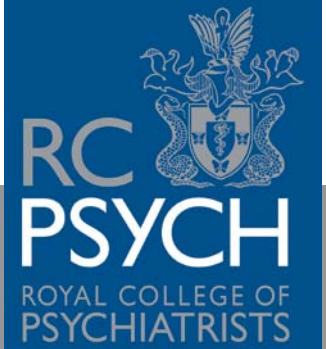


CR159



Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)

July 2011

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Report of the multi-agency group
led by the Royal College of Psychiatrists

College Report CR159
July 2011

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Organisations endorsing the report

The Working Group would like to express their gratitude for the invaluable help and support in producing this report from the following organisations:

- NHS Ambulance Chief Executive Group
- Association of Chief Police Officers
- AMHP Leads Network
- Care Quality Commission
- College of Emergency Medicine
- College of Social Work
- Faculty of Forensic and Legal Medicine
- Mental Health Network of the NHS Confederation
- Royal College of Nursing

ORGANISATIONS SUPPORTING THIS REPORT

- Independent Police Complaints Commission
- Healthcare Inspectorate Wales
- Care and Social Services Inspectorate Wales

Executive summary and recommendations

Until recently, detention under Section 136 of the Mental Health Act 1983 (England and Wales) had not received the same scrutiny as other detentions under the Act, despite the frequency with which it is used. The most comprehensive data are for 2005–2006 when a study showed 11 000 detentions in police stations (Docking *et al*, 2008) and about 5500 detentions in hospital. More recent data have shown a significant increase in the number of those detained under Section 136 in hospital. The data for England found 7035 such assessments in 2007–2008, rising in successive years to 8495 and 12 038 (Care Quality Commission, 2010). A similar increase was initially reported in Wales, with 355 detentions under Section 136 in 2007–2008 and 558 the following year but the figure for 2009–2010 is similar at 555 (Welsh Assembly Government, 2010).

There are only two types of civil detention for which no form is required – Section 135 and Section 136. The person may be taken to a police station or emergency department as a place of safety and be discharged from there, potentially without ever having seen a mental health practitioner. It is therefore unsurprising that it is difficult to obtain reliable data for the overall use of Section 136. Since 2005, we do not have reliable data on the number of individuals taken to custody suites. It is therefore unclear whether the use of Section 136 is increasing or whether it is being better recorded, and to what extent it represents the welcome reduced use of custody suites as the place of safety.

In some areas the police station is still used as the routine place of safety, despite users' complaints that this criminalises the individual and despite concerns with regards to the person's safety raised by the Joint Committee on Human Rights in their report *Deaths in Custody* (2004). The environment is often poorly suited to managing those at risk of harming themselves or those who have medical problems. The revised Codes of Practice to the Mental Health Act 1983 for England and for Wales make clear that this routine use of police custody, deplored by Commander Rod Jarman, Chair of the Mental Health Group of the Association of Chief Police Officers (Johnson, 2007) will only happen on an 'exceptional' basis. It is encouraging that the English Government should have provided £130 million for the development of places of safety within mental health units for England. However, no additional money was given for the staffing of such units. Although the units will be used on an infrequent basis, if used for Section 136 assessments only, it is essential that they should have dedicated staff (or at the very least a supernumerary post attached to the team responsible for the Section 136 psychiatric facility) to ensure that a high standard of care can be provided by healthcare staff, without reliance on police support to safely

assess and care for acutely disturbed individuals. 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. Neither is acceptable. These members of staff can be used to support other teams or wards when not required in the assessment facility, provided that they are available at short notice to return to the unit. No additional capital or revenue funding has been allocated by the Welsh Assembly.

The emergency department should only be used as the place of safety where medical problems require urgent assessment and management. It is important that staff deciding which place of safety to use should be able to assess the likelihood of medical problems as the cause of acute disturbed behaviour.

There are separate Codes of Practice for England (Department of Health, 2008) and for Wales (Welsh Assembly Government, 2008). In relation to Section 136 they are similar and recommendations of this report apply to both countries.

The Codes of Practice state that the local policy should define responsibilities for commissioning and providing secure places of safety in healthcare settings (par. 10.17 E, 7.11 W).¹ The Working Group, the authors of this report, would argue that, in addition, there should be sufficient places of safety to ensure that they can be easily accessed and that there should be sufficient rooms within the place of safety to meet the local need most of the time, noting that this will fluctuate. Neither lack of local availability nor places within them should be reasons for using custody suites except on an exceptional basis.

The Codes go on to say that the local policy should identify the most appropriate places of safety for individual cases. This report identifies the range of options and issues to be covered by the policy. The alternatives should not be seen as an excuse for inadequate staffing of the psychiatric 136 suite but rather should allow the assessment to take place in the most suitable environment for the individual.

If assessments are not carried out in a timely manner the psychiatric place of safety may be unable to accept all those who require such a facility. Therefore it is essential that there are sufficient approved mental health professionals and Section 12-approved doctors (doctors approved under Section 12 (2) of the Mental Health Act 2007) at all times of day and night. The English Code notes the need for prompt assessment and recommends that the time to commence the assessment is determined locally. The Welsh Code is less exacting with monitoring where local policies have set target times. This report recommends that face-to-face contact with the approved mental health professional and preferably the doctor should start within 3 hours where clinically appropriate, with an expectation that this will reduce to 2 hours in the longer term. This may be difficult to achieve in some areas but the standard should be determined by good clinical care rather than the current staffing provision.

Similarly, it is important that the individual can be conveyed rapidly on completion of the assessment. For those discharged this means that there must be ready access to funds to pay for transport, 24 hours a day.

The Working Group welcomes the ability to transfer a person from one place of safety now available in the 2007 Act and offers further guidance on this.

1 The Codes of Practice for England and Wales are referenced as E (England) and W (Wales).

Many of those detained under Section 136 come from a socially deprived background. Some Black and minority ethnic groups are over-represented, as with other detentions under the Mental Health Act. This needs to be better understood in terms of causes and care pathways if solutions are to be found which might reduce the need for the use of Section 136 in the future. Such research requires reliable Section 136 data which are currently unavailable (Mental Health Act Commission, 2005).

Improving standards of care requires clear and well-disseminated local policies and procedures, as well as multidisciplinary training to ensure that staff understand not only their role but that of others involved in the process. This training should include users and carers. There is evidence of considerable variation in the achievement of such standards (Mental Health Act Commission, 2005). Similarly, the London Development Centre Review (Bather, 2006) found that the pan-London guidance *Policing and Mental Health* (Metropolitan Police Authority, 2005) was patchily implemented. The guidance noted that the key areas of concern remain the lack of emergency assessment facilities for those detained under Section 136 within mental health units (leading to the inappropriate regular use of police stations and emergency departments for that purpose), poor communication between agencies, lack of involvement of all organisations in the local review committee and delays in completing assessments.

A standard recording and monitoring form would support improved communication between agencies and provide a reliable local and national monitoring process. The monitoring should be supported by agencies monitoring healthcare services, such as the Care Quality Commission and Health Inspectorate Wales, and for the police, Her Majesty's Inspectorate of Constabulary, the Independent Police Complaints Commission and the National Policing Improvement Agency. The development and use of such a form is the key recommendation of the Working Group as without this it will be difficult to conduct research and audit to ensure that standards of care improve.

RECOMMENDATIONS

Recommendations have been grouped by theme. The key recommendations relate to staffing of psychiatric places of safety and monitoring of the process, both at the local and the national level.

PLACE OF SAFETY

- 1 There should be sufficient places of safety in psychiatric facilities to meet foreseeable local need without recourse to police stations as a convenient local option or because the place of safety is regularly full. Further capital funding may be required to achieve this.
- 2 Police stations should only be used as the place of safety on an exceptional basis. The local monitoring group should check that this is the case and take appropriate action where necessary.
- 3 Emergency departments should be used as places of safety for those who need urgent physical health assessment and management but they may then be transferred to a psychiatric facility for further mental health assessment, provided that this does not result in undue delay.

- 4 Local policy should specify the range of places of safety which can be used and offer guidance as to when this would be appropriate. This should allow for example the young, the elderly and the disturbed to be assessed in an environment more appropriate for their needs.
- 5 When the place of safety being considered is not the preferred psychiatric facility, emergency department or custody suite, it is recommended that the suitability of the alternative facility is first discussed with staff of the psychiatric facility or the approved mental health professional. The place in question (which may include day hospitals, day centres and the home of a friend or family member) must agree to be used in this way before the patient is taken there and have sufficient staff or support at that time to be able to safely manage the situation, given the information on the patient's behaviour received.
- 6 Defined standards for the physical environment should be applied to the place of safety in mental health units. They may be used to inform the development of alternative places of safety, including those in emergency departments and custody suites.

STAFFING ISSUES

- 1 The psychiatric Section 136 facility should ideally have dedicated staffing, or at the very least, a supernumerary post attached to the team responsible for the place of safety.
- 2 Staffing levels should be sufficient 24 hours a day to ensure that the police can leave promptly after a handover period, even when the patient is disturbed. There should be no expectation that the police will remain until the assessment is completed, as currently happens in some places. In many areas this will require additional resources.
- 3 There should be a clearly identified person in charge of the psychiatric assessment facility at all times. A member of staff should be present to receive the patient on their arrival.
- 4 The local implementation group must ensure that there are adequate approved mental health professionals and doctors approved under Section 12 of the Mental Health Act to enable joint assessments to begin within 3 hours currently, with an expectation that in the longer term the target will become 2 hours.
- 5 The description of staff roles, from which competences can be derived, as outlined in this report should be available to assist in commissioning and planning services, the development of local policies and procedures and the provision of appropriate training.
- 6 Consideration should be given to multiprofessional training and the involvement of users and carers in this.

CONVEYANCE OF PATIENTS

- 1 An ambulance (defined simply as a vehicle provided by the ambulance service) is the preferred form of transport to and between places of safety in most cases.

- 2 The police officer should accompany the patient in the vehicle as it is not clear that they can delegate the authority to convey.
- 3 Such work should be prioritised by the ambulance service, even where the clinical situation does not represent an emergency, so as to reduce the distress and embarrassment to the patient. For Section 136 cases the standard ambulance service response is proposed as up to 30 minutes, unless there are life-threatening problems, where the caller will be taken through the ambulance telephone emergency triage system and an emergency response dispatched. If the caller is in a public place and privacy is not able to be accessed for the individual subject, the call may also be upgraded to a more urgent response, subject to commissioning support in each area.
- 4 Joint local policies and procedures should address the issue of individuals being transported across the boundary of the ambulance provider (where relevant).

LOCAL POLICY AND MONITORING OF STANDARDS

- 1 Local commissioners and planners should have responsibility for ensuring the establishment of a multi-agency group to develop jointly agreed policies and procedures. The group's membership should involve all appropriate agencies and so should include the ambulance service, emergency departments and user and carer organisations including, where appropriate, a representative of the Black and minority ethnic user groups. This report gives detailed guidance as to its membership, role and issues to be covered in the local policy.
- 2 The implementation group should ensure that local policies are disseminated to all involved in the Section 136 process and ensure their effective implementation including the provision of training in relation to the policy.
- 3 A standard recording form should be used. This can also be used for monitoring purposes and will ensure reliable information on all individuals detained under Section 136.
- 4 Use of an agreed standard form would assist monitoring and allow local, regional and national comparisons to be made. A model form is offered which would enable the key issues to be monitored. These include the number of detentions, characteristics of the group thus detained, the place of safety used, any transfers between places of safety, time taken to begin and complete the assessment and the outcome. Given the over-representation of those from Black and minority ethnic backgrounds this issue needs to be sensitively monitored. The information should help identify issues to highlight in training and any changes needed in local procedures. It is recommended that a few sites be identified for early implementation of the form with a careful review process before it is adopted for use nationally.
- 5 The Care Quality Commission and Healthcare Inspectorate Wales should report annually on the standards of care in relation to Section 136. This should include trends in the use of places of safety and outcomes experienced by service users. A body should be tasked with monitoring

the standards of care relating to police involvement including the use of the police custody suite. This might be the National Police Improvement Agency.

OTHER KEY POINTS

- 1 The local policy should indicate how the approved mental health professional and, on rare occasions, other professionals can access funds for those who need assistance with transport to return home after being assessed and discharged from the place of safety as this may be a considerable distance from their home. This needs to be accessible at all times to ensure the person can vacate the place of safety when they no longer require to be there, increasing the access to the facility.
- 2 The Department of Health and the Welsh Assembly Government have produced national information leaflets concerning the Mental Health Act including Section 136. The leaflets should be accessible electronically at all the hospital places of safety and be available in all the relevant languages and formats required. This Section 136 leaflet only relates to a person being taken to a place of safety in a hospital setting and not a police station. At the time of publication of this report discussions have taken place with police representatives and a form is currently being produced for use in custody suites. This will include additional information relating to their rights under the Police and Criminal Evidence Act and would be accessible electronically. It is hoped that this initiative will be supported through the National Policing Improvement Agency.
- 3 Research should be commissioned by the Department of Health and the Welsh Assembly Government into the use of Section 136 to determine how usage might be best monitored and the implications for future community care developments addressed.

Preface

In 2006, the Royal College of Psychiatrists set up a Working Group to review the College report on standards relating to the place of safety under Section 136 of the Mental Health Act. It became clear that the original recommendations were largely unchanged so the key issue was to ensure the report's effective implementation. It was also agreed to extend the remit to all aspects of care in relation to Section 136. The small multidisciplinary Group produced a draft updated report, which was circulated to all the organisations involved in developing, implementing or monitoring Section 136. Each organisation was invited to comment on the report and to send a representative to join the enlarged Group which would produce a report supported or endorsed by each organisation, thus widening the breadth of the document, its dissemination and effective implementation.

All the organisations were keen to be involved, and as Chair, I would like to thank all the members of the Working Group for their commitment and enthusiastic participation. I am grateful to the original Group members for their additional role in reviewing the draft documents. I wish to offer particular thanks to the Black and minority ethnic group users and carers for sharing their experience and to Cauline Braithwaite for chairing that piece of work.

We are grateful for the advice and support provided by Alan Brown of the Home Office and for the opportunity to be actively involved in the 2007–2008 consultation on the *Mental Health Act Code of Practice for England* and also the *Code of Practice for Wales* in relation to the chapters on assessment, the place of safety and conveying patients. This report employs terms used in both Codes of Practice. This includes the use of the word 'patient' for those detained under Section 136, although the individual may subsequently be found to have no mental disorder. The report should be read in conjunction with the relevant Code of Practice for England and for Wales.

An initial England-only version of this report was published in September 2008 as at the time of being submitted for publication the Code of Practice for Wales had not been published. The Minister for Health and Social Services in the Welsh Assembly Government established a Task and Finish Group to consider the initial version of this report and we extended out working group to include equivalent Welsh organisations.

We have taken this opportunity to provide a revised version of the monitoring form, developed after a pilot of the form in the previous report across Nottinghamshire, Oxfordshire and the London borough of Redbridge. I am grateful to all the staff in those areas who have contributed to this process.

We know that the number of hospital places of safety has increased markedly but there are no data collected nationally of all those detained on Section 136, only those taken to a psychiatric facility. In addition to the

significant rise in the number of people detained and taken to a psychiatric facility (an increase of over 7000 in England over 4 years), there has been an increase in the proportion of those who are not subsequently detained. We do not know whether they were admitted on an informal basis, or, when discharged, whether they were offered, and accepted, follow-up. That information is key to ensuring that in the longer term, through police training and better community care, the number of individuals who require to be detained under Section 136 is reduced to a minimum, given that it is a restriction of a person's liberty. This report therefore represents the next stage in an ongoing piece of work, with the focus now moving to monitoring and research.

Dr Michele Hampson

*Chair, Multi-Agency Group to Develop Standards of Care in Relation to
Section 136 of the Mental Health Act*

Working Group

CHAIR

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Paula Thornton	Representing the Royal College of Nursing, Forensic Nurse Practitioner, Kent Police
Dr Trevor Turner	General Adult and Community Faculty Executive, Royal College of Psychiatrists and College representative of Department of Health Acute Inpatient Project Board Standards National Steering Group, East London Foundation Trust
Dr Alison Walker	Chair, Clinical Conveyance Group, Ambulance Network
Dr Mark Winston	Welsh Division, Royal College of Psychiatrists

IN ATTENDANCE

Kevin Bailey	Nurse, Department of Emergency Medicine, Heart of England NHS Foundation Trust
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CONSULTED

Professor Kam Bhui	Chair, Transcultural Psychiatry Special Interest Group, Royal College of Psychiatrists
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Gavin Semple	Administrator, Approved Mental Health Professional Service Oxfordshire
Dr Geraldine Strathdee	Specialist Clinical Advisor, Mental Health Strategy Team, Healthcare Commission

Introduction

Section 136 of the Mental Health Act 1983 states that:

- 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 to enable him to be examined by a registered medical practitioner and interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.'

Since the publication of the Royal College of Psychiatrists Council Report on the standards of places of safety provided under Section 136 (Royal College of Psychiatrists, 1997) there have been important developments in mental health services. New teams have been created, such as crisis resolution and home treatment teams to offer an alternative to hospitalisation and assertive outreach teams to support those with severe mental illness who are difficult to engage with existing services. The social exclusion report (Social Exclusion Unit, 2004) emphasised the need for good multi-agency working and a number of homicide inquiries restate the importance of effective communication, for example through the care programme approach (inquiry into the treatment and care of H. (Weeraratne *et al*, 2003)). However, despite the emphasis on social inclusion and attempts to combat stigma, which should make access to mental health services easier, significant numbers of individuals continue to be detained under the Mental Health Act only after coming to the notice of the police or the courts.

The 2004 report of the Joint Committee on Human Rights, *Deaths in Custody*, quoted findings from a study of 153 deaths in police custody (not just in custody suites but including those in police transport, hospitals and public places) between 1998 and 2003, which found that there was a high prevalence of drug and alcohol misuse and just over 50% of individuals had prior mental health problems. In 31.8% of cases intoxication was the cause of death. Of the 153 who died, three individuals were detained under Section 136 of the Mental Health Act, raising the question of when it is appropriate or necessary to use the police station as a place of safety. The report went on to state:

People requiring detention under the Mental Health Act should not be held in police cells. Police custody suites, however well resourced and

staffed they may be, will not be suitable or safe for this purpose and their use for this purpose may lead to breaches of Convention rights. In our view, there should be a statutory obligation on healthcare trusts to provide places of safety, accompanied by provision of sufficient resources for this by the Government (p. 63).

The report makes special reference to Article 2 of the European Convention on Human Rights, which guarantees the right to life and places duties on the state to take steps to prevent deaths of people in detention. There were 27 deaths in police custody in 2006/2007 with one person detained under Section 136 (Docking & Menin, 2007).

Some Black and minority ethnic patients are more likely to experience 'adverse pathways' through the criminal justice system and have higher rates of admission and detention under the Mental Health Act, as noted in the report *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England* (Sashidharan, 2003). The Department of Health has produced a 5-year action plan, *Delivering Race Equality in Mental Health Care* (2005), to address these issues and support the development of culturally competent mental health practice throughout the system. Rates of detention under Section 136 are similarly higher in the Black population (Churchill *et al*, 1999). The Race Relations (Amendment) Act 2000 has introduced duties on agencies to audit and collate data such as usage of statutory powers across ethnic groups. In particular, there is a need to understand why there is an over-representation of the Black and minority ethnic groups under Section 136 as with other detentions under the Mental Health Act, which would form part of a race impact assessment. The Healthcare Commission (2007) recommended that the recording of ethnicity be made mandatory, regardless of whether the person is treated in hospital or in the community, and that the Mental Health Minimum Dataset should be extended to include recording of religion and language, in support of effective monitoring of the Mental Health Act 2007.

The lack of reliable national data on the use of Section 136 was identified in the Mental Health Act Commission (2005) report. The report concluded that there is some evidence of considerable variation in the rate and outcome of detentions under Section 136 across different regions (par. 4168 and 4169), confirmed by Docking *et al* (2008). The *Count Me In* census (Healthcare Commission, 2007) similarly noted the importance of high-quality data monitoring to understand the way individuals access healthcare services, the service they receive and the outcome.

In 2007 the Mental Capacity Act 2005 came into force. The Mental Health Act 2007 makes major amendments to the Mental Health Act 1983, most of which will be implemented in 2008.

LITERATURE REVIEW RELATING TO SECTION 136

A literature search was carried out using the phrase 'Section 136' with the Embase, Health Management Information Consortium (HMIC), Medline, Neurosciences, PsycINFO and Serfile databases. The search identified 28 relevant articles. Most of them were published before 1997 and the research was carried out in London so it may reflect neither the current situation nor the national picture. These studies focused on the circumstances leading to admission and the sociodemographic characteristics of those detained, including past psychiatric history and treatment outcome.

RELIABILITY OF DATA COLLECTION

Three studies have shown major discrepancies (30–50%) in reported Section 136 rates between agencies (Turner *et al*, 1992; Simmons & Hoar, 2001; Bather, 2006). The review carried out by the London Development Centre showed the police figure for Section 136 rates to be a third of that obtained from health service data.

WHO GETS DETAINED?

SOCIODEMOGRAPHIC DATA

All the studies found that the African and African–Caribbean populations were over-represented, especially for men, when compared with the local census data (Dunn & Fahey, 1990; Turner *et al*, 1992; Simmons & Hoar, 2001). In Turner *et al*'s study of 163 detentions (112 individuals) under Section 136 in Hackney (London) from 1985 to 1987, 48% were African or African–Caribbean and that ethnic group accounted for 25 of the 51 detained more than once under Section 136.

The detained African and African–Caribbean men tended to be younger than detained White men (Dunn & Fahey, 1990; Pipe *et al*, 1991).

About 70% of those detained in Dunn & Fahey's and Pipe *et al*'s studies were unemployed, 30–40% had no permanent accommodation and 30–40% lived alone (Pipe *et al*, 1991; Turner *et al*, 1992). In Turner *et al*'s study over 29% had served a custodial sentence and about half were African or African–Caribbean.

PAST PSYCHIATRIC HISTORY

In the studies of Dunn & Fahey (1990), Pipe *et al* (1991) and Turner *et al* (1992) most people detained under Section 136 had a past psychiatric history and had been compulsorily detained, including under Section 136. The most common diagnoses were schizophrenia or bipolar disorder.

REASONS FOR DETENTION UNDER SECTION 136

Turner *et al* (1992) and Simmons & Hoar (2001) noted that behaviour which led to detention was difficult to categorise. In all studies, threats or actual violence to property and others formed the most common group of behaviours (Dunn & Fahey, 1990; Turner *et al*, 1992; Simmons & Hoar, 2001).

In the Simmons & Hoar study (2001) the behaviours least likely to result in admission were threats or acts of deliberate self-harm. All those who were agitated, mute or had a weapon were subsequently admitted.

OUTCOME OF ASSESSMENT

In all the studies there was a high rate of admission to hospital, between 82 and 85%.

There is evidence from these studies that the police appropriately detain individuals under Section 136 as the majority are found to have severe mental illness and are admitted to hospital. The converse is unknown, namely how many people with mental health problems could have been appropriately placed on a Section 136 but whose behaviour was ignored, or

who spent time in custody without a mental health assessment, or who were taken to, or advised to go, to hospital.

The lack of reliable recording and studies outside London make it hard to draw comparisons nationally and to determine changes in practice with mental health service developments. In particular it would be interesting to assess the impact of improved follow-up and culturally sensitive services on the use of Section 136 country-wide.

PROCESS OF ASSESSMENT

The London Development Centre Review (Bather, 2006) commented more specifically on the practice relating to Section 136. Restraint was used in 25% of the detentions. In 20% of cases the individual had committed a criminal offence.

The pan-London guidance for assessment under Section 136 had been inconsistently implemented and it had not been well disseminated to practitioners. Key concerns were:

- failure to use the criminal justice system when an offence had been committed
- police taking individuals to emergency psychiatric assessment centres for 'front-door assessments' without formally applying Section 136 and then leaving the person there
- poor communication between the police and the place of safety staff
- the use of the term 'acute behavioural disorder' (a term used by the Independent Police Complaints Commission and defined as a period of agitation, excitability and sometimes paranoid thinking with violent or aggressive behaviour and non-pain compliance), which was not felt to be helpful by emergency department staff, who preferred a description of the behaviour giving rise to concern
- confusion as to the preferred place of safety
- access to the place of safety denied due to the person being under the influence of drugs or alcohol (the Mental Health Act Commission (2005) recommends it should be ensured that 'policies do not result in patients who are in need of assessment being turned away on spurious or unnecessary grounds, such as staff detecting a smell of alcohol on the patient.')
- variable response by the ambulance service in terms of the place of safety chosen
- multi-agency meetings did not generally include the emergency department staff and the ambulance service.

The London Development Centre 2006 report identified examples of good practice, including mental health training for new police recruits by social services with user involvement, the use of police mental health liaison officers and developed inter-agency working.

A study in Yorkshire looked at the knowledge of police, medical and nursing emergency department staff (Lynch *et al*, 2002). The sampling of the police group and response rate of the healthcare staff is not reported. However, the study revealed a high level of ignorance. For example, 43% of police officers were unaware that Section 136 could only be implemented by

a police officer and half the healthcare staff were unaware of the role of the (then) approved social worker.

PATIENT EXPERIENCE

The London Development Centre and Metropolitan Police Authority joint review of policing and mental health in London (2005) invited mental health service users to provide feedback through focus groups. Seventy users were involved. Key themes were:

- lack of knowledge by police about mental illness, which could influence their ability to make the most suitable decision
- police station being a frightening environment as a place of safety
- stigma
- lack of information being given about the process of detention under Section 136
- concern about information sharing between agencies
- where a person was also the victim of a crime this was not always taken seriously.

This study suggested that training should involve mental health users as part of the overall solution. One group noted the benefit of carrying a crisis card.

Clearly there is need for more research regarding the patient experience and also that of their carers.

These studies highlight the need for clear policies which are well-disseminated and accompanied by training for all relevant staff. The only way to determine the effectiveness of these policies is through monitoring and by obtaining the experience of those detained and their carers.

Comments on preliminary report by users and carers from Black and minority ethnic communities with experience of the use of Section 136 (September 2007)

The Working Group were particularly keen to hear the views of users and carers from Black and minority ethnic background, as they are over-represented in the population thus detained. This was difficult to achieve, as many do not wish to be reminded of this difficult time in their lives. We are extremely grateful to Cauline Brathwaite, user consultant, Dominic Walker of Catch Afiya, and the five service users (two of whom are also carers) and one carer with a first-hand personal experience of Section 136.

The group of service users and carers were asked to comment on an early draft of this report in relation to their personal experience. All spoke as individuals. Their experience related to London police and mental health services only and they did not represent any organisations. The sample was not representative, but the Working Group felt that their views highlighted how distressing an experience being detained could be and identified some ways this could be improved.

USER/CARER FEEDBACK ON EXPERIENCES OF SECTION 136 APPLICATION BY POLICE OFFICERS

- 1 Users want police officers to have a basic understanding of mental health problems and the range of reasons that might be behind apparently disturbed behaviour in public places (e.g. asking 'Why did she do that?').
- 2 Users stressed the need for the police to be sensitive to the process of detention – it may be very visible, it can take place within a tight-knit community and so can be stigmatising.

If you are arrested, you are handcuffed, Black Maria, criminalised in front of your neighbours.

A carer added:

When you live in an area and people know you, they know you have been taken away.

3 Users also recognised the benefit of the police use of Section 136 when all other support systems had failed:

I punched another girl. I was taken in police car to police station by two police officers – middle of night – seemed a long time in cell. I was given the right kind of help at that time.

CONVEYING THE PERSON TO THE PLACE OF SAFETY

See above regarding the stigmatising impact of using a police car to convey to a place of safety, giving the impression that the person may be a criminal.

MENTAL HEALTH HOSPITAL AS THE PLACE OF SAFETY

Having the place of safety close to or on a mental health hospital ward means that it is viewed in the same light as the ward, to which many will be admitted.

Users can have a poor perception/experience of standards on acute in-patient mental health wards. Such wards are also associated with physical restraint, forced medication and over-medication by Black and minority ethnic service users:

I was restrained for not talking. They took my pants down and injected me.

What distresses me – for Black people – it sounds like we are paranoid, but when you hear about sexual assault, physical assault; it's not us being irrational. These are true facts and horror stories. A hospital is not always a 'place of safety' for us.

A carer had experienced unsafe/anti-therapeutic aspects of the ward:

'Place of safety' in our hospital is questionable. They turn a blind eye to the guys who come and sell drugs. I bring food for my son now – I don't give him money. On two occasions that he walked out, he witnessed restraint. It made him frightened – you cannot regain your health in this situation.

POLICE STATION AS THE PLACE OF SAFETY

The police custody suite can be a frightening environment. Service users may feel both unsafe and criminalised.

INFORMATION AND RIGHTS

1 Not all were told they were detained under Section 136, though most had been.

They didn't say this was 136 – they just said 'a doctor will see you'.

- 2 The use of written rights information must be supported by meaningful explanations and support within the place of safety setting:

That's the leaflet they give you. Once they hand you that, you are informed. They don't have time to explain it to you.

- 3 The relief in knowing that an appropriate person is notified of the user's detention at a place of safety was emphasised by users and carers. Such communication also has wider implications for care and safety beyond the immediate crisis stage of a Mental Health Act assessment:

I've been on 136 three or four times – I've never been asked who my nearest relative is.

And from a carer:

From what she (mother) has said it looks like she was sectioned on a 136 at least four times. Even though I am her nearest relative, I was not contacted at the time. Why I was not told when she was on Section 136?

- 4 Service users are empowered by good information and support to understand their rights:

I have done training through my work and learnt about my rights. This meant that I knew when I could challenge the police.

THE PHYSICAL ENVIRONMENT OF THE PLACE OF SAFETY

The needs of distressed and disoriented users detained under Section 136 are for a safe environment where the crisis can be de-escalated, restrictions minimised over the period that an assessment may take, and where all basic human needs can be addressed:

Mentally I got worse and worse. I got a delusion from a sign on a billboard. This made me knock a policeman's helmet off – this was the first legal 136 I experienced. I got to the hospital. It was like a livestock/dead stock room. I felt that I would go into dead stock room. I was bursting for the toilet. My hands were behind my back, there was dried blood on my hand. I had to release my bowels on the floor in the room. The handcuffs get tighter as you struggle. Blood everywhere. (I arrived at that hospital (place of safety facility) at 1.00am and went to hospital (admission ward) at 7.00 or 8.00 am.

SPECIFIC BLACK AND MINORITY ETHNIC ISSUES

- 1 Lack of trust between some members of Black and minority ethnic communities and the established order, represented by the police and

2 The 'Sus Law' was the informal name for the police officers to stop and search on the basis or suspicion or 'sus' alone. It was based on the Vagrancy Law of 1824. Its use was dropped following Lord Scarman's Inquiry into the Brixton Riots in 1981.

other authority figures, has a significant history. This is much wider than mental healthcare alone:

We have average age of around 40. We all experienced 1970s 'Sus' Law.²

Another service user felt that:

Many Black people feel that Sus Laws were replaced by 136.

A carer agreed that Black people with mental health problems are especially vulnerable to harassment:

Police can invite you outside the house and then use S136 on the street. This was our experience.

About 10 years ago. My son is very distinctive. If he just goes to the shop, they stop him on S136. He is 27, it's not appropriate for me to go with him all the time. He has a right to go up the street when he comes home from hospital. One time police stopped him and they wanted to take him to place of safety when he was home from the ward for the weekend. I had to get a lot of help to keep him home. I know the police well and I tell them. It was like Sus Law.

Cultural understanding and sensitivity are essential in meeting the needs of Black and minority ethnic service users. It is too easy to make assumptions and play into stereotypes:

Too many Black people are locked up – we can be very dramatic when we express our anger.

MONITORING HELPS TO RAISE STANDARDS – WHAT NEEDS TO BE MONITORED?

- 1 Repeated use of Section 136 powers in respect of the same individual requires monitoring and investigation of the underlying causes. The stigmatising effect of emergency police action ultimately damages the trust, confidence and reputation in the community of vulnerable individuals living with serious mental health problems and their families.
- 2 Where users are already known to services and have previously been assessed under the Mental Health Act, care programme approach arrangements and multidisciplinary/joint agency communication should address relapse indicators and minimise the necessity for further direct interventions by the police.
- 3 Ensuring that an appropriate person nominated by the service user is informed of their detention at a place of safety is of great importance to users and carers. Monitoring could safeguard this right and support standards, for example those regarding timescales.
- 4 Monitoring of the use and impact of advanced statements and decisions would be a way of strengthening the voice of the service user with direct implications for decision-making by professional staff with Mental Health Act responsibilities.

- 5 The effectiveness of patients' rights information (and what support underpins this) can be monitored by obtaining direct user feedback and by undertaking qualitative audits.
- 6 Service users are deeply concerned about the use of restraint, enforced medication and high doses, as general issues. This concern is widely shared by carers and professional staff. Such incidents in a place of safety should be monitored.
- 7 Cumulative trends, including ethnicity monitoring, should be reported regularly at board meetings to which the public have access, and published in mental health trusts' annual reports.

WORKING GROUP COMMENT

The findings are very similar to those from the London Development Centre (Bather, 2006). They again suggest a role for users and carers in helping with mental health training as well as being involved in giving regular feedback on their experience within the monitoring process.

Place of safety

The 'place of safety' is defined in Section 135, subsection 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.

In practice it is psychiatric units, police stations and emergency departments that are commonly used in England and Wales, although the Mental Health Act does allow other options.

CHOOSING THE PLACE OF SAFETY

The options for the appropriate places of safety should be outlined in the local policy. Both Codes of Practice note that 'consideration should be given to the impact that the proposed place of safety (and, in the case of the Code for England, the journey to it) may have on the person held and the examination and the interview' (par. 10.24 E, 7.21 W).

The English Code states (par. 10.22) that the 'preferred' place of safety is in a psychiatric facility and both Codes make clear that the police station should be used on 'an exceptional basis' when the person's behaviour cannot be safely managed in another environment (par. 10.21 E, 7.18 W). It is therefore essential that the psychiatric facility is adequately staffed to allow for those who are significantly disturbed to be safely assessed there. Police stations should not be assumed to be the second choice if the first choice is unavailable. The use of police stations conveys the impression that the person is seen as a criminal and the distress this causes to the individual and their carers cannot be overstated – it can affect the assessment process. Last, custody suites usually have poor facilities for the management of the acutely mentally unwell and staff will not have the expertise in managing their care, particularly in relation to the assessment and management of self-harm. Where a police station is used, every effort should be made to assess the person promptly or to arrange for them to be transferred to an alternative place of safety, provided this would not cause undue delay in completing the assessment and it would be safe to do so.

The emergency department should only be used as the place of safety where there are concerns for someone's physical health. Each area should be able to use an emergency department for that purpose.

The Welsh Code of Practice notes that the most appropriate place of safety for children and young adults must be considered 'especially carefully' (par. 7.17).

The Codes of Practice both state that local policy should define responsibilities for identifying and agreeing the most appropriate place of safety in individual cases (par. 10.17 E, 7.17 W). Options may include a residential care home or the home of a relative or friend who is willing to accept the person for that purpose (par. 10.22 E).

Mental health service providers should clearly identify the preferred psychiatric place of safety, which should be appropriate, both in terms of the physical environment and staffing levels, for most assessments. Service managers may agree that other parts of the hospital may be used in clearly identified circumstances as a place of safety. A specialist unit may best meet the needs of a young person or an elderly confused person. In the second case this could be a day hospital, but it could also include a day centre, by prior agreement. There may be occasions where the person requires more intensive support in the assessment period on account of disturbed behaviour, without requiring a custody suite. In such cases it may be most appropriate occasionally to use the mental health intensive care facility as the place of safety, where local facilities and resources at the time permit.

In identifying alternative options within the hospital to the preferred place of safety, the managers must satisfy themselves that the physical environment is appropriate for that purpose, using the standards set for the usual psychiatric facility as guidance, to ensure the safety of the individual, staff, other users and visitors. The staffing required for the use of these alternatives should be identified with a clear process to ensure that they can be immediately obtained.

There should be a clear procedure for the use of these alternatives. It is recommended that the police should contact the person in charge of the psychiatric Section 136 place of safety (or, in their absence, the approved mental health professional) to jointly agree the most suitable place of safety, unless the individual requires immediate medical assessment and treatment or is so disturbed as to require a custody suite. The other facility must agree to accept the individual before they could be taken there. Where a ward is used it must be made clear to all concerned that the person is not at that point admitted to an in-patient bed. The use of these alternative facilities should be carefully monitored.

PSYCHIATRIC ASSESSMENT FACILITY

Emergency psychiatric assessment facilities, which can be used for those detained under Section 136, are usually within or adjacent to acute in-patient units to ensure adequate staffing when needed, including access to staff trained in physical intervention.

Such place of safety has the following advantages:

- it is staffed by those with expertise in the assessment and management of psychiatric disorder, including the management of disturbed behaviour
- a doctor and approved mental health professional may be able to attend sooner to carry out the assessment
- it is more likely that the doctor carrying out the initial assessment will be approved under Section 12(2) of the Mental Health Act

- any new assessment suites are likely to be built to the right specifications to ensure the safety of the patients and staff
- the emphasis is placed on the assessment of any mental illness, while allowing for the assessment and management of non-acute physical healthcare issues.

Disadvantages include:

- ensuring adequate staffing for a unit that will be used infrequently but which will, at times, require access to sufficient staff at short notice to assess and manage those with disturbed behaviour; there needs to be provision for coping with periods of high demand for the unit
- if the person is assessed in a psychiatric unit they may be less likely to be discharged as clinicians in practice are less willing to discharge than to admit people
- there is a potential disadvantage in terms of stigma for the person without mental health difficulties
- the facility may be a considerable distance from where the person (and their carer) lives and they may be less likely to be assessed by staff who know them; it can also be more difficult to arrange transport home if they are discharged after the assessment
- the person may be found to require urgent medical attention and the psychiatric facility may be some distance from an emergency department.

The ideal situation would be to have a dedicated emergency psychiatric facility for those detained under Section 136 in close proximity to acute admission wards and with dedicated staff attached to the unit who support the admission wards when the assessment facility is empty. Such a facility would be the place of safety for all individuals assessed under Section 136 unless:

- a medical facility is required for an urgent medical assessment and support which could not be provided in the mental health facility. This would be more likely if the mental health unit were some distance from the nearest medical unit
- a police facility is required
 - when 'the person's behaviour would pose an unmanageable high risk to the patients, staff or users in the healthcare setting' (par. 10.21 E, 7.19 W), or
 - the person has committed a serious criminal offence and it would be more appropriate for them to be charged and not to apply Section 136. This would still allow an assessment under the Mental Health Act to take place.

EMERGENCY DEPARTMENT

The disadvantages of the emergency department as the place of safety are that it may not have:

- the appropriate physical facilities for managing disturbed behaviour and to prevent the person from absconding

- staff trained in the assessment and management of psychiatric disorder, or staff with expertise in managing disturbed and at times violent behaviour arising in the context of mental illness.

Not all emergency departments are closely linked with the local mental health service. There can be a delay of several hours before a suitably qualified doctor and approved mental health professional can attend to carry out the assessment. Police officers are not always willing or able to remain with the person they have brought to hospital, even if their behaviour is disturbed, until the assessment is completed.

Emergency departments should be used for those who require urgent medical assessment or intervention before or alongside the Mental Health Act assessment. This includes assessment and treatment of deliberate self-harm, drug and alcohol intoxication, as well as physical disorders, such as convulsions and bleeding.

POLICE STATION

There are the following disadvantages of the police station as the place of safety:

- it wrongly conveys the impression that the person has committed an offence
- some police stations are not well designed for the observation of those who are at risk of self-harm and those who are disturbed, though this is improving
- police staff receive little training in the management of individuals with a psychiatric disorder.

There is a widespread view among users, carers, police and social workers that the use of police stations as a place of safety is inappropriate even for those with disturbed behaviour. There is official support for that view in the Home Office Circular 66/90 (Home Office, 1990), the joint Home Office and Department of Health review of health and social services for mentally disordered offenders (Reed, 1992) and the Independent Police Complaints Commission (Docking *et al*, 2008).

The advantage of the police station is that it should provide a safe environment for those with seriously disturbed and aggressive behaviour, owing to the facilities and staff trained in the management of such behaviour. They do have access to forensic physicians, who can assist in the assessment and management of those detained under Section 136, though many are not approved under Section 12 of the Mental Health Act. However, there is an increased risk of sudden collapse and death in those with an acute behavioural disorder (see p. 18 for definition) held in police custody. Those detained under Section 136 are therefore best cared for in a hospital setting unless they are too aggressive.

If a police station is used, every effort should be made by health and social services staff to arrange where appropriate the transfer of the person to a more suitable place of safety as soon as possible. The local policy should determine a reasonable timescale for staff to attend to assess or transfer the individual (par. 10.23 E). The healthcare and Social Services staff should discuss how to support the person while in police detention (par. 7.22 W). This could include the coordinator of the Section 136 facility attending the custody suite.

PHYSICAL STANDARDS OF THE PSYCHIATRIC SECTION 136

ASSESSMENT FACILITY

The following guidance is compliant with the National Institute for Health and Clinical Excellence (NICE) guidance on short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (NICE, 2005).

In an ideal world these standards would apply wherever the facility is based, whether that is in a healthcare facility or a custody suite. However, we recognise that this is not practicable. The standards should be essential as of now for psychiatric assessment facilities, where the majority of assessments will take place in the future. The annual report 2006–2007 for the Forum for Preventing Deaths in Custody (2007) highlights the importance of the physical environment and welcomes the development of clear standards by this Working Group. The guidance may be used to inform provision in the emergency departments and custody suites. There are existing criteria for custody suites (Home Office, 2005).

SECURITY

The psychiatric assessment facility must be a locked facility in order to be able to safely care for those who are disturbed.

Levels of staff required to support this facility, when in use, are up to three staff trained in physical intervention, who should be available at short notice without compromising staffing levels and hence safety elsewhere. This is in addition to the staff carrying out the assessment.

The person's belongings should be recorded and kept in a safe place.

ASSESSMENT ROOM

The room must:

- be large enough to accommodate six people, to be able to both assess and restrain where necessary
- be well-lit and have an observation window
- have good exits, with consideration being given to there being two doors at opposite ends of the room; the doors should open outwards for the safety of staff
- have fixed, soft, comfortable chairs in a washable fabric; furniture and fittings should be chosen so they cannot be used to cause injury by offering a weapon of opportunity
- have a clock visible to both staff and the detained person
- have no ligature points
- have good communication with others through a phone line with outside dialling
- have a panic alarm system
- be located near to other staff and be easily accessed by a team trained in physical intervention and the use of resuscitation equipment
- have CCTV to enhance staff protection, in accordance with guidance on

the use of CCTV (see guidance from the Mental Health Act Commission (2005) based on Information Commissioner's Office CCTV Code of Practice); CCTV should not be a reason for lower staffing levels and the CCTV screen must be watched

- have access to resuscitation equipment including a defibrillator.

SUPPORTING FACILITIES

The person may need to remain in the assessment unit for several hours (the Mental Health Act allows detention for up to 72 hours), although it is envisaged that someone would only be detained for prolonged periods in the most exceptional circumstances. The assessment may be delayed, for example when it is unclear whether a person under the influence of drugs and alcohol also has a mental disorder or where the need to administer emergency sedation makes the subsequent assessment impossible until the effects of the medication have subsided. It may take time to gather the relevant information and a person might be more vulnerable if discharged in the night. The assessment unit should be located in an assessment area which has:

- a couch for sleeping or resting and to assist any necessary medical examination
- saliva substance misuse screening or drug urine testing kits
- washing and toileting facilities
- decontamination facilities to remove CS spray and other noxious substances
- provision of beverages and light snacks
- a drug cupboard, where the facility is in a healthcare setting
- a place for writing up notes and briefing of assessment unit staff by those involved in the detention
- if in a hospital, a computer linked to the electronic care system to identify relevant background information, current status under the Mental Health Act, crisis plans, advanced statements or decisions
- it is helpful in all places of safety to have leaflets for patients in less commonly used languages and formats available electronically where they are not otherwise immediately available
- a telephone with outside dialling arrangements
- facilities for carers and legal representatives, including a separate waiting area for them
- access to photocopying facilities.

There should be a written local operational procedure for the use of the assessment facility.

LOCATION OF THE PLACE OF SAFETY

The unit:

- must be accessible to the disabled and should preferably be on the ground floor

- as the person may need to rest, it should be in a quiet area
- should have discrete access avoiding public areas
- should be in a secure area, permitting the individual to wander or pace and if appropriate to talk to their carers and friends.

In determining the size of the unit, consideration needs to be given to the likelihood of there being more than one person requiring this facility at any given time. Where there may be more than one in the unit at one time, the unit should have lockable sections so that the individuals can be kept apart.

SMOKING IN THE PLACE OF SAFETY

Many individuals detained under Section 136 will be smokers and their distress and level of disturbance may be increased by being unable to smoke. The key aim should be to ensure that their length of stay in the Section 136 suite is kept to a minimum. Due to safety considerations in the assessment period it is unlikely that a safe external space within the suite could be provided to permit smoking. Therefore it is envisaged that those detained will be unable to smoke.

MONITORING THE STANDARDS OF THE PLACE OF SAFETY

The Care Quality Commission has responsibility for the monitoring of places of safety in hospitals in England and the Health Inspectorate Wales has a similar function in relation to Wales. Her Majesty's Inspectorate of Constabulary in conjunction with Her Majesty's Inspectorate of Prisons have a similar function for the police stations.

TREATMENT UNDER SECTION 136

Section 136 does not authorise medical treatment. Medical treatment may be given with the patient's capacitous consent or, if the patient lacks capacity in relation to treatment decisions, it may be given in line with the authority of the Mental Capacity Act 2005 and would have to be in the person's best interest.

Staff roles and responsibilities in relation to Section 136

In this section a general description of staff roles and responsibilities is provided. For a specific list of these roles to assist in staff training and for monitoring of standards of care please refer to Appendix 2.

POLICE

The police must determine that the person in a public place meets the criteria for Section 136, which includes an assessment of the need for 'immediate care or control' and that this is the most appropriate course of action. Therefore, they need skills in the assessment of mental illness, risk assessment and management, an awareness of physical health problems which may require urgent attention and the impact of drug and alcohol use.

The police officer should inform the person of the detention. This information may need to be repeated several times.

They need to arrange prompt transfer, on the basis of a dynamic risk assessment, preferably by ambulance, and following discussion with the ambulance service and ambulance clinicians to agree the appropriate place of safety. They may, in line with local procedure, use a police vehicle to transport the person to the place of safety when failure to do so would increase the risks to the individual and others, heighten the individual's distress or compromise their dignity. The police retain responsibility for conveying the individual; it is not clear that they can delegate this to the ambulance clinician and so they should travel with the person to the place of safety.

They should communicate with the place of safety staff, indicating the risks the person poses to themselves and others. Agreement should be reached as to who will inform the approved mental health professional. On arrival they need to ensure that staff are fully aware of the circumstances leading to the detention, which will help them in their initial risk assessment.

Section 136 is a preserved power of arrest under Section 26 of the Police and Criminal Evidence Act 1984. Under Section 32 of that Act the person can be searched when arrested if there are reasonable grounds for believing they present a danger to themselves or others.

It may be necessary for the police to remain at the place of safety for a short period to ensure the safety of the individual or staff. It is the responsibility of the healthcare staff to restrain the person where necessary

but they may ask the police to assist in an emergency, for example while waiting for adequate staff trained in physical intervention to arrive. The staffing of a place of safety ought, therefore, to include the possibility of a maintained police presence to assist in the management of threatened or actual violence. Police presence may occasionally be required until an assessment has been made and appropriate steps have been taken to render the situation safe. National police guidance states that police will not restrain an individual for the purpose of giving medication as they might be liable to prosecution if the wrong medication were given. The least restrictive means of controlling and restraining the individual should be used, treating the person with sensitivity, respecting their human rights and privacy, as well as attending to their physical health issues (par. 7.8 W). Given the implication for police resources it is essential that there are sufficient approved mental health professionals and doctors, including Section 12-approved doctors, to ensure that the assessment can be carried out in a timely manner and for this work to be prioritised.

If the police station is used as a place of safety the custody sergeant should obtain information from the police officer who carried out the detention, assess any health and safety issues that the individual poses to themselves and others, arrange medical attention from the forensic physician and forensic nurse practitioner and contact the approved mental health professional and doctor. Wherever possible, the fitness to detain assessment should be carried out by the forensic physician as they can ensure that the person is discharged from Section 136 if they do not have a mental disorder. The Codes of Practice state that 'the doctor examining the patient should wherever possible be Section 12-approved'. The custody sergeant has ongoing responsibility for the safety of the detained person.

Custody officers will need to ensure that the person is aware of their detention under Section 136 and the Police and Criminal Evidence Act, that they are aware of their right to a solicitor and to have someone notified of their detention. Custody officers should also provide this in written form.

The Code of Practice for England (par. 10.32) advises that 'In no case may a patient continue to be detained in a police station under Section 136 once a custody officer deems that detention is no longer appropriate.' The custody officer has a statutory duty under Police and Criminal Evidence Act to determine who shall or shall not be detained in police custody. We recommend that in reaching that decision the custody officer should first discuss the case with a doctor or an approved mental health professional.

AMBULANCE SERVICE

The primary responsibility for the provision of suitable transportation for a person detained under Section 136 rests with the local National Health Service (NHS) ambulance service provider. Ambulance service clinicians make operational judgements concerning the most appropriate type of vehicle and escort to be used, having taken into account the risk assessment and the resources available at the time of the call. The term 'ambulance' is used in this document to mean a vehicle provided by the ambulance service and does not specify the type of vehicle. If the person detained is violent and the result of the dynamic risk assessment undertaken by the ambulance clinician is a moderate to high risk, it may still be possible to use an ambulance. The police officer should be asked to travel with the ambulance clinician in the

back of the ambulance, to ensure the safety of the person being detained and the ambulance clinician treating and transferring the patient. The police should at all times travel with the individual; it is not clear that the power to convey under Section 136 can be delegated.

Dynamic risk assessment refers to the fact that the risks may change over a short period of time and this is particularly important where the person is under the influence of alcohol or drugs or is withdrawing from them.

Ambulance clinicians may provide emergency treatment if needed in the public place, taking into account issues of capacity, consent and the need to act in the person's best interest.

The police determine which place of safety should be used and may consult the ambulance clinicians. The place of safety should be contacted and staff at the place of safety should have agreed to accept the person before the start of the journey, unless it is a medical emergency. In this situation the nearest emergency department should be forewarned of the estimated time of arrival during the course of the journey. Rarely, the staff at the place of safety may arrange for an alternative facility to be used (see *Choosing the place of safety*, p. 25).

PLACE OF SAFETY

The staff member in charge should have determined how many staff should be in the assessment suite to receive the detained person on the basis of information provided by the police. This will enable the police to leave at the earliest opportunity. The facility must therefore have access to sufficient trained staff who can attend at short notice, without jeopardising the care of patients elsewhere. The level of staffing needed until the assessment is complete will vary. In some individuals the risk posed is of neglect or suicidal ideation whereas others may be agitated or aggressive.

It may be occasionally appropriate for another part of the hospital to be used as the place of safety, such as an intensive care unit. The service provider should designate which areas can be used in this manner, ensuring that they can comply with the guidance for the physical standards of the place of safety. The decision to use another part of the hospital or transfer the person to an alternative area can only be taken by a police officer or an approved mental health professional, or by someone authorised by either (Code of Practice, par. 10.35 E, 9.3 W) and should only be taken in consultation with the person in charge of the proposed place of safety. The use of alternative provision should be monitored. The nurse in charge should ensure that the place in question has adequate staff to safely conduct that role.

The time of arrival at the place of safety should be clearly documented; that is the start of the 72-hour assessment period under Section 136.

The police should not leave the unit until it is agreed with the senior nurse that it is safe for both the individual and staff for them to do so.

The nurse in charge should ensure that the approved mental health professional is aware of the planned arrival of the detained person and should gather as much background information as possible before the person's arrival.

On arrival the nursing team must ensure that they receive adequate information and complete an initial risk assessment, including an assessment

of any physical health problems that might require urgent attention. The nurse in charge should alert the approved mental health professional of the person's arrival and all times should be documented, as per the monitoring form (Appendix 1).

Staff on the unit should be experienced in the assessment and management of risk as well as acute psychiatric disorders. They need to ensure the safety of all those in the assessment suite, with an expectation that the police will be able to leave promptly. They should be able to deal with incidents and, where appropriate, administer medication and monitor its effects. They need to keep their own clinical records and complete a form for monitoring purposes.

Staff are responsible under Section 132 for ensuring that the person is aware that they are detained under Section 136, that they are given an explanation as to its implications and that this is also given in a written form.

APPROVED MENTAL HEALTH PROFESSIONAL

The approved mental health professional should ideally have expertise in intellectual disability (also known as learning disability in UK health services) or child psychiatry if that is thought to be relevant for the individual requiring assessment and where practicable, balancing the desirability of specialist assessment against the possible delay. They will gather information from available sources such as the police, relevant relatives or friends, the general practitioner and the mental health service, and check whether the person is already detained under the Mental Health Act. They should interview the person in a suitable manner. When detained in police custody, the person has a right under the Police and Criminal Evidence Act to be interviewed using an interpreter if they request it. An interpreter should also be used if there is a problem communicating in English or Welsh and none of the interviewers speak the person's language. The approved mental health professional's role is to assess what help the person may benefit from, not simply whether or not they should be detained under the Mental Health Act.

If a doctor has found that the detained person does not have a mental disorder, they must be discharged from detention. However, they should be offered the opportunity to see the approved mental health professional as they may wish to be assessed for further support.

MEDICAL STAFF

The local implementation policy should ensure that, wherever possible, the doctors doing the assessment should be approved under Section 12 (2) of the Mental Health Act. Where this is not the case, the reasons should be recorded (par. 10.27 E, 7.25 W) and we recommend that a non-Section-12-approved doctor discuss the case with a senior doctor who has Section 12 approval. The psychiatrist most suitable for the individual (as discussed in the previous section) should complete the medical assessment. Their role is to determine whether the person has a mental disorder, what further assessment or treatment would be appropriate and whether or not the criteria for detention under the Mental Health Act 1983 are met.

That assessment may ideally require, for example, expertise in intellectual disability or in child and adolescent psychiatry for someone under the age of 18, where this can be achieved without undue delay.

The Code of Practice for Wales should be commended for adopting a more rigorous standard, specifying that a consultant psychiatrist in learning disability and an approved mental health professional with special expertise in learning disability should undertake the assessment, and likewise, that a consultant in child and adolescent mental health and an approved mental health professional with specialist expertise in that area will undertake the assessment of those under 18 years and those who have recently been transferred to adult mental health services. In England, this is 'desirable' for the assessment of those with intellectual disability (par. 10.29) and should happen 'if possible' for the assessment of children and adolescents. It is hoped that services in England will similarly aspire to this standard.

The assessment includes an assessment of physical healthcare needs.

The psychiatrist has the responsibility for arranging that a suitable bed be found where required.

At a police station the forensic physician supports the police in the safe care of the detained individual. They should therefore ideally have had sufficient specialist training and have gained approval under Section 12(2) of the Mental Health Act for that role as, if they find that the detained person has no mental disorder, they must discharge them from Section 136. The European Court of Human Rights has held that for detention on the ground of unsoundness of mind to be lawful other than in an emergency, the presence of a true mental disorder has to be established by objective medical expertise. Therefore, in the longer term, forensic physicians should obtain approval under Section 12 and in future the police station should rarely be used as a place of safety.

TRAINING OF STAFF

All staff need to be familiar with the local policies and procedures, including the roles of all the professionals involved in the Section 136 process. Custody sergeants and emergency staff are often unfamiliar with the use of Section 136 of the Mental Health Act and need to know how to access guidance and staff support. It is recommended that training should include users and carers. There are advantages in some elements of training being multidisciplinary.

It is important that police officers should have training in the identification of mental disorder and, in particular, in the issues relating to drug and alcohol intoxication which can complicate the assessment. They need to have training in medical problems which may present with disturbed behaviour. Police will need basic skills in risk assessment and management, use of physical intervention and basic first aid, including life support.

Healthcare staff who work in Section 136 suites should be trained in risk assessment and management, observational skills, use of the Mental Health Act, use of physical intervention and resuscitation equipment. They need expertise in the assessment and management of substance misuse, including withdrawal syndromes and physical healthcare issues. They must be familiar with the rapid tranquillisation procedure in case this needs to be carried out. This training should likewise be available for healthcare

professionals working in emergency departments and staff in custody suites supported by those with such skills, which may include the forensic physician, forensic nurse practitioner or mental health worker (who might be assigned to the assessment facility).

INTERFACE BETWEEN SERVICES, INCLUDING TRANSFERS ACROSS ENGLAND AND WALES

Police may access the most suitable place of safety and should take into account:

- any known existing mental health service involvement
- the person's usual address or, if homeless, that of their social support network or general practitioner
- accessibility and availability of the most suitable place of safety.

The approved mental health professional and medical staff are employed by their respective organisations in a given jurisdiction but can arrange for assessment or admission in the other jurisdiction if that is more appropriate. Local policy should provide guidance on transfer to places of safety within other NHS trust district and across the English–Welsh border. Local policy should also address the issue of transport for individuals transferred between services.

Local policy and procedure on the use of Section 136

The Codes of Practice make a number of recommendations about the use of Section 136. To these have been added recommendations from the review of Section 136 undertaken by the London Development Centre (Bather, 2006). This section both identifies the key issues and makes suggestions as to how they can be achieved. For each key stage on the journey from initial contact with the police in a public place, through to completion of the assessment and implementation of the resulting decision, we recommend establishing a local Section 136 policy implementation group.

LOCAL SECTION 136 POLICY IMPLEMENTATION GROUP

The local commissioners and planners should have responsibility for ensuring the establishment of a local policy implementation group responsible for deciding local policy in relation to the place of safety and for implementing and monitoring it. Such local multi-agency group should include:

- local commissioners of mental health services
- mental health service providers with Mental Health Act responsibilities, a consultant and staff member of the psychiatric assessment facility/facilities
- emergency departments
- local social services authorities; children's services and intellectual disability services should be included as needed
- police, including the forensic medical service
- ambulance trust/trusts
- user and carer organisations which may include Black and minority ethnic group representation.

A suitable group may already exist, for example a police liaison committee with the remit to oversee court diversion schemes or services for individuals with a mental disorder who offend. In that case it could be easily modified by the addition of one or two members to establish and oversee local Section 136 policy. Where such a committee does not exist, it should be constituted forthwith. In our view, the chair of the local implementation team should ensure that the group meets and, through the use of service contracts, that its policies are implemented.

The policy should define responsibility for the commissioning/planning and provision of suitable and sufficient places of safety and staffing for local needs. It must ensure that staff are adequately trained and familiar with the local policy. The committee should also ensure that joint educational sessions are provided for workers in the main agencies involved in the use of Section 136 and in implementation of local policy relating to the place of safety.

It should include guidance for professionals on the choice of place of safety and, when it is appropriate, to transfer the individual from one place to another. It should determine the responsibility to provide transport for the transfer of the detained patient from one ambulance service's geographical area to another, to ensure that this does not result in undue delay. Locally agreed timescales for the approved mental health professional and doctor to commence the assessment. Specific attention should be given to those in custody suites (par. 10.23 E), safe and timely conveyance to and between places of safety, and support, including follow-up and transport for those not subsequently admitted to hospital or immediately accommodated elsewhere, should be addressed. It is for the local policy to define responsibilities for dealing with those who are also under the effects of alcohol or drugs, those who are or have behaved violently and for arranging access to hospital emergency departments, where necessary (par. 10.17 E, 7.12 W). The policy should also define responsibilities for record keeping, monitoring and audit of practice in relation to the policy. This report recommends that the same paperwork should meet the requirements for record-keeping as for effective communication and monitoring, to reduce the administrative workload (Appendix 1).

The effectiveness of the policy and procedure should be reviewed on an annual basis. The information should also be collected nationally, as this offers an opportunity to learn from one another so that regional variations can be understood and, where necessary, addressed.

It would be good practice for the policy implementation group to publish its policy in the form of a booklet which could be widely distributed to interested parties.

Procedure for implementation of Section 136

A 'place to which the public have access' or a 'public place' is defined under the Public Order Act 1986 and the Crime and Disorder Act 1998 as 'any premises or place to which, at the material time, the public or any section of it have access, on payment or otherwise, as of right or by virtue of express or implied permission.'

In the London Development Centre report (Bather, 2006) this is taken to include:

- places to which the public have access, for example the public highway
- places to which the public have access upon payment, for example cinema
- places to which the public have access at certain times of day, for example a public house.

It does not include the situation where the person is a visitor to private premises, such as a private garden.

REMOVAL FROM THE PUBLIC PLACE TO A PLACE OF SAFETY

If a person appears to be mentally disordered and poses a risk to themselves or others, the police officer can consider other options than detention under Section 136. These include, with the person's agreement, taking them to their home or other place of residence, which may be a residential home or a hospital, if the police officer believes this can provide more suitable support and care to make this a safe option. If the person is already a detained patient and is absent without leave from hospital, the police officer may simply return the person to the appropriate in-patient facility.

DECISION WHETHER TO USE SECTION 136 OR CRIMINAL JUSTICE WHERE OFFENCE HAS BEEN COMMITTED

The Home Office Circular 66/90 (Home Office, 1990) offers guidance as to whether to use the Mental Health Act provision or to charge the individual. The circumstances in which the offence took place, the seriousness of the offence, risk factors and public interest should all be considered. If a serious

offence has taken place, consideration should be given to charging the person and then determining whether they require a Mental Health Act assessment while they are in custody. The forensic physician should determine whether the person is fit to be interviewed and whether there is a need for the Mental Health Act assessment.

The police officer detaining a person under Section 136 should explain their actions to the person and advise that this does not imply that they have committed a criminal offence. In making the assessment and in their subsequent care the individual's diversity and background should be recognised and treated with respect.

Transport from a public place to the first place of safety should involve one journey only, in a vehicle which is safe and fit for the purpose without being unnecessarily imposing or threatening to a person with mental disorder. Ideally, this will be an ambulance as this confers dignity to the individual, attracts less public attention and is similar to care received by those with physical illness. The term 'ambulance' refers to a suitable vehicle provided by the ambulance service. Police should accompany the person detained under Section 136 in the back of the ambulance, as it is not clear that they can delegate the power to convey the individual to the ambulance clinician. Rarely should a police vehicle be used; only when this is the safest option to the individual, staff and public or very occasionally when the alternative would involve an undue delay, which would not be in the individual's best interest. A police vehicle is more likely to be used in a rural area. When the police vehicle is used, this should be noted on the monitoring form to ensure that the use of a police vehicle is kept to a minimum and any problems implementing the local procedure are remedied. Even where the clinical situation does not represent an emergency, the journey should be managed as speedily as possible to reduce distress and so it should always be prioritised by the ambulance service.

For Section 136 cases the standard ambulance service response is proposed as up to 30 minutes, unless there are life-threatening problems, where the caller will be taken through the ambulance telephone emergency triage system and an emergency response dispatched. If the caller is in a public place and privacy is not able to be accessed for the individual subject, the call may also be upgraded to a more urgent response, subject to commissioning support in each area.

The police, usually after discussion with the ambulance clinician, should determine the appropriate place of safety, which should normally be the local psychiatric facility. If the detained individual requires emergency medical treatment they will be transferred to the nearest emergency department. If the preferred local place of safety is not to be used, clear reasons for this should be indicated in the written communication. The Codes of Practice (par. 10.25 E, 7.22 W) recommend that, where the place of safety is a hospital, the police should alert the local Social Services authority or the people arranging services on their behalf of the need for an assessment. This is important if the emergency department is to be used as the mental health assessment can, where appropriate, occur concurrently and it avoids undue delay. In the case of the psychiatric facility the local policy could specify that the person in charge of the place of safety would carry out this role.

There should be joint policies and procedures in place with regards to conveying individuals, outlining the roles and responsibilities of the different groups, the authorisation to convey and guidance on powers available under the Mental Health Act. It should address the issue of patients being

transferred between places of safety, including transfers across the boundary of the ambulance provider. Inspection of these conveyance protocols is within the remit of the Care Quality Commission and Healthcare Inspectorate Wales.

For the psychiatric facility, the person should not start their journey to that facility without contact having been made. This is to ensure that the assessment unit is able to take the person or make alternative arrangements and to arrange for staff to be available on the person's arrival. The police must be able to contact the person in charge of the place of safety swiftly so that this does not delay the person's transfer. There should be a clearly defined mechanism and the relevant telephone number, and the person responsible for receiving such a message should be clearly identified. This communication from the police to the place of safety should be made by the police officer responsible for the person under Section 136 and should include some indication of the nature of the problem and the risk posed. This is most important where such risks are likely to require immediate assessment and intervention on arrival.

The communication from the police officer and the timing of the call should be documented by the place of safety staff. It is then up to the person in charge of the place of safety to ensure that adequate staff will be available to accept the person, and if this is problematic, to discuss the issue with senior managers. There should be a mechanism to identify and monitor situations where the police have not been able to return to other duties at the earliest opportunity so that any healthcare staffing issues are addressed.

RECEPTION AT THE PLACE OF SAFETY

There should be a clearly identified person available at the place of safety to receive the person subject to Section 136 and to take charge over arranging the assessment. They should immediately record the time of arrival. The detention period is for up to 72 hours from the time of arrival at the place of safety. The managers of the place of safety are ultimately responsible for the record keeping.

The police have powers under the Police and Criminal Evidence Act 1984 to search the individual and it is expected that this will occur before or on arrival at the place of safety, while leaving some discretion to the police.

The first task of the receiving nurse or police officer is to check that the person has been brought to the place of safety under Section 136 and is aware of that fact. The simplest way to do this would be to have standard documentation of the procedure.

Appendix 1 gives an example of a single form which meets the needs of all the communication and monitoring between staff and agencies recommended in this report.

After checking that the person is detained under Section 136 an immediate (triage) assessment should evaluate the current risk. Urgent treatment and any other action should be taken before the completion of the psychiatric assessment. This includes checking whether the person is in need of an urgent medical assessment, in which case they would need to be transferred to an appropriate place. Suitable numbers of skilled staff should be called to the assessment area to assist in the management of the patient, should such staff not already be there.

An agreement should be reached between the person in charge of the place of safety and the police as to when the police can leave, without risk to the individual or staff. The local policy should state who should be involved where there is disagreement and such problems should be documented and discussed by the local policy implementation group. Mental health staff should involve senior managers where necessary to help to secure sufficient staff for the police to be able to leave and return to their other duties as swiftly as possible.

The detained individual should be informed verbally and in writing about their detention under the Mental Health Act, the reasons for this and their rights. They should be asked whether they wish to have a relative or friend contacted, who may be invited to attend the place of safety.

It is the responsibility of the staff member in charge of the Section 136 process to ensure that a doctor and an approved mental health professional attend to complete the assessment, if necessary by making the referral if the police have not already done so. The request for the assessment should be made promptly. The approved mental health professional should determine whether to involve the local crisis resolution and home treatment team in the assessment, in case home treatment is an appropriate alternative to admission. Such teams should be gatekeepers for all admissions. The most appropriate doctor would be a psychiatrist approved under Section 12 of the Mental Health Act. If the forensic physician determines that the person has no mental disorder, within the meaning of the Act, the person must be discharged immediately from Section 136. Where the forensic physician is not approved under Section 12 it is recommended that they contact the appropriate mental health professional before reaching this decision. Joint assessments with the approved mental health professional are recommended. There is an expectation that those detained in custody suites will be promptly assessed either to arrange transfer or to complete the assessment process. An interview with an approved mental health professional should be offered, even where the person agrees to informal admission or has been discharged from the Mental Health Act to assess and arrange the need for further assessment, treatment and support. In the case of the latter the person would need to choose to remain on a voluntary basis while awaiting that interview.

The patient should have their detention under Section 136 explained again verbally and in writing, even if the place of safety is not in a hospital where there is a duty on hospital managers to give the individual information under Section 132. It is not sufficient to give the information in a written form alone. The Police and Criminal Evidence Act 1984 applies to those detained in police custody who are deemed to be 'under arrest'. Individuals detained under Section 136 in a police station have the right to have a solicitor present and another person of their choice informed of their whereabouts. The need for an appropriate adult should be considered if they are to be interviewed by the police in respect of a criminal investigation. An approved mental health professional can act in the role with the person's agreement, but not if they have been involved in the Mental Health Act assessment. The custody sergeant must then make alternative arrangements. The role of the appropriate adult is to ensure the person has received and, where possible, understood their rights. This includes the right to have someone informed of their arrest, to consult with a solicitor in private, to receive free legal advice and to consult the Police and Criminal Evidence Act Code of Practice. The appropriate adult can request legal advice even if this right has been declined. They also have the right to inspect the

custody record. Where the detention is not in a police station, the individual's request for access to a relative, friend or advocate should still be facilitated, if it would not cause undue delay. In Wales, where a hospital place of safety is used, the managers must provide access to legal advice if requested (par. 7.37 W) and this is recommended as best practice.

If the place of safety is a mental health ward, it should be made clear to the person and staff that the person is not formally admitted to hospital but is awaiting assessment and the detention period under Section 136 ends when that assessment is completed or after 72 hours, whichever comes first. Section 5 (4) or 5 (2) of the Mental Health Act should not be used to extend this time as the person has not been admitted as an in-patient (par. 10.53 E, 7.40 W).

Reception at the place of safety should be documented. A recording form is recommended, based on the Working Group's revised form for communication and monitoring purposes (Appendix 1). Use of the same form everywhere would not only promote good practice, but would allow comparisons to be made across the country. It is essential to have clear documentation of the risk assessment, which currently is often poorly recorded.

TRANSFER BETWEEN PLACES OF SAFETY

Section 44 of the Mental Health Act 2007 amended Sections 135 and 136 of the Mental Health Act 1983 to enable a person detained at one place of safety to be transferred to another. They may be taken to the second or subsequent place of safety by a police officer, the approved mental health professional or a person authorised by either of the two. They may be transferred before their assessment has begun, after it has started or following its completion while waiting for appropriate arrangements for care and treatment to be put in place.

Both Codes of Practice give guidance with regard to transfers (in chapter 10 of the English Code and chapters 7 and 9 in the Welsh Code) and that guidance is referred to in this section. This section takes account of the outcomes of a National Institute for Mental Health in England East Midlands Regional Development Centre workshop in December 2007.

- 1 Adequate provision and staffing of places of safety in psychiatric facilities needs to be ensured so that it is exceptional to use a police station for people detained under Section 136.
- 2 If a police station must be used, health and social care agencies should work with the police in supporting the care and welfare of the person while in police custody and assist in arranging, where appropriate, the transfer of the patient to a more suitable place.
- 3 Local policy should assist decision-making as to when it is appropriate to transfer the person from one place of safety to another.
- 4 Where a police station is to be used, early assessment should include a discussion as to whether it would be preferable to arrange transfer to an alternative place of safety as soon as it is considered safe and appropriate to do so.
- 5 The principles of the Codes of Practice for England and for Wales should be applied to the decision-making process.

- 6 Whereas local policy should outline circumstances when transfer may be appropriate, the decision on whether or not to transfer the patient must reflect individual circumstances and weigh up the benefits against problems, for example delay in assessment, distress to the patient (par. 10.37 E, 9.5 W).
- 7 The police officer, an approved mental health professional or someone authorised by either has ultimate responsibility to decide whether the patient should be transferred to an alternative place of safety. Unless in an emergency, it is preferable to discuss this with the approved mental health professional, a doctor or another healthcare professional competent to assess whether the transfer would put the patient's health or safety (or that of other people) at risk. The person in charge of the place of safety should participate in the decision-making (par. 10.38 E).
- 8 It should be clear that the new place of safety is willing and able to accept the patient, except in a medical emergency requiring transfer to an emergency department, where that can be presumed but contact should nevertheless be made in advance of arrival (par. 10.39 E).
- 9 Detention is ongoing and so the times of detention in each place of safety must be clearly recorded and information shared effectively between the transferring and receiving place of safety, as the maximum period of detention is not affected by transfer to another place of safety (par. 10.40, 10.41 E).
- 10 Monitoring the transfer should entail:
 - a. circumstances in which the transfer occurs, characteristics of those moved (including age and ethnicity) and final outcome
 - b. time from original detention to transfer and to completion of assessment
 - c. review of information provided to the person detained in the place of safety
 - d. ensuring that data are collected in a way that allows them to be used effectively by all parties to the policy.
- 11 All the relevant partner organisations should be aware of and trained in the powers to transfer between places of safety.

Although the guiding principles in the two Codes differ, they raise similar issues in relation to transfers. An analysis of the similarities and differences between the two Codes is provided in Appendix 4.

THE WAIT FOR AN INITIAL ASSESSMENT

Neither Code of Practice sets a time standard concerning waiting for an initial assessment, but the Code of Practice for England recommends that the local policy should set one (par. 10.43 E). It is reasonable to expect that a suitably qualified medical practitioner and an approved mental health professional can currently attend a place of safety to commence a face-to-face assessment within 3 hours of being requested to do so, with the aim to reach a standard of 2 hours in the future. It is recognised that this stringent target cannot currently be met. However, it is still important to set such a target and through monitoring resolve, where practicable, the issues hindering its

achievement. There will be times when the assessment has to be deferred, for example when gathering information, waiting until the patient is fit to interview or has had their physical healthcare needs addressed (see below). Setting the same time standard for the doctor and approved mental health professional allows for the joint assessment of the individual, which is recommended. This standard should apply regardless of when the person arrived in the place of safety. Before then the approved mental health professional will have begun to gather background information.

It may not be possible to complete the assessment immediately if the person is not in a fit state to be interviewed due, for example, to the effect of medication, illicit drug overdose or drug and alcohol intoxication. Reasons for the delay in conducting the assessment should be documented and the assessment should then be done at the earliest suitable opportunity.

It is important that the assessment itself should be comprehensive, including the collection of available and relevant information from informants so that the right decision is reached, a point emphasised in the report of the Independent Inquiry into care and treatment of H (Weereratne et al, 2003). Those making the assessment should determine relevant background information, including any current or past involvement with psychiatric services, forensic history including any current offence, and issues relating to risk. It involves checking to ensure that the person is not currently subject to other mental health legislation, such as Section 17 leave, guardianship or a supervised community treatment. If the person is on Section 17 leave, on a supervised community treatment or on conditional discharge, the assessors should ask the responsible clinician whether they wish to use the power of recall. An application for detention cannot be made if the person is known to be on supervised community treatment; the community treatment order should be revoked (par. 10.55 E, 7.42 W). If under a guardianship order the assessors can determine whether the person should be detained under the Mental Health Act. If absent without leave, they can be returned to the original hospital by healthcare providers under the provisions of Section 18. There can also be a delay in obtaining all the information needed to support effective decision-making.

The doctors examining the patient, wherever possible, should be approved under Section 12 and where this is not the case the doctor should record the reasons for this. It may not be possible to have an approved mental health professional or Section 12-approved doctor with relevant skills in assessment of intellectual disability or child mental health if this would cause undue delay.

A person awaiting assessment in a place of safety should receive a swift, competent assessment and treatment in the event of acute deterioration of a physical disorder such as infection, drug intoxication or traumatic injuries. To that end, basic first aid and medical equipment should be available and staff trained to assess and manage physical as well as mental healthcare concerns should be able to attend promptly.

An appropriately experienced doctor should be available to offer immediate telephone advice about management in the case of severely disturbed patients, even before the arrival of a doctor to undertake the psychiatric assessment.³

³ The Academy of Medical Royal Colleges report (2008) has set the following response times for mental health staff being called to emergency departments: first-line attendance 30 min in urban and 90 min in rural areas, Section 12-approved doctor 60 min in urban and 120 min in rural areas.

ARRANGEMENTS AFTER THE INITIAL ASSESSMENT

The possible outcomes of the assessment include ongoing assessment for detention under the Mental Health Act, informal admission, ongoing assessment and support in the community and discharge where no mental disorder has been identified (though the assessed person may still receive practical advice). Where the decision has been made to proceed to compulsory admission under one of the provisions of the Mental Health Act, the relevant clinical notes and communication/monitoring form should, wherever possible be completed before transferring the patient from the place of safety to a psychiatric bed, even when both are in the same psychiatric hospital.

There may rarely be circumstances where a severely disturbed patient needs immediate nursing management and medication which can be most safely provided by an in-patient psychiatric unit. If the hospital is a designated place of safety this is not a problem. To ensure it only occurs appropriately (and not, for example, on account of staffing shortfalls), it is recommended that the decision to make such a direct transfer to a ward is discussed with the person in charge of the psychiatric facility and is documented so that it can be discussed by the local policy implementation group.

It is the responsibility of the approved mental health professional to arrange for the detained person to be conveyed to hospital and they should determine the most suitable transport. Where there is no risk to the individual or others, an ambulance should be the preferred option, with police providing an escort where necessary. There can be significant difficulties in finding a bed, especially in a psychiatric intensive care unit or when secure provision or a child and adolescent unit is required. There should be a mechanism for drawing these difficulties to the attention of the local Section 136 monitoring group.

Where the person has been assessed and the decision taken not to place them under another section of the Mental Health Act, they should be informed of this decision as soon as it is reached.

The organisation responsible for the place of safety (where there is one) should ensure that proper records are kept of the end of the person's detention under Section 136.

The Codes of Practice state that local policies should define responsibilities for 'the release, transport and follow up of people assessed under Section 135 or 136 who are not then admitted to hospital or immediately accommodated elsewhere' (par. 10.17 E, 7.12 W). There must be a clear mechanism for informing the police about discharge arrangements (but no other details of the assessment unless there is an overriding obligation to breach confidentiality) when the person is not admitted to hospital. The approved mental health professional will normally take the lead role in these discussions and in making the transport arrangements. They should have access to funds for this purpose 24 hours a day, as the person may have been removed some distance to a place of safety and the assessment may be completed at a time of day which may make the use of public transport difficult. The mechanism for this should be described in the local policy. Other professionals need access to those or alternative funds in the event of the doctor finding that the detained person does not have a mental disorder or the custody officer deciding that they no longer need detention. The detained person should be

invited to remain to see the approved mental health professional but may decline to do so.

Paragraph 10.32 of the English Code of Practice states that 'In no case may a patient continue to be detained in a police station under Section 136 once a custody officer deems that detention is no longer appropriate'. The custody officer has a statutory duty under the Police and Criminal Evidence Act to determine who shall or shall not be detained in police custody. We recommend that in reaching that decision the custody officer should first discuss the case with a doctor or an approved mental health professional.

The outcome of the initial assessment should routinely be recorded on a standard form which indicates the decision made (for example, the recommended form, Appendix 1) and the action taken as well as the people informed.

INFORMATION SHARING IN RELATION TO SECTION 136

1 Information given to the detained individual and their carer:

a. By the police

As previously noted, it is important that the person is informed that they are detained under the Mental Health Act, the reasons for this and their rights. Because of their unsettled mental state, it is important to check that they have understood this information, which may need to be repeated several times. It is particularly important for the police to stress that they have been detained on account of their mental health giving rise to concern and that they are not being charged with a criminal offence.

b. At the place of safety

Information on detention under Section 136 should be given at the place of safety, orally and in writing. The current patient information leaflets are presently not widely used. If the person is detained in a police station they also need to receive information about their rights under the Police and Criminal Evidence Act Code of Practice C (Home Office, 2006). To ensure that the information on Section 136 is available in several languages and forms, including large print, it is advisable that these versions are available electronically in each place of safety. Monitoring should ensure that this information is given.

If the person is transferred from one place of safety to another the staff at the subsequent place of safety must ensure that the person has received all the information and check whether it has been understood. If not, every effort should be made to help them understand.

Although under Section 136 the statutory advocacy service does not apply, it would seem appropriate that the leaflet should give details of local advocacy services.

There should be access to trained interpreters.

2 Information from service users to the police and healthcare professionals

Crisis cards, advance statements and decisions are not likely to be helpful at the point of detention under Section 136 but would help in

the ongoing assessment as they would ensure that the appropriate carers and staff were contacted and that the views and wishes of the person when well were taken into account. Thus it is important that the approved mental health professional, nurses and doctors check whether one is available.

3 Information sharing as part of an enhanced criminal record check

The Police Act 1997, Section 115 (7) allows the chief police officer to disclose information about criminal convictions and to issue criminal record certificates. In the case of enhanced Criminal Records Bureau checks, 'soft intelligence' can also be disclosed (this includes information about detention under Section 136 of the Mental Health Act). The decision whether to disclose such information must balance the human rights confidentiality issues against the need to act in the public interest. The police need to consider the reason why the application for an enhanced criminal record certificate has been made. They may exercise discretion and would benefit from guidance to assist their decision-making and to promote a more uniform response. The Mental Health Act Commission (2008) has gone further by recommending that 'national guidance should instill a presumption that Section 136 incidents are not to be recorded as a police "criminal record".' The police are not responsible for the actions arising from disclosure, such as discrimination by a potential employer.

4 Information sharing between professionals

Information should be shared either with the consent of the individual or on a 'need to know' basis to support risk management and effective decision-making.

Monitoring and audit

Local monitoring is essential to ensure the appropriate use of the Section 136 and a safe assessment process, initiated quickly and with rapid resolution including, where necessary, transfer to an admission ward or discharge. The advantage of a standard national form, which still allows for additional information to be collected for specific local needs, is that it facilitates comparisons across the country, enabling learning as to how to introduce best practice.

Currently it is recommended that the monitoring should take place annually. It should be reviewed by both the local Section 136 monitoring group and the service provider's Mental Health Act monitoring committee, in relation to both local and national standards. The local policy should specify who will collect, analyse and disseminate the information, which should be of use to all the parties involved.

The following information should routinely be collected:

- number of occasions and place where Section 136 is invoked by the police
- sociodemographic characteristics of people made subject to Section 136, such as ethnicity, gender and age (notably, whether they are less than 18 years old); it may also include information on whether they have a permanent residence and whether they live alone
- mode of transport from public place to place of safety
- location used as place of safety, and when not a psychiatric facility, the reasons for this
- whether the person was transferred from first place of safety, reasons for this and the total number of transfers (this and the above point should allow the review of appropriateness of place of safety initially chosen)
- time taken for approved mental health professional to arrive
- time taken for doctor(s) to arrive
- time taken to complete assessment
- time spent by police supporting healthcare staff in place of safety
- outcome of the assessment (informal admission, admission under Mental Health Act or discharge)
- total time spent in place of safety, that is assessment and time to transfer/discharge, to identify any potential delays due to conveyance, escort or bed finding issues

- discharges following assessment solely by doctors without Section 12 approval

- any serious untoward incident.

The following could be audited:

- previous and current psychiatric contacts, whether they were under the care programme approach, whether the individual is currently detained under any mental health legislation and whether the least restrictive option has been considered, including crisis resolution and home treatment team support
- whether the individual has been previously detained under Section 136
- whether drug and/or alcohol consumption was significant
- whether the individual had taken an overdose or harmed themselves and required medical intervention
- adequacy of communication between police and assessors under the Mental Health Act
- use of restraint in initial detention and any injuries sustained in detention
- any untoward incidents (self-harm, violence)
- absconding and action taken, with outcome
- any criminal activity, before or at the time of Section 136 detention and whether the individual was charged.

It would also be helpful to periodically:

- complete a user and carer survey
- obtain the views of all the professional groups involved (police, doctors, including emergency department staff and forensic physicians, approved mental health professionals, nursing staff, including emergency department nursing staff, forensic nurse practitioners and ambulance service) to ensure that the procedures are well understood and effective. Success criteria, drawn up as part of the London Development Centre project (Bather, 2006), may help this process (Appendix 3). As a result, training needs may be identified, including the importance of interagency training.

To ensure that use of Section 136 can be effectively monitored nationally the Working Group recommends that:

- A standard recording form, which can also be used for monitoring, is piloted and agreed. Combining the two roles is likely to improve the completion of the monitoring form as it avoids the need for duplication of recording.
- The local policy states who will collect the data and who will ensure this happens. The local Mental Health Act office of the nearest service provider may be in a good position to do this.
- The data should be reviewed locally by the monitoring groups and nationally by the Care Quality Commission for England Healthcare Inspectorate Wales.

The Working Group have reviewed several monitoring forms and developed an exemplary form (Appendix 1), a modification of the one in use by the Metropolitan Police, so as to take into account the new legislation and Code of Practice. In its simplest version the form consists of two sheets; section 1 is completed by the police officer detaining the individual and section 2 by the person in charge of the place of safety or the approved mental health professional (this will be determined by the local monitoring group). Some police forces may choose to include section 3. A copy of section 1 and where used section 3 should be returned to the local police liaison officer and a copy of sections 1 and 2 should be sent to the designated local healthcare monitoring office. The box for 'no Section 136 suite' can be omitted where this does not apply.

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Appendix 1

Mental health monitoring form

MENTAL HEALTH MONITORING FORM

Station code: _____ Custody record no.: _____ Police URN: _____

Section 1 – To be completed by arresting officer

Time and date of detention: _____ Place of detention: _____

Detainee's surname: _____ Forename(s): _____

Male Female Date of birth: _____

ID code: _____ Self-defined ethnicity code: _____

Address: _____

Notes of incident/arrest (continue on page 3 if necessary):

Outcome of PNC, local check and risk factors place of safety assessment (i.e. self-harm, suicide, violence, impaired judgement, self-neglect, absconding, etc.):

Since detention, has the person received any medical attention prior to arrival at a place of safety? YES NO If YES, please describe:

Has the person been restrained? YES NO If YES, how and for what length of time?

Is the person suffering from the effects of drink or drugs? YES NO UNKNOWN

If YES, please describe: _____

Initial place of safety used: S136 suite Emergency department Police station

Other (describe) _____

If S136 suite not used, why? S136 suite full Emergency medical treatment required

Risk of violence No S136 suite Other _____

Conveyance to place of safety: Ambulance Police vehicle Other (specify) _____

Ambulance requested at: Time: _____ **Date:** _____

If ambulance not used, why? Risk of violence Other _____

Arrival at place of safety: Time: _____ **Date:** _____

Has the person been searched? YES NO

Time of departure (Police): _____ **Received by:** _____

Name of Officer reporting: _____ **Shoulder no.:** _____

This form must be completed and handed to nursing staff or the custody sergeant before leaving the place of safety. A copy must be taken for the local Police Mental Health Liaison Officer.

MENTAL HEALTH MONITORING FORM

Section 2 – To be completed by person receiving patient

Detainee's surname: _____ Forename(s): _____

Rights leaflet given and rights read at – Time: _____ Date: _____

Is the person on medication? YES NO UNKNOWN Comments: _____

Mental health professional name	Contacted at		Arrived at	
	Time	Date	Time	Date
AMHP				
1st doctor				
2nd doctor				
If there were any delays, please state reason(s) in Section 3 on the next page				

Was the first doctor approved under Section 12 of the Mental Health Act? YES NO

Name, address and telephone number of: **Friend** **Relative** **Next of kin**

Were they informed? YES NO

Any incident of concern following detention, including in place of safety? YES NO

If YES, please specify: Minor self-harm Self-harm requiring medical attention Assault

Absconsion Other Details: _____

Transfer requested from one place of safety to another prior to S136 assessment being completed? YES NO

Reason for transfer request: _____

If transfer not facilitated, why: _____

If YES, name of unit: _____

2nd place of safety – Name of unit: _____ Time: _____ Date: _____

Any further transfers? YES NO If YES, please record details in Section 3 – Other

Assessment completed at – Time: _____ Date: _____

Patient discharged at – Time: _____ Date: _____

Decision made after initial assessment

Discharged – Was not suffering from mental disorder

Discharged – Was suffering from mental disorder, but **A. No follow-up required**

B. Follow-up arranged

Admitted/transferred on an informal basis Admitted under MHA Section: 2 3

Other (specify)

To – Hospital: _____ Ward: _____

Arrival on ward – Time: _____ Date: _____

Signed (person completing): _____	Print name: _____
Time: _____	Date: _____

MENTAL HEALTH MONITORING FORM

Section 3 – Optional further information

Notes of incident/arrest

Signed: -----	Print name: -----
Time: -----	Date: -----

Medical assessment

Signed: -----	Print name: -----
Time: -----	Date: -----

AMHP assessment

Signed: -----	Print name: -----
Time: -----	Date: -----

Nursing assessment

Signed: -----	Print name: -----
Time: -----	Date: -----

GP details

Other

Appendix 2

Staff roles, responsibilities and support required

Table 1 Staff roles, responsibilities and support required

Role	Training and support
Police	
Exercising judgment that a person in a place to which the public have access appears to have a mental disorder, poses a risk to his/her health or safety or to the public and should be 'removed' to a place of safety.	Training in mental health.
Inform person that they are detained under Section 136 of the Mental Health Act orally and in writing. May need to be stated several times.	
Exercising judgment that a person's behaviour may be caused by a medical problem requiring urgent assessment and treatment in an emergency department.	Training in evaluation of a disturbed behaviour.
Arrange transfer, preferably with ambulance staff, reaching local agreement on appropriate place of safety and mode of transport.	National and local guidance.
Escorting and assisting ambulance staff in conveying detained person to hospital when there is a risk of violence/danger. Rarely convey in a police vehicle.	National and local policy and procedure.
Contact place of safety to agree transfer and identify risks.	Local policy and procedure.
Ensure Mental Health Act assessment requested in line with locally agreed procedure.	Local policy and procedure.
Provide those making further assessment detailed information on person's behaviour giving rise to concern.	Local procedure and communication form.
Remain in attendance to protect person's health or safety when they are in place of safety other than a police station until appropriate safe local security arrangements can be made.	Hospital to ensure adequate staffing readily available at place of safety.
Providing places of safety within police custody suite for those too disturbed to be managed elsewhere.	Adequate physical environment.
Ensure safety of individual detained in custody suite.	Risk-management training.

Role	Training and support
Informing a detained person at a police place of safety of their right to legal advice and provide verbal and written information regarding Section 136 and the Police and Criminal Evidence Act.	Written information readily available in several languages.
Informing a person nominated by detained person of their presence at place of safety.	
Agreeing actions for satisfactory return to community of persons assessed under Section 136 but not admitted to hospital.	
Appropriate record keeping enabling reasons for use of Section 136 and information for monitoring purposes to be obtained.	National guidance and local policy and procedure.
Involvement in local policy, procedures and guidance development.	
Member of local review group to monitor outcomes and improve standards with partner agencies.	
Ambulance service	
Respond to request from police for assistance to convey detained individual to place of safety.	Standard response time 30 mins unless local agreement to upgrade to more urgent response where no privacy available.
Determine means of transport, police role in this and appropriate place of safety.	Local procedure to include use of medical assistance at scene.
Convey patients to place of safety.	
Convey person from one place of safety to another and from place of safety to hospital where necessary (with police assistance if needed).	
Occasionally, monitoring sedated patients while transferring to place of safety.	Training in management of sedated patient and life support intervention.
Involvement in local policy, procedures and guidance development.	
Member of local review group to monitor outcomes and improve standards with partner agencies.	
Approved mental health professionals	
Provide emergency contact details to police.	Local policy and procedure.
Determine whether the person has past psychiatric history, whether they are currently detained and whether any advanced decisions, statement or crisis cards exist.	
Interview person 'in a suitable manner' as soon as possible after arrival in place of safety. Aim to commence face-to-face assessment within 3 hours currently and 2 hours in future.	Sufficient staff to meet local need.
Contact nearest relative as defined by Mental Health Act with person's consent or if grounds for consultation outweigh right to confidentiality under Article 8 of the European Convention on Human Rights.	
Arrange appropriate psychiatric assessment. Consider involvement of crisis resolution home treatment team.	

Role	Training and support
Consider alternatives to admission.	
Consider whether it is appropriate to transfer to another place of safety.	Local policy and procedure.
Arrange admission/transfer to alternative place of safety or admission ward, where needed, contacting ward and completing Mental Health Act application.	Local policy and procedure.
Exercise authority to convey detained patient using the most humane and least threatening means.	Training, local policy and procedure.
Make necessary arrangements, including transport, where person not admitted.	
Ensure admission ward receives documents, including outline report, at time of patient's arrival.	
Ensure welfare and safeguarding of dependants and children.	
Consider protection of property and pets.	
Involvement in local policy, protocols and guidance development.	
Member of local review group to monitor outcomes and improve standards with partner agencies.	
Psychiatrists	
Ensure prompt mental health examination, ideally by a Section 12-approved doctor.	Training for Section 12 and adequate staffing.
Ensure physical healthcare assessment and management, which may involve a junior psychiatrist.	
Where assessing psychiatrist is not Section 12-approved, they should consult with Section 12-approved psychiatrist before patient is discharged.	
Provide specialist clinical assessment and assist in development of a care plan.	
Make any necessary Mental Health Act recommendation.	
Identify admission bed.	Local policy and procedure.
Provide record of assessment, which should be available at time of transfer if patient admitted to hospital.	
Prescribe emergency medication under common law in emergency if suitably trained staff available to monitor its effect.	
Involvement in local policy, procedures and guidance development.	
Member of local review group to monitor outcomes and improve standards with partner agencies.	
Second medical opinion (preferably general practitioner or Section 12-approved doctor)	
Be available so that assessment completed as quickly as possible.	Local policy and procedure.
Where possible should be Section 12-approved if does not know patient.	Training for Section 12. Local policy and procedure.
Psychiatric nursing staff in place of safety	
Ensure adequate information obtained so that appropriate staffing available when person arrives.	Local policy and procedure.

Role	Training and support
Try and obtain additional information, e.g. case notes and name of care coordinator.	
Alert approved mental health professional unless police have done so.	Local policy and procedure.
Document time of arrival at place of safety, arrival of approved mental health professional, doctors and completion of assessment.	Local monitoring form.
Complete initial risk assessment with information from police and ambulance staff. Ensure no urgent physical health issues.	
Advise approved mental health professional of person's arrival.	
Approved mental health professional or nurse to contact psychiatrist.	Local policy.
Ensure receive detailed information from police.	Local policy to determine paperwork, also used for monitoring purposes.
Advise police when it is safe for them to leave.	Adequate nurse staffing.
Give patient information verbally and in writing on detention under Section 136.	
Inform person with patient's permission of their whereabouts.	
Ensure person's safety and well-being and safety of others throughout their stay in Section 136 suite.	Risk assessment and management training.
Complete notes of assessment and observations in line with standard clinical policy.	
Deal with any incidents that may arise.	Access to staff trained in physical intervention.
Administer and monitor effect of any medication prescribed.	Training in rapid tranquilisation, life support and use of resuscitation equipment.
Involvement in local policy, procedures and guidance development.	
Member of local review group to monitor outcomes and improve standards with partner agencies.	
Emergency department staff (in addition to roles of psychiatric staff in place of safety)	
Agree when emergency department should be used as a place of safety.	Local policy and procedure.
Understand implications of Section 136.	Training.
Ensure suitable environment for assessment of Section 136, to ensure safety of individual and others, including staff.	
Provide emergency medical assessment, treatment and care.	
Involvement in local policy, protocols and guidance development.	
Member of local review group to monitor outcomes and improve standards with partner agencies.	

Role	Training and support
Forensic physicians and forensic nurse practitioners	
Both forensic physicians and forensic nurse practitioners to assist police in ensuring person's safety and well-being pending further assessment.	Training in mental health and risk assessment.
Both forensic nurse practitioners and forensic physicians can advise on fitness to be detained, fitness to interview and to charge.	Police and Criminal Evidence Act applies if in police station.
Either forensic nurse practitioners or forensic physicians may determine whether appropriate adult required for any police procedures.	
Forensic physicians to assess the patient as expeditiously as possible following arrival at custody suite as place of safety.	Adequate staffing.
Forensic physicians should determine whether the person is mentally disordered, within meaning of Mental Health Act and whether Mental Health Act assessment is required.	Encourage forensic physicians to be approved under Section 12 Mental Health Act.
To consult with Approved Mental Health Professional, even if person is not mentally disordered. Particularly important where forensic physician is not Section 12-approved. Determine arrangements for further assessment and care.	
If the person does not have a mental disorder, they must be discharged from detention but should be advised to wait for approved mental health professional assessment to assess and assist with ongoing care needs.	
May assist in Mental Health Act assessment. Preferable to have Section 12 approval for this role; a long-term goal.	Training.
Involvement in local policy, procedures and guidance developments.	
Member of local review group to monitor outcomes and improve standards with partner agencies.	
Managers (social services and ambulance services, emergency departments and mental health services)	
Responsible for clear policies and procedures to be in place and disseminated to frontline staff.	
Ensure adequate staffing levels to achieve timely assessments, safety of all and high standards of care.	
Ensure funding available to provide transport for those discharged from place of safety, where necessary.	
Check that adequate training is provided.	
Review reliability of data collection for monitoring purposes and that this is used to improve and sustain high standards of care.	
Ensure that regular inter-agency meetings occur to review policy implementation and changes needed in response to feedback from monitoring process.	
Determine what changes should be made in the light of information from monitoring and implement changes.	
Ensure feedback from users and carers and that they are involved in training staff of all disciplines.	
In addition, for healthcare managers:	
Ensure adequate Section 136 suites available in acute psychiatric facilities, with sufficient staff available at short notice for them to be safely used to assess the moderately disturbed person, without ongoing support of police officers.	

Role	Training and support
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Health and social care commissioners and planners

Develop adequate provision of suitably designed and staffed places of safety in psychiatric facilities so that they can be routinely used.

Check that the design of the place of safety in emergency departments is fit for purpose and that there are sufficient suitably trained staff for that role.

Ensure adequate staffing of rotas for medical staff with Section 12 approval and approved mental health professionals at all times have been commissioned and planned so assessments quickly initiated.

Ensure care is delivered to nationally and locally agreed standards in line with local and national policy.

Users, carers and their organisations

Provide feedback on their experience so that services can be improved.

Assist in training of staff involved in Section 136 detention and assessment.

Participate in policy development, monitoring and efforts to improve the care provided.

Monitoring agencies (Care Quality Commission, Healthcare Inspectorate Wales and the future National Police Improvement Agency)

Ensure that standards set out in this document are attained and in particular:

- ensure appropriate local policies are in place, involving all the relevant agencies and that these are easy to access and well-disseminated
- ensure place of safety facilities are of an appropriate standard
- ensure all staffing levels are adequate to provide timely, high-quality care and that staff receive appropriate training
- ensure sufficient staff in psychiatric facility to minimise use of police custody suite for this purpose
- review data from local monitoring and compare findings across country and ensure action plan is in place to address any problems highlighted; in particular, compare results of ethnicity monitoring with local census data
- specifically review user and carer involvement in development, training and monitoring of services.

Appendix 3

Success criteria from the *Review of Section 136 Mental Health Act*

As part of the London Development Centre *Review of Section 136 Mental Health Act* (Bather, 2006), a set of success criteria has been developed for individuals and organisations involved in Section 136 Mental Health Act assessments. Those are the following.

- 1 Service user
 - assessment carried out and service user removed to hospital with least stigma possible
 - rapid access to assessment and appropriate care
 - least possible use of force or restraint
 - understanding of illness and situation from all professionals involved
 - maintenance of confidentiality
 - clarity about individual rights.
- 2 Carer/family members
 - access to appropriate support from relevant professionals after assessment
 - assessment carried out and service user removed to hospital with least stigma possible
 - service user detained safely
 - kept in touch with services after assessment.
- 3 Approved mental health professional
 - comprehensive recording of and access to relevant information to support appropriate decisions about the care and treatment for the service user
 - least possible delays to assessment
 - appropriate and proportional support in violent or resistant situation
 - police and ambulance crew have knowledge of mental health
 - opportunity to reflect and feed back with other professionals.

-
- 4 Police officers
 - clear guidance on use of Section 136
 - service user safely detained with least possible use of force or restraint
 - appropriate transport available after detention
 - assessment facilities that are able to deal with any risk and provide appropriate health facilities; this includes those persons who are extremely agitated and in need of restraint for their own or another's safety
 - opportunity to brief clinical staff and leave assessment centre at earliest opportunity.
 - 5 Ambulance crew
 - access to relevant information about service user and situation
 - appropriate support (police officer) during conveyance
 - clear guidance about dealing with Section 136.
 - 6 Medical staff
 - service user detained and conveyed to appropriate assessment facilities able to deal with any risk and with appropriate health facilities
 - access to relevant information about service user and situation with a fully comprehensive and documented handover.
 - 7 Health/social care management
 - alerted to problems, delays, staff safety.
 - 8 Police management
 - service user detained safely
 - officer and public safety
 - positive community relations.

Appendix 4

Comparison of the Codes of Practice for England and for Wales in relation to Section 136 of the Mental Health Act

The two Codes of Practice provide similar direction in relation to Section 136. Section 136 is covered (with Section 135) in chapter 10 (pp. 74–86) of the English Code and chapter 7 (pp. 41–46) of the Welsh Code. The Code for England has a slightly longer section on monitoring of standards in relation to Section 136 and has a section on the application of the principles as they might be applied to transfers between places of safety.

GUIDING PRINCIPLES IN THE CODES OF PRACTICE

The opening chapters in both Codes lay down guiding principles to assist in making decisions about action under the Mental Health Act.

PRINCIPLES FOR ENGLAND

- 1 Purpose principle. Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.
- 2 Least restriction principle. People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.
- 3 Respect principle. People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

- 4 Participation principle. Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.
- 5 Effectiveness, efficiency and equity principle. People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

PRINCIPLES FOR WALES

THE EMPOWERMENT PRINCIPLES

- 1 Patient's well-being and safety should be at the heart of decision-making.
- 2 Retaining the independence, wherever practicable, and promoting the recovery of the patient should be central to all interventions under the Act.
- 3 Patients should be involved in the planning, development and delivery of their care and treatment to the fullest extent possible.
- 4 Practitioners performing functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, and their carers and families, while also ensuring their safety and that of others.

THE EQUITY PRINCIPLES

- 5 Practitioners must respect the diverse needs, values and circumstances of each patient.
- 6 The views, needs and wishes of patients' carers and families should be taken into account in assessing and delivering care and treatment.
- 7 Practitioners should ensure that effective communication takes place between themselves, patients and others.

THE EFFECTIVENESS AND EFFICIENCY PRINCIPLES

- 8 Anyone made subject to compulsion under the Act should be provided with evidence based treatment and care, the purpose of which should be to alleviate, or prevent a worsening of, their mental disorder or any of its symptoms or manifestations.
- 9 Practitioners should ensure that the services they provide are in line with the Welsh Assembly Government's strategies for mental health and intellectual disability.

All the principles in the English Code are effectively included within the Welsh Code. Those in the Welsh Code are broader and more prescriptive; they also address information giving, open and transparent decision-making, avoidance of stigma, communication in languages other than English, safe, supportive and appropriate care environments, and the provision of evidence-based treatments.

Most of the differences between the Codes are ones of emphasis, phrasing or layout. There are some differences, such as the guidance on assessing young people or people with intellectual disability, where the different Codes could result in different levels of care and different priorities for service providers; it may be useful to monitor the impact of these differences. Although each Code formally applies to its own jurisdiction, it could be helpful for practitioners and local policy makers to have knowledge of both Codes.

PURPOSE OF SECTION 136

Both Codes identify the circumstances in which Section 136 should be used, the purpose and duration.

LOCAL POLICY

Both Codes require a jointly agreed policy between commissioners, hospitals, local social services authorities, police and ambulance services. Both Codes state that policy should:

- define each organisation's responsibility
- commission suitable places of safety
- identify appropriate places of safety in individual cases
- secure the attendance of police officers
- ensure prompt assessment
- ensure arrangements for conveyance
- define responsibilities for dealing with people who are under the effects of alcohol or drugs or who are violent
- decide when it is appropriate to transfer from one place of safety to another
- assign responsibility for returning the patient to the community where that is appropriate
- and arrange for monitoring the use of Section 136.

CHOICE OF PLACE OF SAFETY

The Code for Wales makes specific reference (7.17) to considering 'especially carefully' the most appropriate place of safety for children and young people and says that the person should be detained in hospital 'if possible' (7.19).

The equivalent in the English Code is that 'it is preferable for a person...to be detained in a hospital or a health service setting where mental health services are provided' (10.21). Both Codes specify very clearly that police station should only be used on an 'exceptional basis' and that a police station is not the automatic second choice when the first choice of place of safety is unavailable. The English Code emphasises the problems of the use of the police station as a place of safety and mechanisms for ensuring a prompt assessment for the transfer of the individual; the Welsh Code gives responsibility to health and social care agencies to 'discuss support and the care and welfare of the person whilst in police detention'.

THE INTERVIEW PROCESS

Both Codes emphasise the importance of joint assessments and that the first doctor should wherever possible be approved under Section 12 of the Mental Health Act. They recommend the use of professionals with expertise in child and adolescent mental health or intellectual disability where that is required but the requirement is stronger in the Welsh Code. Both require that where the doctor assesses the individual before the arrival of the approved mental health professional and finds him to have no mental disorder, the person must be discharged from Section 136, but the Welsh Code notes that this would be 'in exceptional circumstances', further emphasising the importance of joint assessments. The approved mental health professional role is more clearly described in the Welsh Code (7.29–30). The English Code requires target times for the start of assessment.

TRANSFER OF PATIENTS BETWEEN PLACES OF SAFETY

Both Codes are similar but the English Code offers more guidance including the application of the guiding principles.

RIGHTS OF PATIENTS DETAINED INCLUDING INFORMATION

The information in both Codes is similar.

RECORD KEEPING AND MONITORING

Both Codes emphasise importance of documenting the time of arrival at the place of safety and that this information needs to be transferred if the patient is moved from one place of safety to another. The Welsh Code requires that records should be made of any visitors to the patient, the purpose of such visits and any interventions necessary in requests made by the person (7.44). Both Codes note that the time when the Section 136 ends should be clearly documented and the Welsh Code requires that the outcome of the process should also be documented. Both Codes require that agencies monitor the use of Section 136 effectively. The English Code requires that responsibility for monitoring is formally agreed and that data can be shared and used by all agencies.

COMPARISON BETWEEN THE ENGLISH AND WELSH CODES OF PRACTICE

This table cross-references the Codes where they provide separate guidance or differ in emphasis; the numbers refer to the relevant sections.

Table 3 Comparison of the Codes of Practice for England and for Wales

English Code of Practice	Welsh Code of Practice
Section 136: Mentally disordered people found in public places	Section 136: Mentally disordered persons found in public places
<p>10.13</p> <p>10.14: [Section 136] is not a substitute for an application for detention under the Act, even if it is thought that the person will need to be detained in hospital only for a short time.</p> <p>10.15: The maximum period a person may be detained under section 135 is 72 hours. The imposition of consecutive periods of detention under section 136 is unlawful.</p>	<p>7.7: An officer may use reasonable force where necessary.</p> <p>7.8: The least restrictive means of controlling and restraining the person should always be used with the person being treated humanely and with due sensitivity. Regard must be shown for their human rights, dignity, privacy and any particular care needs such as those associated with their physical health.</p> <p>7.9</p> <p>7.10: Section 136 is not an emergency admission order. It enables an individual to be detained in a place of safety for examination and interview.</p>
Local policies on the use of police powers	Local policies on police powers and places of safety
<p>10.16: All professionals involved in implementation of the powers should understand them and their purpose, and the roles and responsibilities of other people involved, and should follow the local policy; Professionals involved in implementation of the powers should receive the necessary training.</p> <p>10.17: The policy should define responsibilities for:</p> <p>Commissioning and providing secure places of safety in healthcare settings;</p> <p>The safe, timely and appropriate conveyance of the person to and between places of safety (bearing in mind that hospital or ambulance transport will generally be preferable to police transport, which should be used exceptionally, such as in cases of extreme urgency or where there is a risk of violence);</p>	<p>7.11: The policy should clearly define each agency's responsibility, environmental expectations and risk-management standards, how the operation of the policy will be monitored and the timeframe for its review.</p> <p>7.12: In particular the policy should define responsibilities for:</p> <p>Planning and providing safe and secure clinical facilities for the containment of a person requiring examination or interview;</p> <p>Taking the person to the place of safety, safely and promptly;</p>

English Code of Practice**Welsh Code of Practice**

Arranging access to a hospital accident and emergency department for assessment, where necessary;

Record keeping and monitoring and audit of practice against policy;

The release, transport and follow-up of people assessed under section 135 or 136 who are not then admitted to hospital or immediately accommodated elsewhere.

10.18: Responsibilities should be allocated to those who are best placed to discharge them, bearing in mind the different purposes for which health and social services and the police service exist.

10.19: Such policies may be best maintained by the establishment of a liaison committee, which might also take responsibility for examining the processes in place for other multi-agency tasks, such as conveyance of persons under the Act and policies in respect of patients who go absent without leave.

10.54: It should also be borne in mind that a person who is removed to a place of safety may already be on SCT or conditional discharge or may be on leave of absence from detention in hospital and that their recall to hospital may need to be considered. If it becomes apparent that this is the case, the professionals assessing the patient should make an effort to contact the patient's responsible clinician as soon as possible.

10.43: The local policy should address who is responsible for collecting, analysing and disseminating the information required for monitoring purposes. It should also set target times for the commencement of assessment at a place of safety, and the relevant NHS bodies and LSSAs should review local practice against these targets.

Places of safety

10.20

10.22: A police station should not be assumed to be the automatic second choice if the first choice place of safety is not immediately available. Other available options, such as a residential care home or the home of a relative or friend of the person who is willing to accept them temporarily, should also be considered.

10.23: If a police station is used, health and social care agencies should work with the police in arranging, where appropriate, the transfer of the person to a more suitable place of safety. In defining responsibility for providing a prompt assessment, the locally agreed policy should set out the time within which it would be reasonable to expect the appropriate health and social care professionals to attend the police station to assess the person or to assist in arranging to transfer them.

Returning the person to the local community (where the assessment has not led to admission to hospital or other accommodation).

7.13: Local policies should ensure that police officers know whom to contact before removing someone to a place of safety under section 136.

7.14: A person who is removed to a place of safety under section 136 may be subject to supervised community treatment, conditional discharge, or may be on leave of absence and their recall to hospital may need to be considered. The policy should set out the arrangements, in these circumstances, for contacting the patient's responsible clinician as quickly as possible. Similar provisions in the policy will need to relate to patients who are subject to guardianship.

7.16: Where local policies establish target times for the start of the examination or interview, NHS bodies and LSSAs should review local practice against these targets.

Identifying an appropriate place of safety

7.17: While this is a matter for local agreement, consideration must be given to the availability and appropriateness of such facilities, depending on individual circumstances.

The most appropriate place of safety for children and young people must be considered especially carefully.

7.20: Save in certain circumstances, it is not acceptable for a police station to be the first option as a place of safety, or an automatic option in cases where more suitable accommodation is not immediately available.

7.33: see below

English Code of Practice

10.24: In identifying the most appropriate place of safety for an individual, consideration should be given to the impact that the proposed place of safety (and the journey to it) may have on the person and on their examination and interview. It should always be borne in mind that the use of a police station can give the impression that the person detained is suspected of having committed a crime. This may cause distress and anxiety to the person concerned and may affect their co-operation with, and therefore the effectiveness of, the assessment process.

10.25: Where a hospital is used as a place of safety, it is a local decision whether the person is admitted to a bed on arrival or whether that happens only after they have been interviewed and examined.

Where a police station is to be used as the place of safety, contact should be quickly made with the (or its AMHP service) and with an appropriate doctor. This will enable the examination and interview to be conducted as quickly as possible, thus ensuring that the person spends no longer than necessary in police custody before being released or taken to hospital. Early assessment will also allow consideration to be given to the possibility of a transfer to an alternative place of safety as soon as this is considered to be safe and appropriate in all the circumstances.

Assessment at a place of safety

10.26: The same care should be taken in examining and interviewing people in places of safety as in any other assessment. No assumptions should be made about them simply because the police have been involved, nor should they be assumed to be in any less need of support and assistance during the assessment.

10.28

10.31

10.33: see below

10.29: It is desirable for either a consultant psychiatrist in learning disabilities or an AMHP with knowledge and experience of working with people with learning disabilities to be available to make the assessment where it appears that the detained person has a learning disability.

Welsh Code of Practice

7.21: In choosing the place of safety, the professionals should consider the impact that the proposed place of safety may have on the person held and on the examination and interview. Therefore, a police station should be used either in the exceptional circumstances outlined above or when it is considered the safest option for the person, other patients or staff.

7.22:

If a police station is to be used as the place of safety, health and social care agencies should be contacted to discuss supporting the care and welfare of the person while in police detention. Contact should be made quickly with the LSSA and the appropriate doctor (most likely the forensic medical examiner who works with the police). This will enable the examination and interview to begin as quickly as possible, and allow the professionals to consider a transfer to an alternative place of safety as soon as it is safe and appropriate.

Agencies should work together to ensure no unnecessary delay in the examination and interview process.

Examination and interview

7.24: There may also need to be an appropriate adult present, particularly if the patient is a child.

7.26: If, in exceptional circumstances, the doctor has completed the examination before the AMHP arrives and concluded that the person is not mentally disordered within the meaning of the Act, the person can no longer be detained under section 136 and should be immediately released. If the doctor concludes that the person is mentally disordered within the meaning of the Act but does not need to be admitted to hospital, or the person agrees to informal admission, the person should still be seen by an AMHP.

7.27: A consultant psychiatrist in learning disabilities and an AMHP with special experience in learning disabilities should make a joint assessment if it appears the detained person has a learning disability.

English Code of Practice

10.30: Similarly, where the person detained is under the age of 18, or is known to have moved recently to adult mental health services, either a child and adolescent mental health services (CAMHS) consultant or an AMHP with knowledge and experience of caring for this age group should undertake the assessment, if possible.

10.32: In no case may a patient continue to be detained in a police station under section 136 once a custody officer deems that detention is no longer appropriate.

10.33: If the doctor sees the person first and concludes that they have a mental disorder and that, while compulsory admission to hospital is not necessary, they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP.

The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care.

Transfer between places of safety

10.23: see above

10.36: A person may be transferred before their assessment has begun, while it is in progress or after it is completed and they are waiting for any necessary arrangements for their care or treatment to be put in place. If it is unavoidable, or it is in the person's interests, an assessment begun by one AMHP or doctor may be taken over and completed by another, either in the same location or at another place to which the person is transferred.

10.37: Although it may be helpful for local policies to outline circumstances in which a person is usually to be transferred between places of safety, the decision in each case should reflect the individual circumstances, including the person's needs and the level of risk. For example, where the purpose of the transfer would be to move a person from a police station to a more appropriate healthcare setting, the benefit of that move needs to be weighed against any delay it might cause in the person's assessment and any distress that the journey might cause them.

Welsh Code of Practice

7.28: Similarly, if the detained person is under 18, or is known to have only recently moved into adult mental health services, a consultant psychiatrist in child and adolescent mental health services (CAMHS) and an AMHP with special experience in CAMHS should carry out an assessment together.

7.29: The role of the AMHP includes:

- interviewing the person
- contacting any relevant carers, relatives and friends
- finding out if the person has a psychiatric history, through collaboration with other professionals.

7.26: see above

7.30: The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care, and the AMHP should:

- consider any possible alternatives to admission to hospital
- or make arrangements for compulsory admission to hospital
- or make any other necessary arrangements.

Transfer between places of safety

7.33: In the exceptional circumstances where the place of safety is a police station, this should be for as short a time as possible and transfer to a more appropriate place made as quickly as possible.

English Code of Practice**Welsh Code of Practice**

10.38: Someone with the authority to effect a transfer should proceed by agreement wherever possible. Unless it is an emergency, a person should not be transferred without the agreement of an AMHP, a doctor or another healthcare professional who is competent to assess whether the transfer would put the person's health or safety (or that of other people) at risk. It is for those professionals to decide whether they first need to see the person themselves.

10.39: Unless it is unavoidable, a person should never be moved from one place of safety to another unless it has been confirmed that the new place of safety is willing and able to accept them.

Information for people detained under section 136

7.35: If someone has been removed to a place of safety under section 136, they are entitled to have another person, of their choice, informed of the removal and of their whereabouts.

7.38: As soon as detention in a place of safety under section 136 ends, the individual must be informed. Where they are free to leave they must be advised of this promptly and clearly.

Record keeping**Record keeping**

10.40: A record of the person's time of arrival must be made immediately when they reach the place of safety.

7.43: A record of the person's time of arrival at the place of safety should be made immediately. If the person is later transferred to an alternative place of safety, this should be recorded and the information about their original time of arrival passed to the new place of safety.

As soon as detention in a place of safety under section 135 or 136 ends, the individual must be told that they are free to leave by those who are detaining them.

10.41: Given that the maximum period of detention at a place of safety is not affected by any subsequent transfer to a different place of safety, it is very important to ensure that the time of detention at the first place of safety is recorded clearly.

7.45: A record should be made of the time the period of detention under section 136 comes to an end, and the outcome of the examination and interview.

Monitoring the use of the Act to remove people

10.43: The local policy should address who is responsible for collecting, analysing and disseminating the information required for monitoring purposes. It should also set target times for the commencement of assessment at a place of safety, and the relevant NHS bodies and LSSAs should review local practice against these targets.

7.16: see above

10.44: Although information systems (and definitions) may differ between organisations, efforts should be made to ensure that the most important data for monitoring purposes is collected in a way that allows it to be analysed so that it is of use to all the parties to the policy.

English Code of Practice**Welsh Code of Practice****Rights of persons detained in places of safety**

10.48: In all cases, the person detained should be told that the maximum period of detention is 72 hours.

Making necessary arrangements following assessment

10.51: Where compulsory admission is indicated, the AMHP should arrange for a second doctor to examine the patient in accordance with the Act (unless it has been agreed locally that someone else should make such arrangements).

10.55: An application for detention cannot be made in respect of a person who is known to be on SCT.

7.39: After the examination and interview, the doctor and the AMHP are jointly responsible for considering if any arrangements are necessary to provide for the person's care and treatment needs.

7.42: If the patient is on SCT and compulsory admission is required, the community treatment order should be revoked.

AMPH, approved mental health professional; LSSA, Local Social Services Authority; NHS, National Health Service; SCT, supervised community treatment

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