



**Healthy London
Partnership**

Mental Health Crisis Care Toolkit

Resources to support the quality and consistency of mental health crisis care services across London

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This resource pack has been developed to support London's mental health crisis care system in providing high quality and consistent care across the capital.

It includes training materials from sessions delivered to almost 300 multi-agency staff across the capital in 2017 to support local systems in preparing for the changes to the Mental Health Act and to align local policies to the pan-London s136 pathway. Also included are roles and responsibility briefings for staff along the s136 pathway, which summarise the key points from London's s136 pathway guidance.

Lastly, a handover form for voluntary mental health crisis patients has been included to support the safe handover of voluntary patients brought into A&E by the police. This form has been piloted to great success at four A&Es in London and has now been approved by London's Urgent and Emergency Care Transformation and Delivery Board to be rolled out across the capital. All three of London's police forces will start to use this form from mid-January 2018.

01

Training slides on the 2017 changes to the MHA legislation and London's s136 pathway

S.136 Mental Health Act 1983 as amended

On the 11th of December 2017, significant amendments came into force altering the Section 136 (s136) power of the police to detain people who appear to be suffering from mental disorder.

The section now reads 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**, or

(b) if the person is already at a place of safety, 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 & to be interviewed by an AMHP, and of making **any necessary arrangements** for his treatment or care.

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

Where the s136 power can be used

Before the changes in legislation, the s136 power could only be used if the person was 'found in a place to which the public have access', i.e. you don't need permission to be there, this included somewhere where you pay for entry (e.g. a cinema) and somewhere open at specified times (e.g. a pub).

As the 11th of December 2017:

- **the power may be used *anywhere except 'a house, flat or room in which the patient, or someone else, is living'*** - which expressly includes private gardens, private outhouses, etc- the person can only be removed from these places under a warrant (e.g. s.135(1) MHA)
- It is for the police officer to decide whether a place is a 'house, flat or room,' and whether a person is 'living' there

The people

Roles included in the legislation are outlined below, along with a brief definition:

- **“Constable”**: means any warranted police officer. It is that officer’s decision whether to use the s.136 power
- **“Registered medical practitioner”**: can be any doctor, but the MHA Code of Practice suggests that this should be one who has been approved under section 12(2) MHA as having expertise in mental disorder (known as a ‘s12 doctor’)
- **“Approved mental health professional”**: a social worker, nurse, OT or psychologist who has had specialist training. Each AMHP is warranted by a particular Borough or County. Under the MHA, it is the Borough where the person is at the time the assessment is required which has to provide an AMHP (unless an AMHP from their ‘home’ area agrees to do it).
- NB It is the AMHP who ultimately agrees that the person needs to be admitted to hospital- but *the AMHP does not find the hospital which has a bed for them*. This is done in practice by Bed Managers on behalf of the Mental Health Trust.

A “place of safety” under the new legislation

A place of safety is defined in s.135(6) & (7) as:

- residential accommodation provided by a local authority under the Care Act;
- a **hospital**: this is usually the designated ‘health-based place of safety’ (HBPoS- the ‘136 suite’ etc), but can be an inpatient ward, if staff agree- and can be **any hospital**, not just psychiatric hospitals);
- a police station, in very limited circumstances (imminent risk of death or serious injury), and never for under-18s;
- an independent hospital or care home for mentally disordered persons; or
- Any other suitable place. This can include a private home, but only if the person agrees and, if they do not live there alone, at least one of the co-occupiers also agrees.

New timescales

The changes in legislation also brought **new timescales for a s136 detention into force:**

- 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
- Government Guidance, November 2017: **time starts when the individual goes through the door of the first place of safety** (NOT when staff receive them, or when the paperwork is handed over)
- If person is taken first to A&E: time of arrival **MUST** be recorded, to avoid disputes
- 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
- **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* the exam cannot realistically be completed in time
- **CANNOT extend** when the MH exam has been completed and you are now 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:
 - Who is **responsible for their *clinical* treatment & care**?
 - 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*

How the system is supposed to work

- Police are called to **someone who appears to them to be mentally distressed**, and who is *not* in a private residence.
- Police might arrest for a criminal offence- in which case the person goes to the police station in the usual way. Or:
- Officers decide the person needs immediate care and control. After consulting designated mental health professional for advice on care options, they may **arrest under s136 MHA**.
- Officers phone the nearest appropriate HBPoS, who confirm they have space- if not, they advise where the person should be taken. HBPoS contacts the duty AMHP & on-call doctor.
- If person needs immediate medical attention, can be taken to A&E en route. Police will normally sit with them till they are cleared to go on to HBPoS (*or could be assessed at A&E*)
- Person is assessed by doctor & AMHP & decision made as to what happens next, **within 24 hours of arrival** at PoS.

Possible outcomes following assessment (1-5)

The five possible outcomes of a s136 assessment are outlined below:

1. Person is found to have **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 the person is 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 ended by suitably trained 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 & decide what (if anything) they need- community referral, call to care co-ordinator, referral for Care Act assessment?

S136 is ended once AMHP and PoS staff are satisfied that suitable arrangements have been made (could be agreed 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 (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 can be admitted 'informally' with their consent. NB They are *still under s136 till it is formally ended*, so can be restrained if getting agitated while waiting for ambulance etc.
- 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 (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' = naming the hospital which will accept the patient (CQC: must have a bed for them).

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

Some problems with the use of s136

Across London, some common problems have been identified related to the use of s136:

- **Shortage of adequate health-based places of safety:** police often wait outside the PoS until the person can be received
- 75% of s136 detentions happen out of hours, but **HBPoS sites are often not staffed 24/7**
- **Use of A&E as a PoS:** falls within the definition of 'hospital' so person can be assessed there by e.g. psychiatric liaison, but often not geared up for psychiatric assessments, and lack of clarity about the *detention* aspect
- **Lack of co-ordination** between the PoS, the doctor who carries out the examination, the AMHP who **must** normally see the person, and the ambulance service which is needed to take person to hospital
- Most problematic: **shortage of beds for admission.**

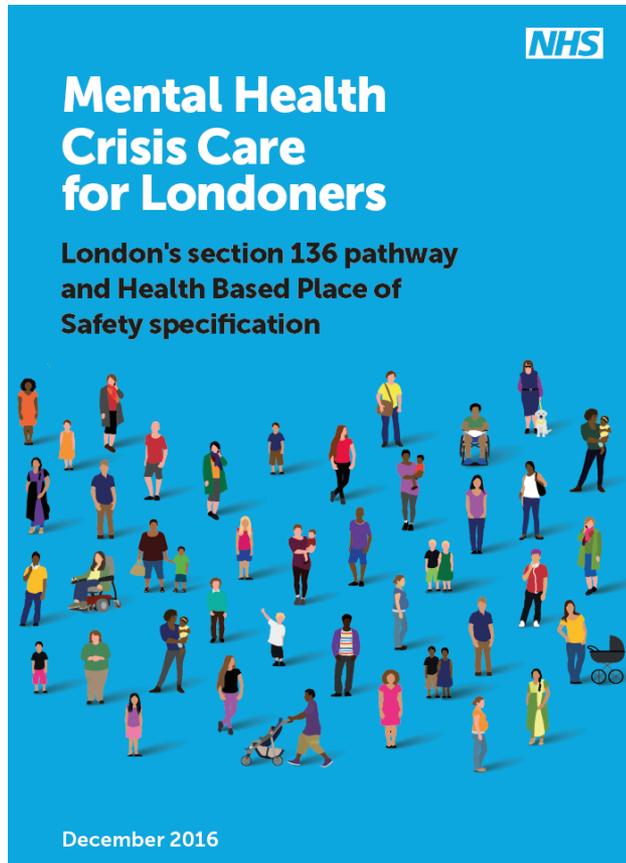
Shortage of inpatient beds / 24 hour timescale

- 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**. This is out of the hands of the AMHP, and of PoS staff.
- Until the hospital is identified, the s2 or s3 admission papers- which authorise further detention- **cannot be completed**
- If no bed has been found after 24 hours have elapsed (and extension cannot be justified), s136 ends and **the individual can leave**
- If **high risk**: what is *legal basis* for restraining them further?
- In exceptional circumstances, if the individual represents a clear and immediate risk to themselves or to someone else, **staff may be able to justify a further, very brief, period of restraint under common law** while appropriate arrangements are being made, but it should be noted that the necessity for this may be challenged.
- In some cases restraint **may also 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 possible to prevent this turning into an unauthorised deprivation of liberty.
- It is the PoS staff who decide whether it is justified to use common law, or in some cases the MCA. **A protocol is needed locally between the mental health and acute trusts to clearly outline the circumstances under which these powers should be used by staff.**
- **Trusts must seek their own legal advice to guide this process and ensure any detention is carried out within the parameters of the law.**

London's s136 pathway & HBPoS specification

Launched 12 December 2016

Endorsed by:



 Sadiq Khan @SadiqKhan · Dec 12

Today I've launched a new set of standards to improve mental health crisis care across London:

 HealthyLDN

Key principles of the s136 pathway (1)

The key principles of the s136 pathway guidance are outlined below:

- If there is no capacity at the local HBPoS, it is that **site's responsibility to ensure that the person is received into a suitable PoS**, through escalation or other arrangements
- Exceptionally, when a person with no physical health needs is taken to A&E as the PoS (because of capacity issues), that **A&E cannot refuse admission unless formal escalation action has been enacted**.
- Someone appearing drunk and showing any aspect of incapability (walking, standing), they **must be treated as drunk and incapable, and treated as in need of medical assistance** by A&E (or alcohol recovery services if available)
- If *protracted* physical health treatment/care is required, **A&E should accept the s136 papers and take legal responsibility for custody** while mental health assessment is carried out
- Every HBPoS should have a designated s136 co-ordinator available 24/7 who is assigned to the HBPoS at all times. **Adequate, dedicated clinical staff must be available 24/7** to ensure staff members do not come off inpatient wards.
- HBPoS staff (both nursing and medical) should have **adequate physical health competencies** to prevent unnecessary A & E referrals.
- **HBPoS & Acute Trusts should have clear pathways and protocols** and the relationships to deliver these for those with physical health problems, but for whom urgent transfer to A & E is not the optimum course of action- including triage, advice, outreach (where possible) to support appropriate responsive & timely physical health care to those in a HBPoS.

Key principles of the s136 pathway (2)

- While a police officer or AMHP has the legal responsibility for authorising the transfer of the detained individual, co-ordinating the conveyance of individuals between HBPoS and A & E departments and vice versa should be undertaken by the Mental Health Trusts and Acute Trusts respectively, led by the s136 co-ordinator. **Co-ordinating and arranging transport is *not the police's role*** unless there is mutual agreement between the parties that it is in the best interest of the person & there is resource to provide support.
- **Legal duty to assess falls upon the AMHP for the area where the person is**, at the point when the assessment is needed, in this case the borough where they are detained under s136.
- **Mental health assessment must be completed within 4 hours** of the person arriving at the HBPoS unless there are clinical grounds for delay.

Some implementation questions

The questions below have been developed to support local implementation. They outline some key issues that should be considered:

- Is it clear locally who the **'health professional'** is who is consulted by police? Is their number available to police?
- Is it clear who is the **s136 co-ordinator** for the local HBPoS? Who covers the role when the lead person is not in?
- **If the HBPoS is full**, is it clear that HBPoS staff are responsible for finding an alternative place of safety where the person can be taken?
- **When will A&E locally accept the s136 papers** (and so accept legal responsibility for custody)? Is this agreed with police?
- Do **security staff** in A&E have suitable training?
- **Do HBPoS staff know what they can do and when**, if the 24 hours have elapsed, there is no bed yet and the person is high risk?
- **Conveying & transferring patients under s136**: do the Trusts, police and LAS have a clear understanding as to how this should be done?
- What about **conveying to hospital** when section papers are completed?

About the author

These training slides have been developed by Simon Foster

Simon 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.

02

Staff roles and responsibility briefings for the s136 pathway

Handover form for voluntary mental health crisis patients

- Alongside the training delivered across London, briefings outlining the roles and responsibilities of different staff groups along the s136 pathway were developed.
- These briefings summarise the key points from the s136 guidance for each staff group into a one page A3 poster briefing.
- Links to each briefing are included below:

HBPoS staff



Adobe Acrobat
Document

A&E staff



Adobe Acrobat
Document

Police



Adobe Acrobat
Document

London Ambulance Service



Adobe Acrobat
Document

03

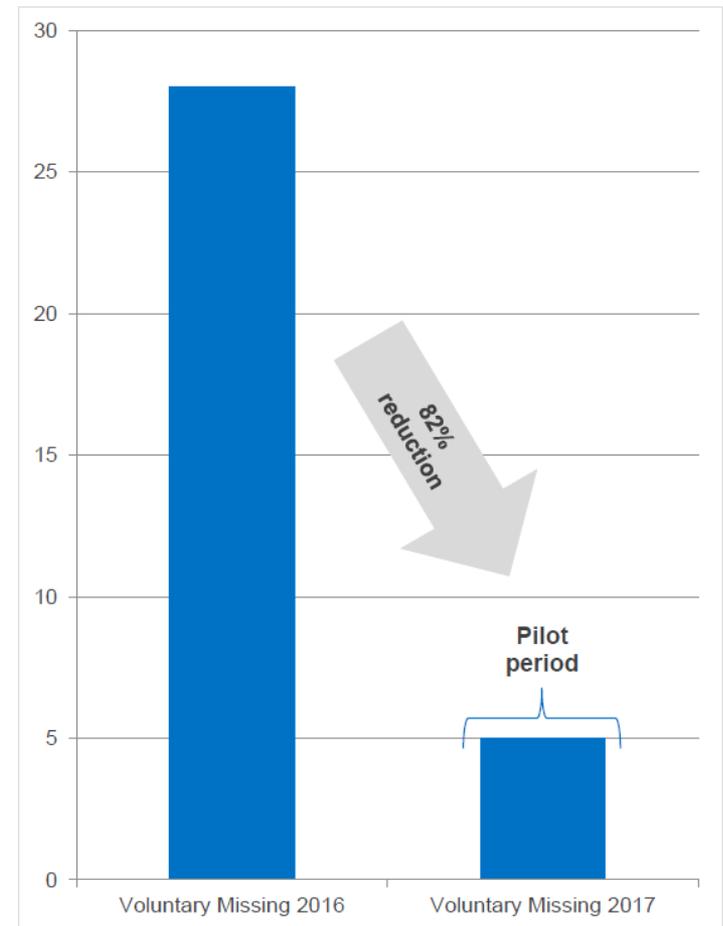
Voluntary Handover Form in A&E

Handover form for voluntary mental health crisis patients

- Earlier this year an independent investigation of a homicide case concerning a mentally ill patient absconding from A&E was finalised. There were many system learnings from this case (across both the NHS and Police) and specific recommendations targeting the Trusts involved and London's Urgent and Emergency Care (UEC) system.
- A key recommendation in the report was *'the need for a process by which the police and other emergency services are able to conduct, on arrival to the A&E department, an appropriate handover of the patient with appropriate health professionals regardless of the manner through which crisis mental health care is sought'*.
- It was therefore agreed by London's UEC Clinical Leadership Group and Met Police to pilot a handover form for police officers and A&E staff to use when the police present to an A&E department with a voluntary mental health crisis patient.
- The handover form aims to support A&E staff identify mental health patients brought in voluntarily by the police, improve information sharing and partnership working between the police and NHS staff and put in place a procedure to appropriately manage the attendance of vulnerable mental health patients to the department.
- The following A&E departments were involved in the pilot:
 - St Mary's Hospital
 - King's College Hospital
 - Homerton University Hospital
 - Lewisham Hospital

Handover form for voluntary mental health crisis patients

- During the pilot over 60 forms were completed across the four sites, this accounted for approximately 70% of occasions where officers attended the department with a voluntary mental health patient.
- Analysis found that reports of missing persons from Emergency Departments fell by 82% in 2017 in comparison to 2016 figures.
- Positive feedback has been received from all four pilot sites.
- Following the success of the pilot, the form has now been approved by London's Urgent and Emergency Care Transformation and Delivery Board to be **rolled out across London's A&E's**
- All three of London's police forces will start to use this form from mid-January 2018



Handover form for voluntary mental health crisis patients

The form can be downloaded by clicking the PDF icon



Adobe Acrobat Document

    		
Voluntary Mental Health Attendance at Hospital (Person Accompanied by Police)		
Section A - Patient Details		Merlin/NICHE Ref
Date:	Time of origin:	CAD/CW Ref:
Surname:		
Forename:		
Address:		
Gender:	Date of Birth:	Ethnicity description (not IC code):
PNC/Local checks completed: Yes <input type="checkbox"/> No <input type="checkbox"/>	Any medical treatment issued prior to arrival at hospital:	
Any medication taken? Yes <input type="checkbox"/> Unknown <input type="checkbox"/>	Has the patient taken any alcohol or illegal drugs Yes <input type="checkbox"/> Unknown <input type="checkbox"/>	
Details:	Details:	
How has the person confirmed that they wish to attend voluntarily?	Patient searched: Yes <input type="checkbox"/> No <input type="checkbox"/> (e.g. S1 FACE: If Yes provide details of items seized)	
Section B - Reason for voluntary attendance		
Circumstances: (use Vulnerability Assessment Framework (VAF) - Appearance, Behaviour, Communication, Danger, Environment)		
Known to NHS Mental Health Services?: Yes <input type="checkbox"/> Unknown <input type="checkbox"/>	Any suicidal thoughts or actions?: Yes <input type="checkbox"/> Unknown <input type="checkbox"/>	
Details:	(If yes, it may be necessary to consider detention under S130 Mental Health Act 1983 if in a place to which this section applies) Details:	
Registered to GP: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Police Supervisor informed (prior to officers leaving hosp):	
Details:	Name: Time:	
Section C - Police handover to hospital		
ED Dept:	Time police arrived:	Time Police arrived left:
Member of staff who received the handover:	Officer reporting:	
Name(print)	Name (print)	Rank /Div :
Role	MPS <input type="checkbox"/> COLP <input type="checkbox"/> BTP <input type="checkbox"/> Other <input type="checkbox"/>	
Signature:	Signature:	

- Police **MUST** keep original and upload copy onto Police Vulnerability system MERLIN/NICHE.
 - Completing Officer to send original to Police MH Lead or Divisional SPMH
 - EDs should take a copy for their records and store appropriately

For further information on this work or the wider mental health crisis care programme, please contact the programme team:

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