



**Healthy London  
Partnership**

# **Mental Health Liaison Workshop**

UEC Improvement Collaborative Event  
The Kia Oval, 07 December 2017

**Neil Brimblecombe** - Chair (co MH Clinical Lead UECC)

**Barbara Cleaver** - Consultant in Emergency Medicine (co MH Clinical Lead UECC)

**Sean Cross** - Consultant Liaison Psychiatrist

**Simon Foster** - independent legal consultant

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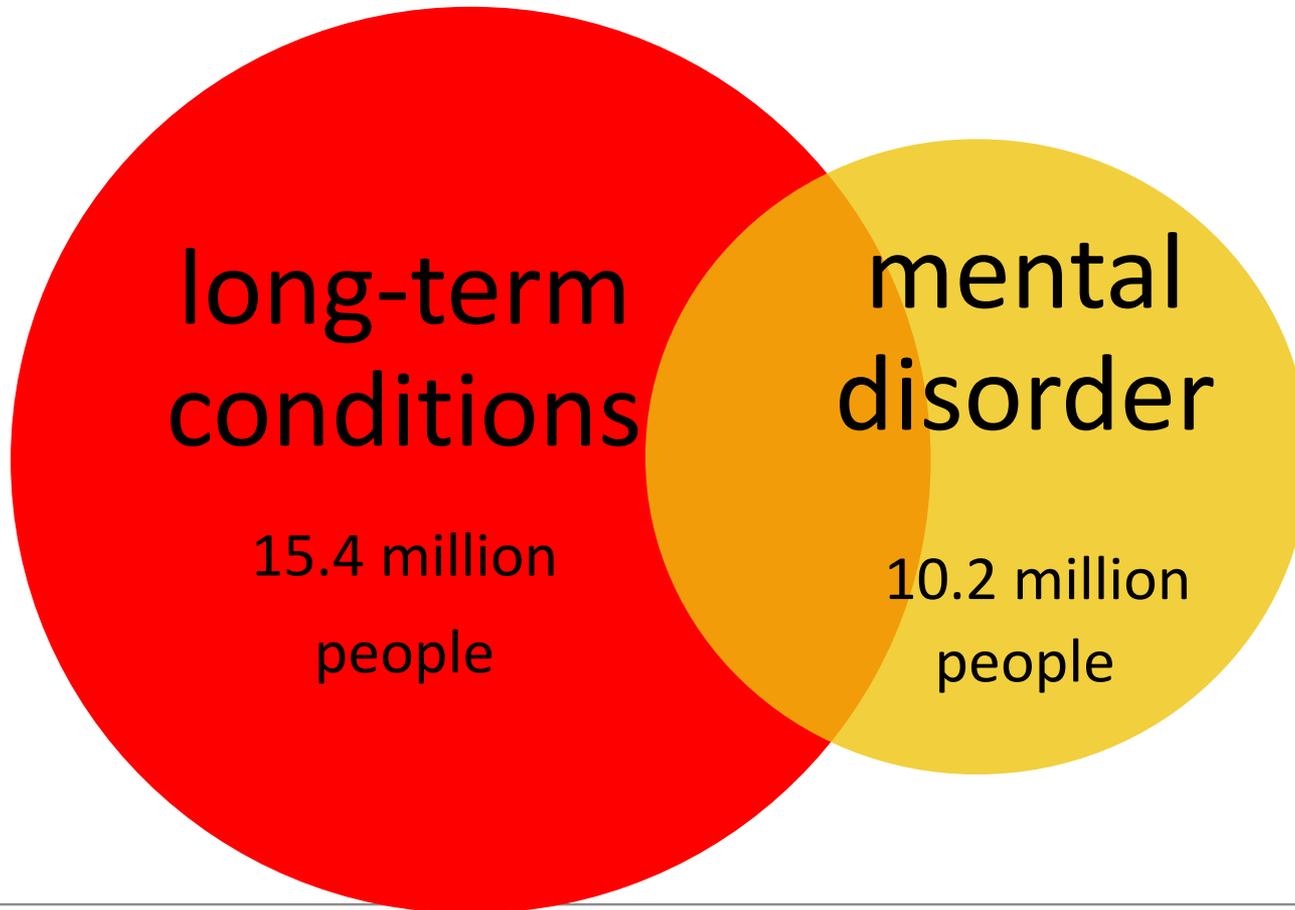
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London's NHS organisations include all of London's CCGs, NHS England and Health Education England

# LTCs and MH disorders

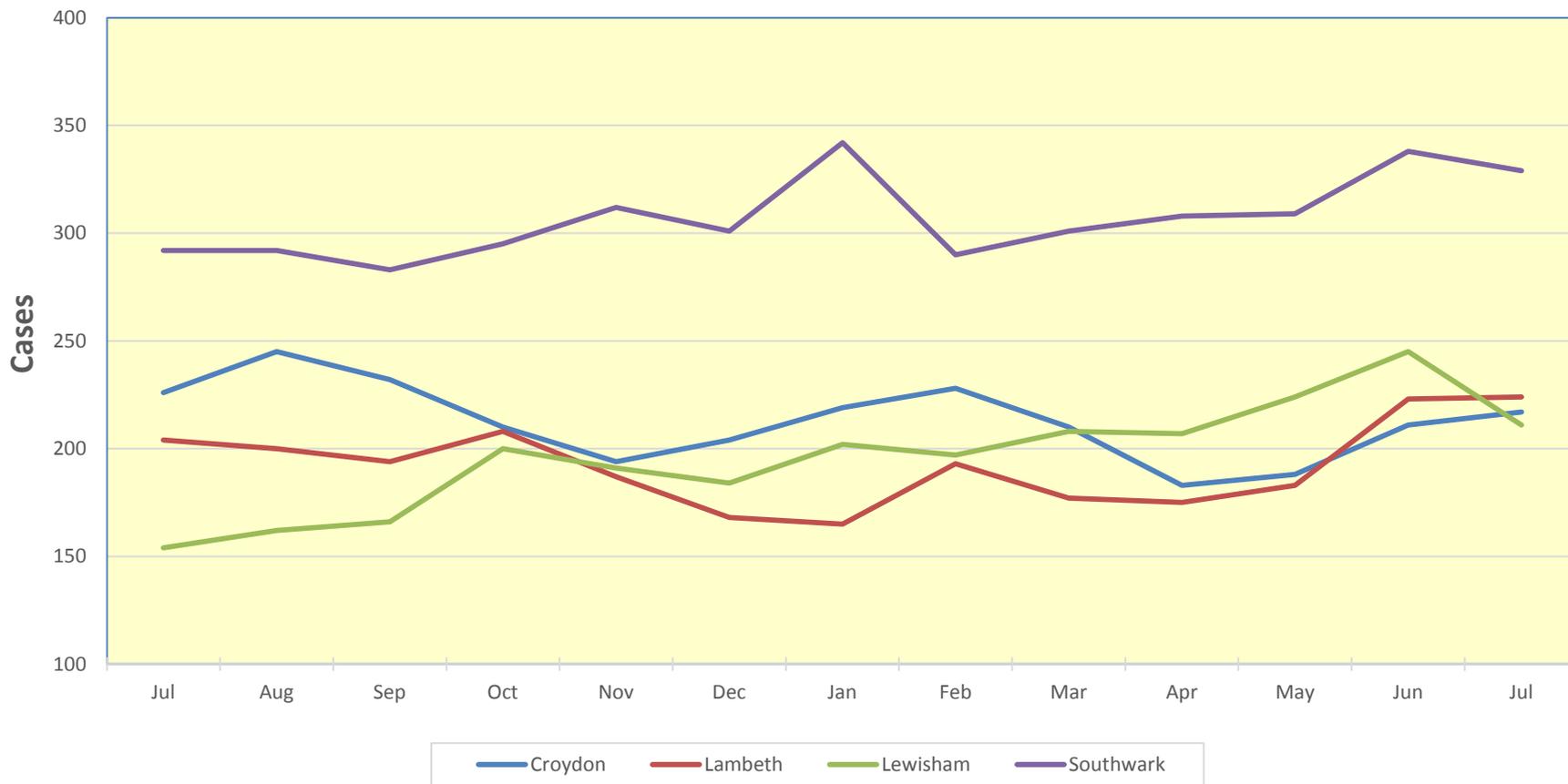
30% with LTC have mental health problems and 46% with mental illness have at least one LTC.

Source: Naylor C, Parsonage M, McDaid D et al. Long term conditions and mental health 2012



# SLaM MHLT EDs

## Liaison ED Referrals 12 month rolling



# London snapshot audits

- 90,000 ambulances dispatched for MH reasons each year in London
- 19% increase in Section 136 detentions from 15/16 to 16/17
- Wait times in 15/16 Northwick Park:
  - 36% waiting more than 12 hours
  - 32% were waiting between 8 and 12 hours
  - 32% were waiting less than 8 hours
- 82% increase in U18s from 2013-16 in 3 year period in south London at King's College Hospital

# Current expansion in liaison psychiatry



THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

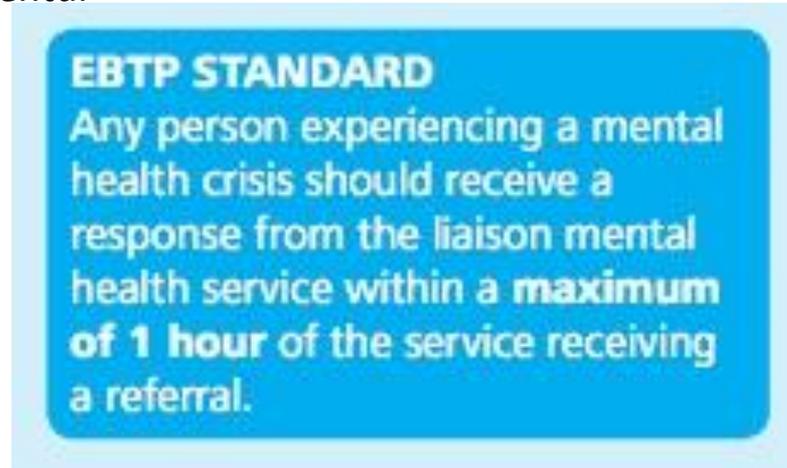
£249m new funding over 4 years from 2017/18 to expand liaison mental health in acute general hospitals



“By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum.”

*“My physical and mental health needs should not be seen as separate from each other and I receive effective care for both in a general hospital setting”*

- “When I experience a mental health crisis in an emergency department or on a general hospital ward, I receive a timely and compassionate response from trained and competent professionals in liaison mental health”*



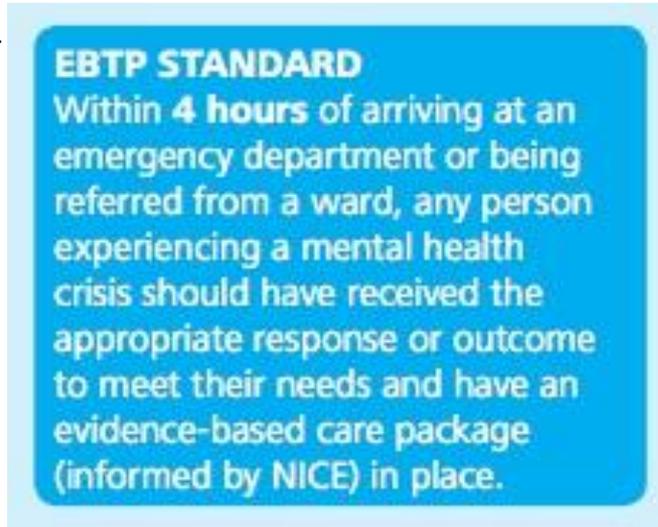
*“If I am an older adult I will receive specialist support from a team skilled in working with older people. I am treated with kindness, compassion and dignity and in accordance with my legal rights”*

*“When I visit hospital experiencing a mental health crisis and I require help and support, this is treated with as much urgency and respect as a physical health emergency and I am able to get a response no matter what time of the day it is, or which day of the week”*

- *“Within one hour of a liaison mental health service being contacted, I have received a response and know that help is on its way”*

*“When I am on a general hospital ward and require an urgent response from a liaison mental health service, I receive a full assessment within 24 hours”*

*“Within four hours of arriving in an emergency department or being referred from a ward, I receive a response and support that meets my needs”*



## Depending on my situation

- ***I have had a full assessment of my physical, psychological and social needs, and an urgent and emergency care plan is in place, and***
- ***I am on my way to another service or location, if needed, or I have been accepted for follow-up care by another service***

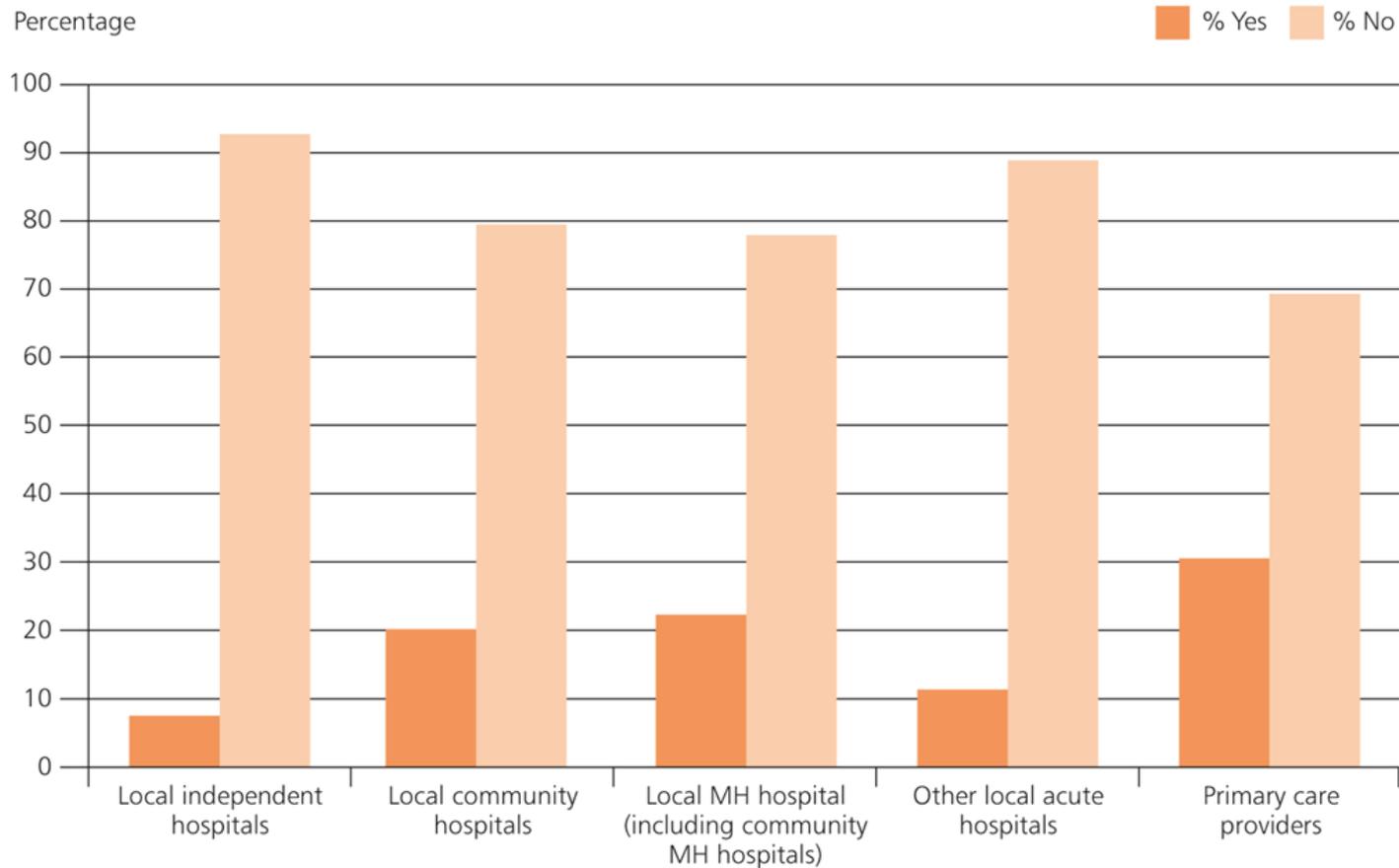
**OR**

- ***I have started assessment under the Mental Health Act***

**OR**

- ***If I feel better within four hours, I can go home.***

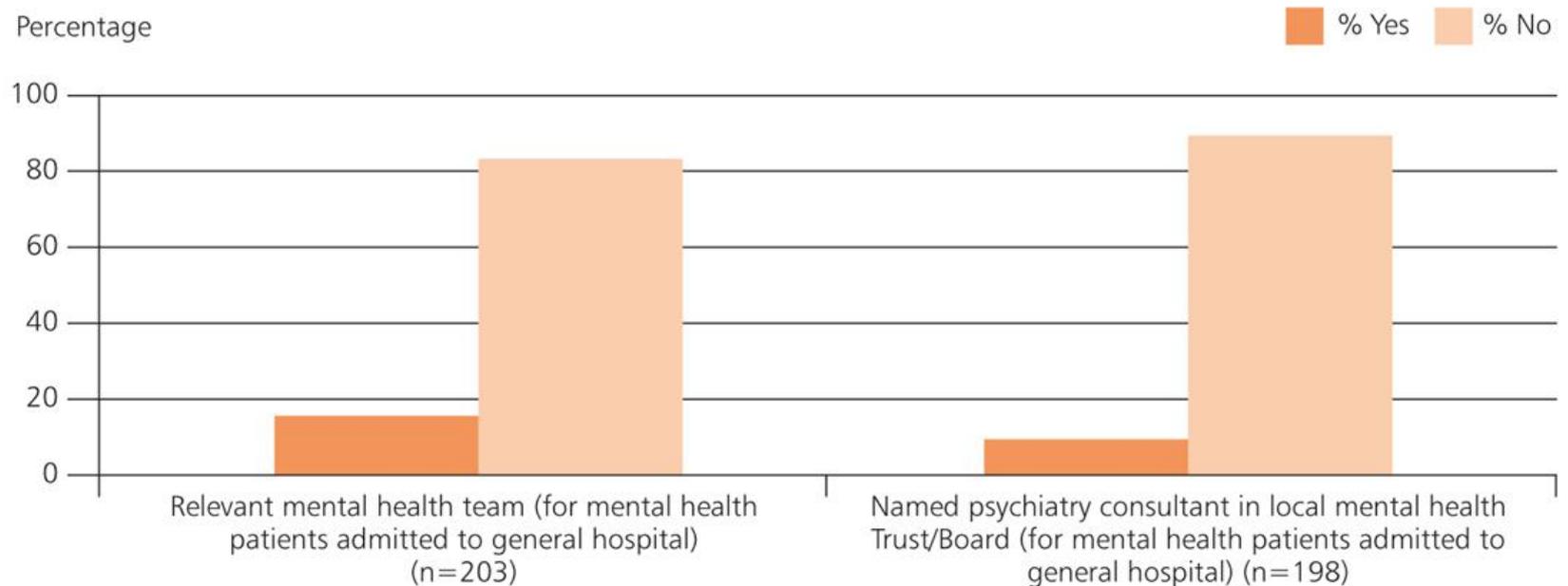
# Clinical record sharing



**Figure 7.2 Ability to share clinical records with different providers**

*n* = 231, Subtotals: Local independent hospitals = 195; Local community hospitals = 195;  
Local mental health hospitals (including community mental health) = 196;  
Other local acute hospitals = 192; Primary care providers = 190

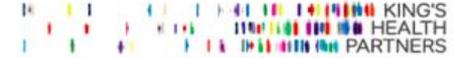
# Discharge summaries copied to community



**Figure 7.3 Discharge summary routinely copied to the relevant mental health team/named psychiatry consultant in the local mental health Trust/Health Board**

# Education, education, Education ...

- Continuing Professional Development
- CEPNs
- Postgraduate Training Schemes
- Undergraduate curriculums



An Academic Health Sciences Centre for London

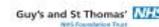
Pioneering better health for all

## Mind & Body (Education): Striving for excellence in KHP

Dr Sean Cross, Chris Attoe



On behalf of the King's Health Partners' **Mind & Body Programme Board**  
Supported by the Education Academy's **Mind & Body (Education) Committee**



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## **Section 136 MHA 1983: The new law**

Simon Foster, Independent Legal Consultant

# Amended s136 of Mental Health Act 1983

## From 11 December 2017, s.136 MHA will read as follows:

(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.

“for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an AMHP, and of making **any necessary arrangements** for his treatment or care.”

- s.136(1C): this says that, **before** using s136, the constable **must**, if practicable to do so, consult a nurse, a doctor, an AMHP, an OT or a paramedic]

*‘Practicable’ = ‘realistic in the circumstances’ – e.g. may not be feasible if problems with getting through, patient is violent, etc*

- Police need to know who to contact - shouldn't be ED staff
- What arrangements are in place locally for this consultation?

# A “place of safety”

## Defined in s.135(6) as:

- residential accommodation provided by a local authority under the Care Act;
- a **hospital**: this is the default PoS. Should usually use a locally-designated ‘health-based place of safety’ (HBPoS- the ‘136 suite’), but can be an inpatient ward or A & E;
- a police station [*in very limited circumstances*];
- an independent hospital or care home for mentally disordered persons; or
- Any other suitable place, if the person responsible for its management agrees; and
- A private residence, provided (i) the patient agrees, (ii) if co-occupiers, at least one of them agrees too.

## New timescales

S.136(b): A person removed to a place of safety may be detained there for 'the permitted period'

In most cases, this is a period not exceeding **24 hours** from the time the person arrives at the place of safety

Govt Guidance, November 2017: time starts **when the individual goes through the door of the first place of safety** (so NOT when staff receive them, or when the paperwork is handed over)

- If person is taken first to ED: time of arrival **MUST** be recorded, to avoid disputes



# Extending time

- The 24 hours can be extended at any time before the end of the initial 24 hour period, by up to 12 hours (**only**), and only by the doctor carrying out the **mental health** examination
- *Law doesn't specify what level of doctor does the mental health examination- Code suggests should be s.12 approved, but it's not mandatory- but it cannot be a trainee*
- New s136B: (The extension can be granted) “**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 136 to be carried out before the end of the period of 24 hours”
- COULD extend if person is intoxicated, in physical pain etc, **and** you can't realistically complete the exam in time
- CANNOT extend when the MH exam has been completed and you are just waiting for a bed to be found for the person

# Clinical responsibility & legal accountability

Someone detained under s136 MHA is in legal custody.

This means there are two accountabilities for them:

1. Who is responsible for their clinical treatment & care?
2. Who is legally responsible for the custody i.e. stopping them absconding?- The same person or someone else?

Problems arise when these accountabilities get blurred (see e.g. *Webley v SW London & St George's MH Trust*, 2014)

At any given time it must be clear who is responsible for the custody of the person on s136, as well as who has clinical responsibility

This is particularly important when person is at A & E: have nursing staff taken over custody, or is it still with police?



## Possible outcomes following assessment

1. Doctor concludes that patient has no underlying mental disorder *of any kind*- they were just drunk, or high, or had a fever which has been brought under control. In this case they are no longer within the scope of the MHA and **must** be sent home at the earliest opportunity, even if the AMHP has not yet seen them. S136 is discharged by doctor at PoS.
2. Person **does** have an underlying mental disorder, & may be known to community mental health services, but does not need hospital admission. The AMHP **must** interview them & agree what (if anything) they need- community referral, call to care co-ordinator, referral for Care Act assessment? It is **unlawful** to send patient home without AMHP seeing them.

S136 is discharged when AMHP & PoS are satisfied that suitable arrangements are made (this could be done by phone). NB Person can continue to be detained *up to the full 24 hours while this is being done*, if it can be justified, to protect themselves or someone else from risk of harm.

## Possible outcomes following assessment (cont)

3. Person has mental disorder and needs hospital admission. If they have capacity- i.e. they understand the full implications of going into psychiatric hospital- they could be admitted 'informally' with their consent. NB *They can be kept under s136 till arrangements are in place-* so could be restrained if getting agitated while waiting for ambulance etc. (Good idea NOT to end the s136 till they leave PoS.)
4. Person needs hospital admission, but lacks capacity to consent. If they are completely compliant with admission, and unlikely to resist treatment, they could be brought in under the MCA 2005. If they are to be kept there, hospital **must** apply for DOLS authorisation. (*Used more often with older adults than with those of working age.*) Again, s136 can be kept in force till person is on their way to hospital.



## Possible outcomes following assessment (cont)

5. Person needs hospital admission but is resistant, or a significant degree of control is likely to be needed. If AMHP has (normally)\* two 'medical recommendations', one from a s.12 doctor, s/he can apply for MHA admission, under
- s2, which allows inpatient assessment **and** treatment- or
  - s3, if the treatment plan is already established.

A '**duly completed**' application gives the AMHP the legal authority to restrain the person and to convey them to hospital, using proportionate force. They can delegate this authority to anyone else who is willing to accept it: police, ambulance, even family. (See ss6(1) & 137(2) MHA.)

**'Duly completed' = with a named hospital which will accept the patient (and should have a *bed* for them).**

*\*(S4 MHA allows urgent admission for 72 hours with only one med rec)*

# Admission beds problem

- In most parts of London- and of the country- there is a scarcity of psychiatric admission beds.
- Usually the person can be assessed by the doctor and AMHP well within the 24 hours, but then they have to wait in the PoS till a hospital can be found which will accept them.
- Until the hospital is identified, the s2 or s3 admission papers- which authorise further detention- **cannot be completed**
- If no hospital has accepted the patient after 24 hours have elapsed (& an extension cannot be justified), s136 ends & person can **leave**
- If **high risk**: what is *legal basis* for restraining them further?
- It's **hospital staff** who decide whether justified under common law (or MCA?)- needs a protocol and/or access to advice



## About the presenter

**Simon Foster** is a freelance legal consultant and trainer, who provided legal advice to the Healthy London Partnership mental health crisis care programme during the preparation of the 'London's s136 Pathway' guidance.

A former local authority solicitor, Simon was previously head of the legal unit at Mind. From 2011-12 he was interim Head of Legal Support Services at Sense, the deafblind charity. Simon has also taught incapacity law at Queen Mary University of London, and social care law to DipSW students at Middlesex and South Bank Universities. In 2005 he helped draft a new Code of Practice for the Department of Health.