strive to tease out where the golden mean lies in this very human drama.

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Declaration of interest

None.

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RE: In the liminal spaces of mental health law – what to do when section 136 expires?

Beyond the limit of section 136

As a forensic psychiatrist, I read with interest the paper by Hassanally et al about what to do when section 136 expires.[1] Section 136 of the Mental Health Act 1983 lasts up to 24 h. What was the intent of Parliament in setting that limit? A literal reading means 24 h and no longer. The logical consequence is that after 24 h, the patient must be released from detention and their liberty restored. In terms of practical management of the clinical scenario, the doctors should complete medical recommendations for a section 2, as this is within their power. Police should confiscate the large knife. The patient should be released at the 24 h mark as no bed is available and the brother who historically brought the patient to hospital notified if possible. This is an unpalatable outcome, and it needs little imagination to foresee what disaster may ensue in the community. Yet it must have been foreseeable to Parliament, as the scenario described is both credible and realistic. Escalation to the director on-call for the NHS trust and the medical director should also be done. There will be moral injury and moral distress to the doctors involved, in addition to the lack of bed and lack of care for the patient. Alternatively, continuing to detain the patient past the 24 h mark would intentionally break the law via false imprisonment and unlawful deprivation of liberty. This is unethical and would require the complicity of several people, who would be opening themselves up to legal jeopardy. Citing public protection would be insufficient. No common law citizen's arrest is possible, as the patient was already under police arrest using section 136. Another alternative could be to criminalise the patient for possession of an offensive weapon and have him charged and taken to the magistrates' court. But that would be unjust, as the patient clearly requires diversion to in-patient services. Four sections along from 136, we find 140. This basically says that health authorities have a duty to notify local social services authorities, specifying the hospitals in which arrangements are in force for the reception of patients in cases of special urgency. And so, going forward, it would be useful for psychiatrists on call to have knowledge of such arrangements at the start of their shifts. I would be interested to read other arguments about this worrying situation. I agree that the care of the patient is the first concern for medical professionals, but this must be within the confines of the law of the land.

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Declaration of interest

None.

References

1 Hassanally K, Laing J, Kishore A. In the liminal spaces of mental health law – what to do when section 136 expires? *BJPsych Bulletin* 2024; **47** (6): 342–346.

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Author's Reply: Positive models of suffering and psychiatry

Beginnings of a dialogue within our profession

I thank Professor Prakash and Professor Breen for their helpful and informed contributions. It is important in the spirit of medicine, which is a profession that is used to working with different professions and different models of care, that we engage with the positive model of suffering if that is the wish of the patient. Professor Prakash outlines a model of how to do so as a medical practitioner. Professor Breen supplements this with both how we can incorporate the positive model in our care and suggestions for working with others who are more experienced in the positive model of suffering. I hope this article stimulates further helpful suggestions and contributions.

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Declaration of interest

None.

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