team that I supervise. But, that would be at least triggered by the patrol officers, who actually go around dealing with things. You'd probably find each individual patrol officer dealing with one a week.

With the exception of Cornwall, the cities had higher rates than rural areas, the highest being Brighton and Hove. Rates in rural areas were thought to be exacerbated by the lack of mental health services and assessment suites. All officers interviewed considered s136 an important and useful law, appropriate for police use.

Wrexham:
As police officers, we are capable of dealing with people under 136, and we know when it needs to be used. I can't really see that anyone else can do it.

On the whole, experience was felt to be more important than training; advice from colleagues who had dealt effectively with past incidents was particularly valued. Although training was seen as useful, it was clear that they did not identify themselves as mental health professionals and could not be expected to make a diagnosis. Rather, it was important to develop confidence in dealing with apparent mental illness.

> Brighton:
> […] a lot of it is down to circumstance […] main thing is to treat them right because they are not

Nearly all the officers we interviewed understood the complexities involved in the scenario of dual diagnosis, but many felt confident that they could distinguish between people who were "just" intoxicated and those who had a mental health problem. Although they readily acknowledged they were not able to diagnose and indeed had no aspirations to do so, they relied on instinct and experience to make these distinctions.

Dangerousness and perceived threat

Each force had examples of extreme cases where there was an urgent duty to protect the public, irrespective of whether the person in question had a real mental illness, as in the following examples.

> Brighton:
> […] in ******we've just had two very bizarre events where the person has walked down the seafront, to the children's play area, with a battleaxe, and knife, and [other] collection of weapons. He was scary. There was another walking down the street waving a scimitar. They had [committed] criminal offences by doing what they did, but also you've got to start saying "they are not quite right" – there is a potential medical need here. So both of those were detained on criminal acts, as well as a 136 detention.
> Exeter:
> We always deal with the most extensive offence. If there is a criminal charge, they will be arrested under that. The doctors will access them first, and determine if they are fit. Sometimes they are sectioned after they have been taken in. If there is a substantial offence we will deal with that but they will be assessed. If they are not fit to be dealt with, they will be sectioned.

In these cases, where there were clear indications of potential public danger, the response was always to arrest rather than use s136, even if officers knew the individual was a mental health service-user. Thus the vast majority of cases where s136 was used were cases where individuals were perceived to be in danger of harming themselves.

Vulnerability, self–harm and suicidal behaviour

As indicated above, the interview transcripts reveal the extent to which the pragmatics of safety in the public interest are applied, the majority of cases involving extreme cases of self-harm and suicidal behaviour. Moreover the case studies indicate a high degree of compassion for desperate individuals whose psychiatric status is often contested by the health professionals as in the following account.

> Camborne:
> We held one woman in the cell for 27 hours because […] she was being physically restrained because she had been released from the hospital, went straight into the garage, took an overdose, the police officers had detained her under 136, took her back to hospital, the hospital turned around and said, "oh, we just released her. She isn't a mental health patient. We don't want her. We're not letting her back in." Well the police [are] not in the position to make that decision, so she came back to the custody centre, and she had to be restrained for 27 hours by two people because she had cut marks up her arms, requiring stitches […] had bashed her head in continuously, tried to choke herself. She ripped some stitches out, got taken to the hospital, assessed, and they said "no, no, we don't want her" and they released her. Then we couldn't get her home, so the police officers that were with her, two female officers from here, had to go with […] to her home, which is about an hour away, and I had to follow up from here. So we have three officers dealing with her. And this is a lady with a broken back, with pins in it, a chest cavity with pins in it. On crutches because she had jumped off the fire duct trying to commit suicide and it didn't work and she lived. And they say she hasn't got mental health issues. She has a "borderline personality disorder". […] and you call the doctor and the doctor phones you back and says, "if she is presenting to you the same as she did to us yesterday, just release her." And what if she dies within 1 h or 24 hours?

Another scenario involved rescuing a confused and disorientated elderly woman, presumably suffering from dementia, was described in a similarly compassionate manner.

> Exeter:
> You just brought them in using 136 because they were wandering around outside, not breaking any laws. So you bring them in for their own safety. Or they broke a law, so you bring them in, and they are safe, not wandering around any more. For example, I had a very old lady who had wandered the streets, we sectioned her in a grammar school. She was just in a world of her own. We drove her around to see if she recognized anything, and she saw her old house, where she had lived 25 years

ago. We brought her here as a place of safety under 136. We found the council [nursing home] where she was living, where she had wandered out from that morning.

The use of s136 in cases of perceived suicidal behaviour and self-harm was a recurrent theme in each region, and officers were candid about their use of the Act to protect a wide range of vulnerable people. These individuals may not have been "ill" by medical criteria, but were nevertheless desperately in need of help.

Wrexham:
Sometimes 136 is used for a back-cover […]. Sometimes it is a self-harmer, and you are trying to get them to a place of safety or trying to get someone else to take responsibility for them, but we know that 80% of the time they will be fine if you leave them wherever. It is that 20%, where, if you as a police officer haven't made the decision to take them and get them assessed, it will come back on you if they do actually do something to themselves. So I would say we use 136 in that situation.

Rather than using complex psychiatric criteria, officers seemed to rely on "common sense" to make judgements about the danger an individual might pose to themselves or others.

Burgess Hill:
I think it's used when perhaps nothing else will work.[…]. like when someone wants to commit suicide. Sometimes we may use [s136] inappropriately, but if we don't use it and they are going to do something […] obviously some people aren't mentally ill but are just going through a stressful period, and they don't need to be taken into custody, but what do you do?
When we use 136, its not always actually people who have mental illnesses, it's the people who are stressed. Who are down on hard times, and are trying to commit suicide. Especially youngsters, or old people, you know, marriage break-ups, and so you use 136, but they are the people who need counselling, not mental health [services]. So we are not always using 136 for mental health, its more for people who can't look after themselves.

Police officers felt morally justified working in this manner, both in the interests of protecting the public, and as a means of helping vulnerable individuals. Although at risk of being criticised for inappropriate usage of s136, the police officers were generally confident that it was protective rather than coercive. The consensus was that there was no stereotypical "case" in terms of gender, ethnicity, sexuality, age or any other social characteristics, with the exception of Dolgellau, where it was thought that s136 was more likely to used with women than men.

Collaboration with mental health services

All teams discussed how they worked proactively with mental health services; in three of the areas, officers described their collaboration in very positive terms.

Brighton:
We have a very proactive relationship with mental health patients. We do have a relationship with our mental health team, and we work together to deal with an individual that poses a risk or concern.[]. just recently we've been involved in more joint detentions of 136, where we've worked alongside.[] if they say "yes, we need them detained" for further assessment, we'll actually go detain under 136, and go through that process […].
Wrexham:
My experience with 136, many time, [is that] the police come, and then within five minutes, a social worker is there […].

Rural teams were generally more negative, one indicating that they might avoid using s136 because negotiations with mental health services were time-consuming and rarely helpful.

Dolgellau:
For someone who is suicidal, it is not my first port of call. If it was a system where you could easily take the person and properly get them help, we would probably use it a lot more.
(Question: Does that stop you from using it?).
[…

The lack of resources, especially secure psychiatric facilities, means that police all too often take on the role of mental health carers, despite their lack of training and frequent competing demands for their time.

Discussion

The use of s136 has been under increased scrutiny over the last five years, as the rate of detentions has risen significantly at a national level, from an estimated 7,035 between 2007 and 2008 to 8,495 (2008-2009) and 12,038 (2009-2010) in successive years in England (RCP, 2011). Various theories abound to explain this increase, including that police use s136 because it is easier and less time consuming than arrest (Borschmann et al., 2010) but our study did not support this view, and there appears to be a scarcity of research which addresses the police perspective.

In our study, the police officers we interviewed generally appeared familiar and reasonably confident with the procedures of using s136, although their knowledge was not formally assessed. The decision to apply s136, regardless of the availability of a "place of safety", was open to interpretation and depended on case-by-case police judgements, with the welfare of the vulnerable person being the most important criteria. We found the police acknowledged both their lack of knowledge and the ethical difficulty of making judgements about mental disorder. They were nonetheless ambivalent about the value of specific training to address these problems. Recognising their inability to make "expert" diagnoses, they generally felt that experience enabled them to tell intuitively when something was wrong with someone's mental state. In these instances, the criteria of serious risk of harm to self or others, ergo vulnerability or dangerousness, were paramount; s136 would be applied whether or not it would lead to a hospital admission. In this sense, it often served as a useful tool to contain potentially life-threatening situations.

Our results show that the police decision to invoke s136 depended on institutional and structural factors, as well as on social context and other particulars of individual cases. Police decisions, whether made urgently in a crisis or following thoughtful assessment, were found to reflect an implicit, process-based classification of mental disturbance and what needed to be done about it. Despite having little or no formal training in psychiatry, officers were generally clear that mental illness deserved to be recognised and compassionately treated. One prominent example was police reluctance to use criminal law to charge mentally ill offenders. In almost all cases, officers expressed the view that s136, or other sections of the Mental Health Act, was a more appropriate intervention.

Personality disorder, as discussed earlier, is a distinctive, highly contested psychiatric diagnosis which commonly presents as public disturbance, often attracting police attention and s136 detention (Spence and McPhillips, 1995) and may be further complicated by drug or alcohol misuse. Repeat presentations by vulnerable individuals, as in some of the examples described here, are common across these groups. This may be partly due to the fact that mental health personnel often view borderline or antisocial personality disorders as "untreatable". Furthermore, s136 suites will generally not accept people who are intoxicated. This leaves the police in a difficult and often unsupported position, as shown in our results. In some cases, custody suites were literally being used to prevent further suicide attempts by compassionate officers who were reluctant to abandon a person who appeared to need support and protection. There is a movement towards abandoning the term "personality disorder" altogether and replacing it with the term "adaptation disorder", which can be graded into mild, moderate and severe, maintaining some continuity with current classification. This may reduce the stigmatising component of the diagnosis and emphasise positive efforts to improve adaptation (Svrakic et al., 2009).

Deficits in inter-agency communication and collaboration have been previously reviewed (Borschmann et al., 2010). The Independent Police Complaints Commission (Docking et al., 2008) and the RCP (2008, 2011) have each offered useful recommendations to address these shortcomings and promote effective collaboration. Our findings show that the relationship between the police officers and mental health services can, at least in principle, be optimistically described as complementary. While police officers clearly appreciated the need for places of

response to many incidents, in especially out of hours, were that the mental health services were disorganised, poorly resourced or frankly unavailable. Moreover, exclusion criteria such as alcohol consumption and drug consumption or perceived risk of violence precluded admission to the s136 suites in many cases. All too often, policy custody suites were the only resource, and although the amount of s136 suites have increased since the time of this study, there still

Can you describe the most memorable incident you have been involved in, during which s136 was considered?

Prompt: what made it memorable?

Prompt: was this the best intervention?

If not, what should have happened?

Prompt: was this your most recent experience ?

What was the extent of your involvement in this case?

At what point did your involvement end?

Prompt: did you have any contact after removal to the place of safety?

In your experience are some people more likely to be sectioned under 136 than others? Who and why?

Prompts for: gender/age/ethnicity/sexuality

Although there are legal criteria for s136, what are your main criteria for using the section in practice?

How do you see your role in these situations?

Prompt: is it a role you are comfortable with? Why or why not?

When and how did you learn about using s136?

Was the training adequate? Why or why not?

To what extent did the training involve mental health services?

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