

Exploring Section 136 of the Mental Health Act (1983/2007) from a  
psychological perspective

Volume I:

Literature review: What is known about what happens when the police detain  
people experiencing mental health crises?

Empirical paper: How are Section 136 of the Mental Health Act (1983/2007) and  
the use of 'places of safety' understood and experienced by police officers?

Public dissemination document: Exploring Section 136 of the  
Mental Health Act (1983/2007) from a psychological perspective

by

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A thesis submitted to the University of Birmingham  
in partial fulfilment of the degree of Doctor of Clinical Psychology

School of Psychology  
College of Life and Environmental Sciences  
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May 2014

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## **Thesis Overview**

This thesis brings together a series of work undertaken by the author in partial fulfilment of the Doctorate in Clinical Psychology programme between September 2011 and May 2014, accredited through the University of Birmingham. During this time the author undertook a series of clinical placements across the West Midlands, UK, while employed by the Black Country Partnership NHS Foundation Trust. This thesis is comprised of two volumes: Volume I – Research; and Volume II – Clinical practice, further details of which are outlined below.

### **Volume I**

This volume is comprised of a literature review, an empirical paper, and a public dissemination document providing an accessible summary of this volume.

The literature review draws together the extant literature on what is known about what happens when the police detain people experiencing mental health crises. It draws on a systematic search of relevant bibliographic databases, identifying a series of themes which are discussed in relation to the quality of the research identified, the limitations of the review, and the implications for future practice and research. This review concludes that while there is a clear remit for the police to be involved in the detention of people experiencing mental health crises (to mitigate risks to individuals and the wider public), there is evidence to suggest that this type of contact can be problematic. While work in this area is developing, there is more to be done to raise awareness of the issues involved, and to support meaningful partnership working with a range of stakeholders.

In building on the work of the literature review, the empirical paper goes on to explore how police officers understand and experience the use of Section 136 of the Mental Health Act (1983/2007). Under this Act, the police have specific powers to detain individuals believed to be experiencing mental health difficulties, in immediate need of care and control *and* in a place to which the public have access where there are concerns for the safety of those individuals and/or the wider public. This study employed interpretative phenomenological analysis to explore ten officers' (from the English Midlands) experiences of this aspect of their work. Individual

interviews were undertaken and a series of themes developed to account for the data. This study concludes that police encounters with people experiencing mental health difficulties are a significant and complex aspect of policing. The police have a key role to play in responding to those in immediate need, yet the lack of service-user involvement in service evaluation was striking. Findings highlighted the potential for the development of greater service-user involvement, supporting communication, and partnership working with other agencies to achieve 'optimal experience' for all involved. These findings are discussed within the context of the quality and limitations of this research, and the implications for practice.

The public dissemination document offers an accessible summary of the literature review and empirical paper, and is designed to share the findings of this volume more widely than academic audiences alone. It is hoped that this research will be of interest to professionals, service-users and their wider social networks, and the general public alike, as the issues presented have the potential to impact upon any of us.

## **Volume II**

This volume brings together a series of five case practice reports outlining clinical work undertaken on placements from adult, older adult, learning disability, and physical health specialties. The first report focuses on the application of two psychological approaches (cognitive behavioural and psychodynamic) to case formulation. The process of assessment and formulation with a woman presenting to primary care psychology services for difficulties with anxiety are outlined. The second report presents a service evaluation of client satisfaction and outcomes with a counselling service, benchmarking outcomes against national standards. The third report outlines a single-case experimental design study based on a therapeutic intervention for anxiety and panic with a woman who was an inpatient in an older adult psychiatric hospital. The fourth report offers a case study of an intervention carried out with a young woman experiencing difficulties with anxiety and anger presenting to a specialist learning disabilities service. Finally, the fifth report offers a one page abstract relating to an oral presentation of a case study that was delivered by the author relating to a woman's experiences of health anxiety as a survivor of cancer.

Dedication

**Dedication**

For all those who have helped me along the way,  
I couldn't have done it without your encouragement and support.

Special thanks to Jason, always there for me.

## **Acknowledgements**

This research would not have been possible without the support of the individual police officers who shared their experiences and time with me for the benefit of this project. I am also extremely grateful for the support I received from West Midlands Police, with special thanks to Chief Inspector Sean Russell, Business Transformation - Customer Perspective and Mental Health Lead. I offer thanks to the University of Birmingham for supporting this research, and would like to express my sincere gratitude for the ceaseless encouragement, support, and guidance offered by my research supervisor, Dr Michael Larkin.

This research was granted ethical approval by the University of Birmingham's Science, Technology, Engineering and Mathematical Ethical Review Committee to protect participant's safety, rights and dignity. I am grateful for the Committee's time and valuable comments in guiding this research.

I am also pleased to acknowledge that this research was supported as part of the Doctorate in Clinical Psychology programme by my employer, Black Country Partnership NHS Foundation Trust.

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## LIST OF ABBREVIATIONS

S136	Section 136 of the Mental Health Act (1983/2007)
IPA	Interpretative Phenomenological Analysis

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**LIST OF ABBREVIATIONS**

HADS	Hospital Anxiety and Depression Scale
PAND	Percentage of All Nonoverlapping Data
RCI	Reliable Change Index
SUD	Subjective Units of Distress
SUDS	Subjective Units of Distress Scale

**Literature Review:**

**What is known about what happens when the police detain people  
experiencing mental health crises?**

## **Abstract**

**Objective:** To identify and draw together the extant literature on what is known about what happens when the police detain people experiencing mental health crises.

**Method:** A systematic review of relevant bibliographic databases was conducted to identify relevant literature on mental health and police custody/detention. Fifteen articles were identified and included in this review.

**Themes:** While it is noted that the articles identified covered a broad range of issues, it was possible to identify five key themes in the research: characteristics; specialised police mental health crisis response services; policies and procedures; cooperation and compliance; and training. Findings are discussed in relation to the quality of the research identified and limitations of this review, and the implications for practice and future research.

**Conclusions:** There appears to be a clear remit for the police to be involved in the detention of people experiencing mental health crises in circumstances where there are risks to individuals and/or the wider public. However, there is evidence to suggest that this type of contact can be problematic at times, with the potential for stigmatisation, criminalisation, injury and even death to occur. While research in this area is developing, there is still more to be done in terms of developing awareness of this area, along with opportunities for developing meaningful partnership working with a range of stakeholders.

**Keywords:** Section 136; Mental Health Act (1983/2007); Place of safety; Detention; Mental health crises; Police; Review.

## **Section 1: Introduction**

### **1.1 Why explore the interface between the police and people experiencing mental health crises?**

In the most extensive examination of policing in England and Wales since the Royal Commission of 1962, Lord Stevens (2013) has published ‘Policing for a better Britain’ a report of the Independent Police Commission. This document highlights the need for policing to “contribute to the creation of a safer, more cohesive and more just society” (p.13) and explores the role of modern policing beyond the criminal justice system towards a social justice model of community involvement. The vision is to develop a police service with a social purpose, combining preventing crime and catching offenders with meeting the needs of the most vulnerable in society, focusing on safety and wellbeing in communities. Indeed, the Commission recommends that “the social purpose of the police should be enshrined in law” (p.14). It is likely that this will lead to changes in how society understands the role of policing, having implications for broader philosophical, social, and psychological discourses about issues relating to concepts such as criminality, vulnerability and justice.

There are indications of a shift in the role of policing as the police service has increasingly become involved in the provision of specialist care, most notably in relation to mental health. The Commission reported on a growing sense that the police were expected to take on this sort of work, not as a result of specialist skills in this area, but rather because of the 24-hour service they provide. Another key area of police demand relating to mental health is the detention of individuals under Section 136 (hereafter referred to as S136) of the Mental Health Act (1983/2007). This relates to a police power to detain individuals suspected of experiencing a mental health difficulty, in immediate need of care and control, *and* in a place to which the public have access. The Commission reported that they had seen evidence to suggest that while these powers should only be used in exceptional circumstances, they were being used regularly (Her Majesty’s Inspectorate of Prisons, 2013). In such circumstances the police have a range of options

for where to take people that would be considered a 'place of safety' (including: a hospital; a police station; some types of local authority residential accommodation; any other suitable place to which the occupier is willing to receive the individual), though there have been some concerns expressed regarding the extent to which police cells are used.

While this points to a significant role for the police in supporting people who become acutely unwell as a result of mental health difficulties, it is worth noting that there seems to be relatively little known about what happens when the police detain people who find themselves in such situations. While there is evidence to suggest that societal attitudes are changing, people experiencing mental health difficulties often face stigma and discrimination, and are often considered to be a particularly vulnerable group within society (Prior, 2011). Often people experiencing mental health difficulties are perceived as dangerous (either to themselves or others) which has implications for how we, as a society, understand such difficulties and respond to them. Indeed, as noted above, a common response is to involve the police in mental health crises, though there is still a way to go in developing discourses around the police as agents of wider social justice as opposed to those more commonly associated with criminality, dangerousness, public protection, and morality. There have been accounts of mental health service-user experiences of interactions with health services that are framed in terms of a 'survivor' movement, and literature focusing on some of the differences between voluntary and involuntary admissions to psychiatric services and the impact this has on outcomes for these individuals (Turner-Crowson & Wallcraft, 2002; Speed, 2006; Kallert, Glöckner & Schützwohl, 2008). It would therefore seem that there is potential here for further developments in interagency working, focusing on communication, training and integration of services (including the police, health and social services, and the voluntary sector), in order to develop more appropriate pathways for individuals that avoid the stigmatisation and criminalisation of mental health difficulties. Indeed, the recent Mental Health Crisis Care Concordat for improving outcomes for people experiencing mental health crises outlined the key role that public services play in supporting people in these situations, responding quickly to protect people, reducing harm to individuals and wider society (Department of Health & Concordat

Signatories, 2014). However, it is also acknowledged that interagency working in this area has not been without its difficulties:

“Where there are problems, they are often as a result of what happens at the points where these services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another.

This is a very serious issue – in the worst cases people with mental health problems who have reached a crisis point have been injured or have died when responses have been wrong. In other cases, patients have had to travel long distances when acute beds have been unavailable.”

(Department of Health & Concordat Signatories, 2014)

There has been an overall shift in how mental health is understood, supported by changes to health policies and practices, for example, the ‘No health without mental health’ outcomes strategy (Department of Health, 2011), moving from institutionalisation towards community-based interventions, and efforts made to promote the destigmatisation agenda. However, it is clear that there is still much more to be done as highlighted in the work carried out by leading UK mental health charities Rethink and Mind, and organisations including the British Psychological Society, the Royal College of Psychiatrists, and the Royal College of Nursing. Statistics can inform us about the scale of mental health difficulties, by focusing on factors such as, prevalence of diagnoses, medication prescribed, economic impacts, health and social care contacts, police encounters and so forth. However, they may be less helpful in terms of developing an understanding of the experiences of those affected and their wider social networks. In order to develop a deeper understanding of how, as a society, we respond to mental health crises and what happens when the police get involved, it would therefore seem pertinent to explore what is already known about this interface, especially in light of the recent changes in policing outlined above. This review therefore seeks to bring together the literature on what happens when the police detain people experiencing mental health crises. In so doing it aims to provide an overview of what is

already known, its limitations and implications for practice, while also highlighting potential gaps in the literature and implications for future research.

## 1.2 Search strategy

A number of bibliographic databases were searched for relevant literature on mental health and police custody/detention. PsycArticles Full Text; Ovid Social Policy & Practice; Embase 1980 – August 2013; Ovid Medline (R) 1946-August 2013; and PsychINFO 1967 – August 2013. These databases were chosen as they represent a wide range of areas of interest including: behavioural science; biomedical and life sciences; social policy; public health; social services; mental health; and community health. Table 1.1 details the number of papers identified for the keyword terms stated. Further inclusion/exclusion criteria for the papers identified are illustrated in Figure 1.1. As some of the papers were excluded for lack of relevance to the present review, Table 1.2 indicates the reasons for exclusion.

*Table 1.1: Keyword search terms for exploration of bibliographic databases*

Search Number	Keywords	Number of results
1	Police	10395
2	Policing	1651
3	1 OR 2	11891
4	Custody	18035
5	Detention	9158
6	Detain*	6466
7	Arrest	300860
8	Caution	96421
9	Section*	1205467
10	4 OR 5 OR 6 OR 7 OR 8 OR 9	1612617
11	Mental	1338283
12	Psychiatric	599127
13	11 OR 12	1657351
14	3 AND 10 AND 13	29
15	Remove duplicates	29

\* Denotes a truncation of the search term to include a wider variety of relevant terms (e.g. Detain/detained, Section/Sectioned etc.).

Figure 1.1: Inclusion and exclusion criteria for articles identified in the initial search strategy

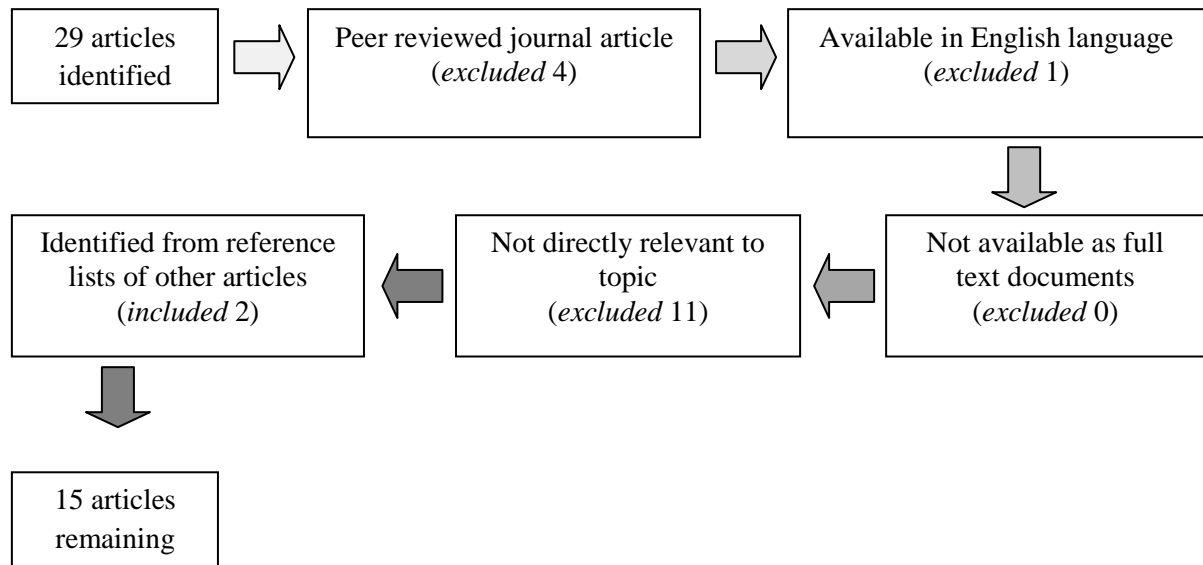


Table 1.2: Reasons for lack of relevance to the present literature review

Of those not directly relevant to this literature review, reasons included:	Number of papers excluded (total 11)
Lack of focus on emergency/crisis responses to people experiencing mental health difficulties, papers identified in relation to references about non-psychiatric emergencies/crisis situations (e.g. Sarin gas attacks in Tokyo, 9/11 USA)	3
Focus on evaluations of the psychological impact of working in the police (e.g. officer suicide rates, job performance, clinical symptoms)	2
Focus on police officer evaluation/performance not within the scope of emergency/crisis responses to those experiencing mental health difficulties	3
Focus on the under-utilisation of psychological services by victims of crime	1
Focus on the under-reporting of crime (linked to psychological factors)	1
Focus on induced confessions (including in vulnerable populations)	1



### **1.3 Overview of the literature**

This paper will provide a conceptual review of the literature (identified through a systematic search strategy) concerned with what is known about police involvement in the detention of people experiencing mental health crises. A systematic search of the literature identified 15 relevant papers for consideration, though it is noted that the literature identified was disparate, spanning a wide period of time (1967-2013), covering broad areas of interest linked to police involvement in mental health crises, and was predominantly USA-focused. However, further exploration of these studies indicated there were identifiable themes in their individual foci. It is also noted that while each paper had a main theme identified by the authors, each paper typically referenced a number of other areas of interest in this field. The primary themes identified are: demographic characteristics of people referred for to emergency health services by the police; specialised police mental health crisis response services; policies and procedures; cooperation and compliance; and training (Table 1.3 provides a summary of each paper and identifies its key theme; while Appendix 1 provides a summary of the themes and the papers for which this is either a primary or secondary focus). As these distinct themes have been identified, it seems pertinent to present them in this way, while also being mindful of how the literature has developed over time and around the world. This review will therefore explore each of these themes in greater detail, making links between the articles and with broader psychological theories to develop a greater understanding of this area.

In order to support this narrative structure, issues regarding the quality of the literature will be explored separately prior to introducing the themes. A synthesis of the key findings of the literature will be provided and discussed in relation to the implications for practice and future research.

Table 1.3: Summary of papers included in the literature review

Summary of the fifteen papers exploring the consequences of police involvement in the detention of people experiencing mental health crises identified within the literature review. This is followed by a summary of themes identified in the foci of the papers (Appendix 1).

Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
Police discretion in emergency apprehension of mentally ill persons  (Bittner, 1967)	N/A	10 months fieldwork with uniformed police patrol  Psychiatric records of the hospital receiving all police referrals	Description of the rules and considerations underlying the exercise of discretion in emergency apprehensions	<ul style="list-style-type: none"> <li>• Exploration of organisational and attitudinal factors influencing emergency apprehensions; conditions surrounding emergency apprehensions; non-official ways of dealing with mentally ill persons; de facto emergency apprehensions; restitution of control; “psychiatric first aid”; and continuing care</li> <li>• Impact on referrals to hospital on an emergency basis</li> <li>• Conceptualisations of “keeping the peace” in differentiation from “enforcing the law”</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>discretion in emergency apprehensions</b>
Blue remembered skills: mental health awareness training for police officers  (Cummings & Jones, 2010)	Not detailed  Population: UK	Review of records <ul style="list-style-type: none"> <li>• Based on previous pilot studies – further details not provided</li> </ul>	Review of records  Comparison of two models of training based in their evaluations – data not provided, summaries only	<ul style="list-style-type: none"> <li>• Police have a key role to play in situations where individuals are experiencing some sort of crisis relating to their mental health</li> <li>• Area often neglected in police training – skills and knowledge largely acquired through experience on duty or from senior colleagues</li> <li>• Comparison of two models of training: working in a mental health unit/classroom based</li> <li>• Focus on key aspects/values of training and commitment needed to implement change in this area</li> <li>• Consideration of impact on clients – some feedback presented</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>training needs</b>  Continued...

Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
<p>Evaluation of consequences of implementation of police crisis intervention team in Louisville</p> <p>(El-Mallakh, Spratt, Butler &amp; Strauss, 2008)</p>	<p>Police records for 2002 – first full year of Crisis Intervention Team</p> <p>Records for 2004 – the year after consolidation of city and community police forces</p> <p>Comparison with 2001 records where possible</p> <p>Population: USA</p>	<p>Review of records</p> <ul style="list-style-type: none"> <li>• Number of CIT calls</li> <li>• Use of force, police and citizen injuries</li> <li>• SWAT callouts</li> <li>• Hostage Negotiation Team callouts</li> <li>• Arrest rates</li> <li>• Jail and mental health unit occupancy rates</li> </ul>	<p>Review of records</p> <p>Descriptive statistics</p> <p>Test of significance of proportional data</p>	<ul style="list-style-type: none"> <li>• Crisis Intervention Team – uniformed police officers specifically trained to deal with mental health issues</li> <li>• Data suggest that the introduction of the crisis intervention team has had an overall positive effect on outcomes of situations in which people experiencing mental health difficulties are confronted by police officers</li> <li>• Arrest rate reduced</li> <li>• Hostage negotiation Team callouts reduced</li> <li>• Mental health unit in the County Jail occupancy remained relatively stable</li> <li>• Referrals to intense psychiatric services greatly reduced</li> <li>• Training and liaison with mental health providers identified as essential</li> </ul>	<p>Consequences of police involvement in the detention of people experiencing mental health crises – focus on pre- and post- <b>Crisis Intervention Team involvement</b></p>
<p>Outcome for psychiatric emergency patients seen by an outreach police-mental health team</p> <p>(Lamb, Shaner, Elliott, DeCuir &amp; Foltz, 1995)</p>	<p>N = 101</p> <p>Follow-up N = 85</p> <p>Consecutive referrals to law enforcement mental health teams</p> <p>Population: USA</p>	<p>Review of records</p> <ul style="list-style-type: none"> <li>• Demographic</li> <li>• Clinical history</li> <li>• Arrest history</li> <li>• Previous violent behaviour</li> </ul> <p>Follow up:</p> <ul style="list-style-type: none"> <li>• Hospitalisations</li> <li>• Arrests</li> <li>• Acts of violence</li> <li>• Mental health treatment</li> <li>• Living situation</li> </ul>	<p>Review of records</p> <p>Chi square analysis with correction for continuity – used to assess significance of relationships between variables</p>	<ul style="list-style-type: none"> <li>• Outreach teams composed of a police officer and a mental health professional are able to deal appropriately with people who have acute and severe mental illness, a high potential for violence, a high incidence of substance abuse, and long histories with both the criminal justice and mental health systems</li> <li>• Outreach teams apparently avoid criminalisation of those experiencing mental health difficulties</li> </ul>	<p>Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>Outreach Teams</b></p> <p>Continued...</p>

Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
Profiling police presentations of mental health consumers to an emergency department  (Lee, Brunero, Fairbrother & Cowan, 2008)	N = 542  Consumers with a mental health problem brought in by the police to the emergency department of a 350-bed community hospital  Population: Australia	Review of records <ul style="list-style-type: none"> <li>Emergency department information system and psychiatric assessment</li> </ul>	Review of records  Multivariate logistic regression analysis	<ul style="list-style-type: none"> <li>Comparison of characteristics of consumers who had been referred by the police to a metropolitan general hospital emergency department with mental health issues with those who presented to the emergency department with mental health problems without police involvement</li> <li>Findings indicate the main factors predictive of police presentation were younger age, male gender, unemployment, alcohol or other drug use, and not having a presenting problem of depression or anxiety</li> <li>Highlights systems need to be developed to facilitate collaboration between emergency departments, hospital security, police services, mental health and ambulance services</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>characteristics of individuals referred by police</b>
Observations on police policy and procedures for emergency detention of the mentally ill  (Matthews, 1970)	N/A  Population: USA	Observations on policies and procedures	Observations on policies and procedures	<ul style="list-style-type: none"> <li>The issue of police handling of people experiencing mental health difficulties is both legal and medical</li> <li>Discussion of police policies and procedures for emergency situations</li> <li>Training – limits acknowledged, potential for resources to be shared</li> <li>Adequacy of community mental health facilities</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>policies and procedures for detention in the case of mental health difficulties</b> Continued...

Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
Characteristics of Patients Referred by Police to a Psychiatric Emergency Service (Redondo & Currier, 2003)	N = 200  N = 100: Consecutive referrals to the comprehensive psychiatric emergency service  N = 100: Control group of patients referred by other sources matched day for day over the same period  Population: USA	Review of records <ul style="list-style-type: none"> <li>• Demographic characteristics</li> <li>• Condition of patient on presentation to psychiatric emergency service</li> <li>• Psychiatric emergency service records</li> <li>• Mental health arrest documentation</li> <li>• Patients charts</li> </ul>	Review of records  Descriptive statistics  Matched samples comparison	<ul style="list-style-type: none"> <li>• Patients who were referred by police had significantly more stressors and required more time for evaluation in the emergency service</li> <li>• No statistically significant differences were noted in admission rates between patients referred by police and those referred by other sources – these findings differ from those reported for other psychiatric emergency services in other localities</li> <li>• As demand increases, the structure, staffing and resource allocation to these service may need to be re-evaluated and adjusted so that the acute needs of this population can be met</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>characteristics of individuals referred by police</b>
Police-referred psychiatric emergencies: advantages of community treatment (Sheridan & Teplin, 1981)	N = 838  Patients referred by the police to a Community Mental Health Centre  2 Year follow-up N = 93: Patients referred pre-programme N = 102: Patients referred post-programme	Review of records <ul style="list-style-type: none"> <li>• Demographic data</li> </ul>	Review of records  Descriptive statistics  Chi-square comparisons	<ul style="list-style-type: none"> <li>• Police-referred patients were typically: seriously disturbed, psychotic, living alone and in need of hospitalisation. Black and young individuals were disproportionately referred. Overrepresentation of single, divorced and separated individuals</li> <li>• Exploration of the advantages of a Police Reception Programme</li> <li>• Exploration of impact of such programmes on recidivism</li> <li>• Even with low motivated, very disturbed patients, with poor or no social support networks, it is possible to greatly reduce inpatient treatment</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>characteristics of individuals referred by police</b> Continued...

Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
<p>Comparing outcomes of major models of police responses to mental health emergencies</p> <p>(Steadman, Deane, Borum &amp; Morrissey, 2000)</p>	<p>N = 297</p> <p>Proportion of mental disturbance calls resulting in specialised police responses and arrests across three sites</p> <p>Population: USA</p>	<p>Comparative cross-site descriptive design of three different police response programmes</p>	<p>Review of records</p> <p>Descriptive statistics</p> <p>Chi-square analysis. One way ANOVA to corroborate the chi-square test. Bonferroni post hoc tests to identify specific differences between sites</p>	<ul style="list-style-type: none"> <li>• Large differences were found across sites in the proportion of calls that led to a specialised response</li> <li>• Two key factors identified: the existence of psychiatric triage and drop-off centres; and the centrality of community partnerships</li> <li>• Data suggests that collaborations between the criminal justice system, the mental health system, and the advocacy community plus essential services reduce the inappropriate use of US jails for people with acute symptoms of mental illness</li> </ul>	<p>Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>specialised police responses</b></p>
<p>A specialized crisis response site as a core element of police-based diversion programs</p> <p>(Steadman, Stainbrook, Griffin, Draine, Dupont &amp; Horey, 2001)</p>	<p>N/A</p> <p>Population: USA</p>	<p>Observations reported emerged from site visits and training sessions involving the a number of the authors</p>	<p>Description of three diversion programmes participating in the Substance Abuse and Mental Health Service Administration jail diversion knowledge development application initiative</p>	<ul style="list-style-type: none"> <li>• Important principles in the operation of those programmes: being a highly visible, single point of entry; having a no-refusal policy and streamlined intake for police cases; establishing legal foundations to detain individuals; cross-training; and linking clients to community services</li> <li>• Effective crisis services provide both treatment on-site and appropriate referrals for individuals when they are stabilised</li> </ul>	<p>Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>specialist police-based diversion programmes</b></p> <p>Continued...</p>

Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
'Mentally disordered persons found in public places'. Diagnostic and social aspects of police referrals (Section 136)  (Turner, Ness & Imison, 1992)	N = 163 referrals  Population: UK	Review of records <ul style="list-style-type: none"> <li>40-point questionnaire designed to obtain information on this cohort using case notes as the data source</li> </ul>	Review of records  Descriptive statistics	<ul style="list-style-type: none"> <li>Previous psychiatric admissions, a diagnosis of schizophrenia, social deprivation, and a bias towards young men of Afro-Caribbean ethnicity were key features</li> <li>There was difficulty obtaining clear, reliable data, and uncertainties within the law that rebounded unfairly on patients, police and psychiatrists</li> <li>Section 136 is not an appropriate diagnostic tool, but can be seen as highlighting unmet social needs in the context of community care</li> <li>There is a need for coordinated resources beyond hospital boundaries</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>characteristics of individuals referred by police</b>
Research in the real world: studying Chicago police department's crisis intervention team  (Watson, 2010)	N = 216  Of those: N = 91: CIT trained  Follow-up at 1, 3 & 6 months variable (dwindling) N = 20: also included in a qualitative sample  Population: USA	Review of literature  Application of the model in Chicago  Individual interviews	Review of literature  Mixed methods (further details not provided)	<ul style="list-style-type: none"> <li>Review of emerging literature</li> <li>Presentation of a conceptual model of Crisis Intervention Team effectiveness</li> <li>Description of a study of a Crisis Intervention Team in Chicago</li> <li>Findings suggest that the crisis intervention team may improve outcomes of police encounters with persons with mental illness, particularly among officers with more passive views on mental health resource responsiveness</li> </ul>	Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>literature review of Crisis Intervention Team involvement</b>  Continued...

Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
<p>The role of stigma and uncertainty in moderating the effect of procedural justice on cooperation and resistance in police encounters with persons with mental illnesses</p> <p>(Watson &amp; Angell, 2013)</p>	<p>N = 139</p> <p>(after missing data removed)</p> <p>Participants recruited from three psychosocial rehabilitation programmes who had had an encounter with the police over the preceding 12 months</p> <p>Population: USA</p>	Individual interviews	<p>Mixed methods linked to Watson, Morabito, Draine &amp; Ottati (2008) study</p> <p>Measures:</p> <ul style="list-style-type: none"> <li>• Police Contact Experience Survey</li> <li>• Perceived Devaluation and Discrimination Scale</li> <li>• Positive and Negative Pressures Scale</li> <li>• Call type (coded by interviewer based on participant response)</li> </ul>	<ul style="list-style-type: none"> <li>• Cooperation and compliance in encounters between the police and people with serious mental illnesses</li> <li>• Social psychology, procedural justice theory perspective</li> <li>• Findings suggest that greater perceived procedural justice is associated with more cooperation and less resistance – the effect on cooperation is moderated by both perceived stigma and the type of encounter</li> <li>• Findings underline the importance of procedurally just treatment in police interactions with vulnerable individuals</li> <li>• Further efforts are needed to reduce the stigma of mental illness</li> </ul>	<p>Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>cooperation and compliance in encounters with the police</b></p> <p>Continued...</p>



Article and Author	Sample	Method of data collection	Method of data analysis	Key themes and findings identified	Particularly relevant to this research?
<p>Improving police response to persons with mental illness: A multi-level conceptualization of CIT</p> <p>(Watson, Morabito, Draine &amp; Ottati, 2008)</p>	<p>N/A</p> <p>Population: USA</p>	Conceptualisation of crisis intervention teams	Literature review and development of conceptualisation	<ul style="list-style-type: none"> <li>Impact of Crisis Intervention Team model on police responses to people with mental illness</li> <li>The crisis intervention team model is being widely implemented. Initial evidence for the effectiveness of these programmes is promising but limited in scope (focusing mainly on officer characteristics and training)</li> <li>Focus on a model conceptualising police responses to people experiencing mental health difficulties accounting for officer, organisational, mental health system, and community level factors likely to influence effectiveness of such models</li> </ul>	<p>Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>Crisis Intervention Team involvement</b></p>
<p>An analysis of police referrals to 10 psychiatric emergency rooms</p> <p>(Way, Evans &amp; Banks, 1993)</p>	<p>N = 362</p> <p>N = 30%: referrals brought in by the police (no further information given)</p> <p>Population: USA</p>	<p>Review of records</p> <div> <p>Univariate comparisons, chi-square (Yates' correction or Fisher's exact test), or t-test. Bonferroni procedure to adjust observed p-values.</p> </div>	<p>Review of records</p> <p>Logistic regression differentiated police and non-police cases across a range of constructs</p>	<ul style="list-style-type: none"> <li>Findings indicated that police cases were as psychiatrically disturbed as referrals from other sources, similar percentages of police and other referrals on all the psychiatric disability indicators</li> <li>Police referrals to psychiatric emergency rooms were more likely to be judged by clinicians to have been referred for behaviour that was dangerous to others, or to have impaired judgment – this led to a higher percentage of these cases being admitted to inpatient care</li> <li>Reflections on the Comprehensive Psychiatric Emergency Program initiative and emergency service models</li> </ul>	<p>Consequences of police involvement in the detention of people experiencing mental health crises – focus on <b>characteristics of individuals referred by police</b></p>

## Section 2: Quality of the research identified

In reviewing this literature, consideration must be given to assessing the quality of the work. It is noted that there will be a certain publication bias in all literature as that which finds striking results is more likely to be published than that which finds insignificant results, or those that go against accepted beliefs (unless, conversely, a striking finding to the contrary seems to be all the more interesting for it). It is also noted that there are a great number of publications available, some of which attract better quality literature than others. However, there are a number of established frameworks available for examining quality based on the type of work under investigation, for example: quantitative approaches (Downs & Black, 1998); qualitative approaches (Yardley, 2000; Cesario, Morin & Santa-Donato, 2002); mixed methods designs (Sale & Brazil, 2004); and systematic reviews (Shea *et al.*, 2009). This review has identified a number of papers that have taken different methodological approaches to exploring the consequences of police involvement in the detention of people experiencing mental health crises. While the themes of these papers are discussed below, attention must first turn towards issues of quality. Appendix 2 provides a summary of the quality frameworks applied and an assessment summary for each paper.

In order to apply a consistent approach to the assessment of the quality of the papers identified, Sale and Brazil's (2004) criteria will be applied to all of the papers, except the reviews which will look to the AMSTAR guidance (Shea *et al.*, 2009) (see Appendix 2 for further details of the criteria applied to the literature identified). The majority (nine) of the papers were quantitative in design, the data typically being collected through reviews of records. While all these papers did meet the basic quality criteria in line with Sale and Brazil's (2004) criteria in terms of truth value, applicability, and consistency, it is noted that there was variance between the papers. In summary, these nine quantitative papers offered differing amounts of detail considering potential extraneous variables, and none of the papers made explicit reference to consent, confidentiality and ethical approval procedures. While all papers included a statement of purpose, there was considerable variance in discussion of methodological issues (including sampling and analytic method used),

and typically limited exploration of the limitations and quality of the work (see Appendix 2 for further details).

Four papers could be described as mixed-methods, having quantitative and qualitative components. These four papers were also assessed in line with Sale and Brazil's (2004) quality criteria and again, there was a similar picture to that noted with the quantitative studies above in terms of the amount of detail given to help the reader assess the quality of the work. Where the qualitative element of the work was reported on, typically brief descriptions of the methods used were provided and the work was summarised with minimal (if any) use of participant quotes. While all papers included author affiliation information, none of these papers made explicit reference to the authors' background and how this may have impacted upon their perceptions and assumptions about the phenomena under investigation.

Two papers included literature reviews, though it is noted that they also had another component (in one case a further mixed-methods design, in another an outline of a conceptual crisis intervention team model). Consideration of these papers in line with Shea and colleagues' (2009) framework again highlights some of the difficulties in assessing the quality of this work. Neither of the papers provided a clear commentary of their search strategies and inclusion/exclusion criteria, nor were potential conflicts of interest mentioned. However, there was some discussion of the impact of assessing the quality of the literature in forming conclusions, namely focusing on work in this area (developing crisis intervention programmes) being in its infancy at present, and pointing to the potential for future developments.

Only one of the papers appeared to be qualitative in design, being loosely ethnographic and based on the authors' observations of services (Matthews, 1970). While this paper provides a statement of purpose, and a description of the methods employed, there was only one extended and some brief quotes used throughout the text. Again, there was no explicit reference made to the author's background and how this may have impacted upon the data collection and analysis.

It is interesting to note that the majority of the articles identified were based on data collected in the USA (of the 15 papers: 12 USA-based; 2 UK-based; 1 Australia-based). So, while

there was a more international picture of the characteristics of individuals detained and referred by police to health services, and some details of training initiatives based in the UK, much of the data on specialist police response services and policies and procedures was biased towards an American perspective. Though this has something to offer in terms of informing international practice, it is important to be mindful of the potential cultural differences and implications for implementation elsewhere (e.g. perceptions of the remit of policing, the use of armed policing, specific laws, the provision of statutory services etc.). In summary, this conceptual review has identified a disparate literature, spanning a wide period of time, across different nationalities, using a variety of research methods. In thinking about identifying themes in this literature and exploring their implications for current practice it is important to be mindful of these differences and the variable scientific quality of this literature (as noted above).

Consideration must also be given to evaluating the quality of this review, so, in accordance with the frameworks outlined above, the AMSTAR guidance was applied. This review sought to answer a clear question and established clear inclusion criteria before the review was conducted. Duplicate data were not included in this review, a comprehensive literature search was performed, and it is noted that this review has been considered and developed through an academic research supervision process. The status of the publications was defined and the limitations identified in the search strategy. A list of studies included and excluded is provided (see Tables 1.2 and 1.3) and the characteristics of the studies detailed. The scientific quality of the studies has been documented and discussed in terms of the implications and limitations of this review. This review has focused on developing a narrative of what happens when the police are involved in detaining people experiencing mental health crises and has considered the potential for publication bias. The author has stated their position and potential for conflict of interest (see acknowledgements and further details included as part of the empirical study), and has also considered this in relation to the publications included.

### **Section 3: Themes identified in the literature**

#### **Theme 1: Demographic characteristics of people referred to emergency health services by the police**

This theme will explore what is known about the characteristics of people detained by the police relating to mental health crises. This theme is presented first as a way of introducing some of those people who may be typically involved in these types of encounters, before moving on to explore the other themes outlined above. Five of the articles identified in the search strategy focused specifically on characteristics including: demographics, diagnostic criteria and social aspects. The articles in this theme will be presented chronologically and further explored in terms of developments in services over this time period (see Table 1.3 for an outline of each paper presented in this review, and Appendix 2 for a summary of the quality of each paper using relevant published frameworks).

In their USA-based study, Sheridan and Teplin (1981) reviewed records of patients referred to mental health services by the police. They reported that police-referred individuals were typically: seriously disturbed, psychotic, living alone and in need of hospitalisation. They found that Black and young individuals were also disproportionately referred, while single, divorced and separated individuals were overrepresented. In terms of recidivism, the rate was favourable for the Community Mental Health Centre and the reduction in total hospital days was striking. The authors concluded that even with low motivated, very disturbed individuals with poor or no social support, it was possible to greatly reduce inpatient treatment.

In work conducted in the UK, Turner, Ness and Imison (1992) reviewed 5136 referrals over a two-year period in a particular inner-city health district. A questionnaire was developed to obtain information about these individuals through retrospective investigation of their records. Findings suggested that previous psychiatric admissions, a diagnosis of schizophrenia, social deprivation, and a bias towards young men of African-Caribbean origin were key features of the data. However, the authors noted difficulties in obtaining clear, reliable data and that uncertainties

in the law impacted unfairly on individuals, police and psychiatrists. The study highlighted that S136 is not an appropriate diagnostic tool (nor was it designed to be), but that it can be viewed as picking up on unmet social needs in the context of community care. The need for coordinated resources beyond hospital boundaries was also noted.

In another USA-based study data were collected on all psychiatric referrals to 10 emergency departments in one state area in a 72-hour period (Way, Evans & Banks, 1993). During this time there were 362 presentations, 30% of which were referred by the police (ranging from 10-53% across the 10 departments). Records were reviewed with a view to comparing police and other sources of referral. Findings indicated that police cases were as psychiatrically disturbed as referrals from other sources, but that police referrals were more likely to be judged by clinicians to have been referred for behaviour that was dangerous to others, or to have impaired judgement, which led to a higher proportion of these cases being admitted for inpatient care.

Redondo and Currier (2003) compared police referrals to the comprehensive psychiatric emergency service with a control group of 100 individuals referred by other sources matched day-for-day over the same period (in the USA). Records were reviewed to gather data on: demographics, condition on presentation, psychiatric emergency records, mental health arrest documentation, and patient charts. Findings suggested that individuals referred by the police had significantly more stressors and required more time for assessment in the emergency service. No statistically significant differences were noted in admission rates between those referred by the police and those referred from other sources, which differed from those reported by other emergency services in other localities. Redondo and Currier noted that as demand increases, the structure, staffing and resource allocation to these services may need to be adjusted to meet the needs of this population.

Lee, Brunero, Fairbrother and Cowan (2008) offered a comparison of characteristics of individuals experiencing mental health problems, some of whom were referred by the police to a metropolitan general hospital emergency department (in Australia), and some of whom were not involved with the police. Findings indicated that the main factors predictive of police presentation

were younger age, male sex, unemployment, alcohol or other drug use, and presenting with a psychotic episode (and not having a presenting problem of depression or anxiety which was less common in police presentations). The authors highlighted the need for systems to be developed to facilitate collaboration between emergency departments, hospital security, police services, and mental health and ambulance services.

In summary, these articles highlight a number of similarities in the demographic characteristics of individuals detained and referred to health services by the police, though it is noted that most of the papers do not discuss the potential limitations of their findings, and should therefore be interpreted with caution. Overall, findings suggested that these individuals were as disturbed, if not significantly more so, than those not referred by the police and often had a diagnosis of, or exhibited symptoms of psychosis. There also seemed to be a disproportionate number of young (particularly males) and/or Black individuals referred in this way. Social deprivation and lack of close supportive networks were highlighted as a potential indicator of this type of referral, as was alcohol and other drug use. While the resources required to support these individuals were highlighted in a number of the papers (e.g. extra time, staffing/interagency working), the impact of police referrals on clinicians' perceptions (namely negative) of the individuals they were treating was also highlighted as a key issue by Way, Evans and Banks (1993). It is interesting to note that this picture of demographic characteristics does not seem to have changed much over the time period in which these papers were published, with implications for supporting and developing community services being highlighted throughout (i.e. reducing demand for inpatient services, and developing greater collaboration and partnership working). How then can these services develop to better meet the needs of those experiencing mental health difficulties who find themselves in crisis situations where the police become involved? A key response to this has been the implementation of specialised mental health crisis training programmes and teams to support the police in this role and facilitate better working practices with other relevant organisations, which will be explored further below.

## **Theme 2: Specialised police mental health crisis response services**

The need for mental health expertise in police field situations has been recognised for a number of years to support police officers when they encounter somebody they believe is experiencing mental health difficulties and in need of support. There have been a number of responses on how best to develop this expertise, and this theme will explore what is known about the development of specialist police mental health response services (typically called ‘outreach’ or ‘crisis intervention’ - CIT - teams). Six papers identified this subject as their key focus, while four others considered it more broadly in relation to other themes (see Appendix 1). It is interesting to note that all of the papers identified originated from data collected in the USA, and it is important to be aware of this context when thinking about the implications for UK policy and practice. Again, the papers in this theme will be presented chronologically to give a sense of developments in this area over time.

In one study, records were reviewed for 101 consecutive referrals to law enforcement mental health teams (85 were followed-up) (Lamb, Shaner, Elliott, DeCuir & Folz, 1995). The review included exploring demographic information, clinical history, arrest history and previous violent behaviour and was compared with hospitalisations, arrests, acts of violence, mental health treatment and living situation at follow-up. These outreach teams were composed of a police officer and a mental health professional to support individuals who experienced acute and severe mental health difficulties. Findings suggested that the outreach teams were successful in avoiding the criminalisation of those experiencing mental health difficulties.

Steadman, Deane, Borum and Morrissey (2000), explored the proportion of mental disturbance calls resulting in specialised police responses and arrests across three sites. At each site, the records for approximately 100 police dispatch calls for “emotionally disturbed persons” (p.645) were examined and the results suggested that large differences occurred across the sites in the proportion of calls that resulted in a specialised response. The authors identified two key factors: the existence of psychiatric triage and drop-off centres; and the centrality of community partnerships. The article concluded that collaborations between the criminal justice system, the



mental health system, and the advocacy community plus essential services reduced the inappropriate use of USA jails for people with acute symptoms of mental illness.

Another study published a year later by Steadman, Stainbrook, Griffin, Draine, Dupont and Horey (2001) reported on the frustrations often felt by law enforcement and mental health professionals in terms of transporting individuals experiencing a psychiatric crisis to an emergency department. This article described three diversion programmes participating in the Substance Abuse and Mental Health Services Administration jail diversion knowledge and development initiative. Findings indicated that key principles in their operation were: being highly visible; having a single point of entry; having a no-refusal policy and streamlined intake for police cases; establishing legal foundations to detain individuals; cross-training; and linking clients to community services. The article highlighted that effective crisis services provided both treatment on-site and appropriate referrals for individuals when they were stabilised.

El-Mallakh, Spratt, Butler and Strauss (2008) reviewed police records for 2002 (the first full year of the CIT) and 2004 (the year after consolidation of the city and community police forces), and made comparisons with data from 2001 (prior to any changes) where possible to determine the impact of the CIT on the outcome of police calls. Here, the CIT was composed of uniformed police officers that had been trained to deal with mental health issues. The findings suggested that the introduction of the CIT had an overall positive effect on outcomes of situations in which people experiencing mental health difficulties were confronted by the police. The authors also noted that: the arrest rate reduced; hostage negotiation team callouts reduced; occupancy remained relatively stable in the mental health unit of the county jail; and referrals made to intense psychiatric services greatly reduced. The paper concluded that training and liaison with mental health providers was essential to facilitate positive outcomes for interactions between the police and those experiencing mental health difficulties.

In their 2008 paper, Watson, Morabito, Draine and Ottati reviewed the literature on crisis intervention teams and presented a conceptual model of police responses to people experiencing mental health difficulties. Findings suggested that the CIT model was being widely implemented,

and initial evidence for these programmes was promising but limited in scope (focusing mainly on officer characteristics and training). The authors argued the need to go beyond this to account for officer, organisational, mental health system, and community level factors likely to influence the effectiveness of such models. Indeed, as noted above, evidence suggests that some groups of individuals are more likely to be disproportionately represented in police referrals and this model advocates a more systemic approach to exploring the potential reasons for this and promoting best practice in the future. While many of the papers highlighted training as a key issue for police officers, the role of this in the wider context of societal attitudes and partnership working will be explored in greater detail below.

Watson (2010) went on to offer a further review of the literature and application of the CIT model in Chicago, USA. The study sampled 91 CIT and 170 non-CIT officers from four districts for in-person interviews, and included phone follow-ups at one, three and six months (though it was noted that response rates dwindled over this time period). Interview items covered: how the individual came to their attention; the individual's characteristics; their level of resistance; the officer's use of force; injuries to the officer or individual; other situational characteristics; the outcome of the call; perception of mental health system resources; and officer use of CIT skills. In addition, 20 officers also completed qualitative interviews to explore their perceptions of the CIT programme. Findings suggested that the CIT may improve outcomes of police encounters with people experiencing mental health difficulties, particularly among officers with more passive views on mental health resource responsiveness.

Overall, the findings seemed to suggest that specialist police mental health response services can have a positive impact on improving the outcomes of encounters between the police and people experiencing mental health crises. Some of the benefits included the avoidance of criminalisation, more efficient treatment, and reduced demand on other resources. It would seem that over time there has also been a move from training focusing on officer characteristics and attitudes towards a more holistic view of the broader range of factors that lead to people with mental health difficulties coming into contact with the police. Indeed, training is seen as a key

issue as is the development of effective collaboration and partnership working between the police and other agencies (e.g. mental health service providers, and the wider community). Watson and colleagues (2008) proposed that saturation of CIT trained officers (which they suggest should be 15-25% of all patrol officers), and the identification of ‘champions’ would be helpful in reinforcing the message that CIT participation and cooperation is valued, supporting genuine interest and involvement rather than relying on top-down enforcement. This approach has clear implications for interagency working, collaboration and service design. Indeed, this links into ideas about societal expectations of what the police are for and the policies and procedures under which they operate, which will be explored further in the next section.

### **Theme 3: Policies and procedures**

The search strategy identified two papers that specifically focused on policies and procedures for detention by the police in the case of mental health crises, though it is noted that a number of others also referenced this more broadly (see Appendix 1). It is acknowledged that the two papers for which this is a key theme are some of the older literature identified in this review, and as such, may be somewhat out of date in terms of current practice. However, it is worth providing an overview of these papers here to illustrate the contrast between them and the more recent literature.

Bittner (1967) reported on his observations of the rules and considerations underlying the use of discretion in emergency apprehensions resulting from 10 months fieldwork with uniformed police patrol in a large West Coast city of the USA. This paper is an early proponent of work in this area of policing and mental health which makes a distinction between ‘keeping the peace’ and ‘enforcing the law’. Bittner explored officers’ role in the provision of “psychiatric first aid” (p.288), a term reported to have been repudiated by the police, but apt in terms of their role upon initial direct contact. At the time of writing, Bittner acknowledged that while police training had come to include some reference to mental health awareness, there was little on offer in terms of techniques save offering kindness and caution. The paper concluded that this work around

‘keeping the peace’ consisted of routines, procedures, skills, standards and information that meets certain tacit public expectations. Indeed, it is interesting to note that the role of the police in UK society is currently the subject of much debate, and there has been a focus on movement towards a social justice model of neighbourhood policing. It is anticipated that this may in part be achieved by managing expectations of, and demand on the police, and facilitating greater partnership working as highlighted by Stevens (2013):

“Over the years the police have taken on more and more tasks ... too often they are expected to take on the work of social services, mental health, various council departments etc. as they are often the only people around 24/7. If the police could focus on a core set of tasks, they would be more effective, even when facing cuts.”

(Attributed to an online submission from the Police Federation in evidence to the Stevens Commission, p.39)

In another article Matthews (1970) presented his observations on policies and procedures, drawing on legal and medical frameworks to explore police encounters with people experiencing mental health crises, questioning the authority and responsibility of the police in such situations. The procedures used to “move apparently mentally ill persons from the community to some place where care may be had” (p.283) and the implications of this for professional police policy were outlined. This focus of this work, undertaken in Chicago, USA, clearly parallels the S136 process in the UK, though it is important to note there are differences in the systems involved and that these may have changed over time.

Matthews identified that the training received by officers was typically limited to cataloguing major psychological symptoms and managing violence, influenced by two typical attitudes: 1) that people experiencing mental health difficulties are unwell and should receive medical attention; and 2) that such people are dangerous and the sooner somebody else takes custody the better. While approaches to understanding and intervening in mental health difficulties have changed over time (from narratives relating to ‘madness’ and institutionalisation towards a

greater understanding of a range of difficulties and community care), many of the papers identified that discuss training do mention attitudes. Before moving on to explore the issues of training in more detail, it is worth exploring here another article that identified issues relating to cooperation and compliance with the police in encounters with individuals experiencing mental health difficulties. Again, this links in with ideas explored above in relation to the role of the police and societal expectations about authority and justice.

#### **Theme 4: Cooperation and compliance**

The role of the police has commonly been associated with criminal justice, and is increasingly being defined in terms of social justice (as highlighted in the introduction). Indeed, it may be said that individuals rarely come into contact with the police because they are having a good day, typically something will have happened that may have left them feeling criminalised, victimised and/or vulnerable. It is also then worth thinking about how interactions with the police are experienced in terms of procedural justice, a theory relating to ideas of fairness, dispute resolution and the allocation of resources, and that can be used to understand variations in compliance with the police (Tyler, 1990, 2011; Folger & Greenberg, 1985).

One paper identified in the search strategy focused on variation in cooperation and compliance between people experiencing serious mental illness and the police (Watson & Angell, 2013). It is worth noting here that while there are some variations in the terminology used, 'serious mental illness' typically refers to diagnoses relating to psychosis (losing touch with reality or experiencing delusions), or high levels of care, which may require hospital treatment. This study focused on the perceptions of people experiencing serious mental illness relating to procedural justice (in which officers encourage citizens to develop a sense of goodwill towards them by behaving respectfully and using fair procedures to make decisions). Watson and Angell explored the potential for stigma and uncertainty to moderate the effect of procedural justice, analysing complete data sets from 139 participants receiving public mental health services in Chicago, USA. Findings suggested that overall, individuals who perceived being treated with

greater procedural justice by the police were more likely to report being cooperative and less likely to be resistant. The association between procedural justice and cooperation was however moderated by perceived stigma and the type of encounter. Indeed, in encounters in which the individual had either been accused of a crime, or was experiencing a mental health crisis, there was a reported larger relationship between procedural justice and cooperation which was linked to uncertainty and vulnerability. However, the authors acknowledged the relatively small sample size and were clear that their findings may not be widely generalisable. The focus on participant self-report of one encounter (not controlling for the effects of previous encounters) and lack of data from police officers or independent observations were also considered to be key limitations of this study.

Watson and Angell made a key point about the potential for stigmatised individuals experiencing mental health difficulties to feel disempowered and submissive in the face of authority, with implications for their rights, citizenship and community integration. This work provides support for interventions like crisis intervention teams (as outlined above) and encourages training for police officers that supports a more patient, respectful and empathic approach to responding to mental health crises. Indeed, as noted above, there is some evidence to suggest that the implementation of CITs can avoid the criminalisation of people experiencing mental health crises and improve interactions and outcomes in related police encounters.

### **Theme 5: Training**

While many of the papers identified training as a key issue for officers, only one of them focused on this as the main subject for discussion. Cummings and Jones (2010) introduced their UK-based work by outlining the potential for the police to play a key role when an individual experiences a crisis relating to their mental health. This is an area often neglected in police training and the Bradley Report (2009) is cited as calling for improved training in mental health issues for staff across the criminal justice system.

Cummings and Jones (2010) outlined two approaches to mental health awareness training for officers that have been undertaken in the UK: a pilot whereby police officers spent time working in the local mental health unit as part of their initial training (Dyfed Powys); and a classroom-based training course. While both models achieved a measure of success, the Dyfed Powys approach was considered to be more effective with a number of key strengths, including: a clear picture of resources in the area; service-user experience at the core and testimonials from local service-user groups; sessions that took place away from the police training base; and the potential to make contacts with local agencies to improve multidisciplinary working. The classroom-based approach was considered to be limited, but still useful in terms of challenging some stereotypical ideas, and providing a forum for constructive and positive discussion of the issues facing staff who work in community mental health services. However, it was acknowledged that compared with a classroom approach, the Dyfed Powys model required a commitment and level of resourcing that might not be easily achievable across wider police services.

The papers exploring the role of specialised police responses to mental health crises necessarily focused on the training needs of officers and emphasised developing a range of skills and making links with other service providers. While Cummings and Jones (2010) outlined a clear case for taking an immersive training experience approach to understanding mental health issues, Watson and colleagues (2008) also identified a varied programme of training as the “cornerstone” (p.363) of their CIT. They outlined the training as typically involving: education; information about mental health detention procedures; personal stories from service-users and family members; visits to treatment providers; and communication and de-escalation skills (often through the use of role-play exercises). However, they also made the case for going beyond officer training to consider a more systemic approach to supporting officers to work with these issues. The idea of “innovative and intensive cross-training” was also considered to be a critical component of training by Steadman and colleagues (2001) with a view to enhancing collaboration and mutual understanding. Indeed, they noted that mental health service providers often have unrealistic perceptions of law enforcement’s authority and rely on stereotypical views of the police.

While Watson and Angell (2013) focused on cooperation and compliance in encounters with the police, they made the point that it is important to understand how training officers to forego traditional policing methods in favour of a more empathic approach to people experiencing mental health difficulties impacts upon their attitudes and behaviour. Also, it is important to explore how this may in turn impact upon individuals' experience and cooperation with the police, with the presumed aim of turning the process into something of a virtuous circle of respectful interaction and destigmatisation.

So, while mental health awareness training for the police is generally considered to be essential, how to implement it in a meaningful way with the resources available is another area of concern highlighted. Cummings and Jones (2010) emphasised the importance of support from senior managers to ensure that training goes ahead and that the skills developed are implemented in routine work, demonstrating both best practice and value for money. Lamb and colleagues (1995) also stressed the importance of initial and ongoing training, which considering the recent pace of change in UK policing, and in mental health services, seems ever more relevant.

In summary, training is seen as a critical component of effective interactions between people experiencing mental health crises and the police. Developments in this area appear promising, especially in light of a general movement towards specialised mental health outreach and crisis intervention teams. The evidence suggests that immersive and intensive cross-training experiences, where multidisciplinary working is a key component, fosters mutual understanding between agencies to the benefit of all. However, it is also acknowledged that this is only one part of the wider role of the police, and as such is competing for resources. It would therefore seem that mental health awareness, and opportunities for further specialised crisis training, should be offered with a view to finding 'champions' to support these approaches to better serve vulnerable individuals and their wider communities.



## **Section 4: Discussion**

### **4.1 Synthesis**

This review seems timely in light of recent developments in mental health crisis care and policing (particularly the Mental Health Crisis Concordat, Department of Health & Concordat Signatories, 2014; and Stevens, 2013), with the interface between the two of particular interest to a range of organisations and groups as stakeholders in this relationship (e.g. government, health and social services and service-users, the voluntary sector, the general public etc.). What is already known about what happens when the police get involved with people experiencing mental health crises has been outlined, providing a narrative of the characteristics of detainees, specialised response services, policies and procedures, cooperation and compliance, and training. It has summarised the work in this area to date, and acknowledged some of the potential quality issues that might limit discussion of the findings. Attention will now turn towards developing a synthesis of this literature in light of broader psychological theories and practice with a view to developing a deeper understanding of the issues involved in such detentions (for the professionals and service-users involved, and for society more widely). The limitations of this review, and implications for practice and future research will also be discussed.

The literature identified highlighted an overrepresentation of some populations (e.g. young, Black, and/or male individuals, likely with a history/diagnosis of psychosis, and links with social deprivation and/or isolation). This is a similar picture to that presented by the statistics of those admitted to psychiatric inpatient facilities (Bowers, Jones & Simpson, 2009; Bhui, Stansfeld, Hull, Priebe, Mole & Feder, 2003) and seems reflective of wider complexities highlighted in narratives about discrimination, stigma, mental health, and policing, and the policies that outline the role of the police in terms of public protection and social control. However, less is known about the specific experiences of service-users and professionals involved in these encounters, and the specific interactions that take place when individuals are detained. Watson and Angell's (2013) work highlights the potential for the application of theories of procedural justice to

exploring encounters with the police, essentially outlining the importance of being seen to be making fair decisions especially in relation to potentially marginalised groups. This would seem particularly relevant in light of what is known about the characteristics of those detained by the police (outlined above). While this is important for the individuals having direct encounters with the police, it also has a role to play in wider public perceptions of trust and confidence in the police with regard to public protection and the treatment of vulnerable individuals. This points to questions about public perceptions about what the police are for and the authority they have to carry out their duties. The language used to talk about what the police do often focuses on terms like powers to ‘arrest’ individuals, leading to perceptions of people being detained by the police as being ‘guilty’, or at least under suspicion, of having committed criminal activity. Again, where the police are involved in the detention of people experiencing mental health crises, there is therefore the potential for criminalisation of vulnerable people feeding into longstanding cultural narratives about madness/badness and dangerousness (Prins, 2010; Hilton, 2006).

The Mental Health Crisis Concordat (Department of Health & Concordat Signatories, 2014) outlines a series of core principles and outcomes that service-users should expect: access to support before crisis point; urgent and emergency access to crisis care; quality treatment of care when in crisis; and recovery and staying well linked with preventing future crises. These principles underpin the way in which statutory agencies should work together to refine and improve services for people experiencing mental health difficulties and in need of urgent help. In terms of the specific role of the police, the Concordat refers to the Stevens Report (2013) highlighting mental health as part of the service’s ‘core business’:

“The Independent Commission on Mental Health and Policing [Stevens, 2013] made recommendations to the Metropolitan Police and forces nationally on how to prevent serious injury and deaths when officers respond to incidents involving people with mental health conditions. **It concluded that mental health was part of the core business for the police, who should be trained to be aware of the vulnerabilities people may have, because mental health issues are common in the population.**

**The report was clear that the support of other agencies is essential because the police “cannot and indeed are not expected to deal with vulnerable groups on their own”.**

(Department of Health & Concordat Signatories, 2014, author emphasis added)

It is therefore clear that perceptions about the role of the police in today's society include mental health as a key feature and thus there are clear implications for training and interagency working. Indeed, the literature identified in this review highlighted a general lack of training in mental health awareness for the police, but also that this sort of training had clear benefits, and that experiential learning was particularly valuable. Clear links have been made in the literature about the provision of training for officers to offer specialised crisis intervention responses, giving a sense that while general awareness is helpful for all officers, not all will require specific detailed training if there are teams available with a clear remit to do this work. Of course, this division requires good links to be made between these teams and the agencies that they work with (e.g. the wider police service, health services, ambulance services, local authorities etc.). The literature also suggested that the initial move towards implementing CIT models has been effective, offering benefits in terms of outcomes for the individuals detained and resource-savings for services.

What is clear from these developments is the need for change, both within, and between organisations, in order to facilitate effective ways of working that go beyond simply doing more of what has been done in the past. The literature identified in this review, though spanning decades, seemed to reveal relatively little effective change in practice overall, though it is noted that the introduction of specialised response teams may be starting to have an impact on this. However, change is often problematic with the potential for emotional, cultural and organisational blocks to contribute to an overall ‘organisational inertia’ that can bring change processes to a halt (Carnall, 1995; Hannan & Freeman, 1989). Psychological theories of change may therefore offer helpful frameworks for conceptualising, implementing and evaluating change processes and may be applied at individual, group, and organisational levels. For example, the literature identified an overrepresentation of certain characteristics of individuals detained by the police and points to a

need for change, yet it would appear that little has changed over the past three decades. The Change Curve Model (Scott & Jaffe, 1988, developed from the work of Kübler-Ross in the sixties with more recent developments outlined in a 2009 publication) may be helpful in identifying change potential in the wider context of organisational socialisation, culture, leadership and management as movement between ‘denial’, ‘resistance’, ‘exploration’ and ‘commitment’ stages can be identified. These stages can be further explored in relation to internal/external and past/future factors with a view to developing appropriate action plans to lead from ‘danger’ to ‘opportunity’. Further exploration of behavioural interactions might also prove useful in developing a better understanding of what happens when people experiencing mental health crises have encounters with the police, and also what happens between professionals as they attempt to collaborate in a coordinated and timely way. Indeed, there may be scope for a range of ways to explore this, for example, through direct observations and functional analyses, disclosure from a range of sources, or through comprehensive reviews of records, with a view to also developing recording systems (e.g. written, audio and visual materials). There would also seem to be potential for greater use of systems thinking in terms of identifying and developing feedback mechanisms that can help organisations understand and map the complexity associated with supporting people experiencing mental health crises to inform interagency best practice.

## **4.2 Limitations**

It is important to acknowledge that this literature review has focused on research relating to a very specific part of a police officer’s role, namely the detention of people experiencing mental health crises. This review has searched a range of bibliographic databases to cover a wide range of relevant fields (e.g. behavioural science, biomedical and life sciences, social policy, public health, social services, mental and community health) while using search criteria to identify a specific area of interest. In linking this work with the wider debate on the role of policing in relation to mental health difficulties it is noted that there are a number of other sources that may be drawn upon (e.g. sociology, politics, economics, criminal justice etc.), and that there may be other

work that has been conducted but less formally disseminated, for example, service audits and reviews. It has also been noted at other points in this review, that much of the literature is USA-based which may well limit its relevance for practice elsewhere. This is something to be mindful of in terms of interpretation and implementation in other cultures. It is also noted that the literature spans a wide period of time, and while this might limit its relevance in terms of current practice, it has been helpful in terms of exploring developments over time and for thinking about future practice and potential areas for further investigation.

#### **4.3 Implications for practice**

Where the literature has focused on training it has typically been on developing interagency collaboration, and encouraging the development of meaningful partnership working. Though while there are calls for this, there is less information available on practical strategies for implementing it, and the recent Mental Health Crisis Care Concordat (Department of Health & Concordat Signatories, 2014) has highlighted that there is still work to be done in addressing these issues (as outlined in the introduction). Indeed, it is interesting that the literature on what happens when these relationships have been problematic was not identified in the search strategy for this review, perhaps a reflection of the content of peer-reviewed research in comparison with that found in government and institutional working documents and evaluations. In the UK, meaningful collaboration is being addressed, in part, by the development of S136 place of safety suites, and the introduction of Street Triage initiatives (whereby mental health nurses and paramedics accompany police officers to incidents where it is believed people need immediate mental health support). Training initiatives, like the crisis intervention and Dyfed Powys models outlined above, highlight the potential power of experiential learning and beneficial impact on partnership working, by getting agencies to share information and exposure to different organisational cultures and practices. Also, there is evidence to suggest that such initiatives are reducing downstream demand on other services, for example, costly inpatient beds, as well as providing better care pathways for service-users (Sheridan & Teplin, 1981).

However, while much of the literature has focused on professional interagency working, there seems to be a potential gap for greater service-user involvement as partners in effective service provision. Where there has been a push towards this in health services (e.g. publication of guidance, Husband, Carr & Jepson, 2010; the Expert Patient Programme etc.) it seems that there could be a role for greater inclusion in relation to how encounters with the police are experienced. Indeed, Watson and Angell's (2013) work acknowledged that there is more to be done on exploring a wider range of available perspectives on police encounters, perhaps also including families, carers, and the public more widely. Also, as the UK police service are increasingly moving towards this sort of model, for example, by conceptualising contact with their service in terms of 'customer journey' narratives and creating champions in this area, there will be scope for evaluating this. Thus, there would also seem to be the potential for developments in how concepts of psychological safety, and environments that provide this, are understood, designed and provided to support effective care pathways for vulnerable individuals, and offer best practice by the professionals involved in this process.

#### **4.4 Implications for future research**

As outlined above, much of the work in this area has come from a USA perspective. However, at this time of change and developments in UK policies and practice it would seem there is scope to learn more about the implications of these, developing the literature for the provision of both evidence-based policing and healthcare. Clearly there is a role for the evaluation of the Street Triage initiative as this is rolled-out more widely across the UK. Developing a national picture of where things are working well and what might be done differently, in line with benchmarking standards for local police and health services, will surely be instrumental in developing best practice for all encounters between the police and people experiencing mental health crises.

Although there is a separate literature on the use of S136 and places of safety in the UK, it is interesting to note that the papers in this review were typically not concerned with the environment in which the person experiencing a mental health crisis was detained. Many made

reference to involving healthcare services, yet the decision-making processes and appropriateness of these were not explored in any depth. However, we know that the needs of people experiencing mental health difficulties may be very different to those experiencing physical health difficulties and that the type of care, and environment in which it is provided, can vary greatly. Indeed, there is an increasing interest in ideas about what constitutes a therapeutic environment (McGrath & Reavey, Accepted 2013; Pinfold, 2000). So, in keeping people physically safe from harm, are we providing spaces for them to feel psychologically safe? This may be a potential area for future research, again linking developments in practice (e.g. Street Triage, use of S136 suites) with the wider literature on safe and therapeutic environments.

There also seems to be a somewhat limited focus on service-user involvement in developing research and services in this area. While it is acknowledged that this review did not set out specifically to investigate this subject, it is clear from the literature identified that the main focus seemed to be on developing professional interagency partnership working. Therefore, a potential area for future research may well be to explore how meaningful service-user involvement could be included in the development of both training and service evaluation. Potential avenues to be explored may relate to the way that systems work at the moment, further exploring the specific circumstances around when police become involved in mental health crises, and what the experience is like for those involved in these interactions (e.g. for the police, people in crisis, their families and friends, and other professionals involved). Also, in addition to what is known about how present systems operate, there may be scope to investigate the potential for service redesign, exploring what might happen in an 'ideal' system, again informed by a range of stakeholder perspectives. Indeed, while much of the literature focused on professional roles and interdisciplinary working, in addition to the potential for service-users' voices to be heard more clearly, there would seem to be scope for further exploration of professionals' stories, through sharing their experiences and perspectives of working in this area.

## **4.5 Conclusions**

During these times of social change and economic austerity there seems to be an increasing focus on providing evidence-based policing and healthcare. By exploring what is known about police involvement in the detention of people experiencing mental health crises, this review has focused on just one potential interface between the police, vulnerable people, and health services. However, it is acknowledged that this is an area which has been identified as presenting serious issues and where the potential for things to go wrong can have catastrophic consequences including serious injury and death (Department of Health & Concordat Signatories, 2014). While such consequences for individuals, their families, and wider social networks are grave indeed, there is the potential for further negative consequences for public perceptions of policing and healthcare which may seriously undermine their ability to provide effective services. As questions are asked about what, as a society, we expect of the police (and our other public services), we must also explore attitudes towards the protection of vulnerable members of society, picking up on narratives concerning stigma, safety, justice and fairness. It is also acknowledged that there are separate, extensive literatures on stigma and attitudes relating to policing and mental health, and that these were beyond the scope of the present review. However, it is clear that there are links to be made, particularly in relation to implications for understanding how these systems work in practice and the personal experiences associated with being involved with them, and in training and interagency working.



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**Empirical Paper\*:**

**How are Section 136 of the Mental Health Act (1983/2007) and the use of  
‘places of safety’ understood and experienced by police officers?**

\*Prepared for submission to Health and Social Care in the Community (See Appendix 3 for relevant guidelines for authors)

## **Abstract**

**Objective:** Police officers might become involved with vulnerable people through encounters involving mental health crises where individuals are in need of immediate support to prevent harm to themselves or others. Police officers have powers to detain people deemed to be at risk under Section 136 of the Mental Health Act (1983/2007). While there is a developing literature in this area, few studies explore it from an experiential perspective. This research therefore seeks to explore how Section 136 and the use of places of safety are understood and experienced by officers.

**Method:** This qualitative study employs interpretative phenomenological analysis, eliciting rich first-person accounts of participants' experience to bring a psychological understanding to this phenomenon. Ten officers took part in individual semi-structured interviews sharing what was meaningful to them in terms of their experience of this specific area of their work.

**Themes:** The data suggested key concerns with: (In)Appropriate responses: Doing the right thing (response, impact on professional and personal lives, and environment); Becoming an 'expert' Jack of all trades; and the Relational activities in policing. These themes were also framed in terms of a series of continua of potentially conflicting positions, which further highlighted the context and complexity of work in this area.

**Conclusions:** Encounters with people experiencing mental health crises are a significant and complex aspect of policing. The police have a key role to play in offering appropriate responses to those in need of support and there seems to be scope for developing opportunities for greater service-user involvement, supporting communication, and developing partnership working with other agencies to achieve 'optimal experience' for all involved.

**Keywords:** Section 136; Mental Health Act (1983/2007); Place of safety; Detention; Mental health crises; Police; Interpretative phenomenological analysis; Qualitative; Experience.



## **Section 1: Introduction**

### **1.1 Police involvement with the Mental Health Act (1983/2007)**

One way that the police might become involved with vulnerable people in their local communities is through the use of the Mental Health Act (1983/2007). The stated purpose of the Act is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public, can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others. It also outlines safeguards for patients, to ensure that these powers are used appropriately (Department of Health, 2009). Indeed, the police have specific powers under Sections 135 and 136 of the Act to detain individuals who are deemed to be at risk as a result of mental health difficulties.

Recently the role of public services in responding to people experiencing mental health crises has been highlighted, with a particular focus on the need to respond quickly and appropriately to protect individuals and society more widely (Mental Health Crisis Care Concordat: Department of Health & Concordat Signatories, 2014). It is acknowledged that interagency working in this area has faced challenges, and that the consequences of inappropriate responses have been grave, with injury and even death resulting from the worst cases.

While the police service in England and Wales is currently undergoing a period of change, it seems clear that intervening in mental health crises will continue to be a key feature of its role regarding the protection of vulnerable citizens, and the public more widely. Indeed, one of the ways that emergency response services are seeking to address their responsibilities in this area is through the development of Street Triage initiatives. In the Midlands (UK), this sees specific teams consisting of a police officer, paramedic, and mental health professional, available to respond together to incidents where it is believed that people are in need of immediate mental health support. It is hoped that these teams, in providing greater opportunities for more cohesive interagency working, will support professional decision-making and improve access to the most appropriate care pathways for people in crisis.

It would therefore seem worthwhile, and timely, to explore ways of developing a deeper understanding of what happens when the police get involved in these situations. One way of doing this is to give voice to police officers' experiences, bringing psychological understanding to the ways in which they make sense of, and act, to inform service development in a way that goes beyond the simply procedural. This research will focus on Section 136 (hereafter referred to as S136), outlining what is already known about its use, going on to explore how police officers experience enforcing it, and the implications for future practice.

## **1.2 S136 and places of safety**

Under S136 the police are able to detain people at designated 'places of safety' if they are suspected of experiencing mental health difficulties, in immediate need of care and control, *and* in a place to which the public have access. While S136 may be enforced by any police officer, there is evidence to suggest that it is not well understood by a range of professionals who may also become involved with those detained (Lynch, Simpson, Higson & Grout, 2002). The definition of a place of safety is relatively broad and may include: some types of residential accommodation provided by a local authority; a hospital as defined by the Act; a police station; a mental nursing home or residential home for mentally disordered persons; or any other suitable place, the occupier of which is willing to temporarily to receive the patient (and may include the patient's own home). The Stevens Report (2013) also highlighted evidence that suggested that police powers of detention under S136, while reserved for exceptional circumstances, were being exercised regularly, and that the use of police cells as a place of safety was of particular concern (HMIC, 2013).

## **1.3 What is known about the use of S136?**

A review of the literature about what is known about the use of S136 (a systematic search of psychology-orientated bibliographic databases) identified twelve papers. Of these, two provided reviews of the literature: 1) Borschmann and colleagues (2010) found that of those detained under

S136 there was a high prevalence of schizophrenia, personality disorders and mania, and an over-representation of black detainees; and noted a lack of qualitative research exploring both detainees' and professionals' experiences; and 2) Apakama (2012) identified a longstanding debate as to the most appropriate place of safety, concluding that a range of options should be available to meet individual needs. Indeed, there is a developing interest in the role of the environment and what constitutes a 'safe' and 'therapeutic' space for people experiencing mental health difficulties (McGrath & Reavey, accepted 2013; Pinfold, 2000; and the work of organisations like the Soteria Network).

Other papers focused on knowledge or ambiguity about the use of S136. Lynch and colleagues (2002) identified that knowledge among different professional groups (N = 179, sample consisted of consultants, Specialist Registrars, Senior House Officers, senior nurses and police officers) was poor, and recommended action through formal education and training. Riley, Laidlaw, Pugh and Freeman (2011) sampled A&E nurses, Approved Mental Health Practitioners, forensic physicians, A&E doctors, police custody sergeants/operational officers and mental health nurses (N = 223), to explore the responses of professional groups to the use of S136. They used mixed-methods design of questionnaires and follow-up focus groups, concluding that there was a gap in the expectations of different agencies involved, that interagency pathways should be developed, and that use of S136 should be better monitored to ensure appropriate use. Another study recruited a sample of doctors (N = 106, consisting of psychiatrists, general practitioners and police surgeons) and found that ambiguity existed about the legal interpretations of the provisions of S136, which needed to be rectified (Ogundipe, Oyeboode & Knight, 2001).

Standards and the quality of treatment provided to those detained by the police were also a feature of the literature. Hampson (2011) suggested that the implementation of S136 was variable, despite guidance published in revised codes of practice by the Royal College of Psychiatrists. The author suggested that custody suites were still used excessively, and that this, and the use of police vehicles rather than ambulances, led to detainees feeling criminalised. Jones and Mason (2002) also found a general sense of dissatisfaction with the quality of care received from both mental

health professionals and the police in their qualitative study of the experiences of sixteen males detained under S136.

The setting up of a place of safety, or using S136 in specific environments (e.g. an airport), also appeared to be a developing area in the literature. Findings suggested that S136 detainees were better served by: access to health based places of safety in addition to those existing in police cells (Laidlaw, Pugh & Maplestone, 2009); a more collaborative, flexible approach being taken to meet the mental health needs of a rural community (Greenberg, Lloyd, O'Brien, McIver, Hessford & Donovan, 2002); and that in some specific environments (e.g. Gatwick airport), a more informal approach could be beneficial in dealing with people under S136 (Lowe-Ponsford, & Begg, 1996).

While a lack of studies of qualitative design was identified in a number of the papers, one did focus on S136 detainees' and carers 'frightening' experiences (Riley, Freeman, Laidlaw & Pugh, 2011). Individual interviews were conducted with eighteen detainees and six carers, suggesting that nearly all felt that the police station was an inappropriate setting for further assessment, prompting feelings of distress and criminalisation.

In summary, much of the research concerned with S136 has focused on knowledge and understanding of this power, highlighting that despite measures to clarify guidance in this area, there is still much work to be done. There also appeared to be confusion among different professional groups, and difficulties in interagency working (e.g. between police and mental health professionals). A number of papers reported an overall sense of dissatisfaction by those who had been detained under S136, identifying particular difficulties around feelings of criminalisation.

#### **1.4 Taking a qualitative approach to the exploration of S136**

Where experience has been investigated in relation to S136, it has focused on detainees' and carers' experiences. A number of papers suggested gaps in the research for future qualitative work, particularly in relation to decision-making and interagency working between the police and mental health professionals (e.g. Borschmann *et al.* 2010). Also, while the enforcement of S136 may be seen as a clearly defined and routine part of an officer's job role, it is designed to be used

only in exceptional circumstances (though as noted above, concerns have been expressed about the extent of its use). There would therefore seem to be a salient rationale for further exploring how S136 is experienced and understood by officers.

All qualitative research seeks to explore language in some way, seeking richness, depth and detail. Sometimes people's perceptions and experiences are of primary interest, while at others it is the use of language itself that is the key feature. Qualitative research can therefore be thought of as being broadly divisible into two main traditions: phenomenology and constructionism (though that is not to say that these traditions are mutually exclusive, rather there is much diversity within, and overlap between, them). Essentially, phenomenology is a philosophical approach to the study of experience that focuses on understanding and meaning-making, taking the view that multiple perspectives are not only possible, but equally valid. Constructionist approaches seek to explore how language itself is used in social interactions and how it is affected by history, culture and social structure.

Taking a phenomenological approach to qualitative research is particularly useful when seeking to develop a greater understanding of situations that are lived through by individuals in everyday life (Giorgi & Giorgi, 2003), and it is worth considering some key approaches to qualitative methodology typically used in psychological research here. Empirical phenomenology aims to take a systematic approach to in-depth analysis with a view to describing the fundamental features of an experience. Giorgi, Wertz and Fischer are thought to be key figures in its development (see Barker, Pistrang & Elliott, 2002). In applying the phenomenological method, bracketing and describing are the central processes applied to the data. Bracketing relates to attempts to set aside personal assumptions and expectations and reflection is required in order to identify and remove oneself from the phenomenon under investigation so as to see it from an outsiders' perspective. Statements are therefore not interrogated with a view to establishing facts or the truth, rather they are interpreted as statements about an experience of the world which is personal to the individual. While it may be impossible to entirely rid ourselves of our assumptions

and expectations, careful reflection on their existence and potential impact on the research process can, and should, be taken into account.

Grounded theory is a qualitative approach that seeks to go beyond rich descriptions of data to generate theory. This approach was developed by sociologists Glaser and Strauss (1967) who sought to challenge the dominant quantitative paradigm of the time. The approach seems to have been taken up by psychologists in the 1980s and has been developed by authors like Charmaz (1991; 2003). In taking a grounded theory approach, the aim is to develop one or more categories that capture the essence of the phenomenon under investigation. The approach is inductive, with the methodology being shaped by the research process as it develops, but with a commitment to explanatory-level accounts. Grounded theory therefore involves the systematic generation of theory, starting with individual cases and building up to create more abstract conceptual categories that offer an explanation of the data. These categories synthesise the data and allow for the development of a theoretical analysis (Charmaz, 2003). In taking a grounded theory approach, methods of data collection are flexible, being shaped by the findings as the research progresses, with the analyst pursuing what they feel to be the most relevant or interesting material. The overall purpose is therefore to develop a theoretical analysis of the data that is relevant to the topic under investigation.

Also, hermeneutic approaches draw on theories relating to interpretation and therefore adds something to empirical phenomenology, seeking to go beyond surface meaning derived from description, to the interpretation of implicit or unconscious meanings embedded in individuals' accounts of their experiences and methodological issues have been discussed by authors such as Ricoeur (1976) and Van Manen (1990).

In an attempt to explore the way in which police officers experience S136 and make sense of its use, this research will be guided by the principles of interpretative phenomenological analysis (IPA) (Smith & Osborn, 2008). This type of research aims to stay as faithful as possible to the experience as described by participants and the context in which it is set and offers a good methodological fit for exploring officers' personal meaning and sense-making in relation to their

experiences of S136 (for further discussion of the application of IPA and its relationship with other qualitative approaches see Smith, Larkin & Flowers, 2009). This approach requires experientially rich data to be appropriate, and it is important to consider this throughout study design in order to elicit rich, detailed, first-person accounts of a particular experience. This research therefore seeks to address the following questions:

**Principal research question:** How are Section 136 and the use of ‘places of safety’ understood and experienced by police officers?

**Secondary research questions:** **1)** How do police officers perceive the role of other professionals/detainees/their carers in the S136 process?; **2)** How do police officers who enforce S136 understand the process and reflect on their decision-making around their use of ‘places of safety’?; **3)** What are the implications of S136 for inter-disciplinary working and training opportunities?

## **Section 2: Method**

### **2.1 Sampling strategy**

This study was designed to focus on police officers' experiences of enforcing S136. However, due to the constraints associated with the time available to recruit participants, the decision was taken when developing the research protocol for this study to apply for ethical and research and development approval to also recruit NHS staff who had been involved with those detained under S136. The aim of this was to provide a wider pool from which to recruit from should there be difficulties in recruiting police officers, offering opportunities to explore a wider range of experiences and make comparisons between different professional experiences. When links had been made with the regional police service, awareness of this research had been raised with officers, and a recruitment plan established, it became clear that there was sufficient interest to proceed with the recruitment of police officers only. Data were therefore collected from a convenience sample of police officers, who had experience of enforcing S136, from a service operating in the English Midlands, UK. The researcher (MP) approached the regional police service through its mental health lead to raise awareness of this research and arrange the necessary permissions to undertake this study. The mental health lead identified a number of officers that had experience of enforcing S136 to be approached regarding recruitment. Information sheets were provided to those who were interested in taking part (see Appendix 4 – Participant information leaflet; and Appendix 5 – Participant information sheet). Officers were then asked to contact the researcher directly to discuss this study and make arrangements to participate.

This research focused on a particular geographical area within the region with a view to increasing homogeneity within the sample (i.e. regarding implementation of S136 within the context of the resources available). It is acknowledged that it may be interesting to compare experiences both across the region and nationally, though this was beyond the scope of the present study.



## 2.2 Participants

A total of ten participants took part in individual interviews with the researcher (details summarised in Table 2.1).

*Table 2.1:* Overview of police officers' demographic details

<b>Job role</b>	<b>Length of time spent working in services</b>	<b>Sex</b>	<b>Age range (years)</b>	<b>Ethnic background</b>
Police Officer (Range of experiences)	Range: 5-9 years Mean: 6.8 years	6 x Male 4 x Female	1 x 18-25 8 x 26-35 1 x 36-45	7 x White British/European 1 x Asian – Indian 2 x Other (mixed background)

(See Appendix 6 - Participant demographic form)

As a function of the sampling method a variety of participants was attracted in terms of the overall demographic profile. While being mindful of protecting participants' anonymity, participants shared experiences of working across several roles (with individual officers often having experience of working across different roles), for example, response teams, neighbourhood teams, community action priority teams, crime and vulnerability teams, and corporate partnership teams, both as constables and sergeants. This study sought to include a wide range of experiences, from those who had little experience of implementing S136, to those who had done so many times, and found that participants had varying degrees of experience in this regard and also in supervising others in this area.

In terms of the context and homogeneity of the data, the participants were identified due to their interest in working with people experiencing mental health crises and the development of the Street Triage initiative in the local area. This sample is therefore biased towards those who have a specific interest in, and motivation to develop services in this area. It is also noted that the range of number of years in service was five to nine years, indicating that this was a cohort of participants who began their service within a relatively short time of each other and therefore have somewhat similar exposure to how the police service has developed over this time.

### 2.3 Data collection

Individual, semi-structured, interviews were conducted with participants. It is important here to note the role of the researcher in this (and the subsequent analytic) process, so these sections will reflect my experience of engaging with participants to elicit their experiences. Much has been written about the ‘phenomenological method’ as developed by philosopher Edmund Husserl, focusing on ideas about ‘bracketing’, or putting to one side, taken for granted assumptions about how the world works, our personal views and biases (Smith, Flowers & Larkin, 2009). In doing this it is hoped to get closer to the ‘essence’ of the experience. While mindful of my personal preconceptions about what officers’ experience might be like being (based on working with people experiencing mental health crises from a psychological, healthcare perspective), it is also important to be aware of the potential impact of participants’ wider experiences, and of engaging with me as a White female of a similar age to themselves, working within public health services and academia.

I arranged each interview through conversations with participants, establishing initial rapport and enabling convenient times and locations to be arranged (all took place at local police service premises). Prior to each interview, I obtained written informed consent to ensure that participants were aware of the purpose of the research and agreed to have their interviews audio-recorded (see Appendix 7 – Consent form).

Each interview lasted for approximately sixty to ninety minutes, and was led by each participant’s engagement with myself and the process. I used a prompt sheet (see Figure 2.1) to provide a framework for the interview, though participants were encouraged to express what was important, and meaningful to them. Indeed, I found participants to be open and honest about their experiences, typically recalling specific incidents, the processes involved, the emotional impact of the work, and avoiding generalisations about what should happen in terms of policies and procedures. Participants acknowledged that their views were biased (being from a police perspective), and that they might well not be representative of other officer’s views. After each interview there was time for reflection on the process, and all participants indicated that it had met

their expectations in terms of what they thought it would be like. They also indicated that they felt comfortable talking with me (representing health services) about their experiences and were interested in opportunities to support and further develop interagency working.

Each interview was audio-recorded and transcribed verbatim for analysis. All participants, and anybody they talked about, were given pseudonyms during the transcription process, and other identifying information was removed.

*Figure 2.1: Interview prompts for participants*

NB. The below are prompts only. The Chief Investigator will rephrase/prompt for more detail as appropriate during each individual interview.

1. Can you tell me a bit about your work with people who experience mental health difficulties/understanding of working with people who experience mental health difficulties? (e.g. training, on the job, personal experiences etc.)
2. Can you tell me about when you first became aware of Section 136 of the Mental Health Act (1983/2007)? (e.g. training, on the job, personal experiences etc.)
3. Could you tell me about how Section 136 features in your work? (e.g. how often it happens, how much time it takes up etc.)
4. Where individuals you have called to assist are suspected of mental health difficulties, what signs indicate a Section 136 might be appropriate? Do you get a Section 136 call/what sort of calls turn out to be Section 136? (e.g. role of others, individual's behaviour, role of substance misuse etc.)
5. Could you outline the process of responding to a/your last Section 136 call? (e.g. is this a typical example of what usually happens – differences/similarities?)
6. Can you tell me about the use of 'places of safety' and the other options available following a Section 136 call? (e.g. how do you decide where to go, can you describe the places themselves)
7. Can you tell me a bit more about using places of safety at the station and the local Section 136 suite? (e.g. decision-making about which to use, why, availability, liaison with mental health services, policies and procedures etc. How does a Section 136 event end? What happens afterwards? How do you think colleagues/other professionals/detainees experience these things?)
8. Who might you talk to regarding working with Section 136/Mental Health Act/mental health difficulties? (e.g. accessing support, training)
9. Is there anything you think might help improve your experience of using Section 136? (e.g. awareness raising/training, confidence, interagency links)
10. Is there anything you think might help improve detainees' experience of Section 136?

## 2.4 Data analysis

Much has been written about conducting IPA research (for a more detailed discussion of its use and application see Smith, Flowers & Larkin, 2009; or Willig, 2008). The analysis of these data followed common analytical practices, starting with a detailed, descriptive coding of the data and becoming increasingly interpretative. The analysis called for immersion in the data following transcription, with interviews being first analysed to explore what was meaningful to each participant. The data were then explored and notations made focusing on the descriptive, linguistic and conceptual content while being mindful of the prompts used and directions from myself in the interview process. Data were clustered into emergent themes (identifying key similarities and striking differences) in preparation for exploring the connections across accounts to form a more holistic account of the data. Superordinate themes were then identified and refined, ensuring that they were fully grounded in the data. A short extract of worked data is presented in Appendix 8 to illustrate the coding process and development of emergent themes. In developing themes, IPA research often uses pseudonyms to identify quotes, but still seeks to offer readers a real sense of who's who in terms of the character of the participants. However, being mindful of the participant group and topic under investigation (active officers sharing work-related experiences as part of a study that would be fed back to their service), the decision was taken to use gender non-specific pseudonyms and to limit discussion of each participant to protect anonymity.

It is important to note that these data provide a snapshot of these participants' experiences at a certain point in time. The interaction between each participant and myself will have influenced what was shared in the interviews, and my own experiences will in turn have influenced the analysis. The analysis of this research was therefore supported through the use of supervision, both peer-led, and also with an experienced researcher (specialising in qualitative methods and IPA), to ensure that a fair and reasonable account of the data has been presented.

## **2.5 Ethical approval**

Ethical approval for this study was granted by the University of Birmingham's Science, Technology, Engineering and Mathematical Ethical Review Committee to protect participants' safety, rights and dignity (Appendix 9). Permission was also granted from the regional police service for participants to be involved in this research (Appendix 10). All participants were given written information about the study and discussed what would be involved with the researcher prior to taking part. All participants were aged over 18 years, had capacity to understand the nature and purpose of this research, and gave written informed consent to participate.

### **Section 3: Themes**

In order to explore how S136 and the use of places of safety have been understood and experienced, participants' accounts were analysed and a series of themes developed. An outline of the themes derived from data is presented in Table 2.2, identified in terms of their overarching essence and key features. As these themes developed, the interpretative work further identified a series of continua of potentially conflicting positions in which participants might find themselves through exploring examples of the intrapersonal conflict they experienced and how they tried to manage these tensions. These continua offered a contextual framework through which to visualise and further explore these participants' experiences, particularly in relation to potential psychological conflict in decision-making and acting effectively with the resources available. Each theme is explored in more detail below and extended extracts of participants' accounts have been used throughout to provide appropriate context to their experiences. The author has added emphasis to parts of this text to illustrate the key points more clearly. The themes are then drawn together and a synthesis in relation to psychological theory is presented in the discussion section.

#### **Theme 1. (In)Appropriate responses: Doing the right thing**

This theme is characterised by ideas about 'what we do' and there being 'right' and 'wrong' ways of doing things when dealing with people experiencing mental health crises. While this dichotomy was presented as somewhat obvious in terms of professional practice (and was guided by training and experience in operational duties), participants noted that doing the right thing could be challenging in light of the complexity involved in these situations. This theme explores this complexity by separating participants' key concerns into three main issues: response; impact on professional and personal lives; and accessing the right environment.

Table 2.2: Summary of themes developed from participants' accounts

Theme		Key features of theme	Continuum of potentially conflicting positions	
1. (In)Appropriate responses: Doing the right thing	a. Response	Focus on developing strategies to respond in the 'right' way using objective powers, policies and procedures, and the more subjective experience of interpreting these, and knowledge and skills developed from learning on the job, within circumstances as they present.	Inappropriate responses	Appropriate responses
	b. Impact on professional and personal lives	Focus on responsibilities and accountability: Maintaining professionalism and managing self-care, accessing support to deal with the challenges of the job.	Caring (Others)	Selfish (Self)
	c. Accessing the right environment	Focus on access to environments available as places of safety including ideas about 'right' and 'wrong' environments.	Traumatic	Therapeutic
2. Becoming an 'expert' Jack of all trades		Characterised by a paradox: becoming an 'expert' Jack of all trades, master of none' (developing expertise in being highly proficient at a wide range of things, yet not necessarily outstanding in any particular one). Focus on formal and informal learning, individual differences and developing confidence in dealing with people experiencing mental health crises.	Training (Classroom, online)	Experience (On the job, practical)
3. Relational activities in policing		Focus on the impact of police presence at mental health crises, expectations about interagency working, negotiation of responsibilities and accountability, and decision-making.	Exacerbate the situation	Calm the situation

*Theme 1a. Doing the right thing: Response*

A key focus of participants' accounts was being able to respond to people experiencing mental health crises in an appropriate way. There seemed to be a clear continuum referenced across the accounts in relation to inappropriate and appropriate ways of responding which were bound up with perceptions about using professional 'judgment' (based on professional and personal experiences) to make effective decisions.

It became clear that while participants were very aware of their responsibilities, the inherent subjectivity, and potential for variance, in making decisions in this area was a key concern. Indeed, this was a common feature of all the accounts, highlighted in the following examples:

"I suppose it's the differentiation between somebody suffering from mental ill health and somebody that's suffering from mental ill health and are in immediate need of that care and control, erm, and **I think that's rather *subjective***, it is, it's something that an officer, **one officer would turn up to and think, "No, detention isn't required" and one officer would think the opposite**, erm, **and numerous elements and variables come into those equations"**

(Chris, author emphasis added)

I mean the, the only people you're going to talk to really are, are your **colleagues** who your with, or your supervisors, **your supervisors will give you their *opinions* and advice**, but then again **it's one of those situations where it's very much *opinion based*** so, it's kind of, you have to be ***confident*** in what you've done, is **what you think is right**, so you can ask for advice, I say you can ask for advice any time about the process, but, not necessarily about the person, it's difficult, **I think it's difficult unless someone feels exactly the way you do, to, to truly agree"**

(Mel, author emphasis added)

While the extracts above highlight the potential for differences of opinion between officers in terms of providing an appropriate response, consideration was also given to how service-users might interpret these encounters. There was a sense that while some service-users might feel that the police had been helpful in supporting them in their distress, a more typical response in crisis



situations would involve people who were more likely to be acutely distressed, perhaps confused and/or aggressive, and often lacking insight into what was happening to them at the time. This often had implications for the type of response they wanted and expectations about what the police were there to do (which also links in with the relational aspects of policing explored in Theme 3). As Chris noted:

**“I think it’s around the negativity surrounding detentions where we get a lot of bad press, but then ultimately they’ll happily justify that most of them were probably absolutely the **right thing to do**, and **it was just a case of that individual didn’t want that to happen, as opposed to it being something, that I put my hands up and say, we shouldn’t have done that**, it’s just a *difference in perception*”**

(Chris, author emphasis added)

This extract also highlights the links between making judgments about ‘doing the right thing’ and being able to justify one’s actions given the differences in perceptions about appropriate responses (further explored in Theme 1b). When asked about opportunities for receiving feedback from service-users about their experiences, participants indicated that they typically did not hear about the longer-term outcomes of their encounters, unless there had been a perceived negative result or complaint. This was seen as being a feature of emergency response work, and while some participants shared their experiences of other roles (where they had greater opportunities for longer-term involvement in cases), this was accepted as not being the norm for most officers. Participants expressed an interest in hearing about service-users’ experiences of police encounters, but also highlighted the point at which they typically intervened, during crisis situations, as not being the right time to access this, as illustrated in the extracts below:

**“...I think the benefits of officers, sort of listening about, you know, to *people’s experiences of how it made them feel*, you know, because I say, possibly, you know, unintentionally we maybe don’t always think about how that person may feel”**

(George, author emphasis added)

“I imagine ultimately, maybe perhaps **if you, you truly understand the situation, or can look back in hindsight and understand the situation, you might think, “Well that was, they were looking after me, trying to do the right thing”, but I imagine, sort of immediately, and maybe in the short term afterwards you would think, “People looked at me and thought this, people, I could hear people whispering”, or, you know, “I was put in a police cell, I was put in a police car, how embarrassing”, you know, but I imagine eventually they might be able to look at it rationally and think, “Okay, it didn’t feel very nice, but I understand why”**”

(Mel, author emphasis added)

A sense of the weight of the personal responsibility experienced also came through across the accounts, with participants sharing their personal ideas about ‘right’ and ‘wrong’, giving an insight into their personal moral codes and the impact of these beliefs on their responses, as highlighted below:

“...ultimately I’ve got to be happy that what I’m doing is right, **what I personally am doing is right**, and if I’m not happy that that is the right thing to do, I simply won’t do it, I, I will look for an alternative, I won’t do nothing, there’s something still needs to be done but if I’m not happy I’ll either need to understand why we’re doing something, or I’ll need an alternative”

(Nat, author emphasis added)

“**I personally debate**, should we be locking up people up who are ill?, really, should we be arresting someone for being ill, I know 136 is technically a detention as opposed to an arrest, **but should we be detaining somebody and forcibly taking them somewhere because they are ill or is there a better route for this?**, which I think is something that we’ll, through the **Street Triage** team, will evolve, **a better route, better pathways**, that’s the whole purpose of it, erm, but yeah you wouldn’t arrest someone for having a broken arm”

(Jay, author emphasis added)

These extracts offer examples of the ways in which participants’ professional roles touched on deeply held personal beliefs about how people who are unwell should be treated, and the importance of acting in ways that are perceived as ‘right’, for example, by being gentle, supportive

and caring (which also links with the personal impacts of the job explored in Theme 1b). They also highlight participants' desire to constantly evaluate their position and the options available to them, using language around 'alternatives' and 'better routes/pathways'. This was also reflected in other participants' accounts where there was frequent use of terms including: 'judgment call', 'perceptions', 'options', 'confidence' and 'experience' (which can be found in many of the extracts throughout this paper).

In responding to questions about what might help them to respond to mental health crises more effectively, participants identified their hopes for the Street Triage initiative. There was a particular focus on the implications for better information sharing and partnership working in terms of attending incidents and sharing responsibility for decision-making to provide the best care possible to individuals in immediate need of support. All participants described what they felt would be helpful in terms of developing services, acknowledging that implementing changes in practice could be difficult but giving an overall sense of being open to new ways of working. This is perhaps not surprising given the nature of the sample (those with an interest in developments in this area), but seemed also to reflect changes in the police service more generally over the past few years in terms of continuous improvement initiatives and reorganisation, as highlighted below:

**"...often the police is the first port of call for people, people who sometimes don't know where else to go, so I think, and I think that's *right and proper* that there should be a response, if people phone, call the police for, for help, and quite often, I mean, if you've got somebody who's, armed with a knife, and, or threatening to hurt people, or hurt themselves, then the police are absolutely the right people to go to the incident, but I don't think that the police should be solely responsible for the decision about that person's future which is why I think Street Triage is a great idea"**

(Mel, author emphasis added)

This extract also seems to capture the wider sense identified in this theme, of participants responding in ways that are considered 'right and proper' in terms of requests for help. Though

they also identified the potential for ambiguities to arise as to which services might be ‘best placed’ to offer the most appropriate response.

Theme 1a has outlined participants’ concerns with ‘doing the right thing’, focusing on ways of responding to people experiencing mental health crises and highlighting the perceived subjectivity, and challenges this can pose. This theme is explored further in terms of the impact this work has on participants’ professional and personal lives, before moving on to look at ideas about being able to access the ‘right’ sort of environment for people in crisis.

*Theme 1b. Doing the right thing: Impact on professional and personal lives*

In addition to providing an appropriate response, participants also talked about the impact of this on their professional and personal lives. In developing this theme there also seemed to be a continuum developing around the implications of: *acting for others* (e.g. doing the right thing for them, being caring, compassionate, going above and beyond the job role and meeting expectations in terms of ‘duty of care’); and *acting for the self* (e.g. self-preservation/protection, managing stress and pressure, maintaining a family life/life outside work). This theme was therefore characterised by a focus on responsibilities and accountability: managing the demands of the job and maintaining professionalism; while also taking action to support self-care.

In terms of their responsibilities and accountability, participants talked about being very aware of their legislative powers and relevant policies and procedures, while also noting the potential for a lack of clarity (inherent in the subjective interpretation of circumstances outlined above), and that the boundaries between agencies’ responsibilities could seem blurred at times, as highlighted in the following extracts:

“I think everyone has, er, quite a formalised plan as it were, so every department kind of knows what they, kind of, **you know these grey areas that did exist, they’re kind of closing in now**, whereas, **I can remember incidents probably [A few] years ago where two departments did attend, the police and the ambulance, and they’re both looking at each other thinking, “[Intake of breath] Who’s taking this one on then?”** [Laughs], and you know, you can laugh about it now, but you know, it’s not

really funny, because really this person needs care, and both agencies or departments are thinking, “Well, this is not really my job”, “Well, this is not really my job”, nobody would leave, and they would reach a decision, but the thing is sometimes you haven’t got time for that, you need to just deal with it, right now, and let’s sort the semantics out later.”

(Sam, author emphasis added)

“...because I think irrespective of policy sometimes **it’s about dealing with a situation that’s presented to us there and then, and ultimately you’re not getting bogged down in policy and procedure, actually providing care to that individual**, because I’m the worst, I because I might get walked over sometimes but I’m, I’m always the person that says, “Look, I’ll do it”, just for the sake of that person, instead of us arguing as emergency services, we’ll sort it.”

(Chris, author emphasis added)

While there was an overall sense of a commitment to continuous improvement in interagency working, it is clear from these accounts that there are still areas that pose challenges (explored further in Theme 3). While the first extract offers a clear example of this, the second further emphasises the more personal experience of being an officer, and the sense of personal responsibility that goes beyond operating within set protocols. Throughout their accounts, participants offered examples of the inherent subjectivity involved in ‘doing the right thing’ and how they develop the confidence to exercise professional judgment in responding to challenging situations. A key factor in this seemed to relate to looking to the experience of others to support decision-making, and also putting in time and effort outside of regular working hours to further develop knowledge and skills, for example:

“... if I’m with someone who’s got a bit more experience than me, I usually look to them and say, “Look, what do we do here?”, and learn off that, but then also speak to my supervision about it and say, “**Look, did we do the right thing?**”, or while I’m on the job, “**Is this what we can do, or do you advise doing something else?**”, erm, and that’s mainly where our learning comes from is by **more experienced officers**, erm, I think more and more, as you kind of, as you do more and more jobs dealing

with mental health, you kind of, I know I do, I look into it a bit more and look at what our powers are and, a lot of **self-research** as well”

(Pat, author emphasis added)

While developing experience and confidence to do the job are explored further in Theme 2, it is worth noting here that several participants made reference to taking personal responsibility for their learning and spending their personal time engaging in these activities. It is acknowledged that this sample had a particular interest in mental health and that they were also motivated to take part in research with a view to supporting the development of services in this area. Throughout the accounts ideas about leaning seemed to be linked with personal motivation, interest, and investment in this particular area, as well as the potential for career development, for example:

“...but in terms of my own, erm, learning, **I always look when I’m outside of work, if I’m at home, I’ll er, it may be something in, you know, I’ll see on the news, erm, there may be an article about police and mental health, I’ll think, oh that’s interesting, what’s that?**”

(Pat, author emphasis added)

Some participants also made reference to (personal/family members’/friends’) experiences of mental health difficulties outside of work which they felt had enhanced their understanding of what the experience of some of their service-users might be like. However, there was a general sense of a lack of feedback about the outcomes of encounters, with officers far more likely to hear about complaints, and not about when things had gone well:

“I suppose **if it goes wrong, or if something happens that you’re not happy with, then yeah you would raise it**, and you would have a conversation, **but actually if everything went to plan then you probably wouldn’t talk about it ever again.**”

(Max, author emphasis added)

In sharing their experiences about the responsibilities of their job roles and using professional judgment to inform decision-making to support others, participants also talked about

the need to focus on themselves, particularly in relation to their professional accountability and lives outside the job. The following extract offers an example of how Nat brought these things together:

**“I think the only way to put it is ... everybody is *self-preserving*, um, because you have to go to the nth degree in everything you do now to justify everything you’ve done which is why I just wouldn’t do it, I just wouldn’t do it, and the same way as if we’d just got back in the car and they’d said, “Yeah I am going to kill myself tonight”, I’d go straight back and knock on their door, because I, if for no other reason than I couldn’t live with myself, I just wouldn’t be able to live with myself”**

(Nat, author emphasis added)

Here, there is a clear sense of the potential for the boundaries between professional and personal lives to be blurred. Indeed, other participants considered the impact of some of the more difficult aspects of policing on officers’ sense of wellbeing, while others talked about leaving the job at the door when they left work:

**“I suppose in a way you’ve got to be careful because there’s, there’s so many occasions where officers deal with mental health, deal with like suicide, depression, how long does it get to the point where you think, actually so many people trying to think about committing suicide, that it starts, brushing off on to the officer ... ultimately, we’re the attitude of, *it’s our job, we get on with it*, we go home and we talk it, sometimes you talk about it to your other halves, if you haven’t, you know, you get on with it, but sooner or later, I think dealing with, it’s, situations of, death, destruction, you know, unhappiness, it will take a toll”**

(Alex, author emphasis added)

**I mean, with, with my, what I tend to do is as soon as I get back in the car to go home I tend to forget about the job altogether, erm, and I don’t think there’s been one incident where it’s affected me that much I’ve sort of thought about it afterwards, but I know if I do need support and guidance and help, I’ve got other colleagues there, I’ve got supervision that are there to help, erm, but also as well, if I wanted to speak to staff at the place of safety suite, erm, I can do.”**

(Pat, author emphasis added)

Several participants talked about the importance of genuinely wanting to do the right thing for the individuals they came into contact with, doing their best to mitigate risk, while offering the least restrictive option available on a case-by-case basis. While participants were aware of the help and support available to them, there was also clear sense of the level of personal responsibility and accountability experienced in the job role. Indeed, across accounts there was a sense of the potential for conflict in this area, managing ideas about justifying one's actions in a way that would be supported by the wider organisation, while also feeling 'ultimately it's on you' and you have to be able to live with the decisions you make, as highlighted below:

**"I think that is the biggest thing, especially for police officers, you know, you've got to have the confidence that you're doing the right thing and that you're going to be supported, you know, and if it does go wrong later on, you know, they're not going to just go, "Well, it was your fault, now look what's happened", you know, you're sacked or whatever, whatever happens, you know, you've got to have the support of actually, okay, this is why I did what I did, I genuinely thought that it was the right thing, I'm really sorry that it has gone wrong but, you know, at the time I genuinely thought that what I was doing was the right thing for, for everybody"**

(Max, author emphasis added)

Theme 1b has outlined participants' experiences of the ways in which this part of their job impacts upon their sense of their professional and personal selves, highlighting the potential for the boundaries to become blurred, as deeply held beliefs about right and wrong are activated and used to inform practice. Managing the needs of others with the need for self-care was highlighted, with participants expressing high levels of perceived personal responsibility which some found difficult to leave 'on the job'. Participants talked about being aware of support available to them, and talked about the ease of drawing on the experiences of colleagues to help them respond to difficult situations, but expressed a sense of it generally being more challenging for officers to seek help for the personal impacts of 'getting on with the job' which routinely involved being exposed to



difficult and distressing situations. The final part of Theme 1 goes on to explore perceptions about being able to access the ‘right’ environment for people experiencing mental health crises.

*Theme 1c. Doing the right thing: Accessing the right environment*

Participants also highlighted the importance of being able to access the right sort of environment as key factor in being able to ‘do the right thing’. Throughout their accounts, participants talked about custody environments being the ‘wrong place’ for people experiencing mental health crises. In exploring the language used around ideas about ‘right’ and ‘wrong’ environments, there seemed to be a continuum developing. Indeed it was possible to frame ideas around those that were more or less: ‘traumatic’ (e.g. words including: cell, detention, control, cold, dark, smells, shouting, fighting, distressing, criminal); and ‘therapeutic’ (e.g. words including: comfortable, welcoming, nice, sofa). In exploring these accounts it seemed that there was a clear sense of what made an ‘inappropriate’ environment, as the following extracts illustrate:

**I don’t think the police *cell* is anywhere near the right place for an ill person to be.** Well I think if, if, sort of, I try to put myself in the place of somebody who’s mentally ill, **it’s *noisy*, it’s *cold*, it’s *dark*, it *smells*, there’s lots of people *shouting* and *fighting*, and you think if you’re already feeling very confused or distressed, putting a person who is completely of sound mind in a custody cell is *distressing*, let alone somebody who’s poorly**, and I just think it is **a place of *detention***, it is a place for, you know, to lock someone away, and **I don’t think that’s where you should put an ill person, at all”**

(Mel, author emphasis added)

**“Yeah, I never ever thought it was the right place for somebody to be anyway,** you know, to put them in a cell, and to just leave them there, it was never the right, **and I think any police officer that you ever speak to will say the same thing**, you know, **that’s not where they should be at all”**

(Max, author emphasis added)

These extracts reflect all the participants' feelings that custody environments were not appropriate places for people experiencing mental health crises, and that there was also a wider sense that other officers would agree with this. However, while there seemed to be more clarity around the 'wrong' sort of environment, there was typically less about what made for the 'right' sort. There was though a sense that having access to a designated place of safety was immensely helpful, as illustrated below:

**"I think it's, it's really good there to have that designated place of safety, designated beds and designated staff, so they, it's what they do, so they understand it, they know about the challenges we face, and they know, they understand, what we, what the pressures on us are and what our powers are, they just get it, I suppose, is probably the best way of putting it, so, and it's really good to be able to go there and if they are happy to accept the person, it's very much a short handover period, and, and then you kind of almost feel comfortable that that person's in the right place, so you can kind of carry on with the rest of your shift thinking, "They're okay".**

(Mel, author emphasis added)

Mel went on to talk about the feelings associated with the sense of having done the right thing (nice, comfortable, guilt at the thought of having not done the right thing, or having upset people alleviated), and how dealing with mental health, while being a large part of the job was not always easily integrated into expectations about the overall job role:

**"Yeah, I suppose it's because, as the police we're, we deal very much with people who don't want us to deal with them, so, people who have committed offences, people who are violent, et cetera, et cetera, and you kind of get used to being a certain way with people, erm, a bit like, 'It's tough luck mate, you're coming with us', kind of, that sort of situation, whereas, in this situation we're dealing with, ill people, and they're, that's not something that we're really trained to do, we're either trained to be, 'there, there' victims, or 'tough luck' offenders, this is er, 'Oh my goodness, this person is poorly'"**

(Mel, author emphasis added)

Other participants also drew on narratives around illness, aggression, and offending, and the challenges of trying to provide an appropriate response in the face of complexity around understanding individuals' roles in encounters (e.g. Is this person 'unwell', 'a victim', 'an offender', 'aggressive', 'confused', 'distressed' or a combination of these things and more?). Therefore, having access to a consistent environment and staff team to support assessment and decision-making in the face of complexity was seen to be reassuring, offering a better service to individuals experiencing mental health crises and support for officers to feel confident in 'doing the right thing' (which also links with the subsequent themes).

Theme 1 has brought together three strands that were identified in the data as being concerned with participants' perceptions about (in)appropriate responses, namely '*doing the right thing*'. The focus on this sense of 'what we do' when faced with people experiencing mental health crises has identified a range of professional and personal factors involved in this type of work. This theme provides an insight into how participants understand and experience the use of S136, and the often complex context of dealing with mental health crises more broadly (with S136 being part of a larger picture), and assessing the possible options for any given situation based on the information and resources available at the time.

## **Theme 2. Becoming an 'expert' Jack of all trades**

In order to support the understanding of that sense of 'what we do' highlighted by the previous theme, participants also focused on 'how we (learn to) do it', often seeking to explain how they came to develop their skills and confidence in being able to 'do the right thing'. This theme is characterised by something of a paradox: becoming an 'expert Jack of all trades, master of none', that is to say, developing expertise (knowledge, skill and judgment) in being highly proficient at a wide range of things, yet not necessarily outstanding in any particular one. This theme also focuses on ideas about a commitment to continuous learning and development, and the crucial combination of training, 'on the job' experience, and individual differences in being able to act effectively when faced with people experiencing mental health crises. This theme therefore

explores how learning about legislative powers, policies and procedures (and seeing these things enforced in practice), combines with a more personal response linked to wider life and job-specific experiences to inform an appropriate response to individual encounters.

In talking about how they came to develop confidence and skills as officers, participants all made reference to their basic training (described as typically classroom-based with some scope for role-playing scenarios with colleagues). Participants emphasised the focus on learning about legislative powers, noting a general lack of input around mental health awareness, before moving on to focus on the importance of practical ‘on the job’ learning. This was nicely summarised by Max:

“If I’m honest, you get a **real small input on mental health**, erm, I think it’s just one, one day that you speak, or part of a day that you speak when you first join, **but I think you pick a lot of things up from the people that you work with and their understanding of it so it’s more sort of on the job training**, you pick things up from paramedics, or and stuff that you’re with, but yeah, training wasn’t that broad I wouldn’t have said.”

(Max, author emphasis added)

Here there is an emphasis on exposure to different situations, learning on the job by working alongside others and drawing on their broader experiences. Indeed, a key feature of developing confidence in being able to deal with circumstances as they arose seemed to be linked to being guided by more experienced colleagues and informally sharing experiences with others, as highlighted below:

“...once you get through it, then again, you start passing on your good experiences to everybody else, and that’s where it, **that’s where it comes down to word of mouth, not the computer, not the training packages.**”

(Alex, author emphasis added)

“...and I’m not saying that we should be trained, you know, to diagnose, because that, that seems ridiculous, but, I think we perhaps need, erm, some input on, what types of

mental disorders there are, and stuff like that, **I mean, we do, we do pick up as you go along, you pick up as you go along** because you meet people throughout the day that suffer from all sorts of disorders, and they will often talk to you about what, how it, manifests in them [Coughs] so you kind of learned, **you learn from experience of going to the jobs to see what, what sort of presents itself in front of you** and whether you've seen it before, or you recognise it in what someone's told you, so **it's very much a sort of *learn on the go* kind of situation**"

(Mel, author emphasis added)

These quotes highlight some of the processes involved in developing one's own learning, and also supporting others to learn 'on the job'. These extracts also speak to the importance of the relational aspects of learning on the job, with officers looking to develop their understanding of each situation through communicating with colleagues, service-users and other agencies to inform responses. Indeed, communication skills came up as a key issue for all participants, with all making reference to the essential nature of the work being about communicating with individuals and groups to achieve outcomes where people are kept safe and the law is upheld. So, while there was a sense of there being things that you can teach people, and things that you can only learn through experience, the importance of individual differences, what sort of person you are, as George noted, "***people bring different skills to our job***" (author emphasis added), was also a clear feature of some of the accounts:

[Decision making] "**I'd like to say that it's down to experience, but I can't**, erm, there will be officers in 10, 15 years who are *exactly the same now as they were in their two year period*, they will struggle to think about it outside of what they're dealing with immediately, **you can also get coloured by the information you get passed over the radio ... you might have already been put in a certain mind-frame that that's your go to option, you can break that, you can think of something else to do, but again, I think that depends on *who you are as an individual* as much as it does on any training**, how well you can start thinking outside the box, and that's why you have supervisors, to make sure that things are done appropriately and that you don't just get caught up in the situation you're dealing with, that you can take that wider perspective"

(Jay, author emphasis added)

“...so if you go to a job, and someone’s in a public place **you’re not taught to recognise signs of mental health, it’s a *judgment call*, I guess based on your own, *perceptions and understandings*, if you think someone is in immediate need of care then you can invoke that power**, but then I guess that’s, what’s the word I’m looking for, **every different *individual* will have a different idea**, certainly in the police because there’s no, clinical, this is, this is mental health, because it’s such a vast area”

(Nat, author emphasis added)

Here, explicit references were made to individual differences in the deployment of skills, experience, judgment, and perception in terms of what individuals bring to the job. So again, while the participants were clearly aware of the relevant legislative powers, policies and procedures, they were also keen to convey the subjectivity inherent in interpreting these and dealing with unique circumstances involving diverse populations.

Two participants also made explicit reference to developing instincts about how to respond to mental health crises. For one participant, the focus was on individual ‘gut instinct’ that came naturally and was informed by general life experiences:

**“I think *life experience*** I think, I think, most people know when something’s not right, and I think it just has to be a kind of, ***gut instinct***, because as I say we have no training whatsoever on what mental disorder looks like, sounds like, smells like, you know, nothing like that [Coughs] so it is all about, talking to the person and thinking, they don’t seem quite right to me so I think we need to take them, and get someone who knows what they’re doing to look at them and **I think it’s sort of very much about picking them up and putting them in the right place”**

(Mel, author emphasis added)

Here Mel identified a sort of need to act on ‘gut instinct’ with reference to a general lack of mental health awareness training, reiterating a view that they had shared near the beginning of their interview (see above). However, it is important to note that in talking about ‘instincts’, participants were describing a process of development through a complex combination of person-centred values, learning, experience, and supervision, and were not advocating for practice based on

implicit biases. There was a clear sense of the need to deal with the individual circumstances as they arose, enlisting the help and support of relevant others to ensure an appropriate response (again, linking with the previous theme). In addition to this view, Jay talked about developing instincts for how to respond through experience, again reinforcing ideas about the importance of ‘on the job’ learning and support from experienced colleagues:

[Attending an incident] “...you get there, you assess immediately, you get three different senses, impact factors of how they’re behaving, environmental factors of what’s around you, **you do that *instinctively* with a bit of experience**, [Taking a drink] excuse me, **with a bit of experience you’ll do that kind of *instinctively*, you’ll turn up and that will be**, “Right, what have I got?”

(Jay, author emphasis added)

All participants talked about developing knowledge, skills and confidence, and a number of them made reference to ideas about developing a sort of ‘expertise’ within the context of the broad remit of policing. Two participants (Sam and Alex) drew upon the idea of the ‘Jack of all trades’ to highlight the need to be highly proficient, yet not necessarily an expert in, a wide variety of skills, as Sam neatly summarised:

“I would say, you could class an officer as a **Jack of all trades**, because they are good at everything but, you know, **they’re not experts in anything realistically, because you can’t be an expert in everything, it’s just not possible**. Yeah, I mean what a constable does, to fining someone for littering to, er, dealing with the scene of a multiple murder, a constable can do all of that, but in terms of having expert knowledge in each area, it’s not feasible, and I think everybody would acknowledge that.”

(Sam, author emphasis added)

This idea also linked with expectations about what the police are for and that this is an area often associated with the relational aspects of policing: how the police work with and through other agencies to support people experiencing mental health crises. In relation to being a ‘Jack of all trades’, Alex made reference to there being a sense of pressure to take on a number of roles,

emphasising a perception of somewhat blurred boundaries between the responsibilities of these agencies. Sam also focused on the broad remit of policing, noting a sense that ‘everybody’ would acknowledge the scope of the jobs that officers deal with. However, there was also an acceptance in this account, and that of others, that the role of the police was not always well understood (by themselves, other agencies, or the public), again emphasising the importance of sensitive and timely information sharing, as highlighted in the following extract:

“...um, the public, I don’t think they understand what we can do around mental health, ... **they don’t want to know until they need to know, when they need to know it’s at that point we need to inform them, and we need to manage their expectations because we can’t do everything, we’re not the panacea to all ills, there are certain things we can do, certain things we can’t do, certain things we should do, certain things we shouldn’t do, where that falls on the scale is on a case by case basis,** but no, I don’t think the public understand what we do, I don’t think the public understand what ambulance do, we don’t understand what ambulance do, we don’t understand what anybody does, you understand what you do [Chuckles]”

(Jay, author emphasis added)

This theme has brought together participants’ concerns with ‘how we (learn to) do what we do’ by exploring their accounts of developing a sort of ‘expertise’ in this specific area of their work. There seemed to be a sense of some dispute as to how best describe this combination of formal and informal learning, experience, confidence and individual differences. However, in linking together the stages of their training and development, participants seemed to be describing their journeys in terms of Dreyfus and Dreyfus’ (1986; Dreyfus, 2004) five-stage model of adult skill acquisition, moving (via a “steep learning curve”) through the stages of ‘novice’, ‘advanced beginner’, ‘competence’, and ‘proficiency’ to ‘expertise’ and a sense of ‘mastery’ where performance was guided by experience and instinct rather than set protocol alone. So, in identifying what helps officers develop the ‘how we (learn to) do what we do’, the importance of effective communication and relational activities has been highlighted as a significant feature, yet something that is more deeply embedded in the nature of expectations about the police and what



police involvement in a situation will bring to it. This will be explored in more detail in the following theme.

### **Theme 3. Relational activities in policing**

In exploring the ‘what we do’ and ‘how we (learn to) do it’ highlighted in the themes above, much of the participants’ accounts also focused on the relational nature of policing, working for, with, and through others to achieve effective outcomes. This theme focuses on participants’ experiences and perceptions of the expectations and anticipation around police involvement in incidents relating to mental health crises. Participants drew on their understanding of a variety of perspectives, including police officers themselves, other agencies (e.g. health and social care), people directly involved in police encounters, and the wider public, in thinking about issues relating to the responsibilities and accountability associated with their particular role.

Generally there was a sense of different agencies working well together, guided by a public service ethos and overall desire to help and support people in need, as illustrated below:

“I think, to be honest, I wouldn’t say that any of us actually bang heads, you know, in terms of, **we all do work quite well as a multiagency teams, because we’re all trying to get the same, you know, result, there’s an individual that need attending to, how best can we all do this?, because ultimately we all want to deal with this, and then ultimately move to the next incident because somebody else needs us.**”

(Sam, author emphasis added)

The role of developing relationships with others was also a key feature of the data. There was a sense of a general lack of consistency in terms of getting to know people from other agencies. However, while there was an overall implication that opportunities for face-to-face contact and relationship-building were helpful, there was also an explicit acknowledgement of using communication skills to develop effective working relationships in any circumstances being part and parcel of policing, as Jay highlighted:

**“I think cross-service communication, tends to be at its best there and then, you arrive, you develop a working relationship, you communicate with whoever’s there at the time, that’s one vehicle and one vehicle, that doesn’t affect the wider services at all, you might have a meeting of minds, you might moan and gripe about whatever it is you’ve had to do”**

(Jay, author emphasis added)

Being able to access a designated place of safety also seemed to affect participants’ sense of having a focal point for this work, being able to contact a consistent staff team for advice and support. Two participants (George and Nat) made specific reference to being “lucky” to have this resource available, acknowledging that this service is beneficial, yet is not something that is available to all localities. Others talked about the getting used to accessing the place of safety in a positive way, often focusing on comparisons with custody processes and environments (highlighted in Theme 1). However, while the overall picture was positive, difficulties were noted, most notably linked to the ability to access other agencies in a timely way.

**“I think any police officer is sensitive to the fact that things take time, it’s just it appears to take far too much time, and that’s a massive issue because it’s a stressful day, I’ve been around people suffering from mental ill health that have been aggressive, for the entirety of the incident, and actually it’s really draining to be hands on with that person, to not have a break that day, to not have a drink of water, all because you’re waiting for a team of people, and we don’t understand where they come from, what the sort of, drafting in process is, erm, you know, these people could be from anywhere, from the four corners of the [Region] or beyond, and we don’t know that, all we see is that it can take hours and hours and hours”**

(Chris, author emphasis added)

The time taken to deal with mental health crises was noted by all participants, and while the difficulties were a common feature of accounts, experiences were not exclusively bad, with some participants offering examples of quick, efficient movement through relevant pathways.

A number of participants focused specifically on the impact of a police presence at an incident. A number of participants talked about times when police attending situations relating to

mental health crises had led to difficulties and there was a sense that there could often be a divide between what people wanted and what they got in terms of an emergency response. So, an individual or family member might request an ambulance but if certain risk factors are present, the police might well be sent as a first response, the potential impact of which is highlighted below:

“...we get a lot of calls for service from the person themselves, erm, a lot do call [ambulance], and then [ambulance] will in turn call us due to the fact that that risk is high, so often, **my view is that we shouldn't be taking primacy on these incidents because that individual has called an ambulance, and often the first people that knock at their door is a police officer, which can a) confuse them, but b) really escalate the situation because they don't want a police officer at the door, they want medical care**, so, er, the police officer is the first port of call, then often”

(Chris, author emphasis added)

[Police attending an incident] “It can make things **escalate**, there have been times where I've turned up to jobs where the paramedics are already in attendance, **we turn up and it makes it all go pear shaped, just from officers' presence**, on our scale of use of force, this is probably useful to know as well, first level of use of force is officers' presence, **simply our presence is on the scale, of use of force** because, **it's an authoritarian uniform, it can have the effect of immediately quelling people, calming them**, stopping them from committing things because they think, “Oooh we could get arrested here”

(Jay, author emphasis added)

While both of these extracts offer similarities in terms of highlighting the potential for police attendance to ‘escalate’ the situation, they also offer contrasting examples of other potential consequences. The first extract offers a clear example of the impact on other agencies, with police presence being explicitly linked to enabling others to get involved (namely safety for the ambulance crew). While examples focusing on the impact of police attendance for the protection of others were typically shared by participants, the second extract highlights another feature of police presence not so emphasised in other accounts, namely the potential for de-escalation. It is interesting to note that there is a key continuum here (exacerbate - calm), yet the focus in these

data is on the situations that are difficult and challenging. This speaks to ideas about more deeply held expectations about getting the police involved to effect resolution to difficult situations, and that the consequences when things go the other way are particularly salient and have the potential to shape wider perceptions of the police and their remit.

So, ideas about what a police presence brings to an incident were varied, yet tended to focus on concerns about making things worse, again linking in with ideas identified in Theme 1 about ‘doing the right thing’. However, all participants made some reference to being typically better placed than most to deal with risk in terms of the potential for aggression because of their experiences in dealing with this on a regular basis and the personal protective equipment with which they were equipped. However, ideas about not being ‘best placed’ to deal with mental health crises, yet looked to by others to take the lead and overall responsibility for the situation, were a common feature of accounts. This could often be a source of frustration for participants:

“We’re not in a public place, we’re in a private house, I haven’t got the power, I don’t have the answer for you”, and we’ve had people contacting our inspectors to complain, saying we’re not doing this, we’re not doing that, well, we’re quite rightly not doing it because it would be illegal, so there’s huge, huge, **misconceptions** I think is a better word, about the **police attending the incident and what that’s going to bring to the table, and what that’s going to bring to the table is, that they get kept safe while they do their job**, which is ultimately the answer isn’t it?”

(Nat, author emphasis added)

[Responding to an incident at a mental health inpatient facility] “...they [Staff] might have a patient in there who was being aggressive they couldn’t control themselves, **it would be my team that would then go there, if we had to go in to restrain somebody or something, then we’d have to go in and support in that way, erm, not always used appropriately, I don’t think, by our partners, I think there’s always that hope that we’re the service that won’t say no, and we will pick up the slack, and that’s as it should be, but I think our partners need to perhaps be a little bit more aware what their powers are, what their responsibilities are, and they should take a little bit more responsibility about dealing with things before trying to get us involved necessarily**, because it does put unreasonable demands

sometimes on police services when our partners don't follow interagency policies and protocols, which they don't always as I'm sure we don't either, again, I'm looking at it from a policeocentric, position"

(Jay, author emphasis added)

These extracts highlight the potential for other agencies' and professionals' misconceptions about what police attendance can and should bring to encounters, leading to possible frustration from multiple perspectives. However, in talking about these issues, participants were careful to acknowledge their own police-centric bias and consider how their actions may be interpreted by others, again, emphasising the importance of information sharing and partnership working, as one participant summarised:

**"...we are trying to make this better, we are trying to work in partnership with each other, ultimately so that the person, it's the members of the public that are going to, that are suffering if we don't get this right"**

(Vic, author emphasis added)

This theme highlights the essential relational nature of policing, drawing on ideas identified in the other themes (e.g. experience, working relationships and individual differences) to explore some of the challenges that officers face in working with, and through, others to respond appropriately to mental health crises. Participants highlighted the complexity of making decisions and the importance of honest, open communication in explaining their actions, managing expectations and negotiating with others from a position of often being perceived, as Jay put it, "the service that won't say no".

A synthesis of these themes is provided in the discussion section, along with links with wider psychological theory, and consideration of the study's limitations and implications for future practice.

## Section 4: Discussion

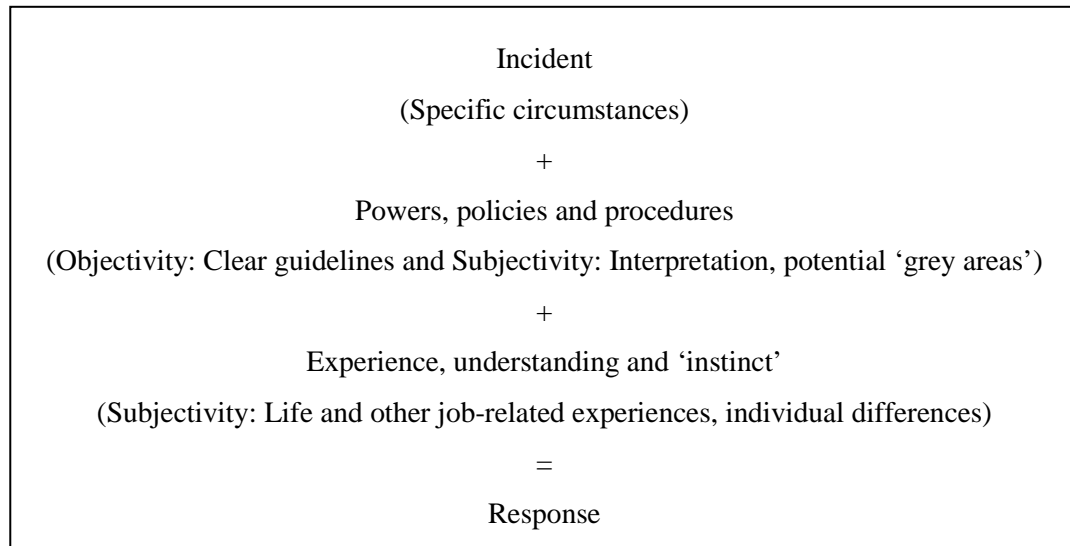
### 4.1 Synthesis of themes

The use of S136, as noted in the introduction, can be viewed as both clearly defined and routine, yet also exceptional. In the region from which this sample of participants was drawn recent figures (1 April 2012 – 31 March 2013) highlighted there were 1,058 S136 detentions (50 went straight to custody, 1008 went directly to a health-based place of safety, figures reported in a Freedom of Information Act request: Beckford, 2013). This identifies this work as a relatively small, yet experientially significant proportion of the police service's work. Participants also identified that a considerable amount of their daily work had a 'mental health flavour' to it, with the figure of approximately 25% commonly cited (MPS Corporate Development, Evidence & Performance, 2013) and questioned (for example, the possible links between offending and/or antisocial behaviours and mental health were considered by a number of participants). While the focus of this research was on S136, it is important to note that participants sought to set this within the wider context of their work, and that not all people experiencing mental health crises who came into contact with the police were detained.

In exploring how S136 and the use of places of safety were understood by the police, a number of themes were identified to account for these data: (In)appropriate responses: Doing the right thing (response, impact on professional and personal lives; environment); Becoming an 'expert' Jack of all trades; and Relational activities in policing. These themes could also be broadly conceptualised as 'what we do', 'how we (learn to) do it'; and 'who we do it with' and were framed in terms of continua of potentially conflicting positions. These continua highlighted some of the considerations in participants' decision-making processes, and experience of acting to achieve appropriate, effective outcomes couched in terms of a desire to 'do the right thing'. These themes suggest that S136 and the use of places of safety were understood and experienced by participants in ways that could be conceptualised as a sort of equation (see Figure 2.2), a combination of knowledge, skills and experience applied to individual circumstances. Each of the

themes map onto the different parts of this equation, at times overlapping, and provide a snapshot of the complexity involved in doing this work.

*Figure 2.2:* Participants' development of responses to encounters with people experiencing mental health crises



Some of this complexity seemed to be accounted for by participants' ideas about working with people who were unwell. In describing their typical work, participants commented on developing communication strategies for dealing with situations that, as Mel summarised, revolved around ideas of, "...there, there victims, or tough luck offenders" (see above, Theme 1c. for extended quote). But, for people experiencing mental health crises, these familiar categories did not offer a good fit. So, here is a third group of people who are inviting a response from officers by activating narratives about illness, innocence/offending (not having done anything wrong, yet in need of immediate care *and* control), and officers wanting to 'do the right thing'. Often, this 'third position' could also be complicated by behaviour that was related to offending and/or could be classed as antisocial, blurring the boundaries about how to provide an appropriate response. In sharing their experiences, participants seemed to identify working with people experiencing mental health crises as placing demands on them for which they were not well-trained, yet developed

confidence in managing through a combination of formal and informal training, supervision, and personal interest and motivation to develop their practice.

Communication, and the relational activities involved in this work were highlighted throughout these data, with participants acknowledging their police-biased perspectives yet mindful of the impact of their personal experiences, and aware of potential differences in others' interpretations. While there was a clear sense of the professional relationships, both in terms of things that worked well, and some of the challenges faced, the lack of service-user feedback and involvement was striking. While it was salient for the author coming from a health perspective whereby service-user feedback is consistently high on the agenda and is becoming increasingly embedded in service design and delivery, the participants also noted their sense of typically wanting to receive more feedback while being mindful of the difficulties associated with collecting it (i.e. appropriateness during times of crises and emergency responses; and how to access feedback sensitively after people had left contact with the service). While participants made attempts to imagine what the experience of being detained might be like, they all acknowledged a lack of direct experiential feedback available to the service, and that where feedback was shared it was typically framed in terms of complaints (drawing on narratives around stigma, illness and criminalisation). However, there was a sense that a greater understanding of what it felt like to be involved in these encounters would be helpful in supporting officers to develop confidence in acting appropriately, with the potential for input from service-users, and their family members/carers. This was consistent with findings from other qualitative research in this area which suggested that detainees felt 'terrified' and criminalised, and that they and their carers felt disempowered by the S136 detention process and were concerned about the lack of follow-up or resources offered afterwards (Riley, Freeman, Laidlaw & Pugh, 2011). Riley and colleagues also suggested that this specific population were willing to engage with research, so it would seem that there is interest from multiple perspectives in finding ways to facilitate the sharing of experiences of S136. However, the research identified in the introduction has also suggested that while research is developing, there is still work to be done, and seems to point towards developing



methods for dissemination that support meaningful partnership working between services and service-users, for example, through greater use of collaboration in research design and action research.

Participants' accounts highlighted their sense of what they do and how they learn to do it in a way that was consistent with a model of adult skill acquisition (noted above, as summarised by Dreyfus, 2004). In taking a more interpretative stance, it is possible to suggest that participants' experiences may be considered in terms of 'optimal experience' and 'flow'. These concepts were explored by psychologist Mihaly Csikszentmihalyi, whereby engagement in activities is, "...so gratifying that people are willing to do it for its own sake, with little concern for what they will get out of it, even when it is difficult and dangerous" (Csikszentmihalyi, 1990, p. 71). Csikszentmihalyi goes on to identify a paradoxical situation in relation to work and leisure: on the job people feel challenged and satisfied, while in their free time they feel there is not much to do and subsequently feel more dull and dissatisfied; yet they would like to work less and have more leisure time. This is thought to have implications in relation to beliefs about what work is supposed to be like (i.e. cultural stereotypes about it being an imposition), motivation and apathy. These ideas may therefore be helpful in exploring officers' perceptions about their job role and the impact this has on their performance. The striking nature of participants' engagement with encounters with people experiencing mental health crises was often reminiscent of flow, with talk about: "instinct" honed through experience; being knowledgeable about, and confident to apply, but "not getting bogged down in policy and procedure"; and communication being at its best "there and then" as encounters unfolded. It is important to note here that the achievement of 'optimal experience' should be based on the complex combination of formal and informal learning, experience, values relating to person-centred care, and supported by colleagues and opportunities for building reflective practice into their work (as identified by participants), and should not be used as an excuse for offering inappropriate responses based on poorly-informed 'instincts'. The sense of participants going 'above and beyond' the expectations of their remit to achieve optimal outcomes was also clear, apparently motivated by wanting to 'do the right thing' in terms of

personal (e.g. having to live with the decisions made), and professional factors (e.g. being accountable and able to justify one's actions to others), in challenging circumstances.

It is therefore suggested that supporting officers to experience 'flow' in their work has the potential to help them to feel skilful, appropriately challenged, creative and satisfied, while reducing some of the potentially negative aspects of the job that might lead to experiences of stress, anxiety, and burnout (it is acknowledged that there is a separate literature relating to these things that is beyond the scope of this study). Developing opportunities to reflect on and talk about these experiences with others would seem to be one key way of doing this, as informal peer networks had already been identified as a key way in which positive experiences were shared. There would also seem to be a case for developing opportunities for experiential learning and flow as part of officers' formalised training structures. While there is a clear case to be made for experiential learning (e.g. through greater service-user involvement, see also Cummings & Jones, 2010), it is also important to acknowledge the role of online learning (eLearning). Participants identified this as being a central feature of how they were expected to update their knowledge and skills. Indeed, while the effectiveness and benefits of eLearning have been the subject of many studies, there is also some research to suggest that measuring 'optimal experience' in the eLearning environment can be helpful in understanding individuals' engagement with the process (Davis & Wong, 2007). A number of participants made reference to feeling that the eLearning courses offered had been beneficial, but also noted that those who were maybe less interested, or feeling pressed for time, would be able to simply click through and complete the presentation without having to meaningfully engage with the material. There is therefore a case to be made for developing ways to optimise this experience for officers, not only to support their practice (and the experience of those they come into contact with), but to also get the best value for training budgets.

In these times of change for policing, it is also important to be mindful of the impact of organisational change on organisational culture, individual employees, and the knock-on effects for other agencies and service-users. The Change Curve Model (Scott & Jaffe, 1988) suggests a way of mapping organisational change as movement between ideas about danger and opportunity.

Stages of ‘denial’, ‘resistance’, ‘exploration’ and ‘commitment’ can be identified and strategies developed to help individuals and groups movement between them. Participants noted a sense of working within an austerity culture, mindful of pressures across public services and ideas about achieving better outcomes with seemingly fewer resources. While some resistance was noted in terms of interagency working (particularly in relation to perceptions about others’ expectations about what the police are for), there was a more general sense of wanting to explore and make a meaningful commitment to changing practice and continuous improvement. However, concerns about being “best placed” to deal with certain jobs was reflected in discussion about twenty-four hour service provision, with participants feeling they had more options available between 9am-5pm when other services were more readily accessible (e.g. primary healthcare, community mental health teams, social services etc.). Supporting interagency communication so that professionals are clear about their own roles, as well as those of others, would therefore appear to be beneficial in terms of cohesive working practices, as well as a key factor in managing public expectations and supporting people to access and engage with services in meaningful ways that go beyond what happens in crisis situations. It is anticipated that the Street Triage initiative will play a key role in this, bringing together police and health professionals in daily practice, as well as offering opportunities for sharing their experiences of working in this way more widely (e.g. with primary healthcare, secondary mental healthcare, and social care teams). It is hoped that as these programmes are evaluated nationally and findings shared, the potential for service development and service-user involvement will be further highlighted, for example, the potential for service-user representation in training, service design and evaluation.

#### **4.2 Quality and limitations**

In interpreting these findings it is important to be mindful of the context of the quality and limitations of this study, and their implications for practice. Yardley (2000) provides a useful framework for assessing the quality of qualitative research identifying the following as key areas

for exploration: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. See Table 2.3 for a summary of these criteria applied to this work.

It is also acknowledged that the findings presented here cannot be said to represent a complete understanding of how S136 and the use of places of safety are experienced by all police officers, rather it provides a snapshot of these participants' experiences at a certain point in time. This research seeks to make a worthwhile contribution to the developing literature in this area by giving voice to these officers' experiences, and suggesting a range of implications for future practice that may be considered in the wider context of police involvement in mental health crises.

Table 2.3: Yardley's (2000) quality criteria applied to this study

Quality Criteria (Yardley 2000)	How demonstrated in this study
Sensitivity to context	<ul style="list-style-type: none"> <li>• Relevant systematic literature reviews relating to S136 presented (Companion literature review: What is known about what happens when the police detain people experiencing mental health crises?; and review presented in the introduction section)</li> <li>• Rationale for the study provided, and gaps in the literature identified</li> <li>• Rationale for IPA method provided</li> <li>• Findings grounded in the data, using participants' language, offering extracts throughout</li> <li>• Sample size is consistent with other IPA research (Smith <i>et al.</i>, 2009)</li> <li>• Consideration of participant and researcher bias presented</li> </ul>
Commitment and rigour	<ul style="list-style-type: none"> <li>• Inclusion criteria and demographic details presented while being mindful of protecting participants' anonymity</li> <li>• Discussion of sample homogeneity presented</li> <li>• Research supervision identified, also the police service mental health lead was involved throughout while being mindful of protecting anonymity</li> <li>• Researcher undertook visits to local police headquarters, control room, custody cells, and designated place of safety to develop an understanding of the context of this work. Also attended a local place of safety conference, providing national networking opportunities</li> </ul>

Continued...

Quality Criteria (Yardley 2000)	How demonstrated in this study
Transparency and coherence	<ul style="list-style-type: none"> <li>• Rationale for study and methodological approach provided</li> <li>• Details of prompts used in interviews provided</li> <li>• Analytic framework identified and referenced</li> <li>• Example of analytic work provided (Appendix 9)</li> <li>• Findings and interpretative work grounded in data (extended extracts provided across the range of participants)</li> </ul>
Impact and importance	<ul style="list-style-type: none"> <li>• It is anticipated that this research will be of interest to a range of individuals and groups involved in this area (e.g. police, health and social care professionals, service-users and their families)</li> <li>• Implications for practice discussed</li> </ul>

The data were collected during December 2013 and January 2014 through a series of ten individual interviews at local police bases (as outlined in Section 2). After each interview, participants reported that the process had met their expectations and that they hoped that sharing their experiences of S136 would lead to opportunities to support the development of work in this area. I transcribed each of the interviews as soon as possible after each session, with all being completed by mid-February 2014. During the transcription process I made notes about participants' interaction with myself and the research process, key details of which are outlined below.

I had wondered with participants about what it was like to be interviewed by someone representing health services and they were keen to talk about joint-working and developing opportunities for collaboration wherever possible, with all being open to and interested in talking with me. In sharing something of my background and what had led me to undertake this research I discussed my academic background with participants. I referred to my work using qualitative IPA methodology to explore informal caring where a family member was affected by severe and enduring mental illness, highlighting some of the findings relating to when people had mentioned crisis situations and police involvement. I had also talked about spending some time with a local Psychiatric Liaison Service in an Accident and Emergency Department and talking about police

involvement in people accessing health services and issues relating to S136 and the use of places of safety. While some participants commented on their own academic backgrounds (e.g. having completed university degrees), and/or having undertaken research projects of their own, others noted feeling somewhat intimidated by the academic process, though noted that talking through my background and the aims of this research had put them at ease before the interviews got underway.

I had also discussed with participants the fact that I had not worked with the police previously and that I was genuinely interested in hearing about their experiences. As a number of participants attended their interviews in their uniforms, I noted that it could be somewhat intimidating to be faced with people wearing personal protective and other equipment (including high visibility jackets, radios, protective vests, handcuffs and batons). Indeed, this was something that many participants commented on in terms of their perceptions of the impact of their presence on situations relating to S136, and working with the public more generally.

Participants were also informed that I would engage with research supervision (peer-led, and with an experienced researcher) throughout the duration of this project, that the findings would be fed back to the police service, and that this work would be written-up and examined as part of a research thesis, and for publication in a peer-reviewed journal. These processes were all instrumental in ensuring the quality of this work and that a fair and reasonable account of the data has been presented.

#### **4.3 Implications for practice**

In light of the findings discussed above, it is necessary to identify the key implications for practice, which may be considered across the following areas:

##### *Developing opportunities for greater service-user involvement*

There is potential for:

- Involvement of service-user and family member/carer representatives (with appropriate training and support) in classroom-based training to offer opportunities for officers to hear

first-hand accounts, and engage with individuals, about experiences of police encounters and being detained

- Service-user input into the design of training packages relating to mental health
- Involvement with local mental health teams, for example, shadowing staff in interactions with service-users to support understanding of service-user engagement with health services

*Developing opportunities to support peer communication*

There is potential for:

- Involvement in peer-led reflective practice activities to support information sharing about things that have gone well, as well as alternative ways of doing things, and lessons learned when things have not gone so well
- The creation of opportunities for assessing the skill-mix of teams, for example, those with a particular interest and/or experience in working with those experiencing mental health crises, and how other areas of work might inform best practice in this area
- Supporting peer-led discussion about the impact of the role on professional life and personal wellbeing, offering opportunities to check-in with each other in a safe environment

*Developing opportunities to support interagency partnership working*

There is potential for:

- Further development of liaison work with partner agencies, building meaningful relationships and structures to share information throughout the organisation
- The creation of further opportunities for information sharing, particularly in relation to feedback so that all agencies can understand and evaluate service-users' journeys through their various systems with a view to improving care pathways (it is acknowledged that at the time of writing the Street Triage initiative is being implemented and is to be evaluated in the near future)

- The further support of opportunities to ensure that mental health-related encounters are kept on the agenda, and that training is up-to-date and relevant to local needs (e.g. the potential to build on training offered by the designated place of safety team)

#### **4.4 Conclusion**

As noted in the introduction, policing in Britain is undergoing a period of immense change and there is a particular remit for examining the interface between mental health and policing with a view to improving services and reducing risks to service-users and wider society (Department of Health and Concordat Signatories, 2014). This work aims to add to the current discussion about these issues by exploring the voices of a population in a way that has not been well represented in the extant literature. This study has therefore focused on the reported experience of a sample of interested and motivated police officers around their experience of using S136 and places of safety in a particular geographical area. In line with other research, this study found that encounters with people experiencing mental health crises are a significant and complex aspect of policing, providing a snapshot of officers' experiences by offering a psychologically-based interpretative account grounded in participants' own words. Overall there would appear to be relatively few studies exploring the experience of this phenomenon, especially from the perspective of police officers (though there have been recent developments, particularly in light of work with liaison diversion and street triage initiatives, for example Menkes & Bendelow, submitted 2013).

This study offers one way of conceptualising police officers' understanding of this specific area of their work and highlights perceptions of being "the service that won't say no" as Jay put it, even though there are other services that would often seem better placed to offer support. It was acknowledged that the police have a key role to play in situations where there are perceived risks to safety, and that it was "right and proper" for the police to attend to mitigate risk. However, there is potential for expectations about what a police presence brings to these crisis situations to be explored with other agencies to help achieve effective outcomes for all concerned. Indeed, there would seem to be scope for developing this research further to explore other professionals' and



service-users' perspectives to support a more holistic understanding of how S136 and the use of places of safety are understood and experienced, as well as the potential to explore public perceptions of the remit of the police and their role in supporting people experiencing mental health crises.

There would also appear to be scope for further developing opportunities for greater service-user involvement (through greater representation at all levels from service design, through training and service delivery and evaluation), supporting communication (particularly in relation to good practice), and developing partnership working with other agencies (e.g. information sharing and training opportunities). It is hoped that in focusing on these areas, alongside their existing commitment to continuous improvement, officers will achieve greater opportunities to develop 'optimal experience' in their work, which is likely to influence the development of appropriate care pathways and similarly influence the experience of others involved in these processes.

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**Public Dissemination Document:**

**Exploring Section 136 of the Mental Health Act (1983/2007) from a  
psychological perspective**

**May 2014**



## **Exploring Section 136 of the Mental Health Act (1983/2007) from a psychological perspective**

Researcher: Dr Michelle Palmer

University of Birmingham &

Black Country Partnership NHS Foundation Trust

### **Aims of this research**

The aim of this research is to explore how police officers understand and experience Section 136 of the Mental Health Act (1983/2007). The purpose of this research is to support different agencies to work together to better support those experiencing mental health difficulties, their families and friends, and the professionals involved in their care. It is hoped that this research will be of interest to professionals, service-users and their wider social networks, and the general public alike, as the issues presented have the potential to impact upon any of us.

### **About the researcher**

My name is Michelle Palmer and I am a Clinical Psychologist in Training employed by Black Country Partnership NHS Foundation Trust. This research was conducted in partial fulfilment of the Doctorate in Clinical Psychology through the University of Birmingham, and in collaboration with Dr Michael Larkin. The development of this research was supported through the use of supervision with research colleagues to ensure that a fair and reasonable account of the data has been presented.

### **Ethical approval for this study**

All research conducted at the University is looked at by independent group of people called a Research Ethics Committee to protect people's safety, rights, wellbeing and dignity. This study was reviewed and given a favourable opinion by the University of Birmingham's Science,

Technology, Engineering and Mathematical Ethical Review Committee. Permission was also granted from the regional police force for officers to take part in this research.

### **Introduction to this research**

One way that the police might become involved with vulnerable people in their local communities is through the use of the Mental Health Act (1983/2007). The primary purpose of the Act is to ensure that people with serious mental health difficulties which threaten their health can be treated where it is necessary to prevent them from harming themselves or others. It also outlines safeguards for patients, to ensure that these powers are used appropriately (Department of Health, 2009). Indeed, the police have specific powers under Sections 135 and 136 of the Act to detain individuals who are deemed to be at risk as a result of mental health difficulties.

Recently the role of public services in responding to people experiencing mental health crises has been highlighted, with a particular focus on the need to respond quickly and appropriately to protect individuals and society more widely (Mental Health Crisis Care Concordat: Department of Health & Concordat Signatories, 2014). However, it is noted that agencies working together in this area have faced challenges, and that the consequences of inappropriate responses have been grave:

“Where there are problems, they are often as a result of what happens at the points where these services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another.

This is a very serious issue – in the worst cases people with mental health problems who have reached a crisis point have been injured or have died when responses have been wrong. In other cases, patients have had to travel long distances when acute beds have been unavailable.”

(Department of Health & Concordat Signatories, 2014)

While the police service in England and Wales is currently undergoing a period of change, it seems clear that intervening in mental health crises will continue to be a key feature of its role regarding the protection of vulnerable citizens, and the public more widely. Indeed, one of the ways that emergency response services are seeking to address their responsibilities in this area is through the development of Street Triage initiatives, whereby specific teams consisting of a police officer, paramedic, and mental health professional, are available to respond together. It is hoped that these teams, in providing greater opportunities for more joined-up working, will support professional decision-making and improve access to the most appropriate care pathways for people in crisis.

To find out more about police involvement in the detention of people experiencing mental health crises a literature review and research study were carried out, details of these are provided below.

### **Literature review**

A systematic review of the academic literature was carried out to find out what is known about what happens when the police detain people experiencing mental health crises. This review seemed timely in light of recent developments in mental health crisis care and policing (as highlighted above). Relevant databases were searched and fifteen articles were identified for examination. While all of the articles considered a number of factors involved in these detentions, a number of primary themes were identified: characteristics of people detained; specialised police mental health crisis response services; policies and procedures; cooperation and compliance; and training. These themes were explored and findings were discussed in relation to the quality of the research identified, the limitations of the review, and what this means for future practice and research.

This review concluded that while there is a clear case to be made for the police to be involved in the detention of people experiencing mental health crises (to reduce risks to individuals and the wider public); there is evidence to suggest that this type of contact can be problematic.

While work in this area is developing, there is more to be done in terms of raising awareness of these issues, and to support meaningful partnership working with people involved in these situations.

### **Research study**

In building on the work of the literature review, the research study went on to explore how police officers understand and experience the use of Section 136 of the Mental Health Act (1983/2007). As noted above, under this Act, the police have specific powers to detain individuals believed to be experiencing mental health difficulties *and* in a place to which the public have access where there are concerns for the safety of those individuals and/or the wider public. This study employed interpretative phenomenological analysis (IPA) to explore ten officers' (from the English Midlands) experiences of this aspect of their work. IPA is a qualitative research approach to the exploration of lived experience that originated in psychology but is becoming increasingly well used in disciplines associated with health and social sciences (Smith, Flowers & Larkin, 2009). This type of research aims to stay as faithful as possible to experience as described by participants and the context in which it is set, relying on experientially rich, first-person accounts to be appropriate. This approach was therefore a good fit for exploring the experientially significant part of police officers' role in working with people experiencing mental health crises and enforcing S136.

Individual interviews were undertaken and a series of themes developed to account for the data. This study concluded that police encounters with people experiencing mental health difficulties were a significant and complex aspect of policing. The police have a key role to play in responding to those in immediate need, yet the lack of service-user involvement in service evaluation was striking. Findings highlighted the potential for the development of greater service-user involvement, supporting communication, and partnership working with other agencies (e.g. health and social care) to achieve 'optimal experience' for all involved. These findings are

discussed within the context of the quality and limitations of this research, and what this means for people working in this area.

## Conclusions

There appears to be a clear case to be made for the police to be involved in the detention of people experiencing mental health crises in circumstances where there are risks to individuals and/or the wider public. These encounters are a significant and complex aspect of policing, defined as being both routine and exceptional, and influenced by the nature of the services' 24-hour emergency provision. However, there is evidence to suggest that this type of contact can be problematic at times, with the potential for stigmatisation, criminalisation, injury and even death to occur in relation to these contacts.

While work in this area is developing, there is still more to be done in terms of increasing awareness of these issues. It is suggested that greater service-user involvement, developing strategies to support communication, and supporting partnership working with other agencies should be encouraged to improve experiences of these encounters.

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## **Volume I: Appendices**

**Appendix 1: Summary of themes identified in the foci of the papers that are relevant to this research**

<b>Summary of main focus of papers identified</b>	<b>Number of papers identified where this is the main focus</b>	<b>Number of papers identified where this is also considered as a key focus within the structure of the paper</b>
Characteristics of individuals referred by police	5 (Lee, Brunero, Fairbrother & Cowan, 2008; Redondo & Currier, 2003; Sheridan & Teplin, 1981; Turner, Ness & Imison, 1992; Way, Evans & Banks, 1993)	1 (Lamb, Shaner, Elliott, DeCuir & Foltz, 1995: <i>Demographic and clinical characteristics at referral</i> )
Crisis intervention team/outreach team involvement/specialised police responses/police-based diversion	6 (El-Mallakh, Spratt, Butler & Strauss, 2008; Lamb, Shaner, Elliott, DeCuir & Foltz, 1995; Steadman, Deane, Borum & Morrissey, 2000; Steadman, Stainbrook, Griffin, Draine, Dupont & Horey, 2001; Watson, 2010; Watson, Morabito, Draine & Ottati, 2008)	4 (Lee, Brunero, Fairbrother & Cowan, 2008: <i>Consideration of the impact of crisis/outreach teams</i> ; Sheridan & Teplin, 1981: <i>Advantages of a Police Reception Programme</i> ; Watson & Angell, 2013: <i>Findings reinforce that procedurally fair treatment for marginalised individuals may provide a theoretical basis for interventions like Crisis Intervention Teams</i> ; Way, Evans & Banks, 1993: <i>Comprehensive Psychiatric Emergency Program initiative</i> )
Policies and procedures for detention in the case of mental health difficulties	2 (Bittner, 1967; Matthews, 1970)	4 (Lee, Brunero, Fairbrother & Cowan, 2008: <i>Impact of profiling on ability to enhance, develop and refine services</i> ; Steadman, Stainbrook, Griffin, Draine, Dupont & Horey, 2001: <i>“Police-friendly” policies and procedures needed/Legal foundations for detaining certain individuals</i> ; Turner, Ness & Imison, 1992: <i>Concern regarding notions of ‘public place’ and ‘places of safety’</i> ; Watson, Morabito, Draine & Ottati, 2008: <i>Implementation</i> )

Continued...

Appendix 1

Summary of main focus of papers identified	Number of papers identified where this is the main focus	Number of papers identified where this is also considered as a key focus within the structure of the paper
Cooperation and compliance in encounters with the police	1 (Watson & Angell, 2013)	1 (Way, Evans & Banks, 1993: <i>Impact of police accompaniment on client disposition</i> )
Training	1 (Cummings & Jones, 2010)	9 (El-Mallakh, Spratt, Butler & Strauss, 2008: <i>Police officer training</i> ; Lamb, Shaner, Elliott, DeCuir & Foltz, 1995: <i>Importance of training, initial and ongoing</i> ; Lee, Brunero, Fairbrother & Cowan, 2008: <i>Consideration of impact of training</i> ; Matthews, 1970: <i>Limited nature of police training</i> ; Steadman, Deane, Borum & Morrissey, 2000: <i>Outline of specialised training for police in mental health</i> ; Steadman, Stainbrook, Griffin, Draine, Dupont & Horey, 2001: <i>Importance of innovative and intensive cross-training</i> ; Watson, 2010: <i>CIT training effect</i> ; Watson & Angell, 2013: <i>Impact of training on police officers relating to subjective experience and cooperativeness for people experiencing mental health difficulties</i> ; Watson, Morabito, Draine & Ottati, 2008: <i>Training in mental health issues/officer suitability for training</i> )



## Appendix 2: Summary of the quality assessment of the papers included in the literature review

Summary of the quality assessment of the fifteen papers exploring the consequences of police involvement in the detention of people experiencing mental health difficulties identified within the literature review\*.

Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
Police discretion in emergency apprehension of mentally ill persons  (Bittner, 1967)	Mixed-methods	A strategy to identify critical appraisal criteria for primary mixed-method studies  (Sale & Brazil, 2004)	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some triangulation of sources (field work and hospital records). Statement relating to interpretative nature of study. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Brief description of method and relevance. Description of study context. Some reference to population/sampling stated.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliation provided. Statement relating to interpretative nature of study. Reference made to author's descriptive process (though no explicit reference to assumptions/researcher's perspective).</p>
Blue remembered skills: mental health awareness training for police officers  (Cummings & Jones, 2010)	Mixed-methods	A strategy to identify critical appraisal criteria for primary mixed-method studies  (Sale & Brazil, 2004)	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Triangulation of theory/perspective. Some use of brief quotations. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Rationale for methodology stated – comparison of two training approaches. Some reference to population/sampling stated. Generalisability to other services/communities referenced.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided. No explicit reference to assumptions/researcher's perspective. Some element of external audit of data (relating to training programmes). Continued...</p>

Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
<p>Evaluation of consequences of implementation of police crisis intervention team in Louisville</p> <p>(El-Mallakh, Spratt, Butler &amp; Strauss, 2008)</p>	Quantitative	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Impact of extraneous variables and limitations of comparison acknowledged. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Brief description of method. Outcome measures identified (e.g. arrest rate, hostage negotiation team calls, mental health unit occupancy). Reference to population/sampling stated. Reference to statistical and clinical significance of findings. Generalisability referenced in terms of comparisons with other localities. Limitations of study discussed.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided and reference made to one of the author's previous affiliation with the police service, no further information provided regarding researchers' assumptions/perspectives.</p>
<p>Outcome for psychiatric emergency patients seen by an outreach police-mental health team</p> <p>(Lamb, Shaner, Elliott, DeCuir &amp; Foltz, 1995)</p>	Quantitative	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods. Outcome measures identified (e.g. demographics, clinical and arrest histories, previous violent behaviour). Reference to population/sampling stated. Reference to statistical and clinical significance of findings.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>

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Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
Profiling police presentations of mental health consumers to an emergency department  (Lee, Brunero, Fairbrother & Cowan, 2008)	Quantitative	A strategy to identify critical appraisal criteria for primary mixed-method studies  (Sale & Brazil, 2004)	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods. Outcome measures identified (e.g. demographics, presenting problems, who seen by, length of stay). Reference to population/sampling stated. Reference to statistical and clinical significance of findings. Limitations discussed.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>
Observations on police policy and procedures for emergency detention of the mentally ill  (Matthews, 1970)	Qualitative	A strategy to identify critical appraisal criteria for primary mixed-method studies  (Sale & Brazil, 2004)	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Use of one extended and some brief quotes. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Brief description of methods. Description of study context.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided – present and past where relevant. No further information provided regarding researchers' assumptions/perspectives.</p>

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Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
<p>Characteristics of Patients Referred by Police to a Psychiatric Emergency Service</p> <p>(Redondo &amp; Currier, 2003)</p>	Quantitative	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods. Outcome measures identified (e.g. demographics, presenting condition, patients' charts). Reference to population/sampling stated. Reference to target population and matched samples (referred from other sources). Reference to statistical and clinical significance of findings. Generalisability referenced in terms of comparisons with other localities.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>
<p>Police-referred psychiatric emergencies: advantages of community treatment</p> <p>(Sheridan &amp; Teplin, 1981)</p>	Quantitative	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods. Outcome measures identified (e.g. demographics, recidivism rates). Some reference to population/sampling stated. Reference to statistical and clinical significance of findings.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>

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Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
<p>Comparing outcomes of major models of police responses to mental health emergencies</p> <p>(Steadman, Deane, Borum &amp; Morrissey, 2000)</p>	Quantitative	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods – comparative cross-site descriptive design. Description of three programmes in different localities. Reference to population/sampling stated. Reference to statistical and clinical significance of findings. Generalisability referenced in terms of comparisons with other localities.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>
<p>A specialized crisis response site as a core element of police-based diversion programs</p> <p>(Steadman, Stainbrook, Griffin, Draine, Dupont &amp; Horey, 2001)</p>	Quantitative	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods – description of three diversion programmes. Reference to population/sampling stated. Reference to statistical and clinical significance of findings. Generalisability referenced in terms of comparisons with other localities.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>

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Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
<p>'Mentally disordered persons found in public places'. Diagnostic and social aspects of police referrals (Section 136)</p> <p>(Turner, Ness &amp; Imison, 1992)</p>	Quantitative	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods. Outcome measures identified (e.g. development of a 40-point questionnaire to collect data from case notes – further details not provided). Some reference to population/sampling stated. Reference to statistical and clinical significance of findings. Limitations discussed, particularly in relation to reliability of data.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Authors note there were considerable problems as to the reliability of the data. Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>

Continued...

Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
Research in the real world: studying Chicago police department's crisis intervention team  (Watson, 2010)	Literature Review  and  Mixed-methods	AMSTAR  (Shea <i>et al.</i> , 2009)  A strategy to identify critical appraisal criteria for primary mixed-method studies  (Sale & Brazil, 2004)	<p>1 Was an "a priori" design provided? <b>Yes.</b>  2 Was there duplicate study selection and data extraction? <b>Can't answer.</b>  3 Was a comprehensive literature search performed? <b>Can't answer.</b>  4 Was the status of the publication used as an inclusion criterion? <b>Can't answer.</b>  5 Was a list of studies (included and excluded) provided? <b>No.</b>  6 Were the characteristics of the included studies provided? <b>No.</b>  7 Was the scientific quality of the included studies assessed and documented? <b>No.</b>  8 Was the scientific quality of the included studies used appropriately in formulating conclusions? <b>Yes.</b>  9 Were the methods used to combine the findings of studies appropriate? <b>Yes.</b>  10 Was the likelihood of publication bias assessed? <b>No.</b>  11 Were potential conflicts of interest included? <b>No.</b></p> <p><b>Truth Value (Credibility Vs Internal Validity)</b>  Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b>  Statement of purpose. Phenomenon of study stated. Description of methods and design of study. Outcome measures identified (e.g. design of an interview tool – further details not provided, some qualitative interviews – sample schedule not provided). Reference to population/sampling stated. Reference to statistical and clinical significance of findings. Limitations discussed.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b>  Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>

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Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
<p>The role of stigma and uncertainty in moderating the effect of procedural justice on cooperation and resistance in police encounters with persons with mental illnesses</p> <p>(Watson &amp; Angell, 2013)</p>	<p>Mixed-methods</p> <p>(linked to Watson, Morabito, Draine &amp; Ottati (2008) study)</p>	<p>A strategy to identify critical appraisal criteria for primary mixed-method studies</p> <p>(Sale &amp; Brazil, 2004)</p>	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods – final phase of a mixed-methods study. Reference to population/sampling stated. Reference to statistical and clinical significance of findings. Limitations discussed.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>
<p>Improving police response to persons with mental illness: A multi-level conceptualization of CIT</p> <p>(Watson, Morabito, Draine &amp; Ottati, 2008)</p>	<p>Literature Review</p> <p>(and details of conceptual CIT model)</p>	<p>AMSTAR</p> <p>(Shea <i>et al.</i>, 2009)</p>	<p>1 Was an “a priori” design provided? <b>Yes.</b>  2 Was there duplicate study selection and data extraction? <b>Can’t answer.</b>  3 Was a comprehensive literature search performed? <b>Can’t answer.</b>  4 Was the status of the publication used as an inclusion criterion? <b>Can’t answer.</b>  5 Was a list of studies (included and excluded) provided? <b>No.</b>  6 Were the characteristics of the included studies provided? <b>No.</b>  7 Was the scientific quality of the included studies assessed and documented? <b>No.</b>  8 Was the scientific quality of the included studies used appropriately in formulating conclusions? <b>Yes.</b>  9 Were the methods used to combine the findings of studies appropriate? <b>Yes.</b>  10 Was the likelihood of publication bias assessed? <b>No.</b>  11 Were potential conflicts of interest included? <b>No.</b></p>

Continued...



Article and Author	Method	Quality criteria framework applied	Quality criteria applied and assessment details
An analysis of police referrals to 10 psychiatric emergency rooms  (Way, Evans & Banks, 1993)	Quantitative	A strategy to identify critical appraisal criteria for primary mixed-method studies  (Sale & Brazil, 2004)	<p><b>Truth Value (Credibility Vs Internal Validity)</b> Some exploration of extraneous variables. References to consent, confidentiality and ethical approval not explicitly stated.</p> <p><b>Applicability (Transferability/Fittingness Vs External Validity/Generalisability)</b> Statement of purpose. Phenomenon of study stated. Description of methods. Reference to population/sampling stated. Reference to statistical and clinical significance of findings. Generalisability discussed in terms of findings supporting other research.</p> <p><b>Consistency (Dependability Vs Reliability) and Neutrality (Conformability Vs Objectivity)</b> Author affiliations provided, no further information provided regarding researchers' assumptions/perspectives.</p>

#### \*Limitations of the quality assessment

It is important to note the potential limitations of this quality assessment. Where Sale and Brazil's (2004) framework has been applied it is important to be aware that the criteria have been applied to studies employing quantitative, qualitative or mixed-methods designs, going beyond the original intentions of the authors, to provide a consistent approach to this review. It is also important to note that using either of the frameworks identified above, it is possible that the criteria have been met, but that they have not been reported by the authors due to a range of factors (e.g. editorial revisions, guidelines on the length of publications etc.).

While this summary provides a brief overview of the consideration of these papers in relation to a number of established quality criteria, it is acknowledged to have relied upon the judgement of the author (MP) and has not been subject to inter-rater reliability checks. However, it is noted that in terms of agreement and reliability, the AMSTAR tool is reported to have excellent interobserver intraclass correlation coefficients (Shea *et al.*, 2009).

### **Appendix 3: Health and Social Care in the Community - Guidelines for Authors**

[http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2524/homepage/ForAuthors.html](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2524/homepage/ForAuthors.html)  
(Accessed in May 2014)

Edited By: Karen Luker

Impact Factor: 1.185

ISI Journal Citation Reports © Ranking: 2012: 8/38 (Social Work)

Online ISSN: 1365-2524























Appendix 4: Participant information leaflet (provided to participants as an A4-sized double sided tri-fold leaflet)

<p><b>Understanding Section 136 of the Mental Health Act (1983/2007)</b></p> <p><b>Would you like to share your experiences of being involved with Section 136?</b></p> <p><b>All one-to-one discussions will be held at a time and location that are convenient to you and travel expenses will be reimbursed.</b></p> <p>When I write about our discussion all names will be changed and identifying information removed.</p> <p>However, I am required to share the details of our discussion if I am concerned that you or anybody else may be at risk of harm.</p> <p><b>There is no obligation to take part if you change your mind after contacting me.</b></p> <p>Contact details can be found on the back of this leaflet</p>	<p><b>Contact details:</b></p> <p><b>Dr Michelle Palmer</b></p> <p>Clinical Psychologist in Training (ClinPsyD)</p> <p>Black Country Partnership NHS Foundation Trust</p> <p>University of Birmingham</p> <p>This project is being supervised by:</p> <p>Dr. Michael Larkin</p> <p>Senior Lecturer University of Birmingham</p> <p>Write to: School of Psychology University of Birmingham Edgbaston Birmingham B15 2TT</p>	<p><b>Research Project: Understanding Section 136 of the Mental Health Act (1983/2007)</b></p> <p><b>Researcher: Dr Michelle Palmer</b></p> <p><b>Have you been involved with enforcing Section 136, or in the care of people detained under Section 136?</b></p> <p><b>Would you be interested in taking part in a research study?</b></p> <p>I am looking for 12 members of the police &amp; healthcare professionals to take part in one-off individual interviews about their experience of being involved with Section 136 of the Mental Health Act (1983/2007)</p> <p><b>Research Study 2012-2014</b></p> <p> <b>UNIVERSITY OF BIRMINGHAM</b></p>
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## Research Project: Understanding Section 136 of the Mental Health Act (1983/2007)

### What is the project about?

The aim of this research is to explore how members of the police & health professionals understand Section 136 of the Mental Health Act (1983/2007) and make decisions around its enforcement. The purpose of this research is to support inter-agency working to better help those experiencing mental health difficulties, their families and friends, and the people involved in their care.

### Who can take part?

I am looking for individuals who have been involved in enforcing Section 136, or the care of people detained under Section 136.

### What will I have to do?

You will be invited to attend a one-to-one discussion with me. Each discussion will be informal and will involve us talking about your experiences of being involved in the enforcement of Section 136, or the care of people detained under Section 136. Our discussion will last for about an hour and will be audio-recorded.

I am interested to hear about what the experience of being involved with Section 136 has been like, and what might help improve the experience for professionals and detainees.

### What will happen to the information?

Audio-recordings of our discussion will be written down. The audio-recordings and written copies will be kept secure and destroyed once the study has ended.

The discussions will be analysed with the aim of identifying themes about experiences of being involved with Section 136. The results will be reported in a thesis, presented to the University of Birmingham, and in a professional journal. The results will also be made available to everyone who takes part in the project if they so wish.

### Will the things I say be kept private?

When I write about our discussion all names will be changed (yours and anybody you talk about) and identifying information removed. The written copy of the discussion will be looked at by me and relevant research staff at the University of Birmingham to make sure that what I present is a fair and reasonable account of what was said. I am also required to share the content of our discussion if I am concerned that you or anybody else may be at risk of harm (e.g. disclosure of unethical practice).

Direct quotes of things you have said may be used in the write-up but these will not identify anybody who took part or was spoken about.

### What happens if I change my mind about taking part?

You do not have to take part if you do not want to. If you choose to take part and change your mind before or during our discussion, you are free to withdraw your participation. You do not have to give a reason for withdrawing from the project and it will not impact on your job role.

You will also have the opportunity to

withdraw either all of your comments, or specific comments, from any analysis up to two-weeks after the discussion has taken place. Any data you withdraw will be destroyed.

### Expenses and payments

You will receive reimbursement for any reasonable travel expenses incurred by participating in this research.

### What if I have any questions?

Please feel free to contact me, I am available during normal office hours (Mon-Fri 9am—5pm). You can always email or leave a message and I will get back to you as soon as I can.

### What happens next?

If you would like to take part in this project, or would like further information, please contact me. Contact details are provided on the back of this leaflet.

### Who is the researcher?

My name is Michelle Palmer and I am a Clinical Psychologist in Training employed by Black Country Partnership NHS Foundation Trust. I have clearance from the Criminal Records Bureau to work with children and vulnerable adults. This research is being carried out in collaboration with Dr Michael Larkin, Senior Lecturer at the University. This research has been approved by the University's Science, Technology, Engineering and Mathematics Ethical Review Committee to protect participants' safety, rights and dignity.

**Thank you for taking the time to read through this leaflet**

**Participant information sheet****Version 1  
1 August 2012****Appendix 5: Participant information sheet****UNIVERSITY OF  
BIRMINGHAM**

School of Psychology

**PARTICIPANT INFORMATION SHEET***Title of Project:* Understanding Section 136 of the Mental Health Act (1983/2007)*Researcher:* Dr Michelle Palmer

I would like to invite you to take part in a research study. Before you decide you need to understand why this research is being done and what it would involve for you. Please take the time to read through the following information carefully. Talk to others about the study if you wish. Take time to decide whether or not you wish to take part.

- **Who is the researcher?**

My name is Michelle Palmer and I am a Clinical Psychologist in Training employed by Black Country Partnership NHS Foundation Trust, conducting this research through the University of Birmingham. I have clearance from the Criminal Records Bureau to work with children and vulnerable adults. This research is being carried out in collaboration with Dr Michael Larkin, a senior lecturer at the University. All research conducted at the University is looked at by independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the University of Birmingham's Science, Technology, Engineering and Mathematical Ethical Review Committee.

- **What is the purpose of this research?**

The aim of this research is to explore how members of the police and health practitioners understand Section 136 of the Mental Health Act (1983/2007) and make decisions around its enforcement. The purpose of this research is to support interagency working to better support those experiencing mental health difficulties, their families and friends, and the professionals involved in their care.

- **Why have I been invited to take part?**

You have been invited to take part because you are a professional who has experience of working with Section 136 of the Mental Health Act (1983/2007). It is up to you if you want to take part. It is hoped that up to 12 professionals will take part in this research. This information sheet is for you to keep and I will discuss the study with you in detail before you make your decision.

- **What would be involved?**

You will be invited to attend an interview with the researcher. The interview will be quite informal and will involve me asking you to tell me about their experience of working with Section 136 of the Mental Health Act (1983/2007). This will include questions like: 'Could you outline the process of responding to a Section 136 call?' The interview will be arranged for a time and location that is convenient to you (e.g. near where you work, or the University of Birmingham) and will last for approximately 60-minutes.

When we meet for the interview I will ask you to fill in a consent form to say that you agree to participate in this research. I will also ask you to complete a brief questionnaire to record some basic details such as: your job role, length of time qualified/working in your job role, gender and age range. This is so that I can present a general picture of who took part in the research when it is written-up. This information will not be used to identify any individual.



- **What will happen to the information?**

With your permission, I will audio-record the interview. After the interview I will make a detailed written copy of it (a transcript) which will be used when analysing all the data collected for this study. I will then write a report which will be assessed as part of my Doctorate in Clinical Psychology. I would be happy to send you a summary of the research findings if you would like to receive this. Access to the entire research project may be arranged through the University of Birmingham. I also hope to write articles for scientific journals and to give presentations to raise awareness of this research.

- **Will the things I say be kept private?**

When I create the transcript, I will change your name and the names of anybody else that you mention. The transcripts will be looked at by myself and relevant research staff at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Direct quotes may be used in the write-up or publication of results but these will not identify you as a participant in this research. The original recording will be kept in a secure place at the University of Birmingham. This will be destroyed once the study has ended. All information collected will adhere to ethical and legal practice and all information about you will be handled in confidence (with the exception of disclosures of unethical practice which will be reported to the relevant authorities to ensure safeguarding procedures are met).

- **What will happen if I do not want to carry on with the study?**

If you do agree to take part you will be free to withdraw at any time before or during the interview, without giving a reason. This would not affect your position as a member of the police or health professional. Once the interview has taken place you will have a two-week period for reflection. During this time, you may contact me to withdraw all, or specific parts, of your data. You can withdraw your data without giving a reason. Any data that you withdraw will not be used in the analysis or write-up of this research.

- **Expenses and payments**

Arrangements are in place for you to receive reimbursement for any reasonable travel expenses incurred by participating in this research (e.g. travel to interview). Should you choose to withdraw from the study you will still be reimbursed for any travel expenses incurred. However, it is not possible to reimburse you for any time that you may decide to take away from work to attend the interview.

Thank you for taking the time to consider this research study. If you think you might be interested in taking part please contact me to discuss the research in more detail. I am available during normal office hours (Mon – Fri 9am – 5pm), or you can email or leave a message and I will get back to you as soon as I can. We can discuss the study over the telephone and I am happy to arrange a personal visit if you feel this would be beneficial. You can contact me at:

Researcher: **Dr Michelle Palmer**

Research Supervisor: **Dr Michael Larkin**  
Senior Lecturer, University of Birmingham  
School of Psychology, Edgbaston, Birmingham, B15 2TT

University of Birmingham Edgbaston Birmingham B15 2TT United Kingdom  
w: [www.bham.ac.uk](http://www.bham.ac.uk)

## Appendix 6: Participant demographic measure

UNIVERSITY OF  
BIRMINGHAM  
School of Psychology**Understanding Section 136 of the Mental Health Act (1983/2007)**  
**Demographic measure**

Please give details or delete as appropriate:

**1. Profession/Job Role**

.....

**2. Number of years qualified/spent working in your profession?**

.....

**3. Gender**

Male

Female

**4. Age range**

18 – 25 years

26 – 35 years

36 – 45 years

46 – 55 years

56 – 65 years

**5. Ethnic background**

Asian – Indian

Asian – Pakistani

Asian – Chinese

Asian – Other

Black – African

Black – African-Caribbean

Black – Other

White – British/European

White – Irish

Other (please state).....

University of Birmingham Edgbaston Birmingham B15 2TT United Kingdom  
w: www.bham.ac.uk



**Consent form**

**Version 1**  
**1 August 2012**

**Appendix 7: Participant consent form**

**UNIVERSITY OF**  
**BIRMINGHAM**  
 School of Psychology

Research site: .....

Understanding Section 136 of the Mental Health Act (1983/2007)

Participant Identification Number:.....

**CONSENT FORM**

*Title of Project:* Understanding Section 136 of the Mental Health Act (1983/2007)

*Researcher:* Dr Michelle Palmer

*Please initial each box:*

I confirm that I have understood the information sheet dated ..... (version ...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my professional role or legal rights being affected.

☐

I understand that the research interview will be audio recorded.

☐

I understand that following the research interview I will have a two-week period for reflection. During this time I may withdraw my interview in full, or in part, without giving any reason, without my professional role or legal rights being affected.

☐

I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.

☐

I understand that direct quotes from the interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments.

☐

I agree to take part in the above study.

☐

.....  
 Name of participant

.....  
 Date

.....  
 Signature


.....  
 Name of researcher

.....  
 Date

.....  
 Signature

### Appendix 8: A short extract of worked data to illustrate the analytic process of developing emergent themes

The following table provides a brief example of worked data to demonstrate part of the analytic coding process. This extract is taken from a larger summary document illustrating a summary of just one theme derived from the data, its key features, the relevant continuum of managing potentially conflicting positions, and some of the key quotes that informed it. It is noted that this summary does not account for all the data, rather a few relevant representative quotes have been selected for illustrative purposes.

Theme	Continuum	Example quotes (Author emphasis added)	Analytic coding
<b>(In)Appropriate responses:</b>  <b>Doing the right thing</b>  <b>Environment</b>  Key features:  Types of environment – right/wrong  Access to designated place of safety	<div> <div>Traumatic</div> <div>Therapeutic</div> <div>  </div> <div>           Traumatic environment keywords:             Cell            Detention            Control            Cold            Dark            Smells            Shouting            Fighting            Distressing            Criminal         </div> <div>           Therapeutic environment keywords:             Comfortable            Welcoming            Nice            Sofa         </div> </div>	<p>[Use of custody blocks] “I would say very rarely now, erm but, pfff, I’m trying to think, <i>I can’t remember, it’s been a long time ago</i>, but <i>I am sure there have been incidents</i> where, they’re in the street, it’s snowing, they’re freezing and shivering, er, and the <i>nearest place</i>, because you’re literally outside the police station, <i>may well be worth</i> taking them into the police station, I mean, not as much as the custody block, but I mean, <b>one of our designated rooms</b> which is like, not a safe room, but, er, <b>a comfortable room with a sofa</b>, with you know, at the interim, to keep them from getting, you know, hypothermia” (P1, L1218)</p> <p>“Okay, erm, I mean we’re very lucky that we’ve had the [Suite] now for several years, when I first, erm, used to, er police the [Area] which is [Locality] and [Locality], erm, we, everyone was brought into the police station, and <i>it was sort of just what you did</i>, erm, there was, you know, obviously hospital if they had some medical issues, but otherwise, <b>it was into the police station, which is, you know, not the right place for someone to be</b>, but there wasn’t sort of, it was kind of the <i>culture</i> I guess, like um, I mean a lot of work’s been done on it since, and <b>there’s been some terrible cases, which have highlighted, sort of, the unsuitability of doing that</b>, but I think, <i>I think as officers we knew, you know, putting somebody in a cell, wasn’t, you know, wasn’t the right place for somebody to be</i>, erm, but then things very much changed when the [Suite] came, and, erm, you know, it’s our designated place of safety so whenever we can we’ll get that person there, erm, and even sometimes when we take them to [Hospital] they transfer, we transfer them to the [Suite]” (P3, L16)</p>	<ul style="list-style-type: none"> <li>• Memory –“ remember” – <b>change</b> over time</li> <li>• “Sure there have been” – generic recall here</li> <li>• Accessibility – what’s available at the time, nearest etc.</li> <li>• Potential consequences – “hypothermia” – contrast with “comfort” offered</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• “What you did” – story of before and after (<b>change</b>), commonly accepted practices – links with organisational <i>culture</i> – implications for drawing on experience of others</li> <li>• “Not the <i>right</i> place” – “Unsuitable”, “Terrible cases”</li> <li>• “As officers we knew” – collective voice</li> <li>• Transfer between places – accessibility, meeting needs</li> </ul>
<i>Analytic note:</i> Theme title and continuum developed in line with, and grounded in participants’ use of language			

...continued from overleaf

<p><i>Analytic notes:</i></p> <p>Language:</p> <ul style="list-style-type: none"> <li>• Right/wrong distinctions</li> <li>• Traumatic/therapeutic distinctions</li> <li>• Appropriateness of environment (and ideas about acceptability)</li> <li>• Ideas about ‘illness’ – particular contrast with ideas about ‘criminal’ behaviour</li> <li>• Distress</li> </ul> <p>Perspectives/Positions:</p> <ul style="list-style-type: none"> <li>• Us, as officers (collective)</li> <li>• Me (professional and personal) (also development over time – ‘thinking back’ etc.)</li> <li>• Imagining experience of someone experiencing mental health difficulties</li> <li>• You, as the researcher (also, element of awareness of information being in the public domain)</li> </ul> <p>Organisations/systems:</p> <ul style="list-style-type: none"> <li>• Processes changing over time (getting better)</li> <li>• Access to new/different environments</li> </ul> <p>Stories</p> <ul style="list-style-type: none"> <li>• What we do do/should do/shouldn’t do</li> <li>• ‘Right’ and ‘wrong’</li> <li>• Consequences (actual/perceived)</li> </ul>	<p>“...but it’s far better a situation than it was before, where it was S136 you go straight to the police station, and obviously <i>I’m sure you’re aware, there have been those deaths, fairly recently</i>, sort of two in [A few months ago], erm, <b>I don’t think the police cell is anywhere near the right place for an ill person to be</b>. Well I think if, if, sort of, <i>I try to put myself in the place of somebody who’s mentally ill, it’s noisy, it’s cold, it’s dark, it smells, there’s lots of people shouting and fighting, and you think if you’re already feeling very confused or distressed, putting a person who is completely of sound mind in a custody cell is distressing, let alone somebody who’s poorly</i>, and I just think it is <b>a place of detention</b>, it is a place for, you know, to lock someone away, and <b>I don’t think that’s where you should put an ill person, at all</b>” (P5, L469)</p> <p>“I think, because you’re treating somebody as a criminal, <b>for me, putting someone in a cell, you’re treating them as a criminal</b>, albeit if you’ve come in under S136 the likelihood you’ll be on constant watch, and likelihood is you’ll have an officer sat at your door, you are still in a police custody block, and you’re still in a cell, for me totally, <b>totally unacceptable</b>” (P6, L1052)</p> <p>“...most of the custody blocks are, I mean when we have superblocs, they definitely won’t be, <b>they are more welcoming, but they are still custody blocks</b>, and you might have someone else in who’s <b>screaming, shouting, kicking doors, trying to fight police officers, is that the best environment for somebody who’s struggling with a mental illness</b>, who might be suffering with paranoia, and they see this person having to be manhandled because it’s the only way you can deal with them is to hold them down and restrain them, and they’re screaming and shouting, and you’ll have people screaming that they’re being raped by police officers, genuinely, you’ve got CCTV cameras, so clearly it’s not occurring, but people will be shouting when you’re trying to strip search them to make sure they haven’t got any weapons or drugs on them when they take them to the cell, they’ll be screaming all sorts of implications, <b>for somebody who’s suffering from mental health is that the best place for them to be?</b>, having that sort of thing which could increase their paranoia, could really upset them?, <b>I’d suggest not</b>” (P9, L1929)</p>	<ul style="list-style-type: none"> <li>• “Better than before” – change, options</li> <li>• Reflection on awareness of researcher – ideas about what’s in the public domain (links to “terrible cases” P3 - above)</li> <li>• Not the “right” place – distressing, detention</li> <li>• “Put myself in the place” – perspective taking</li> <li>• Ideas about ‘illness’</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Cell = criminal – association</li> <li>• Treatment – criminal – ‘yes but not really’</li> <li>• “Totally unacceptable” – unequivocal</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• <b>Change</b> but “Still custody” – something about it being inherently the ‘wrong’ place</li> <li>• “Struggle” – ideas about illness</li> <li>• “Best place?” – not only is it not right, but could make things worse</li> <li>• “I’d suggest not” – personal opinion, sense of prompting agreement from others</li> </ul>
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**Appendix 9: Email correspondence from the University of Birmingham's Science, Technology, Engineering and Mathematics Ethical Review Committee - Full ethical approval confirmation**

**Appendix 10: Email correspondence from the regional police service - Approval to conduct this research confirmation**

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