public that community care can work and be relied upon. It will also help raise the esteem of staff by indicating to them that the service they provide is successful and improvements that they may make in care will be recognised in the future.

Our conclusion is that long term monitoring of patients in the community is essential and that all Districts will have to develop some form of monitoring. It is likely that quite radically different solutions will emerge in different parts of the country and, in view of the lack of established examples, it is important that there is an open discussion of experience gained so far, and research into defining the most efficient and effective methods. Our method may be described as "quick and dirty", only providing indicators of areas that need further exploration. However, elaborate systems that take a long time to set up may be too late!

Acknowledgements

We are indebted to the guidance received from Dr Peter Kennedy, District General Manager, York Health Authority, to the work of Ms Jenny Wheeler, Ms Judy Hodgson and to the co-operation of patients and staff in the York Health Authority.

References

BALDWIN, R. (1988) Late life depression: undertreated? *British Medical Journal*, **296**, 519.

BLESSED, G. & WILSON, I. D. (1982) The contemporary natural history of mental disorder in old age. *British Journal of Psychiatry*, **141**, 59–67.

A Report to the Secretary of State for Social Services by Sir Roy Griffiths (1988) *Community Care: Agenda for Action*. London: HMSO.

JONES, K. (1985) *After Hospital: a study of long-term psychiatric patients in York*. Department of Social Policy and Social Work, University of York.

PANTELIS, C., TAYLOR, J. & CAMPBELL, P. (1988) The South Camden schizophrenia survey. *Bulletin of the Royal College of Psychiatrists*, **12**, 98–101.

Psychiatric Bulletin (1989), **13**, 144–147

Conference report

Royal Society of Health – Implementing Sections 135 and 136 of the Mental Health Act

GEOFFREY WALLIS, Consultant Psychiatrist, Fulford Grange Hospital, Rawdon, Leeds

This meeting, which I attended to represent the Public Policy Committee, was held on 25 May 1988 in the Middlesex Hospital's Courtauld Lecture Theatre, where neither the air conditioning nor the sound amplification worked but neither defect greatly mattered. Most of the 50 or so people there seemed to be social workers. Some were policemen but I think I was the only doctor.

Mr Brian Smith, a member of the Council of the Royal Society of Health, whose multidisciplinary functions he outlined and membership of which he encouraged, said that this meeting had taken two or three years to materialise.

The speakers were Superintendent R. B. Stone, Sub-Divisional Commander for Devonport, of the Devon and Cornwall police, and Mr B. Lillington, who had both mental nursing and social work qualifications and was Chairman of the Southern Region of the Mental Health Act Commission. Both speakers were burly, brisk and avuncular. They quickly dismissed Section 135, Mr Stone saying that for it the police provided muscle only: so, despite its title, the meeting was all about Section 136.

Mr Stone said that Plymouth had high unemployment and 500 police officers for a population of a quarter of a million. The Nuffield Clinic contributed

towards good medical and social work services both during and outside office hours.

He used the word "arrest" to describe the process whereby a constable removed a person to a place of safety under Section 136, although officially such persons were not under arrest. He queried how a policeman, for whom the public expectation was impossibly high, could recognise mental disorder, particularly psychopathy, but rather than give the police more than "fairly minimal" training in these matters, he preferred that they should apply the "test of the ordinary man". Mr Lillington said rather similarly that police constables were told about Sections but their training was more about attitudes to the mentally disordered, as it was to deaf and blind people. In the previous hundred years the "ordinary man" had learned that mental illness was common and treatable.

Of 31 people "arrested" in Plymouth in six months, nine went to mental hospitals after assessment. Four of the 31 were "rearrested", so that there were only 27 people "arrested". All four thus "rearrested" were taken to a mental hospital under a Section of the Act. Mr Stone argued from these figures that the police had judged well in provisionally diagnosing mental disorder. He pointed out that in these circumstances the police, who in this context included railway and Ministry of Defence police, had to decide instantly not only whether the person concerned was mentally disordered but also whether he or she was in a place to which the public had access.

Mr Stone said that a person who had apparently committed an offence could be charged but the police did not like taking people to court and Mr Stone said that in his force the police did not adopt the expedient of charging as a simpler and easier device than applying Section 136. A person taken to a police station because he was charged with an offence could, if then found to be mentally ill, be transferred to hospital under a different Section.

Although the London Metropolitan police had standing orders on Section 136 and were required to complete a document known as form 434 when they applied this Section and the Plymouth police kept records, completed chronologically, and were therefore, in Mr Stone's view, accountable to the public, there was no standard police procedure for acting or recording. Form 434 was usually completed by an inspector at a police station to which the constable took the person whom he had "arrested". The inspector also decided the course of action to be taken. Evidently Section 136 was often used in London but seldom elsewhere in England, notably Birmingham, Leeds and Manchester, and never in Scotland and Ireland. Mr Lillington revealed that some people having to deal with mental disturbances in the community found the Mental Health Act too difficult to apply and took people to hospital unlawfully. He agreed, however, that the degree of any possible unlawfulness in these circumstances might be mitigated if the common law or a charge of breach of the peace were invoked.

Mr Stone said that most of the people "arrested" under Section 136 were dangerous to themselves. From his records 61% were under 35, and when males alone were considered this figure rose to 72%. However, Mr Lillington had figures of Section 136 "arrests" in a London borough to indicate that the percentage of persons aged around 30 fell from 43 in 1985 to 35 in 1986, whereas for those aged around 60 the percentage rose from three in 1985 to six in 1986. In this series Afro-Caribbeans were overrepresented, as they had been in other studies and as they were for the implementation of Sections 2 and 3, but psychiatrists discharged from Section 136 proportionately more black than white persons. Mr Lillington thought that social problems predisposing to circumstances which might lead to the use of Section 136 were greater in London than elsewhere in the UK because there 90 languages were spoken and people of all races were scattered among the population and not comparatively segregated into ethnic groups as they were in Bradford and Liverpool. He believed that we were less flexible than we imagined about culture in that we were apt to maintain that members of ethnic minorities should adapt to our culture, whereas in the days of the empire we never adapted to theirs. Generally members of these ethnic minorities had more religious fervour than we did, and hence police and other members of the community were prone to make wrong diagnoses of "religious mania".

The speakers illustrated individuals subjected to Section 136 proceedings by describing a female who was "always carrying matches" and whom the psychiatrists, to the distress of the police, did not find mentally disordered and who was ultimately charged with arson for setting fire to a plastic bucket; a female who "threatened" 25 times; and a chronic schizophrenic female who, refusing medication when at home, where both she and her husband rejected community psychiatric nurses and social workers, was usually tolerated as long as she stayed on her side of a geographical health boundary, near which she lived, but when she strayed over it and shouted at children and hit adults was taken away under Section 136.

Messrs Stone and Lillington both discussed the place of safety. It could be a mental hospital, social services accommodation, a mental nursing home, a police station or other suitable place, so that it could be anywhere, but the police station was the only place that could not refuse to accept the person. It had the advantages of being neutral, situated in the community and a place to which people naturally went for help in crises but the environment and the staff

there might not be of the best for a mentally ill person. If the person were taken to hospital the police, not the hospital managers, were the detaining authority and strictly speaking a constable should stay with the person until he had been assessed. If a hospital were used as a place of safety, the person was much more likely to be detained formally than if he had been taken to a different kind of place of safety. Mr Lillington thought that the Accident and Emergency Department of a general hospital was more suitable as a place of safety than a mental hospital. In such a department no bed was allocated and the assessment was speeded up. However, a discussant in the audience thought that mentally disturbed patients were not at all welcome in Accident and Emergency Departments. Likewise in "Part III" accommodation a mentally disturbed person would disrupt the home, which was always understaffed by personnel untrained for this task. Mental Health and Crisis Intervention Centres seemed to be the most suitable places but funds were seldom allocated to establish them. Difficulties in finding a place of safety were becoming all the greater as the mental hospitals closed. Often a person was taken from one place of safety, such as a police station, to another, such as a mental hospital. The Act specified *a* place of safety but lawyers apparently considered that the singular included the plural! The general opinion was that moving people in this way was legal provided that no assessment had started.

Some police surgeons were approved under Section 12 and the Royal College of Psychiatrists was thought to have recommended that only doctors thus approved should assess for Section 136. Mr Stone said that some other doctors felt psychiatry was not their forte and that they were "not qualified" to examine for the purposes of Section 136. Mr Lillington recommended that the examining doctor and the Approved Social Worker should see the detainee simultaneously but in discussion he conceded that the detainee had a right to see both the doctor and the social worker individually, although he maintained that after such separate interviews all three should meet. Often the doctor found no mental disorder and the detainee was discharged without having been seen by a social worker but Mr Lillington pointed out that this omission was not only contrary to the Section but also deprived the detainee of care other than medical which the social worker could provide.

Mr Stone said that police at his stations never kept people for more than eight hours under Section 136. Mr Lillington pointed out that the clock for the specified maximum of 72 hours for the assessment started to tick as soon as the person was detained and that this time should be recorded. Any delay, he thought, should be inexcusable other than on grounds of exceptionally heavy work load or travel delays experienced by the doctor or social worker. Mr Stone said that for the maximum time allowed for assessment MIND favoured 24 hours and the British Medical Association only four. The ticking of the clock stopped as soon as the assessment was completed.

Detainees under Section 136 were entitled to know their rights in accordance with Section 132. Somebody should explain these rights as soon as possible but probably the police could not do so, and often nobody did. A detainee under Section 136 could not be treated without consent.

The outcome of the assessment could be discharge or detention in hospital informally or under another Section. Also there was "guesting", which is apparently a euphemism for informal admission. The speakers deprecated the use of Sections 4 or 5 because the patient was already in a place of safety and Sections 2 and 3 could be implemented. There was no mention at the meeting of the second doctor required to give a recommendation for Sections 2 or 3 and one wondered whether this omission was the cause of the meeting's apparent confusion about doctors approved under Section 12.

There was frequent reference during the meeting to MIND's publication *A Place of Safety*, which described research into police referrals, not all invoking Section 136, in parts of London. The research was retrospective, being carried out in 1984 and 1985 and examining records made in 1982 and 1983, and for many features studied there was no entry in the records, so that, for example, whether the persons concerned were registered with their general practitioner was not known for 20.1%. Also comparison of police referrals to three places of safety – a psychiatric hospital, a police station and an emergency and assessment unit – seemed rather meaningless because the three places were serving different populations, whose composition, except for one, was unknown. Nevertheless the speakers at this meeting, and indeed our President, saw the work as valuable. Its main findings were over-representation of the young, males, people in social classes 4 and 5, the unemployed, the homeless, people not registered with a general practitioner, Afro-Caribbeans and patients who had had previous recent contact with the psychiatric services.

The number of Section 136 referrals throughout the country was unknown but, according to *A Place of Safety*, the Department of Health and Social Security kept records of the number of Section 136 hospital admissions, which in 1984 was 1,956, 90% of them occurring in London. The Mental Health Act Commission was in contact with the London Metropolitan police about this Section. Probation officers felt that the frequency of use of Section 136 and the problems surrounding it were large.

The speakers had no doubt that Section 136 was invaluable as a means for rapid response to a crisis but it carried a danger of becoming an instrument of undue social control and needed a central system to find out more about how it was being operated and to standardise procedures. Also several controversial points might have to be tested in the courts: they included the legality of removing from a place to which the public might or might not have access a person, who appeared to a constable to be mentally disturbed, to a police station under the common law, or on a dubious charge of breach of the peace or committing a nuisance; moving the person from one place of safety to another; and holding the person in a place of safety other than a police station in the absence of a police constable.

At a subsequent meeting of the Public Policy Committee, Professor Robert Bluglass said that actually there was much use of Section 136 outside London and that the reason why most people were not aware of it was that it was not recorded unless the patient were to be admitted to hospital. He said, too, that the notion that a constable should stay with the patient during the Section 136 assessment was erroneous. He suggested that an approach to the Association of Chief Constables would be a good way to start standardising procedures and resolving legal uncertainties.

Miscellany

Prizes

The *Welsh Division* has recently established an *annual research prize* consisting of books to the value of £100 and an inscribed scroll. It is confined to trainees in psychiatry who present a report based upon studies carried out during an appointment within Wales. Trainees in psychiatry will only be eligible to enter submissions for the prize up to two calendar years after securing membership of the Royal College of Psychiatrists from the date of the examination results. The subject of the report or dissertation should include original research in relation to the Discipline of Psychiatry. The closing date is 31 August 1989. Further details can be obtained from the secretary, Dr D. D. R. Williams, Cefn Coed Hospital, Cockett, Swansea SA2 0GH.

Dr Don Johnson, the Chairman of the North West Division, was recently awarded the first *Cheadle Royal Prize* of £500.

AUTP postgraduate training in behavioural psychotherapy 1989–90

The Association of University Teachers of Psychiatry with the Institute of Psychiatry runs an annual course in behavioural psychotherapy. The course will begin with a two-day workshop on 28 September and 29 September 1989. This will include the following components: theoretical background, demonstration of treatments and participant practice. After the workshop participants will be asked to undertake behavioural treatment of their own patients in their own centres, and later also to supervise other trainees. Participants will be supervised in small groups at monthly intervals in half-day sessions over the following academic year. During the two-day workshop and throughout the course eminent guest speakers from round the UK will run seminars on behavioural treatment in acute and chronic disorders in adults, the elderly, children, mental handicap, and liaison psychiatry. A certificate will be awarded to those completing the course. The course is organised on lines which qualify for local funding assistance under Study Leave Regulations of the BPMF. Cost of the combined workshop, monthly supervision and reading materials over the following academic year is £340. Applicants should write, stating their qualifications and current appointment, to Professor Isaac Marks at the Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, where the course will be held.

Honour

Professor Michael Shepherd, Institute of Psychiatry, was awarded the CBE in the New Year's Honours List.

Appointment

Chris Thompson has recently been appointed Professor of Psychiatry, University of Southampton.

SANE

SANE (Schizophrenia: a National Emergency) is a new fund-raising and campaigning organisation whose prime objectives are to find a cure for schizophrenia, raise awareness and promote care. Further information: SANE, 5th Floor, 120 Regent Street, London W1A 5FE.