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Police and health operational staff perspectives on managing detainees held under Section 136 of the Mental Health Act: A qualitative study in London

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ABSTRACT

Detention under section 136(1) of the Mental Health Act 1983 allows for the police to detain a person from a public place and "remove [them] to a place of safety" if it is "in the interests of that person or for the protection of other persons in immediate need of care or control." This study examines the interface between police and health professionals covering the conveyance and transfer of detainees to a place of safety and on completion of the assessment prior to inpatient admission. One hundred ninety-six professionals were interviewed across police (*n*=38), London Ambulance Service (*n*=2), Mental Health or Emergency Department staff (*n*=63), and Approved Mental Health Professionals (AMHPs)/Section 12 doctors (*n*=93). The data was analyzed thematically using a Framework analysis. The conveyance and transfer of detainees was framed by various elements of detainee risk. Healthcare professionals cited clinical risk, risk associated with substance misuse, professional safety, culture of risk aversion, staffing issues, and fear of certain detainee groups as the main issues. For police, risk was discussed within the context of institutional or professional fear of negligence due to an adverse incident. It is argued that the negative framing of risk at this point of the detention process by all professionals creates a negative therapeutic environment for detainees. Whilst safety is an essential part of the detention process, these distinctions problematize the process for a detainee. The article argues for a more balanced framing of risk to establish a more therapeutic interaction between detainees and police and healthcare providers.

Key Words Section 136 of the Mental Health Act 1983; risk management; safety.

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INTRODUCTION

The role of police, mental health, and emergency care services in managing the rising demand for interventions has been well documented and is often discussed within the context of financial constraints (Loughran, 2018; Allison, Bastiampillai, & Fuller, 2017; Iacobucci, 2017). For people experiencing a mental health episode in public, use of Section 136 of the *Mental Health Act* 1983 (with amendments included within the *Policing and Crime Act* 2017) allows for police to detain a person and, "in the interests of that person or for the protection of other persons, remove that person to a place of safety." There is flexibility surrounding the definition of a place of safety, which has generally been accepted to be suites attached to existing mental health units or in Emergency Departments within a general hospital. The Mental Health Code of Practice (2016 Code of Practice for Wales) refines the definition as ensuring access to provision of specialist health-based services and support. Use of police custody as a place of safety is only allowed in exceptional circumstances since it is seen as an inappropriate venue for treating people in mental health crises (HM Inspectorate of Constabulary, 2013; Lancet, 2013).

Changes to the provisions (Sub-section 1C) of Section 136 allow for a consultation process with a medical practitioner to support the detention process. Guidance has focused on the process of detention, including deciding on an appropriate location for a place of safety and the maximum

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detention time permitted (Department of Health/Home Office, 2017). The significance of the detention process has largely been neglected from the academic debate in this field. The complexity inherent in the process of transferring an individual undergoing a mental health crisis to a place of safety has been noted to include a range of operational and cross-cultural perspectives that limit the effectiveness of police working with health partners (Short, MacDonald, Luebbers, Ogloff, & Thomas, 2014; de Tribolet-Hardy, Kesic, & Thomas, 2015; Hollander, Lee, Tahtalian, Young, & Kulkarni, 2012; Paterson & Best, 2015). This results in wide variations in the approaches used (HM Inspectorate of Constabulary, 2015). Alongside financial resourcing issues, these factors have been cited as reasons for turning people away at a place of safety and the subsequent delay in receiving treatment (Royal College of Emergency Medicine, 2016; Borschmann, Gillard, Turner, Chambers, & O'Brien, 2010).

Moreover, commentators have been critical of the police's approach to managing people in mental health crisis due to a lack of understanding of an individual's mental health needs (McDaniel, 2019; Independent Commission on Mental Health and Policing, 2013; Clifford, 2010). Studies of detainee perspectives have highlighted the traumatic nature of the detention process, which has resulted in dissatisfaction with both police and health professionals (McGuinness, Dowling, & Trimble, 2013; Laidlaw, Pugh, Riley, & Hovey, 2010; Jones & Mason, 2002). For mental health services, there is an evidence base that largely focuses on treatment and approaches within a ward context once a person is admitted as an inpatient (Slemon, Jenkins, & Bungay, 2017). For detainees, the importance of the police transfer to health services was seen as "framing" the subsequent treatment or support received. Put another way, if the process of transfer between police and health professional was seen negatively, this perception affected detainees' subsequent views of how well their condition was treated (Sondhi, Luger, Toleikyte, & Williams, 2018).

Despite the problems inherent in the detention process requiring a transfer from police to health services, there has been little examination of the nature of the issues underpinning this intersection between partner organizations. The aim of this paper was to explore the intersection between all organizations involved across London and, in particular, to understand the motivations and views of operational staff throughout the process.

METHODS

Design

One hundred ninety-six professional stakeholders involved in the use of Section 136 within London were recruited and interviewed one-to-one or in focus groups using semi-structured schedules between April and December 2016. The sampling strategy included ensuring representativeness through geographical coverage that covered North, South, East, and West London, stratified by inner- and outer-London. The stakeholders included operational police (n=38) and a range of health professionals at the various stages of the Section 136 process, including London Ambulance Service (n=2), clinical Mental Health or Emergency Department staff (n=63), and Approved Mental Health Professionals (AMHPs)/Section 12 doctors (n=93).

Data Analysis

The approach used the six-stage "Framework" method that allowed for the analysis of cross-sectoral qualitative data (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Ritchie & Lewis, 2003). The stages include the recording and transcription of interviews (Stage 1), which allowed for the research team to become familiar with the discussions (Stage 2). Inductive, or "open," coding was undertaken by the research team to create a coding structure that described the Section 136 process (Stage 3). The fourth stage developed a working analytical framework, which was enhanced through the use of NVivo 10 to support the organization and analysis of the data. A spreadsheet was used to "chart" the emerging themes into a framework matrix that allowed for a visual interpretation of themes from different professional perspectives (Stage 5). The final stage interpreted the themes as they emerged, and to support this, a Delphi group of one operational police officer and two mental health professionals was established to explore the themes from differing organizational perspectives.

RESULTS

Themes

Mapping the detention process identified points of tension between police and health professionals often compounded by problems in communication and interpersonal relationships. However, the emergent theme underpinning the relationship between police and health professionals revolved around the concept of managing "risk." Risk occurred across four levels: (a) risk to the detainee resulting from self-harm or suicide ideation, (b) risk to health staff from violent acts committed by the detainee, (c) risk to the general public caused by detainee acts of violence or aggression, and (d) risk to organizations through reputational damage caused by any of the above adverse events. The complex notions of risk are explored below.

Clinical Risk

For health professionals, there was an overriding concern of an inaccurate or misdiagnosis. Interviewees revealed concern that some physical conditions were "similar to" mental health symptoms. For example, issues with head trauma or neurodegenerative conditions, such as Parkinson's disease, were cited. This resulted in an initial assessment that required a confirmatory diagnosis from an Emergency Department to be "medically cleared." Some health professionals lacked the expertise in the relevant areas of medicine and did not have access to the required diagnostic equipment to determine whether there were underlying physical health issues with detainees. There was also a further clinical risk when there was doubt over the detainee's medication regime (including adherence to strong mental health medicines). This was seen to be a specific issue when the detainee exhibited polypharmacy (when the detainee was taking more than one medication for an array of symptoms).

> It can at times [be] a time-consuming and difficult process understanding patient needs, what their actual diagnosis is [as] they may not always be aware of what is going on, let alone tell me what medicine they are taking. It is important to get it [the diagnosis] right; otherwise we are

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> creating problem after problem down the line. (Interview 77, Mental Health Nurse)

Risks Due to Drug and Alcohol Consumption

Cutting across issues with clinical risk is the effect on detainees of drug and alcohol consumption. For some suites, the criteria for admission to a Section 136 suite was based on the levels of alcohol in the blood or on an assessment of the level of intoxication. For detainees, there was an initial assessment at the point of entry into a Section 136 and others thereafter by AMHPs to approve access as an inpatient. For interviewees, alcohol consumption created a major barrier to implementation of timely assessments:

> We've done a breathalyser, and they're actually two and half times over the legal limit. We then say good, actually we're not going to come out, give us a call back in two hours. What's the point of going out to undertake an assessment for somebody who's completely bladdered? (Interview 28, AMHP)

For clinical staff, drug and alcohol intoxication could also mask the symptoms of physical health conditions (e.g., slurring of words, erratic behaviours). Moreover, there was a reluctance to become the front-line treatment for acute substance misuse, including the management of acute withdrawal symptoms. This was considered to require a response from addiction specialists. There was a particular concern among health practitioners over the possibility of detainee overdose resulting from interactions with other medication (particularly antipsychotic medication but also analgesics such as pregabalin or gabapentin).

Compounding the uncertainty over drug and alcohol consumption was perceived changing trends in patterns of use. Health professionals stated that, in terms of illicit drug use, there has been a shift away from the "traditional" use of opiates (heroin) towards a range of new substances including "party drugs," such as gamma hydroxy butyrate (GHB), ketamine, and methamphetamine, often compounded by excessive use of cocaine powder (which was seen to be increasingly pure). Use of opiate-based analgesics, such as tramadol, combined with excessive alcohol consumption was also noted among some detainees. In addition, health and police professionals highlighted "spikes" in the use of novel psychoactive substances (such as "spice") that were particularly prevalent amongst homeless and chaotic detainee populations. For health professionals, there was uncertainty about the treatment of detainees who used these substances, requiring reassurance from acute services that there were no immediate underlying physical health conditions that may affect the detainee's treatment.

Thus health professionals did not feel confident that the treatment provided was appropriate and safe. Detainee drug and alcohol issues further exacerbated the need for "medical clearance," which also lengthened the time required to complete an assessment. This was due to a "sobering" up process, because the assessment at the point of entry into a Section 136 suite and by the AMHP could only be undertaken when the detainee was considered to be fully conscious and able to answer detailed questions. For police, this created a degree of confusion, as police operated a "walking, talking" rule: if a detainee could walk on their own and talk coherently, they were deemed to be sufficiently sober to engage with health professionals. Indeed, as Weston and Trebilcock (forthcoming) argue, police feel particularly ill equipped to predict the risks posed by people displaying mental health issues and often have to step in as "minders" until other health and social care services are able to respond. This disparity in the criteria used for the management of detainees with drug and alcohol issues was the cause of a considerable degree of tension between police and health professionals. The interviews and discussions with police (and some health professionals) cited cynicism that mental health staff "hid behind" these approaches to avoid dealing with problematic cases: "There are some very good mental health services, and there are a lot of people in the old mindset of 'if it's drugs and alcohol, it's not mental health. No, we don't want it'" (Interview 33, Mental Health Nurse).

Risks to Professional Safety

A key sub-theme for health professionals was the need to ensure the safety of staff from acts of aggression and violence by detainees. Interviewees noted that the levels of aggression had worsened over the last few years, with health professionals receiving verbal and physical abuse. Health professionals were either reluctant to engage with aggressive detainees or required police support in the management of antisocial behaviours:

> There is a real concern about risk, and when you go in and assess, and so often there are about five staff that come in with you, and I'm not sure that is helpful to the assessment process, but sometimes it is easy to get caught up in the anxieties of the aggression of the person in the room… This does affect the person, just the humane treatment of that person really does matter. (Interview 3, Focus Group Section 12 Doctor/AMHP)

Culture of Risk Aversion

A common theme of the study was an underlying sense of risk aversion when treating detainees. Risk aversion was often perceived to be associated with the experience of the professionals involved:

> If they're walking across the road and they're staggering, [saying] "I'm going to kill myself"… because of our culture of "you've got to cover yourself and make sure," and sometimes [detainees] were horrified they were taken there [to a Section 136 suite]. You still get ones that maybe go one step further when they're sitting on a bridge, but I'm not going to risk it. (Interview 29, AMHP)

> I think a lot of the difficulties I've had are when the SHO [senior house officer] staff are less experienced, and I've had situations where they're saying they [detainees] don't have a mental disorder, they've got a bit of anxiety and depression, and the person [detainee] wants to leave and think they should go. The SHO wanted to call the SPR [specialist registrar] or Section 12 [doctor]. They're just, I think, a bit intimidated or frightened and want someone a bit more senior, so when I got there, the person clearly did not have a mental disorder, but they still felt the person should be in hospital. (Interview 32, AMHP)

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The emphasis on risk aversion resulted in a reliance on National Health Service (NHS) "rules and procedures." Many health professionals interviewed suggested that defaulting to the agreed procedures was a means of "back covering" to ensure there was no personal, professional, or institutional liability.

> I've seen a lot of those policies, and they're about 40 pages long. Staff don't understand them. They're written just for sort of corporate back-covering. I think the policies need to be more practicable and make sense to the people on the ground. And actually, it would be based on common sense as opposed to what they think should be done. (Focus Group Interview 13, Mental Health Staff)

Staffing and Stigma towards Certain Detainee Groups

There was a major tension in the relationship between staff and risk management. For many suites at the time of the study, inpatient ward staff were "drafted in" to manage Section 136 suites. The lack of specialist training (for example on restraining methods) and a reliance on agency nurses were cited as barriers to the effective treatment and management of detainees. Mental health professionals cited the unintended consequence of drafting ward nurses to oversee the Section 136 suite. Here, a loss of staff continuity in the inpatient wards resulted in agency staff being unaware of a patient's specific needs. This type of situation in turn feeds to patient disengagement and, on occasion, leads to acts of aggression that require police involvement.

In addition, there was often an underlying pejorative view of certain segments of the detainee population, including detainees with chaotic lifestyles, such as homeless people and ex-offenders. This was heightened for long-term drug misusers:

> The heroin addicts are the worst. They are just horrible, nasty people, really manipulative, always trying to get something over you. It can be hard to [treat] them but you just have to swallow your pride. If I had my way, I wouldn't work with them. (Interview 59, Mental Health Staff)

The concept of managing risk also had implications for the police. As Stanford (2012) argues, there may be particular risks, for police officers, attached to dealing with volatile and vulnerable individuals, and with this can come an assumption about their very identity posing risks and being problematic. Officers were often required to take over the management of a detainee to ensure engagement with various health professionals (for example, movement to a Section 136 suite, to an Emergency Department to be "medically cleared," and back to the suite for further assessment). Many police officers highlighted the tension that this created, especially in relation to alcohol consumption or when the reasons for behaviour were unclear. As one interviewee states,

> Most of the time they are sober, they had a couple of drinks, and to us they're completely sober. I think most people are, after one or two drinks, but they [Section 136 suite] won't take them, which is frustrating for us [as] it causes arguments between us. (Interview 34, British Transport Police Officer)

Another interviewee echoes this sentiment:

> If we bring someone in for mental health concerns… on occasion they've been excluded on medical grounds, and sometimes those reasons aren't always clear. They've come back to… Hospital, and then we'll wait a number of hours before they're brought back. So police officers are being delayed [when] there might not be a need to delay them… high blood pressure is often given as a reason, which I think probably isn't a very good reason. (Interview 42, Metropolitan Police Liaison)

For police interviewees, there was a sense that policing was used as a societal "back-stop" to manage the most chaotic and vulnerable in society and, in particular, individuals with whom no one else wants to work:

> There's literally no one left to do it. What else can we do? Everyone can finish their shift and go home, job done. We have to make sure no one does anything stupid because they [other NHS services] all know we are there 24/7 to pick up the pieces. (Interview 8, Metropolitan Police Officer)

The motivation for police to act as a "back-stop" for individuals with an acute mental health need can be explained by the police's own perceptions of risk. In this context, many of the police officers interviewed stated that the professional and institutional risk related to an adverse event such as a detainee suicide or committing an arrestable act was a major concern:

> We're responsible for that individual. Really we're the only ones who are under the pressure and the scrutiny to make sure that they get to where they need to get to. Nobody else is going to be criticized for the length of time it takes or if something goes wrong or if they're injured while they're in our care. It's on us. Nobody else really has the same amount of concern that the individual officer has. (Interview 2, Metropolitan Police Officer)

As Patterson and Best (2015, cited in McDaniel, 2019, 5) suggest, such uncertainty can lead to the police taking the most risk-averse course of action available to them.

DISCUSSION

The literature has largely focused on the police perspective of conveying and transferring detainees subject to Section 136 of the *Mental Health Act*, 1983 (Short et al., 2014, Hollander et al., 2012). Commentators are critical of the police "culture of complacency" (McDaniel, 2019:2) when it comes to mental health. Discussions of the use of legislative levers to support the detention process have focused on the increasing use of Section 136 (Loughran, 2018) and response models aimed at reducing this use (Puntis et al., 2018).

This paper argues that the conveyance and transfer of detainees on Section 136 grounds is framed by concepts of risk for both health and police professionals and is an issue independent of the operational model deployed. In a clinical sense, concepts of "defensive practices" have been used to

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describe health approaches to managing complex and at-risk patients (Reuveni, Pelov, Reuveni, Bonne, & Canetti, 2017; Studdert et al., 2005). These practices can be seen to deviate from standard clinical practice because of their goal of reducing any potential liability to claims of clinical negligence. "Defensive practices" include "assurance behaviours" or "positive defensive medicine," whereby referrals are made to other clinical services to reassure the referring clinician that all aspects of an individual's health have been examined. "Negative defensive practices" involve the reluctance of clinicians to be involved directly in the treatment or management of "high-risk" patients (Reuveni et al., 2017).

From a health perspective, there is a literature examining practices for managing patients in psychiatric treatment within the context of restrictions of liberty and restraint in an inpatient setting (Muir-Cochrane, O'Kane, & Oster, 2018; Slemon et al., 2017; Manuel & Crowe, 2014). Commentators have argued that mental health conditions are synonymous with unpredictable and dangerous behaviours. Such factors affect perceptions of personal and professional safety, as clinicians are held responsible for any adverse consequences to individuals and fear litigation (Slemon et al., 2017). From a mental health perspective, in a psychiatric inpatient environment, clinicians establish defensive practices by "shifting responsibility" through fear of any unforeseen and adverse consequence during treatment (Slemon et al., 2017; Crowe and Manuel, 2014). These practices include strict adherence to documentation, referrals to senior clinicians (e.g., psychiatrist), and spreading the decisions about an individual's treatment across clinical staff (Manuel & Crowe, 2014).

For police, similar discussions argue for an organizational trend towards risk aversion arising from fear of detainee self-harm or death whilst in police custody (Thomas & Forrester-Jones, 2019; Wood & Watson, 2017). Consequently, this paper argues that the various perceptions of risk shown above framed by these two defensive practices on the part of both police and health professionals in the management of detainees on a Section 136 further problematize the experience of these detainees.

This focus on defensive practices has a number of consequences. Firstly, the nature of the interaction between police and health staff is placed on a defensive footing and focused on the avoidance of an adverse event happening rather than on developing a therapeutic relationship with the detainee involving shared outcomes. Police may not appreciate the need for detainees to be "medically cleared," and the transfer to and from mental health units to acute Emergency Departments creates cross-disciplinary tension. As this study has shown, the difference in perceptions of what is considered an "acceptable" level of drug and alcohol intoxication is a major point of tension between police and health professionals. For police, using up valuable police resources in what seems like "dead time" (Herrington & Pope, 2014) is a major factor in the perception of the effectiveness of the conveyance process.

Fear of aggression and antisocial behaviour can also lead to stigmatization of segments of the detainee population, especially drug misusers. This may result in negative outcomes for this group of detainees and, moreover, highlights the notion of detainees as "police property," whereby police are required to lead in the management of difficult and vulnerable groups (Reiner, 2010, cited in McDaniel, 2019). This has important implications, as research with detainees has shown that the conveyance and transfer of an individual in mental health crisis is framed by that experience (Sondhi et al., 2018; Jones & Mason 2002), and negative experiences can determine perceptions of the service received and outcomes gained from treatment (Nyttingnes, Ruud, & Rugkåsa, 2016). Detainees may perceive the experience of detention under Section 136 as a single (often traumatic) episode of care, albeit fragmented by limited recall of the entire event, comprising the sum of its parts as opposed to understanding that there are multiple organizational contacts involved in the detention process (Sondhi et al., 2018). If the detention process is framed by fear and negativity underpinned by defensive practices on the part of both police and health services, then it is likely that any future response model will face the same barriers and tensions.

Although the study aimed to be representative through geographical coverage (by inner-outer as well as north-south-east-west London) and has a large sample size, several limitations should be noted. The study covers London only, which may not be representative of other areas. Indeed, other commentators have been critical of this reliance on London to describe the Section 136 process (Borschmann et al., 2010; Laidlaw et al., 2010). The study was conducted prior to the introduction of the roll-out of street triage schemes, and although some interviews were undertaken with workers, they did not explain adequately how this service could address the issues raised in this paper. In addition, at the time of the study, there were moves to establish dedicated Section 136 suites, and moves to reconfigure service provision across London occurred after the fieldwork had been concluded.

CONCLUSIONS

The role of police in the detention of individuals in acute mental health crisis under Section 136, and related legislation internationally, is often described negatively. This study is one of the few to consider the detention process across police and health partners by interviewing a wide range of professionals involved in the detention process. We argue that defensive practices by both police and health services negatively frame the conveyance and transfer process from the point of detention to admission to a place of safety. The framing is focused on risk and fear of the occurrence of adverse events for which professionals and their institutions will be blamed. For detainees, the conveyance and transfer processes are integral to their cognitive framing of the Section 136 event. Detainees have highlighted the importance of the therapeutic interaction and "being cared for" and how satisfaction with the experience can affect subsequent treatment outcomes (Sondhi et al., 2018; Katsakou & Priebe, 2007).

For police and clinical staff, the identification of risks to the individual, staff, and general public associated with often chaotic and traumatic episodes of care are paramount. Yet the implementation of defensive practices across police and health staff negatively frame the detention for detainees and create other problems (such as worsening of a mental health condition and exacerbating negative attitudes to police and health services). Whilst the management of detainee risk is essential across police and health services, we argue that there is a need for a shift to establish a balance between safety

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and the creation of a therapeutic environment for detainees. Furthermore, as McDaniel (2019) argues, this needs to be accountable, ethical, and transparent.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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