Department of Health

Home Office

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

A Summary of the Evidence

December 2014

Published to gov.uk, in PDF format only.

www.gov.uk/dh

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

A Summary of the Evidence

Executive summary

This report summarises the evidence for the joint Home Office and the Department of Health in England review of the operation of Sections 135 and 136 of the England and Wales Mental Health Act 1983. These sections give the police powers to remove an individual who appears to be mentally disordered and in need of urgent care to a place of safety, where they can be detained for up to 72 hours so that a mental health assessment can be carried out. This forms part of the published evidence base in support of the report '*Review of the operation of Sections 135 and 136 of the Mental Health Act: Review Report and Recommendations*', published separately alongside this report.

This report sets out the responses to the online survey, which received over 1,100 responses, and responses received from national organisations. It should be read in conjunction with the report from the Centre for Mental Health '*Review of Sections 135 and 135 of the Mental Health Act: The views of professionals, service users and carers on the codes of practice and legislation*', published separately, and the Literature Review, published separately.

The evidence gathered during the review of the operation of Section 135 (S135) and Section 136 (S136) of the Mental Health Act 1983 (MHA) raised a number of key legislative and operational issues, which are summarised below.

The use of police cells as a place of safety:

- 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. People were asked to agree/disagree with each statement separately, and a number of respondents agreed with both statements.
- 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 considerable distress of the individual, including stigma and embarrassment. 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.
- Many health professionals and police in the workshops and the open text box responses thought that the use of police cells were sometimes necessary because a person could pose too much of a risk in a health-based place of safety.
- However, 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.
- Two respondents in the survey, as well as several service users in focus groups, raised concerns that detention in police custody will – unlike detention in a health-based place of safety – result in a custody record and potential disclosure of information in future DBS[1] checks

The availability of health-based places of safety:

- A lack of available health-based places of safety was cited in the practitioner workshops as one of the main barriers to reducing the numbers of people who are held in police cells.
- 96% of respondents in the survey said that health-based places of safety should have 24-hour access and staffing available: 92% said that there should always be an age-appropriate place of safety available for under-18s[2]. 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

[1] Disclosure and Barring Service

[2] The Care Quality Commission'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

project team, several health-based places of safety stated that, as they are attached to adult psychiatric wards, they cannot accept children.
- 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 sober.
- The police said in the practitioner workshops that they were often asked to remain in order to ensure the safety and security of the patient and staff – 72% of respondents agreed that 'the police have to wait a long time with patients'.

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

- When mental health crises occur in the person's home, the police may be invited in, or could, if the situation was to 'save life and limb', enter using the Police and Criminal Evidence Act 1984 (PACE) Section 17 - but this gives them no power to remove the person to a place of safety. The Approved Mental Health Professional (AMHP) may apply for a Section 135 warrant. This can take hours to arrange – several AMHPs in the open text boxes and in the practitioner workshops said this usually took more than 4 hours. Section 136 applies only in 'places to which the public have access', not in private homes.
- The evidence gathered confirmed that it can take a long time to obtain a Section 135 warrant, an issue if the person is in urgent need. The process can be lengthy and bureaucratic including, in some areas, paying for the warrant.
- Section 135 warrants can sometimes rely on outdated or inaccurate information. Magistrates sometimes refuse Section 135 warrants unless access has been refused, leaving 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.
- 102 people in the open text box for this section said that Section 136 is misused by police in or outside a person's own home. Examples provided by respondents to the survey included Section 136 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 Section 136. This was echoed by both police and AMHPs in the practitioner workshops.
- The attendees at the practitioner workshops noted that the police sometimes arrest the person for 'Breach of the Peace' but recent case law (R Hicks v Commissioner 2014) suggests this is unlawful unless at the time of arrest the officer had the intention to take the arrested person before the courts, which would rarely be the case in a Section 136-type situation[3]. The police were concerned that this could increase the number of Section 136 detentions happening outside homes.
- 60% of survey respondents (and 78% of police officers) agreed that Section 136 should be extended to apply in people's homes in order to cover these situations. Service users had more mixed views, with 38% agreeing, and 41% disagreeing. There were concerns expressed over the human rights implications of extending the Section 136 power to homes. Some respondents said that the power should be authorised by a senior police officer or health professional, 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.

Maximum length of detention (72 hours):

- 86% of respondents 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 in *any* place of safety.

[3] http://www.bailii.org/ew/cases/EWCA/Civ/2014/3.html

- Most people in the survey felt that either 4 or 24 hours in police custody was more appropriate, and either 24 or 72 (as at present) hours in any place of safety. Some commented that holding people for as long as 72 hours was rare.
- During the visits carried out for the review, some police raised concerns over examples where they appeared to be holding a person in custody unlawfully but for their own safety. Examples given were 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: this can result in the police continuing to hold them in custody for the safety of the person and others while waiting for a mental health assessment. There were also examples highlighted during the visits 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: some police officers said this was a 'common' occurrence'.

Extending powers to other professionals:

- 68% of respondents to the survey agreed that some or all of Section 135 or Section 136 powers should be extended so that health professionals can use them, provided they were not putting themselves at risk.
- Paramedics were particularly in favour, with 93% agreeing with extending the Section 135 and 136 powers to remove a person to a place of safety to other professionals, provided they were trained and equipped. 61 paramedics who went on to give more detail said they thought paramedics should have these powers.
- However, there were also concerns that a health professional or AMHP could be putting themselves at risk by exercising such powers, that they did not have the powers, training or equipment to restrain, that not being a frontline emergency service they would not be 'out and about' to encounter such individuals, and that being able to exercise such powers could jeopardise the therapeutic relationships between patient and doctor.

Conveying patients to and between places of safety:

- 65% of all 1,104 respondents agreed that patients detained under Section 136 have to wait for longer than 30 minutes for an ambulance, and 55 people further commented that ambulances were so slow to respond that, often, the police ended up transporting the person.
- The majority of paramedics and ambulance staff (70%) thought that ambulances shouldn't routinely be used to transport people detained under Section 136. In the open text box, and in the practitioner workshops, paramedics said that ambulances are unsafe 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.

Other findings:

- The academic roundtable noted that the use of Section 136 appears to have risen in recent years, possibly because of increasing use of Section 136 for people who have personality disorders complicated by substance misuse.
- The academic roundtable further showed that the majority of people detained under S136 do not go on to further detention under other parts of the Mental Health Act, suggesting that sometimes the police use Section 136 to detain a person who a health professional would not have detained. People who are intoxicated can pose particular problems, because it is often unclear whether or not they have an underlying mental health issue until they have sobered up.
- 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.

- There is a need for good multi-agency working to ensure the best outcomes for patients, including care plans for people who are repeatedly detained to ensure consistency of approach across health, policing, and criminal justice agencies.
- In the practitioner workshops, there was some confusion over where Section 136 can apply (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 visits, there was some confusion over who can discharge a person from a Section 136 detention – for example, if the situation changes over time, and detention is no longer felt to be appropriate.
- The lack of availability 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.
- The language used in the Mental Health Act 1983 was seen by some as reflecting outdated views and practices on mental health – phrases such as 'in need of care and control' were felt by some in the survey to be discriminatory against people with mental health problems.
- Police in the workshops said that hospitals sometimes can't or won't use their powers to detain people, resulting in a person absconding and then being reported to the police as a high-risk missing person.
- The survey showed that 64% of people thought there should be greater accountability and oversight of Section 136 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.
- Diversity and equality need further consideration in the operation of S136 detentions. 63 people highlighted that Black and Minority Ethnic groups are more likely to be detained under Section 136 compared to the general population, and that this can be perceived as discriminatory: this issue was also raised in the workshop run by Black Mental Health UK and in the academic roundtable discussion.

Contents

Introduction

This report summarises the evidence for the joint review between the Home Office and the Department of Health in England, to review the operation of Sections 135 and 136 of the England and Wales Mental Health Act 1983. These sections give the police powers to remove an individual who appears to be mentally disordered and in need of urgent care to a place of safety, where they can be detained for up to 72 hours so that a mental health assessment can be carried out.

The review considers how the legislation works in practice to support the response to a person's mental health crisis, including whether any changes could be made to improve the legislation or associated guidance, or if there are issues such as noncompliance with the legislation. It examined existing evidence and data about the operation of these parts of the legislation, and engaged a range of stakeholders including the police, health professionals, mental health service users and the wider public. The evidence-gathering phase included:

1. Literature review (published separately) including relevant data and case law.
2. Online survey open to everyone in England and Wales for 8 weeks, and additional responses received as submissions to the review.
3. Practitioner workshops held around England and Wales reported on in a separate report by the Centre for Mental Health.
4. Focus groups and one-to-one interviews with service users reported on in a separate report by the Centre for Mental Health.
5. Two seminars with Black Mental Health UK focusing on the views of people from black and minority ethnic groups.
6. Visits to areas reporting high and low numbers of Section 136 detentions.
7. Academic roundtable event.
8. A review of written evidence submitted to the Home Affairs Select Committee's inquiry into Policing and Mental Health.

The main body of this report sets out the responses to the online survey, and responses received from national organisations. The practitioner workshops and service user focus groups and interviews are summarised in the accompanying report by the Centre for Mental Health. Annex A lists the organisations which responded to this review. Annex B sets out the main findings of the workshops and visits carried out as part of the review, including two events held with Black Mental Health UK. Annex C summarises the academic roundtable discussion and key conclusions. Annex D describes the methodology used to analyse the survey responses, including the open text boxes. Annex E sets out the list of external independent advisers who quality-assured the evidence base.

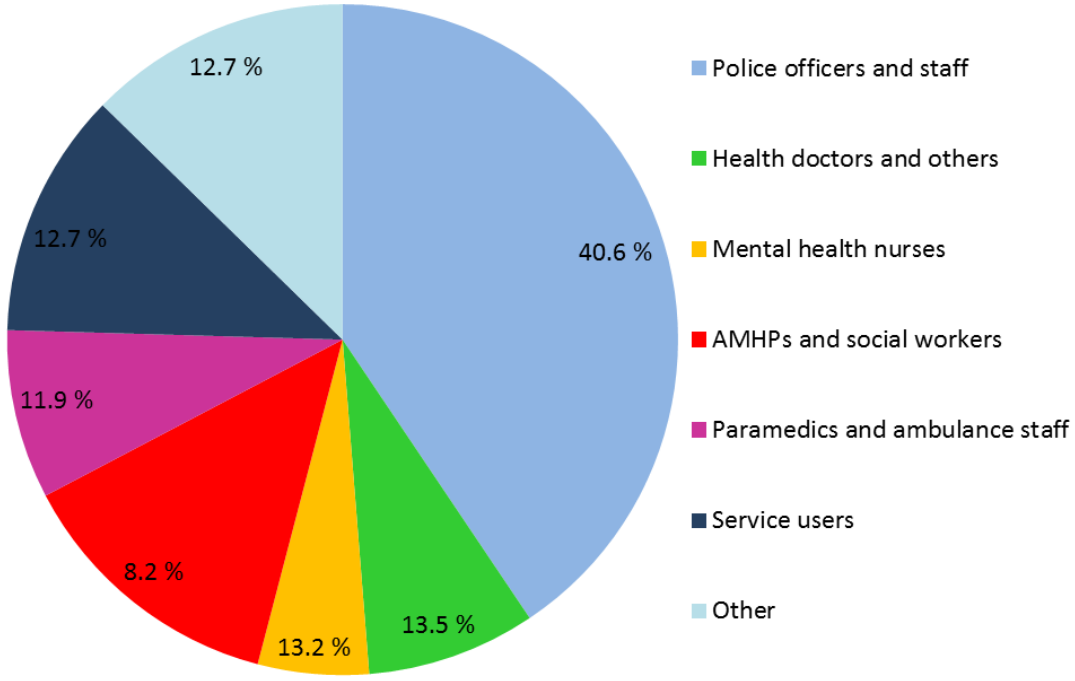
About the survey

The online survey ran on www.gov.uk from 8th April to 3rd June 2014 (8 weeks) and received 1,104 responses. The types of respondents were:

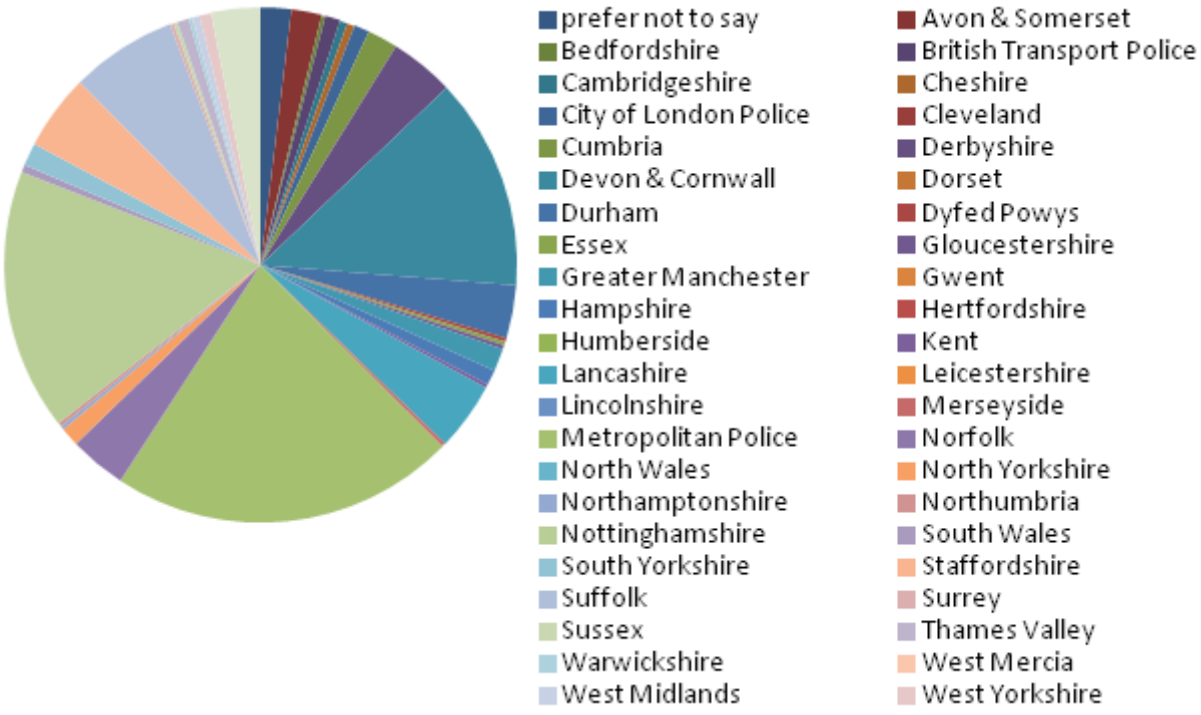
Category	No.	% of total	Breakdown of category	No.	% of total
Police	443	40.1	Police constables	206	18.7
			Police sergeants	139	12.6
			Police inspectors	49	4.4
			Police chief inspectors	4	0.4
			Police superintendent	1	0.1
			Police chief superintendent	1	0.1
			Police chief officer	0	0.0
			Police special constable	4	0.4
			Police community support officer	1	0.1
			Police staff	38	3.4
			Police staff association	0	0.0
Health doctors and others	90	8.2	Hospital doctor	24	2.2
			Psychiatrists	30	2.7
			General Practitioner (GP)	1	0.1
			Other health professional[4]	35	3.2
AMHPs[5]	117	10.6	Approved Mental Health Professionals	117	10.6
Paramedics	90	8.2	Paramedic	71	6.4
			Other ambulance staff	19	1.7
MH nurses	59	5.3	Mental Health nurses	59	5.3
Local Authority	29	2.6	Local Authority staff	18	1.6
			Social workers (not AMHP)	11	1.0
Voluntary sector	29	2.6	Voluntary/ charitable organisations	29	2.6
Service users	131	11.9	Person who has been detained under either S135 or S136	53	4.8
			Persons with experience of mental health issues generally	78	7.1
Other	116	10.5	Mental Health Commissioner	7	0.6
			Office of Police and Crime Commissioners	5	0.5
			Magistrate	1	0.1
			General public	27	2.4
			Prefer not to say	3	0.3
			Organisation[6]	73	6.6
TOTAL	**1104**		**TOTAL**	**1,104**	

[4] This category was provided for health professionals who did not identify as one of the other categories.
[5] Approved Mental Health Professionals.
[6] A list of the organisations who responded to the review, including by filling out the survey, is in Annex A.

In order to be able to analyse large enough groups for meaningful conclusions to be drawn, and because of low numbers in some groups, the analysis uses the overall categories as set out above. The percentages of respondents by type were:



Respondents other than the police were not asked for their place of work, although the survey recorded where they lived. Police officer's responses were split fairly evenly between police forces. In nine forces there were zero respondents, while the highest number of responses came from Devon and Cornwall Police, the Metropolitan Police, and Nottinghamshire Police:

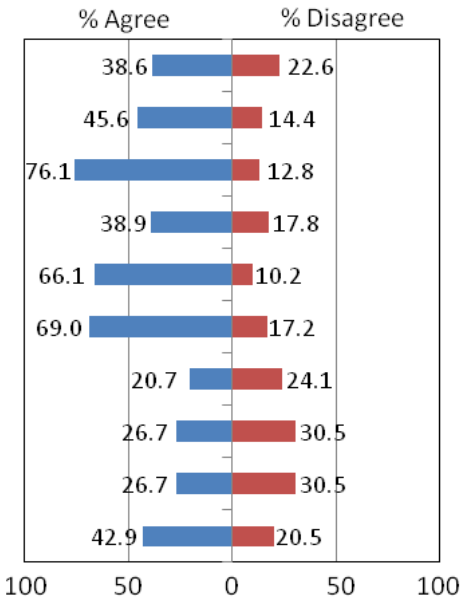


Section 1: Use of powers

Q1: To what extent do you agree or disagree with any of these statements about the use of powers in the operation of Sections 135 and 136?

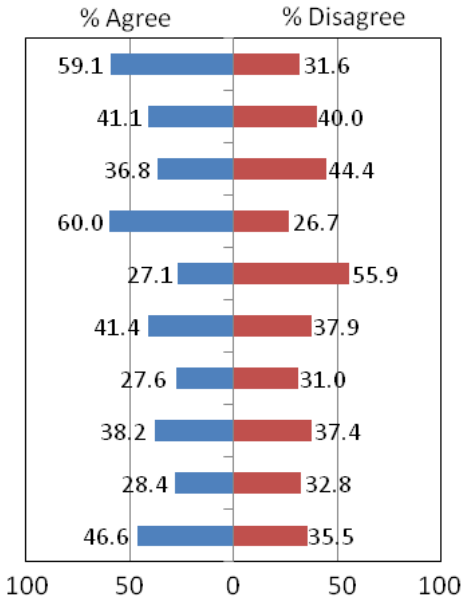
1.1 Section 135 is used correctly

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	8.6	30.0	19.4	13.8	8.8	18.1	1.4	443
Health	12.2	33.3	8.9	10.0	4.4	31.1	0.0	90
AMHPs	26.5	49.6	9.4	11.1	1.7	1.7	0.0	117
Paramedics	8.9	30.0	20.0	15.6	2.2	18.9	4.4	90
MH nurses	25.4	40.7	15.3	5.1	5.1	8.5	0.0	59
Local Authority	10.3	58.6	6.9	13.8	3.4	3.4	3.4	29
Voluntary sector	10.3	10.3	34.5	20.7	3.4	10.3	10.3	29
Service users	5.3	21.4	16.8	16.0	14.5	21.4	4.6	131
Other	11.2	21.6	11.2	13.8	6.9	13.8	21.6	116
OVERALL	**11.7**	**31.3**	**16.2**	**13.3**	**7.2**	**16.3**	**4.1**	**1104**



1.2 Section 136 is used correctly

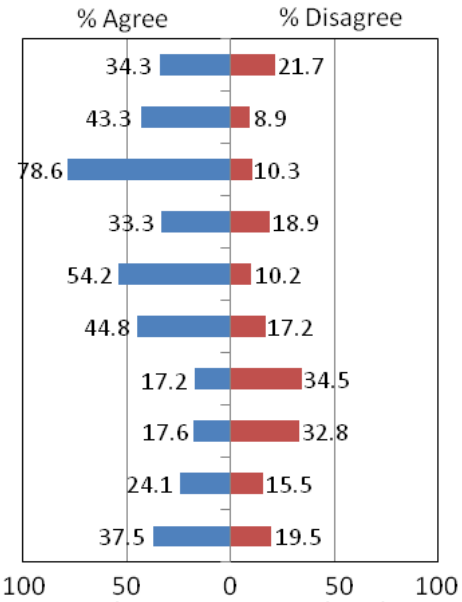
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	11.5	47.6	7.4	19.4	12.2	1.4	0.5	443
Health	5.6	35.6	13.3	31.1	8.9	3.3	2.2	90
AMHPs	4.3	32.5	17.1	29.9	14.5	0.9	0.9	117
Paramedics	14.4	45.6	10.0	21.1	5.6	3.3	0.0	90
MH nurses	1.7	25.4	15.3	33.9	22.0	1.7	0.0	59
Local Authority	0.0	41.4	10.3	37.9	0.0	6.9	3.4	29
Voluntary sector	13.8	13.8	27.6	24.1	6.9	6.9	6.9	29
Service users	9.2	29.0	12.2	19.8	17.6	7.6	4.6	131
Other	6.9	21.6	11.2	25.0	7.8	3.4	24.1	116
OVERALL	**9.0**	**37.7**	**11.1**	**23.6**	**11.9**	**2.9**	**3.8**	**1104**



These questions suggest that, overall, more respondents think that Sections 135 and 136 are used correctly than disagree that they are used correctly, but less than 50% in each case agree with this proposition. AMHPs, mental health nurses and Local Authority workers are confident that Section 135 is in the main used correctly. Police and paramedics are broadly confident that Section 136 is used correctly; but there is more disagreement among mental health nurses and AMHPs.

1.3 It is made clear when a Section 135 warrant has been executed

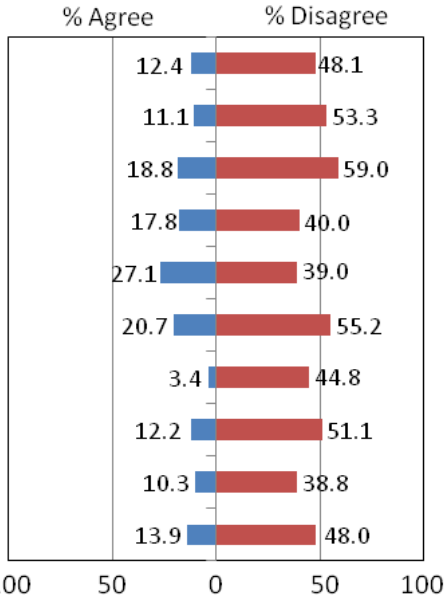
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	8.1	26.2	22.3	15.3	6.3	19.2	2.5	443
Health	12.2	31.1	13.3	5.6	3.3	32.2	2.2	90
AMHPs	25.6	53.0	8.5	5.1	5.1	0.9	1.7	117
Paramedics	7.8	25.6	16.7	14.4	4.4	27.8	3.3	90
MH nurses	16.9	37.3	25.4	5.1	5.1	10.2	0.0	59
Local Authority	6.9	37.9	17.2	13.8	3.4	13.8	6.9	29
Voluntary sector	3.4	13.8	24.1	34.5	0.0	10.3	13.8	29
Service users	2.3	15.3	16.8	15.3	17.6	24.4	8.4	131
Other	6.0	18.1	19.0	12.1	3.4	12.9	28.4	116
OVERALL	**9.7**	**27.8**	**18.8**	**13.0**	**6.5**	**18.1**	**6.2**	**1104**



The majority of AMHPs are confident that they make it clear when a Section 135 warrant has been executed; while respondents from the voluntary sector, and service users, tend to disagree.

1.4 The use of Section 135 'for other arrangements for the person's treatment or care' (not as a precursor for a mental health assessment) is well understood[7]

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	2.0	10.4	22.1	32.1	16.0	16.0	1.4	443
Health	3.3	7.8	14.4	40.0	13.3	18.9	2.2	90
AMHPs	5.1	13.7	18.8	42.7	16.2	1.7	1.7	117
Paramedics	4.4	13.3	18.9	26.7	13.3	17.8	5.6	90
MH nurses	3.4	23.7	22.0	27.1	11.9	11.9	0.0	59
Local Authority	3.4	17.2	13.8	31.0	24.1	6.9	3.4	29
Voluntary sector	0.0	3.4	20.7	34.5	10.3	10.3	20.7	29
Service users	3.8	8.4	10.7	27.5	23.7	18.3	7.6	131
Other	3.4	6.9	10.3	25.0	13.8	12.1	28.4	116
OVERALL	**3.1**	**10.9**	**18.0**	**31.9**	**16.1**	**14.1**	**5.9**	**1104**

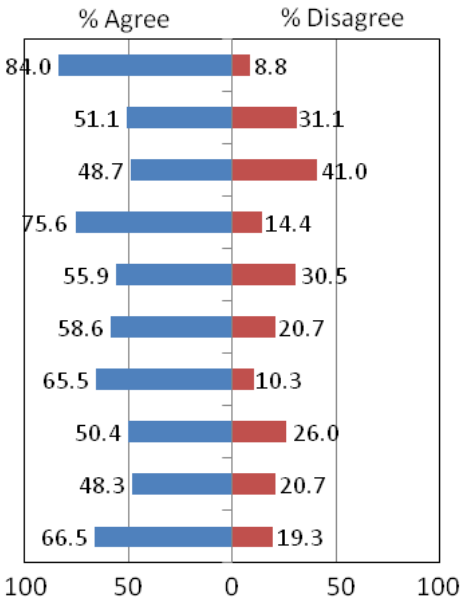


Every type of respondent mainly disagreed that the use of Section 135 in order to make 'other arrangements for a person's treatment or care' was well understood; several respondents erroneously suggested the question should have referred to Section 136 not Section 135. There seem to be few instances of Section 135 being used in this way, and little awareness of this potential usage.

[7] http://www.legislation.gov.uk/ukpga/1983/20/section/135

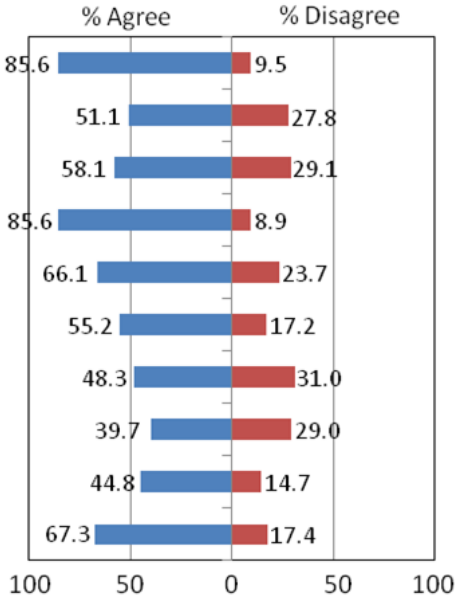
1.5 Police use Section 136 because they don't have any alternative

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	49.0	35.0	6.8	7.0	1.8	0.2	0.2	443
Health	14.4	36.7	14.4	26.7	4.4	3.3	0.0	90
AMHPs	11.1	37.6	10.3	34.2	6.8	0.0	0.0	117
Paramedics	26.7	48.9	8.9	11.1	3.3	1.1	0.0	90
MH nurses	16.9	39.0	10.2	15.3	15.3	1.7	1.7	59
Local Authority	20.7	37.9	13.8	17.2	3.4	3.4	3.4	29
Voluntary sector	10.3	55.2	10.3	3.4	6.9	6.9	6.9	29
Service users	25.2	25.2	9.2	11.5	14.5	7.6	6.9	131
Other	20.7	27.6	5.2	15.5	5.2	3.4	22.4	116
OVERALL	**31.1**	**35.4**	**8.5**	**13.9**	**5.4**	**2.1**	**3.6**	**1104**



1.6 Police don't have the right powers to act in an emergency in people's homes

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	63.4	22.1	4.1	7.4	2.0	0.7	0.2	443
Health	21.1	30.0	13.3	21.1	6.7	7.8	0.0	90
AMHPs	29.1	29.1	12.8	19.7	9.4	0.0	0.0	117
Paramedics	63.3	22.2	3.3	5.6	3.3	2.2	0.0	90
MH nurses	30.5	35.6	5.1	11.9	11.9	5.1	0.0	59
Local Authority	13.8	41.4	13.8	10.3	6.9	10.3	3.4	29
Voluntary sector	10.3	37.9	10.3	24.1	6.9	0.0	10.3	29
Service users	17.6	22.1	19.8	15.3	13.7	6.1	5.3	131
Other	26.7	18.1	10.3	11.2	3.4	5.2	25.0	116
OVERALL	**42.6**	**24.7**	**8.7**	**11.8**	**5.6**	**2.9**	**3.7**	**1104**



These two questions together suggest there is overall agreement – especially among police and paramedics who, being emergency services, are most likely to be called to the scene - that the police have few options available other than the use of Section 136; and that the police do not have the right powers to act if there is a mental health emergency situation in a person's home.

Open text boxes

The survey provided unlimited space in each section for respondents to elaborate on the topic if they wished to do so. While most questions began with asking people to agree/disagree with various statements, two questions had only open text boxes for people to reply, and the final open text box invited people to add anything else not covered elsewhere, and examples of good practice. The word count in the open text boxes for the survey as a whole was 301,361 words.

The methodology for the analysis is explained in Annex D, p.115. The open text boxes were analysed by drawing out the common themes which emerged amongst respondents. All the responses were tallied against these common themes, to give a broad idea of how prevalent each theme was, broken down by type of respondent to explore whether police, for example, had a different point of view to AMHPs. Comments which merely re-stated a point already agreed/disagreed with – such as 'I agree that the police don't have any alternatives' – were not included unless the respondent added further judgement or qualification such as 'Section 136 is used because the police are taking a risk if they fail to act'.

The figures shown in the tables are a percentage of the actual number of respondents who made each point, by type of respondent, with the actual number in the final column. Respondents may have made more than one comment in their answer and were counted for each separate point they made, so one respondent's answer may be included in more than one row (for that reason, there is no total given for each column).

Quotes were only included from survey respondents who ticked the box agreeing that their responses could be used. Where the quotes were from individuals, their 'role' was given where possible (e.g. 'AMHP, police constable, paramedic') and where it was the response of an organisation, this has been named. All quotes used are the opinions of the person and do not represent the views of government.

Open text box analysis

466 people added additional comments to Section 1. 119 people (26%) thought there was a lack of knowledge about Sections 135 and 136 and a need for more training. 102 people (22%) including police officers, health professionals and AMHPS said that Section 136 was used wrongly or misused. Examples of Section 136 being used wrongly, or misused, include examples of Section 136 being used either 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 Section 136[8]. For example:

> *'On Mind's Legal line we have heard complaints from people about Section 136 being used where it is not a public place.'* (Response to the survey from Mind)

> *'There are too many instances when people report that they were placed on Section 136 within their own home, which is clearly incorrect use. I have also some concerns that 136 is used as alternative to charging people with anti-social behaviour whilst under the influence of alcohol and drugs.'* (AMHP)

> *'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 a Section 136 is placed instead of a 135.'* (Paramedic)

63 people, mainly police officers, said that they had no other options available and want to do the best thing they can for the person; several police officers also said that if they had contact with a person who went on to take their own life or harm others their actions would come under scrutiny by the Independent Police Complaints Commission:

[8] Section 136 can be used in a 'place to which the public have access': this does not include private homes or gardens. If a person is in a home, a Section 135 warrant should be obtained to remove them to a place of safety.

> *'Section 136 is most often used because Police have no other alternative and ultimately just want to safeguard the individual who may be intimating self-harm or suicide. Officers are risk averse and many are afraid of losing their jobs having been the last contact.'* (Police constable)

74 people (16%) of respondents – mainly police officers - said that this was why there needed to be a power to take action in people's homes in an emergency, such as by extending Section 136 to enable it to be used in homes (also see Section 5, p.35).

96 people (21%), mainly police officers, said that the issue was a lack of resources, especially the availability of mental health services out of hours. A number of police officers felt that the police service was left to fill in the gaps between other agencies:

> *'Due to the lack of provision for persons with mental health problems the police service is left with the responsibility for the immediate care and provision for such persons. I have numerous examples where a person who claims to have mental health problems initiates contact with police because there is no other agency [that] is available for them or able to deal with their concerns.'* (Police constable)

> *'Outside office hours there is no mental health service provision capable of securing an emergency warrant under Section 135. It is often the case that Crisis Teams will tell police to "use Section 136" when it is clearly unlawful and inappropriate.'* (Police inspector)

The table below shows the main themes broken down by type of respondent:

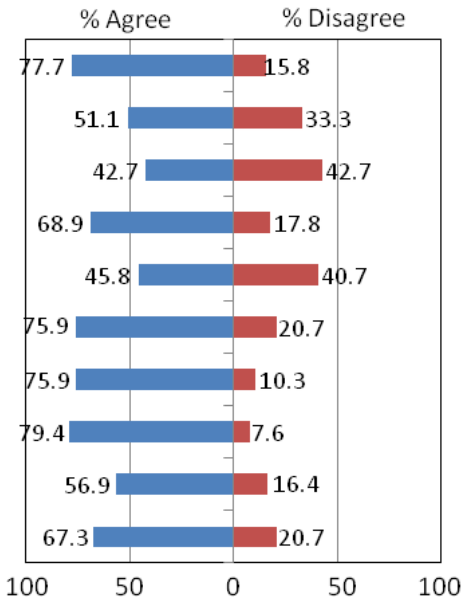
%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
There is a lack of knowledge/ training about S135 and S136	25.2	5.9	26.1	5.9	6.7	2.5	5.9	12.6	9.2	119
Section 136 is used wrongly/ misused	24.5	19.6	21.6	4.9	9.8	2.0	1.0	7.8	8.8	102
Not enough resources/ lack of out of hours availability	49.0	4.2	8.3	7.3	6.3	4.2	6.3	5.2	9.4	96
Section 135 warrants are under-used/ take too long	55.3	3.5	17.6	5.9	10.6	3.5	0.0	0.0	3.5	85
Section 136 should be extended to private homes/ there needs to be a power to act in homes	62.2	2.7	4.1	9.5	1.4	5.4	0.0	2.7	12.2	74
Police have no options/ are risk averse	55.6	3.2	15.9	1.6	9.5	3.2	4.8	0.0	6.3	63
It's a health issue/ shouldn't be for police	61.4	0.0	0.0	4.5	0.0	0.0	2.3	18.2	13.6	44
Not clear what is meant by a 'place to which the public have access'	25.0	0.0	50.0	0.0	0.0	16.7	8.3	0.0	0.0	12
Section 136 is over-used by police	10.0	10.0	0.0	10.0	40.0	0.0	0.0	20.0	10.0	10
Better access to information is needed	10.0	10.0	0.0	0.0	10.0	0.0	30.0	10.0	30.0	10
Street triage is useful	11.1	11.1	33.3	0.0	22.2	0.0	0.0	0.0	22.2	9

Section 1: Places of Safety

Q2: To what extent do you agree or disagree with any of these statements about places of safety?

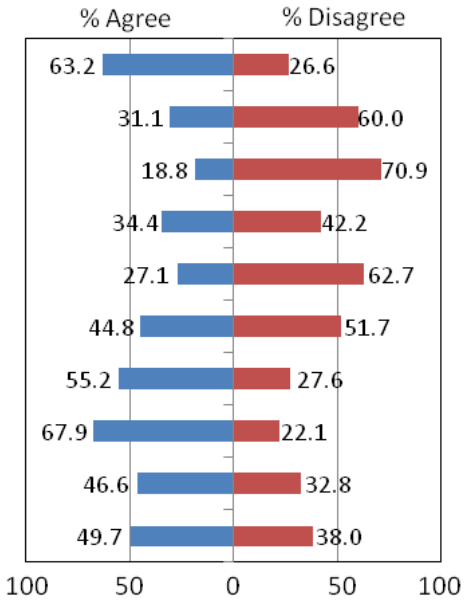
2.1 Police cells are often used as a place of safety because there aren't enough health-based places of safety

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	55.5	22.1	5.9	11.3	4.5	0.0	0.7	443
Health	17.8	33.3	8.9	26.7	6.7	4.4	2.2	90
AMHPs	24.8	17.9	14.5	29.9	12.8	0.0	0.0	117
Paramedics	42.2	26.7	4.4	15.6	2.2	8.9	0.0	90
MH nurses	15.3	30.5	10.2	25.4	15.3	3.4	0.0	59
Local Authority	31.0	44.8	3.4	17.2	3.4	0.0	0.0	29
Voluntary sector	41.4	34.5	3.4	3.4	6.9	6.9	3.4	29
Service users	48.1	31.3	2.3	3.8	3.8	9.2	1.5	131
Other	26.7	30.2	6.0	10.3	6.0	2.6	18.1	116
OVERALL	**41.0**	**26.3**	**6.6**	**14.6**	**6.1**	**2.8**	**2.6**	**1104**



2.2 Police cells should never be used as a place of safety

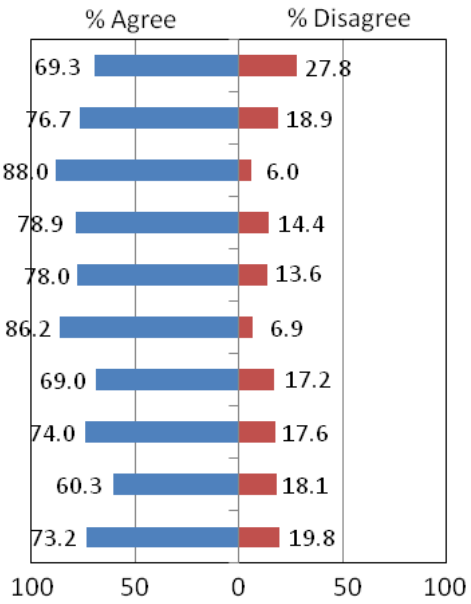
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	38.4	24.8	9.5	22.8	3.8	0.0	0.7	443
Health	15.6	15.6	8.9	35.6	24.4	0.0	0.0	90
AMHPs	9.4	9.4	9.4	53.0	17.9	0.0	0.9	117
Paramedics	15.6	18.9	22.2	32.2	10.0	1.1	0.0	90
MH nurses	15.3	11.9	8.5	35.6	27.1	0.0	1.7	59
Local Authority	20.7	24.1	3.4	34.5	17.2	0.0	0.0	29
Voluntary sector	37.9	17.2	13.8	20.7	6.9	0.0	3.4	29
Service users	41.2	26.7	9.2	18.3	3.8	0.0	0.8	131
Other	25.0	21.6	4.3	22.4	10.3	0.0	16.4	116
OVERALL	**28.8**	**20.9**	**9.8**	**28.2**	**9.9**	**0.1**	**2.4**	**1104**



Most respondents felt that police cells are 'often' used as places of safety because of a lack of health-based places of safety, although the response from AMHPS was evenly split between those that agreed and disagreed with 2.1. There was a more mixed picture about whether police cells should 'never' be used as a place of safety. Police and service users were the groups most likely to agree with the statement, while health professionals, AMHPs, and mental health nurses in particular, felt that police cells were sometimes a necessity. Some people raised concerns over whether violent people could be safely managed in a healthcare setting, with strong support across all groups that the use of police cells should be 'exceptional' such as if the person is violent:

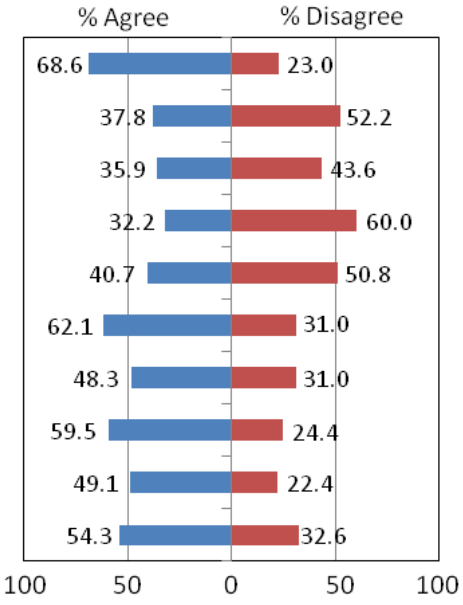
2.3 Police cells should only be used as a place of safety in exceptional circumstances such as if the person is violent

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	38.8	30.5	2.5	15.1	12.6	0.2	0.2	443
Health	27.8	48.9	4.4	14.4	4.4	0.0	0.0	90
AMHPs	46.2	41.9	6.0	3.4	2.6	0.0	0.0	117
Paramedics	34.4	44.4	6.7	11.1	3.3	0.0	0.0	90
MH nurses	40.7	37.3	8.5	8.5	5.1	0.0	0.0	59
Local Authority	58.6	27.6	6.9	6.9	0.0	0.0	0.0	29
Voluntary sector	27.6	41.4	10.3	13.8	3.4	0.0	3.4	29
Service users	42.0	32.1	4.6	9.9	7.6	0.8	3.1	131
Other	21.6	38.8	2.6	12.9	5.2	0.0	19.0	116
OVERALL	**37.2**	**36.0**	**4.3**	**12.0**	**7.8**	**0.2**	**2.5**	**1104**



2.4 Emergency departments in hospitals should be places of safety

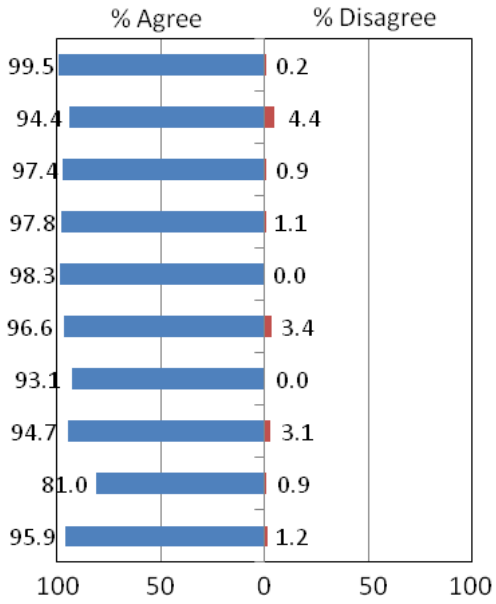
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	38.8	29.8	7.7	17.6	5.4	0.0	0.7	443
Health	8.9	28.9	10.0	23.3	28.9	0.0	0.0	90
AMHPs	6.8	29.1	18.8	29.1	14.5	0.9	0.9	117
Paramedics	3.3	28.9	5.6	28.9	31.1	1.1	1.1	90
MH nurses	10.2	30.5	8.5	25.4	25.4	0.0	0.0	59
Local Authority	31.0	31.0	6.9	24.1	6.9	0.0	0.0	29
Voluntary sector	20.7	27.6	17.2	31.0	0.0	0.0	3.4	29
Service users	32.1	27.5	10.7	11.5	13.0	0.8	4.6	131
Other	23.3	25.9	7.8	14.7	7.8	0.9	19.8	116
OVERALL	**25.5**	**28.9**	**9.5**	**20.1**	**12.5**	**0.4**	**3.2**	**1104**



Police and Local Authority workers, in particular, agreed that hospital emergency departments (A&E) should be considered a place of safety: however opinions were divided with paramedics, health professionals, and mental health nurses tending to the view that they should not be.

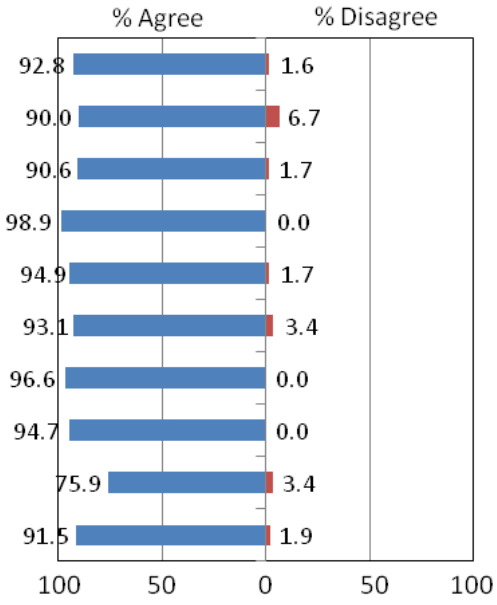
2.5 Health-based places of safety should have 24/7 access and staffing

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	85.8	13.8	0.0	0.0	0.2	0.0	0.2	443
Health	64.4	30.0	1.1	1.1	3.3	0.0	0.0	90
AMHPs	74.4	23.1	0.9	0.0	0.9	0.0	0.9	117
Paramedics	75.6	22.2	1.1	0.0	1.1	0.0	0.0	90
MH nurses	69.5	28.8	1.7	0.0	0.0	0.0	0.0	59
Local Authority	69.0	27.6	0.0	3.4	0.0	0.0	0.0	29
Voluntary sector	55.2	37.9	0.0	0.0	0.0	0.0	6.9	29
Service users	77.9	16.8	0.8	1.5	1.5	0.0	1.5	131
Other	62.1	19.0	1.7	0.0	0.9	0.0	16.4	116
OVERALL	**76.4**	**19.5**	**0.6**	**0.4**	**0.8**	**0.0**	**2.3**	**1104**



2.6 There should always be an age-appropriate place of safety available for under 18s

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	70.4	22.3	4.7	1.4	0.2	0.0	0.9	443
Health	64.4	25.6	2.2	4.4	2.2	0.0	1.1	90
AMHPs	70.1	20.5	6.8	0.9	0.9	0.0	0.9	117
Paramedics	72.2	26.7	1.1	0.0	0.0	0.0	0.0	90
MH nurses	69.5	25.4	1.7	0.0	1.7	0.0	1.7	59
Local Authority	79.3	13.8	3.4	3.4	0.0	0.0	0.0	29
Voluntary sector	75.9	20.7	0.0	0.0	0.0	0.0	3.4	29
Service users	79.4	15.3	2.3	0.0	0.0	0.0	3.1	131
Other	53.4	22.4	2.6	2.6	0.9	0.0	18.1	116
OVERALL	**69.7**	**21.8**	**3.6**	**1.4**	**0.5**	**0.0**	**3.0**	**1104**

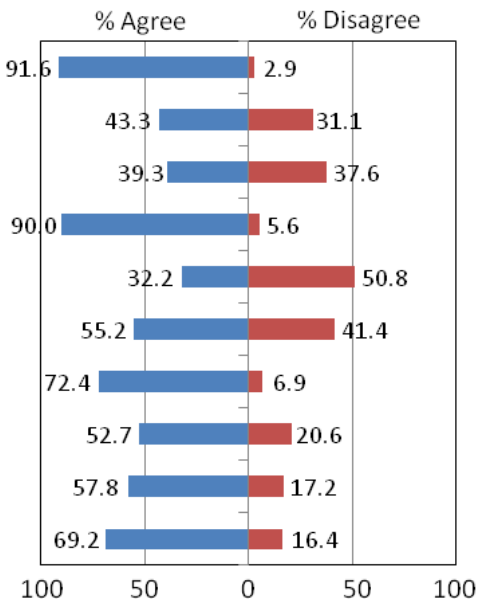


These statements attracted the strongest degree of support across the board, with near-total agreement that health-based places of safety need to be available 24/7 (with the right staffing) and that under-18 year olds should always have an age-appropriate place to go to. In contrast, the Care Quality Commission's map of health-based places of safety found that 56 (35%) of the 161 health-based places of safety do not accept young people under the age of 16[9].

[9] http://www.cqc.org.uk/media/new-map-health-based-places-safety-people-experiencing-mental-health-crisis-reveals-restrictio

2.7 Health-based places of safety should accept people who are intoxicated

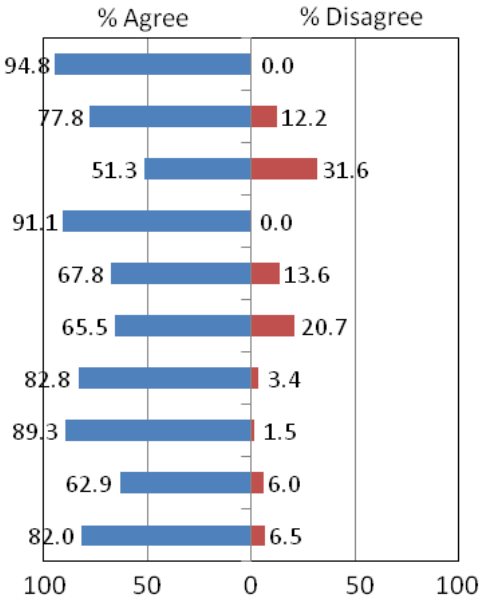
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	64.8	26.9	4.5	2.0	0.9	0.5	0.5	443
Health	15.6	27.8	22.2	17.8	13.3	1.1	2.2	90
AMHPs	15.4	23.9	19.7	21.4	16.2	1.7	1.7	117
Paramedics	55.6	34.4	4.4	4.4	1.1	0.0	0.0	90
MH nurses	22.0	10.2	11.9	25.4	25.4	3.4	1.7	59
Local Authority	17.2	37.9	3.4	31.0	10.3	0.0	0.0	29
Voluntary sector	10.3	62.1	17.2	6.9	0.0	0.0	3.4	29
Service users	22.1	30.5	20.6	10.7	9.9	3.8	2.3	131
Other	33.6	24.1	6.9	12.9	4.3	1.7	16.4	116
OVERALL	**41.5**	**27.7**	**10.4**	**9.9**	**6.5**	**1.3**	**2.7**	**1104**



How to support people who are intoxicated was a concern that came out clearly throughout this review. Police and paramedics, in particular, thought that health-based places of safety should not exclude a person on the grounds of intoxication; while mental health nurses made the point that the person could not undergo a mental health assessment until sober, and until then was blocking a bed that another person might need.

2.8 It can take too long (more than 4 hours) to get a mental health assessment

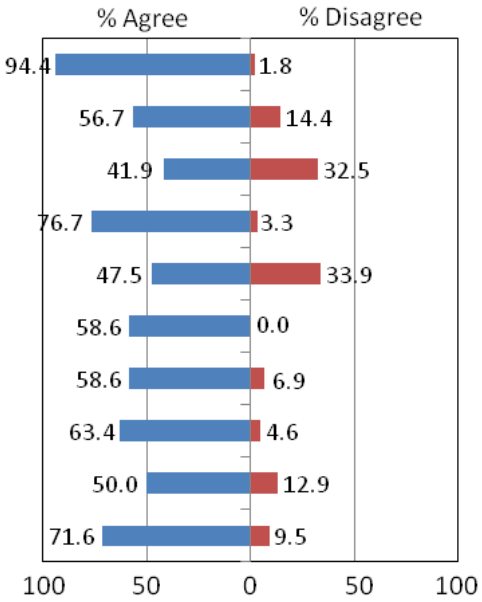
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	78.8	16.0	2.9	0.0	0.0	1.4	0.9	443
Health	45.6	32.2	6.7	10.0	2.2	2.2	1.1	90
AMHPs	18.8	32.5	15.4	25.6	6.0	0.0	1.7	117
Paramedics	72.2	18.9	5.6	0.0	0.0	3.3	0.0	90
MH nurses	33.9	33.9	16.9	11.9	1.7	1.7	0.0	59
Local Authority	34.5	31.0	6.9	20.7	0.0	3.4	3.4	29
Voluntary sector	51.7	31.0	10.3	0.0	3.4	0.0	3.4	29
Service users	66.4	22.9	3.1	0.8	0.8	3.8	2.3	131
Other	42.2	20.7	10.3	6.0	0.0	3.4	17.2	116
OVERALL	**59.6**	**22.4**	**6.6**	**5.4**	**1.1**	**2.0**	**2.9**	**1104**



There was agreement that it can take 'too long' to begin a mental health assessment, and that it is desirable for the person to have this as soon as possible. Some health professionals pointed out that the process of carrying out a mental health assessment can itself take many hours.

2.9 Police have to wait a long time with the person at the place of safety

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	77.0	17.4	3.2	1.6	0.2	0.2	0.5	443
Health	22.2	34.4	22.2	10.0	4.4	5.6	1.1	90
AMHPs	12.0	29.9	23.9	23.1	9.4	0.0	1.7	117
Paramedics	40.0	36.7	7.8	3.3	0.0	11.1	1.1	90
MH nurses	20.3	27.1	15.3	20.3	13.6	3.4	0.0	59
Local Authority	34.5	24.1	37.9	0.0	0.0	3.4	0.0	29
Voluntary sector	24.1	34.5	17.2	3.4	3.4	13.8	3.4	29
Service users	38.2	25.2	14.5	0.8	3.8	16.0	1.5	131
Other	29.3	20.7	11.2	11.2	1.7	6.9	19.0	116
OVERALL	**47.5**	**24.1**	**11.4**	**6.6**	**2.9**	**4.7**	**2.8**	**1104**



This was a near-universal view from the police with 94.4% agreeing overall, and in 77% of cases strongly agreeing that police have to wait a long time with the person at the place of safety. The police often felt this was a poor use of their time.

Open text box analysis

511 people added additional comments. 164 respondents (32%) said that there weren't enough health-based places of safety and that low staffing levels caused difficulties. 111 (22%) – mainly police officers – said that low staffing levels resulted in police having to wait a long time with the patient at a health-based place of safety, or in A&E, in order to provide security for the staff/ other patients. 63 people (12%) felt that health-based places of safety turned people away unnecessarily because of intoxication, and that they should be better able to take people with mental health problems who may self-medicate with alcohol or drugs.

> '*I recently had to sit for 7 hours with a voluntary patient to prevent them walking out of hospital. As due to the long waiting times many mental health patients abscond before they are seen. NHS procedures are woefully inadequate in terms of referring patients to their own mental health wards. This creates a situation where people are being detained under 136 by police, as it is easier and less time consuming than allowing voluntary admission/assessment.*' (Police constable)

95 people (19%) commented further on whether emergency departments in hospitals (A&E) should be considered a place of safety. 57 (11%) felt that emergency departments are unsuitable as places of safety because of the disturbance caused to other patients, the lack of secure facilities (people can easily walk out), and because the noise and activity could exacerbate the symptoms of a person experiencing a severe mental health crisis. Another 38 people (7%) said that emergency departments must be part of the picture for places of safety, because the person may also have urgent physical health needs, especially if intoxicated, on drugs or under the influence of 'legal highs'.

> '*From a Paramedic point of view... A&E's are not a place of safety, they are over capacity at the moment with very few secure areas to keep people who have been placed under a 136 safe and provide them the care they need. Also taking acutely unwell Mental Health patients can put at risk the other patients. Also A&E staff are not Mental Health experts so the initial (and often very important) care that is received is not from an expert.*' (Paramedic)

'*...the practice of absolute refusal to commence any mental health assessment on those who are intoxicated is simply unrealistic in practice, especially if they have a history that could be drawn upon to assist. Intoxication is often the way with a high volume of those patients and to refuse to assist these people and either have officers sat with them until sober or put in cells is hardly focused on the individual's best interests.*' (Police constable)

The main themes, by type of respondent, were:

%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
There are not enough health-based places of safety/ staff	38.5	11.5	21.2	1.9	3.8	3.8	1.9	1.9	15.4	164
Police have to wait a long time at hospitals to provide security for health staff/ poor use of resources	58.7	3.2	11.1	7.9	6.3	0.0	0.0	1.6	11.1	111
Health-based places of safety should accept intoxicated people if they have mental health problems	12.3	26.3	10.5	33.3	8.8	0.0	1.8	7.0	0.0	63
A&E is unsuitable as a place of safety because of risks to other patients/ noise could exacerbate	36.8	10.5	13.2	10.5	10.5	2.6	2.6	0.0	13.2	57
Police station is the correct place if the person is violent as health staff should not be placed at risk	69.4	1.8	9.0	1.8	2.7	0.0	0.9	1.8	12.6	52
A&E should be a place of safety/ needs to be because people may also have urgent physical health needs	42.1	6.7	13.4	9.1	3.7	4.9	1.8	6.1	12.2	38
Intoxicated people should not be held in Custody/ police refuse to accept intoxicated people	20.0	0.0	80.0	0.0	0.0	0.0	0.0	0.0	0.0	12
There need to be more alternative places of safety/ more use of alternatives	22.2	0.0	66.7	0.0	11.1	0.0	0.0	0.0	0.0	9
Drunk people should be arrested rather than taken to health-based places of safety	58.3	0.0	16.7	16.7	0.0	0.0	0.0	0.0	8.3	6
Police use Section 136 as it is easier than making an arrest or finding another resolution	16.7	0.0	83.3	0.0	0.0	0.0	0.0	0.0	0.0	5

Q3: The Code of Practice for the Mental Health Act 1983 sets out that a police station should only be used in 'exceptional' circumstances, but in some places it is used the majority of the time. How would you address this issue?

This question offered an unlimited open text box for people to respond to this statement.

841 people made comments. 559 people (66%) said that this issue could be resolved if there were more health-based places of safety available, suggesting that very often, police cells are used because the health-based place of safety is already full. This concurs with the finding at 2.1 where 67.3% agreed that '*Police cells are often used as a place of safety because there aren't enough health-based places of safety*'.

> '*There needs to be an investment in 136 facilities within mental health units. That investment should include the safe staffing by mental health nurses. Increasingly staff in inpatient units...are expected to manage 136 suites from within their shift establishment. This places an already overburdened area at even greater risk*' (Mental health nurse)

> '*...there must be a legal pressure brought to bear on Commissioning Bodies in the NHS to have sufficient space for people to be brought to in an acutely unwell mental state. Police Station Custody Suites are rarely safe for anyone, least of all the Mental Health Patient.*' (Paramedic)

> '*This is a capacity issue. Insufficient space is available in mental health hospitals, especially finding places at short notice for patients requiring assessment. Out-of-hours support is, in my experience, lacking with the few practitioners working over night under pressure from management and work load to only attend to those of immediate risk to themselves or others.*' (Paramedic)

134 people (16%) said that more training and security in health-based places of safety could help them to manage violent and intoxicated people so they do not end up in police cells.

> '*As manager of a health based place of safety I feel that commissioners should give consideration to the necessary staffing numbers and skill mixed required to provide a health based place of safety which can safely manage needs of those who are intoxicated and at risk of violence to prevent people being assessed at custody wherever appropriate. Having lower graded staff in small numbers generally means that risk assessments are policy based rather than individualised and I feel that more people would be sent to custody than would be if the decision was to be made by more senior practitioner with the availability of additional staff to safely manage a violent/intoxicated individual*.' (Mental health nurse)

However, there were concerns expressed from health professionals that intoxicated people may well prove not to have underlying mental health problems, once sober:

> *'People who are only intoxicated should not go to a Section 136 place of safety. Better training is needed to manage intoxicated members of the public. Police already have powers to do so but understandably do not want to fill the cells as this group of people can also have high risk health complications from alcohol.*'(AMHP)

> *'The police cells are an appropriate place for those intoxicated with alcohol. The police should receive training not to detain intoxicated people on Section 136, but instead arrest them as drunk and disorderly. The number of Section 136 detentions in the police cells would likely go down as a result.'* (Psychiatrist)

113 people (13%) said that 'exceptional' use should be defined in law as being only those cases where the person is unmanageably violent, rather than the health-based place of safety being full or excluding the person for other reasons. 76 people (9%) said that there needs to be more use of alternatives to

police custody: while 60 people (7%) – half of them police officers, said the law should be changed to remove police stations. Some also suggested other solutions:

> '*24/7 Emergency mental health assessment units which would take ambulance/police/GP referrals including intoxicated patients following ambulance/GP assessment*' (Paramedic)

> '*More access to direct referral to mental health units. Specialist mental health staff in localities. A specialised mental health cell within police custody for mental health patients for short-term stay until referral to a mental health unit.*' (Paramedic)

> '*All psychiatric units - outpatient/inpatient - should have an assessment suite nominated as a place of safety*.' (AMHP)

> '*Remove the right to detain under Section 136 from the police and move it to approved registered paramedic, possibly as a joint power with the police, who may still be called upon for violent patients. This creates 'parity of esteem' with physical health emergencies and ensures patients are assessed for physical health needs. By specifying this power to only approved paramedic staff it ensures a higher level of MH training than the police currently have, and ensures that patients are seen by a registered health care professional at the earliest opportunity.*' (Paramedic)

> '*Impose a fine upon police if a certain amount of Section 136's are detained in cells. Measure this against an exceptional area who clearly do use the cells in exceptional circumstances*.' (AMHP)

The main themes, by type of respondent, were:

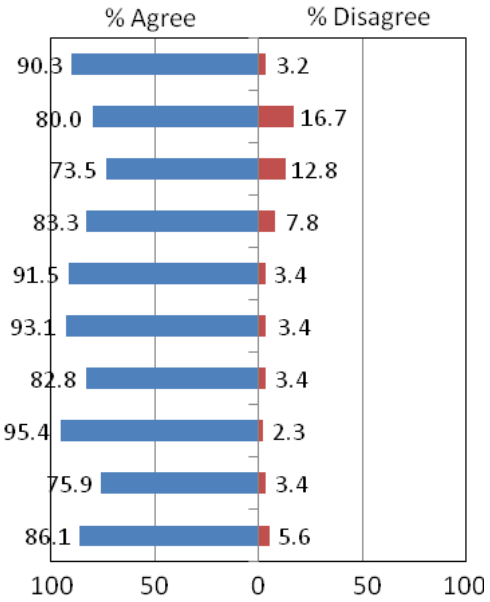
%	Police	Health	AMHPs	Paramedics	MH nurses	Local Authority	Voluntary sector	Service users	Other	No. respondents
Need more health resources/ NHS should provide beds	39	9.3	11	9.8	5.2	2.5	2.7	12	8.4	**559**
More training/ security in health-based places of safety so they can manage violent and intoxicated people	44	0	0	11.1	0	0	0	22	22	**134**
Define 'exceptional' in law/ police custody should be used exceptionally if the person is unmanageably violent	60	5.2	0.7	14.9	7.5	2.2	0.7	4.5	4.5	**113**
Need more alternative places of safety/ more use of other places	65	1.7	5	3.3	0	0	0	22	3.3	**76**
Police stations should be removed as a place of safety by changing legislation	50	0	13	0	13	0	0	25	0	**60**
Other professionals need powers	17	6.6	5.3	7.9	5.3	7.9	5.3	33	12	**9**
Police should arrest if person is violent rather than use S136	43	7.8	8.3	9.0	5.2	2.9	2.4	13	8.2	**8**

Section 3: Maximum length of detention

Q4: To what extent do you agree or disagree with any of these statements about the maximum length of detention under Sections 135 and 136?

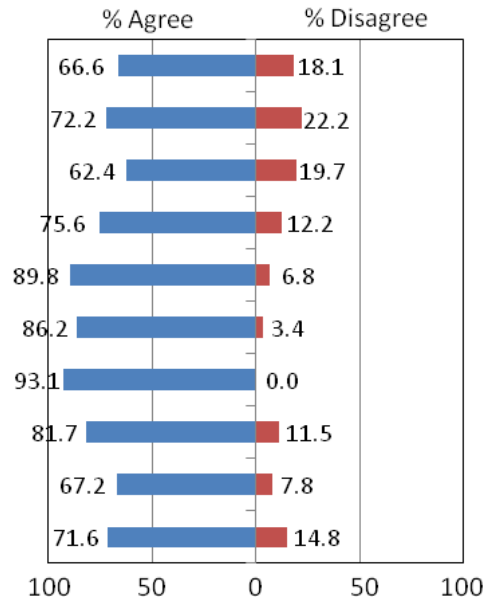
3.1 The maximum length of detention (72 hours) is too long for a person to wait for a mental health assessment in police custody

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	67.3	23.0	5.4	1.8	1.4	0.7	0.5	443
Health	50.0	30.0	2.2	12.2	4.4	0.0	1.1	90
AMHPs	39.3	34.2	12.8	10.3	2.6	0.0	0.9	117
Paramedics	47.8	35.6	5.6	6.7	1.1	1.1	2.2	90
MH nurses	59.3	32.2	5.1	1.7	1.7	0.0	0.0	59
Local Authority	69.0	24.1	3.4	3.4	0.0	0.0	0.0	29
Voluntary sector	62.1	20.7	3.4	3.4	0.0	0.0	10.3	29
Service users	88.5	6.9	2.3	2.3	0.0	0.0	0.0	131
Other	52.6	23.3	3.4	3.4	0.0	0.0	17.2	116
OVERALL	**61.8**	**24.4**	**5.3**	**4.3**	**1.4**	**0.4**	**2.6**	**1104**



3.2 The maximum length of detention (72 hours) is too long for a person to wait for a mental health assessment in any place of safety

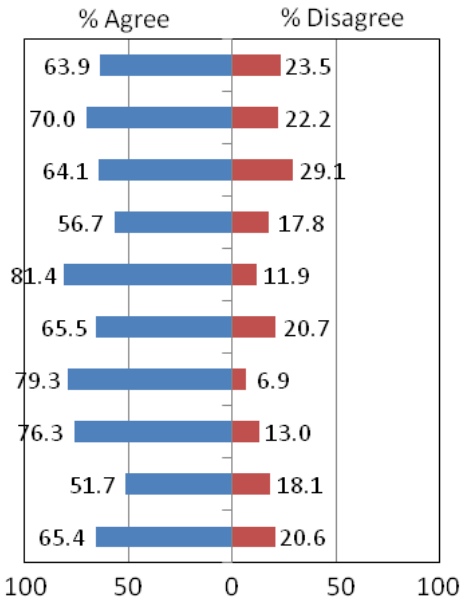
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	39.5	27.1	13.3	12.4	5.6	1.8	0.2	443
Health	41.1	31.1	4.4	15.6	6.7	0.0	1.1	90
AMHPs	32.5	29.9	15.4	14.5	5.1	0.0	2.6	117
Paramedics	38.9	36.7	7.8	10.0	2.2	1.1	3.3	90
MH nurses	50.8	39.0	3.4	5.1	1.7	0.0	0.0	59
Local Authority	44.8	41.4	10.3	3.4	0.0	0.0	0.0	29
Voluntary sector	58.6	34.5	0.0	0.0	0.0	0.0	6.9	29
Service users	60.3	21.4	4.6	10.7	0.8	0.0	2.3	131
Other	41.4	25.9	6.9	7.8	0.0	0.0	18.1	116
OVERALL	**42.8**	**28.9**	**9.7**	**11.1**	**3.7**	**0.8**	**3.1**	**1104**



Overall there is strong agreement that the maximum length of detention is too long, especially in police custody (86.1% of people agreed, of which 61.8% strongly agreed). Many people also felt that 72 hours was too long as the maximum length of detention in any place of safety, including health-based places of safety (71.6% agreed, and 42.8% strongly agreed).

3.3 There should be regular reviews of detention in police custody to assess whether it is still appropriate and the person should be able to be released by the custody officer

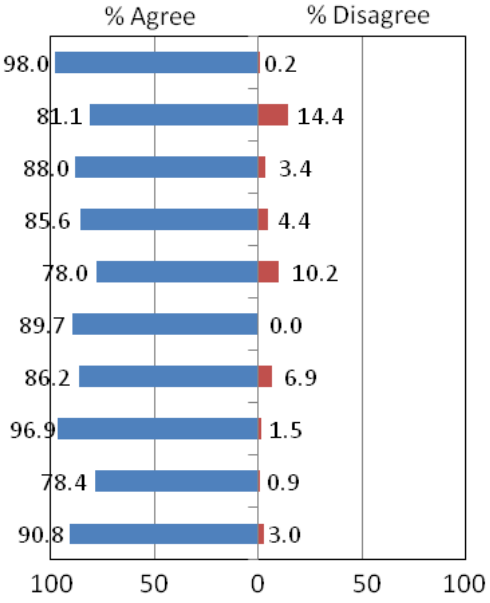
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	28.4	35.4	9.9	14.4	9.0	1.8	0.9	443
Health	30.0	40.0	6.7	15.6	6.7	1.1	0.0	90
AMHPs	34.2	29.9	5.1	18.8	10.3	0.9	0.9	117
Paramedics	22.2	34.4	20.0	12.2	5.6	3.3	2.2	90
MH nurses	59.3	22.0	5.1	8.5	3.4	0.0	1.7	59
Local Authority	48.3	17.2	10.3	10.3	10.3	0.0	3.4	29
Voluntary sector	44.8	34.5	3.4	6.9	0.0	3.4	6.9	29
Service users	51.1	25.2	4.6	6.1	6.9	3.1	3.1	131
Other	29.3	22.4	8.6	10.3	7.8	0.9	20.7	116
OVERALL	**34.1**	**31.3**	**8.8**	**12.8**	**7.8**	**1.7**	**3.5**	**1104**



There was particularly strong support for regular reviews of detention in custody from mental health nurses, service users, voluntary sector workers, and health professionals. Several people commented that the review should be carried out by a medical professional, and there were some concerns over a Custody Sergeant releasing the person before they had been seen by a medical professional.

3.4 Anyone taken to police custody under Section 135 or 136 should be transferred to a health-based place of safety as soon as possible

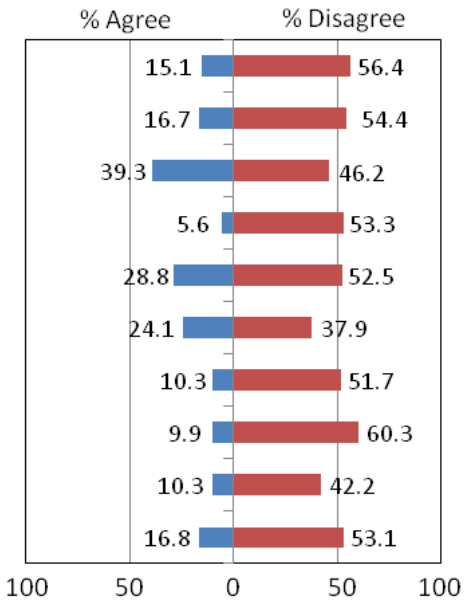
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	85.8	12.2	0.9	0.2	0.0	0.0	0.9	443
Health	53.3	27.8	4.4	8.9	5.6	0.0	0.0	90
AMHPs	56.4	31.6	7.7	3.4	0.0	0.0	0.9	117
Paramedics	62.2	23.3	7.8	2.2	2.2	0.0	2.2	90
MH nurses	54.2	23.7	8.5	5.1	5.1	1.7	1.7	59
Local Authority	72.4	17.2	6.9	0.0	0.0	0.0	3.4	29
Voluntary sector	65.5	20.7	0.0	3.4	3.4	0.0	6.9	29
Service users	84.0	13.0	0.0	0.8	0.8	0.0	1.5	131
Other	60.3	18.1	2.6	0.0	0.9	0.0	18.1	116
OVERALL	**72.6**	**18.1**	**3.1**	**1.8**	**1.2**	**0.1**	**3.1**	**1104**



There was very strong support across all groups that it is generally undesirable to hold the person in police custody, and that the person should be transferred to a health-based place of safety.

3.5 Powers of discharge (who can discharge and under what circumstances) are well understood

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	3.8	11.3	20.8	34.5	21.9	6.1	1.6	443
Health	3.3	13.3	22.2	34.4	20.0	6.7	0.0	90
AMHPs	7.7	31.6	10.3	38.5	7.7	1.7	2.6	117
Paramedics	2.2	3.3	22.2	35.6	17.8	16.7	2.2	90
MH nurses	11.9	16.9	11.9	33.9	18.6	6.8	0.0	59
Local Authority	3.4	20.7	27.6	31.0	6.9	10.3	0.0	29
Voluntary sector	10.3	0.0	20.7	41.4	10.3	13.8	3.4	29
Service users	2.3	7.6	10.7	34.4	26.0	15.3	3.8	131
Other	2.6	7.8	17.2	26.7	15.5	10.3	19.8	116
OVERALL	**4.3**	**12.4**	**18.0**	**34.2**	**18.8**	**8.4**	**3.7**	**1104**



In every group of respondents more people disagreed with this statement than agreed, suggesting many people think that who can discharge (or de-arrest) a person and under what circumstances is not well understood. A majority of police, health professionals, mental health nurses, voluntary sector workers, and in particular service users (60.3%), did not think this was well understood, suggesting the need for further guidance.

The survey went on to ask respondents to select from a range of options what they felt would be the appropriate maximum length of detention in police custody, and in any place of safety.

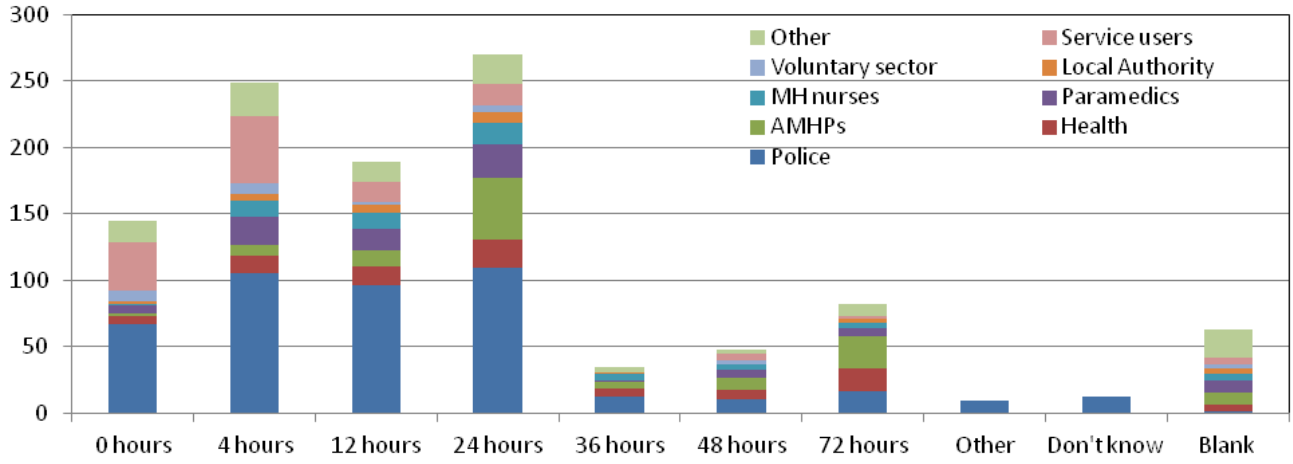
Q5: What do you think is the appropriate maximum length of detention...?

3.6 In police custody

% by type of respondent	Hours							Other	Don't know	Blank	Actual no.
	0	4	12	24	36	48	72[10]				
Police	15.1	23.7	21.7	24.6	2.9	2.5	3.8	2.3	2.9	0.5	443
Health	6.7	14.4	15.6	24.4	6.7	7.8	18.9	0.0	0.0	5.6	90
AMHPs	1.7	7.7	11.1	39.3	4.3	7.7	20.5	0.0	0.0	7.7	117
Paramedics	6.7	23.3	17.8	27.8	1.1	6.7	6.7	0.0	0.0	10.0	90
MH nurses	1.7	20.3	20.3	27.1	8.5	6.8	6.8	0.0	0.0	8.5	59
Local Authority	6.9	17.2	20.7	27.6	3.4	0.0	10.3	0.0	0.0	13.8	29
Voluntary sector	27.6	27.6	6.9	17.2	0.0	10.3	0.0	0.0	0.0	10.3	29
Service users	28.2	38.2	11.5	13.0	0.0	3.8	1.5	0.0	0.0	3.8	131
Other	13.8	22.4	12.9	19.0	3.4	2.6	7.8	0.0	0.0	18.1	116
OVERALL	**13.1**	**22.6**	**17.1**	**24.5**	**3.2**	**4.3**	**7.4**	**0.9**	**1.2**	**5.7**	**1104**

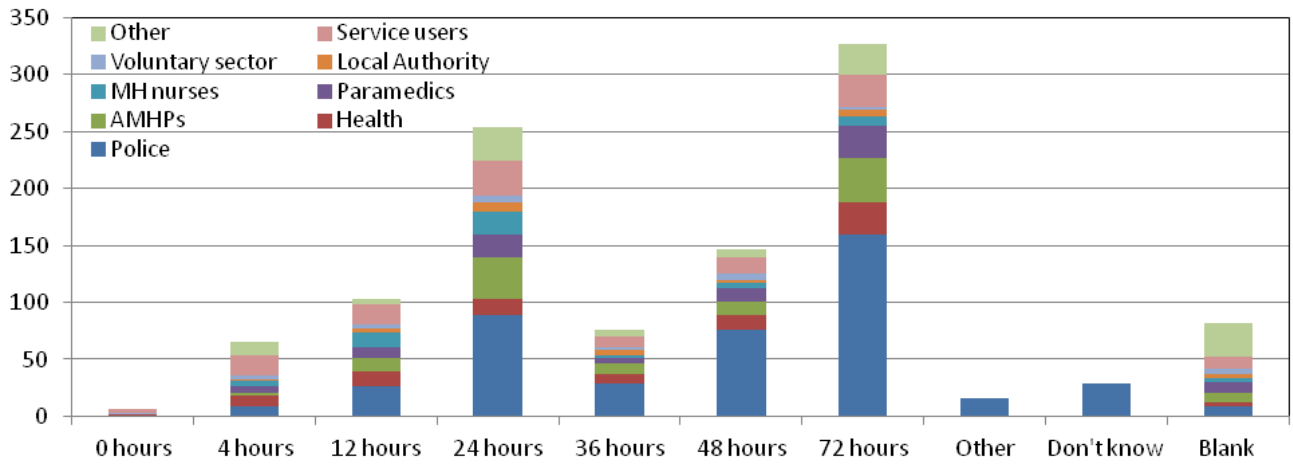
The graph below shows the actual number of respondents who selected each option. For police custody, 270 respondents chose 24 hours maximum, and another 249 chose 4 hours:

[10] 72 hours, as at present



3.7 In any place of safety

% by type of respondent	Hours							Other	Don't know	Blank	Actual no.
	0	4	12	24	36	48	72[11]				
Police	0.2	2.0	5.9	20.1	6.5	17.2	35.9	3.6	6.5	2.0	443
Health	1.1	10.0	14.4	15.6	8.9	14.4	32.2	0.0	0.0	0.7	90
AMHPs	0.0	2.6	10.3	30.8	7.7	9.4	32.5	0.0	0.0	1.8	117
Paramedics	0.0	5.6	10.0	22.2	5.6	13.3	32.2	0.0	0.0	2.3	90
MH nurses	0.0	8.5	23.7	33.9	5.1	8.5	13.6	0.0	0.0	0.9	59
Local Authority	0.0	3.4	10.3	31.0	13.8	10.3	20.7	0.0	0.0	0.7	29
Voluntary sector	3.4	13.8	10.3	20.7	10.3	17.2	6.9	0.0	0.0	1.1	29
Service users	2.3	13.7	13.7	22.9	6.9	11.5	21.4	0.0	0.0	2.3	131
Other	0.0	9.5	4.3	25.0	5.2	6.0	24.1	0.0	0.0	6.8	116
OVERALL	**0.5**	**5.9**	**9.3**	**22.9**	**6.9**	**13.3**	**29.6**	**1.4**	**2.6**	**18.5**	**1104**



For the maximum length of detention 'in any place of safety' including health-based places of safety, 327 people chose to retain it at 72 hours, while 253 thought 24 hours preferable.

[11] 72 hours, as at present

Open text box

451 people provided further comments. Most agreed that 72 hours was too long, especially compared with PACE arrests for criminal offences.

> '*72 hours is far too long for someone to be detained without assessment and the commencement of formal legal procedures for continuing detention in any setting, but is particularly unacceptable in police custody where this period far exceeds the maximum time that a suspected offender can be held without charge or review...we recommend that the maximum period for detention should be four hours in any setting unless there are good reasons for extending it...We are also aware that it can be very difficult for people to be held in police custody in what is a very stressful and distressing situation, then to be released without any support. We know of people who have become suicidal and harmed themselves. If there are no grounds to continue to detain the person, support should still be arranged if the person is in need of support and willing to accept it.*' (Response to the review from Mind)
>
> '*Police custody may be appropriate for particularly violent patients, but that should precipitate a more urgent mental health assessment. 72 hours is far too long for an assessment whatever the location - potentially depriving a person of their liberty for no valid cause.*' (Hospital doctor)
> '*People can get more anxious and agitated the longer they have to wait which can then impact on how they present at the assessment*' (AMHP)

However, a few thought that 72 hours was sometimes needed to make suitable arrangements:

> '*Sometimes we need time in order to source a bed. Other factors may arise in individual circumstances that may require detention to continue up to the maximum allowed. Although rare, such occasions do occur.*' (AMHP)
>
> *'It is very rare in my experience for a detention to last 72 hours, however in some cases with intoxication such a time period may be used. Also allows for weekends/holidays/ out of hours being stretched.*' (AMHP)

70 people (16%) said that intoxicated people would need additional time to sober up before a mental health assessment could commence:

> '*Intoxication can make assessment impossible, as can physical health problems. These need to be taken into account but detention should be regularly reassessed. In mental health settings outside Section 136, patients are assessed in seclusion every four hours by a doctor to review ongoing need for seclusion. This should also apply to patients in police custody on 136.*' (Psychiatrist)
>
> '*Sufficient time to allow intoxicated detained persons to sober up is needed. Drug induced symptoms also need to be allowed to settle before assessment takes place. Other than these examples, assessment needs to take place within 4-6 hours*' (GP)

50 people (11%) thought that reducing the maximum length of detention could only work if the appropriate funding and resources were in place in order to reduce lengths of detention and avoid delays; 24 people (5%) said the overall length of detention would depend upon the availability of the AMHP and Section 12-approved doctor.

35 people (8%) thought it was essential that the police – not being medical professionals – should not be able to discharge the person until they had been assessed by a health professional.

While 12 people (3%) thought that reducing the maximum length of time might encourage mental health services to prioritise assessments, there were opposing views also:

'*Reducing the maximum length of detention would not result in people being assessed more quickly. It would simply run the risk of the police having to release someone who they have genuine concerns about, for no reason other than because an arbitrary time limit has expired.*' (Psychiatrist)

14 (3%) made the point that there would need to be arrangements in place to extend the length of detention in certain circumstances, rather than release the person before they had been seen by a health professional.

Other individual comments included:

'*The local police are quite happy to keep me locked in the back of their police vans for hours if the S135/S136 room on the local mental health unit is occupied. There is no legislation to look at as to how long people are detained in the back of police prison vans. They can keep people for hours locked in the back of a van, even if parked outside a mental health unit.*' (Service user)

Comments in the open text box included:

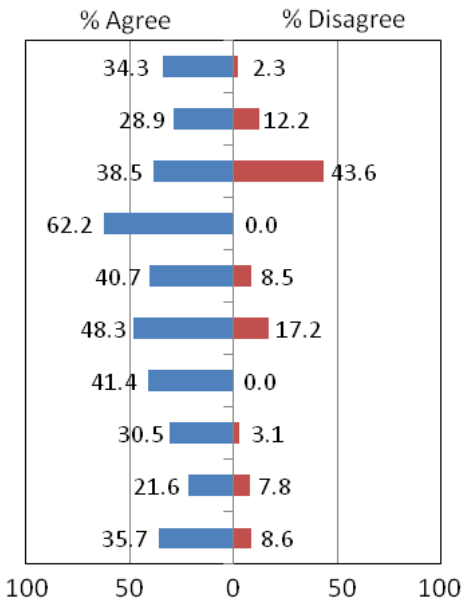
%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
If intoxicated/ on drugs, people will need time to sober up but this could be within 24 hours	16.7	3.7	44.4	0.0	14.8	7.4	1.9	1.9	9.3	70
Needs funding/resources in place to reduce lengths of detention	26.7	6.7	33.3	6.7	0.0	0.0	0.0	13.3	13.3	50
Police should not discharge/ not medical expert/cannot judge risk	3.7	11.1	40.7	3.7	22.2	7.4	0.0	0.0	11.1	35
It will depend on AMHPs/Doctor availability	40.5	9.5	14.3	9.5	9.5	7.1	2.4	4.8	2.4	24
Need extension for exceptional cases	61.5	15.4	7.7	7.7	0.0	0.0	7.7	0.0	0.0	14
Reducing the time could encourage health to prioritise	18.9	17.6	35.1	1.4	12.2	4.1	0.0	2.7	8.1	12

Section 4: Getting a Section 135 warrant

Q6: To what extent do you agree or disagree with any of these statements about Section 135 warrants?

4.1 Takes too long to get a Section 135 warrant

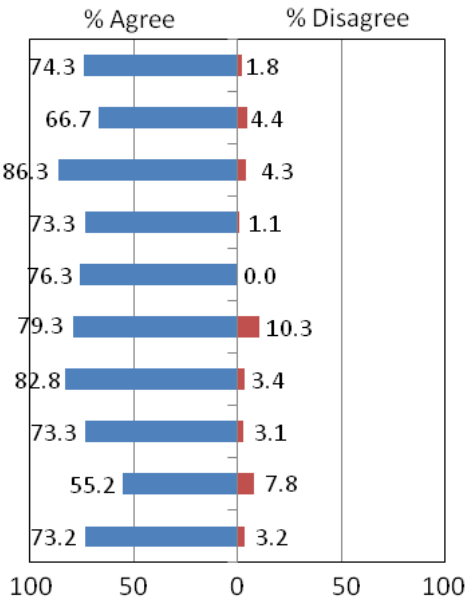
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	15.8	18.5	27.5	2.0	0.2	35.0	0.9	443
Health	7.8	21.1	10.0	10.0	2.2	48.9	0.0	90
AMHPs	13.7	24.8	14.5	35.9	7.7	1.7	1.7	117
Paramedics	30.0	32.2	7.8	0.0	0.0	25.6	4.4	90
MH nurses	18.6	22.0	23.7	6.8	1.7	25.4	1.7	59
Local Authority	24.1	24.1	17.2	13.8	3.4	6.9	10.3	29
Voluntary sector	17.2	24.1	27.6	0.0	0.0	20.7	10.3	29
Service users	17.6	13.0	22.9	0.8	2.3	36.6	6.9	131
Other	7.8	13.8	19.8	5.2	2.6	27.6	23.3	116
OVERALL	**15.9**	**19.8**	**21.3**	**6.8**	**1.8**	**29.6**	**4.8**	**1104**



Paramedics were particularly likely to agree with this statement, perhaps because they are likely to be called to an address where there is a mental health emergency but have to wait for a warrant to be obtained to enter, if access is refused. AMHPs had mixed views on the matter, with several saying that obtaining a warrant was not too much of a problem and others saying the process is complicated and lengthy. Almost 30% of respondents didn't know, having not experienced getting a Section 135 warrant themselves. However, most people agreed that AMHPs should not pay:

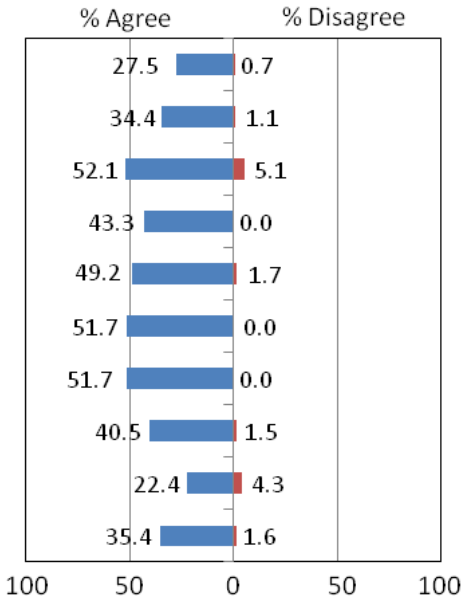
4.2 Approved mental health professionals shouldn't have to pay for a warrant

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	42.9	31.4	9.7	1.1	0.7	13.1	1.1	443
Health	42.2	24.4	1.1	2.2	2.2	26.7	1.1	90
AMHPs	60.7	25.6	5.1	2.6	1.7	2.6	1.7	117
Paramedics	45.6	27.8	4.4	1.1	0.0	16.7	4.4	90
MH nurses	49.2	27.1	8.5	0.0	0.0	13.6	1.7	59
Local Authority	51.7	27.6	0.0	6.9	3.4	0.0	10.3	29
Voluntary sector	48.3	34.5	0.0	0.0	3.4	6.9	6.9	29
Service users	54.2	19.1	8.4	2.3	0.8	9.9	5.3	131
Other	31.0	24.1	4.3	2.6	5.2	11.2	21.6	116
OVERALL	**45.7**	**27.4**	**6.8**	**1.7**	**1.4**	**12.3**	**4.5**	**1104**



4.3 Payment for warrants costs too much to process

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	14.4	13.1	26.0	0.5	0.2	44.7	1.1	443
Health	26.7	7.8	10.0	1.1	0.0	53.3	1.1	90
AMHPs	31.6	20.5	25.6	3.4	1.7	13.7	3.4	117
Paramedics	25.6	17.8	6.7	0.0	0.0	44.4	5.6	90
MH nurses	30.5	18.6	18.6	1.7	0.0	27.1	3.4	59
Local Authority	34.5	17.2	20.7	0.0	0.0	17.2	10.3	29
Voluntary sector	24.1	27.6	17.2	0.0	0.0	20.7	10.3	29
Service users	26.0	14.5	16.0	0.8	0.8	35.9	6.1	131
Other	13.8	8.6	18.1	1.7	2.6	32.8	22.4	116
OVERALL	**21.1**	**14.3**	**20.3**	**1.0**	**0.6**	**37.5**	**5.2**	**1104**



Section 135 warrants have recently gone up from £18 each time, to £20. Many people were unaware that Section 135 warrants are paid for by Local Authorities (or in some cases by the AMHPs themselves, at least initially), and in over a third of cases respondents ticked 'Don't know' to this statement. Several AMHPs said they did not have to pay in their area, suggesting that in some places Local Authorities have invoice arrangements with the courts. Of those that did express a view, more than a third overall agreed that processing the payment costs too much.

Open text box

209 people made further comments. 37 people (18%) thought that the courts were too slow or inflexible, with several AMHPs citing waits of several hours to see a magistrate, or that the process was very difficult. 10 (5%) said that the courts did not understand the urgency of a Section 135 warrants.

> '*Although things have improved here recently, I have in the past had to sit outside a courtroom for several hours waiting for a break in proceedings in order to be seen by a magistrate. This is a waste of my time and potentially delays what might be a very urgent assessment.*' (AMHP)
> '*Can depend on court clerk. Generally very helpful but can be waiting around and no guarantees it will happen in a timely manner.*' (AMHP)

> '*I find that if I go to court first thing in the morning I can get a warrant before the main court hearings start. AMHPs should not have to pay for warrants out of their own purse. Claiming the money back is a difficult and arbitrary process.*' (AMHP)

> '*The Court System are unclear about the process to apply for a local warrant and apply inconsistent charging mechanisms. Clear guidance is required to understand if Section 135 warrants should be issued within the procedure associated with the recently revised Criminal Procedure Rules - 6.30-6.33 - different courts...apply different interpretations causing confusion.*' (Local Authority worker)

20 AMHPs (10%) said that in their area, they did not have to pay or their Local Authority was invoiced instead. Many others expressed surprise that AMHPs have to pay for warrants.

> '*Until completing this survey I was not aware that Mental Health professionals had to pay for warrants. I think this absolutely ridiculous and will only cause more of a barrier in helping people with mental health [issues].*' (Police constable)

7 respondents (3%) said that warrants can be granted too easily with little robust challenge from the magistrate, and sometimes based on outdated or incorrect information. The magistrate is likely to rely on the professional opinion of the AMHP.

> '*The warrants can be applied for with misinformation and not evidence. Can be prone to misuse based on incorrect opinions of poorly trained professionals and too much emphasis on previous case histories, resulting in a harsh approach for certain BME individuals.*' (AMHP)

> '*...even the AMHP is embarrassed by how little evidence is required to obtain a Section 135(1) warrant. In addition there is often no interrogation of the information by the bench.*' (AMHP)

Some suggested Section 135 warrants are too slow to act in an emergency, and suggest introducing 'retrospective' warrants or other emergency measures in order to allow fast response:

> '*Warrants should also be available retrospectively to allow an AMHP to act swiftly to protect individuals.*' (Police inspector)

> '*With the huge increase in the use of community treatment orders and consequent need to often obtain a s135 warrant, there should be an emergency provision by which a warrant can be obtained within a very short time i.e. 2 hours. It would be extremely helpful if (as for Section 135(2)) an AMHP need not personally attend court but could delegate to health staff.*' (Mental Health Commissioner)

Comments in the open text box included:

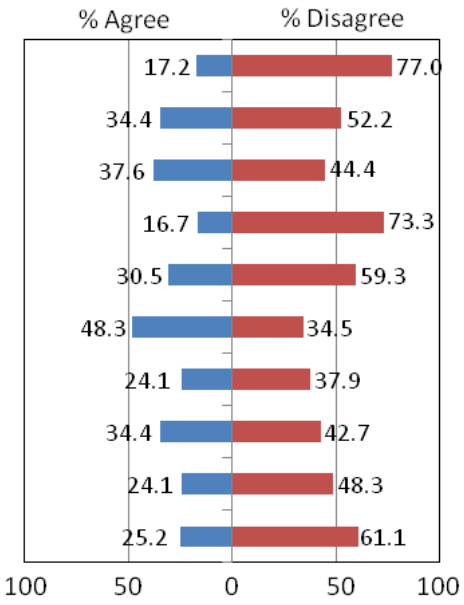
%	Police	Health	AMHP	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
Courts are too slow/ inflexible/ AMHPs have to wait for hours	10.0	0.0	60.0	0.0	0.0	0.0	0.0	20.0	10.0	37
Service is invoiced in our area/ we don't have to pay	18.9	8.1	45.9	2.7	2.7	5.4	0.0	5.4	10.8	20
Should be able to enter without warrant/ abolish S135	0.0	20.0	80.0	0.0	0.0	0.0	0.0	0.0	0.0	11
Difficult to obtain S135 warrants out of hours	36.4	18.2	0.0	0.0	0.0	0.0	0.0	18.2	27.3	11
Courts do not understand urgency of S135 warrants	10.0	0.0	50.0	0.0	0.0	10.0	0.0	0.0	30.0	10
We rarely use S135 warrants	42.9	0.0	14.3	14.3	0.0	14.3	0.0	0.0	14.3	7
Warrants can be granted based on misinformation/ little evidence needed to convince the magistrate/ reliance on outdated information	14.3	0.0	42.9	0.0	0.0	0.0	0.0	14.3	28.6	7
Haven't had any problems	0.0	0.0	36.4	18.2	9.1	9.1	0.0	0.0	27.3	5

Section 5: Where Section 136 should apply

Q7: To what extent do you agree or disagree with any of these statements about the places in which Section 136 applies?

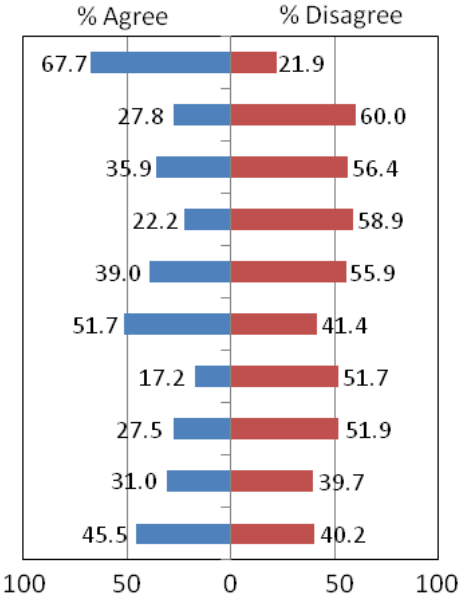
5.1 It is right that Section 136 should apply only in 'places to which the public have access'

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	7.9	9.3	5.2	33.4	43.6	0.2	0.5	443
Health	12.2	22.2	12.2	43.3	8.9	0.0	1.1	90
AMHPs	16.2	21.4	14.5	35.9	8.5	1.7	1.7	117
Paramedics	3.3	13.3	8.9	37.8	35.6	1.1	0.0	90
MH nurses	16.9	13.6	8.5	39.0	20.3	1.7	0.0	59
Local Authority	27.6	20.7	13.8	27.6	6.9	3.4	0.0	29
Voluntary sector	13.8	10.3	20.7	34.5	3.4	10.3	6.9	29
Service users	19.8	14.5	13.0	25.2	17.6	6.1	3.8	131
Other	6.9	17.2	2.6	31.9	16.4	2.6	22.4	116
OVERALL	**11.2**	**13.9**	**8.5**	**33.9**	**27.2**	**1.8**	**3.4**	**1104**



5.2 It is clear what is meant by 'a place to which the public have access'

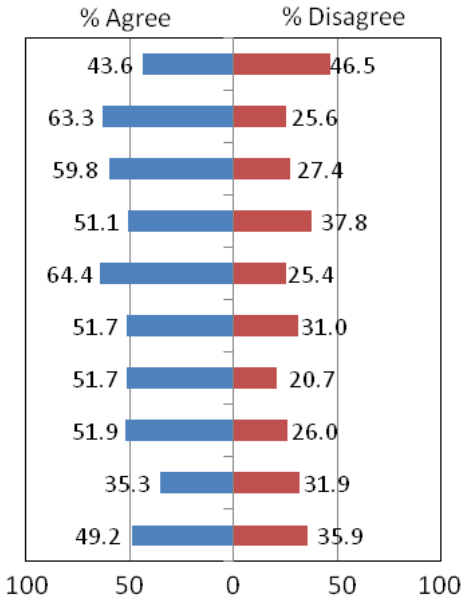
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	14.0	53.7	9.5	17.4	4.5	0.2	0.7	443
Health	0.0	27.8	10.0	40.0	20.0	0.0	2.2	90
AMHPs	10.3	25.6	6.8	45.3	11.1	0.0	0.9	117
Paramedics	4.4	17.8	18.9	40.0	18.9	0.0	0.0	90
MH nurses	10.2	28.8	5.1	39.0	16.9	0.0	0.0	59
Local Authority	6.9	44.8	3.4	34.5	6.9	3.4	0.0	29
Voluntary sector	0.0	17.2	17.2	51.7	0.0	6.9	6.9	29
Service users	9.2	18.3	8.4	37.4	14.5	6.9	5.3	131
Other	6.0	25.0	5.2	31.9	7.8	4.3	19.8	116
OVERALL	**9.5**	**36.0**	**9.2**	**30.4**	**9.8**	**1.6**	**3.4**	**1104**



Overall, the majority of people (61.1%) disagreed that Section 136 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. The majority of police felt they knew what was a 'place to which the public had access' meant, but a majority of health professionals, AMHPs, paramedics, mental health nurses, voluntary sector workers, and service users did not feel the legislation made it clear what was meant.

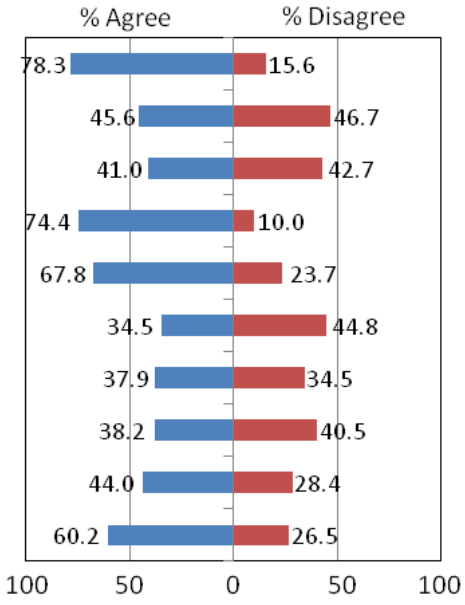
5.3 Section 136 should apply anywhere except for a person's own home (including railway lines, police stations, hotel rooms and private vehicles)

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	21.7	21.9	7.7	26.6	19.9	0.5	1.8	443
Health	30.0	33.3	6.7	22.2	3.3	2.2	2.2	90
AMHPs	22.2	37.6	10.3	24.8	2.6	0.9	1.7	117
Paramedics	27.8	23.3	6.7	20.0	17.8	1.1	3.3	90
MH nurses	39.0	25.4	6.8	16.9	8.5	1.7	1.7	59
Local Authority	20.7	31.0	17.2	20.7	10.3	0.0	0.0	29
Voluntary sector	24.1	27.6	10.3	17.2	3.4	10.3	6.9	29
Service users	26.7	25.2	9.9	14.5	11.5	6.1	6.1	131
Other	12.1	23.3	9.5	13.8	18.1	1.7	21.6	116
OVERALL	**23.5**	**25.7**	**8.5**	**21.8**	**14.0**	**1.8**	**4.6**	**1104**



5.4 Section 136 should apply anywhere including a person's own home (please note Section 136 has no power of entry)

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	55.8	22.6	5.6	9.3	6.3	0.2	0.2	443
Health	14.4	31.1	5.6	33.3	13.3	1.1	1.1	90
AMHPs	19.7	21.4	11.1	26.5	16.2	2.6	2.6	117
Paramedics	52.2	22.2	14.4	6.7	3.3	1.1	0.0	90
MH nurses	33.9	33.9	6.8	10.2	13.6	0.0	1.7	59
Local Authority	13.8	20.7	20.7	24.1	20.7	0.0	0.0	29
Voluntary sector	3.4	34.5	17.2	27.6	6.9	6.9	3.4	29
Service users	22.9	15.3	8.4	20.6	19.8	6.9	6.1	131
Other	25.0	19.0	4.3	13.8	14.7	2.6	20.7	116
OVERALL	**37.5**	**22.7**	**7.9**	**15.6**	**11.0**	**1.8**	**3.5**	**1104**



These two questions asked respondents whether they thought that Section 136 should apply anywhere apart from a person's own home, or also be able to be used in homes. Overall, more respondents agreed than disagreed that Section 136 should apply anywhere except for a person's own home, which would include railway lines, and other places where a person may be in urgent need of help (for example, by being suicidal).

60.2% of respondents thought that Section 136 should be able to be used anywhere, including a person's own home, if the person needed urgent help. The police and paramedics were particularly in favour of this (78.3% and 74.4% respectively) as they felt it offered a solution to situations where they

are called to a person's home and the person is in urgent need of care, where their primary concern lay with keeping the person safe. Extending Section 136 in this way could reduce misuse where, at present, the police may try to encourage the person to step outside; although some felt this would result in AMHPs and health professionals relying on the police to use these powers instead of Section 135 warrants. However, health professionals, AMHPs, Local Authority workers and service users were more likely to disagree than agree. Several respondents – including police and paramedics - cited concerns for privacy and human rights, and that that health professionals should have these powers in a person's home, rather than the police.

Open text box

346 people made further comments. 39 people (11%) said that police officers misuse Section 13 powers by persuading the person to step outside in order to be able to detain them under Section 136, or arrest them using Breach of the Peace, or illegally using Section 136 inside the home.

> '*I have been sectioned under [Section] 136 in my own home.*' (Service user)
>
> '*The police stormed into my own home on several occasions and dragged me outside and then claimed Section 136, stating that I had been 'found in the street'. Clearly abusing their powers.*' (Service user)
>
> '*The rules are sometimes - fairly frequently - bent by police officers. To be fair to them, they are the ones with the person and the behaviour in front of them and are very afraid of under-reacting and then facing an inquiry.*' (AMHP)
>
> '*There are occasions where other powers need to be considered to get someone to a place of safety. I personally feel that if an officer genuinely believes the person to be at risk then acting in their best interests regardless of location should be the primary concern - the first sworn duty of a police officer is to save life.'* (Police sergeant)

33 respondents (10%) said that the situation as it stands must be changed in order to keep people safe, as very often, people experiencing a mental health crisis are at home. Some said that the police stated they were unable to help due to the lack of powers, while many thought the key issue was the need of the person to access care, rather than their exact location at the time.

> '*Our experience of this was that as soon as the police arrived, the mental health crisis social worker left and so there was no clinical discussion around the need for our son to be sectioned under either Section 136 or that he was going to have a mental health assessment, so we were left outside his home with no help from anyone and the police stating they could not section him.*' (Service user)
>
> '*Officers are often at a person's property for hours as they refuse to come outside. By allowing officers to remove the person it would allow the assessment and treatment of the person to take place much faster and reduce the number of hours that officers are tied up, leaving them free to deal with policing matters.*' (Police staff)
>
> '*Section 136 should apply anywhere even in a person's home. If the police have legally entered originally, then they should then be able to deal with any mental health issues once inside. That clearly makes sense. [Section] 136 is rarely misused by the police as the aim is simply to get a person help from a medical professional, therefore there would be little room for abuse of any increase in powers as it is a well-intentioned act*' (Police sergeant)
>
> '*This limits the ability of police / mental health professionals to protect the individual from themselves or others. With more people with mental health issues being managed in the community, this is an unnecessary and unhelpful situation which must be changed*.' (Police Superintendent).

'Many mental patients attempt suicide in their own homes, on railway lines, in private vehicles and in hotel rooms. It is absolutely stupid to exclude powers under [Section] 136 from these places. The government are putting police officers at risk of breaking the law if they make the right decisions for the right reasons that aren't necessarily within the bounds of their powers under [Section] 136. Protect police officers and members of the public by including any place in the powers under [Section] 136.' (Police constable)

'I feel the act should be in place to help people no matter where they are if they are deemed to cause harm to themselves or others.' (Voluntary sector worker)

However, there were concerns over civil liberties and an individual's right to behave as they choose in their own home, should the safeguard of the Section 135 warrant be removed or a new emergency power of entry be created.

'*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)

'*Section 136 should not apply anywhere such as one's own home or a hotel room, nor one's own car if it is not in motion and the engine switched off i.e. out of doors in the street only. The car owner bit is iffy but definitely not in own home or a hotel room. Once you have been sectioned once, people use it as a way to intimidate, i.e. neighbours if you have a disagreement with them they simply say I will call the police and have you sectioned simply for telling them off or indeed breathing!*' (Service user)

'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)

'*There are huge human rights issues about charging police with responsibility for removing people from their own home without the safeguard of a warrant. This will eventually damage the policing by consent system we benefit from now.*' (AMHP)

'*I appreciate the effect that a power under 136 in the home would have on the human rights aspect of an individual but a robust process for authorising and examining its use could be set in legislation'.* (Police sergeant)

12 people (3%) said that, if extended to private homes, the police would use Section 136 much more or that health professionals would rely on the police to do so. 19 respondents (5%) – especially police officers and paramedics - felt that it is health professionals rather than police who should have powers under these circumstances. This was echoed by service users:

'*I think a Section 136 should apply anywhere. However, in the case of the person's own home, a decision needs to have been made that the person needs treatment. This should come from the person's health professional in consultation with next of kin for example. A warrant from a magistrate is irrelevant.*' (Service user)

There were examples of cases where confusion over what was a public/private place, or places where Section 136 cannot at present be used, caused poorer outcomes for the patient and left the police liable when they tried to do the right thing.

'I had to uphold a complaint against an officer, where a patient in a hospital exhibiting mental health issues...on the main ward [of a hospital] had been invited into a small consultation room off

the main corridor. The detainee had been moved from a public place to a non-public place by staff and although she was in a place of safety the doctor who could have authorised Section 135 had gone off duty. The only way the person could be detained to have their mental health assessed was by the officer (who acted in good faith) making an unlawful arrest and then had to take her to a police station...Police are now likely to be sued for wrongful arrest.' (Police staff, Professional Standards department)

'It needs a simpler understanding; I have had too many arguments with police constables about this issue, for example, whether a patient admitted to a general hospital ward can be detained (I say no, because the power to use Section 5(2) exists) whereas a person in A&E can (as the public clearly has access).' (AMHP)

Comments in the open text box included:

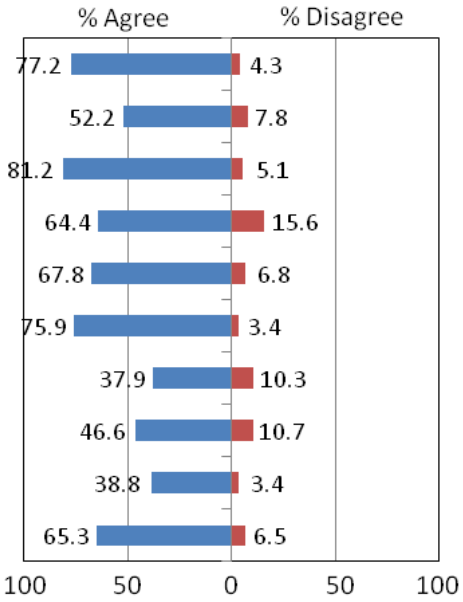
%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
Police Officers misuse S136 by getting the person to step outside/ arrest using Breach of the Peace	30.8	20.5	20.5	2.6	10.3	0.0	0.0	7.7	7.7	39
Situation must change/ people need to be kept safe	9.1	21.2	3.0	39.4	3.0	0.0	6.1	18.2	0.0	33
Individual's rights/civil liberty	3.6	21.4	32.1	3.6	0.0	17.9	3.6	10.7	7.1	28
Health should respond/have powers	36.8	10.5	0.0	36.8	0.0	0.0	0.0	5.3	10.5	19
Police would use more often/ number of S136s would increase/ health would rely more on police if extended	75.0	8.3	0.0	0.0	0.0	0.0	0.0	0.0	16.7	12
Police would misuse if S136 extended to private premises	0.0	30.0	30.0	10.0	10.0	0.0	10.0	0.0	10.0	10
S17 PACE is sufficient	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5
Mental Capacity Act is sufficient	25.0	0.0	25.0	50.0	0.0	0.0	0.0	0.0	0.0	4
Not being able to use Section 136 in homes results in misuse of the Mental Capacity Act	50.0	50.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4

Section 6: Transporting a person to a place of safety, or between places of safety

Q8: To what extent do you agree or disagree with any of these statements about transporting people to or between places of safety under Sections 135 and 136?

6.1 People detained under Sections 135 or 136 have to wait longer than 30 minutes for an ambulance

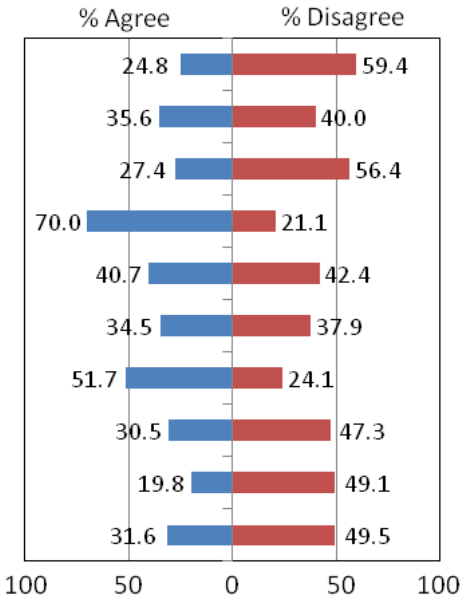
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	46.5	30.7	12.2	3.2	1.1	5.6	0.7	443
Health	18.9	33.3	14.4	5.6	2.2	22.2	3.3	90
AMHPs	56.4	24.8	9.4	2.6	2.6	4.3	0.0	117
Paramedics	32.2	32.2	13.3	11.1	4.4	6.7	0.0	90
MH nurses	37.3	30.5	20.3	6.8	0.0	5.1	0.0	59
Local Authority	48.3	27.6	6.9	3.4	0.0	13.8	0.0	29
Voluntary sector	17.2	20.7	20.7	6.9	3.4	24.1	6.9	29
Service users	29.8	16.8	14.5	6.1	4.6	23.7	4.6	131
Other	24.1	14.7	14.7	1.7	1.7	20.7	22.4	116
OVERALL	**38.6**	**26.7**	**13.2**	**4.4**	**2.1**	**11.3**	**3.6**	**1104**



Most respondents agreed there were long waits for ambulances. The ambulance service recently introduced a Section 136 protocol for a 30 minute response time.

6.2 Ambulances shouldn't routinely be used to transport people detained under Sections 135 or 136

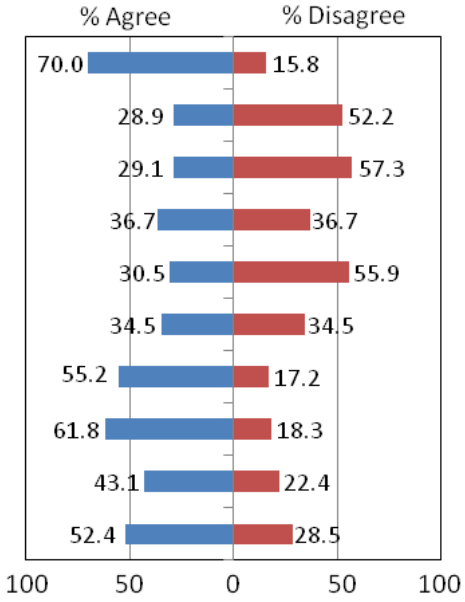
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	9.3	15.6	14.4	32.5	26.9	0.9	0.5	443
Health	11.1	24.4	18.9	31.1	8.9	3.3	2.2	90
AMHPs	9.4	17.9	13.7	29.9	26.5	0.9	1.7	117
Paramedics	38.9	31.1	7.8	14.4	6.7	0.0	1.1	90
MH nurses	16.9	23.7	16.9	28.8	13.6	0.0	0.0	59
Local Authority	6.9	27.6	27.6	24.1	13.8	0.0	0.0	29
Voluntary sector	6.9	44.8	17.2	20.7	3.4	0.0	6.9	29
Service users	12.2	18.3	14.5	27.5	19.8	4.6	3.1	131
Other	6.0	13.8	8.6	24.1	25.0	0.9	21.6	116
OVERALL	**12.1**	**19.5**	**14.1**	**28.4**	**21.0**	**1.4**	**3.4**	**1104**



The majority of paramedics and ambulance staff (70%) agreed that *ambulances* shouldn't routinely be used to transport people detained under S136 (being designed and equipped for saving lives), while most police and AMHPs thought they should. Conversely, 70% of police agreed that *police vehicles* shouldn't be used, along with a majority of voluntary sector workers and service users; while a majority of health professionals, AMHPs and mental health nurses thought the police should transport:

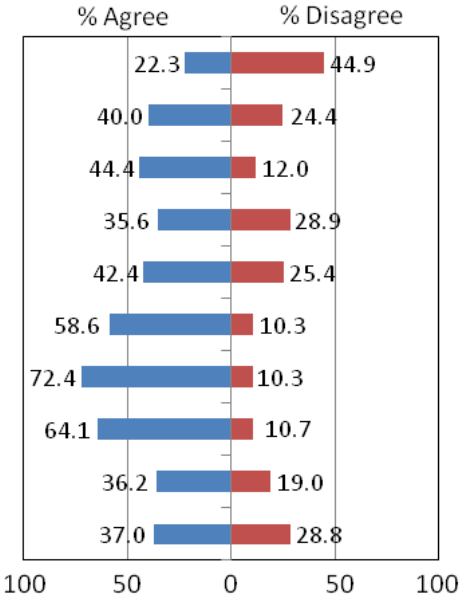
6.3 Police vehicles shouldn't be used to transport people detained under Sections 135 or 136

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	43.6	26.4	13.5	12.4	3.4	0.0	0.7	443
Health	7.8	21.1	14.4	38.9	13.3	1.1	3.3	90
AMHPs	7.7	21.4	13.7	36.8	20.5	0.0	0.0	117
Paramedics	15.6	21.1	25.6	22.2	14.4	1.1	0.0	90
MH nurses	13.6	16.9	13.6	37.3	18.6	0.0	0.0	59
Local Authority	17.2	17.2	27.6	27.6	6.9	0.0	3.4	29
Voluntary sector	24.1	31.0	17.2	17.2	0.0	0.0	10.3	29
Service users	29.8	32.1	15.3	13.0	5.3	2.3	2.3	131
Other	26.7	16.4	13.8	16.4	6.0	0.9	19.8	116
OVERALL	**28.4**	**24.0**	**15.3**	**20.3**	**8.2**	**0.5**	**3.3**	**1104**



6.4 It is important to use an unmarked vehicle to preserve the dignity of the person

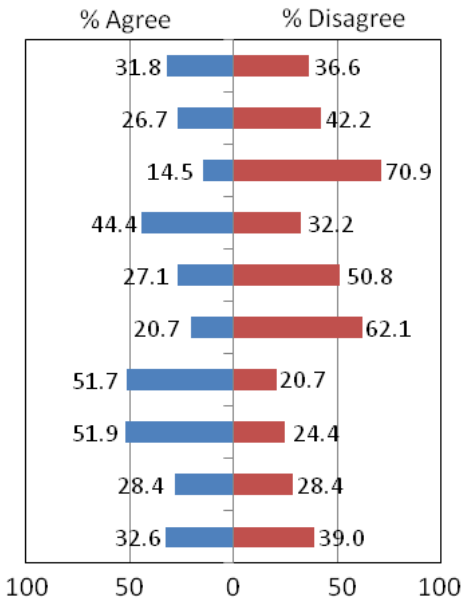
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	7.9	14.4	31.6	30.5	14.4	0.7	0.5	443
Health	11.1	28.9	31.1	18.9	5.6	1.1	3.3	90
AMHPs	15.4	29.1	41.9	11.1	0.9	1.7	0.0	117
Paramedics	10.0	25.6	34.4	23.3	5.6	0.0	1.1	90
MH nurses	15.3	27.1	30.5	16.9	8.5	0.0	1.7	59
Local Authority	34.5	24.1	31.0	10.3	0.0	0.0	0.0	29
Voluntary sector	27.6	44.8	10.3	6.9	3.4	0.0	6.9	29
Service users	34.4	29.8	22.9	7.6	3.1	0.8	1.5	131
Other	16.4	19.8	25.9	14.7	4.3	0.0	19.0	116
OVERALL	**14.8**	**22.2**	**30.6**	**20.7**	**8.2**	**0.6**	**3.0**	**1104**



Voluntary sector workers, service users, and Local Authority workers were most likely to agree that unmarked vehicles help to protect the dignity of the person being transported.

6.5 The approved mental health professional should be allowed to use their own car

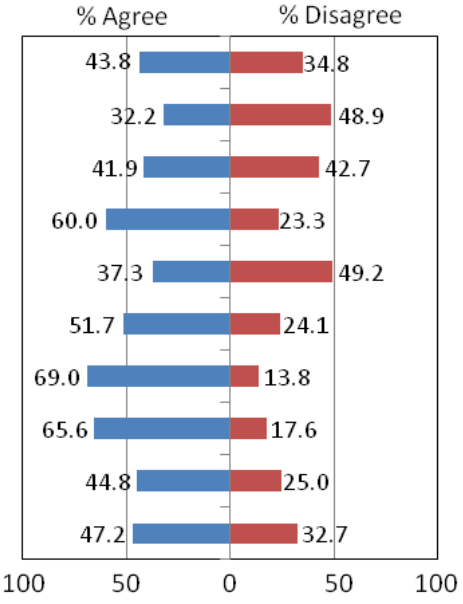
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	8.8	23.0	27.3	21.7	14.9	3.4	0.9	443
Health	3.3	23.3	23.3	25.6	16.7	6.7	1.1	90
AMHPs	5.1	9.4	12.8	29.1	41.9	0.9	0.9	117
Paramedics	11.1	33.3	20.0	22.2	10.0	2.2	1.1	90
MH nurses	11.9	15.3	16.9	32.2	18.6	3.4	1.7	59
Local Authority	0.0	20.7	17.2	24.1	37.9	0.0	0.0	29
Voluntary sector	10.3	41.4	24.1	6.9	13.8	0.0	3.4	29
Service users	20.6	31.3	14.5	16.0	8.4	6.9	2.3	131
Other	9.5	19.0	19.0	15.5	12.9	4.3	19.8	116
OVERALL	**9.6**	**23.0**	**21.6**	**21.7**	**17.3**	**3.6**	**3.2**	**1104**



The majority of AMHPs were opposed to using their own cars (70.9% disagreed that they should be allowed to). Most Local Authority workers and mental health nurses similarly disagreed. Many cited concerns over AMHPs' safety, although some AMHPs said they had used their car on occasion. Several also said their insurance would not permit it. In contrast, a majority of voluntary sector workers and service users agreed that the AMHPs should be allowed to use their car, as this is less stigmatising than police vehicles.

6.6 Family, carers or friends should be able to transport the person

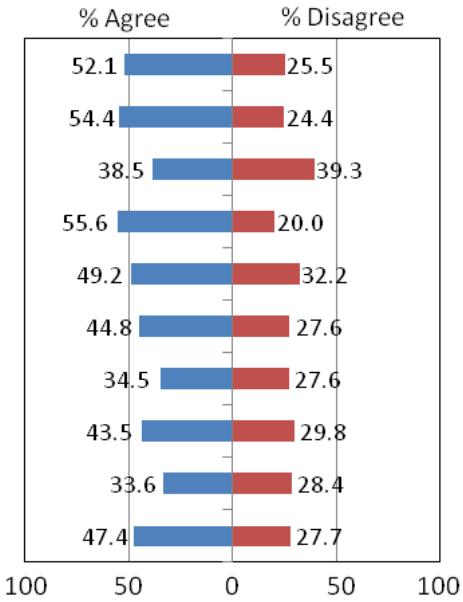
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	11.3	32.5	19.4	21.7	13.1	1.1	0.9	443
Health	3.3	28.9	13.3	28.9	20.0	3.3	2.2	90
AMHPs	6.8	35.0	12.0	25.6	17.1	2.6	0.9	117
Paramedics	15.6	44.4	16.7	15.6	7.8	0.0	0.0	90
MH nurses	5.1	32.2	11.9	22.0	27.1	1.7	0.0	59
Local Authority	6.9	44.8	24.1	17.2	6.9	0.0	0.0	29
Voluntary sector	24.1	44.8	13.8	10.3	3.4	0.0	3.4	29
Service users	27.5	38.2	10.7	9.9	7.6	3.1	3.1	131
Other	13.8	31.0	9.5	16.4	8.6	0.9	19.8	116
OVERALL	**12.6**	**34.6**	**15.4**	**19.8**	**12.9**	**1.5**	**3.2**	**1104**



Concerns over safety were slightly less evident with regard to whether friends, carers or family members should be able to transport the person, with a majority of paramedics, voluntary sector workers, and service users agreeing that they should be able to. AMHPs were split equally, but several said that they would only permit this if they were satisfied the risk was low.

6.7 I don't think it matters what vehicle is used as long as the person is kept safe

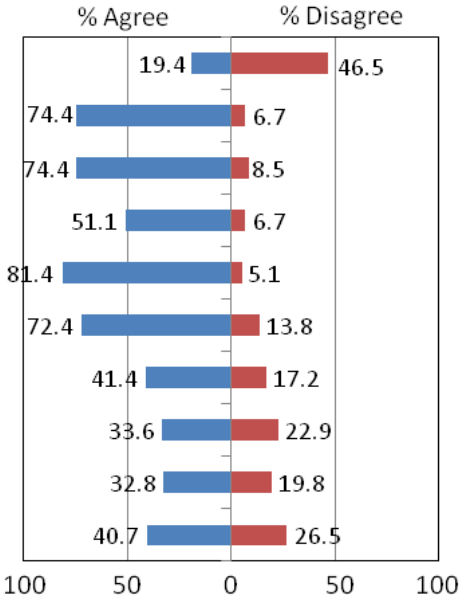
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	19.9	32.3	21.0	17.8	7.7	0.2	1.1	443
Health	20.0	34.4	14.4	16.7	7.8	1.1	5.6	90
AMHPs	12.8	25.6	19.7	26.5	12.8	0.9	1.7	117
Paramedics	16.7	38.9	24.4	15.6	4.4	0.0	0.0	90
MH nurses	30.5	18.6	15.3	25.4	6.8	1.7	1.7	59
Local Authority	17.2	27.6	24.1	17.2	10.3	0.0	3.4	29
Voluntary sector	13.8	20.7	31.0	17.2	10.3	0.0	6.9	29
Service users	17.6	26.0	19.8	13.7	16.0	1.5	5.3	131
Other	12.1	21.6	15.5	18.1	10.3	1.7	20.7	116
OVERALL	**18.1**	**29.3**	**19.9**	**18.4**	**9.3**	**0.7**	**4.3**	**1104**



Roughly half of most respondents agreed that keeping the person safe was more important than which vehicle was used, suggesting that waiting a long time for the 'correct' vehicle to arrive can contribute to a poorer experience for the patient, while it is preferable to get them to the place of safety quickly.

6.8 The police should escort the person to a place of safety

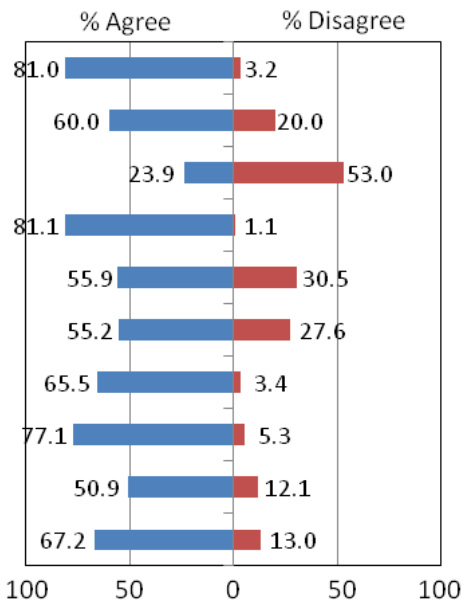
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	3.4	16.0	33.0	29.6	16.9	0.2	0.9	443
Health	30.0	44.4	15.6	5.6	1.1	0.0	3.3	90
AMHPs	25.6	48.7	16.2	7.7	0.9	0.0	0.9	117
Paramedics	14.4	36.7	41.1	6.7	0.0	0.0	1.1	90
MH nurses	33.9	47.5	11.9	5.1	0.0	0.0	1.7	59
Local Authority	31.0	41.4	13.8	13.8	0.0	0.0	0.0	29
Voluntary sector	10.3	31.0	34.5	10.3	6.9	0.0	6.9	29
Service users	12.2	21.4	35.9	10.7	12.2	4.6	3.1	131
Other	11.2	21.6	21.6	9.5	10.3	0.9	25.0	116
OVERALL	**13.2**	**27.4**	**28.0**	**16.8**	**9.7**	**0.7**	**4.1**	**1104**



A majority of health professionals, AMHPs, paramedics, mental health nurses, and Local Authority workers agreed that the police were the right people to escort the person to the place of safety, ideally following behind the ambulance. However, 46.5% of the police disagreed with this.

6.9 The approved mental health professional should escort the person to a place of safety

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	33.6	47.4	14.7	2.9	0.2	0.5	0.7	443
Health	18.9	41.1	18.9	16.7	3.3	0.0	1.1	90
AMHPs	9.4	14.5	18.8	30.8	22.2	1.7	2.6	117
Paramedics	35.6	45.6	17.8	1.1	0.0	0.0	0.0	90
MH nurses	16.9	39.0	13.6	15.3	15.3	0.0	0.0	59
Local Authority	27.6	27.6	13.8	10.3	17.2	3.4	0.0	29
Voluntary sector	20.7	44.8	20.7	3.4	0.0	0.0	10.3	29
Service users	38.9	38.2	15.3	2.3	3.1	0.0	2.3	131
Other	19.0	31.9	12.9	6.0	6.0	1.7	22.4	116
OVERALL	**27.7**	**39.5**	**15.7**	**8.0**	**5.0**	**0.6**	**3.5**	**1104**



A majority of police and paramedics (81%) as well as service users (77.1%) thought that the AMHP should escort the patient to a place of safety, to provide continuity of care and a properly informed handover to health staff. However the majority of AMHPs (53%) disagreed with this, having delegated this role to the paramedics/ police.

Open text box

391 people made further comments. Many paramedics felt that ambulances were unsuitable for these situations and could be better utilised elsewhere.

> '*Ambulances are not the safest place as they are easy to exit from and often have sharps such as needles, this means if the patient is likely to try and leave it...could result in the patient having to be restrained.*' (Paramedic)

> '*Ambulance services are massively over-stretched currently and transporting (basically being a taxi) means that people with life threatening conditions are waiting longer. If paramedics were given an appropriate level of Mental Health training I would be more inclined to agree with using ambulances to transport.*' (Paramedic)

> '*There are occasions where the current mandated use of an ambulance is detrimental to the health and safety of the patient, police and ambulance staff. This applies where the patient is extremely agitated and disturbed. Ambulances are not designed for the transport of such patients, and as such contain many sharp edges and surfaces which can cause injury. It is unsafe for staff to be stood in the back of a moving vehicle trying to restrain a patient for their own safety. There have also been incidents where patients have attempted to, or succeeded in, escaping from a moving vehicle.*'(Paramedic)

> '*Where the patient does not have any physical need for medical attention, (i.e. has not self-harmed), the use of an ambulance to transport is a waste of this service since it is only being used as an expensive taxi.*' (Paramedic)

Conversely, many felt the ambulance service was best placed to convey patients:

> '*The ambulance service should be involved wherever possible, because what a police officer...thought a mental health problem has turned out to be something else...when paramedics*

> *have undertaken basic pre-hospital screening. Examples I am aware of have included, brain tumours, diabetes, Addison's disease and others. [However] police vehicles cannot be ruled out of play, because some patients are too resistant and violent to be transported safely in an ambulance.*' (Police inspector)
>
> '*Police are not medically trained, patients should be transported in ambulances'* (Police constable)

Several people thought the police should be responsible for conveying:

> *'If the police make a decision that someone has a mental health issue and needs to be put on Section 136 then it MUST be their responsibility to convey them to the place of safety, it should not be devolved to someone else. For the AMHP to convey an unknown individual who they are most likely not to know (and sometimes will know but there may be risks) is too dangerous.* (AMHP)

While views on whether AMHPs and/or family members should be able to transport were mixed:

> '*The approved mental health professional should not be allowed to use their own car as I do not think this is practical or safe. This also poses issues which conflict with local lone worker policies and allowing cars to transport service users. I do not think this is the safest means of transporting a service user.*' (AMHP)
>
> '*Transportation of people to places of safety in many cases can be done by professionals and without the police. It would be ideal, I would suggest if family or friends were the ones involved in the transportation of people where ever possible.*' (Public)
>
> '*Where a patient is calm and poses no risk, transport by the AMHP in their own vehicle seems appropriate to reduce demand on the ambulance service*.' (Paramedic)

109 respondents (28%) said that decisions over who should convey needed to be based on the level of risk posed: if the person was violent then the police are the most appropriate agency to transport them. 55 people (14%) said that there were long waits for ambulances, or that they never use an ambulance. 49 respondents (13%) said that it was a commissioning issue, and that appropriate vehicles (not necessarily ambulances) should be commissioned.

> '*Ambulance waits are routinely greater than 4 hours so not an option. Also if [the] detained person is violent, the back of an ambulance is not the best option. There is no one size fits all. Each case needs to be risk assessed and the safest, quickest, most appropriate form of transport organised.*' (GP)
>
> *'The police should not have any responsibility for the above process, which is a medical situation. Health Care Trusts should provide all resourcing. Police should only be on standby to prevent a breach of the peace, and then immediately released.'* (Police inspector)
>
> '*With limited numbers of front line operational police officers transport of detainees becomes problematic if their destination is a long way off. Transport alternatives should be sought. Some forces areas...are massive and travelling across the area takes hours.*' (Police inspector)

The use of restraint was commented upon, with 41 people (10%) saying that putting people in handcuffs or restraining them was treating them like criminals and stigmatised mental health patients. Others felt that health professionals called on the police whenever any force was required.

> '*We have got ourselves into a position where no one is prepared to use force and whenever force is anticipated to be required the police are called. In mental health cases some degree of force is always likely and the staff involved should be prepared to use it. Even in cases of violence, there*

is no reason health service can't employ, train and equip staff to handle this contingency.' (Police inspector)

19 people (5%) – mainly police and paramedics – said that the NHS used the police/ ambulance as a taxi service, while 13 said that transportation should never be in the back of a 'caged' police van.

'*In practice the NHS seem to use police vehicles as a matter of routine ...I have first-hand experience of being sent to my local hospital to transfer [a] 'violent' patient to find that the person is calm, pleasant and sometimes drugged or medicated. It seems that the NHS use Police as a free taxi service as they don't have enough vehicles of their own. The NHS staff need to realise that often the Police vehicles are just normal cars inside, we don't have secure cages or special padding in them.*' (Police constable)

Comments in the open text box included:

%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
Decisions on who conveys should be made on a case-by-case basis depending on risk: if the person is violent the police should convey	22	17	5	17	10	5	7	13	6	109
There are long waits for ambulances/ Ambulances too slow/don't respond/ we never use an ambulance	23	8	0	15	0	0	0	38	15	55
Mental health service/ NHS should provide an appropriate vehicle or commission private ambulance provision	37	16	12	18	2	0	2	8	4	49
Using police vehicles/use of handcuffs is stigmatising/criminalising for patients	22	7	7	10	10	5	0	27	12	41
The NHS use police/ ambulances as a taxi-service	47	5	0	42	0	0	0	5	0	19
Transportation should not be in a police van	29	11	33	5	4	2	0	9	7	13

Section 7: Police powers to act in a mental health emergency

Q9: Some people have suggested that when a person is suffering a mental health crisis in their home, and the situation is so urgent that there is no time to wait for a warrant to be obtained, there is no provision to allow the police or health professionals to take immediate action. Section 135 of the Mental Health Act 1983 requires a magistrate to grant a warrant but this can take more than 4 hours. While Section 17 of the Police and Criminal Evidence Act 1984 does give the police an emergency power of entry to 'save life and limb' it gives no further powers to act, for example to remove the person to a place of safety for the purposes of a mental health assessment. ***How would you address this issue?***

This question offered an unlimited open text box only, for people to respond in any way they chose. 917 people responded to this question.

366 people (40%) said that the law should be changed to allow Section 136 to be used in private homes in an emergency, and that doing so would reduce the misuse of Section 136 where the police encourage people to step outside. 70 people (8%) said that PACE Section 17 should be amended instead to provide a power to remove a person to a place of safety. 55 people (6%) thought there should be a safeguard attached, such as an AMHP or police inspector being able to authorise entry to a person's home in an emergency.

> '*I think police need powers to respond and intervene to mental health crisis in a person's own home. This is a gap in provision and is often cropping up as a potential risk to a person's health and safety (police and mental health professionals aware but unable to intervene immediately)*' (AMHP)
>
> '*A new section should be written specifically for this situation since it is not a rare event. Safeguards need to be added and the new section should only be used when there is an urgent need that means Section 135 would be too slow.'* (Hospital doctor)
>
> '*A senior police officer should be able to authorise officers to transport a person to a health based Place of Safety if it is to save life and limb'* (AMHP)
>
> *'The Section 135 [warrant] is not effective and actually using the Section 17 of the Police and Criminal Evidence Act 1984 is a good idea. Could the amendments be extended to cover removing of people to a place of safety?'* (Mental Health Commissioner)
>
> *'Create new power 'S135A' obviating the need for a magistrate's warrant if the circumstances appear to a constable, AMHP or registered medical practitioner sufficiently urgent as to justify immediate removal to a place of safety for assessment. The use of this power would be subject to monitoring'*. (Mental Health Commissioner)
>
> '*I believe the police and mental health professionals should be given the power to enter a person's home and have the power to take the person to a place of safety.'* (Service user)
>
> '*By giving senior police officers on-duty the right to immediately authorise officers near to a patient to force entry into private places to remove a person to a place of safety. This authorisation could be retroactively revoked if deemed by a magistrate to have been used incorrectly, and a code of practice would be put in place by senior police officers to ensure good practice'*. (Service user)

79 people (9%) said that the AMHPs/ 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.

> '*Allowing AMHP's using Section 115 powers to gain access to effect an assessment if the person is in urgent need as such an assessment is a necessity if access is denied. Maybe giving AMHP the power to do a one-off assessment prior to obtaining a Section 135(1) warrant*.' (AMHP)

> '*Give the power to remove from home address to an AMHP*' (AMHP)

> '*Provide Health Professionals with appropriate legislation for them to take action'* (Police chief inspector)

> '*Section 136 should apply to anywhere. It should also be a power usable by 24hr medical teams - ambulance service - ...air ambulance...doctors*.' (Police constable)

> '*Section 17 could be extended to include MH professionals or amended to include police accompanied by mental health professional which would replace the need for a warrant.'* (Police constable)

> *'Give health professionals powers to enter if a person is deemed at risk, provided a police officer is present'* (Mental health nurse)

> *'Power should be given to ambulance crews as they are in a position to attend rapidly and assess a person's physical and mental health.'* (Paramedic)

> '*The police should have no powers in a mental health emergency. Only medical staff should be taking action in the person's best interests (and by that I mean making sure the individual affected is safe, not making them quiet or removing them in a harmful manner for the sake of other's comfort, which is essentially why I was bundled into a police van for trying to kill myself).'* (Service user)

57 people (6%) thought the solution lay in improving Section 135 warrants by speeding up the process, introducing a 'retrospective' Section 135 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.

> '*Either extend Section 136 to cover own home or provide easier, quicker access to Section 135 warrants*.' (AMHP)

> '*Make obtaining a warrant easier and quicker, don't keep trying to lead me in this survey to the answer your paymasters are so clearly seeking i.e. letting the Police enter into people's homes on their own initiative and or whim.'* (Service user)

56 (6%) thought that the Mental Capacity Act should be used in these circumstances. 42 people (5%) were concerned at the idea of extending Section 136 to be used in homes, saying that the Section 135 warrant provided necessary safeguards to protect individuals' human rights.

> '*The Mental Capacity Act is…available for police or ambulance staff to allow removal from any location.'* (Hospital doctor)

> '*Warrant can be time consuming but a necessary legal safeguard*.' (AMHP)

Other respondents suggested other solutions:

> '*If the police are already in the property they request a mental health act assessment and wait for the assessment team to arrive...This is not a piece of work which moves quickly as there are so*

many different elements which need to work together in a co-ordinated way. This appears to be the police saying we want nothing to do with this leave it all to the AMHP, which is unfair given that it is the police who are first on the scene.' (AMHP)

'If there is a serious risk of violence, or there has been violence, the police can use powers of arrest and the person can be assed in custody. If there is no imminent risk of violence, but concerns about mental health, local health and social care emergency teams should have the capacity, 24/7 to respond to requests by the police to visit the person at home.' (Local Authority staff)

Comments in the open text box included:

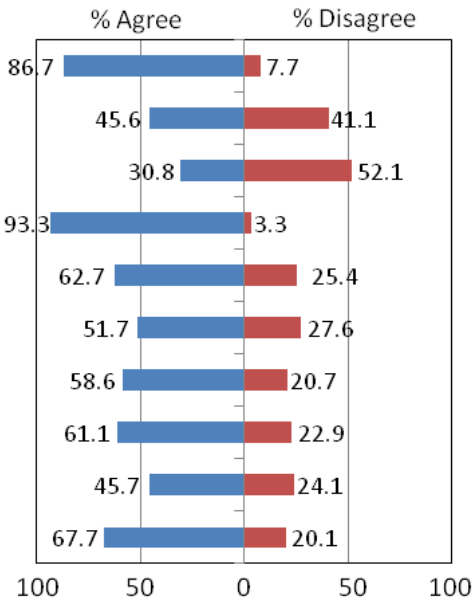
%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
S136 should apply in private premises so police can help the person/ extending S136 would prevent misuse	54	0	6	10	2	3	3	15	6	366
AMHPS/ health professionals need more powers	13	13	30	0	9	0	0	26	9	79
Amend PACE S17 to give power to remove to a place of safety	28	3	3	61	0	3	0	3	0	70
S135 process should be quicker/ introduce a retrospective S135 warrant/ Magistrates should be available out of hours	30	5	15	18	3	8	3	8	8	57
Should use Mental Capacity Act	35	9	11	28	7	2	0	2	7	56
AMHP/Police Inspector/Other person should be able to authorise entry in an emergency	25	0	38	0	0	0	0	25	13	55
S135 warrant provides a safeguard/concerned at idea of extending S136 to private premises/leave as is	22	8	30	6	3	9	3	11	9	42
Paramedics need powers/ to be able to use S136 in homes	4	13	40	0	6	6	2	19	10	35
Police can convene MH assessment in home	49	7	11	10	6	1	2	8	7	17
Agree there's a gap in legislation	19	10	22	16	6	8	2	10	8	6

Section 8: Powers for health professionals to help a person experiencing a crisis

Section 136 requires the police officer to make an assessment as to whether the person *appears to be suffering from mental disorder and to be in immediate need of care or control*. A medical practitioner, approved mental health professional, or mental health nurse will be better able to make a judgement as to the mental state of the person, compared to a police officer. Some people think that doctors, mental health nurses and approved mental health professionals should be able to exercise Section 135 and 136 powers, provided they are not put at risk by doing so. The health professional or approved mental health professional would still be able to call the police to attend in situations where the person is, or is likely to be, violent. If health professionals had the right powers, the number of situations where the police have to be called to use Section 136 powers when a qualified professional is already present might be reduced. Issues over human rights, training, and safeguards, would need to be carefully considered.

Q10: To what extent do you agree or disagree with extending the Section 135 and 136 powers for a police officer to remove a person to a place of safety to other professionals?

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	58.9	27.8	5.0	3.6	4.1	0.7	0.0	443
Health	17.8	27.8	10.0	15.6	25.6	2.2	1.1	90
AMHPs	13.7	17.1	9.4	18.8	33.3	6.8	0.9	117
Paramedics	61.1	32.2	3.3	1.1	2.2	0.0	0.0	90
MH nurses	32.2	30.5	11.9	6.8	18.6	0.0	0.0	59
Local Authority	20.7	31.0	13.8	10.3	17.2	3.4	3.4	29
Voluntary sector	27.6	31.0	13.8	13.8	6.9	3.4	3.4	29
Service users	35.1	26.0	9.9	9.2	13.7	4.6	1.5	131
Other	27.6	18.1	7.8	10.3	13.8	2.6	19.8	116
OVERALL	**41.6**	**26.1**	**7.4**	**8.0**	**12.1**	**2.2**	**2.6**	**1104**



A majority of police and paramedics were strongly in favour of extending powers to other professionals (93.3% of paramedics agreed, with 61.1% strongly agreeing; while 86.7% of police agreed overall, with 58.9% strongly agreeing). A majority of mental health nurses, Local Authority workers, voluntary sector workers and service users also agreed. In contrast, a majority of AMHPs disagreed (52.1%), and the 'health' category (doctors and 'other health professionals') were more evenly split, with no clear view emerging. Overall, 67.7% of respondents agreed that some other health professionals could usefully hold some or all Section 135 or Section 136 powers, provided they were not putting themselves at risk of harm by doing so.

Open text box

646 people added further comments. Of these, 202 respondents (31%) agreed that medical staff were better placed than the police to make a judgement as to whether a person needed to be detained under Section 136 or not, or that mental health crises were a medical issue and not a policing matter: 59% of those who agreed were police officers and another 14% service users.

151 people (23%) who commented agreed with healthcare professionals having these powers, saying it would help to avoid delays in waiting for the police to arrive, for example if a person presented at a hospital emergency department (A&E) and needed to be detained under Section 136[12], as well as reducing the number of inappropriate Section 136 detentions. 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 Section 136, as they are medically trained. 73 people (11%) – mainly police officers – said that a uniformed police presence could act to escalate the situation and having less police involvement could reduce the demand for police resources. 44 people (7%) thought that the best solution was for the police to use the powers only on the advice of a health professional, perhaps as part of a street-triage-type model. However, 26 people – mainly police – suggested that it would make little difference as the police would routinely be called out anyway.

> *'It would be appropriate to give this power to AMHPs'* (AMHP)
>
> *'Too many [Section] 136's are used inappropriately (drunk and disorderly). If mental health professionals had the support in terms of managing risk in the community they would have a better idea as to who fits the criteria for [Section] 136 and therefore would reduce the amount of those being arrested under that order.'* (AMHP)
>
> *'As long as the Mental Health Practitioners are appropriately trained in personal protection it makes sense. For a police officer to have powers of detention regarding mental health, when experts within this field of medical care do not, appears wrong.'* (Police sergeant)
>
> *'The occasions when violence is used are few in number compared to the total number of detentions, extending the power could remove what is often a health issue from the police service'.* (Police superintendent)
>
> *'In many cases the presence of a Police Officer can cause the person suffering a mental health crisis unnecessary distress and could inflame a situation due to the perception of the person feeling 'criminalised'; Police Officers should only be involved if there is an active risk.'* (Police constable)
>
> *'Powers should be extended to appropriate health care professionals including paramedics and GPs particularly put of hours when crisis teams are frequently unavailable. Health care professionals frequently make decisions regarding the mental capacity of patients and with appropriate training would be more than capable of using S136. Using health care professionals will also likely lessen risk of misuse of powers as they would not have physical means of detaining someone e.g. handcuffs.'* (Paramedic)
>
> *'Paramedics should also have this training and power. Paramedics attend these instances a lot sooner than AMHP or Nurses.' (*Paramedic)
>
> *'[I] can envisage the exercise of these powers being very useful in a wide-range of mental health services. [It] would be particularly useful where ready access to an inpatient setting, less so in community where likely to require police assistance anyway. [It} would certainly reduce current delays in obtaining Section 135 warrants.'* (Mental Health Commissioner)
>
> *'Other health professionals may be less heavy handed than the police who are used to treating people like criminals when they might be just ill.'* (Service user)
>
> '*Subject to training, oversight and other safeguards, powers should be available to mental health doctors or specially-trained/qualified mental health nurses / mental health paramedics / approved*

[12] Doctors and nurses do have some emergency powers to detain for short periods under Section 5 of the Mental Health Act 1983: however these can only be used on inpatients who have been admitted to the hospital, so cannot be used in emergency departments.

mental health professionals so that HEALTH professionals can deal effectively with HEALTH situations without involving the police. It would be consistent with other situations for power of entry to require police involvement. They should always be able to call on police to ASSIST if they consider it necessary but police should not be dealing with health situations if health professionals are present/available. Police (and ordinary paramedics) should only be trained/equipped to deal with initial response to an emergency, unanticipated situation & then to 'hold' for the minimum time necessary to allow specially-trained mental health professionals to attend (ideally a blue-light response by specially-trained mental health paramedics).In ALL non-emergency, anticipated situations, MH professionals should be empowered to deal with situations without needing to involve police unless they consider it necessary for practical reasons, not just because they don't have necessary powers (with the possible exception of power of entry to private premises). (Service user)

'We agree that a medical practitioner, approved mental health professional, or mental health nurse is likely to be better able to make a judgement as to the mental state of the person, compared to a police officer, therefore they should be able to exercise Section 135 and 136 powers.. We recommend a consultation body is set up, which involves people with mental health conditions.' (Voluntary sector organisation: Inclusion London response)

A large number of people (106, or 16%) expressed concerns over the safety of the professional in a potentially risky situation, and felt that the police – while not being medically qualified – are best placed to make Section 136 detentions because they are trained in restraint techniques, have personal protective equipment, and appropriate back-up. 69 people (11%) made the point that the police would still be needed in violent or dangerous situations. 50 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, or that they have no ability to convey or detain a person. 25 people – mainly AMHPs – were concerned that, if powers were extended to other people, the police would refuse to respond to mental-health incidents.

'*This really does need to be debated more and a measured response developed. There will be legitimate fears from professionals of all types finding themselves in a position where trust will be rapidly eroded by the use of such powers'.* (Royal College of Nursing)

'The public's first port of call when they come across a distressed individual is to call Police, who in the vast majority of circumstances will be first on the scene. Extending powers of Section 136 and Section 135 to health or AMHPs would not have any considerable advantages. It may increase their vulnerability if they were to try and remove a person under Section 135/6 without Police assistance.' (AMHP)

'Agree in principle but I am concerned that the police might resist becoming involved if another professional had made the decision, putting that professional at risk from the detained person' (Psychiatrist)

'I could envisage that police would decline to intervene to requests from other professionals expecting them to take action instead. Other staff lack the required resources or skills to manage violence or aggressive' (AMHP)

'Police would be very hard to engage and this would place far too much pressure on an already overburdened NHS. This is just a way for police to absolve themselves of responsibility towards the patient and public. The police already show reluctance to work cooperatively with NHS services. This would simply make matters worse.' (Mental health nurse)

39 respondents (6%) were concerned that, if given the powers, they might be misused, or felt that health professionals and AMHPs did not have a proper understanding of the legal frameworks. Some were concerned that giving health professionals and AMHPs these powers would alter the therapeutic relationships between them and their patients, leading to less trust.

'*This is inappropriate – it would move a 'police' role and powers and displace these to professionals whose role is to provide expertise in assessment and which is therapeutic.'* (Health professional)

'*It is our experience that whilst mental health professionals may be best placed to assess someone's mental state that they do not assess risk to others effectively. We would also be concerned about how other professionals would practically remove people and transport them. We are also concerned that the necessary checks and balances in such a serious act do not exist.'* (Voluntary sector organisation: Shepherds Bush Housing Association)

'*Safeguards [would be needed] to ensure independence and scrutiny. No return to families being able to pay for private professionals in medicine/psychiatry to section difficult relatives. The presence of a local authority social worker may ensure this.'* (Police sergeant)

Comments in the open text box by type of respondent, included:

%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
Medical staff are better placed/ it's a health issue	59	2	4	6	1	0	3	14	9	202
Healthcare professionals should have powers/ it would help to avoid delays	46	7	5	11	5	3	7	9	9	151
Not safe/ situation is too risky/ police are best placed as have training, equipment, etc.	10	18	38	7	7	4	2	8	7	106
Police involvement is costly/ escalates the situation/ extending powers could reduce use of police resources	63	4	4	11	3	3	3	4	5	73
Police support would be needed in violent/ dangerous situations	43	6	13	9	4	4	3	10	7	69
AMHPS should have these powers	44	0	14	10	12	2	4	6	8	50
Concerns over health professionals facing risks/ using restraint/ practicalities of detention and conveyance	18	14	30	14	8	2	4	2	8	50
Police should use their powers on advice from healthcare professionals/ joint assessment/ Street Triage model	23	11	23	2	7	7	7	7	14	44

% *(continued from previous page)*	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
Medical professionals may misuse the powers/ don't understand legal framework/ changes therapeutic relationships between health professional and patient	13	10	26	0	18	5	0	15	13	39
Paramedics should have powers	32	0	0	61	0	0	0	5	3	38
Nurses/ S12 Doctors should have powers	43	3	7	10	20	0	3	13	0	30
Police will be called out anyway/ what's the point of extending powers/ don't think this would make a difference	58	15	8	0	0	0	0	4	15	26
Police would disengage/ refuse to take responsibility/ divert to ambulance services	0	16	60	4	12	4	0	4	0	25
Would place pressure on NHS/ would need resources/ training/ ability to deal with violent people	52	8	16	0	20	0	0	4	0	25
Separation of powers is a check on the balance of power/ protects civil liberties	0	15	31	0	8	0	8	15	23	13

Section 9: Diversity and equality

Q11: What are the equality and human rights issues that need to be considered in the operation of Section 135 and Section 136? Are there examples of good practice, or areas for improvement?

This question offered an unlimited open text box only, for people to respond in any way they chose. 543 people responded to this question.

67 people (12%) said that people needed to be treated with dignity and respect, that there should be tolerance for different behaviours. 64 (12%) said that everyone should be treated equally. 59 respondents (11%) said that diversity was not a relevant issue, while 31 police officers (6%) said that safeguarding a vulnerable person was their most important concern.

> *'There aren't any [diversity issues]. Any person can suffer mental [ill] health regardless... As long as all people are treated with dignity and respect there should be no issues.'* (Police constable)

> *'I have to say that, as an operational officer, I find it quite offensive that it may be suggested that the use of Section 136 powers may be in some way abused by officers unlawfully discriminating/ harassing/ victimising. My experiences of this power exclusively show officers faced with a genuine need to protect someone, and this legislation provides the only framework (sometimes) under which this aim can be achieved.'* (Police constable)

> *'Let's not get hung up on diversity-related issues. This is about keeping people safe and getting them the appropriate help they need.'* (Police inspector)

However, 63 people (12%) expressed concern over the over-representation of BME groups detained under Section 136. 25 people (5%) suggested the police could be ignorant about different cultures, races and beliefs, were sometimes violent, or treated people badly.

> '*Police generally accurately assess whether a person is experiencing mental disorder. However, I would argue that certain minorities are often targeted above White British.'* (AMHP)

> *'There is substantial evidence that those from certain ethnic minorities being taken to places of safety under Section 136 are much higher than most other groups.'* (AMHP)

> *'The reasons behind why young black men form a much higher group in [Section] 136 and under [other] sections needs some calm objective research, also sometimes in the ethnic debate [people tend] to attribute too much to culture and not act i.e. young Asian women and higher suicide rate'* (AMHP)

> '*Cultural differences have seen people wrongly assessed as having a mental health issue. Appropriate language support is another issue, sometimes the needs of the family are heard rather than the needs of the service user when using family members as interpreters. There exists inequality/discrimination towards certain groups such as sexual orientation, race, religion and disability. People with Learning Disability often have anything they say or do attributed to their diagnosis and used to try and detain them*.' (AMHP)

> '*Ethnic minorities and people with alcohol or drug addiction issues often seem to be treated worse and not get the health support they need.'* (Service user)

> *'Mental ill health itself would fall under the protected characteristic of disability, as such codes of practice and protocols need to ensure that all elements of any revised Section 135/6 arrangements do not mean that those to whom it is applied are treated unfairly. Human rights will need to be properly considered in this respect. They will of course be engaged as we are depriving people of their liberty (and potentially extending this to within their own home), but this*

needs to be outweighed by the need to provide that person with protection, support and treatment, for any powers to be engaged. In addition to this we need to ensure that people with other protected characteristics are not disproportionately affected by Section 135/6, for example, people from BME groups should not be disproportionately subject to Section 135/6 detention due to cultural differences. Safeguards should be in place to ensure that proper monitoring identifies and any such inequalities and explores the reasons for this.' (Police inspector)

'*Language problems are a cause for concern and lead to tensions and misunderstanding.*' (Mental health nurse)

'In my opinion, the police service as a whole is institutionally discriminatory against people with mental health problems. They see us as a threat, a menace and an easy target for abuse as we have no recourse to appeal. The use of 'reasonable force' as an excuse for abuse is rife as the police know that someone with mental health issues will not be believed/ taken seriously. The attitude of police dealing with someone with mental issues is often one of sneering contempt. I went to train police officers in an area of mental health once and they admitted themselves that this was the case. I think you would need to start by informing police that people with mental health problems are human beings. This would be a first step.' (Service user)

However, several said that in their local areas there was no over-representation of BME groups:

'*It is a well know 'statistic' that Section 136 is over-used for black ethnic minorities. We would like to put on record that, although we have regularly monitored this, and cover four London boroughs, three of which have a high proportion of BMEs, use of Section 136 in our Trust is exactly in line with population figures. We recognize the legitimate concern about over-use for the BME community but do not feel that this should be used to undermine the function of Section 136, which is, as stated above, a life-saving one. Over-use for the BME community, where it exists, should be dealt with locally by training and effective management. There is no role here for legislative change.'* (Organisation: North East London NHS Foundation Trust)

51 people (9%) said that there were human rights/ civil liberties issues, especially relating to the powers in a person's own home. 47 people (9%) said that Sections 135 and 136 were intrinsically discriminatory against mentally ill people because having the police involved stigmatised mental ill health. Others raised concerns over Section 136 detentions being disclosed in DBS[13] checks.

'*There is currently a huge amount of discrimination against people with mental health conditions. They receive a service which falls well below that provided to people with physical health conditions. I cannot imagine a person who was experiencing a physical illness being asked to sleep in a police cell because there were no beds available at a health centre.'* (Police constable)

'*This act as a whole discriminates against mentally ill people as a whole because it allows their homes to be invaded by police.'* (Member of the public)

'*The fact that S.136 sometimes gets registered on the Police National Computer as an 'arrest' (though not in all cases) can have a deplorable effect on someone's social standing and ability to get a job. There must surely be some way to stop this unnecessarily stigmatising practice'.* (Organisation: North East London NHS Foundation Trust)

30 people (6%) supported monitoring diversity in the uses of Sections 135 and 136, and 26 (5%) said there should be parity of esteem between physical and mental health.

20 people (4%) commented on mental health provision for children and young people, and also older people:

[13] Disclosure and Barring Service

'Section 136 often gets applied to children because the provision of CAMHS[14] is so bad that children are allowed to get into a crisis.' (Hospital doctor)

'[I] have seen a 12 year old in the [Section] 136 suite which was very inappropriate. Age appropriate facilities need to be thought of. Older people also may need medically clearing in A&E to check for delirium so is not appropriate for them to come straight to [a Section] 136 [suite] either.' (Psychiatrist)

'Having so few places of safety means that no provision can be made to meet peoples' different needs. Our local Section 136 suite is upstairs so not accessible for disabled or elderly patients, [there is] nowhere specific for young people etc'. (Voluntary sector worker)

15 people mentioned gender issues (such as having female police officers available) and 6 said there should be more understanding around trans/ gender identity issues.

*'Women should be attended by female officers. Dignity is a huge issue' (*Service user)
'As someone from the LGBT community, I believe good practice is already being shown.' (Service user)

'Appropriate gender of attending officers. Full diversity training of all concerned. Respect and appropriate responses regarding an individual's gender identity- i.e. appropriate and safe places for Trans people, which recognise gender identity. Good relations with faith communities so that trained representatives may also be available to individuals' (Service user)

One AMHP raised a case of homelessness which had posed some problems:

'I have been running with a case in Manchester which I believe highlights that the current scope of Sections 135 (1) and 136 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 Section 136 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 s.136 is meant for. Also, we have been told by Counsel that we cannot use a Section135 (1) [warrant] as it is not a private premises and would not be a trespass. 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 Section 135(1) needs to be used but, homeless people in the above situation [cannot]...Extension of Section 136 powers would resolve this.' (AMHP)

Comments in the open text box included:

%	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
People need to be treated with dignity/ respect/ tolerance for different behaviours/ need confidentiality/ humane treatment	22.4	7.5	9.0	7.5	1.5	4.5	1.5	32.8	13.4	67

[14] Child and Adolescent Mental Health Services.

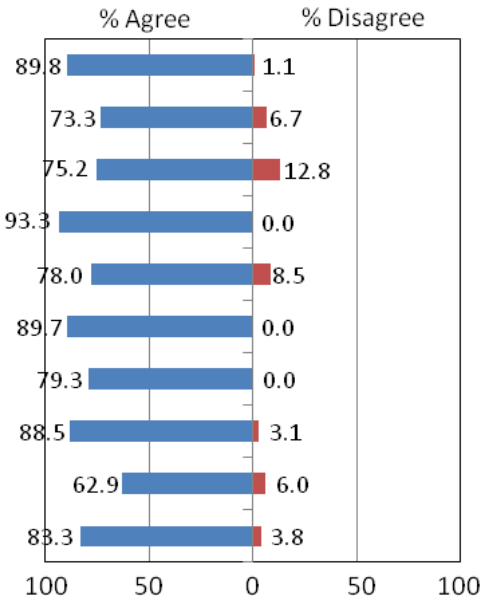
% *(continued from previous page)*	Police	Health	AMHPs	Paramedics	Mental health nurses	Local Authority	Voluntary sector	Service users	Other	Actual No.
Everyone should be treated the same/ all protected characteristics should be taken into account	29.7	7.8	14.1	15.6	9.4	3.1	3.1	10.9	6.3	64
Higher proportion of BME detained/ BME are treated worse/ authorities fail to understand different cultures/ can be language barriers	15.9	14.3	23.8	3.2	9.5	1.6	6.3	6.3	19.0	63
Diversity is not an issue/ not relevant because it's an emergency situation	55.9	6.8	13.6	8.5	6.8	1.7	0.0	1.7	5.1	59
Human rights/ right to a private life/ civil liberties in homes	41.2	3.9	25.5	2.0	5.9	0.0	3.9	9.8	7.8	51
S135/S136 is discriminatory against mentally ill/ fails to protect rights/ having police involved is discriminatory in itself	29.8	8.5	10.6	6.4	2.1	6.4	4.3	14.9	17.0	47
Safeguarding is the most important thing	96.8	0.0	0.0	0.0	3.2	0.0	0.0	0.0	0.0	31
Diversity should be monitored/ data should be collected	20.0	26.7	16.7	0.0	20.0	3.3	0.0	0.0	13.3	30
Should be parity of esteem between mental health and health	42.3	7.7	7.7	7.7	11.5	3.8	3.8	3.8	11.5	26
Police can be ignorant/ violent/ treat people badly	0.0	4.0	4.0	4.0	0.0	0.0	16.0	48.0	24.0	25
Need to have places of safety suitable for under-18s	5.0	15.0	30.0	0.0	5.0	0.0	10.0	5.0	30.0	20
There is discrimination against women/ gender/ needs female officers	20.0	6.7	6.7	0.0	6.7	0.0	6.7	26.7	26.7	15
Police and places of safety should be more aware of trans/ gender identity and needs	0.0	0.0	33.3	0.0	0.0	0.0	0.0	50.0	16.7	6

Section 10: Other relevant issues

Q12: To what extent do you agree or disagree with any of these statements about the operation of Sections 135 and 136?

10.1 There aren't enough approved mental health professionals

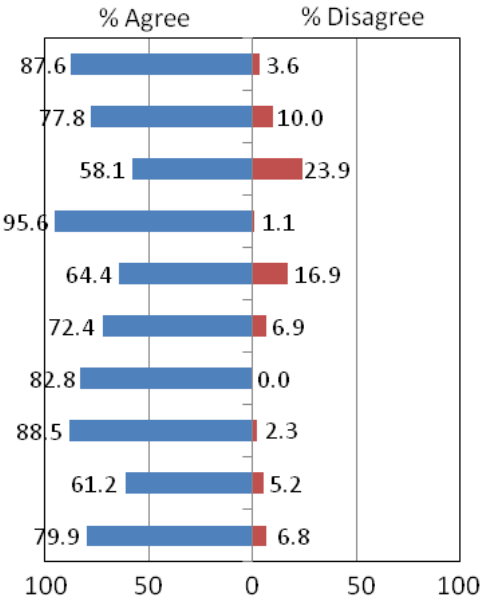
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	59.1	30.7	3.8	0.9	0.2	4.7	0.5	443
Health	37.8	35.6	13.3	5.6	1.1	5.6	1.1	90
AMHPs	48.7	26.5	11.1	11.1	1.7	0.0	0.9	117
Paramedics	64.4	28.9	4.4	0.0	0.0	2.2	0.0	90
MH nurses	42.4	35.6	11.9	8.5	0.0	1.7	0.0	59
Local Authority	65.5	24.1	10.3	0.0	0.0	0.0	0.0	29
Voluntary sector	51.7	27.6	10.3	0.0	0.0	6.9	3.4	29
Service users	74.0	14.5	4.6	0.8	2.3	3.8	0.0	131
Other	41.4	21.6	6.9	5.2	0.9	5.2	19.0	116
OVERALL	**55.7**	**27.6**	**6.6**	**3.1**	**0.7**	**3.8**	**2.4**	**1104**



There was widespread agreement that there need to be more AMHPs, especially out of hours when a single on-call AMHP may be covering an entire area, including a range of other duties.

10.2 Communication between different agencies is poor

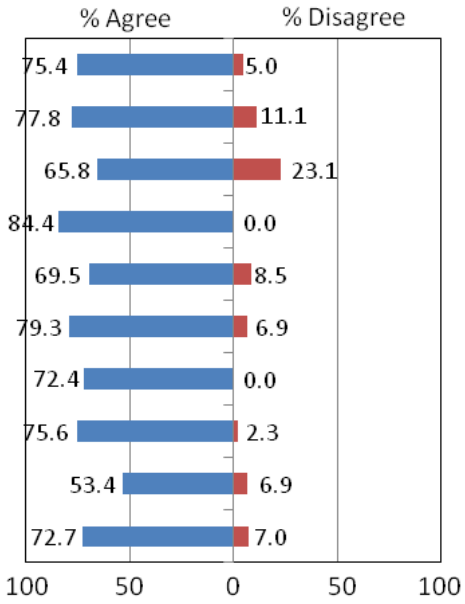
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	49.0	38.6	8.6	3.2	0.5	0.2	0.0	443
Health	38.9	38.9	11.1	10.0	0.0	0.0	1.1	90
AMHPs	23.1	35.0	17.1	21.4	2.6	0.0	0.9	117
Paramedics	64.4	31.1	3.3	1.1	0.0	0.0	0.0	90
MH nurses	30.5	33.9	18.6	15.3	1.7	0.0	0.0	59
Local Authority	51.7	20.7	13.8	6.9	0.0	3.4	3.4	29
Voluntary sector	48.3	34.5	6.9	0.0	0.0	6.9	3.4	29
Service users	61.8	26.7	2.3	1.5	0.8	6.1	0.8	131
Other	35.3	25.9	14.7	4.3	0.9	0.9	18.1	116
OVERALL	**45.8**	**34.1**	**9.8**	**6.1**	**0.7**	**1.2**	**2.4**	**1104**



There was agreement across all types of respondents that communication is an area for improvement; paramedics in particular thought that communication was poor (95.6% agreed, and 64.4% strongly agreed).

10.3 Agencies aren't sharing data

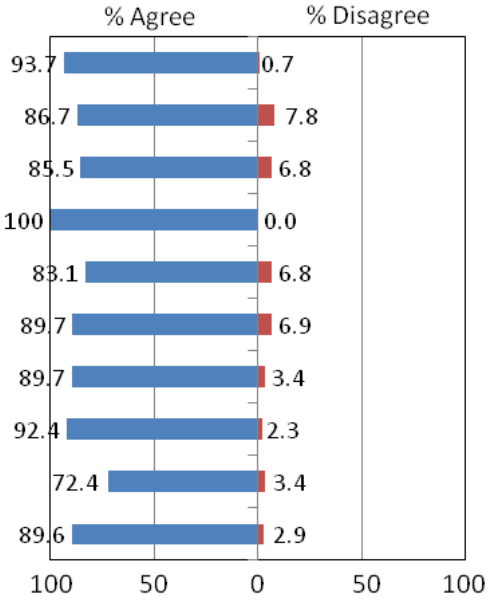
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	40.0	35.4	13.8	4.5	0.5	4.5	1.4	443
Health	33.3	44.4	8.9	11.1	0.0	1.1	1.1	90
AMHPs	17.1	48.7	9.4	21.4	1.7	0.0	1.7	117
Paramedics	51.1	33.3	1.1	0.0	0.0	12.2	2.2	90
MH nurses	40.7	28.8	16.9	8.5	0.0	3.4	1.7	59
Local Authority	48.3	31.0	3.4	6.9	0.0	6.9	3.4	29
Voluntary sector	44.8	27.6	13.8	0.0	0.0	10.3	3.4	29
Service users	51.9	23.7	7.6	1.5	0.8	12.2	2.3	131
Other	26.7	26.7	13.8	6.9	0.0	6.0	19.8	116
OVERALL	**38.3**	**34.4**	**11.1**	**6.5**	**0.5**	**5.6**	**3.6**	**1104**



All types of respondents agreed that agencies do not share data as much as they should do. Improving information-sharing between agencies, who often encounter the same individuals, could help to improve outcomes for the patients by ensuring a well-informed and consistent response.

10.4 There are gaps in local mental health services leading to more people in crisis in the community

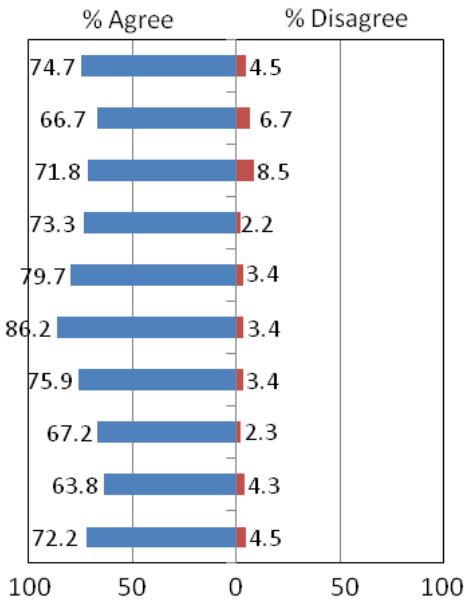
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	67.3	26.4	2.5	0.7	0.0	2.3	0.9	443
Health	66.7	20.0	3.3	7.8	0.0	2.2	0.0	90
AMHPs	54.7	30.8	6.8	6.0	0.9	0.0	0.9	117
Paramedics	86.7	13.3	0.0	0.0	0.0	0.0	0.0	90
MH nurses	52.5	30.5	10.2	6.8	0.0	0.0	0.0	59
Local Authority	69.0	20.7	3.4	6.9	0.0	0.0	0.0	29
Voluntary sector	62.1	27.6	3.4	0.0	3.4	0.0	3.4	29
Service users	79.4	13.0	1.5	1.5	0.8	2.3	1.5	131
Other	43.1	29.3	6.0	3.4	0.0	1.7	16.4	116
OVERALL	**65.5**	**24.1**	**3.5**	**2.6**	**0.3**	**1.5**	**2.4**	**1104**



There was a high degree of support across all types of respondents that gaps in local mental health services lead to more people reaching crisis point: 100% of paramedics agreed, with 86.7% strongly agreeing. 93.7% of the police agreed, with 67.3% strongly agreeing: while 92.4% of service users agreed, with 79.4% strongly agreeing.

10.5 Better inter-agency working such as through street triage is the way to resolve issues

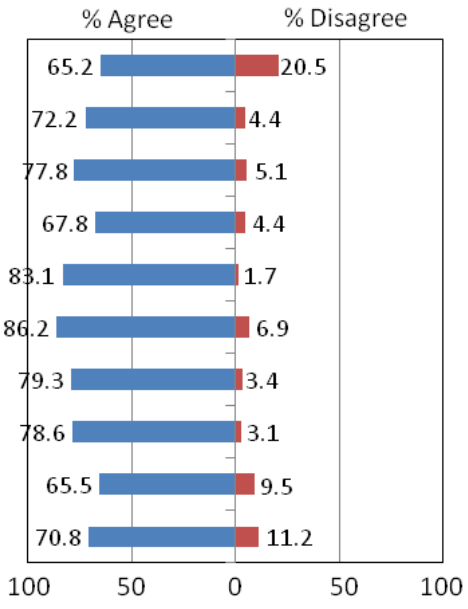
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	40.6	34.1	16.9	3.6	0.9	2.9	0.9	443
Health	26.7	40.0	20.0	3.3	3.3	6.7	0.0	90
AMHPs	23.1	48.7	14.5	6.0	2.6	3.4	1.7	117
Paramedics	50.0	23.3	15.6	2.2	0.0	8.9	0.0	90
MH nurses	49.2	30.5	15.3	3.4	0.0	1.7	0.0	59
Local Authority	48.3	37.9	6.9	3.4	0.0	3.4	0.0	29
Voluntary sector	34.5	41.4	13.8	3.4	0.0	3.4	3.4	29
Service users	42.0	25.2	13.7	2.3	0.0	9.9	6.9	131
Other	29.3	34.5	8.6	3.4	0.9	4.3	19.0	116
OVERALL	**37.9**	**34.3**	**15.1**	**3.5**	**1.0**	**4.7**	**3.4**	**1104**



There was strong support for better inter-agency working, such as in the Street Triage pilots, with Local Authority workers in particular agreeing that this was the way to resolve issues. However, there were some negative comments about Street Triage (see Open Text Box below).

10.6 Police training on mental health is inadequate

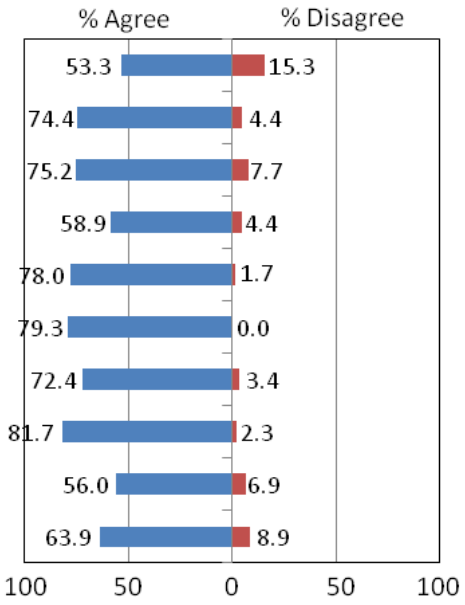
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	32.5	32.7	13.3	18.5	2.0	0.5	0.5	443
Health	36.7	35.6	14.4	3.3	1.1	7.8	1.1	90
AMHPs	44.4	33.3	12.8	3.4	1.7	3.4	0.9	117
Paramedics	37.8	30.0	7.8	4.4	0.0	20.0	0.0	90
MH nurses	55.9	27.1	10.2	0.0	1.7	3.4	1.7	59
Local Authority	48.3	37.9	6.9	6.9	0.0	0.0	0.0	29
Voluntary sector	62.1	17.2	10.3	0.0	3.4	3.4	3.4	29
Service users	61.1	17.6	9.2	1.5	1.5	7.6	1.5	131
Other	36.2	29.3	6.0	8.6	0.9	2.6	16.4	116
OVERALL	**40.8**	**30.1**	**11.2**	**9.7**	**1.5**	**4.3**	**2.4**	**1104**



The majority of every group of respondents agreed that the police need more training on mental health issues, so they can be more understanding and to reduce inappropriate use of Section 136 powers. However, 20.5% of police disagreed, saying that they were never going to become experts in mental health issues and that health professionals were better qualified to make these judgements.

10.7 There should be greater accountability and oversight of the use of Sections 135 and 136

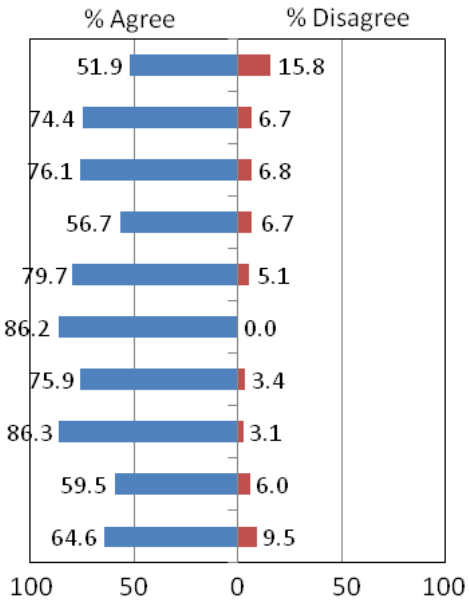
% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	22.6	30.7	28.0	12.9	2.5	2.0	1.4	443
Health	36.7	37.8	12.2	4.4	0.0	5.6	3.3	90
AMHPs	40.2	35.0	13.7	6.8	0.9	1.7	1.7	117
Paramedics	26.7	32.2	27.8	2.2	2.2	8.9	0.0	90
MH nurses	47.5	30.5	16.9	1.7	0.0	3.4	0.0	59
Local Authority	44.8	34.5	17.2	0.0	0.0	0.0	3.4	29
Voluntary sector	48.3	24.1	17.2	0.0	3.4	0.0	6.9	29
Service users	61.8	19.8	8.4	2.3	0.0	6.1	1.5	131
Other	30.2	25.9	14.7	5.2	1.7	3.4	19.0	116
OVERALL	**34.0**	**30.0**	**20.3**	**7.3**	**1.5**	**3.4**	**3.4**	**1104**



The majority of every type of respondent agreed that there should be more accountability and oversight of the use of Sections 135 and 136: health professionals, AMHPs, mental health nurses, Local Authority workers and service users were all particularly in agreement, with 81.7% of service users agreeing in total, and 61.8% strongly agreeing.

10.8 There should be more monitoring of the use of Section 135 and Section 136

% by type of respondent	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know	Blank	Actual No.
Police	21.4	30.5	30.2	13.1	2.7	1.6	0.5	443
Health	40.0	34.4	12.2	5.6	1.1	3.3	3.3	90
AMHPs	41.9	34.2	14.5	6.0	0.9	0.9	1.7	117
Paramedics	25.6	31.1	26.7	4.4	2.2	10.0	0.0	90
MH nurses	42.4	37.3	10.2	3.4	1.7	5.1	0.0	59
Local Authority	51.7	34.5	10.3	0.0	0.0	0.0	3.4	29
Voluntary sector	51.7	24.1	13.8	0.0	3.4	3.4	3.4	29
Service users	63.4	22.9	5.3	3.1	0.0	4.6	0.8	131
Other	31.9	27.6	12.9	3.4	2.6	2.6	19.0	116
OVERALL	**34.2**	**30.3**	**20.0**	**7.6**	**1.9**	**3.0**	**2.9**	**1104**



The literature review completed for the evidence gathering phase of the Review highlighted the paucity of good quality data collected at a national level about the uses of Sections 135 and 136[15]. Most respondents agreed that the use of Sections 135 and 136 should be monitored more closely, with Local Authority workers and service users particularly supportive. 86.3% of service users agreed with this, while 63.4% strongly agreed.

[15] See literature review, published separately alongside this report.

Open text box

The open text box invited people to add *any further comments or additional issues not covered above, including case studies, examples of good practice or other ways to improve outcomes*.

359 people made further comments. No particular themes emerged, so no attempt was made to quantify the comments against themes as elsewhere, but a selection of comments which highlight new or different issues not covered in the survey before is set out below. Comments which duplicated those already made, or which reiterated support/ disagreement for one of the statements in the survey, have not been included.

Some of the points made were about poor data and monitoring, or areas which have introduced their own forms as areas of good practice:

> *'Figures are incomplete for most Force areas and data collection needs to improve significantly to allow policy makers to take evidence based decisions'* (Respondent to survey)

> *'The use of these powers is often controversial and is sometimes seen as heavy handed. It is however a critical power that ought to be extended. I recognise the impact its use has on people, and as such have no issue with its use being monitored and perhaps greater accountability (i.e. perhaps having decisions to detain ratified by an Inspector?)'* (Police constable)

> *'In Cumbria, our current monitoring of Section 135 and Section 136 follows every use from initial police involvement to eventual assessment outcome. This allows a clear understanding of the police's use and misuse of the power. Whilst the HMIC/CQC Inspection report provided extremely helpful guidance, it did not include, in its review of the 70 cases, of the actual circumstances of the initial detention nor the eventual assessment outcome. As such, the recommendations are, in our view, based on a 'flawed' inspection and may lead to inappropriate pressures being placed on psychiatric units to manage persons taken inappropriately under Section 136 and whose eventual assessment reveals no mental health needs at all. In Cumbria, because we have this information available to us, we would be concerned if there was a change to the legislation based on such an approach. In Cumbria, we have taken steps to address the issue of police (and multi-agency) training, but this is based on a 'goodwill' approach. The sharing of information is good within statutory agencies, but more problematic when there are a number of different providers.'* (Cumbria Mental Health and Criminal Justice Steering Group)

> *'We have a lot of local monitoring on the use of Section 135 and Section 136, led by the mental health NHS Trust but involving all the partner agencies. What is missing is 1) monitoring and scrutiny of local arrangements by the national regulator, the CQC; 2) feedback to practitioners from the local monitoring arrangements to celebrate achievements and to escalate areas for practice improvement on the frontline; and 3) any indication that NHS CCG commissioners are doing anything about holding mental health NHS Trusts to account for their failure to provide realistic and fully-staffed alternatives to police station custody centres.'* (AMHP)

There were a number of comments about Street Triage, both positive and negative:

> *'As I am myself a Mental Health Triage Officer I can only emphasise the importance of such teams. In the past month in the City and County of Nottingham we have attended nearly 200 hundred incidents and from memory I believe we have only taken somebody under 136 on half a dozen occasions. Normally without this I can only imagine that triple that amount would have been taken under 136. We have saved Officers so much time taking them away from Mental Health incidents that this can only benefit the safety of the public as Officers an now concentrate on crime and reassuring the public. I'm aware that there is a lack of information sharing between mental health professionals and the Police and this causes frustrations on both sides.'* (Police constable)

'*Street triage is unrealistic and flawed. Staff (NHS) are unlikely to be experienced and difficult to obtain - and this model really only has a limited amount of application in highly compact urban areas - and even then pretty unrealistic. Laughable, really, as a concept and in practice. I comment as a former manager of NHS mental health services who has returned to frontline practice as an AMHP in an emergency duty service.*' (AMHP)

'*Police Officers in their nature are risk averse, which tends to increase the use of section 136. Mental Health professionals are able to look at risk in a more positive way. Initiatives such as street triage can create a balanced approach involving different agencies and with communication and two different expertise can be beneficial to the person, family and to the services in general as more likely to be a smooth operation.'* (Mental health nurse)

'In general, it would be preferable for police officers to seek telephone advice in this connected age before taking the decision to use Section 136 where possible; locally, the street triage car has fulfilled this function with good effect. On the other side, the other professionals (doctors, psychiatric nurses...) need educating in the proper role of the police in mental health matters; I see too many inappropriate demands (not requests!) which serve only to cause friction. Examples would be:

- *Asking the police to 'pick someone up' on a 136; (the decision whether to do so is that of the officer attending, no one else);*
- *Asking the police to do a 'safe and well' check, with no clarity about what action is expected.*
- *Asking Police to detain and return an absconded patient without supplying the evidence of the legal authority to do so.*
- *Refusing to accept responsibility for supervising and detaining the person in the place of safety.*
- *Adequate staffing of AMHPs and CRT staff would enable more prompt responses to requests for advice, and timely attendance.'* (AMHP)

'*Street Triage has been proven to be effective in urban areas. The challenge for Dyfed-Powys is how such approaches can effectively be applied to low populations over large geographical areas. The mobile mental health triage unit will hopefully provide part of the solution. Police training on mental health is most effective when delivered in conjunction with partner agencies, especially when delivered by heath / social care providers. Chief Constables and Police and Crime Commissioners have a duty to monitor and scrutinise the use of s135/6 detentions into police custody. As a PCC office we are now building this into our performance framework. The data is useful for evaluation purposes of pilots and will be used to evidence issues to partner agencies.'* (Office of Police and Crime Commissioner, Dyfed-Powys)

A number of people mentioned resources, funding, and staffing levels.

'*One of the biggest issues is the lack of flexibility in terms of freeing up professionals to support people in crisis within their own homes. Also, the Crisis/Home Treatment Teams are under resourced and the numbers of psychiatric beds are reducing all over the country which could free up informal admissions for some people. The numbers of AMHPs are reducing all over the country which has a serious knock-on effect for the speedy resolution of Mental Health Act assessments - and their pay is dire so many are leaving the profession as the support and guidance continues to be pared down whilst the risks increase.*' (AMHP)

'*There needs to be greater investment from the government, with ring fenced budgets in order to make this work. We are all currently overstretched and most AMHPs are fed with working up to midnight for no extra pay or TOIL every time we manage something coming in from the police station. The monitoring mentioned should be in the public domain. Most members of the public have no idea of the extent of the crisis occurring on the streets.* (AMHP)

Paramedics said that they found it difficult to access mental health services as they cannot refer directly:

> '*As a paramedic, we struggle to access appropriate services, either acute or chronic; for individuals experiencing mental health issues'* (Paramedic)

> '*In 13 years of front line service I can count on one hand the number of times I have managed to refer a patient to acute mental health services. Most often patients suffering from an acute mental health crisis end inappropriately up in their local A+E. There seems to be very little cooperation between services...and the ambulance service emergency departments ends up picking up the pieces.'* (Paramedic)

Some people were critical of the police:

> *'Police often use Section 136 indiscriminately; escalating the mental distress of individuals when they are taken somewhere and informed they are to be confined in a suite (especially those with no mental health history). In April 2014 a young lady made an off-the-cuff comment about suicide to her mother, was detained on Section 136 and brought to the place of safety. She had a Learning Disability and was extremely anxious, distressed and unable to understand what she was doing in a psychiatric hospital. We discharged her as soon as possible but she was exposed to two hours of unnecessary distress and alarm. If Police were to telephone services prior to considering Section 136, or if health staff with mobile technology were on site when consideration of S136 was being undertaken, then this could reduce significantly the numbers of inappropriate S136's. S136 contingency plans need to be written into Care Plan's for well-known clients. Police should have to call the local AMHP or other health professional for agreement of the use of s136. Police often discharge Section 136 when no 136 suites are available without the person being assessed. When you call back to check the whereabouts of the person they simply do not even acknowledge the person was on a Section 136. Due to a lack of documentation purporting to the incident people are not being safeguarded properly and in some cases being discharged illegally.'* (AMHP)

> *'There has been a large increase in use of Section 135 in [place] over the past five years due to the police no longer being willing to support AMHP's carrying out MHA assessments unless a Section 135 warrant is first obtained. This has the effect of making far more vulnerable people subject to an intrusive and fairly draconian legal restriction than was previously considered necessary.'* (AMHP)

> *'There is also the massive issue that Security staff and Nursing staff are asked to act in a manner you would expect a police officer to do, as the police drop the Section 136 person in an A&E and leave - this is then a massive issue, unsafe for staff, patients and the 136 patient. Security are having to restrain, search and secure in rooms in an attempt to try and 'sort out the mess'. NHS security staff should be accredited in a national manner, given powers and official roles, there should be a minimum standard and a national way of calculating the number of staff required. Please do not underestimate the level of violence and aggression that a person in mental health crisis shows, and due to the fact there may be no history and intoxication - sedation is not always possible.*' (Health professional)

> *'I have been in positions where I know the patient will abscond when they are in my care, police and mental health workers agree but do nothing until the patient does abscond instead of providing an escort. I have transported patients while the escort or police follow, leaving ambulance crews vulnerable. I have transferred patients who have not been searched correctly and who have a weapon of some kind. I have been left to force a patient into and out of the ambulance while police and mental health workers stand by watching. I have taken mental health patients to A&E because this is the only place of safety available, only to find the patient ignored, left alone even witnessed leaving the department without any assistance.'* (Hospital doctor)

Several people said that training was an issue:

'*Police training on such issues is inadequate. I have been in post for almost ten years, and do not recall ever having any training on how to recognise potential signs of mental health problems.'* (Police constable)

'Police training on mental health was a very brief input at training school (less than a morning session out of 15 weeks) but mental health impacts heavily on our work on a daily basis.' (Police constable)

Others mentioned problems over information-sharing:

'*However, poor information technology infrastructure and the complexity of legislation governing mental health, restraint and information governance means the sharing of patient data is underdeveloped and fraught with difficulties.'* (Hospital doctor)

'*The primary issue with regard to information sharing are the duties of confidentiality surrounding patient data and medical conditions-this creates risk aversion and a bureaucracy around record keeping 'just in case' there is a complaint.*' (Police inspector)'

'Healthcare professionals are so reluctant to share information that it sometimes becomes impossible to conduct accurate and meaningful risk assessments.' (Police inspector)

There were also some examples of good practices:

'Over the last 18 months there has been increasing and improving professional links between the place of safety and police at a local level to formulate more efficient working practices. Significant issues remain and can be summarised as:

- *Cross border disputes between AMHPS who have to travel out of their area.*
- *No effective roster or call out method for Section 12 Doctors.*
- *Inadequate staffing at places of safety meaning police stay as 'security guards' or take patients to a custody centre, sometimes for excessive periods.*
- *No engagement from the Ambulance Service at planning and coordination meetings.*
- *Very poor out of hours information sharing by NHS and local authority partners; a one way street from Police to partners and little in return'.* (Police inspector)

'*Locally we have a robust system of monitoring Section 136 – County-wide Strategic Group and a local Operational group, meet on a regular basis and are made up of commissioner, service, professional and service user representatives. Although there are enough AMHPs in Stoke City Area, there are occasional issues with emergency assessments as it can be difficult to co-ordinate the assessors quickly, especially out of hours…the local community triage team is making significant progress in supporting the Police to consider alternatives and assist with requesting urgent / emergency assessment.'* (AMHP)

'While sometimes inter-agency working can be sub-optimal, locally a multi-agency group meets monthly with representation from the mental health trust, acute hospital trusts, local police forces, county council, social services, and ambulance services. There are well established operational policies and protocols, exception monitoring, audit and feedback processes that have contributed to a well-run and efficient service...Locally most police officers have received very good training in mental health powers and awareness, but there remains areas of uncertainty within the legislation that can lead to variation in practice and application. This applies not only to the MHA (see points above regarding definitions of "place to which the public have access" and "place of safety"), but also application of the Mental Capacity Act 2005. Where issues arise, the exception monitoring process allows a line of communication and feedback between agencies, which are met efficiently and constructively by all parties.' (Hospital doctor)

'Location of mental health staff in police control rooms is proving very effective. Monthly monitoring of shared pathways is essential. Management and support of people who present more than once within a short period of time requires careful and sensitive collaboration in light of safeguarding concerns...Robust information sharing protocols are essential. AMHP cover should provide equitable service provision at all times of the day. Bed availability under Section 140 should be a mandatory requirement for NHS to ensure that access to admission is not delayed within a set time frame. Places of Safety should be available to ALL age ranges (with specific reference to under 18s).Successful implementation of Street Triage projects should be commissioned as core services.' (Local Authority staff)

'We had a problem with large numbers of people being detained under Section 136 by the police, the vast majority of whom were discharged following a mental health assessment... By establishing regular formal and informal contacts between local police and mental health services we have been able to substantially change this picture, markedly reducing the number of people detained (whilst increasing the proportion who end up in mental health services following the assessment) and at the same time improving the relationship between the two services , improving training for police officers around mental illness and working on improving the sharing of relevant information between the services.' (Psychiatrist)

Characteristics of survey respondents

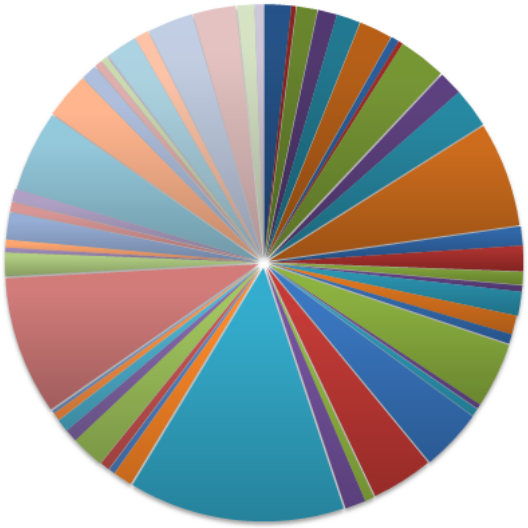
811 out of 1,104 respondents agreed to allow the review to use personal data about them.

150 people ticked that they were responding on behalf of an organisation (14.4%) and 886 were responding as individuals (85.5) out of 1036 people that completed this section.

162 gave us further details about their organisation or contact details.

Q15: Which county do you live in?

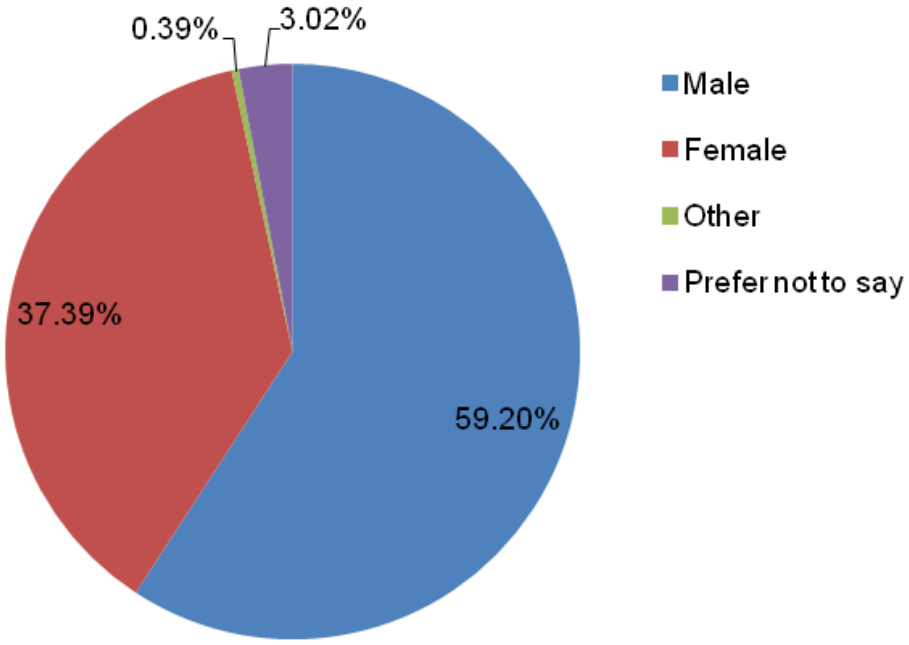
1,002 people answered this question. Responses were evenly spread, with more from Devon (6.7%), Hampshire (4.1%), London (13.8%), Nottinghamshire (8.8%), and Staffordshire (5.1%).



Avon
Bedfordshire
Berkshire
Buckinghamshire
Cambridgeshire
Cheshire
Cleveland
Clwyd
Cornwall
Cumbria
Derbyshire
Devon
Dorset
Durham
Dyfed
East Sussex
Essex
Gloucestershire
Gwent
Gwynedd
Hampshire
Herefordshire
Hertfordshire
Isle of Wight
Kent
Lancashire
Leicestershire
Lincolnshire
London
Merseyside
Mid Glamorgan
Middlesex
Norfolk
North Humberside
North Yorkshire
Northamptonshire
Northumberland
Nottinghamshire
Oxfordshire
Powys
Rutland
Shropshire
Somerset
South Glamorgan
South Humberside
South Yorkshire
Staffordshire
Suffolk
Surrey
Tyne and Wear
Warwickshire
West Glamorgan
West Midlands
West Sussex
West Yorkshire
Wiltshire
Worcestershire
prefer not to say
don't know

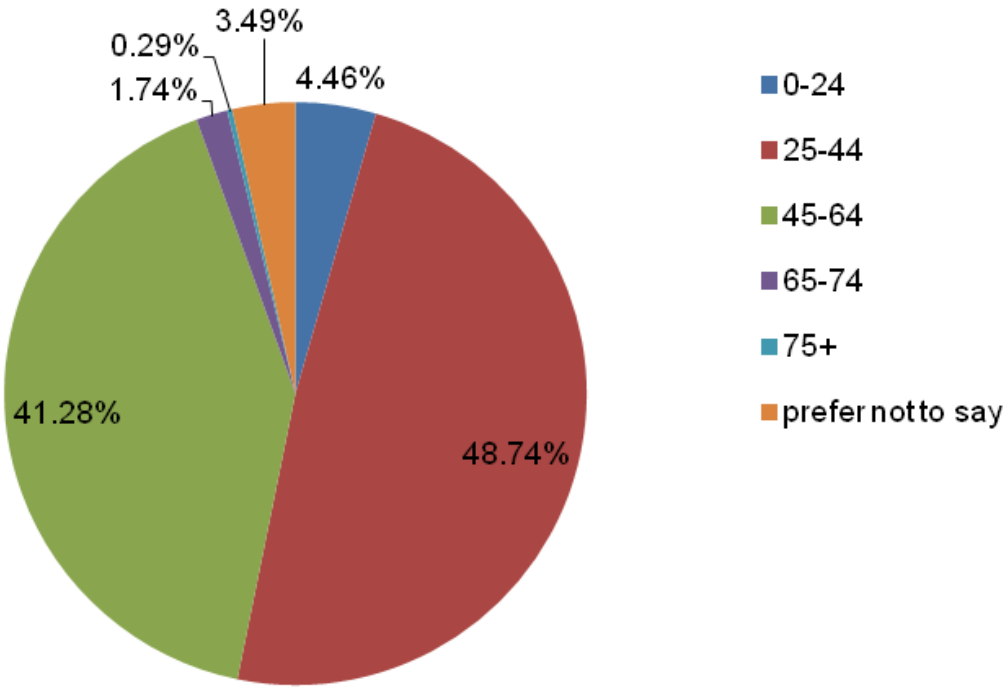
Q16: Please state your gender

1,027 people answered this question. 59.2% were male, and 37.4% female. Four respondents said they were 'other' (0.4%) and 3% preferred not to say.



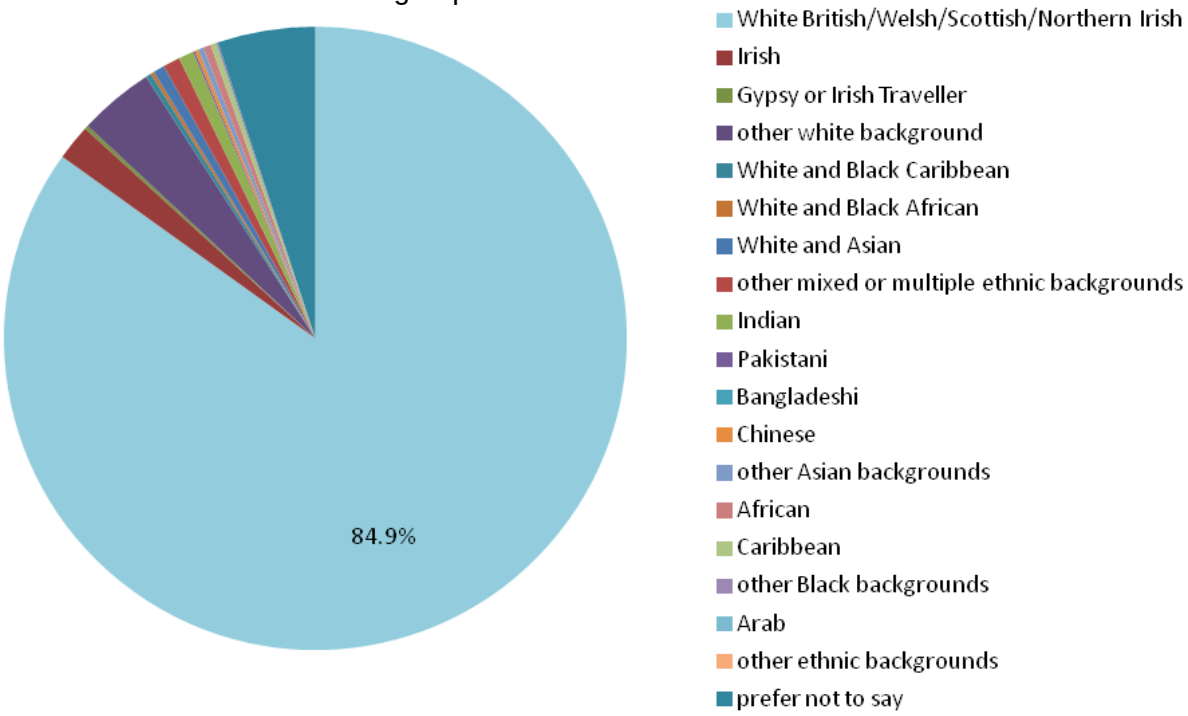
Q17: Please indicate your age group

1,032 people answered this question. 48.7% were aged between 25 – 44, and 41.3% aged between 45 – 64.

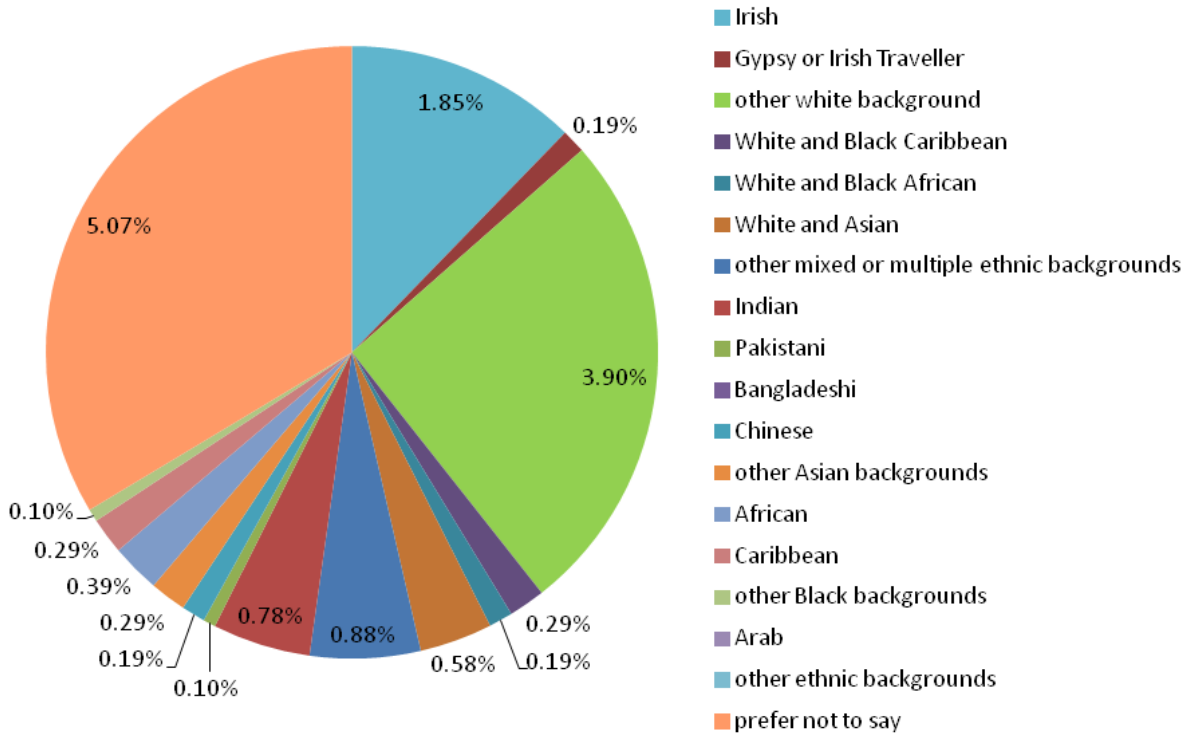


Q18: What is your ethnic group?

1,027 people answered this question. 84.9% were White British, and 15.1% non-White British or preferred not to state their ethnic group.



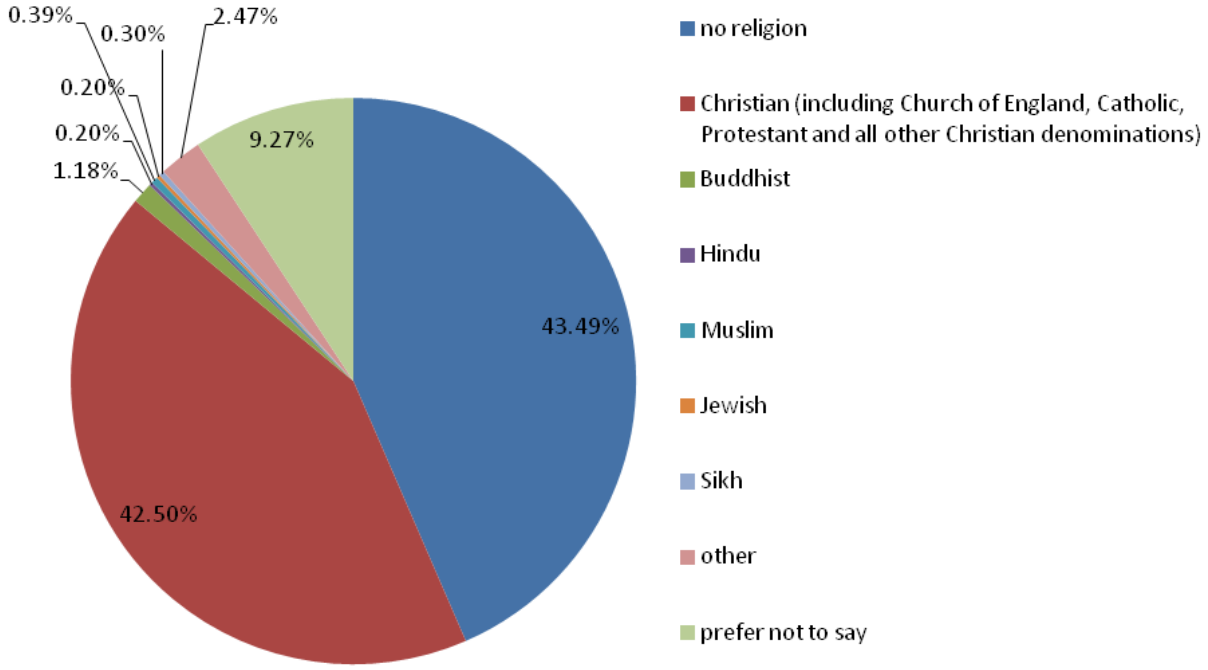
Of non- British/Welsh/Scottish/Northern Irish, the breakdown was:



40 people said they were of 'Other White background' including English (six people), Cornish (three people), White European, German, Ashkenazi Jew, Lithuanian, Spanish, Danish, Dutch and North American Indian/French Canadian. 19 people said they were Irish, eleven 'White and Asian', nine 'other mixed or multiple ethnic backgrounds', eight people said they were Indian, four people said they were African, three 'Other Asian', three Caribbean, two Chinese, two Gypsy or Irish Traveller, one Pakistani, and one person was African, Caribbean and Asian.

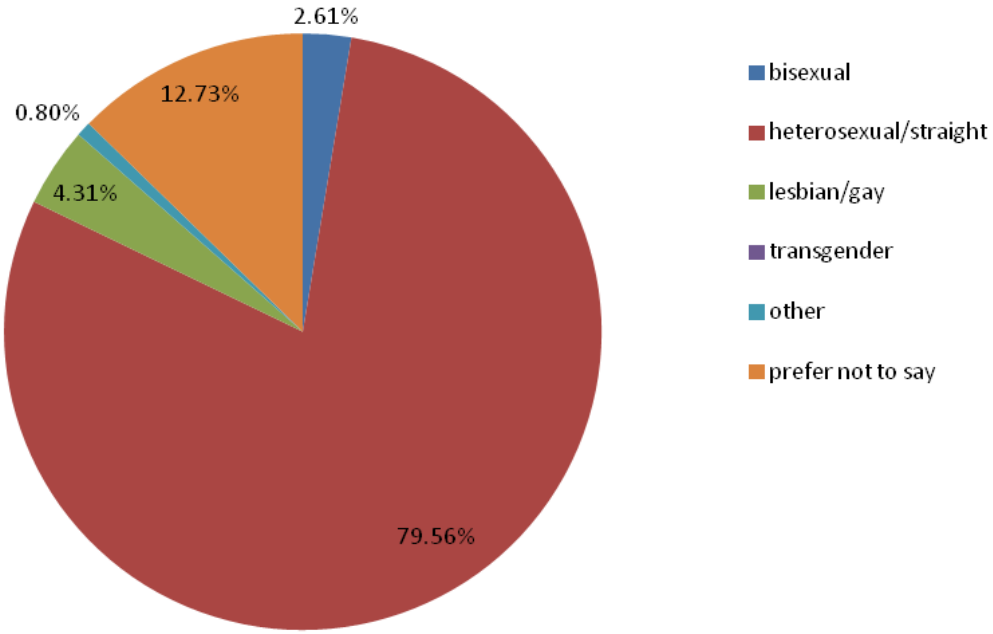
Q19: Please state your religion

1,014 people answered this question. 43.5% said they had no religion, while 42.5% said they were Christian.



Q20: Which of these best described how you think of yourself?

998 people answered this question. 79.6% said they were heterosexual and 20.4% preferred not to say, or stated they were bisexual, lesbian/gay or other. No-one said they were transgender.



Organisations' responses to the review

This section sets out a series of edited highlights representing the views of several national organisations which provided responses to the review.

Association of Ambulance Chief Executives

1. The key issues of debate for AACE are conveyance of patients experiencing mental health crisis to Health Based Places of Safety and the potential to extend powers under section 135 and 136 of the MHA to other professionals.

2. AACE fully support the overall goals of the concordat - in particular the need to provide parity of care to people experiencing mental health crisis. AACE agree that people experiencing mental health crisis should be treated as patients not prisoners and that Section 136 incidents should be managed sensitively by appropriately trained professionals.

3. AACE agree that appropriately trained healthcare professionals are better placed to make an assessment of an individual's mental health than a Police Officer. Whilst AACE agree that there may be benefits in extending Section 136 powers to other professionals, it should not be assumed that all healthcare professionals are able to make informed mental health assessments.

4. Whilst it may on the face of it seem logical to extend these powers to ambulance staff, the reality is that currently front line ambulance staff are not adequately trained to make informed assessments of an individual's mental health. AACE believe that if these powers are to be extended then it should be with a view to improving the patient experience. This is most likely to be achieved by ensuring that any extension of powers is focussed on appropriately trained mental health professionals.

5. If emergency access to mental health services was improved Section 136 might be used less frequently (especially in a person's home). If patients could be seen promptly -including at home - and direct referrals from ambulance staff were accepted (rather than via a GP), then immediate detention might not be required in many instances where Section 136 is currently applied.

6. AACE believe that ambulance trusts could play a key role in hosting and co-ordinating arrangements for the provision of mental health professionals. Bids for funding have previously been submitted to provide Mental Health Nurses in Emergency Operations Centres in order to provide 24/7 expertise in relation to mental health issues. These bids were not successful but AACE remain ready to engage in discussions about the central role ambulance trusts could fill in enabling patients and other healthcare providers to access the care pathways they need more effectively.

7. In addition ambulance trusts have engaged in "street triage" pilots which involves Mental Health Professionals, Police Officers and Ambulance Clinicians co-responding to Section 136 incidents. AACE await the formal evaluation of these schemes and would welcome the opportunity to discuss what role ambulance trusts could play in contributing to and/or hosting these arrangements.

8. AACE is aware that there has in the past been some dissatisfaction on the part of the Police Service with the time taken to provide an ambulance for conveyance of Section 135 and Section 136 patients. This is due to overall ambulance workload in dealing with patients with immediately life threatening conditions and the fact that Section 135 and 136 patients do not usually have a clinical condition that warrants such a fast response. As a consequence the Police Service often use their own vehicles to convey patients experiencing mental health crisis to Health Based Places of Safety rather than wait for an ambulance response. In two areas the Police have commissioned private ambulance providers to convey patients experiencing mental health crisis.

9. Ambulance services are examining the opportunities to redesign their response to a wide range of incidents as part of Sir Bruce Keogh's review of urgent and emergency care. This will encompass the response offered to patients experiencing mental health crisis.

10. In April 2014 AACE introduced a new national protocol for the management of Section 136 incidents which is designed to provide an on scene response within 30 minutes of a request being made. This protocol has been adopted by all 10 ambulance trusts in England and AACE expect to see an improvement in national response times. Internal measures are being developed in order to gauge the effectiveness of the protocol. This response time is second only to that received by patients with life threatening conditions and hence demonstrates the commitment of AACE to the delivery of parity of care for patients experiencing mental health crisis.

11. Ambulance trusts are not currently commissioned to provide this enhanced response and AACE would welcome any discussion about including this, and other improvements in the management of patients experiencing mental health crisis, in commissioning arrangements.

Association of Police and Crime Commissioners

12. Police and Crime Commissioners consider this review and resultant changes in current practice to be crucial both in supporting the needs of vulnerable individuals and in ensuring that police resource is dedicated to the issues it is best placed to support. The purpose of Sections 135 and 136 of the Act is primarily about health need - to ensure that individuals in need are given the medical assessment required, that they and the public are protected, and any necessary medical treatment is received. It is the view of Police and Crime Commissioners that this a question of health needs which are best supported by health and social care professionals, not by the police.

13. Police and Crime Commissioners consider that use of Section 136 in cases where an individual is detained in a police cell, rather than a Health-based place of safety, is too high and is being used more than 'exceptionally'. 36 % of Section 136 detentions in the last year for which statistics are available, were detentions to police custody. This is far too high. Any Section 136 Detention in Custody should be considered a Serious Incident within NHS Mental Health Contracts and be reported to NHS Commissioners. NHS Commissioners should consider examining the circumstances of each Section 136 use of police custody so as to consider how health provision can be adapted to ensure that police custody is not used. Police officers should not routinely need to wait with individuals in hospital before an assessment takes place.

14. Police and health partners must work together to divert these cases to the health/social care treatment that is best suited to support such crises. It cannot be the case that individuals are detained in police custody because there is no better alternative. The Mental Health Crisis Care Concordat is clear that there is a responsibility to provide 24/7 support sufficient to local need. If the use of police custody is to be reduced there needs to be greater provision of 24/7 access to health based places of safety.

15. At present, estimates suggest that between 20 – 40% of police time is spent on incidents involving vulnerable or mentally ill people, in some cases police may be the appropriate first responder, but in many cases health and social care are best placed to support these needs. Time the police spend with such incidents, where others can better tackle the fundamental need, is time that is not spent on the policing and criminal justice issues where police are most needed.

16. Police and Crime Commissioners are clear that aspects of Section 136 are ripe for reform. In particular, the detention period of 72 hours must be reduced. It is unequal that a suspect of a crime can be detained for 24 hours but an individual, who in some cases may have committed no crime at all, can be detained for up to 72 hours. This is a fundamental parity of esteem issue, at present an individual suspected of criminality can be held for 24 hours, an individual thought to be demonstrating signs of mental health crisis can be held for 72. This is neither fair nor right.

17. Should an individual be demonstrating such disordered behaviour that they may represent a risk to themselves or others, they should not be waiting 72 hours for medical assessment. They need help fast. In no circumstances in either a health based place of safety or in police custody should an individual fail to receive an assessment within 24 hours. In police custody, this assessment should be delivered as early as possible within that 24 hour period. The decision to detain should be regularly reviewed within the 24 hour period. Where an alternative health based place of safety becomes available during that period, the expectation should be that the individual is moved to the health setting where it would be safe to do so and would not further delay assessment and treatment.

18. The legislation must be reformed to particularly give consideration to the specific needs of young people. In no circumstances should a person under the age of 18 be detained in a police cell under Section 136. It is unacceptable that 45% of the young people detained in 2012/2013 under this provision were held in police custody. Thought should be given by the NHS to nationally mandating a detention of a person under the age of 18 under Section 136 as a 'Never Event.' It is inexcusable that the current legislation could potentially permit a child to be held in police custody for up to 72 hours, when they are in mental health crisis.

19. The Concordat was clear that police vehicles should not be used for transport. For an individual in crisis, it could be a significant additional potential cause of stigma or further add to their alarm. The commitment of ambulance services to provide a 30 minute response to individuals in mental health crisis should not be undermined by continued use of police vehicles.

20. Sadly, both police and health care professions every day work with individuals who are violent or who may have abused alcohol or drugs, that this may illustrate an underlying health need, or contribute to exacerbate a health condition, is no reason for excluding an individual from health care. Police and Crime Commissioners support the commitment in the Concordat that neither is grounds for exclusion.

21. Data should be kept, better recorded and examined on use of Section 136 in police custody. There should be an increasing use of this data to ensure that use of custody is dramatically reduced.

Care Quality Commission

22. The primary aim of any change to the current legislation should be to ensure all services involved are acting with the least restriction principle in mind, preventing risk and protecting patient's rights.

23. One area that we feel requires emphasis is the need to reduce the use of S136 overall and ensure all agencies are operating with a focus on the least restriction principle set out in Section 118 of the MHA and Chapter 1 of the MHA Code of Practice. This is demonstrated by the increasing number of people who are placed on s.136 and not felt to require further detention by MH professionals following assessment. The number of detentions continues to rise while the number of continuing detentions declining although we acknowledge that there needs to be further work in reviewing the data held on outcomes and this should be a key aspect of local multi-agency reviews of how the powers are being applied. To begin to effect the required change in this area local and national attention to increasing the training for police officers may be required facilitated through closer working relationships between MH services, police and alternative options for people in a crisis need to be explored by all agencies involved.

24. We also recognise the numbers of returns made to this survey are reflective of the system wide concerns for each of the interest groups. Section 135/136 represents significant impacts on patients who are affected by the powers and the agencies involved in responding to the emergency nature of the situations that result in Sections 135/136 being applied.

25. Issues remain with the variable quality of data, both ACPO and health care data, despite the progress made in recent years to improve the recording of S135/136's. We are unclear if there is

outcome data within the reports available from ACPO and would welcome increased information being routinely available from these systems and the data items being reviewed to identify if there is a possibility of ensuring standards between ACPO and KP90/MHMDS[16] to improve the national data held.

26. The questions raised by the survey of whether the power is being used correctly would be reliant upon us understanding the types of patients which are being detained. Their previous contact with services, whether they are already known to services, people who are being repeatedly brought in by the police are just a few of the data items that are missing from the national picture and may help to identify areas for further development.

27. CQC also recognise that Sections 135 and 136 are just one component of the link between MH services and police forces. The broader issues of police meeting their public safety responsibilities, restraint approaches for patients who are in custodial settings both under MHA or criminal powers and diversion panels are examples of the other areas that are intrinsically linked with the joint working between MH and policing. Any review of policing and mental health needs to consider the broad approach and how to ensure the safety of all patients is protected.

28. Historically there have been practical issues reported with the application of s.135 and we welcome this area being included in the survey. We believe a streamlining of the legislation to improve the expediting of the process would be of great benefit. This would particularly look to reducing the risk to patients who are affected by Section 135 and ensuring a speedy response to identified risk is possible. However, we would not wish to see a reduction in the potentially lengthy process resulting in reduced safeguards for patients and an avoidance of due legal process considering the power to enter the patient's private home.

29. The availability of Approved Mental Health Professionals was also recognised by the CQC respondents as being vital to ensuring patients are safeguarded and processes are in place to support other agencies. The role of the AMHP offers significant benefits through their knowledge of the MHA and local systems in avoiding unnecessary restrictions being placed on patients.

30. A core aspect of our inspection and monitoring of providers is their adherence to the Code of Practice. Although this is under review the current edition does set out a number of areas that help to prevent misapplication of the MHA. For s.135/136 this includes the joint local agency forum, training, policies and reporting. There is also the acknowledgement of alternative places of safety being used beyond the health based place of safety and police stations that could include care homes, GP's, relatives or carers homes. It is unclear how often this is considered as an option when police are considering application of s.136. This may indicate a lack of awareness of the alternatives and MHA Code or an absence of local support for these alternatives being used. Further training and awareness raising in this area would be beneficial.

31. We would also like to see more consideration of how local Clinical Commissioning Groups are using their s.136 information to consider providing alternative options for people in crisis. One of our respondents noted that this should include cultural and BME issues based on local needs analysis and the recognition that some communities are more likely to go to the police and bypass health services. The public health role in ensuring local crisis responses are considered for both current provision and future development is an area that should be explored as part of any review of s.135/136.

32. The focus on the 'maximum' time limits for s.135/136 needs to be balanced with a review of the alternative options in a crisis, ensuring least restriction and avoiding staff prioritising the 'target time' at the risk of patient safety. While a clear steer on the expected standards for commencing assessments and being able to offer the patient a maximum time for outcome of assessments is

[16] Mental Health Minimum Data set

helpful it should not be the overriding priority in reviewing s.135/136. Local joint policies and protocols can ensure they have clearly stated expected times and routes of escalation or rationale when these timescales are surpassed but this isn't the same as reducing the national standard and recognising the situations that may offer increased patient safeguards by allowing more time for the assessments to be completed.

33. The fundamental differences between the PACE and MHA should be a key aspect when formulating a national response to the changes that may be required in legislation. Unlike PACE the MHA offers vulnerable and high risk people an opportunity to receive assessment and access to treatment. This could be compromised by seeking a reduced time scale that could be portrayed as benefitting services rather than patients. This recognises there are some circumstances when further admission or detention could be avoided for some patients if the 72 hours are available and it is clinically appropriate to monitor the patients and offer support rather than meet shorter timescales. The Code of Practice and local policies and procedures can be used to set standard times for ensuring services complete assessments or release detaining police officers to avoid inappropriate delays.

34. It is noted that in the case of Ward v Commissioner of Police for the Metropolis [2005] that Sections 15 and 16 of PACE apply to warrants under s.135. It is unclear how this is practically applied and monitored locally. An example of this would be the requirement of PACE that a copy of the warrant is left at the property if the person the warrant has been issued for is not present at the time the police visits or the requirement to provide copies of the warrant to the person it applies to even where this is not executed.

35. Another area that was raised during our internal review of the survey is the use of coercion outside of s.135/136. We have heard of observations of local practices that in effect avoid the s.135 process by police accompanying mental health staff to private homes. In these scenarios people who are visited by the police and mental health services may believe they have to allow access or face repercussions. As these instances would not require a record to be made it is unknown how frequently they are occurring and what information is provided to the patients either during the visit or following....We believe there is evidence that the powers under section 135 or 136 can be misused or interpreted in ways that are wider than Parliament's intention. As CQC reports nationally it should be recognised that this obviously varies across localities and regions. As a result the information collated from our MHA activities offers reports of both good and poor application of the MHA.

36. Another practical issue is the ability to contain people once they enter the property under s.135. When applying PACE the police have the ability to contain a person in their own home while the premises are searched. This is not replicated in the MHA and it is unclear what power may protect the person, police or mental health staff if the person wishes to move about their property. Again there is no available data but this could be an area that requires exploration when engaging with the police to ensure there is appropriate guidance and protection for those involved.

37. For Section 135 there is also an absence of data on how many times the person is immediately removed from their property when a warrant is being executed. There is no requirement to take the person to a place of safety so they may be assessed in their own home if it is felt safe to do so. Due to the pressures of expediting the process by the services involved there is a concern that people may be unnecessarily taken from their own homes to facilitate the assessment when this could be completed in their properties.

38. Within this survey of Section 135/136 the use of Section 135(2) does not appear to be fully reflected or explored. This power allows for any person who is already detained to be retaken. It is unclear how often this has been exercised since it allows any person who is not an AMHP to apply for the warrant including Mental Health Act Administrators, nurses etc. This may be another area that raises difficulties in practice as the person who will be applying for the warrant may not be as familiar with due process as an AMHP.

39. The current provision of health-based places of safety may not be sufficient to allow for police stations never to be needed as a last resort. On the grounds that a person detained under s.136 may be displaying extremely aggressive or destructive behaviour, it also seems unwise to ban the use of police cells as a place of initial containment when that may be the only practical option. However, we are aware of health-based places of safety that try hard not to exclude people on the basis that they are highly disturbed and aggressive (such as the NAVIGO place of safety in Grimsby) and any use of a police station for any reason should be seen as exceptional and an incident to be avoided wherever possible. We would expect the local interpretation of 'exceptional' to acknowledge that the person would be completely unmanageable in a health setting but there should be a mechanism in place for reviewing the rationale provided for this – with all agencies involved.

40. Responses to this survey felt the change to law may not be wholly necessary as the important point is to define the circumstances that may be considered exceptional rather than the frequency of using the police cells. This appears in the 2008 Code of Practice (para 10.2) but could be stronger to allow greater clarity for local services and for national monitoring and regulation purposes. Any planned change to the law to strengthen this would take time and may not add much more in practice than increased detail in the Code could do through the current review process. A greater flexibility over types of hospital-based services that are available and better provisioning of A&E departments may help to discourage the use of police cells.

41. Problems in the availability of places of safety for children and adolescents appear to reflect more general issues of CAMHS provision. Our survey of health-based places of safety found that over a third do not accept young people under the age of 16, and half of those also do not accept 17-18 year olds. This results in a lack of access for under 16s in 33 of 152 upper tier local authority areas (22%), and a lack of access for 16-17 year olds in 17 of the upper tier local authorities (11%). It is therefore important that this message remains clear in the revised Code of Practice. CQC can and will take appropriate action relating to this issue with the provider through our regulatory and MHA powers.

42. Whilst it is important that detention in a place of safety is not prolonged for longer than necessary, it is also important that sufficient time is allowed for making any necessary arrangements appropriate for care – and that such arrangements are not limited to a consideration only of whether or not further formal detention is warranted. It has been suggested to CQC by one Mental Health Act Commissioner who responded to this survey felt because 72 hours is available, staff work to that and do not deal with the situation with an appropriate degree of urgency. However, for health based places of safety local policies and procedures should identify the expected times and support people in understanding how to escalate when these are not met and ensure discussions take place to review the timescales and exceptions through the multi-agency group. It should also be noted that reducing the legal timeframe will only work if resources are available for patients to be assessed within the stipulated time. There are already rare occasions where police have kept a person beyond the 72 hour limit without legal authority, for want of daring to do otherwise because of that person's distress and vulnerability. That must not become a more regular occurrence and as such any timescale must be achievable in practice.

43. We have heard anecdotally that the charge for a warrant is an unhelpful bureaucratic hurdle for social workers, and it does seem likely that the amount does not cover the costs of its processing, particularly if a wider view is taken of processing costs to both courts and local authorities.

44. We have received conflicting views from CQC Mental Health Act Commissioners on whether the S136 power might be extended to private places.

45. There is a danger in extending Section 136 powers to doctors, nurses and mental health professionals that such powers would be over-used, just as section 4 powers were overused in the early days of the Mental Health Act 1983, because they are the least bureaucratic means of effecting a hospital admission. As such careful consideration should be given to the safeguards.

46. It is arguable that the proposal focuses too much on the medical question of whether the person is in fact suffering from mental disorder, and too little on the police power of taking a person in need of care and control out of a public place where he or she may come to harm, or cause harm to others. Whilst it is undoubtedly true that mental health professionals would be better placed to address the 'medical' issue, it would be a serious extension of police powers to other agents to provide them with an effective power of arrest and conveyance, and it is not clear that mental health professionals should have such a role in society.

Mind

47. Incorrect use of Section 135(1): We expect that the powers will be used in accordance with the Act, possibly most of the time, but are aware of occasions when they are not. On Mind's helpline we have heard from people who have been shocked by the sudden entry of police and AMHP to their home under Section 135(1). People tell us that no steps or no adequate steps had been taken to contact them directly before the warrant was obtained. It has a profound effect upon their ability to trust the mental health services or to ask for assistance if they need it. There have been misunderstandings on the part of the AMHP and statutory services about the true situation and no time for the occupier or person suspected to have a mental health problem to correct the misapprehension.

48. In one case police forcibly entered a home where the two occupants were frightened that the police were intruders. We are also aware of other instances where S135(1) was used unnecessarily; in one case there were inadequate inquiries made and there was no cause for concern about the person, and in another the social worker would have been able to access the person without this measure being used.

49. Incorrect use of s136: On Mind's Legal line we have heard complaints from people about S136 being used where it is not a public place e.g. a person being dragged out of their own tent and made subject to s136.We have also heard from people with mental health problems where S136 has been used as a way of reacting to antisocial or challenging behaviour associated with a mental health condition, e.g. a person with a diagnosis of personality disorder who had a tendency to ring emergency services repeatedly and inappropriately when profoundly distressed or a person with cognitive disabilities who makes repeat calls to the police about perceived disability hate crime being subject to s136.The purpose of detention is to enable the person to be interviewed and arrangements made for their care. There is a real risk that s136 is used as a form of short term control measure. There needs to be more emphasis on assisting people in other ways than through s136 and in offering people who do not meet the threshold for detention with community or inpatient alternatives.

50. The police are sometimes the appropriate first responders to mental health emergencies, but often they act as a default because of failings in mental health services. If people were able to access mental health crisis care when they requested it, there would be less need for involuntary admissions and police involvement. One person told us about the points at which she could have been provided with mental health support – when she phoned for help and when, following an overdose, she was discharged from the ED before she was well and with no plan. This led to a life-threatening situation where the police needed to intervene and she was held in police custody on s136.Therefore there needs to be commissioning of sufficient mental health services, including health-based places of safety.

51. ...Use of police cells as places of safety should only occur in the most exceptional cases when there is extreme violence. It is completely unacceptable that police custody is used routinely or because of intoxication or behaviour (or history of behaviour) that could be managed in hospital. We know that people find police custody traumatising and it is totally unsuitable for a person who has committed no crime and who may be mentally unwell and in need of urgent mental health assessment. The use of police custody should be genuinely exceptional, so while we agree that there should be regular review to see if a person in police custody should be released or can be taken to a health-based place of safety, this should not be a frequent occurrence. We are also aware that it can be very

difficult for people to be held in police custody in what is a very stressful and distressing situation, then to be released without any support. We know of people who have become suicidal and harmed themselves. If there are no grounds to continue to detain the person, support should still be arranged if the person is in need of support and willing to accept it.

52. A person who is intoxicated should be in a health-based place of safety as they may need urgent medical help and there is no reason why the police should be expected to assume responsibility for holding someone until they are fit to be assessed. Emergency departments need to be able to be used as places of safety as people may need urgent medical assessment and/or treatment, but should not normally be used otherwise. They should have appropriate environments and staffing, which are also important for others in mental health crisis who come to the emergency department other than via police intervention.

53. 72 hours is far too long for someone to be detained without assessment and the commencement of formal legal procedures for continuing detention in any setting, but is particularly unacceptable in police custody where this period far exceeds the maximum time that a suspected offender can be held without charge or review....We know that people often wait many hours and often much longer than four (and certainly longer than the maximum of three hours recommended by the Royal College of Psychiatrists)... we recommend that the maximum period for detention should be four hours in any setting unless there are good reasons for extending it, and the scope of these should be set out.

54. While provision should be age appropriate this must not be used to exclude young people such that they are placed in police custody or taken a long way from home. It is much better to be in a place of safety that is attached to an adult ward than to be held in police custody or driven longer and further than necessary because of age restrictions in a health-based place of safety. Where the place of safety is a self-contained suite attached to an adult ward, the age appropriateness is more about the skills and approach of the staff. Police should still recognise the seriousness of using Mental Health Act powers when health-based places of safety are used and always seek to achieve cooperation and voluntary access to support where possible.

55. There should be a stronger requirement on clinical commissioning groups to commission sufficient places of safety with enough staffing to be available when needed 24/7. This should be supported and monitored by NHS England. The use of police stations as places of safety should be monitored with every occurrence being reported so that all local partners are aware and to the CQC and HMIC. The CQC should inspect mental health providers against their acceptance of people held on section 135 & 136 for assessment. All commitments made in the Crisis Care Concordat need to be fulfilled at national and local level, including inter-agency working to improve practice around s136 and commissioning both sufficient crisis care and sufficient places of safety.

56. S136 is a power that should be used proportionately and in limited circumstances. To allow it to be used in the home or in private premises would be a disproportionate interference with individual freedom and right to private and home life. However we would recommend bringing railway lines and police stations within the scope of places where s136 can apply. The public clearly do practically have access to railway lines even if this is sometimes an act of trespass and we would want people who are putting themselves in danger in this way to be kept safe; it is perverse not to allow the power to be used in a police station so that a person who has been arrested can be taken to a place of safety to be assessed. If this power is retained, it may be helpful to have a non-exhaustive list of places that do not count as public places.

57. We welcome the new national Ambulance Service protocol which means that NHS ambulance trusts will aim to respond to s136 incidents within 30 minutes to conduct an initial clinical assessment and to arrange transport to a place of safety or emergency department.S136 situations are health emergencies and the safest, most appropriate means of transport is that provided by the ambulance service – sometimes an ambulance but more often a secure car would be preferable. Police vehicles should not normally be used. We know of the profound distress and trauma people have experienced from being kept in the back of a police van and taken long distances. It is stigmatising and

humiliating to be seen by neighbours and friends being bundled into a police van. People in a state of distress need to have paramedics or nurses on hand. Using a friend or relative's car would be fine if the person was coming in voluntarily but would not be appropriate for detention as in the case of s136. A police officer or AMHP or both should escort the person to the place of safety.

58. We do not agree with extending police powers in any way. It would be more helpful to focus on police training in how to respond to people who may be in a serious mental health crisis. The case of ZH v Commissioner of Police for the Metropolis (2013) EWCA Civ 69 demonstrates the importance of police being equipped to make reasonable adjustments in their responses to situations involving people with disabilities. Further extension of powers would further involve a service primarily concerned with enforcing law and order in safeguarding functions. This could be felt particularly in BME communities where there may already be distrust of the police.

59. People have told us that they do not want additional powers for professionals to enter their homes.

60. Making reasonable adjustments in responding to incidents involving disabled people including people with mental health problems, BME community concerns around policing, coercive mental health interventions and disproportionate use of force; need for mental health services that provide equal access. Failure to provide enough health-based places of safety may breach the Equality Act public sector dutys135 is discriminatory and disproportionate. Mind's police guide includes examples of good practice.

61. Improving better interagency is very important but is only one way to solve things. Mental health is core police business. Good awareness of mental health and skills in communicating with people with mental health problems are essential to policing whether officers are responding to victims of crime, witnesses, suspected offenders or people in mental health crisis. Our police guide includes good practice examples including training initiatives.

62. Section 135 warrant: We have serious concerns about section 135. The way this power is framed is archaic – it refers to the person not being kept under proper control; it is discriminatory as only people with a mental health disability are subject to such a power of entry and removal from their own homes. People have been devastated by the experience of being led out in front of their neighbours in handcuffs by police, and by not being given adequate information as to the intentions and purpose of the intervention or what their rights are. As currently framed, the law is arguably a disproportionate interference with Article 8 rights for the following reasons:

- There is no requirement in section 135(1) that the local authority has to show that it has made reasonable attempts to access the person or enter the premises in question first
- A magistrate's procedure does not provide adequate scrutiny of the reasonableness of the request and may sometimes be a rubber stamping exercise. The approved mental health professional makes a request to the magistrate for a warrant without giving notice to the people concerned, while magistrates have no expertise in mental health or the Mental Health Act
- The emphasis must always be on joint planning and eliciting cooperation. Greater attention to arranging treatment and care rather than removal for assessment might result in a more collaborative approach. Police entry to the home can be severely distressing and traumatising and does not promote trust or cooperation. It is important that people have the opportunity to know about the concerns about them and the chance to comply or correct inaccurate information.

63. We propose the following to address these concerns:

- A requirement on local authorities to show that reasonable attempts have been made to access the person or enter the premises
- Guidance on the kinds of evidence of attempts to contact the person and elicit cooperation that must be provided to get a warrant
- Amending the law such that applications are made to a judge who is experienced in this area and on notice to those concerned except in exceptional emergency circumstances. This would give people

time to comply or correct inaccurate information or to challenge the application and argue that it is not required.

64. There needs to be legal aid and help and advice for people faced with proceedings or wishing to make claims subsequently. It is difficult for people to challenge this power because s139(2) requires that they obtain permission to take action against the police, and recent changes to legal aid for judicial review mean that people will not be funded to make claims. However, these amendments would not alter the fundamentally discriminatory nature of the power in that it is restricted to people with mental health problems. If there is to be a power of entry for general concerns about neglect or vulnerability of a person living in the community then this should not be reserved to those people who are alleged to have a mental disorder. One possible solution to this would be to repeal s 135(1) and instead have an HRA compliant amendment covering vulnerable people in general and not with reference to a disability. There still remains s 135(2) for retrieving detained people who have gone AWOL and this might need to remain in some form but could be made more HRA compliant.

National Policing Leads for Mental Health and Learning Disability

65. Parliament very clearly stipulated that Police cells are only to be used in 'exceptional' circumstances. Despite this, for the last full year of figures we know that some 9,000 people went to police cells, out of the 24,000 detained under the Mental Health Act Section 136 powers. This cannot be regarded as 'exceptional' in any way at all. We are also struck by the fact that there is huge disparity across the country with, in some places, up to 80% of Section 136 detainees being taken to Police cells whereas in other parts of the country that figure is 3%. This cannot be right. It is also the case that such detentions in cells can have implications in regard to CRB[17] checking of individuals.

66. We do not see this situation as being anything other than untenable. The Government has made quite clear its belief in parity of esteem, yet there is no parity of esteem present in a system with such stark data. It is our strongly held position, and one that is also held by the national policing lead on custody, Assistant Chief Constable Dawn Copley, that Police cells should be removed from the Mental Health Act as a place of safety and that health provision should be utilised as the Act intended to ensure that people who are ill experience a care pathway rather than being locked in a concrete box surrounded by suspected offenders.

67. We are particularly concerned that children continue to suffer the trauma of being placed in a cell for being ill; I believe that we would look askance at other nations if we heard that was how they dealt with mentally ill children and yet it is happening daily in England and Wales at present.

68. It is also the case that health trusts were given capital funding in 2006 to provide places of safety to fulfil their responsibilities under the Mental Health Act. It is not abundantly clear in some parts of the country how this money has been spent.

69. Our hope that Police Stations are no longer regarded as a place of safety would obviate any need for discussion around the length of detention under these powers. We are struck by the case of MS v the UK in which a man was detained for over 72 hours by the Police because of the inability of health services to find a medium secure bed anywhere in the country. This ruling, made in the European Court, again fundamentally challenges the concept of parity of esteem.

70. If the review concludes that Police Stations can properly be a place of safety, then 24 hours should be the maximum detention period possible. Currently we can detain murderers for less time than we can people who are mentally ill. This is perverse. Any detention period should be accompanied by a review process congruent with the requirements of the Police and Criminal Evidence Act but requiring input from an accredited mental health trained medical practitioner as well as any reviewing Police Officer.

[17] Criminal Records Bureau – now Disclosure and Barring Service

71. We believe passionately that the Police have more than adequate powers to take urgent action in a person's home when they are suffering a mental health crisis. Section 17 of PACE gives powers to enter if a life is at risk. We believe that the debate about expanding those powers reflects more the lack of access to other crisis care provision that is more appropriate, than the need for Police to have more intrusive powers than they presently already hold. Parity of esteem will not be achieved while legislation supports enforcement action in someone's house by the Police Service more than it supports health treatment by a health service.

Police Federation of England and Wales

72. A person suffering a breakdown or crisis situation as a result of mental ill health is a medical emergency and as such the first responders should be from within a medical discipline equipped with appropriate powers and training to resolve and/or manage the crisis. Police should only be involved if there is a real and imminent threat to members of the public and/or the medical professionals in attendance. The Health Service needs to be able to accommodate any changes in legislation and a transition period will be necessary to enable and develop staff and ensure a successful implementation of any new/revised legislation and procedures.

73. Although S135 is greatly misunderstood and in some areas misused I have focused on S136 as this is where the greatest problems are for policing and where the greatest improvement and positive impact can be made.

74. Recommendations:

- Removal of police stations and police custody as a place of safety in the MHA
- In the short term a reduction from 72 to 24 hour detention time limit for a MHA S136 assessment in police custody
- Stopping the PACE clock for those arrested for a criminal offence but identified as needing a MH assessment (this should be undertaken in a hospital)
- Extending use of s136 powers to some health professionals (AMHP's & trained paramedics)
- Extending use of S136 powers to private premises
- Statutory requirement to provide sufficient health-based places of safety
- Abolition of informal exclusion from health-based places of safety due to drugs, alcohol, or age
- Mandatory awareness training for police officers delivered jointly with MH partners
- Appropriate Adults for Adults provision put on a statutory footing
- Prohibition of calling police to MH establishments to restrain patients
- Provision of real properly resourced and effective 24/7 crisis teams to be first responders to people in MH breakdown crises

75. The recommended reduction from 72 to 24 hour detention time limit for a MHA section 136 assessment to take place should only be for when a police place of safety is utilised (72 hours should remain for Health Based Places of Safety. If a S136 detainee is transferred from police custody to a Health Based Places of Safety then the time reverts to the 72 hours from when detention is first authorised. This would then reflect the detention time limits in the Police and Criminal Evidence Act 1984 (PACE). To support this, a statutory time limit for assessments to be undertaken by all Health professionals in police custody should be put in place. However our view is that at the end of any reasonable (but not extensive) transition period police custody must be permanently removed from the MHA as a place of safety.

76. We highly recommend the change that as per detainees who are taken to hospital for treatment, the PACE clock should be stopped for those detainees arrested and detained for a criminal offence awaiting a mental health assessment. We have raised this at the PACE Strategy Board. In order to safeguard those most vulnerable and in crisis ensuring that they do not spend excessive time in police custody they should be transferred to hospital for the assessment to take place. As an alternative safeguard should this prove not to be feasible then to ensure that persons are not held in police custody longer than is necessary and that assessments are carried out in a timely fashion. We therefore recommend that the PACE clock can only be stopped initially for a maximum of 4 hours. An Inspector who is satisfied that custody staff/investigating officers have done all they can to expedite the assessment can then extend this to 6 hours but must also contact health professionals to expedite the assessment. If necessary after that any further extension would require a Superintendents authority up to a maximum of 12 hours and the Superintendent be required to intervene. We recommend that the S136 power as it currently exists be extended to include use on private premises with a power of entry. We do not believe it is necessary to attach an Inspectors authority for the power of entry (however this could be monitored over a 6 or 12 month period and reviewed/amended as necessary). Currently officers utilise what is commonly known as 'the ways and means act' when a person is suffering a mental health breakdown on private premises, this is in order to move them to a public place and then exercise their 136 powers. Although done with the best of intentions and in the interests of the person in crisis this is unhealthy practice which leaves everyone involved vulnerable.

77. The recommendation by Lord Bradley regarding mental health training for officers delivered jointly with local mental health partners should be made mandatory by the Home Secretary. Currently police training nationally is disjointed and the use of online training as a cheap alternative is wholly ineffective. There are some forces that have gone beyond the national ACPO recommendations and provide joint training i.e. North Wales and they have seen a big reduction in the number of S136 detainees as a result of that enlightened and sensible approach. The College of Policing together with key stakeholders and mental health professionals must be tasked with the development of a classroom based national mental health awareness training curriculum to be delivered jointly with local mental health partners. Police officers must not be called to mental health premises to assist in the restraint of aggressive/violent patients – this inappropriate practice must cease. Mental Health professionals are properly trained in the control and restraint of mental ill health patients and have powers to sedate them, whereas police officers are trained to subdue, restrain and arrest violent people. There has been at least one MH Trust who had stopped training staff and just call police on every occasion to restrain patients. This is wholly inappropriate and for the purpose of sedation unlawful.

78. There should be a statutory requirement on commissioning boards to provide an adequate number of properly and effectively staffed health-based places of safety in every part of the country (i.e. 5 beds for the whole of Kent is not adequate or sufficient). Our view is that officers should be required to stay with patients they have taken to a health-based place of safety for a maximum of 2 hours. We fully support the abolition of the informal exclusion criteria around drugs, alcohol, aggression, children and learning disabilities. The people concerned are suffering a health crisis and should be received and cared for in a health facility whose staffs are trained to assess, monitor and deal with medical matters such as alcohol or drug poisoning.

79. As an aside we are supportive of a change in legislation that will allow police officers to restrain those in an excited delirium (acute behavioural disorder) condition so that can be sedated by paramedics, escorted to A&E for effective and timely treatment thus providing a greater chance of save their life.

80. Having heard criticism of the police service for it's over use of MHA Section 136 powers and looking to the longer term we invite the start of a debate to consider removing MHA Section 136 powers from police officers.

81. As already stated when a person is in a mental health breakdown situation it is a health crisis and as such should be attended by health practitioners as first responders and not police officers. Properly

trained health practitioners (Approved Mental Health Practitioners (AMHP's) or suitably trained and qualified Paramedics) have a far greater chance of de-escalating the crisis to a point where the use of 136 powers may not be required.

82. Whereas this would need initial additional investment the impact of this could well be a cost saving across all areas of mental health and health services. These savings would be achieved through patients crisis's being more effectively managed, less use of all health-based places of safety and hospitalisation therefore less staff etc. required.

83. Police officers may still have a role to play in supporting health colleagues i.e. paramedics or crisis teams who are first responders if other members of the public or health colleagues themselves are at serious risk of harm or the person is considered so volatile that police support is necessary to contain and assist in the person's restraint in a public place. Other than to provide an escort to an health-based place of safety, police involvement should cease once the person is restrained and controlled.

84. As an absolute minimum the S136 detention powers should be extended to AMPH's and paramedics so that when they are in attendance at an incident (in particular without police) they can properly and appropriately exercise the power. Having looked closely at the Leicestershire Triage Pilot and had a colleague spend a shift with them it is the AMPH who when it is necessary is making the decision to use S136 powers but having to get police to do so as they do not have the power – this cannot be right?

Royal College of Nursing

85. The need to use Section 136 causes much concern amongst mental health nurses. They deal with the aftermath of a detention in police custody and there is good evidence that alternative arrangements such as the presence of nurses and appropriate facilities can avoid the use of cells. We consider joint training between health and police personnel could be beneficial. Street triage has clearly shown the benefits of joint working

86. A mental health crisis needs to be addressed in a compassionate yet safe manner. It is not a criminal matter and the use of police custody does both the clients and the police officers a disservice. To consider emergency departments a place of safety would require a shift in culture and operational practice and resource.

87. There needs to be a multi-agency agreement to address this issue. The Crisis Care Concordat needs to be operationalised as the signatories intended. We recognise that in extreme circumstances such a place may be appropriate but doubt that current practice is not merely following traditional patterns of provision.

88. On maximum length of detention: Too long a time period can enable delays. The system needs to be energised to act promptly to facilitate transfer of clients. We also consider the presence of a nurse could facilitate shorter stays.

89. On where S136 should apply: It would seem these distinctions are effectively barriers to people receiving timely and appropriate interventions and need to be reviewed

90. On conveying: It is essential that a person is transported not only in a safe and effective manner but with due regard to their dignity. Decisions should be underpinned by a risk assessment process.

91. There should be a multi-agency and service user debate about how this could be improved but also with due regard to a person's human rights. Fears of abuse of power can lead to disengagement from services and a lack of trust. This needs to be addressed.

92. On extending powers to health professionals: We have not decided on a position as we believe this will need much wider discussion between professional, other agencies and service users. This really

does need to be debated more and a measured response developed. There will be legitimate fears from professionals of all types finding themselves in a position where trust will be rapidly eroded by the use of such powers.

93. On equality and diversity: Such legislation with its potential to be considered discriminatory amongst some communities needs to be exercised in an open manner with clear accountability and transparency of usage.

94. This is an area where there is great potential for mutual learning and opportunities to develop good practice. This is a complex topic with a very vulnerable group, we consider simplistic solutions or shifting resources is not sufficient. The RCN supports inter-collegiate learning and believes that such learning can facilitate better understanding of roles and therefore better outcomes in practice.

Royal College of Psychiatrists

95. Limited data suggests a change in the pattern 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 availability of hospital-based resources may result in a lowering of the threshold for the use of s136 and thus an increase in detentions.

96. Use of police cells as a place of safety: In some areas police stations continue to be used routinely as a place of safety, in clear breach of the Code of Practice. Overall, 36% of all s136 cases still go to police custody. In 2012/13 an estimated 7,761 orders were made where the place of safety was a police custody suite. Where Hospital-based Places of Safety (HPOS) are available, some exclude patients on the grounds of age or presence of intoxication and some are not staffed 24 hours a day (see CQC map). Moreover, there is significant geographical variation in the use of police custody suites. The Health and Social Care Information Centre (HSCIC) report identified five areas where there were more than 500 uses of Section 136 during 2012/13 where the place of safety was police based. But there is also good practice. Four areas recorded 10 or fewer uses (and one had zero) during 2012/13.

97. Police cells should remain a possible place of safety in defined circumstances, i.e. if there is a high risk of violence, and in exceptional circumstances. It is better to define circumstances than expected frequency of use. It may be helpful to define what constitutes exceptional circumstances (and what is not) in more detail and for this to form the basis of reporting to CQC if custody is used outside these defined circumstances. There may need to be flexibility about where might be an appropriate place of safety in certain geographical areas where the HPOS may be many miles away but any decision to use a police station should be a positive one based on what is best for the patient. If police facilities are to be used consideration may need to be given to using areas of the police station other than a cell. A more flexible use of alternative POS may help, especially for children.

98. In 2012/13, 580 children and young people under the age of 18 were detained under Section 136. Of those, it is estimated that 263 (45%) were taken to police custody. It is likely that the restriction on access for young people to health-based places of safety in some areas is a key reason for police custody being widely used. CQC's recent map of places of safety found that 56 (35%) of the 161 health-based places of safety do not accept young people under the age of 16.

99. The College's view is that those with behaviour of concern leading to use of s136 that is complicated by alcohol or other substances should be managed in a healthcare setting, either in a s136 suite or, if the level of intoxication poses a medical risk, in an emergency department. However, while this is a

sound principle based on patient safety, translating this into practice is potentially more difficult. For example, there may be a delay in assessment while the person sobers up sufficiently for a valid interview, thus blocking the s136 room, as in many areas there is only one dedicated facility. Acute mental health providers will also need to ensure staff are competent to physically monitor these patients, given that mental health nurses have a different training to general hospital nurses.

100. What constitutes good practice is clearly outlined in the Code of Practice and in professional guidance is well known and widely disseminated. Improving compliance with these documents (and better experiences for those detained) will have a wide range of solutions including investment in appropriate services, more effective interagency working and robust governance. CQC inspections of crisis pathways and improved reporting of data through the annual Monitoring of the MHA publication could identify those who are failing to meet the necessary standards and such transparency may drive providers and commissioners to focus on service development / improvement. It may be helpful to define what constitutes exceptional circumstances (and what is not) in more detail and for this to form the basis of reporting to CQC if custody is used outside these defined circumstances. There may need to be flexibility about where might be an appropriate place of safety in certain geographical areas where the HPOS may be many miles away but any decision to use a police station should be a positive one based on what is best for the patient. If police facilities are to be used consideration may need to be given to using areas of the police station other than a cell.

101. The College guidance strongly supports the use of a vehicle from the ambulance service, in part as there is the benefit of staff who can provide physical health screening. A fully equipped emergency ambulance is usually not necessary - an ambulance car would suffice. We do however recognise there may be situations where, for pragmatic reasons, and if it is safe to do so, it might be appropriate for an assessment to be expedited if there is going to be too long a wait. Waiting times for ambulances are likely to be variable currently but there has been a recent move to a national contract recognising the needs of the police. If a s136 is necessary then it suggests that the person is objecting to accessing help informally, therefore family and friends should not be relied upon to provide transport.

102. The removal of the option to use police stations by making changes to the primary legislation without the parallel provision of adequate NHS resources in all areas could potentially have an adverse effect on vulnerable people, by leading to an increase in the threshold for using Section 136 in areas where there are insufficient numbers of and/or insufficiently resourced hospital places of safety.

103. The Royal College of Psychiatrists' key areas of concern in relation to the use of s136 (some of which are set out above) are as follows:

a. That patients, their families and others (including the police) have ready access to appropriate crisis services, and, if known to services, that relevant information is shared so that the use of s136 may be avoided or reduced whenever possible.
b. For there to be suitably staffed hospital places of safety in all areas, catering for all age groups and available 24 hours a day, which do not exclude on the grounds of age, diagnosis or presence of intoxication. A key question within this is how it is possible to ensure there are designated places of safety for young people under 18 in every area.
c. A specific training issue for the Police is the significant challenge of multi-agency working in this area, and how to respond appropriately to the reasons why children and young people are presenting as being at risk, in the additional context of child care and parental responsibility legislation.
d. To reverse the recent rise in the use of s136, particularly in people who, after assessment by mental health professionals, are not further detained.
e. The development of models of joint working between mental health and the police, and of a range of alternative support services for people in crisis.
f. That police stations are never used as a default position due to lack of Hospital Places of Safety.

g. For there to be high-quality data on the use of s136 and the needs of the population affected to better inform development of services. In particular, attention needs to be given to the sub-group of chaotic individuals with complex health and social problems who are repeatedly detained under s136.

104. We consider that the priority should be to reduce S136 overall, not just change how it works, particularly as most patients are not re-detained by mental health services after assessment. This means that we need: (1) better commissioning of crisis services (2) joint working between police and mental health. Both these are more important than changing the law or the time limits. Time limits in law may force unsafe decisions about release in individual cases.

Superintendent's Association of England and Wales

105. There is evidence amongst many forces of alternatives to Section136 being used and trained to staff. This includes the Government sponsored street triage scheme, health workers in custody and mental health professionals in control rooms. This, with a refreshed perspective achieved through training, has led to significant reductions in s136 detentions in some force areas.

106. Resourcing in other services (mental health Trusts and Adult/Children social care) is the issue that needs addressing and police officers should not be used as a gateway for mental health services. If life is at risk then police officers have a power to exercise to protect this (s.17 PACE). The Mental Capacity Act would appear to provide safeguards in other such scenarios. If powers are extended there would need to be sufficient safeguards to prevent police officers being used to plug these resource gaps in other agencies. Perhaps any new legislation to provide for emergency action in private premises could be made available to people other than police officers (Dr's/AMHPs)?

107. Use of police cells as a place of safety: The key is properly commissioned mental health crisis care. Where this isn't in place, and providers haven't worked to find a solution under existing contracts, the result is police stations being used. Once the provision is commissioned appropriate performance management is required to ensure Trusts do not use the beds for non-crisis patients. The CAMHs place of safety provision is even more challenging with relatively few individuals detained compared to adults. Trusts providing such a place of safety should ensure adequate staffing, or the place of safety becomes useless. Effective local partnerships have led to SLAs where police officers will only remain until the handover is made. Violent detainees are a challenge, but health Trusts are trained to manage violent people who are mentally unwell, whereas police are trained to manage via pain compliance.

108. The only individuals who can release someone from a s.136 detention are medically trained professionals. This should remain the case. The risk implications if this were changed are great for the service.

109. On maximum length of detention: If there is no alternative other than to use a police cell this should be for a maximum of 12 hours after which the individual needs to be transferred to a health based place of safety. 24 hours would appear to be enough time for a patient to sober up, if drunk, or calm down, if violent, to enable an initial assessment by medical staff. The 72 hours is sometimes misused or viewed as the total time available, leading to less immediate attention from health professionals.

110. On Section 135 warrants: Obtaining a warrant can be time consuming but it is not a painful process. I believe that the payment issue is not the reason why obtaining a Section 135 warrant is avoided. It is the time taken to complete forms and travel to a Magistrate that could put health professionals off. I do not think that police officers pay for warrants. The same should apply to s.135 warrants, they are there to protect someone believed in need of care.

111. On where Section 136 should apply: The additional provisions for railway lines, hotel rooms etc would be welcome. As per a previous answer the power to detain immediately inside a dwelling

could be provided to health professionals. If given to the police there is the risk that the police officers would be left managing the patient. Section 135 provides for this situation, with the Mental Capacity Act being appropriately used in some circumstances.

112. On who should convey patients: The issue is stigmatisation is important when removing people from public places or their own homes. A police vehicle exacerbates these issues. The risk should the patient deteriorate in police vehicles is a concerning one for the service. The use of ambulance staff to check the patient at the scene of a s.136 would appear to be good practice. There are some private contractors that help with transportation in some force areas. Pressures on the ambulance service should be noted. There are often times when ambulances are unable to respond for calls for assistance from officers at medical emergencies and if these resources are used more often for mental health issues this will compound the problem. What is possibly needed is a less urgent, perhaps less equipped, medical vehicle with appropriately trained staff.

113. On powers to act in an emergency in people's homes: There could either be retrospective powers to seek authorisation from a Magistrate but again, as per previous answers, the solution does not solely rest on providing police officers with additional powers. Doctors or AMHPs could be provided with this power.

114. On extending powers to health professionals: The occasions when violence is used are few in number compared to the total number of detentions, extending the power could remove what is often a health issue from the police service.

115. Good practice seen in some force areas involves the debriefing of every section 136 detention with health partners. The aim is more information to be shared to provide the best possible service to that patient should they represent. This may also prevent a section 136 detention in the future as 'care plans' can be devised to inform other agencies of agreed ways to manage that patient, particularly out of hours when access to health systems is made more challenging.

116. With budget reductions funding is often diverted to higher risk areas [such as] child protection. This may have led to a reduction in the number of approved mental health professionals for adults employed by local authorities. There is evidence in many police forces of good information sharing arrangements, which have proven to reduce demand for the police .Local oversight of mental health crisis care could be either via local partnerships or via Health and Wellbeing Boards - or both. Centrally delivered police training could be improved. Many forces have invested locally for partnership delivered MH training or devised their own. This has led to a difference in approach for what is the same issue across England and Wales.

Annex A: List of organisations which responded to the review

This includes organisations who replied separately, as well as those who completed the survey.

A
Association of Police and Crime Commissioners
Avon & Somerset Police

B
Barnet Enfield & Haringey Mental Health NHS Trust
Basildon & South Essex Disability Forum
Bedfordshire Police
Black & Minority Advisory Group
Birmingham City Council

C
Calderdale District Police
Cambridgeshire Police
Care Quality Commission
Carers Advice & Resource Establishment – Sandwell
Cheshire Police
Cumbria Mental Health & Criminal Justice Steering Group – Cumbria Partnership NHS Foundation

D
Devon & Cornwall Police
Durham Police

E
East Midlands Ambulance Service
Essex Police

F
Faculty of Forensic & Legal Medicine

G
Greater Manchester Police

H
Hampshire Police
Hampshire Adult Services
Herefordshire CCG
HMI Prisons

I
Independent Police Complaint Commission

K
Kent Police
Kirklees Council

L
Law Society
Lancashire Police
Leeds Adult Social Care Services

Lynfield Mount Hospital

M
Manchester Public Health Network
Merseyside Police
Metropolitan Police
Mind

N
National Policing Leads for Mental Health and Learning Disability
National Police Leads for Custody
Newcastle Council
Nicholas Hospital – Newcastle Upon Tyne
North East London NHS Foundation Trust
Northumberland Tyne & Wear NHS Foundation Trust
North Yorkshire Police
Nottinghamshire Healthcare NHS Trust
Nottingham Police

O
Oxford Health NHS Foundation Trust

P
Police Federation of England and Wales
Police Federation in Wales
Public Health England

R
Redbridge Concern for Mental Health
Royal College of Nursing
Royal College of Psychiatrists
Royal College of Physicians' Faculty of Forensic and Legal Medicine

S
Seccombel Informatics & Governance Lead Self Help Services
Sheffield Children's NHS Foundation Trust
Shepherds Bush Housing Association
South Central Ambulance Service
South Gloucestershire Clinical Commissioning Group
Southend on Sea AMHP Service
South Locality Mental Health Team
South London & Maudsley NHS Foundation Trust
South Staffordshire & Shropshire Healthcare NHS Trust
South Wales Police
SWLSTG Mental Health Trust
South West Yorkshire Mental Health Foundation Trust
South Western Ambulance Service
South Wiltshire Council
Staffordshire Police
Stoke on Trent City Council
Suffolk County Council AMHPs service
Suffolk Police
Sussex Police

T
Thames Valley Police

Trafford Youth Offending Service Police

W

West Mercia Police
West Yorkshire Police
Wiltshire Police
WISH – A voice for women's mental health
Wolverhampton Local Authority
Work for Staffordshire Police

Y

Yorkshire Ambulance Service
Yorkshire County Council

Annex B: Key findings from workshops and visits

In addition to the online survey, the review sought to gather qualitative evidence to explore with frontline practitioners the issues they experienced. The review commissioned the Centre for Mental Health to undertake as series of practitioner workshops around England and Wales, as well as events held with service users, and their family, friends, and carers. In addition, the review held two events exploring the experiences of Black African-Caribbean communities with Black Mental Health UK, and undertook a series of visits to areas with very high and very low numbers of section 136 detentions to explore regional variation. The findings are summarised below.

Centre for Mental Health Practitioner Workshops

The Centre for Mental Health ran a series of practitioner workshops and events with service users and their family, friends, and carers, around England and Wales, which are set out in a separate report published alongside this report. The findings are summarised below:

Places of safety

- In many areas, the use of police cells as a place of safety was becoming more exceptional, in line with the codes of practice.
- Staffing the 136 suites was a problem in many areas, as staff already had duties on other wards. Staffing worked best 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.
- Staffing the 136 suites and indeed the assessment teams makes a significant demand on resources which did not appear to be taken any account of by some area's local commissioning.
- Finding an appropriate bed after an assessment was cited as a reason for some people remaining under section 136 longer than 24 hours, and this had been the case for those aged under 18 years in many areas. Again the consensus was that this was a commissioning issue and one that local Clinical Commissioning Groups and NHS England (particularly in the case for beds for under 18s) needed to address.
- Most areas struggled to achieve a completed assessment in four hours (as recommended by the Royal College of Psychiatrists) 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 a place of safety with availability.
- Intoxication was a problem for most areas, and some emergency departments and most S136 suites would reportedly not accept a person whom they deemed too incapacitated to assess. How staff judged incapacity varied by area. Some mental health practitioners used breathalysers and judged by its reading; others, and indeed most, judged by the apparent coherence of the person. In some areas the default location for an intoxicated person was a police cell.

Section 135

- The whole process from organising a warrant (including collecting ample evidence to justify its issue), organising the police, ambulance and necessary mental health professionals, to arranging a place of safety, was reported to be very time consuming; in some areas, 4 to 12 hours was not uncommon.
- Considerable delays in police providing a response were reported: in one case, five days had elapsed since a request for police support had been made, though such lengthy delays were exceptional.
- Organising Section 12 doctors was reported to be difficult in some areas.

Mental health emergencies in private homes

- Police across most of the forces attending the events reported once inside a private property and on encountering someone whom they considered in need of treatment and care, their removal from a private place was difficult without a warrant. This meant some officers had to remain in the private place with the vulnerable person for several hours.
- There were also examples of unlawful practice reported in all police force areas, typically an officer persuading the vulnerable person to enter a public space and then applying Section 136.
- Service users in the workshop events were universally against changing the legislation around Section 135 and did not wish to see Section 136 being extended into private homes. They stressed that someone's home was very different to a public space and that Section 135 was experienced as more of a "violation" than Section 136 for most service users who had experienced sectioning under both parts of the Mental Health Act.
- Conversely carers were by and large in favour of anything that would speed up the process of a Section 135 and most saw the benefit of police powers being extended to allow the application of Section 136 in the circumstances of an emergency once a police officer had already legitimately entered a property (under other legislation).
- Those in favour of change generally favoured the extension of Section 136 to private premises if legal entry had already taken place and only in emergencies for which specific criteria would need to be met.

Maximum length of detention

- The vast majority considered that 24 hours was ample time for an assessment to take place. Further to this some service users felt there should be a monitored target of a maximum stay of 6 hours in a place of safety, barring exceptional circumstances. The maximum time for completion of assessments was also felt by some stakeholders to move from a recommendation to a requirement.

Conveyance

- The timely attendance of an ambulance was an issue in many cases and could add several hours' delay, resulting in police choosing to provide conveyance in many such cases) and almost impossible in parts of South and North East England and across Wales. Most stakeholders felt that these sections were not really reflected in commissioners' contracts with ambulance services.
- 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.
- Service users, carers and professionals alike were unhappy about the conveyance of a vulnerable person in a police vehicle and use of such vehicles was felt to *"criminalise a health crisis".*
- In two areas, private ambulances were regularly used. One area in the South of England commonly *"gave the public sector service an opportunity to fail"* before engaging the private service. One area in the North East had piloted use of a private ambulance service and the local evaluation had produced a strong case for extended the contract and making them the norm. Other areas in the North East were looking to adopt this model.

Service users and carers experiences

- The sectioning under Sections 135 or 136 was experienced as a traumatic event in most cases by service users. Many service users and their carers reported feeling embarrassed and humiliated (e.g. in front of their neighbours) at being removed in police vehicles and at having an obvious police presence outside their homes.
- Section 135 was traumatic for some carers because of the length of time it took from requesting help to the full execution of the warrant, the response of the police e.g. having several blue-lighted vehicles arriving and witnessing the person they cared for being restrained. However, in most cases carers had a positive experience of the police response, and the execution of a section 135 warrant was often the conclusion of a lengthy and largely frustrating experience of seeking help for the person they cared for.

- While the experience of being detained under Section 136 was generally a traumatic one, but there were some positive experiences reported; these involved what they termed as “humane”, “softly-softly” approaches to their detention, where clear and simple explanations were given and where they had someone to speak to throughout the process and could readily contact relatives/carers. Several service users reported similar positive experiences of police custody, particularly where an officer sat with them and talked to them.
- The experience of being in a 136 suite for these service users could be quite negative and they reported that they were less likely to have someone available to talk to, but were simply observed.
- Several service users reported negative impacts on seeking employment and voluntary positions, as their detainment in police custody under Section 136 had been disclosed by Police under a Disclosing and Barring Service check. Service users and professionals alike felt that this should be standardised and Section 136 should not be disclosed unless in exceptional circumstances. Additionally service users wanted to be given accurate information on this issue.
- Several carers and service users reported that they had been actively seeking help in the days or weeks leading to the sectioning, and that these had largely been frustrated attempts, which led to a crisis point. All the service users spoken to supported information sharing and police having knowledge of aspects of their care plans.

Equality and diversity

- In some areas a period in a police cell was the ‘default’ for young people aged under 18. With the exception of one area, Sections 135 and 136 were considered problematic for those under 18. This was largely due to the suitability of Places of Safety. In some areas the NHS Trust had 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 most police forces deemed this unacceptable and would no longer countenance the use of custody except in the case of very violent young people.

- The experience in most areas was of longer delays for under 18s 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 with poor mental health differently to adults, and are harder to diagnose.

- Two service users of 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 and it occurring earlier on during the episodes described.

Workshops with Black Mental Health UK

Two workshops were held in Luton and Lewisham, London by Black Mental Health UK to give people from the Black African-Caribbean community an opportunity to feed into the review. Approximately 25 people attended the Luton event and another 10 attended the London event. The section below reports the discussions without further checking facts or independently verifying any of the instances referred to.

Attendees were provided with information about the review and asked to discuss it on each table. Notes were taken by a nominated representative from each table, and the session was written up by the project team. The groups were asked to consider these questions as a starting point for discussion:

- *Should police stations be used as a place of safety?*
- *Should police be able to use Section 136 powers in people’s homes, in an emergency when there is no time to get a warrant?*

- *Should other professionals (such as doctors and Approved Mental Health Professionals) have the same or similar powers?*
- *Do you think Section 135/ Section 136 powers are misused? How?*
- *How could the Government address the over-representation of some groups in Section 136 detentions?*

The main points made were:

Places of safety

Police custody should only be used as a last resort, but is often the first option. In Lewisham, one table stated that it 'always' used to be a police cell or is 'mostly' police stations, but that it should always be a hospital. All the groups felt that generally police stations should not be used. There was acknowledgement that there are exceptional circumstances where it may be necessary to hold a person in police custody, but practice needs to change to ensure it is only used in these instances. People said it was very traumatic to be taken into custody. Some individuals believed there was a financial gain for the police (£175 per detention)[18] which lead to police custody being used in preference to hospitals. There was little knowledge that the legislation sets out where can be used as a place of safety. In Luton, it was thought that trying to contact friends and family that may be willing to accept the person, should be the first option, with police stations as a final fall-back position after health settings have been tried.

Some thought that places of safety could be expanded to include voluntary organisation settings, with more use of crisis intervention teams. Several said the main thing was to get quicker access to assessments and facilities. In Lewisham, they suggested that police could provide a separate suite that could be made available for people with mental health problems or people in a crisis. They felt there should be a separate place for people who are drunk, so that they do not take up a health-based place of safety when someone really needs it.

There was emphasis on providing advocacy to those detained, and that there should be a standard procedure to do so countrywide. It was noted that considerable sums of money were spent on IPCC investigations, and that these funds could be used to provide these services. It was highlighted that the Asian community often had a large support network of family and friends, but this was not so strong in the African/Caribbean community who can be more isolated individuals. One lady said that African-Caribbean families are more divided, often with members in prisons or institutions, and that this could lead to vicious circles where a black man with schizophrenia wouldn't be permitted to rejoin his family, leading to the next generation growing up fatherless.

It was understood that funding and feasibility would not be available for separate places of safety for African/Caribbean individuals, particularly taking in to account areas where there are smaller African/Caribbean communities.

In discussing accessing hospital places of safety, several people said that mental health services would not see people if they so much as detected alcohol on their breath. They said that there is a big difference between one glass of wine and being intoxicated, and places of safety need more leeway on accepting individuals who have consumed alcohol/ drugs. In Lewisham, they said that people have been refused a Place of Safety in another borough if the ones within their own borough are full, and instead have been detained in a police cell until a health-based place of safety in their borough is free.

Conveyance to places of safety

In Lewisham, the groups felt strongly that it should be an ambulance, stating that they 'don't know why the police come'. In Luton, there was not a definitive 'no' to conveyance by the police, and attendees

[18] It should be emphasised that there is no financial gain to the police in making Section 136 detentions and in fact this is a use of police time and resources.

were aware that ambulances were not always safe environments. It was felt that it needed to be a case-by-case decision about the most appropriate vehicle, depending on the situation. Some objected to the term 'removal' to a place of safety.

Extending S136 to people's homes

Views were mixed about whether Section 136 should be able to be used in the home. Some said they supported Section 136 being used in the homes because this could save lives, but there were concerns over how the powers would be used. There was strong resistance to the Police alone having powers to remove someone from their home, and some said this should only occur if an AMHP or paramedic is also present. Several said that the powers are already misused, so if the powers were extended to the home, there was the possibility of misuse here. Others said that this should only be possible if the person was removed to a health-based place of safety, and never to police custody.

In Lewisham, one table felt that Section 136 should not be extended into people's homes as it is an intrusion on people's privacy, and it was also felt that this power would be abused by certain emergency services in order to detain a person.

Individuals were more inclined to agree that there needed to be powers in people's homes in an emergency situation if there was an assessment made by a qualified mental health professional that it was necessary, perhaps requiring authorisation by a more senior person, and only if the person was at imminent risk of harm.

In Luton, one person proposed a new role be created for a mental health assessor to be available 24/7, to accompany police, and be trained to cope with all situations. Another suggested a specially trained 'safety officer' to accompany AMHPs, rather than the police. In Lewisham, one group said that it should ideally be the GP in the person's home, as they would know them, and one table said there should be a new 'fourth emergency service' with specially trained paramedics, police and AMHPs, and that a unit of trained paramedics should be created who were trained to handle violent people. One said that this team could include a community advocate who could help the team to interact with the community. Several people agreed there should always be an available and trained on-call AMHP to accompany police to ensure the police are acting correctly.

In Lewisham, one table agreed that how a Section 135 order was carried out was very important – that the process for how it is implemented should take into account the sensitivities of the person and the situation. Some said that having a health professional involved early on could help to identify alternatives to detention and prevent the need to detain them, such as GPs signposting people towards 'talking therapies': however they felt that budget cuts to voluntary services were reducing the options available. One group said that more street triage teams are needed within communities to be able to assess a situation when it happens.

Extending powers to other professionals

In Lewisham, one person said they felt that Section 135 warrants were 'criminalising' because of police involvement: one person said that a uniformed person makes it worse and the approach should 'start from the standpoint of a gentle person', feeling that 'the police is for force'. There was quite a lot of support in both workshops for extending powers to other professionals, particularly health professionals and AMHPs, though one table in Lewisham felt that AMHP's should not have the power to remove people from their homes[19]. In Luton, the groups thought that qualified mental health professionals should be upfront in the process, such as in triage schemes. Some said that mental health nurses should have more powers and training, especially as they can often be assaulted by patients and that many mental health nurses are themselves BME individuals.

[19] AMHPs have this power under Section 4 of the Mental Health Act 1983.

In Lewisham, one group thought having doctors and AMHPs and medically qualified persons would be 'more humane' and 'gives us back our human rights'. They thought health professionals would have more empathy, and would 'know what to say', but some had concerns that a health professional may know the person's history and might use this 'historical' knowledge to bias their judgement, failing to be objective and to react to the current situation as it presented itself. One person said that this would mean they wouldn't use police so much but would be 'using health professionals to do a police role'.

Maximum length of detention

In both workshops everyone agreed that 72 hours was far too long. It was thought that maximum length of detention should be lowered from between 12-24 hours, to take in to account that time may need to be allowed for individuals that may be intoxicated to sober up. In both workshops, some people said an assessment should be carried out within 4 hours.

Misuse of Sections 135/136

There was considerable discussion about this at both workshops, with many attendees feeling that the police do misuse their authority, including 'tricking' people to go outside so that Section 136 powers can be used. It was felt that the police also detain people unnecessarily under Section 136 when the situation did not call for it.

In both workshops some people said this was due to fear on the part of the police, and that the police over-reaction to the situation due to a lack of knowledge and understanding. Both groups in Luton and Lewisham felt that, although they were in a minority, they get disproportionate attention from police. In both workshops, people felt there was a 'big, black and dangerous' perception of African-Caribbean people and that the police often perceive them as aggressive, fail to understand cultural behaviours and attitudes, misconstrue shouting and gesticulation, and mistake innocent situations for mental health problems. One person said that religion (such as praying aloud) could be misinterpreted as becoming psychotic.

In Lewisham, one person said if the police found out about a mental health problem (even based on old information) their attitude changed completely and they treat people as dangerous and threatening. Both workshops said that the police can take a heavy handed approach, individuals do not respond well and this leads to situations escalating unnecessarily. One person cited an example of a person hoarding possessions, who got upset when the police came in and was provoked: in their view the police over-reacted by detaining him. They felt that training needs to incorporate understanding of how individuals express themselves differently.

In Luton, it was felt that there needed to be a clearer definition about what mental health is, and is not, so that the right decisions are made about detention, and to ensure the right onward care pathway. In Lewisham, one group felt that communications between social workers and AMHPs and police need to be much clearer especially in terms of risk and using 'labels' for people which can be misunderstood by people who are not health professionals.

One woman in Luton said that, in her view, Section 136 was part of a longer history dating back to the era of slavery, lunatic asylums, and the Poor Laws. In Lewisham, one person felt that there was a correlation with Section 11 of the Local Education Act excluding black pupils, who then became over-represented in prisons and mental health services.

There were several examples given in both Luton and Lewisham of encounters with the police in mental health or stop-and-search situations which were seen as unhelpful, especially for a person experiencing a psychotic episode. One woman said her son had just been released from a psychiatric unit when the police came and knocked her door down and took him to custody for an alleged offence, without explaining why. A number of others indicated they were aware of other examples of these kinds of behaviours by the police.

It was thought that particularly with intoxicated individuals, the police did not give the benefit of the doubt to an African/Caribbean individual in the same way they would for a white person.

In Lewisham, one table said that the police were 'not sympathetic' and treated people 'like an escaped convict'. The groups generally agreed that the police handle people 'badly', mentioning instances of being stopped and having background checks done, or being searched, and that this makes them feel unsafe and defensive towards police officers[20]. One person said they resented having to pay money to the police via Council Tax.

Some said that health professionals were more likely to prescribe medication and that enforced medication was more likely to be used for the African/Caribbean community. Some said that this was driven by pharmaceutical companies. There was a perception that mental health is a money making industry.

How to address over-representation of BME in S136 detentions

In Luton, several people said that more help is required, before reaching crisis point. It was felt that when black individuals ask for support, they are often turned away. The groups also felt there needed to be a grassroots approach to rethinking the way that mental health situations and assessments are approached, not just in crisis situations but more widely, and to change the existing structures to ensure that the right people are in the community and can be integrated. People being released from prisons and other institutions who were unable to cope was seen as part of the problem.

In Lewisham, the groups felt that there should be an advocacy role for someone from the BME community to represent the person detained, who had the experience and understanding to help to train police.

Police officers' training was a key theme across both workshops, with many saying police needed to be more sensitive and professional, with a better awareness of cultural differences, with training provided by communities to help the police to appreciate cultural differences. Many said that police officers did not receive enough training, but that this could vary between police forces. They need to understand and be able to recognise when a person is terrified and unable to respond to them. Training needs to be up to date, mandatory, and with regular refresher courses. One person in Lewisham said the police need separate, independent, regular supervision with sanctions for police officers who misuse their powers. Restraint was also an issue, and people said the police needed better training on restraint and to understand that using restraint on a person who was taking anti-psychotic drugs, or who had learning difficulties such as autism, could be dangerous, and that mental health issues often coexist with physical health issues which could make restraint more dangerous for some people. It was highlighted that the Police are trained to use restraint techniques for criminals, and these were not appropriate for those with mental health issues. In Lewisham, one group talked about the police 'dragging a person out of their house by force' and that this had a traumatic impact on the whole family, who felt guilty and wished they hadn't called for help.

Both workshops thought there needs to be accurate recording of incidents and exactly what happens i.e. a log by the officer including times, dates, action taken – to allow for more accountability. There was a clear call for more scrutiny and accountability, and sanctions against police officers found to be misusing their powers. In Luton, some said that the use of body warn cameras would help, and would build trust amongst the community. In Lewisham, the groups said that recording of Section 135 and 136 detentions by the Police needs to be more robust and detailed, and be made available for scrutiny by the community.

Several said that there needs to be better access to individual's records, so informed decisions can be made. It was highlighted that there needed to be 24/7 access to this information, and, in general, 24/7

[20] These issues were more to do with police Stop and Search powers than the use of Section 135 or 136.

access to mental health services. Some said the police were being called upon because of a backlog in mental health services and cuts in services.

Visits to explore regional variation

In order to explore local variation in the numbers of Section 136 detentions, in urban and rural areas, and understand some of the difficulties and good practice, a number of visits were carried out by the project team in June and July 2014. The visits were to:

- **Sussex** (high use of S136, semi-rural)
- **Devon and Cornwall** (rural, high use of police custody)
- **West Yorkshire** (mixed urban (Leeds) and rural, lack of places of safety, high use of S136 and police custody)
- **Hertfordshire** (rural, low use of S136)
- **Merseyside** (urban, low use of S136), and
- **Kent** (mixed with urban areas, fairly low use of S136, cited as area of good practice in HMIC report)

Examples of areas with high use of Section 136 and police custody were Sussex, and Devon and Cornwall, where the review team particularly explored the reasons for this:

Sussex

The project team attended the local multi-agency Mental Health Act Monitoring meeting and went on to visit the local health based place of safety at Eastbourne District General Hospital, and the local police custody suite at Eastbourne.

Key points made were:

- They hold a quarterly multi-agency meeting to monitor the uses of Section 136 and the use of paces of safety, with good local data available. The meeting is chaired by the Head of Social Care – Specialist Services for Sussex Partnership NHS Foundation Trust, and attendees include representatives from A&E, acute services, the ambulance service, the mental health trusts across Sussex, and the mental health police liaison officer. Topics of discussion include the monitoring (and looking at the figures) of S136s, conveyance issues, serious incidents (including “near misses”), the street triage pilot, beds/availability.

- The number of Section 136s is going down. Over the last 4 years it has decreased from 1,923 to 1,447 – although this is still high nationally. The view is that the Police are being more scrupulous in the use of their powers. They have seen a reduction from 56 to 21 in the number of young people detained in custody over the same period. They have been looking in to utilising other options such as protection orders.

- The main reason that police custody is used is because the health-based place of safety is often full and can only take one person at a time. There have been discussions about looking at options for non-statutory ‘safe houses’ and if this could be piloted. The concern is that the police would still be expected to stay with the individual.

- The triage pilot has been successful. In Eastbourne, they have for the first time seen the health-based place of safety take more S136s than custody in the last quarter. In areas which do not have triage, more people detained under S136 go to police custody than health-based places of safety. They have so far done 223 assessments via triage and believe they have avoided 89 Section 136 detentions. There have been more calls to people’s homes than initially envisaged, rather than public places. Relationships between health and police staff has grown, with a better understanding of what is entailed with each other’s roles and the demands on services, including

good information sharing. They felt it is key that the triage is managed through the Crisis Resolution Home Treatment team (CRHT) so the triage team therefore has direct access to services.

- Although the Ambulance protocol has now officially been signed up to and agreed, in practice this is not happening. Use of private ambulances at cost to the trust has to be routinely used. Ambulance services highlighted that an ambulance not often a safe environment for an individual in crisis, and SECAMB (South East Coast Ambulance Service) do not have any secure vehicles. If they are supposed to be transporting all Section 136s the right commissioning needs to be in place.

- Police appear more risk averse than health professionals. This is where triage is working well. If the nurse says they are happy to leave someone, the police are happy to then leave the individual. Police are not health professionals, it's not possible to train them when to leave someone. If the triage were not to continue, likely you may see Section 136 figures start to rise again.

- There are difficulties getting warrants for S135. The process to pay for the warrant has got more and more difficult over time. It used to be that you paid in person, then it changed to cash only, and has now moved to a telephone credit card scheme via a call centre in Liverpool which is not available 24/7. This causes significant delays out of hours and relies on health professionals using their own cards for payment and claiming back.

- High numbers of Section 136 detentions are due to the popularity of Beachy Head as a well-known suicide spot, and partly due to good quality data. They felt that some other areas were not accurately recording their data, as there is no statutory duty to do so, and so appeared to have much lower numbers. They also felt that they had to use Section 136 in order to access mental health services, because if the individual was willing to go to hospital voluntarily, the place of safety will not accept them, and that this was a driver of S136 use.

- The average length of detention was 10 – 15 hours and would support reducing the maximum length of detention to 24 hours, in order to encourage health to respond more quickly. They thought some delays were caused by having to find two Section 12-approved doctors to undertake the assessment, and thought that allowing other qualified individuals to assess could be helpful, especially as nurses are now very highly trained.

- Discussions with CAMHS about whether they could provide a place of safety for under-18s have suggested that CAMHS do not believe their facilities are the correct place to have a place of safety, see it as 'medicalising' the issue and almost go as far as indicating they think police custody is preferable to a health-based place of safety.

- They thought there was a need for clarity about what can be a place of safety and whether a whole hospital ward could be designated as a place of safety.

- The Section 136 suite could accommodate one person at a time. It consisted of two linked rooms, the outer one with a desk and chairs with CCTV for the MHP to observe the individual, and resuscitation/emergency equipment. The outer room could be entered into via its own door from outside, not via the main entrance and ward. The door between the rooms could be locked from the outer room. There was a glass window to view the other room, and external window. The patient's room had a sofa bed and chairs, magazines, and an en suite wet room. All facilities were appropriate for the safety of the individual, such as heavy furniture that could not be lifted, rounded corners, no taps in the bathroom. They said the television had been removed because it has previously been smashed and they could not afford to keep replacing it. Both rooms had doors onto the corridor. The patient would initially be accepted by a charge nurse/band 6 or higher nurse. They would then be observed (continuously), likely by a Band 2 nurse. The staff are taken from the ward, not separately funded.

- The main reasons for excluding individuals were because they were already full, if an individual was deemed too violent to be safely accommodated there, or if intoxicated. Reasons for not accepting intoxicated individuals was that once sober, may find there is not an issue, or that whilst they are sobering up, it puts the health-based place of safety out of use for any other S136s that may arise. The police also said that the health-based place of safety has sometimes refused to take a person on the basis that someone is a smoker and they do not have the facilities (police are also not able to permit people to smoke), and that sometimes because the person was 'messy' the health-based place of safety did not like to take them, despite having en-suite shower facilities. One example given was an individual in custody who had covered herself in blood.

- Eastbourne Custody is a purpose built custody block (rented from Tascor) and is more spacious than other custody facilities. It has shower facilities at the end of each wing, and an outdoor exercise area. Other custody facilities such as Hastings are in old buildings with no natural light in the cells and much less spacious. When an individual is taken to custody, they are booked in like anyone else brought in to custody on criminal charges but they are not required to provide fingerprints. This can be a very intimidating experience.

- The cell used in preference for detaining someone under S136 varies slightly from the rest of the cells: a black line is painted round the wall (found to be calming and helpful to those visually impaired), the raised bed area (with a thin plastic mattress) is slightly higher off the ground, and the intercom is next to the bed area rather than at the door. All the cells are designed for safety and to prevent the possibility of self-harm, with taps removed, no plugs in plugholes, and special blankets and clothing that are rip proof. People detained will be checked on a 30 min basis, unless it is deemed necessary to have an officer observing at all times for the individual's safety – this is hugely resource intensive.

Devon and Cornwall

The project team visited Devon and Cornwall Police Headquarters, and went on to visit the local health based places of safety at Wonford Hospital, Exeter, and the Glenbourne Unit, Plymouth, and the local police custody suites at Exeter and Plymouth.

Key points made were:

- Devon and Cornwall have high numbers of Section 136 detentions: various reasons were cited including being risk averse in finding other options, needing to S136 a person in order to access mental health services for them, a lack of training and understanding of what mental health is and so a high proportion of 'inappropriate' detentions, an assumption that anyone threatening self-harm should be detained under S136, that they have a large transient and tourist population, that being at the 'end of the line' increases the number of people with mental ill-health, and that people sometimes travel there to attempt suicide because they remember holidays there. They also said it was linked to the high number of bail hostels in the area, and having a lot of veterans and older people with dementia.

- Each health-based place of safety (in Exeter and in Plymouth) could accept one person at a time, and were often full, meaning that people went to police custody instead. 70% of S136 detentions go to police custody in Exeter. It was mentioned that last year Cornwall's health-based place of safety was closed for months for refurbishment because the hospital did not pass fire regulations, and no health alternative was provided, meaning that all S136 detentions were taken to custody instead.

- Both places of safety are adult-only and there is no facility for under-18s in Devon. Exeter said the reason why it therefore could not be used for under-18s was because the staff are not trained for this and it would need to be staffed by CAMHS to do this. CAMHS is a different provider. For

17 year olds transferring to adult services, they will try to take them. They find it difficult to engage with CAMHS. The small number of under-18 year olds being detained under Section 136 would not warrant purpose built facilities, and even if there were to be just one for all of Devon and Cornwall, this could involve lengthy travelling distances.

- The health-based place of safety in Exeter had problems with staffing levels which led to it being closed on occasions. They do not have dedicated staff and have to take staff off the main ward, so if there is an incident on the main ward, the S136 suite cannot be used. Plymouth health-based place of safety has dedicated staff, but they are not nurses, and so police must stay with an individual when taken there. In Plymouth, mental health assessments are normally conducted within 2 hours. The Plymouth facility has a separate entrance from the main unit, en suite bathroom to the patient's room, comfortable chairs (but no bed, due to quick turn-around time of the assessments), a projector for individuals to watch TV/film (often a welcome distraction that is not available in custody), and a secure outdoor area that allows individual to get air and/or smoke.

- Plymouth health-based place of safety used to breathalyse people but would now take a more flexible approach. However, the health-based places of safety regularly refuse people on the basis of violence, even if it is a historical incident 10 years ago. Waiting more than 24 hours to have an assessment was common, but rarely up to the 72 hour maximum.

- Several police said there were issues about contrasting organisational cultures between police and health services. The police cited examples of health calling them to come and '136' someone rather than seeing it as a health issue. Feeling is that the police are very risk averse due to a fear of IPCC investigations into deaths following police contact, hence their high number of S136 detentions, but do not feel there is the same level of accountability in health services.

- Police felt that AMHPs often prioritise cases in the community over S136s, as it's thought, that they're somewhere safe, so respond to the community issue first. The police said that keeping someone in custody can often exacerbate a person's anxiety and their mental state can worsen quite quickly.

- Although most police agree that custody is not the right place to take someone at the point of mental health crisis, the operational repercussions of removing police stations as a place of safety would likely make the situation even worse both for the individual and the police. They struggle to get individuals taken by the health-based place of safety, particularly regards intoxication and violence (or history of), and it is with even more difficult for children and young people with CAMHS. Some said that the vast majority of those held in custody had an element of violence, so reducing the use of police custody only to those who are violent may not bring numbers down. However, others said this was only a minority of cases: one said that 80% of people brought in to Exeter custody on S136 were not violent and would not be a risk to a health setting, while only 1 or 2% were of such a high risk to themselves that they needed a constant watch.

- Street Triage (having a mental health nurse in the police Control Room to offer advice) was seen as being very beneficial, with better access to information across agencies, cross-training between health and police, and signposting towards alternatives to custody. This should help to reduce inappropriate use of S136 detention.

- In Cornwall, the figures average about one S136 detention per day, and it is estimated that 50% of these are inappropriate, so they are currently piloting a process where all decisions are run past an inspector before decision to detain under S136 is made. These inspectors have been given more training to try and look at alternatives to S136 for these type of incidents. They have calculated that it costs £1544 for health to undertake a MH assessment – if 50% of their S136s are inappropriate and could be averted, this could be a huge cost saving.

- Sometimes they are holding people illegally in police custody while waiting for mental health assessments to be carried out, or waiting for an acute bed to become available. Examples are when an individual brought in for a criminal offence appears to need a mental health assessment but the original offence is dropped, or when a person in custody has received a mental health assessment and needs to be further detained in hospital, but no bed is currently available and the paperwork to section the person cannot be signed off until it is known where they are going to.

- At the time of the visit, one man had been held in Custody for five days altogether, and for three days since the mental health assessment decided he should be detained under Section 2 of the Mental Health Act, but no acute psychiatric bed had been found to transfer him to. Another man was in Plymouth custody suite who had been arrested originally for an offence, but it was decided that no further action would be taken. He had had a mental health assessment and decided to admit him to hospital, but he could not be formally sectioned as the paperwork was not signed off and no bed had been secured. The police were not in a position to release him, and were holding him in the knowledge that was likely to be an unlawful detention, but for the individual's and public's best interests. They were also unable to administer the prescribed medicine for him even though they had a mental health nurse present in Custody, because the police would not restrain him for the purposes of sedating him and the nurse felt it unsafe to attempt to administer the medication without restraint. The ambulance would not transport the man to hospital until he had been sedated.

- The police said they would never release a person from detention before they had received a mental health assessment even if the situation seemed to have changed, citing the case of Mr Legowski in 2008, an 88 year old man with dementia who had been released by the police following a mental health assessment, and was then found dead in a field[21]. The IPCC investigation found that the police should have done more to help him. This was given as an example of where there can be miscommunication between agencies and whose responsibility these cases fall under

- There were difficulties with getting Section 135 warrants because a lot of magistrate's courts are closing so getting the warrant is more challenging, especially out of hours.

- In terms of alternative places of safety, the police said they had good links to local voluntary organisations and that the Salvation Army was availability to take 40 people, and were sometimes used as a place of safety.

West Yorkshire

- Leeds police have monthly meetings with the health-based place of safety to review s136 activity. There are also quarterly multi-agency S136 meetings. There is a Yorkshire and Humber Mental Health Improvement Group co-chaired by Yorkshire Ambulance and NHS England. They currently have street triage in Leeds, and are looking at possibility of introducing it in the other districts. Police thought that street triage was drastically reducing the number of s136s in Leeds. Previously, many were being released straight away after assessment at the place of safety.

- The health-based place of safety in Bradford is linked to five CCGs, so there are complicated commissioning arrangements. AMHPs are based there 9-5, Monday to Friday. An out of hours emergency team is based off-site.

- Individuals are identified by police or ambulance – the majority are identified by ambulance, who then refer to the police to detain them. Police will do an assessment with paramedics, then call the single point of access at the Leeds health-based place of safety, where a referral form is filled

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

out and passed to a clinician. The person is then brought into the centre via an entrance at the back of the building.

- The health-based place of safety normally will not accept anyone who is violent or intoxicated. They said that if more than two police officers are needed to manage someone, then normally they will ask the police to take them to custody. They may go to custody to see the Forensic Medical Examiner prior to being transferred to the health-based place of safety. If the person is intoxicated, the police usually take them to A&E. The health-based place of safety said that it wasn't staffed to nurse someone while they sober up. Police will normally remain with the person in A&E until they are fit for admission to HBPOS. The health-based place of safety suggested that there should be clear guidance on what constitutes exclusion from HBPOS for intoxication as this covered a broad spectrum of cases. They felt that there shouldn't be a set threshold for admission/refusal. It needed to be judged on a case by case basis as there were other factors to consider.

- The health-based place of safety is setting up a Crisis Assessment Unit where police can take people without detaining them under S136 (voluntary attendance). For people that are intoxicated, it will provide more space for them to sober up and get proper assessment.

- Police said that they should have a Service Level Agreement with the health-based place of safety setting out when police can leave. The HBPOS in Leeds said that it had reduced waiting times for the police. They are working hard on educating staff on not keeping police waiting around as care support. They have a target of less than two hours. Police records show average officer time between the point of detention and the officer resuming duties is just over 2 hours. In Bradford, the protocol is for assessment to happen within 6 hours of police arrival. From the police perspective this is too long and they are pushing the mental health trust on this. Police records show the average police officer time dealing with a S136 detention using a health based place of safety is over 5 hours (from point of detention under S136 to an officer resuming from the incident).

- The police were clear that they wanted police custody removed from the legislation as a place of safety. They thought the term 'exceptional circumstances' (as set out in the Code of Practice) was too open to interpretation by health partners. Police cells are not suitably equipped for those with mental disorders.

- In some cases the police reported that arresting the person for breach of the peace was necessary in private homes. The health-based place of safety supported the idea of extending police powers under S136 to include private premises, so that police wouldn't have to use breach of the peace powers to gain access. But they felt the codes of practice would need to be clear about when S136 could be used in this way.

- The Yorkshire Ambulance representative noted that paramedics couldn't currently access the street triage contact centre – it has to be police. This was important as access for paramedics could help prevent police involvement. Health partners felt that S136 powers could be extended to paramedics, though they would need additional training in place for this to work effectively and to manage risk. Police felt S136 powers should be extended to paramedics. Where the individual is compliant there is often no need for the police to be involved. They felt ambulance services should manage the risk in these types of situations and decide whether the police need to be involved.

- Prior to November 2012 police did all transportation. Ambulance are now reaching their attendance time targets in approximately 80% of cases. They are collecting data on police contact with ambulance service and ambulance response times in S136 situations to understand the issue better.

- Redressing responsibilities with health partners was a clear issue for the police. In one area, Bradford police were very clear that the HBPOS was not meeting its responsibilities, consequently police were having to pick up the pieces. Police have a strong, open relationship with the MH Trust. However, getting the CCG to prioritise the issue of resources is a real issue. They felt the Yorkshire and Humber Mental Health Improvement Group was moving things forward too slowly.

- The health-based place of safety do not have enough resources, which means that police time are spending long periods waiting and/or police cells are being used too often as the place of safety. Both police and health partners said that the 136 suite was not sufficiently staffed with AMHPs and consultants to run effectively. As a result, roughly two thirds of clients are taken to police custody. The HBPOS are looking at taking the issue to the CCG. Police would like to see something similar to the RAID (Rapid Assessment, Interface and Discharge) model which has been developed in Birmingham. The model provides specialist multi-disciplinary mental health support for people presenting at A&E. They work closely with hospital psychologists, substance misuse practitioners, and acute hospital clinicians. They suggested that commissioners could use HBPOS as triage into wider services such as drugs and alcohol.

- Need better training for the police to enhance patient care. They are looking at introducing bespoke training for officers.

- Police said that getting hold of health information was an issue. Street triage was helping with this in Leeds but it was less effective across the other districts.

- Police said that they shouldn't really need to be involved in every section 135 situation[22].

Hertfordshire

- Hertfordshire reported a very low number of section 136 detentions in comparison to other forces 336 last year. They expect more this year as there is growing awareness among police of mental health issues. They only work with one mental health trust - Hertfordshire Partnership Foundation Trust (HPFT) – this was felt to be beneficial. Police and HPFT meet on a regular basis to discuss s136 activity. They are now setting up a S136 inter-agency working group to take this forward more formally.

- Hertfordshire has four health-based places of safety in total. We visited the new S136 suite which is set within a new HPFT centre for mental health and learning disability. It has three beds, and can manage four S136 assessments at any time. There is a dedicated place of safety for under 18s. They also have a secure facility which is equipped to admit violent people and the staff are trained to manage violent behaviour and trained in restraint.

- In Hertfordshire, police custody is not used for S136 detentions as there is sufficient health provision. However, police felt that it should be kept as a place of safety in law as a back up in exceptional circumstances.

- In cases where the person is intoxicated, police are asked not to bring them to the health-based place of safety, but to take them to emergency departments and wait with them until they are fit to take to health-based place of safety. It was felt that there's not enough guidance on intoxication. Similarly, if a person has a physical injury or physical health issues, they will be taken to A&E first to ensure it's safe to proceed to admission at the health-based place of safety.

[22] It is required by law for the police to be involved in carrying out a S135 warrant.

- The HPFT suggested that law could be changed so that A&E could be used as a place of safety[23]. This would allow the initial mental health assessment to happen at A&E.

- In the health-based place of safety, the police bring people in through a secure gated access at the back of the building. A Band 6 Junior Sister will do an initial risk assessment to see if they need the police to remain, a one hour target for officers to leave is in place unless there's a serious concern. If necessary, the band 6 will ask for a full clinical assessment. Approximately 40% of those admitted to the HBPOS are referred for full clinical assessment.

- Health staff felt that 72 hours was a good length of time to allow for comprehensive assessment to take place. If, after the 72 hour assessment period, they decide that a person needs acute care, they can take them to the main ward, where there are additional S136 beds.

- The police officers spoken to felt that it would be helpful if S136 were to be extended to apply in private premises. The police also thought it would be useful to be able to de-arrest someone before they are assessed at the place of safety[24].

- The AMHP estimated that they use approx 10-20 S135 warrants per year. Decisions about using S135s are taken with great care and warrants are seen as an absolute last resort. The first step is to carry out a risk assessment on the individual. This is sometimes carried out on the doorstep without police involvement. A key challenge is getting relevant partners together to operate S135s. HPFT has a scheme with local social services to ensure warrants are paid for.

- A key issue is police access to health information. There is now an information sharing protocol in place and secure email set up so police can access certain mental health information. The police and HPFT also share their assessment forms. New software enables better case management and data collection on a range of issues. There is potential for police and health to use this to create robust care plans for individuals to prevent repeat S135/6 detentions.

- The police noted that there was frequently a safeguarding element to mental health cases. They currently have a Multi-Agency Safeguarding Hub for children and they are exploring the possibility of having one for adults. This would improve information sharing and case management across local agencies.

- Police and health partners are looking at ways for assessment to happen earlier in the process, which would reduce impact on police time and resources e.g. street triage. The HPFT thought having a dedicated triage car might not be the right model for Hertfordshire as there wouldn't be sufficient demand. Having a health professional available on the phone would be more beneficial.

- The key challenge from a police perspective was a shortage of AMHPs to carry out assessments at the health-based of place of safety, which causes a delay in completion of risk assessments. This is a particular issue during out-of-hours. Transportation from the health-based place of safety was also a challenge as the facility is extremely isolated and there's no agreement between the police and HPFT over who should transport.

Merseyside

- Merseyside Health and Wellbeing Board will bring trusts together to agree a local concordat declaration. Mental health triage is in place across the Merseycare footprint (covering Liverpool, Sefton and Kirby). It uses a wide cadre of trained officers – the force would prefer a more

[23] In law, an emergency department can be a place of safety.
[24] If the person no longer meets the threshold for S136 detention ('mentally disordered and in need of care or control'), and the police consider it safe to do so, then the police should discharge them.

dedicated resource, but needs to spread resources more widely due to shift patterns. (The other MH Trusts are '5 boroughs' and Cheshire and Wirral) Merseycare provides the training for appropriate adults - the Local Authority no longer provides them. RAG assessments have led to 9½ hour delays for assessments being reduced to 2hrs 50. Over 600 assessments are conducted each year. However, the MHA Code of Practice guidance around joint assessments causes problems – doctors are often available before the AMHPs are.

- Liverpool City Council has seconded 47 staff to Merseycare. 39 are social workers, some others AMHPs. The AMHPs are made up of social workers, psychiatrists, nurses and occupational therapists. They deal with around four referrals each day, including any mental health act assessment. There is a helpline called 'Careline'. An AMHP hub has been set up, so the AMHPs feel more supported, the service is better known and they can provide a more co-ordinated response.

- Police felt that AMHPs too often put attendance at S136 assessments to the back of their priority list, because the police are there (and they consider the person to be safe). The AMHP role includes duty of care to find beds (for those sectioned) and arrange transport. NWAS will only convey when their risk assessment allows. If they consider too risky, they police have to do that. They would like to see a greater availability of mental health beds.

- The health-based place of safety felt that the Mental Capacity Act sometimes misused by the police, in private places – where it is deemed to be the best option to enable them to act quickly. Around 75% of section 136 detentions do not end with formal admission under the Act.

- The availability of court slots adds to difficulty of getting Section 135 warrants from magistrates. Perversely, it is easier to use the out of hours magistrate. The payment is inconvenient but not big problem.

- GPs are most reluctant to share information when needed. Example given of a woman who keeps contacting the police with threats to self harm and is clearly of concern but GP's won't share any info about her, citing patient confidentiality. It is also difficult to get hold of the right GP when needed and they expect information to be exchanged bureaucratically e.g. by fax.

- There are problems with getting a response for an ambulance from North West Ambulance Service, when the police request it. Around one third of S136 patients are being transported by ambulance.

- Some felt that S136 should not be extended to private places but that it would be good for the S136 power to be extended to mental health staff.

Kent

- Between January - March 2014 Kent have reported an average of 74 S136 detentions per month and between 2013 – 2014 Kent Police detained 1,100 under S136, 30 of which were young people under the age of 18. There are very low numbers for young people detained, and there is no dedicated S136 facility for under 18's because of a commission gap in provision. There is now a joint agreement with Sussex Partnership Trust to use a facility in Dartford, although it is recognised that this is not necessarily suitable, as young people can find themselves far away from their families, friends and school at a time of most need during a mental health crisis. The facilities used for young people are seen as a stop gap rather than a long term facility. They also highlighted that a high percentage of children who are assessed under the Mental Health Act are Local Authority Looked After Children.

- Within the operational boundaries of Kent Police there are three mental health service providers. Two provide care for children and adolescents. They work with one single Approved Mental Health Professional Service (Kent County Council), and one ambulance service (South Eastern

Coastal Ambulance Service). There are 4 S136 suites in Kent so an A & E is rarely used as a Place of Safety unless there is a physical health condition which would need to be dealt with before the patient can be taken to the health-based place of safety.

- Occasionally Police have turned up unannounced or not booked S136 suites and another patrol car may have arrived before them. Officers cite other problems such an AMHP delays, no available beds or either police officer or health staff breach of joint protocols or no suitable or nearby place of safety for young people. Since the end of June 2014 the Kent AMHP Service went operational as a dedicated 24/7 Service. This has improved response rates, although assessments remain protracted due to bed demand.

- If a person is intoxicated the general practice is to accept that person and wait until their levels of alcohol have reduced so an appropriate mental health assessment can be carried out. Kent Police and KMPT do not have a policy of excluding someone who is intoxicated. However, this can impact on resources and cause significant problems. KMPT does have a Dual Diagnosis Policy with Substance Misuse Agencies across Kent.

- Child and Adolescent Mental Health Services are provided by the Sussex Partnership Trust. There is no S136 suite in Kent for under 18's. There is now a commissioned S136 suite in Dartford and children no longer have to go outside Kent for an assessment, so either Dartford is used or another supplied by SLAM (South London and Maudsley Trust) who assist with a place of safety for young people although they are not commissioned to do so - however the Bethlem Hospital in Beckenham is normally used for young people. There are plans to commission a suitable 136 suite for young people as the lack of accommodation is causing resource implications for police and the young person and their families. Numbers of young people being detained is low but issues tend to be attempted suicide or signs of being extremely disturbed. Assessments for children can be protracted at times due to a delay in getting CAMHs doctors to attend on site.

- Health professionals that we met felt the maximum 72 hours should be reduced to 24 hours: however one AMHP felt that 72 hours was necessary to carry out a full assessment especially in the case of intoxication. This was not widely supported by other Mental Health professionals. The police felt this could carry risk if the holding power is reduced considerably, if an assessment conclusion were not reached and there is no holding power, there would be little services could do, other than use the MCA is applicable. A wholesale reduction in the holding power must be carefully thought through…as 24 hours could be problematic and the national bed situation is unlikely to change.

- Generally the feeling was that there should be more flexibility in interpreting the definitions of private and public places. They cited a case of having to wait a week to gain a s135 warrant.

- Kent is looking into using unmarked cars for travelling to properties where there is a S135. There are the usual problems of obtaining warrant and gaining entry to properties when there is a mental health crisis in a private abode.

- There are good examples of partnership working with the three Health Trusts and ambulance services. Kent shares its children and young person's mental health service with Sussex Partnership Trust. However there are examples when joint protocols are breached by either health or police partners causing issues such as the health-based place of safety not being booked ahead of bringing a patient to the suite. While the number of 136 patients transported in an ambulance is improving there are still instances when the patient it transported in a police car.

- Kent has a Street Triage scheme and a dedicated 863 telephone number, which gives police officers the advice and the information they require when considering a S136 detention. In one custody suite the NHS mental health nurse works 9 to 5 with access to NHS patient records but

outside these hours the custody nurse employed by Kent Police and would not have access to this patient information.

- The triage pilot is funded jointly by Kent Police and Commissioners and is provided by KMPT staff. It has brought together the police and health professionals

- From the 1st of April 2014, the Triage scheme ran with one police officer working from 18.00 to 02.00 Thursday, Friday and Saturday from a Mental Health car reporting to St Martin's Hospital and a mental health nurse to work alongside the police officer. From the 1st July KMPT the street triage was extended to seven days a week.

- Key challenges include providing long and short term solutions for health-based places of safety; providing better solutions for young people (even though numbers are low); exploring contingency plans for scenarios where no beds are available for longer term admissions; ensuring that KMPT and police staff understand the distinction between intoxication, drunk and incapable and what the best health care intervention is for that person; sharing information between agencies on request; creating a mechanism for repeat presenters and developing protocols to share this information; revising the 136 policy and joint working agreements; reviewing the current bed situation and evaluating or resolve it where insufficient, and having a range of commissioned alternatives to admissions.

Annex C: Academic roundtable event

On 25th April 2014 an academic roundtable was held for the review. The group was asked to consider what the Literature Review and their own research indicated about the use of Sections 135 and 136 of the Mental Health Act 1983 and the issues faced by the police and health agencies, how specific groups (BME groups, children and those with complex co-morbidity) might be affected. The group then discussed possible solutions to the problems identified and made suggestions.

The roundtable was attended by:

Prof Louis Appleby (Chair), University of Manchester
Prof Jill Peay, London School of Economics
Professor Gillian Bendelow, School of Applied Social Science, University of Brighton
Professor Phillip Fennell, Professor of Law, Cardiff University
Aileen O'Brien, St George's South West London and St George's Mental Health Trust
Dr David Ndegwa, South London and Maudsley NHS Foundation Trust
Dr. Karen M. Wright, University of Central Lancashire
Dr Iain McKinnon, Newcastle University
Dr Jane Senior, The University of Manchester
Professor Ian Cummins, The University of Salford
Dr. Caroline Lawlor, South London and Maudsley NHS Foundation Trust
Claire Warrington, Sussex Partnership NHS Foundation Trust

The main conclusions were:

- The number of S136 detentions being taken to health-based places of safety has increased in recent years, although there is a lack of good trend data over the use of police custody. Some felt that the police are using Section 136 to detain people much more often now, including for people who are intoxicated or 'sad'. There is a need for better data, with regular monitoring of numbers, and characteristics such as ethnicity, and outcome.
- The police need advice to made available to them by health professionals to help them use the powers appropriately (street triage was discussed in this context). National models of joint police/ mental health working, such as street triage, need evaluation.
- The police are often very risk-averse and this can lead to more use of Section 136.
- These days, 80% of Section 136 detentions do not go onto further hospital admission, suggesting that in many cases alternative resolutions may have been a possibility. In the 1990s a much higher proportion of Section 136 detentions went on to be admitted, suggested to some that the police threshold for Section 136 detentions has become lower. Commissioning of broader range of crisis services, corresponding to people's needs, could address this problem of a lower threshold.
- People with mental health issues should ideally not be held in police cells. The long time spent waiting in police cells could worsen symptoms. Police stations could have facilities specifically for people who are distressed and very vulnerable.
- Detaining children on Section 136 is an issue. Police cells should not be used for children.
- Standards are needed to include the time to begin assessment of S136 cases (perhaps within 3hrs), time to disposal (24hrs?) - so no change to law but notification (to CQC?) for any breach of standards.
- There is a broader cultural issue for the police and their understanding of mental health that needs to be addressed. Police training in mental health issues is key to better outcomes for patients. Improved training for police officers is needed, including on personality disorder, BME issues (the College of Policing is reviewing training on this issue).
- Poorer outcomes for BME groups – this needs a different solution. Services to promote community engagement on mental health, particularly in BME communities (though NHS

England), to encourage help-seeking through health services rather than police, as well as on safer alcohol use.
- Multi-agency personality disorder strategy could help to reduce repeated use of services by these individuals.

Discussion of the evidence base and key issues

Trends in Section 136 detentions

The group felt that the evidence showed that the use of Section 136 had increased in recent years, especially after the Mental Health Act 2007 and increased investment in health-based places of safety.

It was reported that population changes (increases and decreases) affected the ability of health agencies to deliver community mental health services.

Looking at the evidence (both research and anecdotal) the group discussed the issue of thresholds. It was reported that there were concerns over a change in threshold leading to high numbers of people being brought in under Section 136, many of whom are not further detained following a mental health assessment by a medical professional. Although national rates of mental ill health have not appeared to double, use of the power has increased in the past decade, although it was widely agreed that the availability of data was poor. It was also noted that the police do not currently record data on ethnicity and sexuality.

Health professionals reported that in the past those who were brought in under Section 136 were generally *very* mentally ill, but that in recent years people were being brought in who were intoxicated and displaying other problems but did not appear to be severely mentally unwell. The group agreed that the threshold issue meant that there was a mis-match between health professionals and the police's perceptions of what a Section 136 case should be.

The application of the power by police was discussed as an issue. It was reported that police selectively use their own biases when deciding whether to use the power, For example, an older person found wondering the streets displaying signs of dementia did not tend to be detained under Section 136 but an aggressive adult male was more likely to be detained.

It was reported that the police's decision to use the power was affected by their perception that healthcare follow up was not happening (it was reported that 83% do not go on to be detained following assessment and only a minority are discharged to a GP). Furthermore, it was reported that the police do not understand what other options are available to them that might be more appropriate than using a s136 and this is because the police are being risk averse. It was reported that one third of police did know of other options for resolving incidents (through the use of initial response teams) but that they were still using this power.

The issue of increasing levels of intoxication leading to a rise in Section 136 cases was discussed. It was reported that in one hospital that sees between 50 - 80 Section 136 detentions a month, over 60% were intoxicated and so were not admitted to the hospital. The group recognised that assessments cannot be completed whilst the individual is intoxicated. The Drunk Tank model was reported as being effective in some parts of the USA to tackle the issue of providing a safe place for individuals whilst the effects of alcohol wore off. It was suggested that whilst there was a lack of evidence which looked at the impact on the individuals of time spent in detention, factors such as passing time, exhaustion and sobering up had an impact on the decision whether to further detain following the use of the power.

Use of police cells as places of safety

The use of police cells has declined in some areas especially where there are good multi-agency working practices. It was reported that there was no variation between urban and rural area of the

proportion of Section 136 detentions that went into custody compared with a hospital or health based place of safety. The group also recognised that there was an issue over the degree to which A&E units were willing to accept a Section 136 detention and even when they did, this impacted negatively on police time as officers were required to wait with the individual for assessment or even wait in the van outside the A&E unit whilst they waited to be admitted into the building.

The group noted there was considerable geographic disparity in approaches and numbers of Section 136 detentions, with good multi agency working in some places, and a lack of health based places of safety in other areas.

Human rights

It was also reported that England is the only country in the EU that uses such a power and this was argued to be contrary to European legislation (UN article 12) which states that individuals cannot be detained for mental incapacity. This raises the question of whether the power needed to be abolished and whether it was appropriate at all.

The question about international evidence from countries where Section 136 or equivalent police powers were not part of the legislative framework was raised. The group pointed to good practice examples from Trieste, Italy.

Police training

The availability, take up and quality of police training was discussed. It was suggested that police training was not sufficient but that equally, police were not healthcare specialists and so it was argued that they did not need more training on understanding different mental illnesses- what they needed was capacity to refer potential vulnerable cases to healthcare professionals, quickly and with the least possible risk. It was also reported that the police were often not as good as they believed in their use of restraint but that nurses were now less willing to get involved in instances of restraint, and were tending to call on the police and so as a consequence, police involvement is increased.

Equality and diversity

The issue of BME representation in Section 136 figures and mental health services was discussed. It was reported that in some urban areas, following an overuse of the power in the 80s and 90s where the police were over-detaining in people from BME communities, police are now over cautious to detain people from BME groups under Section 136.

It was reported that rates of mental illness amongst BME communities were increasing but there is evidence that young black males will come into contact with mental health services through the Criminal Justice System (CJS), rather than through GPs or health pathways. Furthermore, families of BME communities had a role in referring family members through the CJS and that BME groups often used faith teachers before seeking medical help which meant that those from BME groups were presenting at the point of crisis, rather than at an earlier stage. It was reported that this may explain higher numbers of Section 136 detentions as a proportion of population. It was also suggested that those from BME communities were less likely to be intoxicated and more likely to present as psychotic/aggressive, which suggests that the use of the power for this group might be more appropriate.

It was suggested that the role of the police and the experience of the individual at the point of contact with services has implications for their future engagement. This includes those from BME groups. If the first port of call in a crisis is the police this creates the perception by the individual that they have done something wrong. It can also be traumatic and can increase their mental health problem. However, it was also suggested that this still raises the question as to whether it is the power that is the problem, or the experience of the service user which is more problematic. It was reported that following a s136 incident the individual often reports that the decision to detain was appropriate.

The issue of why the power was being used on children was discussed. It was reported that children as young as eight were being detained in health based places of safety. The group offered that this power might be appropriate for those at the transition ages (16-18) but that there needed to be diversity of provision.

Suggested solutions

Following an in depth discussion of the issues and evidence the group offered suggested solutions and made specific recommendations to the review as follows:

- On whether Section 136 is needed at all, it was suggested that the police are good at talking down or de-escalating situations and so problems could be resolved in different ways. It was considered by some that there is still an argument to remove the power completely and that police involvement is objectionable and potentially discriminatory.

- The police often come into contact with vulnerable people and then use the power to convey the individual somewhere else and so the group suggested that this power is still necessary to enable safe conveyance.

- It was suggested that better responses by other agencies and improved inter-agency working may mean that s136 detentions may not need to be used as much. The solution clearly lay with a collaborative approach and improving local commissioning for adequate, responsive crisis care services.

- Schemes, such a street triage were suggested as effective as a different sort of emergency response and can result in a lower use of s136 (which has been reported in some street triage pilot areas).

- On whether the use of police cells was appropriate and whether this provision should be removed from legislation as a place of safety, it was suggested that some individuals are clearly in need of a s136 detention but that there was a huge grey area of those who may require a different response.

- Drunk-tanks were reported to be a good solution to tackling those in that grey area and who are intoxicated and so cannot not be assessed - a model adopted in parts of the USA should be considered.

- Addressing the disparity across the country of the use of ambulances to convey people to places of safety was suggested as a necessary alterative to police van conveyance.

- Improved police training was necessary to reduce the inappropriate use of s136
- On the issue of whether the time limit for detention (of 72 hours) should be reduced, or whether it was appropriate was discussed, the group largely felt that this time period was not arbitrary but was necessary to complete assessments and that there would be a risk in reducing it as it would place huge pressures on health services and could be detrimental to the individual as the process was not robustly completed.

- The group suggested that statutory notifications should be introduced mandating the Care Quality Commission to look at time spent and time taken for assessment to reduce the risk to the police.

- Use of police cells/police stations: any use of police facilities should carefully consider how ‘mentally ill’-friendly the process and environment is. Police cells should only ever be used in exceptional circumstances, the threshold for Section 136 detentions needs to be carefully assessed and root cause of the rise in detention rates addressed. The group made a direct recommendation that it should be made clear in legislation that no children should be detained in police stations and that more S136 suites should be made available to support children.

- The group agreed that there needed to be enough flexibility in the time limits to move swiftly to the assessment point in order to free up facilities as quickly as possible.

- The group also concluded that further work, research needed to be done to look at the needs of those with complex co-morbidity to ensure that services could flexibly adapt to support their complex needs in a holistic way.

- The group considered ways to support BME groups who were subject to detention under the powers. It was suggested that better engagement of those groups at earlier points in the process was necessary, particularly through joint CRISIS planning to involve the patients in the decision making process. There was recognition by the group that improvements in the responsiveness of crisis care services, improvements in police training and shared decision making in crisis care planning would benefit BME groups, arguing for mainstreaming as well as addressing the specific issues of BME and other diversity groups.

- The group recommended that Section 136 detentions should never be disclosed on Disclosure and Barring Service (DBS) checks completed by the police.

Annex D: Methodology

The evidence-gathering phase of the review included:

1. A full literature review of published evidence relating to the uses of Section 135 and 136 in England and Wales which underwent double-blind academic peer-review. This includes an Annex summarising relevant Case Law.
2. Online survey which was open to everyone in England and Wales between April – June 2014, including in hard copy if needed. Additional submissions to the review were received separately from a number of organisations.
3. Practitioner workshops held around England and Wales in April – June 2014 run by the project team and the charity The Centre for Mental Health (separate report).
4. Visits to areas with very high and very low numbers of Section 136 detentions mainly in June – July 2014 (Annex B).
5. Two seminars on diversity issues held with the charity Black Mental Health UK focusing specifically on black and minority ethnic views on Section 136, held in Luton and London in July 2014 (Annex B).
6. Focus groups and one-to-one interviews with service users, run by the Centre for Mental Health.
7. Academic roundtable event held in April 2014 (Annex C).
8. Written and oral evidence submitted to the Home Affairs Select Committee[25] inquiry into Policing and Mental Health.

Other potential evidence sources explored included Tweets and Blogs relating to mental health, including blogs by mentalhealthcop[26], and report on investigations relating to the police and mental health by the Independent Police Complaints Commission (IPCC)[27]. The CQC and National Policing Lead for mental health were asked to provide any data on complaints which had been made to police, or to health-based places of safety, relating to the uses of Sections 135 or 136 but both the CQC and police informed us that complaints data was not collected in a form which made it possible to search for complaints specifically on detention under Section 135 or Section 136.

Analysis of the online survey

The online survey was available on www.gov.uk from Tuesday 8th April 2014 to Tuesday 3rd June 2014 (8 weeks). It could be completed online, or via downloading and completing a pdf which could be returned by post or electronically to a dedicated email address. Both large-print and easy-read versions of the survey were created and distributed on request. There were no requests for versions in alternative languages. All responses received by email or post within the deadline were added to the online survey for ease of analysis.

Once completed, the survey responses were downloaded for analysis as a spreadsheet. This was divided up by 'type of respondent' such as police, health professional, approved mental health professional and so on. Due to low numbers of respondents in some categories (such as magistrates, where only one magistrate responded), some of the categories were combined to form useful units for analysis (as set out on p.11). Because of the low numbers of some types of respondents, it was not considered useful to analyse them further broken down by categories, for example by age, ethnicity, or location, because such small numbers in some categories would be not permit any meaningful conclusions to be drawn. However, the overall data on age, ethnicity, and other personal characteristics is presented on p.68 – 71.

[25] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/oral/11179.html
[26] http://mentalhealthcop.wordpress.com/
[27] http://www.ipcc.gov.uk/investigations_and_reports

The survey questions which asked the respondent to tick one of ‘Strongly Agree/ Agree/ Neither Agree nor Disagree/ Disagree/ Strongly Disagree/ Don’t know’ for each statement. Tables were created showing the responses received, by type of respondent, and graphs created from these showing the extent of which there was agreement/ disagreement for each statement overall and broken down by type of respondent. These are included in the main body of the report above.

Respondents could also add additional comments into open text boxes for each question. These had unlimited character limits. All these open-text responses were read, and the main themes emerging identified. These themes were discussed and verified between two separate readers. A framework was then developed which set out the main themes and examples of the types of wording and responses considered to fall within that category.

The individual responses were then tallied against these themes to give a quantitative overview of particular views, broken down by type of respondent. For consistency throughout, this entire analysis was undertaken by two people working together, and discussing together any point of uncertainty or where interpretation was needed. These findings form the tables included in the body of the report above. While reviewing comments, any points which did not form part of the overall themes, but which were felt to be important points, were set aside for later consideration as part of the final review report.

To draw out particular quotations for use in this summary of evidence report, a separate spreadsheet was created which included only those people who ticked the box to agree their responses could be used. The responses in the open text boxes in this subset were reviewed and particular comments highlighted for possible use as examples in the report. These were where they illustrated a particular theme effectively, or made a point which had not been picked up as part of the themes which it was felt important to include as a direct quotation.

The selection of quotes attempted to represent the strength of feeling of some respondents over some issues, and to provide a balance of different viewpoints. Although respondents were quoted anonymously, it was felt helpful to specify the type of respondent (for example, AMHP, paramedic) and where the respondent was a police officer, to also specify their rank, in order to give more insight as to the likely experience, professional expertise, and perspective of the person quoted. Where an organisation was quoted, they were named as this provides relevant context for their response, to help the reader judge their likely perspective.

This summary of evidence was reviewed by an invited group of external experts (full list at Annex E) who were asked to comment on the quality of the evidence base presented.

Practitioner workshops, seminars, and visits

27 practitioner workshops, and focus groups with service users, are summarised in the separate report by the Centre for Mental Health. The project team attended four practitioner workshops to speak to police officers, health professionals, ambulance workers, and approved mental health professionals, and made notes of the discussions.

Two events were run by Black Mental Health UK which the project team attended, where notes were taken both by the project team and by a nominated person on each table: these were amalgamated into an overall summary of the discussion, which was shared with participants to ensure that it accurately represented their views.

The team carried out six visits to areas with very high and very low numbers of Section 136 detentions to explore local variation and meet both policing and health professionals. Notes were made of these visits, which are summarised in Annex B.

Academic roundtable

The project team convened a number of prominent academics to attend an academic roundtable event in order to discuss the evidence base. The draft literature review was provided to participants to initiate discussions. The discussion is summarised in Annex C.

Other stakeholder events attended by the project team in the course of the review included meetings of the National Police Mental Health Forum, and the National Police Working Group on the use of restraint in healthcare settings, the Royal College of Policing Section 136 Group, the London Mental Health Partnership Board, and the National Ambulance Mental Health Working Group, as well as individual meetings with senior stakeholders in policing, health, and ambulance services.

Annex E: List of external expert advisers

Several independent subject experts were invited to review this summary of evidence, and make comments. They were offered open access to the survey and original notes and documents. They were:

	ROLE
Lord Victor Adebowale	Chief Executive for Turning Point and Non-Executive Director of NHS England
Mike Boyne	Association of Ambulance Chief Executives
Kim Shepherd	Mental Health Act policy manager, Care Quality Commission
Dr. Julie Chalmers	Chair Section 136 Group, Royal College of Psychiatrists
T/DAC Christine Jones	Metropolitan Police Service, National Policing Lead on Mental Health
Dr. Geraldine Strathdee	National Clinical Director for Mental Health and co-Chair of the National Mental Health System Board
Professor Louis Appleby	Professor of Psychiatry at the University of Manchester and former National Director for Health and Criminal Justice
Sean Duggan	Director, Centre for Mental Health
Clare O'Sullivan	Senior Policy Development Manager – Criminal Justice and Partnerships, The Association of Police and Crime Commissioners
Ruth Allen	Chair of Mental Health Faculty, The College for Social Work
Steven Chamberlain	Former chair of The College of Social Work's Approved Mental Health Professional (AMHP) network
Sarah Yiannoullou	Managing Director, National Survivor and User Network representative
Ian Hulatt	Mental Health Advisor at the Royal College of Nursing
Dru Sharpling	HMIC
Matilda MacAttram	Director, Black Mental Health UK
Morris Arbuthnot	Head of the Royal College of Psychiatrists Service Users Forum

Acknowledgements

With thanks to all who contributed to this evidence base and responded to the survey. Particular thanks to all who attended workshops or talked to us during visits, including:

- Association of Ambulance Chief Executives
- Black Mental Health UK
- British Association of Social Workers
- Care Quality Commission
- Centre for Mental Health
- College of Social Work
- College of Policing
- Devon and Cornwall Police
- Hertfordshire Police
- Glenbourne S136 Suite, Plymouth Hospital
- Eastbourne District General Hospital psychiatric department
- Hertfordshire Police
- Kent Police
- London Mental Health Partnership Board
- London Metropolitan Police
- London Ambulance Service
- Merseyside Police
- Metropolitan Police Service
- National Ambulance Mental Health Working Group
- National Policing Mental Health Group
- Royal College of Psychiatrists Section 136 Group
- Royal College of Nursing
- South Central Ambulance Service
- South London and Maudsley MH Trust and Maudsley Hospital
- Sussex Partnership Trust
- Sussex Police
- Thames Valley Police
- West Yorkshire Police
- Wiltshire Police

ISBN: 978-1-78246-680-2