both electronic and hard copy, must be received by the secretary of the Research Ethics Sub-Committee 14 days prior to the date of the meeting. Applications which fail to meet this deadline will not be considered by the Panel.

Approval will be for two years for staff research and five years for taught courses.

SECTION 10: DECLARATION

I undertake to abide by accepted ethical principles and appropriate code(s) of practice in carrying out this programme.

Personal data will be treated in the strictest confidence and not passed on to others without the written consent of the subject.

The nature of the investigation and any possible risks will be fully explained to intending participants, and they will be informed that:
(a) They are in no way obliged to volunteer if there is any personal reason (which they are under no obligation to divulge) why they should not participate in the programme; and
(b) They may withdraw from the programme at any time, without disadvantage to themselves and without being obliged to give any reason.

Signatures

Applicant **Date:**

Supervisor (if appropriate): **Date:**

11. SUPERVISOR CHECKLIST	
To be completed by the supervisor for all student research – please tick	
The proposal is viable and the student has appropriate skills to undertake the research	☐
The student has read an appropriate professional code of ethical practice	☐
The student has completed a risk assessment form (if appropriate)	☐
The information sheet for participants is appropriate	☐
The procedures for recruitment and obtaining consent are appropriate	☐
Ethical issues been included as part of the preparation for the research	☐

Section 12: APPROVALS

Signatures

Chair of REP (if appropriate): **Date:**

Chair of RESC: **Date:**

INFORMATION SHEET FOR PARTICIPANTS *Protocol Number.….....*

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: IPCC Research into Police Custody as a Place of Safety under the Mental Health Act 1983

We would like to invite you to participate in this original research project being conducted by the Independent Police Complaints Commission (IPCC). The research will also be used by the lead IPCC researcher on this study for their own postgraduate study with the IPCC's permission and approval. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

INSERT DETAILS OF STUDY

Under section 136 of the Mental Health Act, individuals can be detained in a place of safety if they are in a public place and thought to be in immediate need of care. A place of safety includes a police cell and this study seeks to find out the extent to which people are held in police cells under this legal power, the make-up of those detained and variations in the use of this power across police force areas. The study collected data

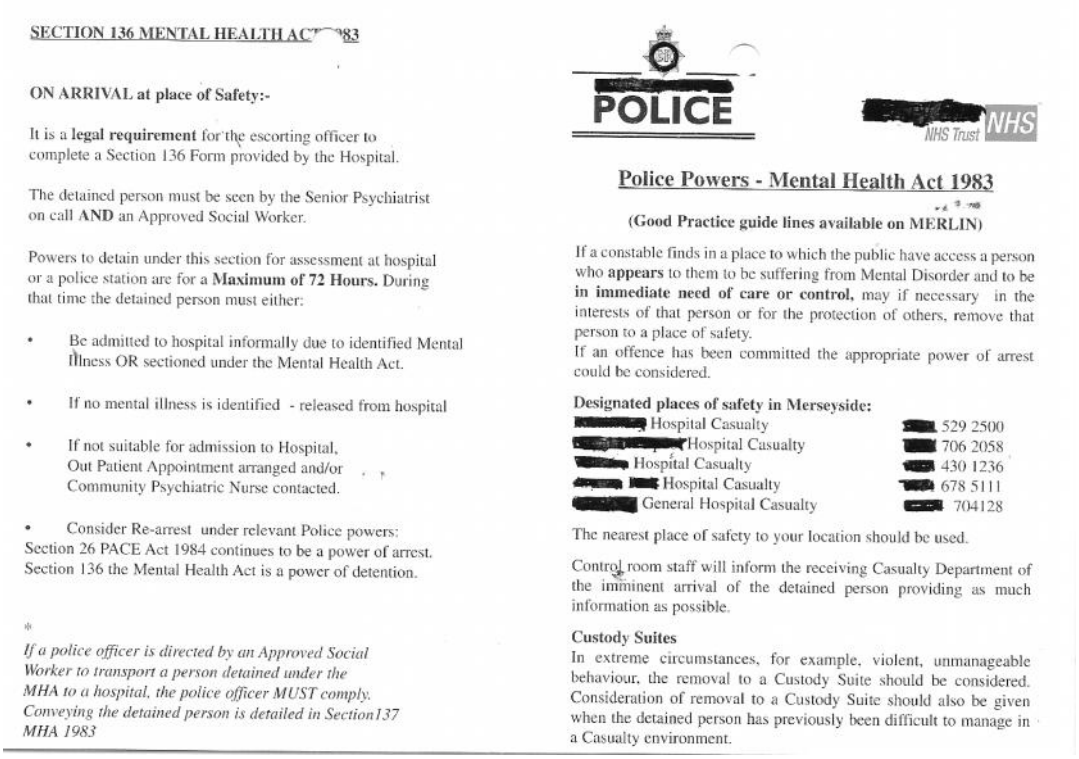
from police forces across England and Wales on their section 136 detentions and then chose nine areas in which to carry out follow-up work. This follow-up work seeks to look at why the variations in the amount of section 136 detentions, how the police and health service work together, what information sharing arrangements exist, how relationships could be improved, what training might be needed, and identify any good practice.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to consent to the interview being recorded. The interview will last approximately 50 minutes and will cover your professional knowledge and experience of the topic of police custody being used as a place of safety, in addition to wider issues such as training and multi-agency working. The interview will be recorded for accuracy and will be professionally transcribed, at the start of the interview you will be asked to state on tape that you have consented to participate in the research and are happy to have your views recorded. You will not be identified in the research or any subsequent publications by name or police force/organisation, and the views you give will be treated as your own and not representative of your police force/organisation.

If you decide to take part you are still free to withdraw at any time and without giving a reason up until the point of publication, but we would appreciate you informing us if you decide to withdraw so we can rearrange our plans. You will remain anonymous in the research as will your police force/organisation.

If you would like to speak to someone about this study before or after your interview please feel free to contact Maria Docking on 020 7166 XXXX or maria.docking@xxxxx . Alternatively you can reach Tom Bucke (Head of Research at IPCC) at tom.bucke@XXXXXXXXX

Appendix J: Example Aide Memoires from a low rate force



SECTION 136 MENTAL HEALTH AC[redacted]83

ON ARRIVAL at place of Safety:-

It is a **legal requirement** for the escorting officer to complete a Section 136 Form provided by the Hospital.

The detained person must be seen by the Senior Psychiatrist on call **AND** an Approved Social Worker.

Powers to detain under this section for assessment at hospital or a police station are for a **Maximum of 72 Hours.** During that time the detained person must either:

- Be admitted to hospital informally due to identified Mental Illness OR sectioned under the Mental Health Act.
- If no mental illness is identified - released from hospital
- If not suitable for admission to Hospital, Out Patient Appointment arranged and/or Community Psychiatric Nurse contacted.
- Consider Re-arrest under relevant Police powers: Section 26 PACE Act 1984 continues to be a power of arrest. Section 136 the Mental Health Act is a power of detention.

If a police officer is directed by an Approved Social Worker to transport a person detained under the MHA to a hospital, the police officer MUST comply. Conveying the detained person is detailed in Section137 MHA 1983

POLICE

[redacted] NHS Trust NHS

Police Powers - Mental Health Act 1983

(Good Practice guide lines available on MERLIN)

If a constable finds in a place to which the public have access a person who **appears** to them to be suffering from Mental Disorder and to be **in immediate need of care or control,** may if necessary in the interests of that person or for the protection of others, remove that person to a place of safety.
If an offence has been committed the appropriate power of arrest could be considered.

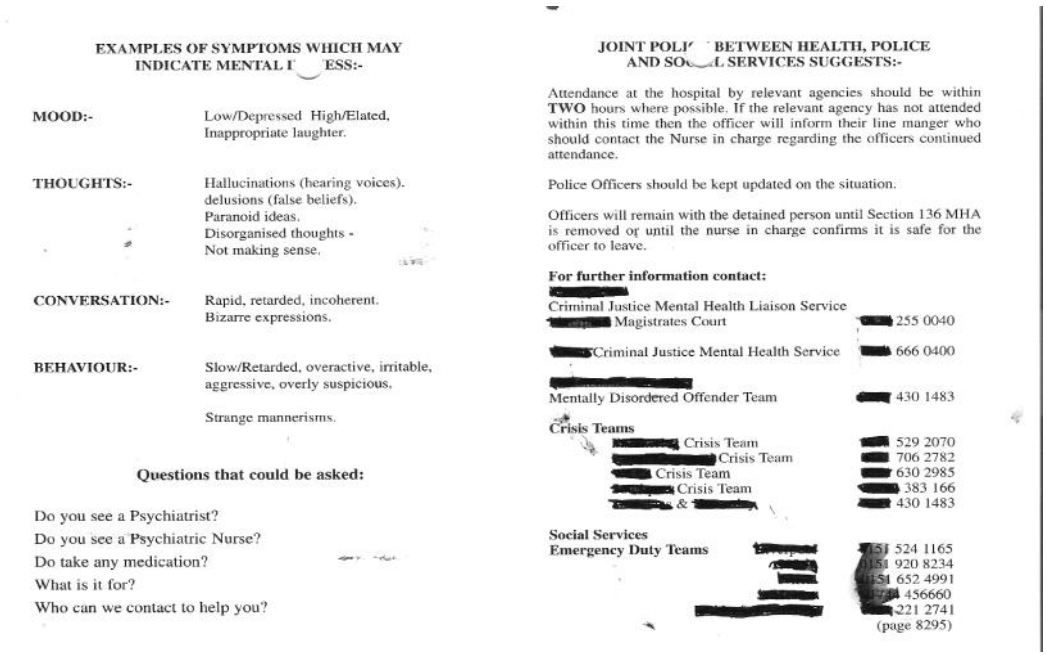
Designated places of safety in Merseyside:

[redacted] Hospital Casualty	[redacted] 529 2500
[redacted] Hospital Casualty	[redacted] 706 2058
[redacted] Hospital Casualty	[redacted] 430 1236
[redacted] Hospital Casualty	[redacted] 678 5111
[redacted] General Hospital Casualty	[redacted] 704128

The nearest place of safety to your location should be used.

Control room staff will inform the receiving Casualty Department of the imminent arrival of the detained person providing as much information as possible.

Custody Suites
In extreme circumstances, for example, violent, unmanageable behaviour, the removal to a Custody Suite should be considered. Consideration of removal to a Custody Suite should also be given when the detained person has previously been difficult to manage in a Casualty environment.



EXAMPLES OF SYMPTOMS WHICH MAY INDICATE MENTAL I[redacted]ESS:-

MOOD:-	Low/Depressed High/Elated, Inappropriate laughter.
THOUGHTS:-	Hallucinations (hearing voices). delusions (false beliefs). Paranoid ideas. Disorganised thoughts - Not making sense.
CONVERSATION:-	Rapid, retarded, incoherent. Bizarre expressions.
BEHAVIOUR:-	Slow/Retarded, overactive, irritable, aggressive, overly suspicious. Strange mannerisms.

Questions that could be asked:

Do you see a Psychiatrist?
Do you see a Psychiatric Nurse?
Do take any medication?
What is it for?
Who can we contact to help you?

JOINT POLI[redacted] BETWEEN HEALTH, POLICE AND SO[redacted]L SERVICES SUGGESTS:-

Attendance at the hospital by relevant agencies should be within **TWO** hours where possible. If the relevant agency has not attended within this time then the officer will inform their line manger who should contact the Nurse in charge regarding the officers continued attendance.

Police Officers should be kept updated on the situation.

Officers will remain with the detained person until Section 136 MHA is removed or until the nurse in charge confirms it is safe for the officer to leave.

For further information contact:

[redacted]
Criminal Justice Mental Health Liaison Service
[redacted] Magistrates Court [redacted] 255 0040

[redacted] Criminal Justice Mental Health Service [redacted] 666 0400

[redacted]
Mentally Disordered Offender Team [redacted] 430 1483

Crisis Teams

[redacted] Crisis Team	[redacted] 529 2070
[redacted] Crisis Team	[redacted] 706 2782
[redacted] Crisis Team	[redacted] 630 2985
[redacted] Crisis Team	[redacted] 383 166
[redacted] & [redacted]	[redacted] 430 1483

Social Services
Emergency Duty Teams [redacted] [redacted] 524 1165
[redacted] 920 8234
[redacted] 652 4991
[redacted] 456660
[redacted] 221 2741

(page 8295)

Section 136 Mental Health Act 1983

Points and Information when using Section 136

1. DEFINITION: A Constable finds in a place to which the public have access a person who appears to him/her to be suffering from Mental Disorder and to be in immediate danger or need of control, the Constable may, if he thinks it necessary to do so in the best interest of that person or for the protection of others, remove that person to a place of safety.

2. EXAMPLES OF SYMPTOMS WHICH MAY INDICATE MENTAL ILLNESS.

MOOD: Low/Depressed High/Elated, inappropriate laughter.

THOUGHTS: Hallucinations (impaired perceptual experiences involving the senses, e.g. 'voices') Delusions (false beliefs), Paranoid ideas. Thought Disorder (inability to process thoughts, they become disorganised).

CONVERSATION: Rapid, Retarded, Incoherent, Bizarre expressions.

BEHAVIOUR: Slow/Retarded, Overactive, Irritable, Aggressive, Suspicious. Strange mannerisms.

3. WHAT NEXT? Remove to a place of safety.

4. WHERE TO? Take the person to the local Casualty at either The [redacted] Hospital or [redacted] Aintree OR under extreme circumstances a Police Station

Ms 14371/L

Section 136 Mental Health Act

5. ON ARRIVAL AT CASUALTY: Complete all necessary Section papers and documentation

6. WHO DOES THE PATIENT NEED TO SEE?
Psychiatrist (Senior Registrar or above) AND Approved Social Worker.

7. JOINT POLICY BETWEEN HEALTH, POLICE AND SOCIAL SERVICES SUGGESTS:

a) That attendance by agencies should be within FOUR Hours.

b) That Police Officers are kept informed every thirty minutes about events.

c) They are placed in an appropriate environment.

8. HOW LONG DO THESE POWERS LAST?
For up to SEVENTY TWO Hours OR until Disposal is complete.

9. WHAT CAN DISPOSAL BE?

a) Admission to Hospital due to identified Mental Illness either informally OR Sectioned under the Mental Health Act.

b) No Mental Illness identified, allowed home.

c) Not suitable for admission to Hospital, arrange Out Patient Appointment and/or contact Community Psychiatric Nurse.

d) Possible re-arrest under Police powers of arrest.

NOTE: Section 136 is a power of detention under the Mental Health Act and is also a power of arrest as described within the PACE guidelines.

Criminal Justice Mental Health Liaison Nurses
[redacted] Magistrates Court
Tel: [redacted]-255 0040
Fax: [redacted]-236 4799
For further information.

Appendix K: Policy Recommendations to improve practice

These were the recommendations made in the IPCC report published using the empirical data also collected for this thesis, taken from Docking et al, 2008: pg: 41-43.

NHS commissioners should:

Recommendation 1: work with relevant organisations to develop alternative places of safety to police custody. Consideration should be given to using existing facilities, such as hospital emergency departments and psychiatric units where it may be possible to set aside a space that can be used as a place of safety. These facilities should adhere to the Royal College of Psychiatrists standards on places of safety (2008).

Recommendation 2: consider applying for Department of Health funding to set up purpose built facilities where necessary; taking into account how they will staff these facilities using their existing resources. This funding does not apply to Wales and health boards there will need to consider local funding arrangements.

Recommendation 3: consider what preventative outreach work might be conducted to help individuals who are detained under Section 136 frequently. Such outreach work may help to prevent some Section 136 detentions and ensure that at risk individuals receive appropriate care and treatment.

Recommendation 4: use specialists, such as community psychiatric nurses to provide outreach services to police custody and arrange mental health assessments. Joint funding from both the police and primary care trust/NHS commissioner would increase staff availability outside normal working hours.

Police forces should:

Recommendation 5: consider ways to improve the co-ordination and timeliness of mental health assessments. For example, where specialists such as community psychiatric nurses are not available to arrange assessments, agreements could be made for approved social workers to co-ordinate assessments.

Recommendation 6: raise any problems with lengthy delays in mental health assessments in hospital emergency departments with the relevant primary care trust/NHS commissioner to see if a solution can be agreed – for example, the implementation of target times.

Recommendation 7: ensure that officers on the street have adequate training to recognise symptoms of mental disorder, understand their powers under the Act, and know what their local arrangements are for places of safety.

Recommendation 8: agree with other agencies that officers can contact individuals with mental health expertise, such as approved social workers, to get advice on particular individuals.

Recommendation 9: ensure that custody officers and staff receive refresher training on mental health symptoms and Section 136 processes so that detainees held in police custody receive appropriate care and attention.

Police forces and NHS commissioners should jointly:

Recommendation 10: meet at a strategic level to review the current arrangements with regard to Section 136 detentions in their area. This should include a review of the effectiveness of existing protocols and agreements, if they exist. Section 136 should be seen as a joint problem and joint solutions should be sought.

Recommendation 11: review their arrangements for detaining under Section 136 people who are intoxicated and/or violent to ensure that they get the most appropriate care. It might be possible to provide a non-police facility where individuals can be safely detained and assessed with police officers present.

Recommendation 12: look for solutions that improve the availability and/or timely attendance of doctors approved under Section 12 of the Act, where this is a problem. Forces should require their forensic medical examiner provider to ensure that sufficient

forensic medical examiners are Section 12 approved. This could be particularly helpful in increasing the availability of specialist doctors outside normal working hours.

Recommendation 13: accurately and consistently record Section 136 detentions both in police custody and hospital environments. The records should include key demographic details such as age, gender and ethnicity, along with the length and outcome of the detention (for example, whether the individual was taken to hospital). We support the Royal College of Psychiatrists' (2008) suggestion that one national recording form for England and Wales is introduced. Police forces should also work to ensure that offenders with mental disorders are captured on their systems in order to identify the true scale of the detention in police custody of people with mental disorders.

Police forces, NHS commissioners, ambulance services, and social services should jointly:

Recommendation 14: agree a policy on the transportation of Section 136 detainees being admitted to hospital following an assessment (within the wider conveyance policy required under the Mental Health Code of Practice). This should include detainees being held in police custody and at alternative places of safety. Ambulances should generally be used for transportation, unless there is sufficient risk to ambulance staff due to the violence of the individual. In such cases it may be acceptable to use a police vehicle. It is imperative that the transportation of a detainee occurs as promptly as possible, so as not

to prolong their detention in police custody. It is therefore important that appropriate and realistic target times for transportation are set, agreed and adhered to.

Recommendation 15: agree a policy on the transportation of Section 136 detainees being released back into the community (when transportation is necessary). This should include detainees being held in police custody and at alternative places of safety. The policy should specify which organisations are responsibility for transportation in the different circumstances, and which is responsible for paying for the costs involved in using taxis.

Recommendation 16: monitor Section 136 detentions by multi-agency groups at a local level to identify any problems. This should include monitoring of the new power to transfer between places of safety to see how it is being used in practice.

The Care Quality Commission, should:

Recommendation 17: collate annual data on Section 136 to improve data collection and increase understanding of the use of Section 136. If a national form is adopted for recording all Section 136 detentions in custody and alternative places of safety, as suggested by the Royal College of Psychiatrists (2008), this information should be collected locally. The information can then be provided to the Care Quality Commission for collation.

Recommendation 18: conduct analysis into the data gathered on Section 136 detentions, such as the make up of the detainees, length of time they are detained and the outcome of Section 136 detainees to see what happens to the individuals. This will help to determine whether this power is being appropriately used across police forces. The data should be presented annually and be made available to the public.

The police, social services and mental health trusts should:

Recommendation 19: provide joint training on Section 136 and mental health. This will help to improve communication and understanding about the different roles and responsibilities between the various organisations.

Recommendation 20: clarify the current situation by providing joint training on information sharing and what can be shared legally about a Section 136 detainee.

Further research should:

Recommendation 21: examine and seek to *explain* disproportionality in the ethnic make up of Section 136 detainees.

Recommendation 22: explore the experiences and perceptions of Section 136 service users' experiences. This is an important gap in our knowledge and understanding the

experiences of these individuals could help improve the detention process and the care that people receive.

With regard to preventing future deaths in custody, police forces should:

Recommendation 23: adopt procedures to ensure that custody officers and staff adhere to PACE Code C with respect to risk assessing, checking and rousing. It should be emphasised that:

- Rousing involves the use of a stimulus designed to elicit a response from the detainee (as per PACE Code C Annex H).
- Cell visits and checks are completed and recorded in a timely manner.
- All detainees should be risk assessed on arrival to the custody suite and throughout their detention, regardless of their level of intoxication.
- A detainee's unwillingness or inability to participate in a risk assessment should be viewed as a possible warning of risk.