Appendix C

Kent and Medway

Crisis Care

Section 136 Pathway Standards

and Health Based Place of Safety Specification

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Part 1: Kent and Medway Crisis Care Pathway

1. Foreword

Mental illness is a challenge for everyone. When a person's mental state leads to a crisis episode, this can be very difficult to manage for the person in crisis, for family and friends and for the services that respond. Failure to provide care early on means that the acute end of mental health care is under immense pressure.

There have long been concerns about the way in which health services, social care services and emergency services work together in response to mental health crises. In recognition of this the Kent and Medway Crisis Care Concordat (KMCCC) builds on the mandate from the Government to NHS England (2014) that every community should have plans to ensure the delivery of a shared goal to have crisis services that are at all times accessible, responsive and as high quality as other health emergency services. These standards build on the work that has already started, undertaking as a system to deliver our long-term vision for a 24/7 Mental Health Crisis Response Pathway in Kent and Medway

There is recognition that despite the different strategic alignments of the Kent and Medway CCGs there is a unified goal defined by the KMCCC and the Sustainability and Transformation Plan (STP) footprint, to ensure that consistent arrangements are in place to enable delivery on crisis care and also to facilitate implementation of the Kent and Medway Mental Health and Well Being Standards.

Securing the highest quality, cost-effective and compassionate health and care, as close to home as possible for our residents would not materialise without the ethos of placing partnerships at the centre of everything we do and will remain crucial as we implement this whole system pathway. This will ensure that we are in a better position to meet the requirements of the legislative amendments with local partnership agreement.

The KMCCC would like to acknowledge the work undertaken by colleagues in London to develop the London Mental Health Crisis Care Section 136 Pathway and HBPoS Specification (2016) which has provided the core structure and framework for the development of the pathway required to meet the needs of the local population of Kent and Medway.

The concordat would also like to thank all agencies involved in Kent and Medway for their participation in the series of task and finish groups that were set up to agree the standards for

this pathway.

2. Purpose

The purpose of the s136 standards is to provide a collaborative approach in response to the amendments of Section 135 (S135) and Section 136 (S136) of the Mental Health Act (MHA) 1983 (revised 2007) by the Police and Crime Act 2017 (PACA) and to define a clear pathway.

The standards have been informed and developed collaboratively by representatives of Kent and Medway CCGs, local authorities, acute trusts, mental health trusts, service users, SECAmb and Kent Police.

The standards aim to:

1) Ensure that a person experiencing a mental health crisis receives the best possible care at the earliest possible point and to ensure the competent and speedy assessment by a doctor and (where also required) an Approved Mental Health Professional (AMHP) of the person detained under Section 136 MHA.
2) Ensure that at all times staff act in the best interests of the detained person. In doing so, all agencies are required to deliver care to the people they serve within the legal framework of the Mental Health Act 1983 and in accordance with the MHA Code of Practice.
3) Describe our response as a system to the amendments of the MHA by PACA that came into effect on 11 December 2017.
4) Describe the Kent and Medway agreed standards required to deliver the s136 pathway from when the individual is detained in a public place, conveyance processes, the interface with Accident and Emergency departments and processes at the HBPoS (including the MHA assessment and arranging follow-up care).
5) Set the scene for the wider transformative agenda to develop a 24/7 Mental Health Crisis Response Pathway.

These standards cannot anticipate every situation. All agencies involved should use their professional judgement to take any action that is deemed necessary to protect the safety of the person and the public based on an assessment of risk for each individual person.

3. What is Section 136?

Section 136 of the Mental Health Act 1983 is the power that allows a police officer to detain and remove a person they believe to be mentally disordered and in need of immediate care or

control to a place of safety. Either finding or being directed towards a person with mental disorder in a place that is not a private dwelling is not sufficient justification to detain under s136. The power requires three conditions to be fulfilled before police can act:

- The individual must appear to the officer to be suffering from mental disorder.
- The individual must appear to the officer to be in immediate need of care or control.
- The individual must be found anywhere that is not a private dwelling and be able to be taken to a place of safety to enable a mental health assessment to be undertaken. The officer must think that removing the individual is necessary in the individual's interests or for the protection of others.

'Legal responsibility for custody' means formal responsibility for keeping the detained person (and others) safe and preventing the individual from absconding while they are subject to the s136 detention power. It must be clear at all times whether this role has been formally accepted by another agency or still rests with the police.

The clinical and legal responsibilities of different stakeholders throughout the s136 pathway are defined in Appendix 1: Pathway for Adults, Appendix 2: Pathway for Children and Young People and Appendix 3: A&E flowchart. It is vital that, if legal responsibility for custody is transferred to another agency, that agency is provided with the fullest available information about the individual and any known risk factors.

The standards outline the procedures to be followed by all agencies involved in the reception and care of people under s136 MHA. It also describes how KMPT staff, the police, South East Ambulance staff, A&E staff and any other healthcare professionals should work together in the discharge of their duties under this section of Act.

4. The Police and Crime Act 2017 (PACA)

PACA includes provisions which will improve the response to those in a mental health crisis and the changes this legislation makes to the MHA came into effect on December 11 2017. These changes have significant implications for mental health, and demonstrate how important it is for organisations to work together to implement them so that we can better support individuals suffering a mental health crisis by helping to ensure that they get the most appropriate support and care, promptly.

Previous arrangements for s136 of the MHA prior to the PACA allowed the police to remove someone suffering an apparent mental disorder from a public place to a place of safety (PoS)

for up to 72 hours so that their immediate mental health needs could be assessed. The place of safety at that time could be a police station or hospital (often a specialist s136 suite). Historically, too often people ended up in a police cell rather than a suitable alternative place of safety. This has now changed due to amendments made in the Act.

The legislative amendments to the MHA by PACA detail that:

- No children or young person (under 18) should be taken to police stations as PoS under any circumstances.
- Adults must only be taken to custody as PoS under the following circumstances: - where behaviour poses an imminent risk of serious injury or death to themselves or another person (see Appendix 4: Use of a police station as a POS Guidance)
- The previous maximum assessment time of 72 hours in PoS has been reduced to 24 hours – which can be extended to 36 hours if authorised by the doctor leading the assessment or a superintendent if a custody suite has been used as the PoS.
- Before exercising a s136 power police officers must, where practicable, consult one of the health professionals listed in section 136 (1C) (Doctor, mental health professional or AMHP). No such requirement previously existed.
- S135 (1) provides for a magistrate to issue a warrant allowing a police officer to enter premises to remove a mentally disordered person to a place of safety. The amended legislation allows an assessment to take place in the premises under certain circumstances.
- S136 powers may now be exercised anywhere other than in a private dwelling (whereby S135 could be used).

See Appendix 5: Full wording of changes made to the MHA 1983 Section 136 – removal of mentally disordered persons without warrant.

5. Governance Structures

Urgent and Emergency Care (UEC) networks have collective responsibility for the equitable provision of care and patient outcomes across their footprint, ensuring that the Kent and Medway standards of care relating to urgent physical and mental health are delivered.

The Kent and Medway Crisis Care Concordat will be responsible for the monitoring framework that enables us to deliver on the s136 pathway.

Local Governance Structures:

The countywide s136 meeting will be responsible for monitoring the action plan which measures progress towards meeting the standards where improvements are required.

A local multi-agency group is led by the provider, attended by senior representatives from the health based place of safety (KMPT), Children and Young People Services (NELFT) local A&E departments (including liaison psychiatry staff), Approved Mental Health Professionals (AMHP), the police and SECAmb.

The multi-agency group will be established to perform the following roles:

- Discuss individual case studies where issues have occurred across the pathway to ensure learnings across the system from these specific cases.
- Understand the contact s136 detainees have had with mental health services previously and what alternative pathways or interventions could have been applied in order to prevent the use of s136.
- Facilitate training initiatives on local policies and protocols which include key partners and local acute trusts.

The multi-agency group will report directly to the s136 countywide group.

Local Concordats: Local Concordats will be responsible for:

- Monitoring any local issues that arise specific to the geographical area
- Monitoring performance in the local geographical area
- Maintaining the Local Action Plan and reporting back to the KMCCC

For monitoring metrics please see Appendix 10: Monitoring metrics of Local Multi-Agency 136 Monitoring Group

6. Whole Systems Working

As partners we have all agreed and signed up to undertake the following as part of the standards:

CCGs

- Ensure that services are commissioned to deliver a whole system approach to ensure individuals who experience a mental health crisis receive a high-quality, effective and

seamless service.

- Commissioners have a responsibility to provide high-quality and responsive mental health crisis services which are in line with the s136 Standards and HBPoS specification and are well suited to meet local population needs, ensuring that services are designed to serve the needs of all ages, ethnic backgrounds and cultures. Parity of esteem should be reflected in how services are commissioned as well as the contribution of primary, secondary, community and inpatient hospital care.
- Commissioners in each local CCG are responsible for the evaluation, funding, planning and delivery of mental health crisis care services in a local area; this will be monitored through the update of the KMCCC action plan and reported to the Strategic Crisis Care Concordat meeting.
- Commissioners should have well established links with other agencies to enable an effective and integrated approach to a mental health crisis and urgent care
- Drive data quality improvements and require services to provide data and analysis to inform commissioning decisions
- Co-production and service user engagement should be included to promote values based commissioning and take into account the patient and carer perspectives and values.

Mental Health Trusts

Are responsible for delivering services and pathways that facilitate:

- Effective Street Triage
- Efficient HBPoS and bed management
- S136 centralised management and escalation plan
- Partnership working with other agencies to ensure good communication
- Appropriate and holistic aftercare and follow-up plans for people discharging from services
- Responsive Crisis Resolution and Home Treatment Team
- Effective liaison psychiatry.

Local Authorities

Ensure that MHA assessments are undertaken within timescales by ensuring:

- Effective AMHP rota management to maximise capacity
- Implementation of the AMHP recruitment and retention strategies
- Recommendation of care following assessment

Kent Police

Will work with partners to:

- Implement street triage
- Divert activity to more suitable pathways
- Support effective A&E/HBPoS handover protocols
- Roll out mental health training.

Acute Trusts

Will ensure A&E departments are geared up to meet any additional mental health activity through:

- Implementing the handover protocols with the police/SECAmb
- Providing dedicated mental health rooms
- Continued joint working with liaison psychiatry.

SECAmb

Will work with partners to:

- Divert activity to more suitable pathways
- Support effective A&E/HBPoS handover protocols
- Roll out mental health training.

7. S136 & HBPoS Task & Finish Group

Stakeholders across Kent and Medway care systems, which included Kent Police, Kent and Medway Partnership Trust, SECAmb, service users, Kent County Council, Public Health and representation from the clinical commissioning groups participated in a series of workshops to review the London pathway standards and make modifications to ensure they met the needs of the local population of Kent and Medway.

A gap analysis of the services has been undertaken and, to ensure as part of a system, we take ownership of delivering the required individual organisation actions and hold each other to account for the implementation of the collective response, a S136 action plan has identified key areas that require improvement to ensure the most vulnerable individuals are cared for in the most effective and most appropriate way when placed on a S136.

The gap analysis action plan describes the necessary collaborative undertaking required to

meet the standards of the legislative amendments and ensure that any subsequent pressures on the system are minimised whilst we make progress on the wider 24/7 Mental Health Crisis Response transformation agenda. This action plan is being monitored by the Kent and Medway Countywide S136 Steering Group, which is overseen by the Kent and Medway Crisis Care Concordat

8. Mental Health Act (MHA) Assessments

Once someone has been detained under s136, a MHA assessment will need to be undertaken to determine the treatment and care requirements for the individual. The assessment is done by Section 12 Approved Doctors and an Approved Mental Health Professional (AMHP). They exercise functions under the MHA relating to making decisions about individuals with mental disorders, including whether to apply for compulsory admission to hospital.

There is a shortage of AMHPs nationally and locally, this therefore impacts on response times to undertake the assessments. In Kent and Medway, the number of AMHPS and section 12 doctors is currently under review to ensure the model will provide an efficient and timely service particularly in view of the reduced turnaround time of 24 hours, however, wider system collaboration will play an essential part in addressing efficiency, particularly in relation to conveyance and bed management.

9. South East Coastal Ambulance (SECAmb)

Any police officer having detained an individual under s136 of the MHA will contact SECAmb through a locally agreed route. Where there is an immediate threat to life a 999 call must be made. On arrival SECAmb will carry out a clinical assessment to identify any underlying medical/life or limb threatening conditions. A decision should then be made prior to conveyance by the senior ambulance clinician on scene as to whether the patient has a medical need which requires Emergency Department assessment using an agreed assessment criteria.
The national target for primary conveyance under s136 (category 2 responses) is within 18 mins of which 90 per cent must be reached within 40 mins. Response times are recognised as an area that requires improvement and SECAmb are currently looking at options to explore how response times can be improved.

10. BPoS 136 Suites

For the purpose of these standards the mental health s136 suites are referred to as the health based place of safety (HBPoS), A&E is referred to as a Place of Safety (PoS), any other agreed venue outside of the NHS setting is referred to as an Alternative Place of Safety (APoS)

There are three adult Health Based Places of Safety (HBPoS) s136 suites in Kent and Medway (Priority House, Maidstone, St. Martins Canterbury, Littlebrook Dartford) providing a total of five assessment bays. Littlebrook hospital, while primarily an adult suite, is also used for CYPs. Kent and Medway is currently reviewing options for an alternative CYPs' 136 suite that would ensure there is adequate capacity in the system to meet demand without defaulting to A&E as a Place of Safety.

The CCGs and mental health trust are coordinating the demand management of the suites to ensure efficient service flows.

11. Mental Health Street Triage (MHST)

Mental Health Street Triage (MHST) is the term used to describe schemes that provide mental health expertise to Kent Police and SECAmb as part of response to incidents in the community. The Street Triage service is a crucial and critical component of the s136 pathway, as well as ensuring people receive the best possible outcomes when in a mental health crisis. In view of this, options are being explored to increase the MHST service to include extended hours of operation in 2018 – 2019.

12. S136 Pathway Protocol for Adults and Children and Young People (CYP)

To ensure a streamlined pathway across acute trusts and Health Based Places of Safety local protocols have been agreed, all stakeholders have signed up to the shared responsibility of delivering these pathways, roles are clarified and agencies are committed to collaboratively meeting the needs of those in a mental health crisis in a compassionate and consistent manner.

Protocols should give specific attention to:

- Communication systems for clinical advice and handover

- Triage systems for directing the referrer in a timely way to the appropriate service in the appropriate clinical timeframe with flexible assessment and treatment options (e.g. outreach or next day review)
- Clarity around the roles and responsibilities of individuals in delivering care and supporting safe transitions between care environments
- Clarity around transfer, escort and nursing support responsibilities
- Preventing absconding
- Discharge documentation.

13. A&E as a Place of Safety Protocol

To ensure acute trusts are in a position to support individuals in a mental health crisis who are conveyed to A&E departments as a result of a s136 detention and to meet the requirements of the new legislative amendments, a protocol has been agreed through the A&E delivery boards and Crisis Care Concordat to ensure a whole system approach and provide support to acute staff during the use of A&E as a PoS.

A Kent and Medway flowchart for 'A&E as a Place of Safety for S136 detention' demonstrates the key responsibilities of all agencies when an individual is detained under s136 in A&E either because it has been identified that there is a physical health need that requires treatment or because there is no availability in the HBPoS 136 suites. Different staffing models should be explored particularly separating children and adult services.

There is also national funding aligned to implementing the Five Year Forward View for Mental Health to ensure that by 2020/21, all acute hospitals will have all-age mental health liaison teams in place. In Kent and Medway liaison psychiatry (when available) will provide support to the senior clinician on duty in A&E in the risk assessment and decision making process of whether A&E can safely take legal custody for the S136 detained individual for the purpose of the MHA assessment due to prolonged physical treatment, enabling police to withdraw. This decision will only be agreed if they are confident that A&E staff, including security staff, are suitably trained and able to manage them appropriately.

A&E departments that currently have a 24/7 liaison psychiatry service and, where practicable, should be prioritised as a PoS for S136 detainees who have to go to A&E.

14. Multi-Agency Crisis Care Planning

High level thematic analysis of data collated by both the police and mental health trusts demonstrates that a significant amount of activity could be diverted from the s136 pathway into more appropriate service provision that would best meet the complex social needs being evidenced. This would be supported by proactive care planning and multi-agency collaboration to address the mental health needs, substance misuse needs and criminal justice interface which would be assisted by defined follow-up pathways. This has been highlighted as an area that requires improvement across Kent and Medway.

15. Alternative Crisis Support Services

As part of the crisis pathway, many CCGs and the Police and Crime Commissioner have commissioned and co-commissioned alternative crisis support services across Kent and Medway, for instance the Sunlight Wellbeing Café, The Hope Café, the Solace Café, all of which provide out of hours support for people experiencing a mental health crisis.

The Concordat is working to support the use of these services as an alternative for the police and the mental health professional (that they consult with for advice prior to considering a s136) to consider to de-escalate the crisis.

16. Performance Trajectories

The ambition is for 0 per cent of s136 detainees to be taken to A&E except in circumstances where medical concerns are indicated and 0 per cent use of custody as PoS except in exceptional circumstances as directed by the Police and Crime Act 2017.

This is dependent on the work that is being carried out in Kent and Medway to improve the whole systems crisis pathway through early intervention and supporting crisis care. New initiatives are also underway that focus on alternative places of safety and the Concordat capitalises on opportunities to bid for additional funding to improve crisis services when they become available.

17. Monitoring and Metrics

The monitoring and metrics of s136 will be completed by Kent Police, KMPT and SECAmb and reported back to the KMCCC, the s136 countywide group and local performance will be reported to the Local Crisis Concordats.

Part 2: Key Principles of the S136 Pathway

The principle components of the care pathways should include:

- Support and buy in from the emergency department who understand and respond flexibly to the distinct clinical challenges presented by this population's needs.
- Providing clarity and consistency over case ownership with clear agreed shared care arrangements.
- Optimising available clinical advice and triage systems including telephone consultation and advice between Trusts and with social care.
- Supporting flexible assessment and treatment arrangements.
- The requirement of direct verbal medic to medic handovers prior to transfer between the health based place of safety and acute trust.
- Clear requirements for transfer of clinical information including specific systems to facilitate transfer (e.g. jointly agreed handover documentation).
- Referrals and discharge plans that include the name and contact number of clinicians who have responsibility for that individual's care and can be contacted to provide clinical information about the individual from both mental health and acute trust sites.
- Ensuring the agreed discharge plan from acute services to mental health services support rapid medicines reconciliation/ pharmacist handover. Plans should ensure specific detail about the transfer of medications from the acute hospital to mental health trust and vice versa
- Optimising available technology, for example, secure clinical transfer systems, shared notes systems and telemedicine facilities.

The pathway standards are divided into five key sections:-

Standard 1: Initial detention and access to a HBPoS

Standard 2: Initial conveyance, handover, initial assessment at HBPoS

Intoxication pathway, secondary conveyance

Standard 3: The role of the A&E department in the s136 pathway

Standard 4: MHA Assessment (by Sect 12 doctor & AMHP)

Standard 5: Workforce and development

Standard 6: Follow up care / discharge

Standard 7: HBPoS specification

The key principles of the standards that have been agreed for Kent and Medway are highlighted below:

1. If there is no capacity at the local HBPoS when the police officer makes initial contact, the police retain responsibility to ensure that the individual is received into a suitable place of safety, through agreed escalation protocols or making alternative arrangements, whether the individual is from that area or not.

2. When the HBPoS states that it has capacity it means it is able to receive the detained individual as soon as they arrive on site.

3. Under exceptional circumstances when an individual under s136 presents to an A&E department with no physical health needs (due to limited HBPoS capacity) the A&E cannot refuse access unless a formal escalation action has been enacted.

4. The Association of Chief Police Officers and the Independent Police Complaints Commission (2012) describe 'drunk and incapable' as an individual that has consumed alcohol or appear intoxicated by drugs to the point of being unable to either walk unaided or stand unaided or is unaware of their own actions or unable to fully understand what is said to them. Clinically where an individual is 'drunk and incapable' there is potential for airway compromise and the individual may be in need of urgent medical attention.

   If someone appears to be drunk and showing any 'aspect' of incapability (e.g. unable to walk or stand unaided) which is perceived to result from that drunkenness, then that person must be treated as drunk and incapable. A person found to be drunk and incapable by the police should be treated as being in need of medical assistance at an

A&E department or other alcohol recovery services.

5. An A&E department can itself be a Place of Safety within the meaning of the Mental Health Act. Therefore, if protracted physical health treatment or care is required, where appropriate the acute trust should accept the s136 papers and take legal responsibility for custody of the individual for the purpose of the mental health assessment being carried out.

6. Every HBPoS should have a designated s136 nurse available 24/7 who is assigned to the HBPoS at all times.

7. HBPoS staff (including both nursing and medical staff) should have adequate physical health competencies to prevent unnecessary A&E referrals.

8. HBPoS and local acute trusts should have clear pathways and local protocols and the relationships to deliver these for those with physical health problems but for whom urgent transfer to an A&E is not the optimum course of action.

9. While a police officer or an AMHP has the legal responsibility for authorising the transfer of the detained individual, coordinating the conveyance of individuals between Health Based Places of Safety and A&E departments and vice versa should be undertaken by the mental health trusts and acute trusts respectively, led by the s136 nurse. Coordinating and arranging transport is not the police's or AMHP's role unless there is mutual agreement between parties that it is in the best interest of the individual and there is resource to provide support.

10. When a mental health assessment is required the legal duty to assess falls upon the AMHP service for the area where the person is at the point when the assessment is needed, in this case the area in which they are currently being detained under s136. The mental health assessment should be completed within four hours of the individual arriving at the HBPoS unless there are clinical grounds for delay. It is good practice for the Section 12 doctor and the AMHP to carry out a joint assessment, however in exceptional circumstances (i.e. prolonged delay of AMHP attending above 4 hours) then the s12 doctor may see the individual before the AMHP arrives. If they are satisfied that there is no evidence of underlying mental disorder of any kind, the person can no longer be detained and must be immediately released, even if not seen by an AMHP.

Part 3: Section 136 Pathway Standards

Standard 1: Initial detention and access to a HBPoS

Ref	Standard 1: Initial detention and access to a HBPoS	Responsibility
1:1	Before deciding to use their power under s136, a police officer is required (where practicable) to consult with a healthcare professional (including prioritising street triage services when available). The healthcare professional may be a registered medical practitioner, a registered nurse, an approved mental health professional (AMHP), an occupational therapist or a paramedic. (see appendix 1, 2 & 3) s136 Pathway Flowchart for CYPMHS, 2: s136 Pathway Flowchart for Adults & 3: Flowchart for A & E as a PoS). The purpose of the consultation is for the police officer – who is considering using their powers under section 136 – to obtain timely and relevant mental health information and advice that will support them to decide a course of action that is in the best interests of the person concerned. The police officer should seek to ascertain, and the healthcare professional being consulted should offer, where possible, information or advice regarding: • an opinion on whether this appears to be a mental health issue based on professional observation and, if possible, questioning of the person. • whether other physical health issues may be of concern or contributing to behaviour (e.g. substance misuse, signs of physical injury or illness). • whether the person is known to local health service providers. • if so, whether it is possible to access medical records or any care plan to determine medical history and suggested strategies for appropriately managing a mental health crisis. • whether in the circumstances, the proposed use of section 136 powers is appropriate. • where it is determined that use of section 136 powers is appropriate - identification of a suitable health based place of safety (HBPoS), and facilitation of access to it. • where it is determined that use of section 136 powers is not appropriate - identification and implementation of alternative arrangements (such as escorting the person home, to their own doctor, to hospital, or to an alternative crisis care provision such as crisis cafes). The police officer should ensure that any decision not to consult before using section 136 powers, and the reason, is recorded.	KMPT NELFT Kent Police Street Triage

	Use of Section 136 in Relation to Children With incidents involving children who are experiencing mental health problems or distress, the overriding consideration should always be the welfare of the child, ensuring protection from harm and access to assessment where appropriate. There is no age limit for using s136. However, children under the age of 18 may not be taken to a police station as a place of safety. In addition and separate to the powers under the MHA, any person under 18 years of age may be taken into police protection, using a Police Protection Order (PPO) section 46 of the Children Act 1989. A PPO may help ensure that the child is not unnecessarily institutionalised or stigmatised by the process. A PPO also does not require a police officer to make judgement as to whether a child is likely to be suffering from a mental disorder and in need of care and control. There is also no restriction on using a PPO in a home or place to which the public do not have access, so police officers may use a PPO to move a disturbed child who is at home, in the interests of their health and safety. Whilst detained under PPO officers are able to request that the child has access to all necessary assessments (including, if required, an assessment for detention under section 2 or section 3 MHA 1983, or a social care assessment). If the decision is to place the CYP on s136 then the police need to contact NELFT CYPMHS at the earliest opportunity, and a member of staff from that team will attend the HBPoS or A&E within one hour of the individual arriving.	
1.2	If there is a multi-agency crisis care plan in place then the instructions in the crisis care plan for managing a mental health crisis should be followed wherever possible to avoid detention under s136. However, if a crisis care plan includes a preferred place of safety for their MHA assessment based on the individual's needs then this should always be taken into account and acted upon where feasible. The crisis care plan should be accessible through the suitable health professional when first contact is made, however, if the person clearly needs 'care or control' (as expressed in the MHA 1983) the s136 pathway should be followed. The responsibility for that decision rests with the police.	KMPT NELFT Kent Police SECAmb AMHP Street Triage

Ref	Standard 1: Initial detention and access to a HBPoS	Responsibility
1.3	Trusts commissioned to provide the local HBPoS must have dedicated 24/7 telephone numbers in place to enable the police officer, SECAmb and crisis teams to always phone ahead to inform them of the individual's expected arrival and to confirm that the site is able to receive them. The individual will be transported to the HBPoS closest to where the individual was detained. When the HBPoS states that it has capacity, this means it is able to receive the detained individual as soon as they arrive on site. If there is no capacity at the local HBPoS, then it is the responsibility of KMPT/NELFT to ensure that the individual is received into a suitable HBPoS, through agreed escalation protocols or making alternative arrangements whether the individual is from that area or not. Such occurrences must be fully documented. If the HBPoS becomes unable to accept the individual during the time taken to convey, all efforts should be made to inform the conveying officers and an alternative HBPoS should be identified by HBPoS staff. Under exceptional circumstances if no alternative HBPoS site has capacity to accept the individual detained then the individual should be taken to the most appropriate A&E department. A&E cannot refuse access unless a formal escalation process set out in local policy has been enacted. If a patient is refused entry to a PoS for any reason the escalation process set out in the local operational protocol will be followed. Please refer to Kent and Medway Multi-Agency Local Policy for s136.	KMPT NELFT ED SECAmb Kent Police
1.4	It is the Trust's responsibility to ensure that all key telephone numbers are available and communicated to partners and regularly updated on the Directory of Service. Information communicated to the HBPoS by the police or SECAmb must include: • The reason for detaining the individual under s136 and events leading up to it. • Detail of behaviours since being detained under s136. • Any suspicion of drugs and alcohol and the degree of intoxication if present. • Any use of weapons or crime. The involvement of SECAmb and the medical assessment performed, including any suspicion of co-morbid physical health condition or	Police HBPoS ED AMHP NELFT KMPT

	concurrent injuries and any other risks to the individual or others.	

Ref	Standard 1: Initial detention and access to a HBPoS	Responsibility
1:5	It is essential that the AMHP service for the area where the HBPoS is located is notified as soon as is practicable of the individual's expected time of arrival there. The following responsibilities has been agreed: - • The police will be responsible for contacting the AMHP if the person is taken directly to A&E. • If the person is taken directly to the HBPoS, then the staff there will assume responsibility to contact the AMHP. • In exceptional circumstances when A&E accepts responsibility for the custody of the s136 for the purpose of the MHA assessment then A&E assumes responsibility for continued communication with the AMHP. • Each failure to notify the AMHP should be logged on according to local policy (i.e. on Datix / Shift Report) form which should be escalated and reviewed by the local multi-agency group. If the individual is a Child or Young Person (CYP) then the police need to contact NELFT CYPMHS at the earliest opportunity, and a member of staff from that team will attend the HBPoS or A&E within 1 hour of the individual arriving.	Police HBPoS ED AMHP NELFT KMPT
1:6	A capacity management tool should be maintained by the s136 quality manager to support the process of identifying a HBPoS by indicating each site's real-time capacity during working hours. Out of hours this function will be completed by the Crisis Resolution Home Treatment Team (CRHTT). The service manager on call should be informed by the HBPoS staff when capacity has reached 'full'. To enable effective capacity management and the best possible response for individuals detained under s136, HBPoS sites must prioritise the immediate needs of the detained individual above any other competing organisational demands. All escalation processes with regard to bed capacity should be initiated and carried out by the HBPoS s136 nurse in liaison with the manager on call. Where necessary, escalation processes should be initiated immediately with the on call manager.	KMPT NELFT HBPoS
1:7	If there are issues relating to the clinical picture, advice could also be sought through an on call senior doctor e.g. Higher Specialty Trainee (SpR), Associate Specialist (staff grade) or on call consultant. Direct contact with the above should always be available through the	KMPT NELFT HBPoS ED

	Trust's switchboard.	

Standard 2: Conveyance, Handover, Initial Assessment at HBPoS, Intoxication Pathway and Secondary Conveyance

Ref	Standard 2a: Initial Conveyance	Responsibility
2.1	An ambulance should be used to convey the individual with police support where appropriate. The ambulance should arrive at the location in which the police detained the individual within the agreed timescales*. This reduces to seven minutes for physically restrained patients when they are notified that there may be a risk of positional asphyxia (when someone's position prevents the person from breathing adequately) or where the clinical information provided is of concern. When the police officer makes contact with the ambulance service to carry out the conveyance of s136 detainees, officers must be explicit in using the terms 'section 136' and/or 'restraint' to help ensure the appropriate triage category is applied and the timeframes above are met. *average response time 18 minutes of request 90 per cent of which must be reached within 40 minutes	SECAmb Kent Police
2.2	The use of ambulance services should always be considered first in order to convey the individual to the HBPoS. An ambulance can be used for conveyance on behalf of the police for the purposes of medically screening individuals detained under s136; this includes assessing vital signs like breathing, temperature, blood pressure etc. There is no formal handover of responsibility for the detained individual to the ambulance service. The individual subject to s136 is still in the custody of the police, who must therefore accompany them to the HBPoS. However, it is not unlawful to use police transport as a last resort. If the individual is violent this can provide an appropriate rationale for the use of police conveyance, but when this occurs it must be properly documented. Where the ambulance service has identified that there is likely to be a significant delay (over 40 minutes) this should be communicated to the police. In these circumstances, the police officer may consider transporting the patient in a police vehicle. If this is the case, the police officer should notify the duty inspector for consent to do so and must inform the ambulance service of their decision. The rationale for using a police vehicle must be recorded by the officer responsible for detaining the person under the MHA and should stipulate which inspector was informed.	SECAmb Kent Police

Ref	Initial Conveyance cont.	Responsibility
2.3	Where it is necessary to use a police vehicle because of the risk involved, it may be necessary for the highest qualified member of an ambulance crew to ride in the same vehicle with the patient, with the appropriate equipment to deal with immediate problems. In such cases, the ambulance should follow directly behind to provide any further support that is required.	SECAmb Kent Police
2.4	While the police still retain overall responsibility for the individual during the initial transfer, clinical judgements during conveyance regarding the detained individual must be made by paramedic staff with support from (if necessary) mental health nurses in the ambulance clinical 'hub' or local mental health triage lines.	SECAmb Kent Police
Standard 2b: Handover to HBPoS / A&E		
2.5	The time of arrival at and admission to the HBPoS must be clearly recorded at the HBPoS and also by the police officer. The information must also be passed on to any further site if the individual is transferred. The time of arrival is the start of the 24 hour detention period under s136. If the individual is taken directly to an A&E department first under s136, the 24 hour detention period commences on arrival at A&E, not when they subsequently arrive at the HBPoS. When the individual arrives it is important that the status of the individual is communicated to A&E staff straight away. On arrival at either HBPoS or A&E, the individual must be informed of their rights under s136 by the clinical staff as specified in the local policy	HBPoS ED SECAmb Kent Police
2.6	Paperwork must be completed for every patient conveyed under s136. To accept the individual under s136 there must be a formal handover of the completed136 monitoring form which Kent Police force* uses when a detention under s136 is made. This form is held by the police. The form should be signed by both parties and used as a record of handover from the police to the HBPoS. (see Appendix 6: Kent and Medway s136 record form) **If conveyed by an alternative Police force i.e. Met Police or British Transport Police, Dover Dock Police then they may use their own forms* After assessment the HBPOs will email a copy of the outcome to the police as per local policy.	HBPoS/ED SECAmb Kent Police
2.7	On arrival at the HBPoS site or A&E the police or ambulance staff must give a verbal handover to the staff, the police/ambulance must remain with the detainee until HBPoS or A&E staff have accepted responsibility for the	HBPoS/ED SECAmb

Ref	Standard 2: Handover cont.	Responsibility
	individual's custody.	Kent Police
	This initial handover process where HBPoS staff takes responsibility for the individual (including preventing the person from absconding before the assessment can be carried out) must occur within 30 minutes of arrival, however the police and ambulance service should not have to wait longer than 15 minutes to gain access to the HBPoS facility. Handover should include physical health findings, clear detail of mental health presenting circumstances and evolution of patient presentation over time with ambulance staff or the police. Sufficient documentation should be provided to HBPoS staff. If the individual has been transferred from the A&E department this must include the appropriate clinical discharge documentation from A&E (see Appendix 7: Physical health risk assessment for admission to a KMPT Mental Health Unit). If insufficient or incomplete written documentation has been provided, this should not obstruct the patient's care. A Datix form should be logged which should be fed back and reviewed by the local multi-agency group.	HBPoS ED Kent Police SECAmb
2.8	If requested by staff, police will remain at the HBPoS up to a maximum of an hour, but in most cases the police should be free to leave within 30 minutes of the handover. If the person represents a significant risk of violence, the safety of the individual and staff should be explicitly assessed. A longer time period may be negotiated if there is mutual agreement between parties that it is in the best interests of the individual and permission is granted by the police supervising officer that there is the resource to provide further support. If in complex cases it is proving difficult to reach a consensus, senior management from the provider trust and the police should liaise to resolve the situation.	HBPoS SECAmb Kent Police
Standard 2c: Initial assessment at HBPoS		
2.9	If on arrival at the s136 suite the s136 nurse and HBPoS team feel unable to meet the physical needs of the individual and they need to go to the A&E department, staff at the HBPoS has the right of refusal to the site. All A&E sites should have a dedicated contact number for HBPoS to use for s136. Concerns should always be escalated to an on call doctor e.g. on call Higher Specialty Trainee (SpR), Core Trainee (SHO) or Associate Specialist. The on call consultant could be approached for mediation or consultation if an agreement has not been reached but the final clinical decision as to whether	HBPoS SECAmb Kent Police ED

Ref	Standard 2c: Initial Assessment at HBPoS cont.	Responsibility
	the individual requires medical assistance at the A&E department lies with the doctor at the HBPoS. Conversations will involve discussions regarding the specific concerns of staff and what additional assessment or intervention is required.	
2.10	The initial medical screening and physical health assessment should occur as soon as a person arrives, no later than one hour after the individual arrives at the HBPoS. The initial physical health screening should include the collection of collateral information from the individual's locality mental health services as well as from family and/or carers. This assessment should be proportionate and should not cause unnecessary delay to the mental health assessment process carried out by AMHP/Section 12 doctor. HBPoS staff must be able to summon extra help at short notice from the staff on the wards if required.	HBPoS
2.11	Brief drug and alcohol interventions should be embedded as standard practice if it is identified that substance misuse is apparent. Once these individuals are identified a brief intervention with the individual's consent should be embedded in the initial assessment process and if appropriate signposting or onward referral to substance misuse service should be supported.	HBPoS
Standard 2d: Intoxication pathway		
2.12	The Association of Chief Police Officers and the Independent Police Complaints Commission (2012) describe 'drunk and incapable' as an individual that has consumed alcohol or appear intoxicated by drugs to the point of being unable to either walk unaided or stand unaided or is unaware of their own actions or unable to fully understand what is said to them. Clinically where an individual is 'drunk and incapable' there is potential for airway compromise and the individual may be in need of urgent medical attention. If someone appears to be drunk and showing any 'aspect' of incapability (e.g. walking unaided or standing unaided) which is perceived to result from that drunkenness then that person must be treated as drunk and incapable. A person found to be drunk and incapable by the police should be treated as being in need of medical assistance at an A&E department or other alcohol recovery services.	HBPoS Kent Police SECamb ED
2.13	If the person is intoxicated but not showing any 'aspect' of incapability and is detained under s136, they must be conveyed to the locally agreed HBPoS by the ambulance service. The HBPoS must not conduct tests to determine intoxication as a reason for exclusion to the site; this should be based on clinical judgement. It is the clinical decision of the suitably qualified doctor at the HBPoS to make	Kent Police ED HBPoS

	the decision as to whether the individual requires medical assistance at the A&E department. See Appendix 8: Intoxication scenario examples.	
Ref	**Standard 2d: Intoxication pathway cont.**	**Responsibility**
2.14	If it is identified during clinical assessment that the individual requires ongoing support related to substance misuse, the appropriate referrals must be made by the assessing team (in an A&E department or HBPoS). There must also be robust systems in place to confirm that onward referrals, discharge plans or discharge letters are received by the appropriate care provider within the next working day and that onward services are provided with the information gathered throughout the assessment.	HBPoS ED
Standard 2e: Secondary Conveyance (Transferring individuals between places of safety under s136: legal & clinical responsibilities)		
2.15	Transfers of an individual under s136 from one place of safety to another are the legal responsibility of an AMHP, a police officer or someone that has been authorised by one of the two (s136 (3) MHA). Where they do not undertake it themselves, an AMHP or police officer must authorise any transfer. Before doing so they must satisfy themselves that the proposed method of conveyance is appropriate for the person, and that suitable arrangements are in place to keep the person safe during the transfer and until they are formally received elsewhere. Whoever carries out the transfer is then responsible for the process occurring safely and efficiently. Trusts must ensure robust and cohesive policies are in place and monitored for conveying detained individuals between sites and escalation process are in place which is instigated where timescales are not met for all transfers.	AMHP Kent Police HBPoS ED
2.16	Individuals should only be conveyed between sites when it is in their best interests. Relatives and/or carers are to be properly communicated with and informed where and when the individual is being transferred. The individual's privacy and dignity is to be maintained as far as possible throughout the transfer. An individual may be conveyed between HBPoS sites 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.	AMHP Kent Police HBPoS ED
2.17	If a transfer between sites is necessary the transfer should be performed via the locally commissioned patient transport service unless urgent physical healthcare is required and the ambulance service is necessary. In instances where the individual is first taken to A&E but legal.	AMHP Kent Police HBPoS

Ref	Standard 2e: Secondary Conveyance (Transferring individuals between places of safety under s136: legal & clinical responsibilities) cont.	Responsibility
2.17 cont.	responsibility is not transferred, the police and A&E staff must liaise and decide on the most appropriate support required when the individual is conveyed on to the HBPoS; this may be an appropriately equipped transport provider. It is the CCG's responsibility to ensure non-emergency patient transport services are commissioned in the local area. A request to the transport provider is not to be made until transfer is approved by an AMHP or police officer, with appropriate clinical involvement where necessary. Once the inter-hospital transfer is approved the transfer should occur within one hour.	ED Patient transport
2.18	If the individual is out of area and needs to be transferred to their local service, the current HBPoS is responsible for coordinating the individual's transport, however, they will require assistance from the receiving hospital in doing so.	HBPoS AMHP Kent Police ED
2.19	The sending hospital retains clinical responsibility for the individual until handover at the receiving hospital has taken place; clinical responsibility in this instance refers to the overall duty of care and not legal responsibility for the s136. When a patient is transported between hospital sites it must always be carried out with appropriate clinical documentation. On arrival at the receiving hospital, a full clinical handover to the receiving team is required.	HBPoS ED
2.20	All individuals who have received rapid tranquillisation (in an A&E department or by the ambulance service) or have been restrained for an extended period must always be transported in a fully equipped emergency ambulance because of the risk of rapid deterioration of their physical health.	AMHP Kent Police HBPoS ED
2.21	A person must 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. The receiving hospital is to inform the sending hospital whether it can accept an individual within the agreed timeframes and the acceptance must be recorded by both hospitals. An up-to-date directory of services should support transfers to alternative services. If a person is transferred from A&E to HBPoS or vice versa, then a direct verbal medic to medic handover must be undertaken prior to transfer.	AMHP Kent Police SECAmb HBPoS ED
2.22	While a police officer or an AMHP has the legal responsibility for authorising the transfer of the detained individual, coordinating the conveyance of individuals between the HBPoS and A&E departments and vice versa should	AMHP Kent Police

	be undertaken by the mental health trusts and ED departments respectively, led by the s136 nurse or A&E.	HBPoS ED
Ref	**Standard 2e: Secondary Conveyance: Transferring individuals between places of safety under s136: legal & clinical responsibilities cont.**	**Responsibility**
	person in charge. Coordinating and arranging transport is not the police's role unless there is mutual agreement between parties that it is in the best interest of the individual and there is resource to provide support.	cont.
2.23	If the individual has had a mental health assessment and it is decided that they need to be detained in hospital, the AMHP takes over legal responsibility for them as soon as he or she has been able to complete an application for admission. At this stage the AMHP formally discharges the s136. The AMHP is responsible for arranging for the person to be conveyed to the admitting hospital, however, they will require assistance from the sending hospital in coordinating suitable transport and may request police support where needed. It will normally be appropriate for the s136 nurse to arrange the transport. However, unless the coordinator will actually travel with the person to the hospital, the formal conveying responsibility should not be delegated to them as it cannot in law be re-delegated to the crew transporting the individual. Instead, the AMHP should formally delegate the conveying responsibility to the person(s) who in practice will take the individual and the admission papers to hospital.	AMHP Kent Police HBPoS Patient transport
Standard 2f: Transfer from HBPoS to A&E (after HBPoS accepts responsibility for the individual)		
2.24	Emergency physical health needs must always be prioritised over mental health assessment needs. If emergency physical health care needs are identified once the individual is accepted into the HBPoS then a decision to transport a person from the HBPoS should be considered by the suitably trained medical professional. Clear reasons for the decision and targeted advice on further care must be provided to the sending hospital. The name of the staff member giving advice should be recorded in the individual's medical notes at the sending hospital. It is the s136 nurse's responsibility to notify the A&E department of this transfer as soon as the decision has been made, so staff are ready and able to receive the individual when they arrive.	AMHP HBPoS SECAmb ED Patient Transport
2.25	Appropriate transport should be arranged by the Trust, however, this must still be approved by the police or AMHP and not delayed due to other external factors. In making this decision, consideration must be given to the benefits and risks of the move, any delay and distress caused and any other	AMHP Kent Police HBPoS Patient

	relevant circumstances.	transport SECAmb
Ref	**Standard 2f: Transfer from HBPoS to A&E (after HBPoS accepts responsibility for the individual)**	**Responsibility**
	If the police have left the site approval could be obtained by the responsible person at the Place of Safety via a phone call with the AMHP, who should satisfy themselves that the transfer arrangements are suitable as described above. However, if in the event of a medical emergency where there is no time to obtain authorisation, the person's medical needs should be prioritised and the AMHP notified as soon as possible thereafter.	HBPoS AMHP
2.26	The s136 nurse is responsible for ensuring that an appropriate member of staff will travel with the person to take legal responsibility for their management and safety at all times until they either return to the HBPoS or are formally accepted by the A&E department for the purposes of the mental health assessment. During the time in A&E, the detained individual remains in the custody of the staff member from the HBPoS unless A&E staff agree that the mental health assessment can be carried out in their department and accept formal legal responsibility for the custody of the individual under s136. A discussion needs to take place between senior clinicians at both HBPoS and ED as to how long mental health staff need to stay if a patient is transferred back for urgent physical health needs i.e. if the patient is going to be receiving physical healthcare treatment that will require them to be in A&E for a prolonged period of time then a common sense approach is required to assess if KMPT staff need to remain. If it is decided that they do not need to remain, then A&E will accept legal responsibility for the s136 (refer to standard 3.6).	HBPoS ED

Standard 3: Roles and responsibilities in the A&E department

<table>
<tr><th>Ref</th><th>Standard 3a: A & E as a Place of Safety</th><th>Responsibility</th></tr>
<tr><td>3.0</td><td>A&E can itself be a Place of Safety within the meaning of the Mental Health Act. Therefore, if protracted physical health treatment or care is required, where appropriate the ED should accept the s136 papers and take legal responsibility for custody of the individual for the purpose of the Mental Health Act assessment being carried out.

In these circumstances the individual continues to be detained under s136 (see point 3.1).</td><td>ED</td></tr>
<tr><td>3.1</td><td>When an individual detained under s136 is conveyed directly to an A&E department, (see point 3) the individual remains in police custody throughout the period in A&E until one of the following takes place:
The s12 doctor, or in exceptional circumstances* another doctor with mental health experience, concludes that there is no underlying mental disorder and the individual is discharged from s136. If this occurs, the AMHP should be notified by the doctor concerned and the individual should be told that they are free to leave when they wish. Where appropriate they should be referred on for consideration of any other, non-mental health care needs by the local authority under the Care Act.
A&E accepts legal responsibility for s136 and the individual’s detention for the purpose of the mental health assessment.
The individual is conveyed to the local HBPoS site.
*The decision to conclude there is no mental disorder should be exceptional and should only be taken by a non s12 doctor if they have adequate understanding of mental disorder to make the judgement.</td><td>AMHP
Kent Police
ED</td></tr>
<tr><td>3.2</td><td>On arrival at A&E:
Individual is triaged by A&E staff for physical health needs.
Clinical staff must inform the individual of their rights under s136. They will also give the individual the s136 information leaflet (see Appendix 11: Patient Information s136).
Responsibility of this is to be agreed locally for each A&E and form part of the local KMPT & NELFT s136 policies.</td><td>ED
Kent Police
HBPoS
AMHP
NELFT
KMPT</td></tr>
</table>

Ref	Standard 3a: A & E as a Place of Safety cont.	Responsibility
	• As an interim standard this will be completed by liaison psychiatry staff, however, for sites that do not have a 24/7 service then this will be covered by A&E staff / on-site managers. • A&E staff will need to inform liaison psychiatry at the earliest opportunity that someone has been brought to A&E who is detained on s136 to allow them time to arrange to see the individual and inform them of their rights. Pilot projects will be undertaken to train A&E staff to carry out this function, these will be agreed in local operational policies and monitored by the appropriate commissioners for that area.	ED liaison psychiatry
3.3	• The police will be advised by A&E staff if the detained person requires medical treatment. The police will liaise with the HBPoS and AMHP. • The accompanying police officers need to contact the duty AMHP (the AMHP contacts the s12 doctor) as quickly as possible to ensure the prompt attendance to carry out the mental health assessments, particularly out of hours, this should include arrival, details of the presentation, including physical and mental health concerns, location of the patient and the named A&E clinician in charge of patient's care.	AMHP Kent Police HBPoS NELFT ED
3.4	Where there are no clinical grounds for delay, completion of the mental health assessment by the AMHP and s12 doctor should occur within four hours of the individual's presentation to A&E. A&E departments should have a dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis. These areas should be designed to facilitate a calming environment while also meeting the standards of safe delivery of care. A mental health assessment should not be delayed for delivery of physical health treatment that has no predictable significant impact upon mental state so a parallel assessment can be undertaken. A mental health assessment should not, however, take place if there is suspicion that a physical condition is leading to or significantly worsening a disturbance of mind. These instances provide clinical grounds for delay and will prevent the mental health assessment being completed within four hours.	AMHP Kent Police HBPoS ED NELFT

Ref	Standard 3a: A&E as a Place of Safety cont.	Responsibility
3.5	Due to the nature of A&E departments, managing individuals detained under s136 in this environment can be challenging. Given this, when an individual detained under s136 is in the A&E department police officers will retain legal responsibility for s136 and provide the necessary support needed unless there is mutual agreement between the department and the police officers that they are able to leave.	ED Kent police
3.6	Any decision by A&E to accept legal responsibility for an individual detained under s136 should be made by the senior clinical staff member on duty on behalf of the Trust; this is usually the senior nurse in charge. This person should only accept legal responsibility for an individual on s136 after a risk assessment is completed and they are confident and satisfied that they are aware of the likely risks that the person presents and that their own staff can safely manage these. If they intend to use security staff for this purpose, it is their responsibility to ensure that the relevant officers are fully briefed about the risks posed by the individual. Where available, liaison psychiatry will assist A&E staff in carrying out the risk assessment to determine if A&E accepts legal responsibility for the individual. If after the risk assessment the senior clinical staff member decides against accepting the s136 papers the department must ensure the individual's physical healthcare is expedited to ensure the mental health assessment is able to commence promptly at the closest HBPoS. The decisions for which must be fully documented. Where staff have not accepted legal responsibility for custody, the police will continue to have this responsibility, but may ask for support from security staff where necessary.	ED liaison psychiatry
3.7	If after the risk assessment A&E accept legal responsibility, it is vital that information about the individual's needs, and any associated risks, are clearly explained to A&E staff receiving the person and also documented in the s136 paperwork. Any security staff at the A&E department must likewise be properly briefed about the person before A&E takes responsibility for them. A&E now has the legal power to detain the person there until the s136 is discharged, security and other staff employed by the Trust	AMHP ED Police

	may use reasonable and proportionate restraint where necessary to keep the person safe.	
Ref	**Standard 3b: A&E accepting legal responsibility for s136 cont.**	**Responsibility**
3.7 cont	KMPT must be advised by ED if a person is restrained, this needs to be recorded on the physical health documentation and must include details of how long the individual was restrained and in what position, along with any medication that was administered.	
3.8	A&E staff will assume responsibility for: • Informing the AMHP service for the area where the hospital is located, as soon as is practicable, that they have taken responsibility for the individual. • Alerting the AMHP of the physical healthcare required so that consideration can be given to carrying out a parallel and concurrent mental health assessment alongside physical treatment by medical staff. • A&E and AMHP agree together the next stages of a care plan, including time frame for referral and completion of the mental health assessment (if considered appropriate) and time frames and nature of further physical health assessment and treatment. • If the decision is taken that it is in the individual's best interest to transfer them from the A&E (after they have received treatment for their physical healthcare) to a HBPoS for the purpose of the mental health assessment, it is A&E's responsibility to liaise with the s136 nurse (HBPoS) and the AMHP to secure confirmation that the HBPoS has capacity and is willing to receive the individual before the transfer takes place. • Once a transfer has been agreed and authorised by the AMHP, A&E is responsible for arranging the transport. • If there is no availability in the local HBPoS, then the HBPoS are responsible for checking the other K&M HBPoS suites availability and KMPT must keep A&E updated of the status of availability.	AMHP ED HBPoS NELFT
3.9	A&E is responsible for the transfer of the s136 form and physical healthcare documentation (see Appendix 6 & 7) on transfer to the Mental Health Trust.	ED

Standard 4: Mental Health Act Assessment

Ref	Standard 4: Mental Health Assessment	Responsibility
4.1	Mental health assessments must not be delayed due to uncertainty regarding the availability of a suitable bed.	AMHP Sec12 doctor
4.2	The mental health assessment should be completed within four hours of the individual arriving at the health based place of safety unless there are clinical grounds for delay, such as the person being significantly intoxicated, acutely unwell following self-harm and in need of care and treatment at the A&E department or, after being clinically assessed by the team, being deemed to require more time for their mental state to settle. **Any Breach of the 4-hour standard must be recorded and reported to the local multi-agency group for monitoring.**	AMHP Sec12 doctor
4.3	Medical staff at the health based place of safety, A&E and Kent Police must have contact information for the AMHP serving the local area, particularly out of hours. It is the AMHP service's responsibility to ensure this number is available to all.	HBPoS AMHP
4.4	Where possible the mental health assessment should be conducted jointly by the s12 doctor and the AMHP, however, the need to coordinate a joint assessment should not be a reason for delaying the overall process. Unless it is clear that the person will not require a hospital admission the AMHP should arrange for a second doctor to examine the individual. The second doctor should either have had previous acquaintance with the person under assessment, or also be a s12 approved doctor.	AMHP Sec12 doctor
4.5	If hospital admission is likely, one of the s12 doctors undertaking the assessment should normally be employed by the Trust responsible for providing care for the geographical area in which the patient is being assessed. If this would cause unreasonable delay it is not unlawful to proceed on the basis of two doctors not from the geographical area, however, if both s12 doctors are employed by a different NHS Trust or organisation then at least one of the doctor's assessments should be recorded either as a paper record or on the local electronic patient record system.	AMHP Sec12 doctor

4.6	Both the AMHP and the s12 doctor should be in attendance as soon as possible in all cases where there are not good clinical grounds to delay assessment. If the s12 doctor is	AMHP Sec12 doctor
Ref	**Standard 4: Mental Health Assessment cont.**	**Responsibility**
4.7 cont.	already in attendance, they should not wait for the arrival of the AMHP to commence assessment, but where possible a telephone call should take place between the doctor and AMHP to discuss the interim response. To ensure the prompt attendance of AMHPs and s12 approved doctors at mental health assessments, particularly out of hours, different staffing models should be explored separating children and adult services.	AMHP Sec12 doctor
4.8	If the s12 doctor sees the individual before the AMHP and is satisfied that there is no evidence of underlying mental disorder of any kind, the person can no longer be detained and must be immediately released, even if not seen by an AMHP. If this occurs the AMHP should be notified by the doctor concerned without delay, and the individual must be told that they are free to leave when they want. Where appropriate they should be referred on to other, non-mental health teams in the local authority, for example under the Care Act.	AMHP Sec12 doctor
4.9	When the person is already known to mental health services in a different area from where they have been detained it is good practice for an AMHP from their home area to consider attending to carry out the assessment; see the MHA Code of Practice para 16.28. However, this should not be a reason for unduly delaying the assessment. It should be noted that (in the absence of local agreements to the contrary) the legal duty to assess falls upon the AMHP service for the area where the person is at the point when the assessment is needed - in this case, the area in which they are currently being detained under s136.	AMHP Sec12 doctor
4.10	If the s12 doctor sees the person first and concludes that they do have a mental disorder and that compulsory admission to hospital is not necessary, the person should still be seen by an AMHP, to consider what arrangements are necessary to support the person's mental health, for example an informal hospital admission or support in the community. Even if a hospital admission is not required, the AMHP might still decide that the person needs to be held at the health based	AMHP Sec12 doctor

	place of safety for a period while community arrangements are made, for their own safety or exceptionally to protect someone else. This should only happen if the AMHP believes that the risks are too great for such arrangements to be made after the person has returned home.	
Ref	**Standard 4: Mental Health Assessment cont.**	**Responsibility**
4.10 cont.	Decisions to immediately release the individual should not be made lightly. While many people assessed under s136 of the Mental Health Act may not have a mental disorder of the severity or nature to warrant further detention under the Act, the majority of people placed on a s136 are likely to have some form of mental disorder or to be vulnerable. Hospital staff should not take it upon themselves to discharge the s136 without reference to the AMHP, as once this has been done there is no power to prevent the person from leaving even if necessary arrangements for the person's treatment or care have not yet been made.	AMHP Sec12 doctor
4.12	Exceptionally, if it is unavoidable, or it is in the person's interests, an assessment begun by one AMHP or s12 doctor may be taken over by another AMHP or S12 doctor, either in the same location or at another place to which the person is transferred (which may be in a different borough and so come under a different AMHP team). However they would not be able to 'continue' the original assessment and will have to start a new assessment process. A local policy should be in place to ensure that a replacement AMHP or s12 doctor has been identified and formally confirmed to take over the assessment before the first professional departs. Where this occurs, the AMHP taking over the process is legally responsible for making any MHA application, which may therefore require re-interviewing the individual and family members where appropriate.	AMHP Sec12 doctor
4.13	If the individual is under 18 years old or has recently been referred to adult services they should, where this is available, be taken to an appropriate health based place of safety where there is a s12 approved CYPMHS specialist doctor, a consultant with experience in CYPMHS or an AMHP with knowledge and experience of caring for this age group available to undertake the mental health assessment.	AMHP Sec12 doctor NELFT
4.14	The Trust commissioned to provide the health based place of safety should ensure assessing doctors and AMHPs have up	AMHP KMPT

	to date knowledge and readily available information about alternatives to admission via the local directory of services, which should be considered as part of the assessment.	NELFT
4.15	The AMHP and assessing doctors must also have prompt access to interpreting and signing services if required.	AMHP Sec12 doctor
Ref	**Standard 4: Mental Health Assessment cont.**	**Responsibility**
4.16	Occasionally the AMHP may decide that they need to return to re-interview the person in order to decide upon an appropriate course of action, for example, if at the first interview the person is under the influence of drugs or is 'electively mute'. In these circumstances the s136 detention continues in the usual way until the final decision is taken.	AMHP
4.17	The person may continue to be detained while all these arrangements are being made, provided that the maximum period of detention under s136 (24 hours) is not exceeded. The 24-hour period begins at the time of arrival at the first place of safety (including if the individual needs to be transferred between places of safety). It should be noted that A&E is itself a Place of Safety within the meaning of the MHA, so if the person subject to s136 is first taken to A&E department the detention period starts at the time of their arrival at A&E, and not at their arrival at any subsequent health based place of safety.	AMHP Sec12 doctor
4.18	The detention under s136 comes to an end 24 hours after the individual's arrival at the health based place of safety (or arrival at the first Place of Safety they have been transferred to including A&E). The period may be extended to 36 hours by a doctor, but only on clinical grounds. Once the detention period has come to an end the individual cannot continue to be detained under s136 and should be told that they are free to leave. The 'holding powers' under s5 (2) and 5(4) of the Mental Health Act 1983 cannot be used to extend the detention period.	AMHP Sec12 doctor HBPoS
4.19	Exceptionally, if the individual represents a clear and immediate risk to themselves or to someone else, health based place of safety staff may be able to justify a further, very brief, period of restraint while appropriate arrangements are being made, but it should be noted that this would be under common law, not the Mental Health Act, and the necessity for it might be challenged. Likewise restraint may be justified for a brief period under the Mental Capacity Act if the person lacks capacity to make decisions about their own safety and it is clearly necessary to restrain them in their own interests. In this case there would need to be a formal record that the person's capacity was appropriately assessed, and other arrangements must be put in place as quickly as	AMHP Sec12 doctor HBPoS

Ref	Standard 4: Mental Health Assessment cont.	Responsibility
	possible to prevent this turning into an unauthorised deprivation of liberty. A decision to restrain in this way is made by the senior staff member at the relevant Place of Safety, who should take internal advice where appropriate.	
4.20	After the outcome is agreed, the person should be discharged or transferred to hospital as quickly as possible. Failure to discharge promptly compromises the individual's care. The AMHP is responsible for arranging the individual to be conveyed to the admitting hospital, however, they will require assistance from the sending hospital in coordinating suitable transport and may request police support where needed.	AMHP Sec12 doctor
4.21	The Trust responsible for arranging inpatient psychiatric beds needs to be aware that detention in the health-based place of safety cannot be extended beyond the maximum time permitted (24 hours) simply because of an inpatient bed shortage. The Mental Health Trust has a duty of care (within what is permitted in law) to the individual requiring admission, so each Trust is expected to make provision to address the situation.	KMPT NELFT AMHP Sec12 Doctor
4.22	If an application for detention under section 2 or section 3 has already been completed at the time when the s136 detention period expires, the individual may continue to be appropriately restrained for a short time by the staff responsible for conveying them to hospital, or someone authorised by them, while waiting for suitable transport	AMHP Sec12 doctor
4.23	If an inpatient admission is required following detention under s136, this should be treated as an emergency admission, with the decision on where to admit the individual determined by what is judged to be clinically safest and in the individual's best interest. This may mean admitting the individual at the site where the health based place of safety is located, even if they are usually resident in a geographical area served by a different Trust. The underlying principle is that there should be no gaps in responsibility and no treatment should be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual's healthcare provision.	AMHP Sec12 doctor KMPT NELFT
4.24	It should be noted that, while Wales is covered by the MHA 1983, Scotland, Northern Ireland, the Channel Islands and the	AMHP Sec12 doctor

	Isle of Man have different mental health legislation. Any transfer of patients who are usually resident in these areas can give rise to both funding and legal issues. Sections 80-92 of the MHA 1983 outline the legal processes required. However, if the person clearly needs a hospital admission this should be arranged locally and not delayed while a transfer to the home area is being organised.	

Standard 5: Workforce and Staff Development

Ref	Standard 5a: Workforce	Responsibility
5.1	Every health based place of safety should have a designated s136 nurse available 24/7 who is assigned to the health based place of safety at all times. The designated s136 nurse role should be performed by the most senior nurse in the health based place of safety team at any one time. It is recommended this is no less than a Band 6 ward nurse. Sufficient staff should be trained in this role to ensure that there is someone available to undertake this responsibility at all times, with contingency in place for accommodating sickness and annual leave.	KMPT NELFT CCGs
5.2	The designated s136 nurse should be the first contact for the police or ambulance service on arrival at the site. The designated s136 nurse will assume immediate responsibility for: • Accepting the individual to the health based place of safety (including both in-area and out-of-area individuals) or accommodating the individual through escalation processes or other alternative arrangements (supported by a real-time capacity management tool). • Notifying the AMHP service for the area that someone. subject to s136 has arrived, or will do so imminently and passing on initial information about the individual. • Informing clinical staff (to conduct an initial medical screening and physical health check) as well as the AMHP and Section 12 doctor when the individual arrives and liaising promptly with care partners or family where required. Note it is the AMHP's responsibility to contact the independent s12 doctor if necessary. • Informing any other externally provided services that might be required when the individual arrives e.g. interpreting services. • With the individual's consent, informing immediate family and/or carers that the person is being detained under s136, and where they are. However, if the person does not wish family and/or carers to be notified then their right to	KMPT NELFT

Ref	Standard 5a: Workforce cont.	Responsibility
	confidentiality should be upheld unless disclosure without consent can be justified on the usual 'need to know' principles. • Identifying and making contact with an appropriate A&E department if physical healthcare is required after accepting the s136, ensuring A&E staff are ready for the arrival of the individual. The designated s136 nurse is also responsible for arranging transport from the health based place of safety to the A&E department, obtaining authorisation from the police officer or AMHP in attendance (authority can be obtained by telephone if necessary, when neither police nor AMHP is currently present) and arranging an appropriate escort to accompany the individual.	
5.3	Adequate, dedicated staff must be available 24/7 in the s136 suite to ensure staff members do not come off inpatient wards, (except when drawn upon for emergency situations see standard 6.7).	KMPT NELFT
5.4	At all health based place of safety sites staffing levels should be modelled on accurate and up-to-date activity data for that area and contingency plans should be in place for responding to demand that exceeds average usage.	KMPT NELFT
5.5	There should be a service manager available on call out of hours in addition to the clinical out-of-hours cover. When complex issues arise a senior manager should be available above the designated s136 nurse via the service manager.	KMPT NELFT
5.6	There should be a minimum of two mental healthcare professionals (minimum of at least one registered mental health professional) immediately available to receive the individual from the ambulance service and the police. One of the two mental healthcare professionals must have CYPMHS competencies or access to senior CYPMHS advice. These two roles should provide support to the designated s136 nurse as well as clinical staff when performing the initial medical screening and physical health checks.	KMPT NELFT
5.7	Extra clinical staff (minimum of three) must be available at short notice if required as there should be sufficient staff to cope with all but the most challenging behaviour, without recourse to on-going police support. The needs of individuals with learning disabilities should be specifically planned for including access to trained staff and specialist advice through a 24/7 rota, this could cover nurses who have completed a module or doctors on a rota.	KMPT NELFT
5.8	All staff must have the competencies of all-age inpatient staff including the administration of rapid tranquilisation medication. The Trust commissioned to provide the health based place of	KMPT NELFT

	safety should ensure these competencies are up to date.	
5.9	The use of physical restraint should follow NICE guidelines [NG10]: Violence and aggression: short-term management in mental health, health and community settings. There must be clear protocol about the exceptional circumstances when police may be used to help physically restrain an individual in a health based place of safety.	KMPT NELFT

Ref	Standard 5a: Workforce cont.	Responsibility
5.10	There should be sufficiently trained clinical staff that can take over the restraint if sedation is needed within a health based place of safety, police officers should not be restraining when sedation is administered.	KMPT NELFT
5.11	If police officers do have to restrain, healthcare staff should take over that restraint as soon as control has been achieved. During any period of restraint within a health based place of safety, healthcare staff are responsible for the health and safety of that patient and should monitor the patient throughout the restraint.	KMPT NELFT Police
5.12	In instances where the A&E department has accepted legal responsibility for the person's custody, they have the legal power to detain the person there until the s136 is discharged. Security and other staff employed by the Trust may use reasonable and proportionate restraint where necessary to keep the person safe.	ED
5.13	In these instances any security staff at the A&E department must be properly briefed about the person before the A&E takes responsibility for them and the A&E should be confident that security staff are suitably trained and able to manage them appropriately. It should be noted that security staff have no greater legal powers to manage a person's behaviour than any other hospital staff member. A&E staff should also be informed that it is their responsibility to inform the AMHP service for the area where the hospital is located, as soon as is practicable, that they have taken responsibility for the person.	KMPT NELFT
5.14	The health based place of safety should have sufficient staffing to safely manage the mental health needs and care of the young person. This includes a minimum of two nursing staff (of which at least one should be registered) dedicated to the management of the young person, including line-of-sight supervision and access to additional staff for de-escalation and restraint if needed.	KMPT NELFT
Standard 5b: Staffing for Health Based Places of Safety accessible for children and young people		
5.15	Staff responsible for the care of a young person must be enhanced DBS checked, have level 3 safeguarding training, an understanding of the Children Acts and have developmentally appropriate training (staff trained in understanding the different ways that children and young people behave and respond at different stages of psychological development).	KMPT NELFT CCGs
5.16	There should be access to on-call CYPMHS trained doctors and to	NELFT KMPT

	general paediatric staff when a medical assessment is required.	
Standard 5c: Health Based Place of Safety staff physical health competencies		
5.17	Health based place of safety staff (including both nursing and medical staff) should have the following physical health competencies to prevent unnecessary A&E referrals, further detail is provided in Appendix 9: Physical Health Competencies: • Provide monitoring and basic physical interventions e.g. hydration to support basic physical health status. • Safely administer and monitor medication used or rapid tranquilisation. • Be able to provide basic life support. • Recognise and refer on the acutely deteriorating patient providing initial supportive treatment, including seizures, chest pain, breathlessness, lowering of consciousness. • Manage simple superficial wounds. • Screen and respond to non-acute illness including management of co-morbid infection and identification and onward referral for chronic stable disease. • Perform basic lifestyle screen assessment. • Screen for, prevent and manage uncomplicated alcohol or substance (including nicotine) withdrawal. • Provide full medical examination and systems review (and if appropriate blood tests) to screen for co-morbid physical health conditions to support onward referral if appropriate.	NELFT KMPT
Standard 5d: Staff Training		
5.18	• The provision of training should be covered in the jointly agreed policies and procedures developed by the local multi-agency group (refer to section 1).	NELFT KMPT

5.19	• Healthcare staff who work in a health based place of safety should be trained in: - Mental state and physical health assessments. - Rapid tranquillisation procedure. • The use of physical intervention and safe restraint. • CPR. • Age appropriate basic life support. • Risk assessment and management including risk to others, from others, to self and to health (including self-neglect). • Observational skill including the level and manner of detail contained in written observations.	NELFT KMPT
Ref	**Standard 5d: Staff Training & Development cont.**	**Responsibility**
	• The use of the Mental Health Act, Mental Capacity Act and an overview of the Care Act. • The ability to use resuscitation equipment. • Assessment and management of substance misuse, intoxication and withdrawals and basic physical healthcare (refer to physical health competencies in Appendix 9). • Up to date mandatory training in Trust protocols (i.e. information governance, safeguarding, promoting safer and therapeutic services - PSTS). • Liaison with families and carers.	
5.20	All staff providing care to a young person must have appropriate training in prevention and management of violence and aggression, an awareness of relevant aspects of the Children Acts and training in developmental approaches to assessment and treatment.	NELFT KMPT
5.21	The Trust commissioned to provide the health based place of safety is responsible for ensuring the training for staff is regularly available. The frequency must be determined to ensure that staff are always fully trained before commencing their role in the health based place of safety, taking training rotations and staff turnover into consideration.	NELFT KMPT
5.22	The Trust is also responsible for ensuring that all bank/agency staff are competent and aware of the Trust's processes and protocols regarding the management of individuals detained under s136 before being put in post.	NELFT KMPT
Standard 5e: Patient information		
5.23	During any handover between services, from the ambulance service, police or between acute and mental health trusts, it is essential that a	SECAmb Police ED

	copy of all information regarding the episode and patient information is transferred. Where available, this should include a copy of investigations undertaken, diagnosis made, an updated crisis plan, discharge plan and any recommended follow-up, signed by the medical staff responsible.	NELFT KMPT
5.24	When the individual first arrives at the health based place of safety the transfer process must include the transfer of the s136 handover form which each police officer should carry. All sections should be completed and signed by the police officer and health based place of safety staff.	Police SECAmb HBPoS
5.25	When managing an individual detained under s136, confidential patient information may be shared to the extent that it is necessary for: • medical treatment which may be given without a patient's consent	All
Ref	**Standard 5e: Patient information cont.**	**Responsibility**
	• under the Act. • safely and securely transporting a patient to hospital (or anywhere else) under the Act. • finding and returning a patient who has absconded from legal custody or who is absent without leave. • transferring responsibility for a patient who is subject to the Act from one set of people to another (e.g. where a detained patient is to be transferred from one hospital to another, or where responsibility for a patient is to be transferred between England and another jurisdiction).	
5.26	Patient information that is transferred needs to be handled and held securely, this is the shared responsibility of all organisations involved. Before information is disclosed, those proposing the disclosure should be confident that it is necessary in the circumstances, that the aim of disclosure cannot reasonably be achieved without it, and that any breach of the patient's confidentiality is a proportionate response given the purpose for which the disclosure is being considered. The consent of the person should normally be sought before a decision is made to share information without consent, unless the very act of seeking consent would itself heighten the risks to the person or to others.	All
5.27	There should be access to appropriate records from all care providers under which the patient has received an episode of care or contact. If the patient is transferred, it is the transferring team's responsibility to ensure records are handed over and the receiving team's responsibility to ensure they are uploaded on the clinical notes system.	All

5.28	The individual should be provided with information about s136, both verbally and in writing. This should be provided in alternative languages otherwise the health based place of safety must ensure interpreters are available. Health based place of safety staff must ensure they comply with provisions of s132 MHA (the giving of information).	Police ED liaison psychiatry HBPoS NELFT

Standard 6: Follow-up care / discharge

Ref	Standard 6: Follow up and discharge	Responsibility
6.1	Follow-up care must be arranged for people in their area of residence when they are not admitted to hospital following a mental health assessment unless they have no mental disorder or care and support needs of any kind. This might include a referral to a community-based crisis team or for an assessment under the Care Act 2014. This should also include prompt and adequate communication with the individual's GP.	HBPoS AMHP
6.2	The AMHP has responsibility for ensuring follow-up care arrangements are in place but the s136 nurse on that shift should ensure there are robust systems to confirm onward referrals, discharge plans or discharge letters are received by the appropriate care provider within the next working day and onward services are provided with the information gathered throughout the assessment.	AMHP HBPoS NELFT

6.3	Discharge documentation from a health based place of safety or A&E (if a mental health assessment takes place in the department) should contain: • Patient name / Date of Birth • NHS Number • ICD Code (International Classification of Diseases) • Care Coordinator (if applicable) • Time of admission • Circumstances of admission • Progress in the health based place of safety • Mental health history • Physical health history and current physical health • Social history including drug, alcohol and smoking status and access to funds. • Care plan including medication and medication monitoring, mental and physical health follow up, and recovery interventions including lifestyle, social, employment and accommodation plans where necessary for physical health improvement. • Crisis plan including signposting 24 hour crisis line information. • Discussions with next of kin, family and carer. • Time of discharge, discharge destination and method of transport.	HBPoS ED

Ref	Standard 6: Follow-up and discharge cont.	Responsibility
6.4	The individual should also be aware of support available if their situation deteriorates in between treatment, this could be a 24/7 crisis line available in each local area. Sometimes it may be appropriate to refer the individual to the local safeguarding team, for example, if there are indicators of abuse or self-neglect.	KMPT NELFT AMHP
6.5	Staff should be aware of alternative community services to support the individual's mental health and social needs. This includes peer support and community based services that are on offer for the individual.	KMPT NELFT AMHP
6.6	If it has been decided not to admit under the Mental Health Act, responsibility for any further engagement reverts to community services where the person lives. Where the individual does not reside in the local area, the s136 nurse is responsible for making any necessary referral to the appropriate local service, obtaining advice if the person's place of residence is not clear.	HBPoS NELFT
6.7	If an individual declines follow-up care there may be other issues that need to be pursued (e.g. safeguarding). The s136 nurse retains responsibility for an appropriate referral being made to other local services within the appropriate timeframes, however the tasks may be performed by administrative staff.	HBPoS NELFT
6.8	If it is requested, there should be proactive collection and analysis of patient feedback, individuals should be aware of feedback routes to both the Trust as well as independent organisations.	KMPT NELFT

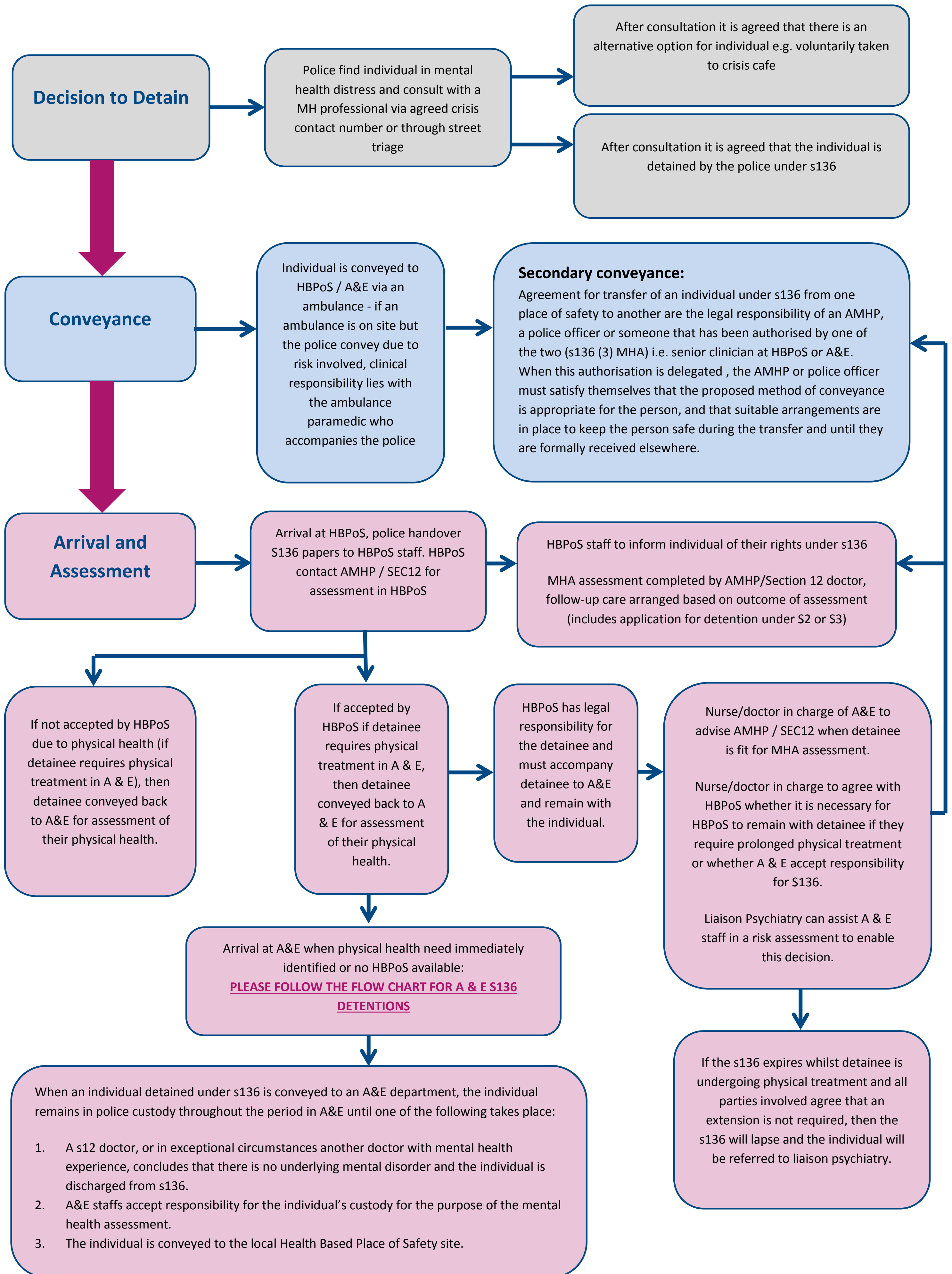
Standard 7: Kent and Medway's Health Based Place of Safety Specification

Ref	Standard 7: HBPoS Specification	Responsibility
7.1	The health based place of safety should be a hospital or other health based facility where mental health services are provided. A police station should never be used as a place of safety unless in exceptional circumstances as stated in the Police and Crime Act 2017.	HBPoS NELFT Kent Police
7.2	Where possible, the health based place of safety should be situated near an A&E department to ensure the continuity of care for individuals and to avoid long transfers between health based place of safety sites and A&E departments. If the health based place of safety is not near an A&E, robust clinical pathways and local protocols must be established in order to provide an effective and efficient pathway.	HBPoS NELFT ED
7.3	There should be an area for the police and ambulance staff to wait on arrival at the health based place of safety site while the necessary handover processes occur.	HBPoS Kent PolicePolice SECAmb
7.4	Within the health based place of safety there must be assessment rooms with the following features: • Large enough to accommodate six people, to be able to both assess and restrain where necessary. • Well-lit (ideally natural light through appropriate windows) and an observation window to enable good visibility throughout. • Have good exits, with consideration given to there being two doors at opposite ends of the room; the doors should open outwards for the safety of staff. • Have soft, comfortable and clean 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 individual. • Have no ligature anchor points. • Have a panic alarm system that is regularly tested. • Be located near other staff and be easily accessed by a team trained in physical intervention and the use of resuscitation equipment.	HBPoS KMPT NELFT

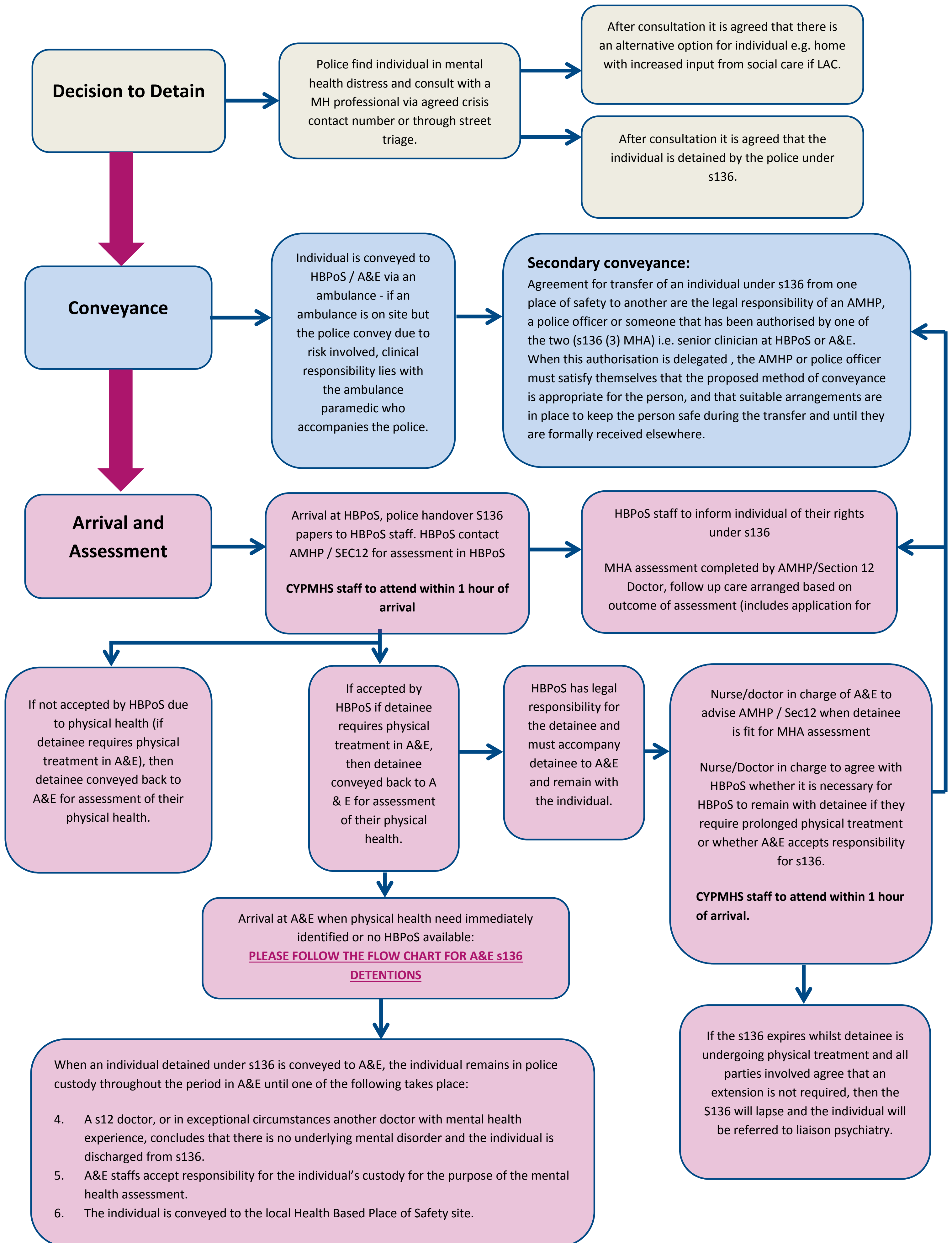
Ref	Standard 7: HBPoS Specification cont.	Responsibility
	• Have CCTV with visibility of the entire room to enhance staff protection and safeguarding. Optimally a room that is visually appealing, with some ability to play music which can provide a sense of calmness and facilitate recovery.	
7.5	The number of assessment rooms at the health based place of safety must be modelled using accurate and up-to-date activity data for that area which should include contingency for temporary closure of assessment rooms to repair damage acquired during use.	HBPoS KMPT NELFT
7.6	If closure is required for refurbishment to take place, the provider of the health based place of safety must take action quickly to ensure the assessment room is reopened as soon as it is feasible to do so.	HBPoS KMPT NELFT
7.7	In close proximity to the assessment rooms, the following should be available: • Washing and toileting facilities with appropriate security protocols. • Provision of beverages and light snacks, enough to meet nutritional needs. • Telephone for staff or support for the individual to contact family, carers and other services when appropriate. • A place for writing up notes and briefing of assessment unit staff by those involved in the detention. • Computers for staff linked to the electronic care system to identify relevant background information, current status under the Mental Health Act, crisis plans, Mental Capacity Act advance statements or decisions. • Leaflets for patients on Mental Health Act rights, mental health conditions and treatments and local services on offer. Leaflets should be available in less commonly used languages and take into account different cultures, ages and religious beliefs. They should also be available in accessible formats and be available electronically where they are not otherwise immediately available. • Following an individualised risk assessment appropriate writing, drawing and reading material could be available to support recovery while the individual is in the assessment room. • Clean clothes for emergencies should be available.	HBPoS KMPT NELFT

Ref	Standard 7: HBPoS Specification cont.	Responsibility
7.8	The following medical equipment should be available on-site or within close proximity to the health based place of safety. The exact location must be determined at an organisational level following a risk assessment which gives consideration to local circumstances: • ECG machine • Equipment for taking routine bloods • Blood pressure machine (sphygmomanometer) • Thermometer • Stethoscope • Equipment for measuring oxygen saturation levels • Breathalyser (however not to be used as a way of accepting individuals into the site) • Glucose meters (with ketone readings) • Urine dip stick testing kits • Weight and height measurement • Carbon monoxide monitor • Peak flow test • Equipment for measuring respiratory rate • Resuscitation equipment including a defibrillator • Saliva substance misuse screening or drug urine testing kits • Tendon hammer and sensory testing equipment • Pregnancy testing equipment • Equipment and dressing for simple open wounds • Light for assessing pupillary response.	HBPoS KMPT NELFT
7.9	The site should ensure the individual is able to be safely and constantly observed, as appropriate. This includes visual observations of mental state and physical health status including observations to allow calculation of an individual's respiratory rate.	HBPoS KMPT NELFT
7.10	Health based place of safety staff should be able to use the equipment above, interpret test results or have formal working arrangements with Trust staff in other departments who can do so efficiently.	HBPoS KMPT NELFT

Appendix 1: S136 Pathway Flowchart Adults



Appendix 2: S136 Pathway Flowchart CYPMHS



Appendix 3: Kent and Medway Flowchart for A&E as a Place of Safety for S136 detention

Health Based Place of Safety (HBPoS) is a dedicated mental health suite, while A&E is referred to as a Place of Safety (PoS) it is not included in any reference to HBPoS.

Detention made under S136 and detained person taken to A & E because either:
No *HBPoS available
Or
Detainee is identified as having a physical health need which requires treatment at A&E.

Contacting A&E
~**Police** contact A&E to let them know that they are on route to them with a s136 detainee.
(Priority phone lines are being established in EDs for this purpose).
Police must notify the AMHP that they going to A&E with a s136 detainee. If the person is under 18 NELFT must be notified at the earliest opportunity and a member of CYPMHS will attend within 1 hour of the individual's arrival.

On Arrival at A&E
Police to notify **Nurse/Doctor in charge of A & E** on arrival and to inform the **AMHP** at the earliest opportunity
Paramedic to give clinical handover to Nurse/Doctor in charge if conveyed by ambulance
Nurse/Doctor in charge of A&E to arrange for detained person to be assessed if they are medically fit and have capacity to be provided with their rights under the MHA.

Yes → Liaison psychiatry / ED staff to provide detained person with their rights under the MHA.

No → Liaison Psychiatry / ED staff to provide detained person with their rights under the MHA as soon as they are in a state/condition whereby they have capacity to understand them.

Nurse/doctor in charge of A&E to advise police if the detained person has a physical health need which requires treatment.

No → **Nurse/doctor in charge of A&E** to advise **police** when the person is fit for MHA assessment.

- **Police** to contact **HBPoS** to determine availability/appropriate length of time to a **HBPoS** being available to transfer
- **HBPoS** to agree police transfer can go ahead
- **A&E** to send electronic physical Health Assessment form to HBPoS
- **HBPoS** to request a medic to medic consultation and agree a clinical management plan.
- If HBPoS available **Police** to notify **AMHP** of time of transfer so that MHA assessment can be completed at HBPoS

Yes → **Nurse/doctor in charge of A&E to advise police** estimated time until the person has been treated for their physical condition/injury and is fit for assessment.

Prolonged Physical Treatment
If person requires prolonged physical treatment then **Police and Nurse /Doctor in charge of A & E** to discuss option of A & E taking responsibility for the S136 (If A & E can safely manage detainees)

Liaison Psychiatry to assist A & E in joint risk assessment for this decision.

Police to remain

Does the **police officer** agree with the decision?

No → **Police** to initiate escalation process

Yes → **Police** to remain until either:-

Physical treatment is completed and detained person is fit for MHA assessment
Or
S136 expires before MHA assessment is completed.

Yes → **Nurse/Doctor in charge of A&E** to assume responsibility for the detained person as soon as is practicable to enable police to withdraw.
Police to handover s136 papers.

A & E staff to take over liaison with **AMHP and HBPoS** for the purpose of the MHA assessment being completed.

S136 Expires
If S136 expires whilst detained person is still receiving treatment for their physical health (and extension is not agreed) then **Nurse/Doctor in charge of A&E** to inform **Liaison Psychiatry** who will carry out a mental health assessment once the person is fit to be assessed.

Appendix 4: Use of a police station as a place of safety for s136 in exceptional circumstances guidance:

1. In Kent the only custody suite that will accept patients detained under such circumstances will be Medway.

2. The Police and Crime Act 2017 (PACA)

PACA has amended the MHA and specified strict regulations for when a police station can be used as a POS. It must be noted that the term police station applies not only to a custody suite but any part of a police station.

No-one under 18 detained under S135/S136 can be brought into a police station under any circumstances; PACA puts a total ban on this.

An adult may only be removed to, kept at, or taken to a POS which is police station under s136A where an Inspector (or above) is satisfied that:

a) The behaviour of the detained person poses an **imminent risk of serious injury or death to anyone.**
b) Because of that risk, no other POS can reasonably be expected to detain them.
c) So far as reasonably practicable, a healthcare professional is present and available to the person throughout the entire period they are detained at the police station, BUT
d) There must be a healthcare professional present in the police station to check on the welfare at least once every 30 minutes of the detained person and take any appropriate action for the treatment and care of the detained person.

The decision maker must be satisfied that the person's behaviour poses an imminent risk of serious injury or death to the person or to others. The decision maker should consider whether, if no preventative action is taken:

- The person's behaviour presents a risk of physical injury to the person or to others of a level likely to require urgent medical treatment AND
- That risk already exists or is likely to exist imminently.

Such judgements will inevitably be partly subjective and based on the available information. For example, a verbal threat to use violence may not of itself meet the threshold. However, if the person has already been violent towards officers the consideration may be different. The likely ability of the person to inflict the degree of serious injury is also a factor (thus for example issues like stature, strength, and co-ordination may be relevant considerations).

Being intoxicated and/or uncooperative may not necessarily meet the threshold. Past behaviour (for example a criminal record for a violent offence) can be relevant, but should not be taken as an indication in isolation from any demonstrable current behaviour, that the person poses an imminent risk of serious injury or death to themselves or others.

Even where the above regulations are met, there must be consideration for police support to staff at another POS rather than for a person to be held in a police station. Custody should not be used merely to enable officers to be released to other duties.

If there is consideration for using a police station as a POS, the only part of the police station which will be used to hold the person for their own safety and the safety of others is custody.

3. Decision making to use a police station:

The following process will be applied:

- If the detaining officer believes that the detained person presents an **imminent risk of serious injury or death to anyone** they must seek the authority of an officer of at least the rank of inspector must be given for the use of a police station in such circumstances.
- The inspector must be satisfied that no place of safety in the area other than a police station can reasonably be expected to detain the person in the light of the risk posed.
- Consultation with healthcare professionals will serve to help officers identify the availability and capacity of places of safety and will assist with facilitating access to them.

A healthcare professional would be someone who is classed as one of the following:

- Registered medical practitioner
- A registered nurse
- An AMHP
- A paramedic
- An occupational therapist.

The final decision maker as to the use of a police station will be the custody/PACE inspector. Any disagreement should be escalated to the Silver Commander to resolve

4. Section 136 Mental Health Act 1983 or arrest for criminal Offence?

It is ultimately up to the discretion of the arresting officer as to whether to prioritise the offence or use Section 136 where both options exist however; it is best practice to choose one option over the other. Consideration should be given, where the offending is low level, possibly 'victimless' and/or where the behaviour is most likely to be related to their mental health condition, to the investigation being paused for the purpose of the mental health assessment under Section 136. The investigation may be revisited after an assessment, especially if an officer's initial concerns about a person's mental ill health are not supported by medical opinion.

If you have decided to arrest and PACE Code G is complied with then an investigation should occur. A mental health assessment may be considered alongside the criminal investigation in police custody; if this is the case then early notification should be given to Community Psychiatric Nurses in custody so a mental health assessment can be undertaken.

If a person is about to be released from custody and there are concerns remaining around their mental health status, consideration can be given to detention under Section 136 Mental Health Act and removing to a health based place of safety for assessment.

Unless paragraph 3.4.3 in SOP O18a Detention under Section 136 Mental Health Act applies the detainee should be removed from custody and immediately taken to a health based place of safety.

5. Review of a Detained Person under s136 held in a police station

The custody officer must review at least hourly whether the circumstances which warranted the use of a police station still exist. If they do not, the person must be taken to another place of safety that is not a police station.

A person does not however need to be taken to another place of safety if this would cause a delay in carrying out a Mental Health Act assessment, which would be likely to cause them distress.

If an adult is detained at a police station then:

a) A Forensic Healthcare Professional is required to conduct 30 minute health check observations on the patient during their time in cells and any appropriate action is taken for the treatment and care of the detained person. The practitioner is required to remain on duty if this detention takes place between 0500 and 0730.

b) The custody officer must review the behaviour of the detained person **at least once an hour** for the purpose of determining whether the circumstances still exist that:
i) The behaviour of the detained person poses an **imminent risk of serious injury or death to anyone.**
ii) Because of that risk, no other POS in Kent or Medway can reasonably be expected to detain the person.

c) When completing the review, where reasonably practicable, consult the healthcare professional that carried out the most recent check as per a).

d) The frequency of the reviews may be reduced to no less than once every three hours where the detained person is sleeping and the healthcare professional has not identified any risk that would require the person to be woken more frequently.

If when the custody sergeant completes their review and they determine the circumstances set out in points 5b) i) and ii) do not still exist they must arrange for the detained person to be taken to another POS other than a police station. This does not apply where:

- Arrangements have been which will enable the MHA assessment to be commenced sooner at the police station than at another POS; AND
- To postpone the assessment would likely cause distress to the detained person.

In addition to the above The custody officer must, in accordance with PACE Code C paragraph 9.5 and the MHA, ensure that appropriate medical attention is given as soon as practicable to any - detainee who:

- Appears to be physically ill, injured or need medical attention
- Appears to be, they suspect, or have been told may be, experiencing mental ill health (or disablement or difficulty that means that the detainee is likely to be vulnerable or require additional support)
- Appears to have a drug or alcohol dependence or withdrawal likely to affect safety;
- Requests a medical examination.

6. Extension of detention in a police station

The period of maximum detention under the MHA has been reduced to 24 hours. There is provision for this to be extended by up to a further 12 hours – to a maximum of 36 hours – but only in very specific and limited circumstances. These are that, for medical reasons alone, it is not practicable to conduct (or complete) a meaningful mental health assessment within the 24-hour period. Such circumstances might arise, for example, if the person is too mentally distressed or is particularly intoxicated with alcohol or drugs.

The circumstances where the period of detention can be increased to 36 hours if the detained person is in a police station must first be authorised, as it would be in any other POS, by the responsible medical practitioner who is responsible for completing the MHA assessment. It must, however, also be approved by a police officer of the rank of superintendent or higher which would be recorded on the custody record.

Appendix 5: Full wording of changes made to the MHA 1983

Section 136 – removal of mentally disordered persons without warrant.

(1) If a person appears to a constable 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:

(a) Remove the person to a place of safety within the meaning of section 135, or

(b) If the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

(1A) the power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than:

(a) Any house, flat or room where that person, or any other person, is living, or

(b) Any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.

(1B) For the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force.

(1C) Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult:

(a) a registered medical practitioner

(b) a registered nurse

(c) an approved mental health professional, or

(d) a person of a description specified in regulations made by the Secretary of State.

(2) A person removed to or kept at a place of safety under this section may be detained there for a period not exceeding the permitted period of detention for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

(2A) In subsection (2), "the permitted period of detention" means:

(a) the period of 24 hours beginning with:

(i) in a case where the person is removed to a place of safety, the time when the person arrives at that place

(ii) in a case where the person is kept at a place of safety, the time when the constable decides to keep the person at that place, or

(b) where an authorisation is given in relation to the person under section 136B, that period of 24 hours and such further period as is specified in the authorisation.

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the permitted period of detention mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the permitted period of detention mentioned in that subsection.

(5) This section is subject to section 136A which makes provision about the removal and taking of persons to a police station, and the keeping of persons at a police station, under this section.

Section 136A – use of police stations as places of safety.

(1) A child may not, in the exercise of a power to which this section applies, be removed to, kept at or taken to a place of safety that is a police station.

(2) The Secretary of State may by regulations:

(a) provide that an adult may be removed to, kept at or taken to a place of safety that is a police station, in the exercise of a power to which this section applies, only in circumstances specified in the regulations.

(b) make provision about how adults removed to, kept at or taken to a police station, in the exercise of a power to which this section applies, are to be treated while at the police station, including provision for review of their detention.

(3) Regulations under this section:

(a) may make different provision for different cases

(b) may make provision that applies subject to specified exceptions

(c) may include incidental, supplementary or consequential provision or transitional, transitory or saving provision.

(4) The powers to which this section applies are;

(a) the power to remove a person to a place of safety under a warrant issued under section 135(1)

(b) the power to take a person to a place of safety under section 135(3A)

(c) the power to remove a person to, or to keep a person at, a place of safety under section 136(1)

(d) the power to take a person to a place of safety under section 136(3).

(5) In this section:

(a) “child” means a person aged under 18

(b) “adult” means a person aged 18 or over.

Section 136B – extension of detention

(1) The registered medical practitioner who is responsible for the examination of a person detained under section 135 or 136 may, at any time before the expiry of the period of 24 hours mentioned in section 135(3ZA) or (as the case may be) 136(2A), authorise the detention of the person for a further period not exceeding 12 hours (beginning immediately at the end of the period of 24 hours).

(2) An authorisation under subsection (1) may be given only if the registered medical practitioner considers that the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment of the person for the purpose of section 135 or (as the case may be) section 136 to be carried out before the end of the period of 24 hours (or, if the assessment began within that period, for it to be completed before the end).

(3) If the person is detained at a police station, and the assessment would be carried out or completed at the station, the registered medical practitioner may give an authorisation under subsection (1) only if an officer of the rank of superintendent or above approves it.

Section 136C – protective searches

(1) Where a warrant is issued under section 135(1) or (2), a constable may search the person to whom the warrant relates if the constable has reasonable grounds for believing that the person:

(a) may present a danger to himself or herself or to others, and

(b) is concealing on his or her person an item that could be used to cause physical injury to himself or herself or to others.

(2) The power to search conferred by subsection (1) may be exercised:

(a) in a case where a warrant is issued under section 135(1), at any time during the period beginning with the time when a constable enters the premises specified in the warrant and ending when the person ceases to be detained under section 135.

(b) in a case where a warrant is issued under section 135(2), at any time while the person is being removed under the authority of the warrant.

(3) Where a person is detained under section 136(2) or (4), a constable may search the person, at any time while the person is so detained, if the constable has reasonable grounds for believing that the person:

(a) may present a danger to himself or herself or to others, and

(b) is concealing on his or her person an item that could be used to cause physical injury to himself or herself or to others.

(4) The power to search conferred by subsection (1) or (3) is only a power to search to the extent that is reasonably required for the purpose of discovering the item that the constable believes the person to be concealing.

The power to search conferred by subsection (1) or (3)—

(a) does not authorise a constable to require a person to remove any of his or her clothing other than an outer coat, jacket or gloves, but

(b) does authorise a search of a person's mouth.

(6) A constable searching a person in the exercise of the power to search conferred by subsection (1) or (3) may seize and retain anything found, if he or she has reasonable grounds for believing that the person searched might use it to cause physical injury to himself or herself or to others.

(7) The power to search a person conferred by subsection (1) or (3) does not affect any other power to search the person.

Appendix 6: Kent & Medway S136 record form

Kent and Medway NHS
NHS and Social Care Partnership Trust

SECTION 136 RECORD FORM

Please note – ALL information recorded on this form is strictly confidential.
Complete ALL parts, clearly and legibly, this is a legal document that evidences why a persons' freedom has been removed and may be subject to scrutiny under the Human Rights Act.
(Revised May 2018)

<table>
<tr><th colspan="10">DETAILS OF DETAINED PERSON AND DETENTION</th></tr>
<tr><td>Surname:</td><td colspan="5"></td><td>Forename/s:</td><td colspan="3"></td></tr>
<tr><td>Address:</td><td colspan="9"></td></tr>
<tr><td>Date of Birth:</td><td></td><td></td><td></td><td>Gender:</td><td>M</td><td>F</td><td colspan="2">Self-defined ethnic code (see guidance)</td><td></td></tr>
<tr><td>Date of Detention:</td><td></td><td></td><td></td><td colspan="3">Time of Detention:</td><td colspan="3"></td></tr>
<tr><td colspan="4">Place the Person was removed from:</td><td colspan="6"></td></tr>
<tr><td>Initial health based place of safety</td><td colspan="3">North Kent</td><td colspan="3">West Kent</td><td colspan="3">East Kent</td></tr>
<tr><td colspan="5">Police station if used:-</td><td colspan="5">General Hospital, A&E, if used:-</td></tr>
<tr><td>Date of Arrival:</td><td></td><td></td><td></td><td colspan="3">Time of Acceptance at health based place of safety:</td><td colspan="3"></td></tr>
<tr><td colspan="5">DETAINING POLICE OFFICER
Rank:

Number:

Name:

Station:</td><td colspan="5">ACCOMPANYING POLICE OFFICER
Rank:

Number:

Name:

Station:</td></tr>
<tr><td>Reference No STORM:CAD</td><td colspan="4"></td><td colspan="5">Time Police Departed:</td></tr>
<tr><td>Relevant Risk Factors:

(from Police records)</td><td colspan="9"></td></tr>
<tr><td colspan="4">Have Police been asked to stay by Trust staff?</td><td colspan="2">Yes</td><td>No</td><td colspan="3">If yes, Appendix E must be downloaded & completed.</td></tr>
</table>

What behaviour led the police officers to believe the patient may be suffering from a mental health disorder? Has the person being searched? Have the officers any other concerns over dependents? Mode of transport to place of safety Police car Ambulance Other

Strictly Confidential

MANAGEMENT PLAN **DECISION MADE FOLLOWING ASSESSMENT** (To be completed by assessing professionals)	
Admitted informally ☐ **Admitted under Section 2** ☐ **Not admitted** ☐ **No evidence of mental disorder** ☐	
WARD NAME -	UNIT -
Please provide <u>details </u>as to outcome of assessment, other Services/agencies involved where not admitted and plans for support :- (include any risk identified that may not be related to mental health issues) Where person is discharged home but there are risks identified which may not be related to a mental health problem, it is recommended that as well as emailing this form to the Force Control Room, telephone contact should be made to a senior police officer on duty via the Police switchboard (01622 690690) Please indicate here if telephone conversation with a senior police officer has occurred Yes No	
What assistance was offered to the person on leaving the place of safety? (taxi etc) Section 136 end date……………… Time…………………… Time left unit ……………………..	

<u>Information from sender</u>

Time	**Date**			**Name & Designation, please print**	**Contact Number**

This page to be forwarded by secure e-mail to Kent Police, Force Control Room within 1 hour of Section 136 assessment being completed.

Appendix 7: Physical health risk assessment for admission to a KMPT Mental Health Unit

Patient Name:	**NHS No:**
Location:	**DOB:**

☑	**Does the patient have any of the following?** (please tick)	**Comments:**
	Ongoing IV fluids or IV medications	
	Parenteral feeding via NG or PEG tube	
	Syringe driver	
	Sliding scale IV insulin	
	Rehab beyond the scope of KMPT physiotherapy provision	
	Long term oxygen therapy	
	Grade 3/ 4 pressure ulcers/wounds requiring tissue viability team (Treatment plan, please state in comments)	
	Long term urinary catheter	
	Unstable diabetes (treatment plan, please state in comments)	
	Stoma bag (any location)	
	Supra-pubic catheter	
	Pulmonary embolus during this admission (state medications in comments)	
	Unstable epilepsy or history of status epilepticus (please note medications in comments)	
	Nebuliser treatment	
	Successful trial without catheter	
	At risk of falls	
	Simple wound which does not require tissue viability team	
	Constipation	
	Other medical devices? i.e.: BiPAP, Insulin pump?	
	Unmanaged pain	
	Any other physical health condition of note	
Are there any concerns re adequate hydration and ability to maintain oral intake**? Yes / No If yes please explain what the plan of care has been and ongoing**		

recommendations.
Comments: *(Dietetic input):*

☑	**Mobility** (please tick)	**Comments:**
	Fully independently mobile	
	Walks with aids: assistance 1 or 2? (Note aids used in comments)	
	Mobilises with wheelchair: requires manual handling equipment?	
	Bedbound (what is the treatment plan? Note in comments)	
	Able to manage stairs	
Are any pressure relieving devices needed? (e.g. Cushion/Air Mattress) **Yes / No If yes please explain what is required in comments below**		
Comments:		

☑	**Physical Health** (please tick)	**Comments:**
	Observations completed within last 24 hrs (are they stable)	
	Blood tests been reviewed	
	Abnormalities to note from investigations (bloods, CT scan, chest x-ray etc.)	

☑	**Is the patient/client an infection risk?** *(Please tick most appropriate box and give confirmed or suspected organism)*	
	Confirmed risk	Organism:
	Confirmed risk	Organism:
	Suspected risk	Organism:
	No known risk	

Patient/client exposed to others with infection e.g. D&V Yes / No
If patient/client has diarrhoeal illness, please indicate bowel history for last week (based on Bristol stool form scale)**:** **Is the diarrhoeal thought to be of an infectious nature? Yes / No**
Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant, Enterococcus SPP, *C. difficile***,** multi-resistant Acinetobacter SPP) and treatment information. Including antimicrobial therapy: **Specimen:** **Date:** **Result:** **Treatment Information:**
Comments:
Is the patient/client aware of their diagnosis/risk of infection? **Yes / No**
Does the patient/client require isolation? **Yes / No (If Yes Liaison Psychiatry must be informed before consideration of transfer)**

☑	**Information to be transferred with the patient** (tick when attached)
	Electronic discharge letter / Emergency Dept. notes

	Copies of follow-up care plans as needed
	Copies of MHA paperwork (if needed) including a completed H4 if section being transferred
	2 weeks of medication
	Copies of medication charts
	Copies of EWS (Early warning score) / PAR Score / MEWS

Declared medically fit for discharge home? (please tick)	**Yes**	**No**	**Declared by**: Doctor: ______________________ Contact No: ______________________	**Date:**

Name of staff member completing form:	**Occupation:**
Signed:	**Date:**

PLEASE NOTE THE PATIENT MUST BE REVIEWIED BY LIAISON PSYCHIATRY AND THIS FORM MUST BE UPDATED BY THE WARD DOCTOR EVERY 24 HOURS UNTIL THE PATIENT IS PHYSICALLY TRANSFERRED.

Appendix 8: Intoxication scenario examples

1. Intoxicated and incapable with no mental health disorder

Police officers come across a male unconscious in the early hours of the morning lying on a quiet residential street. The male smells strongly of alcohol and officers are unable to rouse him. There are no other apparent injuries. Police officers place the male in the recovery position and request an ambulance, monitoring his vital life signs until an ambulance arrives. The ambulance service conveys the male to hospital where necessary medical checks are conducted. There is no requirement at this time for s136.

2. Intoxicated with no mental health disorder

Police officers come across an intoxicated female walking alone in the early hours of the morning. Concerned for her welfare they speak to the female who tells the officers that she is lost and is trying to get home after a night out. The female is apologetic about her intoxicated state, is not committing any crime and does not appear to be suffering from any mental illness. Police officers manage to trace a friend/ relative who attend the scene and collect the female. There is no requirement at this time for s136.

3. Intoxicated and behaviourally disordered with no mental health disorder

Police are called to the High Street to an intoxicated male shouting and swearing, kicking shop windows and turning over bins. On arrival of police, the male continues to shout and swear and refuses to calm down. There are no apparent mental health issues and officers decide to arrest the male for being drunk and disorderly. They convey the male to a police custody centre. There is no requirement at this time for s136.

4. Intoxicated and incapable, with a mental health disorder

Police officers come across a male unconscious in the early hours of the morning lying on the floor on a bridge situated over a river. The male smells strongly of alcohol and there are bottles of spirits on the floor around the male. Witnesses explain to officers that the male was shouting that he wanted to end his life and was trying to climb over the bridge railings to jump into the water below. However, due to his intoxicated state, he fell backwards and struck his head. Although the male was conscious, he was incapable due to the alcohol and insisted he wanted to commit suicide. He was so intoxicated that he was unable to pick himself up.

Due to the male being uncooperative and in immediate need of care and control, officers seek advice from an appropriate MH professional and decide to detain him under s136 MHA. The police request an ambulance and escort the male with the ambulance, to the nearest A&E department and the A&E s136 pathway is followed. While being treated for the alcohol ingestion and head injury, police remain with the male until it is appropriate for a MH assessment to be undertaken by s12 doctor and AMHP.

5. Intoxicated and behaviourally disordered with a mental health disorder

Police are called to the High Street to an intoxicated male shouting and swearing, kicking

shop windows and turning over bins. On arrival of police, the male is in a distressed state, stating that he is unable to stop the voices in his head and that he knew he was entering a mental health crisis. He tells the officers that his medication is not working, so he relies on alcohol to ease his suffering. Police officers seek advice from an appropriate MH professional and discover that he is well known to mental health services and is currently under the care of a Community Mental Health Team. The male continues to act in a distressed manner and continually bashes his head in attempts to stop the voices. Officers decide to detain under s136 MHA and request an ambulance to convey to a health based place of safety, where it will be determined by the HBPoS staff if the man is able to be assessed dependent upon his level of intoxication. If he is incapable of being assessed he will be transferred to the nearest A&E and the s136 pathway for A&E to be followed, unless the HBPoS decide to let him remain there until he has sobered up enough to have a MH assessment carried out.

6. Intoxicated, behaviourally disordered with a mental health disorder but arrested (minor offence)

Police are called to the High Street to an intoxicated male shouting and swearing, kicking shop windows and turning over bins. On arrival of police, the male is pointed out by passers-by as being responsible for smashing a shop window. Officers decide to arrest the male for criminal damage.

While waiting for a police van, the male tries to self-harm by banging his head on the floor and begins to struggle violently in attempts to inflict self-harm. The male shouts that he wishes to kill himself and is constantly hearing voices.

Consideration should be given, where the offending is low level, possibly 'victimless' and/or where the behaviour is most likely to be related to their mental health condition, to the investigation being paused for the purpose of the mental health assessment under Section 136. The investigation may be revisited after an assessment, especially if an officer's initial concerns about a person's mental ill health are not supported by medical opinion.

The officers seek advice from an appropriate MH professional and the male is identified as having an extensive mental health history. Officers choose to detain under s136 MHA and decide to request an ambulance to convey him to a health based place of safety.

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Appendix 9: Physical Healthcare Competencies for staff in s136 Suite

Description

*M refers to a medically qualified doctor

- Able to complete, document and act upon basic physical observations (pulse, temperature, blood pressure, heart rate, capillary glucose levels). Be aware of cut offs indicating an abnormality and be able to respond appropriately to these in accordance with NEWS/ MEWS chart monitoring and escalation protocols.

- Trained and competent in delivery of intermediate life support including appropriate use of a defibrillator.

- Able to assess for the requirement of rapid tranquilisation and initiate treatment if required. (M)

- Able to safely and appropriately monitor individuals according to protocol after the administration of medications for rapid tranquilisation.

- Trained and be competent in early identification and management of the deteriorating patient. Be familiar with the presentation and acute management of infection, physical trauma, shortness of breath, chest pain, lowering of consciousness and aware of the need for rapid response and referral.

- Able to provide emergency assessment, support, interventions and referral in the event of a seizure. Aware of the risks associated with acute withdrawal or intoxication in respect of both physical and mental health.

- Be able to identify early signs of withdrawal and initiate appropriate treatment.

- Able to assess shortness of breath including measurement of peak flow, respiratory rate and be able to administer acute medications for shortness of breath including inhaler, nebuliser and oxygen.

- Able to assess hydration through history and basic physical observations and monitor ongoing fluid intake and output including response to oral fluids.

- Able to assess, complete and evaluate documentation regarding food and fluid

intake and output and be able to respond appropriately and in a timely way to findings.

- Aware of the risk of deterioration in suspected infection and the importance of fluid management and rapid administration of antibiotics if prescribed.

- Able to conduct a risk assessment for deep vein thrombosis and escalate as appropriate.

- Aware of and be able to assess for hyper or hypoglycaemia.

- Able to summarise and communicate acute physical health presentation including relevant investigations in a clear, structured and efficient manner to other health professionals.

- Able to provide acute emergency treatment for hyper or hypoglycaemia and refer onwards as appropriate.

- Able to perform an ECG and understand and act upon required governance protocols surrounding conducting medical investigations by ensuring an appropriately qualified professional is shown, interprets and as appropriate acts upon the ECG.

- Able to interpret an ECG and refer onwards for more specialist advice as appropriate. (M)

- Trained in phlebotomy and be able to safely take bloods. Be aware of governance protocols surrounding conducting medical investigations and ensuring an appropriately qualified professional is alerted that bloods have been taken and assumes responsibility for following up and acting on results.

- Able to interpret and act upon abnormalities in routinely conducted blood tests. (M)

Appendix 10: Measurements to be monitored by the local multi-agency group

- Percentage/number of occasions where the police conveyed to the place of safety with no paper record for s136 / under the Mental Capacity Act (instead of s136).
- Number of occasions when someone detained under s136 was refused access to the HBPoS for whatever reason or when police have to wait longer than 15 minutes to gain access to HBPoS (e.g. no space, condition of patient).
- Percentage/number of occasions when the HBPoS is full to capacity and Police/SECAmb are forced to convey elsewhere (including A&E).
- Percentage/number of occasions where the police did not phone in advance before arriving at the HBPoS.
- Percentage/number of occasions where the police were unable to get through to the HBPoS prior to arriving at the site.
- Percentage/number of occasion's police conveyed the patient to the HBPoS without SECAmb.
- Percentage/number of occasions that more than four hours elapsed before the assessment began other than where agreed on clinical grounds.
- Percentage/number of occasions where the HBPoS transferred patients to A&E for physical health treatment.
- Percentage/number of occasions where the HBPoS was closed due to staff shortages and Police / SECAmb are forced to wait or convey elsewhere.
- Percentage/number of occasions where a police cell was used for adults.
- Percentage/number of occasions where police had to remain for over an hour before HBPoS staff were able to take over.
- Percentage/number of occasions where children and young people are not seen by someone with the required competencies to work with young people under 18 years and the time of day that this occurred.
- Percentage/number of occasions where those detained under s136 were further detained under the Mental Health Act.

Appendix 11: Patient Information Leaflet s136

Patient Information **S136**

ADMISSION OF MENTALLY DISORDERED PERSONS FOUND IN A PUBLIC PLACE

(Section 136 of the Mental Health Act 1983)

1. Patient's name	
2. Name of hospital and ward	

Why am I in hospital?

You have been brought to this hospital by a police officer because they are concerned that you may have a mental disorder and should be seen by a mental health professional.

You are being kept here under section 136 of the Mental Health Act 1983 so that you can be assessed to see if you need treatment.

How long will I be here?

You can be kept here (or in another place where you will be safe, known as a Place of Safety) for up to 24 hours so that you can be seen by a doctor and an approved mental health professional.

The maximum period of detention of 24 hours can be extended by up to a further 12 hours to a maximum of 36 hours because of the person's condition (physical or mental) which means it is not practicable to complete a Mental Health Act assessment within the 24 hour period

An approved mental health professional is someone who has been specially trained to help decide whether people need to kept in hospital.

If the doctor and the approved mental health professional agree that you need to remain in hospital, a second doctor may be asked to see you to confirm their decision.

During this time you must not leave unless you are told that you may. If you try to go, the staff can stop you, and if you leave you can be brought back.

If the doctors and the approved mental health professional have not seen you by the end of the 24 hours (or 36 if this is extended), you will be free to leave. You may decide to stay on as a voluntary patient. But if you do want to leave, please talk to a member of staff first.

Appendix 12: Acknowledgements

1. Mental Health Crisis Care for Londoners
2. Mental Health Network NHS Confederation (2016) Is mental health crisis care in crisis?
3. Jacquie Pryke (Author), Commissioning Manager for Mental Health West Kent CCG
4. Task and Finish Group
5. South East Kent Ambulance Service
6. Kent Police Force
7. Kent and Medway CCGs
8. Service User Representatives for Kent and Medway
9. Kent County Council
10. Kent and Medway Partnership Trust
11. North East London Foundation Trust
12. Emergency Department Leads from Maidstone and Tunbridge Wells, Medway, Dartford and East Kent Acute Trusts
13. Oxleas NHS Trust
14. Care Quality Commission (2015) Right here, right now: Mental Health Crisis Care Review
15. Care Quality Commission: A safer place to be (2014)
16. College of Policing Mental Health Authorised Professional Practice (APP).
17. Department of Health and Home Office guidance for the implementation of changes to police powers and places of safety provision in the Mental Health Act 1983.
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NHS
Ashford
Clinical Commissioning Group

NHS
Canterbury and Coastal
Clinical Commissioning Group

NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

NHS
Medway
Clinical Commissioning Group

NHS
Swale
Clinical Commissioning Group

NHS
Thanet
Clinical Commissioning Group

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South Kent Coast
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West Kent
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