

**REPORT**

Centre for  
Mental Health



# **Review of Sections 135 & 136 of the Mental Health Act**

**The views of professionals, service users and  
carers on the codes of practice and legislation**

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## About the review

This work is one of the accompanying reports to the government's review of Sections 135 and 136 of the Mental Health Act 1983. The evidence base is set out in more detail in the accompanying reports: the Summary of Evidence, this report from the Centre for Mental Health and a Literature Review.

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## 1. Introduction

*“Experience should teach us to be most on our guard to protect liberty when the Government’s purposes are beneficent. The greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well meaning but without understanding.”*

Louis Brandeis  
(1928, *Olmstead vs United States*)

The Mental Health Act, 2003 and significantly amended in 2007, applying across England and Wales is one of the few pieces of legislation that allows the deprivation of liberty by confinement to an institutional setting or via measures of control in the community for people who have committed no crime nor that are suspected of doing so. It can compel people to receive treatments they might not voluntarily accept, and all of this will be done with the best intentions. The application of such powers is always controversial and always requires balancing an individual’s right to health and their right to liberty; both rights are enshrined in our Human Rights Act and in international law and convention. As will be apparent from the findings below, the execution of our mental health legislation and particularly those concerning police powers, with which this report is concerned, can be difficult and tie up considerable resource for lengthy periods. Changing the code of practice or the legislation itself could resolve such difficulties, but might also mean that an individual could lose their liberty and that such decisions might be made with less oversight.

The experience of being detained can feel punitive and criminalising, but our findings reveal that the application of police powers under the Mental Health Act can vary and therefore so too can the experience. People who have experienced what they feel is more humane treatment whilst being detained feel

less damaged by the experience and even, on some occasions, helped. So it matters not only whether we apply the law but how we apply it too.

This is a report of the main findings of 27 events the Centre for Mental Health arranged to seek a broad range of stakeholders’ views. Centre for Mental Health was commissioned by the Department of Health and Home Office to meet key stakeholders across England and Wales. These stakeholders fell into two groups, those professionals and managers involved in Sections 135 and 136 of the Mental Health Act and service users (and carers) who have directly experienced (someone) being detained under these parts of the Act. The latter included some people who are now involved in training professionals in mental health awareness and in use of police powers under the Act; it also included those who felt traumatised by their experiences.

In this report ‘codes’ (plural) of practice are referred to, this is because this is a review of Sections 135 and 136 across England and Wales, and although the legislation applies across both nations, the Codes of Practice, though similar, do differ.

### **The Mental Health Act and police powers**

The current Mental Health Act (2007) covers both England and Wales and is a significantly amended version of the 1983 Act. However, the police powers in this act were not significantly amended, and indeed bear strong resemblance to the powers in the 1959 Act, and have the same section numbers, Section 135 and Section 136. The subsequent Code of Practice, i.e. how the law is to be interpreted, was revised. The 1983 Act extended the powers of removal from a private place (Section 135) to those living with others and was followed with guidance that police custody be used in exceptional circumstances (Section 136) from the 1959 act that preceded it.

### Section 135

Section 135 has two parts; part 1 allows a magistrate to issue a warrant to the police allowing entry (by force if necessary) to a private place, for example someone's home, to remove a person who an Approved Mental Health Practitioner (AMHP) has reasonable grounds for suspecting is suffering from a mental disorder and not capable of caring for themselves, or is being mistreated/neglected or is not able to be controlled. The warrant has to specify the private place but does not have to name the person. The AMHP will have approached the court for the warrant and will have had to provide evidence to justify its issue. Ideally a warrant should be executed as soon as possible, however, the warrant can be executed anytime within a calendar month of issue. The warrant authorises the removal of the person to a place of safety for the purpose of an assessment under the Mental Health Act. The police officer must be accompanied by an AMHP and a registered medical practitioner. The place of safety can be a hospital (in practice often a suite designed for this purpose) or local authority residential accommodation or another care setting or a police station. Guidance on place of safety for both England and Wales states that police custody should only be used in exceptional circumstances, for example where the detained person poses a risk of violence that cannot be managed in another place of safety. The Act allows for a person to be moved between different places of safety. The total period a person can be detained is 72 hours.

Part 2 covers the return of a person to hospital and other people liable to removal under the Act. A typical case might be when someone is absent without leave from hospital (where they are detained on a section of the act). The purpose of the warrant is to allow entry to a specified private place and then removal to the place where the person is meant to be (or a place of safety). A police officer or any other person qualified under the Act can apply for the warrant, and the police can execute the warrant by themselves, but guidance states it is good practice for them to be accompanied by the "patient's responsible clinician" (DH 2008; Welsh Government 2012). Guidance in England

under Section 135 (1) allows for the AMHP and Registered Medical Practitioner to make an assessment (at least an initial one) within private premises if possible and to choose not to remove the person if they deem a removal to a place of safety is not required: "after entering the premises the AMHP and registered medical practitioner shall determine whether it is necessary to remove the person to a place of safety for the purpose of a more detailed assessment" (eg. West Sussex County Council 2012, page 50). Centre for Mental Health was informed that in Wales the execution of a Section 135 warrant would always result in the removal to a place of safety for an assessment.

### Section 136

Section 136 allows a police officer to remove a person from a public place (a place where the public has access to, including by payment). That person must "appear[s] to a police officer to be suffering from mental disorder and to be in immediate need of care or control." (DH 2008, page 74). The removal is in order that the person in question can be assessed under the conditions laid out in the Mental Health Act. No warrant is required. As in Section 135, the maximum period a person may be detained is 72 hours and moving between more than one place of safety is permissible within this time period.

Both Section 135 and 136 are a form of arrest and police officers are empowered as such under the Police and Criminal Evidence Act 1984 and, for example, can conduct a search of the person being detained under the act. Linked to this, people detained under Sections 135 and 136 have the same rights as other arrested people and that includes the right to legal representation.

Both English and Welsh Codes of Practice state a preference for conveyance to a place of safety by ambulance.

It is also important to note that both Sections 135 and 136 are for the purposes of assessment only, and the detained patient has the same rights as a voluntary patient when it comes to treatment.

## 2. Review methodology

Centre for Mental Health met with professionals, service users and carers in a series of events run across England and in Wales. Table 1 lists the events that took place.

**Table 1: Stakeholder events around the country**

Newcastle	Professionals from Newcastle, Northumbria, South Tyneside, Durham & Cleveland and Sunderland
Manchester	Service users and professionals
Stafford 1	Professionals
Stafford 2	Service users and carers
Shrewsbury 1	Professionals
Shrewsbury 2	Service users and carers
Leicester	Professionals
Wiltshire 1	Professionals
Wiltshire 2	Service users and carers
London (Dragon Café - Southwark)	Service users
London (Lambeth) 1	Service users
London (Lambeth)2	Service users
London (Wandsworth)	Professionals
London ( New Scotland Yard)	Professionals
Hampshire 1	Professionals
Hampshire 2	Service users
Southampton	Service users and a carer
Portsmouth	Professionals
Bournemouth	Professionals
Dorchester	Professionals
Bodmin 1	Service users and carers
Bodmin 2	Professionals
Exeter	Professionals (Police and PCC office)
North Wales 1	Service users and carers
North Wales 2	Professionals
South Wales	Professionals
London	Police and Crime Commissioners

The views of approximately 70 service users and carers were collected through these events and also through a small number of one to one interviews. Some service users provided written evidence to the Centre. 140 professionals contributed to the review.



The Centre sought answers to two questions:

- **What is your experience of sections 135 and 136, both positive and negative?**
- **What would you like to see changed?**

The Centre used the topic headings from the Department of Health and Home Office online survey to guide the discussions in the focus groups. These headings were:

1. Use of powers
2. Places of safety
3. Maximum length of detention in a place of safety
4. Getting a Section 135 warrant
5. Where Section 136 should apply
6. Transporting a person to a place of safety, or between places of safety
7. Police powers to act in a mental health emergency
8. Powers for health professionals to help a person experiencing a crisis
9. Diversity and equality
10. Other issues relating to Sections 135 and 136

The events were organised with the help of Department of Health, Home Office and Centre for Mental Health networks and particularly through seeking those who had a lead role on the Mental Health Act and Sections 135 and 136. These local 135/136 leads were asked to invite a range of professionals to each event, and to include those with ‘front line’ role and those with a strategic overview. We also asked these local leads to organise events for service users and carers, and this was possible in several areas. A number of service user organisations and forums were contacted independently and several of these were able to organise events. In most cases, service user events also included carers.

There was only a short period available to organise these events and some localities were not able to respond within the time constraints. The Centre was asked to organise events across England and Wales and whilst events took place in most regions, some had better coverage than others. No events took place in the East of England.

Professional stakeholder representation varied across events; police, mental health staff and managers and Approved Mental Health Practitioners were well represented; Ambulance services were reasonably well represented but were absent from some events (notably in Wales) and stakeholders from Emergency Departments only attended one event. Some health commissioners did attend events, but were not represented at all events. There was also limited representation from local courts. Most professional events had a reasonable mix of staff with direct experience of working with sections 135 and 136 and also those with a local strategic role.

The Centre’s brief was to explore stakeholders experience of these police powers and where they saw the need for change, and to seek this for each of the 10 areas listed above.

Detailed notes were taken at each of the events and the ten headings above and the two questions provided a framework for analysis. Whilst the primary aim of the analysis was to seek out consensus, differences were also noted, particularly where these were between stakeholder groups (e.g. where a particular profession, sector or service user view could be distilled) and also where there were regional or local differences in experience or on what reforms might take place.

### 3. Overview - issues relevant to both sections

#### Places of safety

Most areas we visited had one or more designated suites for the assessment of people under sections 135 and 136. While by their very nature admissions via section 135 were planned events, the nature of risk might not be known before executing the warrant and admission to an inpatient facility might not be appropriate. In England (as reported at these events), risk allowing, at least an initial assessment took place in the person's home.

By and large in the areas we visited use of police cells as a place of safety was becoming more exceptional in line with the codes of practice. However, in some areas a period in a police cell was the 'default' for young people aged under 18. (see below).

Virtually all areas reported that use of police custody as place of safety was decreasing and where it was used it was used appropriately, i.e. for people who posed marked risk especially to others, but it was reported that increasingly police forces preferred to provide officers to support mental health staff in the 136 suite in these circumstances, and therefore use of police custody was becoming highly exceptional in most police areas where we held events.

Staffing the 136 suites was a problem in many areas, as the suites were staffed from other wards and there was pressure for these staff to return to duties on their ward of origin. Staffing worked best where two posts on the supplying inpatient wards were supernumerary or where there was a cluster of inpatient wards and the burden of staffing was shared across more than one ward. Staffing the 136 suites and indeed the assessment teams makes a significant demand on resources which did not appear to be taken any account of by some area's local commissioning.

#### Maximum length of detention in a place

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

Finding an appropriate bed post assessment was cited as a reason for some people remaining under section 136 longer than 24 hours, and this was reported to be the case for those aged under 18 years at most events. Again the consensus for virtually all our stakeholders was that this was a commissioning issue and one that local Clinical Commissioning Groups and NHS England (particularly in the case for beds for under 18s) needed to address.

#### Transporting a person to a place of safety, or between places of safety

In most areas it was the police who provided the means of conveyance as although local policy dictated the primary means be via ambulance, in practice ambulance providers were not able (and nor indeed were commissioned) to respond in a timely fashion. We were told that in parts of England and all of Wales the respective ambulance services were seldom, if ever, involved in the conveyance of patients under these sections. This too was seen primarily as a commissioning issue and that ambulance providers needed to be contracted appropriately to resource this demand on top of the other vital services they provide.

## Children and adolescents

With the exception of one area, Sections 135 and 136 were considered problematic for those under 18. This was largely due to the suitability of places of safety. In some areas the NHS Trust had policy of not accepting under 18s in the section 136 suite but did not have an alternative. In a few areas, police custody was used, but it was clear that the forces we spoke to (and likewise Police and Crime Commissioners) deemed this unacceptable and would no longer countenance the use of custody except in the case of very violent young people. Some forces felt even in these circumstances the use of a cell was not acceptable and would rather supply sufficient officers to manage the risk presented in a section 136 suite. The sectioning of young people was a relatively rare event in most areas. However, the greater issue was finding an inpatient bed for young people after their assessment.

The single area we visited that had not experienced particular problems with children and young people had Approved Mental Health Practitioners (AMHPs) and Section 12 doctors (a doctor who has been recognised under section 12(2) of the Act and who has specific expertise in mental disorder and training in the application of the Act) with child and adolescent psychiatric experience and could staff the 136 suite with staff from an adolescent acute admission unit. However, the suite itself was shared with adult services and its design and decor were felt not to be suited to young people. In this London-based unit around two young people per month were admitted and the issues were similar to those facing adults, in that if the place of safety was already taken, finding another suite, particularly with neighbouring mental health service providers, was difficult.

The experience reported at most of our events was of longer delays (than for adults) in finding a place of safety in the first instance, then further delays in finding a bed post-assessment, and assessments themselves were conducted by AMHPs and doctors with no or limited child and adolescent experience. The latter point was felt to be crucial as young people present poor mental health differently to adults and are harder to diagnose.

As stated previously NHS England was seen to have a potential role particularly in the commissioning of child and adolescent beds for use post assessment.

Most areas we visited struggled to achieve a completed assessment in four hours and this was linked to difficulties in getting all the necessary professionals together to complete the assessment and also to delays in transportation or finding an available place of safety .

## The experience of people from Black and Minority Ethnic communities

Two service users at different events and both from African Caribbean heritage made the same comment, “we are seen as big, black and dangerous”. Service users from black and minority ethnic communities at stakeholder events consistently reported they were more likely to be perceived as aggressive and posing risk to others and subject to physical restraint. While most service users experienced being sectioned under Section 135 and 136 as traumatic, there was a marked difference between white and black service users in their experience of the police. Black service users more commonly reported the use of force and it occurring earlier on during the episodes described.





### 3. Section 135

#### Professionals' experience of applying Section 135

*“What’s the difference between section 135 and 136? 10 yards.”*

~ Police Officer

The majority of professional stakeholders we spoke to experience Section 135 as difficult to execute and very time consuming.

The degree of difficulty in execution varied considerably by area, but in some it was used quite infrequently (as reported in parts of the North East of England and North Wales), and in one or two areas it was not perceived as problematic. Where difficulties were reported, they included the following:

##### Time and delays

The whole process from organising a warrant (including collecting ample evidence to justify its issue), organising the police, ambulance and necessary mental health professionals, to arranging a place of safety, was reported to be very time consuming; in some areas, 4 to 12 hours was not uncommon. There were often further delays in finding an inpatient bed post-assessment. A small number of areas did not experience these time delays.

##### Police response

From a mental health practitioner point of view, the police response to requests to support the execution of a Section 135 warrant had changed in recent times and in some areas Approved Mental Health Practitioners (AMHPs) felt they were being asked to provide quite rigorous evidence of risk. Considerable delays in police providing a response were reported to us. In one case, five days had elapsed since a request for police support had been made, though such delays were exceptional.

Police across most of the forces attending the events reported that entering a private property was relatively easy and various legislation provided for this. However, once inside and on encountering someone whom they considered in need of treatment and care, their removal from a private place was difficult without a warrant. This meant some officers had to remain in the private place with the vulnerable person for several hours. There were also examples of unlawful practice reported in all police force areas where we held events, typically an officer persuading the vulnerable person to enter a public space and then applying Section 136.

##### Ambulances

The timely attendance of an ambulance was an issue in most cases. The execution of a Section 135 warrant is a planned event, but pre-booking an ambulance for conveyance was reported as difficult in most areas (and could add several hours' delay, resulting in police choosing to provide conveyance) and almost impossible in parts of South and North East England and across Wales. Most stakeholders felt that these sections were not really reflected in commissioners' contracts with ambulance services.

In two areas, private ambulances were regularly used. One area in the South of England commonly “gave the public sector service an opportunity to fail” before engaging the private service. One area in the North East had piloted use of a private ambulance service and the local evaluation had produced a strong case for extending the contract and making their use the norm. Other areas in the North East were looking to adopt this model. In both South and North East England, the private ambulance service was able to give a rapid response and have a range of appropriate vehicles available. The ambulance crews were well trained and were willing to provide ongoing support.

## Courts

Some Magistrates and clerks of courts were not familiar with the legislation and AMHPs reported additional scrutiny and time taken to issue warrants as a result. Different courts seem to operate different procedures.

There was marked variability in accessing warrants from courts, with some areas reporting delays during office hours in obtaining a warrant and in others there was difficulty out of hours. In both cases this was primarily a delay in accessing a Clerk of the Court.

Payment arrangements were an issue in many areas and often involved “primitive” arrangements, such as cash only and ‘pay in advance’. Very few areas had special card-based systems or retrospective invoicing.

## Medical staff

Organising Section 12 doctors was reported to be difficult in some areas, as during the daytime they may be engaged in other clinical work (some of an urgent nature). Most areas found it easier at night; but where there was no robust rota arrangement this proved difficult. This was also an issue for Section 136 assessments. There was consensus amongst stakeholders that mental health commissioners needed to commission adequate coverage of Section 12 doctors, and indeed other professionals (i.e. AMHPs) and ensure they had the right experience.

Insufficient AMHPs were reported in some areas and there were concerns that not enough mental health professionals were undergoing training to become AMHPs and therefore this could become a greater problem in the future.

In most areas expertise in children’s and adolescent mental health was lacking in both AMHPs and doctors, and also in 136 suite staff.

## Service user and carer experiences of Section 135

The sectioning under Sections 135 or 136 was experienced as a traumatic event in most cases by service users and Section 135 was traumatic for some carers. In the case of the latter, this was for two reasons:

- The length of time it took from requesting help to the full execution of the warrant.
- The response of the police e.g. having several blue-lighted vehicles arriving and witnessing the person they cared for being restrained.

However, most carers we spoke to had a positive experience of the police response, and the execution of a section 135 warrant was often the conclusion of a lengthy and largely frustrating experience of seeking help for the person they cared for.

Service users we spoke to saw the two sections as being very different and stressed the importance of the symbolic value of the home when discussing section 135. One service user summed up the experience of Section 135, “*it was like being burgled, my home was violated. I don’t feel the same about my home anymore*”. Another stated, “*I have a right to be ill in my own home*”, and another summed up the view of several others, “*I find it very difficult to feel safe, even my home isn’t a safe place now. My home should be my ‘place of safety’*”.

Many service users and their carers reported feeling embarrassed and humiliated (e.g. in front of their neighbours) at being removed in police vehicles and at having an obvious police presence outside their homes. This sense of embarrassment and humiliation was usually felt once they were well and returned home and could last for months if not longer, adding to their sense of stigmatisation.

## Views on changing the practice of Section 135

Service users we met were universally against changing the legislation around Section 135 and did not wish to see Section 136 being extended into a private place and, as stated above, challenged the quote that opened this section of the report. They stressed that someone’s home (most commonly where Section 135 was applied) was very different to a public space and that Section 135 was experienced as more of a “violation” than Section 136 for most service users who had experienced both.

Conversely carers were by and large in favour of anything that would speed up the process of a Section 135 and most saw the benefit of police powers being extended to allow the application of Section 136 in the circumstances of an emergency once a police officer had already legitimately entered a property (under other legislation). However, many carers reported experiencing mental health services as being unresponsive until there was a crisis that required seeking a warrant under section 135, and that the latter could be avoided with services being “more willing to engage” in earlier intervention.

A small number of areas reported fewer issues concerning section 135. One particular area in the South of England reported being able to conduct the whole process in most cases in less than four hours and often within two: the following were cited as factors in their “more successful” experience of the section:

- Good relationships between mental health services and the police
- Mental health and police triage (like Street Triage) being in place
- A stand-alone and dedicated AMHP service
- Good relationships with courts
- Sound commissioning arrangements
- A small geographical area where different agency boundaries were largely coterminous
- Retrospective invoicing for warrants
- Creativity over places of safety (especially for known clients and where risks were known)
- Assessments taking place within the private place (usually the vulnerable person’s home) where appropriate
- Robust rota arrangements for Section 12 doctors
- Robust crisis and bed management services
- Use of a private ambulance service with well-trained crew and a range of vehicles.

Most of the above also applied to the successful operation of Section 136.

Interestingly, stakeholders from the police and mental health service in this area did not see a case for any extending of Section 136 powers to a private place. The stakeholders’ experiences of both Sections 135 and 136 were ones of good relationships, good commissioning and adequate resources.

One AMHP stated, *“if I am going to take someone’s liberty from them I think I should be made to work hard. I don’t think it should be made any easier”*.

This area was able to get assessments under way often within an hour for both Sections 135 (after obtaining a warrant) and 136.

However, most areas experienced difficulties with the Section and consequently most professionals were in favour of changes to both the Code of Practice and the legislation.

*“The guidance is all about local agreements. I think commissioners should have responsibility in legislation to contract and resource to enable timely application of the Act”*, stated one stakeholder, who also stated at the very least Commissioners (primarily Clinical Commissioning Groups, but also local authorities) should have their responsibilities prescribed in the guidance.

Those in favour of change generally favoured the extension of Section 136 to private premises if legal entry had already taken place and only in emergencies for which specific criteria would need to be met. The criteria for such enactment of Section 136 were discussed but stakeholders found it hard to define them in clear and unambiguous terms. As a result, there was some concern that just as some officers currently unlawfully apply Section 136 (e.g. persuading people to move from a private place to a public one) that any new application of Section 136 might involve officers “stretching” the criteria to expedite an outcome.

A minority of professional stakeholders wanted the complete removal of Section 135 and argued that Section 136 should apply in all circumstances. With the exception of the circumstance described in the paragraph above, discussions on such a radical reform revealed that such views were driven largely by frustrations with how the Section 135 process currently operates, which, after discussion, was often due to poor relationships and gaps in commissioning and resources. Some stakeholders, when reflecting on this, became less convinced of the case for such a change in legislation, preferring that there be a greater responsibility to commission and monitor arrangements for Section 135.



## 4. Section 136

### Professionals' experience of applying Section 136

Police representatives at the events saw the value of having close working relationships with mental health practitioners, *“we are not mental health experts and find it very difficult to walk away from a situation. If someone kills themselves and we are the last people in contact then the IPCC (Independent Police Complaints Commission) gets involved and all our actions are heavily scrutinised”*.

#### Street triage

Better joint working and relationships were reported as the key to the reduction in use of police custody as a place of safety. The prime examples of such were the Street Triage arrangements, typically where mental health practitioners joined police patrols at identified 'peak' times. This was felt to work best in urban areas and those with entertainment zones, but less manageable for rural and semi-rural areas. The minimum effective triage arrangement appeared to be having mental health practitioners available to police officers by phone and preferably by phone and radio via police control centres, thereby providing direct access to mental health expertise and information (about people known to services) wherever the officer is. This latter arrangement seemed to work in any type of locality. All areas that had tried such triage arrangements reported positive results, even more so in areas where this was extended to neighbourhood police (e.g. Cornwall) and other enforcement teams, including a reduction in use of both Section 135 and 136, a reduction in incidents likely to lead to arrest and later court appearance, earlier intervention and mental health support averting a crisis and reduced police time on such incidents. In Cornwall the people who received this preventative intervention via triage support to neighbourhood policing tended to suffer from serious mental illness but were not receiving mental health support.

One area in the North East of England had piloted a street triage arrangement whereby two mental health practitioners provided a response to police referrals and offered a 'No Nos' policy, i.e. no exclusions. It responded to all referrals of vulnerable people and offered short term intervention, which consisted of signposting, referral and connecting to appropriate services. The scheme operated for 12 hours a day, 7 days a week. It followed up all cases a week after the initial response and would do so assertively to ensure the referred individual had been connected to services. The team would make continued efforts for those people who did not respond or for whom services had not responded. This approach was felt to have been highly successful during the hours it operated. Use of Section 136 was negligible during its hours of operation, but quite high in the 12 hours when the team was unavailable, and local stakeholders felt there was a strong case for a 24/7 service.

Such triage arrangements were reported to work well when robust protocols were in place and monitored closely, such as: all police attending an incident that might ultimately result in a Section 136 should always make contact with triage staff.

More areas were seeking to pilot such arrangements and one is due to be launched in South Wales. Like several in England, this is being driven by the local Police and Crime Commissioner (rather than local health commissioners).

Other reported 'good practices' were the availability of miniature care plans to police control centre staff and there was one reported incidence of police agreeing to enter on their information system a miniature Advance Directive, i.e. a service user's preferences for when being considered by police for sectioning. A small number of areas treated all uses of Section 135 and 136 as a 'serious incident' and regularly reviewed the circumstances and process for each.

Conversion rates for Section 136 to other sections or informal admissions were reported at anywhere from 15% to over 40%. It was unknown in most areas how many people were connected or reconnected to community mental health teams after the application of Section 136.

### Conveyance

As for Section 135, there were big issues concerning conveyance to the place of safety. In some areas conveyance by ambulance for Section 136 was deemed even more difficult than Section 135, because of the unplanned nature of such incidents. The greatest difficulties appear to be in Wales where the ambulance service were reported to be much less engaged in the issue of supporting mental health crises than in England (it should be noted, however, that no ambulance service representatives attended the event in Wales and we did not have an opportunity to hear their views).

A key driver for multi-agency engagement in England is the Crisis Care Concordat. There is currently no equivalent in Wales but most professionals, service users and carers expressed a desire for a national Welsh policy concerning improving responses to mental health crisis.

In most incidents of Section 136 in England and all in Wales reported at the events, a police vehicle was the means of conveyance to a place of safety. Service users, carers and professionals alike were unhappy about the conveyance of a vulnerable person in a police vehicle and use of such vehicles was felt to “*criminalise a health crisis*”.

### Section suites

Section 136 suites were generally also available for conducting assessments under Section 135. The one exception was one locality in South Wales where Section 135 assessments could not be conducted in the local 136 suite, due to local contracting arrangements. This was a particular problem as both the Welsh Code of Practice and local practice dictate that a person who is removed from a private place will always be taken to a place of safety for an assessment.

The staffing of 136 suites was reported as a problem in most areas as they were not in continual use and did not have dedicated staff. This proved less of an issue where there were a critical mass other mental health inpatient facilities on the same site (i.e. several wards). Difficulty in staffing was compounded where the suite was ‘standalone’ or where located near a single ward or Psychiatric Intensive Care Unit (PICU). In some areas, acute admission staff simply acted as hosts for the assessments teams, but any prolonged requirement for them to remain in the 136 suite placed a strain on the unit they came from. However, other areas staffed their suites by having two supernumerary staff (typically one qualified and one unqualified) on the local acute admission ward (or PICU) and available to staff the suite without stretching their unit’s resources. Where these arrangements were in place, few if any staffing problems were reported.

While most suites were open to all ages, there were some exceptions and in these areas there were greater problems in finding an appropriate venue for the assessment of under 18s. Stakeholders reported that the use of Section 136 was unpredictable and that demand on suites was therefore likewise. If more than one assessment was required this could, and often did, result in vulnerable people needing to be transported out of area to find a place of safety, or spending considerable time, usually in police transport.

## Assessment

This issue of intoxication was a problem for most areas, and some emergency departments (EDs) and most 136 suites would reportedly not accept a person whom they deemed too incapacitated to assess. How staff judged incapacity varied by area. Some mental health practitioners used breathalysers and judged by its reading (the legality of such action was questioned by some police stakeholders); others, and indeed most, judged by the apparent coherence of the person. In some areas the default location for an intoxicated person was a police cell. None of the areas we visited had the equivalent of ‘drunk tanks’ or ‘safe buses’ (trials in some localities) i.e. somewhere safe where an intoxicated person could sleep off the alcohol whilst being monitored by a suitably qualified person.

Where a patient was transferred from one place of safety to another, in some cases the paperwork transferred with the patient did not make clear what time the section had commenced; this was reported at two of the events.

Mental health staff and management often did not recognise that patients detained under police powers have the same legal rights as other arrestees, particularly concerning the hospital management’s responsibility to ensure that a patient held under such a section on hospital premises has the same right to legal representation, should they wish it, as those in held in a police station.

## Inpatient care

Robust crisis teams and well managed capacity on acute mental health wards (reported to be ideally 85% or less occupancy) supported timely stays in 136 suites, as one of the issues was finding an appropriate resource for those requiring further an inpatient bed after assessment. Finding a bed for someone under 18 was a considerable difficulty across all of Wales and all but one area in England we visited. Most stakeholders felt that although

the sectioning of a person under the age of 18 was a relatively rare event, it was virtually always problematic and therefore there is a role for specialised commissioning, and that NHS England and the Welsh Government should commission more child and adolescent inpatient facilities according to need. Also with regard to those under 18 years, there was consensus among our stakeholders that there ought to be identified at all times a range of potential places of safety available, catering for different ages and risk posed; these facilities would be on call, and, though in practice rarely used, would always be available. For adults, some areas were considering alternatives to 136 suites, such as using crisis houses where appropriate, to increase the range of places of safety available.

## Joint working

It was reported that EDs were starting to join more in multi-agency meetings on mental health crisis and an ED representative attended one of the West Midlands events. In this and other areas, protocols were being developed for the circumstances in which an ED might be used as a place of safety. Primarily this would be when there was an immediate concern for the person’s physical wellbeing, including in cases of intoxication. Across the events in England, the Crisis Care Concordat was seen as a driver for better engagement of and with EDs, but this was an area where most stakeholders felt there needed to be considerably more work.

Some police and mental health practitioners felt the Code of Practice should spell out much more clearly what was a public space; an example was given of some parts of an Emergency Department being considered a public space whilst others were not.

## Service user and carer experience of Section 136

The experience of being detained under Section 136 was generally a traumatic one, but there were some positive experiences reported – these involved what they termed as ‘humane, softly softly’ approaches to their detention, where clear and simple explanations were given and where they had someone to speak to throughout the process and could readily contact relatives/carers.

*“I have been sectioned several times and when it has gone well, the cell door has been open and an officer has just spoken normally to me, it’s really calmed me. A couple of officers have disclosed mental health difficulties they have faced and I have felt really understood.”*

Several service users reported similar positive experiences of police custody, particularly where an officer sat with them and talked to them.

The experience of being in a 136 suite for these service users could be quite negative and they reported that they were less likely to have someone available to talk to, but were simply observed,

*“I felt really distressed and all they did was stare at me.”*

This may be related to the nature of how some 136 suites are staffed and designed. For example Centre for Mental Health visited one unit where a member of staff could observe two patients simultaneously via one way mirrors whilst remaining in the suite office. One manager stated “...we encourage staff where the risk assessment allows to be with and engage the patient but I think there is a big training issue for mental health staff on Section 136”.

As reported earlier for most service users the use of police vehicles and custody makes them feel criminalised:

*“I thought I must have done something wrong. I felt like a bad person.”*

*“I didn’t know why I had been arrested, no one explained anything to me. I thought I might be going to prison and I didn’t know why.”*

*“I was ill and they put me in handcuffs, and put me in a cage” (referring to the caged area in a police van).*

Several service users reported spending lengthy periods in places of safety, and this was worse if it was a police cell with the door locked. Several examples were given where people had been locked in the cell for hours without company, food or fluids.

### Impact on employment

Several service users reported negative impacts on seeking employment and voluntary positions, as their detention under Section 136 had been disclosed by Police under a Disclosing and Barring Service (DBS, formally CRB) check. Centre for Mental Health was told that police forces varied over what they would disclose and in what circumstances for DBS. Service users and professionals alike felt that this should be standardised and Section 136 should not be disclosed unless in exceptional circumstances. Additionally service users wanted to be given accurate information on this and as with all information to be given it when they were best able to absorb it. One service user reported avoiding applying for various positions until she learned the police force where she was currently located had a different policy to the previous force she had encountered.

### Service levels

Several carers and service users reported that they had been actively seeking help in the days or weeks leading to the sectioning, and that these had largely been frustrated attempts, which led to a crisis point. Service users with personality disorder also reported they felt they had particular struggles to get help when not in a crisis, except that ‘offered’ by the police through Section 136. There was a desire expressed by several service users and carers for community services to work shift patterns and to be available at weekends and in the evenings.

*“I can be ill 24/7. In fact I am more likely to have a crisis in the evening or at night and the police are often the only service there.”*

All the service users spoken to supported information sharing and police having knowledge of aspects of their care plans.

Service users and professionals saw a need for co-produced training and of having ‘experts by experience’ at the core of such training.

### Views on changing the practice of Section 136

The most significant change mooted was that concerning Section 136 being applied in a private place under the limited circumstances previously described. Some police officers expressed the desire to have all such 135 and 136 powers removed from them and that mental health practitioners have such powers, the police role being to support and manage risk. Mental health practitioners had more mixed views and most were not in support of such an extension of Section 136 powers, partially as they doubted they would be sufficiently resourced to provide what “would in effect be an emergency service”.

The general consensus amongst stakeholders was for the maximum duration of both Sections 135 and 136 to be reduced from 72 hours to 24 hours. Further, some service users mooted the view there should be a monitored target of a maximum stay of six hours in a place of safety, barring exceptional circumstances.

The maximum time for completion of assessments was also felt by some stakeholders to need “firming up” and to move from a recommendation to a requirement.

The general view for Section 135 and 136 is that both codes of practice and legislation ought to spell out more clearly the responsibility of commissioners and particularly local health commissioners.





## 5. Conclusion

In most areas difficulties are experienced in the operation of Sections 135 and 136 and there is an obvious need for change. However, it is the nature of the required change that is in question. A very small number of areas experience far fewer difficulties and whilst unique geography may help to explain this; it is only part of the explanation. Fewer difficulties are also strongly associated with better inter-agency relationships, good commissioning and robust service provision.

There are number of themes that run through the report, but one that perhaps features most is the crucial role commissioning plays in ensuring the effective execution of the law and in the experience of those whose duty it is to exercise it and, more importantly, in the experience of service users and their carers. Commissioners have a role in ensuring mental health services can intervene early before there is a crisis, in ensuring that there is adequate place of safety provision covering all ages, that ambulance services are adequately resourced to give a timely response, the availability of AMHPs and suitably qualified medical practitioners and beds post assessment, particularly for under 18s. In the case of the latter most of our stakeholders thought NHS England might play a significant role.

A number of stakeholders proposed changes to the code of practice and to the legislation that on further discussion would not be required if commissioners filled current perceived gaps in service.

A significant driver for change has been the Crisis Care Concordat in England. There is no similar policy vehicle in Wales but there is a clear desire of most of our stakeholders in Wales to have a similar commitment from the Welsh Assembly.

By and large there were few differences between the views of professional stakeholders and service users and carers. For example most agreed that police custody should seldom, if ever, be used, all agreed that humane treatment should be part of the sectioning process, and that the length of duration should be reduced. However, where there was a difference in views it was significant. The most crucial difference was in the extension of section 136 powers to a private place. All of the service users we spoke to were firmly against any extension of the current requirements and stressed that entry to a private place by force if need be and removal from home again by force if need be, was significantly different to the current application of section 136. Most professionals did not argue for the complete removal of Section 135, but instead for the limited extension of section 136 in certain circumstances. This being when police had already legally entered a private dwelling (e.g. under PACE) and were then confronted with someone posing either a danger to themselves or others and deemed to be in need of care and control. Examples were given

where individuals were seen to have suffered for some considerable time with no assessment or subsequent care due to the lengthy period it then took to seek a warrant. This, like the counter argument provided by service users was compelling. However, it was very difficult during our discussions to establish some unambiguous criteria where such an extension of Section 136 might apply. There was also concern that in some cases for the sake of expediency, officers may apply this extension. It should also be noted not all areas experienced the same level of difficulty and perhaps there is a need for further exploration of changes to practice or resource which might achieve a similar result to this extension but without losing the oversight a magistrate provides.

A theme in recent mental health and indeed health reform is ‘nothing about us without us’ – the engagement of service users and carers in the shape and design and operation of any reform. This stakeholder exercise sought to achieve that and an idea that occurred repeatedly is the role service users in particular could play in training police, paramedics and all other professionals involved. This was seen as important in improving the crisis care provided for everyone, but all the more important for service users from minority ethnic and cultural communities.

The development of Street Triage and related arrangements, albeit in their infancy, is a most positive one and the early and emerging evidence shows the significant reductions in the use of Section 135 and 136 and even in arrests, but also improvements in the experience of the service user and their carer. There appears to be an economic case for such arrangements, but there is certainly a moral case for providing help much earlier. The events we ran make it clear that it is not just a matter of changing how we operate sections 135 and 136 but that there is also a need for a more radical reform of mental health care and inter-agency working to support and prevent mental health crisis.

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## About Centre for Mental Health

Centre for Mental Health is an independent national mental health charity. It aims to inspire hope, opportunity and a fair chance in life for people of all ages living with or at risk of mental ill health. The Centre acts as a bridge between the worlds of research, policy and service provision and it believes strongly in the importance of high-quality evidence and analysis.

The Centre encourages innovation and advocates for change in policy and practice through focused research, development and training. It works collaboratively with others to promote more positive attitudes in society towards mental health conditions and those who live with them.

### Areas of work

- **Criminal justice:** identifying effective methods of supporting and diverting people with mental health problems in the criminal justice system
- **Employment:** developing and promoting new ways of helping people with mental health problems get and keep work
- **Recovery:** helping mental health services across the UK to support people more effectively to make their own lives better on their own terms.
- **Children:** undertaking work which aims to improve the life chances of children through the support they need early in life.

The Centre carries out research, policy work and analysis to improve practice and influence policy in mental health as well as public services.



## Review of Sections 135 and 136

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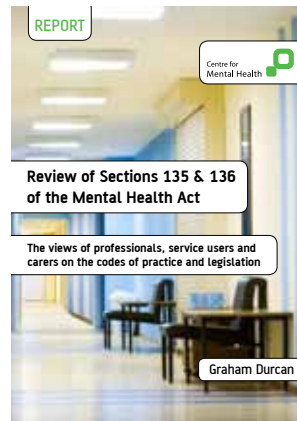
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