

Mental Health Crisis Care for Londoners

**London's section 136 pathway and Health
Based Place of Safety Specification**



The first edition of this guidance was published in December 2016. Following the implementation of changes to the legal framework for s136 introduced by the Policing & Crime Act 2017¹, the guidance has since been updated as was reissued in December 2017. A refresh of the operational guidance has been completed in February 2023 and in May 2024 however original context in relation to the data remains unchanged. A further refresh has been completed in September 2025 to include the custody pathway protocol.

Endorsed by



TOTAL POLICING



¹ [Policing and Crime Act 2017](#)

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Foreword



Dr. Emma Whicher

Medical Director, Southwest London and St George's Mental Health NHS Trust

Clinical lead of London's mental health crisis care programme

It is estimated that in any given year 1 in 4 Londoners will experience a diagnosable mental health condition. Mental ill health affects 13 Londoners on the busy bus in the morning, more than 100 Londoners on the tube on their way into work and three children in every school class. These staggering figures show we must work harder to prevent mental illness and provide a range of support for Londoners to access to prevent people reaching crisis point.

Unfortunately, Londoners are experiencing mental health crises in ever increasing numbers. The National Crisis Care Concordat, and more recently the Mental Health Five Year Forward View, has put the spotlight on crisis care to ensure there are high quality and co-ordinated crisis services available when people reach this point.

These challenges are well recognised in London, and it has been a privilege to work with partners across the system who have been passionate about improving care and ensuring the service user voice is at the heart of what underpins changes. Over 300 service users have been involved in these developments to ensure their expectations on dignity, respect and care are met and delivered in the right environment to facilitate recovery and together we have developed a pan-London Section 136 pathway and Health Based Place of Safety specification.

The key principles from the Crisis Care Concordat were the basis for this work and through extensive engagement with service users, clinical and operational colleagues and key partners - the Police, Local Authority and the voluntary sector - we understood what further guidance was needed in order to set the right standards of care for Londoners.

The next step is for London's crisis care system to carry the momentum created in

these developments through to implementation. The widespread collaboration that has got us to this stage needs to continue so we can overcome challenges together.

I'd like to thank everyone involved for coming together and reaching this point, the commitment that has been shown across all partners has been inspiring and I have every confidence that together we can make a real difference to the outcomes of our service users.



Dr. Marilyn Plant

GP, Richmond CCG

Clinical lead of London's mental health crisis care programme

Many Londoners receive timely, effective healthcare leading to positive patient outcomes and a healthy, vibrant population. Yet this is not true for all of our patients. London's mental health crisis care is an example of a system that is under immense pressure and Londoners are suffering because of it. Our patients and all partners involved realise that the status quo isn't good enough, changes need to be made and none of us can make this change alone, we need to make the change together.

Whilst there must be a focus on local action to prevent crises occurring, when a crisis does happen, we want our patients to have timely, high-quality care respecting individual needs. Service users have told us they want crisis care that is always available, consistent and respectful across all stages of the pathway. There are many cases that illustrate this support isn't available, resulting in the ED department being a regular default; people with mental health problems are three times more likely to attend ED and only half of community teams offer an adequate 24/7 crisis service - this is not a good enough response.

The number of different agencies and services increases the complexity across the crisis care system, but together we, as London, have worked hard to form a shared vision between Mental Health and Acute Trusts, Ambulance services, the Police and local authority to improve the care for London's most vulnerable patients. This programme has focused on the section 136 pathway and Health Based Place of Safety

sites, however, to improve crisis care we need to have a whole system approach focusing on prevention, early intervention and the wider urgent care pathway.

There have been significant changes across London's Urgent and Emergency Care system to improve care for those with emergency care needs which have largely focused on physical healthcare; it is now time to build on these successes and transform the care for those with mental health needs; progressing the government's stand on parity of esteem and the National Crisis Care Concordat principles.

It is recognised that this transformation won't happen overnight but with the commitment and collective effort shown in this work to date I am confident that the aspirations in the Better Health for London report, describing a pan-London multi-agency model of care for mental health patients in crisis, can be achieved.

I would like to thank all those that have contributed to the development of the pan-London section 136 pathway and Health Based Place of Safety specification; the engagement from service users, NHS organisations and our key partners has been pivotal to ensure this work is developed in collaboration, and that those facing a mental health crisis are placed at its centre.

Part 1: Overview

Introduction

Aim of this document

This guidance document is aimed at stakeholders involved in the section 136 (s136) pathway. Specifically, London's police forces, London Ambulance Service, Approved Mental Health Professionals and Acute and Mental Health Trusts. It outlines a consistent pathway of care across London and a minimum standard for Health Based Place of Safety sites.

Both the s136 pathway and Health Based Place of Safety specification focus on all ages and should be used together to improve consistency of care in London. This document should be used in addition to London mental health crisis commissioning standards and recommendations (2014), the Mental Health Act 1983: Code of Practice (2015) and core principles of the Mental Health Crisis Care Concordat and Future in Mind (2015).

The guidance covers 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 Health Based Place of Safety (including the Mental Health assessment and arranging follow up care).

What is section 136?

Section 136 of the Mental Health Act 1983 is the power that allows a police officer to detain someone they believe to be mentally disordered and in need of urgent care or control. Either finding or being directed towards a person with mental disorder 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 officer must think that removing the individual is necessary in the individual's interests or for the protection of others

- With effect from 11 December 2017, use of the s136 power is no longer limited to a 'public place' but may be exercised anywhere other than in a private dwelling (defined as 'any house, flat or room in which that person, or any other person, is living'). This includes any yard, garden, shed, etc which is associated with that dwelling, unless it is used communally with other dwellings.

Summary of the Section 136 power

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 they think it necessary to do so in the interests of that person or for the protection of other persons, remove the person to a place of safety, or, if they are already in a place of safety, keep them there.

The s136 power may be exercised by a constable 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.

For the purpose of exercising the s136 power, a constable may enter any place where the power may be exercised, if need be, by force.

A person removed to a place of safety under this section may be detained there for a period of up to 24 hours, for the purpose of enabling an assessment by a registered medical practitioner and interview by an approved mental health professional, and to make any necessary arrangements for their treatment or care.

The doctor carrying out the mental health assessment can extend the 24-hour period to a maximum of 36 hours, for the purpose of completing their assessment (and not for other reasons – see section 2.20 below).

Before using the s136 power the constable must, if it is practicable (= realistic) to do so, consult a health professional (see section 1.1 below).

The police have an express power to search the person at any time during the s136 detention if they have reasonable grounds for believing that the person may present a danger to themselves or to someone else, and that they are concealing on their person an item which could be used to cause physical injury to themselves or to others, including in their mouth.

What is a place of safety?

A 'Place of Safety' is used when an individual of any age has been detained under s135 or s136 of the Mental Health Act 1983. In law, the place of safety to which the person is taken can be residential accommodation provided by the Local Social Services Authority, a hospital as defined in the Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place where the occupier is willing to temporarily receive the person: see s135(6) of the Mental Health Act.

This can include the place where someone is living - if it is agreed to be suitable-provided (i) if the person who appears to be mentally disordered is living there, they agree to it being used as a place of safety (Guidance states that they have to understand what this means, etc), (ii) if someone else is living there, at least one of the occupiers has to agree as well as the person themselves.

The Mental Health Act 1983: Code of Practice 2015 normally requires a Place of Safety to be a hospital or other health-based place of safety where mental health services are provided. In practice, psychiatric units and hospital Accident and Emergency departments are most commonly used. With effect from 11 December 2017, a police station cannot in any circumstances be used as a place of safety for someone under 18, and may only be used for an adult in exceptional circumstances set out in Regulations (related to risk of death or serious injury), when additional safeguards must be applied. Police stations should never be used because local service provision is inadequate.

Whole system model of care

Preventing a mental health crisis is a central goal of mental health services; preventative services must be adequately in place across the urgent care pathway and within the community to prevent crises occurring.

Unfortunately, adequate 24/7 crisis care is not always available, and crisis services are patchy across the capital. A recent report² outlined that only half of community teams offer an adequate 24/7 crisis service, and when in crisis people often have contact with at least three different mental health services; 12 per cent even stated that they had come in to contact with between six and ten services.

If crisis episodes were prevented not only would patient outcomes and experience significantly improve but the overall system would operate more effectively alleviating the pressure on ED departments, mental health and ambulance services and London's police forces. Crisis teams are known to have an impact on reducing readmissions and numbers of days in inpatient care³, recent studies also outlined reductions in Mental Health Act admissions and falls in readmissions.

A study based on a sample of patients in south London⁴ estimated that in today's prices the cost to the NHS of a crisis episode among patients with schizophrenia is nearly £20,000.

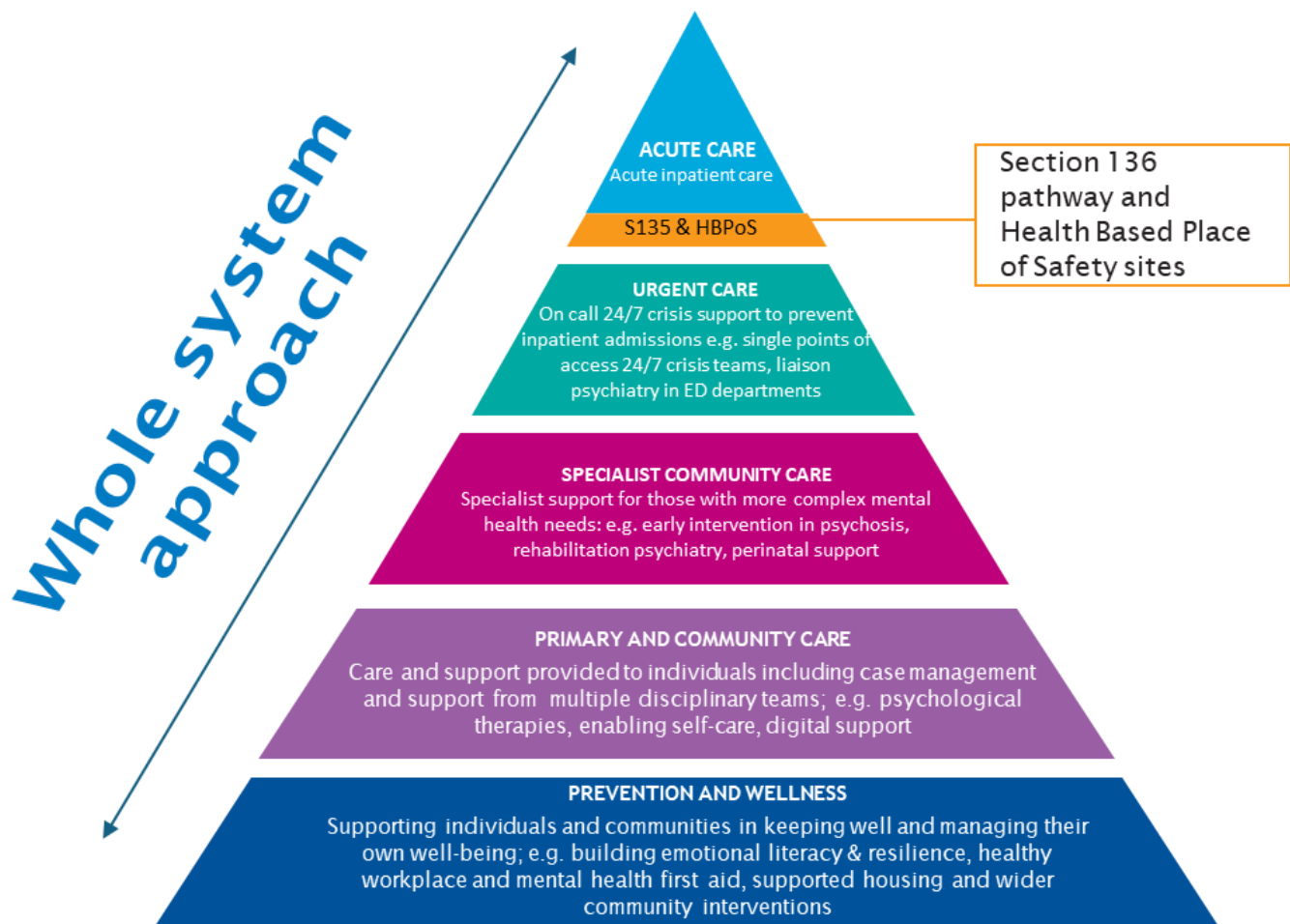
This guidance focuses on the acute end of the pathway where individuals are detained under s136 of the Mental Health Act. However, it is recognised that in order for the acute end of the pathway to work a whole system approach is needed that focuses on an effective, coordinated system with seamless transitions when the intensity of need increases.

To ensure an effective whole system approach a commitment and shared vision is required by providers, local health and care partners and commissioners. Mental health services need to be embedded deeply within the wider healthcare system ensuring parity of esteem, integrated physical and mental health care and overall improving the care for the most vulnerable of individuals.

² [Is mental health crisis care in crisis? – Quality Improvement News](#)

³ [Crisis teams: systematic review of their effectiveness in practice | The Psychiatrist | Cambridge Core](#)

⁴ [Hospital treatment and management in relapse of schizophrenia in the UK: associated costs | The Psychiatrist | Cambridge Core](#)



National context

In 2014, the NHS Five Year Forward View (5YFV) set out a future vision for the NHS based on new models of care. It specifies the need to break down barriers across systems to integrate urgent and emergency care (UEC) services for people of all ages experiencing physical and mental health problems. This aligns with Professor Sir Bruce Keogh's 2013 review of the NHS urgent and emergency care system in England which addressed the growing and unsustainable pressures on urgent and emergency care across the country. The Keogh Review recommends system-wide transformation towards highly responsive, effective and personalised services for people with urgent physical and mental health needs.

More recently the Mental Health Five Year Forward View (2016) outlines a strategic approach to improving mental health outcomes across the health and care system. It emphasises the importance of having an effective, responsive urgent and emergency care system, and highlights the need to have mental health care accessible 24 hours a day, seven days a week. The report asserts that this is the only acceptable level of emergency mental health care and that commissioners, providers and health workers across the entire urgent and emergency care pathway must work together to meet this expectation.

In addition to these reviews, Future in Mind is a joint review by NHS England and the Department of Health that outlines what must be done to improve children's mental health and wellbeing. It specifies that children in crisis must receive appropriate support in-hours and out-of-hours. Those under s136 must have an age-appropriate service that ensures police cells are never used.

A number of national developments have also highlighted the issues facing crisis care. Especially, the different approaches required across the health and social care system to improve current care:

- The Crisis Care Concordat has been signed by 27 national bodies involved in health, policing, social care, housing, local government and the third sector. It is a national agreement, based on core principles, setting out how organisations work together so people experiencing a mental health crisis get the help they need. This is a significant step for those responsible for commissioning, providing and delivering crisis service, ensuring consistent effective care and support for people when they are at their most vulnerable will be challenging.

- As part of the Care Quality Commission's commitment to the Concordat, it conducted an in-depth review looking at the quality, safety and effectiveness of crisis care services across the country. The review found clear variations in the help, care and support available to people in crisis. It also found that experiences of care depend on where people live and which what part of the system they encounter. Key recommendations were put forward relating to different parts of the system, recognising local issues and the partnerships that are needed to develop solutions.



London context

London faces many challenges across the crisis care system. Services often fall short in providing effective access, care and treatment for the capital's most vulnerable people:

In any given year, an estimated 1 in 4 Londoners will experience a diagnosable mental health condition⁵.

Over 75 per cent of 136 detentions occur out of hours, yet the majority of sites do not have dedicated staffing 24 hours a day, seven-days a week⁶.

Only 14 per cent of people say they had the support they needed in a crisis⁷.

⁵ [Microsoft Word - Mental health report.docx](#)

⁶ Healthy London Partnership (2015) UEC Programme: HBPoS audit

⁷ Healthy London Partnership (2015) UEC Programme: 'I' statements

Almost two thirds of those detained under s136 say they do not feel safe once they arrive at a 'place of safety'⁸.

These challenges were reinforced by the London Health Commission's Better Health for London report. The report identified the need to reduce variation in care and improve the quality, access and coordination of care for people in crisis. It recommended that health and care commissioners develop a pan-London multi-agency model of care. This recommendation has been taken forward through the development of this s136 pathway and Health Based Place of Safety specification.

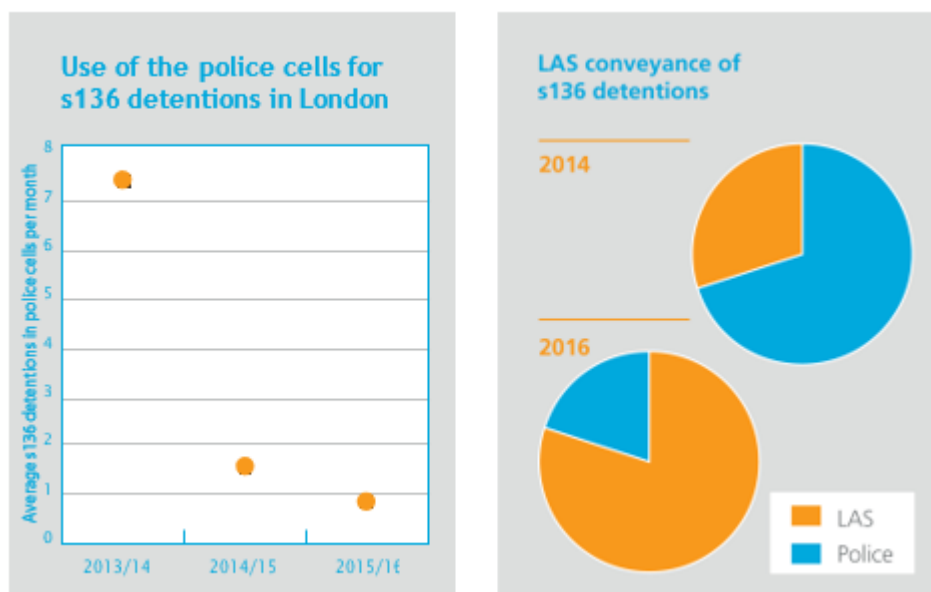
To address these challenges, London's crisis care system has achieved significant progress in recent years. In 2014, the London Mental Health Crisis Commissioning Standards were agreed as part of the region's response to the Crisis Care Concordat. These standards align with the concordat focus areas and set out the care Londoners suffering mental health crisis should expect to receive. The standards aim to ensure equity between physical and mental health and are integral to London's Coordinated, Consistent and Clear Urgent and Emergency Care (2015) standards that included UEC facilities and system specifications, developed in response to the Urgent and Emergency Care Review.

A number of improvements have also been achieved by London's Mental Health Trusts and their key partners. This includes the work of the Mental Health Partnership Board that developed the s136 action plan and set an example nationally in reducing the use of police cells for those detained under s136, as of October 2016 the use of police cells in London has fallen below one per month⁹. The involvement of the London Ambulance Service in conveying those detained under s136 to the Health Based Place of Safety has also significantly improved. Mental health crisis is integral to the future planning and delivery of UEC services in London and five UEC geographical networks have been established to transform the whole urgent care system including physical and mental health.

Significant improvements have also been made through local service models that are preventing people from reaching crisis point; this includes street triage, single points of access and CORE24 liaison psychiatry services in ED departments.

⁸ Healthy London Partnership (2015) UEC Programme: 'I' statements

⁹ London Mental Health Partnership Board (2013-2016) Individuals under section 136 held in police cells



Londoners' statements

As a starting point to this work, in early 2016 with support from Mind and Young Mind charities over 150 service users and carers took part in an online survey to tell us about their recent experiences of London's crisis care system, including time spent at an ED department and Health Based Place of Safety sites. Service users and carers outlined what was good about the care they received, what could have been better, and what is most important to them in helping to prevent a crisis, during a crisis and following a crisis.

A face-to-face service user focus group was then undertaken to develop a series of 'I' statements from the survey responses and the statements were tested and refined through further online consultation. The 'I' statements are a series of first-person statements which clearly set out what Londoners expect from the services and agencies involved in their care and are what people should be able to say when London's crisis care is working well.

Further engagement was also undertaken with children and young people to better understand where their experiences and needs might differ from those of adults. As a result, some additional statements were compiled to reflect what was heard from Londoners who have experienced a mental health crisis as a young person.

These 'I' statements have directly informed the development of the s136 pathway and Health Based Place of Safety specification.

Londoners' mental health crisis care 'I' statements

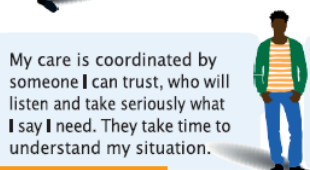
Preventing Crisis



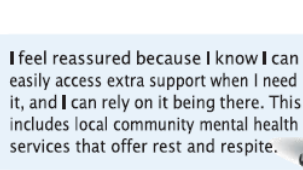
When I'm not coping I can get the support I need at that time to manage everyday life, such as help to keep me from becoming isolated.



The care I receive is tailored to my needs and circumstances at that time, and helps me reach my aspirations. It follows any plan I have agreed with support services, and covers all areas where I need assistance.



My care is coordinated by someone I can trust, who will listen and take seriously what I say I need. They take time to understand my situation.



I feel reassured because I know I can easily access extra support when I need it, and I can rely on it being there. This includes local community mental health services that offer rest and respite.



Friends and family are involved in my care where we both want this and staff recognise their contribution. My carer is offered support in their own right, to help them stay well.



During Crisis



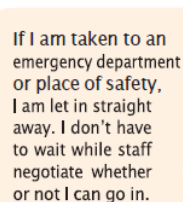
If I am taken to an emergency department or place of safety, it is in health service transport such as a paramedic car or ambulance and not a police vehicle.



Right from the beginning, and throughout the crisis, all the professionals involved recognise me as a person in crisis. They treat me skilfully and lawfully, with care, compassion and respect.



When I am in crisis police presence is as low key as possible and there is no unnecessary use of restraint.



If I am taken to an emergency department or place of safety, I am let in straight away. I don't have to wait while staff negotiate whether or not I can go in.



I am listened to and my voice is heard; at the point of crisis I might not be able to think clearly, make decisions or say everything I am feeling, but I am still a person and should not be ignored.



In the emergency department or place of safety I am seen in an environment that is safe and calm. The room is private, quiet, clean and comfortable. If it is important to me to be cared for by female or male staff this is respected and I can choose to have someone with me to provide friendly support.



If I wish to involve family members, friends or carers, staff listen to them in my presence; they do not exclude them or ignore what they say.



Staff in the emergency department or place of safety spend time with me and explain clearly and calmly what is happening and what is going to happen. They keep communicating and tell me if the plan changes. I am not left waiting, without explanation or on my own.

Emergency staff pay attention to any advance statement or crisis plan I have made and adhere to it.



All staff treat me with the same respect, confidentiality and care as all other patients and are skilled in managing mental health problems.



Following Crisis

If I am discharged from an emergency department or place of safety, I am provided with advice and support if I want it and safe transport home, especially at night.



My aftercare is helpful, reliable, easily accessible and local - it covers my wider needs (such as housing or benefits), supports my wellbeing and helps me achieve my aspirations.



There is a reasonable and realistic plan for my aftercare that I and any chosen friends, family and carers have made with relevant professionals. People who are responsible for providing aftercare understand and perform their role fully.



Children and young people

These are specific children and young people 'I' statements to capture and emphasise their specific needs and expectations in crisis.



Case for change

It has often been said recently that London's crisis care system is itself in crisis. There are significant challenges across the system, due to inadequate care and services and also the levels of mental ill health and 'Crisis' that the capital faces. The 'I' statements from service users are not unreasonable but we are falling short of these expectations.

Nearly 7 per cent of Londoners have either attempted or thought about suicide in their lifetime¹⁰ and mental health services are struggling to support individuals in their care; there are now three times as many patient suicides under Crisis Resolution Home Treatment Teams as in inpatient care¹¹.

The issues are escalating, by 2030 it is estimated that compared with 2013, approximately two million more adults across the UK will experience mental health problems¹². In London throughout 2015-2016 over 4500 s136 detentions have taken place (including over 220 children and young people), during this time period the number of detentions per month rose by 8 percent¹³. If London's crisis care system remains the same these numbers are expected to increase, especially as the scope of s136 expands with new legislation. There is a need to ensure services are available in the community to prevent crises occurring and the appropriate crisis care is then available across the system to those that need it.

Current demand is impacting London's ambulance and police services. On an average day, 385 people experiencing a mental health crisis will call the London Ambulance Service. This is 13 per cent of the London Ambulance Service's daily calls¹⁴. A further 200 calls are made to the Metropolitan Police Service¹⁵. Mental health call outs result in the longest scene time for paramedics – often, up to six hours. These occurrences are rising. Over the past year there has been a 15 per cent increase in mental health related calls.

Mental health facilities for those detained under section 136

¹⁰ [Microsoft Word - Mental health report.docx](#)

¹¹ [Is mental health crisis care in crisis? – Quality Improvement News](#)

¹² [Is mental health crisis care in crisis? – Quality Improvement News](#)

¹³ Therapeutic Solutions (2016) Section 136 Health Needs Assessment

¹⁴ London Ambulance Service (2016) Mental health crisis care data

¹⁵ Metropolitan Police Force (2016) Mental health crisis care data

There are currently 31 'designated' Health Based Place of Safety sites across London¹⁶. Instead of choosing a location based on need or demand sites are historically located where space has been available.

This map shows the locations of London's Health Based Place of Safety sites; the black dots refer to ED departments which are currently 'designated' Health Based Place of Safety sites.



London's Health Based Place of Safety sites have had varying Care Quality Commission (CQC) ratings. In 2016, three Trusts received 'needs improvement' ratings, while another was rated 'inadequate'. Key themes from the CQC reports include the lack of dignity, comfort and confidentiality; inadequate processes regarding the Mental Health Act; staff levels and training; and information recording.

These themes correspond with national issues. It was recently reported that 80 per cent of acute mental health wards inspected by CQC before July 2016 had safety concerns¹⁷. This needs to change. Evidence suggests that mental health facilities that are fit-for-purpose and meet the needs of service users improve patient outcomes and safety. Trends also lean towards reduced involuntary admissions and overall aggression levels¹⁸.

Londoners with lived experiences have expressed similar concerns. Only 36 per cent of Londoner's detained under s136 said they felt safe in a Health Based Place of

¹⁶ A 'designated Health Based Place of Safety' is the health based setting that has been locally agreed by providers and commissioners to be the chosen site to receive individuals detained under s136

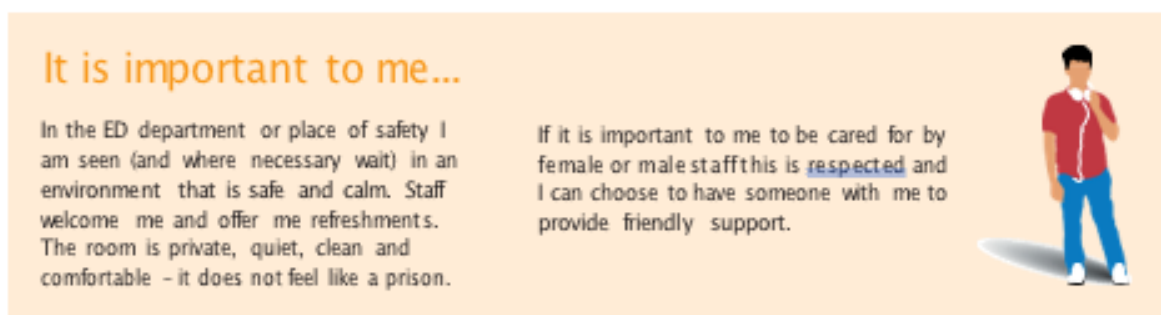
¹⁷ Brennan (2016) Vast majority of mental health trusts have safety concerns, CQC warns. Available at: [Vast majority of mental health trusts have safety concerns, CQC warns | News | Health Service Journal](#)

¹⁸ [Patient Safety and Quality: An Evidence-Based Handbook for Nurses - PubMed](#)

Safety. In London's EDs, only 12 per cent of those assessed thought their assessment rooms were pleasant, comfortable and welcoming¹⁹.

“I’ve been sectioned before and held in a police cell before and that was bad, it was cold and dark and miserable, and I just curled up on those bunks and cried my eyes out. The place they take you now is only a little bit better, and I mean only little bit better, it’s not as cold and they don’t make you wear those paper suits but it’s still like a police interrogation room than a place where you should be getting better.”

London Mental Health Crisis Care Service User



It is important to me...

In the ED department or place of safety I am seen (and where necessary wait) in an environment that is safe and calm. Staff welcome me and offer me refreshments. The room is private, quiet, clean and comfortable – it does not feel like a prison.

If it is important to me to be cared for by female or male staff this is respected and I can choose to have someone with me to provide friendly support.



Current service provision for those detained under s136

The police forces, London Ambulance Service and NHS Trusts constantly struggle to find capacity at London Health Based Place of Safety sites. The number of s136 detentions is rising and London's capacity situation is unique; whereas police in other parts of the UK can offer support to people in crisis beyond detainment or ED, London is limited in its alternatives²⁰. This means the number of s136 detentions persist, adding increased pressure to London's ED departments. Evidence shows that where crisis care alternatives are offered, rather than using the s136 power or presenting to an ED department, patient experiences improve and there are substantial cost savings

¹⁹ Healthy London Partnership (2015) UEC Programme: 'I' statements

²⁰ South West London St. George's Mental Health Trust is planning on opening a Psychiatric Decision Unit in late 2016 to provide an alternative pathway away from ED for patients experiencing a mental health crisis.

Learning from outside of London

The Birmingham Psychiatric Decisions Unit provides a facility for people in a mental health crisis to have an enhanced assessment and short-term support (up to 72 hours). The unit plays an important role in the urgent care pathway and has demonstrated significant benefits in reducing bed days and diverting people from the ED department²¹.

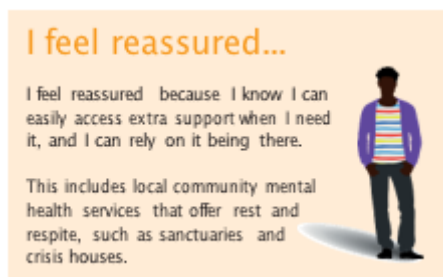
The Aldershot Crisis Café (Safe Haven) opened in 2014 to provide alternative support for mental health crisis patients. Since the café has been

opened the number of admissions to acute inpatient psychiatric beds has fallen by 33 per cent from within the 'Safe Haven' catchment area. During a three-month period, there were 63 confirmed reports

of using the café as an alternative to ED which was estimated as a cost savings of £20,223²².



Nearly **70 per cent** of Londoners feel there are missed opportunities to prevent their mental health deteriorating to crisis point. **FACT**



I feel reassured...

I feel reassured because I know I can easily access extra support when I need it, and I can rely on it being there.

This includes local community mental health services that offer rest and respite, such as sanctuaries and crisis houses.

Issues and tensions occur between different agencies because of the challenges in securing capacity at a Health Based Place of Safety. In 2015, over 210 issues were reported by frontline police officers; half of these were specifically related to capacity and access across the s136 pathway²³. Monthly comparisons of issues logged between 2015-2016 show a 30 per cent increase, delays in accessing sites continue, often with waits of over seven hours.

²¹ An evaluation of the Psychiatric Decisions Unit (PDU) and its role within the urgent care pathway in Birmingham (2016)

²² <https://acem.org.au/getmedia/d955dbb0-86c6-4ca2-b25c-ac367b949bb8/Hampshire-Crisis-Cafe-Evaluation-ReportUK>

²³ Metropolitan Police Mental Health Escalation Log (2015)

Clinical staff have noted that these delays in accessing support and ongoing treatment negatively impacts patient experience and outcomes. Staff have stated that those who experience poor treatment at the start of the pathway are less likely to engage with health services, co-produced crisis plans are jeopardised and a lot of the trust between clinicians and the patient is lost. This is illustrated by the fact that in 2015/2016 there were approximately 320 Londoner's who were detained again under s136 within two days.

Current funding and incentives do not promote Trusts to accept patients into Health Based Place of Safety sites based on need; this is driving a system where patients are accepted and assessed based on their home address or registered GP. The temporary closure of Health Based Place of Safety sites across the capital is also problematic. It occurs due to the lack of dedicated staff and damaged facilities. This highlights the inconsistencies between mental and physical emergency care. It is otherwise rare that an emergency care service for physical health shuts down.

Very few London Health Based Place of Safety sites have dedicated staff and staffing levels are generally minimal out of hours. This is despite over 75 per cent of s136 detentions occurring outside of regular working hours. This is exemplified for children and young people. Many London Health Based Place of Safety sites have local protocols that restrict children from the site. ED departments are often used as the default position when Health Based Place of Safety sites are unable to adequately manage children detained under s136

“The suite is staffed but not by a dedicated team. There is a manager, but the team consists of rotating staff from the wards so they’re a team of people, some of whom know what the role is and are very good at the role, some of whom are very disinterested in the role in the suite and don’t really understand the role particularly or aren’t that interested, so you’ve got a mixed bag of staff”

AMHP Staff Interview



Capacity and delays

Police request access to a Health Based Place of Safety but were denied as the site was full, staff at the site refused to facilitate arranging elsewhere for the patient to go. Eight hours later officers had the patient assessed at a London ED department, following assessment the patient was then transferred back to the original site where the Place of Safety was situated to be admitted into an inpatient psychiatric bed.

There is a role for commissioners and providers to have better oversight when these capacity issues occur. It was recently recorded that only 32 per cent of London CCGs are using provider, police and local authority data to monitor and understand the demand for Health Based Place of Safety sites (as well as outcomes for s136 detainees)²⁴. Over 62 per cent thought they were not compliant in instigating joint incident reviews when someone detained under s136 has been refused access to a Health Based Place of Safety, or taken into police custody, or both.

“Police and LAS waited five hours with a suicidal lady detained under s136 before being able to access a Health Based Place of Safety. During this time the female who was extremely distressed and cold had no access to drink or toilet facilities.”

Metropolitan Police Escalation Log



Capacity and delays

In 2016, Stacey was refused access to a London Health Based Place of Safety due to concerns she was under the influence of alcohol. Staff at the site requested that Stacey have a physical health clearance, so she was transported to the nearest ED department. When Stacey, London Ambulance Service and the Met Police arrived at the ED they were all refused access as the ED was too busy to safely accept her.

Stacey was instructed to go elsewhere and was taken to another ED where she was refused again due to concerns, she was out of area and should have been accepted by the first ED. LAS and the Met Police took Stacey back to the first ED for her physical health clearance. After 6 hours she was finally given clearance to be

²⁴ [ccg-iaf-initial-clinical-methodology.pdf](#)

assessed under the Mental Health Act at the Health Based Place of Safety where she was originally taken.

Impact on the system and patient outcomes

The current situation of London's crisis care system significantly impacts on London's ED departments, as police officers will often convey patients to ED due to no capacity at HBPoS. On top of this other local protocols and system issues have significantly increased ED's involvement in this pathway:

- Many Health Based Place of Safety sites instruct that children detained under s136 should go to the nearest ED due to local sites not being the right environment for younger patients. In 2015/16 over 220 children under 18 were detained under s136 and the ED department was commonly used as the place of safety. When EDs are used those detained under s136 can be in the department for over 15 hours due to delays in obtaining the most appropriate staff or the lack of CAMHS Tier 4 beds;
- Both national and London policy prevent the use of police cells for those detained under s136; there has been a 94 per cent reduction over the past three years which is a positive trend however this has increased pressure on the system given Health Based Place of Safety capacity hasn't changed.

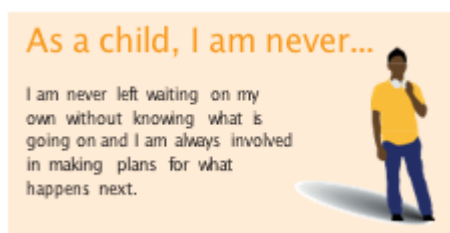
To provide an example one London Trust over the time of 12 months was unable to provide a health-based place of safety on more than 70 occasions and the majority of these individuals were taken to the nearest ED. This trend has been confirmed nationally, the 2015 CQC report stated that more than half of England's ED's routinely receive patients who were detained under s136 but did not have a physical health condition²⁵.



London activity

One London ED department has seen an 82 per cent increase over the past two years in the number of children and young people requiring an emergency mental health assessment in ED, over 60 per cent of these patients present to the ED department out of hours.

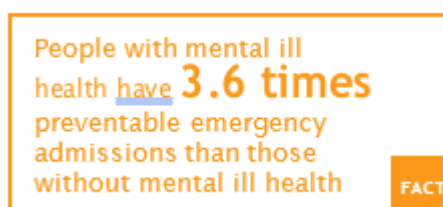
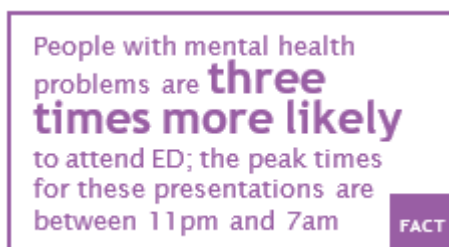
²⁵ [Right here, right now: Mental health crisis care review - Care Quality Commission](#)



Evidence suggests that mental health patients are more likely to use emergency care than those without mental ill health, in 2014 mental health patients had 3.2 times more ED attendances and 4.9 times more emergency inpatient admissions²⁶, and when mental health crisis patients are in ED nearly 40 per cent breach the four hour target²⁷

A recent study in North Central London²⁸ showed approximately 60 mental health patients breached across five Trusts per week and the breach rate in mental health patients was 6.5 times greater than the overall breach rate in the participating EDs. An additional study in London showed delays specifically related to mental health assessments when performed in ED, this study showed that 68 per cent of patients waited over 8 hours for an outcome of their assessment, 36 per cent waited over 12 hours.

Evidence suggests that prolonged ED stays are associated with increased risk of symptom exacerbation and absconding for those with mental health issues, these delays have a strong link with poor patient experiences leading to increased hospital readmissions and less desirable clinical outcomes.



²⁶ [qualitywatch-mental-ill-health-and-hospital-use-full.pdf](#)

²⁷ [Focus on: People with mental ill health and hospital use | Nuffield Trust](#)

²⁸ Moore, A. (2014) Urgent and Emergency Mental Health Audit. In: Urgent and Emergency Care for Mental Health. London.

Improving London's section 136 pathway

Developing the guidance

A crisis care multiagency professional group was established in 2015 with representation from Mental Health and Acute Trusts, the London Ambulance Service, the Met Police, social services and general practice. This group led the development of the new model of care that includes the pan-London s136 pathway and a specification for Health Based Place of Safety sites.

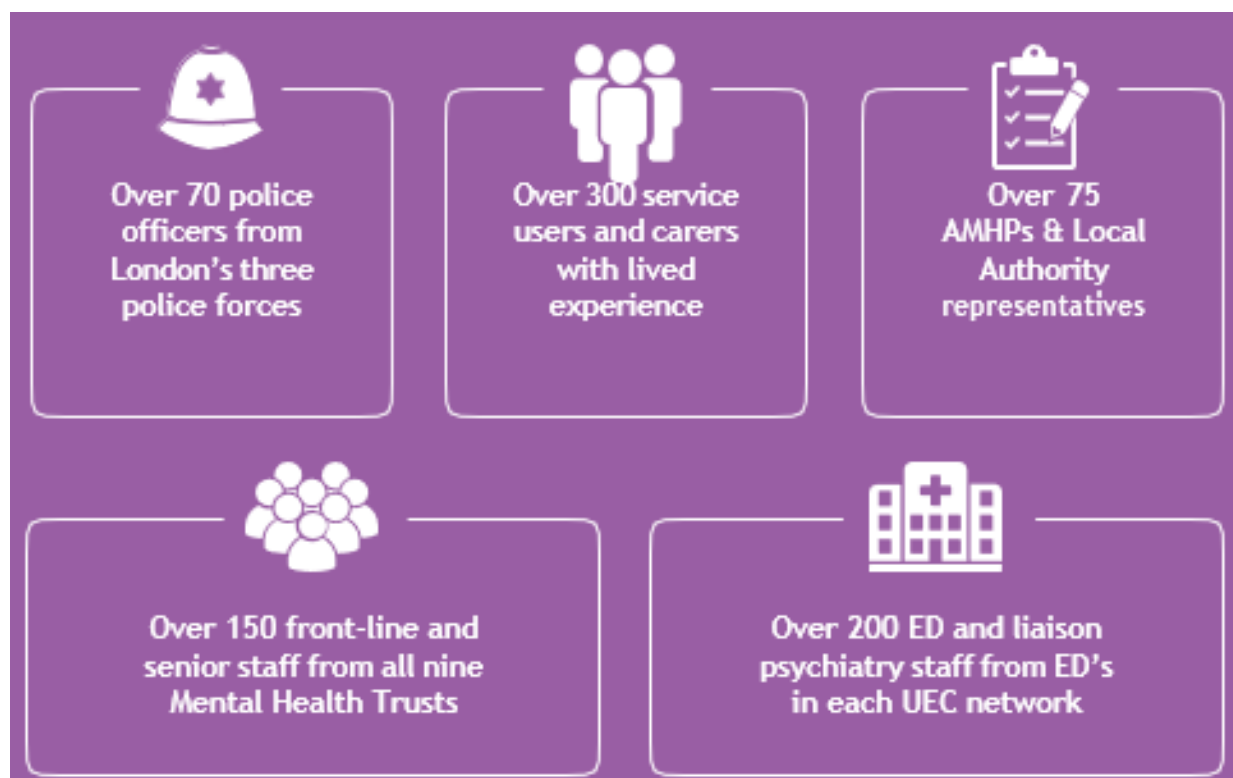
Both sets of guidance include information sourced from national and London publications and local protocols. This information was tested with members from the crisis care multiagency professional group and subject matter experts across London's crisis care system.

Clinical champions were also sourced from London's Mental Health Trusts to explore certain topics and ensure the documents address frontline issues in the system.

Key areas of the s136 pathway, the Health Based Place of Safety specification and the wider vision of transformational change needed to improve London's crisis care system were discussed at London's first Mental Health Crisis Care Summit in February 2016. Over 200 delegates attended the event. They welcomed the guidance, a pan-London focus to the s136 pathway and Health Based Place of Safety sites and a wider whole system approach to improving London's crisis care system.

The guidance was updated in December 2017, following the implementation of changes to the legal framework for s136 introduced by the Policing & Crime Act 2017.

Engagement across London's crisis care system



Engagement across London's crisis care system

Service users have been integral to the development of this work. Over 300 Londoners with lived experience of a mental health crisis have ensured the guidance meets service user needs and expectations.

This has taken place through a series of workshops covering London's five UEC networks, and 1:1 discussions and surveys with both adults and children. Ensuring London's diverse population is represented has also been important. Specific attention has been given to London's black and ethnic minority groups to guide the development of this work. See Appendix 1 of the Health Based Place of Safety specification which outlines the key themes that came out of the service user workshops.

A partnership model was used to ensure extensive engagement with stakeholders across the crisis care system. The Met Police, British Transport Police and the City of London Police Force; Acute and Mental Health Trusts; London Ambulance Service; Local Authorities; and the voluntary sector, particularly Mind and the National Crisis Care Concordat initiative, have all been actively engaged.

Activities have included large workshops, local team meetings, focused discussions with senior and operational staff, and shadowing of front-line staff. Combined, these have enabled a clear picture of the challenges.

London's s136 pathway and Health Based Place of Safety specification have been endorsed by key national and London organisations. All have a critical role in achieving effective mental health crisis care.

There is broad support for implementing this model of care with local action to prevent crises whenever possible. All stakeholders across the system are clear that there should be parity of esteem for mental and physical health. London has successfully transformed care for those in a physical health crisis and to achieve parity of esteem we now need to put the same impetus towards those suffering a mental health crisis. Together London needs to work together to ensure this guidance is put to action and improvements in patient care and outcomes are achieved.

'We have transformed care in London for those who have a stroke or a heart attack and now we need to do the same for those in a mental health Crisis'

Mental Health Crisis Care Clinical Lead

London's section 136 pathway and Health Based Place of Safety Specification

Scope of the guidance

London's s136 pathway requires all agencies involved to work in line with the main principle of cooperation and collaboration underpinning the Crisis Care Concordat, to which all partners have agreed²⁹:

“We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.”

- This document is directed at all ages; children and young people up to the age of 18 should receive the same standards of care as outlined throughout this document. The care they receive should be developmentally appropriate and relevant multi-agency safeguarding procedures and systems should be in place in each Health Based Place of Safety and Accident & Emergency department. Clear and agreed arrangements should be in place for care for those of transition ages between 16 and 18 years old.
- Throughout this document, the term Health Based Place of Safety refers to the health-based setting that has been locally agreed by providers and commissioners to be the chosen site to receive individuals detained under s136 of the Mental Health Act.
- The guidance has been developed based on key national and London documents; this includes:
 - Association of Chief Police Officers and Independent Police Complaints Commission (2012)
 - London Quality Standards, including inter-hospital transfers. London Health Programmes (2013)
 - Independent Commission on Mental Health and Policing Report (2013)

²⁹ [London's All Age Crisis Care Concordat](#)

- Guidance for Commissioners: Service Provision for s136 of the Mental Health Act 1983. Royal College of Psychiatrists (2013)
- The operation of s136 in London. Mental Health Partnership Board (2013)
- London Mental Health Crisis Commissioning Guide. Mental Health Strategic Clinical Network (2014)
- Mental Health Act: Code of Practice 1983. Department of Health (2015)
- Defining a Health Based Place of Safety (s136) and Crisis Assessment Sites for young people under age 18 (2016). Child and Adolescent Faculty Executive, Royal College of Psychiatrists

Key principles of the guidance

Throughout this process stakeholders across London's crisis care system identified some key principles to ensure the capital's most vulnerable individuals are cared for in the most effective and most appropriate way. These principles are embedded within the guidance and are outlined below:

- When the Health Based Place of Safety 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 a Health Based Place of Safety closest to where the patient is located (whether the individual is from that area or not) when the Mental Health Clinical Advice Line (MHCAL) makes initial contact, it is the hub's **responsibility to ensure that the individual is directed to a suitable place of safety**, as near as possible to their current location.
- Under exceptional circumstances when an individual under s136 presents to an ED department with no physical health needs (due to limited Health Based Place of Safety capacity) the **ED cannot refuse access** unless a formal escalation action has been enacted.
- 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 ED department or other alcohol recovery services (where available).

- An ED 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.
- Every Health Based Place of Safety should have a designated s136 coordinator available 24/7 who is assigned to the Health Based Place of Safety at all times. **Adequate, dedicated clinical staff must be available 24/7** to ensure staff members do not come off inpatient wards.
- Health Based Place of Safety staff (including both nursing and medical staff) should have **adequate physical health competencies to prevent unnecessary ED referral**, any requests for medical optimisation should follow the Physical Health Assessment & Treatment Protocol in Appendix 11.
- When the patient has been conveyed to ED, the responsibility of the MHCAL ends. Responsibility falls to the Liaison team to commence arranging the MHA assessment.
- **Health Based Place of Safety and local 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 an ED is not the optimum course of action. These should include triage, advice and where possible outreach systems to support appropriate responsive and timely physical health care to those in a Health Based Place of Safety.
- 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 ED departments and vice versa should be undertaken by the Mental Health Trusts and Acute Trusts respectively, led by the s136 coordinator. **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.
- If the s12 doctor (or another doctor with adequate mental health experience) 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.

- 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 borough in which they are currently being detained under s136.
- **The mental health assessment should be completed within 4 hours** of the individual arriving at the Health Based Place of Safety unless there are clinical grounds for delay.

Part 2: London's Section 136 Pathway

1 Initial detention and access to a Health Based Place of Safety

Ref	Specification	Responsibility
1.1	Before deciding to remove a person to a place of safety, the officer must (in the interest of improved patient care), if it is practicable to do so, consult the MHCAL for clinical advice, or one of the following: - a registered medical practitioner, - a registered nurse, - approved mental health professional, or - a person of a description specified in regulations made by the Secretary of State. (these currently specify an occupational therapist and a paramedic, in addition to the above).	Police
1.2	Consultation with the MHCAL, or one of the above listed professionals, will help the officer to consider alternatives to s136 detention, providing further information on the individual or signposting to alternative services. However, it is still the officer's decision whether to use s136, in the light of any information received. The officer is not legally required to consult a health professional if in the circumstances it is not 'practicable' (= realistic) to do so.	Police
1.3	Local arrangements must be in place to ensure there is always a suitable health professional for the police officer to consult with, prior to detaining the person under s136. The agreed London-wide arrangement to access MH clinical advice is via the MHCAL, which operates 24/7. The MHCAL provides a mental health triage, that supports police with alternative options to S136 detention.	Mental Health Trust Police
1.4	If there is a co-produced crisis care plan ³¹ in place the instructions in the crisis care plan for managing a mental health crisis should be followed wherever possible to avoid detention under s136. The crisis care plan should be accessible to the MHCAL when first contact is made, however if the person clearly needs 'care or control' (as expressed in the Mental Health Act 1983) the s136 pathway should be followed. The responsibility for that decision rests with the Police.	Mental Health Trust MHCAL Police
1.5	On each occasion when the s136 power is used, the police officer involved is expected to phone the MHCAL to identify the best placed HBPOS to receive them. If there is no capacity in the HBPOS to receive the person, officers will be directed to ED as a place of safety. Failure by the MHCAL to ring ahead may result in the person in the HBPOS being unable to accept the patient upon arrival, resulting in avoidable delay. The involved ED are expected to inform the psychiatric liaison team and Nurse in Charge as soon as practicably possible (refer to section 3.10).	MHCAL Police

Ref	Specification	Responsibility
1.6	Trusts commissioned to provide the local Health Based Place of Safety must have dedicated 24/7 telephone numbers in place, to enable MHCAL to always phone ahead prior to the detained individual arriving on site. It is recommended that Trusts work towards streamlining the first point of access so the same number can provide crisis support and Health Based Place of Safety capacity.	Mental Health Trust
1.7	It is the Trust's responsibility to ensure the numbers are available and communicated to key partners and regularly updated on the Directory of Service.	Mental Health Trust
1.8	Information must be communicated to the Health Based Place of Safety by the MHCAL, or the psychiatric liaison team who are responsible for communicating the information below with their local HBPOS in cases of transfer from ED. The information required must include: - background summary & demographics; - 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 the ambulance service and the medical assessment performed; - any suspicion of co-morbid physical health condition or concurrent injuries and any other risks to the individual or others.	MHCAL Psychiatric Liaison Team (PLT)
1.9	It is essential that the Approved Mental Health Professional (AMHP) service for the area where the Health Based Place of Safety is located is notified as soon as is practicable of the individual's imminent arrival there. It has been agreed that this contact should be made by staff at the Health Based Place of Safety themselves (or by the ED department if the person is being taken straight to ED, rather than by the police) ³² . The police officer or ambulance crew who are bringing the individual to the relevant place of safety must always check that the staff there are aware that it is their responsibility to do this.	Health Based Place of Safety Police Ambulance Service
1.10	The Ambulance service or other service transporting the individual will go to the Health Based Place of Safety closest to where the individual was detained. However, crisis care plans which may include a preferred place of assessment based on the individual's needs should always be taken into account where feasible.	Ambulance Service
1.11	If there is no capacity at the local Health Based Place of Safety when the MHCAL makes initial contact it is the hub's responsibility to ensure that the individual is directed to a suitable place of safety, whether the individual is from that area or not. If the PLT are looking to transfer from ED to HBPOS, any arrangements should be made through local channels. Such occurrences must be fully documented. However, the Health Based Place of Safety has no legal power to transfer the individual of their own volition; this needs to be done by or on behalf of a police officer or AMHP (see s136(3) MHA)	MHCAL Psychiatric Liaison Team (PLT)

Ref	Specification	Responsibility
1.12	When the Health Based Place of Safety states that it has capacity, this means it is able to receive the detained individual as soon as they arrive on site.	Health Based Place of Safety
1.13	If the police officer has been informed that a Health Based Place of Safety has capacity to accept an individual, action should be taken to ensure this capacity remains available up until the individual arrives on site. If, in exceptional circumstances, the Health Based Place of Safety 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 Health Based Place of Safety should be identified by Health Based Place of Safety/MHCAL staff.	Health Based Place of Safety/ MHCAL
1.14	If no alternative site has been identified by the time the person arrives at the original Health Based Place of Safety, the police officer will notify staff there of their arrival, at which point the handover clock is deemed to have started, and the person will be kept in custody by the police officer, supported by the ambulance crew where appropriate, until an alternative place of safety has been identified. A record must be kept of any such occurrences.	Police
1.15	A capacity management tool should be available to support the process of identifying a Health Based Place of Safety by indicating each site's real-time capacity. This will require local governance arrangements, and the service manager on call should be informed when capacity has been set to 'full' by the Health Based Place of Safety staff. To enable effective capacity management and the best possible response for individuals detained under s136 Health Based Place of Safety sites must prioritise the immediate needs of the detained individual above any other competing organisational demands.	Health Based Place of Safety
1.16	All escalation processes with regard to bed capacity should be initiated and carried out by the Health Based Place of Safety s136 coordinator in liaison with the hospital bed manager. Where necessary, escalation processes should be initiated immediately with the on-call service manager. 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 both should always be available through the Trust's switchboard.	Health Based Place of Safety
1.17	Under exceptional circumstances when an individual under s136 presents to an ED department with no physical health needs (due to limited Health Based Place of Safety capacity) the ED cannot refuse access unless a formal escalation action has been enacted.	Acute Trust

2 Conveyance and handover

Initial conveyance to Health Based Place of Safety or Accident & Emergency department

Ref	Specification	Responsibility
2.1	An ambulance should be used to convey the individual with police support where appropriate. The ambulance must arrive at the location in which the police detained the individual within 30 minutes of request or 7 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.	Ambulance Service
2.2	The use of ambulance services should always be considered first in order to convey the individual to the Health Based Place of Safety; 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.	Ambulance Service Police
2.3	Where the ambulance service have identified that there is likely to be a significant delay (over 60 minutes) this should be communicated to the police/MHCAL staff. 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 Officer or if they are unavailable a supervisor as soon as practicable and must inform the ambulance service of their decision. The rationale for using a police vehicle should be recorded by the officer responsible for detaining the person under the MHA and should stipulate which supervising officer was informed.	Ambulance Service Police
2.4	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.	Ambulance Service Police
2.5	When the police officer/MHCAL staff makes contact with the ambulance service to carry out the conveyance of s136 detainees, officers/ MHCAL staff 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. Refer to the definition of restraint in 2.1 above.	Ambulance Service Police/MHCAL Staff
2.6	The ambulance is being 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 Health Based Place of Safety.	Ambulance Service Police

Ref	Specification	Responsibility
2.7	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.	Ambulance Service Police
2.8	The time of arrival at and admission to the Health Based Place of Safety must be clearly recorded at the Health Based Place of Safety 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. Time of arrival is defined as when the person physically enters the first Place of Safety (see para 4.2 of the Department of Health/Home Office Guidance, October 2017) ³³ .	Health Based Place of Safety Police
2.9	Form 434 must be completed for every patient conveyed under s136. To accept the individual under s136 there must be a formal handover of the completed 434 form which each London police force uses when a detention under s136 is made. The form should be signed and used as a record of handover from the Police to the Health Based Place of Safety. Met Police use the digital form 434, British Transport Police and the City of London Police use their own paper forms, see examples of these forms in figures A, B, C on page 31. The detention period starts at the moment of physical arrival (see 2.8 above), not at either the time of handover or the completion of form 434, which is non-statutory.	Health Based Place of Safety Police
2.10	If the individual is taken to an ED department first under s136, the 24-hour detention period commences on arrival at ED, not when they subsequently arrive at the Health Based Place of Safety (see para 4.4 of the Department of Health/Home Office Guidance, October 2017). When the individual arrives, it is important that the status of the individual (whether they are detained under s136 or not) is communicated to ED staff straight away, then as appropriate to the relevant Liaison Teams.	Acute Trust Police
2.11	In instances where the individual is first taken to ED, but legal responsibility is not transferred, the Police and ED staff must liaise and decide on the most appropriate support required when the individual is conveyed on to the Health Based Place of Safety. This may be an appropriately equipped transport provider, or a staff member may be provided from the liaison psychiatry team.	Acute Trust Police
2.12	If the s136 coordinator and Health Based Place of Safety team feel unable to meet the physical needs of the individual and they need to go to the ED department, staff at the Health Based Place of Safety has the right of refusal to the site. However, 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 the individual requires medical assistance at the ED department lies with the doctor at the health Based Place of Safety. Conversations will involve discussions regarding the specific concerns of staff and what additional assessment or intervention is required.	Health Based Place of Safety

Mental Health Crisis Care for Londoners

Ref	Specification	Responsibility
2.13	If the individual has had a mental health assessment and it is decided that they have a mental disorder but that this does not require a psychiatric hospital admission, they remain subject to s136 and may continue to be held for their own safety for as long as is necessary for any care arrangements to be put in place, including transfer to another Place of Safety if this is appropriate. The individual should be discharged from the s136 when the AMHP and the s136 co-ordinator at the Health Based Place of Safety are both satisfied that any necessary care arrangements are in place. The maximum period of detention cannot be extended if the person is transferred to another place of safety or to any other hospital site.	Health Based Place of Safety Approved Mental Health Professional
2.14	Clinical staff should be present to meet the individual on arrival at the Health Based Place of Safety and receive a verbal handover from the ambulance staff or the Police.	Health Based Place of Safety
2.15	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.	Health Based Place of Safety Police Ambulance Service

New Detection - 9000001 (Section 136 Mental Health Act 1983) Form 434

SELECT OPTION TO CONTINUE

Section 136 Mental Health Act 1983 - Removing a mentally disordered person found in a public place

Section 5-6 Mental Capacity Act 2005 - Restraining a person lacking mental capacity and at risk of serious harm

Form Progress

Complete all sections of this form. If needed, see the notes for guidance.

To be completed **on arrival** at the Place of Safety.

Person & Address Details

Details of location at time of arrest

Instructions for staff at the Place of Safety

To be completed **on arrival** at the Place of Safety.

Details of Place of Safety

Current Place of Safety

Section 136 Mental Health Act 1983 - Removing a mentally disordered person found in a public place

Section 5-6 Mental Capacity Act 2005 - Restraining a person lacking mental capacity and at risk of serious harm

To be completed **on arrival** at the current Place of Safety.

Details of arrest

PRINT

TRANSFER TO OFFICE

NEXT ALERT PERSON

Section 136 Mental Health Act 1983
Section 5-6 Mental Capacity Act 2005

Form 434

☐ Section 136 Mental Health Act 1983 - Removing a mentally disordered person found in a public place

☐ Section 5-6 Mental Capacity Act 2005 - Restraining a person lacking mental capacity and at risk of serious harm

Instructions

This booklet contains 2 sets of forms. After use the booklet cover and any unused forms should be discarded.

Form 434

This is a dual purpose booklet. Any police actions involving detention under Section 136 Mental Health Act 1983 or using restraint in accordance with Sections 5-6 Mental Capacity Act 2005 must be recorded using the appropriate sections of this booklet. The layout of Form 434 is as follows:

Section 1 - for detentions using Section 136 Mental Health Act 1983

Part A - copy for DVV SP/PH

Part B - copy for Hospital/Place of Safety

Part C - ~~Removed/Deleted~~ (all references to part C are no longer applicable)

Part D - copy for DVV SP/PH

Section 2 - for restraint using Section 5-6 Mental Capacity Act 2005

Part A - copy for Hospital/Place of Safety

Part B - ~~Removed/Deleted~~ (all references to part B are no longer applicable)

Part C - copy for DVV SP/PH

Part D - copy for DVV SP/PH

Part E - copy for A&E and/or Place of Safety

Section 136 Mental Health Act 1983

Guidance can be found in the text of Part A.

Section 5-6 Mental Capacity Act 2005

Sections 5 and 6 of the Mental Capacity Act 2005 operate together and may be relied upon where restraint is required in emergency situations. This is to ensure that someone who is at risk of serious harm and lacks the mental capacity to make decisions about their own healthcare needs is either conveyed to an Accident and Emergency Department, returned home or seen by the L&S. Restraint should only be used as a very last resort where persuasion has failed or is impractical. Examples of its use include:

- An elderly confused person found wandering in inclement weather conditions who is likely to suffer harm if not returned home.
- A person suffering from an epileptic fit who is likely to suffer harm if not kept away from danger until the fit stops.
- A person with a serious injury following an accident/assault who refuses medical care, is at risk of serious harm and whose traumatic state prevents them having capacity to make the decision to attend A & E.
- An acutely distressed person in the act of self-harm or who threatens to do so and then is threatening/attempting to take their own life, as distinct from someone who makes vague threats to do so in the future.

The Act only applies to people who lack mental capacity or who are reasonably believed to lack mental capacity. It applies to public and private locations. When officers encounter a person, whom they reasonably believe to lack mental capacity, they should consider taking action to safeguard the person's best interests, always having regard to how that purpose can be achieved in a way that puts the least restrictions on the person's rights and freedom of action.

Police occasionally come across individuals with serious injuries that may result in serious harm or death, but who decline medical aid. If such a person has the mental capacity to make this decision there is no power to compel her him to accept medical treatment. If an officer reasonably believes that a person lacks mental capacity then the Act will apply and that person may be treated in their best interests. Officers must always weigh up the risks of forcing help on an unwilling person against the benefits it may offer.

Unlike medical and ambulance personnel, police officers are not trained in the assessment of mental capacity. Where police are the only service on scene it may be necessary to make an assessment and act accordingly before other services arrive, where the seriousness or urgency of the situation dictates. The guidance contained within this form will help officers make these fast-track decisions. When a doctor, member of the L&S or appropriate service arrives on scene, or is already present, police will defer to their expertise and provide support as appropriate.

AN INTELLIGENCE REPORT should be completed in every case where this booklet is used.

CITY OF LONDON POLICE

Form 434

Section 136 Mental Health Act 1983
Section 5-6 Mental Capacity Act 2005

☐ Section 136 Mental Health Act 1983 - Removing a mentally disordered person found in a public place

☐ Section 5-6 Mental Capacity Act 2005 - Restraining a person lacking mental capacity and at risk of serious harm

Instructions

This booklet contains 2 sets of forms. After use the booklet cover and any unused forms should be discarded.

Form 434

This is a dual purpose booklet. Any police actions involving detention under Section 136 Mental Health Act 1983 or using restraint in accordance with Sections 5-6 Mental Capacity Act 2005 must be recorded using the appropriate sections of this booklet. The layout of Form 434 is as follows:

Section 1 - for detentions using Section 136 Mental Health Act 1983

Part A - copy for DVV SP/PH

Part B - copy for Hospital/Place of Safety

Part C - ~~Removed/Deleted~~ (all references to part C are no longer applicable)

Part D - copy for DVV SP/PH

Section 2 - for restraint using Section 5-6 Mental Capacity Act 2005

Part A - copy for Hospital/Place of Safety

Part B - ~~Removed/Deleted~~ (all references to part B are no longer applicable)

Part C - copy for DVV SP/PH

Part D - copy for DVV SP/PH

Part E - copy for A&E and/or Place of Safety

Section 136 Mental Health Act 1983

Guidance can be found in the text of Part A.

Section 5-6 Mental Capacity Act 2005

Sections 5 and 6 of the Mental Capacity Act 2005 operate together and may be relied upon where restraint is required in emergency situations. This is to ensure that someone who is at risk of serious harm and lacks the mental capacity to make decisions about their own healthcare needs is either conveyed to an Accident and Emergency Department, returned home or seen by the L&S. Restraint should only be used as a very last resort where persuasion has failed or is impractical. Examples of its use include:

- An elderly confused person found wandering in inclement weather conditions who is likely to suffer harm if not returned home.
- A person suffering from an epileptic fit who is likely to suffer harm if not kept away from danger until the fit stops.
- A person with a serious injury following an accident/assault who refuses medical care, is at risk of serious harm and whose traumatic state prevents them having capacity to make the decision to attend A & E.
- An acutely distressed person in the act of self-harm or who threatens to do so and then is threatening/attempting to take their own life, as distinct from someone who makes vague threats to do so in the future.

The Act only applies to people who lack mental capacity or who are reasonably believed to lack mental capacity. It applies to public and private locations. When officers encounter a person, whom they reasonably believe to lack mental capacity, they should consider taking action to safeguard the person's best interests, always having regard to how that purpose can be achieved in a way that puts the least restrictions on the person's rights and freedom of action.

Police occasionally come across individuals with serious injuries that may result in serious harm or death, but who decline medical aid. If such a person has the mental capacity to make this decision there is no power to compel her him to accept medical treatment. If an officer reasonably believes that a person lacks mental capacity then the Act will apply and that person may be treated in their best interests. Officers must always weigh up the risks of forcing help on an unwilling person against the benefits it may offer.

Unlike medical and ambulance personnel, police officers are not trained in the assessment of mental capacity. Where police are the only service on scene it may be necessary to make an assessment and act accordingly before other services arrive, where the seriousness or urgency of the situation dictates. The guidance contained within this form will help officers make these fast-track decisions. When a doctor, member of the L&S or appropriate service arrives on scene, or is already present, police will defer to their expertise and provide support as appropriate.

AN INTELLIGENCE REPORT should be completed in every case where this booklet is used.

The 434 form is used for handover purposes when an individual is detained under s136. The form has been digitalized for the Metropolitan Police Service, which records the same information as the paper form.

Ref	Specification	Responsibility
2.16	On arrival at a site the police must remain with the detainee until Health Based Place of Safety staff have accepted responsibility for the individual's custody and there has been a handover of form 434 between the police and the individual who is responsible for keeping the person safe pending the Mental Health Act assessment (this should be the s136 coordinator or nominated staff member).	Police
2.17	This initial handover process where Health Based Place of Safety staff take 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 Health Based Place of Safety facility. Note that the detention period could well have started before handover and should be recorded accordingly: see 2.8 above.	Health Based Place of Safety Police Ambulance Service
2.18	A person removed to a place of safety under section 136 may be detained there for the permitted period of detention for the purpose of enabling an examination by a registered medical practitioner and interview by an approved mental health professional, and to make any necessary arrangements for their treatment or care. The "permitted period of detention" is defined in the legislation as - 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. if a doctor has authorised an extension of time (see 2.20 below), the 24 hours plus the extra period that has been authorised, up to a maximum of 36 hours.	Health Based Place of Safety
2.19	The initial medical screening and physical health assessment should occur as soon as a person arrives, no later than 1 hour after the individual arrives at the Health Based Place of Safety.	Health Based Place of Safety
2.20	The doctor who will be involved in the mental health assessment has the power, at any time before the expiry of the 24-hour period mentioned above, to extend the detention period by up to 12 hours. Authorisation for extending the detention period may be given only if the condition of the person is such that it is not practicable for the mental health assessment to be carried out within the initial 24 hours (or, if the assessment began within that period, for it to be completed before the end).	Health Based Place of Safety & Acute Trust

Ref	Specification	Responsibility
2.21	An extension may arise if, for example, the person is too intoxicated for the assessment to take place, or if their physical condition means that they cannot yet be assessed. If this appears likely, those conducting the initial medical screening should notify the doctor who will be doing the mental health assessment at the earliest opportunity, so that they can consider whether they wish to extend time. Any decision to extend time should be recorded, with a note of the time when the decision was taken, how much additional time has been authorised, and giving a brief note of the reasons (currently there is no official paperwork for this). Note that the extension can be granted at any point up to the expiry of the initial 24 hours.	Health Based Place of Safety & Acute Trust
2.22	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 to extend the period of detention only if an officer of the rank of superintendent or above approves it.	Police
2.23	The initial medical screening and physical health assessment 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.	Health Based Place of Safety
2.24	On arrival, sufficient documentation should be provided to Health Based Place of Safety staff. If the individual has been transferred from the ED department this must include the appropriate clinical documentation. In any case, if insufficient or incomplete written documentation has been provided, this should not obstruct the patient's care. A serious incident form should be logged which should be fed back and reviewed by the local multi-agency group.	Health Based Place of Safety Acute Trust
2.25	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 ³⁴ 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.	Health Based Place of Safety
2.26	If requested by staff, Police will remain at the Health Based Place of Safety 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.	Health Based Place of Safety Police
2.27	Health Based Place of Safety staff must be able to summon extra help at short notice from the Trust's emergency team.	Health Based Place of Safety

Intoxication pathway

Case studies have been developed to provide further detail on the different 'intoxication' scenarios; these are available in Part 2 Appendix 2. Please refer to the Physical Health Assessment & Treatment Protocol in Appendix 11 for further information.

Ref	Specification	Responsibility
2.28	The Association of Chief Police Officers and the Independent Police Complaints Commission (2012) describe 'drunk and incapable' as an individual that has consumed alcohol 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.	Police
2.29	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 ED department or other alcohol recovery services. The same should occur for those who appear intoxicated by drugs to the point of being incapable. In instances above where the individual is intoxicated and 'incapable' but they have been detained under s136 the law must be adhered to in the usual way and the s136 pathway should be followed, but the individual may need to go to ED as per the Physical Health Assessment & Treatment Protocol.	Police Acute Trust
2.30	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 Health Based Place of Safety by the Ambulance service. The Health Based Place of Safety 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 Health Based Place of Safety to make the decision as to whether the individual requires medical assistance at the ED department. If so, the doctor should consider whether an extension of the detention period can be justified: see 2.20-2.22 above.	Health Based Place of Safety
2.31	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 ED department or Health Based Place of Safety). 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.	Health Based Place of Safety Acute Trust

Transferring individuals under s136 to another place of safety: legal responsibilities

Ref	Specification	Responsibility
2.32	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.	Approved Mental Health Professional Police
2.33	The transfer of an individual from a Health Based Place of Safety to an ED department occurs when the detained individual has urgent physical healthcare needs which cannot be safely managed at the Health Based Place of Safety. Again, this transfer needs to be approved by an AMHP or Police Officer. 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, 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.	Approved Mental Health Professional Police
2.34	The s136 coordinator is responsible for ensuring that an appropriate member of staff will travel with the person to take responsibility for their management and safety at all times until they either return to the Health Based Place of Safety or are formally accepted by the ED department for the purposes of the mental health assessment. During the time in ED, the detained individual remains in the custody of the staff member from the Health Based Place of Safety unless ED 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.	Health Based Place of Safety Acute Trust

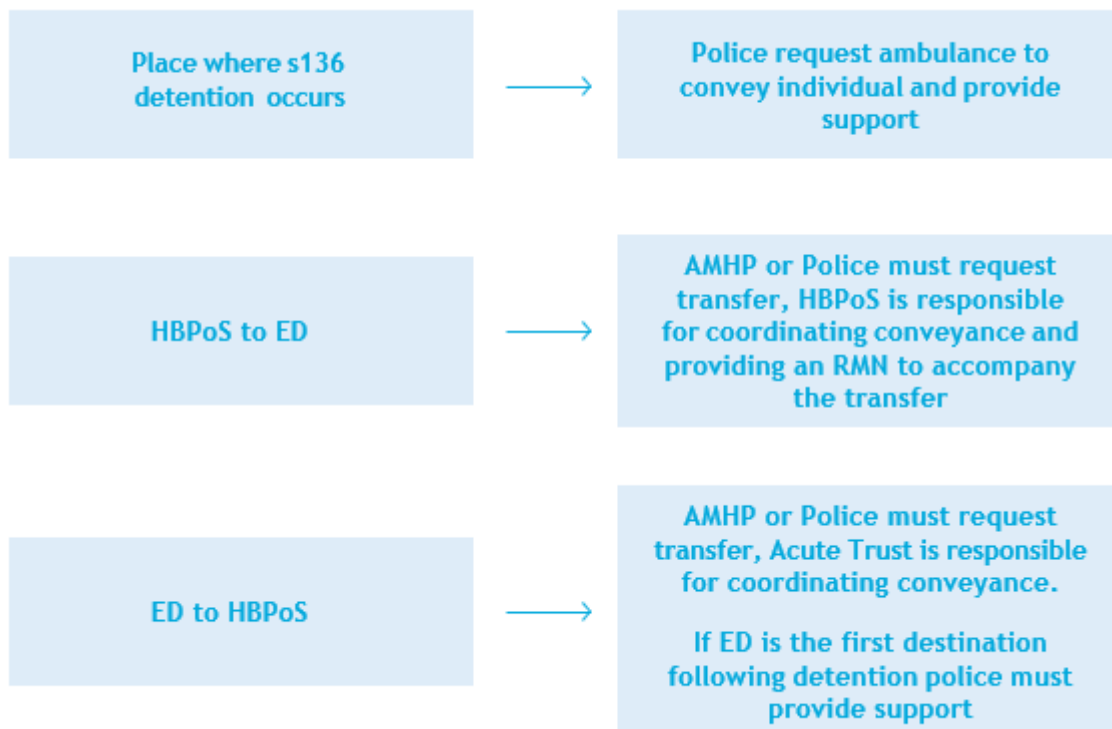
Ref	Specification	Responsibility
2.35	'Legal responsibility for custody' means formal responsibility for keeping the detained person (and others) safe and preventing the individual from absconding while they are subject to the s136 detention power. It must be clear at all times whether this role has 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 4. 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.	Health Based Place of Safety Acute Trust
2.36	Before ED staff accept formal legal responsibility for the person's custody, they must satisfy themselves 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. (See further at 3.6 below.) If ED are not willing or able to accept legal responsibility for the person, they continue to be in the legal custody of the police or Health Based Place of Safety staff who brought them to ED, who must not therefore leave the hospital until ED staff have formally accepted responsibility for the person.	Acute Trust

Responsibilities for coordinating conveyance between sites for those detained under s136

Ref	Specification	Responsibility
2.37	An individual detained under s136 may be conveyed between Health Based Place of Safety 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. There are no formalities under the MHA 1983 for such a transfer, but the following protocols have been agreed for the London area.	Health Based Place of Safety Acute Trust
2.38	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. Note that the detention period runs continuously from arrival at the first Place of Safety, which includes ED.	Health Based Place of Safety Acute Trust
2.39	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. It is the ICB's responsibility to ensure non-emergency patient transport service are commissioned in the local area. Coordinating the conveyance between sites should be led by the s136 coordinator at the Health Based Place of Safety. In an ED department this will usually be done by the ED nurse in charge.	Health Based Place of Safety Acute Trust ICB
2.40	If a transfer to ED is necessary it is the s136 coordinator's responsibility to notify the ED department of this transfer as soon as the decision has been made (when practicably possible), so staff are ready and able to receive the individual when they arrive.	Health Based Place of Safety Acute Trust
2.41	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 ED departments and vice versa should be undertaken by the Mental Health Trusts and Acute Trusts respectively, led by the s136 coordinator. 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.	Health Based Place of Safety Acute Trust
2.42	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 1 hour.	Approved Mental Health Professional Police

Ref	Specification	Responsibility
2.43	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 Health Based Place of Safety, then a decision to transport a person from the Health Based Place of Safety should be considered by the suitably trained medical professional. 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 relevant circumstances. In these circumstances the doctor who is responsible for the mental health assessment should consider whether an extension of the detention period can be justified: see 2.20-2.22 above.	Health Based Place of Safety Acute Trust Approved Mental Health Professional Police
2.44	If the individual is out of area and needs to be transferred to their local service, the current Health Based Place of Safety is responsible for coordinating the individual's transport; however, they will require assistance from the receiving hospital in doing so.	Health Based Place of Safety
2.45	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. Handover (which includes the formal transfer of papers) should take place within 30 minutes of arrival, which means the Health Based Place of Safety has taken over the legal responsibility for that individual. When a patient is transported between hospital sites (e.g. ED to Health Based Place of Safety) it must always be carried out with appropriate clinical documentation. On arrival at the receiving hospital, a full structured handover to the receiving team is required.	Health Based Place of Safety Acute Trust
2.46	All individuals who have received rapid tranquillisation (in an ED 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.	Health Based Place of Safety Acute Trust Ambulance Service
2.47	If Acute or Mental Health Trusts are unable to accept a transfer on clinical grounds, 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.	Health Based Place of Safety Acute Trust
2.48	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.	Health Based Place of Safety Acute Trust
2.49	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.	Health Based Place of Safety Acute Trust

Summary of conveyance responsibilities across the s136 pathway



Conveyance following a decision to admit an individual under the Mental Health Act

Ref	Specification	Responsibility
2.50	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 ends 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.	Approved Mental Health Professional
2.51	It will normally be appropriate for the s136 coordinator 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.	Health Based Place of Safety Approved Mental Health Professional
2.52	It should be noted that a MHA application cannot be completed until a specific hospital has agreed to make a bed available for the individual, who will therefore remain under s136 until this is done and will normally remain in the Health Based Place of Safety in the interim. As the Mental Health Act Code of Practice makes clear (see paras 14.77 ff), finding a bed is the responsibility of the doctors concerned and not the AMHP. In practice responsibility is normally delegated to bed managers at the relevant Mental Health Trust. (For further details of the admission process, see section 3 of London's Health Based Place of Safety Specification.)	Health Based Place of Safety Approved Mental Health Professional
2.53	If the application has been completed before the s136 detention period expires, it may sometimes be necessary for the detained individual to remain in the Health Based Place of Safety for a short period while transport is being arranged. The individual may continue to be appropriately restrained by the AMHP responsible for conveying them to hospital, or someone authorised by them, while waiting for transport (see sections 6(1) & 137 MHA). This applies even if the person has agreed to informal hospital admission.	Health Based Place of Safety Approved Mental Health Professional

3 The role of the ED department in the s136 pathway

Roles and responsibilities in the ED department

Ref	Specification	Responsibility
3.1	When an individual detained under s136 is conveyed to an ED department, the individual remains in police custody throughout the period in ED until one of the following takes place: - A s12 doctor, or another doctor with appropriate mental health experience, concludes that there is no underlying mental disorder and the individual is taken off s136. - ED staff accept responsibility for the individual's custody for the purpose of the mental health assessment. - The individual is conveyed to the local Health Based Place of Safety site. - The detention period under s136 has elapsed, however it is not good practice to let this happen.	Acute Trust s12 doctor
3.2	The decision to conclude there is no mental disorder should be exceptional. The decision should only be taken by a non s12 doctor if they have adequate knowledge of mental disorder to make the judgement. 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.	Acute Trust s12 doctor Approved Mental Health Professional
3.3	ED 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. In these circumstances the individual continues to be detained under s136 until formally discharged by a doctor if no mental disorder is present, or with the agreement of an AMHP in all other cases. The doctor who will be carrying out the mental health assessment at ED (liaison psychiatry or other doctor) should consider whether an extension of the detention period can be justified: see 2.20-2.22 above.	Acute Trust s12 doctor Approved Mental Health Professional
3.4	In these instances, it is vital that information about the individual's needs, and any associated risks, are clearly explained to ED staff receiving the person and also documented in the s136 paperwork. Any security staff at the ED department must likewise be properly briefed about the person before the ED takes responsibility for them. ED 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 individual.	Acute Trust Police

Ref	Specification	Responsibility
3.5	If the ED department decides against accepting the s136 papers the department must ensure the individual's physical health care is expedited to ensure the mental health assessment is able to commence promptly at the closest Health Based Place of Safety.	Acute Trust
3.6	Where ED staff have accepted legal responsibility for the person's custody, they have the legal power to detain the person there until the s136 is ended. Security and other staff employed by the Trust may use reasonable and proportionate restraint where necessary to keep the person safe. 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.	Acute Trust Police
3.7	Any decision to accept 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's custody if they are confident that ED staff, including 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.	Acute Trust
3.8	Due to the nature of ED departments, managing individuals detained under s136 in this environment can be challenging. Given this, when an individual detained under s136 is in the ED department police officers will provide the necessary support needed unless there is mutual agreement between the department and the police officers that they are able to leave.	Acute Trust Police
3.9	If the decision is taken that it is in the individual's best interest to transfer them from the ED department to a Health Based Place of Safety for the purpose of the mental health assessment, it must first be confirmed that the Health Based Place of Safety has capacity and is willing to receive the individual before the transfer takes place. It is the responsibility of the s136 coordinator/Liaison Team in the ED department to secure this confirmation.	Acute Trust Police
3.10	Whilst the individual is in the ED department, ED staff and mental health services must respond in a timely way to support appropriate assessment and consideration of alternative legal pathways. This includes: - Liaison psychiatry services seeing the individual within 1 hour of receiving a referral from the ED department (pre-assessment of immediate needs); - Where there are no clinical grounds for delay completion of the mental health assessment by the AMHP and s12 doctor should occur within 4 hours of the individual's presentation to ED.	Acute Trust Acute Trust s12 doctor Approved Mental Health Professional

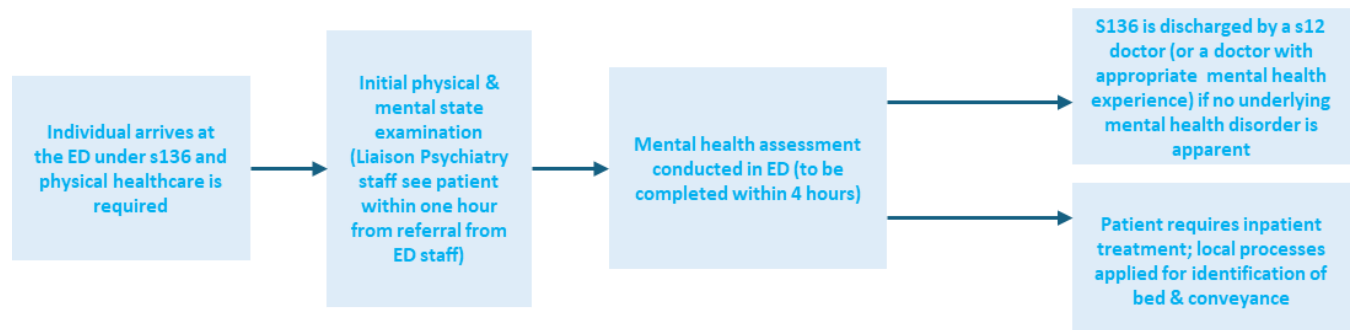
Ref	Specification	Responsibility
3.11	When the individual is referred to the liaison psychiatry team, the team (in particular the psychiatric liaison nurses and non-section 12 approved doctors) have a key role in supporting the mental health assessment process but are not involved in the assessment itself. The team's role includes: - Alerting the AMHP and s12 doctor of the arrival of the individual and the need to consider whether the mental health assessment should take place in ED. - Supporting the liaison with the medical team in the first instance to establish any relevant mental health history including medications to inform the physical health assessment and treatment plan. - Deciding whether there are safeguarding concerns, if so, a safeguarding alert should be raised. - Liaising with police, involved professionals or family/friends to gain collateral information on the presentation. - Liaising with the medical team during their initial assessment to obtain information for the s12 Dr and AMHP. - Providing an initial mental health examination to ensure the individuals' needs are met, such as arrangement of 1:1 nurse support and completion of immediate mental health risk assessment (pre-assessment of immediate needs). - Liaising with police, Health Based Place of Safety and ED staff to support in risk assessment and contribute to the decision regarding whether there is a need to transfer the individual to the local Health Based Place of Safety for a mental health assessment. - Considering whether an extension of the initial detention period can be justified (see 2.20-2.22 above). This decision can only be taken by a doctor who is responsible for the s136 assessment (i.e. the mental health examination). However, the law does not specify what level of doctor can take it. (Trusts may wish to have their own policy in this regard.) - Supporting the transfer of physical health care documentation from the ED to the Mental Health Trust. - Supporting the police who are supervising the detained patient	Acute Trust
3.12	To help meet the timeframes set out in above, ED department staff should ensure that those detained under s136 are referred to the liaison psychiatry team (or community CAMHS specialist) as quickly as possible and that the duty AMHP and s12 doctor are notified once they have arrived at the department. 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 particularly separating children and adult services (see Appendix 5).	Acute Trust s12 doctor Approved Mental Health Professional

Parallel assessments in the ED Department

Ref	Specification	Responsibility
3.14	To support the timely delivery of care for individuals detained under s136 and requiring physical health input, consideration should be given to a parallel and concurrent mental health assessment and treatment by medical staff.	Acute Trust
3.15	A mental health assessment should not be delayed for delivery of physical health treatment that has no predictable significant impact upon mental state. 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. The doctor who will be carrying out the mental health assessment at ED (liaison psychiatry or other doctor) should consider whether an extension of the detention period is justified: see 2.20-2.22 above).	Acute Trust
3.16	On initial presentation to ED consideration should be given immediately to the appropriate assessment of both physical and mental health needs. A shared care plan should be agreed between named mental health liaison and ED staff including the timeframes for assessment and treatment of both aspects of the individual's needs. Key steps of this process are outlined below: - Individual arrives at the ED department under s136 requiring physical health care; - Individual is triaged by ED staff for physical health needs and information handover given to mental health liaison team. This should include arrival, details of the presentation including physical and mental health concerns, location of the patient and the named ED clinician in charge of patient's care. - Liaison team to consider the clinical details and form an initial assessment plan which will include either a focused face-to-face review or waiting until the individual is stabilised. The liaison team to communicate this plan including the name and contact details of the liaison worker allocated to that individuals care whilst in the department. - ED staff concurrently complete assessment of physical health needs and communicate this to named liaison worker. - Liaison worker and ED staff agree together the next stages of 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.	Acute Trust

Ref	Specification	Responsibility
3.16 cont.	f. Mental health assessment will proceed alongside medical care at the point when there is no cause to believe that physical health assessment or treatment outstanding will impact significantly upon <i>mental state</i>. <i>Case studies are available in Appendix 6 providing examples of when parallel assessments should occur. The case studies also include when it is appropriate to transfer the individual to a Health Based Place of Safety to complete a Mental Health assessment.</i>	
3.17	If an individual has been assessed in an ED department and requires admission as an inpatient for further physical health care treatment at the Acute Trust, the patient will continue to be detained under s136 unless one of the following takes place: - The s12 doctor (or a non s12 approved doctor with appropriate mental health experience) finds the person to have no underlying mental disorder, in which case they must discharge the individual from the s136 without input from the AMHP. - A mental health assessment has been undertaken by a s12 doctor and AMHP and any necessary arrangements for the person's mental health care have been made, at which point the AMHP should agree with ED staff that the s136 can be discharged. - The detention period under s136 has elapsed, however it is not good practice to let this happen.	Acute Trust s12 doctor Approved Mental Health Professional
3.18	While the detained individual is in the ED department and is being treated for their physical health, the ED department staff have a clinical duty of care to that individual with support from medical and psychiatry specialties. This duty of care continues until the individual leaves the ED department. ED staff should also support the police who are supervising patients under s136.	Acute Trust
3.19	ED 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.	Acute Trust

The following diagram outlines the pathway for those detained under s136 in an ED department:



Further detail outlining the standards Accident and Emergency departments should adhere to in terms of mental health crisis care is included in the London Urgent and Emergency Care Facilities Specification that was developed in 2015 to support coordinated, consistent and clear urgent and emergency care provision in London.

Individuals under arrest in ED departments

Ref	Specification	Responsibility
3.20	On occasion, individuals who have been arrested for a criminal offence will require treatment for a physical health problem in the ED department. On initial assessment it may be determined that they are also in need of acute mental health care. In this case liaison psychiatry staff (nursing or medical as available/ appropriate) should provide mental health care in accordance with their duty of care to all individuals presenting to ED regardless of the fact the individual is under arrest. This includes all core roles carried out by psychiatric liaison nurses and wider liaison team (refer to 3.11).	Acute Trust
3.21	People under arrest for a criminal offence are not normally also subject to s136 Mental Health Act, so the procedures in this document would not be applicable. Exceptionally, someone may be both placed under arrest for a criminal offence and also made subject to s136. In this situation, ED staff must be notified immediately of the person's legal status, and the processes in this document should be followed.	Acute Trust

4 Acute Trust and Health Based Place of Safety care pathways

Ref	Specification	Responsibility
4.1	To ensure a streamlined pathway Acute Trusts and Health Based Places of Safety (when provided by the Mental Health Trust) should have local protocols in place that 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	Acute Trust Health Based Place of Safety
4.2	Discharge documentation from a Health Based Place of Safety or ED (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 plan 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	Acute Trust Health Based Place of Safety

Ref	Specification	Responsibility
4.3	The principal components of the care pathways should include: • Support and buy in from surgical, medical teams and the ED 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 including outreach and fast track care pathways. • 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. shared care records, location specific clinical communication templates) • 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. • Optimising available technology for example secure clinical picture transfer systems, shared notes systems and telemedicine facilities. • Ensuring an agreed plan to support the rapid medicines reconciliation/ pharmacist handover. Plans and pathways should ensure specific detail about the transfer of medications from the Mental Health Trust or patient supply as appropriate to support immediate reconciliation on arrival in the Acute Trust. This will also reduce an unnecessary volume of activity for pharmacy in accessing and ordering the required medications.	Acute Trust Health Based Place of Safety

Examples of care pathways are included in Appendix 7.

1. Part 3: London's Health Based Place of Safety Specification

1 Governance and monitoring

Strategic governance – Urgent and Emergency Care Networks

Ref	Specification	Responsibility
1.1	London's Urgent & Emergency Care (UEC) networks have collective responsibility for the equitable provision of care and patient outcomes across their footprint, ensuring that the London standards of care relating to urgent physical and mental health are delivered.	UEC network
1.2	National guidance outlines that the UEC Network should ensure appropriate representation from key organisations across the network geography, whilst maintaining a lean core membership. The following should be present or clearly represented: • Constituent local ED Delivery Boards, and ICBs (including lead commissioner for ambulance services) • Acute Trusts and Urgent Care Centres • Mental health Trust and provider of health-based place of safety • Health and Wellbeing Board • NHS 111 provider • GP out-of-hours provider • London Ambulance Service • Community healthcare provider • Local authority • NHS England regional representatives • Community pharmacy services • Local Healthwatch or similar patient and public representation • Other key commissioned independent providers	UEC network

Operational governance – Local multi-agency groups

Ref	Specification	Responsibility
1.4	A local multi-agency group led by the provider Trust providing the Health Based Place of Safety should exist for each Health Based Place of Safety across London and be overseen by the respective UEC network. Each group should be positioned within the local governance system and have appropriate representation to ensure that there is adequate oversight and accountability in line with local approaches across the health and social care system.	Local multiagency group
1.5	The local multi-agency group must be attended by senior representatives from the Health Based Place of Safety, local ED departments (including liaison psychiatry staff), Approved Mental Health Professionals, the Police, London Ambulance Service and Healthwatch (or other patient representatives). The group should ensure the membership is able to represent all ages.	Local multiagency group
1.6	The group should perform the following roles: • Measure and analyse current performance at the Health Based Place of Safety (specific measurements to be monitored are included in Appendix 8). • 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. • Discuss specific case studies where issues have occurred across the pathway to ensure learnings across the system from these specific cases. • Facilitate training initiatives on local policies and protocols which include key partners and local Acute Trusts. • Network with other local multiagency groups across London to ensure consistency of service across the s136 pathway. • Ensure the Directory of Services is regularly updated showing accurate up-to-date information regarding the Health Based Place of Safety site.	Local multiagency group

2 Estates

Location and facilities

Ref	Specification	Responsibility
2.1	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.	CCG Mental Health Trust
2.2	Where possible the Health Based Place of Safety should be situated near an ED department to ensure the continuity of care for individuals and to avoid long transfers between Health Based Place of Safety sites and ED departments. If the Health Based Place of Safety is not near an ED robust clinical pathways and protocols must be established in order to provide an effective and efficient pathway – clinical pathways between the Acute and Mental Health Trust are outlined in ‘London’s s136 pathway’.	CCG Mental Health Trust
2.3	There should be an area for the police and ambulance staff to wait on arrival at the Health Based Place of Safety or ED site whilst the necessary handover processes occur.	Mental Health Trust
2.4	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. • Have CCTV with visibility of the entire room to enhance staff protection and safeguarding. • Optimally a room that is visually appealing, painted murals on the walls and some ability to play music which can provide a sense of calmness and facilitate recovery. • A clean mattress for sleeping or resting and to assist any necessary medical examination.	CCG Mental Health Trust

Ref	Specification	Responsibility
2.5	The number of assessment rooms at the Health Based Place of Safety must be modelled off 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.	CCG Mental Health Trust
2.6	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.	CCG Mental Health Trust
2.7	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 whilst the individual is in the assessment room (Refer to the South London and Maudsley Mental Health Trust case study on page 55). • Clean clothes for emergencies should be available. • Facilities for visitors including a separate waiting area.	CCG Mental Health Trust

Equipment

Ref	Specification	Responsibility
2.8	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	Mental Health Trust
2.9	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. If the individual is asleep the site should be designed to support auditory as well as visual observations of respiratory rate for example through a high-quality intercom system.	Mental Health Trust
2.10	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.	Mental Health Trust

3 Mental health assessment process

Ref	Specification	Responsibility
3.1	Mental health assessments must not be delayed due to uncertainty regarding the availability of a suitable bed.	Approved Mental Health Professional Mental Health Trust
3.2	The mental health assessment should be completed within 4 hours of the individual arriving at the Health Based Place of Safety ³⁶ 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 ED department or, after being clinically assessed by the team, being deemed to require more time for their mental state to settle.	Approved Mental Health Professional s12 doctor Health Based Place of Safety
3.3	Medical staff at the Health Based Place of Safety 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 Health Based Place of Safety staff.	Approved Mental Health Professional Health Based Place of Safety
3.4	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 (see below).	Approved Mental Health Professional s12 doctor
3.5	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.	Approved Mental Health Professional s12 doctor Mental Health Trust

Ref	Specification	Responsibility
3.6	The first doctor carrying out the assessment should normally be approved under section 12(2) of the Mental Health Act. In exceptional circumstances where mental health assessments are undertaken by core psychiatry trainees who are not approved under s12, a discussion with the senior s12 doctor must occur and their name and advice must be recorded in the notes. However, it should be noted that a hospital admission under s2 or s3 MHA 1983 can only take place if recommendations are received from two doctors, and if one of the medical recommendations is completed and signed by a s12 approved doctor. The Mental Health Act Code of Practice states that, if neither doctor has previous acquaintance with the person, both doctors giving the medical recommendations should be s12 approved.	Approved Mental Health Professional s12 doctor Mental Health Trust
3.7	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 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.	Approved Mental Health Professional s12 doctor
3.8	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 borough in which they are currently being detained under s136.	Approved Mental Health Professional
3.9	If the s12 doctor, or other doctor with mental health training/experience (for example a liaison psychiatrist), 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.	Approved Mental Health Professional Mental Health Trust Acute Trust

Ref	Specification	Responsibility
3.10	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 consider that the person needs to be held at the Health Based 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.	Approved Mental Health Professional Mental Health Trust Acute Trust
3.11	Decisions to immediately release the individual should not be made lightly. Whilst 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.	Approved Mental Health Professional Mental Health Trust Acute Trust
3.12	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 and completed by another, 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). 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.	Approved Mental Health Professional Mental Health Trust Acute Trust
3.13	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 CAMHS specialist doctor, a consultant with experience in CAMHS or an AMHP with knowledge and experience of caring for this age group available to undertake the mental health assessment.	Approved Mental Health Professional Mental Health Trust Acute Trust
3.14	The Trust commissioned to provide the Health Based Place of Safety should ensure assessing doctors and AMHPs have up 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.	Mental Health Trust

Ref	Specification	Responsibility
3.15	The AMHP and assessing doctors must also have prompt access to interpreting and signing services if required.	Mental Health Trust
3.16	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, subject to the legal time limit.	Approved Mental Health Professional
3.17	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, unless extended - see below) 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 ED is itself a Place of Safety within the meaning of the MHA, so if the person subject to s136 is first taken to ED department the detention period starts at the time of their arrival at ED, and not at their arrival at any subsequent Health Based Place of Safety.	Acute Trust Health Based Place of Safety
3.18	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, including ED). The period may be extended to 36 hours by the doctor conducting the mental health assessment, but only if they cannot complete their assessment within the 24 hours because of the person's condition. 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. Unless the person is being held on an in-patient ward the 'holding powers' under s5(2) and 5(4) of the Mental Health Act 1983 cannot be used to extend the detention period.	Acute Trust Health Based Place of Safety Approved Mental Health Professional
3.19	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 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. Trusts should have their own policy on this, which should be made available to staff at the Health Based Place of Safety, and also at ED if it is used as a Place of Safety.	Acute Trust Health Based Place of Safety

Ref	Specification	Responsibility
3.20	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.	Acute Trust Health Based Place of Safety
3.21	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 (see above) 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.	Mental Health Trust
3.22	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 AMHP responsible for conveying them to hospital, or someone authorised by them, while waiting for suitable transport (see sections 6(1) & 137(2) MHA).	Approved Mental Health Professional Health Based Place of Safety
3.23	When 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.	Health Based Place of Safety CCG
3.24	It should be noted that, while Wales is covered by the MHA 1983, Scotland, Northern Ireland, the Channel Islands and the Isle of Man have different mental health legislation. Any hospital 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 in the usual way and not delayed while a transfer to the home area is being organised.	Mental Health Trust CCG

The mental health assessment may result in one of six outcomes:

- S12 doctor or other doctor with mental health expertise concludes that there is no mental disorder at all, and the person is immediately discharged.
- S12 doctor and AMHP conclude that the person's mental disorder does not require a hospital admission, but that arrangements need to be made for support from community-based services. The AMHP has responsibility for ensuring that these arrangements are put in place. In this case the person should normally be discharged home, unless the AMHP and the s136 co-ordinator is satisfied that the risks in doing so justify keeping them in the HBPoS while these arrangements are being made. During this process the individual should be made aware of support available if their situation deteriorates in between treatment, this could be a 24/7 crisis line available in each local area.
- S12 doctor and AMHP conclude that a hospital admission is required, and the patient with capacity to do so consents to it (s.131 of the Act). It is the AMHP's judgement as to whether the patient has the relevant capacity and whether it is safe to rely upon their consent (see MHA Code of Practice, 2015 edition, paras 14.14 – 14.15).
- S12 doctor and AMHP conclude that a hospital admission is required and the AMHP is satisfied that the person lacks the capacity to give a valid consent to this but is not likely to resist admission or medical treatment once in hospital. In this case the person could be admitted under the Mental Capacity Act, but the hospital is responsible for making any deprivation of liberty lawful, by applying for a DOLS authorisation or, where appropriate, going to the Court of Protection. It is the AMHP's judgement as to when a MCA admission is appropriate.
- S12 doctor and AMHP conclude that a hospital admission is required but that the person is resisting admission or any necessary inpatient medical treatment or is likely to do so. This includes where the person is known to have made an 'advance decision' refusing the treatment which they are judged likely to need. In this case the AMHP should normally apply for admission under the MHA 1983, though they have the discretion to delay making the application for up to 14 days following the second medical recommendation being made.

- S12 doctor and AMHP conclude that the person needs a hospital admission but is currently subject to a Community Treatment Order. In these circumstances the patient's Responsible Clinician (consultant legally responsible for their mental health treatment in the community, or their authorised deputy) should be notified as soon as possible and invited to provide a signed Notice of Recall (Form CTO3), which requires the person to be taken to the hospital specified in the Notice. If the Responsible Clinician cannot be contacted in time, or if they do not provide a signed Notice of Recall within the necessary timescale, the patient may be admitted to hospital voluntarily, under the MCA or under s.2 MHA 1983 and the Notice of Recall can if required be served on them at that stage.

4 Workforce

Section 136 coordinator

Ref	Specification	Responsibility
4.1	Every Health Based Place of Safety should have a designated s136 coordinator available 24/7 who is assigned to the Health Based Place of Safety at all times. The s136 coordinator role should be performed by the most senior person 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.	Health Based Place of Safety
4.2	The s136 coordinator should be the first contact for the police or ambulance service on arrival at the site. The s136 coordinator will assume immediate responsibility for: - Accepting the individual to the Health Based Place of Safety - 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 individual³⁵. - 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 their right to 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 ED department if physical health care is required, ensuring ED staff are ready for the arrival of the individual. The s136 coordinator is also responsible for arranging transport from the Health Based Place of Safety to the ED 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).	Health Based Place of Safety

Staffing requirements within a Health Based Place of Safety

Ref	Specification	Responsibility
4.3	Adequate, dedicated staff must be available 24/7 to ensure staff members do not come off inpatient wards to fulfil this function. Similarly, if the Health Based Place of Safety is co-located with an ED department there must be adequate staff available to ensure that the unit does not have to rely on members of the liaison psychiatry team to fulfil this role in addition to other demands.	Health Based Place of Safety
4.4	At all Health Based Place of Safety sites staffing levels should be modelled off 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.	Health Based Place of Safety
4.5	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 s136 coordinator via the service manager.	Health Based Place of Safety
4.6	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 CAMHS competencies or access to senior CAMHS advice. These two roles should provide support to the s136 coordinator as well as clinical staff when performing the initial medical screening and physical health checks.	Health Based Place of Safety
4.7	Extra clinical staff (minimum of three) from the wider MDT 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.	Health Based Place of Safety
4.8	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 Safety should ensure these competencies are up to date.	Health Based Place of Safety

Ref	Specification	Responsibility
4.9	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.	Health Based Place of Safety Police
4.10	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.	Health Based Place of Safety
4.11	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.	Health Based Place of Safety Police
4.12	In instances where the ED 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.	Acute Trust
4.13	In these instances, any security staff at the ED department must be properly briefed about the person before the ED takes responsibility for them and the ED 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. ED 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.	Acute Trust

Staffing for Health Based Places of Safety accessible for children and young people

Ref	Specification	Responsibility
4.14	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.	Health Based Place of Safety
4.15	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).	Health Based Place of Safety
4.16	There should be access to on-call CAMHS trained doctors as well as access to general paediatric staff when a medical assessment is required.	Health Based Place of Safety

Health Based Place of Safety staff physical health competencies

Ref	Specification	Responsibility
4.17	Health Based Place of Safety staff (including both nursing and medical staff) should have the following physical health competencies to prevent unnecessary ED referrals; further detail is provided in Appendix 9. • 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.	Health Based Place of Safety

Staff training

Ref	Specification	Responsibility
4.18	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).	Local multiagency group

4.19	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. • 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.	Health Based Place of Safety
4.20	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.	Health Based Place of Safety
4.21	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.	Mental Health Trust
4.22	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.	Mental Health Trust

5 Patient information

Ref	Specification	Responsibility
5.1	During any handover between services, from the ambulance service, police or between Acute and Mental Health Trusts, it is essential that a 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.	Police Ambulance Service Health Based Place of Safety Acute Trust
5.2	When the individual first arrives at the Health Based Place of Safety or ED the transfer process must include the submission of the '434 form ', and completion of Part 2 of the form by the receiving NHS organisation.	Police Health Based Place of Safety Acute Trust
5.3	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 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).	Health Based Place of Safety Acute Trust

Ref	Specification	Responsibility
5.4	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.	Health Based Place of Safety Acute Trust
5.5	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.	Health Based Place of Safety Acute Trust
5.6	The individual should be provided with information about s136, both orally 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).	Health Based Place of Safety

6 Follow up or discharge

Ref	Specification	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 or further support. This should also include prompt and adequate communication with the individual's GP, together with any information on the treatment plan which has been formulated.	Health Based Place of Safety
6.2	The AMHP has responsibility for ensuring follow up care arrangements are in place but the S136 coordinator 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. If a S136 or alternative pathway has been agreed, it is the host S136 co-ordinator's responsibility to inform the responsible trust verbally and follow up with notes. The responsible trust will make the necessary arrangements for ongoing care.	Health Based Place of Safety Approved Mental Health Professional
6.3	Discharge documentation from a Health Based Place of Safety or ED (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 plan 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	Health Based Place of Safety Acute Trust

Ref	Specification	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.	Health Based Place of Safety
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 talking therapies that are on offer for the individual.	Health Based Place of Safety
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 coordinator is responsible for making any necessary referral to the appropriate local service, obtaining advice if the person's place of residence is not clear.	Health Based Place of Safety
6.7	If an individual declines, follow up care there may be other issues that need to be pursued (e.g. safeguarding). The s136 coordinator 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.	Health Based Place of Safety
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.	Health Based Place of Safety
6.9	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.	Mental Health Trust ICB

Appendix

Appendix 1: Key messages from service user workshops

Engagement with service users and carers has been central to the development of this work. Five workshops were held across London's UEC networks as well as a further two workshops specifically focussed on children and young people and individuals from black, minority, ethnic (BME) communities. A number of key themes were identified throughout this engagement process:

- Staff should introduce themselves to the patient and make them feel welcome and wanted. On arrival, patients should receive an explanation of the process for assessment and their rights under the Mental Health Act; this should be repeated during the detention where appropriate. Staff should recognise that patients often find the use of compulsory powers humiliating
- Staff should treat patients with compassion, kindness, dignity and respect. Staff should have received interpersonal skills training for communicating with patients. Communication should be empathic, positive and honest. Staff should not make pre-judgements about any patient; this discourages patients from speaking openly and honestly about their situation.
- The patient's mental health needs should be taken seriously. Listening to the patient and understanding the situation from their perspective is extremely important and staff should take time to engage, ask questions and listen to their needs, including needs beyond mental health.
- It is important for patients to have contact with a family member, carer or friend during a crisis. Staff should contact a nominated person to inform them of the patient's detention, the care they are receiving and the s136 process. When a family member, carer or friend is not available peer support should be considered to support the patient and a mental health advocate if the patient is further detained under the mental health act.
- Therapeutic engagement should be facilitated; staff should spend quality time with patients to empower the patients to actively participate in their care
- Approaches to managing care should be patient centred. All interventions should be based on equality and diversity principles.

- Staff should understand and be responsive to the cultural and religious needs of patients, it is important for staff to take time to understand the factors related to the patient's culture and background. Follow up support should consider cultural implications and the barriers to accessing support as cultures may view mental health differently. Staff should arrange follow up community support in the patient's first language.
- Staff should understand how to calm a patient down and deescalate a situation to prevent violence and aggression. Staff should have a knowledge of 'talk down' intervention models and may want to refer to models promoted by Safewards.
- Trusts should involve 'experts by experience' in staff training to ensure staff fully understand patient needs.

Appendix 2: Alternative to s136 detention – Case Studies

Mental Health Triage, Leeds and York Partnership NHS Foundation Trust and West Yorkshire Police

In December 2013 a mental health triage advice line was launched to enable police officers to receive specialist mental health support between 3pm and 1am seven days a week. The triage team consisted of two Band 6 mental health clinicians (nurse, AMHP, occupational therapist) and a health support worker. The staff would make an initial assessment via the advice line before deciding if an intervention could be made over the phone or whether a face-to-face assessment was needed. It cost £200,000 to run and was funded by the Department of Health as part of nine pilot schemes.

Impact: s136 detentions reduced by 26 per cent during this initial pilot and there was an indication this power was being used more appropriately as formal admissions to health services following a detention increased by 33 per cent. The Police and NHS services reported improved partnership working and sharing of information which led to quicker interventions for individuals in crisis.

Expanding the service: In December 2014 the Crisis Triage service was extended to operate 24 hours a day, seven days a week with referrals into the service extended to the British Transport Police and Yorkshire Ambulance Service. The team involves one Band 6 mental health clinician who undertakes the assessments with support from either a Band 5 clinician or a Band 3 health support worker. The service is jointly funded by West Leeds Clinical Commissioning Group, Leeds & York NHS Partnership Foundation and West Yorkshire Police at a cost of £481,630 a year.

The level of s136 detentions remains low but the reduction in detentions has slowed as the activity for mental health crisis services has significantly increased. Evidence indicates that there continues to be less inappropriate s136 detentions year on year with around 30 per cent of s136 detentions resulting in an admission of which 70 per cent are admitted formally.

24/7 Single Point of Access: Central and Northwest London NHS Foundation Trust (CNWL)

Central and Northwest London NHS Foundation Trust (CNWL) launched a Single Point of Access (SPA) line in November 2015 as a one-stop integrated referral point into adult secondary mental health services for patients residing in the Northwest London. Designed as part of a broader new urgent care pathway for mental health, the service was implemented to improve 24-hour support and access for mental health crisis care, reducing the number of individuals presenting to ED and providing a streamlined and centralised entry point to adult mental health.

The service runs 24 hours a day, 7 days a week and offers mental health triage for routine, urgent and emergency referrals, information and advice. Where a patient needs secondary adult mental health services, the SPA will book them into an appointment with the relevant team or access the local Crisis Resolution Team in the case of emergency or urgent referrals.

Impact: Since its launch, the service has received positive feedback from GPs, carers and service users. GPs have reported that the 24/7 line has led to increased confidence in dealing with mental health crises, and the quick, paperless access to a clinical opinion has significantly cut the amount of time between a crisis being reported, evaluated and acted upon.

The service received 27,000 calls in its first seven months of operation and referrals are increasing every month. Nearly 50 per cent of referrals are for urgent or emergency cases and the service works closely with home treatment and rapid response teams to provide intensive support to people in acute mental crisis in their homes.

The service is also developing links with London's 111 service to facilitate warm transfers from 111 to the SPA. This will ensure that those requiring mental health support can access a mental health professional 24/7, reducing the need to defer to ED.



Mental Health Crisis Care for Londoners

Psychiatric decision units

Birmingham and Solihull Mental Health NHS Foundation Trust Psychiatry Decision Unit (PDU)

The PDU is a 24-hour mental health acute assessment unit that enables more in-depth assessments which can last up to 72 hours for individuals experiencing a mental health crisis. Individuals are referred to the PDU via the Rapid Assessment, Interface & Discharge (RAID) liaison psychiatry service from four hospitals and the street triage team.

The unit is an ambulant assessment area that includes eight recliner chairs and provides the opportunity for staff to explore the patients' complex needs in more detail.

The ability to observe patients for a longer period of time enables staff to develop a tailored care plan to manage the patients' acute crisis and further care, which usually occurs in the community.

Staff members at the PDU have worked to build relationships with community services and increase the awareness of the PDU service. This engagement has increased staff members' understanding of community services and the acceptance criteria to enable rapid and appropriate referrals of individuals.

The PDU forms part of the Oleaster Centre Psychiatric Hospital located on the Queen Elizabeth Hospital site. It was originally commissioned in November 2014 by

Birmingham Cross City CCG to address winter pressures at Heart of England NHS Foundation Trust and University hospital Birmingham NHS Foundation Trust and is now funded on a recurrent basis.

Impact: An evaluation of the service in 2015 showed:

- 26 per cent decrease in inpatient bed admissions via the RAID team (down to 219 admissions) and 6,900 inpatient bed days saved
- 39 per cent decrease in the number of patients Street Triage brought to ED as a result of being taken to the PDU (reduced to 180 patients)

- Patients stayed on average 16.46 hours at the PDU and 84 per cent stayed less than 24 hours

Patients and staff have been very positive about the PDU and feel it is a more appropriate place for mental health crisis patients than an ED department.

Leeds and York Partnership NHS Foundation Trust Crisis Assessment Unit (CAU)

The CAU is open 24 hours a day to manage an individual's acute and complex mental health crises and undertake a brief period of extended assessment (up to 72 hours) to understand how their medium-term care needs can be met. Referrals are made via the Crisis Assessment Service (CAS).

The unit consists of assessment rooms, dining facilities, toilets and showers and amenities such a laundry facility, with overnight facilities for up to six people and the Health Based Place of Safety next door with capacity for four. The unit has been designed to be flexible to respond to changes in demand for accommodation for service users of one sex or the other.

The service operates a recovery-focussed approach with personalisation of care, shared decision-making and supported self-management. Staff manage the patient's immediate crisis through tailored psychosocial interventions and medical treatment as required.

The CAU is always staffed by a minimum of five people per shift with two Registered Mental Health Nurses and a Registered Clinician. Additional staff can include occupational therapists, AMHPs, social workers, psychiatrists, support workers and harm reduction workers. The staff to patient ratio enables staff to spend more time to engage with patients in a therapeutic way. The unit opened in July 2015 and forms part of the Becklin Centre Mental Health Unit located next to St James's University Hospital in Leeds. The CAU has been jointly funded by the Trust and the three Leeds Clinical Commissioning Groups (CCGs) at a start-up cost of £1.3million.

An initial evaluation has showed the following impacts:

- 182 admissions to the CAU between April 2015 and November 2015.
- 20 per cent reduction in average weekly hospital admissions.

- Majority of individuals returning to their home following discharge from the service.
- Staff and service user feedback on the service has been very positive. The unit expects to assess around 1500 patients per year.

Appendix 3: Intoxication pathway scenarios

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 convey the male to hospital where necessary medical checks are conducted.

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.

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.

Intoxicated and incapable, with a mental health disorder

Police Officers come across a male unconscious in the early hours of the morning laying on the floor on a London Bridge situated over the River Thames. 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 and was unable to pick himself up. Due to the male being uncooperative and in immediate need of care or control,

officers decide to detain him under s136 MHA. Officers request an ambulance and escort the male with the ambulance, to the nearest ED department. Whilst being treated for the alcohol ingestion and head injury, the hospital liaison and psychiatry services also arrange a mental health assessment to be conducted once he has sobered up and whilst the male is treated within the ED department. Police guard the male until either a doctor with mental health experience decides there is no mental disorder present, or an AMHP agrees with ED staff to end the s136 detention.

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 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.

Intoxicated with a mental health disorder

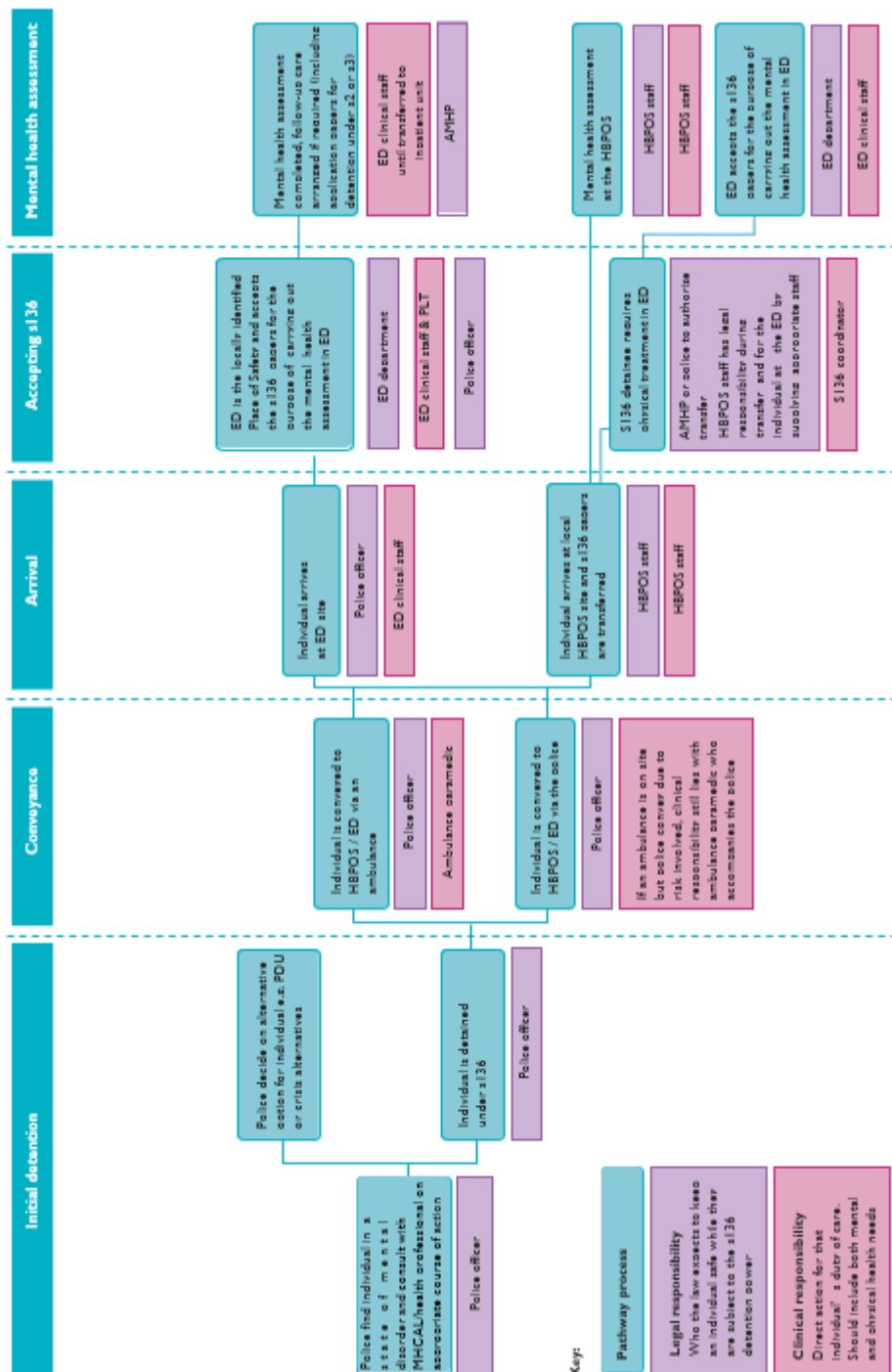
Police are called to a female standing on a road bridge threatening to jump. Officers manage to engage the female in conversation and can tell she is under the influence of alcohol. Her speech is slurred, yet she is aware of her surroundings and intentions to kill herself. She claims it's due to her personal circumstances and her inability to fight continual feelings of depression. As she prepares to jump, officers on scene manage to grab her and pull her to safety. She is detained under S136, the ambulance service arrives and medically screen her and decide to take her to a Health Based Place of Safety because despite being intoxicated she is still able to be assessed.

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. Whilst 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. 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. When assessed and detained under the Mental Health Act, they later choose to street bail the male for the criminal damage. It is no longer necessary under Code G PACE to keep the male under arrest.

Appendix 4: Clinical and legal responsibilities in the s136 pathway



Appendix 5: 24 hour Approved Mental Health Professional (AMHP) service model

Adequate provision of AMHPs out of hours is a common problem across many London boroughs and can result in individuals who have been detained under s136 waiting for excessive periods of time to have a Mental Health assessment. The case studies from the boroughs of Hackney and Greenwich provide an example of how these issues can be addressed.

Case for change: Hackney and Greenwich boroughs have both reviewed their arrangements of their AMHP provision. The out of hours service in Greenwich was provided by children's services and Hackney relied upon their Emergency Duty Team (EDT). Similar to many other boroughs at the time, Mental Health assessments were often delayed when the out of hours service had to prioritise with competing demands due to the responsibility of covering all emergency social work situations (e.g. safeguarding children and crises in adult social care). Mental Health assessments were often deemed a lower priority. Consequently, people were waiting in Health Based Places of Safety for several hours, on occasions up to the 72-hour maximum duration. There was also an inconsistent approach for assessments between the different teams managing the in hours and out of hours service.

Solution: Greenwich and Hackney developed innovation 24/7 dedicated AMHP services to provide a single point of access and seamless pathway to all referrals for individuals in mental health crisis who may require a Mental Health assessment.

In Greenwich, there is now a 24-hour AMHP services made up of a core team of AMHPs who operate with the support of locality AMHPs employed in other mental health teams who feed into the centralised rota three days each month. In addition, there is also a pool of sessional AMHPs that can be called on 'as and when' to meet increasing demand. In hours (9am to 5pm), a team of up to seven (which includes a team manager and assistant manager) is located in the community with one member based at the local psychiatric unit which has a dedicated HBPoS on site. The HBPoS continues to be manned by the out of hours AMHP between 5pm and midnight to meet the increasing demand of s136 activity and they remain on call until 9am. Greenwich undertakes approximately 27 out of hours assessments per month.

Hackney decommissioned their EDT to provide a dedicated 24-hour London Borough of Hackney and East London Foundation Trust AMHP service. The service

is staffed by AMHP's from other mental health locality teams who feed into the rota for a maximum of five days per month. In hours, the service is staffed by three AMHPs who are based at the Homerton hospital next to the HBPOS before they handover to a member of the team who is on call from 5pm to 9am. The service aims to respond in a timely manner and to provide consistency and continuity of care to people requiring a mental health assessment at any time of the day. Hackney undertakes approximately 25 assessments out of hours per month.

Impact: The 24 hour centralised models have enabled both AMHP services to be accessible and responsive and this has led to improved response times. The services provide consistency and continuity of care to people requiring a mental health assessment at any time of day. The core team in Greenwich have developed a better understanding of the needs of the community and referrers to the Hackney out of hours service have reported it being more accessible and responsive. The Hackney out of hours service also operates at a lower cost than commissioning the boroughs EDT to provide Mental Health assessments.

Appendix 6: Examples of parallel assessments in ED

Example 1 – Individual unknown to mental health services, detained under s136 for behaving bizarrely in public but no previous history of such behaviour. Evidence of laceration to head and clinical concern that organic (physical) reason for disturbance of behaviour. Mental health assessment should not proceed until medical reasons for presentation (e.g. physical examination, bloods and neuroimaging) have been concluded.

*There is potential that a physical disorder is the cause of disturbed mental state and full assessment should be performed and physical aetiology excluded before a mental health assessment proceeds.

Example 2 – Individual well known to services with relapsing and remitting psychotic illness brought into ED after two-week history of showing relapse signs. Just prior to being detained under s136 the individual fell whilst running from the police and suffered laceration to arm.

Mental health assessment should proceed concurrently with physical health assessment and treatment ensuring that appropriate treatment for pain has been administered prior to commencing the assessment. If individual is in substantial pain and there is suspicion this could be significantly impacting upon mental state, there may be cause to delay the assessment until treatment has stabilised the individual, but plans should be made from point of arrival at ED to proceed to an assessment. Doctor undertaking the mental health assessment considers whether an extension to the detention period can be justified (see 2.20-2.22 above).

* There is clear evidence of a primary mental disorder and relapse leading up to the incidental physical health problem and delays should be avoided in providing urgent mental health care.

Example 3 – Individual brought into ED on s136 following intentional overdose of paracetamol. They require administration of treatment for overdose which will take 12- 24 hours. Mental health assessment should proceed concurrently with administration of overdose treatment.

Example 4 – Individual brought to ED on s136 showing floridly psychotic, highly agitated and disturbed behaviour. When placed on s136, noted to be limping with swollen foot so conveyed by the ambulance service to ED. Individual fast tracked

through ED and receives x-ray with no further action required. Individual continues to show high levels of disturbed and agitated behaviour whilst in ED, therefore they are transferred promptly with police escort to the nearest Health Based Place of Safety to undergo a mental health assessment in the most appropriate environment for his needs.

Appendix 7: Acute and Mental Health Trust care pathway examples

Presentation and disordered behaviour suspected to be directly due to physical pathology (e.g. postictal, head injury, cerebral infection and organic psychosis) requiring immediate treatment

Actions:

Referrer (London Ambulance Service, s136 coordinator or HBPOS medic)

Direct referral to the ED department with an ambulance transfer

Referrer to telephone receiving clinician at the ED department
Transfer of additional required clinical information to be agreed during phone call

Name and number point of contact exchanged for referrer and clinician receiving and documented in both notes

Liaison psychiatry/specialist CAMHS to provide departmental mental health advice as required.

Presence of additional co-morbid acute pathology that is compounding presentation in mental state and presents acute risk to health requiring urgent treatment (e.g. infection, pain, surgical or medical aetiology)

Actions:

Telephone triage advice from the ED department medical, surgical or paediatric registrar

Referrer to provide medical summary, clinical findings, labs and bed side tests as appropriate and available
Transfer of required clinical information to be

agreed during phone call. Name and number point of contact exchanged for referrer and clinician receiving and documented in both notes

Ambulance transfer if agreed to the ED department, Surgical Assessment Unit or Medical Assessment Unit as appropriate

Liaison psychiatry/specialist CAMHS to provide departmental mental health advice as required

<i>Presence of additional unstable pathology with no overt impact on mental state (e.g. musculoskeletal injury, wounds)</i>	Actions: Telephone Triage advice: HBPoS medic to ED triage nurse or speciality registrar Access to secure image transfer to support referral assessment Fast track, in reach or outreach review including assessment appointment time (if next day review deemed appropriate) to be agreed during referral consultation Name and number point of contact exchanged for referrer and clinician receiving and documented in both notes Transfer of required clinical information to be agreed during phone call.
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<i>Risk factors for, or presence of, undiagnosed or treated stable pathology including chronic disease requiring further medical input (e.g. obesity, hypercholesterolaemia, hypertension, diabetes, chronic obstructive pulmonary disease, liver disease, congestive cardiac failure)</i>	Actions: Health Based Place of Safety to arrange assessment and follow up with primary care provider
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Appendix 8: Measurements to be monitored by the local multiagency group

- Percentage of occasions where the police conveyed to the place of safety with no paper record / under the Mental Capacity Act (instead of s136).
- Percentage of occasions when the HBPoS is full to capacity and Police/LAS convey elsewhere (including ED).
- Percentage of occasions where the police did not phone in advance before arriving at the HBPoS.
- Percentage of occasions police conveyed the patient to the HBPoS without LAS.
- Percentage of occasions where the S136 has expired without an extension and the patient remains in a HBPoS/PoS.
- Percentage of occasions where the HBPoS transferred patients to ED for physical health treatment.
- Percentage of occasions where a police cell was used for adults and children and young people.
- Percentage of occasions where police had to remain for over an hour before HBPoS staff were able to accept the patient.
- Percentage of occasions where those detained under s136 were further detained under the Mental Health Act.

Appendix 9: Notes

1. The amendments to sections 135, 136 and 138 of the Mental Health Act 1983, made by the Policing and Crime Act 2017, Part 4, Chapter 4 “Powers under the Mental Health Act” <http://www.legislation.gov.uk/ukpga/2017/3/part/4/chapter/4/enacted>
2. Mental Health Network NHS Confederation (2016) Is mental health crisis care in crisis?
3. Carpenter, R; Falkenburg J; White, T; Tracy, D (2013) Crisis teams: systematic review of their effectiveness in practice. *Psychiatrist* (37) pp. 232–237.
4. Munro, J; Osborne, S; Dearden, L; Pascoe, K; Gauthier, A; Price, M (2011) Hospital treatment and management in relapse of schizophrenia in the UK: associated costs. *Psychiatrist* (35) pp. 95-100.
5. Greater London Authority (2014) London Mental Health: The invisible costs of mental ill health.
6. Healthy London Partnership (2015) UEC Programme: HBPOS audit
7. Healthy London Partnership (2015) UEC Programme: ‘I’ statements
8. Healthy London Partnership (2015) UEC Programme: ‘I’ statements
9. London Mental Health Partnership Board (2013-2016) Individuals under section 136 held in police cells
10. Greater London Authority (2014) London Mental Health: The invisible costs of mental ill health.
11. Mental Health Network NHS Confederation (2016) Is mental health crisis care in crisis?
12. Mental Health Network NHS Confederation (2016) Is mental health crisis care in crisis?
13. Therapeutic Solutions (2016) Section 136 Health Needs Assessment
14. London Ambulance Service (2016) Mental health crisis care data

15. Metropolitan Police Force (2016) Mental health crisis care data
16. A 'designated Health Based Place of Safety' is the health-based setting that has been locally agreed by providers and commissioners to be the chosen site to receive individuals detained under s136
17. Brennan (2016) Vast majority of mental health trusts have safety concerns, CQC warns. Available at: www.hsj.co.uk/topics/quality-and-performance/vast-majority-of-mental-health-trusts-have-safety-concerns-CQC-warns/7011452.article?blocktitle=CQC-News&contentID=1774
18. Hughes, R. (2008) Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Agency for Healthcare Research and Quality (US)
19. Healthy London Partnership (2015) UEC Programme: 'I' statements
20. Southwest London St. George's Mental Health Trust is planning on opening a Psychiatric Decision Unit in late 2016 to provide an alternative pathway away from ED for patients experiencing a mental health crisis.
21. An evaluation of the Psychiatric Decisions Unit (PDU) and its role within the urgent care pathway in Birmingham (2016)
22. 'The Safe Haven' Aldershot Evaluation Report (2014)
23. Metropolitan Police Mental Health Escalation Log (2015)
24. CCG Improvement and Assessment Framework report (September 2016)
25. Care Quality Commission (2015) Right here, right now: Mental Health Crisis Care Review
26. The Health Foundation and Nuffield Trust (2015) Focus on: People with mental ill health and hospital use
27. Moore, A. (2014) Urgent and Emergency Mental Health Audit. In: Urgent and Emergency Care for Mental Health.

London.

28. Thomson, A., Tariq, I., Gallagher, P., Dear, K., Duncan, E. (2015) Time to complete Mental Health Act Assessment in the Emergency Department. Quality Improvement Project Report.
29. London agencies who are signatories to the Concordat include the Metropolitan Police Service, British Transport Police, City of London Police, London Ambulance Service, all NHS providers and all Local Authorities.
30. The crisis plan should be co-produced, reflecting service user priorities for their care. It should outline treatment and service preferences agreed together between the service user and clinician.
31. The MHA Code of Practice states that it is the police who should contact the AMHP (see Code paragraph 16.44, 2015 edition). However, this causes practical and operational difficulties for both the police and the AMHP service. The Code is not legally binding if there is good justification for departing from it (see Code Introduction paragraph V). It has been agreed that the above procedure is a reasonable and justifiable departure from the Code.
32. Department of Health and Home Office (2017). Guidance for the implementation of changes to police powers and places of safety provisions in the mental health act 1983, October 2017. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/656025/Guidance_on_Police_Powers.PDF
33. An alcohol brief intervention (ABI) is described as a short, evidence-based, structured conversation about alcohol consumption that seeks in a non-confrontational way to motivate and support the individual to think about and/ or plan a change in their drinking behaviour.
34. The MHA Code of Practice states that it is the police who should contact the AMHP (see Code paragraph 16.44, 2015 edition). However, this causes practical and operational difficulties for both the police and the AMHP service. The Code is not legally binding if there is good justification for departing from it (see Code Introduction paragraph V). It has been agreed that the above procedure is a reasonable and justifiable departure from the Code.
35. The four-hour timeframe aligns with on NICE Guidance [CG136] 1.8.8: When a service user is admitted to a 'place of safety' ensure they are assessed for the



Mental Health Crisis Care for Londoners

Mental Health Act (1983; amended 1995 and 2007) as soon as possible, and certainly within four hours.

Appendix 10: Physical Health Assessment & Treatment Protocol

PHYSICAL HEALTH ASSESSMENT & TREATMENT GUIDANCE FOR INDIVIDUALS DETAINED UNDER SECTION 136

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1) PURPOSE OF THE GUIDANCE

Whenever an individual in a mental health crisis is detained by the police under section 136 of the Mental Health Act, a rapid assessment should be made in order to determine whether the individual presents with any physical health complaints which would indicate the need for the individual to be taken to the nearest emergency department for physical health assessment, and treatment where required. This guidance aims to: -

- i) Set out the pathway for physical health assessment and treatment of individuals detained under section 136
- ii) Detail physical health presentations where a individual MUST be taken to the nearest emergency department to be seen
- iii) Detail the responsibilities of emergency service and health care staff engaged in supporting and caring for an individual detained under section 136 detention in relation to the physical health assessment & treatment process.

This guidance applies to individuals of all ages detained under section 136.

2) PATHWAY FOR THE MEDICAL ASSESSMENT & TREATMENT OF AN INDIVIDUAL DETAINED UNDER SECTION 136 MHA

- i) See Appendix 1) – “Pathway for the medical assessment & treatment of individuals detained under section 136”

3) PHYSICAL HEALTH PRESENTATIONS REQUIRING ASSESSMENT / TREATMENT IN AN EMERGENCY DEPARTMENT

See Appendix 2) – “Physical health presentations requiring assessment / treatment in an Emergency Department”

4) ROLES & RESPONSIBILITIES OF KEY STAFF IN RELATION TO THE MEDICAL OPTIMISATION OF INDIVIDUALS DETAINED UNDER SECTION 136 MHA

4.1 Responsibilities of the MHCAL professional with whom the police first make contact

4.1.1 When receiving a call from the police with regard to an individual for whom detention under section 136 is being considered, the MHCAL care professional should check to ascertain if the individual is known to a London mental health trust. If the individual is known, the mental health professional should check their clinical record to note whether they have any physical health conditions which may be relevant to share with the police. Please refer to the MHCAL SOP.

4.2 Responsibilities of the police

- 4.2.1 The guidance “Mental Health Crisis Care for Londoners” (also known as “The Blue Book”) advises that the use of an ambulance should always be considered first when conveying a individual under section 136 to an appropriate Place of Safety. Where the ambulance service have identified that there will be a significant delay (over 60 minutes), this should be communicated to the police. In these circumstances, the police officer may consider transporting the individual in a police vehicle. If this is the

case, the police officer should notify the Duty Senior Police Officer or, if they are unavailable, a supervisor as soon as practicable and must inform the ambulance service of their decision. The rationale for using a police vehicle should be recorded by the officer responsible for detaining the individual under section 136 and should stipulate which supervising officer was informed. Any changes in the individual's physical condition noted by the police should be communicated to the ambulance control room who will review and re-prioritise the calls as appropriate.

- 4.2.2 An ambulance crew should always accompany the individual to the emergency department, other than in emergency circumstances where the ambulance service has indicated that a significant delay in the attendance of an ambulance is likely and the individual is in need of urgent medical attention. The ambulance is being 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 section 136 is still in the custody of the police, who must therefore accompany them to the HBPOS or ED.
- 4.2.3 In the event of a decision to convey an individual under section 136 in a police vehicle, the police should make a rapid assessment of the circumstances surrounding the individual's detention under section 136 and their physical presentation in order to determine whether the individual requires conveyance to an Emergency Department (ED) for an assessment of their physical health. It is recognised that police officers are not healthcare professionals and cannot be expected to recognise anything other than very obvious signs that an individual requires medical attention (e.g. trauma such as a witnessed collision or fall, bleeding, open wounds or following subsection to a Taser or pepper or PAVA spray). For this reason, **only in exceptional circumstances** should the individual be conveyed to the emergency department in a police vehicle. In this event, the police should notify the duty senior police officer or shift supervisor as soon as practicable, as well as the ambulance service, of their decision. This non-availability of an ambulance crew must be documented by the ambulance service, and the rationale for using a police vehicle must be recorded by the police officer detaining the individual under section 136, clearly articulating the individual's urgent need for medical attention for their physical health needs and the non-availability of an ambulance crew.
- 4.2.4 Wherever possible, the police or ambulance crew should convey the individual to the ED nearest to where the patient has been detained. The only exceptions to this should be in situations where the nearest ED has a formal escalation plan enacted.
- 4.2.5 The police must ensure that prior to conveying an individual to an ED under section 136, where there are reasonable grounds to believe the individual detained may be a danger to themselves or others and is concealing something which could be used to physically injure themselves or others, that they have conducted a search of the individual and their possessions and removed any items which might be used to harm themselves or others.³⁰
- 4.2.6 On arrival to the ED (*note that 24 hour period of detention commences upon checking the individual into ED*), the police officer should provide a comprehensive verbal handover to ED and (where in line with locally agreed protocol) mental health

³⁰ This same standard would apply when conveying a patient to an HBPOS

liaison team staff regarding the circumstances of the individual's detention under section 136 and, if an ambulance crew is not in attendance, the reasons why the individual has been conveyed to the ED. This should be done in conjunction with the handover from the ambulance crew (where in attendance) relating to the individual's physical health.

- 4.2.7 Following initial physical health assessment at the ED, if it appears that the individual can be fully assessed / treated and ready for subsequent transfer to a Health-Based Place of Safety (HBPOS) within 1 hour, the police should remain with the individual and conduct the transfer to the HBPOS. If it is expected that the assessment and treatment will take longer than one hour, the ED and site team, along with the Mental Health Liaison Team should liaise with the police to formulate an action plan and discuss how long the police need to remain. The police must not leave until a full handover of information has been provided and the acute trust staff have accepted responsibility for the ongoing management of the individual and any presenting risks. Every effort must be made by the ED and site team to provide alternative security provision for the individual allowing the police to leave at the earliest opportunity.

4.3 Responsibilities of the Ambulance Service

- 4.3.1 Ambulance staff called to attend to an individual under section 136 should make a rapid assessment of the circumstances of the individual's detention under section 136 and their presenting physical condition. This should include taking a history from the police of events surrounding the detention in order to ascertain if the individual has sustained any trauma or recent self-harm.
- 4.3.2 The ambulance staff should attempt to take a history from the individual in order to ascertain whether the individual has any signs or symptoms that might indicate that a physical health condition is likely, including whether the individual has self-harmed in any way that might not be immediately obvious (e.g. overdose, self-poisoning), whether they have any pre-existing medical conditions and whether they have any drug or alcohol dependencies or current intoxication.
- 4.3.3 Older people are at greater risk for the development of delirium (manifestation of physical illness through symptoms of mental and behavioural disorders). Particular attention should therefore be paid to the physical health assessment of elderly persons detained under section 136 to ensure that the risk of the individual having a delirium is eliminated.
- 4.3.4 Where the individual is known to mental health services (previously or currently), the ambulance staff should endeavour to obtain collateral information from the mental health trust treating the individual in order to inform any decision to convey the patient to an ED for physical health assessment / treatment.
- 4.3.5 The ambulance staff should make an assessment of the individual's physical health including Glasgow Coma Scale (GCS) score and a recording of respirations, pulse, blood pressure, temperature, blood glucose, pulse oximetry & NEWS2.
- 4.3.6 Where the individual presents as too agitated or behaviourally disturbed to complete a recording of the individual's vital signs, the ambulance staff will use their professional judgement in determining the need to convey the individual to the ED for further physical health assessment. Individuals meeting any of the criteria listed below should **always** be conveyed to the ED for further medical assessment: -

- Meeting any of the criteria for physical health assessment / treatment detailed in appendix 2) of this guidance
 - Acutely disturbed behaviour in the absence of any known previous episodes of mental illness
- 4.3.7 The ambulance staff should lead the decision regarding the need for the individual to attend an ED for further physical health assessment and / or treatment. The ambulance staff should use the medical optimisation criteria (appendix 2) to guide them in making this decision.
- 4.3.8 Any individual taken to the ED for medical assessment and / or treatment should wherever possible be conveyed in an ambulance. If it is necessary to use a police vehicle due to the level of the individual's behavioural disturbance and aggression, the highest qualified member of the ambulance crew should travel in the police vehicle, with the appropriate equipment to deal with any immediate physical health needs or possible physical health emergencies that might arise whilst the individual is en-route to the ED
- 4.3.9 While the police still retain overall responsibility for the individual during the initial transfer of the individual to the HBPOS or ED, 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 street triage team.
- 4.3.10 **Individuals who have received rapid tranquillisation** 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.
- 4.3.11 On arrival to the ED, the ambulance crew will provide a clear handover to ED and mental health liaison team staff regarding the individual's physical health needs. This should be done in conjunction with the handover from the police relating to the circumstances of the individual's detention under section 136.
- 4.4 Responsibilities of the staff at the health-based Place of Safety (where an individual has been conveyed directly & not via an emergency department)**
- 4.4.1 Following the arrival of an individual to the Health-based Place of Safety (HBPOS), registered nursing or medical staff should make an immediate assessment of the individual's physical health presentation in order to determine whether the individual presents with any physical health needs requiring assessment and / or treatment in an ED. The HBPOS staff should use the physical health criteria detailed in appendix 2 to guide them in making this decision.
- 4.4.2 If the HBPOS staff feel unable to meet the physical needs of the individual and consider that the individual needs to go to an ED, staff at the HBPOS have the right of refusal to the site. However, this decision should not be made without consultation with and the agreement of the HBPOS duty doctor. Staff must not conduct tests to determine intoxication as a reason for exclusion to the site; the decision to direct an individual to ED should be based on clinical judgement and make reference to the physical health criteria outlined in appendix 2.
- 4.4.3 It is expected that nurses and doctors working in HBPOS will possess the physical healthcare competencies outlined in appendix 9 of the Blue Book in order to avoid unnecessary ED referrals

- 4.4.4 Individuals must not be sent to the ED for “medical optimisation” where there is no presenting physical health abnormality or where the presenting complaint is minor and could be managed in a mental health setting. This would include: -
- Mild levels of alcohol intoxication where the individual is conscious and able to walk (even if unsteadily)
 - Minor cuts not requiring closure with glue or sutures
 - Covid testing (where it is assessed that this is required)

For individuals with physical health problems, but for whom urgent transfer to an ED is not the optimum course of action, HBPOS sites & acute trusts should have clear pathways and protocols to meet their needs, and the relationships to deliver these. These should include triage advice and where possible, outreach to support appropriate and timely physical healthcare to those in a HBPOS.

- 4.4.5 Prior to advising the police and / or ambulance crew to take an individual detained under section 136 from an HBPOS to an ED for assessment / treatment of medical needs, the shift co-ordinator (or doctor) from the HBPOS **should** telephone (when possible) the nurse or physician in charge of the emergency department to discuss the decision and reach an agreement that it is appropriate. This must be done before the individual leaves the premises of the HBPOS. The physical health criteria (appendix 2) should be used to inform this discussion and agreement. The only exception to this requirement is in the event of a medical emergency where the individual requires immediate conveyance to an emergency department under a blue light call.
- 4.4.6 The HBPOS coordinator is responsible for ensuring that an appropriate member of staff travels with the individual to take responsibility for their management and safety at all times until they either return to the HBPOS or are formally accepted by the ED

4.5 Responsibilities of the Emergency Department staff

- 4.5.1 Following the arrival of an individual detained under section 136 MHA to the ED, a senior clinical member of ED staff should meet, alongside a member of the Mental Health Liaison Team (where in line with locally agreed protocol), with the police and ambulance crews in order to receive a handover regarding the circumstances of the individual’s detention, presenting risks and the nature of the concerns about the individual’s physical health which have necessitated conveyance to an ED rather than a HBPOS.
- 4.5.2 The ED staff should make a rapid assessment of the individual’s physical health in order to determine whether any physical health needs can be immediately assessed / treated with subsequent transfer to a Health Based Place of Safety (HBPOS) thereafter (known as “Treat & Transfer”), or whether the individual is required to remain in the ED for a sustained period of physical health assessment and treatment. The assessment should include, as a minimum, a measurement of the individual’s Glasgow Coma Scale (GCS) score and, where possible recording of respirations, pulse, blood pressure, temperature, blood glucose, pulse oximetry and NEWS2, plus examination of any wounds where appropriate.
- 4.5.3 Other medical interventions employed whilst the individual remains in the ED

should be determined by the individual's presenting physical health needs and local trust guidance and protocols.

4.5.4 Where the MHLT are not present at the initial handover of information by the police following the arrival of the individual to the ED, the ED staff should facilitate the subsequent handover of information from the police to the MHLT.

4.5.5 In the event of a decision to "treat and transfer" an individual, ED staff should endeavour to expedite physical health assessment and treatment to assist timely transfer to an HBPOS for further assessment under section 136

4.5.6 In the event of an individual being "treated & transferred", the ED staff should ensure that a written discharge summary accompanies the individual to the HBPOS detailing the assessment and treatment conducted in the ED and recommendations for further care and treatment.

4.5.7 Where ongoing physical care and treatment will be required to be delivered following the transfer of the individual to the HBPOS, the ED doctor or nurse caring for the individual in the ED should make contact with a doctor at the HBPOS to detail what is required. Any discharge medications or dressings required by the individual for aftercare following transfer to the HBPOS should accompany the individual to the HBPOS; they should be given to the conveying ambulance crew to handover to the HBPOS staff upon arrival.

4.5.8 In the event of an individual being "treated & transferred", under the Blue Book, it is the responsibility of the nurse responsible for the co-ordination of section 136 presentations to the ED to locate HBPOS capacity and communicate this to the police.

4.5.9 Coordinating the conveyance of individuals to the HBPOS should be undertaken by the acute trust, led by the s136 coordinator in ED. Coordinating and arranging transport is not the police's role unless there is mutual agreement that it is in the best interest of the individual and there is resource to provide support.

4.5.10 The ED team should ensure that the individual and any engaged family / carers are kept informed of progress on completion of the physical and mental health assessment process and next steps.

4.6 Responsibilities of acute trust ward staff (where an individual detained under section 136 is admitted to an acute trust ward prior to transfer to a mental health ward)

4.6.1 Whilst the individual remains in an acute trust ward, staff should note the contents of any Advanced Directives that the individual might have and liaise with the individual's carers or nominated advocates, where appropriate, in ensuring that due consideration is paid to the individual's preferences and choices relating to care.

4.6.2 The acute trust ward staff will ensure that a written discharge summary accompanies the individual to the mental health ward detailing the assessment and treatment

conducted whilst in the acute trust and recommendations for further care and treatment.

- 4.6.3 Where ongoing physical care and treatment will be required to be delivered following the transfer of the individual to the mental health facility, the acute trust doctor or nurse caring for the individual should make contact with clinical staff from the mental health ward to detail what is required and to confirm that the unit has the ability to safely and effectively provide what is required. Any discharge medications or dressings required by the individual for aftercare following transfer to the mental health ward should accompany the individual to the mental health ward; they should be given to the escorting nurse or conveying ambulance crew to handover to the mental health ward staff upon arrival.

4.7 Responsibilities of the Mental Health Liaison Team

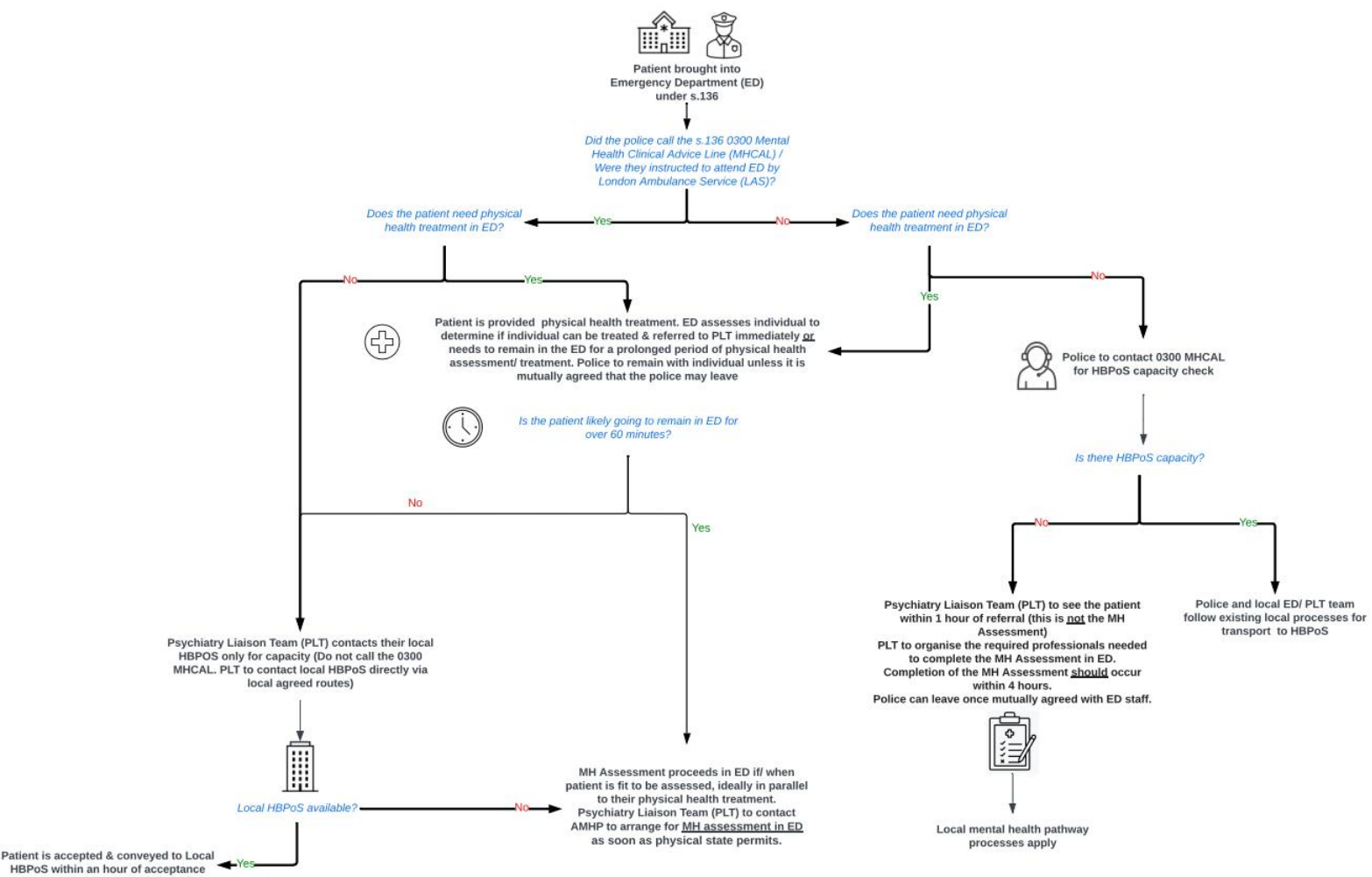
- 4.7.1 Following the arrival of an individual detained under section 136 to the ED, a member of the Mental Health Liaison Team (MHLT) should (where in line with locally agreed protocol) attend the ED in order to meet, alongside a senior clinical member of the ED staff, with the police and ambulance crews in order to receive a handover regarding the circumstances of the individual's detention, presenting risks and the nature of the concerns about the individual's physical health which have necessitated conveyance to an ED rather than an HBPOS.
- 4.7.2 The MHLT should liaise with the ED staff in order to ascertain whether the individual can be "treated and transferred" thereafter to an HBPOS or whether the individual is required to remain in the ED / acute trust for a sustained period of assessment and / or treatment of physical health concerns.
- 4.7.3 Prior to an individual being transferred from the ED to an HBPOS, the MHLT should provide a full telephone handover to the staff at the receiving HBPOS regarding the circumstances around the individual's detention under section 136, their current mental health presentation, any presenting risks and details of any physical health assessments and treatments received in the ED.
- 4.7.4 Where an individual is to remain in the ED for ongoing assessment & treatment of their physical health, **the MHLT should initiate and arrange the mental health assessment required under section 136 MHA in parallel with physical health care processes**. Assessment should commence within 1 hour of receipt of referral from the ED.
- 4.7.5 The MHLT should check the individual's mental health records, as well as asking the individual, and carers or nominated advocates where appropriate, in order to ascertain the contents of any Advanced Directives that the individual might have outlining their preferences around care and treatment in the event of a mental health crisis
- 4.7.6 Where the individual's state of physical health precludes completion of the assessment of their mental health within the initial 24 hour period of detention under section 136, the assessing doctor from the MHLT may extend the duration of the section 136 by a period of 12 hours in order to allow the mental health assessment to be completed where possible (*note that a lack of bed availability is **not** a permissible reason for the extension of a detention under section 136*)

- 4.7.7 Following completion of the section 136 assessment, the MHLT should ensure that the details of the mental health assessment are provided to any teams responsible for the ongoing care of the individual's mental health.
- 4.7.8 The MHLT should ensure that the individual and any engaged family / carers are kept informed of progress on completion of the mental health assessment process and next steps.

APPENDICES

1	Pathway for the medical assessment & treatment of an individual detained under section 136 MHA
2	Physical health presentations requiring assessment / treatment in an emergency department

Appendix 1: Pathway for the medical assessment & treatment of individuals detained under s136



Appendix 2) Physical health presentations requiring assessment/ treatment in an Emergency Department*

PHYSICAL HEALTH ASSESSMENTS REQUIRING ASSESSMENT / TREATMENT IN AN EMERGENCY DEPARTMENT	
TRAUMA	SERIOUS PHYSICAL ILL-HEALTH / INJURIES
- Falls from > 4 feet (1.2m) - Injury from edged weapon or projectile - Throttling / strangulation - Electrocution - Hit by a moving vehicle - Ejected from a moving vehicle - Occupant of a vehicle in a collision - Head injuries - Bleeding from nose or ears - Deep cuts / lacerations in need of closure (accidental or self-harm) - Suspected broken bones - Significant blows to the body (e.g. hit with a baseball bat) - Individual has been hit by a Taser - Individual has been subjected to use of pepper / PAVA spray	ACTUAL (CURRENT) ATTEMPT OF SELF-HARM
	- Noisy breathing - Severe shortness of breath / hypoxia - Chest pain - Not rousable to verbal command - Loss of consciousness at any time - Facial swelling - Acute confusion - Sickle Cell pain - Severe headache - Severe allergy - Possible sepsis
	- Actively head banging - Attempted self-ligature - Evidence of self-poisoning / overdose - Carbon monoxide poisoning
DRUG / ALCOHOL USE	ACUTE BEHAVIOURAL AROUSAL WITH ONE OR MORE OF THE FOLLOWING: -
- Evidence of drug ingestion / intoxication - Evidence of GHB / GBL dependence - Alcohol intoxication to the extent that individual is unable to walk or unrousable to speech - History of alcohol dependence with current signs of Delirium Tremens (including agitation, nausea, vomiting, tremors, sweating, confusion, impaired consciousness, seizures, visual / tactile / auditory hallucinations)	PREGNANCY
	- High body temperature - Profuse sweating or hot skin - Acute confusion / incoherence - A period of prolonged restraint with ongoing struggling / resistance
	- Pregnancy alone is not a reason to convey an individual to ED. - Pregnant individuals should only be conveyed in circumstances where there are specific obstetric concerns.

Conveyance to the nearest Emergency Department of an individual for medical reasons must wherever possible be conducted in an ambulance. On arrival to the Emergency Department, it is the responsibility of the ambulance service to communicate to staff the medical reasons for the individual's conveyance to the Emergency Department. It is the responsibility of the police service to communicate to staff the reason for and the legal aspects of the detention under section 136.

* This is not an exhaustive list of physical health presentations requiring conveyance to an Emergency Department; the judgement of the police / ambulance will also be used when determining the need for a individual to be conveyed to an ED for medical attention.

Appendix 12: Custody Pathway Protocol

Protocol for people in police custody who require urgent mental healthcare:
process, responsibilities and expectations

Version 1.9 July 2025

Scope of this protocol

This protocol applies specifically to people who have been arrested and while in police custody are identified as having acute mental health needs.

This protocol should be read in conjunction with the accompanying flowchart.

Numbers in the protocol refer to steps in the flowchart.

Decisions on fitness to be interviewed are not covered within this protocol.

Objective

The overarching principle is that people with an acute mental health need should be cared for in a healthcare environment wherever possible and should not spend any more time in police custody than is necessary except in certain extenuating circumstances that will be addressed within this protocol.

Abbreviations used

AMHP	Approved Mental Health Professional
CTO	Community Treatment Order (s17A MHA)
ED	Emergency Department
HBPoS	Health-Based Place of Safety
L&D	Liaison and Diversion service
MHA	Mental Health Act, 1983
MHCAL	Mental Health Clinical Advice Line
MPS	Metropolitan Police Service
PACE	Police and Criminal Evidence Act 1984
PHCP	Police Custody Healthcare Practitioner

s12 Doctor	Section 12 Approved Doctor
s136	Section 136 of the Mental Health Act 1983

Reference to flowchart	Expectation	Responsibility	Related document(s)
1.1	For detainees that disclose or present with acute mental health needs or current psychiatric diagnoses	Police custody team	MPS Mental Health in Custody Toolkit, BTP In Custody Process Document
1.2	Police refer to the L&D team (in hours) or PHCP (out of hours).	Police custody team	Existing L&D / PHCP ways of working
1.3	The L&D team (in hours) / PHCP (out of hours) completes an initial mental health assessment. Physical and mental health assessment (as soon as possible and always within one hour of referral) – PHCP will consider physical health issues. *See Annex B for special circumstances	PHCP / L&D team	Existing L&D / PHCP ways of working
1.4	L&D / PHCP contact the MHCAL hub prior to advising a person to be placed on a S136	PHCP / L&D	Existing L&D / PHCP ways of working
1.4.1	If the detainee is intoxicated, existing guidance should be followed; advice from the PHCP about health risks and fitness for assessment is paramount. It should be noted, however, that any mental health assessment or potential treatment should not be delayed if an individual is already conveyed to an Emergency Department for		Physical Health Assessment and Treatment Protocol

	treatment of a physical condition. They should not be returned to police custody without having access to mental health care should they require it as the L&D service is not a full, 24-hour liaison psychiatry service in police custody, unlike in the ED.		
1.4.1	If the detainee would benefit from mental health inpatient admission and is suitable for informal admission, healthcare professionals should liaise with the responsible Trust, following the process set out in the Compact. Go to 1.10 (flowchart)	L&D / PHCP	Compact
1.5	Decision to be made whether to use S136 or request a MHA assessment. Go to Section 1.6	Police custody team	
1.6	Question 1. Has the person been arrested for a serious crime? A serious crime is defined as a crime that typically carries severe penalties, involves significant harm, or poses a threat to public safety or national security. These are crimes that are usually tried in a Crown Court and often involve long custodial sentences. Under the Serious Crime Act 2015, a 'serious offence' is: - Any offence listed in schedule 1 of the Act - The courts discretionary power to classify an offence as serious based on specific circumstances See Annex A for non-exhaustive examples. If yes, go to 1.6.1 If no, go to 1.6.2	Police custody team responsible for conveyance to court	MPS Mental Health in Custody Toolkit, BTP In Custody Process Document
1.6.1	In these circumstances, the aim is to manage	Police	Pan-London

	the person through the criminal justice system in the first instance. Appropriate handover with relevant background and contextual information should be provided to the receiving court and prison teams, detailing any mental health issues and other concerns the individual may present with, along with any necessary adjustments to facilitate a smooth transition from custody to court to prison. This involves coordinating with all relevant parties at each stage, such as court L&D, Serco and prison mental health teams. *See Annex C for details Discussions should take place as early as possible between the police, PHCP and the L&D team to consider contingency planning in scenarios where the person arrested who has mental health concerns cannot be progressed to a charge with specific focus on both the criminal justice and health risks the individual may present with. For complex cases and in cases where the criminal justice process cannot be progressed for any reason, the L&D service has access to the L&D consultant psychiatrist for support and advice. Options may include the consideration of a Mental Health Act assessment with advice or input from a forensic specialist. In highly complex cases, escalation via agreed Trust processes to clinical directors may be required, and involvement of NHS commissioners may be necessary. *In out of hours cases, advice can be sought via the MHCAL * In all cases, proportionate information sharing between the police and health services is essential not only to facilitate robust risk assessments but to ensure the best and safest	custody team L&D service Mental Health Services PHCP	guidance for individuals arrested under suspicion of a very serious offence, who have urgent physical and mental health needs
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	outcome for the individual and the general public (including health staff who may be receiving the individual into their care).		
1.6.2	Is the criminal investigation likely to be ongoing¹? If the police are not going to take any further action or where there is no ongoing necessity to detain the person in relation to the offence for which they were arrested, go to 1.6.3. If the investigation remains ongoing, go to 1.7. <i>¹The term 'ongoing' means with an ongoing necessity to detain to secure or preserve evidence relating to the offence for which they are under arrest or to obtain such evidence by questioning the person</i>	Police custody team	MPS Mental Health in Custody, Toolkit, BTP In Custody Process Document
1.6.3	If no further necessity to detain, PACE no longer applies, and the person cannot continue to be held by the police. [see Annex A on PACE 1984]	Police responsible for arranging transfer/ MHCAL staff	s136 pathway / Blue Book
	The police, police custody healthcare & L&D staff should contact the MHCAL to seek clinical advice as a matter of urgency to whether the person should be detained under s136 of the Mental Health Act due to the police's lack of lawful authority to continue to hold the individual in custody. As noted, proportionate information sharing between the police and health services is essential not only to facilitate robust risk assessments but to ensure the best and safest outcome for the individual and the general public (including health staff who may be receiving the individual into their care). This information may be related to any risk that the individual may immediately pose to others as well as other potential issues which might		

	be deemed important to share with health professionals in order to enable health colleagues to determine the appropriate level of security required for managing the individual (acute ward vs. PICU). The police may share risk and high-risk alerts with health staff in order to safeguard them from harm. Non-relevant information that does not feed into an immediate management plan or help identify a suitable hospital trajectory should not be shared by the police unless specifically requested for a specialist risk assessment by a qualified risk assessor (forensic specialist clinicians) and only in specific situations (for e.g. if the information is needed to obtain a PICU/secure bed in the rare scenario where one is needed and available). Discussions should be had with L&D and/or police healthcare to determine the health risk information that should be shared with receiving health partners and/or the MHCAL to once again enable the identification of a suitable hospital trajectory. Information regarding the outcome of searches should be shared with health partners in order to help inform the risk assessment. In exceptional cases, where the person is extremely violent and posing an imminent risk of death or serious injury, in discussion and agreement with both the Police and MHCAL, the person may have their MHA Assessment in the custody suite, however, the final decision regarding the suitability of a detainee remaining in police custody is ultimately that of the police. The MHA assessment should take place within 3 hours.		
1.7	If the person is detained under s136 of the Mental Health Act, arrangements will be made to transfer the person to an HBPOS or ED following the s136 protocol and advice of the MHCAL. All relevant physical and mental health, as well as relevant risk information,	Police custody team	s136 pathway / Blue Book

	must be shared with the HBPoS.		
1.8	The Mental Health Act assessment takes place within the place of safety, either HBPoS or ED If the person is to be detained under the Mental Health Act and admitted to a mental health inpatient unit, go to 1.9.1 If the person consents to an informal admission to a mental health inpatient unit, go to 1.9.2 If the person is not detained under the Mental Health Act, go to 1.9.3	AMHP HBPoS staff/Liaison Psychiatry in ED	
1.9.1	If the person is recommended to be detained under the Mental Health Act, the AMHP should liaise with the responsible Trust to identify a bed and arrange admission, following the process set out in the Compact. The PACE clock stops, but the police investigation may remain ongoing. See 1.10 (flowchart).	AMHP	Compact
1.9.2	If the person is not detained under the Mental Health Act, the health team should arrange any other mental health follow-up if required with support from the MHCAL. This might include informal admission.	HBPoS/ED staff (with advice from AMHPs and doctors as well as MHCAL, as appropriate)	MHA Code of Practice (16.51) Compact
1.9.3	Regardless of the outcome of the Mental Health Act assessment, the police will make a parallel decision about whether and how to take forward the criminal justice process for the offence for which the	Police custody team	MPS Mental Health in Custody, PACE, BTP In Custody

	person was originally arrested. The police and health colleagues should maintain close contact in order to facilitate progress through the criminal justice process if required. The Police should engage in early discussion with relevant partners (HBPoS staff or ED staff) about their decision/plan to re-arrest the individual should they not be detained under the MHA and not admitted informally to hospital. This may include the police staying for the duration of the wait until the completion of the MHA assessment or to leave the health environment but to stay in regular contact with it in order to determine the time to return to the HBPoS or ED to be present for the MHAA/await the outcome of the MHAA. Following the decision not to detain or admit informally, the health sector will have no lawful means to hold someone against their will if they do not choose to stay, even to facilitate a re-arrest by the police. Ultimately, the decision to re-arrest is one for the police to make with support and advice from health colleagues, as required in complex cases (with access to all available resources) or in cases where re-arresting may be detrimental to the individual's mental health, in order to consider any reasonable adjustments which might need to be made in order to progress with the criminal justice process. If the police do not plan to re-arrest the individual, this information should be shared with the HBPoS or ED on arrival, with a suitable plan to be communicated to the individual regarding further steps (if required) regardless of if they are detained in hospital or not.	HBPoS/ED health staff	Process Document
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Related documents

Mental Health in Custody Toolkit, Metropolitan Police Service, 2021 British Transport Police In Custody Document, British Transport Police
[Access to Mental Health Inpatient Services](#) ("the Compact"); NHS England, July 2022
[Physical Health Assessment and Treatment Protocol](#)

[S136 pathway / Blue Book](#)

[Code of practice: Mental Health Act 1983](#), Department of Health and Social Care, January 2015
[Mental Health Act 1983](#),

ANNEX A – PACE & Serious Crime

Serious Crime Act 2015

The Serious Crime Act does not provide a single definition for what a 'serious crime' is, however, it introduced specific provisions in relation to a number of specific offences including: human trafficking and modern slavery, child sexual exploitation, gang-related offences, forced marriage, cybercrime, and controlling or coercive behaviour.

Other crimes such as murder, grievous bodily harm, rape, other sexual offences, kidnapping, false imprisonment, firearms offences, armed robbery, arson with intent, etc. are generally regarded as serious offences and carry significant penalties.

There may be other scenarios where the offences themselves may not be 'serious' (for e.g. criminal damage), however, the context of the offending behaviour may put others at risk of serious harm.

PACE 1984

The Police and Criminal Evidence Act 1984 (PACE) was introduced to address concerns about confidence in the criminal justice system following several miscarriages of justice in criminal trials involving terrorism perpetrators during the

1970s. These convictions were primarily based on confessions made under police interrogation and forensic evidence that was later found to be unreliable.

The legislation aimed to standardise and professionalise police work. PACE 1984 introduced three main concepts: reasonable suspicion, regulation of police use of force, and regulation of police behaviour in evidence collection.

The legislation's key element in regulating police behaviour is the Codes of Practice, which set minimum standards for fair evidence collection. For example, Code C governs the treatment of detainees during police interviews. The Home Office provides statutory guidance on police detention powers as outlined in PACE Code C. Police forces are mandated to detain individuals under PACE in compliance with this code.

Individuals detained under PACE should be processed expeditiously. Officers are mandated to periodically review the detention of a suspect and release them as soon as the necessity for detention ceases to exist.

Arrested individuals can be held without charge for up to 24 hours. For serious offences, a senior officer can extend this by 12 hours. Detention beyond 36 hours needs court approval, and in exceptional cases, courts can authorize detention for up to four days. This period is often called the 'PACE clock'.

Investigation

Detaining a suspect is important for the police investigation into a crime. When a suspect is detained, the police have the authority to interview them and collect their biometric details. This evidence assists the police in deciding whether to charge the suspect. If there is insufficient evidence to issue a charge before the 'PACE clock' expires, the police must release the suspect. This means that the police will need to release the individual even if they have not spent 24 hours in custody, so long as the

PACE clock stops because the police can no longer proceed, it is unlawful to continue to detain an individual.

There are four possible outcomes once a person has been arrested and detained by the police:

1. Charged or issued an 'out of court disposal'.
2. Released on pre-charge bail.
3. Released under investigation (RUI).
4. Released with no further action. The police should give written notice to the person confirming that they are no longer suspected of a crime.

The 2017 amendment to Section 136 of the 1983 Act, under Part 4, Chapter 4 of the Police and Crime Act 2017, restricts the use of police custody as a "place of safety" for individuals in mental health crises. The default is now to detain people in specialist facilities like hospitals or care homes. However, police stations can still be used as places of safety in limited situations.

A police station can only be regarded as an appropriate 'place of safety' when:

- the behaviour of the person being detained "poses an immediate risk of serious injury or death" such as no other place than a police station can reasonably be expected to detain the person; and
- an officer of at least the rank of Inspector has authorised the use of a police station as a 'place of safety'. People who are detained at a police station under the Mental Health Act 1983 must be checked at least once an hour (unless they are sleeping and an assessment has been made not to wake them more than once every three hours) to ensure that they are safe and that their behaviour continues to require their detention at a police station. As soon as there is no longer a need for them to be detained at a police station, they should be transferred to another place of safety.

Section 41 PACE:

41 Limits on period of detention without charge.

- (1) Subject to the following provisions of this section and to sections 42 and 43 below, a person shall not be kept in police detention for more than 24 hours without being charged.
- (2) The time from which the period of detention of a person is to be calculated (in this Act referred to as "the relevant time")—

- (a) in the case of a person to whom this paragraph applies, shall be—

(i) the time at which that person arrives at the relevant police station;
or

(ii) the time 24 hours after the time of that person's arrest,

whichever is the earlier;

...

(6) When a person who is in police detention is removed to hospital because he is in need of medical treatment, any time during which he is being questioned in hospital or on the way there or back by a police officer *for the purpose of obtaining evidence relating to an offence* shall be included in any period which falls to be calculated for the purposes of this Part of this Act, but any other time while he is in hospital or on his way there or back shall not be so included.

(7) Subject to subsection (8) below, a person who at the expiry of 24 hours after the relevant time is in police detention and has not been charged shall be released at that time

(8) Subsection (7) above does not apply to a person whose detention for more than 24 hours after the relevant time has been authorised or is otherwise permitted in accordance with section 42 or 43 below.

(9) A person released under subsection (7) above *shall not be re-arrested without a warrant for the offence for which he was previously arrested unless, since the person's release, new evidence has come to light or an examination or analysis of existing evidence has been made which could not reasonably have been made before his release but this subsection does not prevent an arrest under section 46A below.*

42 Authorisation of continued detention.

(1) Where a police officer of the rank of superintendent or above who is responsible for the police station at which a person is detained has reasonable grounds for believing that—

(a) the detention of that person without charge is necessary to secure or preserve evidence relating to an offence for which he is under arrest or to obtain such evidence by questioning him;

(b) an offence for which he is under arrest is an indictable offence; and

(c) the investigation is being conducted diligently and expeditiously,

he may authorise the keeping of that person in police detention for a period expiring at or before 36 hours after the relevant time.

43 Warrants of further detention.

(1) Where, on an application on oath made by a constable and supported by an information, a magistrates' court is satisfied that there are reasonable grounds for believing that the further detention of the person to whom the application relates is justified, it may issue a warrant of further detention authorising the keeping of that person in police detention.

Annex B – Special Circumstances

Detainees on a CTO:

Occasionally, individuals who are arrested may already be under a section of the MHA – s17A, otherwise known as the Community Treatment Order.

Criminal justice procedures should take precedence over CTOs as individuals are generally expected to be stable in their mental states while on CTOs. However, if the power to recall to hospital has been utilized; there should be careful consideration as to whether proceeding down the criminal justice route or detention in hospital would be the better and safer outcome. If there are serious concerns around risk, especially if the alleged offence is particularly serious or the context of the offending behaviour belays a significant risk to others, then the criminal justice pathway should be prioritized. Robust handovers should be provided to receiving teams as per the usual process.

L&D practitioners should contact the individual's care coordinators and responsible clinician for a view. Out of hours, police custody healthcare and AMHPs should contact the on-call psychiatrist if the individual is known to the local service as information pertaining to their CTO or recall status may be available on the individual's clinical records.

If there is a need to enact the power of recall at that juncture, the delegated responsible clinician should be contacted. This is usually the on-call consultant psychiatrist for the local area the individual is made subject to the CTO.

Once the power of recall has been used, the individual is legally considered to be Absent Without Leave (AWOL) and can be returned to hospital under s18 of the MHA

by any AMHP, staff of the hospital, police officer or anyone authorized in writing by the managers of the hospital.

Detainees on Conditional Discharge (formally detained under s37/41):

Similarly, a detainee may be subject to conditional discharge under the MHA and subject to certain conditions as stipulated by the Mental Health Casework Section of His Majesty's Prison and Probation Service (HMPPS), otherwise colloquially known as the MoJ (Ministry of Justice).

In these cases, there should be close liaison with the individual's social and clinical supervisor, who are usually part of a community forensic team and/or the responsible local authority. There may be opportunities for direct recalls to secure inpatient beds via the individual's responsible team or delegated on-call consultant (forensic) psychiatrist and the MoJ, who will issue the warrant. However, there may be circumstances where a recall to hospital is not warranted, and the matter should proceed down the criminal justice route. Guidance should be taken from the treating team or the medical records, especially if there is a plan in place to manage the individual and their risks.

Progress down the criminal justice route should always be considered in these cases, with liaison with the responsible clinician (clinical supervisor) and social supervisor, even if the individual has been recalled and admitted to secure hospital.

As per individuals under a CTO, once recalled, the individual is considered AWOL and can be returned to hospital under s18 of the MHA.

Detainees on probation licence:

Detainees who may experience mental health crises who are recalled on probation licence should not be diverted via the mental health pathway without first consulting the individual's community offender manager (probation officer).

Detainees on both probation licence and CTO:

In these scenarios, L&D and/or police custody healthcare should facilitate close liaison between the responsible clinician, the community offender manager and the custody team to determine the best course of action based on clinical judgement and a robust risk assessment. In most cases, a licence recall to prison should take priority unless it is unsafe to do so and diversion should only be considered with close liaison with the community offender manager.

Annex C – Miscellaneous

Serious Offences Pathway in London:

Unlike other regions, London does not facilitate direct admissions from police custody to secure wards due to the limited availability of appropriate beds and high levels of acuity in the forensic system.

If a patient were to be admitted directly to a secure bed where there was a waiting list, for example out of hours, this would risk inequitable access to beds without a full balancing of the clinical needs of all those requiring admission.

Individuals arrested for serious offences are processed through the criminal justice system, enabling oversight under Part 3 of the Mental Health Act:

- This ensures justice to take its course naturally, allowing the judiciary the ability to consider all appropriate options at the point of sentencing without any attempt to circumvent the system or depriving those who are mentally ill at the time of the serious offence of appropriate disposal outcomes (for e.g. criminal justice process not progressed due to suspect being lost in the acute mental health system, defendants not supported through the court process due to communication issues between court and acute mental health wards, hospital orders not recommended as defendants have been 'treated' and remitted to prison quickly to ensure flow rather than considering the need of the individual prior to sentencing, etc.).
- Progressing through the criminal justice pathway then, if appropriate, the secure detention route ensures that the wider public, witnesses and/or victims and their families are safeguarded from any potential or ongoing serious psychological and/or physical harm. It eliminates the risk of the individual being discharged from their detention under part 2 of the Act back into the community as for most sections in part 3, the individual is considered a transferred prisoner and must be returned to prison should the MHA detention end.
- This process also provides an opportunity to gather essential information regarding an individual's risk history. This enables careful consideration of the appropriate level of security required. It also determines whether measures are needed to protect the individual from extensive media coverage, which could potentially bias future jury members during court proceedings. This can be facilitated by admitting them to high secure hospitals.
- Maximizing the prospects of achieving a safe criminal justice outcome and suitable disposal would also eventually enable dedicated specialist work to be done with the individual to reduce the prospect of future harm. Early diversion can reduce the chances of a safe criminal justice outcome and suitable disposal.

Prison Psychiatric Support:

London's prison system is commissioned to be well-equipped with psychiatric services, ensuring timely assessment and treatment for individuals with serious mental health needs, including hospital transfers under ss48/49 of the Act when required. Timely transfer to hospital for those who require this is a priority and a focus for all secure hospital providers in London.

Appendix 13: Serious Offence Guidance

Pan-London guidance for adults arrested under suspicion of a very serious offence, who have urgent physical and mental health needs

1. Context

- 1.1** A recent case example has highlighted the need for further clarity on the appropriate pathway and location for assessment for an individual who is under arrest on suspicion of having committed a very serious offence, and who has accompanying urgent physical and mental health needs.
- 1.2** Following an After-Action Review, it was determined that updated pan London guidance was required to clarify roles and responsibilities in these very rare situations.
- 1.3** This guidance seeks to set out the roles and responsibilities for health and police in the circumstances where an individual is under arrest on suspicion of having committed a very serious offence (not charged) and is in need of urgent/emergency care in relation to physical and mental health needs.
- 1.4** To note that an individual being under arrest does not mean that they have, or will be, charged with the offence, and this should not contextualise their treatment pathway

2. Purpose

- 2.1** The purpose of this guidance document is to clarify the principles that should apply and the approach that should generally be taken by police and healthcare staff when meeting the healthcare needs of individuals arrested under suspicion of (not charged with) a very serious offence, who have urgent physical and mental health needs.
- 2.2** This applies to adults only, and when the physical and mental health need requires immediate and acute assessment/intervention.
- 2.3** It will set out roles and responsibilities of healthcare and police and describe the most appropriate pathways of care in certain cases. It aims to build

on/clarify already established guidance set out in the [Blue Book](#) relating to the S136 pathway.

- 2.4** This guidance sits alongside the 'Protocol for people in police custody who require urgent mental healthcare' which is referenced throughout the supporting flow chart (section 7)

3. Roles and responsibilities

- 3.1** Police officers hold a duty of care for the person placed under arrest on suspicion of an offence, with PACE and the Human Rights Act clear that police must facilitate medical assessment and treatment in a suitable location as soon as possible.
- 3.2** Healthcare staff are responsible for assessing and meeting the specific healthcare needs of the person under arrest. In discharging these responsibilities there should be no inappropriate delays, ensuring timely resolution based on the urgency of the situation.
- 3.3** The ED would only be expected to address immediate/emergency mental health needs, as support exists within the criminal justice pathway (e.g. custody suites and prisons) for less urgent needs.
- 3.4** We recognise that bed capacity within the system is under pressure, therefore healthcare staff must ensure consistent application of the escalation processes within the London [Compact](#) to resolve any disputes in a timely manner, ensuring this does not delay care to the patient. Whilst the Compact does not apply to secure beds, the starting point would be PICU as per Compact. If forensic/secure beds are necessary then this will be case by case via local escalation processes, with the appropriate forensic service.
- 3.5** Joint decision making between healthcare and police is imperative to all processes outlined in this guidance. Proportional information sharing between the police and health services is essential, not only to facilitate robust risk assessments, but to ensure the best and safest outcome for the individual and the general public (including ensuring the safety of health staff who may be receiving the individual into their care, and patients in healthcare settings).

- 3.6** This information may be related to any risk that the individual may immediately pose to others as well as other potential issues which might be deemed important to share with health professionals in order to enable health colleagues to determine the appropriate level of security required for managing the individual (acute ward vs. PICU).
- 3.7** The police may share risk and high-risk alerts with health staff in order to safeguard them from harm, health colleagues could request for access to more police information via their usual processes, however, the information shared is a policing decision. Non-relevant information that does not feed into an immediate management plan or help identify a suitable hospital trajectory should not be shared by the police unless specifically requested for a specialist risk assessment by a qualified risk assessor (forensic specialist clinicians) and only in specific situations (for e.g. if the information is needed to obtain a PICU/secure bed in the rare scenario where one is needed and available).
- 3.8** A clinical risk assessment primarily focuses on the potential risk to self-and/or to others that the individual may pose as a result of their mental state/mental disorder. It necessitates the availability of all relevant information relating to the presentation of the individual; including some basic details of the alleged offence and the context that led to the individual's arrest, alongside any concerns anyone may have had about their mental state leading to the request for an assessment. Police colleagues should feel able to share their concerns with health colleagues so their views and observations can be taken into account as part of the assessment. Clinical risk assessment will only look at potential issue arising out of ill mental health. If it is determined that the risk issues are not related to a mental health condition, concerns should be discussed with the police to facilitate the police's own risk assessment process.
- 3.9** Given that ED's are not secure environments, and we need to ensure that healthcare staff and other patients are safe, under the police duty of public protection, officers should stay with the individual while their needs are being assessed, and until healthcare are confident that they can manage the patient without police assistance.

4. Process to follow

4.1 In rare cases, individuals arrested under suspicion of a serious offence, and not yet charged, may be conveyed direct to ED from the scene due to an immediate mental and physical health need.

4.2 A suggested pathway for cases like these is:

4.2.1 The individual's physical health needs are met in ED and stabilised; an HBPOs, or custody suite would not be suitable for physical health clearance.

4.2.2 Mental health needs of the patient are also met in ED; mental health assessment or potential treatment should not be delayed if an individual is already conveyed to ED for treatment of a physical condition.

4.2.3 Assessment of the individual's mental health needs takes place in ED, by ED staff, and mental health staff aligned to ED. Assessments should be private, however police should accompany if there is a risk to the assessor, in these cases, bodycams should not be activated during the private health consultation. Following the assessment there will be consideration of whether detention under the Mental Health Act would be appropriate

4.2.4 This should be a clinical decision based on the urgency of the individual's treatment needs, with a robust clinical risk assessment, focused on the potential risk to self-and/or to others that the individual may pose as a result of their mental state/mental disorder.

4.2.5 In the majority of cases it is expected that individuals would be assessed and immediate needs addressed, e.g. de-escalation via contact with mental health professionals, medication to reduce levels of arousal, in order to ensure safe containment and enabling the individual to be processed via the criminal justice pathway and diverted out via more suitable routes, if appropriate.

4.2.6 If the individual is unable to have their immediate mental health need met in the ED setting, and meets the threshold for detention under the

Mental Health Act, it may be deemed necessary to detain the individual under the Act to enable appropriate treatment

4.2.7 The AMHP should liaise with the responsible Trust to identify a bed and arrange admission, following the process set out in the [Compact](#). The [PACE](#) clock stops, but the police investigation may remain ongoing. Under core policing duties, officers will ensure public protection, including of healthcare staff, even if PACE ends.

4.2.8 In any case, senior clinical advice should be sought on the appropriate environment to manage the individual, e.g. from forensic clinicians.

4.2.9 If the individual is detained under a civil section and admitted, or an informal admission, there should be open communication between healthcare and police colleagues so that the police can follow up once the patient is discharged if required. Health should consider the risk assessment and decide individually whether police need to be informed, considering risk to public, staff and the individual.

4.3 Clinicians and the individuals being assessed are advised that they do not have to discuss the details of offences, as the focus of the assessment is on the immediate needs of the patient, and to preserve the right of the individual to discuss their issues with a solicitor. However, a basic understanding of the offence would be shared with the clinician by police colleagues. However, this would not stop clinicians from obtaining more information from other means or directly from the patient should it be necessary for a risk assessment, with the knowledge that this information may then be used as part of the evidence in the case.

4.4 If clinicians are requested by the police to comment on whether the individual has the capacity to commit the offence (this is not the same as capacity as understood within the context of the Mental Capacity Act), the clinician should make it clear that this is not the purpose of their assessment, and no direct conclusion can be drawn from their assessment as to whether the individual has a psychiatric defence of insanity at the time of the offence.

- 4.5** Police should never request any comment regarding capacity at this point, this is based on a legal direction from the CPS, and as such if such a request is made this should be declined.

5. Escalation routes

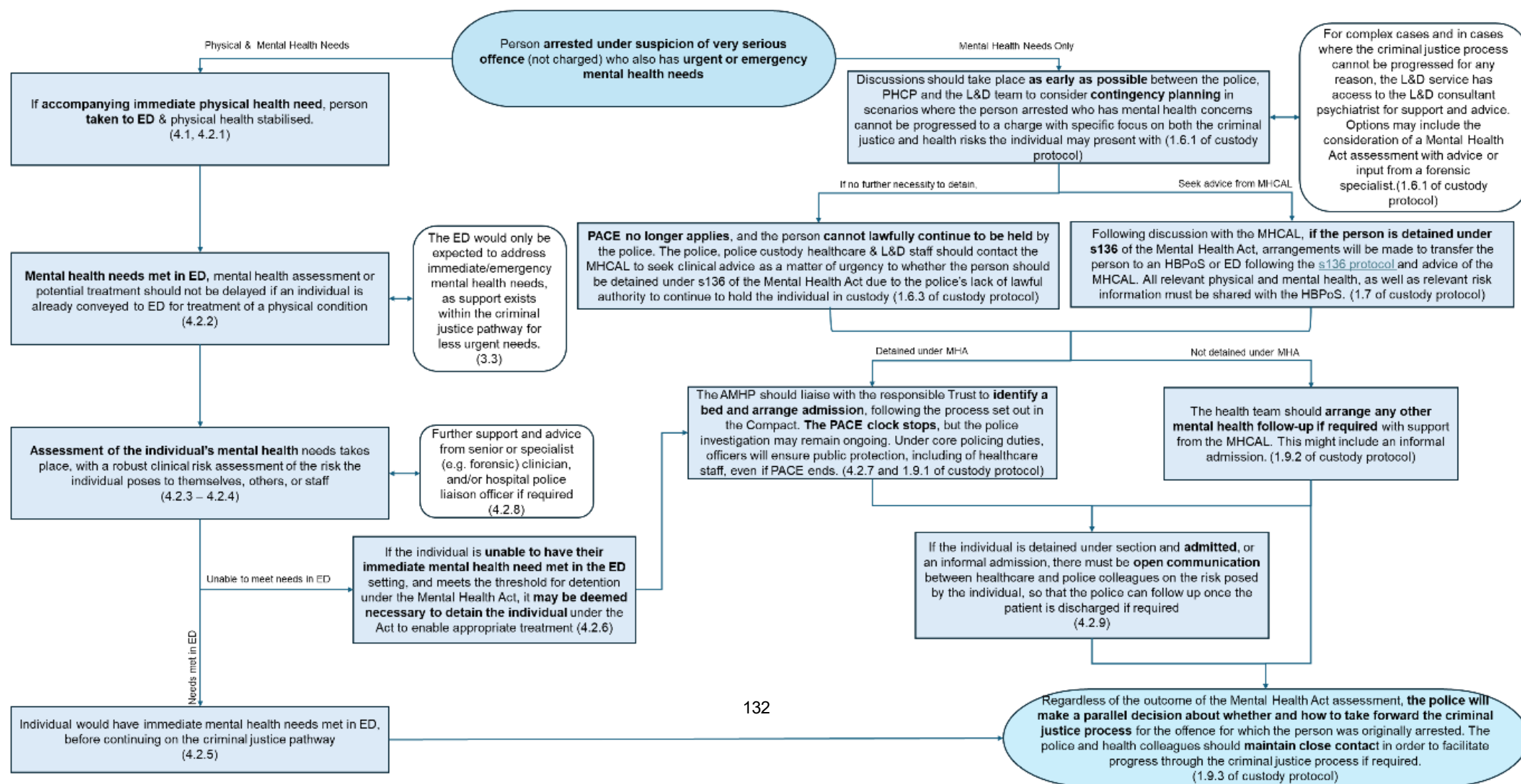
- 5.1** In the case of further clarity being required, or an escalation of any disagreement, local escalation processes apply.
- 5.2** Escalation routes relating to beds are clearly outlined in the [Compact](#) and should be followed
- 5.3** This could include, but is not limited to: Police Inspector, Chief Inspector, MH Lead, NHS on-call Consultant, Clinical Director, Medical Director.
- 5.4** As the Compact does not apply to secure beds, local escalation processes to locally aligned forensic services should be followed

6. Relevant documentation

- 6.1** 'Protocol for people in police custody who require urgent mental healthcare', embedded within the Blue Book: [NHS England — London » Mental Health Crisis Care](#)
- 6.2** Blue Book: [NHS England — London » Mental Health Crisis Care](#)
- 6.3** Side by Side consensus statement: [liaison-sidebyside.pdf \(rcpsych.ac.uk\)](#)
- 6.4** The London Mental Health Compact: [NHS England — London » Mental Health Compact](#)
- 6.5** Police and Criminal Evidence Act 1984 (PACE): [Police and Criminal Evidence Act 1984 \(PACE\) codes of practice - GOV.UK](#)

7. Supporting Flowchart

Serious Offence Policy: Pan-London guidance for adults arrested under suspicion of a very serious offence, who have urgent physical and mental health needs



8. Appendix 1: Glossary of Terms

A glossary of key terms used throughout the guidance can be found below:

Term	Definition
Criminal Justice Pathway	A criminal justice pathway refers to the sequence of processes and interventions that an individual goes through within the criminal justice system, from initial contact with law enforcement to potential rehabilitation and reintegration into society
Forensic clinician	A forensic clinician is a healthcare professional who specializes in the intersection of mental health and the legal system. This role often includes forensic psychiatrists, psychologists, and social workers who have received specialized training in legal procedures and the administration of mental health services.
Hospital police liaison officer	A hospital police liaison officer facilitates communication and coordination between healthcare providers and law enforcement to manage situations involving patients and police intervention.
L&D	Liaison and Diversion (L&D) services are designed to identify and support individuals with mental health issues, learning disabilities, substance misuse problems, or other vulnerabilities when they first come into contact with the criminal justice system. The primary aim is to ensure these individuals receive the appropriate care and support, which may involve referring them to health or social care services or diverting them away from the criminal justice system altogether.
Liaison Psychiatry	Liaison psychiatry is a subspecialty of psychiatry that provides mental health care to patients in general hospitals
MHCAL	The Mental Health Clinical Advice Line (MHCAL) is operated by the NHS, in a North and South hub, and provides a mental health triage, that supports police with alternative options to S136 detention
PACE	The Police and Criminal Evidence Act 1984 (PACE) sets out the rules for police powers and the rights of the public in the UK.
Released under investigation	Being released under investigation means that after being arrested, you are allowed to leave police custody while the investigation continues. The police do not have enough evidence to charge you yet, but they also don't have grounds to keep you in custody.

Serious Offence	Grievous Bodily Harm (GBH), rape or other serious sexual assault, murder, attempted murder, other homicide or other serious offence where there are indications that the patient could pose a threat of serious harm to others. Noting that this is not a definitive list, and that judgements will need to be made about levels of potential risk/threat a person poses in individual cases.
The Blue Book	This guidance document is aimed at stakeholders involved in the section 136 (s136) pathway, including; London's police forces, London Ambulance Service, Approved Mental Health Professionals and Acute and Mental Health Trusts. It outlines a consistent pathway of care across London and a minimum standard for Health Based Place of Safety sites.