Department of Health

Home Office

Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983

Review Report and Recommendations

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Forewords

Since I became Home Secretary back in 2010, I have been determined to take on policing's toughest and most intransigent issues. Subjects such as domestic violence, public trust in the police, modern slavery and stop and search, all of which go to the heart of a just, decent and humane society.

The police response to people with mental health problems is another of these issues. Most members of the public won't think of the police in relation to people with mental health needs. The police catch criminals, arrest lawbreakers and deal with violent thugs. Unless you have done something wrong, or been a victim of crime, you won't expect to come across a police officer.

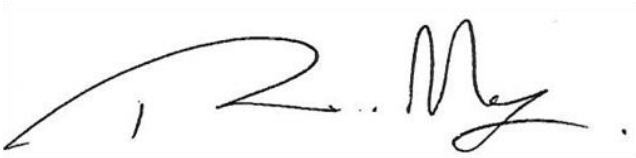
Yet all too often, it is a police officer who responds to the vulnerable person in crisis. I have been clear that it is incumbent on every officer to treat every person in crisis, every vulnerable victim of crime, and everyone in need of assistance, not just with respect and professionalism, but with care and compassion too. And it is incumbent upon government to make sure they are not put in impossible situations they are not trained to face and that vulnerable people – at moments when they are most in need – receive the right care and support.

That is why I announced this Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983 at the Police Federation conference in May 2013, and why it is so important.

We have already made significant progress in the past year. The street triage pilots that we launched in nine police force areas are showing promising signs: the number of people being detained has fallen by an average of 25% across all pilot areas, and all areas are recording a reduction in the use of police stations for mental health detentions. I have piloted a new data collection form among police forces, and will roll that out nationally to ensure we have the best possible picture of what is really happening. And in October I held a Policing and Mental Health Summit with Black Mental Health UK to explore – among other things – the issues around diversity in the operation of Section 136 of the Mental Health Act, and to address concerns over the way some people are treated by the police.

We know from the Care Quality Commission's review of health-based places of safety earlier this year that police cells in England are being used because of a lack of health-based places of safety provision, or because people are being unnecessarily excluded from health-based place of safety. I am very clear that this must not happen. It is vitally important for the person – someone who is experiencing a mental health crisis, not suspected of any criminal offence – that they are dealt with by the right agencies. That means health services, not the police. This is why, at the summit, I announced a pilot in Sussex of an alternative place of safety, to reduce the reliance on police cells as the back-up option when the health-based place of safety is full, or is unable to take the person.

Progress is being made, but there is more still to do. Some of this can only be addressed through changing the legislation, which will help us to ensure that people are being dealt with at the right time, by the right people, in the right place.

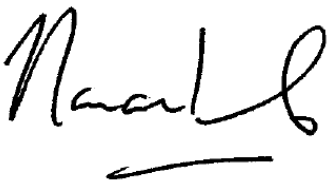


Home Secretary, Theresa May

Thank you to everyone who has contributed to this review of the operation of Sections 135 and 136 of the Mental Health Act 1983. It is clear from the level of engagement that this is an area that many people feel strongly about – from health and policing practitioners who do their best every day for the vulnerable people they encounter, through to people who have bravely come forward to tell us about their experiences of being detained under these parts of the Act, and their families and carers, who also took the time to contribute to the review. Thank you also to the Centre for Mental Health. The team travelled the length and breadth of England and Wales to help us to understand the range of perspectives. We have listened very carefully to everyone in developing the recommendations set out here.

It is clear that there is much good practice happening around the country, with areas where partners are working closely together in a positive way, to find solutions which are focused on the needs of the person who has been detained. In some places, the numbers of Section 136 detentions are very low – or are falling – and in some places no-one now is being taken to police stations when they are experiencing a mental health crisis. I commend everyone working in those areas to make this happen. So it is clear that it can be done.

The Crisis Care Concordat for England we published in February this year set out a detailed action plan and this has driven considerable improvement. This includes additional guidance for commissioners to make sure the right services are being commissioned, developing a programme of work to support primary care to work collaboratively with other services, facilitating access to specialist expertise and secondary care services including crisis care mental health and substance misuse services. We have also revised and updated the Code of Practice for the Mental Health Act 1983 in England, including reflecting the findings of this review. This review forms part of that wider picture and helps us to understand better the challenges, and solutions.



Minister for Care and Support, Norman Lamb

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Executive summary

This is a report by the Home Office and the Department of Health in England on their joint work to review the operation of sections 135 and 136 of the England and Wales Mental Health Act 1983.

The Mental Health Act 1983 ('the Act') is the main Act of Parliament covering the care and treatment of people with mental health problems. It aims to provide a balance between the need to detain, when this is necessary for the health and safety of the person and for the protection of other persons, and safeguarding an individual's human rights and civil liberties.

When a person is experiencing a mental health crisis, it is important that they are kept safe while an assessment is made of their needs. Section 135(1) (hereafter S135) and section 136 (S136) of the Mental Health Act 1983 can play a key role in these emergency situations[1]. The Act sets out how and when a person believed 'to be suffering from mental disorder' can be removed to a place of safety and detained there. Under both S135 and S136, the person may be detained for a maximum of 72 hours.

S136 provides emergency powers for the police to deprive a person of their liberty temporarily, if the person is in a place to which the public have access and certain conditions are met. The police may remove the person if it appears to the police officer that they are suffering from a mental disorder and are in immediate need of care or control, and that it is necessary to remove that person to a place of safety in their own interests or for the protection of others. The person is not removed because they are suspected of committing any criminal offence. In the case of S136, the person must be removed to a place of safety for the purposes of enabling them to be examined by a registered medical practitioner[2], and to be interviewed by an approved mental health professional (AMHP) and for any necessary arrangements to be made for their care or treatment.

S135 only applies when a person is in private premises, such as their own home. It requires an AMHP to apply to a magistrate for a warrant which allows the police officer to enter, using force if necessary, and to search for and remove the person, to a place of safety, in circumstances as set out above. The AMHP may make a further application in respect of the patient under the Act, or make other arrangements for their treatment or care.

This review focused on the operation of these sections of the Act in order improve the outcomes for people in mental health crisis who may be detained under these provisions, focusing specifically on S135(1), S135(3)[3], S135(6)[4], and S136. These outcomes are essentially concerned with ensuring the detained person is assessed in the most appropriate way, with due regard to their needs and dignity. The review considered views from police officers, AMHPs, health professionals, paramedics and ambulance workers, people who have experienced detention under these parts of the Act, and families, carers and the public[5].

The main issues the review explored were:

- how these sections work in practice;
- whether the present legislation provides a balance between flexibility and safeguards;
- whether police stations should be used as places of safety;
- whether the maximum length of detention of 72 hours is appropriate;
- whether the legislation supports a person receiving help as quickly as possible if they are experiencing a mental health emergency in their own home; and
- whether there would be any benefit in extending the powers to others as well as the police.

[1] S135(2) permits a warrant to be granted to the police to retake a person already formally detained in a hospital who has gone absent without leave and who is found in private premises. It is not the main focus of this review.
[2] It is preferable that this should be a Section 12 approved doctor. Further details are online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281253/Instructions-2014.pdf

[3] S135(3) sets out that 72 hours is the maximum length of detention under this part of the Act.
[4] S135(6) provides a list of places of safety.
[5] The review is online at: https://www.gov.uk/government/consultations/review-of-the-operation-of-sections-135-and-136-of-the-mental-health-act

How do these sections work in practice?

The review gathered evidence through an online survey, practitioner workshops, focus groups with service users, engagement with academics, and visits to explore local practices in different areas. This suggested there was widespread variation both in the frequency of S135 and S136 detentions and in the extent to which police stations are used as places of safety rather than those provided in health settings. In areas of effective practice, working relationships and communication between different agencies is good with active information-sharing, a multi-agency group which meets regularly and a shared understanding of the responsibilities, processes and practices of each agency. Access to health-based places of safety is a key factor in ensuring a person is not detained in a police station.

A multi-agency approach is critical to the effective operation of legislative provisions as set out in the Crisis Care Concordat for England[6], the Codes of Practice for England and Wales[7], and in local partnership agreements. The Crisis Care Concordat states that facilities should be available for the person experiencing mental health crisis regardless of age or location. NHS Clinical Commissioning Groups (CCGS) in England and local health boards in Wales must engage closely with partner agencies as they are responsible for ensuring that facilities and appropriate transport are available.

Does the present legislation provide a balance between flexibility and safeguards?

The evidence informing this review has suggested that some aspects of the primary legislation are sufficiently broad, while in other respects it lacks flexibility and there is some confusion about its application in practice.

The threshold to justify a S136 detention is '*if a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety*'. This provides the police with the flexibility to use individual judgement as to whether or not the person should be detained. A proportion of S136 detentions will be of people who, following removal from the situation and once assessed by a medical professional, are not deemed to require detention in a mental health hospital under the Mental Health Act. This review considers whether further or strengthened safeguards would improve outcomes for people detained under S136.

The restriction that S136 applies only in 'places to which the public have access' was reported to create considerable confusion in practice over whether the power can or cannot be used in a particular situation. From the survey, it was apparent that some people believe there are places which may not, in effect, be adequately covered either by S135 or S136 at present[8]. For example, there is confusion about most workplaces (which often have fob or swipe-card access), private car parks, and railway lines (because the railway network is privately owned and the line is not accessible to the public). While S135 covers any private premises, some have questioned whether a magistrate would consider granting a warrant to remove a person from a workplace, car park or railway line given that S135 requires there to be '*reasonable cause to suspect that a person believed to be suffering from mental disorder has been or is being ill-treated, neglected or kept otherwise than under proper control in any place within the jurisdiction of the justice, or being unable to care for himself is living alone in any such place*'[9]. Furthermore, in some cases there may not be proper processes in place to ensure a warrant can be obtained in a timely manner.

The review uncovered a number of issues in the operation of S135 and S136 which can cause delays. For example, in the practitioner workshops, some people noted that a paramedic does not have powers to detain a person under the Mental Health Act 1983 and would, in cases where removal and detention is required and the person refuses to consent, need to call the police and wait for them to arrive. Others felt that the procedure involved in

[6] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

[7] Online at: https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

[8] See Summary of Evidence, p.38

[9] *ibid*

obtaining a S135 warrant in order to enter a person's home and take them to a place of safety can also cause considerable delay.

Should police stations be used as places of safety?

The government's concerns over the use of police cells for people detained under S136 are shared by a number of service users, police, and health professionals. However, many practitioners believe that in exceptional circumstances where the person is too violent to be safely managed in a hospital, a police cell may sometimes be the most appropriate place.

Although most service users who were detained in police cells found the experience 'criminalising', distressing, and often de-humanising, a few felt that this was preferable provided that the cell door was open and that the police officer talked to them and was sympathetic, compared to being in a health-based place of safety where they felt 'observed' at a distance[10].

There was strong support for police cells never to be used as a place of safety for people aged under 18.

Is the maximum length of detention of 72 hours appropriate?

Once detained under S136, the detention is for the purpose of enabling a mental health assessment to be carried out and, if needed, any further arrangements made for the person's care. The Act currently sets a maximum length of detention of 72 hours for both S135 and S136. This is rarely reached in practice[11] and good practice dictates that assessment should take place within three hours where clinically appropriate[12].

72 hours is longer than most other European countries permit under equivalent emergency mental health legislation[13] given that the person is initially detained without being assessed by a medical professional. Many practitioners and service users who responded to the review supported a reduction in the maximum length of detention (currently 72 hours) in police custody to 24 hours, with some drawing a parallel with the fact that, for people arrested for criminal offences, the police may only detain them for 24 hours in the first instance with extension on application to a magistrate.

Views on the maximum length of detention in *any* place of safety (i.e. health-based places of safety) were more mixed. Some responses noted that a period of time was useful to allow the person to settle down or, if necessary, recover from the effects of drugs and alcohol, and for the mental health assessment to take place without being rushed. However, there was overall support for a reduction in the maximum period of detention in any place of safety.

Does the legislation support a person receiving help as quickly as possible if they are experiencing a mental health emergency in their own home?

S136 does not apply in private homes. So when a person in their own home experiences a mental health crisis, the police do not have the power to remove them to a place of safety until an AMHP obtains a S135 warrant for entry and removal which can in practice take hours to arrange. Moreover, if the person or their family permit entry, some people said that the magistrate might refuse to grant the warrant leaving the police officer and AMHP with no power then to remove the person to a place of safety and detain them for the purposes of a mental health assessment.

The review heard from several police officers that this situation can lead to them working around the limitations out of a desire to help the person. For example the police may encourage the person to move outside into a public area so they can be detained under the provision.

There is considerable support among many practitioners and the families and carers of service users for legislative change to address this situation, so that a person can be helped wherever they are at the time provided that there are safeguards in place to prevent abuse of this power. However, many service users and health professionals were concerned about the suggestion that police (or other professionals) could remove a person from their home without a warrant if such a change were

[10] Centre for Mental Health report, p.17
[11] See literature review, p.39 – 40, Centre for Mental Health report, p.7, and Summary of Evidence, p.30
[12] Royal College of Psychiatrists guidance, online at: http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf
[13] See literature review, p.52

introduced because of the potential for such a power to be over-used or applied inappropriately.

Would there be any benefit in extending the powers to others as well as police?

Views on this were mixed but many people felt there could be benefits in the powers being extended, in particular to paramedics, if there was appropriate training.

Aims

The overarching aim of this review was to improve access to mental health services for people detained under S135 or S136 and decrease the stigmatising association with criminality. The focus was to review the operation of S135 and S136 and make recommendations for any changes to primary legislation which could improve the outcomes for people in mental health crisis detained under these provisions.

Based on the evidence presented to the review, a number of recommendations are set out below which seek to:

- **significantly reduce the use of police custody as a place of safety;**
- **encourage and enable innovation in using alternative places of safety;**
- **remove barriers preventing a person in mental health crisis from accessing help wherever they are while protecting human rights and civil liberties;**
- **encourage more rapid assessment and to ensure a person is not detained for longer than the minimum time necessary;**
- **reduce inappropriate use of S136;**
- **improve the operation of S135; and**
- **ensure that police, paramedics, AMHPs and health professionals have appropriate powers.**

Legislative Recommendations

Subject to affordability considerations and consultation prior to the full parliamentary process the review recommends:

1. Amending legislation so that **children and young people aged under 18 are never taken to police cells** if detained under S135 or S136;

2. Ensuring that **police cells can only be used as a place of safety for adults if the person's behaviour is so extreme they cannot otherwise be safely managed**;

3. Amending the list of possible places of safety in S135(6) so that **anywhere which is considered suitable and safe can be a place of safety** – this will remove barriers to using community-run places of safety or other alternatives which could not be said to have a single 'occupier'. This could help to enable innovative practice in terms of identifying places of safety;

4. Amending **S136 to apply anywhere <u>except</u> a private home** but including railway lines, private vehicles, hospital wards, rooftops of buildings, and hotel rooms. This would ensure that the provision could apply in workplaces, for example, where neither S136 nor S135 currently apply;

5. **Reducing the maximum length of detention under S135 and S136 to 24 hours** from 72 hours, in any place of safety. This would be subject to the possibility of an extension (length to be determined through further consultation) to be authorised in unavoidable cases where an assessment could not be carried out in the timeframe;

6. Requiring the police to **consult a suitable health professional prior to detaining a person under S136** provided it is feasible and possible to do so (for example if neither the police officer nor the person is put at risk by waiting for a clinical opinion). This means that local areas would need to have arrangements in place to ensure there would always be somebody available. This could, for example, include having street triage arrangements, calling the mental health nurse or on-duty doctor in the custody suite, or having arrangements in place to call the crisis service;

7. Setting out clearly in legislation that when a S135 warrant is carried out, **assessments can take place in the home** as part of the warrant process if it is considered appropriate and safe to do so, and that **police, paramedics, and AMHPs can remain present** while this is carried out. This ratifies existing practice in many areas

(where a person consents) and reduces pressure on health-based places of safety;

8. Potentially creating a new limited power for **paramedics to convey a person to a health-based place of safety from anywhere other than a private home.** The feasibility of extending this or any other powers to suitable health professionals should be explored fully in consultation with the relevant stakeholders.

The proposals for legislative changes will be subject to further scrutiny and consideration, including considering the financial implications. In order for any amendments or revisions to the Mental Health Act 1983 to also apply in Wales, changes in relation to all health related matters would need to be agreed by the National Assembly for Wales.

Non-legislative Recommendations

During the review a number of issues were raised about the operation of S135 and S136 which would not require amendments to primary legislation and which should be addressed through improved practice and understanding between different partner agencies. Many of these issues have been fed into the parallel review of the Code of Practice for the Mental Health Act 1983 in England. Many are already reflected in the action plan of the mental health Crisis Care Concordat for England published in February 2014[14]. The Mental Health Act Code of Practice for Wales is currently being revised and will take into account the findings of this review. Specific guidance regarding S135 and S136 in Wales was issued in April 2012[15].

The review concurs with the recommendations of the recent Care Quality Commission's (CQC) report '*A safer place to be: Findings from the Care Quality Commission's survey of NHS mental health trusts to examine the availability, accessibility and operation of health-based places of safety for people detained under section 136 of the Mental Health Act*'[16] that:

9. **Health-based places of safety and CCGs in England (local health boards in Wales) should understand the demand and provide adequate levels of service, which may include increasing the capacity and staffing in health-based places of safety.** Health-based places of safety should agree plans to improve any areas of shortfall in discussion with partners. They should review and amend their exclusion criteria in relation to people who are under the influence of drink or drugs, whose behaviour is disturbed or who have a previous history of offending or violence. This may mean that there needs to be greater flexibility in which places are designated a place of safety, or having a greater range of places that can be used when needed. Health-based places of safety should ensure that a minimum of two healthcare staff are allocated to receive an individual brought to the place of safety by the police, and that training for staff who work in the place of safety should be reviewed. Plans should then be developed to address any shortfalls. This should include training for security staff that may be required to intervene physically with an individual brought to the place of safety.

10. **CCGs and their equivalents in Wales should review the availability and use of health-based places of safety to identify whether provision meets local needs.** This includes reviewing when people are unable to access the local place(s) of safety and the reasons for this. CCGs will need to ensure that there are sufficient and appropriate places of safety for children and young people. They will also need to put in place commissioning specifications, including appropriate and timely arrangements for transporting people subject to S136 to hospital. This may require a needs assessment for specialist ambulance provision for people in mental health crisis. The Association of Ambulance Chief Executives' national protocol as part of the Crisis Care Concordat in England sets out that response times should be within 30

[14] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

[15] Online at: http://wales.gov.uk/topics/health/publications/health/guidance/section/;jsessionid=0CswQf3fqCPmGQpS4ZW9TjppsgQyFvyjkv3rrSVfVxhWv8BNnB9!-1988510053?lang=en

[16] Online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

minutes or an immediate priority response for people who are being actively restrained or if their condition is life-threatening.

Consideration will need to be given to how these recommendations will be implemented. In addition to these recommendations made by the CQC, the review also recommends that:

11. **CCGs in England (and their equivalent in Wales) should review their commissioning processes for places of safety** to ensure they are commissioning to CQC standards. CCGs or their equivalent should ensure that sufficient spaces are available for children and young people, and that no child or young person is being turned away from a health-based place of safety because of their age. CCGs or their equivalent should specifically consider the transportation of people detained under S136 when commissioning ambulance services.

12. **CCGs in England, and their equivalent in Wales, and partner agencies should explore alternative places of safety**, such as designated care homes, or modifying the environment and facilities in police stations so that a space other than a normal cell could be used for S136 detentions. Key considerations include ensuring the alternative facility is legally permissible under S135(6), can keep the person safely and securely, has appropriate clinical staff if necessary over and above that of day to day staffing levels, and is part of existing health services processes for assessment and admission. They should have access to health staff and to medical records and be able to take responsibility for the person so the police officer can leave. They should be capable of managing complex cases such as people who may also be drunk or misusing drugs.

13. **Speed up S135 warrants and streamline processes:**

    a. Local Authorities should sign up to the new Fee Account system to ensure payment for the warrant does not become a delaying factor[17];

    b. Courts should prioritise S135 warrants where the AMHP explains that it is very urgent, and magistrates should understand that without the S135 warrant, the person cannot be removed to or detained in a place of safety. Magistrates should understand the differences between S135(1) and S135(2) warrants, and that it is not necessary for permission to enter to have been refused to grant a S135(1) warrant. Additional guidance will be provided on this;

    c. There are proposals for digital warrants to be introduced which would reduce the time spent travelling to and from courts. This is to be encouraged; and

    d. In some areas, close working arrangements between out-of-hours magistrates and AMHPs have helped to ensure that obtaining a warrant does not introduce unnecessary delays. This should be adopted as best practice.

14. **The Code of Practice should, where possible, provide guidance and clarification on issues where custom and practice has developed that is not compliant with the current legislation.** Recommendations have been fed into the parallel review of the Code in England.

15. **The Disclosure and Barring Service (DBS) and police service should issue additional guidance to police on DBS disclosures relating to detention under the Mental Health Act.** This will help ensure that chief officers of police responsible for disclosures are fully aware of the factors which should be taken into account and, in particular, whether the circumstances of any detention indicate a risk to the public. The Home Office should explore whether the statutory guidance and quality assurance framework should be amended.

[17] More information can be found at: http://www.justice.gov.uk/courts/fees/payment-by-account

16. **The police and health services should work towards improved data capture, monitoring and review.** The police should record every use of S136 carefully including ethnicity and length of detention, and record S135 involvement, so that any issues can be properly reviewed and lessons learnt. A new data toolkit was trialled by three police forces in England in autumn 2014, with the potential for national roll-out from April 2015. The toolkit involved the collation of more in-depth and consistent data about police interactions with people with mental ill-health. Also, the Home Office will also be working with the police to explore whether data on S135 and S136 can be made part of the police's Annual Data Requirement (ADR).

17. **Multi-agency groups should meet regularly to review data and discuss issues.** In some areas multi-agency groups regularly review S136 detentions, identifying repeat detentions, and using this information to drive improvements. This should be considered best practice everywhere. It may be helpful for people repeatedly detained under S136 to have multi-agency care plans put in place to ensure they receive a consistent response across different agencies and that they are 'flagged' on different IT systems. In Wales a shared data collection method has recently been developed. Such collaboration between health providers and the police forces should be encouraged.

18. **Training on mental health needs to be improved for all agencies.** All agencies involved in mental health processes need to work together to develop a multi-agency framework of training that delivers better understanding of the legislation and the roles and responsibilities of the other partner agencies involved to ensure the individual in crisis is dealt with dignity and within the legislative framework. The College of Policing are already undertaking a review of mental health training for police and partners.

19. **Health services and police should work together to explore the potential for new technologies to improve police and health responses to mental health crises.** Investment by the police and health agencies in video messaging, texting, or instant messaging technology could help the person in crisis and the police to access emergency health advice lines and speak to a health professional immediately to determine how to support the person in crisis.

These non-legislative options may also have financial implications which will need to be considered. In Wales, changes in relation to all health related matters would need to be agreed by the National Assembly for Wales.

Conclusion and Next Steps

This review has shown that in a number of areas there is a case for legislative change and that there is strong support for change from practitioners and from service users. In particular, there is a need to reduce the use of police cells as places of safety for people detained under S136 to those circumstances where such use is unavoidable and to end their use for children or young people. There is also a continuing need to ensure that people can get the help they need as soon as possible wherever they are at the time.

The Home Office and Department of Health in England will work together to explore the impact of any legislative and non-legislative changes including further detailed consultation with health and police stakeholders and those affected by any such changes. This work will include diversity and equality considerations. The government's commitment to the principles of the mental health Crisis Care Concordat will continue.

About the review

This is a government review of those parts of the Mental Health Act 1983 which deal with police powers to act when a person is appears to be experiencing a mental health crisis, and to be in immediate need of care. This section sets out the background to the review and explains the legislation. It also describes how the review has gathered evidence from a wide range of people.

The subsequent section discusses the main findings. The evidence base is set out in more detail in the accompanying reports: the Summary of Evidence, the report from the Centre for Mental Health, and a literature review.

The report makes a number of recommendations both for legislative and non-legislative changes. These will depend upon funding considerations, which can be explored in the Spending Review 2015, and the full parliamentary process as part of the next legislative session.

Finally, the review then sets out the conclusions and next steps.

What are Sections 135 and 136 of the Mental Health Act 1983?

Section 135(1) (S135) and section 136 (S136) of the Mental Health Act 1983[18] set out how and when a person considered to have a 'mental disorder' can be removed to a place of safety and detained there without their consent if specific requirements are met. Under both S135 and S136, a person may be detained for a maximum of 72 hours. This review focuses specifically on S135(1), S135(3)[19], S135(6)[20], and S136.

S136 provides emergency powers for the police to deprive a person of their liberty temporarily, if the person is in a place to which the public have access and certain conditions are met. The police may remove the person if it appears to the police officer that they are suffering from a mental disorder and are in immediate need of care or control, and it is necessary to remove that person to a place of safety in their own interests or for the protection of others. The person is not removed because they are suspected of committing any criminal offence. In the case of S136, the person must be removed to a place of safety for the purposes of enabling them to be examined by a registered medical practitioner[21], and to be interviewed by an approved mental health professional (AMHP)[22] and for any necessary arrangements to be made for their care or treatment.

S135 only applies when a person is in private premises, such as their own home. It requires an AMHP to apply to a magistrate for a warrant in order for the police to enter the premises and remove the person. The warrant allows the police officer to enter, using force if necessary, search for and remove the person, in circumstances as set out above, to a place of safety. The AMHP may make a further application in respect of the patient under the Act, or make other arrangements for their treatment or care.

[18] S135(2) permits a warrant to be granted to the police which provides police officers with a power of entry to private premises for the purposes of removing a patient who is liable to be taken or returned to hospital or any other place or into custody under the Act.
[19] S135(3) sets out that 72 hours is the maximum length of detention under this part of the Act.
[20] S135(6) provides a list of places of safety.

[21] It is preferable that this should be a Section 12 approved doctor.
[22] 'Approved mental health professionals' (AMHP) exercise functions under the Mental Health Act 1983 relating to decisions made about individuals with mental disorders, including whether to apply for compulsory admission to hospital. Social workers, mental health and learning disabilities nurses, occupational therapists and practitioner psychologists, registered with their respective regulator, may train to become AMHPs. Successful completion of an approved programme is required to be approved to act as an AMHP. Only those who have completed approved training and have been approved to act as an AMHP by a local authority in England may perform the functions of an AMHP. Online at: http://www.hcpc-uk.org/assets/documents/1000414DApprovalcriteriaforapprovedmentalhealthprofessional(AMHP)programmes.pdf

A place of safety is defined as being:

- residential accommodation provided by a local social services authority;
- a hospital;
- an independent hospital or care home for mentally disordered persons;
- a police station; or
- any other suitable place where the occupier is willing to temporarily receive the patient[23].

The Mental Health Act 1983 applies in both England and Wales, although they have separate Codes of Practice[24] and guidance[25].

Why is the Government reviewing these sections?

The government reviewed the operation of sections 135 and 136 of the Mental Health Act 1983 in England and Wales to make sure that the legislative framework facilitates getting the right support for people at the right time[26].

The review focused on the operation of the powers and the use of places of safety. A place of safety in the majority of cases is a hospital. There have been concerns raised over the use of police stations as places of safety[27]. Police stations are often not the most appropriate place to detain a person suffering a mental health crisis[28]. There have been particular concerns over police cells being used to hold children and young people detained under S136[29], and about the maximum length of detention under S135 and S136 (currently 72 hours)[30].

The review aimed to examine the evidence and determine whether or not changes to the primary legislation would improve outcomes for people experiencing a mental health crisis. Any proposed changes would be subject to full parliamentary processes and timetables.

Our approach

The review was conducted jointly by the Home Office and Department of Health between February 2014 and November 2014. It was initiated in a speech made by the Home Secretary in May 2013[31], and formally announced to Parliament in a written

[23] S135(6), online at: http://www.legislation.gov.uk/ukpga/1983/20/section/135

[24] The Code of Practice for the Mental Health Act 1983 in England is online at: http://www.lbhf.gov.uk/Images/Code of practice 1983 rev 2008 dh_087073%5b1%5d_tcm21-145032.pdf http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_4132161 and the Code of Practice for Wales is online at: http://www.wales.nhs.uk/sites3/Documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf

[25] Association of Chief Police Officer's guidance is online at: http://www.acpo.police.uk/documents/edhr/2010/201004EDHRMIH01.pdf
Welsh Government guidance on sections 135 and 136 is online at: http://wales.gov.uk/topics/health/publications/health/guidance/section/;jsessionid=0CswQf3fqCPmGQpS4ZW9TjppsgQyFvyjkv3rrSVfVxhWv8BNnB9!-1988510053?lang=en

[26] Online at: https://www.gov.uk/government/consultations/review-of-the-operation-of-sections-135-and-136-of-the-mental-health-act

[27] Her Majesty's Inspectorate of Constabulary (HMIC) (2013) *A Criminal Use of Police Cells*, online at: http://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf
and Independent Police Complaints Commission (IPCC) (2008) *Police Custody as a 'Place of Safety'*, online at: http://www.ipcc.gov.uk/sites/default/files/Documents/guidelines_reports/section_136.pdf

[28] Home Office Circular 66/90 (1990), online at: http://www.cps.gov.uk/CC882EC6-56EF-426A-AF1D-5ACED6E881B6/FinalDownload/DownloadId-E5F03B6A4EEAEB12BEBB08FB0F6AF02C/CC882EC6-56EF-426A-AF1D-5ACED6E881B6/legal/assets/uploads/files/Home%20Office%20Circular%2066%2090.pdf, and the Reed Report (1992), *Review of health and social services for mentally-disordered offenders* (Final Summary Report, Cm 2088, Home Office and Department of Health).

[29] For example, http://www.theguardian.com/society/2014/aug/17/mentally-ill-children-police-cells

[30] Mental Health Alliance (2007), online at: http://www.mentalhealthalliance.org.uk/pre2007/documents/LordsCtteeStage_136_Briefing.pdf

[31] Online at: https://www.gov.uk/government/speeches/home-secretary-speech-to-police-federation-annual-conference-2013

ministerial statement made by the Secretary of State for Health on 26 March 2014[32].

The approach taken was to gather and analyse the available relevant evidence and to make recommendations for any proposed changes to legislation or other guidance or programmes of work.

At every stage the review has engaged external stakeholders including academic experts, professionals in health, ambulance services and policing, people who have experienced being detained under these parts of the legislation, and their families and carers.

Separate reports published alongside this main report set out the evidence base gathered in the course of the review. These are:

- a Summary of Evidence report setting out the findings, in particular of the online survey: this was quality-assured by several external expert advisers[33];
- a report from the Centre for Mental Health summarising their findings from the events they were commissioned to hold in support of this review; and
- a literature review of the existing research into S135 and S136.

The project team conducted field work, nationally and regionally, during the course of the review to elicit as wide a range of views as possible.

The review consisted of:

1. An eight-week online survey on www.gov.uk to invite views from a wide range of stakeholders	See Summary of Evidence
2. Work by the Centre for Mental Health to hold 27 practitioner workshops and focus groups with 'service users' and families and carers, around England and Wales	See Centre for Mental Health's report
3. Two seminars held by Black Mental Health UK	See Summary of Evidence
4. Visits carried out by the project team to areas with very high and very low numbers of S136 detentions	See Summary of Evidence
5. A full academic literature review which underwent double-blind academic peer-review and was also provided to all those who attended the academic roundtable event	See literature review
6. An academic roundtable event to explore the published evidence base	See Summary of Evidence

Representation from 'mental health service users'

The review recognised the importance of seeking views from people who had experienced being detained under these powers, their families and carers, to better understand their views.

The Centre for Mental Health was commissioned to support the review. They held workshops across England and Wales, attended by about 70 service users and carers. A small number of people also had one-to-one interviews, and others provided written evidence.

Around 35 people attended two workshops held by Black Mental Health UK in order to provide views from the Black African-Caribbean communities in Luton and London.

53 respondents to the online survey said that they were a 'person who has been detained under either S135 or S136' and another 78 identified themselves as a 'person with experience of mental health issues generally'. Together, these made up 11.9% of the total sample of respondents (131 respondents out of 1104 responses). Another 27 respondents identified themselves as members of the general public.

The National Survivor and User Network and the Royal College of Psychiatrists' service users' forum were invited to review and comment upon the Summary of Evidence.

[32] Online at: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm140327/wmstext/140327m0001.htm#14032769000007

[33] With thanks to all the expert advisers who contributed.

Practitioner representation

Other key stakeholders for the review included health practitioners such as psychiatrists, hospital doctors, GPs, mental health nurses, and their professional organisations (NHS England, Public Health England, the Royal College of Psychiatrists, the Royal College of Emergency Medicine, and the Royal College of Nursing), AMHPs and their professional organisations (the College of Social Work and the British Association of Social Workers), police officers including the National Policing Leads on mental health and learning disability, Police and Crime Commissioners, and the Association of Police and Crime Commissioners, paramedics and ambulance workers including the Association of Ambulance Chief Executives, CCGs and Mental Health Commissioners, magistrates, and local authorities, as well as voluntary sector organisations and charities, and inspectorates such as Her Majesty's Inspectorate of Constabulary (HMIC), and the Care Quality Commission (CQC).

The Centre for Mental Health held workshops with a range of practitioners across England and Wales. About 140 practitioners attended.

A range of practitioners completed the online survey with 1,104 responses received overall. The police made up 40% of responses (443 respondents including police staff) as well as 90 responses from doctors (8.2%) and 59 mental health nurses (5.3%), 117 responses from approved mental health professionals (10.6%), and 90 from paramedics and ambulance staff (8.2%).

Responses to the online survey were also received from 73 national and local organisations[34]. Others provided separate responses which are included in the Summary of Evidence. In addition, 29 responses were received from Local Authority staff (2.6%), and another 29 from Voluntary Sector organisations or staff (2.6%).

Responses were also received from seven NHS Commissioners, five Police and Crime Commissioners, and one magistrate.

[34] Views from national organisations are set out in the Summary of Evidence, p.72 – 109

Other programmes of work

The Department of Health was already in the process of conducting a review of the Code of Practice for the Mental Health Act 1983 in England[35] at the time of this review. The initial findings of this review will feed into the relevant chapters of this review of the Code of Practice where clarification of the existing legislation or practices was required.

Alongside this review, the Home Affairs Select Committee held an Inquiry into Policing and Mental Health[36]. We have drawn on both the written and oral evidence provided to that inquiry to inform our findings.

[35] Online at: https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

[36] Online at: http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/inquiries/parliament-2010/policing-and-mental-health/

Discussion of the evidence base

The evidence gathered during the review of the operation of S135 and S136 of the Mental Health Act 1983 is discussed in this section. More detail is in the Summary of Evidence report, the report from the Centre for Mental Health, and the literature review, published separately.

The evidence suggests that there are a number of areas where changes could be made to improve the experiences and outcomes for people detained under S135 or S136. Throughout the review, people felt there was more that could be done to:

- **significantly reduce the use of police custody as a place of safety;**
- **encourage and enable innovation in using alternative places of safety;**
- **remove barriers preventing a person in mental health crisis from accessing help wherever they are while protecting human rights and civil liberties;**
- **to encourage more rapid assessment and to ensure a person is not detained for longer than the minimum time necessary;**
- **reduce inappropriate use of S136;**
- **improve the operation of S135; and**
- **ensure that police, paramedics, AMHPs and health professionals have appropriate powers**

Other issues raised included clarifying roles and responsibilities for transporting the person, improving the quality of data so there is a better understanding of how S135 and S136 are used, and addressing diversity and equality issues in the operation of both provisions, especially S136.

The main findings were:

The use of police cells as a place of safety

The Code of Practice for the Mental Health Act sets out that the use of police cells as places of safety should be 'exceptional'. Despite this, police cells have continued to be used in approximately one quarter of cases (based on 2013/14 figures).

In Scotland, a place of safety 'shall not include a police station unless by reason of emergency there is no place as aforesaid available for receiving the patient' (i.e. when a place of safety is not immediately available)[37]. Northern Ireland also permits the use of police stations as place of safety[38].

The use of police cells is perceived by many service users as criminalising. Being taken to police cells by police officers can add to the distress of the individual, including feeling embarrassed or stigmatised. People booked into the custody suite may be searched, have possessions removed, have their fingerprints taken and, if thought to be at risk of attempting self-harm, may have their clothing changed to special anti-harm clothes.

> *This is where I think custody is not really the place for people under 136. We will go through their rights and we offer them a solicitor for one thing. That automatically sets them thinking, "What have I done wrong criminally?" when we are there trying to help them...If they have tried to harm with a knife or they have a blade concealed or something, we may well have to strip search them just to make sure they do not have anything concealed in an orifice. That, while degrading, needs to be done and it is not the ideal place in custody. They may have to be placed in anti-harm clothing, which again is another factor to cause them stress... Vulnerable people or with mental illness do not like bright lights or shouting, and yet we are putting them in a police cell where we have to put a bright light on them so we can see them. Potentially, the person next door could be banging and shouting and it is completely the wrong environment.'* (Oral evidence to the Home Affairs Select Committee, by Sergeant Kressinger, Devon and Cornwall Police, 28 October 2014[39])

Police cells were also felt to be a very poor environment for people experiencing a mental

[37] Online at: http://www.legislation.gov.uk/ukpga/1984/36/section/117

[38] Online at: http://www.legislation.gov.uk/nisi/1986/595

[39] Online at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/oral/15016.html

health crisis: some said that they were not a 'place of safety' because the person did not feel 'safe'.

Several people in the open text responses to the survey, in workshops, and focus groups with services users said that having police officers involved can sometimes escalate a situation because their uniform and authority can cause the person to become more agitated.

49.7% of people who responded to the survey said that police cells should never be used as a place of safety. 73% thought that police cells should be used only in exceptional situations if the person was very violent[40]. Many health professionals and police in the workshops and the open text box responses thought that the use of police cells was sometimes necessary because a person could pose too much of a risk in a health-based place of safety.

67% of survey respondents thought that police cells were often used because of a lack of health-based places of safety, rather than because of the risks posed. Some police officers felt that the patients detained in police custody had longer periods of detention because the AMHP thought they were being safely managed so other cases could be prioritised.

Two respondents to the survey, as well as several service users in focus groups, raised concerns that detention in police custody may – unlike detention in a health-based place of safety – result in a custody record and potential disclosure of information in future DBS[41] checks.

Both the Centre for Mental Health and the review project team visits found that the use of police cells as a place of safety is decreasing in many areas, in line with the mental health Crisis Care Concordat's commitment[42]. The number of S136 detentions in police custody in 2013/14 in England was 6,028, a reduction of 24% from the previous year[43]. The use of police stations also reduced as a proportion of all S136 detentions, from 36% in 2012/13 to 26% in 2013/14. There was a corresponding increase in the use of health-based places of safety, up from 14,053 in 2012/13 (64% of S136 detentions) to 17,008 in 2013/14 (74% of S136 detentions). Several police forces felt their use of police cells was becoming more appropriate (such as for people who posed a high risk especially to others), while others have substantially reduced their use of police cells. Some police forces choose to provide officers to support mental health staff in the place where such persons can be accommodated (the S136 suite) to provide security, rather than taking the person to a police station.

The Crisis Care Concordat sets out a commitment to reduce the use of police stations as places of safety, by setting an ambition for a fast-track assessment process for individuals whenever a police cell is used. However several police forces continue to have a very high use of police cells, including for people who could have been safely managed in health-based places of safety. In some areas, police custody was the 'default' for under 18 year olds because the local health-based place of safety would not accept them.

This review has found no evidence of places other than a health-based place of safety (a S136 suite, or emergency department[44]) or a police station being used[45]. This supports the findings of other published research[46]. On some occasions police officers have tried to use other places, such as doctors' surgeries, but have been refused as these are not designated places of safety. Sometimes the police have made use of the person's home address as the place of safety, or the home of another family member, but for some this resulted in lengthy waits for the health

[40] People were asked to agree/disagree with each statement separately, and a number of respondents agreed with both statements.
[41] Disclosure and Barring Service checks, required for certain jobs or voluntary work, such as working with children or in healthcare, or applying to foster or adopt a child. More information is available online at: https://www.gov.uk/disclosure-barring-service-check/overview
[42] The Crisis Care Concordat committed to a target to reduce the use of police cells by 50%.
[43] Health and Social Care Information Centre (HSCIC), online at: http://www.hscic.gov.uk/catalogue/PUB15812.
[44] The use of any other place is not recorded in the annual figures, which only gather data from police and health services.
[45] Devon and Cornwall Police mentioned they sometimes use the Salvation Army to provide a place for a person to stay overnight, though it was not clear that this was for people detained under s136.
[46] Apakama 2012

professionals to arrive[47]. Police officers are under pressure to respond to other emergency calls and this use of their time adversely impacts on their availability to address crime.

Health-based places of safety

Many people in the practitioner workshops and online survey said that a lack of available health-based places of safety was one of the main barriers to reducing the numbers of people who are held in police cells.

96% of respondents to the survey said that health-based places of safety should have 24-hour access and staff available: 92% said that there should always be an age-appropriate place of safety available for under 18s[48]. Availability is affected by capacity, staffing levels, and exclusion criteria such as not taking under 18s or intoxicated people. During the visits by the review's project team, several health-based places of safety stated that their local policies say they cannot accept children (as they are attached to adult psychiatric wards).

The CQC's 2014 survey of health-based places of safety in England (refreshed October 2014) found that the majority (102) of local authorities are served by only one health-based place of safety. 22 local authorities are served by two, 17 local authorities are served by three, 7 local authorities are served by four, Essex and Hampshire are served by six, and Lancashire is served by 12[49]. Many places therefore can only accommodate one person detained under S136 at a time. Therefore if the place of safety is already occupied, there is no further capacity to accept another person detained under S135 or S136 until it becomes free again. This was reported to the review as a main reason why people are turned away and detained in police cells instead.

The CQC found that '*where there is greater capacity in health-based places of safety, it is more likely that people will be taken there, rather than to police stations. Where local authorities are served by only one designated place of safety there is a lack of resilience for instances where multiple people are detained simultaneously. This is made worse in areas where the place of safety serves more than one local authority, and where it can only physically accommodate one person.*'

The CQC survey found considerable variation in the use of individual places of safety. Some were only used a few times a month, whereas others had their spaces used more than 30 times in the same period. In contrast in the case of S135 detentions, the AMHP must find a bed for the person prior to removing them from their home (in order to be able to sign off the paperwork) so these cases usually go to a health-based place of safety or directly onto a psychiatric ward.

The CQC has previously highlighted exclusions from health-based places of safety on the grounds of intoxication or violence:

> *'We hear that section 136 detainees have been turned away from hospital-based places of safety on the grounds of intoxication when this appears to be slight, or where the detainee merely smells of alcohol...Similarly, while we recognise that police cells may have to be used when a detainee is exhibiting extremely aggressive behaviour, some hospitals have refused to take detainees that probably should have been manageable within health services.'*[50]
>
> *'The exclusion of people who appear to be under the influence of drink or drugs from health-based places of safety has been a long-standing issue. Some mental health services justify this practice on the basis that no meaningful mental health assessment*

[47] Pers. comm. Frankie Westoby, National Mental Health Policing Portfolio Staff Officer to Commander Jones and MPS Central Mental Health Team.

[48] The CQC's map of health-based places of safety in early 2014 found that 28 (11%) of the 161 health-based places of safety do not accept 16 or 17 year olds and 56 (35%) do not accept young people under the age of 16: http://www.cqc.org.uk/media/new-map-health-based-places-safety-people-experiencing-mental-health-crisis-reveals-restrictio

[49] The location and coverage of the places of safety was published by CQC in an online map in April 2014, available from www.cqc.org.uk/hbposmap.

[50] CQC Monitoring the Mental Health Act 2009/10. Online at: http://www.cqc.org.uk/sites/default/files/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf

can be carried out on someone who is intoxicated…We have seen examples where hospitals have refused to admit detainees because they smell of alcohol… This leads to the use of police cells.'[51]

The CQC's 2014 survey of health-based places of safety found that '*Too many providers operate policies which exclude young people, people who are intoxicated, and people with disturbed behaviour from all of their local places of safety, which in many cases leaves the police with little choice but to take a vulnerable individual in their care to a police station'*.

Provider and/or inter-agency policy to exclude people who:	**% (number) of providers**
Are intoxicated	48% (28)
Have disturbed behaviour	36% (21)
Have committed a criminal offence	17% (10)
Have a history of violence	10% (6)
Are at risk of self-harming	3% (2)

Table 1: CQC's survey of health-based places of safety, 2014.

The CQC found that exclusions on the basis of intoxication, disturbed behaviour, a history of violence, or having committed a criminal offence are not uncommon. Two-thirds of health-based places of safety reported that their trust policy and/or inter-agency policy contained some or all of these exclusion criteria. The CQC found that some health-based places of safety exclude the person if they are considered too intoxicated for assessment. During the review, a number of concerns were raised by police and health partners about the use of S136 on people who are under the influence of drink or drugs[52], namely:

- sometimes the police use S136 inappropriately on people who are under the influence of drink or drugs but not necessarily suffering from a mental health problem, albeit it can be difficult for a police officer to distinguish reliably between the two at the point of detention. A person who is under the influence of drink or drugs may well appear to be 'to be suffering from mental disorder and to be in immediate need of care or control', thus in the view of the police officer, meeting the threshold for S136;

- it can be very difficult or impossible to carry out a mental health assessment on a person who is under the influence of drink or drugs, meaning that they must wait until the person has recovered from the effects of the substances at which point it may be that they no longer satisfy the criteria for detention. This means that people who are intoxicated and who appear to be suffering from a mental disorder can sometimes be detained under S136 and then released with no further action taken; and

- using health-based places of safety as a temporary respite for people to recover from the effects of drugs and alcohol, sometimes for many hours, can block their use for a person who is in more urgent need of a mental health assessment.

Some health professionals felt that the police were using S136 as an easy way to discharge their duty of care by removing the person to a place of safety (other than a police station) and handing them over to the care of health staff. During the review, some health professionals pointed out that S136 should not be used where a person is only under the influence of drink or drugs and there is no suspected mental health condition. Section 1(3) of the Mental Health Act 1983 explicitly states that dependence on alcohol is not considered to be a mental disorder or disability of the mind for the purposes of the Act, including S136. If the police believe the person has committed a criminal offence under Section 91 of the Criminal Justice Act 1967 by behaving in a disorderly manner while drunk in a public place, they could arrest them under S24 of PACE 1984 provided they felt the arrest was necessary for one of the stipulated reasons[53].

The Crisis Care Concordat and Code of Practice set out that, as some people with mental health problems use or are dependent on alcohol or drugs[54], intoxication should not disqualify a person

[51] CQC, *Monitoring the Mental Health Act 2012/13*. Online at: http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

[52] See Centre for Mental Health report, p.16, and the Summary of Evidence, p.21 – 23

[53] Set out in http://www.legislation.gov.uk/ukpga/1984/60/section/24

[54] For example, http://www.mentalhealth.org.uk/help-information/mental-health-a-z/A/alcohol/ and http://www.dualdiagnosis.org/mental-health-and-

from being detained under S136 or from being admitted to a health-based place of safety. Several practitioners in the workshops mentioned that health-based places of safety in a few areas routinely breath test people for alcohol use and refuse them access on that basis. The lawfulness of this practice was queried as the sole basis for the decision whether or not to admit the person, since it provides no information about intoxication other than whether the person is over the legal limit for driving. Several practitioners felt that it would seem more appropriate that the decision on admission and whether or not a person poses a risk is based upon their actual behaviour or presentation.

The Crisis Care Concordat in England sets out that irrespective of factors such as intoxication, a history of offending, or violence when a person is in crisis, they should expect to be supported in a health-based place of safety. People who are under the influence of drink or drugs should be managed in either the designated place of safety or, if there is a medical need, the emergency department. In the online survey, 69% of respondents said that health-based places of safety should accept intoxicated people who are experiencing mental health crises. However, several health professionals in the open text box responses said that these people cannot undergo a mental health assessment until recovered from the effects of drugs and alcohol.

The Royal College of Psychiatrists' guidance states that '*mental health service providers should clearly identify the preferred psychiatric place of safety, which should be appropriate, both in terms of the physical environment and staffing levels, for most assessments… It is…essential that the psychiatric facility is adequately staffed to allow for those who are significantly disturbed to be safely assessed there...The emergency department should only be used as the place of safety where there are concerns for someone's physical health. Service managers may agree that other parts of the hospital may be used in clearly identified circumstances as a place of safety. A specialist unit may best meet the needs of a young person or an elderly confused person. In the second case this could be a day hospital, but it could also include a day centre, by prior agreement'*. Criteria for a health-based place of safety are set out by the Royal College of Psychiatrists as being a locked facility in order to be able to safely care for those who are disturbed, a quiet area with discrete access avoiding public areas and having (appropriate) levels of staff available at short notice[55].

The Royal College of Psychiatrists recommends that the AMHP and the doctor[56] should attend within three hours of the person detained under S136 arriving at the place of safety unless there are good clinical grounds to delay assessment[57]. The CQC found that there were delays in assessments and that some patients had to wait up to 20.5 hours[58]. For those who arrived at the place of safety during daytime working hours, the assessment was completed more quickly. This is likely to be because out of hours resources often have to prioritise assessments: '*It is common that a S136 referral from the previous evening is handed over to day services the following morning*'[59].

Responses to the online survey and practitioner workshops undertaken for the review by the Centre for Mental Health cited staffing as a key issue for many health-based places of safety. Many such places of safety are attached to psychiatric wards, and staffing is drawn from the ward as and when needed. This arrangement has the advantage of flexibility, so when the S136 suite is not in use it is not staffed unnecessarily. However, the need to staff the S136 suite when in use is often not built into staffing levels more generally. Drawing staff from the ward can pose difficulties where this leaves the ward staff too stretched to manage, or when the ward is understaffed, and can mean that the S136 suite cannot be opened. This issue has been overcome in some areas, which have arrangements that ensure 24/7 staffing[60].

The Centre for Mental Health also found that staffing levels can mean that it is more likely that the police will have to remain with the person until they

addiction/the-connection/ and www.rethink.org/resources/d/drugs-

[55] http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf
[56] It is preferable that this should be a Section 12 approved doctor.
[57] Royal College of Psychiatrists, online at: http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr159.aspx
[58] CQC, *Monitoring the Mental Health Act 2012/13*.
[59] *ibid*
[60] Centre for Mental Health report, p15

can be assessed to ensure safety – a point that was reiterated by the police in the practitioner workshops. The Centre for Mental Health's report says that a minimum of two health staff members is recommended to ensure the person can be safely managed and that staff are not being put at personal risk. In the online survey, 72% of respondents agreed that 'the police have to wait a long time with patients' and in the open text boxes waiting times of seven hours or more were cited.

The CQC's 2014 survey of health-based places of safety found that '*Too many places of safety are turning people away or requiring people to wait for lengthy periods with the police because they are already full or because of staffing problems, which raises questions about provision and capacity*'.

The Centre for Mental Health found that *'staffing the S136 suites was a problem in many areas, as staffing was drawn from acute inpatient / PICU*[61] *staff...it was least problematic where two posts on the supplying inpatient wards were supernumerary or where there was a cluster of inpatient wards, and the burden of staffing was shared across more than one ward'*[62].

This finding echoes an earlier report by the CQC which found that '*The police reported that quite often the hospital places of safety are closed. Hospital staff also acknowledged that from time to time they have to close the places of safety, due to the shortage of staff. Most places of safety are staffed by nurses from the wards. As the wards are run with minimum numbers of staff, sometimes it is impossible to take staff off the ward. This is more of an issue during the night when staffing is less than during the day*'[63].

The availability of health-based places of safety for under 18s, and access to Children and Young People's Mental Health Services (CAMHS) was seen as a particular issue by those who contributed to this review. In 2013/14 753 children and young people aged under 18 were detained under S136. Of these, 236 under 18s were detained in police cells under S136 (31%). Many health-based places of safety do not accept people aged under 16, or under 18. There are only four places of safety in England specifically for young people – the St Aubyn Centre in Essex (for under 18s), the paediatric ward in St Mary's Hospital on the Isle of Wight (for under 18s), the emergency department in Alder Hey Children's Hospital (for under 16s), and the Parkview Clinic s136 suite in Birmingham Children's Hospital (for under 16s)[64].

The CQC survey and subsequent report found that '*Despite the comparatively small numbers of children and young people detained, statistical analysis of this data shows that adults were significantly less likely to be taken to a police station than people under the age of 18*'. They raised '*significant concerns about the restrictions in place preventing children and young people from accessing health-based places of safety*'[65].

The Centre for Mental Health found that

> *'In some areas the NHS Trust had a policy of not accepting under 18s in the section 136 suite but did not have an alternative. In a few areas, police custody was used, but it was clear that the forces we spoke to (and likewise Police and Crime Commissioners) deemed this unacceptable and would no longer countenance the use of custody except in the case of very violent young people. Some forces felt even in these circumstances the use of a cell was not acceptable and would rather supply sufficient officers to manage the risk presented in a section 136 suite...The experience reported at most of our events was of longer delays (than for adults) in finding a place of safety in the first instance, then further delays in finding a bed post-assessment, and assessments themselves were conducted by AMHPs and doctors with no or limited child and adolescent experience. The latter point was felt to be crucial as young people present poor mental health differently to adults and are harder to diagnose.'*[66]

Among the issues raised during the review was that sometimes the police take a person detained under

[61] Psychiatric Intensive Care Unit
[62] *ibid*
[63] CQC, *Monitoring the Mental Health Act 2012/13*
[64] CQC, pers. comm. December 2014.
[65] CQC 2014, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf
[66] Centre for Mental Health report, p.8

S136 to a hospital Emergency Department (A&E) only to be told that it is not a designated place of safety and the person cannot be accepted there. The evidence gathered in the online survey gave a number of perspectives about whether A&E should or should not be a place of safety. The Mental Health Act S135(6) list of 'places of safety' includes 'hospital'. This means that different areas in a hospital could potentially be a place of safety and CCGs could be more flexible about using a wider range of alternatives. A number of people in the workshops, especially the workshops held with Black Mental Health UK (BMHUK), expressed a desire for more innovation in places of safety so that it is not always a choice between a health-based place of safety or a police cell. It was felt that there could be potential for community-led places of safety, or for third sector provision.

Powers for police to respond in an emergency in people's homes

Sometimes the police find a person experiencing a mental health crisis when they respond to an emergency call to attend a person's home. The police may if necessary enter using the Police and Criminal Evidence Act 1984 (PACE) Section 17 to 'save life and limb', or they may be admitted either by family members or the person themselves. However, unless the police officer has been granted a S135 warrant, which gives them a power both to enter a property and to remove the person to a place of safety, they do not have the power to remain or remove the person to a hospital or place of safety under S136. S136 applies only in 'places to which the public have access' and it cannot be relied upon in private homes.

> *'More often than not mental health patients who need immediate care are in their own homes. Entry is usually permitted by the patient, but then the police have no power to remove the patient to a place of safety. The subsequent removal of the patient can take hours using up both valuable time for the ambulance services as well as the police. This process also has a detrimental effect on patient outcome, as they cannot be left [alone]... and the process becomes very drawn out.'* (Paramedic, in response to the survey)
>
> *'I could give dozens of examples in my own career where health service professionals, be it in mental health or be it from accident and emergency, have asked police officers to go to a private house to do a "safe and well check", as it is called, on somebody who may be at risk with a view to detaining them under the Mental Health Act. Of course, the police service do not have the power on a private premises to detain anybody under the Mental Health Act, so asking the police to go and do that puts the officer in a position where they are present at a private address where somebody may not be necessarily well. There may be an immediate need to do something in terms of safeguarding them, but the police service do not have a power to do that under the Mental Health Act...There was a stated case in 2010, the case of Sessay, where...the judge in that case ruled that what should have happened is that an AMHP and a doctor should have attended the premises at police request in order to consider an assessment. That is a very difficult thing to achieve in practice—to ring up crisis team services, for example, and ask them to attend an address at no notice in order to conduct an emergency mental health assessment.' (*Oral evidence given to the Home Affairs Select Committee, by Inspector Michael Brown[67], 2 September 2014[68])

Some people noted that this situation can result in frustration for the family members, who may have called the police, and cause delays which lead to a poorer outcome for the person. The police made the point that they may find they are in a position of sole responsibility for a person who may be in a highly disturbed or distressed state, possibly suicidal or threatening suicide, and unable to assist them to access the medical help they need. A few people said that when a person is at risk, it should not matter where they are.

> *' I personally feel that if an officer genuinely believes the person to be at risk then acting in their best interests regardless of location*

[67] Insp. Michael Brown blogs at http://mentalhealthcop.wordpress.com/

[68] Online at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/oral/12272.html

should be the primary concern - the first sworn duty of a police officer is to save life' (Police sergeant, in response to the survey)

An AMHP may apply for a S135 warrant to enter and remove the person to a place of safety. Many people during the review said that this can take several hours to arrange – usually more than four hours and, in some cases cited to the review, days. The process, including paying for the warrant, can be lengthy, although there is considerable local variation in how quickly it can be completed. Some of the responses to the survey from AMHPs said that S135 warrants can sometimes rely on outdated or inaccurate information and that magistrates sometimes refuse to issue a S135 warrant unless access to the premises has already been refused. This leaves the police and AMHPs with no power to remove the person to a place of safety if the patient has let them in voluntarily.

67% of respondents in the survey agreed that the police do not have the right powers to act in an emergency in people's homes.

Evidence submitted to the review showed that sometimes the police, when trying to do what they believe is best for the person, can sometimes go beyond the powers permitted to them under S136. Examples provided by respondents to the survey included S136 being used in people's homes despite not being a place 'to which the public have access', or the police encouraging a person to step outside so that they could be detained under the power. The police emphasised that they are trying to help the person and may be acting after several hours of trying to safely manage the person in their home. 102 people in the open text box for this section said that S136 can be misused by police in or outside a person's own home. This was echoed by both police and AMHPs in the practitioner workshops. Some police officers said they had been advised to use S136 in homes by AMHPs or health professionals who did not understand that police do not have this power.

'I have seen on numerous occasions the police using the S136 powers inside peoples' homes' (Member of the public, in response to the online survey)

'Section 136 is often used inappropriately as a person is often persuaded to leave a private property - in my experience a person is often invited outside to have a cigarette or similar and at this point [detained under] a Section 136' (paramedic, in response to the online survey)

'Officers are bending the rules to get people out of their homes to utilise S136. S136 needs to be amended to include homes or a separate section created to utilise that power within a home.' (Police inspector, in response to the survey)

It is clear that the police are sometimes placed in a very difficult position and may feel that they must 'do something' to help the person. However, as the Code of Practice states, it is not appropriate to encourage a person to step outside in order to use S136 powers so that they can be detained and removed to a place of safety. S135 should be used if the person is in private premises.

The attendees at the practitioner workshops including the police themselves noted that the police sometimes arrest the person for breach of the peace as a 'workaround'[69]. This means that they make an arrest in a person's home for this offence, then de-arrest the person outside their home before detaining them under S136.

'Breach of the peace is often used as an alternative to protect/persuade mentally disordered persons to go to a place of safety or take them to a place of safety, often at the request of family members who fear physical harm either from the mentally disordered person or fear for the safety [of the patient].' (Police sergeant, in response to the online survey)

This practice has been considered to be unlawful[70]. If arrested for breach of the peace, the person must be either released unconditionally after a very short period of detention or promptly brought before the magistrates' court[71]. The police also drew attention to recent case law which suggests that using breach of the peace as a proxy power to arrest a person with the intention of taking them to have a mental

[69] For example, *Webley v St George* (2014)
[70] *Seal v UK* (2010)
[71] *Williamson v Chief Constable of West Midlands Police* (2004)

health assessment may be unlawful unless there is the intention at the time of arrest to bring the person before a court[72]. This would rarely be the case in a S136-type situation.

In the online survey, 60% of respondents agreed that 'S136 should apply anywhere including a person's own home'. Police officers, paramedics, and mental health nurses were more likely to agree with this (78%, 74%, and 68% respectively). Health professionals, AMHPs, local authority workers and service users were more likely to disagree than agree, although views were more mixed in these groups. Among service users, 38% agreed and 41% disagreed. In the analysis of the open text box, 366 people (40% of those who gave a response) said that the law should be changed to allow S136 to be used in private homes in an emergency and that doing so would reduce the potential misuse of S136 where the police encourage people to step outside. 54% of people who agreed with this were police officers.

There were concerns expressed over the human rights implications of extending the S136 power to homes. Some service users fear the police might abuse any additional powers given to them.

> '*You should not physically, psychologically or emotionally violate the privacy and dignity of a mentally ill person. The home has a special place in British law. To take that away from someone takes away our/their humanity/ human rights.'* (Service user, in response to the survey)

> *'People have a right to behave in their own home as they see fit (given that no crime is being committed). Section 136 is for those people who are acting in a way that raises concern that they may have a mental health issue. In their own home the family, GP, police etc can request a mental health assessment. If the person is not willing and it is felt that the risk to the individual or others is high then a request for a mental health act can be requested which can be completed in their home.*' (AMHP, in response to the survey)

Some respondents said that the power should be authorised by a senior person, or only carried out with a health professional (an AMHP or paramedic) also present, or only if the person is removed to a health-based place of safety and not police custody. In the online survey, 79 people who responded to the open text box (9%) said that the AMHPs or health professionals were the people who needed more powers in order to take action in an emergency in a person's home. 35 people (4%) said that paramedics needed to have these powers in people's homes, or that the power should be extended only if the police were accompanied by an AMHP, paramedic or health professional. 57 people (6%) thought the solution lay in improving S135 warrants by speeding up the process, introducing a 'retrospective' S135 warrant (so the police could remove the person to a place of safety, and then apply for a warrant), or that magistrates should always be available including out of hours to issue a warrant. 56 (6%) thought that the Mental Capacity Act should be used in these circumstances. 42 people (5%) were concerned at the idea of extending S136 to be used in homes, saying that the S135 warrant provided necessary safeguards to protect individuals' human rights. Others said that if there was an imminent risk of violence, the police should arrest the person for a criminal offence.

Maximum length of detention (72 hours)

The literature review showed that although there is no national-level data available on the length of detentions of people detained under S135 or S136, the reason the maximum length of detention was originally set at 72 hours because that was then considered to be the length of time potentially necessary for a full assessment (including time to allow for intoxication from drink or drugs not to interfere with the assessment) by both an 'approved social worker' (now an AMHP) and a registered medical practitioner. It would also allow time for a bed to be found if the person needed to be further detained under the Mental Health Act. The Mental Health Act Commission (2005) recommended that the holding powers relevant to police stations should be limited to 12 hours but the proposal of a reduction to 24 hours was rejected in the debate on the 2007 Act.

However, some people felt that in some parts of the country it could prove difficult to obtain the

[72] *Hicks v The Commissioner of the Metropolitan Police* (2014), http://www.bailii.org/ew/cases/EWCA/Civ/2014/3.html

assessments in a much shorter period of time[73]. Some people said that 72 hours provided flexibility for bank holiday weekends or times when the right doctor may not be available, or to cover the period of time post-assessment when it may take some hours to locate a suitable bed. However, others felt that a lack of availability of qualified staff is not a valid reason for detaining a person longer than is strictly necessary. Attempts should also be made in good time to escalate the situation, and deadlines as necessary, to senior health service partners, to ensure that efforts are being made to find appropriate accommodation.

Some health professionals felt that in some circumstances it is best to wait for a period before carrying out the assessment, especially if the person is under the influence of drink or drugs and may be unable to answer questions. There was a consensus that rapid assessment is not always appropriate where alcohol or drugs are involved[74].

Several other countries have set the maximum period of detention under emergency mental health legislation at 24 hours. Denmark, most of Germany, the Republic of Ireland, Luxembourg, The Netherlands, Spain, Sweden, and Scotland have all set a maximum period of 24 hours under their legislative equivalents of S135 and S136[75]. In Scotland, the maximum length of detention was reduced in 2003 from 72 hours to 24 hours from the point the person was removed from a public place[76] (in England and Wales the detention point begins from the point of arrival at the place of safety). In Northern Ireland, Austria, France, Greece, and Portugal the maximum limit is set at 48 hours. Only England and Wales, one Federal State of Germany, and Finland set the limit at 72 hours. In Belgium it is ten days.

86% of respondents to the survey said that 72 hours was too long as the maximum length of detention in *police* custody: 72% said it was too long for a person to wait for an assessment or other arrangements to be made in *any* place of safety.

Most people in the survey felt that either four or 24 hours in police custody was more appropriate, and either 24 or 72 hours (as at present) in any place of safety. Some commented that holding people for as long as 72 hours was rare. This is borne out by several studies which showed that the average length of detention was variously four hours[77], nearly seven hours[78], just over nine hours (with a range of between four hours 30 minutes minimum to over 16 hours maximum)[79], nine hours 36 minutes[80], ten hours 39 minutes in 2012/13[81] or 12 hours 19 minutes (739 minutes)[82]. It is generally agreed that the majority of detentions are of fewer than 24 hours duration, and only a tiny minority go up to 72 hours, usually due to very unusual circumstances.

In the Centre for Mental Health's report, '*The vast majority of those we met considered that 24 hours was ample time for an assessment to take place, and therefore that the maximum time of detention should be reduced to 24 hours. Incidents were cited where individuals had, due to alcohol use, remained without capacity for periods beyond 24 hours, however, such incidents were thought to be rare and it was questionable whether the Mental Health Act would have been the right legislation to detain such an individual in the first incidence*'[83].

The Centre for Mental Health noted that *'Finding an appropriate bed post assessment was cited as a reason for some people remaining under S136 longer than 24 hours, and this was reported to be the case for those aged under 18 years at most events.'*[84]

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[73] Kent and Gunasekaran 2010
[74] Riley et al 2011a
[75] Online at: http://ec.europa.eu/health/ph_projects/2000/promotion/fp_promotion_2000_frep_08_en.pdf
[76] As amended by the Mental Health (care and treatment) (Scotland) Act 2003, online at: http://www.scotland.gov.uk/Publications/2005/08/29100428/04400
[77] Revolving Doors Agency 1995
[78] Borschmann et al 2010b
[79] Online at: http://ww5.swindon.gov.uk/moderngov/documents/s65510/Mental%20Health%20-%20Section%20136%20detentions.pdf
[80] IPCC 2008
[81] Online at: http://www.dyfed-powys.police.uk/sites/default/files/disclosurelog/operational-policing/2013/final_response_doc_571.2013.pdf
[82] Online at: http://www.nottinghamshire.police.uk/sites/default/files/documents/files/FOI%20011630%2013.pdf
[83] Centre for Mental Health report, p.7
[84] Centre for Mental Health report, p.7

The Royal College of Psychiatrists' guidance states that ' face-to-face contact with the approved mental health professional and preferably the doctor should start within 3 hours where clinically appropriate, with an expectation that this will reduce to 2 hours in the longer term'[85]. However, the Centre for Mental Health found that '*Most areas we visited struggled to achieve a completed assessment in four hours and this was linked to difficulties in getting all the necessary professionals together to complete the assessment and also to delays in transportation or finding an available place of safety*'[86]. The CQC found that the most common reasons for delay was the AMHP being unavailable, delays on clinical grounds (including intoxication), and also the doctor being unavailable[87].

During the visits carried out for the review, some police staff and officers voiced their concerns over examples when they appeared to be holding a person in custody unlawfully but for their own safety because they could not detain a person under S136 if they were already in police custody. An example is if the person was originally arrested for an offence and it was decided not to take further action (i.e. the 'PACE clock' was stopped), but it was felt the person had mental health issues and could not safely be released. There were also examples of people being held in custody for some time following a mental health assessment because of the time taken to find an acute psychiatric bed.

Extending powers to other professionals

The online survey asked whether there would be any benefit in other professionals having any or all of S135 and or S136 powers because a medical practitioner, approved mental health professional, or mental health nurse is better able to make a judgement as to the mental state of the person compared to a police officer.

68% of respondents to the survey agreed that some or all of S135 or S136 powers should be extended so that health professionals can use them, provided they were not putting themselves at risk. Of the 90 paramedics who responded to the survey, 93% were in favour subject to the provision of appropriate training and equipment and 61 of them said that paramedics should have these powers.

Conveying patients to and between places of safety

65% of respondents agreed that patients detained under S136 have to wait for longer than 30 minutes for an ambulance, and 55 people further commented that ambulances were so slow to respond that the police often ended up transporting the person.

The majority of paramedics and ambulance staff (70%) who responded to the survey thought that ambulances should not routinely be used to transport people detained under S136. In the open text box, and in the practitioner workshops, paramedics said that ambulances were not a safe place for people in mental health crisis and a waste of NHS resources if there was no life-threatening emergency.

70% of police and 62% of service users said that police vehicles should not be used. Using police vehicles can be distressing for the patient and can be seen as stigmatising.

The Centre for Mental Health found that *'In most areas it was the police who provided the means of conveyance as although local policy dictated the primary means be via ambulance, in practice ambulance providers were not able (and nor indeed were commissioned) to respond in a timely fashion.'*

This is supported by the police's figures for 2013/14 which showed, of the 26 police forces that provided data, on 8,913 occasions (74%) people detained under S136 were taken in a police vehicle to the place of safety, and on 3,066 occasions (26%) by ambulance[88]. Several forces recorded zero use of ambulances. These data have not previously been collected and are incomplete. The data do not record the reasons for ambulances not being used. This may be because waiting times for the ambulance were too long, or for other reasons such as an ambulance not having been called. The Code

[85] Royal College of Psychiatrists 2011, online at: http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf
[86] Centre for Mental Health report, p.8
[87] CQC 2014, p.38, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

[88] Health and Social Care Information Centre (HSCIC), Experimental Data Tables, online at: http://www.hscic.gov.uk/catalogue/PUB15812.

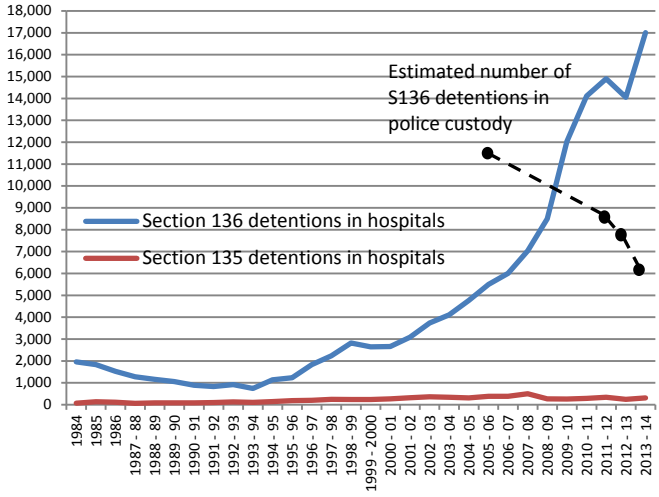
of Practice and the mental health Crisis Care Concordat state that people should be taken to places of safety by ambulance or suitable health transport rather than in police vehicles.

In April 2014 a new national ambulance protocol was introduced with the aim of ensuring a response to S136 incidents within 30 minutes to conduct a clinical initial assessment and to arrange transport to a place of safety or emergency department[89]. It also outlines how patients who are being actively restrained will receive an immediate, high priority response.

Data and trends in S135 and S136

There has been an increase in the numbers of people detained in hospitals in England under S136, while numbers of S135 have remained very low. In 1984 there were 1,959 detentions under S136 in hospitals which increased to 17,008 in 2013/14. This is partly accounted for by the additional investment in health-based places of safety in 2007 which saw the number of S136 detentions made in hospitals in England double in the following five years. The literature review also includes a discussion of data and trends.

In 2013/14, 74% of all persons detained under S136 went to health-based places of safety, and 26% to police custody (6,028 people). However, the historic numbers of people being detained under S136 in police cells is unknown – a potentially major gap in understanding long-term trends in S136 detentions. The first estimate of this is from the IPCC report which suggested that in 2005/06, 11,500 people were detained in police custody – double the 5,495 who were held in hospitals that year. This suggests that until around 2009/10, police custody was used much more frequently than health-based places of safety were. More recent figures – while still not complete - have shown that the use of police custody in England has fallen in recent years, and was used about 8,667 times in 2011/12 (37% of S136 detentions), 7,881 times in 2012/13 (36% of S136 detentions), and 6,028 times in 2013/14 (26% of S136 detentions).



The number of Sections 136 and 135 detentions in hospitals and police stations in England between 1984 and 2013/14[90].

This increase in S136 detentions in hospitals seems to be due to the combined effects of more people being detained in health-based places of safety rather than police cells (see below) and to some extent a real rise in the use of S136 in recent years. Clearly, the police are taking people to health-based places of safety more often which demonstrates better awareness of good practice.

This review convened a roundtable event with academics to discuss the evidence. This group suggested the increase may be partly explained by increasing use of S136 for people who have personality disorders complicated by substance misuse. Some academics and health professionals suggested that the police's thresholds for detaining under S136 have reduced (because the person is frequently not further detained after a mental health assessment), and that the police are detaining more people than ever before. Some have also suggested that this apparent increase in S136 detentions coincides with a period in which police targets for arrests have been removed, meaning that a person who might previously have been arrested is now being detained under S136 instead. There was also a suggestion that changing police attitudes mean that it is felt to be more appropriate and humane to help a person to receive mental healthcare rather than put them into the Criminal Justice System.

[89] Association of Ambulance Chief Executives Annual Report for 2013/14, online at: http://aace.org.uk/wp-content/uploads/2014/06/AACE-ANNUAL-REPORT-2013-2014-03.06A.pdf

[90] Based on HSCIC data sets, plus the IPCC 2008 and HMIC 2013 reports which contain estimates for numbers in police cells.

The majority of people detained under S136 do not go on to further detention under other parts of the Mental Health Act 1983. The statutory tests applied for using S135 and S136 are different to those for detention under S2 or S3 of the Act, and so the low conversion rates are not solely due to differences between the police and healthcare professionals. The proportion of those who went on to be formally detained under another part of the Mental Health Act 1983 in England dropped from 26% in 2007/08 to 17% in 2013/14. This suggests that sometimes the police use S136 to detain a person who a health professional would not necessarily consider sufficiently seriously ill to be further detained under the Act[91]. During the review, some people suggested that it is possible that part of the reduction in the proportion of people going on to further detention under S2 or S3 of the Act may also be related to pressures on those services and a lack of acute psychiatric beds.

Although only a minority of S136 detainees go on to be formally detained under another part of the Act, a large proportion go on to be voluntarily admitted to hospital or receive other community-based care and support. The proportion of S136 detentions which have gone on to 'informal' legal status (that is, not detained formally under the Mental Health Act but admitted as a voluntary patient for observation, or if lacking capacity, under the Mental Capacity Act[92]) increased from 68% in 2003/04 to 78% in 2013/14, with nearly all that increase taking place after 2007/08. This suggests that the police are not extensively overusing the S136 powers to detain people who have no need to be seen by mental health services. If the person is willing to be admitted voluntarily then this is likely to be the preferred option.

It is possible that in a significant proportion of cases the police are using S136 to detain a person who actually consents or even volunteers to their own removal and detention – perhaps to gain quicker access to mental health services – and there is some support for this from the proportion of people that consent to be admitted informally, as set out above. An unpublished audit of 100 cases of the use of S136 submitted to the review showed that in at least 20% of cases, the person had clearly agreed to go to the place of safety (and in some cases requesting to be taken) and therefore their formal detention by the state under S136 powers was not necessarily the 'least restrictive' course of action possible[93].

Relatively small numbers of detentions are made under S135 – with just 307 recorded in 2013/14 – but these data on S135 detentions are thought to be an undercount because they only include those persons brought to hospital under S135. They do not include: being admitted to hospital informally; being released or returned to hospital, for example under S135(2) rather than being taken to a place of safety; or being removed to police custody rather than a health- based place of safety (although it is rare for a person detained under S135 to be taken to a police cell because the AMHP should have located a bed for the person before they can be removed). The Health and Social Care Information Centre (HSCIC) are working with local authorities and AMHPs to improve recording of S135. Efforts being made by the police to record formally all uses of S135 and S136 should also help to provide a more accurate picture in the future.

The workshops noted that a number of people were detained under S136 because they expressed suicidal ideation. It was felt that this is a judgement call for the police officer and often may be a life-saving intervention. However, it was noted that such a person may not have any diagnosed mental health condition or necessarily be known to mental health services prior to their detention. Using S136 indiscriminately for anyone expressing a suicidal intent was not the intended purpose of the power and may mean that others with an urgent need for mental health services were turned away or not assessed as soon as they could have been because the place of safety and the Section 12 doctors/AMHP were otherwise occupied.

Since the Mental Health Act 2007 there has been a power to transfer persons detained under S135 or S136 from one place of safety to another. This was intended to provide a means for a person originally

[91] In Wales, data suggests that 65-70 %of the detained under S136 do need some sort of mental health intervention. Pers. comm. Welsh Government.

[92] Pers. comm. HSCIC

[93] Robert Keys (February 2013) *An Examination of Section 136 of the Mental Health Act 1983: looking at current usage and whether the law needs reform in accord with the needs of a modern mental health service.* Unpublished Masters in Medical Law (MML) dissertation, University of Northumbria. Quoted by permission.

taken to police custody to be moved into a health-based place of safety within the overall maximum period of detention of 72 hours. However, this review found few examples of it occurring in practice.

No figures are collected on transfers between places of safety, and so it is not known how often the powers are used[94] or whether it is more usually used to transfer the person from a police station to a health-based place of safety or vice versa. It would be desirable for such transfers to be recorded by police and health services so that people are tracked and continuity of care is ensured. It would also be desirable to ensure that records are kept of their overall period of detention to mitigate the legal maximum being exceeded. This would also mean that accurate statistics can be gathered on the overall uses of this power.

European Convention on Human Rights

At the academic roundtable the question of consistency with the European Convention on Human Rights (ECHR) and United Nations (UN) Convention on the Rights of Persons with Disabilities were discussed. The UN Convention on the Rights of Persons with Disabilities stated that '*Involuntary treatment or placement may only be justified, in connection with a mental disorder of a serious nature, if from the absence of treatment or placement serious harm is likely to result to the person's health or to a third party. In addition, these measures may only be taken subject to protective conditions prescribed by law, including supervisory, control and appeal procedures*[95]'.

The Steering Committee on Bioethics (CDBI) makes provision for the assessment of a person's mental health in *Article 17 – Criteria for involuntary placement:*

> 2. *The law may provide that exceptionally a person may be subject to involuntary placement, in accordance with the provisions of this chapter, for the minimum period necessary in order to determine whether he or she has a mental disorder that represents a significant risk of serious harm to his or her health or to others if:*
>
> *i. his or her behaviour is strongly suggestive of such a disorder;*
> *ii. his or her condition appears to represent such a risk;*
> *iii. there is no appropriate, less restrictive means of making this determination; and*
> *iv. the opinion of the person concerned has been taken into consideration*[96]*.*

S135 and S136 could be considered to fall into this category of emergency situations where a person is detained in order to determine whether or not they have a mental disorder that poses a serious risk of harm.

Where S136 applies

It was clear from the evidence submitted to the review that there is some confusion over where S136 can and cannot apply under current law (the definition of a 'place to which the public have access'), and disagreement over whether it should or should not apply in some places such as railway lines. In the online survey, 45.5% of respondents agreed that it was clear what a 'place to which the public have access' meant, but 40.2% disagreed. The majority of police, in particular, felt they knew what a 'place to which the public had access' was (67.7% agreed), but a majority of health professionals, AMHPs, paramedics, mental health nurses, voluntary sector workers, and service users did not feel that they had a clear understanding of the term

A number of examples were given to the review where it was felt that the power to detain a person under S136 or not seems to be unclear, such as hotel bedrooms, a person in a car or private vehicle (on the public highway), a person in an office or in restricted-access parts of buildings (the back of a shop, for instance), and parts of hospitals. A 'place

[94] Online at: http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/58407.htm

[95] Statement on the United Nations Convention on the Rights of Persons with Disabilities adopted by the Council of Europe's Steering Committee on Bioethics at its 41st meeting (2–4 November 2011).

[96] Online at: https://wcd.coe.int/ViewDoc.jsp?id=771489&BackColorInternet=DBDCF2&BackColorIntranet=FDC864&BackColorLogged=FDC864

to which the public have access' is not defined in the primary legislation, but there is some relevant case law[97].

As set out in the Code of Practice, a place to which the public have access includes any place to which members of the public have open access, or access if a payment is made, or access at certain times of the day. It does not include private premises, such as the person's own place of residence or private homes belonging to others, in which case a S135 warrant is needed. The emergency department of a general hospital has been considered by the courts to be a place to which the public have access and the police may detain a person under S136 there[98].

The difficulties experienced by the British Transport Police in relation to S136 and railway lines were reflected in the evidence provided to the Home Affairs Select Committee:

> *'We have a specific issue with this inasmuch that the power applies to people who are in a place to which the public have access. Railway lines are a place to which the public do not have access, so our officers need to remove somebody from a place of danger, get them to a public place, and then make that judgment as to whether they need care and control for the power to be made out and executed. Now, albeit there is some legal precedent that would support us doing that because we do have powers to remove people as trespassers from the network, it is a clunky way of doing things.'* (Oral evidence given to the Home Affairs Select Committee, by Mark Smith, British Transport Police, 28 October 2014[99])

Another issue raised by police during the review was whether or not S136 can be used to detain a person who is already in a 'place of safety', in order to remove them to another 'place of safety' or to prevent them leaving if present voluntarily. Some felt that this could result in a potential conflict between a 'place of safety' and a 'place to which the public have access'. For example the emergency department of a hospital or the front counter of a police station may potentially be considered as both a 'place of safety' and also places 'to which the public have access'.

Ending a S136 detention

In the visits and practitioner workshops, there was some confusion over who can discharge a person from a S136 detention, for example if the detained person's presentation changes over time. A person detained under S136 can be examined by a doctor and interviewed by an AMHP, although it is not necessary for both these actions to happen before the person's detention ceases. For example, where a doctor has completed an examination of a person prior to the arrival of the AMHP and concludes that the person is not mentally disordered, the person can no longer be detained and must immediately be released.

During the visits, one police force stated that once a person is detained under S136, only a doctor or medical professional can discharge them following a full assessment[100]. Therefore, once detained, the assessment must be completed. They cited a report by the IPCC which criticised the police for releasing a person without their having been assessed by an approved social worker or suitably qualified medical practitioner and the person then committed suicide. The IPCC report found that:

> *'A custody sergeant believed he had the discretion to make his own assessment of the mental health of a detainee. The other officers present agreed with this decision and Martin was released from custody within 15 minutes. That is a decision that had tragic consequences.'*[101]

The report went on to say that S136 '*does not give a custody sergeant the discretion to release someone or refuse to authorise the detention of a person who*

[97] Case Law is listed in Annex C of the literature review, p.74

[98] Divisional Court in *R. (on the application of Sessay) v South London and Maudsley NHS Foundation Trust (2011)* EWHC 2617 (QB), quote from Supperstone J, at para. 39.

[99] Online at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/oral/15016.html

[100] See Summary of Evidence, p.103

[101] IPCC (2004*). Investigation into West Yorkshire Police contact with Martin Middleton*.

has been detained under S136 before an assessment has been carried out'.

Another case which was cited by the police was the death in 2008 of 87-year old Hipolit Konrad Legowski in Devon[102]. He had been detained under S136 and was assessed by a doctor who found that he had no mental health issues that could justify his continued detention. The police therefore had no formal powers to detain Mr Legowski any further and released him, escorting him to his car. His body was found in a field two days later. He was found to have died from natural causes. The IPCC found that the police should have done more to help him reach his home (in Shropshire) safely. This goes even further than simply requiring the police to seek medical assessment, suggesting that for the most vulnerable people the police should consider the safety of the person following release.

The CQC also takes the view that the police must not release people until they have been seen by a medical professional:

> *'In 2009, we discussed this matter with the coroner who had presided over the inquest into the death of Mr S, a man with a history of inpatient treatment for self-harming. The coroner stated that neither experienced police officers nor the custody officer involved in the case had understood the significance of the provisions of section 136. As a result, Mr S was taken under that power to a police station as a place of safety by police officers who had good reason to believe that he was mentally disordered and at risk of suicide, and was released from custody without any form of mental examination. He went home and hanged himself. In this case, it would seem that the custody officer failed to appreciate the breadth of the assessment expected under section 136. The test is not whether the person appears to be sufficiently disordered to be detained under mental health law, but whether he or she is mentally disordered at all, and whether any arrangements can be made to help and support him or her. We have encountered the same misconception in other police stations. This is particularly dangerous where custody officers either appear to make their own judgment over the mental state of the person, or rely upon the judgment of a forensic medical examiner who may not be appropriately qualified to make such an assessment. As in the case of Mr S, this can result in extremely vulnerable people being released inappropriately, either because indications of mental disorder have been missed altogether, or because the release cuts off the possibility of support from mental health services.'*[103]

The police, during the visits, noted that it is not clear whether they may 'de-detain' a person who has been detained under S136. For example, that the person has just been assessed under the Mental Health Act and not found to be suffering from mental health problems. In such cases, it could waste the person's time, as well as police and health resources, to undergo a further full assessment by an AMHP.

Although, unlike criminal arrests made under the Police and Criminal Evidence Act 1984 (PACE), there is no requirement for the police officer (or the Custody Officer) to reconsider the basis of this decision to detain (providing that the detention was lawful), some felt it would be good practice for the police, in making periodic checks on the welfare of the person they are detaining, to satisfy themselves that the person's detention remains necessary.

S136 and 'voluntary' patients

During the visits carried out for the review, the issue of whether a person could be detained under S136 'voluntarily' was raised. It was noted that, unlike other parts of the Mental Health Act 1983, S136 makes no mention of whether or not the person must be refusing to consent or is voluntarily accepting assessment. An unpublished audit of 100 detentions under S136 over two years in London which was submitted to this review found that:

> *'...at least 20% and probably far more patients were agreeing to assessment. In*

[102] http://www.ipcc.gov.uk/news/ipcc-concludes-investigation-death-87-year-old-polish-man

[103] Online at: http://www.cqc.org.uk/sites/default/files/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf

interpreting this figure it should be borne in mind that, because willingness/refusal to attend, is not part of the S136 criteria, it is not reflected in the standard Metropolitan police form. It is only by reading the description that a tentative judgement can be made about whether the person was willing or refusing to attend voluntarily. It is likely that in many more cases than can be inferred from the description, the person was either agreeing or could have been easily persuaded to attend for assessment voluntarily. The following quotes from the Audit illustrate the attitude of some patients:

'The person was shouting '' Help Me!'

'The person wants to be in hospital.'

'Stated she needed help and did not feel safe.'

'If you leave me here I will kill myself.'
'Phoned police himself wanting help.''[104]

Because the principle of 'least restrictive means' applies throughout the Mental Health Act 1983 (i.e. using the least coercive approach possible in the circumstances), some people have suggested that if the person is willing to go with the police officer voluntarily then S136 cannot and should not be used to detain them.

Some police officers noted that provided that the person met the criteria for S136 detention (appearing to be suffering from a mental disorder and to be in immediate need of care or control), then there is nothing to prevent the police officer detaining the person under that power if he thinks it necessary to do so in the interests of that person or for the protection of other persons, whether or not the person consents or even requests to be detained. However, during the practitioner workshops some health professionals said that a health-based place of safety may require the person to have been formally detained under S135 or S136 in order to access the S136 suite. This is because without a formal detention having been made, they could not hold the person should they decide to leave.

Another possible issue raised by some health professionals in the review was the extent to which a person understood that they had a free choice, or whether they were given to understand that having been requested to attend a hospital with the police officer that they had to comply. It was thought that in some cases the person believed they had been formally detained when this was not the case.

Some hospital staff who gave evidence to the review said that police officers, wishing to avoid having to remain with a person detained under S136, sometimes simply brought a person to an emergency department, said they were there voluntarily, and departed leaving the health staff to take over [105].

'Police are regularly detaining people for reason relating to Mental Health, but don't for whatever reason put them under a S136/135. I have lost count on the amount occasions Police Officer bring in a patient to our Emergency Department that are restrained in handcuffs and leg restraints and are carried in by 4 police officers. The officers then place the person in one of our secure rooms, remove the restraints, lock the door on their way out and then tell the Nursing and Security staff the patient attended hospital voluntarily. This causes a number of issues for the hospital as because there was no S135/135 or Mental Capacity Act powers used by the Police the hospital staff don't have any lawful power available to them to stop the person leaving or continue the detention, and it is also questionable [whether] the way the police completed their duties is legal. The staff act in the best interest of the patient and we often stop them from leaving, but this sometimes leads to restraint and again the powers staff use to do this could be

[104] Robert Keys (February 2013) *An Examination of Section 136 of the Mental Health Act 1983: looking at current usage and whether the law needs reform in accord with the needs of a modern mental health service.* Unpublished Masters in Medical Law (MML) dissertation, University of Northumbria. Quoted by permission of the author.

[105] If the person was an inpatient, doctors and nurses have powers to detain temporarily under Section 5 of the Mental Health Act 1983.

*questionable legally.' (*Doctor, in response to online survey)

S136 as an 'arrest'

Other issues raised in discussions included whether a person detained under S136 is 'arrested'. Prior to the current revisions, the Code of Practice noted that a person detained under S136 is only considered arrested 'for the purposes of PACE Code C[106]', which means that they are given the same rights and protections available to any vulnerable person in police custody including the option of a solicitor (although as the person is not suspected of having committed any criminal offence and will not face any criminal charges, this is not usually necessary). PACE permits the person to be searched. However, some felt that as the person has not been arrested for any criminal offence, and will not be charged with any offence, it is preferable to describe them as 'detained' or 'temporarily detained for the purposes of a medical assessment to be carried out'.

Cross-border arrangements

During the visits to areas, an issue was raised over the difficulties faced when a person is brought to a health-based place of safety other than in the local authority area in which they live, which can lengthen the overall S136 detention. If the person lives in another local authority or CCG area, the health-based place of safety to which they are brought may sometimes refuse to accept them (because this reduces the service available to people from the area which they serve). At times this can result in the person being taken to police custody, although some areas have alternative local arrangements in place to use neighbouring health-based places of safety.

The CQC in their survey found that none of the providers reported that their local policies included being resident in a different area as a reason for exclusion and most places of safety also reported that this was not an issue, although a small number did occasionally exclude people who lived out of area – however anecdotal evidence suggests that refusing to take someone who is resident out of area is a problem in some places, but that this is not routinely recorded.[107].

A similar issue can arise over AMHPs, where the AMHP from the area where the person is detained believes that they cannot assess them because the person is not the responsibility of that local authority and the AMHP does not know the mental health services in their home authority. This is further complicated when the AMHP from the authority in which they are resident will not travel out of that area to interview them in the area in which they are detained. This can leave gaps in services which can cause considerable delays in getting an AMHP to interview the person. It is unclear in the Act whose responsibility it is to provide the AMHP service in these situations. This should be clarified in the revised Code of Practice.

Diversity and equality issues

The review explored equality and diversity in the operation of S135 and S136 through the literature review, the online survey (which had a specific question about these issues), the work undertaken by the Centre for Mental Health to interview service users, and workshops run with Black Mental Health UK. In 2013 the *Independent Commission on Mental Health and Policing* report examined a number of serious incidents including deaths of patients with mental health problems in police custody in London. The report describes a lack of mental health awareness amongst officers, with patients reporting feeling that the police understanding of mental illness was poor[108]. In 2011 the Royal College of Psychiatrists reported that:

'Many of those detained under Section 136 come from a socially deprived background. Some Black and minority ethnic groups are overrepresented, as with other detentions under the Mental Health Act. This needs to be better understood in terms of causes and care pathways if solutions are to be found

[106] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/311276/PaceCodeC2014.pdf

[107] CQC, p.29 – 30, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

[108] Adebowale (2013) *Independent Commission on Mental Health and Policing* Report. Online at: http://www.turning-point.co.uk/news-and-events/news/independent-commission-on-mental-health-and-policing-report-published.aspx

which might reduce the need for the use of Section 136 in the future. Such research requires reliable Section 136 data which are currently unavailable.[109]

Research shows that there are gender, age, disability, and racial issues in S136 detentions[110]. A 2013 study of all 95,618 detentions in hospital under S 136, and 5,896 under S135 between 1988/9 and 2010/11 showed that on average, 59% of S136 detentions were of males, and that the proportion of males detained under S135 increased steadily from 40% in 1988/1989 to 57% in 2010/11[111]. The mean age for both men and women detained under S136 is between 32 – 41 years[112], with some variation between different ethnic groups. Black people are more likely to be younger and white people older[113].

Several respondents to the survey pointed out that mental health is in itself a protected characteristic under the PSED, and felt that having the police involved in S135 and S136 is inherently discriminatory and stigmatises mental ill-health. Factors associated with being detained under S136 are being aged under 40, living alone or homeless, unemployed, male, not registered with a GP, often suffering from psychosis, and with a past history of mental illness[114]. Many of those detained are already known to mental health services.

Several studies into S136 suggested that BME groups – in particular Black African Caribbean men – were disproportionately over-represented in S136 detentions compared to the general population[115]. A meta-analysis of the literature suggested that black people were 4.31 times more likely to be detained in in-patient facilities on long term sections of the Act than white people[116]. The police are more likely to be involved in admissions or readmissions of black people, and black people are more likely to present in crisis[117]. Black communities are over-represented across mental health services, not just in S136 detentions[118], and are over six times more likely to be detained under S2 of the Mental Health Act[119]. A range of possible reasons for this has been proposed including ignorance and misinterpretation of different cultures, stigma or different interpretations of mental health symptoms, mistrust of mental health services and the police, and prejudice[120].

A number of people mentioned BME over-representation in the open text responses to the survey, although some Mental Health Trusts said it was not an issue in their area. In the online survey, 63 people highlighted that BME groups are more likely to be detained under S136 compared to the general population, and that this can be perceived as discriminatory. The Centre for Mental Health's service user focus groups found that *'Two service users at different events and both from African Caribbean heritage made the same comment, '*we are seen as big black and dangerous'*. Service users from black and minority ethnic communities at stakeholder events consistently reported they were more likely to be perceived as aggressive and posing risk to others and subject to physical restraint. While most service users experienced being sectioned under Section 135 and 136 as traumatic, there was a marked difference between white and black service users in their experience of the police. Black service users more commonly reported the use of force [by the police] and [force] occurring earlier on.'*

The deaths of several people who were detained under S136 either in police custody, or following contact with the police[121], have caused great concern in some BME communities[122].

In the workshops held with Black Mental Health UK, several people said that it could be helpful to have

[109] Royal College of Psychiatrists (2011) *Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)*, CR159. Online at: http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf

[110] See literature review, p.29 - 33

[111] Keown 2013

[112] Borschmann 2010a

[113] Fahy et al 1987

[114] Fahy 1989, Spence and McPhillips 1995, Gray 1997, Churchill et al 1999, Borshmann et al 2010b

[115] Rogers and Faulkner 1987, Dunn and Fahy 1990, Pipe et al 1991, Bhui et al 2003, Fernando et al 2005, Borschmann et al 2010b

[116] Bhui et al 2003

[117] Commander et al 1999

[118] Cope 1989, Keating 2004

[119] Audini and Lelliott 2002

[120] Bean 1991, Pipe 1991, Shaw 1999, Sharpley 2001, Bhui 2003, Keating 2004, Fernando 2005, Singh 2006, Lawlor 2012

[121] See literature review, p.47

[122] Online at: https://www.gov.uk/government/speeches/home-secretary-at-the-policing-and-mental-health-summit

'community advocates' who could act as mediators in situations where the police are considering detaining a person under S136[123]. Diversity and equality need further consideration in the operation of S136 detentions, and improved data collection and monitoring are needed to understand the issues in more depth.

Other issues raised in the review

Many of the responses to the online survey and in the practitioner workshops said that the police are not medical professionals and that mental health crisis care is a health issue. A number of police officers in the workshops said that they were increasingly being relied upon to support mental health services that seemed under increasing strain. The lack of advice and support out of hours can result in the police dealing with some very vulnerable people, often with little knowledge of their background. There is a need for good multi-agency working to ensure the best outcomes for patients. This could include identifying people who are repeatedly detained under S136 and working on multi-agency care plans which will break this cycle.

The use of restraint for people with mental health issues, including those detained under S136, was an issue which was mentioned repeatedly in the workshops. However, this issue is much wider than the operation of S135 and S136. In April 2014 the Department of Health launched a two year programme of work on the use of restraint in healthcare settings, 'Positive and Safe'[124], including new guidance on the use of restrictive interventions for patients with difficult behaviour[125].

There is no specific legislative framework setting out when the police can or cannot use restraint for people experiencing mental health crisis. Case law suggests that *'a police officer in exercising his powers under S136 is entitled to use reasonable force. If someone is violent, he can be restrained'*[126]. The Code of Practice requires the mental health hospital where a patient is detained to make sure staff are properly trained in the restraint of patients, and to set out a clear local protocol about the circumstances when, very exceptionally, police may be called to manage patient behaviour within a health or care setting, recognising that the threshold for any police involvement should be high.

In the online survey, several people suggested that the police and mental health professionals alike needed better training to understand the powers and responsibilities of other agencies. Some police officers described health professionals or family members requesting that the police officer detain a person under S136 who is in their own home, not understanding that the police cannot use this power in a person's home. This was reflected in evidence presented to the Home Affairs Select Committee:

> '*I have been asked numerous times in my career to do things that are just illegal. No malice involved; just mental health professionals not understanding what police powers are, what police procedures are, or practical things about whether you can force entry to a premises or whether you can detain somebody in certain circumstances*.' *(*Oral evidence given to the Home Affairs Select Committee, by Inspector Michael Brown, 2 September 2014[127])

The language used in the Mental Health Act 1983 was seen by some people as reflecting outdated views and practices in mental health. It was noted that the wording of S135 and S136 has remained essentially unaltered since the Mental Health Act 1959[128] while social attitudes towards mental health have changed.

Some evidence given to the review raised concerns about powers as they apply to homeless people:

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[123] See Summary of Evidence, p.98

[124] Online at: https://www.gov.uk/government/speeches/positive-and-safe-reducing-the-need-for-restrictive-interventions

[125] *Positive and Proactive Care: Reducing the need for restrictive interventions*. Online at: https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions

[126] R (Anderson) v. HM Coroner for Inner North London (2004)

[127] Online at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/oral/12272.html

[128] Annex A of the literature review sets out the wording of the 1959 and 1983 Acts, p.68 - 69

> *'I have been running with a case in Manchester which I believe highlights that the current scope of S135(1) and S136 discriminates against certain street homeless people having mental health issues. We are trying to assess a street homeless woman where the only premises we know she frequents is the public library. The police are refusing to use S136 as she does not appear to be in need of immediate care/ control and they say it is a 'planned' assessment which is not what S136 is meant for…So we are left to consider undertaking a hurried and undignified Section 2 assessment when we would really prefer to undertake a more considered assessment at a place of safety...but the current police powers do not appear to allow this...effectively, this means that non-homeless people can have a more considered assessment in their own homes or at a place of safety if S135(1) needs to be used but, homeless people in the above situation [cannot]...Extension of S136 powers would resolve this.'* (AMHP, in response to online survey)

Discussions with the police further noted that AMHP's powers in such cases are limited by needing a specific address to make any application for assessment. A homeless person would not have an assessment.

Police in the workshops said that hospitals sometimes cannot or will not use their powers to detain people, resulting in a person absconding and then being reported to the police as a high-risk missing person – this can tie up a lot of police resources. The online survey showed that 64% of people thought there should be greater accountability and oversight of S136 detentions; and 65% agreed there should be more monitoring of the use of S136. Poor data quality was a key issue discussed in the academic roundtable and in the literature review[129].

[129] See Summary of Evidence, p.110, and the literature review, p. 14

Discussion of legislative options

This section sets out the government's position on potential areas of legislative change, and shows the options that were considered. The overarching aim of this review was to improve the outcomes for people detained under S135 or S136 of the Mental Health Act. The aims of the recommendations set out below are to:

- **significantly reduce the use of police custody as a place of safety;**
- **encourage and enable innovation in using alternative places of safety;**
- **remove barriers preventing a person in mental health crisis from accessing help wherever they are while protecting human rights and civil liberties;**
- **to encourage more rapid assessment and to ensure a person is not detained for longer than the minimum time necessary;**
- **ensure appropriate use of S136;**
- **improve the operation of S135; and**
- **ensure that police, paramedics, AMHPs and health professionals have appropriate powers**

The evidence submitted to the review provided a strong direction as to areas where changes could potentially be made, both legislative and non-legislative. This section sets out a list of options which were considered, the arguments for and against, and which options thought viable.

In terms of legislative change:

- **Places of safety:** reducing the use of police cells as places of safety for people detained under the Mental Health Act 1983, improving access to health-based places of safety, including addressing the issue of people being excluded if intoxicated, and enabling innovation in developing alternative places of safety;

- **Emergency powers to remove a person to a place of safety when they are in their home:** exploring what powers police and health professionals have to remove a person to a place of safety if the person is experiencing a mental health crisis in their home and there is insufficient time to obtain a S135 warrant, and addressing any consequent misuse of powers by the police such as encouraging the person to move into a place where they can be detained under S136;

- **Reducing the maximum length of detention** in any place of safety, including a police station;

- **Extending powers to health professionals:** whether the operation of S135 or S136 would be improved if health professionals had additional powers;

- **Clarifying where S136 should apply** rather than simply 'in a place to which the public have access';

- **Clarifying responsibilities for transportation:** setting out who should have responsibilities for transporting a person to a place of safety, the type of vehicle, and who should escort;

- **Addressing excess/ inappropriate use of S136:** differing perspectives from health professionals and police over when S136 is used properly and whether S136 is used inappropriately, for example to discharge a duty of care towards a person who is simply under the influence of drink or drugs; and

- **Clarifying S135 responsibilities and powers:** making it clearer who has responsibility to do what – for example whether the AMHP can convene a mental health assessment in the person's home.

The review identified a number of potential legislative options, summarised in Table 2. Each option is discussed in detail including setting out the evidence, recommendations, and potential implications. The proposals for legislative change are subject to impact assessments, including financial implications. The proposals will also be subject to ongoing considerations with regard to the Public Sector Equality Duty, and the Secretary of State for Health's responsibilities to reduce healthcare inequalities.

Key issue	Possible options considered by the review	Legislative recommendation	Non-legislative recommendation
Reducing the use of police cells as places of safety	1. Remove police stations as a place of safety	✗	
	2. Remove police stations as a place of safety for under-18s	✓	
	3. Define 'exceptional' circumstances under which a police station could be used	✓	
	4. Provide a cross-charging framework	✗	
Improving access to health-based places of safety	5. CCGs to provide adequate health-based places of safety and safe staffing levels to meet demand		✓
	6. Health-based places of safety to accept patients detained under S136 even if under the influence of drink or drugs		✓
	7. CCGs to provide suitable places of safety and inpatient beds for under-18s detained under S136		✓
	8. Explore models of provision for alternative places of safety		✓
Exploring emergency powers to remove a person to a place of safety from their home, and current police misuse of S136	9. Extend S136 to apply in people's homes, or create a separate emergency power if authorised by an appropriate person	*Not at present but requires further consideration*	
	10. Speed up S135 warrants		✓
	11. Permit S135 warrants to be granted retrospectively	✗	
	12. Removal of S136 powers from the police	✗	
Reducing the maximum length of detention	13. Reduce the maximum length of detention in police custody, or in any place of safety, with the possibility of extension	✓	
		✓	
	14. Set a statutory minimum time for an assessment to commence	✗	
Extending powers to health professionals	15. Extend S135 power to remove to a place of safety to paramedics/ AMHPs/ other health professionals	*Needs further consideration*	
	16. Extend S136 power to remove a person to a place of safety to paramedics/ AMHPs/ other health professionals	*Needs further consideration*	
Clarifying where S136 should apply	17. Amend S136 so that it applies anywhere except for a person's home	✓	
Responsibilities for transportation	18. CCGs to commission appropriate transport services (not necessarily ambulances)		✓
	19. Explore private sector/ other models of provision		✓
Excess/ inappropriate use of S136 e.g. for people under the influence of drink or drugs	20. Create a separate power for police and paramedics to take an intoxicated person to appropriate health facilities	✓	
	21. Police to seek advice from a health professional/ AMHP before detaining under S136	✓	
Clarifying S135 responsibilities and powers	22. Allow a mental health assessment in a person's home and set out that police, and health professionals can remain	✓	

Table 2: Potential legislative options

Police cells as places of safety

Section 135(6) sets out that a police station can be a place of safety. Police cells are used as an emergency resource to detain people with diverse and sometimes severe problems linked to their mental and physical health or drug and alcohol consumption, usually when the person has been arrested for a criminal offence. In the case of S136, the person is detained on a short-term basis not because they have committed any criminal offence, but simply in order to be safely held until they can receive a mental health assessment and follow-up care and treatment provided.

The academic roundtable raised a query as to whether the use of police cells is compliant with the ECHR. This review considers that it is acceptable to use police custody as set out in Options 1 and 3 below.

There are questions over the suitability of the facilities for people with often very acute mental healthcare needs[130]. Most police custody suites do not currently have an appropriate healthcare professional available 24/7. Researchers have suggested that police cells are often 'noisy, small and unpleasant'[131]. If the person is deemed at risk of suicide, a police officer will be stationed outside the cell on constant 'suicide watch'. If a person detained under S136 is not separated from those arrested for criminal offences, there is also the potential for harassment[132]. These factors could worsen the mental state of the person.

> *'Detention in police cells conflates mental illness with criminality, increasing stigma, and could be particularly problematic in people having their first episode of psychosis, for whom initial negative experiences of mental health care could have lifelong ramifications'* [133].

Researchers who have interviewed service users who had experienced such a detention found that the experience was described by them as 'criminalising', and 'de-humanising'[134]. They felt they were being treated the same as people suspected of a criminal offence when they were suffering a mental health crisis. Some found the experience frightening and confusing.

The Sainsbury Centre for Mental Health recommended in 2008 that the *'Use of police custody as a place of safety should only be used as a last resort. Assessment suites should be established in all areas to provide places of safety for individuals detained under section 136 – and staffing levels agreed…to ensure their effectiveness'*[135]. The Crisis Care Concordat and Code of Practice require that police cells should be used only on an 'exceptional' basis.

However, the evidence shows that police custody is not used exceptionally as a 'last resort', but has instead been used in between a third and a quarter of cases. Table 3 below shows the proportion of S136 detentions which have been made in police custody where data were available for the last three years:

	No. S136 detention made in hospitals	No. S136 detentions in police custody	Total No. S136 detentions	% in police custody
2011/12	14,902	8,667	23,769	37.3%
2012/13	14,053	7,881	21,934	35.9%
2013/14	17,008	6,028	23,036	26.2%

Table 3: Proportion of S136 detentions in police custody, in England. Source: Health and Social Care Information Centre[136]

There is considerable variation between police forces areas in both numbers of S136 detentions, and their use of police custody. In 2013/14, 11 police areas recorded more than 1,000 uses of S136, while 13 police forces recorded under 500 uses. In 2013/14, six police forces had more than 50% of their S136 detentions held in police custody, while seven had fewer than 10%: West Midlands police had only 0.4% of their S136 detentions taken to police cells (5 people out of 1,260), Kent had only 3.7% (45 people out of 1,210), and the Metropolitan

[130] Online at: http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1509.htm#n147
[131] Riley et al 2011b
[132] HMIC 2013
[133] *The Lancet* 2013, Editorial, June 29, p.2224.
[134] See literature review, p.36 - 37
[135] Bather, P., Fitzpatrick, R. and Rutherford, M. 2008
[136] HSCIC 2014, Experimental Data Tables, online at: http://www.hscic.gov.uk/catalogue/PUB15812.

Police Service used police cells in only 4.6% of their S136 detentions (75 people out of 1,645). In contrast, other areas recorded much higher use of police cells[137]:

Police force	Number taken to police custody	Total number of S136 detentions	% taken to police custody
Devon and Cornwall	767	1,117	69%
Sussex	856	1,358	63%
Lincolnshire	333	552	60%
Dyfed Powys	134	228	59%
Gwent	154	275	56%
Cleveland	162	307	53%

Table 4: Selected police force data on S136 detentions in 2013/14, for England and Wales[138]

The report by the CQC into health-based places of safety found that the use of police stations as a place of safety is directly linked to the provision (or lack of) health-based places of safety[139]. This suggests that on many occasions, the person is detained in a police cell not because they are too violent to be safely managed in a healthcare setting, but because the health-based place of safety is unavailable or declines to accept them (see next section).

Police forces record on custody records the reasons why the person has been held in custody on S136, but it is difficult to analyse these for trends as each record would have to be individually accessed and interpreted. For that reason there are currently no national-level records of why police custody has been used.

However, a snapshot of one year's data from Thames Valley Police for 2013/14[140] gives an outline of the reasons why the person was detained in custody:

Reasons for police custody being used	Actual number	%
Place of safety had no capacity or refused to take them	127	46.7%
Behaviour unmanageable (police decision)	43	15.9%
Intoxicated (police decision)	26	9.7%
Intoxicated (refused by health-based place of safety)	11	4.0%
Other behaviour problems	9	3.3%
Behaviour unmanageable (health-based place of safety decision)	4	1.5%
Escape risk	3	1.1%
Already absconded from hospital	1	0.4%
Complaint about place of safety	1	0.4%
Other/ not stated or unclear	27	9.9%
TOTAL	272	100%

Table 5: Data from Thames Valley Police for S136 detentions in police custody in 2013/14[141]

This shows that on 127 out of 272 occasions (47%) when a person was held in police custody under S136, this was because the place of safety did not have capacity to take them. On 47 occasions in total the person could not be taken to a health-based place of safety because their behaviour was unmanageable (such as violence), and this was mostly a police decision (43 times out of 47). On 37 occasions police custody was used because the person was under the influence of drink or drugs.

Option 1: Remove police stations as a place of safety

Some people have suggested that amending the legislation to remove police stations as a place of safety is the only way to ensure that people detained under S136 are never taken to police stations.

Amending S135(6) to remove police stations as a place of safety was considered in detail during this review. It was felt that this would reduce the perceived 'criminalisation' of people detained under S136 of the Mental Health Act 1983 and would be

[137] Data for some other forces was incomplete or unreliable. North Yorkshire has not been included, as it only had a health-based place of safety available since early 2014 and so 90% of its recorded S136 detentions were in police custody.
[138] HSCIC 2014, Experimental Data Tables, online at: http://www.hscic.gov.uk/catalogue/PUB15812.
[139] CQC, 2014, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf
[140] This level of detailed data is not available for all police forces. Thames Valley Police covers Oxfordshire, Berkshire, and Buckinghamshire, including Milton Keynes.
[141] Quoted with permission from Insp. Jan Penny, Thames Valley Police.

welcomed by many – though not all – service users. Because a police cell is often not a therapeutic environment, preventing people being detained there under S136 would lead to better outcomes for the person provided that they were taken to a health-based place of safety instead where they could be supported by mental health professionals.

49.7% of people who responded to the survey said that police cells should *never* be used as a place of safety. 63% of police officers and 68% of service users agreed that police stations should never be used, but 27% of police officers and 22% of service users disagreed. AMHPs, mental health nurses and other health professionals were most likely to disagree that police cells should never be used (71%, 62%, and 60% respectively).

Many people raised concerns over whether violent people could be safely managed in a healthcare setting if a police station was not an available option, and that this could pose too much of a risk to health staff and potentially other patients[142]. This is a very legitimate concern, although only a very small proportion of S136 detainees are too violent to be safely managed in these circumstances. Furthermore, if the person was violent, the police could be asked to remain to ensure security, or the person could be arrested by the police for the violent offence and thus taken to police custody, even if they were detained under S136 as well.

A key consideration is whether alternatives to police custody would always be available, including at times of peak demand. Unless the overall numbers of S136 detentions were reduced, removing police stations would place additional pressures on health-based places of safety to take more people, and some facilities would likely need to increase their capacity, and staffing levels.

If a police officer has made the decision to detain a person under S136, the police are responsible for that person until they can be safely handed to a responsible authority such as a hospital where they person can be kept safely and securely until they received a mental health assessment. If no health-based place of safety is available, or it cannot accept the person, the police remain legally responsible for them. If the police are not permitted to take the person to the facilities available to them – police custody – this could potentially create a very difficult situation.

It seems probable that removing police stations entirely as a place of safety could potentially have some unintended consequences. For example, the police could have to travel long distances with the person in order to find an available place of safety, or hold them for periods in a police van while waiting for a place of safety to become available, which could lead to a worse experience for the person. This period of detention would not be recorded under current systems as the 72 hours maximum length of detention does not start until the person has been accepted in a place of safety.

Alternatively, if the situation met the threshold for arrest for a criminal offence, such as breach of the peace, the police may take this option to detain the person in a police cell rather than try to find an available place of safety. Arresting them for a criminal offence could criminalise a person unnecessarily leading to a criminal record and potentially prosecution. It could also lead to them failing to promptly receive the care and treatment they need.

This review has concluded that **that police stations should not be removed as a place of safety** as it is useful to retain them as an option in exceptional circumstances to be used only when all other options have been explored. This ensures that police officers may use S136 whenever it is necessary to do so in the knowledge that there is a safe and secure facility to take the person to.

Option 2: Remove police stations as a place of safety for under-18s

The mental health Crisis Care Concordat[143], states that it is unacceptable for a child to be held in a police cell while awaiting medical help and that all services should work together to minimise the chance of young people with mental illness ending up in a police cell. The Concordat reinforces the duty

[142] 68% of all assaults on NHS staff are on mental health professionals (although only a very tiny proportion will involve people detained under S136).

[143] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

on the NHS to make sure that people under 18 are treated in an environment suitable for their age according to their needs, and builds on the objective set out in the NHS Mandate that every community should have plans to ensure no-one in crisis will be turned away. The mental health Crisis Care Concordat specifically states that adult places of safety should be used for children if necessary so long as their use is safe and appropriate. While it is preferable for children to be treated in dedicated CAMHS units, such as Tier 4[144], and not general children's wards or adult psychiatric wards, if the only alternatives are a police cell or a place of safety then it is acceptable for children to be held in a S136 suite attached to an adult psychiatric ward.

The CQC's refresh of their map of health-based places of safety in October 2014 found that two local authority areas have no provision for under 13s, a further 12 local authorities have no provision for under 16s, and another 14 have no provision for under 18s. This means that 26 out of 152 local authority areas (17%) have no provision for under 16s, and a further two have no provision for under 13s. Of the 26, 13 local authorities have no provision for 16-17 year olds[145].

The data published by HSCIC from the Mental Health Minimum Dataset are for England only. These showed that in 2013/14 753 children and young people aged under 18 were detained under S136. Of these, 236 under 18s were detained in police cells under S136 (31%), compared with 26% of all S136 detentions in that year[146]. In 2012/13, at least 580 children and young people were detained in England under S136[147], with 263 (45%) going to police custody, compared with 35% of all S136 detentions in that year[148]. This may suggest that a person aged under 18 is more likely to be detained in a police cell than an adult.

Figures gathered by a recent survey for the Howard League for Penal Reform are significantly higher than previous data. This shows that 958 children and young people detained under S136 were accommodated by mental health trusts in 2012 and 2013, including 109 recorded as being taken to police custody (11.3%). The majority of these young people were aged 16 or 17, but there are a few examples of children as young as 11 years old being detained under S136. Other young people detained under S136 may be sent home, or taken to a Tier 4 mental health unit, paediatrics department in a hospital, referred to CAMHS, admitted to an adult ward, or found a place in foster care[149].

Age when detained	Number detained	% of total
11	2	0.3%
12	6	0.8%
13	26	3.4%
14	44	5.8%
15	92	12.2%
16	239	31.7%
17	338	44.8%
Not known	8	1.1%
Total	755	100%

Table 6: Results of a survey of children detained under S136 in 2012 and 2013 in Mental Health Trusts by the Howard League for Penal Reform[150]

The issue of children and young people being held in police cells under the Mental Health Act has been highlighted previously[151]. In 2007, evidence

[144] Tier 4 consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated. Tier 4 services are commissioned nationally by NHS England.
[145] CQC, online at: http://www.cqc.org.uk/content/map-health-based-places-safety-0
[146] HSCIC 2014, Table 12, online at: http://www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-exp-tab-v2.xls
[147] This includes an estimated figure for Durham Constabulary, and excludes Northamptonshire Police and Derbyshire Constabulary, who were unable to provide this information.
[148] Online at: http://www.cqc.org.uk/media/new-map-health-based-places-safety-people-experiencing-mental-health-crisis-reveals-restrictio
[149] http://www.howardleague.org/emergency-provision-for-children/ (accessed September 2014)
[150] Some Mental Health Trusts provided incomplete data, citing Section 40 of the Data Protection Act, or combined age brackets. Online at: http://www.howardleague.org/emergency-provision-for-children/ (published September 2014)
[151] For example, http://www.bbc.co.uk/news/uk-20377493 and http://www.theguardian.com/society/2014/aug/17/mentally-ill-children-police-cells and http://www.howardleague.org/emergency-provision-for-children/ (accessed September 2014).

submitted to the Mental Health Bill Committee to the stated that:

> '*CAMHS services do not usually provide any facilities for a 'place of safety' for children subject to S136 of the Mental Health Act, and even in those areas where there is appropriate 'place of safety' provision in the local adult mental health services, these hospital-based S136 suites do not accept children or young people under the age of 18, so instead these vulnerable distressed youngsters are held in police custody, an even more inappropriate setting for them'*[152].

The CQC's *Monitoring the Mental Health Act* annual report 2012/13 reported that in one area, 41 young people had been detained in police cells that year, the youngest of whom was 11, on the grounds that the health-based place of safety was not age-appropriate as they were connected to adult psychiatric wards[153]. The CQC described this as 'clearly unacceptable practice'.

The CQC's recent report on their survey of health-based places of safety recommended that places should ensure that appropriate arrangements are in place for children and young people[154]. The survey showed that 16% of health-based places of safety reported that there was no provision at all in their local area for people aged 16-17, and 26% reported that there was no provision for people aged under 16.

Since April 2010, hospital managers have had a statutory duty to ensure that any psychiatric patient under the age of 18 (whether or not they are subject to detention under the Mental Health Act) is accommodated in a 'suitable' environment, 'having regard to his age (subject to his needs)'[155]. A health-based place of safety which is attached to an adult psychiatric ward may well not be considered a 'suitable' environment. However, it is recognised that in emergency situations if a no more suitable environment is available, it is acceptable to put a young person in an alternative environment for a short period of time: '*Even though such facilities may not be ideal places to hold children and adolescents (for example, they are unlikely to have specialist CAMHS nurses immediately available), the practical alternative in many areas is a police cell, which is clearly worse...it is our view that any hospital-based place of safety must usually be a better option for children and adolescents than a police cell, even if the place of safety is not entirely self-contained.*'[156].

In November 2014 the Health Select Committee said '*It is wholly unacceptable that so many children and young people suffering a mental health crisis face detention under S136 of the Mental Health Act in police cells rather than in an appropriate place of safety. Such a situation would be unthinkable for children experiencing a crisis in their physical health because of a lack of an appropriate hospital bed and it should be regarded as a 'never event' for those in mental health crisis. In responding to this report we expect the Department of Health to be explicit in setting out how this practice will be eradicated.*'[157]

In July 2014 NHS England published a review of Tier 4 CAMHS[158]. In response, the Department of Health set up a Task Force to follow up on actions. The Children and Young People's Mental Health and Well-Being Taskforce is exploring how to improve the way children's mental health services are organised, commissioned and provided, and how to make it easier for young people to access help and support, including crisis care. It will report in spring 2015. This year an additional £6.5m has been invested in providing an additional 50 mental health beds for children and young people. This review forms part of the Department of Health's

[152] Memorandum submitted by Penny Stafford (MH 57)to the Mental Health Bill Committee, April 2007, online at: http://www.publications.parliament.uk/pa/cm200607/cmpublic/mental/memos/ucm5702.htm

[153] CQC, online at: http://www.cqc.org.uk/content/mental-health-act-annual-report-201213

[154] CQC, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

[155] Section 131(A) of the Mental Health Act 1983, as amended by the Mental Health Act 2007.

[156] CQC 2010 online at: http://www.cqc.org.uk/sites/default/files/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf

[157] Online at: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34213.htm

[158] Online at: http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf

programme of work, alongside the Children and Young People's Taskforce[159].

This review considered the option of amending primary legislation so that police stations could not be used as places of safety for those aged under 18. Although the online survey for the review did not specifically ask about this option, there was strong agreement with the statement 'there should always be an age-appropriate place of safety available for under 18s, with 92% agreement.

Removing police stations as a place of safety for under 18s would ensure that no child or young person is held in a police cell under S136. The numbers of S136 detentions of children and young people are much smaller than those of adults; there is therefore less potential impact on health-based places of safety. The main reason why a child or young person may not be accepted in a health-based place of safety is because the place is already full, or because its policy states that it cannot accept a person aged under 18, or under 16. Unless health-based places of safety alter their policies this could leave a gap in provision which could result in poorer outcomes for the person concerned.

Article 3 of the UN Convention on the Rights of the Child[160] states '*In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration*'.
Section 11 of the Children Act 2004 sets out a duty on specific persons and bodies to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children[161]. Section 131A of the Act applies to persons aged under 18 who are liable to be detained in a hospital (including those taken to a hospital as a place of safety under sections 135 and 136). It requires the managers of a hospital to provide a suitable environment having regard to the person's age[162]. Therefore, some health professionals take the view that an adult psychiatric ward is not a suitable environment for a child or young person and that there are safeguarding issues which could arise. Furthermore, children and young people require assessment by appropriately qualified professionals and this may not be available.

The Crisis Care Concordat stated that *'unless there are specific arrangements in place with Children and Adolescent Mental Health Services, a local place of safety should be used, and the fact of any such unit being attached to an adult ward should not preclude its use for this purpose.'*

Introducing this change could require additional investment in health-based places of safety so that they can accept people aged under 18, including providing the appropriately trained staff. This is an issue which can be considered by the Department of Health's Children and Young People Taskforce. However, the relatively small number of child detentions and the fact that the main barriers are local policies and access to specialist services rather than lack of capacity means that this could be achieved provided the S131 (A) requirements are met.

It is possible that in exceptional circumstances, removing police stations as an option may leave the police with nowhere suitable to take a child or young person detained under S136. However there are a range of other possible places of safety permitted by S135(6) (for example, other parts of the hospital such as a paediatrics ward, local authority residential homes including children's homes, care homes,

[159] Online at: https://www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce
[160] Online at: http://www.ohchr.org/en/professionalinterest/pages/crc.aspxo
[161] Online at: http://www.legislation.gov.uk/ukpga/2004/31/section/11

[162] S131A of the MHA 1983 Accommodation, etc. for children:
(1) This section applies in respect of any patient who has not attained the age of 18 years and who (a) is liable to be detained in a hospital under this Act; or (b) is admitted to, or remains in, a hospital in pursuance of such arrangements as are mentioned in section 131(1) above.
(2) The managers of the hospital shall ensure that the patient's environment in the hospital is suitable having regard to his age (subject to his needs).
(3) For the purpose of deciding how to fulfil the duty under subsection (2) above, the managers shall consult a person who appears to them to have knowledge or experience of cases involving patients who have not attained the age of 18 years which makes him suitable to be consulted.

private homes of family or friends (if appropriate), or any other suitable safe place – as set out in Option 7 below) and so CCGs may be able to develop more flexible approaches which would remove the need to use police stations as places of safety for children and young people.

It might be appropriate in these settings for a police officer or an appropriate adult or health professional to remain with the young person until the mental health assessment has been undertaken and, if needed, other arrangements made for their further treatment or care. Very exceptionally, the police officer may be able to sit with the young person in an emergency department or a waiting area until a doctor or AMHP was able to attend.

There is a potential conflict here with option 1 (see above) if the young person proved both too violent to be safely held in a health-based place of safety, and was aged under 18. It is hoped that in these very rare cases the health-based place of safety would be able to accommodate them with police assistance if necessary. The police could remain with the young person in the health-based place of safety to enable them to be safely managed in a place other than police custody.

It may be that in some instances it is difficult for the police officer to determine whether the person is aged under 18 or not, if they refuse to give accurate details and the information is not available, and the police officer cannot accurately determine by appearances. In such circumstances, if the police officer believes they are aged under 18, the police officer should treat the person as if they were aged under 18 and seek an alternative place of safety other than a police station.

The review recommends, depending on resolving any funding issues, and a full impact assessment, amending legislation so that **children and young people are never taken to police cells** if detained under S135 or S136**.**

Option 3: Define 'exceptional' circumstances for using a police station

An alternative option to removing police stations as a place of safety is to define clearly the circumstances under which a police station could be used.

There was strong support in the survey for permitting police stations only to be used as places of safety in exceptional circumstances such as if the person was violent or their behaviour otherwise so extreme that only a police cell can be used to hold them safely. As a result of this review, recommendations have been made that the Code of Practice is amended to define 'exceptional' as being because the person's behaviour would pose an unmanageably high risk to other patients, staff or users of a healthcare setting. However, given that the Code of Practice has for some years specified 'exceptional' use only and yet the use of police stations remains high in some areas, it is worth exploring whether this could be enshrined in statute as a more effective means of changing practices in some areas.

73% of people who responded to the survey thought that police cells should be used only if the person was too violent to be safely managed in a healthcare setting, with strong support for this from AMHPs (88%), paramedics (79%), mental health nurses (77%), other health professionals (77% agreed) and service users (74%). 69% of police officers also agreed.

The advantage of this approach is that rather than removing police stations entirely as a place of safety, it would permit them to be used but only in very exceptional circumstances where the person is very violent, or their behaviour so extreme, that they pose a real threat to staff or other patients in a healthcare setting. This should eliminate the use of police cells because the place of safety was already in use or for other reasons. The use of a police station would have to be agreed by the police, who should ensure that the relevant threshold had been met. It would be possible for this to be achieved by requiring authorisation from both a senior health professional and senior police officer who would determine whether the use of a police station in a particular case was appropriate and lawful.

It is recognised that it is very difficult to define exactly what threshold of behaviour would constitute a valid use of a police station. In addition, there may be circumstances in which a health-based place of safety is not available to take a person, but the person is not exhibiting behaviour which would justify using a police station. In these circumstances, local agencies should agree alternative places of safety which can be used (see below).

Figures set out by Thames Valley police showed that in only 16.6% of cases in 2013/14 the person was held in police custody because their behaviour was unmanageable in a health setting. If this is representative of England and Wales as a whole, it may be expected that introducing this change could reduce the use of police custody by around 80%.

To reduce the routine use of police stations as places of safety for people detained under S136 or people who could be safely managed in a health-based place of safety or alternative places of safety, we recommend, depending on resolving any funding issues, and a full impact assessment, ensuring that **police cells can only be used as a place of safety for adults if the person's behaviour is so extreme they cannot otherwise be safely managed in a health based place of safety.** It may be useful to record and review every instance when a police cell was used, to ensure that its use was necessary and unavoidable.

Consideration will need to be given to how 'extreme behaviour' for these purposes is defined. Consideration will also need to be given to what should happen if there is a disagreement between the police and the health professionals regarding the risks posed, and if the person is arrested for a serious criminal offence in addition to being detained under S136, in which case there may be a need for forensic evidence recovery which would require the person to be in police custody. For example, local partner agencies could work closely together to agree a joint local protocol to set out what should happen in these cases.

Option 4: Provide a cross-charging framework

During the review, several police officers suggested they should be able to charge the NHS for their services. Police and Crime Commissioners and police forces do not have any express legal framework that would permit them to charge for the provision of services provided under the Mental Health Act 1983. Neither the Mental Health Act 1983 or the Police and Criminal Evidence Act 1984 (PACE) provide the police with any statutory framework to allow them to charge for the use of a police station as a place of safety, nor the use of police vehicles to transport a patient to or between places of safety, nor for the use of police time spent, for example, in waiting for a patient detained under Section 136 to be seen in a hospital.

The Police Act 1996 (S25) permits the police to charge for the provision of 'special police services', for example for policing a football match[163]. However, the use of police resources for the purposes of enacting a detention made by the police under S135 or S136 does not fall within this scope. Section 15 of the Police Reform and Social Responsibility Act 2011 applied Section 1 of the Local Authority (Goods and Services) Act 1970 to elected policing bodies (Police and Crime Commissioners). This covers administrative, technical or professional services. However, the police's use of police vehicles or police cells or the use of police time would not constitute a service provided for this purpose.

The general principle of the police charging the NHS, CCGs, local authorities, or ambulance services, for the use of police vehicles or police cells, or for police time, does not reflect the aims and purposes of the Mental Health Act 1983. Creating any legal framework for charging could provide perverse incentives for both police and health to enter into a financial arrangement whereby health services could discharge their responsibilities to provide places of safety by paying for the use of police cells. It could give an implicit message that a police cell was an acceptable substitute for a health based place of safety for a vulnerable person experiencing a mental health crisis. Therefore **the review does not recommend this option.**

Health-based places of safety

The Act sets out, in S135(6), what constitutes a place of safety, including hospitals, police stations, local authority residential accommodation, care homes and 'any other place the occupier of which is willing to temporarily receive them[164]'.

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[163] 'The chief officer of police of a police force may provide, at the request of any person, special police services at any premises or in any locality in the police area for which the force is maintained, subject to the payment to the police authority of charges on such scales as may be determined by that authority'. Online at: http://www.legislation.gov.uk/ukpga/1996/16/section/25

[164] S135(6) of the Mental Health Act 1959 previously provided an almost identical definition (set out in Annex A of the literature review, p.68 - 69).

Discussions with police officers during the visits carried out for the review suggested that there were few alternatives available to the police. Whether an alternative place of safety would necessarily be able to keep the person safely and securely was a key concern. Some officers suggested that it would require a continuing police presence in order to ensure safety and that this could take up a lot of an officer's time.

The courts have previously touched upon what is required in relation to places of safety:

> *'The powers contained in S136 of the 1983 Act to remove to a place of safety inevitably require that the person concerned can be kept safe in the sense that harm to himself or others is prevented until he can be seen by a doctor and, if necessary, given some form of sedation'*[165].

The use of health-based places of safety was considered generally preferable by most police officers, health professionals and service users who contributed to this review. 96% agreed that health-based places of safety should have 24/7 access and staffing. The Code of Practice and the Crisis Care Concordat suggest this is the preferred option. However, previous research suggests that some health professionals feel that detainees should not automatically be assessed in a hospital setting, especially a psychiatric hospital, because of the stigma attached to mental health problems and because being taken to a psychiatric hospital before being assessed may prejudge the person as being mentally ill[166]. Other evidence suggests that providing health-based places of safety may encourage the police to detain more people under S136, rather than consider alternatives[167].

The availability of health-based place of safety emerged as a key theme in the evidence for this review. The CQC's 2014 survey of health-based places of safety in England provided a more detailed view of health-based places of safety[168]. The report found that too many:

- places of safety are turning people away, or requiring the police to wait for lengthy periods with the person, because they are already full or because of staffing problems, which raise questions about provision and capacity;
- providers operate policies which exclude young people, people who are under the influence of drink or drugs, and people with disturbed behaviour from all of their local places of safety, which in many cases leaves the police with little choice but to take a vulnerable individual in their care to a police station; and
- providers are not appropriately monitoring their own service provision.

The CQC found that a quarter of providers did not believe that their local provision was sufficient, and the use of police stations as a place of safety was directly linked to the provision (or lack of) health-based places of safety.

The review considered whether legislative change could help to alter this landscape to encourage more capacity and resilience in health-based places of safety, or the provision of more alternative places of safety to reduce the reliance on police custody.

Option 5: CCGs to provide adequate health-based places of safety

S140 of the Act sets out the duty on CCGs (formerly Primary Care Trusts) to give notice to local authorities in their areas of arrangements which are from time to time in place for receiving patients in cases of special urgency[169]. It does not require CCGs to make provision for all S135 and S136 detentions nor to provide adequate staffing levels for health-based places of safety. Having such a designated place of safety does not preclude the possibility of using other parts of a hospital for this purpose, for example, if the Hospital Authorities and CCG agreed

[165] *R (Anderson) v. HM Coroner for Inner North London* (2004)
[166] Riley et al 2011a
[167] CQC 2010, online at http://www.cqc.org.uk/sites/default/files/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf
[168] CQC, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf
[169] Online at: http://www.legislation.gov.uk/ukpga/1983/20/section/140

to designate a ward or other area as a place of safety in order to provide additional capacity at times of high demand.

The National Health Service Act 2006 prescribed legislative duties and functions in relation to the NHS. The Department of Health sets the high-level strategic aims via the NHS Mandate in England. However, this means that Government cannot mandate specific levels of service, such as requiring CCGs to provide numbers or staffing levels for health-based places of safety: this would be contrary to the ethos and direction set out in the Health and Social Care Act 2012. The NHS Mandate for 2014/15 sets out several objectives on mental health[170]:

- ensuring people have access to the right treatment when they need it, including... services for children and adults with mental health problems;

- to make rapid progress, working with CCGs and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services. This includes ensuring there are adequate liaison psychiatry services. We expect every community to have plans to ensure no one in crisis will be turned away; and

- NHS England will need to work with CCGs to ensure that providers of mental health services take all reasonable steps to reduce the number of suicides and incidents of serious self-harm or harm to others, including effective crisis response.

In 2004 the Joint Parliamentary Committee on Human Rights stated:

> *'People requiring detention under the Mental Health Act should not be held in police cells. Police custody suites, however well resourced and staffed they may be, will not be suitable or safe for this purpose, and their use for this purpose may lead to breaches of Convention rights. In our view, there should be a statutory obligation on healthcare trusts to provide places of safety, accompanied by provision of sufficient resources for this by the Government. Ensuring the safety of people detained by the police is not a single agency problem that can be addressed by the police alone. It also involves the responsibilities of health authorities, and requires good co-ordination between health authorities and the police. Transfers from police cells to hospital must operate more effectively. We recommend that a statutory duty be placed on healthcare trusts to take responsibility for people detained under section 136 of the Mental Health Act.'*[171]

The CQC report found that many commissioners are not sufficiently involved with the operation of health-based places of safety[172], despite guidance from the Royal College of Psychiatrists[173]. This means that it is difficult for those providers and commissioners to evaluate conclusively whether local provision is meeting the needs of their local population.

Several people who contributed to the review noted that health-based places of safety are not specifically commissioned by CCGs but that these services form part of a block contract for mental health services. This could mean that CCGs are not monitoring the quantity or quality of health based places of safety provision.

The Crisis Care Concordat sets out that local commissioners have a clear responsibility to put sufficient services in place to make sure there is 24/7 provision sufficient to meet local need. NHS England, as part of its Parity of Esteem programme, is producing a range of tools and resources to support effective commissioning of mental health services, including crisis services.

[170] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf

[171] Online at: http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1510.htm

[172] CQC, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

[173] Royal College of Psychiatrists, online at: http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr159.aspx

This review supports the recommendations of the CQC's recent report on health-based places of safety[174], that **health-based places of safety and CCGs should understand the demand and provide adequate levels of service, which may include increasing the capacity and staffing in health-based places of safety.** Further consideration needs to be given to how to achieve this objective.

Health-based places of safety should agree plans to improve any areas of shortfall in discussion with partners. They should also review and amend their exclusion criteria in relation to people who are under the influence of drink or drugs, whose behaviour is disturbed, or who have a previous history of offending or violence. This may mean there is a need for greater flexibility as to what constitutes a designated a place of safety, or having a greater range of places that can be used when needed. Health providers should ensure that a minimum of two healthcare staff are allocated to receive an individual brought to the place of safety by the police, and that training for staff who work in the place of safety should be reviewed. Plans should then be developed to address any shortfalls. This should include training for security staff where relevant.

The CQC also recommended that **CCGs should review the availability and use of health-based places of safety to identify whether provision meets local needs.** This includes reviewing the frequency that people are unable to access the local place(s) of safety, the reasons for this and making sure that there are sufficient and appropriate places of safety for children and young people, and put in place commissioning specifications.

The review also recommends that **CCGs should review their commissioning processes for places of safety** and consider specifications for providing health-based places of safety with sufficient staffing. CCGs should ensure that sufficient spaces are available for children and young people and that no child or young person is turned away from a health-based place of safety because of their age. Consideration will need to be given to how best to implement this.

[174] Online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

Option 6: Health-based places of safety to accept patients under the influence of drink or drugs

This option was considered in response to concerns from police that health-based places of safety were refusing access to people on the grounds that they were under the influence of drink or drugs, even if only very slightly. As many people with severe mental health conditions may also self-medicate with alcohol or drugs, a person may be in mental health crisis and in need of urgent care while being under the influence of drink or drugs, and so should not be excluded from a health based place of safety simply on the grounds of intoxication. This would mean that the person would have better access to urgent medical care, if needed, than they could have in police custody.

Although most police forces do not gather these data, in the sample of one year's data from Thames Valley police, 13.7% of S136 detentions were held in police cells rather than in a health-based place of safety, because the person was under the influence of drink or drugs.

S136 suites operate varying local policies on intoxication[175] ranging from breathalysing the person before access in some areas, to managing people in the suite 'as long as they can stand up'[176]. Some people felt that a health-based place of safety should have the facilities to cope with a person who is under the influence of drink or drugs even if they are unpredictable and potentially problematic, rather than relying on using police custody in such circumstances or sending the person to an emergency department. It is possible that this shift could result in more people being detained under S136 who are under the influence of drink or drugs but do not have mental health conditions.

However, many health professionals were concerned that the police were over-using S136 to detain people who were only intoxicated and who, once they have recovered from the effects of drugs and alcohol, had no evidence of a mental health condition. It can be difficult for a police officer to

[175] CQC, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

[176] Quote from a visit by the review team to South London and Maudsley Hospital's place of safety.

determine whether or not a person has a mental health condition, or is only intoxicated. Many health professionals made the point that a mental health assessment cannot commence until the person has recovered from the effects of drugs and alcohol.

Detaining a person under S136 can have lifelong ramifications for the person, for example if this is disclosed on enhanced DBS checks. S136 suites should not be used other than for those who appear to meet the threshold for detention ('appears …to be suffering from mental disorder and to be in immediate need of care or control').

It would be preferable for hospitals or other places to provide suitable facilities for intoxicated people without requiring them to be formally detained by the police or held in places of safety, which may instead be needed for people in mental health crisis.

Introducing such change does not require any legislative change but a step-change in practice to reduce the number of unnecessary S136 detentions, and the proportion being held in police custody. Further consideration will need to be given to how this can be achieved.

Requiring the police to seek medical advice before using S136 (see Option 20 below) could help the police to identify which people are only under the influence of drugs or alcohol and do not need to be detained.

Encouraging health-based places of safety to accept people under the influence of drink or drugs does not require any change in primary legislation.

Option 7: CCGs to provide suitable places of safety for under-16/ under 18s

It is clear in the CQC's survey of health-based places of safety that there is a gap in provision particularly for under 16s and to some extent for under18s. This option would require CCGs to commission places of safety which can receive children and young people, so they would never need to be detained in police cells under S136.

S140 of the Act already sets out a duty on CCGs to give notice to local authorities in their areas of arrangements which are from time to time in place for receiving patients in cases of special urgency, as well as providing accommodation or facilities designed to be especially suitable for children and young people aged under 18[177]. Legislative change is therefore not considered necessary to bring this about. However, additional resources and prioritisation are required.

The review therefore **recommends that CCGs should review their provision and ensure that sufficient spaces are available for children and young people, and that no child or young person is turned away from a health-based place of safety because of their age.** Further consideration will need to be given to how this can be achieved.

Option 8: Explore models for alternative places of safety

The IPCC recommended in 2008 that NHS commissioners should develop alternative places of safety to police cells[178]. However, the review found few examples of anything other than a health-based place of safety, police cell, or sometimes emergency department, being used.

It is possible that other models of provision could help to increase the availability of alternative places of safety. For example, if they were able to provide suitable facilities and staffing, these could potentially include:

- Voluntary and Community Sector organisations;
- Mutuals[179] or social enterprises;
- NHS Walk-in centres or urgent care centres or other NHS provision;
- GP surgeries;
- private providers;
- other police-run provision; and
- using other parts of prison or probation estates.

[177] Online at: http://www.legislation.gov.uk/ukpga/1983/20/section/140

[178] Independent Police Complaints Commission 2008

[179] A public service mutual is an organisation which has left the public sector (also known as 'spinning out'), but which continue to deliver public services; and, importantly, staff control is embedded within the running of the organisation. More can be found online at: https://www.gov.uk/start-a-public-service-mutual-the-process

The safety and security of the person in detention is the key factor in making decisions about where the person should be detained[180] and should include human rights considerations[181]. The provision of adequate, timely and appropriate medical care to people in detention is essential. The place of safety therefore has to be somewhere that is secure and where the individual's needs can be met by an appropriate healthcare professional. If the person is taken to anywhere other than a health-based place of safety, the police may have to remain in order to ensure security and safety, as in emergency departments. Any alternative places of safety would need to be equipped and staffed to manage people who potentially have seriously disturbed and agitated behaviour.

A further consideration is whether the place of safety is currently permissible under S135(6), either as residential accommodation (including a care home or residential home) provided by a local authority, or under 'any other suitable place the occupier of which is willing temporarily to receive them'.

S135(6) takes the general approach of ensuring a variety of locations are potentially available to be used as places of safety. There is a need for a 'catch-all' option as it is unfeasible to list all the potential places of safety that could be used. However, the meaning of 'any other suitable place the occupier of which is willing temporarily to receive them' is open to interpretation, particularly in respect of premises where there is no readily identifiable 'occupier' within the meaning of S136.

Using GPs surgeries as places of safety, as they are in Scotland, would depend upon their suitability, including the facilities available and the staffing arrangements in place. The facilities, unless significantly altered, are not likely to be secure. Any proposals for their use in England and Wales would need to consider the safety of other patients, and the additional burden of provision and staffing.

The evidence considered during this review suggests that the location where a person can be detained is only part of the picture. If the relevant health professionals (Crisis Care Teams, AMHP, and psychiatric doctor) were able to respond quickly to provide a mental health assessment in a person's home, or a relative's home, and to make any further arrangements for care if needed, then it would be possible to be more flexible about what place of safety could be used as this would only be on a very temporary basis and the police could remain for the short period of time needed.

However, it can be difficult for health services to respond very quickly to these often unpredictable detentions. Further, if the person was too agitated, or also under the influence of drink or drugs, an immediate mental health assessment might not be possible and the person would need to be safely held somewhere for a period of time until the assessment could take place.

There may be scope for exploring voluntary and community sector provision of alternative places of safety, as well as commissioning additional capacity from independent hospitals. It is likely there will be challenges in developing new models to ensure the provision of suitable facilities and staffing, the need to be registered with the CQC as providing these healthcare services, and managing the potential risks involved in managing very vulnerable people.

[180] For example, in *Keenan v UK,* the suicide in custody of a mentally ill prisoner was found to breach Article 3, since there had been insufficient monitoring and psychiatric assessment, and the prisoner had been inappropriately detained in segregation.

[181] Joint Committee on Human Rights (2004), Third Report. Online at: http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1509.htm

Within the remit of the current legislation there are options available to provide alternatives. The review recommends that **CCGs and partner agencies should explore alternatives to police custody**, provided that they are able to keep the person safely and securely and meet the required standards in facilities and staffing. This could include specialist care homes, or modifying the environment and facilities in police stations so that a space other than a normal cell could be used for S136 detentions. The use of 'occupier' in S135(6) can give rise to confusion or ambiguity, particularly in respect of places which do not have a readily identifiable single occupier. In light of the recommendation to explore increased use of alternative places of safety, it would also be beneficial to reconsider the wording used in S135(6) to make provision more clearly for the use of alternatives and amend the list of places of safety in S135(6) so that **anywhere which is considered suitable and safe can be a place of safety** provided that the owner/occupier or responsible organisation consents. This would remove barriers to using community-run places of safety or other alternatives which could not be said to have a single 'occupier' and could help to enable innovative practice (see Case Study).

Emergency powers in homes

This is one of the most controversial and difficult areas of the review. A number of people who responded suggested there was a gap in legislation when a police officer has been called to the home of a person who is suffering a mental health crisis but has no powers to remove them immediately to a place where they can be assessed and arrangements made for their treatment and care. S136 does not apply in private homes and waiting for an AMHP to obtain a S135 warrant from a magistrate can take several hours. Importantly, a large proportion of mental health emergencies occur in the home, rather than in public places.

The Police and Criminal Evidence Act 1982 (PACE) provides the police with a power of entry under S17(1)(e) which allows the police to enter and search a property without requiring a warrant for the purposes of saving life and limb or preventing serious damage to property. This means that the police have to reasonably believe that there is a risk to the individual's life or a risk of serious bodily injury, not just concern for the welfare of a person inside the premises[182].

S17 of PACE allows the police to use reasonable force when exercising PACE powers, including the power in section 17(1)(e). So for example, if a constable enters and searches under section 17(1)(e), if a person was in the act of harming themselves, the police could use force to prevent this[183].

The police must have regard to the ECHR including relevant obligations to protect a person's right to life where there is a foreseeable risk of a threat to their life. This might require the police, if they come across a person about to attempt self-harm or suicide, to use force to disarm. It might require the police to stay with that person and supervise them whilst other forms of help or assistance are sought. Both of these actions can be lawfully taken under PACE.

CASE STUDY

The Home Secretary recently announced that the Home Office will fund a short pilot for an alternative place of safety in Sussex, working closely with Sussex Police, Sussex Partnerships NHS Foundation Trust, and the Richmond Fellowship. The aim is to explore whether a care home can be used as an alternative place of safety, when the health-based place of safety is unable to accept the patient, in order to reduce the numbers of people being held in police custody. It is anticipated that in the course of the pilot, around 90 people will be able to use the care home when they otherwise would have been held in cells. The pilot will also explore the cost-effectiveness of this approach and share the lessons learnt.

[182] *Syed v Director of Public Prosecutions* (2010)
[183] *Baker v Crown Prosecution Service* (173 J.P. 215, DC)

There is, however, no legal power in PACE or under the Mental Health Act 1983 to detain or remove a person in mental health crisis from private homes without a warrant, even in urgent situations or where there is a risk of harm. Nor is there power to permit the police to remain in the private home if permission to be there has been withdrawn or the situation is no longer so urgent as to justify entering under PACE S17.

The use of a S135 warrant is the proper procedure in the case of mental health emergencies in homes[184].

Option 9: Extend S136 to apply in people's homes, or create a new emergency power if authorised by an appropriate person

Extending S136 to cover private homes was seen by many survey respondents as a solution to this issue. It would permit the police (and possibly also paramedics and other health professionals, if powers were extended to them – see below) a means to remove a person from their home and take them to a place of safety, provided that they met the threshold for detention under S136. Alternatively, a new emergency power could permit, in very limited emergency circumstances, removal to a place of safety without a S135 warrant.

In the case of a mental health emergency in a person's home, the situation may at times be so urgent and so serious as to justify entering and removing them to a place of safety for a short period of time in order to prevent harm to themselves or others and to protect life. A typical instance may be of a suicidal person where the police officer feels they cannot wait for a S135 warrant to be obtained. However, there are a number of issues which require very careful consideration, including human rights and civil liberties.

To be justified in particular circumstances, the power would need sufficient, detailed safeguards. The government has undertaken a review of all Powers of Entry[185] and created a Gateway which aims to balance the need for public protection against individual liberties. The detailed guidance[186] sets out that the power to enter private dwellings should only be exercised with consent, or with a warrant. Entry to premises without a warrant would rarely be considered acceptable where force may be used to gain entry, or where the powers are exercised by anyone other than a police officer. A power to enter without a warrant would also need to be subject to detailed conditions, such as senior level authorisation by a doctor, other health professional, or senior police officer. To ensure that the need for any power of entry is justified and proportionate any amendment to S135 would be subject to approval via the Gateway[187].

Safeguards considered by the review included:

- that the situation should be an emergency where there is an immediate emergency or immediate risk of harm – so that the test is significantly narrower than it is currently framed in section 135(1);
- that no additional power of entry be created, so the police must rely on the high threshold of PACE S17 to enter, if entry is not permitted by the householder or occupier;
- a requirement for authorisation by a senior official such as a senior police officer and/or senior medical authority;
- that the person could only be removed from a private home to a health-based place of safety or place other than a police cell to reflect the fact that the situation is so serious the person needed to be seen quickly by a health professional;
- that the person could only be held for a shorter period of time (such as six hours) unless re-detained under a separate power; and
- that every use of the power should have a mandatory multi-agency review to ensure it was used appropriately.

However, adding too much additional bureaucracy risks losing the element of speed and may restrict

[184] *R (Sessay) v South London and Maudsley NHS Foundation Trust and another* (2011)
[185] Online at: https://www.gov.uk/powers-of-entry
[186] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98385/powers-entry-review-guidance.pdf
[187] Guidance on the Powers of Entry Gateway is online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98386/powers-entry-guidance.pdf

the police too much. A S135 warrant would still be required in many cases. This option does not include repealing S135 which would therefore remain available for less urgent situations.

Other health professionals and paramedics do not have this PACE power of entry available to them. This would require a new power of entry would have to be created for these specific circumstances with appropriate safeguards.

The review noted that there may be a number of other legal powers held by AMHPs or health professionals under the Act, the Mental Capacity Act 2005 or other legislation that will need to be taken into consideration to determine whether these could be of any use to the police or health professionals dealing with this situation, or whether more significant changes will be necessary.

The review considered in some detail whether or not an additional emergency power could be created, with safeguards, to cater for very extreme situations, provided that this was authorised by a suitable person such as a health professional. On balance, given the complexities of human rights and civil liberties considerations, the review **does not recommend the introduction of such an emergency power at this time** but recognises the need for further detailed discussion and consultation with those affected on these issues; in particular, the need to explore whether more can be done to provide support and advice to police in such situations, and ensuring that, for example, crisis services are able to respond to provide assistance.

Option 10: Speed up S135 warrants

The review explored options for reducing delays in getting S135 warrants, rather than extending S136 or creating any new powers. There are various stages of the S135 warrant process which can cause delays, including:

- locating an AMHP to apply for the warrant (if not already on scene);
- gathering the requisite information;
- organising payment for the warrant;
- travelling to the court and waiting to be seen or other out of hours arrangements;
- delays with the Clerk of the Court (who may not appreciate the urgency of a S135 warrant);
- queries by the magistrate as to whether entry had been refused; and
- co-ordinating the presence of the AMHP, police, ambulance, and potentially also a locksmith to gain access.

Several AMHPs said it could take more than four hours to get a warrant, while during the practitioner workshops the availability of magistrates out of hours was cited as a common reason for delays. One AMHP said that their local magistrate only did warrants ‘on Fridays’.

Typically, a S135 warrant situation might be where concerns arose for the well-being of a person who was already known to mental health services, and the AMHP might need to take them to a safe place for assessment. Workshop participants did not describe using S135 warrants in any sort of emergency situation, and several said warrants were under-used or never used because of the bureaucracy and length of time involved. Some police officers said that AMHPS relied on them to use their S136 powers in emergencies even though these do not apply in homes.

At present a S135 warrant costs £20 having recently gone up from £18. A number of AMHPs responding to the survey said that they have to find this money out of their own pocket, or navigate bureaucratic systems which create delays – for example, having to travel back to their local authority headquarters to obtain a means of payment, or phone a number and give credit card details in return for a reference number to give the court. However, in some areas courts are able to invoice local authorities directly removing the problem for the AMHP.

HMCTS are encouraging local authorities to sign up to a payment system known as Fee Account. The service offers customers improved fee management and court application processing. There is no charge for use of the service. Once signed up, any applications for warrants can be made to the court quoting the appropriate fee account reference, reducing delays. AMHPs could encourage their local

authorities to sign up and ensure that they have the authority to use the Fee Account[188].

A further issue raised during the review was that some magistrates conflate the provisions of S135(1) and S135(2) and refuse to grant a S135(1) warrant unless entry has been refused to the property. S135(2) requires that it must appear that entry to the property has been refused or that a refusal of such admission is 'apprehended'. S135(1) does not rely on entry having been refused to the property: it is entirely possible that the person or their family has allowed the AMHP or police inside. Some AMHPs also felt that magistrates are not providing sufficient independent challenge and simply relied on the professional opinion of the AMHP that a warrant was considered necessary.

There are various programmes of work underway which could help the S135 process, including simplifying payments and potentially introducing digital warrants in due course. However, these will never be fast enough to grant a warrant in an emergency situation, such as if someone's life was at stake, the process will continue to rely on the availability of magistrates and court processes.

However, it is recommended that local partners take steps to **speed up S135 warrants and streamline processes** as much as possible. Further consideration will need to be given to how this can be achieved in practice, but options identified by the review include**:**

- Local Authorities could sign up to the new Fee Account system to ensure payment for the warrant does not become a delaying factor;

- Courts could prioritise S135 warrants where the AMHP explains that it is very urgent, and magistrates should understand that without the S135 warrant, the person cannot be removed or detained in a place of safety. Magistrates should understand the differences between S135(1) and S135(2) warrants, and that it is not necessary for permission to enter to have been refused to grant a S135(1) warrant. Additional guidance will be provided on this;

- The Ministry of Justice will continue to explore the potential for digital warrants to be introduced which would reduce the time spent travelling to and from courts; and

- In some areas, close working arrangements between out-of-hours magistrates and AMHPs have helped to ensure that obtaining a warrant does not introduce unnecessary delays. This should be best practice.

Option 11: Permit S135 warrants to be granted retrospectively

It was suggested during the course of the review that it may be possible for a provision to be created whereby the police could remove a person to a health-based place of safety for a short period of time, or place the person under detention in their home temporarily, while a S135 warrant was sought on a 'retrospective' basis.

This option was explored and ruled out on the grounds that there are no precedents for a 'retrospective' warrant to give a power of entry after the fact.

The risks are that the magistrate then refuses to grant the warrant, for example because the grounds for it were not shown to be sufficiently strong, which then renders the entry and any subsequent detention illegal.

The review therefore does not recommend creating 'retrospective' S135 warrants for emergency situations.

Option 12: Removal of S136 powers from the police

The Police Federation suggested to the review that S136 powers be removed entirely from the police[189].

[188] For all enquiries on the fee account service please contact the team on FeeAccountPayments@hmcts.gsi.gov.uk. Further information can be found at: http://www.justice.gov.uk/courts/fees/payment-by-account

[189] Police Federation response, in Summary of Evidence, p.83. See also, *Police* magazine, September 2013, online at:

This was also suggested at the academic roundtable and in workshops[190].

This option was considered but was ruled out. In addition, there are many instances – as the number of S136 detentions shows – where the police encounter people who are experiencing mental health crisis during the course of their work and it is necessary for the police to have a power in place to address the situation. The power also gives the police a legitimate role which can prove helpful to health professionals, paramedics, and AMHPs in the course of their work.

Several police officers who contributed to the review noted that S136 had 'saved lives' and to remove it entirely could put people at risk.

It is also reasonable in practical terms for the police to have this power as they can be readily called out in an emergency situation and they are trained, equipped, and able to deal with potentially violent people within an existing legal framework which provides appropriate safeguards for the person (through PACE Code C).

The review did consider transferring the powers entirely from police to paramedics and/or other health professionals. This option was also rejected. It is essential for the police, given their role and range of responsibilities, to have a power other than criminal law to manage a person in mental health crisis, safely and to have a legitimate presence in assisting health professionals in the course of their work.

In other countries the police often have similar, but not identical, powers[191].

In light of the above, the review **does not recommend removing S136 powers from police.**

Maximum length of detention

S135 and S136 allow a person to be detained up to a maximum period of 72 hours. Irrespective of the 72 hour maximum time limit, any examination and interview or other steps must take place as soon as possible and the length of detention should not exceed the minimum required to enable this to happen.

The 72 hour period does not start until the person has arrived at the place of safety and does not include travelling time. However, some police officers contributing to this review felt that the time should properly begin at the point at which the police officer detained the person because it could take some hours for appropriate transport to arrive and for the person to be taken to and accepted into a place of safety[192]. This time is not recorded at present as being part of the overall period of detention. This could lead to a person being, in terms of their actual experience, detained more than 72 hours after the point at which they were first removed.

Detention under S136 ends once the medical assessment and AMHP interview have been carried out *and* any further arrangements have been made for the person's care and treatment, if needed[193]. If the mental health assessment has determined that the person does not suffer from a mental disorder, they must be immediately released.

A detention may be continued following a mental health assessment, if this is necessary to make further arrangements for their care or treatment, including taking steps to detain a person under another part of the Act such as finding a suitable placement.

The CQC found in their survey of health based places of safety that almost three-quarters of health-based places of safety set target times for starting assessments within the three hours recommended by the Royal College of Psychiatrists, and over half had target times of two hours or less – however these were often missed[194].

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http://www.policemag.co.uk/editions/0913_Time_for_healthy_debate.aspx

[190] See Summary of Evidence, p. 112, and Centre for Mental Health report, p. 13

[191] See discussion of international comparisons in the literature review, p.49 - 53

[192] For example, if the person is first taken to an emergency department and has to wait there for some hours, it is unclear whether this should be 'counted' as being within the 72 hours maximum length of detention.

[193] It is permissible to continue the detention while such arrangements are being made, up to 72 hours.

[194] CQC, 2014, chapter 4, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

In practice, the 72 hour limit is rarely breached but a proportion of detentions do continue for more than 24 hours.

The evidence presented to the review showed that a majority of people felt that 72 hours was too long for a person to be held, especially in a police station. 86% of respondents to the survey agreed that 'The maximum length of detention (72 hours) is too long for a person to wait for a mental health assessment in police custody', of which 61.8% strongly agreed. 72% also agreed that the maximum length of detention was too long for any place of safety – in practice, a health-based place of safety.

The Mental Health Act 2007 amended the law to permit a person to be transferred between places of safety, so a person initially taken to police custody could be moved to a health-based place of safety. 91% of people who responded to the survey agreed that 'Anyone taken to police custody under Section 135 or 136 should be transferred to a health-based place of safety as soon as possible'.

Whilst the 72 hour time limit does not breach relevant legal requirements, a shorter period would be a less restrictive interference with a person's fundamental rights.

Option 13: Reduce the maximum length of detention in police custody, or in any place of safety, with provision for extension

One option is to reduce the maximum length of detention in police custody and/or in any place of safety. Having two different maximum lengths of detention, one for police custody and one for other places of safety, is in principle an option.

Parliament has expressed concerns in recent years over the use of police cells in particular to detain people under the Mental Health Act 1983[195]. It is seen as particularly concerning that people are being held in police stations for long periods of time on occasion. This can be perceived as criminalising the person. It is therefore desirable to have a shorter period of detention in a police station. This is also consistent with the changes made in the Mental Health Act 2007 to enable transfer between places of safety.

However, there were concerns that having a different period of detention in police cells to other places of safety could have unintended consequences. Operating two different periods of detention could cause confusion and could embed a system whereby a person was taken to a police cell for the first 24 hours and then routinely transferred into a health-based place of safety for a further period of time. Furthermore, if a person is likely to receive an assessment more quickly in a police cell than in a health-based place of safety as a consequence of having a shorter maximum period of detention in police custody, then this creates an incentive to take the person to police custody first.

72% of people who responded to our survey supported a reduction of detention in any place of safety (from 72 hours). Views were more mixed about what the acceptable length of time should be. 23% supported a reduction to 24 hours, and 30% thought it should stay at 72 hours as it is at present. Some people felt that lowering the maximum length of detention might encourage mental health assessments to take place more quickly. It is clear that the assessment should take place as quickly as possible. This is not dictated by the maximum length of detention which should only be reached in very rare cases where the assessment could not take place more quickly.

Several people said that sometimes more time would be needed to find a bed to transfer the person onto once they left the S136 suite. A number of people said that if the person was under the influence of drink or drugs, more time would be needed before a mental health assessment could take place – although in many cases 24 hours would be sufficient. Others felt that leaving the additional flexibility of a maximum length of detention at 72 hours meant that it was more likely that the person would receive the right outcome, rather than a decision to be made to suit the time available.

The proposal envisages that it would be possible to obtain a short extension (duration to be determined) in situations where it was not possible to carry out the required steps (such as any medical assessment and making arrangements for subsequent care and

[195] Westminster hall debate, 28 November 2014, online at: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm

treatment) within the 24 hours. Different approaches might be required for different places of safety with roles potentially for doctors, other health professionals and senior police officers in the first instance, possibly with provision made for any subsequent extensions to require a higher level of approval, such as an application to a magistrate. If the person is in a health-based place of safety, one option might be to amend legislation so that a shorter S136 could be converted to a S5 detention on the advice of a doctor, if need be. Any possible options will need detailed further consideration in due course so as to ensure any processes are clear, workable and appropriately safeguard a person's human rights.

The majority of other EU countries with broadly comparable emergency mental health legislative frameworks including Scotland, permit detention up to a maximum of 24 hours[196].

The approach of a shorter initial period of detention, which can be extended if need be, parallels the arrangements made under PACE with regard to people who have been arrested for a suspected criminal offence. At present, PACE Code C dis-applies the system of PACE reviews to S135 and S136 cases. This would need to be amended as a consequence of this change, if made by Parliament.

A system of reviews could help to ensure compliance with human rights legislation since it will introduce procedural safeguards and provide reassurance that detention was considered necessary and proportionate.

The review recommends **reducing the maximum length of detention under S135 and S136 to 24 hours** from 72 hours, in any place of safety, with provision for an extension (duration to be determined) to be authorised in unavoidable cases where any assessment or other necessary steps (such as arranging subsequent care or treatment) could not be carried out in the timeframe.

Option 14: Set a statutory minimum time for an assessment to commence

The current guidance from the Royal College of Psychiatrists states that that the AMHP and doctor should attend within three hours where there are no clinical grounds to delay assessment.

This is especially important in the case of S136 detentions where the detention is made initially without the person having been seen by a health professional.

Consideration was given in the review to recommending the creation of a statutory minimum time period for the assessment to commence – recognising that some assessments may take many hours to complete. However, the review concluded that while local agreements should set out a minimum standard for assessments including acceptable time frames, it will be down to local arrangements, availability, geography, and staffing levels, to ensure that the assessment can comment within a reasonable time frame. It is unnecessary to provide for this in primary legislation and to do so would reduce the flexibility available for example if the person is under the influence of drink or drugs and the assessment cannot commence immediately.

Powers for health professionals and others

In the review, many people made the point that the police are not medically trained or qualified, and yet are being relied upon in exercising S136 to make a judgement about whether a person should or should not be temporarily detained under the Mental Health Act 1983. Respondents felt that a health professional or AMHP will usually be better able to make a judgement as to the mental state of the person.

The survey and workshops explored with stakeholders whether doctors, mental health nurses approved mental health professionals, or paramedics, should be able to exercise some or all S135 and 136 powers provided this did not increase the risk to practitioners or the person detained.

Views were mixed in both the workshops and in the survey responses. A majority of police and paramedics were strongly in favour of extending powers to other professionals (93% of paramedics and 87% of police agreed)[197]. A majority of mental

[196] See discussion of international comparisons in the literature review, p.49 - 53

[197] See also views from national organisations in the Summary of Evidence, p.72 – 109.

health nurses, local authority workers, voluntary sector workers and service users also agreed. A majority of AMHPs disagreed (52%) and health professionals were more evenly split, with no clear view emerging. Overall, 68% of respondents agreed that some other health professionals could usefully hold some or all S135 or S136 powers provided there was no increased risk of harm.

Of those who were in favour of extending the powers, views included that it would help to avoid delays in waiting for the police to arrive. Several paramedics in particular felt that it made no sense for them to have to wait for the police to arrive in order to detain a person under S136.

Many police officers welcomed the idea that others would be able to use the powers without relying on the police to provide that role. Many police officers said that a uniformed police presence could escalate the situation and having less police involvement could be beneficial for the person. The police said that if the person was potentially violent, they would still attend to assist the health professional but would be content to leave the decision in the hands of health professionals or medically qualified personnel. However, a number of police officers also suggested that it would make little difference to the use of police resources as the police would routinely be called out anyway.

It was widely acknowledged that issues over human rights, training, and safeguards would need to be carefully considered should any powers be extended. Several people said that they were concerned that health professionals could be asked to restrain a person when they were not trained or equipped to do so and that other than calling an ambulance, health professionals have no appropriate means by which to convey a person to a place of safety.

A number of people – mainly AMHPs – were concerned that, if powers were extended to other people, the police would refuse to respond to mental health incidents.

Option 15: Extend some or all S135 powers

This option would envisage the AMHP, doctor, or possibly a paramedic having some of all of the powers under S135 to enter a person's home, search for, and remove them to a place of safety if the situation met specified circumstances. Although the police would likely be needed on occasion to assist with gaining entry, if entry had to be forced and if there was any risk to the safety of the health professionals, there may be some situations which could then be managed without police involvement, thus reducing the stigmatisation of the patient by having uniformed police officers and marked police cars present. Extending some of the powers – for example the power to remove the person – could reduce the police role and embed the leading role of the AMHP in making those decisions.

The online survey invited respondents to comment on the possible extension of powers, and this was also discussed during the practitioner workshops. Views were mixed, with some feeling it would be appropriate for AMHPs, health professionals, or paramedics to take the lead role, provided they did not put themselves at risk; while others felt that the power of entry, in particular, and responsibility for managing risks rightly lies with the police. The review concluded that this option needed **further detailed consideration and consultation** with those affected.

S135 already supports a degree of multi-agency working, and shared decision-making, as the AMHP is responsible for applying to a magistrate for a warrant, and the AMHP and a doctor must attend with the police officer when the warrant is executed. However, some concerns were raised that the precise roles of the various people acting under S135 are not made clear in the legislation. Some commentators suggest that it is the police officer's responsibility to gain entry to the premises and then to ensure the safety of the doctor and the AMHP, whose joint role is to assess whether or not the patient should be removed to a place of safety[198]. The AMHP is seen as being responsible for arranging a bed at the place of safety, and ensuring that appropriate transportation arrangements are made. The operation of S135 could potentially be strengthened by clarifying the roles and responsibilities of the various parties, and this is mainly achieved in the Code of Practice (see also Option 22 below).

Option 16: Extend some or all S136 powers

[198] Jones 2013

This option reflects the desire on the part of some professionals – mainly paramedics – to be able to use S136 powers because they are often called to an incident where a person is having a mental health crisis and have no powers to act to remove the person to a place of safety[199]. Extending powers could prevent delays in having to call the police, because the paramedics or health professional could act immediately and it would be more appropriate for health professionals to have these powers.

> *'As ambulance staff we encounter problems where we have been called into a person's house (so power of entry is not a problem) and it is clear that the person requires a mental health assessment. If they were in a public place they would be detained under section 136 but because they are in their own house and have capacity we cannot help them. This causes us concern and often the family some distress.'* (Paramedic, in response to online survey)

Another point made was that health professionals may be better able to judge whether a person needs to be detained leading to fewer S136 detentions where following assessment, the person is released with no further action taken.

In general, the involvement of health professionals, at an earlier stage of the process under S136 would seem to be desirable in securing a better outcome for the patient. However, this raises a number of practical issues. Many health professionals were concerned that the use of such powers could involve dealing with potentially violent or dangerous people, for which the police are better trained and equipped. The duty of care owed by employers to their staff also needs to be considered if employees are to be placed in potentially violent or dangerous situations. Several people who responded to the survey made the point that the police are likely to come across such people in the course of their daily work, while a health professional may not (particularly not in public places where S136 applies).

Several health professionals were also concerned about the impact of having or exercising such powers upon the therapeutic relationship with their patients, feeling that this could change the dynamic and reduce trust in them. It may be desirable to have the initial removal under S136 undertaken by a person separate to those who will subsequently examine or interview the patient. The effectiveness of the examination could otherwise be impeded by the involvement of the person who detained the patient to begin with.

Any extension of S136 would also have implications for PACE. The power to arrest under S136 was specifically preserved by S26 and Schedule 2 of PACE. Similarly, PACE Code C applies to persons removed to police stations under S136. The applicability of these provisions (such as the right of the person to be told they have been arrested and of the grounds of arrest as soon as practicable, amongst others) would need to be considered if the use of S136 powers was extended to others other than the police.

The review concluded that this option of extending S136 powers to health professionals needed **further detailed consideration and consultation** with those affected to explore the implications more fully.

However, there is a rationale to provide paramedics with a more limited power, and the review therefore recommends potentially creating a new specific power for **paramedics to convey a person to a health-based place of safety from anywhere other than a private home**, subject to further discussions This is in line with the recommendation set out below (see Option 17). If introduced, it would be necessary for the Code of Practice or other accompanying guidance to make clear the remit of these powers, including a requirement that the person detained be informed of the reasons for their removal to hospital without their consent.

Where S136 should apply

In the course of the review, a number of people suggested that there are places where it is unclear whether or not S136 can apply. Examples where S136 could not be used (because they are not 'a place to which the public have access' include, for example, most workplaces (which often have fob or swipe-card access)and railway lines (the railway

[199] Paramedics do have some powers under the Mental Capacity Act but not to remove the person to, and detain in, a place of safety.

network is privately owned and the line is not accessible to the public).

While in theory S135 covers any private premises, it is questionable whether a magistrate would consider granting a warrant to remove a person from a workplace, car park, or railway line, given that S135 requires there to be 'reasonable cause to suspect that a person believed to be suffering from mental disorder has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or being unable to care for himself, is living alone in any such place'.

Furthermore, it is likely there would not be adequate time to obtain a warrant during the period of time that the person was in any private premises other than a private home.

Concerns were raised during the review by British Transport Police. They felt that being unable to use S136 to detain people (often suicidal) on railway lines meant that they were having to criminalise the person inappropriately by arresting them for trespass or for breach of the peace in order to keep them safe and remove them from danger.

People who are suffering serious mental disturbances or intending serious harm to themselves may deliberately seek out places which are inaccessible to the general public.

The online survey explored this issue and found that the majority of people (61.1%) disagreed that S136 should apply only in places 'to which the public have access' with many feeling that this could prevent some people from accessing the help they needed. Asked whether 'S136 should apply anywhere except for a person's own home (including railway lines, police stations, hotel rooms, and private vehicles)', 49.2% overall agreed and 35.9% disagreed. A majority of health professionals, paramedics, mental health nurses, local authority workers, and service users agreed.

The evidence presented to the review suggests that there is a need to clarify this area of the law in a way which can improve the operation of these powers in practice to ensure that a person who is mentally disordered and in need of immediate care or control can be promptly taken to a place of safety from wherever they are, unless they are in a private home for which a warrant would be needed.

Option 17: Extend S136 to apply anywhere except for private homes

The option of amending primary legislation to the effect that S136 applies anywhere except for private property (including railway lines, private vehicles, hospital wards, rooftops of buildings, and hotel rooms) was considered at length in the review, including whether this creates a much broader power, whether the police would necessarily have access to exercise the power (or whether an additional power of entry would be required), and the need for procedural safeguards in the form of a warrant for areas such as commercial premises, such as workplaces[200].

The use of S136 by a police officer in a 'place to which the public have access' manages the risk that the person may pose to a member of the general public. However, when a person is suffering from a mental health crisis in a place to which S136 does not currently apply, there remain issues relating to the risk a person poses to themselves as well as the potential risk to other people who may be present such as colleagues (in a workplace).

As workplaces and other areas expose other people to the potential risk of harm (for example, the risks to people in a train of a person committing suicide on the railway line) it is desirable for the police to be able to use S136 powers in these places, if the person meets the threshold for S136 detention.

The review recommends legislative amendments to the effect that the powers currently available under **S136 can be used anywhere except a private home.** This would include railway lines, private vehicles, hospital wards, rooftops of buildings, and hotel rooms). To ensure ECHR compliance, procedural safeguards would also need to be considered in respect of this change.

It is envisaged that this change would also permit the police to use S136 in police custody, for example when a person originally arrested for a criminal offence (but where the offence will not be taken

[200] Online at: http://www.echr.coe.int/Documents/Convention_ENG.pdf

forward) appears to require an urgent mental health assessment[201] as a means to detain them legally so they can be kept safely until they have received this assessment. However, the overall period of detention should not exceed the legal maximum for S136. This means that the police could not let the PACE clock run out at 24 hours and then re-detain the person for another consecutive period of time under S136[202]. If Option 13 was introduced then the period of detention permissible under S136 would match that of PACE (24 hours). Further specific guidance for police would be needed on this point.

Responsibilities for transport

The Code of Practice sets out that ambulances or other suitable health service transport should be used to transport people detained under S135 and S136.

However, many paramedics and ambulance workers made the point during the practitioner workshops and in the online survey that ambulances are not ideal vehicles because they can be an unsafe environment for a person detained under S136, who may be disturbed, seeking to self-harm, or potentially try to escape. Several said that it would be helpful for roles and responsibilities to be more clearly set out over conveying people under these powers.

The review considered what responsibilities the police or others have for conveying the person and whether these could be delegated to another party[203]. It seems probable that the 'power to detain' can be delegated to others, such as ambulance staff or other healthcare professionals, whether involved in the conveyance of the patient or for their detention at the place of safety[204]. S137 of the Mental Health Act enables those people authorised to convey the patient to have all the powers of a police constable, since the person is deemed to be in 'legal custody'. Ambulance staff have powers to detain the person when conveying them to a place of safety.

Some police forces, such as Hampshire, now commission private ambulance providers to respond to S136 detentions. This is permissible under the power. It is considered beneficial to the person being conveyed to use transport manned by health care professionals, if available and where safe and appropriate to do so, rather than a police car because it provides more appropriate support and lessens the stigma surrounding the mental health crisis.

The revised Code of Practice states that people taken to a health-based place of safety who are detained under S136 should be transported there by an ambulance or other health transport arranged by the police who should also escort them in order to facilitate hand-over to healthcare staff. Under S135, there may be less need for the police to escort.

Option 18: CCGs to commission appropriate transport

Many police officers in the practitioner workshops said that there were problems in getting an ambulance to transport the patient to a place of safety and that it was quicker to use police vehicles

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[201] Whenever a person arrested on suspicion of a criminal offence is suspected of suffering from mental illness, PACE Code C requires an appropriate healthcare professional to be called, as well as an appropriate adult, so the expectation must be that the need for mental health assessment would be recognised long before release from detention under PACE is required. In these circumstances, action should be conditional upon the health professional deciding that assessment is necessary, and not the police.

[202] Although it is possible that the person may have already been detained under the PACE pre-charge detention regime for a wholly different reason. It would be envisaged that this period of detention could be extended if necessary as per Option 13.

[203] In *Woodland v Essex* (2013) UKSC 66 the Supreme Court identified a number of criteria which, if satisfied, give rise to a non-delegable duty on the part of a person or organisation. These criteria - such as whether the person concerned is vulnerable, the degree of control exercised over the person, and whether [the police] have a positive duty to prevent the person coming to harm – would appear seem relevant for consideration in respect of to apply to S136. This means it is likely that the police cannot delegate their duty to a private ambulance provider, although it is possible a court may take a different approach to the circumstances of any particular case.

[204] In *Ward v Commissioner of Police of the Metropolis* (2005) UKHL 32, Baroness Hale stated , in respect of S135, that '*It may also be that the police officer can authorise others, such as the ambulance service or an approved social worker, to transport the person to the place of safety rather than doing it himself*'.

to do so. There were concerns from the police that they should not be transporting very ill people in police vehicles, because of the risk of death. Service users often felt that being transported in police cars was stigmatising and there was strong opposition to being transported in police 'caged' vans.
The review considered setting out in legislation or in the Code of Practice that police vehicles cannot be used to convey individuals detained under S135 or S136. However, this option was ruled out on the grounds that, in a case where there was an imminent risk of an individual coming to serious bodily harm or loss of life, it would be incompatible with Article 2 of the ECHR to leave the police with no lawful means of getting the individual to hospital if no ambulance or medical vehicle were available.
The review also took the point from paramedics that ambulances are not ideal vehicles and must, rightly, prioritise life-threatening health situations in their response times.

While the review came to the conclusion that this is an issue for local area agreements rather than primary legislation, CCGs could explore in their commissioning processes whether other suitable vehicles could be used, perhaps unmarked to be more discreet and preserve the dignity of the person being transported.

The review agrees with the CQC that CCGs should make sure that arrangements for transporting people subject to S136 to hospital by ambulance are appropriate and timely. This may require a needs assessment for specialist ambulance provision for people in mental health crisis. Response times should be within 30 minutes or an immediate priority response for people who are being actively restrained or if their condition is life-threatening (in line with the Association of Ambulance Chief Executives' national protocol as part of the Crisis Care Concordat).

In addition, the review recommends that **CCGs should consider specific contracts for the transportation of people detained under S136** to and between, places of safety, and consider commissioning vehicles other than ambulances to transport, as well as having service-level agreements for responses to most S136 calls within 30 minutes. Further consideration will need to be given as to how this will be achieved in practice.

Option 19: Explore private sector/ third sector/ community-led or other models of provision

To reduce pressures on the ambulance service, and improve the response times for people detained under S136 to be conveyed to a place of safety, it might be possible to use secure private ambulances or taxi services, as already being piloted in some areas such as Hampshire and the West Midlands. The review would encourage the exploration of other models. This does not require changes to primary legislation.

Excess or inappropriate use of S136

S136 relies on the judgement of the individual police officer as to whether the person:

- appears to be suffering from mental disorder; and
- is in immediate need of care or control; and
- that it is necessary to remove the person in their own interests or for the protection of other persons.

The police receive some training on mental health. Police training is currently being reviewed by the College of Policing. However, some people feel that the involvement of medically unqualified personnel in such decision making is inappropriate:

> *'S136 is the only part of the Mental Health Act 1983 where one person, acting without medical evidence or training, has the authority to deprive another person of their liberty.'*[205]

> *'[Health professionals] have the experience/knowledge of dealing with people suffering mental health issues. Police officers are ill equipped and lack training'* (Police sergeant, in response to survey)

It is worth noting that neither the legislation nor the Code of Practice require the police to be medically trained or qualified. Section 136(1) specifically sets out in the phrase 'appears to him' (the police constable), indicating that the decision is based on

[205] Latham 1997

judgement that the person is in immediate need of care and control and that their removal is in the interests of themselves or for the protection of others. No medical evidence is needed for the police officer to exercise this power.

Although this in effect permits a person to be detained without medical evidence based on the decision of a police constable, it is strictly an emergency power and the detention is only for a limited period of time. The person must be examined by a doctor and interviewed by an AMHP as soon as possible, and can be detained for no longer than 72 hours currently n any event.

There is no specific requirement for this preliminary assessment to be undertaken by a medical practitioner and so the police are given the authority to apply these criteria, subject to the additional safeguard that any period of subsequent detention is only for a limited period. There is also a clear therapeutic rationale for the subsequent detention since it is initially for the purposes of securing an examination by a doctor and interview by an AMHP, which could help to identify any care or treatment for the person which might be necessary.

The police officer is only using their individual judgement, and therefore the law provides only a temporary holding power for the purposes of receiving a mental health assessment by a doctor, being interviewed by an AMHP and for the making of any necessary arrangements for the person's treatment or care

Even if a health professional decides, once they have seen the patient, that they are well enough to leave with no further action taken, this decision does not necessarily mean that the police officer has acted wrongly, provided they have acted with good faith and taken reasonable care under all the circumstances[206].

Early small-scale studies (see literature review) suggested that in the 1980s and 1990s the police were fairly accurate in identifying people who needed to be removed to a hospital for assessment by health professionals, that they made fewer detentions under S136, and that a high proportion of those detained went on to be further detained under either S2[207] or S3[208] of the Mental Health Act 1983.

However, this seems to have changed over the past decade as the Royal College of Psychiatrists noted in their response to the review:

> *'There is limited research data on outcomes, but the evidence would suggest a change over the past 24 years, with 88% of S136 detentions in 1990 resulting in hospital admission, compared to 29% in 07 /08 and only 17% 12/13. While this may be due to improved community services obviating the need for admission, it is however more likely to reflect the nature of the population being detained by the police.*
>
> *Studies in the 1990s, mainly in London, suggested that the majority of those detained under S136 had schizophrenia, mania or drug-induced psychosis. However, current experience of members of the College suggests a greater proportion of those with personality disorder or chaotic behaviour complicated by substance misuse are now being detained under S136. There is anecdotal evidence, and a suggestion from two studies, that the availability of hospital-based resources may result in a lowering of the [police's] threshold for the use of S136 and thus an increase in detentions.'* (Royal College of Psychiatrists, response to the review)

The issue of whether the police's thresholds have changed in whether or not they felt it appropriate to detain a person under S136 arose several times in

[206] S139 of the Mental Health Act 1983 sets out that no person shall be liable to any civil or criminal proceedings in respect of any act carried out under the Mental Health Act 1983, if they have acted with good faith and with reasonable care under all the circumstances. Online at: http://www.legislation.gov.uk/ukpga/1983/20/section/139

[207] Section 2 of the Mental Health Act 1983 permits a person to be admitted for the purposes of assessment for up to 28 days, on the agreement of two doctors. Online at: http://www.legislation.gov.uk/ukpga/1983/20/section/2

[208] Section 3 of the Mental Health Act 1983 permits a person to be admitted for treatment, on the agreement of two doctors. Online at: http://www.legislation.gov.uk/ukpga/1983/20/section/3

the review. There are a number of factors at play which make it difficult to determine if this is the case.

The number of people being detained in health based places of safety under S136 has risen considerably over the past decade. The general direction of this trend may be expected as the population has increased. However, this does not explain the extent of the increase. Some believe the increase in S136 detentions is particularly notable following investment by the Department of Health in providing more health-based places of safety in 2007. The CQC suggested that increasing the provision available may have had the effect of encouraging the police to use S136 more - although the example given is one in which the police could not use their S136 powers anyway (in a private home):

> *'The use of hospital-based places of safety has increased significantly in recent years, due partly to additional capital investment in facilities. Even though there are no comparable national data on the use of police cells, it is reasonable to assume that the increasing use of hospital-based facilities means that fewer people were taken to a police cell than would otherwise be the case. However, we have also seen that the development of a hospital-based place of safety can itself lead to an increase in the use by police of the detention power. In light of this, police officers may need better advice and support – particularly from community mental health teams – to help them contain a crisis situation without them having to use their powers under S136.*
>
> *We collected the following example during a pilot visit to some hospital-based places of safety in south-west England at the end of 2009/10: The Commissioner was told that the use of section 136 of the Act has increased by about 30% since the opening of the hospital's place of safety. Details of when police have been called to a situation, which has led them to use their section 136 powers, indicate that they may not have needed to use the power had there been better joint working between the police and the trust. In some circumstances, it would appear that expeditious and constructive involvement of an extended hours crisis team may have avoided the need for the police to use section 136. An example is of a patient who was very well known to services and who was self harming in her own home to which police were called. Staff at the place of safety felt she should never have been brought there, but instead supported by community services.'*[209]

It is, however, difficult to be certain about trends without knowing the historical figures for the number of S136 detentions made where the person was taken into police custody, and these data are not known. It is likely that at least some of the apparent increase is due to a shift away from taking people to police cells to taking them to health-based places of safety, especially once more health-based places of safety became available after 2007.

Some people felt that the police were now over-using S136 for situations where its use is inappropriate. Examples given to the review were typically of a person who was under the influence of drink or drugs being detained under S136. Health professionals felt these types of detentions were unnecessary (in that following a mental health assessment they were likely to simply be released with no further action) and consumed health service resources which might have been better used for other people in need.

> *'I have some concerns that S136 is used as alternative to charging people for anti-social behaviour whilst under the influence of alcohol and drugs.'* (AMHP, in response to the survey)
>
> *'Police are too quick to resort to S136, resulting in huge numbers of service users being detained under S136 who are subsequently discharged following assessment by AMHP and doctor...the vast majority of S136 detentions are when people are under the influence of drink or drugs - when they have sobered up they are quickly released from custody. It is my strong belief that Police should be given direction to*

[209] CQC 2010, online at http://www.cqc.org.uk/sites/default/files/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf

> *arrest people in drink and drugs who are threatening harm to themselves or others on the charge of drunk and disorderly. Police prefer the use of S136 because it reduces their workload and paperwork processes.'* (AMHP, in response to the survey)

Some felt that the police were taking an easy option by detaining a person under S136, or that by doing so they were trying to help the person receive medical help rather than criminalising them.

> *'Police tend to think S136 is more 'humane' than arrest for breach of the peace, but [the] long term implications are far more severe.'* (AMHP, in response to the survey)

Conversely, others felt that sometimes the police wrongly arrested a person for a criminal offence who should have been detained under S136.

> *'I sometimes find that people who should be on a S136 are arrested for criminal matters e.g. drunk and disorderly'* (health professional, in response to the survey)

As the responses showed, it is very difficult to define exactly in which circumstances S136 should or should not be used, especially for people whose behaviour at that time may make it difficult, even for a qualified health professional, to determine whether they are under the influence of drink or drugs, have a physical health problem, and/or have a mental health problem. Several health professionals noted that they had to wait for the person to recover from the effects of drugs and alcohol before it was possible to carry out a mental health assessment and determine whether further detention was necessary.

Detaining a person under S136 is not without consequences which can be far-reaching for the person detained, such as potentially having their detention under the Mental Health Act 1983 disclosed in future vetting checks (see section on DBS disclosures). If a person is under the influence of drink or drugs and acting inappropriately, consideration should be given to arresting them (e.g. an appropriate public order offence), or if they agree to accompany the police taking them to an emergency department, rather than detaining them under S136.

Option 20: Create a separate power to take a person under the influence of drink or drugs to hospital

Intoxication was a key theme which emerged during the review. It can be difficult for a police officer to identify 'on the spot' whether a person is under the influence of drink or drugs, or has a mental health condition, or both. S136 requires that the officer considers that the person appears to be 'suffering from mental disorder and in immediate need of care or control'. This could be perceived to be the case for a person who is under the influence of drugs or alcohol, but it would not be a proper or lawful use of S136. A proportion of people with severe mental health conditions also self-medicate with alcohol, and arguably even more so at a time of crisis, so a person may well meet the threshold for a S136 detention while also being under the influence of drink or drugs, or intoxication could be contributing to their condition at the time.

Many mental health trusts and health professionals felt that the police were using S136 too often to detain people who are under the influence of drink or drugs but do not suffer from mental disorder and who, once sober, are simply released with no further action. This was seen as a drain on an expensive health resource – S136 suites are typically single-occupancy and must be staffed all the time when a person is being held[210].

Health professionals also felt that a very drunk person may have need of urgent medical assistance which can best be provided in an emergency department. It is therefore desirable that a person who is not otherwise experiencing a mental health crisis, but is under the influence of drink or drugs, should not be detained under S136.

The police already have powers to arrest a person for drunk and disorderly behaviour under Section 91 of the Criminal Justice Act 1967, which makes it a criminal offence for a person in a public place to behave in a disorderly manner while drunk. So, if the police reasonably suspected that a person had committed, or was committing, an offence, they would have the power to arrest them, provided that

[210] CQC 2014, online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

they considered that arrest was 'necessary' for one of the stipulated reasons in section 24(5) of PACE.

This power of arrest, however, does not permit the police to take a person to hospital and pass them into the care of hospital staff, unless the person is willing to go voluntarily (and has capacity to consent). Arguably, there is a potential need for a wider power for police, and paramedics, to be able to take a person who is under the influence of drink or drugs that appears in urgent need of care or control, to hospital for the purposes of their receiving any medical help required. This could substantially reduce the numbers of S136 detentions which otherwise occur in order for the police to discharge their duty of care under such circumstances.

This option is broader than the remit of this review, in that it would involve new primary legislation not under the Mental Health Act 1983, and so is not considered further here.

Option 21: Require police to seek health advice before detaining under S136

This proposal for legislation would provide an additional safeguard on S136 powers which would require that a health professional is consulted by the police, prior to the person being formally detained under S136, provided that the situation was not so urgent that the patient, police officer, or others would be put at risk by doing so. This supports the direction being explored in street triage pilots for early engagement with health professionals. It is envisaged this could potentially reduce the overall numbers of S136 detentions and address the concerns raised during the review about the detention of people under S136 who, following medical assessment, are released without any further action being taken. The question of whether or not the police use S136 powers appropriately was explored in this review.

Many health professionals felt that, too often, the police use S136 to detain people who do not need to be detained. BME communities are concerned that they are over-represented in S136 detentions and a number of people cited instances where they felt they had been detained under S136 wrongly. The police agree that they are not medically qualified and are only using their individual judgement as to the situation at the time.

The current street triage pilots have shown that, when the police have the benefit of advice on the scene or over the telephone from a mental health nurse, a proportion of S136 detentions can be averted because the health professional can access medical records to help to assess risk, and use their professional expertise to assist the police in deciding whether or not the person needs to be detained or whether an alternative resolution would be appropriate.

A similar process could be put in place for all S136 detentions to enable the police to seek further information and advice from a health professional.

It is envisaged that this would reduce the number of S136 detentions by perhaps 20 - 40% - a comparable figure to that found in the street triage pilots. It is clearly preferable for a health professional to be involved as early as possible in the initial decision-making, to provide assistance.

It is not envisaged that, in a S136 detention, a health professional would be required to *authorise* the use of the power, as proposed for Option 10. The police officer may be called upon to make a quick decision and a health professional may not always be available. Furthermore, the police officer must take the responsibility for whether or not to use their powers if they consider that the person satisfies the criteria for removal under S136, and while they may have regard for the advice given them by a health professional, the decision remains their own.

This consultation process could help the police to be less risk-averse – a theme that came out strongly in the review – as they would be reassured by the advice and have more confidence in their decisions as a result.

The review recommends legislative change that would require the police to **consult a suitable health professional prior to detaining a person under S136**, provided it is feasible to do so (if neither the police officer nor the person is put at risk by waiting for a health professional's input). This could be, for example, having street triage arrangements, calling the mental health nurse in the custody suite, or having local arrangements in place to call the Crisis Resolution Team or on-duty doctor.

Clarifying S135 responsibilities and powers

During the review, concerns were raised over several aspects of S135. Many AMHPs talked about how long it takes to get a warrant in some areas and the bureaucratic processes involved. Others raised the issue of whether magistrates provided an effective safeguard. There were also issues raised about the current wording of S135.

The S135 warrant empowers the police to enter the premises, search for the person concerned and remove them to a place of safety. Some felt that this means the police can remain on the premises for as long as is necessary for the decision to be taken whether to remove the person to a place of safety. Some police officers were concerned that the legislation under S135 did not explicitly provide for a fuller assessment to be carried out in the home (being a power to enter, search for, and *remove*), nor specifically provide a power for them to remain if asked to leave[211]. They pointed out that, if the AMHP chooses to hold the assessment in the person's home, this can only be with the consent of the patient and if while this assessment was being carried out, the situation then deteriorated and they were asked to leave, they would likely not be able to rely on the S135 warrant to remain.

Option 22: Allow a mental health assessment in a person's home and for police and health professionals to remain

Wherever possible, and if deemed safe and appropriate by the AMHP, a mental health assessment should be able to take place in the person's home once entry has been gained through a S135 warrant. This would provide a better outcome for the person, since the outcome of the assessment may be that the person need not need to be removed from their home. This could also reduce pressure on health-based places of safety and psychiatric wards. Whether the police need to remain for this process will be by negotiation on a case-by-case basis between partner agencies, and be informed by local agreements in place, but the AMHP should not rely on the police to ensure the safety of themselves and others in these circumstances.

S135 as drafted currently does not permit for the detention to occur in the person's home, unless their home is being used as a place of safety under S135(6) 'any other place the occupier of which is willing to receive them'. This does not seem to imply that the person themselves can be the 'occupier' as this is clearly envisaged as being a third party. It is therefore doubtful that the person's own home could be used as a place of safety in this way, even if they consented to it, and without their agreement there is no power to detain them in their home.

The review recommends legislative changes to set out in explicitly legislation that when a S135 warrant is executed, **assessments can take place in the person's home** if it is considered appropriate and safe to do so. This ratifies existing practice in many areas (where a person consents) and reduces pressure on health-based places of safety.

Although there is nothing in current legislation to prevent the police remaining while an assessment is carried out, if the AMHP considers it necessary for them to remain to ensure safety and the person consents to their presence, it is not clearly set out that there is a legal basis for them to do so. To avoid any confusion on this point, the review also recommends amending the legislation to make explicit provision for the **police, paramedics, and AMHPs to remain present** while the assessment is carried out – again, ratifying existing practices where the person consents to this.

[211] See Summary of Evidence, p.34

Discussion of non-legislative options

The review raised a number of issues that could be addressed by non-legislative means. Many of these issues were reflected in the action plan of the Crisis Care Concordat published in February 2014[212].

A number of issues were fed into the parallel review of the Code of Practice in England for the Mental Health Act 1983, and amendments were made as a result. The review recommends that the **Code of Practice should clarify, where possible, the issues arising from this review.** Amendments have been made to the relevant chapter of the revised Code of Practice as a result of this review.

The remaining issues relate to additional guidance, multi-agency working, data collection and monitoring, training and in the longer term, exploring the potential for new technologies to improve the experiences and outcomes for people detained under the Mental Health Act 1983.

DBS disclosures

Some evidence provided to the review suggested that the police may disclose a S136 detention as part of enhanced DBS checks. Concerns were raised as to whether this could adversely impact on the person's right to privacy and affect careers. The review team also considered whether the disclosure might also depend on whether they had been taken to a health-based place of safety or a police cell, a factor outside of their control.

Data have been gathered from police forces on what information was included on DBS disclosures that made reference to mental health and/or S135 or S136 of the Mental Health Act 1983. The data show that in the year prior to the Protection of Freedoms Act 2012, 716 DBS disclosure certificates mentioned mental health issues, of which 103 mentioned both mental health and S136. Following the changes made in the Act, in the two years between September 2012 and August 2014 only 668 certificates mentioned mental health, and 81 DBS disclosures mentioned mental health and S136. This is only a tiny proportion of all DBS disclosures made during these periods and has fallen since 2012:

No. of DBS disclosure certificates which mention:	**Pre- Protection of Freedoms Act 2012** (01/09/2011 to 09/09/2012)	**Post- Protection of Freedoms Act 2012** (10/09/2012 to 31/08/2014)
Mental health	608	584
Mental health and S136	103	81
Mental health and S135	1	0
Total no. which mention mental health	716	668
No. DBS certificates containing Local Police Force information	14,038	19,741
No. all DBS certificates	4,202,650	7,873,967
% of DBS certificates containing Local Police Force information which mention mental health	5.1%	3.4%
% of all DBS certificates which mention mental health	0.017%	0.008%

Table 7: Data from Disclosure and Barring Service showing the fall in DBS disclosure certificates mentioning mental health.

Home Office guidance states that on its own, information relating to physical health or mental health is unlikely to be appropriate for disclosure[213]. The Quality Assurance Framework for the police on Mental Health and Disclosure gives more detailed consideration to balancing the potential risk posed to vulnerable people against the applicant's right to a private life, suggesting that under some circumstances disclosure could be appropriate[214].

Section 113B(4) of the Police Act 1997 states that before issuing an enhanced criminal record certificate, the DBS must request the chief police

[212] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

[213] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118017/statutory-disclosure-guidance.pdf

[214] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/274373/QAF_v9_GD3_Mental_Health_and_Disclosure.pdf

officer to provide 'any information which he reasonably believes to be relevant' and which in the chief officer's opinion ought to be included. This means that it is the responsibility of the chief constable of each police force to provide any information which they consider relevant in the context of the job that the applicant is applying for.

If the police possess information about a person's detention under the Mental Health Act 1983 they are obliged under statute to consider its relevance to the position applied for and whether that information ought to be disclosed. If an applicant believes the police have exercised their judgment wrongly, they can refer the case to an 'independent monitor' for a binding review of the police's decision[215].

The information possessed by the police, relating to a person's detention under S136, may vary. Information about a S136 detention would usually be held on police IT systems only if the person had been held in custody and not if the person had been taken to a health-based place of safety. The police would not routinely seek this information from a hospital but, if there is some indication on police files that a hospital may have relevant records, then it may be appropriate for the police to seek information from that hospital. The police are only required to disclose relevant information which is in their possession.

In practice, this means that a person held in a health-based place of safety is less likely to have this information disclosed, while a person held in custody is more likely to have the information disclosed.

However, it is worth noting that if the police begin to keep records of every S136 detention regardless of which place of safety was used, it may be the case that more S136 detentions would become potentially disclosed, including those in health-based places of safety.

If a person had been detained under S136 and then held in a police cell, this would appear as part of a police custody record which is retained indefinitely. Information may also be placed on the Police National Computer (PNC). It is not the record which is disclosed, but information such as that the person was detained under S136 of the Mental Health Act 1983 at a particular time and place. Some service users felt that the phrasing of what was disclosed criminalised them by describing this as an 'arrest', and that it did not differentiate by outcome (for example, if following a mental health assessment they were released with no further action taken). An individual may write to their chief constable (or the data protection officer for their police force) to request the removal of information from the PNC under the 'exceptional cases procedure'. However, this does not include situations where a person wishes to have his record removed because it appears on his DBS check and causes difficulties in finding employment[216].

Under the Rehabilitation of Offenders Act 1974, convictions, cautions, and alternatives to detention can be considered 'spent' after a period of time. However, this is not the case for custody records or information about people held under the Mental Health Act 1983, even if the person was aged under 18 at the time of the detention.

However, if the detention occurred a very long time ago, the historical nature could be a factor in the chief police officer's decision to disclose as they may consider the information irrelevant. Equally, the police might take into account the person's age when they were detained in deciding whether the information was relevant, and whether it was necessary and proportionate to disclose the information. Age is not a bar to disclosure within the Police Act 1997, and there are no special rules in the legislation for information pertaining to individuals who are under the age of 18, or who were under 18 at the relevant time.

The review considered whether the practical implications – that a person who was held in police custody under S136 may have this information disclosed in a DBS check, while a person held in a health-based place of safety would not – constituted a breach of the Equality Act 2010 by treating one group more favourably than another.

The review recommends that **the Disclosure and Barring Service and police service should issue**

[215] Section 117A of the Police Act 1997

[216] Online at: www.parliament.uk/briefing-papers/SN06441.pdf

additional specific guidance to police on DBS disclosures relating to detention under the Mental Health Act to ensure that chief officers of police responsible for disclosures are fully aware of the factors which should be taken into account, and in particular whether the circumstances of any detention indicated a risk to the public. The Home Office should explore whether the statutory guidance and quality assurance framework should be amended.

Inspection and monitoring

An accurate understanding of the uses of S135 and S136 of the Mental Health Act 1983 is impeded by a lack of complete data and accurate monitoring[217]. In 2008 the IPCC recommended that police forces should:

> *'Accurately and consistently record section 136 detentions both in police custody and hospital environments. The records should include key demographic details such as age, gender and ethnicity, along with the length and outcome of the detention (for example, whether the individual was taken to hospital). We support the Royal College of Psychiatrists' (2008) suggestion that one national recording form for England and Wales is introduced. Police forces should also work to ensure that offenders with mental disorders are captured on their systems in order to identify the true scale of the detention in police custody of people with mental disorders.'*[218]

Many police forces are now very good on recording accurate data on S136 detentions. However, despite efforts to date, some police forces are still unable to retrieve easily information on S136 detentions in police custody because the computer system makes automated searches for this impossible[219].

The Metropolitan Police introduced a form some years ago to record S136 detentions. However, the issue raised earlier in this report over where S136 can apply, and a lack of powers in private homes, could potentially skew accurate reporting. An unpublished audit of 100 S136 cases over two years in London concluded that:

> *'Research for this project has shown that the existing S136 documentation used by the Metropolitan Police is sometimes less than honestly completed, as is apparent either from internal evidence e.g. contradictions on the form, or later reliable testimony from the patient. The most common is to state that the patient was in a public place when they were not. Alternatively the form is deliberately completed so as to avoid any statement of where the patient was when detained...There is therefore a strong case for ending the current position where forms are purely local, often illegible, lacking in sufficient detail, or simply not completed. A single statutory form governing S136 usage, completed not at the point of use, but en route or on arrival at the place of safety, would send powerful messages about the need to use this important but contentious power with due regard for the liberty of the individual.'*[220]

The Royal College of Psychiatrists have advocated a single data collection form should be used for S136 detentions[221]. In July to September 2014 a pilot was carried out in three police forces to trial a single form with a view to rolling this out nationally from April 2015.

The police have also been undertaking internal audit and peer-review to learn from each other and identify areas for improvement.

More could be done to ensure that good quality data are available, to identify and share best practice

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[217] See literature review, p.14

[218] Online at: http://www.ipcc.gov.uk/sites/default/files/Documents/guidelines_reports/section_136.pdf

[219] For example, http://www.nottinghamshire.police.uk/sites/default/files/documents/files/FOI%20004149%2013%20Detention%20under%20S136%20Mental%20Health%20Act.pdf

[220] Robert Keys (February 2013) *An Examination of Section 136 of the Mental Health Act 1983: looking at current usage and whether the law needs reform in accord with the needs of a modern mental health service.* Unpublished Masters in Medical Law (MML) dissertation, University of Northumbria. Quoted by permission.

[221] Royal College of Psychiatrists 2013, online at http://www.rcpsych.ac.uk/pdf/PS02_2013.pdf

on a multi-agency basis, and to strengthen the inspection regime so that poor practice is identified and can be acted upon, and areas of best practice recognised.

The review recommends that **the police and health services should work towards improved data capture, monitoring and review. The police and health services should work towards improved data capture, monitoring and review.** The police should record every use of S136 carefully including ethnicity and length of detention, and record S135 involvement, so that any issues can be properly reviewed and lessons learnt. A new data toolkit was trialled by three police forces in England in autumn 2014, with the potential for national roll-out from April 2015. The toolkit involved the collation of more in-depth and consistent data about police interactions with people with mental ill-health. Also, the Home Office will also be working with the police to explore whether data on S135 and S136 can be made part of the police's Annual Data Requirement (ADR).

The review also recommends that **multi-agency groups should meet regularly to review data and discuss issues.** In some areas multi-agency groups regularly review S136 detentions, identifying repeat detentions and use this information to drive improvements: this should be considered best practice everywhere. It may be helpful for people repeatedly detained under S136 to have multi-agency care plans put in place to ensure they are receiving a consistent response across different agencies, and that they are 'flagged' on different IT systems.

Training

Many people who responded to the review said that the police needed more training to be able to use the powers appropriately, while others felt that it was not reasonable to expect the police to be fully trained in recognising and responding to all kinds of mental disorders.

The College of Policing are reviewing the training and guidance for police officers responding to victims, witnesses and offenders suffering mental ill-health. This will result in the development of Approved Professional Practice (APP) and an updated set of learning tools to help officers and staff understand how they can best support vulnerable people in mental health crises. The need for better training arose repeatedly during the review's evidence-gathering with many people advocating multi-agency training to help partner organisations to work more smoothly together.

The review recommends that **training on mental health needs to be improved for all agencies.** A multi-agency framework of training would help to deliver a better understanding of the legislation, and the roles and responsibilities of the other partner agencies involved.

Using new technologies

Technology has the potential to make significant (and cost-effective) contributions to police and health responses to mental health crises. Investment by the police and health agencies in video messaging, texting, or instant messaging technology could help the person in crisis and the police to access emergency health advice lines and speak to a health professional. It may be possible for such advice to be provided in the privacy of a person's home, or other suitable venue, which would negate the need to remove the person to a place of safety and reduce pressure on those facilities. If alternative options were agreed with the person concerned, such as a visit by local mental health services the next morning, this could avert some S136 detentions made under the Mental Health Act and release the police officer to deal with other incidents. Examples could include:

- Smartphone and tablet apps could be used to help alert healthcare response teams to a person in crisis. In future, sensors and alert systems could monitor a patient's mental status and wellbeing, and whether they are taking medication, and help to provide highly personalised mental healthcare services;

- Introducing electronic methods to obtain urgent warrants more quickly could help to reduce delays and encourage AMHPs to make better use of Section 135 warrants. Introducing better methods of payment nationally could reduce time spent travelling by the AMHP to and from Court, and time spent waiting for a magistrate;

- The use of body-worn video cameras by the police could potentially help health professionals see what the behaviours were at the point of

detention, once the person arrives at the place of safety and during assessment, provided that implications for human rights were properly explored. Video evidence could, with consent, be used for therapeutic purposes to help the person later on to understand what has happened and why. Video evidence could also be used later (for example by a multi-agency mental health group) to review the case or if needed in court;

- Investment by the police and health agencies in video messaging technology could help the person in crisis, and the police, to access emergency health advice lines and speak to a health professional immediately. This could be done in the privacy of a person's home, or other suitable venue, without the need to remove the person to a place of safety. If alternative options were agreed with the person concerned, such as a visit by local mental health services the next morning, this could avert some detentions made under the Mental Health Act and release the police officer to deal with other incidents;

- Creating other routes for advice to be accessed at earlier stages can help police to make the right decision at the right time. Making use of existing technologies, such as texting or instant messaging might be preferable and more discreet than making a phone call, providing that such routes were adequately staffed so that advice can be obtained in a timely way;

- Once a person has been discharged from detention under S135 or S136, online services can help them to access follow-up care, especially those who would have to travel a long way and people who are culturally or socially isolated; and

- The police and mental health teams could make better use of online information from chat-rooms and social media, such as suicide discussions forums, to identify those at potential risk of harm and ensure that support mechanisms are available to prevent self-harm. Processes could be introduced to ensure that, where concerns are raised, they are shared with the appropriate authorities and appropriate action is taken.

The review recommends that **health services and police should work together to explore the potential for new technologies to improve police and health responses to mental health crises.** Investment by the police and health agencies in video messaging, texting, or instant messaging technology could help the person in crisis and the police to access emergency health advice lines and speak to a health professional immediately. This could avert some S136 detentions made under the Mental Health Act provided that the use of such technologies is proportionate and that human rights considerations are taken into account.

Summary of Recommendations

Legislative Recommendations

Subject to affordability considerations and consultation prior to the full parliamentary process the review recommends:

1. Amending legislation so that **children and young people aged under 18 are never taken to police cells** if detained under S135 or S136;

2. Ensuring that **police cells can only be used as a place of safety for adults if the person's behaviour is so extreme they cannot otherwise be safely managed**;

3. Amending the list of possible places of safety in S135(6) so that **anywhere which is considered suitable and safe can be a place of safety** - removing barriers to using community-run places of safety or other alternatives which could not be said to have a single 'occupier'. This could help to enable innovative practice in terms of identifying places of safety;

4. Amending **S136 to apply anywhere <u>except</u> a private home** but including railway lines, private vehicles, hospital wards, rooftops of buildings, and hotel rooms. This would ensure that S136 could apply in workplaces, for example, where neither S136 nor S135 currently apply;

5. **Reducing the maximum length of detention under S135 and S136 to 24 hours** from 72 hours, in any place of safety. This would be subject to the possibility of an extension (length to be determined through further consultation), to be authorised in unavoidable cases where an assessment could not be carried out in the timeframe;

6. Requiring the police to **consult a suitable health professional prior to detaining a person under S136** provided it is feasible and possible to do so (for example if neither the police officer nor the person is put at risk by waiting for a clinical opinion). This means that local areas would need to have arrangements in place to ensure there would always be somebody available, which could for example include having street triage arrangements, calling the mental health nurse or on-duty doctor in the custody suite, or having arrangements in place to call the crisis service;

7. Setting out clearly in legislation that when a S135 warrant is carried out, **assessments can take place in the home** as part of the warrant process if it is considered appropriate and safe to do so, and that **police, paramedics, and AMHPs can remain present** while this is carried out. This ratifies existing practice in many areas (where a person consents) and reduces pressure on health-based places of safety;

8. Potentially creating a new limited power for **paramedics to convey a person to a health-based place of safety from anywhere other than a private home.** The feasibility of extending this or any other powers to suitable health professionals should be explored fully in consultation with the relevant stakeholders.

The proposals for legislative changes will be subject to further scrutiny and consideration, including considering the financial implications. In order for any amendments or revisions to the Mental Health Act 1983 to also apply in Wales, changes in relation to all health related matters would need to be agreed by the National Assembly for Wales.

Non-legislative Recommendations

During the review a number of issues were raised about the operation of S135 and S136 which did not require amendments to primary legislation and which should be addressed through improved practices and understanding between different partner agencies. Many of these issues have been fed into the parallel review of the Code of Practice for the Mental Health Act 1983 in England. Many are already reflected in the action plan of the Crisis Care Concordat for England published in February 2014[222]. The Mental Health Act Code of Practice for Wales is currently being revised and will take into

[222] Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

account the findings of this review. Specific guidance regarding S135 and S136 in Wales was issued in April 2012[223].

The review concurs with the recommendations of the recent CQC report '*A safer place to be: Findings from the Care Quality Commission's survey of NHS mental health trusts to examine the availability, accessibility and operation of health-based places of safety for people detained under section 136 of the Mental Health Act*'[224] that:

9. **Health-based places of safety and CCGs in England (local health boards in Wales) should understand the demand and provide adequate levels of service, which may include increasing the capacity and staffing in health-based places of safety.** Health-based places of safety should agree plans to improve any areas of shortfall in discussion with partners. They should review and amend their exclusion criteria in relation to people who are under the influence of drink or drugs, whose behaviour is disturbed or who have a previous history of offending or violence. This may mean that there needs to be greater flexibility in which places are designated a place of safety, or having a greater range of places that can be used when needed. Health-based places of safety should ensure that a minimum of two healthcare staff are allocated to receive an individual brought to the place of safety by the police, and that training for staff who work in the place of safety should be reviewed. Plans should then be developed to address any shortfalls. This should include training for security staff that may be required to intervene physically with an individual brought to the place of safety.

10. **CCGs and their equivalents in Wales should review the availability and use of health-based places of safety to identify whether provision meets local needs.** This includes reviewing when people are unable to access the local place(s) of safety and the reasons for this. CCGs will need to ensure that there are sufficient and appropriate places of safety for children and young people. They will also need to put in place commissioning specifications, including appropriate and timely arrangements for transporting people subject to S136 to hospital. This may require a needs assessment for specialist ambulance provision for people in mental health crisis. The Association of Ambulance Chief Executives' national protocol as part of the Crisis Care Concordat in England sets out that response times should be within 30 minutes or within eight minutes for people who are being actively restrained or if their condition is life-threatening.

Consideration will need to be given to how these recommendations will be implemented. In addition to these recommendations made by the CQC, the review also recommends that:

11. **CCGs in England (and their equivalent in Wales) should review their commissioning processes for places of safety** to ensure they are commissioning to CQC standards. CCGs or their equivalent should ensure that sufficient spaces are available for children and young people, and that no child or young person is being turned away from a health-based place of safety because of their age. CCGs or their equivalent should specifically consider the transportation of people detained under S136 when commissioning ambulance services.

12. **CCGs in England, and their equivalent in Wales, and partner agencies should explore alternative places of safety**, such as designated care homes, or modifying the environment and facilities in police stations so that a space other than a normal cell could be used for S136 detentions. Key considerations include ensuring the alternative facility is legally permissible under S135(6), can keep the person safely and securely, has appropriate clinical staff if necessary over and above that of day to day staffing levels and is part of existing health services processes for assessment and admission. They should have access to health staff and to medical records and be able to take responsibility for the person so the police officer can leave. They should be capable of managing complex cases such as people who may also be drunk or misusing drugs.

[223] Online at: http://wales.gov.uk/topics/health/publications/health/guidance/section/;jsessionid=0CswQf3fqCPmGQpS4ZW9TjppsgQyFvyjkv3rrSVfVxhWv8BNnB9!-1988510053?lang=en

[224] Online at: http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

13. **Speed up S135 warrants and streamline processes:**

    a. Local Authorities should sign up to the new Fee Account system to ensure payment for the warrant does not become a delaying factor[225];

    b. Courts should prioritise S135 warrants where the AMHP explains that it is very urgent, and magistrates should understand that without the S135 warrant, the person cannot be removed to or detained in a place of safety. Magistrates should understand the differences between S135(1) and S135(2) warrants, and that it is not necessary for permission to enter to have been refused to grant a S135(1) warrant. Additional guidance will be provided on this;

    c. There are proposals for digital warrants to be introduced which would reduce the time spent travelling to and from courts. This is to be encouraged; and

    d. In some areas, close working arrangements between out-of-hours magistrates and AMHPs have helped to ensure that obtaining a warrant does not introduce unnecessary delays. This should be adopted as best practice.

14. **The Code of Practice should, where possible, provide guidance and clarification on issues where custom and practice has developed that is not compliant with the current legislation.** Recommendations have been fed into the parallel review of the Code in England.

15. **The Disclosure and Barring Service and police service should issue additional guidance to police on DBS disclosures relating to detention under the Mental Health Act.** This will help ensure that chief officers of police responsible for disclosures are fully aware of the factors which should be taken into account and, in particular, whether the circumstances of any detention indicate a risk to the public. The Home Office should explore whether the statutory guidance and quality assurance framework should be amended.

16. **The police and health services should work towards improved data capture, monitoring and review.** The police should record every use of S136 carefully including ethnicity and length of detention, and record S135 involvement, so that any issues can be properly reviewed and lessons learnt. A new data toolkit was trialled by three police forces in England in autumn 2014, with the potential for national roll-out from April 2015. The toolkit involved the collation of more in-depth and consistent data about police interactions with people with mental ill-health. Also, the Home Office will also be working with the police to explore whether data on S135 and S136 can be made part of the police's Annual Data Requirement (ADR).

17. **Multi-agency groups should meet regularly to review data and discuss issues.** In some areas multi-agency groups regularly review S136 detentions, identifying repeat detentions, and using this information to drive improvements. This should be considered best practice everywhere. It may be helpful for people repeatedly detained under S136 to have multi-agency care plans put in place to ensure they receive a consistent response across different agencies and that they are 'flagged' on different IT systems. In Wales a shared data collection method has recently been developed. Such collaboration between health providers and the police forces should be encouraged.

18. **Training on mental health needs to be improved for all agencies.** All agencies involved in mental health processes need to work together to develop a multi-agency framework of training that delivers better understanding of the legislation and the roles and responsibilities of the other partner agencies involved, to ensure the individual in crisis is dealt with dignity and within the legislative framework. The College of Policing are already undertaking a review of mental health training for police and partners.

19. **Health services and police should work together to explore the potential for new technologies to improve police and health responses to mental health crises.** Investment

[225] More information can be found at: http://www.justice.gov.uk/courts/fees/payment-by-account

by the police and health agencies in video messaging, texting, or instant messaging technology could help the person in crisis and the police to access emergency health advice lines and speak to a health professional immediately to determine how to support the person in crisis.

These non-legislative options may also have financial implications which will need to be considered. In Wales, changes in relation to all health related matters would need to be agreed by the National Assembly for Wales.

Conclusion and Next Steps

This review has shown that in a number of areas there is a case for legislative change with strong support for change from practitioners and from service users. In particular, there is a need to reduce the use of police cells as places of safety for people detained under S136 to those circumstances where their use is unavoidable and to end their use for children or young people. There is also a continuing need to ensure that people can get the help they need as soon as possible wherever they are at the time.

The Home Office and Department of Health in England will work together to explore the impact of any legislative and non-legislative changes including further detailed consultation with health and police stakeholders and those affected by any such changes. This work will include diversity and equality considerations. The government's commitment to the principles of the mental health Crisis Care Concordat will continue.

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