



Department
of Health



Home Office

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

A Literature Review

December 2014

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

A Literature Review

Executive summary

This Literature Review forms part of the Governments' review of Sections 135 and 136 of the Mental Health Act 1983¹. The main report and other evidence are published alongside this literature review and should be read in conjunction with this Literature Review. This report summarises all the published evidence relating to the operation of Section 135 (S135) and Section 136 (S136) of the Mental Health Act 1983 in England and Wales. It especially focuses on research over the past decade which is of greatest relevance to the review, and includes a discussion of the available data sets on S135 and S136, and a summary of relevant case law.

The relevant sections of the Mental Health Act 1983 are set out in full at Annex A. Section 135(1)² and section 136 (S136) of the Mental Health Act 1983 set out how and when a person believed 'to be suffering from mental disorder' can be removed to a place of safety and detained there. Under both S135 and S136, the person may be detained for a maximum of 72 hours. S136 provides emergency powers for the police to temporarily deprive a person of their liberty, if the person is in a place to which the public have access and certain conditions are met. The police may remove the person if it appears to the police officer that they are suffering from a mental disorder and are in immediate need of care or control, and it is necessary to remove that person to a place of safety in their own interests or for the protection of others. The person is not removed because they are suspected of committing any criminal offence.

In the case of S136, the person must be removed to a place of safety for the purposes of enabling them to be examined by a registered medical practitioner³, and to be interviewed by an approved mental health professional (AMHP) and for any necessary arrangements to be made for their care or treatment. S135 only applies when a person is in private premises, such as their own home. It requires an AMHP to apply to a magistrate for a warrant in order for the police to enter the premises and remove the person. The warrant allows the police officer to enter, using force if necessary, search for and remove the person, in circumstances as set out above, to a place of safety. The AMHP may make a further application in respect of the patient under the Act, or make other arrangements for their treatment or care. A place of safety is defined as being residential accommodation provided by a local social services authority, or a hospital, an independent hospital or care home for mentally disordered persons, a police station, or 'any other suitable place where the occupier is willing to temporarily receive the patient'⁴.

The literature review covers the wider social and legislative context including human rights, published data-sets and trends, who is detained, where they are held, and for how long, issues over diversity and equality, and the experiences of patients and practitioners including relationships between police and health services.

Key Findings

There is strong evidence in the literature for several key findings:

¹ The main report and the rest of the evidence base can be found at:

<https://www.gov.uk/government/consultations/review-of-the-operation-of-sections-135-and-136-of-the-mental-health-act>

² S135(2) permits a warrant to be granted to the police to retake a person already formally detained in a hospital who has gone absent without leave and who is found in private premises. It is not the main focus of this review.

³ It is preferable that this should be a Section 12 approved doctor.

⁴ Section 135(6), online at: <http://www.legislation.gov.uk/ukpga/1983/20/section/135>

1. The number of people being detained in hospitals under S136 has increased considerably since the mid-1990s and especially after 2007, and is still rising. However the trend for people detained in police stations is less clear. No data on this was collected prior to 2008, and even recent data is incomplete, meaning that the trend in the overall number of S136 detentions made is not definite. It is thought that in recent years more patients have been detained under S136, and there has been a shift from the use of police stations as places of safety in the majority of cases, to health-based places of safety located in hospitals.
2. The quality of data overall is poor, especially historical data for people detained under S136 in police stations, the ethnicity of people held in police stations, and data on outcomes for those held in police stations.
3. No datasets or research studies included people detained anywhere other than a hospital or police custody, although the Act permits care homes and some other places to be 'places of safety': this probably means that no use is made of other places of safety, but again this is not definite due to a lack of police recording.
4. Research suggests that the use of S136 powers is highly variable across the country and that large differences exist between different – even neighbouring – areas.
5. The majority of S136 detentions are made outside of normal business hours when some services are not always available.
6. There is a high prevalence of schizophrenia, personality disorders, mania and drug-induced psychosis in individuals detained under S136.
7. People detained under S136 are often white, single, unemployed young men in their 20s, with a diagnosis of schizophrenia and a previous psychiatric history.
8. Black and Minority Ethnic groups are over-represented in S136 detentions, and across mental health services more generally, and this appears to have been consistent over the past three decades.
9. Although the Code of Practice for England states that police custody should only be used as a place of safety in 'exceptional' circumstances, it is clear that in some areas police cells are routinely used as the place of safety for people detained under S136 of the Mental Health Act 1983.
10. Despite some examples of good practice, S136 is poorly monitored in some areas of England and Wales with little oversight or accountability. Despite the guidance published in revised Codes of Practice and by the Royal College of Psychiatrists, implementation of S136 of the Mental Health Act 1983 is still highly variable between police forces.
11. There is little published research relating to the use of S135, which has attracted far less criticism than S136.
12. Other European and comparable countries generally have a shorter maximum length of detention permitted under their equivalent S136 legislation than in England and Wales, and not all distinguish in the same way between 'public' and 'private' premises.

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Introduction

In 2013 the Home Secretary announced the government would review Section 136 of the Mental Health Act 1983 because of concerns over the use of police cells as places of safety⁵. The Secretary of State for Health made an announcement to Parliament on 27th March 2014 launching the review of section 135 (S135) and section 136 (S136)⁶.

The provisions of S135 and S136 of the Mental Health Act 1983 are set out in full in Annex A. Both the S135 and S136 provisions were introduced, in almost identical terms, in the Mental Health Act 1959 (Annex B). There has been no full Government review into Section 136 of the Mental Health Act 1983 since 1999 (Churchill 1999), apart from some limited consideration of these parts of the legislation during the Mental Health Bill prior to the introduction of the Mental Health Act 2007, which resulted in only minor amendments to these parts of the Act. These were to update the language (for example, changing 'mental welfare officer' to 'approved mental health professional'), and to enable transfer of patients between places of safety in Section 44 of the Mental Health Act 2007⁷.

The Mental Health Act 1983 applies in both England and Wales, although England and Wales have published separate Codes of Practice⁸ and guidance⁹. The Code of Practice for England was revised in parallel with this review of the legislation¹⁰.

A considerable amount of research has been published into use of S136 of the Mental Health Act 1983 (Gray 1997, Borschmann 2010a), owing both to the controversy of the role of the police in making the judgement to detain a person under S136, and in the use of police cells as places of safety to detain people held under S136. Although research is limited in that studies have focused on samples in specific areas of the country at specific times, there are a number of key findings which are discussed below.

A previous literature review on S136 found 42 relevant papers published between 1983 and 2008, which include four literature reviews, 29 population and demographic studies, surveys of police officers and mental health professionals, and qualitative studies (Borschmann 2010a). This literature review identified 84 articles in peer-reviewed journals published between 1983 and 2014, 7 books, and 27 reports. There are data sets published by the Health and Social Care Information Centre (HSCIC). There have also been several Parliamentary debates, which

⁵ <https://www.gov.uk/government/speeches/home-secretary-speech-to-police-federation-annual-conference-2013>

⁶ Column 41WS. Online at:

<http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm140327/wmstext/140327m0001.htm>

⁷ Online at: <http://www.legislation.gov.uk/ukpga/2007/12/section/44>

⁸ The Code of Practice for the Mental Health Act 1983 in England is online at: http://www.lbhf.gov.uk/Images/Code_of_practice_1983_rev_2008_dh_087073%5b1%5d_tcm21-145032.pdf

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_4132161 and the Code of Practice for Wales is online at:

<http://www.wales.nhs.uk/sites3/Documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf>

⁹ Association of Chief Police Officer's guidance is online at:

<http://www.acpo.police.uk/documents/edhr/2010/201004EDHRMIH01.pdf>

Welsh Government guidance on sections 135 and 136 is online at:

<http://wales.gov.uk/topics/health/publications/health/guidance/section/:jsessionid=0CswQf3fqCPmGQpS4ZW9TjpppsgQyFvyjvk3rrSVfVxhWv8BNnB9!-1988510053?lang=en>

¹⁰ Draft Code of Practice for England is online at: <https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice>

are used as additional sources. Relevant case law is set out in Annex C, and data sets are in Annex D.

The search terms for this literature review included both S135 and S136¹¹, but little was found on S135. The lack of published research into S135 may be because there are fewer S135 detentions compared to S136, and because S135 is less controversial. S135 detentions entail obtaining a warrant and so have the additional safeguards of involving an approved mental health professional (AMHP) in making the warrant application, and a magistrate in granting it. S135 detentions often result either in community-based care, or often an assessment in the home which may lead to a detention under Section 2, 3, or 4, and removal to a psychiatric ward. It is relatively rare for a person detained under s135 to be removed to a place of safety – as reflected in the very low numbers of S135 detentions recorded by the HSCIC in hospitals, which do not reflect the actual number of S135 warrants granted or executed¹². Because the approved mental health professional should have located a place in a hospital for the patient before they can sign off the paperwork, it would be very unusual for a person detained under S135 to be taken to a police cell. It is also possible that some of the studies discussed treated S135 and S136 detentions together without specifically noting the fact. In terms of case law (see Annex A, p. 74), the courts treat S135 and S136 as inter-related pieces of legislation (Bartlett and Sandland 2013) and findings relating to, for example, public places, and places of safety, will apply to both S135 and S136. However, most of the research findings relate only to S136.

S136 detentions are more frequent than S135 (there were more than 23,000 S136 in 2013/14), are more unpredictable, and rely on the individual police officer's judgement whether or not to detain a person (Jones 2013). The use of police cells to detain people held under S136, in particular, has drawn considerable criticism¹³. Of the research which has been done into the use of S136, sample sizes vary considerably, and the majority of research has been conducted in London, with some studies in rural areas.

Due to the nature of S135 and S136 detentions, there are no randomised control trials or intervention studies relating to their use. Most research has focused on the role of the police, the demographic detained under S136, including ethnicity, patient experiences of being detained, and the experiences and training of practitioners.

The HSCIC publishes annual data for inpatients detained *in hospitals* under the Mental Health Act 1983, which does include, for S136 detainees held in NHS and independent hospitals, whether they have gone on to be detained informally, or on S2 or S3, gender breakdown, provider, local authority area, repeat S136 detentions, and ethnicity, based on the Mental Health Minimum Data Set (MHMDS) and the KP90 data set. In 2012/13 they also published experimental police data on numbers of S136 held in police cells, number of under-18s held under S136 in cells, and methods of conveyance for S136 patients (see Annex D)¹⁴.

¹¹ See Methodology, p. 51.

¹² Attempts were made as part of this review to obtain this data from Courts but it was not possible to gather the data in a way which distinguished S135 warrants applied for, or granted.

¹³ HMIC (2013) *A Criminal Use of Police Cells?* Online at: <http://www.hmic.gov.uk/media/a-criminal-use-of-police-cells-20130620.pdf> and IPCC (2008) *Police Custody as a 'Place of Safety'*. Online at: <http://www.ipcc.gov.uk/sites/default/files/Documents/%5BNPM%5D%20LtL%20Bulletin%205%20-%20Case%202.4.pdf>

¹⁴ The HSCIC publishes data on 'Inpatients formally detained in hospitals under the Mental Health Act 1983', online at <http://www.hscic.gov.uk/catalogue/PUB12503>, which includes experimental data from police forces as well as more detailed data on S136 patients in hospitals. There are plans to introduce improved national reporting and a standard form is presently being trialled.

Social context

The provisions currently in S135 and S136 of the Mental Health Act 1983 were originally enacted in the Mental Health Act 1959. Policing and health service provision, and practices, have changed significantly since that time, as have social attitudes to mental health and the prevalence of diagnosed mental health conditions in the population. It is now estimated that one in four people will suffer mental illness in any one year¹⁵. The management of mental health crises has become a key social and health care issue (Lipson 2010). Recent legislative changes in England have placed mental health on a par with physical health¹⁶.

There has long been perceived to be a need both to protect people suffering from mental disorders, and to protect the public, by taking them to a safe place for care and treatment. S136 is based on a power originally set out in the Vagrancy Acts of 1714 and 1744, which allowed a constable on the order of a magistrate to lock up a 'lunatic pauper' in a secure place, often a lunatic asylum (Lynch et al. 2002, Riley et al 2011b). These attitudes are now considered archaic (Walker 1973, Rogers and Faulkner 1987, Appelbaum 1994, Spence 1995) with researchers noting that while an individual's behaviour might deviate from what is accepted by society, this often does not constitute a criminal offence (Morgan 1991). However, the state also has responsibilities to protect citizens who cannot care for themselves, such as those who are acutely mentally ill (Lamb et al 2002). The police, as representatives of the public¹⁷, are given the power and authority by the state, through a legislative framework, to protect the safety and welfare of the community.

Throughout the development of mental health legislation, the use of coercive powers has been the most controversial aspect (Bartlett 2008). There are several key principles involved in S135 and S136 powers, in particular in the use by police of S136 powers, including human rights and civil liberties. Both the state and police are governed by the European Convention on Human Rights (ECRH)¹⁸. Article 2 and Article 5 are both relevant to S135 and S136 of the Mental Health Act 1983. Article 2 is an obligation to protect life, which places a positive obligation on the police to take steps to protect a person's right to life where there is a foreseeable risk of a threat towards their life, and also to safeguard the lives of persons in their care. Article 5 protects people's rights to liberty and security, but is limited so that persons who have committed a criminal offence, or are of unsound mind (Article 5 (1)(e)) can be lawfully detained by the proper authorities. Any such detention must be necessary and proportionate and should not continue for longer than is necessary (Bindman et al 2003).

Case law has established the legal principle that in order to be compliant with human rights law, an individual must have been reliably shown to be of unsound mind (as in *Winterwerp v Netherlands* (1979) 2 EHRR 387 in relation deprivation of liberty) and some have questioned

¹⁵ Online at: <http://www.mentalhealth.org.uk/help-information/mental-health-statistics/UK-worldwide/>

¹⁶ Department of Health (2011) *No Health Without Mental Health: a cross-Government mental health outcomes strategy for people of all ages*. Online at: <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>. Parity of esteem for mental health was set out in Section 1(1) of the Health and Social Care Act 2012, which states that the 'Secretary of State must continue the promotion in England of a comprehensive health service designed to secure Parity of Esteem for Mental and Physical Health improvement (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness', Health and Social Care Act 2012, online at: <http://www.legislation.gov.uk/ukpga/2012/7/section/1/enacted>

¹⁷ Sir Robert Peel (1829) *Principles of Law Enforcement*. Online at: https://www.durham.police.uk/About-Us/Documents/Peels_Principles_Of_Law_Enforcement.pdf

¹⁸ Online at: http://www.echr.coe.int/Documents/Convention_ENG.pdf

whether S136 is compliant with this principle, given that no medical evidence is required and the constable making the decision is not medically trained: however S136, as an emergency short-term measure, is exempt from *Winterwerp* (Spencer-Lane 2013).

The aspect of S136 detentions in particular, which causes controversy in the human rights context is the involvement of the police in making the judgement to detain a person who appears to be suffering from a mental disorder and in need of care and control: Latham (1997) notes that 'S136 is the only part of the Mental Health Act 1983 where one person, acting without medical evidence or training, has the authority to deprive another person of their liberty' – as well as the use of police cells as a place of safety, which is seen as criminalising a person who has not committed a crime (Jones and Mason 2002, Docking et al.2008). As far back as 1992, the Reed Committee recommended that mentally disordered offenders ought to receive supportive care without first being taken to a police station (Department of Health and the Home Office 1992), while in 2013 *The Lancet* stated that 'Mental illness is not a crime, and should never be treated as such' (*The Lancet* 2013). *The Lancet* editorial advocated policy changes 'so that no-one is remanded in police custody solely for being ill', stating:

'Detention in police cells conflates mental illness with criminality, increasing stigma, and could be particularly problematic in people having their first episode of psychosis, for whom initial negative experiences of mental health care could have lifelong ramifications' (*The Lancet* 2013, June 29, p.2224).

Despite this, the data shows that in some areas in particular, police custody is still often used, especially for those who are brought in intoxicated, or those otherwise excluded by the criteria of health-based places of safety (HMIC 2013).

A number of researchers have highlighted the ethical and moral ambiguity of the S136 power (Latham 1997, Jones and Mason 2002). In using S136, the police need to balance their duty to protect the safety and welfare of the community, and their obligations to protect individuals with disabilities (Lamb et al 2002). Finding the right balance between these sometimes competing considerations, in the unique context of individual cases, can present the police and health services with some difficulties which on occasions lead to failures in the operation of S135 and 136 powers to reach the best outcome for the person concerned (Costen and Milne 1999) and to risk aversion (Mental Health Act Commission 2007). Failures include at worst, deaths in police custody, and sometimes, very distressing experiences for the person, and also police and health professionals.

Some observers believe that deinstitutionalization and the introduction of community-based care for people with mental health problems has resulted in the police coming into greater contact with people at the point that they reach crisis (Teplin and Pruett 1992, Jones and Mason 2002). Some have suggested that, in effect, health service costs are being passed to the police services by giving the police a 'gatekeeper' role through their powers under S136, in deciding whether or not a person with a mental health emergency should enter the mental health system or the criminal justice system: issues which are paralleled in the US (Lamb et al 2002). Many police officers now consider this role an integral part of their duties, while others are more reluctant or even resentful of the extent to which dealing with people with mental health issues absorbs police time and resources (Lamb et al 2002). Some police consider that this role is not 'proper' police work, and that seeking help from other agencies for a person in mental health crisis is time-consuming, and frustrating (Dunn and Fahy 1987a, Jones and Mason 2002). Despite these frustrations, the police often consider they have both a duty of care, and a

responsibility to act; a view underlined by the investigations into a number of deaths following police contact or S136 detentions by the Independent Police Complaints Commission (IPCC)¹⁹.

Some of these aspects have, however, received surprisingly little detailed consideration in the published literature on S136, such as why people have been detained, where they are held, for how long, and what happens to them afterwards. A few articles explore how S136 is used by the police, attitudes towards its use, and the experiences of people detained under the power. Several articles raise concerns over the extent to which the police can, or should, become involved in managing a person suffering a mental health crisis, given that the person is suffering a health problem and is not committing any crime, and with issues over coercion and consent (Mental Health Act Commission 2009). Concerns have been raised over the consistency and appropriateness of the use of S136 by police (Revolving Doors Agency 1995), as well as how the different agencies interact.

Many commentators, as well as police officers, feel that the police lack expertise in dealing with mental illness. The police receive little training in how to perform this sometimes very complex and difficult role, how to recognise different forms of mental illness, and how to exercise their discretion, for example in finding an informal resolution (Jones and Mason 2002), and there have been calls for better police training on mental health and learning disabilities which has led the College of Policing to review the training on offer²⁰.

It is worth noting that part of the difficulty in examining the consistency of key findings between various research studies lies in the different terminology used in understanding mental health and mentally disordered offenders (Peay 2010, Bartlett and Sandland 2013). While it is out of the remit of this review to go into detail, in different places references are made in the literature to mental disorder, mental illness, personality disorder, and difficulties in diagnosis and co-morbidity, which make it problematic to be clear about overall numbers. Considering health professionals can find it difficult to be clear about the degree of severity of mental ill-health that could warrant compulsory detention, it is understandable that the police can find it challenging to use S136 appropriately when the legislation merely makes reference to the person 'appearing' to be suffering from a mental disorder – because at that stage no diagnosis has necessarily been made. The issue of whether a person who is, for example, suicidal is or is not suffering from a mental disorder is highly complex even for medical professionals:

'...the actual disposition of a mentally disordered person is inherently a complex social process. While the law provides the legal structure and decrees the police officer's power to intervene, it cannot dictate the police officer's response to that situation. Unlike other professionals, the police do not have a body of technical knowledge with respect to psychiatry [to use]...in the performance of their role...the police must exercise discretion in choosing the most 'appropriate' disposition in a given situation' (Teplin and Pruett 1992, p. 140)

The police may decide to use S136 powers because there is nothing better available to them to address those particular circumstances, or may be forced to use other inappropriate powers, such as breach of the peace, because for example the person is in a place where S136 does not apply (in private premises). The police officer may also make other calculations over the probability of finding a place in a hospital, whether the person is likely to be excluded from

¹⁹ For example, <http://www.ipcc.gov.uk/sites/default/files/Documents/%5BNPM%5D%20LtL%20Bulletin%205%20-%20Case%202.4.pdf>

²⁰ See <http://www.college.police.uk/en/21742.htm>

hospital, and the relative length of time and difficulty of each course of action (Jones and Mason 2002) - meaning that 'the disposition of a mentally disordered citizen is based less on the degree of apparent psychiatric symptomatology than on a complex array of contextual and situational variables' (Teplin and Pruett 1992, p.141).

Recent research found that a decision to invoke S136 depends on social context and other particulars of individual cases, and noted that 'tasked primarily with protecting the public and keeping the peace, police 'diagnoses' of risk often contrast with that of mental health professionals' (Menkes and Bendelow 2014). It is possible that a police officer may be making a finely balanced choice between detaining a person under S136, or arresting them for a minor criminal offence such as breach of the peace, or being drunk and disorderly in a public place. Clearly, if the person was committing a more serious criminal offence it is likely to be most appropriate to arrest them for the offence, and if they are also suffering mental health problems, support can be given in custody or the person could be referred to a psychiatric unit by the courts. However, there may be local variations for more minor offences where anti-social behaviour is closely linked to a mental health condition, depending upon the preferred course of action in different areas, and perhaps previous experiences with the individual concerned, where it is more of a judgment call between an arrest or a S136 detention (Costen and Milne 1999).

There is the potential to criminalise a person if the police officer does not make the correct decision. However, the police officer sometimes does not have the information that may be available to others in the health system, over the person's history and potential risk factors, and does not have training in recognising mental health problems or other factors such as learning disability or autism. In some cases these shortcomings have been addressed through creating crisis teams bringing together different partner agencies, in order to improve the overall response. Collaboration between the law enforcement and mental health systems is crucial, and the very different areas of expertise of each should be recognized but should not be confused (Lamb et al 2002).

Trends in the use of S135 and S136

A 'major and long-standing problem in understanding the trends in the use of [the Section 136] power has been the failure to collect complete information on the use of Section 136' (Chalmers 2013). The lack of quality historic data, especially on S136 detentions where the place of safety was a police station, limits the interpretation that can be made over trends in the uses of S136. When a S136 detention is made, at present the police have no statutory duty to record that it has been made and why (although several police forces have introduced local recording practices and a new national form has been piloted). In the past, when a person was detained under S136 and taken to police custody, there may have been no record of this other than the custody record: these are not designed to capture such information and cannot be easily searched, meaning that in effect large numbers of people who had been detained in police cells have not been recorded nationally. This means that the available data on S136 detentions is almost certainly an underestimate, and that accurately interpreting long-term trends is very problematic. There is a clear need for better data from the police, in particular, and efforts are focusing on improving the data picture²¹. In 2012 the Mental Health Alliance recommended that data on the number of uses of police cells as places of safety should be collected as part of local monitoring, and monitored by the Care Quality Commission (Mental Health Alliance 2012).

There is no clear data available on how often the police come into contact with people with mental health problems in the course of policing work (Mental Health Act Commission 2005), but some police estimate that around 20% of police time is spent in dealing with people who to some degree have a mental health problem²². This may include a person suspected of committing a criminal offence, a person reporting a criminal offence, a victim, or a witness. In the context of S136, which implies a person with a more severe mental health problem who has reached a crisis point, the police may have been called to a disturbance, or are responding to reports of a person acting oddly, or have encountered a person in the course of patrolling who the police officer believes may be in need of assistance. Only a small proportion of these, however, will result in a S136 detention. Research in the US suggests that the police tend to prefer to resolve situations informally, irrespective of the person's state of health (Teplin and Pruett 1992) suggesting that a large number of interactions between the police and mentally disordered persons do not result in any formal response or recording, so 20% may be an underestimate. If the situation is not too serious and there is little risk of serious harm, the police may prefer to find a family member or other responsible person who can take care of the person, and may be able to offer advice for example on where to find support services.

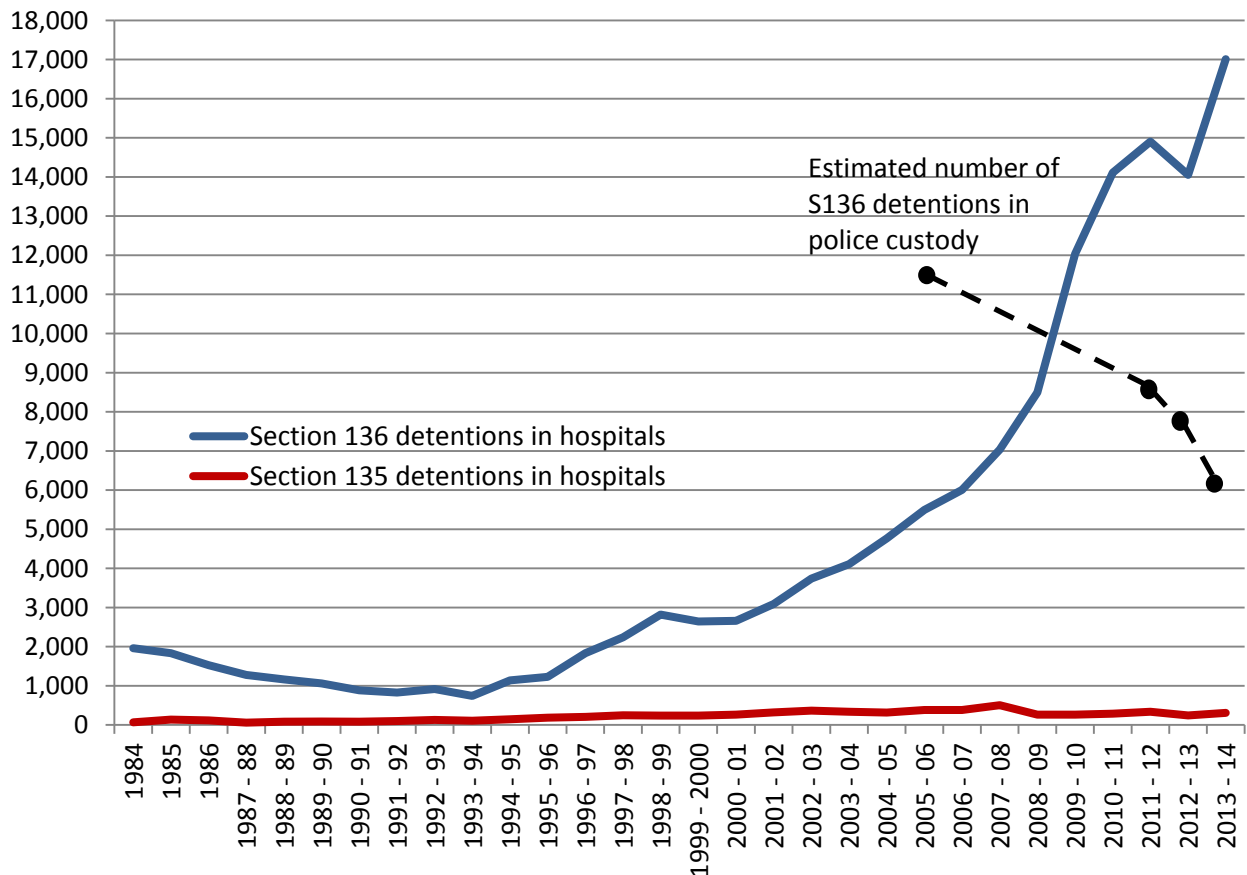
There will be other occasions where a S136 detention is a possibility, but was not used. If the situation is so serious that a criminal offence may have been committed, the police may choose to arrest for the offence (for example, for breach of the peace, antisocial behaviour, or affray) and the person will then be able to access mental health services while in police custody. There are also situations where S136 cannot be used, for example in a person's home, where the police officer has taken the decision to arrest instead in order to resolve the situation, and so S136 may be used less frequently than it might have been even if the person did, in the view of

²¹ Department of Health (2014) *Mental Health Crisis Care Concordat*, Action 1.2, p.37. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

²² Speech given by the Home Secretary, July 2014, online at: <https://www.gov.uk/government/speeches/care-not-custody-speech>

the police officer, meet the threshold for emergency detention under the Mental Health Act 1983.

The Health and Social Care Information Centre (HSCIC) publishes an annual report setting out the data for inpatients formally admitted to hospital under the Mental Health Act 1983 in England, which includes detentions made under S135 and S136 to both NHS and independent hospitals, known as ‘place of safety orders’²³. This data is available from 1984 onwards and includes the number of detentions made under different parts of the Act (see Annex D). In 2012/13 and 2013/14, this report included experimental data on the number of detentions made where the place of safety was a police cell. The Welsh Government also publishes annually data for Wales on detentions made in hospitals under the Mental Health Act 1983²⁴. The data collected in England show an increase in rates of detention in hospital under both S136, in particular, increasing from 1,959 S136 detentions in 1984 to 17,008 in 2013/14, an increase of over 850%, while S135 rates increased from 68 in 1984 to 307 in 2013/14, an increase of 450% (see Annex D for data tables). Over the same period, the population of England has increased from 47 million to 53 million, a 13% increase. Although the rate of detentions in hospitals was already increasing after 2001 (Borschmann 2010a), most of the increase occurred after 2007 when capital investment in health-based places of safety increased their availability²⁵, while the use of police cells as places of safety has been falling.



The annual number of place of safety orders (Sections 136 and 135) to hospitals in England between 1984 and 2013/14.

²³ Online at: <http://www.hscic.gov.uk/catalogue/PUB12503> (accessed August 2014)

²⁴ Online at: <http://wales.gov.uk/statistics-and-research/admission-patients-mental-health-facilities/?lang=en#/statistics-and-research/admission-patients-mental-health-facilities/?lang=en> (accessed August 2014)

²⁵ <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/58407.htm#n79>

In Wales, data for the last five years shows some increase from 587 places of safety orders made in hospitals in 2008/09, to an estimated 860 in 2012/13²⁶, of which S136 detentions rose from 558 in 2008/09 to 842 in 2012/13, an increase of 150%.

In contrast, the figures for S135 have stayed relatively low, peaking in 2008/09 at 0.98 S135 per 100,000 population in England. In Wales, S135 have also remained low per 100,000 population, falling from 0.96 S135 per 100,000 population in 2008/09 to 0.59 in 2012/13. Further historical data could not be obtained from the Welsh Government.

The ratio of S136 per 100,000 population suggests that until 2000/01 there was very little change, and then the use of S136 increased rapidly from 5.4 S136 per 100,000 population in England, up to 26.27 S136 per 100,000 population, meaning that the chances of being detained under S136 in hospital in England is now five times higher than in 2000. In Wales, S136 increased from 18.4 S136 per 100,000 population in 2008/09 to 27.4 S136 per 100,000 population in 2012/13, comparable to England over the same period. A 2013 study also found that the rate of detention under Section 136 in hospitals in England increased more than six-fold between 1984/5 to 2010/11, from 5.2 to 33.4 per 100,000 adult population (1,959 in 1984/5 to 14,111 in 2010/11). The use of Section 135 also increased, from 0.2 to 0.7 per 100,000 adult population (68 in 1984/5 to 288 in 2010/11) (Keown 2013).

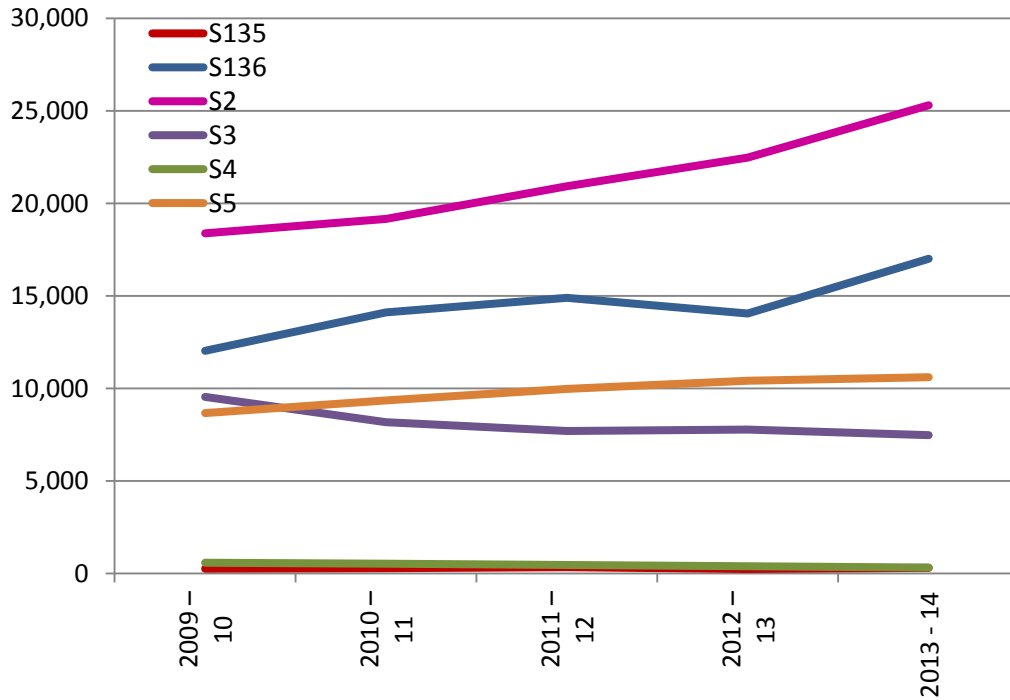
There are a number of possible explanations for this increase in S136 detentions in hospitals. While it is possible there has also been a real increase in incidents of mental health crises, or increasing use of S136 by the police (either by using the power inappropriately, or improved recognition of mental health issues), it is most likely that the recorded figures represent decreasing use of police custody at least in some areas, and increasing availability of health-based places of safety, while data collection in hospitals has also improved. Hospitals may now be more willing and able to take in S136 patients who previously would have ended up in police custody. The table below shows the overall number of S136 detentions, for those years where some data is available. It seems there has been a move from the *majority* of S136 detentions being taken to police custody (67.7% in 2005 /06) to only a quarter being taken to police custody in 2013 /14 (26.2%). This suggests that the lack of historic data on S136 detentions in police custody is a serious gap in the picture when considering trends in S136 use.

	S136 in hospitals	S136 in police custody	Total no. S136	% in hospitals	% in police custody
2005 - 06	5,495	11,500	16,995	32.3	67.7
2006 - 07	6,004	-	-	-	-
2007 - 08	7,035	-	-	-	-
2008 - 09	8,495	-	-	-	-
2009 - 10	12,038	7,035	19,073	63.1	36.9
2010 - 11	14,111	-	-	-	-
2011 - 12	14,902	8,867	23,769	62.7	37.3
2012 - 13	14,053	7,881	21,934	64.1	35.9
2013 - 14	17,008	6,028	23,036	73.8	26.2

The numbers of S136 detentions made by police officers which resulted in detention in a health-based place of safety is compared below to the numbers of detentions made by health professionals under other parts of the Mental Health Act 1983. It is notable that detentions

²⁶ <http://wales.gov.uk/docs/statistics/2013/131030-admission-patients-mental-health-facilities-2012-13-en.pdf>

under S2 have also risen over the past five years, reaching 25,300 in 2013/14, and to a lesser extent S5 detentions have also risen to 10,609 in 2013/14. Over the past 5 years, S3 and S4 detentions have decreased. The increase in S136 is therefore not entirely out of step with trends in mental health detentions generally, especially those which entail a shorter term detention period. It may also be the case that pressures on acute psychiatric beds has resulted in a reluctance to detain people for longer periods, alongside preferences towards Community Treatment Orders and community-based care.



	Section 135 ²⁷	Section 136 ²⁸	Section 2 ²⁹	Section 3 ³⁰	Section 4 ³¹	Section 5 ³²
2009 – 10	262	12,038	18,385	9,545	587	8,672
2010 – 11	288	14,111	19,163	8,174	535	9,351
2011 – 12	338	14,902	20,931	7,701	458	9,977
2012 – 13	243	14,053	22,477	7,776	396	10,420
2013 - 14	307	17,008	25,300	7,481	326	10,609

Detentions under the Mental Health Act 1983 in NHS facilities and independent hospitals by legal status, 2008-09 - 2012-13³³

²⁷ This is not the total number of S135 warrants issued or executed, only the number which went on to be detained in hospital under S135, rather than admitted under Section 2, Section 3, or Section 4.

²⁸ This does not include S136 detentions which resulted in detention in police custody.

²⁹ Section 2 is a civil admission for assessment (or assessment followed by treatment) authorised by two doctors, and lasts for a maximum of 28 days.

³⁰ Section 3 is a civil admission for treatment authorised by two doctors. The initial duration is for a maximum of 6 months. It can be renewed for a further period of 6 months; after that, for further periods of 12 months.

³¹ Section 4 is used to detain a person when emergency assessment is required and compliance with the usual Section 2 requirements would involve an 'undesirable delay'.

³² Section 5 of the Mental Health Act includes holding powers used by a doctor or a nurse to prevent informal patients leaving hospital when informal treatment is no longer appropriate and it is necessary for their health, safety or the protection of others. It should only be used where it is not possible or safe to use Sections 2, 3 or 4. Section 5(2) can be used on any inpatient and has a maximum duration of 6 hours.

³³ Online at: <http://www.hscic.gov.uk/catalogue/PUB12503>

One area where the police sometimes attract criticism is that only a minority of people detained by the police under S136 go on to be further detained by the hospital under either Sections 2 or 3. Over the past five years, the number of S136 detentions in hospitals who go on to S2 or S3 has averaged around 17%, suggesting that around 83% of S136 detentions result either in being admitted as an informal inpatient for observation, given other community-based support, or are released with no further action taken. The table below shows that more than three quarters of people detained under S136 go on to 'informal' status, and this has risen from 73% in 2008/09 to 81% in 2012/13, and 78% in 2013/14. Only a small minority of people brought in by the police on S136 to hospitals are released with no further action being taken.

	Section 136 in hospitals	S136 to S2 or S3	S136 to informal	S136 to any other outcome
2009 – 10	12,038	1,922 (16%)	9,211 (77%)	905 (8%)
2010 – 11	14,111	2,376 (17%)	10,753 (76%)	982 (7%)
2011 – 12	14,902	2,582 (17%)	11,397 (77%)	923 (6%)
2012 – 13	14,053	2,426 (17%)	11,330 (81%)	297 (2%)
2013 – 14	17,008	2,837 (17%)	13,186 (78%)	985 (6%)

Outcomes of S136 detentions under the Mental Health Act 1983 in NHS facilities and independent hospitals by legal status, 2008-09 – 2013/14³⁴

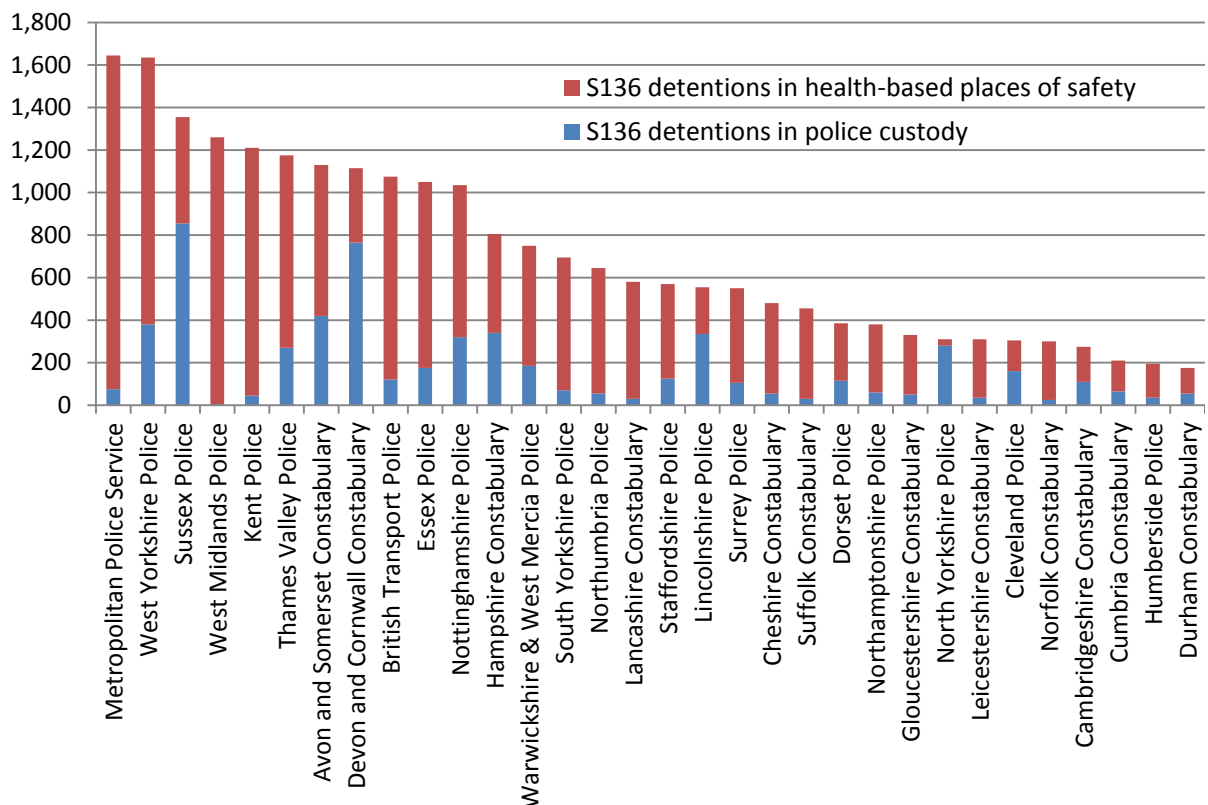
³⁴ Online at: <http://www.hscic.gov.uk/catalogue/PUB12503>

Local variation in S136

It is clear that there is a considerable degree of local variation in the use of S136 and the extent to which police stations are used as places of safety. Because of the piecemeal nature of many studies, it is difficult to assess the overall rates of detention in different areas.

One study of 57 individuals in Westminster noted that – even though their figures were likely an under-estimate of S136 referrals in six months – the rate of S136 detentions was high at nearly 11 per month (Spence and McPhillips 1995). Another study in Camberwell of 268 S136 referrals over 27 months showed a rate of under 10 per month (Dunn and Fahy 1990). One rural study of the use of S136 in Gloucestershire between 2002 and 2006 showed that on average 192 people (ranging from 176 – 203) were detained each year under S136, a rate of 32.8 detentions per 100,000 population (Laidlaw et al. 2010).

Although there is no good data nationally, experimental data collection in 2012/13 suggested that the number of S136 detentions recorded by police forces varied widely from area to area, as does the proportion of S136 detentions being detained in police custody, depending upon the local level of provision of suitable health facilities. During 2013/14, 11 police areas recorded more than 1,000 uses of S136 (see graph below), while 13 police forces recorded under 500 uses of S136³⁵. The proportion of S136 detentions going to police custody, rather than a health-based place of safety, also varied widely.



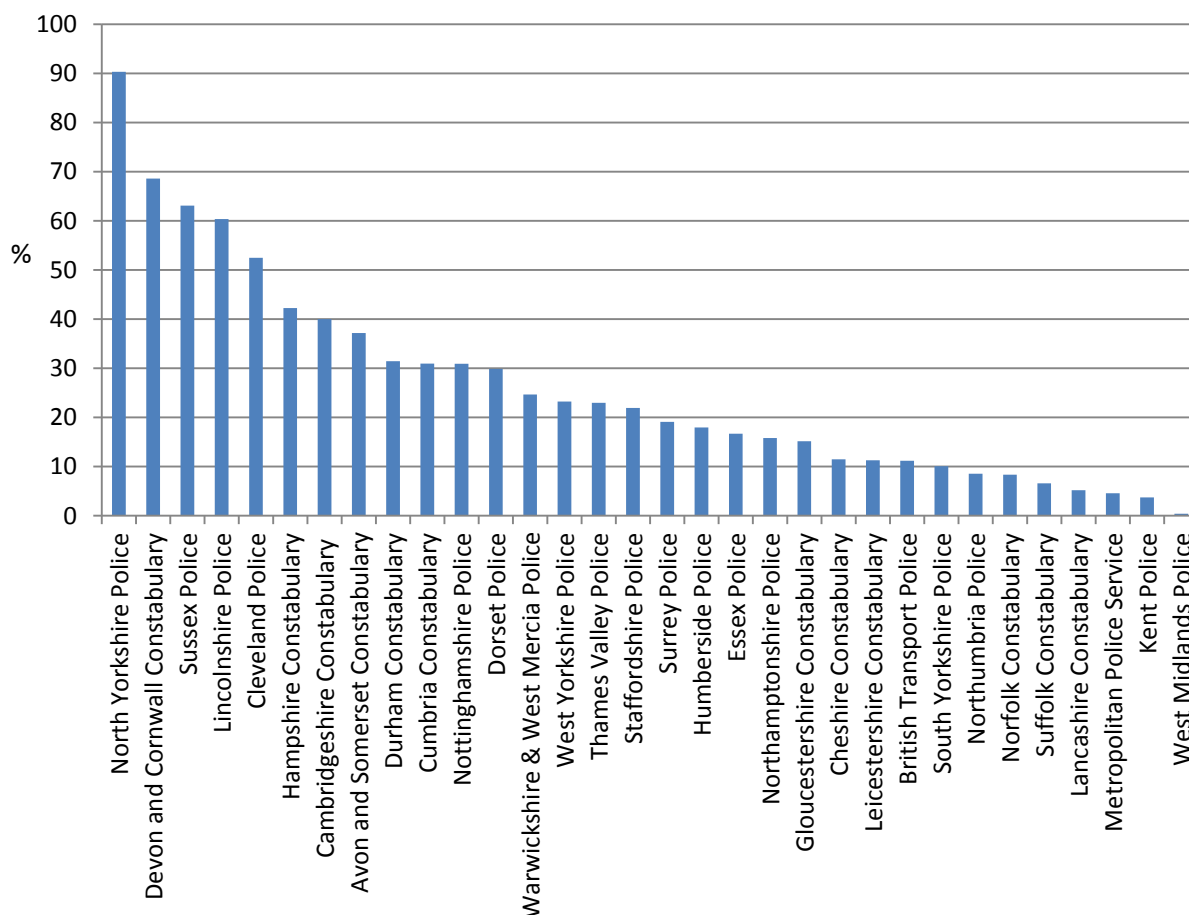
Number of S136 detentions recorded by the police in England, 2013/14, where data was available³⁶

³⁵ Online at: <http://www.hscic.gov.uk/catalogue/PUB12503>

³⁶ Based on table12, HSCIC, online at: <http://www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-exp-tab-v2.xls>. Four forces were unable to provide data on the number of times police custody was used to detain people under S136.

One 2013 study of places of safety orders made between 1984/5 and 2010/11 showed wide variation between regions in the use of hospitals or police stations as places of safety. In 2003/2004 the average rate of Section 136 detentions to places of safety in NHS facilities in each Government Office Region was 8.5 per 100 000 adult population, and varied from 1.5 in the West Midlands to 24.6 in London. In 2005/2006 the rate of Section 136 detentions in police custody was 24.6, and the corresponding rates were 31.7 in the West Midlands and 1.3 in London. Those regions with below-average detentions in NHS facilities tended to be the same regions that 2 years later had above-average numbers of detentions in police custody ($r = 70.71$, $n=9$, $P = 0.03$) (Keown 2013).

This variation is borne out by the data published by the HSCIC, based on police force data, which shows that in 2013/14, five police forces had more than 50% of their S136 detentions being detained in police custody, while seven had less than 10% going to police custody (West Midlands Police had only 0.4% of their S136 detentions being taken to police cells). In this year, North Yorkshire only had a health-based place of safety available for a short period in early 2014, hence the high proportion going to police custody. Similarly, in Cornwall the health-based place of safety was closed for part of the year, contributing at least in part to the high proportion of S136 detentions in police custody recorded by Devon and Cornwall Constabulary.



Percentage of S136 where detention was police custody, as recorded by the police 2013/14³⁷

³⁷ Based on table12, HSCIC, online at: <http://www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-exp-tab-v2.xls>. Four forces were unable to provide data on the number of times police custody was used to detain people under S136.

The reasons for such a level of variation are not clear (Churchill et al. 1999), and may in part relate to varied recording practices between police forces. One study suggested that to some extent compulsory psychiatric admission was associated with socio-economic deprivation but this did not fully explain the level of variation observed (Bindman et al. 2002). The person may also be transferred between places of safety in order to remove them from police custody to an appropriate health-based place of safety, or to access staff more familiar with the patient (Hampson 2011), and these transfers are not clear in the published data (for example, it is possible there is double-counting of some individual S136 detentions both in custody and in hospital). A recent CQC survey of health-based places of safety suggests that there is some correlation between areas which have higher numbers of health-based places of safety available, and areas with low use of police cells (CQC 2014).

In 2013 and 2014 a number of areas introduced street triage pilots to provide a dual response where a police officer is supported by a mental health professional (Dean 2013). While these have yet to be evaluated, early indications are that in these areas the number of S136 detentions has reduced (Cole 2014).

The role of the police in mental health

The police respond to emergency calls and provide services 24 hours a day, seven days a week, including patrolling areas. A proportion of these calls will relate to people who have mental health conditions, who may or may not also be suspected of criminal offences, or may be victims of crime or witnesses to crime. Research also suggests that people with mental illness are anywhere between 2.3 to 140 times more likely to become victims themselves (Lipson 2010) and are placed at a higher risk because of deficits in social skills, planning, problem solving, reality testing and judgement, as well as living in disadvantaged neighbourhoods and unsafe housing. As Mind put it, 'Mental health is core police business'³⁸.

It appears to be rare for the police to have initiated contact with a person suspected of having a mental disorder: in most cases members of the public, relatives or other statutory agencies such as social services are responsible for the police involvement (Kent and Gunesekaran 2010). The police may become involved when there is a perception of threat or actual violence to people or property, or when mental health services have not responded when called upon by relatives or neighbours (Rogers 1990). The police are also called to respond when a person absconds from a mental health unit: more than 40,500 patients absconded from mental health units in the past five years³⁹, and police officers are expected to find and return these individuals, even when they pose no risk to wider society. The police are also sometimes called to respond to understaffed mental health units, where a patient's behaviour is deemed to be unmanageable and restraint is needed.

There is a common perception that persons with mental illness are more violent, dangerous and unpredictable; and the police and health professionals may share this view in undertaking assessments of risk. Many people with mental health conditions also self-medicate with alcohol or drugs, and can develop drink or drug addictions which can exacerbate their symptoms especially at a time of mental health crisis, and make it difficult for police or health professionals to diagnose a problem or to provide the right help.

The police are often involved in transporting patients to or between places of safety. The Health and Social Care Information Centre found that, even where a place of safety was health based, in 74% of cases transportation was provided by police, not the ambulance service. Taking a person to a place of safety, remaining with them, monitoring at-risk individuals, and arranging mental health assessments, and waiting for assessments to be carried out, removes the police officer from the front-line for a period of time, perhaps an entire shift.

Some have suggested that a lack of health resources, combined with a move towards community-based mental healthcare, mean that health service costs are being passed to the police services⁴⁰ (Lamb et al 2002). The impact on the police service of dealing with mental health issues is difficult to evaluate in terms of costs or resources. The Centre for Mental Health states that police are often the first point of contact for a person in mental health crisis and that up to 15% of police incidents have a mental health dimension⁴¹. Estimates of the impact on police time are varied and the evidence is often lacking due to recording practices, but some

³⁸ Online at: <http://www.mind.org.uk/media/553151/mind-briefing-on-police-and-mental-health.pdf>

³⁹ Online at: <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm>

⁴⁰ <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm>

⁴¹ http://www.centreformentalhealth.org.uk/pdfs/briefing36_police_and_mental_health.pdf

people think mental health interventions occupy approximately between 20 - 40% of police time⁴². Only a minority of this, however, will be S135 and S136 detentions.

Places of safety

The Mental Health Alliance recommended in 2012 that Mental Health Commissioners should ensure that their areas include a range of appropriate places of safety (Mental Health Alliance 2012). However, although S135(6) of the Mental Health Act 1983 provides for a range of options to be used as places of safety, in practice psychiatric units, police stations and hospital emergency departments are most commonly used (Apakama 2012). There is no data or literature that covers detention in any place of safety other than a health-based place of safety or a police station. The use of police cells as places of safety for detentions under S135 is not an issue because S135 requires pre-planning, including identifying an available mental health bed, so S135 patients do not go to police stations (Mental Health Act Commission 2005).

In law, a 'place of safety' is not clearly defined and has no specific characteristics, and the assumption is made that the definition will be agreed locally. There has been longstanding debate between the police forces and emergency department physicians as to the most appropriate place of safety (Ryan and Perez-Avila 1997). A 2000 survey found that police and health professionals had differing views as to what constitutes a place of safety. The survey found that 43.75% of consultants and 50% of Specialist Registrars did not consider A&E to be a place of safety (Lynch et al. 2002) but almost all considered a police station to be one: while 78.3% of police officers considered both A&E departments and police stations to be places of safety.

The main issues professionals have are trying to ensure safety and security for all parties involved, in a situation where a person can often be unpredictable and sometime aggressive. AMHPs and mental health nurses often feel that they may need support from police officers should a detainee become violent or aggressive, because the police have greater powers of physical force available to them, and additional training in restraint techniques which is not available to health professionals (Riley et al. 2011a). In one survey, doctors felt that the place of safety should remain the police station, because of these concerns over safety, but in a more suitable environment, equipped with safe furniture. Health professionals felt that detainees should not automatically be assessed in a hospital setting, especially a psychiatric hospital, because of the stigma attached to mental health problems and because being taken to a psychiatric hospital before being assessed may prejudice the person as being mentally ill (Riley et al. 2011a).

A study of the attitudes of professionals to the use of S136 in Gloucestershire showed that 74% of participants thought that there should be an alternative place of safety to the police station, with many also thinking that A&E was unsuitable; 58% thought a psychiatric hospital should be the place of safety. The findings suggest some divergence in views between professional groups: 100% of police custody sergeants said that a psychiatric hospital was their first choice, compared to only 33% of mental health nurses, who said that A&E and psychiatric hospitals were acute settings which were not suitable places for a person to be brought to, when accompanied by police, with concerns over there being no appropriate suite, insufficient

⁴² <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm>

staffing, and that doing so could put staff, patients and visitors at risk, and this risk was not so high in the police station (Riley et al. 2011a):

Do you think there should be an alternative to the police station as the only place of safety?

Professional Group	Yes	No
Police custody sergeants	12 (100%)	0 (0%)
Police operational officers	67 (97%)	2 (3%)
AMHP	26 (96%)	1 (4%)
Forensic physicians	7 (87%)	1 (13%)
A&E doctor	9 (75%)	3 (25%)
A&E nurses	9 (60%)	6 (40%)
Section 12 doctors	20 (56%)	16 (44%)
Mental health nurses	14 (33%)	29 (67%)
Combined groups	164 (74%)	58 (26%)

If alternative place of safety were available, which would you prefer?

Alternative POS	First choice	Acceptable alternative	Unacceptable alternative
Psychiatric hospital	118 (53%)	46 (21%)	59 (26%)
A&E department	16 (7%)	80 (36%)	127 (57%)
GP walk-in assessment centre	16 (7%)	80 (36%)	127 (57%)

The appropriateness of A&E as a place of safety has long been in dispute (Royal College of Psychiatrists 1996, Royal College of Psychiatrists 1997, Ryan and Perez-Avila 1997) with suggestions that a crowded casualty department, or a room off it, is not a helpful place to have to wait for several hours, given the disturbance that a subject might cause and the effect of the environment on the subject (Revolving Doors Agency 1995). However, a study undertaken by the IPCC (Docking et al 2008) concluded that a hospital emergency department provides a better environment than police custody.

The view that a police station should not be considered a place of safety also has a long pedigree, with a 1987 survey of 41 police officers in 1987 suggesting that some police officers were unhappy with the inclusion of police stations as a place of safety for, although safe, it was not always considered to be an appropriate place to detain a mentally disordered person (Dunn and Fahy 1987a) and this view is echoed today (see below).

Failure to agree on a local definition of a place of safety leads to misunderstandings, conflict between agencies and potential risk to patients, staff and the public (Royal College of Psychiatrists 1997). In the absence of locally agreed protocols, there is potential for misunderstanding, conflict and the development of dangerous situations. Local arrangements need to be clear and unambiguous in order to avoid the possibility of conflict (Royal College of Psychiatrists 2004). Unfortunately, it is often left to junior doctors and frontline police constables, often outside of normal working hours, to resolve these situations (Ryan and Perez-Avila 1997).

The Government's last detailed review of the operation of the Mental Health Act in 1999 concluded that police stations and emergency departments in hospitals should not be considered places of safety, and that places of safety should be clearly designated, disassociated from formal inpatient facilities, able to provide security and multidisciplinary assessment, and to be within easy access of medical facilities (Churchill et al. 1999). The report

recommended that a general revision of S136 was needed, including provision to implement S136 on private premises and improved policies surrounding the use of S136. In 2007 the Department of Health embarked on a £130m programme of building capacity in health-based places of safety, including dedicated facilities⁴³, although no money was provided for staffing the units. The Royal College of Psychiatrists noted that ‘without adequate staffing provision the danger is that either police will be expected to remain in the place of safety, which is an inappropriate use of their time and potentially stigmatising, or the police custody suite will continue to be used excessively (Royal College of Psychiatrists 2011).

Police Stations as places of safety

There has long been recognition that police cells are inappropriate as places of safety (Department of Health and the Home Office 1992, Jones and Mason 2002, Docking et al. 2008). In July 2011 the Royal College of Psychiatrists published *CR159: Standards on the Use of Section 136 of the Mental Health Act 1983* recommending that a police station should not be used as a place of safety (Royal College of Psychiatrists 2011). This was echoed in the HMIC report ‘*A Criminal Use of Police Cells*’, which recommended removing police stations as places of safety in the Mental Health Act 1983, and remanding patients in custody only in truly exceptional circumstances, and for a maximum of 24 hours (HMIC 2013). The Code of Practice for the Mental Health Act states that police cells should not generally be used unless in exceptional circumstances (Department of Health 2008). Only one definition of ‘exceptional use’ exists in the available academic literature, as arising ‘when the patient is too disturbed to be managed safely elsewhere’ (Hampson 2011). Despite this consensus that police stations should only very rarely be used as places of safety, police cells are widely used in practice, and not only on an exceptional basis, although figures vary across the country (Chalmers 2013).

The Joint Committee on the Draft Mental Health Bill 2005 estimated that, across the country as a whole, police cells may be used as a place of safety in approximately three out of every four uses of current powers (Joint Committee on the Draft Mental Health Bill 2005). The HMIC report found that the use of police custody as a place of safety varied from 6% to 76% of the total number of people detained under section 136, and noted that ‘those detained under section 136 who were taken to a police station were generally treated like any other person in respect of the booking-in procedure; risk assessment; and, ultimately, being locked in a cell (rather than being taken to another part of the station)’ (HMIC 2013).

A 1995 study of inner London police divisions showed that of 72 S136 detentions in six months, 50 were taken to a police station (69%) and 22 taken to hospital (31%); many of those initially taken to a police station were later removed to a hospital for psychiatric assessment (Revolving Doors Agency 1995). This may indicate that using police custody was at that time prevalent, although this may not be representative. HSCIC data suggests that in 2011/12 in England, 8,667 S136 detentions were made in police cells and 14,902 in hospitals (23,569 in total, of which 37% were in police custody) while in 2012/13, 7,761 S136 detentions were made in police cells and 14,053 in hospitals (21,814 in total, of which 36% were in police cells). This still suggests that police cells are currently used in more than a third of cases.

Patients can feel criminalised by this use of custody suites (Jones and Mason 2002), and by the use of police vehicles rather than ambulance transport for conveyance to the place of safety. Cells are small and unpleasant (Riley et al. 2011a), visibility is poor (of concern in those at risk of self-harm), and often people detained under S136 are not separated from those arrested for

⁴³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/243293/7093.pdf

criminal offences, allowing for potential harassment (HMIC 2013). Furthermore, detaining a person in a police cell could be perceived as treating them like a criminal, when they have not committed any offence. One survey of professionals engaged in S136 processes in Gloucestershire found that police officers sometimes expressed guilt at detaining individuals in police cells because of their mental illness, and felt the use of police custody was disproportionate, although recognising that the cells offered a degree of protection (Riley et al. 2011a):

'I find it really hard to get someone like that and have to keep them locked in a cell, because they are mentally ill, I just feel that there must be somewhere more appropriate to keep people like that. And then they start crying, hysterical, and it just seems wrong to me that you keep people like that, in a police cell, I find it really hard to do' (PC4, Riley et al. 2011a, p.40)

In interviews with 18 people who had experienced detention under S136, 16 of them thought that a police cell as a place of safety was unacceptable (Riley et al. 2011b). Most wanted somewhere they could feel safe, a sanctuary with suitable facilities which would prevent them from self-harming while detained. Most of the detainees and carers interviewed (12 out of 18) thought that emergency departments were not suitable places of safety as the staff had little experience of dealing with acute mental illness, and that there were great pressures on emergency departments to deal with patients who had been physically injured. Some commented that future provision of a place of safety should be either in a specialized unit adjacent to a psychiatric hospital or police station, where they would have access to treatment and someone with whom to talk (*ibid*).

'Just somewhere like [a psychiatric unit], somewhere with a room where you can talk to someone, a trained nurse like on [name of ward] with no mirror or coat hangers so you can't self-harm. Somewhere you don't feel threatened.' (084 detainee, Riley et al. 2011b, p.166)

To avoid police-cell detention, it has been proposed that S136 suites - dedicated environments for acute psychiatric assessments – should be created nationwide; that protocols should be standardised and rigorous; that police officers and mental health professionals should receive more training and be better integrated; and mental health care overall should be made more accessible and patient-friendly, thereby reducing acute crises and S136 admissions (*The Lancet* 2013).

Health-based places of safety

Since 2007 the number of health-based places of safety in England has increased, to 162 in 2014, according to the CQC's recent survey (CQC 2014) which was refreshed most recently in October 2014. The 162 designated health-based places of safety open at the end of March 2014 had a combined physical capacity for at least 208⁴⁴ people to be accommodated simultaneously. The most recent update found that the majority (102) of local authorities are served by only one health-based place of safety. 22 local authorities are served by two, 17 local authorities are served by three, 7 local authorities are served by four, Essex and Hampshire are served by six, and Lancashire is served by 12⁴⁵. As several police forces cover more than one

⁴⁴ Six places of safety responded that there was no limit on the number of people they would accept at any one time (five of which were emergency departments in acute hospitals); this has been counted as one for this purpose.

⁴⁵ The location and coverage of the places of safety was published by CQC in an online map in April 2014, available from www.cqc.org.uk/hbposmap.

local authority area, six police forces have just one health-based place of safety located within their jurisdiction, and Warwickshire Police are the only force to not have a health-based place of safety within their jurisdiction, although the Warwickshire local authority is served by a place of safety in Coventry. Forces with the highest numbers of health-based places of safety in their area are the Metropolitan Police Service (MPS) with 32, Greater Manchester Police with 12, and Lancashire Constabulary with 12 health-based places of safety.

132 (81%) of the 162 health-based places of safety are located on a mental health hospital site. Twenty three (14%) are based in an A&E department in an acute hospital and 7 (4%) are part of a mental health service on an acute hospital site. Of the 151 upper tier local authorities served by a health-based place of safety, 129 are served by places of safety located in mental health services only (whether on a mental health hospital or acute hospital site), 12 are served by places of safety located in both mental health services and A&E departments, and 10 are served by places of safety in A&E departments only.

There has been a six-fold increase in the rate of the Mental Health Act Section 136 detentions to places of safety in hospitals between 1984 and 2011, from 5.2 to 33.4 per 100 000 adult population (1959 in 1984/1985; 14 111 in 2010/2011) (Keown 2013). The author suggests this may reflect a shift from using police cells, but may also reflect a real increase in overall rate of detention and possibly a change in the threshold for the use of Section 136 detentions (*ibid*).

The CQC has said that in 50% of areas, bed occupancy is 90%, and in 15% of areas it is 100%. As well as the availability of beds in suitable, staffed, health-based places of safety, potential delays in the system also include the availability of suitably qualified section 12 approved doctors⁴⁶. A number of surveys comment on manpower shortages both in the police and health professions for dealing with patients with mental health disorders, including long waits for a social worker to arrive to assess a patient, and the impact on police resources when officers were required to transport a patient to hospitals which were a long distance from police stations (Dunn and Fahy 1987a). A survey from the 1980s of 41 police inspectors from the Metropolitan Police found that 71% of officers felt the levels of assistance they received in relation to S136 is inadequate, 61% reported having received inadequate training, and 56% said that hospitals did not provide enough support to the police (Dunn and Fahy 1987a). The report of the Mental Health Act Commission (2005, p.288) suggested that 'many patients are held for some time post-assessment in police stations whilst mental health professionals struggle to identify an available bed'.

The Mental Health Partnership Board for London produced standards for improving section 136 provisions across London, based on a survey of every accident and emergency and place of safety in London (over 400 units). They described the situation of patients being refused admission to a place of safety most commonly because of intoxication, physical health problems, boundary issues or because the place of safety is full. There is a description of police waiting with patients in vans, and the stress the situation is causing to the often fragile relationship between police and mental health services.

A survey in 2000 suggested that the police often felt dissatisfied by the scarcity of social workers (approved mental health professionals) and the strain placed on police resources: the survey looked at 178 consecutive S136 episodes in Devon and Cornwall, and found that the longest delay in completing S136 assessments was the arrival of the approved mental health professionals which took on average, three hours and 25 minutes (significantly longer than the

⁴⁶ <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm>

arrival of the psychiatrist), albeit in rural counties where resources can be more thinly spread (Greenburg et al. 2002). Social workers may expect the police to play a supportive or reassuring role in assessments, but the police view their involvement as only legitimate if there is a risk of violence or disorder.

Who is detained under S136?

Definitions of mental illness can be broad, sometimes serving as an umbrella-term for a number of different disorders. Approximately 7% of the UK's population have a serious mental illness such as schizophrenia, personality or delusional disorders, and there is a significant co-morbidity between mental illnesses, and other health problems, as well as over-representation among the offender population (Offender Health Research Network, 2012). Particularly vulnerable groups can include homeless people, people with drink and/or drug problems, veterans of military conflict, and the elderly who may suffer dementia.

A very small proportion of people with severe mental health conditions may at some time experience a mental health crisis which requires an emergency response from mental health crisis care teams, paramedics, or the police. The police do not routinely record who they have detained under S136, or the reasons why in terms of what behaviours were being exhibited (although in some areas local forms have been introduced to capture some of this information).

A typical patient profile for a S136 detention is a young, white, single, unemployed male, who is working class, homeless, without a GP, often suffering from psychosis, and with a past history of mental illness (Fahy 1989, Spence and McPhillips 1995, Gray et al. 1997, Churchill et al. 1999, Borshmann et al 2010b). It is clear that many of those detained come from socially deprived backgrounds. Another study noted that individuals detained under S136 were often disorganised and unsupported, with a high absconding and self-discharge rate, were less likely to be registered with a GP, and were unlikely to attend a follow-up (Fahy 1989).

Age profiles

The mean age for both men and women detained under S136 is between 32 – 41 years (Borschmann et al. 2010a), with some variation between different ethnic groups: black people are more likely to be younger; and white people older (Fahy et al. 1987). One study of 887 consecutive detentions in five south London boroughs between 2005 and 2008 showed that 57.4% were men, and detainees ranged in age between 13 to 86 years old (Borshmann et al 2010b).

There are particular concerns over the application of S136 to under-18s, especially where that results in police stations being used as the place of safety (because adult mental health units will not take them). Experimental data for 2011/12 suggested that 263 children and young people were held in police custody under S136 in that year, although that figure may not be exactly accurate due to different recording practices.

A recent study of 40 adolescents and adults detained under S136 over a three year period in a London Mental Health Trust, found that twice as many female as male adolescents were brought in on S136. Adolescents were found to have higher rates of institutionalization, abuse, criminal histories, and more likely to be brought in due to self-harm. Despite evidence of vulnerability and psychiatric problems, about half were admitted to hospital following assessment. The researchers went on to state that 'further research to address the needs and improve service provision for this group is indicated' (Patil et al 2013).

It is believed that S136 is very little used for elderly people, perhaps because they are felt to pose less of a risk, but anecdotal examples given to the review by the police included the detention of people in their 80s and 90s, as well as children as young as 11.

Gender profiles

Men account for between 50 – 60% of S136 samples (Spence and McPhillips 1995). The 2013 study of all 95,618 detentions in hospital under Section 136 and 5,896 under Section 135 between 1984/5 and 2010/11, once data on gender was available from 1988/9 onwards, showed that on average 59% of Section 136 detentions were of males (s.d. = 2.2, range 54-63%), and that the proportion of males detained under Section 135 increased steadily, from 40% in 1988/1989 to 57% in 2010/2011 (Keown 2013), but overall detentions were equally split between the genders (51% male on average between 1988 and 2011, s.d. = 6.7).

Although there are no studies of gender differences in S135 or S136 detentions, one study looked at 49 women (not S136 detentions) who were admitted mainly under S2 or S3 to a female-only psychiatric intensive care unit in Bristol in 2008, from police stations. This showed that, among this cohort, 65% of patients were single, 73% were Caucasian and 26% had BME background (Gintalaite-Bieliauskiene et al 2011). The most dominant diagnoses were Schizophrenia and Personality Disorder. 77% of admissions were due to physical aggression and severe self-harm. Most patients had more than 5 previous admissions to Mental Health wards. Most patients went on to be transferred to open acute wards.

LGBT profiles

No studies explored the detention rates for LGBT communities under S136 and this data is not gathered by police forces or health services. However, LGBT people are just as likely to experience in their lifetime poor mental health as the rest of the population. There is some evidence in the US and UK to suggest that some LGBT people are at higher risk of mental disorder, suicidal behaviour and drug misuse, often due to experiences of discrimination (Mays and Cochran 2001, King and McKeown 2003). Discrimination has been shown to be linked to an increase in deliberate self-harm in LGBT people (Meyer 2003). Gay and bisexual young men appear to be particularly vulnerable to suicide and suicide attempts, often associated with experiences of discrimination such as physical attacks and bullying (Warner, McKeown, and Griffin et al 2004).

LGBT people use mental health services more frequently than the general population but sometimes report poor experiences, including a lack of empathy about sexual orientation to incidents of homophobia (King and McKeown 2003): one in five lesbians and gay men and a third of bisexual men stated that a mental health professional made a causal link between their sexual orientation and their mental health problem (*ibid*). If such experiences discourage LGBT people from further approaching mental health services, they may be more likely to reach crisis point and so to come to the attention of the police, for example through detentions under S136.

Ethnic profiles

Although the majority of patients are white, there is a well-established over-representation of Black and Minority Ethnic groups among S136 detentions. Several research studies since the 1980s have found disparities between ethnic groups in the frequency with which S136 is applied, with African-Caribbeans particularly likely to be detained under S136 (Rogers and Faulkner 1987, Dunn and Fahy 1990, Pipe et al. 1991, Bhui et al. 2003, Fernando et al. 2005, Borschmann et al 2010b). Because this issue is also wider than S136 detentions, in this section the remit has been widened to reflect broader research including detentions made under other parts of the Mental Health Act 1983 and differing pathways to care.

Research shows that black communities are over-represented across mental health services (Keating and Robertson 2004), not only in S136 detentions. More African-Caribbeans, in particular, than would be expected based on the proportion in the general population, enter the psychiatric in-patient system, and at each point in the system the proportion of African-Caribbeans increases, from informal to civil commitment to detention on forensic sections via the courts (Cope 1989).

Bhui et al. (2003) undertook a meta-analysis of the literature and found that Black people were 4.31 times as likely to be compulsorily admitted to in-patient facilities and 18 out of 23 papers showed that Black people had a higher rate of admission compared with White patients. The police are more likely to be involved in admissions or readmissions of Black people, and Black people are more likely to present in crisis, including seeing the duty psychiatrist in A&E, and experience poorer outcomes including being over six times more likely to be detained under Section 2 of the Mental Health Act (Audini and Lelliott 2002, Bhui et al. 2003). However, no studies have looked at S135 detentions so any potential over-representation in S135 detentions is unknown.

There have been fewer studies on White subgroups, South Asians, services outside of London, and community and primary care (Bhui et al. 2003). Black and Asian patients experience more complex pathways to psychiatric care and have higher levels of police involvement and compulsory detention (Commander et al. 1999). A study of 120 psychiatric patients in north Birmingham in 1999 showed that, of 40 black patients, in 24 cases the police were involved in the decision-making process, compared to 16 out of 40 Asians, and 4 out of 40 white patients; while 21 of the black patients had been accompanied by the police in being brought to the facility, compared to 15 Asian and 4 white patients (*ibid*).

One study of 189 compulsory admissions under Section 2 of the Mental Health Act 1983 between 1996 and 1997 in Birmingham showed that Asians has the highest proportion of psychosis (64%) compared to African-Caribbean patients (48%) and White patients (41%), and almost half the group went on to be readmitted with Asian and African-Caribbean patients more likely to be readmitted (65% compared to 56% for Asian and 49% for White patients), and on readmission, African-Caribbean patients were more likely to be detained (87%) compared to White (61%) and Asian (65%) patients (Law-Min et al. 2003). More men than women were detained in all the ethnic groups. 64% of the sample were single and African-Caribbean patients were most likely to be single (83%) compared to White patients (65%) and Asian patients (40%) (*ibid*).

Various reasons for this over-representation have been proposed, including: ignorance and misinterpretation of different cultures (Bean 1991); that black people are more likely to find a route into mental health care through a point of crisis, rather than their GP (Bhui et al. 2003, Singh and Burns 2006), partly because of stigmas over mental health in black communities or because they are less likely to have their mental health problems recognised by their GP (Shaw et al. 1999); that Black people may have had experiences that encourage them to mistrust or fear mental health services (Keating and Robertson 2004) and the police; communication problems and language difficulties; and police attitudes which may be influenced by stereotypical or discriminatory views (Pipe et al. 1991) – particularly because S136 relies on the discretion and subjective judgement of the arresting officer (Sharpley et al. 2001, Fernando et al. 2005). One study on the operation of the civil sections of the Mental Health Act found that police officers are prone to associating Black people with higher risk factors (Browne 1997). 'Black people mistrust and often fear [mental health] services, and staff are often wary of the black community, fearing criticism, and not knowing how to respond, are fearful of black people,

in particular, young black men. The situation is fuelled by prejudice, misunderstanding, misconceptions and sometimes racism' (Keating and Robertson 2004, p.439).

Although most research has noted the disproportionately high rates of compulsory detention for young black men, there is also limited research suggesting there are also marked ethnic inequities between white British and black women, and also between white British and 'white other' women in experiences of acute admission. A study of 287 women from white British, white other, black Caribbean, black African and black other groups showed that, adjusting for social and clinical characteristics, all groups of black patients and white other patients were significantly more likely to have been compulsorily admitted than white British patients (Lawlor et al. 2012). The study also showed that white British patients were more likely than other groups to be admitted to a crisis house and more likely than all the black groups to be admitted because of perceived suicide risk.

Immediate pathways to care appear to be different for different ethnic groups (Lawlor et al. 2012). White other, black African and black other groups were less likely to have referred themselves in a crisis, and more likely to have been in contact with the police. When adjustment was made for these differences in pathways to care, the ethnic differences in compulsory admission were considerably reduced. Differences between groups in help-seeking behaviours in a crisis were considered a potential explanation for the differences in rates of compulsory admission. The findings apply to both migrant and British-born African-Caribbeans, and the highest detention rates are found in the second generation. The possible explanations put forward for these findings include the effects of socio-economic disadvantage, as well as racial stereotyping (*ibid*).

One study of psychosis among the African-Caribbean population in England (Sharpley et al 2001) explores a range of hypotheses for the increased rates of reporting of schizophrenia among the African-Caribbean population in England, suggested that there is no simple hypothesis that explains these results, but that the African-Caribbean population in England is at increased risk of both schizophrenia and mania, and that these higher rates remain when operational diagnostic criteria are used. The study noted that the findings for England are at odds with incidence rates reported for Caribbean countries, as the incidence of schizophrenia in Jamaica, Trinidad and Barbados is similar to the rate for the white population in England; therefore an explanation is needed as to why the incidence of schizophrenia is raised for African-Caribbeans living in England relative to their host population, and relative to their population of origin. The study concluded that factors included cultural variation in reporting symptoms, social disadvantage, and differences in interpretation of symptoms, diagnosis and expectations by health professionals (*ibid*). This finding that ethnic minority groups have higher rates of psychosis has been the subject of extensive research and has also been replicated in several other countries, such as the Netherlands.

There is a lack of qualitative research exploring detainee and professional experience of S136, and in particular the patient pathway to mental health care via S136 experienced by black detainees (Borschmann 2010a). Borschmann's study of 887 S136 detainees in a South London Mental Health Trust between 2005 and 2008 showed that black detainees were over-represented across all five London boroughs studied, averaging over the three years a threefold over-representation; while black people made up 5.2% of the general population of the area at the time, they accounted for 17.2% of the S136 detentions over the three year period (Borschmann et al 2010b). This was most pronounced in Wandsworth, where black people made up 7.6% of the general population, yet accounted for 29.7% of all S136 detentions (9.7% Black British, 6.7% Black African and 13.3% Black Caribbean). Black detainees were 57.9% men and 42.1% women, with an average age of 35.2 years (*ibid*). Significant differences were

found in the outcome of S136 assessments between different ethnic groups: black people were more likely than white and Asian people to be further detained under the MHA, and less likely to be either admitted informally or discharged.

However, not all studies showed an over-representation of the BME communities. One study of 93 first-episode psychoses in Haringey, London, did not find that ethnicity was the main predictive factor in whether the police were involved, showing that the majority (59%) consulted a health or social service as their first point of contact and only 14 (15.1) were brought in by the police, while there was no significant ethnic differences among those who were detained by the police. The researchers found that police involvement, compulsory admissions, and S136 were all strongly associated with the absence of GP involvement and the absence of a help-seeking friend or relative (Cole et al. 1995). The authors suggest that 'the debate about the relationship between Black people and psychiatry may have led the police force to become more sensitive to the concerns of the Black community in general and mentally ill Black people in particular, resulting in a more cautious approach in applying Section 136' (*ibid*, p.775). Alternatively, they suggest that police officers may be escorting patients to hospital more often on an 'informal' basis or that mentally ill people are diverted into the judicial system and that this may disproportionately affect the African-Caribbean community.

One rural study of the use of S136 in Gloucestershire between 2002 and 2006 showed, unlike some other studies, there was only a 'minor' over-representation of ethnic minorities. Of those individuals detained, about a third were admitted, a lower rate than in other studies (Laidlaw et al. 2010).

A recent study of 4,423 Mental Health Act assessments (not just S136) found that 2,841 (66%) resulted in a detention. A diagnosis of psychosis, the presence of risk, female gender, level of social support and London being the site of assessment were predictive factors in whether or not a person was detained, but ethnicity was not an independent predictor of detention (Singh et al 2013).

The police are not required to monitor the ethnicity of people they detained under S136 and this leads to a lack of good quality, national-level, data about the potential over-representation of these groups. Although not widely commented upon, one 1995 report says 'In view of the current sensitivity of the race issue for both police and psychiatric services the lack of agreed forms of ethnic monitoring as recommended by the Code of Practice is particularly disappointing' (Revolving Doors Agency 1995, p.33).

Social and health profiles

Many people detained under S136 are considered to be vulnerable people, who are more at risk of poor outcomes and sometimes have complex or hidden health needs, as well as possibly have contact with other services such as social services, housing services, and possibly drug services.

Unemployment was found to be a key factor in police involvement in a hospital admission, with the police 5.5 times more likely to be involved for an unemployed person compared to those in employment (Burnett et al. 1999). Other predictive factors include having a previous S136 admission, being previously known to psychiatric services (Pipe et al. 1991), living alone and not having a friend or family member to provide support. One 1993 study found that half of the 39 offenders detained in inner London over one year were listed as transitory or having no fixed abode and three quarters were unemployed (Mokhtar and Hogbin 1993).

Drug and alcohol misuse was reported as contributing to detention under S136 in between 8 – 29% of cases (Mohkhtar and Hogbin 1993, Fahy 1987 et al., Turner et al. 1992, McPhillips and Spence 1993). One large-scale study of 1,369 people with severe mental illness showed that 324 (24%) had used alcohol and/or drugs problematically in the previous year (Graham et al. 2001). Although drunkenness is specifically excluded as a sole reason for detention under the Mental Health Act, Greenberg et al (2002) found that 15% of 178 people detained under S136 were detained on the grounds of drunkenness. Some local police policies may state that a person cannot be assessed while drunk, and therefore they will not be accepted under S136 (Greenberg and Haines 2003).

A recent study of 245 individuals detained under S136 between February 2012 and July 2012 at a London Mental Health Trust showed that threatening to self-harm ($n = 100$, 44.8%) was the most common reason for assessment, and of the 245 patients assessed, 108 (44.1%) were found to be intoxicated with drugs and/or alcohol. Intoxication resulted in longer assessment times and a decreased likelihood of admission to hospital (Zisman and O'Brien 2014).

One study of the healthcare needs of detainees in police custody in London in 2007, which may have included some people detained there under S136 (although this is not clear), showed that mental health is a key issue for the police when holding people in police custody for whatever reason. Of 201 detainees in police custody, 25% were already in contact with other health teams, and 7.1% had previously been sectioned under the Mental Health Act 1983 (12 people) with a further three people having previously been in-patients at a psychiatric hospital as informal patients (Payne-James et al 2010). Mental health issues and depression predominated among the sample, and 16.7% had previously self-injured, including cutting themselves, overdosing, burning themselves, and attempted hanging. 16 of those detained received a mental health assessment, while 165 were examined to assess their fitness to be detained or interviewed. Drugs were also a significant factor (33.9% were dependent on heroin, 33.9% on crack cocaine; 25% on alcohol, 16.6% on benzodiazepines and 63.1% on cigarettes). Other medical conditions included asthma, epilepsy, diabetes, deep vein thrombosis, pulmonary embolism, hepatitis, and hypertension: of those prescribed medication, only 3 out of 70 had their medication available and many were not taking their medication at all, including six subjects with severe mental health issues who were not taking their anti-psychotic medication (*ibid*).

Reason for detention

Reasons for detention under S136 are not routinely collected, monitored or reviewed, but small-scale studies suggest that behaviours commonly precipitating a detention under S136 include causing a disturbance, threatened or actual violence towards a person or property, threatened or actual self-harm, verbal abuse and aggression, wandering in traffic, speech abnormalities, disorientation, threatening behaviour, and overt sexual behaviour (Gray et al. 1997). The available literature shows a high prevalence of schizophrenia, personality disorders, mania and drug-induced psychosis in individuals detained under S136 (Rogers 1990, Pipe et al. 1991, Turner et al. 1992, Mohkhtar and Hogbin 1993, Spence and McPhillips 1995, Martin and Thomas 2013). Diagnoses of schizophrenia and/or personality disorders were found to be significantly higher in individuals detained repeatedly under S136 (Pipe et al. 1991, Turner et al. 1992). Symptoms of psychosis such as hallucinations, delusions and paranoia can increase the risk of violence (Lipson et al. 2010).

Acts or threats of self-harm were common (55%), but acts or threats of violence (28%) and evidence of intoxication (16%) were present in a minority, suggesting that detainees are more

likely to pose a risk to themselves than others (Laidlaw et al. 2010). In a small study undertaken by the HMIC, the most frequent reason for detention (57 of 70, or 81%) was the perception of a risk of suicide or self-harm (HMIC 2013).

Studies in the US have suggested that most police-initiated referrals to mental hospitals were precipitated by an overt act or threat of self-harm, but that the presence of a psychiatric history, creation of a public disturbance and/or bizarre conduct were all potential behaviours resulting in the decision by the police to refer the person, mainly based on whether the police officers judged the situation to have the potential to escalate to a serious problem with danger to life or to others (Teplin and Pruett 1992).

One concern is that the police might inappropriately detain a person under S136 who has a learning disability, dementia, or is in fact suffering from the effects of alcohol, or toxicity such as aspirin overdose, which can lead to a very confused state (Apakama 2012) and for whom detention in a hospital is necessary so they can receive the correct diagnosis and medical care. Detention of people with health problems, and lack of access to medical care and prescribed medications, could also contribute to the number of deaths in police custody. It should be noted that providing involuntary psychiatric treatment is not possible in police custody and so appropriate medication should be administered in the appropriate medical setting (Ogloff et al. 2011).

Where S136 has been used

There is relatively little research into where the police have apprehended a person. One study of 57 individuals detained in 65 assessments under S136 (because of repeat detentions) in Westminster showed that the police had apprehended them on the streets (46.1%), railway station premises (16.9%) and Thames bridges (9.2%) and in 27.6% the place was unrecorded (Spence and McPhillips 1995). It might be that few researchers have considered where the person was detained as unimportant, or that this information is not recorded or is difficult to obtain from the police. Given that S136 applies only in 'places to which the public have access' and cannot be used in private homes, the place where it is used is a crucial aspect and its omission is a gap in the research literature.

Some evidence suggests that in practice S136 is not always used only in public places. Research studies suggested that between 74.5% (Rogers and Faulkner 1987) and 80% (Turner et al. 1992) of patients placed on S136 were detained in a public place (Lynch 2002) suggesting the rest were not. Anecdotal evidence from the police suggests that, when they are called to a person in mental distress in their own home, they sometimes find their own way around the requirement of S136 to be carried out in a 'public' place, such as making an arrest under breach of the peace until such time as the person is outside when they are de-arrested and the detained under S136. Alternatively the person may be coaxed out of the private place in order to be detained' (Revolving Doors Agency 1995, p.28). Some police report encouraging a person to move to a public place in order to apply a S136, in order to manage an urgent situation and feeling that no other appropriate power was applicable⁴⁷.

⁴⁷ <http://mentalhealthcop.wordpress.com/2011/12/19/section-136-and-private-premises/>

Patient experiences

There have been a small number of peer reviewed journal articles examining patient experiences of S136, using qualitative methods (Borschmann et al. 2010a) and very few studies of patient experiences of S135 detentions. One recent article explores the experiences of a person detained under S136 and their interactions with the police and health agencies, noting that while there were areas for improvement, the person had gone on to engage in a very positive way with the local police force and become engaged in training police officers (Gregory and Thompson 2013).

A small study of 16 all-male patients detained under S136 during 12 months in 1998, found that their initial interaction with the police left them in a state of passiveness, with little say in the decisions being made about them. There was a contrast between those who had been detained in hospital as a place of safety compared to those held in police cells. Those in hospital said they felt more safe and secure and part of the 'real world', while those taken to a police cell reported a more negative experience, feeling that police procedure removed not just their personal possessions, but also their sense of being an individual in the real world: 'Feeling dehumanised and being treated as a criminal was a common theme in this group... This created a feeling of being 'out of touch with normality' and feeling 'not quite human'' (Jones and Mason 2002, p.78). They felt punished for being mentally disordered and for taking up police time (Jones and Mason 2002, Katsakou and Priebe 2007), and moreover reported that this was simply what they expected, with one person commenting that 'being detained, handcuffed and thrown into a cell is part and parcel of mental illness these days' (*ibid*). While they expected the police to be negative and indifferent, they had anticipated that the hospital staff would be welcoming and reassuring: however, in the hospitals the ward staff were viewed as inaccessible, busy with other things, and disinterested.

One research project used semi-structured interviews for 40 patients from an English inner-city area, and found a general dissatisfaction with the quality of treatment they received both from the police and mental health professionals. This included receiving little attention, being viewed as a nuisance, having few treatment options, and expecting a higher level of care than they received (Jones and Mason 2002). The police were regarded as providing a lower quality of care than from mental health professionals, but this was – as in the previous study - seen as more acceptable.

A further piece of research was published in 2011, based on detailed interviews with 18 people who had experienced detention in police custody under S136, and their 6 carers (Riley et al. 2011b). This again showed a general dissatisfaction with the quality of care and treatment both from police and health professionals. Many of the detainees felt that the police lacked the skills needed to meet their needs, and 16 out of the 18 felt that the police station was an inappropriate setting. They found their experiences distressing, and made them feel like criminals. Some commented there was no-one to talk to or who would help calm them down. Others reported being cold and hungry, and unable to sleep because of noise from other people in the cells. One reported being kept in the dark as the light-bulb had been removed, presumably as a precaution against self-harm. All the detainees interviewed recalled being frightened by their experiences of being detained in a police cell. Some were handcuffed prior to their custody, which made them more agitated, and a few reported being shoved into a police van. Some had their personal possessions removed which had a 'dehumanising' effect (Riley et al. 2011b, p.167). Some said they had wanted to make a phone call but it was some hours

before they were allowed to do so. Only a few said the police had been good to them and had calmed them down quickly.

'I was handcuffed and put into a police van and taken straight from the van into the cells. I was terrified' (004 detainee, Riley et al. 2011b, p.165)

A few of the detainees though their condition had been made worse by not being allowed access to medication while in a cell, or because access to a medical practitioner was delayed. Some commented that their mental state had been worsened by being detained in a cell as it added to their stress and anxiety (Riley et al. 2011b):

'Not a nice place to stay. I didn't feel safe, it almost felt like I was being punished for having a mental illness, as if I wasn't allowed to feel depressed. Lots of other people in the cells were screaming and shouting and kicking doors, it made me really nervous, they handcuffed me, I started to struggle and I was on the floor in the police station and they were kneeling on me and my wrists were really hurting. The handcuffs made me more agitated.' (078 detainee, Riley et al. 2011b, p.166)

Of those interviewed, several reported being scared and confused and hearing voices that contributed to their feelings of paranoia (Riley et al. 2011b). Only a few recalled being informed about the reasons why they were in custody, being told by the police it was for their own safety, but said they were not listening when they were being restrained but were told later. Very few recalled being informed of their rights to make a telephone call (4 out of 18), see a solicitor (6 out of 18) or have someone notified of their detention (8 out of 18), although it is possible that their recall may not be factually accurate at such a time of crisis. The detainees were mainly aware of their deteriorating condition and health needs, and many admitted they were a danger to themselves (15 out of 18) but not to others (2 out of 18). Some recalled losing control, hearing voices, self-harming and suicidal feelings at the time of arrest, while 7 out of 18 were under the influence of alcohol when they were detained and knew that alcohol exacerbates their mental state. Some had no recall of the events leading up to their detention.

A study of psychiatric patients' experiences of involuntary hospital admission and treatment similarly showed that they experienced violations of their autonomy, feeling that their rights are taken away and they are given no say in what happens to them (Katsakou and Priebe 2007); sometimes they experience physical violations and coercion, when they are restrained, secluded, or given forced medication against their will. Patients found the ward environment not conducive to their wellbeing, and frightening; however in some cases people felt that the police and staff looked after them, took time to interact with them, and were interested in their progress. Overall, 'people suffering from mental health problems are particularly sensitive against any intrusions into their autonomy and privacy' but when given the chance to participate in decisions they find it easier to accept compulsory treatment (Katsakou and Priebe 2007, p.177).

There is very little research into whether people detained under S136 in police custody receive the appropriate care. One 1995 study of inner London police stations found that, of 23 S136 detentions taken to Paddington Green police station, in not one case was a solicitor called, nor an appropriate adult, despite this being laid down in the PACE Code of Practice (Revolving Doors Agency 1995). However, this is only a snapshot and may be unrepresentative, while awareness may have improved since then.

Outcomes

The usual outcome for a person detained under S135 or S136 is either formal or informal admission to hospital, or to be released following a mental health assessment. Data on the outcome of detention in hospitals under Section 136 is available from 1988 (on average, for 93% of such detentions in each year). The most common outcome was a change to informal status (67%), followed by detention under Section 2 (24%) and detention under Section 3 (9%). However, in years when there were fewer Section 136 detentions to hospitals, a greater proportion were subsequently detained under Section 2 or 3 (48% in 1994/1995). Conversely, in years where there were more Section 136 detentions, a smaller proportion was subsequently detained under Section 2 or 3 (17% in 2009/2010) (Keown 2013). In 2003/04, 69% of S136 detentions led to an informal discharge, and 30.2% went on to be detained under either Section 2 or 3; while by 2012/13 80.6% of S136 were informally discharged and only 17.3% detained under Section 2 or 3.

Evidence for the rates of discharge without being admitted to hospital vary considerably. One study of patients in Westminster showed 34% were released and 66% were admitted to hospital (Spence and McPhillips 1995): 32.3% were detained under S2 and 4.6% under S3. The main diagnoses were schizophrenia and personality disorders, but five were found to have other organic psychoses, two were alcohol dependent, two were not considered mentally ill, one had neurotic depression and one a mental handicap.

One large scale review of demographic and referral patterns for 887 people detained under S136 in a south London Mental Health Trust from 2005 to 2008 found that a high proportion of detentions (372 out of 887, 41.2%) did not result in hospital admission, while a further 209 (23.1%) resulted in an informal admission. Compulsory admissions accounted for 34.4% of detentions: 255 (28.2%) under Section 2, 52 (5.9%) under Section 3, and three (0.3%) under Section 4. The authors go on to say that 'implications for practice and service user experience should be considered as long as Section 136 remains an entry point to mental health services...there are implications for inter-professional practice where Mental Health Trust resources are expended supporting Section 136 detentions in which no hospital treatment follows' (Borshmann et al 2010b).

However, this result was higher than in several other older studies which suggest rates of discharge without hospital admission of 18% (Mohktar and Hogbin 1993), 8% (Turner et al. 1992). Other studies have shown rates of discharge without hospital admission of less than 10% (Rogers and Faulkner 1987, Dunn and Fahy 1990). All these figures, while varied, suggest that in the majority of cases, a S136 detainee is eventually admitted to hospital. However, one study of a rural area suggested that only 32% of people detained under S136 were eventually admitted to hospital (Greenberg et al. 2002).

In 2003/4, 30% of S136 detentions in London were further detained under S2 or S3 of the MHA, and almost all the remainder became informal inpatients, with only 0.5% discharged (Mental Health Act Commission 2005). In the surrounding regions, where data was available, admission was much less likely, with only 20% of S136 detainees in the East of England being admitted to hospital under S2 or S3, and 22% for South East England, while in the South West only 12% of people taken to hospital under S136 were detained under S2 or S3 after assessment, and 20% were released without entering formal or informal psychiatric care (*ibid*).

A recent data set from 1st April 2013 to 30th June 2013 in Wales showed that over 77% of people brought to hospital as a place of safety under Section 136 had not been formally admitted under either Section 2 or Section 3 following assessment (Goodwin 2013).

Length of detention

An individual detained under S136 may be held for a maximum of 72 hours. There is no national or systematic information available on the length of detentions of people held under S136.

The IPCC report suggested they have found the average length of detention to be nine hours 36 minutes (IPCC 2008). One study of 887 consecutive S136 detainees in a south London Mental Health Trust between 2005 – 2008 found that the mean average length of detention was six hours and 54 minutes (Borschmann et al 2010b), with no significant differences between ethnic groups or genders. Another study of 72 S136 detentions in inner London showed the average time spent in police custody before removal to a hospital for a psychiatric assessment was just under 4 hours (Revolving Doors Agency 1995). Another study of 57 people detained 65 times under S136 in Westminster over six months in 1991 showed 34% were not admitted to hospital: of those admitted to hospital, 27.9% stayed for less than 24 hours, between a day and a week in 37.2% of cases, and between a week and 28 days for 20.9%. Six people (14%) stayed for more than one month (Spence and McPhillips 1995).

Several Freedom of Information requests have been made to police forces which yielded some data on the issue. The average length of detention was just over nine hours (with a range of between 4 hours 30 minutes minimum to over 16 hours maximum)⁴⁸, ten hours 39 minutes in 2012/13⁴⁹ or 12 hours 19 minutes (739 minutes)⁵⁰. It is generally agreed that the majority of detentions are of less than 24 hours duration, and only a tiny minority go up to 72 hours, usually due to very unusual circumstances. In an example of case law, *MS v United Kingdom* 2012, in the European Court of Human Rights, the detention of a vulnerable person suffering from acute mental distress in a police cell for more than 72 hours was considered to be an affront to human dignity and reached the threshold of degrading treatment amounting to a breach of Article 3 of the ECHR⁵¹.

There is little data available on how long people had to wait for an assessment, although because, once an assessment has been carried out, the person must be either detained under another section of the Act, informally admitted to hospital, or released, so this should approximate to the total length of S136 detention. An unpublished study of 240 patients who had been placed on S136 in London showed that the average delay from the time the section was implemented to the time of presentation at the hospital was more than three hours (Dunn and Fahy 1987a). Other research found there is often a delay in commencing the assessment, and the first doctor does not always have Section 12 approval as recommended in the Codes of Practice (Hampson 2011).

The length of time was originally thought necessary to enable assessment by both an approved social worker and a registered medical practitioner. The time allowed for detention has led to fierce criticism, particularly as in many cases the place of safety is police custody. The Mental Health Act Commission (2005) recommended that the holding powers relevant to police stations should be limited to 12 hours. However, it is considered that in some parts of the country it could prove difficult to obtain the assessments in a shorter period (Kent and Gunasekaran 2010). Some health professionals suggested that in some circumstances it is best to wait for a

⁴⁸ Online at: <http://ww5.swindon.gov.uk/moderngov/documents/s65510/Mental%20Health%20-%20Section%20136%20detentions.pdf>

⁴⁹ Online at: http://www.dyfed-powys.police.uk/sites/default/files/disclosurelog/operational-policing/2013/final_response_doc_571.2013.pdf

⁵⁰ Online at: <http://www.nottinghamshire.police.uk/sites/default/files/documents/files/FOI%20011630%2013.pdf>

⁵¹ *MS v United Kingdom* (2012) 55 EHRR 23,

period before carrying out the assessment, especially if the person is intoxicated and may be unable to answer questions. There was a consensus that rapid assessment is not always appropriate where alcohol or drugs are involved (Riley et al. 2011a).

There have been anecdotal concerns raised by the police about how long they have to wait with a person before an assessment is carried out, sometimes suggested as often between 2 and 6 hours (Revolving Doors Agency 1995). A monitoring exercise in Holloway in 1993 showed that 5 S136 detentions took 59 hours and 50 minutes of police time, averaging just under 12 hours per S136 detention (*ibid*): the report added 'it would be interesting to see the effect on waiting times if the police were to charge the hospital for waiting time' (*ibid*, p.26).

Follow up care

Few research studies have included whether the person was later followed up or any further care provided. The study of 57 people in Westminster in 1991 showed that 'follow up of these patients was disparate' (Spence and McPhillips 1995). Over half (55.4% were followed up in another area: the hospital which admitted them followed up in 15.3% of cases, GPs followed up in 7.6% of cases, and social work follow-up in one case: 20% received no follow up care at all.

Of the 18 S136 detainees held in police custody who were interviewed in one study, 14 said they did not receive any follow-up following their release (Riley et al. 2011b). A third of them were admitted to a psychiatric hospital following assessment but most were released and carried on with community-based support from either secondary or primary mental health services (13 out of 18) and a few were referred to a community mental health team. Some said they had self-harmed since detention, and 8 of the 18 further attempted or considered suicide. Very few reported taking more care of themselves. A few had contacted their GP who in one case was able to change their medication, but other GPs were reported to give little help.

Out of hours care

Several studies have published findings showing that a majority of incidents involving S136 typically occur outside of standard business hours, with as many as 77% of cases taking place between 6pm and 9am the following morning (Mokhtar and Hogbin 1993, Pipe et al. 1991, Turner et al. 1992, Dunn and Fahy 1987b, Greenburg et al. 2002) –perhaps not surprising given that 76.2% of the hours in a week are outside of normal office hours (Borschmann et al 2010b).

The study of 887 S136 detainees in a South London Mental Health Trust between 2005 – 2008 showed that 220 (24.8%) detentions were made on weekdays between the hours of 09.00 and 17.00, and 665 (75%) detentions were made after 17.00 or on weekends (Borschmann et al 2010b): those detained out-of-hours spent significantly longer detained at a place of safety before a decision was made (7 hours and 14 minutes on average), compared to those detained during business hours (5 hours and 59 minutes on average). The study notes that 'the heaviest detention periods were also those when locating qualified mental health professionals can be most problematic', leading to pressure on resources (Borschmann et al 2010b).

Research suggests that the provision of round-the-clock mental health services can affect suicide rates, with one study of suicide rates between 1997–2006 showing that the provision of 24 hour crisis care was associated with the biggest fall in suicide rates: from 11.44 per 10,000 patient contacts per year (95% CI 11.12–11.77) before recommendations were implemented, to 9.32 (8.99–9.67) after ($p < 0.0001$) (While 2012).

Repeat S136 detentions

While there is no nationally available trend data for repeat detentions under S136, one study of 887 individuals detained under S136 in a South London Mental Health Trust between 2005 – 2008 showed that 70 individuals were detained more than once in the three year period (19.4% of the total number of detentions) and that one person, a white man in his late 20s, was detained on seven separate occasions (Borschmann et al 2010b). Recent data from 2012/13 showed that, of 8,072 people subject to S136 in that year, 7,117 were only detained once, 636 twice, 179 three times, and 140 four or more times.

Another 2011 study of S136 arrests in Gloucestershire over 18 months showed there were 250 arrests of 204 individuals, with some being detained on more than one occasion (Riley et al. 2011b).

Several authors report a lack of clinical follow up provided to individuals detained under S136 and not subsequently admitted to hospital, with results indicating that as many as 42% of those discharged without hospital admission receive no follow up from health or social services (Fahy et al. 1987, Pipe et al. 1991, Spence and McPhillips 1995).

Practitioner experiences

Several studies explored the different roles of police and health services in the operation of S136. They report poor communication between different agencies, poor levels of knowledge regarding the implementation of S136 (Lynch et al. 2002), and gaps in expectations between different agencies involved in the S136 process (Riley et al. 2011a). Studies have shown that relations between the social workers, health professionals and police officers can sometimes be poor and characterised by mistrust and misunderstanding (Churchill et al. 1999, Lynch et al. 2002, Maharaj et al. 2013).

A 1987 survey of 41 police officers found that some medical staff were cited as being 'obstructive and antagonistic', and police officers expressed surprise at the speed with which some patients under S136 were released from hospital, 'a feeling intensified by the lack of feedback from the hospital to the police station' (Dunn and Fahy 1987a). One study in the US found that the police did not understand the policy of community care: they perceived rapid release of people they had referred as a personal slight on their judgement, a waste of their time, and representing an unwillingness by the mental health profession to 'do something' (Teplin and Pruett 1992). However, it should be noted that the role of the police is to assess whether the person appears to them to be suffering from a mental disorder, and they do not necessarily need to be correct in their diagnosis (Jones and Mason 2002).

Psychiatric nurses can also be concerned that the police sometimes refer people who are inappropriate for hospital admission (Maharaj et al. 2013), with drugs and alcohol abuse being a common feature, and police-referred patients being among the most aggressive:

They are so wound up...they've gone right to crisis point...all they want to do is fight, they are not coherent, they are irrational, they are agitated, they are very often delusional. ('Wayne', Maharaj et al. 2013, p. 315)

The nurses also suggested that some persons were exploiting police and the mental health system for reasons other than accessing care and treatment, believing that some patients seeking care were manipulative, or attention-seeking:

Sometimes police bring them in, they have done something wrong, they may be looking at being charged for something and patients will turn around and say they are suicidal at the time...but on assessment they might not be found to be actually suicidal...they might be suicidal because they don't want to go to jail...if they threaten self-harm or suicide, the police will bring them here. ('Pauline', Maharaj et al. 2013).

'Some of the patients we admit should really not be admitted' ('Eddie', Maharaj et al. 2013)

In this study, nurses in a psychiatric hospital described patients presenting with alcohol misuse and often spending just one night in the locked ward only to be reviewed by the doctor and discharged the following day when they were no longer considered a risk. The nurses felt they were taking responsibility for the safety of the community by caring for patients who posed a risk to the community, and many felt that overnight admission for safety reasons was beneficial for the patients and the community, although created additional work, frustration over having to move on people who could benefit from more time on the ward to make space, and pressures on resources:

The drunks that wake up in the morning...at the end of the day we've given him a safe night, kept him from maybe killing himself or his wife ('Janet', Maharaj et al. 2013, p.316)

One recent study, of a small sample of nine police constables, sergeants, and community officers who were interviewed in depth on their views and experiences of dealing with people with mental health problems, suggested that they felt anger and frustration when they had problems accessing services for vulnerable individuals, and had to wait with the person for assessment only for that person to be released, and that repeated incidents with unsuccessful outcomes left the officers feeling powerlessness and resigned (McLean and Marshall 2010).

'I would say it's extremely frustrating...particularly when they have sat there hours and hours for them to walk out.' (Officer C, quoted in McLean and Marshall 2010).

The officers also highlighted the potentially negative impact of their intervention, recognising that police intervention had the potential to exacerbate the situation and increase the risk to both officers and the vulnerable person, and that taking a person to a police station could be very frightening for them and could exacerbate their symptoms (McLean and Marshall 2010).

A survey of professionals engaged in the S136 process in Gloucestershire suggested that there was a conflict between police and health professionals over the management of people with personality disorders, with the police describing experiences where they have detained a person who they believe to be mentally disordered, only for them to be released following assessment, and then found behaving the same way the next day (Riley et al. 2011a):

'Then you are presented with a situation where you have the same individual week later, presenting themselves in the same way, clearly there is something not right about them. There's clearly something strange about their behaviour, they're vulnerable because they're clearly not able to sort of look after themselves, attention is being drawn to them. But you know that only a few days before they've been brought in, and professionals have said that they are not fit to be detained, or that they don't need to be detained

because they don't have a disorder that fits with the definition of the MHA, as described for detention. So, we are between the devil and the deep blue sea' (S12 Dr 3, Riley et al. 2011a, p.39 – 40)

One of the main differences is, where the police are completely convinced the patient is...mad...generally it's the opposite. Where they don't think there's a problem, often again it's the opposite, they are the ones we end up admitting, because their view and our view is so radically different' (S12 Dr 3, Riley et al. 2011a, p.40)

Concerns were also expressed by mental health nurses when police leave detainees in the care of nurses at the hospital, having brought in a potentially dangerous individual for assessment, and then release them to hospital care and depart the premises (Riley et al. 2011a). Other research has found among some mental health professionals an 'anti-police' sentiment, as well as friction and a degree of non-co-operation between the services (Bean et al. 1991).

Failures in multi-agency working were cited in the study as resulting in the police being called upon to fill gaps, referring to lengthy waiting times, strict referral criteria, local mental health policies and lack of resources contributing to police officers' negative experiences of mental health services (McLean and Marshall 2010). Negotiating with a hospital can be frustrating for a police officer, who may not know the right catchment areas, and problems can arise over people who are of no fixed abode, or when the hospital has no mental health 'beds' available (Dunn and Fahy 1987a).

Difficulties in contacting a social worker, or long delays before they can attend, can act as a disincentive for police officers to involve social workers at a crisis stage (Dunn and Fahy 1987a). 66% of 41 police officers responding to a survey said that they had to apply S136 where more efficient back-up from health and social services might have avoided such an eventuality (Dunn and Fahy 1987a).

'The picture that emerges at present is one of health authorities with divergent policies (or no policy) on section 136 and the police trying to do a good but thankless job in a very difficult situation. Greater communication between psychiatrists, social workers and the police, and better back-up facilities could go a long way to make the operation smoother and more efficient, and help to stem the rising tide of criticism which threatens to engulf this section of the Mental Health Act 1983' (Dunn and Fahy 1987a).

Although the evidence on communication problems is patchy at best, anecdotal evidence suggests that it is fairly common for police officers taking people in mental health crisis to accident and emergency or medical-based places of safety for an assessment to be told, 'There's no bed available', 'The person is too drunk', 'They are under the influence of drugs', 'They are aggressive', 'They are a child', or, 'They have a learning disability', all of which mean the person will spend a night in police custody rather than a health based place of safety⁵².

During interviews with a range of professionals involved in S136 detentions in London in 2006 (Bather 2006), the most common issues raised were:

- **Lack of clarity of where the place of safety is** - confusion as to what the local designated place of safety is and how to access it, and access often being declined because of issues relating to alcohol consumption or dual diagnosis.

⁵² <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm>

- **Lack of understanding of roles, responsibilities and constraints of other agencies** – with frustrations about decisions being made in respect of those detained voluntarily or under section 136 powers.
- **The use of appropriate transport** – with different levels of response by the ambulance service, as a result of different local arrangements some crews would go to an accident and emergency unit where others would transport a patient direct to a psychiatric assessment centre. Police transport is still frequently used.
- **The inappropriate use of voluntary admissions** - it was reported that police often take a person to an accident and emergency unit or psychiatric assessment centre as a voluntary patient, and then leave the person in a waiting area to be seen in due course. This may expose those dealing with the individual to risk and as they have been dealt with as a voluntary patient there are limited powers to deal with the individual.
- **Using the health service instead of the criminal justice system** – there was a lack of clarity of when, why and how to access the criminal justice system as opposed to the Mental Health services.
- **Lack of guidance as to appropriate places of safety** - this is especially difficult when there has been an involvement of restraint or violence and a capacity to resuscitate may be required.
- **Inconsistent assessment facilities** - current facilities to undertake appropriate assessments are inconsistent in their build, furnishing and facilities. There is currently no clear guidance to deal with those occasions when the assessment centre is full, CS spray has been used or when those attending are turned away. The issue of alcohol consumption/dual diagnosis is dealt with inconsistently between assessment centres. Existing facilities are often unable to deal with the mix of mental illness, medical emergency and violence.
- **Lack of prior communication and information to support handovers** - when police do detain an individual under section 136 there is often no communication between police and the partner agencies prior to arrival at the assessment facility meaning the handover between police and clinical teams is inconsistent. Relevant information, including the use of any restraint and whether the person has been searched or not, is often not being communicated.
- **There is no clarity as to who is responsible when Police arrive at the assessment centre and how long they are expected to remain.**
- No debriefs - there is often no feedback or explanations to the police officers taking a person to the assessment centre by those conducting the assessment as to actions taken or diversions put in place.
- **Inconsistent monitoring** to ensure the appropriate use and evaluation of the 136 systems.
- **Lack of regular meetings for all agencies** – although there are regular liaisons between psychiatric assessment facilities and Police but generally this does not include accident and emergency units and the ambulance service.

Knowledge and training

Lord Adebawale's report in 2013 examined a number of serious incidents including deaths of patients with mental health problems in police custody in London. The report describes a lack of mental health awareness amongst officers, with patients reporting feeling that the police understanding of mental illness was poor. Patients said they wanted greater empathy and respect in their contact with police (Adebawale 2013).

Better mental health training for police officers has been identified a number of times as a key area for improvement (Riley et al. 2011a). It is not a problem unique to the UK (Ogloff and Thomas 2014). It has been widely suggested that police officers can lack understanding of mental health problems and may not know how best to help in a crisis situation. Police officers are often the first to be called to any incident of a person experiencing a mental health crisis, and may spend significant amounts of time interacting with people with mental health problems, but currently receive very little training in mental health awareness and recognition (Mental Health Act Commission 2005, Bather et al. 2008), nor has the effectiveness of training been adequately explored (Cummings and Jones 2010). A survey of professionals engaged in S136 processes found that this was an area where health professionals felt greater formal training should be offered to the police rather than mainly learning through experience 'on the job':

'No, training is minimal, unless you've got previous experience, um, to fall back on, um, it's you pick up that experience as you move along, as you...on the hoof' (PC2, Riley et al. 2011a, p.40)

'I feel that this leads back into the need for constant increased training of police officers out in the community around the appropriateness of the circumstances where they would choose to detain people on Section 136 rather than doing something else' (AMHP 4, Riley et al. 2011a, p.40)

The Westminster Hall backbencher debate on mental health and policing in November 2013 said that: 'There needs to be a higher level of training and awareness for police officers. The online training that is currently available is just not good enough. Some forces have teamed up with community groups, local health trusts and universities, working with mental health patients, to improve their operation. Best practice from these groups needs to be shared and expanded'⁵³. One US study suggested that, as the population grows and ages, dementia and mental health problems will become more common, and frontline officers will need to have the strategies to respond accordingly (Lipson et al. 2010) including de-escalation techniques, challenging stereotypes, and intervening safely and effectively.

A small number of surveys have been carried out of police officers and mental health professionals, which have found unsatisfactory levels of knowledge and confusion over correct practices (Latham 1997). One survey in 2000 of 87 doctors and senior nurses, and 92 police constables, in the Yorkshire region found that 24.1% of casualty staff and 10.9% of police did not realise that a person needs to appear to be suffering from a mental disorder to be detained under S136. Knowledge of who could apply a S136 was very poor: 29.9% of A&E staff thought that S136 could be enacted by any doctor, 60.9% of police officers thought that a psychiatrist could apply S136, and 40.2% of police did not even know that S136 is a police power. Over half, 55.2%, of casualty staff and 14.1% of police officers incorrectly believed that S136 could be applied within an individual's home. 25.3% of A&E staff and 16.3% of police officers were not aware that S136 applies only to places to which members of the public have access. 68.5% of police officers incorrectly thought that an official S136 form had to be provided, and 67.8% of A&E staff thought they should be provided with such a form, even though no such form existed at that time in the area. The survey also found that 22.8% of police officers and 10.3% of casualty staff had received any formal training on S136 (Lynch et al. 2002).

Despite concerns that police officers are not adequately qualified to recognise or diagnose mental illness (Jones and Mason 2002), police officers were found to be correct in their

⁵³ <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm>

decisions to detain individuals for psychiatric assessment in the majority of cases (Weller et al. 1988, Rogers 1990, Pipe et al. 1991, Morgan and Cordingley 1991, Spence and McPhillips 1995, Simmons and Hoar 2001) and may even under-use the power (Weller et al. 1988, Mokhtar and Hogbin 1993).

There are several examples of good practice and recommendations for improvement in the literature, including helpful medical staff, and local Crisis Teams who can be called out to police stations to assess a mentally disordered patient and decide on their subsequent management (Dunn and Fahy 1987a). In 2010 the National Improvement Agency issued guidance for police forces on how to respond to people with learning disabilities and mental health problems, although there were concerns that the approach would not be backed up by adequate and regular training (Mackenzie and Watts 2010).

Lack of adherence to law and Code of Practice

A 2005 review of S136 across London found there were no consistent auditing processes to ensure the appropriate use and evaluation of S136 systems (Care Services Improvement Partnership 2005). It is clear that sometimes S136 is used other than in 'a place to which the public have access' or patients have been unlawfully taken to hospital (Wallis 1989, Weller et al. 1988, Lynch et al. 2002) or excessive force has been used (Edeh 1987). However, there are pockets of good practice. One study of levels of adherence to S136 policy in Cardiff between October to December 2011, and the same months in 2012, found that adherence was high with the psychiatric hospital being used as the place of safety in the majority of cases, and all the assessments being joint assessments with an AMHP and Section-12 approved doctor (Oruganti and Andrew 2013).

A 2010 letter to the *Psychiatric Bulletin* suggested that Section 136 is very poorly managed as compared with the other sections of the Mental Health Act: 'There is no unitary form for Section 136 assessment documentation and no accountability for the assessments and detention of persons on Section 136' (Sadiq and Acharya 2010). Inconsistencies mentioned include that sometimes junior trainees attend to the Section 136 assessments, despite clear guidance in the Mental Health Act Code of Practice that it should be done by Section 12-approved doctors (Tate 2010); and that there are times when patients are admitted to in-patient beds under Section 136 for more than 48 hours, for example because the concerned Section 12-approved doctor is reluctant to come out to complete the Section 136 assessment out of hours.

Another potential issue is where health professionals feel that the police have used S136 'inappropriately' or 'excessively'. Early studies showed that the police make quite an accurate assessment of people needing psychiatric care: however as S136 numbers have increased in recent years there are concerns that the police are over-using the power in situations where health professionals judge that the person does not have a mental health problem, suggesting that something may have changed. Possibly, this suggests differing views taken by the police and health professionals over the circumstances where S136 should be used, or the lack of alternative police powers to address particular situations.

Deaths in police custody or afterwards

Approximately half of all deaths in or following police custody involve detainees with some form of mental health problem⁵⁴, although not necessarily having been detained under the Mental Health Act. The number of deaths in or following police custody for people detained under S136 is very small, but each death represents a tragedy. The deaths of people who were detained under S136 either in police custody, or following contact with the police, are particularly controversial, particularly for Black and Minority Ethnic (BME) communities where a small number of high profile deaths have caused great concern.

A report by the IPCC in 2010 found that in the decade between 1998/99 and 2008/09, seventeen people died after being detained under Section 136 of the Mental Health Act 1983 and being taken to a place of safety. Of these 17 individuals, nine were taken to police custody as a place of safety instead of hospital, despite guidance to the contrary. A further two people were detained under other sections of the Mental Health Act, and 39 additional people were identified either during the arrest or once in police custody as having possible mental health needs. A further 11 people were identified as being a possible suicide/self-harm risk⁵⁵.

Between 2004/05 and 2013/14, the overall trend has been for reductions in the number of deaths in custody. The number of people who have died while detained under S136 has remained very low over the past decade. In total, 15 people have died in the past 10 years in police custody while detained under S136 (7.3%):

	No. fatalities in police custody	No. fatalities in police custody detained under S136	Ethnicity of deaths in custody		No. fatalities in two days following police custody ⁵⁶
			White	Black	
2004/05	36	1	34	2	46
2005/06	28	2	23	1	40
2006/07	27	1	22	3	47
2007/08	22	2	19	1	45
2008/09	15	0	10	3	56
2009/10	17	2	16	0	54
2010/11	21	2	20	1	46
2011/12	15	2	13	1	39
2012/13	15	1	14	0	65
2013/14	11	2	10	0	68
Total	207	15	181	12	506

Deaths in police custody⁵⁷

⁵⁴ <https://www.ipcc.gov.uk/page/mental-health-police-custody>

⁵⁵ IPCC (2011) *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09*. Online at:

https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_In_Custody_Report_0811.pdf

⁵⁶ Including apparent suicides

⁵⁷ Including deaths that occur while a person is being arrested or taken into detention, and deaths of persons who have been arrested or have been detained by police under the Mental Health Act 1983. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle. Online at:

<https://www.ipcc.gov.uk/page/deaths-during-or-following-police-contact>

In 2009/10 four people of the 17 people who died in custody were identified as having mental health issues – of these, two had been detained under S136 of the Mental Health Act 1983⁵⁸. In 2010/11, two of the 21 people who died had been detained under S136⁵⁹. In 2011/12 and 2012/13, the number of deaths in police custody was 15 per year, fewer than in earlier years. But almost half (7 out of 15) of those who died both in 2011/12 and 2012/13 were known to have mental health concerns, the same proportion as in 2011/12. Four of those who died were known to have been restrained by police officers⁶⁰. In 2013/14, two of the 11 deaths in police custody were of people detained under S136, and in another two cases the persons was identified as having mental health concerns including post traumatic stress disorder, dementia, or erratic behaviour⁶¹. Both men detained under S136 had been restrained by police. One man was restrained using handcuffs, leg restraints and a spit hood, which was later replaced by a body cuff. The other man was physically restrained and had handcuffs and leg restraints applied. Both were taken ill while in custody and were transferred to hospital by ambulance where they died later that day. The cause of death is awaited for both men. All the incidents are subject to an independent investigation.

In 2012/13 and 2013/14 there was a considerable rise in the number of apparent suicides within two days of release from police custody, with 65 and 68 such deaths respectively⁶². A number had been arrested in connection with alleged sexual offences. In 2013/14 two-thirds of these individuals (45) were reported to have mental health concerns and three of these had been detained under the Mental Health Act 1983 prior to their death. Other mental health concerns included previous suicidal thoughts, suicide attempts, personality disorders or depression.

Among deaths following police contact in 2013/14, out of 33 ‘concern for welfare’ checks which resulted in deaths following police contact that were investigated by the IPCC, 5 fatalities occurred following concerns being raised about someone being a risk to themselves with regard to their mental health. All five people died as a result of self-inflicted acts, which included drug overdose and hanging.

Inquest raised concerns that ‘discriminatory assumptions concerning those with mental illness may be informing an inappropriate and dangerous policing response to those presenting in a medical crisis’⁶³ and suggest that a number of those deaths are linked to police restraint techniques.

⁵⁸ Online at: http://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_2009-10_v5.pdf

⁵⁹ Online at: http://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/deaths_report_2010_11.pdf

⁶⁰ <https://www.ipcc.gov.uk/news/ipcc-publishes-annual-deaths-during-or-following-police-contact-201213-%E2%80%93-mental-health-key>

⁶¹ Independent Police Complaints Commission (IPCC) (2014). *Deaths during or following police contact: Statistics for England and Wales 2013/14*. IPCC Research and Statistics Series: Paper 27. Online at: http://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1314.pdf

⁶² Independent Police Complaints Commission (IPCC) (2014). *Deaths during or following police contact: Statistics for England and Wales 2013/14*. IPCC Research and Statistics Series: Paper 27. Online at: http://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1314.pdf

⁶³ Online at: http://inquest.gn.apc.org/pdf/briefings/INQUEST_briefing_on_police_procedures_and_mental_health_Nov_2013.pdf

International comparisons

The review explored available literature in English on comparable police powers under emergency mental health legislation in other countries. However, because legal systems are very different, care needs to be taken with interpreting this as it is not comparing like with like.

Involuntary hospital admissions are practiced more or less throughout the world (Katsakou and Priebe 2007) and in most developed countries, the police have a power under relevant legislation to apprehend and detain for psychiatric assessment any person they believe to be in mental distress, and in most countries there is legal provision for compulsory emergency admission to hospital for mental health problems (Bindman et al. 2002). Legislation usually sets out situations where such powers can be used (for example, where the behaviour of persons with mental disorders represents a danger to themselves or to the public) and most countries permit the police to enter private premises, and take that person to a place of safety when there are reasonable grounds to suspect that person represents a danger to self or others. In an emergency, where the health and safety of the individual and/or those around him/her are at risk unless immediate action is taken, provision may be made in legislation for the police to act without a warrant.

Police usually have powers to take a person subject to involuntary admission to a designated mental health facility, for example, following an assessment by a mental health professional, or returning a person who is absent without leave from a mental health facility. Legislation may place restrictions on the activities of the police to ensure protection against unlawful arrest and detention of persons with mental disorders, including restricting police powers to take a person to a mental health facility or other secure location but not a prison or police facility, or only permitting them to act on the decision of a medically qualified person⁶⁴. One important goal of the criminal justice system should be to ensure that no one with a mental disorder is inappropriately held in police custody or in a prison.

Scotland has very similar powers relating to compulsory detention under mental health legislation to the UK, as set out in the Mental Health (Scotland) Act 1984⁶⁵, and amended by the Mental Health (Detention) (Scotland) Act 1991 and the Mental Health (Care and Treatment) (Scotland) Act 2003 (Macaskill et al 2011). Under Sections 292 to 298, which are comparable to S135 and S136 of the Mental Health Act 1983 in England and Wales, the police operate similar powers to detain people for up to 24 hours, for the purposes of a mental health assessment. However, the places of safety 'shall not include a police station unless by reason of emergency there is no place as aforesaid available for receiving the patient'. Scotland only permits entry to private premises with a warrant (S292)⁶⁶, while S297 applies only in places to which the public have access.

However, there are some differences from the England and Wales Act. In Scotland, a warrant granted under Section 293 or Section 294 authorises the removal of a mentally disordered person aged over the age of 16 to a specified place of safety, and also grants authority to enter premises to any Mental Health Officer specified in the warrant, any constable for the police

⁶⁴ Online at: http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf

⁶⁵ Online at: <http://www.legislation.gov.uk/ukpga/1984/36/contents>

⁶⁶ Online at: <http://www.legislation.gov.uk/asp/2003/13/section/292>

force area in which the premises are located or any other person specified in the warrant. The warrant also specifically authorises a police constable to open locked premises⁶⁷.

In Scotland, a place of safety is defined as a hospital, premises used for the purposes of providing a care home service, or any other suitable place (other than a police station), the occupier of which is willing temporarily to receive a mentally disordered person. The legislation specifically says that a police station may not be used as a place of safety, except where a mentally disordered person is removed from a public place under Section 297 and where no place of safety is immediately available. The person should be detained in the police station for the shortest time possible until a suitable place of safety is identified. The Code of Practice for Scotland goes on to say that 'Any designated place of safety will need to be suitably equipped and staffed by qualified mental health staff who have experience in the management of acute mental disorder. Although it may be necessary to designate an A&E department as a place of safety, their use should not be standard practice and should, wherever possible, be restricted to occasions where the person also has significant physical health problems related to, for example, self harm or substance misuse.. Where local agencies are designating places of safety within their locality, it would be expected that they would also develop contingency plans for occasions where a person is removed to an establishment other than a designated place of safety'⁶⁸.

While originally Scotland had 72 hours as the maximum period of detention, in 2003 this was reduced to 24 hours, from the point at which the police officer detained the person, not from the point of arrival at a place of safety as it is in England and Wales. Scotland has also placed their health boards under a legal obligation to provide a place of safety that is not a police station, other than in exceptional circumstances. The 2003 Act also placed a duty on police officers to inform several parties, including the Mental Welfare Commission for Scotland, of their use of the legislation within a specified timescale, although compliance with this requirement seems to have been variable (Macaskill et al 2011).

In Northern Ireland, the Mental Health (Northern Ireland) Order 1986 has some significant differences from the UK's legislation⁶⁹. Northern Ireland sets out in mental health legislation a definition of mental illness ("a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he requires care or medical treatment in his own interests or the interests of other persons") and requires that in order to justify detention, the person must suffer from mental disorder warranting detention in hospital, and that failure to detain him or her would create a substantial likelihood of serious physical harm to the patient or to others. However, S129 and S130 of the Act are substantially similar in function to S135 and S136 of the Mental Health Act 1983 for England and Wales. Section 129 provides for a warrant to be issued to grant police entry to private premises, while S130 applies only in a 'place to which the public have access'.

In certain circumstances where a member of the police force (the Garda Síochana) has reasonable grounds for believing that a person is suffering from a mental disorder and that there is a serious likelihood of that person causing immediate and serious harm to himself or herself or to others, the Garda may take the person into custody and, if necessary, enter any premises by force where he or she has reasonable grounds for believing that the person is to be found therein. In the Act, a place of safety can be any hospital, any police station, or any other suitable

⁶⁷ Online at: http://www.nes-mha.scot.nhs.uk/people_questions.htm

⁶⁸ Online at: <http://www.scotland.gov.uk/Publications/2005/08/29100428/04400>

⁶⁹ Online at: <http://www.legislation.gov.uk/nisi/1986/595>

place the occupier of which is willing temporarily to receive such persons'. Following taking a person into custody, the Garda must then make an application to a medical practitioner for the examination of the individual and a decision as to whether or not a medical recommendation should be made that the person be conveyed to an approved centre. It is the responsibility of the applicant to convey the person to the specified centre. If the applicant is unable to do so, then he or she may request the assistance of the centre and, if the centre finds itself unable to comply, then the applicant can request the police to convey the person. Once arrived at the approved centre, a consultant psychiatrist on the staff of the centre shall, 'as soon as may be', carry out an examination of the patient and, if he or she is satisfied that the person is suffering from a mental disorder, shall make the involuntary admission order which legally entitles the centre to receive and detain the individual. The person can be detained at the place of safety for a maximum of 48 hours.

In the Republic of Ireland, the police have powers under the Mental Health Act 2001⁷⁰, which include the power to make an application for a person to be involuntarily admitted (Section 9), and having powers to remove a person from private premises (Section 12): 'Where a member of the Garda Síochána⁷¹ has reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons', the police officer may take the person into custody; and enter, if need be by force any dwelling or other premises or any place, if he or she has reasonable grounds for believing that the person is to be found there." The police may take all reasonable measures necessary for the removal of the person concerned to the approved centre including, where necessary, the detention or restraint of the person concerned. The police must then make an immediate application to a registered medical practitioner, and if this is refused, must release the person immediately. If the medical practitioner is satisfied that the person is suffering from a mental disorder, then a consultant psychiatrist, a medical practitioner or a registered nurse on the staff of the 'approved centre' can take charge of the person concerned and detain him or her for a period not exceeding 24 hours for the purpose of carrying out an examination. An approved centre means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder that is registered by the Mental Health Commission.

In the Republic of Ireland, health practitioners have similar emergency powers to the police, as well as a power to require the police to assist. The clinical director of the approved centre or a consultant psychiatrist and the registered medical practitioner may, if they believe there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, request the Garda Síochána to assist the members of the staff of the approved centre in the removal by the staff of the person to that centre and the Garda Síochána must comply with any such request.

Most EU Member States regulate compulsory admissions of mentally ill people by means of special mental health laws. Only Greece, Italy and Spain do not. Almost all EU Member States have reformed their legislation within the last decade. Although all Member States stipulate a given and confirmed mental disorder as a major condition for detaining a person, some set additional criteria are not uniform across the European Union. Danger to oneself or to others is lacking as a criterion in Italy, Spain and Sweden. Among those countries that stipulate the need for treatment as a criterion, Finland, Ireland, Portugal, Spain and Sweden additionally emphasise a given lack of insight by the patient.

⁷⁰ Online at: <http://www.irishstatutebook.ie/pdf/2001/en.act.2001.0025.pdf>

⁷¹ Irish Police Service

Different countries permit different maximum length of detention under short-term emergency mental health legislation. The table below compares the maximum length of short-term detentions under mental health legislation in various different countries where information was available, and the decision-making authority (who can use the powers)⁷²:

	Maximum length of emergency short-term detention	Decision-making authorities for short-term detention
Denmark	24 hours	Psychiatrist
Germany (in 15 Federal States)	24 hours	Municipal public affairs office or psychiatrist
Republic of Ireland	24 hours	Psychiatrist
Luxembourg	24 hours	Police or physician or psychiatrist or guardian or social worker
New Zealand	24 hours	Police and duly authorised health professional
The Netherlands	24 hours	Mayor
Scotland	24 hours	Police or physician plus social worker
Spain	24 hours	psychiatrist
Sweden	24 hours	psychiatrist
Canada	48 hours	Police may take person to a physician
Northern Ireland	48 hours	Police plus physician
Austria	48 hours	psychiatrist
France	48 hours	mayor (Paris: police)
Greece	48 hours	prosecutor
Portugal	48 hours	psychiatrist
England and Wales	72 hours (3 days)	Police or physician plus social worker (AMHP)
Germany (in one Federal State)	3 days	Municipal public affairs office or psychiatrist
Finland	3 days	psychiatrist
Belgium	10 days	prosecutor

In France, when police officers are informed that someone presents a high risk of suicide, they must call for emergency medical services (Lepresle et al. 2013). A physician takes the decision to transfer the person to hospital. Any person suffering from mental disorder and needing immediate care is examined by a psychiatrist. In Paris, the Psychiatric Ward of the Police Prefecture allows police officers to get a psychiatric assessment for individuals with mental health needs who threaten their own safety or that of others, whether or not they have committed a crime and are kept in police custody. Any arrestee might, at their request, be examined by a doctor during custody (Chariot et al. 2008). A police officer, as part of their duty of protection, can also request a medical examination. Despite these legislative protections, many mentally ill patients are detained in custody (Falissard et al. 2006).

⁷² Based on information in http://ec.europa.eu/health/ph_projects/2000/promotion/fp_promotion_2000_frep_08_en.pdf

In Australia, under Section 22 of the 2007 New South Wales Mental Health Act, police can apprehend and refer a person for psychiatric assessment if the person appears to be ‘mentally ill or mentally disordered’ and ‘is committing or has committed an offence’, or is ‘imminently dangerous to self or others or is threatening or attempting suicide’ (Maharaj et al. 2013). Recent changes to legislation in New South Wales, Australia, sought to reduce police involvement in mental health by expanding state coercive powers to paramedics and registered mental health practitioners. While paramedics are taking on more emergency mental health responsibilities, police involvement does not appear to have been substantively reduced (Bradbury et al 2014) although the data quality is not ideal, because many voluntary transportations by ambulance are not recorded:

Financial year	Police (s. 22),* no. (%)			Ambulance ⁷³ (s. 20),no. (%)			Total no. presentations ⁷⁵
	Admitted	Not admitted	Total ⁷⁴	Admitted	Not admitted	Total†	
2008–09	2712 (80%)	682 (20%)	3394 (22%)	263 (99%)	4 (1%)	267 (2%)	15 496
2009–10	2536 (74%)	889 (26%)	3425 (23%)	494 (85%)	88 (15%)	582 (4%)	15 199
2010–11	2293 (71%)	940 (29%)	3233 (22%)	669 (69%)	301 (31%)	970 (7%)	14 566
2011–12	2150 (69%)	968 (31%)	3118 (20%)	742 (73%)	272 (27%)	1014 (6%)	15 765

In New Zealand, the Mental Health (Compulsory Assessment and Treatment) Act 1992 sets out the powers of police and others. A duly authorised officer (DAO) is a health professional granted particular powers under this Act. A DAO can take all reasonable steps to take the person to a medical practitioner for an examination if less-restrictive options of facilitating a medical examination have been exhausted, and if there are reasonable grounds for believing a person may be mentally disordered. A DAO will be consulted for advice as they may be best placed to determine whether police assistance is necessary. If necessary, a DAO can request police assistance to take a proposed patient to a nominated place for the purposes of an examination under section 10 of the Act. Police can be called to assist a medical practitioner under sections 110, 110A or 110B of the Act. Under section 113A, a Director of Area Mental Health Services (DAMHS) can request a warrant from a District Court Judge for police to help enter premises. The examining doctor may arrange for the patient’s admission to hospital⁷⁶. Where a person is found in a public place and gives rise to the reasonable belief that he or she may be mentally disordered, the police may take that person to an appropriate place and arrange for a medical practitioner to examine the person as soon as practicable. Police may detain the person until an assessment examination has been conducted, up to a maximum of 24hrs from the time they were first apprehended.

In Canada, there are several different, but broadly similar, Acts covering different Areas. In British Columbia, the Mental Health Act 1996, Chapter 228, Section 28 sets out that a police officer may ‘apprehend and immediately take a person to a physician for examination ‘if

⁷³ These data refer to the Australian Mental Health Act ss. 20 (paramedics) and 22 (police) only and do not include mental health transports by police under other sections of the Act, including police assistance to ambulance (s. 21), doctors and accredited persons (s. 19), carers (s. 23 and s. 26), courts (s. 33), breach of Community Treatment Orders (s. 142 and s. 58), nor voluntary or informal transports by police or paramedics.

⁷⁴ Proportion of total agency (police or ambulance) transports (under schedule) to total presentations at mental health facilities (NSW Health).

⁷⁵ Does not include people reclassified from informal to involuntary.

⁷⁶ *Pers. Comm.* New Zealand Ministry of Health, August 2014.

satisfied from personal observations, or information received, that the person is acting in a manner likely to endanger that person's own safety or the safety of others, and is apparently a person with a mental disorder'. This applies both in public and private places and does not require a warrant to remove the person from private premises. The person must be released if the physician does not complete a medical certificate under S22(3) and (4) within 48 hours. A judge may also issue a warrant for the apprehension of the person to be admitted and for the transportation, admission and detention of that person for treatment in or through a designated facility⁷⁷.

In Ontario, Canada, the Mental Health Act 1990, Section 17, sets out that 'Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself, has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her, or has shown or is showing a lack of competence to care for himself or herself, and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in serious bodily harm to the person or others, and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician⁷⁸. A medical examination under section 16 or 17 shall be conducted by a physician immediately after receipt of the person at the place of examination and, where practicable, the place shall be a psychiatric facility or other health facility.

Legal reform since 1983

Mental health legislation in England and Wales has a very long history and reform has traditionally been slow, piecemeal, and difficult, and set within a changing social context of attitudes towards mental health, stigma, and increasing understanding of mental health issues (Bartlett 2009). As a key book on mental health law notes, 'wholesale statutory reform has so far been elusive. This is not for want of trying on the part of Government' (Bartlett and Sandland 2007). This literature review cannot encompass the entirety of change in mental health legislation, but has highlighted some areas relevant to S135 and S136.

The process of reforming the Mental Health Act 1983 began in the late 1990s but the draft Mental Health Bill of 2002 was abandoned, as was the modified version which was published in 2004. Both encountered controversy and widespread opposition, although not relating to S135 or S136. In 2005 the Mental Capacity Act came into effect, and in 2006 the Government introduced another Mental Health Bill. The subsequent Mental Health Act 2007 did make significant changes to the 1983 Act, but did not substantially amend S135 or S136, only making provision for persons to be transferred between places of safety during the 72 hours of detention.

In 2002, the Joint Committee on Human Rights recommended that healthcare trusts should have a statutory duty to take responsibility for and look after people detained under S136. However, this was not introduced. In 2005, the World Health Organization (WHO) published its *Resource Book on Mental Health, Human Rights and Legislation* (Geneva: WHO), presenting a

⁷⁷ Online at: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01#section28

⁷⁸ Online at: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm#BK14

detailed statement of human rights issues which need to be addressed in national legislation relating to mental health (Kelly 2011). Legislation in England and Wales was considered to meet 90 out of the 166 (54.2%) of the WHO standards examined (while legislation in Ireland met 80 of the standards - 48.2%). Areas of high compliance include definitions of mental disorder, relatively robust procedures for involuntary admission and treatment (although provision of information remains suboptimal) and clarity regarding offences and penalties.

There were lengthy debates leading to the introduction of the Mental Health Act 2007, including aspects of S135 and S136, and there were a number of controversies. Lord Patel said ‘the Mental Health Act appears to be a set of second-rate provisions, outdated attitudes and the shifty machinations of a Home Office forever seeking unfettered powers of social control’ (Hansard 26th February 2007, col. 1482).

In its submission to the Joint Committee on the Draft Mental Health Bill, the IPCC recognised that police cells may be required as last resort places of safety, but suggested that the next Act should provide a duty upon health authorities to provide alternative facilities, and that any use of holding powers at a police station should be limited to 12 hours rather than 72 hours, with the presumption that any holding power running over 12 hours should be continued following transfer to health facilities⁷⁹.

During the Lords Committee stage, amendments No. 54⁸⁰ and No. 58A⁸¹ would have substituted in S136 and S135 respectively ‘24 hours’ for ‘72 hours’ as a maximum limit of detention, and under S136 put into primary legislation that ‘a police station must not be used as a place of safety under this section unless the circumstances of the case are exceptional’, further stating that where a police station is the place of safety, the person must be as a matter of urgency be examined by a registered medical practitioner and interviewed by an approved mental health professional and necessary arrangements made for care or transfer to another place of safety. Under S135, Amendment 58A would have amended the definition of a place of safety. Neither amendment was made.

The subsequent debate on the use of police cells as places of safety stated that the police do not have the training and expertise required to look after mentally disordered or suicidal persons, and that police stations carry an implication of wrongdoing making them inappropriate for the management even of very disturbed mentally ill people, and that a significant number of deaths in police custody have involved people with mental health problems (Earl Howe, Lords Committee stage debate, 17th January 2007: Column 754) – resulting in ‘fragile, vulnerable and very sick people held in police custody for up to three days’ (Baroness Neuberger, Lords Committee stage debate, 17th January 2007: Column 755).

For the Home Office, Lord Hunt of Kings Heath said that the issue the government have to deal with is that there may be occasions when a police station is the only available facility and when it is necessary, in some circumstances, to detain a person there for longer than 24 hours, if it was impossible to get a doctor and approved mental health professional to get to the police station and interview him within that time, perhaps in a rural area, noting that the person may be agitated or behaving aggressively or violently, or may be uncooperative. The debate noted that

⁷⁹ Joint Committee on the Draft Mental Health Bill (2005) *Draft Mental Health Bill*. Vol 3. Memorandum from the IPCC (DMH 206) para 7, p.912.

⁸⁰ <http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70117-0017.htm>

⁸¹ <http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70117-0018.htm>

the Code of Practice stated that police stations should be used only in exceptional circumstances.

In the Commons debate in 2007, amendment No. 7⁸² would have altered the definition of a place of safety to read 'if in the circumstances of the case it is impracticable to use any of these places, a police station', noting that 'police cells are the norm, not the exception', and inserted the phrase 'where a police station is used as the place of safety the person may not be detained there for a period longer than 24 hours' (Tim Loughton, Commons Public Bill Committee, 15th May 2007, Column 381). The debate suggested that being taken into custody may delay the provision of effective treatment and exacerbate the illness, and also suggested that the use of police cells as a place of safety has significant resource implications for police custody facilities. The debate noted that the issue is of particular relevance to black and minority ethnic communities, especially African and Caribbean communities, because rates of S136 orders are disproportionately high for this group. It was noted that the Committee has received reports flagging the use of police cells, particularly for young people aged 16 - 18. Evidence submitted to the Mental Health Bill Committee stated that:

'CAMHS services do not usually provide any facilities for a 'Place of safety' for children subject to S136 of the Mental Health Act, and even in those areas where there is appropriate 'Place of safety' provision in the local adult mental health services, these hospital based S136 suites do not accept children or young people under the age of 18, so instead these vulnerable distressed youngsters are held in police custody, an even more inappropriate setting for them'.⁸³

Dr Pugh added that 'if 24 hours is thought to be too short a period because places might not always be available in that timescale, we could adopt a more sophisticated amendment whereby the 24-hour provision would be the norm, with a requirement for exceptional permission to be sought if a longer period were required' (Dr. Pugh, Commons Public Bill Committee, 15th May 2007, Column 386). For the Home Office, Ms Winterton noted that the IPCC report suggests that the average amount of time in police custody under S136 of the Act is 10 hours and that the vast majority of detainees leave police custody within 18 hours, meaning that a small minority do need to stay in detention for longer than 24 hours, which the amendment would have made impossible. She also said that the issue was whether imposing statutory restrictions was the right way to address the concerns: 'we believe that the right way forward is to limit the use of police stations by facilitating the good practice that we know occurs in some places', through revisions to the Code of Practice (Ms Winterton, Commons Public Bill Committee, 15th May 2007, Column 388).

In a Westminster Hall debate in November 2013⁸⁴, it was stated that 'Too often, between 5 pm and 9 am during the week, at weekends and on bank holidays, police officers are the only first responders available in a mental health crisis, despite the fact that they lack the medical knowledge, skills and training to resolve and manage the crisis...The Centre for Mental Health states that the police are commonly a first point of contact for a person in a mental health crisis. and that up to 15% of police incidents have a mental health dimension. Other people have told me that mental health interventions occupy up to 30% of police time' (Madeleine Moon, Westminster Hall backbench debate, Thursday 28th November 2013). The debate went on to

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<http://www.publications.parliament.uk/pa/cm200607/cmpublic/mental/070515/am/70515s03.htm#07051550000150>

⁸³ <http://www.publications.parliament.uk/pa/cm200607/cmpublic/mental/memos/ucm5702.htm>

⁸⁴ <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm>

state that we 'should move to a situation in which we do not, in a civilised and compassionate society, house people in police cells when they are suffering some of the most desperate moments in their life' (James Morris, Westminster Hall backbench debate, Thursday 28th November 2013, Column 145WH).

In February 2014 an amendment was laid, and then withdrawn following Committee debate, to the Care Bill which would have required the police to record information about the age of each person detained under S136 in police custody, how long they were detained for, what medical and other assessments were made of their needs, what the result was in each case, and to provide a report on the implications of the police charging local authorities and NHS commissioning bodies for the use of police cells.

Methodology

This literature review includes academic peer-reviewed journal articles, previous literature reviews, Hansard debates, and other reports and data sets. It does not cover articles predating 1983 (although these parts of the Act have been in place since at least the Mental Health Act 1959), or older mental health legislation generally apart from a brief introduction to legal reform in this area. This is in order to focus the literature review on more recent studies which reflect current issues, and because both policing and health systems, as well as attitudes to mental health, have changed significantly since 1959. All the information used here is open source.

Searches were carried out on Google Scholar, for all years since 1983, on the search terms: 'mental health and police', 'Section 135', 'Section 136', 'S135', 'S136', 'police stations place of safety', 'places of safety'.

Searches were carried out on EMBASE, HMIC, MEDLINE, PsycINFO, and BNI, for the following search terms: 'Section 135', 'Section 136', 'S135', 'S136' 'police AND mental health', for publication years 2010 to current.

Searches were also carried out on the Social Policy and Practice database for the terms: 'Section 136', 'Section 136 and mental health act', 'mental health and police' for 2010 - 2013. Additional references were obtained from the published references in other articles.

The draft Literature Review was circulated to the attendees of the academic roundtable event held for the review of the operation of Sections 135 and 136 of the Mental Health Act 1983 in April 2014.

The draft then underwent double-blind peer review with three external reviewers, and an audit was kept of comments and changes made as a result. The draft was then circulated among a group of external experts alongside the summary of the evidence base for the review.

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Annex A: Legislation

Sections 135 and 136 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007 and other legislation)

135 Warrant to search for and remove patients.

(1) If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder –

- a. has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or
- b. being unable to care for himself, is living alone in any such place,

the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

(2) If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act or under article 8 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (Consequential Provisions) Order 2005 to take a patient to any place, or to take into custody or retake a patient who is liable under this Act or under the said article 8 to be so taken or retaken –

- a. that there is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice; and
- b. that admission to the premises has been refused or that a refusal of such admission is apprehended,

the justice may issue a warrant authorising any constable to enter the premises, if need be by force, and remove the patient.

(3) A patient who is removed to a place of safety in the execution of a warrant issued under this section may be detained there for a period not exceeding 72 hours.

(3A) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (3) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(3B) A person taken to a place of safety under subsection (3A) above may be detained there for a period ending no later than the end of the period of 72 hours mentioned in subsection (3) above.

- (4) In the execution of a warrant issued under subsection (1) above, a constable shall be accompanied by an approved mental health professional and by a registered medical practitioner, and in the execution of a warrant issued under subsection (2) above a constable may be accompanied –
- a. by a registered medical practitioner;
 - b. by any person authorised by or under this Act or under article 8 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (Consequential Provisions) Order 2005 to take or retake the patient.
- (5) It shall not be necessary in any information or warrant under subsection (1) above to name the patient concerned.
- (6) In this section “place of safety” means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948..., a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient.

136 Mentally disordered persons found in public places.

- (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.
- (2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.
- (3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.
- (4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection.

Annex B: Comparison with the Mental Health Act 1959

Mental Health Act 1983 (as amended by the *Mental Health Act 2007* and other legislation)

Mental Health Act 1959 (as enacted)

135 Warrant to search for and remove patients.

(1) If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder –

- a. has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or
- b. being unable to care for himself, is living alone in any such place,

the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

(2) If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act or under article 8 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (Consequential Provisions) Order 2005 to take a patient to any place, or to take into custody or retake a patient who is liable under this Act or under the said article 8 to be so taken or retaken –

- a. that there is reasonable cause to believe that the patient is to be found on premises within the

135 Warrant to search for and remove patients.

(1) If it appears to a justice of the peace, on information on oath laid by a mental welfare officer, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder –

- a. has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or
- b. being unable to care for himself, is living alone in any such place,

the justice may issue a warrant authorising any constable named therein to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part IV of this Act, or of other arrangements for his treatment or care.

(2) If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act to take a patient to any place, or to take into custody or retake a patient who is liable under this Act to be so taken or retaken, –

- a. that there is reasonable cause to believe that the patient is to be found on premises within

<i>Mental Health Act 1983 (as amended by the Mental Health Act 2007 and other legislation)</i>	<i>Mental Health Act 1959 (as enacted)</i>
<p>jurisdiction of the justice; and</p> <p>b. that admission to the premises has been refused or that a refusal of such admission is apprehended,</p> <p>the justice may issue a warrant authorising any constable to enter the premises, if need be by force, and remove the patient.</p> <p>(3) A patient who is removed to a place of safety in the execution of a warrant issued under this section may be detained there for a period not exceeding 72 hours.</p> <p>(3A) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (3) above, take a person detained in a place of safety under that subsection to one or more other places of safety.</p> <p>(3B) A person taken to a place of safety under subsection (3A) above may be detained there for a period ending no later than the end of the period of 72 hours mentioned in subsection (3) above.</p> <p>(4) In the execution of a warrant issued under subsection (1) above, a constable shall be accompanied by an approved mental health professional and by a registered medical practitioner, and in the execution of a warrant issued under subsection (2) above a constable may be accompanied –</p> <p>a. by a registered medical practitioner;</p> <p>b. by any person authorised by or under this Act or under article 8 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions)</p>	<p>the jurisdiction of the justice; and</p> <p>b. that admission to the premises has been refused or that a refusal of such admission is apprehended,</p> <p>the justice may issue a warrant authorising any constable named therein to enter the premises, if need be by force, and remove the patient.</p> <p>(3) A patient who is removed to a place of safety in the execution of a warrant issued under this section may be detained there for a period not exceeding seventy-two hours.</p> <p>(4) In the execution" of a warrant issued under subsection (1) of this section, the constable to whom it is addressed shall be accompanied by a mental welfare officer and by a medical practitioner, and in the execution of a warrant issued under subsection (2) of this section the constable to whom it is addressed may be accompanied –</p> <p>a. by a medical practitioner;</p> <p>b. by any person authorised by or under this Act to take or retake the patient.</p>

Mental Health Act 1983 (as amended by the *Mental Health Act 2007 and other legislation*)

Mental Health Act 1959 (as enacted)

Order 2005 to take or retake the patient.

- (5) It shall not be necessary in any information or warrant under subsection (1) above to name the patient concerned.
- (6) In this section "place of safety" means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948..., a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient.

136 Mentally disordered persons found in public places.

- (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.
- (2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.
- (3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a

- (5) It shall not be necessary in any information or warrant under subsection (1) of this section to name the patient concerned.
- (6) In this section " place of safety" means residential accommodation provided by a local authority under Part III of the National Health Service Act, 1946, or under Part III of the National Assistance Act, 1948, a hospital as defined by this Act, a police station, a mental nursing home or residential home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient.

136 Mentally disordered persons found in public places.

- (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of the last foregoing section.
- (2) A person removed to a place of safety under this section may be detained there for a period not exceeding seventy-two hours for the purpose of enabling him to be examined by a medical practitioner and to be interviewed by a mental welfare officer and of making any necessary arrangements for his treatment or care.

<i>Mental Health Act 1983</i> (as amended by the <i>Mental Health Act 2007</i> and other legislation)	<i>Mental Health Act 1959</i> (as enacted)
<p>place of safety under that subsection to one or more other places of safety.</p> <p>(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection.</p>	

Annex C: Relevant Case Law

Section 135 case law:

Case name
R (Sessay) v South London and Maudsley NHS Foundation Trust and another (2011) [2011] EWHC 2617 (QB)
Ward v Metropolitan Police Commissioner and another (2005) [2005] UKHL 32
R v Rosso (2003) [2003] EWCA Crim 3242
D'Souza v Director of Public Prosecutions (1992) [1992] 1 WLR 1073

Section 136 case law

Case name
MS v United Kingdom (2012) (2012) 55 E.H.R.R. 23
Seal v UK (2010) (2012) 54 E.H.R.R. 6
Seal v Chief Constable of South Wales Police (2007) [2007] UKHL 31
R (on the application of Anderson) and others v HM Coroner for Inner North Greater London (2004) [2004] EWHC 2729 (Admin)

Other relevant case law

Case name
Webley v St George's (2014) [2014] EWHC 299 (QB)
Commissioner V Hicks (2014) [2014] EWCA Civ 3
Harriot v Director of Public Prosecutions (2005)

[2005] EWHC 965 (Admin)
Williamson v Chief Constable of West Midlands Police (2004) [2003] EWCA Civ 337
Williams v Director Public Prosecutions (1992) [1992] 95 Cr. App. R. 415
Carter v Metropolitan Police Commissioner (1975) [1975] 1 W.L.R. 507
Pugh v Knipe (1972) [1972] R.T.R. 286
Sandy v Martin (1972) [1974] R.T.R. 263
R v Kane (1965) [1965] 1 All E.R. 705
R v Waters (1963) (1963) 47 Cr. App. R. 149

Annex D: Data sets for S135 and S136

Table 1: Places of safety orders made where detention was in NHS and independent hospitals. England only, compiled from Health and Social Care Information Centre (HSCIC) published annual reports. Police data from IPCC (2008), HMIC (2013) and HSCIC experimental data sets for 2012/13 and 2013/14⁸⁵.

	England - all POS orders in hospitals	England - S135 detentions in hospitals ⁸⁶	England - S136 detentions in hospitals	S136 detentions in police custody	S136 detentions in hospitals converted to S2 or S3	S136 detentions in hospitals converted to informal status
1984	2,027	68	1,959	-	-	-
1985	1,969	136	1,833	-	-	-
1986	1,641	115	1,526	-	-	-
1987 - 88	1,333	58	1,275	-	-	-
1988 - 89	1,245	83	1,162	-	-	-
1989 - 90	1,147	87	1,060	-	-	-
1990 - 91	967	81	886	-	-	-
1991 - 92	927	99	828	-	-	-
1992 - 93	1,043	127	916	-	-	-
1993 - 94	850	108	742	-	-	-
1994 - 95	1,281	145	1,136	-	-	-
1995 - 96	1,413	184	1,229	-	-	-
1996 - 97	2,037	204	1,833	-	-	-
1997 - 98	2,483	246	2,237	-	-	-
1998 - 99	3,058	239	2,819	-	-	-
1999 - 2000	2,880	237	2,643	-	-	-
2000 - 01	2,925	264	2,661	-	-	-
2001 - 02	3,405	318	3,087	-	-	-
2002 - 03	4,101	363	3,738	-	-	-
2003 - 04	4,443	337	4,106	-	1,239	2,815
2004 - 05	5,079	314	4,765	-	1,348	3,385
2005 - 06	5,877	382	5,495	11,500 ⁸⁷	1,489	3,896
2006 - 07	6,387	383	6,004	-	1,581	4,406
2007 - 08	7,538	503	7,035	-	2,020	4,939
2008 - 09	8,759	264	8,495	-	1,753	6,236

⁸⁵ Online at: <http://www.hscic.gov.uk/catalogue/PUB15812>

⁸⁶ The majority of S135 warrants will have resulted in admission to hospitals under another part of the Mental Health Act so this figure is not the number of uses of S135. The total number of S135 warrants issued, or executed, is not known.

⁸⁷ IPCC 2008, for England and Wales

2009 - 10	12,300	262	12,038	7,035 ⁸⁸	1,922	9,211
2010 - 11	14,399	288	14,111	-	2,376	10,753
2011 - 12	15,240	338	14,902	8,867	2,561	11,397
2012 - 13	14,296	243	14,053	7,881	2,411	11,330
2013 - 14	17,315	307	17,008	6,028	2,837	13,186
TOTAL	131,050	6,476	124,574	-		

Table 2: Places of safety orders made where detention NHS and independent hospitals. Wales only⁸⁹

	Wales - all POS orders in hospitals	Wales – S135 detentions in hospitals	Wales - 136 detentions in hospitals
2008 - 09	587	29	558
2009 - 10	576	21	555
2010 - 11	697	25	672
2011 - 12	799	25	774
2012 – 13 ⁹⁰ (estimated)	860	18	842
2013 - 14	Not yet available	Not yet available	Not yet available
TOTAL	3,519	118	3,401

Table 3: Detentions under Section 136 in police and hospital based Places of Safety recorded by Police Forces (including detainees aged under 18), 2013/14⁹¹

	All ⁹²		Under 18	
	Police	Health	Police	Health
England total	6,028	18,461^e	236	517^e
Avon and Somerset Constabulary	420	710	15	..
Bedfordshire Police	115	..	*	..
British Transport Police	120	955	*	*
Cambridgeshire Constabulary	110	165	5	10
Cheshire Constabulary	55	425	*	30
City of London Police	*	50	*	*
Cleveland Police	160	145	*	*
Cumbria Constabulary	65	145	*	10
Derbyshire Constabulary	80	..	*	..
Devon and Cornwall Constabulary ⁽²⁾	765	350	30	*
Dorset Police	115	270	*	..

⁸⁸ HMIC 2013, for England and Wales

⁸⁹ Online at: <http://wales.gov.uk/statistics-and-research/admission-patients-mental-health-facilities/?lang=en>

⁹⁰ Data collection in Wales changed in 2012/13 so data is not directly comparable to previous years.

⁹¹ Data source: Police Force IT Systems (All Forces and Constabularies of England). Copyright © 2014, Association of Chief Police Officers. Copyright © 2014, Health and Social Care Information Centre, Community and Mental Health Team. All rights reserved.

⁹² ".." denotes data not available. 'e' denotes an estimated figure.

Durham Constabulary	55	120	*	10
Essex Police ⁽³⁾	175	875	10	20 ^e
Gloucestershire Constabulary	50	280	*	30
Greater Manchester Police	*	240	*	10
Hampshire Constabulary	340	465	20	..
Hertfordshire Constabulary	*	325	*	20
Humberside Police	35	160	*	5
Kent Police	45	1,165	*	20
Lancashire Constabulary	30	550	*	15
Leicestershire Constabulary	35	275	*	..
Lincolnshire Police	335	220	25	*
Merseyside Police ⁽⁴⁾	*	645	*	50 ^e
Metropolitan Police Service	75	1,570	*	45
Norfolk Constabulary	25	275	*	5
Northamptonshire Police	60	320	5	*
Northumbria Police	55	590	*	10
North Yorkshire Police	280	30	20	*
Nottinghamshire Police	320	715	15	35
South Yorkshire Police	70	625	10	10
Staffordshire Police	125	445	5	10
Suffolk Constabulary ⁽⁵⁾	30	425	*	25 ^e
Surrey Police	105	445	*	15
Sussex Police	855	500	20	25
Thames Valley Police	270	905	10	55
Warwickshire & West Mercia Police	185	565	10	15
West Midlands Police	5	1,255	*	15
West Yorkshire Police	380	1,255	10	40
Wiltshire Constabulary	70	..	*	5

- (1) These figures were based on figures extracted from local police force custody databases in response to the following questions:
- "How many Section 136 detentions did your force have from 1st April 2013-31st March 2014 that went directly to a police station? (This figure is not to include anyone who was arrested for a substantive offence and subsequently arrested whilst in custody)";
 - "How many S 136 detentions did your force have from 1st April 2012- 31st March 2013 that went directly to a health based place of safety? (This figure does not include any that first went to a police station and then onto a health based place of safety?";
 - "Of those detainees that went directly to a police station, how many were under the age of 18 years?";
 - "Of those detainees that went directly to a health based Place of Safety, how many were under the age of 18 years?";
- (2) One health based Place of Safety was closed for part of 2014.
- (3) Figure for under 18's in health based Places of Safety excludes one of the two hospital Trusts.
- (4) Figure for under 18's in health based Places of Safety is an estimate based on quarter 4 2013/14.
- (5) Figure for under 18's in health based Places of Safety is an estimate based on quarters 2-4 2013/14.

As with previous collections these experimental figures are expected to be an undercount. However, significant improvements have been made to local collection methodologies since the previous reporting year. For more details please see the report and data quality statement for this release:

<http://www.hscic.gov.uk/pubs/inpatientdetmha1314>

Table 5: Uses of Section 136 under the Mental Health Act in hospitals by broad ethnic group, England, 2013/14⁹³

England(2)	Census population (aged 18+) ³	Number S136	S136 per 100,000 population ⁽¹⁾
White	45,281,100	8,083	17.9
Mixed	1,192,900	213	17.9
Asian or Asian British	4,143,400	343	8.3
Black or Black British	1,846,600	608	32.9
Other Ethnic Groups	548,400	229	41.8
Unknown ethnic groups	-	889	-
All orders	53,012,500	10,365	19.6

Table 6: Uses of Section 136 under the Mental Health Act in hospitals, by age and gender, 2013/14⁹⁴

	Census population (aged 18+)	Number S136	S136 per 100,000 population
All orders⁽²⁾:	53,865,800	10,365	19.2
Male	26,534,000	6,074	22.9
Under 18	5,894,800	69	1.2
18 to 24	2,509,700	1,174	46.8
25 to 34	3,672,400	1,764	48.0
35 to 44	3,559,000	1,404	39.4
45 to 54	3,732,500	1,175	31.5
55 to 64	2,979,600	361	12.1
65 to 74	2,418,600	94	3.9
75 and over	1,767,300	33	1.9
Female	27,331,800	4,287	15.7
Under 18	5,611,600	92	1.6
18 to 24	2,420,700	913	37.7
25 to 34	3,695,000	1,060	28.7
35 to 44	3,600,000	977	27.1
45 to 54	3,810,800	840	22.0
55 to 64	3,074,400	288	9.4
65 to 74	2,605,000	88	3.4
75 and over	2,514,300	29	1.2

⁹³ Source: Mental Health Minimum Dataset (MHMDS) 2013/14 annual data file; Mid-2012 Population Estimates: Single year of age and sex for local authorities in England and Wales Copyright © 2014, The Health and Social Care Information Centre. All Rights Reserved. The MHMDS does not include learning disability services, child and adolescent mental health services or acute hospitals.

⁹⁴ Mental Health Minimum Dataset (MHMDS) 2013/14 annual data file; Mid-2013 Population Estimates: Single year of age and sex for local authorities in England and Wales. Copyright © 2014, The Health and Social Care Information Centre. All Rights Reserved.

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