



## Section 136 (including section 135(1)) Policy Mental Health Act 1983 (M-024)

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Author (name and job title)	Michelle Nolan, Mental Health Act Clinical Manager Kirsten Bingham, Hull AMHP Lead Helen Collins, Team Manager (MHCIT)
Executive Lead (name and job title):	Dr Kwame Fofie, Medical Director
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*Policies should be accessed via the Trust intranet to ensure the current version is used*

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## 1. INTRODUCTION

### SECTION 136 – MENTAL HEALTH ACT (1983) Mentally Disordered Persons Found in Public Places

A police officer may use section 136 if they encounter the person in any place other than any house, flat or room where that person, or any other person, is living, or 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. This includes where the officer is already on scene, responding to a call, are approached, or otherwise come in to contact with the person.

If an officer finds a person who appears to be suffering from mental disorder and to be in immediate need of care or control, the Officer may, if necessary, to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.

### SECTION 135(1) – MENTAL HEALTH ACT (1983) Warrant to search for and remove patients

A person removed to a place of safety under this section and S135(1) may be detained there for a period not exceeding 24 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health practitioner and of making any necessary arrangements for his treatment or care. However, the Registered Medical Practitioner who is responsible for the examination of the person detained under S136/S135(1) may at any time before the expiry of the 24 hours authorise the detention of the person for a further period not exceeding 12 hours. The authorisation may be given only if the registered medical practitioner considers that the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment of the person for the purpose of section 135(1) / 136 to be carried out before the end of the period of 24 hours (or, if the assessment began within that period, for it to be completed before the end). 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 for extension only if an officer of the rank of superintendent or above approves it.

This policy aims to address the implementation of Section 136 of the Mental Health Act and related legislation. It applies to all age groups and acts as guidance for Trust staff. The guidance in this policy was compiled and agreed originally by the Yorkshire and Humber Joint Interagency S136 Working Group and updated by the Mental Health Steering Group in 2017. Further guidance can be found in the Code of Practice 2015. The guidance for the implementation of changes to police powers and places of safety provisions in the Mental Health Act 1983 (DoH October 2017).

This policy has been prepared with local agreements from all stakeholders within the nationally accepted framework; this ensures that agencies with a county wide remit are not subject to individual practices which may be diverse.

For advice regarding the exchange of information between agencies reference should be made to the relevant local Information Sharing Protocols.

Much of the guidance within the Code of Practice applies to individual agencies. There are, however, requirements for formal agreements on the way in which different agencies work together in certain situations.

The document should be of assistance to staff that work together in crisis situations, sometimes with an incomplete understanding of the role and responsibilities of colleagues from other agencies. The interagency group emphasises the need for all professionals to consult and be familiar with the full Code of Practice, together with the Mental Health Act itself and any other legislation within which they carry out their professional duties.

This policy is in accordance with and/or has been formulated with due consideration to the guidance and recommendations contained within:

- The Mental Health 1983 Act (MHA 1983)
- The Mental Health Act Code of Practice (2015)
- The Mental Capacity Act 2005 (MCA)
- The Police and Criminal Evidence Act 1984 (PACE)
- The Policing and Crime Act 2017
- The Safer Detention and Handling of Persons in Police Custody 2006 (Safer Detention)
- The Independent Police Complaints Commission (IPCC) report, Police Custody as a 'Place of Safety' (2008)
- Royal College of Psychiatrists report, Standards on the use of Section 136 of the Mental Health Act 1983 (CR149 2008)
- The Bradley Report, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (2009)
- NPIA (National Police Improvement Agency) guidance on "Responding to People with Mental Ill Health or Learning Disabilities" 2010
- NPIA (National Police Improvement Agency) Protocol for the provision, management and conveyance to places of safety (Section 136 MHA 1983)

The purpose of removing a person to a place of safety is to enable the person to be examined by a doctor and interviewed by an Approved Mental Health Professional (AMHP), so that necessary arrangements can be made for the persons care and treatment. The removal should be for no other purpose than that stated above.

In Hull, the most appropriate Mental Health Based Place of Safety (MHBPoS) for detention under Section 135(1) or section 136 of the 1983 Mental Health Act is the Section 136 Suite at Miranda House. A police station should not be used as a place of safety. The use of ED should only be considered for a person detained under a Section 135(1) or section 136 if there is a need for further medical intervention.

The 136 suite receives referrals from British Transport Police (BTP) and Humberside Police (HP).

### **S135(1)**

The expectation remains that, with limited exceptions, for a person served a S135(1) warrant their needs will most appropriately be met by taking them to a health-based place of safety – a dedicated section 136 suite where they can be looked after by properly trained and qualified mental health and other medical professionals. The detention (24 hour period) starts as soon as the person arrives at the S136 suite.

Once the person arrives at the S136 suite they should be treated exactly the same as if they were detained on a S136; police will leave within the hour if the person is settled.

MHCIT will take over the person's care as soon as they arrive at the suite and start Humber part of the S135(1) / 136 monitoring form.

The S135 warrant is authority in itself to bring the person to the place of safety so the police **do not** need to complete their part of the S135(1) / S136 form for a S135(1).

**Please note:** either the S135(1) warrant or the police's 136 documentation (depending on whether S135 or S136) is crucial to accompany the MHCIT paperwork to ensure the legality of the detention.

## **2. SCOPE**

This policy and its procedures apply to all statutory agencies who fulfil a role in the undertakings and requirements of S136 and who have signed this agreement:

- Humber Teaching NHS Foundation Trust

- Humberside Police Service
- Yorkshire Ambulance Trust
- Hull and East Riding Acute Service
- Hull and East Riding Local Authorities

### 3. POLICY STATEMENT

The aim of the policy is to ensure:

- All agencies that are party to this policy are aware of their roles and responsibilities.
- Persons detained under S136 / S135(1) MHA 1983 are treated with respect, without discrimination and are assessed as quickly as possible taking into account the guiding principles listed in the Mental Health Act Code of Practice 2015.
- Persons with mental health issues detained for criminal offences, are processed with due regard to the law. A mental disorder whilst correctly taken into consideration is not an automatic bar to due criminal process.
- All agencies focus on providing the best possible support for the detained person to enable a quick recovery and return to their place in the community.

### 4. DUTIES AND RESPONSIBILITIES

#### **Chief Executive**

The chief executive in partnership with the local authorities (LA) has responsibility to ensure that policies, protocols and processes of a multiagency perspective are in place for the Trust staff to understand regarding the implementation of Section 136.

#### **Executive Director of Nursing, Allied Health and Social Care Professionals**

The Executive Director of Nursing, Allied Health and Social Care Professionals is responsible for ensuring that procedures are understood and carried out by nursing staff involved in the implementation of Section 136.

#### **Medical Director**

The medical director as lead director has responsibility for the development, review/monitoring of this policy and for the appropriate training and education to support implementation. The medical director is responsible for ensuring that procedures are understood and carried out by medical staff involved in the implementation of Section 136.

#### **Divisional Managers and Divisional Clinical Leads**

Responsible for ensuring that this policy is implemented within their areas of responsibility.

#### **Modern Matrons, Team Leaders and Charge Nurses:**

Modern matrons, team leaders and charge nurses are responsible for implementing operational systems to ensure adherence to the principles and standards of the policy.

#### **AMHPs**

AMHPs should involve MHCIT in any planning regarding the application of a S135(1) warrant so that MHCIT can prepare for the arrival of the person at the S136 suite.

### 5. PROCEDURES

#### 5.1. Governance

This policy is owned by the Strategic Crisis Care Concordat for Hull and East Yorkshire. The group has responsibility for ensuring that the guidelines within this policy are followed, for reviewing emerging 'lessons learnt' and for monitoring performance.

## **Applicable Standards**

### **NICE Guidelines (relevant to the long term mental health conditions model of care)**

National Institute for Health and Clinical Excellence (2006) Bipolar - management of bipolar disorder in adults, children and adolescents in primary and secondary care disorder guidelines, (CG38) London.

National Institute for Health and Clinical Excellence (2007) Drug Misuse: psychosocial interventions, (CG51) London.

National Institute for Health and Clinical Excellence (2009) Medication Adherence: involving patients in decisions about prescribed medicines and supporting adherence, (CG76) London.

National Institute for Health and Clinical Excellence (2011) Psychosis with coexisting substance misuse (CG 120).

National Institute for Health and Clinical Excellence (2011) Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG120) London.

National Institute for Health and Clinical Excellence (2009) Psychosis and schizophrenia in adults: treatment and management (CG178 – replaces CG82).

National Institute for Health and Clinical Excellence (2008 modified Nov 2013) Smoking cessation. Services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities (PH10).

National Institute for Health and Clinical Excellence (2006) Obesity (CG43) London.

National Institute for Health and Clinical Excellence (2009) Borderline Personality Disorder (BPD) (CG 78).

National Institute for Health and Clinical Excellence (2009) Antisocial personality disorder: Treatment, management and prevention (CG77).

National Institute for Health and Clinical Excellence (2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG 115).

National Institute for Health and Clinical Excellence (2011 – modified Oct 2013) Quality standard for end of life care for adults (QS13).

National Institute for Health and Clinical Excellence (2013) Psychosis & Schizophrenia in Children and Young People (CG 155).

National Institute for Health and Clinical Excellence (2011) Self-Harm (longer term management) (CG 133).

National Institute for Health and Clinical Excellence (2009) Depression in Adults (up-date) (CG 90).

National Institute for Health and Clinical Excellence (2011) Quality Standards on depression in Adults (QS8).

National Institute for Health and Clinical Excellence (2012) Autism in Adults (2012) (CG 142).

National Institute for Health and Clinical Excellence (2013) Self Harm (2013) (QS 34).

National Institute for Health and Clinical Excellence (2011) Self Harm (CG 16).

National Institute for Health and Clinical Excellence (2011) Anxiety (CG 113).

National Institute for Health and Clinical Excellence (2013) Conduct Disorders in Children and Young People (CG 158).

National Institute for Health and Clinical Excellence (2011) Contains general guidance about referral in a crisis (QS 10 from CG136 Improving the experience of care for people using adult NHS mental health services).

National Institute for Health and Clinical Excellence (2005) Identification and management in primary, community and secondary care (CG28).

National Institute for Health and Clinical Excellence (2009) Depression in adults with a chronic physical health problem: Treatment and management (CG91).

National Institute for Health and Clinical Excellence (2005) Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care (CG26).

National Institute for Health and Clinical Excellence (2005) Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (CG31).

National Institute for Health and Clinical Excellence (2005) Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (CG25).

Staff should be trained to recognise alcohol misuse and alcohol dependence. Appropriate protocols and care pathways should be put in place for the safe management of these individuals. Care should be taken to protect other patients from inappropriate exposure to challenging or unpleasant behaviours (NICE CG115).

Staff should be trained and the service should have systems in place to recognise and respond appropriately to individuals with psychosis and co-existing substance misuse as per NICE guideline (CG 120).

People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed. Staff should be supported on an on-going basis and appropriately trained to understand and work with individuals with a borderline personality disorder (KUF training or equivalent). The service should have in place appropriate protocols and pathways linked to and agreed with other agencies, for the safe and appropriate management of individuals assessed as having a border line personality disorder (NICE CG78).

The service should have in place a clear protocol and pathway, linked to and agreed with other agencies, for the safe and appropriate management of individuals assessed as having an anti-social personality disorder (NICE CG 77).

NICE Guidance (CG16) for the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care should be implemented.

### **Assessment of Caring Responsibilities**

The service will ascertain whether the person receiving care has any caring responsibilities for children or vulnerable adults and whether such persons have appropriate alternative carers in the immediate and short-term.

Where this is in doubt, the service will assist the detained person to arrange alternative family carers, or contact appropriate services to check or arrange, following standard safeguarding procedures from the outset.

### **Think Family**

A think family approach should be incorporated into training courses, including awareness of the impact of adult mental health difficulties on children.

[www.scie.org.uk/publications/guides/guide30/summary.asp](http://www.scie.org.uk/publications/guides/guide30/summary.asp).

### **Young Carers**

In families where a parent has mental health needs, children and young people often take on caring roles; they need information about mental health. The training needs of young carers will be considered in planning training and there needs to be close links with young carer services.

All Trust staff should refer to the Safeguarding Adults Policy (N-024) and the Safeguarding Children Policy (N-045)

### **Safeguarding Children Standards**

Ensuring children and young people receive treatment in a timely and appropriate manner is not just a key priority for the Trust, it is also in line with the United Nations Convention on the Rights of the Child and Local Safeguarding Children Partnership responsibilities.

In circumstances where admission to an adult ward is unavoidable the overriding concern must be safeguarding the young person. Children admitted to hospital should be accommodated in the most suitable environment; and this must take account of their age and developmental needs; and their right, where they are competent, to exercise choice as to where they receive treatment.

This involves:

1. Ensuring that services for children and young people are fit for purpose and meets their assessed needs, taking into consideration the requirements of the United Nations Convention on the Rights of the Child (UNRC)
2. Working together to ensure that care for children and young people is integrated across services in a robust, seamless pathway of care. This involves liaising with family, other professionals and agencies involved in the young person's care
3. Individual needs should be considered and services developed to best meet these needs.
4. Safeguarding consideration for the young person should be paramount in all decisions made in respect of admissions of young people into adult mental health wards. Contribution to all safeguarding children processes must be ensured where relevant
5. Recognising the needs of young people and being responsive to those needs, including receiving services in their language of choice or ensuring the availability of support from other relevant services.

### **Safeguarding Adult's Standards**

Safeguarding Adult's Standards Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (NHS England 2015) sets out clearly the safeguarding roles, duties and responsibilities of all organisations in the NHS. The Care Act also gives duties to all organisations including the NHS. Safeguarding adults at risk is core business for the organisation. All staff have responsibilities to safeguard those in our care.

1. The Trust will ensure that they have up to date organisational safeguarding policies and procedures, consistent with relevant legislation, which reflect and adhere to safeguarding adult board policies and procedures. They should include guidance on how to recognise and refer a safeguarding adult concern, ensuring the involvement of the person in line with Making Safeguarding Personal Guidance.
2. The Trust will ensure that that staff within the Trust receive Safeguarding Training relevant to their area of work.
3. Working together to ensure that care for adults is integrated across services in a robust, seamless pathway of care. This involves liaising with family, other professionals and agencies involved as deemed appropriate.
4. All adults have a right to protection. Some people are more vulnerable to abuse and neglect due to a variety of factors impacting on their own, and/ or their families, parents' or carers' welfare. All providers of services commissioned by NHS Hull CCG are required to share information with other agencies, in a safe and timely manner, where this is necessary for purposes of safeguarding, in accordance with the law and local multiagency safeguarding information sharing procedures.

This may include personal and sensitive information about:

- the child or young person(s) at risk of or experiencing abuse
  - the adult(s) at risk of or experiencing abuse
  - family members of those experiencing or at risk of abuse
  - staff
  - members of the public
5. All staff have a duty to empower our service users and to protect them. Service users should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent, such as lack of capacity or other legal or public protection.



If during the course of treatment disclosures of domestic violence /abuse are made, practitioners should follow safeguarding adults and children procedures escalating all safeguarding concerns including follow up.

### **Older Adults**

Older Adults will have equal access to this service. The provider will need to ensure that appropriate responses to an individual's circumstances and clinical presentation are delivered in conjunction with the need to accommodate issues of physical frailty and other physical health requirements.

### **Advance Decisions/Advance Statements; Crisis Plans and Wellness Recovery Action Plans (WRAP)**

All people who are under the care of Mental Health Services should be asked if they have any advance statements for a Crisis Plan/WRAP. These should be documented and taken into account when necessary and where possible.

### **Green Light**

The 'Green Light for Mental Health' is a framework and self-audit toolkit for improving mental health support services for people with learning disabilities. All staff to ensure they understand and support S136 presentations with a Learning Disability.

## **5.2. Initial Police Contact (s136)**

A police officer **must**, if it is reasonably practicable to do so, consult:

- a) a registered medical practitioner,
- b) a registered nurse,
- c) an approved mental health professional, or
- d) a person of a description specified in regulation 8(1) an occupational therapist, or a paramedic.

**This contact** will primarily be the Mental Health Crisis Intervention Team (MHCIT) via telephone (01482 335788) **before placing a person under Section 136**. Police Officers can contact MHCIT to find out if that individual has a crisis plan that mental health services can follow in the situation, prior to detaining the person on a 136. Hull's MHCIT will be able to take a referral from the police officer in certain circumstances, as "a police officer is not obliged to detain the person", consequently providing a less restrictive intervention.

For young people under the age of 18 years the CAMHS Crisis and Home Treatment Team can be contacted either directly or through the MHCIT to have this discussion. If the Team is contacted and a decision to place the young person under Section 136 a discussion will take place with MHCIT as to how the CAMHS Crisis and Home Treatment Team can support the assessment. This could be either as part of the pre-assessment discussion (whether this is face to face or virtually), as part of the assessment (consideration should be made as to the appropriateness of this on an individual basis and capacity of the team to do so) and the decision making afterwards.

In the instance of both Section 136 and Voluntary Drop Off's, the Police Officer contacting MHCIT will need to promote inclusion of the detained person in discussion with MHCIT. This can be useful in determining the detained person's point of view, and the potential of a least restrictive alternative being sought and agreed if possible. Ideally discussion of this nature should be with a qualified Nurse, Social worker or AMHP if at all possible.

### **Places of Safety**

The following are the principle places of safety within the Hull & East Yorkshire catchment area:

#### **Mental Health Unit/ Hospital (Designated Place of Safety)**

A designated Mental Health Unit or hospital is the most preferable place of safety.

#### **Emergency Department**

These departments should only be used if a detained person requires urgent medical treatment.

## Care Home/Family/Friends

Although these locations are rarely used all parties must consider the value, they can add to the care treatment and support of the individual. Discussions must take place between the Police, Health and Social Care Providers (MHCIT/EDT) regarding the use of such a location in order for a Mental Health Act assessment to be carried out by the AMHP and RMP; a follow up plan of support must be agreed.

## Police Custody

Police custody can be identified as a Place of safety however following changes in the Policing and Crime Act 2017 the following is required:

- An adult detained under S136 requires the authority of an Inspector or above to use Police Custody as a PoS. Humberside Police do not authorise custody for this purpose and therefore no one detained under S136 will be taken to custody.
- For children (under 18) detained under S136 a Police Station (not just custody) cannot be used as a PoS.

It should be borne in mind that violence/extreme aggression may have clinical undercurrents which still require an Emergency Department assessment.

In the event of there being no vacancy at the appropriate place of safety, an alternative suitable place of safety should be identified, it may be that an interview room is available at Miranda House for police to wait with detained individuals (see Appendix 13) until the S136 Place of Safety is free. While waiting for transfer the 24 hour detention period commences and a minimum of 30 minute checks should be conducted by health staff while waiting for transfer into the S136 Suite.

At the point that police consider a detention, officers must contact MHCIT first to discuss their concerns and decide on best course of action. It may be a consideration to speak to or see the service user informally /voluntary at Miranda House rather than detaining S136, on other occasions signposting may be beneficial. It is important that a meaningful discussion takes place and that this discussion is recorded within the Service User notes.

A unique Police referral and triage form (APPENDIX 21) has been developed in order to assist this process. It is important that prior to the Police decision to implement Section 136 a discussion takes place between Police as a referrer and MHCIT (or with the CAMHS Crisis and Home Treatment Team for a young person under 18 years) as care giver cover the following points:

- Is the patient known to Mental Health Services, if so, which service?
- If the patient is open to a community mental health service provided by Humber NHS Foundation Trust, and the referral is within normal working hours, is there an opportunity to access support from the patient's designated community service?
- Is the patient a 'Frequent Attender' (Data captured for audit purposes)
- Police perspective – why are the Police considering implementing Section 136?
- Evidence of substance / alcohol use. (intoxication / withdrawal requiring hospital care)
- Current medical issues impacting upon mental health (again, is hospital care required?)
- Has a discussion between MHCIT staff and the patient been attempted and achieved? and if not, why not?
- (MHCIT to patient) what has led to the current situation?
- (MHCIT to patient) What are the mental health concerns?
- (MHCIT to patient) What does the patient think will help?
- (MHCIT to patient) Exploration of any protective factors?

At this point the 136 triage form requires the MHCIT triage clinician to undertake risk screening questions and provide a written summary. Any identification of immediate risk to public safety should be reflected back to the Police.

Possible and alternative outcomes at point of triage: It may transpire that following the clinical discussion between patient and MHCIT clinician that the following least restrictive outcomes may be expedited, such as:

- Crisis Pad referral (currently over 18s only)
- Informal assessment of mental health (discussion with CAMHS crisis if under 18).

- Agreement of a support plan and follow up contact agreement.
- Engagement with treatment team.
- Involvement with carer (s)
- Other?

If all of the above have been exhausted, discussed and documented then a record of the discussion between the detaining Police Officer on scene and MHCIT clinician must show any agreement or disagreement, before the 136 decision has been concluded.

Should no other option be considered a section 136 detention will be undertaken. This communication between the detaining officer and Hull MHCIT staff; preferably a Senior Crisis Practitioner (SCP) ensures that the 136 suite is the most appropriate venue in terms of intoxication or physical health needs\*.

It is not sufficient for police control room staff to phone through, on behalf of the detaining officer, with just a name and an expected arrival time unless in exceptional circumstances consultation prior to detention by the police was impracticable and detention has already taken place.

\*None of these factors should be used as exclusion criteria from the Health based place of safety.

### **S136 Service Contact Details**

Police Custody Suite:

Grimsby	tel 01472 264720	ext 4720
Clough Road	tel 01482 578664	

MHCIT and designated S136 suite (emergency services only)	tel 01482 335788
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EDT East Riding	tel 01377 241273
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### **5.3. Referral**

The detaining officer will refer the detained person to the MHCIT, agree the place of safety and give an estimated time of arrival. If the detaining officers choose to take the person to ED then the referral must still be processed by the MHCIT triage element of the service and the onset of the S136 starts as soon as they arrive at the ED.

Upon receipt of referral, a “triage and referral form” will be created on Lorenzo and referred to MHCIT Emergency to ensure activity is recorded appropriately and for audit purposes; regardless of the venue used as place of safety.

Information to be provided by officers at referral will include:

- Reason for use of S136
- Whether any restraints have been used
- Whether the person has been searched
- Place and time of detention
- Name, address, date of birth and next of kin
- The presence or absence of immediate physical health care needs
- The degree of violence or aggression being shown
- Complications of recent CS spray use
- If the person is intoxicated, preferably with what substance
- Whether there is reason to doubt the person’s capacity to understand the reasons for the detention

This should be documented on the Pre-arrival form (section A) found in Appendix 1

Arrivals at the S136 suite or the Emergency Department (ED) at Hull Royal Infirmary without prior telephone referral will create a delay in response from 136 staff.

### **Risk**

Any indicators of risk and previous contact with police should be provided when known. Each individual’s details will be checked on the PNC and or Humberside Police systems. Triage and assessment clinicians should make reference to the Humber Teaching NHS Foundation Trust Risk

Decision Matrix and in particular, the Red Flag Indicators as part of the decision making process. The S136 coordinator should observe if the service user has any warning indicators already active within Lorenzo and share relevant indicators (such as risk's to professionals / carrying / use of weapons etc)

### **Background health information**

The S136 coordinator will immediately arrange to check details as per, NHS Spine Portal and Lorenzo.

## **5.4. Documentation**

A S135(1) / S136 pack will be completed (see Appendices 1-8) as a requirement for each person detained under a S135(1) / S136 for statutory monitoring purposes.

Those required to record information are:

- S135(1) / S136 coordinator
- the detaining police officers (except for S135(1))
- the AMHP
- the Registered Medical Practitioner

S135(1) / S136 documentation pack will be available at the Miranda House 136 suite for each assessment and include:

- A Section 136 MHA, 1983 Record with sections A, B and C. (Appendix 1) – this is now an electronic form on the person's EPR; police have their own electronic version.
- Risk Assessment form, completed with Police (Appendix 2)
- Information Leaflet (as per S132) (Appendix 3)
- Property form (Appendix 4)
- Observation care plan/form (Appendix 5)
- NEWS2 (Appendix 6)
- PAWs (Paediatric Advanced Warning Score) for those aged under 16 (in both the Child and Adolescent Mental Health Service, and the Adult Mental Health Service Clinical Charts on Lorenzo).
- Minimum Data collection form (Appendix 7)
- Outcome form (Appendix 8)

Checking – all staff involved will have a responsibility to complete the required documentation. Duty doctors and AMHPs will be required to leave a contact number in order that paperwork may be checked before it is sent out. If going off duty, an agreement about further contact should be made.

MHCIT will take responsibility for monitoring completion of detention forms and other S135(1) / S136 paperwork.

S136 Coordinator will check with the police that they have completed and forwarded their electronic form before they leave (if S136).

The S135(1) / S136 Coordinator will be responsible for ensuring the electronic form is fully completed on the EPR and inform mental health legislation team of its existence at the earliest opportunity so it can be legally scrutinised.

Voluntary assessments – If the Police Officer or ambulance crews (whether alone or in conjunction with the police) have conveyed the service user to Miranda House or A&E, the officer(s) are required to provide a full handover to the receiving clinician in both environments and complete the voluntary handover form for either Miranda House or A&E. The ambulance handover must take place within 15 minutes of arrival. See appendices 16, 17, 18, 19. At certain times, these forms will be subject to clinical audit, it is important that these forms capture the details of decision making.

## **5.5. Information Gathering and Sharing**

The protection of life and prevention of crime (assault) enable information sharing between all the

relevant agencies. An information sharing agreement has been established and is operational. This document can be found on the Trusts Intranet site: General Protocol for Sharing Information between agencies in Kingston Upon Hull and the East Riding of Yorkshire 2008.

In order to facilitate a safe and comprehensive assessment on each detained person as much background information as possible will be sought before the assessment. The S136 Coordinator will have access to Lorenzo, inpatient discharge summaries and MHCIT electronic notes held within Trust medical records where possible. Additional, up to date information from the GP should be sought where possible.

The detaining officer will provide the necessary information in order to assess and manage risk safely; where known or ascertainable, where there have been previous S136 detentions or where there is suspicion of a significant history of violent offences.

Contact with carers – where a detained person gives consent, further information may be sought from carers or other parties.

## **5.6. Arrival at the MHBPoS**

Conveyance to the S136 should be undertaken by an ambulance which is the preferred choice for transport, unless there are exceptional circumstances which would make this unsafe for either the detained person or the ambulance crew. Any intelligence or information which relates to the risk of transportation in an ambulance/by an ambulance crew must be shared by the Police to enable a joint decision about whether to use an ambulance or a police vehicle for the transfer. If a Police vehicle is used the reasons for this must be clearly documented on the ePR and Police log.

Except in exceptional circumstances the detaining officer should travel in the ambulance with the service user. Where this is not possible a dynamic risk assessment must be undertaken with between the Police and Ambulance crews, reasons should be clearly documented and there should be consideration given to how the Ambulance crew and Police will communicate in the event of a change in presentation or circumstances. Depending on which vehicle is transporting the service user the other must follow immediately and consideration should be given to ensuring the two vehicles stay together, although there are strict rules for the use for sirens and lights on police vehicles and not all officers are authorised to use them. This cannot be determined by the transportation of a detainee.

On arrival to the MHBPoS:

1. The designated S135(1) / S136 coordinator and/or allocated nurse will come out to meet the transport in the parking area. If there is no contraindication to acceptance, the detained person and accompanying police officers will then be escorted inside. Ambulance handover should take place within 15 minutes of arrival.
2. It would be good practice for the S135(1) / S136 co-ordinator to meet the police straight away and start to discuss and observe for the completion of the risk assessment time up to one hour.
3. The risk assessments need to be repeated every half hour if the police are staying and must be recorded.
4. The risk assessment/review of the individual should continue be part of the process when the police have left. Agree time scales for this - to be discussed with the Clinical Lead and S135(1) / S136 Co-ordinator. This ensures the process is robust.
5. If there are more than two S135(1) / S136 detainees the band 7 and S135(1) / S136 co-ordinator need to be flexible and responsive in finding rooms and discussing with other 136 suites to support. MHCIT are the service responsible for looking for solutions.

Police waiting area and 136 suite:

If a 136 suite is available when the Service User arrives at the MHBPoS escorted by police, the S135(1) / S136 Coordinator and police will complete a joint risk assessment (See '136 pack' in Appendices 1-8) and this will influence decisions around on-going police support within the MHBPoS. The police should be released within an hour, if safe to do so, or as soon as possible following the risk assessment taking place. The risk assessment should predominantly focus on presenting risk and although historical information should be considered, it should not be the basis

for decision making alone. Warning indicators should be brought into the rationale for decision making.

After 30 mins the S135(1) / S136 coordinator has responsibility for reassessing the situation and communicating with the police to update them and offer a rationale for them having to stay with the detained person. After 1 hour the S135(1) / S136 coordinator should have a discussion with the main MHCIT coordinator to consider other options and then the main MHCIT coordinator will have a collaborative discussion with the police. These discussions and agreements must all be documented on S135(1) / S136 paperwork.

If the 136 suite is already occupied the Clinical lead/co-ordinator will look at other accommodation while waiting for the 136 suite to be free, this would also include MHCIT contacting other 136 suites etc., It may be that an interview room is free in which case the detained person and Police will be directed to use this room as a waiting area, until the 136 suite is available. Police will remain in the waiting area with the detained person until the 136 suite is available. If the detained person in the 136 suite is not able to be assessed for any reason, the AMHP can be consulted by the Clinical Lead on duty/136 co-ordinator to complete an assessment if it is appropriate for the other detained person to be assessed in the waiting area. If this is considered, attention needs to be placed upon risk assessment and appropriateness of using the waiting area for the purposes of Mental Health Act assessment and the potential risks of not doing so. All decisions should be underpinned by a clinical rationale for decision making and recorded within the patient notes/136 documentation.

There is an agreement in place between Police and Yorkshire Ambulance Service (YAS) that the detained person receives a physical health screen prior to or on arrival at the MHBPoS. This should be done at scene prior to conveying the detained person to ensure that conveyance to MHBPoS is safe/appropriate and that physical presentation requiring ED conveyance is ruled out.

If the service user is voluntarily attending the department (MHCIT/ED) with conveyance by the police, at time of arrival a full handover must be given to the receiving clinician and completion of the voluntary service user handover form (appendix 18, 19). Following this handover, usual assessment procedures apply and do not fall within the 136 framework.

### **Intoxicated Service User**

Where people are so intoxicated by alcohol or drugs as to present a health risk to themselves, the police should follow the normal 'drunk and incapable' procedures and ensure they are taken to the local ED for medical assessment.

Nothing in law prevents using section 136 MHA 1983 in respect of someone who is intoxicated by drugs and alcohol. Officers should be wary of making a judgement that behaviour arises from a mental health problem, however, where the subject is believed to have consumed a considerable quantity of alcohol or drugs.

If a paramedic believes that an individual who is mentally vulnerable has a health risk due to drink and/or drugs, they (the paramedics) are likely to recommend that the individual is taken to an ED in the first instance. If a person is legally detained under MHA 1983 and safe, a health care professional may decide to delay assessment until the person is able to adequately engage and respond.

The [Mental Health Crisis Care Concordat \(2014\)](#) for England and the [Mental Health Crisis Care Concordat for Wales \(2014\)](#) make it clear that the presence of alcohol and/or drugs will not be a routine reason for a health-based place of safety to refuse to admit a mental health patient. The concordats also state that it is inappropriate and unacceptable for healthcare staff to use breathalysers to support decision making. Forces should consider including plans for managing these issues in local multi-agency mental health response protocols.

Breath tests can form part of assessment and safety/management plans, however in isolation do not define level of dependence. Caution should be taken with severely dependent persons, as they may have a high breath reading when they begin to experience withdrawal symptoms.

If a detained person is placed on section 135(1) / section 136 but is intoxicated, then a capacity assessment can be carried out to determine if the detained person is fit / able to be assessed under the Mental Health Act. ***'Breath testing is not appropriate to use to assess the value or necessity of clinical assessment. No arbitrary level should be used as a reason to not undertake a clinical assessment.'*** A formal assessment of capacity will determine if the service user is fit for assessment under the Mental Health Act. The documentation of this on the Mental Capacity Assessment form will provide a robust rationale for delaying the assessment if this is required. Given that it is the AMHP's role to coordinate the process of assessment under the Mental Health Act (14.41 MHA 1983 Code of Practice), then the decision to either undertake or delay the assessment lies with the AMHP. Under the Mental Capacity Act 2005, it is the decision maker that completes the Mental Capacity Assessment form; therefore it will fall to the AMHP making the decision to complete this form. Again, an assessment of capacity is time and decision specific, and it is to be expected that the service user will regain fitness for interview in due course. Lack of Capacity does not necessarily mean the patient should not be assessed; this is a clinical decision. Once fit for assessment this can be arranged. Given the presumption of capacity in the MCA, there may not need to be the requirement for a further MCA form to be completed, as long as the reasons for the change in decision are noted fully in any communication sheet.

### **Search**

The police may search the person, at any time while the person is so detained, if the officer has reasonable grounds for believing that the person may present a danger to himself or herself or to others and is concealing on his or her person an item that could be used to cause physical injury to himself or herself or to others.

The power to search is only a power to search to the extent that is reasonably required for the purpose of discovering the item that the officer believes the person to be concealing. There is no authority to request a person remove any of his or her clothing other than an outer coat, jacket or gloves, but does authorise a search of a person's mouth.

This does mean police cannot search intimately which can cause operational risks that staff should be aware of. Other than the clothing stated, garments cannot be removed or searched.

Police are not able to routinely search people detained under S135(1) / S136, or their bags/belongings, without reasonable grounds for believing that the person searched might use it to cause physical injury to himself or herself or to others. An officer searching a person in the exercise of the power to search may seize and retain anything found.

In accordance with the Trust's in-service user Search Policy, Trust staff have the ability to search the service user should this be required and there are sufficient grounds to do so. The service user should first be provided with the list of contraband items and asked to pass any items they may have in their possession, on this list, to the Trust staff. Should the service user consent to a search and this is deemed necessary due to intelligence received or known, this can be conducted via the equipment in the MHBPOS, via appropriately trained staff and in accordance with the Trust's Search Policy.

Should the service user not have been searched prior to arrival at the suite and the police are still in attendance, the Trust staff can request that the police officers conduct the search, as per the law available, along with Trust staff. It is also important to consider gender appropriateness, privacy and dignity when undertaking all searches upon a Service user.

It is expected that the attending officers then engage in recording property, jointly, with MHCIT staff. All items deemed to be of risk to the individual or staff will be removed and stored securely until resolution of the detention. Such items will either be returned to the individual if deemed appropriate or handed over, with a receipt of exchange; to the receiving organisation a small safe is available for valuable items.

**If there is a current or historical ligature risk consideration should be made of removing items such as belts or shoes, slippers can be provided in these situations and rationale should be clearly documented in the notes.**

Continued police attendance (136 suite) – staff in charge of the place of safety can take on the responsibility for the care and detention of the detained person, once a formal handover with the

police has occurred with the joint risk assessment form completed (Appendix 2). Staff at the Place of Safety are empowered by the MHA to stop and restrain, (using reasonable force) anyone who is attempting to leave if they have been detained under S136.

Following the joint risk assessment, the police will remain in attendance until the S136 MHA assessment is ended or there is an agreement that it is safe for the police to leave. S136 Coordinator will ensure the police have completed their part of the paperwork before leaving. On completion of the assessment, continued police presence (e.g., whilst the detained person is awaiting a hospital bed) will be by mutual agreement.

Where police officers are required to remain in attendance, this should be continuously reviewed. If the need for them to remain exceeds 4 hours this should be reviewed jointly by the duty inspector and the designated 136 coordinator. The police should be released from duty as soon as possible, when safe to do so, and professional decision making should be agreed upon and recorded within the risk assessment documentation.

### **Joint Professional Decision-Making**

Any conflicting professional opinion should be discussed by the S135(1) / S136 coordinator and Duty Sergeant. If necessary, this can be escalated to the Duty Clinical Lead, for the 136 (or on call Service Manager out of office hours) and Duty Inspector

If a Service User is accepted into the suite and the 136 staff determine that there is an urgent medical need which requires immediate transfer of the detained person to ED, this will be achieved by requesting an immediate ambulance via 999, if necessary, with the assistance of the attendant police or the 136 staff. Decisions to seek further medical attention of this nature need to be underpinned by clinical opinion and physical health observations to evidence such decision making. Police should not be called back unless the detained person is too violent or aggressive to travel unaccompanied by the police.

### **Physical Health Screen prior to arrival at MHBPoS**

If conveyance has occurred via YAS the detained person should receive a physical health screen prior to or on arrival at the MHBPoS. Once the service user has arrived at the MHBPoS RSS staff will need to carry out their own physical assessment using the NEWS (Appendix 6) regardless of YAS health screen. See Appendix 21.

## **5.7. Rights**

Once a detained person is accepted into the MHBPoS MHCIT staff need to ensure that the provisions of section 132 'reading rights' are complied with as they are required to notify the person of their rights both orally and in writing. This is a good opportunity to gauge the detained person in terms of capacity and their willingness to engage in the assessment process.

The response to this interaction will assist in setting the supportive engagement frequency and negotiations relating to the on-going presence of the Police in the MHBPoS. Also consider the Guidance on Fitness for Assessment for Hull S136 (see Appendix 10).

Rights leaflets (Appendix 3) will be available in S135(1) / S136 assessment packs at all places of safety, in languages other than English and for those with a learning disability please access the following internet page and print off appropriate leaflet, [www.mentalhealthlaw.co.uk/Foreign-language-information-leaflets](http://www.mentalhealthlaw.co.uk/Foreign-language-information-leaflets).

Contact with Carers – if a detained person wishes, their carer, nearest relative or a friend may be contacted and asked to attend the 136 unit.

## **5.8. Staffing Procedures and Process**

The S135(1) / S136 coordinator (registered professional) will liaise with the police and other agencies **and ensure that there is sufficient staff available to supervise the service user in the 136 suite.**

Shift Coordinator – the shift coordinator within MHCIT will allocate a S135(1) / S136 coordinator for



the suite.

The S135(1) / S136 coordinator will be responsible for completing the risk assessment with the police and accepting the detained person on to the unit and making an agreement for the police to leave.

The S135(1) / S136 coordinator will allocate a band 3, 5 or 6 staff member to be responsible for the detained person in the 136 suite.

Other Staff - If additional staff are required, the MHCIT shift coordinator can use the band 3, 5, and 6 staff within the team if they are available and negotiate with the inpatient services for support from the wards at Miranda House.

**Increase in patients with complex presentations means more professionals are involved in the Sec 136 process. Leadership and accountability needs to be established:**

1. The leadership within the 136 will take place via discussions between the 136 co-ordinator and the main co-ordinator. Any subsequent conversations with Charge Nurses and AMHPs should only be with these two individuals to ensure communication and decision making is robust. The actions of these two individuals and the Clinical lead need to be recorded on a clinical note to ensure a timeline of decisions is kept up to date.
2. Leadership in regard to the 136 suite to be clear including lines of communication / escalation process for all staff.
3. AMHP to ensure they hold clinical discussions with a nurse at the earliest opportunity following assessment and that they update the S135(1) / S136 co-ordinator and the main co-ordinator.

**Dispute Resolution** - the 136 co-ordinator and the main co-ordinator must agree escalation when there is a dispute. All staff must be aware of escalation processes. In MHCIT this is the already established: any issues must be escalated to the Band 7 then the Service Manager or on call manager. For the police this is via the supervisor of the police officer or the Police Mental Health Operations Manager if on duty. Any disputes can be discussed after the incident with the Police Mental Health Operations Manager in the monthly 136 meeting or the next working day.

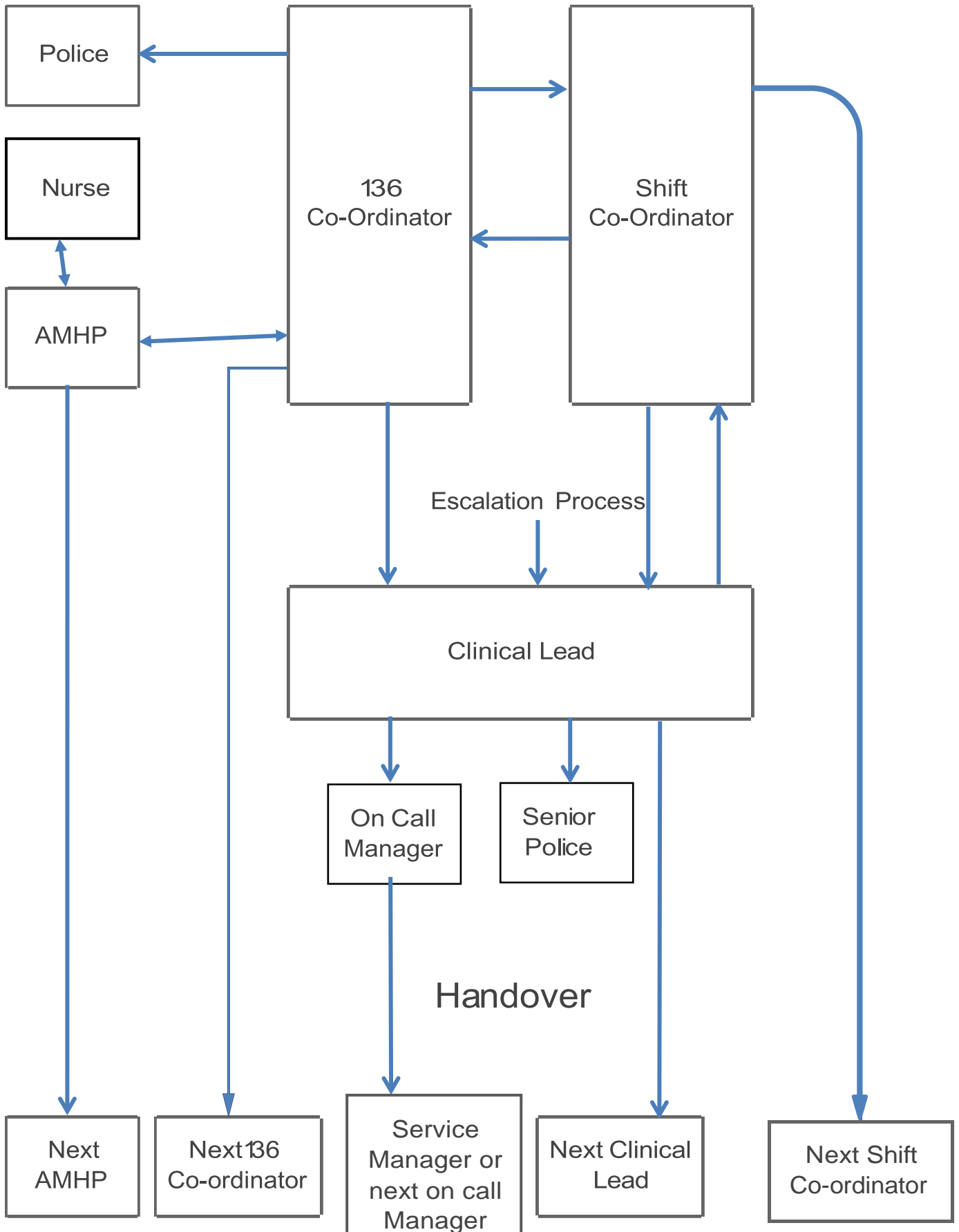
**Raising /discussing any 136 legal issues** - MHCIT staff and AMHPs must discuss any legislation related problems with Mental Health Legislation Managers immediately. The 136 co-ordinator and AMHP will lead on speaking to Mental Health Legislation Managers to ensure no duplication of information and outcomes.

**Observations / supportive engagement**

MHCIT Staff Duties – there must be at least one MHCIT staff member present, at all times within the MHBPoS, when it is occupied by a detained person. The minimum frequency of physically observing the detained person is every fifteen minutes; under no circumstances can this be substituted with only observing the CCTV. This can be increased accordingly, in relation to the level of risk to the detained person and staff. It is necessary to explain to the detained person, exactly what they can expect and the reasons, for being observed. Supportive engagements will be planned and recorded in the S135(1) / S136 Pack (see Appendices 1-8). Also consider the Guidance on Fitness for Assessment for York S136 (see Appendices 10).

Health Support Workers (HSW) can manage the detained person supportive engagements within the suite, however, clinical decision making cannot be deferred to HSWs.

**Flowchart of clinical leadership of 136 process**



**Increasing responsiveness and support for patients in the 136 suite** - MHCIT staff are to implement supportive engagements with the patient in 136 and move away from observation. Staff must use Supportive Engagement documentation on Lorenzo within the 136 suite and record more in-depth, robust and meaningful clinical notes on supportive engagements and S135(1) / S136 monitoring forms. The recording and evidence of supportive observations can be incorporated within the 136 plan record of contact, and such evidence should also record if the patient is 'refusing' supportive contact i.e.: staff have offered this and are also respecting the patients request for privacy at certain times during the detention. These should be reviewed regularly throughout the detention and evidenced within documentation.

### **Use of CCTV**

The 136 room is fitted with a CCTV unit to help protect staff and service users.

It should not be used to replace responsibility to observe and engage with a detained person.

**The Supportive Engagement Policy** must be followed, and service users who require constant supportive engagement in order to keep them safe will need to be observed/supported by an allocated member of staff not using CCTV.

There will be signs displayed so that service users are aware that this is in use for their protection and the protection of staff.

### **Physical Health monitoring**

Physical health observations should be undertaken in line with the NEWS2 process and documented on an A3-sized colour chart, which will then follow the service user into the in-service user admission or scanned into the EPR. Should the service user refuse observations to be conducted, the Trust staff member should attempt again where possible to gain these baseline physical information's in line with making every contact count. Follow NEWS2 procedure for escalation.

### **Lone Working**

Lone worker issues should be considered at all times.

It may be suitable for one member of staff to be in the 136 suite with a detained person following a risk assessment, with support available via the alarm system should that be required.

MHCIT staff must carry an alarm trigger-fob at all times when working in the 136 suite, and self-test the alarm to ensure it is functioning. It is the responsibility of each staff member to test their alarm before use on each and every clinical use.

Emergency assistance will be available through the alarm system from the wards within the unit. MHCIT will also respond to alarms in other parts of the unit as required.

**Food and Drinks** – hot and cold drinks along with basic food will be provided along with disposable crockery and cutlery to ensure standards of infection prevention and control are recognised.

**Record Keeping and Assessment** – the S135(1) / S136 Pack must be completed (see Appendices 1-8).

If there are signs of injury or bruising to a detained person on admission staff should document these on a body map form.

All 136 detentions referred to the MHCIT will be recorded on Lorenzo as an urgent assessment, once all completed all documentation will be recorded on the excel spreadsheet by the 136 coordinator before being collected by the legislation department. The AMHP will complete the S136 assessment details on the AMHP excel spreadsheet

There must be a regular supportive engagement record kept, using the designated paperwork (see

Appendix 5), describing the Service User's behaviour, mood and mental state and any interventions required while they are in the 136 suite (including medication, restraint etc).

The AMHP and Registered medical Practitioner will document their assessment using Trust approved documents. MHCIT staff should complete a clinical record on Lorenzo where there are significant events relating to the detention and at the outcome to summarise the detention.

The 136 coordinator will be responsible for completing the referral form, care cluster and FACE Risk assessment as part of the assessment process. The coordinator can commence the FACE risk at any time and does not need to be commenced at the time of the assessment. The 136 coordinator will also be responsible for ensuring that the remaining documentation has been completed by all involved parties, that this is collated and provided to admin for electronic recording purposes.

The 136 coordinator will also be required to complete the 136 monitoring spreadsheet, following the assessment to ensure all data is captured for the purposes of future audit.

\*\*The 136 coordinator's duties are reduced if the 136 assessment takes place elsewhere to the health based place of safety. In this instance, the 136 coordinator would be responsible for ensuring that the spreadsheet is updated with the monitoring information and that a referral form has been completed initially. The 136 coordinator would not be expected to complete a FACE risk if this service user is off site, as they are not under the direct care of Humber Teaching NHS Foundation Trust.\*\*

**Carers and Family/significant others** – carers and family/significant others may be able to give additional support to an individual held on a section 135(1) / S136.

The S135(1) / S136 coordinator in charge of the 136 unit can make the decision to allow or prevent individuals being accompanied by a carer or relative/significant other, however best practice would indicate that considerations of this nature should also be discussed with the AMHP to demonstrate that the inclusion of family is beneficial in the process of support and assessment, however this may not be feasible in all situations in terms of risk management. The rationale for this decision will be documented on Lorenzo and should take into account the following:

- Service User choice – do they want to be accompanied
- Risk to the carer/relative/significant other, and also carer stress within the S135(1) / S136 process
- Risk that the presence of the carer/relative/significant other, may cause the individual to become agitated
- Risk to staff
- Consideration of any safeguarding requirements (vulnerable persons)

People under 18 years old will not be permitted to visit an individual in the 136 suite.

Carers, family/significant others should not be expected to take responsibility for an individual's safety. Carers, family/significant others should be told how to summon staff if they need assistance. Carers, family/significant others should be given support and be invited to be involved in decisions about the person who is detained on the 136 if they have given permission. Carers, family/significant others acting in an inappropriate or aggressive manner will be asked to leave the unit. See appendix 21.

## 5.9. Assessments

Timeframe – the assessment must be completed within 24 hours. The Code of Practice (16.47) recommends in cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and AMHP to attend within 3 hours; this is in accordance with the best practice recommendations made by the Royal College of Psychiatrists. AMHP's should consider that there may be clinical grounds to delay, perhaps making sure daytime team / family / etc are involved or due to alcohol / substance use.

The first doctor and AMHP attend within three hours, to enable completion it is advised that both

doctors attend. If S135(1) the AMHP and the first doctor will arrive at the suite with the person as per S135(1) process.

Urgent transfer to ED – if it is determined that there is an urgent medical need by the 136 staff, specifically by doctors, which requires immediate transfer of the detained person to ED, this will be achieved by requesting an ambulance via 999, if necessary, with the assistance of the attendant police or the 136 staff. This should be coordinated by the 136 coordinator.

Joint assessment – the emphasis throughout should be upon joint working and joint decision-making between the S12 doctor crisis staff and AMHP.

Assessing doctor – wherever possible, the first medical practitioner assessing the detained person should be S12 approved. If not, the reasons for this should be recorded on the Detention Form.

S12 doctor – the first choice for the first S12 doctor will be the patient's regular Section 12 Psychiatrist, or if unavailable, the Duty Section 12 Psychiatrist (Consultant, Registrar or SAS Dr).

Second doctor – if a second doctor is required the AMHP will have access to lists of S12 approved doctors.

AMHP – the AMHP will be from the duty rota or MHCIT (EDT in East Riding). The availability and accessibility of the AMHP and Medical team for the 136 Suite will be governed by clinical need, for example, the Mental health act Assessing Team may have to prioritise community assessments before 136 MHA assessments due to the potential increased risk facing community patients by not being in a designated place of safety.

Children and Adolescents – The assessing doctor should be a higher trainee or consultant psychiatrist from CAMHS. The 136 suite is an ageless service, there is no lower or upper limit as to who will be cared for in the suite. The revised Code of Practice (2015) states that if a young person is admitted in a crisis it should be for the briefest time possible. All detentions to the 136 suite for an under 18 are required to be reported via completion of a Datix. CAMHS crisis must be made aware of all young people under 18 detained on a 136 and should be part of any future plans of care.

Learning disability – if a person with a learning disability is detained, the higher trainee or consultant psychiatrist from LD services should be called (during working hours).

Managing Violence and Aggression – only Trust staff with MAPA training may use such procedures, in line with current trust policy, and in exceptional circumstances.

Whilst any restraint used by police officers will be the responsibility of Humberside Police, Trust staff still have a responsibility for the detained person on their premises. Throughout the incident health staff will remain responsible for the detained person's health and safety. This will require active monitoring of the detained person's vital signs. Health staff must alert police officers regarding any concerns as to the detained person's welfare during any period of restraint. Emergency resuscitation/defibrillator equipment with trained healthcare staff should be immediately available at all times. The evidence is clear; any use of restraint or other force involves increased levels of risk and no period of time spent under restraint (especially prone restraint) is inherently safe.

Trust staff should take over the care of the detained person from the Police at the earliest opportunity. However whilst an individual is detained under a section 136 the police are responsible for them (even when they are not present) therefore MHCIT Staff are to ensure they carry out robust reviews and comprehensive record keeping to give assurance to the police whilst the individual is detained under a section 136. When a patient is detained the AMHP is responsible for their care and transfer of care.

Trust staff need to be aware that other services may not use restraint techniques, i.e. Yorkshire Ambulance Service. Any practice of restraint techniques used will require thorough documentation

as to rationale for implementation and consideration of least restrictive alternatives. The Lead Nurse responsible for 136 suite will have regular attendance within the Trust's Reducing Restrictive Interventions Meetings (RRI) to maintain up to date practice and disseminate aspects of new practice and methods of approaching supportive interventions to the MHCIT team.

Frequency and necessity of use of restraint techniques will be included in the regular monitoring of the service.

### **The Trust's role and responsibilities when restraint is used by the police**

- Throughout the incident health staff will remain responsible for the service user's health and safety. This will require active monitoring of the service user's vital signs by being present in the suite continuously restraint is being used by the police.
- Health staff **must** alert police officers regarding any concerns as to the service user's welfare during any period of restraint.
- Allocate a lead member of staff to co-ordinate the incident and instruct and inform attending police.
- Trust Staff should record details of all incidents, including details/rationale of the restraint and complete a Datix.

The importance of de-escalation and other verbal skills in managing violence and aggression by **all** agencies cannot be overstated. Appropriate preventative strategies are known to be effective in preventing / lessening incidents of violence and aggression and the corresponding need to consider the use of any force. All staff using restraint to deal with violence and aggression from people suffering from mental health issues or physical illness should be aware of potential additional problems, (e.g., medication, obesity, co-morbidity of drug and alcohol problems; Acute Behavioural Disorder etc.). These factors can raise the risks of restraint.

MHCIT staff are expected to have the confidence and competence to manage violence and aggressive presentations however it is recognised that MHCIT staff rarely have to implement DMI and when they do it's usually a highly volatile situation in the 136 suite or reception. This problem is heightened further if there is a second 136 in suite 2, also requiring a DMI procedure. In terms of managing aggression, there should be enough staff available in MHCIT regularly to undertake DMI procedures.

If the situation(s) require increased level of staffing to ensure safety and support for the detained patient the 136 coordinator should call upon the Avondale Clinical Decisions Unit Team or PICU Team for assistance. If further assistance is still required then the 136 coordinator should inform the Band 7 Clinical Lead to escalate the need to further, utilizing On Call Manager (if Out of Hours) to locate further staffing via any available floating staff. All attempt to manage this situation and its resolution need to be recorded in patient notes and DATIX completed if appropriate.

All restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need based on the fundamental principles in *Positive and Proactive Care*. This is supported by the 2015 Mental Health Act Code of Practice which states that "unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position".<sup>2</sup> NICE guideline *NG10: Violence and aggression* also recommends avoiding prone restraint, and only using it for the shortest possible time if needed. The long lasting impact and distress caused to service users, staff and relatives can be substantial. For these reasons, wherever possible, every effort must be made to utilise methods of dealing with violence and aggression that does not involve the use of restraint.

Simultaneous S136 detentions – if a number of people have been detained on S136 in different places of safety at the same time, the S136 coordinator will assign a priority rating to each and keep staff at all sites informed when the next available space in the 136 suite is likely to become available. If this occurs people will need to be detained in the ED or an agreed alternative. This alternative may be another S136 suite within the Humberside Police area.

## 5.10. Treatment

Smoke Free – the Trust became smoke free on 1 October 2018. As a result, any service user brought to the HBPOs at Miranda House will not be able to smoke tobacco or any other substance, including the use e-cigarettes on Trust premises. Please see appendix 15 for flow chart for guidance on managing a service user who has nicotine cravings.

The service user should be assessed within 30 mins of arrival at the suite for their use of tobacco and the need for nicotine replacement therapy. This should be conducted in line with the Trust policy on Nicotine Replacement Therapy.

Only staff members who have the level 2 training in smoking cessation should assess the service user for the need for nicotine replacement therapy and provide this to the service user as needed. All staff can complete the Fagerstrom Screening Tool, regardless of level 2 training.

The suite has NRT products and these can be used, following the risk assessment of the service user, to make the service user more comfortable during their assessment and reduce nicotine cravings.

If the service user has any smoking products on them on arrival, these should be removed and recorded on their property log as usual procedure.

Please use in conjunction with documentation and information on the Smoke Free and NRT policies from the Trust.

An assessment of risk is required if a service user wishes to leave the building for a smoke, the rationale and plan needs to be documented in the 136 paperwork.

In the event a service user goes AWOL during any time in the 136 suite then the following action should be taken:

- Immediate review of risk and concerns around mental health.
- If face to face at time of disengagement then encourage service user to stay and complete the assessment process.
- Consider MCA and best interests of the service user.
- Attempt to contact service user via phone, risk and mental health presentation at triage will determine the urgency of this.
- If unable to make contact via telephone (depending on risk/areas identified on the TAG score/concerns at triage) an unannounced home visit to be conducted. If risk is considered 'very severe' then to consider police welfare check.
- Also consider contacting nearest relative/significant other, initial referrer and GP to be completed.
- All clinical decision making to be discussed within MDT/Band 7.

Medication – treatment with medication may be appropriate for some service users. Voluntary consent should always be sought and recorded, as well as details of the medication. This includes where a detained person has a supply of their own (Safe and Secure Handling of Medicines Procedure should be followed for all PODs brought into the MHBPOs). Medications should be prescribed by a Doctor, Junior Doctor, Non-Medical Prescriber (NMP) or in their absence the on-call doctor on a medicine chart as per Medicines Code. Any medication needed for potential symptoms of mental illness should only be prescribed in agreement with the Crisis Teams medical team and/or on call Consultant who has been called to complete the assessment. Prescribing of a medicine for administration or administration of a PGD (Patient Group Directive) for a service user in the MHBPOs should be recorded via the electronic prescribing and medicines administration (ePMA) module on Lorenzo. Please see related policies and procedures on ePMA (community) for how this should occur.

S135 and S136 MHA are not included within the provisions of Part 4 of the MHA and therefore the Act confers no power to treat a person detained under this section without their consent (Code of Practice 16.72). In other words, they are in exactly the same position in respect of consent to

treatment as patients who are not detained under the Act. The same applies for persons who are liable to be detained.

A person with mental capacity may consent to care or treatment, thus making the treatment lawful. People without capacity can be treated under the MCA in these circumstances; otherwise there is no legal framework to treat a person against their will. The best option is to transfer to the ward if the MCA cannot be used in these circumstances.

Staff must carefully consider whether their assumption of capacity of the person detained under S135(1) / S136 to decline medication is in fact correct, and whether the person does indeed have capacity. A number of people will likely be affected (perhaps temporarily) by the stress of the situation, influence of drugs or alcohol, or symptoms of their mental disorder or indeed some physical disorder.

It should be borne in mind that individuals with mental disorder may become temporarily incapacitated. Within the provisions and limits of sections 5 and 6 MCA an incapable person may be given treatment provided:

- Reasonable steps have been taken to establish whether the person lacks capacity in relation to the matter in question and, if they do lack capacity, and it is in the person's best interest to be treated, and the doctor believes that it is necessary in order to prevent harm to the person, and that it is a proportionate response. In such circumstances a detailed case note entry should be made explaining and justifying the decision made in relation to treatment.

Before commencing treatment, the doctor should try to establish whether the incapable person has a lasting (health and welfare) power of attorney and, if so, whether it is valid and applicable.

Adverse drug reactions/allergies - details of any known drug allergies or adverse reactions should be recorded before any medication is given.

Mental Capacity assessment can be undertaken and decision-specific outcomes will require full documentation on the recognised capacity assessment pro forma on Lorenzo. Any subsequent decisions made in the person's best interests will also need recording on the relevant best interest pro-forma. More formative decisions around capacity should also be documented to support decision-making and defensible documentation standards.

Emergency medical treatment – The MHBPOs at Miranda House has access to emergency equipment for a medical emergency. Located in the suite is a grab bag, oxygen, defibrillator and emergency medications for use by appropriately trained clinicians or medical team. Should the service user have a medical emergency, the staff member should alert for help through the alarm system and follow Immediate Life Support procedures. See appendix 21.

#### 5.11. Outcomes and Care Needs

Following MHA assessment a clear outcome is required. This requires discussion with MHCIT Shift Coordinator and if necessary, the wider MHCIT MDT. The S136/shift coordinator is required to capture clinical discussion and outcome within Lorenzo. Please ensure all information has been obtained during S136 assessment to support the formulation and plan of care. **Further request for assessment by MHCIT should not be required following MHA assessments.** Possible outcomes of MHA assessment will include:

**No need for further assessment/care** – discharge to GP, the AMHP, in conjunction with the MHCIT has the responsibility of ensuring that the necessary arrangements are made for the individual to return to the community. A pre-release risk assessment should be conducted and consideration made re transportation of the person where this is deemed appropriate. The outcome and any follow-up arrangements resulting from the process must be shared with the police.

**Need identified as minor/moderate mental health problem (external agency)** – supply information on seeking further assessment/care, refer to agency, the AMHP, in conjunction with the MHCIT has the responsibility of ensuring that the necessary arrangements are made for the



individual to return to the community. A pre-release risk assessment should be conducted and consideration made re transportation of the person where this is deemed appropriate. The outcome and any follow-up arrangements resulting from the process must be shared with the police.

**Need for further assessment/care in secondary mental health services** – refer Home Based Treatment or to CMHT (for young people aged under 18 years refer to either CAMHS Crisis and Home Treatment Team or Contact Point – single point of access for Core CAMHS teams), the AMHP, in conjunction with the MHCIT has the responsibility of ensuring that the necessary arrangements are made for the individual to return to the community with the appropriate level of support. A pre-release risk assessment should be conducted and consideration made re transportation of the person where this is deemed appropriate. The outcome and any follow-up arrangements resulting from the process must be shared with the Police.

*If Home Based Treatment is being considered, as an alternative to hospital admission, the 136 coordinator and assessing team should discuss this possibility. The AMHP (if necessary) 136 coordinator and the HBT coordinator should then discuss this referral and ascertain whether a HBT referral is required at this time. If the referral is not agreed upon by the involved parties then the service user should be booked into a follow up appointment with MHCIT for the next day to be seen face to face, either in their home, at a locality base or other appropriate venue. Usual escalation procedures apply should the clinicians disagree. At this appointment a clinical review of presentation and risk should occur, with the completion and/or review of appropriate documentation. There should be a clear, clinical rationale, for the outcome of the follow up.*

*Following being seen in the follow up clinic, if the clinician from MHCIT urgent care can evidence a HBT referral being required, they can then make the referral to HBT. Should the service user DNA or cancel, usual DNA and disengagement protocols apply (Please see the Trust's MHCIT SOP).*

For young people aged under 18 years: If extended crisis intervention (72 hours) or home treatment is being considered as an alternative to hospital admission, the S135(1) / S136 co-ordinator and the assessing team should discuss this possibility with the CAMHS Crisis and Home Treatment team. If the referral is agreed upon CAMHS Crisis and Home Treatment Team will attend and complete a signed safety plan with the young person in the 136 suite or agree with the AMHP / young person a safety plan over the phone and arrange follow up within 24 hours.

**Need for informal admission** – arrangements for transfer to hospital in-patient care to be made by AMHP. The responsibility for arranging a bed lies with the local mental health services via the Bed Manager during working hours and MHCIT out of hours. If informal admission is not available locally then the Service User must be advised of the potential that the admission will be sought out of area and the Service Users opinion must be brought into the decision making. With consent of the detained person, they may also require that family member as identified by the service User is also made aware of the location of an out of are bed, and the circumstances surrounding this in order for informed choices to be made.

**Need for compulsory admission** – a bed should be sought as soon as possible so that the admission can be effected without further distress and/or risk. Medics to complete medical recommendations and an application for admission is to be made by an AMHP, they have a professional responsibility to ensure that all necessary arrangements are made for the person to be conveyed to hospital using an ambulance. However, a police vehicle may be used when violence is present, or police may choose to travel with paramedics in a medical ambulance if required. It is the responsibility of the local mental health services to ensure that a hospital bed will be available (for child and adolescent inpatient pathway see 5.11.1). Where difficulty is experienced in locating and securing health service facilities, communication will be maintained with the police to advise of ongoing situation. The patient should not be discharged from S135(1) / S136 until arrangements for the patient's treatment or care have been put in place.

In addition for young people aged under 18 years: For both informal and compulsory admissions to CAMHS in-patient beds a Form One Referral form must be completed by the assessing team (for child and adolescent inpatient pathway see 5.11.1), this process will be supported by a Core

CAMHS Clinician (if an open referral in hours) or CAMHS Crisis and Home Treatment Team (for a new referral or out of hours).

### **Awareness of legal responsibility for AMHPs**

#### **Ending a section S135(1) / S136 to be clarified for all staff involved in the S135(1) / S136 process:**

- The authority to detain a person under section 135(1) or section 136 ends as soon as the assessment has been completed and **suitable arrangements have been made** (MHA Code of Practice 16.50). “The patient will remain subject to detention under this section (s136) until...., and any necessary arrangements for the patient’s treatment or care have been put in place” (Jones MHA Manual).
- If the assessment by the AMHP and the doctor has resulted in an application being made under part 2 to detain the person, the patient can continue to be detained under this provision, within the permitted period of detention, pending arrangements for transporting the patient to the admitting hospital being put in place. If a decision is taken to admit the person to hospital under S2, the admission should be actioned without undue delay (Jones p659 23<sup>rd</sup> edition).
- The S135(1) / S136 should not be ended until the necessary arrangements have been made for the person’s care and treatment **but we cannot** say that the S135(1) / S136 should not be ended until the patient has actually left the 136 suite as this is not lawful. As soon as care is in place staff should arrange to transfer immediately.

### **Use of S136 suite as detaining hospital**

**In exceptional circumstances** the S136 suite could be utilised as the named ‘unit’ to detain the patient however this would not be the ideal scenario. A new application would need to be made out to Miranda House.

### **Delegation of authority to convey under the MHA:**

- Once the application is made, in terms of conveyance, the patient is deemed to be in the legal custody of the AMHP so the person awaiting conveyance can lawfully be held in the S136 suite as long as the AMHP remains with the patient (or at least remains in the building).
- The AMHP, as the applicant, has a professional responsibility to ensure that all necessary arrangements are made for the patient to be transported to the named unit.
- The AMHP can delegate the power of conveyance to other persons if the patient is likely to be unwilling to be moved and they must provide written authorisation (delegation of authority to convey).
- Trust staff have legal power under the MHA (if delegated by the AMHP) to use restraint to convey the patient who is liable to be detained to the ward. “Either the applicant or the persons delegated by the applicant (including ambulance staff and police) can use such force as is reasonably necessary to achieve the objective of conveying the patient to the hospital named in the application. They may act on their own initiative to restrain patients and prevent them absconding, if absolutely necessary. If the patient is likely to be violent or dangerous, police assistance should be requested”.
- Without this delegation, if the AMHP is no longer on site, it would be lawful for the person to be transferred to the unit under the MCA if they lack capacity to understand the need for their detention.

**Need for secure care** – arrange a bed on PICU, complete medical recommendations and an application for admission is to be made by an AMHP, they have a professional responsibility to ensure that all necessary arrangements are made for the person to be conveyed to hospital using an ambulance. However, a police vehicle may be used when violence is present or police may choose to travel with paramedics in a medical ambulance if required. It is the responsibility of the local mental health services to ensure that a hospital bed will be available. Where difficulty is experienced in locating and securing health service facilities, communication will be maintained with the police to advise of ongoing situation.

**Criminal Process** – once the assessment is complete, normal police procedures will be followed if there remain outstanding legal matters.

**S12 doctor role** – the S12 approved doctor, after his or her assessment, will advise on the preferred outcome and record this on the S136 Detention Form.

**AMHP role** – the AMHP has the professional responsibility for ensuring the necessary arrangements are made for treatment and care. This will include giving information, referring on to other services or transferring to hospital when an application for compulsory detention has been made.

**Returning a person to their home** – a pre-release assessment of risk will include whether or not the person is able to make their own way home (a small budget is available for those who require assistance. In the majority of these cases public transport costs should be covered. A taxi should only be considered when public transport is unavailable and the MHCIT are unable to transfer home). If not can they be released to the care of a relative or other responsible person.

**Delay obtaining second doctor** – if there is undue delay obtaining a second doctor out of hours (and although the rest of the 24 hour period can be used for making necessary arrangements for treatment or care), it may be worth considering the use of S4 to admit in an emergency, in order that the detained person can be placed in a more appropriate environment than the S136 suite, ED or a police cell. However Section 4 should only be used only in a genuine emergency, where the detained person's need for urgent assessment outweighs the desirability of waiting for a second doctor.

**Coordination of arrangements** – the AMHP and S136 coordinator will ensure that one of the above options is coordinated with other relevant agencies, and formally recorded via the S136 Detention Form

#### **Transportation of patient at conclusion of MHA assessment**

If a Doctor assesses the detainee and deems them not to have a mental disorder they can end the S136 detention without the need for an AMHP assessment. Once the S135(1) / S136 assessment process is concluded by the MHA team), arranging transport (if required) will be coordinated via the AMHP. The police will not transport patients from a 136 suite to a hospital however the Humber Teaching NHS Trust have access to private secure patient transport services if required as well as NHS Ambulance and Humber Teaching NHS Trust vehicles for less secure transport needs. Please refer to the Trust's multi-agency 'Conveyance under the MHA Policy'.

**Police support to be clarified in the event of needing to return to the 136 suite** - clarify when the police are required to assist in transfer of patient - *'If requiring the police to return to assist in a transfer whilst still in the 136 suite, the AMHP should inform the police that the patient is liable to be detained and that they police are requested to help convey under S6'*

- Trust staff have legal power under the MHA (if delegated by the AMHP) to use restraint to convey patient who is liable to be detained to the ward. The AMHP, as the applicant, has a professional responsibility to ensure that all necessary arrangements are made for the patient to be transported to the named unit. The AMHP can delegate the power of conveyance to other persons if the patient is likely to be unwilling to be moved and they must provide written authorisation (delegation of authority to convey). "Either the applicant or the persons delegated by the applicant (including ambulance staff and police) can use such force as is reasonably necessary to achieve the objective of conveying the patient to the hospital named in the application. They may act on their own initiative to restrain patients and prevent them absconding, if absolutely necessary. If the patient is likely to be violent or dangerous, police assistance should be requested".
- Once the application is made, in terms of conveyance, the patient is deemed to be in the legal custody of the AMHP. However the AMHP would need to remain with the patient for this to be lawful.

#### **Referrals for a CAMHS Inpatient Bed**

All child and adolescent Mental Health Inpatient beds are nationally commissioned by NHS

England. Inspire access assess all referrals on behalf of NHSE, for all young people living in Hull and East Riding, based on a set of Criteria laid out in the NHSE CAMHS Tier 4 Operating Handbook. If a bed is deemed appropriate and a suitable bed is available at Inspire arrangements can be made to transfer the young person.

If a suitable bed is not available at Inspire then the young person remains the responsibility of Community services to support the young person until a bed can be found. To support this Humber has identified two adult wards to support young people aged 16-18 (Westlands for females, Newbridges for males) Please follow the Humber Emergency and atypical admission of young people to adult mental health units: [Emergency and atypical admissions of young people to adult mental health units](#)

Young people should not be admitted to adult wards unless a bed has been agreed through the Access Assessment process.

Referrals are made using the NHS England Referral Form and following the [guidance](#).

Referral for a CAMHS General Adolescent bed will be from Community CAMH Service and endorsed by a consultant psychiatrist – CAMHS on-call consultant (if out of hours).

Referrals for a CAMHS PICU bed will be accepted from CAMHS General Adolescent Units or occasionally directly from Community CAMHS where it is evident that the young person's needs could not be met within the CAMHS General Adolescent Unit.

#### **Orion: (GAU) response times**

The following descriptions are taken from the service specifications and describe the expected timeframe for each specialist area to respond to a referral:

- It is essential that Community CAMHS fully complete the Referral Form for Access to Tier 4 CAMHS and provide all relevant information to enable the Inpatient Team to respond within timescales outlined below
- Unplanned referrals will be reviewed and responded to by a specialist nurse in consultation with a member of the senior leadership team within 4 hours; emergency assessment will be offered within 12 hours.
- Urgent transfer referrals (inpatients requiring transfer from one service to another) will be reviewed and responded to within 48 hours.
- Routine/planned referrals will be reviewed and responded to within 1 week

#### **Nova: (PICU) response times**

- Response to referrals will be within 2 hours.
- Referrals to PICU will be managed as per GAU referrals (see above).

### **5.12. Transport (Conveyance to/between Places of Safety)**

Onward transport – once in the 136 Suite at Miranda House, a detained person can be transferred to a different place of safety. Transfers should take place only when it is in the person's best interests. Guidance on this is available in the Mental Health Act 1983: Code of Practice.

Unless it is an emergency the decision to transfer a person from one Place of Safety to another should only be made following discussion between the person in charge of the Place of Safety and the AMHP, RMP or other appropriate healthcare professional. A person should not 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 benefit of the move needs to be weighed against any delay the move may cause in the person's assessment and any distress the journey may cause them.

Transport following release – where a person is not able to make their own way home, or cannot be released to the care of a relative, transport should be arranged by the S135(1) / S136 coordinator, ED practitioner or custody officer respectively, depending on the place of safety, to return a vulnerable detained person to their home. Options include public transport in operating hours, taxi (a budget is available for both these) or patient Transport/MHCIT vehicle.

Out of area transport – where a detained person’s home is out of the Hull area, careful consideration must be given to transport issues. If onward transport is required to take a person to hospital in their own district liaise with that locality to agree how transport can be arranged.

Private ambulance or a suitable recognised private transport alternative’ should be used if the local resident is to be transferred out of area for admission in order to meet the required safety and transport needs of the person and any accompanying care team.

Escorting to the Wards – due to the location of the 136 suite the majority of admissions should be transferred onto Avondale, Clinical Decisions Unit should a Community Treatment Unit be identified a risk assessment must be completed to determine the appropriate transport for transfer.

### **5.13. Contingencies**

#### **Approved Mental Health Professional**

In law, responsibility for interviewing a person in the S136 suite at Miranda House sits with the Hull AMHPs given the person is detained in Hull (a Memorandum of Good Practice is currently under development).

The local arrangement is that the AMHP service responsible for interviewing the person will be the service that covers where the person resides. If an AMHP is not available in the East Riding to interview the person at the place of safety, or to coordinate an assessment under the Act if such an assessment is indicated, the designated manager of the Local Social Services Authority (LSSA) accessed via the Local Authority switchboard service, whose responsibility it is to provide such services under the Mental Health Act, must be informed at the earliest opportunity. Although it is preferable for a joint assessment to be carried out, the duty consultant should be contacted at this point in order to carry out an assessment as the detained person may be suitable for discharge.

#### **The assessment of persons from outside of the local authority area**

Where a person detained under section 136 who is from a different local authority area, it is essential that the assessment is not delayed. The assessment is to be processed by the most appropriate authority and takes into account the place of detention, the persons address, and GP details. If there is no information available about the service user to support normal place of residence but the place where the detention occurred, then AMHPs acting on behalf of Hull Local Authority will undertake the assessment.

#### **Registered Medical Practitioner**

If an RMP or S12 approved doctor is not available, contact on-call manager for mental health services via the Trust/hospital switchboard.

#### **Bed Availability**

Where there are no beds available locally it is the responsibility of the local mental health service to secure an alternative admission.

### **5.14. Data Collection and Lorenzo**

Before any professional leaves the S136 HBPoS the S135(1) / S136 Coordinator must ensure all sections of the monitoring form is completed electronically. Following discharge from the S136 suite all other paperwork must be placed in S136 admin tray. Each day the admin team will input all the relevant information into Lorenzo completing all statutory Mental Health Act legislation information. The monitoring form information is also inputted onto the monthly S136 spreadsheet to support monitoring and governance purposes

The S135(1) / S136 Coordinator will be responsible for ensuring the monitoring form is fully completed on the EPR and mental health legislation team informed for scrutiny at the earliest opportunity

**Clinical Safety checks and cleaning:** Safety checks for all medical and non-medical devices and equipment have been implemented within the 136 suite environment.

**Medical devices:** Formal daily checks for all medical devices are undertaken by the 136 coordinator and records of these checks are kept within a file within the suite for reference and audit purposes. The check includes full cleaning of devices and testing / checking of batteries and calibration to ensure fitness for purpose.

**Emergency grab bag:** Daily checks and sealed with a tag to prevent tampering. There is also an emergency back-up bag kept in reception for immediate replenishment of supplies.

**Oxygen:** Oxygen cylinder kept within the 136 suite and checked alongside Emergency grab Bag. Backup oxygen cylinder also held within the reception area.

**Medicines cupboard:** (Bristol Maid) The medicines cupboard continues Patient Group Directive (PGD) medication, Nicotine replacement Therapy and associated supplementary prescribed medication for medial administration. The cupboard also contains a USB temperature data logger for monitoring of temperature parameters for medicines storage.

**Patient Group Directive medication (PGD):** The 136 medicines cupboard contains medication recognised within the Humber Teaching NHS Trust PGD directory of recognised medications.

**Emergency medications:** Grab bag is also available for Medical practitioners and appropriately trained BLS/ILS clinicians within the 136 suite. This medicines bag is sealed, and if used replenished via the Pharmacy Technician.

**136 Medicines stock checks:** Daily checks performed by the 136 co-ordinator and weekly medicine stock reconciliation checks are undertaken via Pharmacy technician, reporting to the Clinical Lead on a regular basis with any discrepancies of changes to storage of or access to the medicines held within the 136 suite.

**136 Medicines access:** Access to medicines within the 136 suite are available only to qualified Nursing and Medial staff via a key safe, password protected.

**136 Suite Cleaning schedule:** The 136 Suite is subject to a daily cleaning schedule recorded within the daily checks file.

**Domestic Cleaning Staff:** In house cleaning takes place daily where possible (not when occupied with service user).

**Clinical Staff:** Clinical cleaning schedule daily including checks, cleaning of equipment and clinical patient waste following 136 use and clinical incident.

**Deep Cleaning:** If deep clinical cleaning is required (following infection risk posed by patient bodily fluids) can be undertaken via external agency coordinate by the Estates Department. The 136 suite is will be declared unfit for purpose following such incidents until deep clean has been undertaken.

**Infection Prevention and Control (IPC):** All team members are provided with Infection prevention and management training. The MHCIT has two team IPC leads that contribute to the cleaning checks and address signage, presence of PPE and associated equipment for patient and staff safety within the 136 suite as a clinical environment. The IPC Leads work closely with the Clinical Leads and the IPC Senior Trust Clinician to maintain checks and contemporary practice issues.

### **Fitness for detained person interview (conditions)**

#### **Detained person use of substances and treatment of intoxication (alcohol and known / unknown substances)**

At referral and initial police meaningful discussion, levels of intoxication or any suspected intoxication of the detained person need to be established. In emergency situations (immediate danger to life) Emergency then the Dual Diagnosis Pathway and Intoxication Pathways (within Mental Health Crisis Intervention Team Standard Operation Procedure) should be followed in response to the care and management of any physical health deterioration.

This may involve attendance of the Emergency Ambulance Service Paramedic and may also lead to comprehensive medical assessment and treatment to attend to identified stages of intoxication or withdrawal to promote a state of physical health stabilisation **before** commencing the formal assessment under the Mental Health Act.

### **Emergency Immediate Life Support (ILS)**

Developed by Resuscitation Council UK, ILS training is provided for healthcare professionals who may have to act as the first responder in an emergency, giving them the skills to manage patients in cardiac arrest before a cardiac arrest team arrives. An ILS course provides a variety of skills, from managing a deteriorating patient, identifying causes and treating cardiac arrest, to improving abilities as both a team member and leader.

Each S135(1) / S136 coordinator is or has access to a clinical member of staff who can act as emergency responder and operationalise emergency response within the role of the Immediate Life Support interventions. Specific Humber Foundation NHS Teaching Training is provided and recertification is required yearly by all ILS clinicians to meet ILS skills competency.

## **6. EQUALITY AND DIVERSITY**

This policy aims to ensure that all people detained under S135(1) / S136 will be offered services that are safe and effective and led by the needs of the person. The standards within the policy will be applied equally to all detained persons, including those discharged from services and those who discharge themselves against medical advice.

The Human Rights Act 1998 requires public authorities and their employees to respect the Convention rights, to understand those rights and to take them into account when carrying out this policy and procedures.

## **7. MENTAL CAPACITY**

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

## **8. IMPLEMENTATION**

This policy will be disseminated by the method described in the Document Control Policy.

All other stake holders, partners and services to be made aware of the policy via Mental Health Legislation Steering Group members and distributed via their internal systems.

This policy does not require additional financial resource.

## 9. MONITORING AND AUDIT

The Crisis Care Concordat Local Reference Group in collaboration with HFT's Mental Health legislation Steering Group is responsible for the section 136 monitoring and audit of this policy and will look for ways to further improve partnership working in the field of mental health.

## 10. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

The following have been referred to and consulted in the development of this policy:

- Department of Health (1983), The Mental Health Act 1983, (Amended 2007), HMSO, London.
- Department of Health (2015) The Mental Health Act Code of Practice , Department of Health, London
- The Policing and Crime Act, 2017, HMSO, London
- The Department of Health, The Mental Capacity Act 2005 (MCA), HMSO, London
- Ministry of Justice (1984) The Police and Criminal Evidence Act (PACE), HMSO, London
- Ministry of Justice (2006) The Safer Detention and Handling of Persons in Police Custody (Safer Detention), HMSO, London.
- The Independent Police Complaints Commission (2008) (IPCC), Police Custody as a 'Place of Safety', HMSO, London.
- Royal College of Psychiatrists (2008), Standards on the use of Section 136 of the Mental Health Act 1983, Royal College of Psychiatry, London.

## 11. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Humber Teaching NHS Foundation Trust policies and protocols which are relevant to this policy are:

- Bed Management Standard Operational Procedure (2017)
- Mental Health Crisis Intervention Team Standard Operating Procedure (2018)
- Mental Health Act Legislation Policy
- Missing Patient Procedure and Section 18 Absence Without Leave
- Search Policy
- Section 135 – Warrant to Search for and Remove Patients Protocol

### **Appendix 1: S.136 Mental Health Act 1983 Communication/Registration Form (Monitoring Form)**

**This form is now available for completion electronically on the patient's EPR; the Police complete their section electronically via an App.**



**Appendix 2: Initial Screening Tool (Risk Factors and Warning Signs)**

**On arrival at place of safety, prior to any decision for the police to leave, the joint risk assessment must be undertaken by a Police Officer and S136 Coordinator within 30 minutes of arrival.**

**State reason if not assessed within 30 mins:**

CATEGORY	COMMENTS/OBSERVATIONS
<b>RISK TO THE INDIVIDUAL</b>	
<b>Symptoms indicative of risk - examples</b>	
Deliberate self-harm	
Suicide attempt/s	
Plans or preparation to commit suicide	
Ideas of self-harm/suicidal thoughts	
Drug/alcohol abuse	
Hallucinations, listening or acting on 'voices'	
Severe self-neglect	
<b>RISK TO OTHERS</b>	
<b>Symptoms indicative of risk – examples</b>	
Physical harm to others	
Ideas of harming others	
Preparation to harm others	
Delusions, unreal ideas about self or others	
Damage to property	
Expressed thoughts beyond accepted norms	
Impulsivity/lack of impulse control	
<b>RISK OF ABSCONSION</b>	
<b>Symptoms indicative of risk – examples</b>	
Absconder	
Wandering (age related confusion/dementia)	
Homelessness	
Social isolation	
Lack of meaningful employment/occupation	
<b>UNKNOWN RISKS</b>	
<b>Symptoms indicative of risk – examples</b>	
Concerns expressed by others (relatives/carers)	
Observations by professionals	
Demeanour	
Evidence of reckless, unsafe or risky behaviour	
Cultural/lifestyle issues (diversity, gender etc.)	
Other know/relevant information	

RISK CATEGORY	✓
<b>Low Risk:</b> No behavioural indicators (other than very mild substance use) are presented <b>AND</b> No recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety. <b>Action: Officers remain, if at A&amp;E, pending transfer to mental health PoS; they do not remain once at mental health PoS following appropriate handover period, including re-assessment of risk.</b>	
<b>Medium Risk:</b> Some behavioural indicators (including substance use) are presented <b>AND</b> Some recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety. <b>Action: Agreed between hospital staff/Police Officers as to whether the police will remain at PoS – disputes resolved via Duty Inspector and Duty Senior Manager.</b>	
<b>High Risk:</b> Behavioural indicators (including substance intoxication) are causing significant concern <b>AND</b> Significant recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others. <b>Action: Police officers MUST remain at PoS in sufficient number.</b>	

**Completed by:** ..... **Police Officer**      **Signature:** .....

..... **HC Professional**      **Signature:** .....

## Appendix 3: Admission of Mentally Disordered Persons found in a Public Place

Information leaflets in other languages can be accessed here:

[http://www.mentalhealthlaw.co.uk/Foreign-language\\_information\\_leaflets](http://www.mentalhealthlaw.co.uk/Foreign-language_information_leaflets)

### ADMISSION OF MENTALLY DISORDERED PERSONS FOUND IN A PUBLIC PLACE

(Section 136 of the Mental Health Act 1983)

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

#### Why am I in hospital?

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

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

#### How long will I be here?

You can be kept here (or in another place where you will be safe) for up to 24 hours and in some circumstances 36 hours if the Doctor feels your condition is such that it would not be practicable for the assessment to be concluded within 24 hours or that further treatment is required before you can be seen by a doctor and an approved mental health professional.

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

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

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

If the doctors and the approved mental health professional have not seen you by the end of the 72 hours, you will be free to leave. You may decide to stay on as a voluntary patient. But if you do want to leave, please talk to a member of staff first.

In your case the 24 hours end at:

Date	Time
------	------

#### What happens next?

When the doctors and an approved mental health professional have seen you, they may say that you need to stay in hospital for longer. They will tell you why and for how long this is likely to be. You will be given another leaflet that explains what will happen.

If they decide that you do not have to stay, someone will talk to you about what other help you should have.

#### Can I appeal?

No. Even if you do not agree that you need to be in hospital, you cannot appeal against the decision to keep you here under section 136.

## Will I be given treatment?

The hospital staff will tell you about any treatment they think you need. You have the right to refuse any treatment you do not want. Only in special circumstances, which would be explained to you, can you be given treatment you do not agree to.

## Letting your nearest relative know

A copy of this leaflet will be given to the person the Mental Health Act says is your nearest relative.

There is a list of people in the Mental Health Act who are treated as your relatives. Normally, the person who comes highest in that list is your nearest relative. The hospital staff can give you a leaflet which explains this and what rights your nearest relative has in connection with your care and treatment.

In your case, we have been told that your nearest relative is:

If you do not want this person to receive a copy of the leaflet, please tell your nurse or another member of staff.

## Changing your nearest relative

If you do not think this person is suitable to be your nearest relative, you can apply to the County Court for someone else to be treated as your nearest relative instead. The hospital staff can give you a leaflet that explains this.

## Your letters

All letters sent to you while you are in hospital will be given to you. You can send letters to anyone except someone who has said they do not want to get letters from you. Letters to these people can be stopped by the hospital staff.

## Code of Practice

There is a Code of Practice that gives advice to the staff in the hospital about the Mental Health Act and treating people for mental disorder. The staff have to consider what the Code says when they take decisions about your care. You can ask to see a copy of the Code, if you want.

## How do I complain?

If you want to complain about anything to do with your care and treatment in hospital, please speak to a member of staff. They may be able to sort the matter out. They can also give you information about the hospital's complaints procedure, which you can use to try to sort out your complaint locally. They can also tell you about any other people who can help you make a complaint, for example an independent mental health advocate (see above).

If you do not feel that the hospital complaints procedure can help you, you can complain to an independent Commission. This is called the Care Quality Commission and it monitors how the Mental Health Act is used, to make sure it is used correctly and that patients are cared for properly while they are in hospital. The hospital staff can give you a leaflet explaining how to contact the Commission.

## Further help and information

If there is anything you do not understand about your care and treatment, a member of staff will try to help you. Please ask a member of staff to explain if there is anything in this leaflet you do not understand or if you have other questions that this leaflet has not answered. Please ask if you would like another copy of this leaflet for someone else.

**Appendix 4: Section 136 Suites – Record of Property**

<b>Name:</b>	<b>D.O.B.</b>	<b>Date:</b>
<b>Property list:</b>		
<b>The above is a true record of my property:</b> <input type="checkbox"/> <b>yes</b> <input type="checkbox"/> <b>no</b>		
<b>Signature of Detained Person:</b>		
<b>Signature of 136 Coordinator:</b>		
<b>Received the above property which is correct:</b> <input type="checkbox"/> <b>yes</b> <input type="checkbox"/> <b>no</b>		
<b>Signature of Detained Person:</b>		
<b>Signature of 136 Coordinator:</b>		

## Appendix 5: 136 Supportive engagement Plan

### Supportive engagement record form (To be completed for each period of observation)

Service User's Name:	DOB:	Consultant:
136 Unit:	Named Health Care Professional completing plan:	
Supportive engagement type required and reason (what risk is the observation addressing and what support does the service user require):  <i>Minimum 15 minutes</i>		
Further information/instructions regarding the supportive engagement:  NAME..... To be nursed on..... observations.  This supportive engagement plan requires review by the Senior Crisis Practitioner as and when the presentation of the detained person changes, to ensure the observation set, safely and effectively manages risk.		

Unit:  <b>Section 136 Miranda House</b>	Date:	Service User Signature:	Level of observation discussed with the service user. Yes:  No:  Unable to engage:	Observation discussed with carer, when present.  Yes:  No:
---	-------	----------------------------	---	--

Date	Time	<b>Supportive engagements/notes</b> Description of activity, emotional state/attitudes, interaction with others, risk issues, physical health	<b>Allocated member of staff Sign, Print &amp; Designation</b> (I have maintained the required level of interactions as agreed above)

Date	Time	<b>Supportive engagements/notes</b> Description of activity, emotional state/attitudes, interaction with others, risk issues, physical health	<b>Allocated member of staff Sign, Print &amp; Designation</b> (I have maintained the required level of interactions as agreed above)

## **Appendix 6: National Early Warning Score**

### **Guidance**

#### **Guidelines for use of the National Early Warning Score (NEWS) in Mental Health Inpatient Units**

##### **Introduction**

This guideline outlines how the NEWS should be used to help you in the management of patients in Mental Health Inpatient Unit. It should not replace clinical review, but does provide a consistent way of detecting acute illness in patients. Aimed at all GPs, consultants, nursing, medical, and therapy teams that provide medical and health care to patients in community hospitals or mental health Inpatient Units, this guideline is intended to ensure care is consistent and of a high quality.

##### **What is the National Early Warning Score (NEWS)?**

NEWS was introduced by the Royal College of Physicians. It is a simple system in which a score is given to certain physiological observations that are already routinely undertaken when patients come to, or are being monitored in hospital.

The NEWS charts used within the Trust are based very closely on the guidelines from the Royal College of Physicians to ensure a high level of consistency in the detection of acute illness in patients in our care.

##### **Using NEWS**

The scoring system is made up of six simple physiological observations:

- Respiratory rate
  - Oxygen saturations
  - Temperature
  - Systolic blood pressure
  - Pulse rate
  - Level of consciousness.
- A score is allocated to each observation as they are measured with greater scores reflecting the potential for acute illness in the patient in our care. The score for all six measurements is then combined, to provide an overall early warning score for the patient.
  - The NEWS should always be reviewed with a consideration of the patient's actual clinical condition.
  - The scores are recorded on the NEWS chart which can be found within the nursing documentation notes or by the patient's bed.

##### **Mental Health Inpatient Units Deteriorating Patient Escalation Policy**

All inpatients have their physiological observations monitored on admission, and routinely after that.

Patients being cared for in mental health inpatient units:

- All new step up or step down patients admitted should have at least four hourly observations for the first twenty four hours.
- Regular observations should be completed on patients throughout their episode of care. Patients in community hospitals will have a minimum of daily observations performed. In mental health inpatient units this will be decided by the patient's Responsible Clinician/psychiatrist. A review of the NEWS over several hours or days also allows us to



look at trends in a patient's condition.

**All patients must have a clearly-documented treatment/medical plan in place, regardless of their NEWS indicating the ceiling of care for the patient, whether they would be admitted to the acute hospital trust and DNACPR status.**

**In a situation where a patient normally has altered physiology which gives them a NEWS score of 1-3 then the frequency of observations and whether or not to escalate care based upon the NEWS score can be decided upon by the GP/consultant and where possible with the patient.**

Where the patient NEWS is elevated to a score of 1-3 because of the pre-existing altered physiology (e.g. in COPD where the patients normal Spo2 of 91%-92% results in a NEWS score of 3) then the Responsible Clinician or psychiatrist should make clear in the patient record that unless other factors regarding the patient's condition are of concern, then the nurse in charge does not necessarily have to escalate to the GP or ward/unit doctor. They may however increase the frequency of vital sign and NEWS recording.

For patients with known hypercapnoeic respiratory failure due to COPD, recommended BTS target saturations of 88–92% should be used. These patients will still 'score' if their oxygen saturations are below 92% **unless the score is 'reset' by a competent clinical decision-maker and patient-specific target.**

**The patient's management plan must contain a clear and explicit plan of ceiling of care for the patient, whether they would be admitted to the acute hospital trust, DNACPR status.**

**However, where other physiological parameters in the news score change or there exists professional concern regarding the patient's condition, then in these instances the care must always be escalated.**

**For where a NEWS instruction is recorded by the responsible doctor in the patients notes (Right Hand Column with low score 3-4):**

Patients are escalated according to their NEWS being low/medium/high risk.

Community Hospital and Mental Health Inpatient Units  
Deteriorating Patient Escalation Protocol

New step up patients from GP must have 4 hourly observations for 24 hours.  
All other adult patients should have at least daily observations recorded.

NEWS SCORE		Clinical Response	
For use where a NEWS instruction is NOT recorded in patient notes:		For use where a NEWS instruction IS recorded in patient notes:	
<b>1</b>          <b>4</b>	<b>1-4</b>  RN <ul style="list-style-type: none"> <li>Registered nurse must assess the patient.</li> <li>Registered nurse to decide if increased frequency of monitoring and/or escalation of clinical care is required.</li> </ul> Monitor Minimum 4-6 hourly	<b>3</b>  <b>3-4 or Clinical Concern</b>  RN <ul style="list-style-type: none"> <li>Inform nurse in charge</li> <li>RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment</li> <li>Consider commencing fluid balance monitoring</li> <li>nurse in charge to decide if escalation of care is required to GP or Doctor/Consultant using SBAR form.</li> </ul> DR <ul style="list-style-type: none"> <li>If escalation is requested patient must be assessed within 4 hours</li> <li>Document management plan for patient to include ceiling of care, for acute hospital admission, DNACPR status and usual observation parameters for patient</li> <li>In some occasions a phone conversation about the patient may be acceptable, this is at the discretion of the nurse in charge.</li> </ul>	<b>4</b>
	<b>5</b>  <b>5-6 or 3 in one parameter or urine output &lt;30ml/hour for 2 consecutive hours (only catheterised patients)</b>  RN <ul style="list-style-type: none"> <li>Inform nurse in charge</li> <li>RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment</li> <li>Commence fluid balance monitoring</li> <li>Contact GP or doctor/consultant to review patient within one hour using SBAR form</li> </ul> DR <ul style="list-style-type: none"> <li>Assess patient within one hour</li> <li>Decision required re transfer to acute hospital</li> <li>If patient is staying in the community hospital, document management plan for patient to include ceiling of care, for acute hospital admission, DNACPR status and usual observation parameters for patient</li> <li>If DR fails to attend or RN concerned call 999 for Emergency transfer to acute hospital</li> </ul> Monitor Minimum hourly		
<b>7</b>  <b>7 or more</b>  RN Monitor every 15-30 minutes	<b>7</b>  <b>7 or more</b>  RN Call 999 for Emergency transfer to acute hospital. If you have any clinical concern about a patient with, or without, a high NEWS score, and think they require escalation, immediately call 999.	<b>8</b>	

### **Low Score – NEWS 3-4 or Clinical Concern**

- Nursing staff should assess the patient using the ABCDE assessment and ensure nursing interventions have been completed.
- The patient should be commenced on minimum four hourly observations
- Report the deterioration to the nurse in charge of the ward who should decide if the patient needs to be escalated to the medical team. If escalation is requested they should use the SBAR communication tool to communicate this to the GP/unit medical officer or psychiatrist.
- If the medical team is required to review the patient they must attend within four hours and assess the patient making a decision about whether the patient should be for escalation to the acute hospital and confirming DNACPR status for the patient.
- In some cases a phone conversation may be acceptable; this is at the discretion of the nurse in charge.

### **Medium Score – NEWS 5-6 or Score 3 in one parameter**

or:

Urine output less than 30mls/hr for two consecutive hours in a catheterised patient or if the patient has not passed urine for eight hours in a non-catheterised patient.

- Nursing staff should assess the patient using the ABCDE assessment and ensure nursing interventions have been completed and start fluid balance monitoring.
- The patient should be commenced on minimum one-hourly observations.
- Report the deterioration to the nurse in charge of the ward and escalate to the medical team using SBAR communication tool
- The patient should be escalated to the medical team responsible for the patient. GP/unit medical officer or psychiatrist who are required to review the patient and they must attend within one hour and document the ceiling of care: whether the patient should be for escalation to the acute hospital and confirming DNACPR status for the patient.
- If the nurse caring for the patient is concerned that the patient is deteriorating or the doctor fails to attend call 999 for emergency transfer to acute hospital.

### **High Score – NEWS above 7**

- Nursing staff should assess the patient using the ABCDE assessment and ensure nursing interventions have been completed.
- Inform nurse in charge and assess whether the patient is for acute hospital admission. If they are you should call 999 for emergency transfer to acute hospital.

There are some circumstances in which the NEWS may not reflect the severity of a patient's condition. If there is clinical concern about a patient, frequency of observations must increase and the patient should be escalated to the GP/on-call consultant, even when the NEWS is not rising and fails to trigger.

The mental health inpatient unit escalation protocol should not be followed for palliative/EoL patients who have made explicit their place of death (unless admission to acute hospital is their choice) or patients who are not for admission to the acute hospital.

**Where no NEWS instruction is recorded in the patients notes then the non-modified NEWS escalation protocol should always be used (left-hand column with low score 1-4)**

**Patients are escalated according to their NEWS being low/medium/high risk**

Community Hospital and Mental Health Inpatient Units  
Deteriorating Patient Escalation Protocol

New step up patients from GP must have 4 hourly observations for 24 hours.  
All other adult patients should have at least daily observations recorded.

NEWS SCORE		Clinical Response		
For use where a NEWS instruction is NOT recorded in patient notes:		For use where a NEWS instruction is recorded in patient notes:		
1 <b>LOW</b>	1-4 RN <ul style="list-style-type: none"> <li>Registered nurse must assess the patient.</li> <li>Registered nurse to decide if increased frequency of monitoring and/or escalation of clinical care is required.</li> </ul>	3 <b>LOW</b>	3-4 or Clinical Concern RN <ul style="list-style-type: none"> <li>Inform nurse in charge</li> <li>RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment</li> <li>Consider commencing fluid balance monitoring</li> <li>Nurse in charge to decide if escalation of care is required to GP or Doctor/Consultant using SBAR form.</li> </ul>	DR <ul style="list-style-type: none"> <li>If escalation is requested patient must be assessed within 4 hours</li> <li>Document management plan for patient to include ceiling of care, for acute hospital admission, DNACPR status and usual observation parameters for patient</li> <li>In some occasions a phone conversation about the patient may be acceptable, this is at the discretion of the nurse in charge.</li> </ul>
	4 Monitor Minimum 4-6 hourly		4 Monitor Minimum 4-6 hourly	
5 <b>MEDIUM</b>	5-6 or 3 in one parameter or urine output <30ml/hour for 2 consecutive hours (only catheterised patients) RN <ul style="list-style-type: none"> <li>Inform nurse in charge</li> <li>RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment</li> <li>Commence fluid balance monitoring</li> <li>Contact GP or Doctor/Consultant to review patient within one hour using SBAR form</li> </ul>	6 Monitor Minimum hourly	DR <ul style="list-style-type: none"> <li>Assess patient within one hour</li> <li>Decision required re transfer to acute hospital</li> <li>If patient is staying in the community hospital, document management plan for patient to include ceiling of care, for acute hospital admission, DNACPR status and usual observation parameters for patient</li> <li>If DR fails to attend or RN concerned call 999 for emergency transfer to acute hospital</li> </ul>	
	6 Monitor Minimum hourly			
7 <b>HIGH</b>	7 or more RN <ul style="list-style-type: none"> <li>Call 999 for Emergency transfer to acute hospital.</li> <li>If you have any clinical concern about a patient with, or without, a high NEWS score, and think they require escalation, immediately call 999.</li> </ul>			

The parameters for NEWS2

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

\*The NEWS initiative flowed from the Royal College of Physicians' NEWS2IG, and was jointly developed and funded in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation.



## Appendix 7: Questionnaire

While you are waiting for your assessment could you please fill in this questionnaire.

We are asking you to do this to make sure our records are complete and up to date.

Personal data about you is not shared with anybody not directly involved in your care.

**If you have any questions or need any help to fill this form in, please ask**

**Name**.....

**Address**.....

.....

.....

**Date of Birth**.....

### Ethnicity (please circle)

White - British	Asian - Indian	Black - Caribbean
White - Irish	Asian - Pakistani	Black - African
White - Other	Asian - Bangladeshi	Black - Other
Mixed - White/Black Caribbean	Asian - Other	Chinese
Mixed - White/Black African	Asian - Kashmiri	Rather not say
Mixed - White & Asian	Other ethnic group	
Mixed - Other		

### Language (please tell us the main language you speak)

.....

### Religion (please circle)

None	Hindu	Sikh
Christian	Jewish	Jehovah's Witness
Buddhist	Muslim	Any Other Religion
Rather not say		

### Marital Status (please circle)

Single	Separated	Widowed/Surviving Partner
Married/Civil Partnership	Divorced/Civil Partnership Dissolved	Rather not say

### Living Status (please circle)

Live Alone	Lives with Parent/Guardian	Residential Care
Live with Family	Lives with Partner/Spouse	Supported Living
Live with Other	No Fixed Abode	Rather not say

### Accommodation Status (please circle)

Owner occupier	Mobile accommodation
Tenant - Housing Association, private landlord etc.	Sheltered Housing
Homeless	Other (please state).....
Rather not say	

### Employment status (please circle)

Employed	Unemployed - Seeking Work	Student
Employed - Unpaid/Voluntary	Unemployed - Sick/Disabled	Other
Looking after Family/Home	Unemployed - Not Seeking work	Rather not say
Retired (Aged 18-69)	Self Employed	

### Smoking status (please circle)

Do you smoke Yes/No

**Appendix 8: Section 136 Outcome Plan**

**S136 Outcome**

(To be completed by the AMHP or mental health professional copy handed to the person upon leaving S136 suite and original to be attached to S136 form)

Name	
Date of Birth	
Address	

**Outcome of your assessment**

**Your ongoing support arrangements**

Useful contact addresses and telephone numbers:

Consent to inform GP Y/N

Consent to send copy to home address Y/N

Name of AMHP or MHP completing this form .....

Signed .....

Date .....

## Appendix 9: Ethnicity Categories

### Self-Defined

#### White W

A	White - British	W1
B	White - Irish	W2
C	Any other White background	W9

#### Mixed M

D	White and Black Caribbean	M1
E	White and Black African	M2
F	White and Asian	M3
G	Any other Mixed background	M9

#### Asian / Asian - British A

H	Asian – Indian	A1
I	Asian – Pakistani	A2
J	Asian – Bangladeshi	A3
K	Any other Asian background	A9

#### Black / Black – British

L	Black – Caribbean	B1
M	Black – African	B2
N	Any other Black background	B9

#### Other O

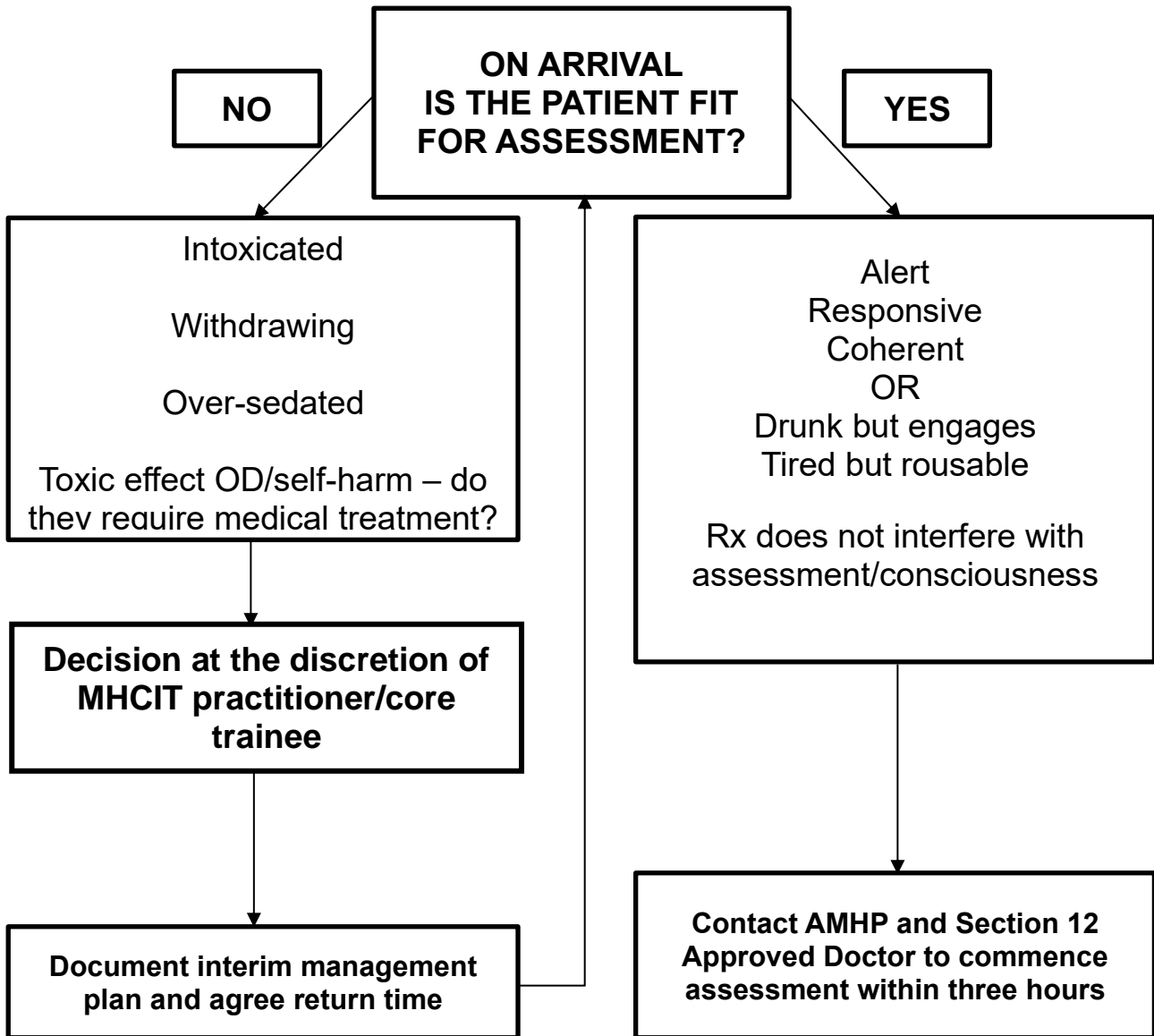
O	Chinese	O1
P	Any other	O9

Not stated NS

### Officer-Defined

0	Unknown
1	White European
2	Dark European
3	African Caribbean
4	Asian
5	Oriental
6	Arabic

**Appendix 10: Guidance on Fitness for Assessment for Hull S136**



**Assessment team (AMHP and Consultant) need to be involved in the discussions even if the detained person is not fit for assessment.**



## **Appendix 11: Section 136 – Statement of Responsibilities**

### **Local Authorities**

Local Authorities have a statutory responsibility to provide AMHPs under the provisions of Section 13 of the Mental Health Act 1983 (2007). In Hull this responsibility has been passed to the Trust and is managed through the MHCIT.

The Department is committed to providing AMHPs involved in implementing the local response to joint working for S136 in accordance with the Code of Practice to the Act.

### **Police**

Police will ensure they undertake their responsibilities efficiently and effectively with their primary focus being the care and treatment of the detained person. Custody will only be used as a last resort and not simply as line of least resistance.

Hospital liaison and dealing with disputes will be the responsibility of the Duty Inspector on a 24-hour basis. Police should have appointed a Mental Health Liaison Officer who is available for assistance in respect of mental health related matters during normal working hours.

### **Health Trusts**

The local commissioning body, along with the Trust providing mental health services, will ensure sufficient designated places of safety. MHCIT are commissioned to manage and monitor S136 and will ensure sufficient staff are available to remain with the service user until transfer or discharge from the MHBPoS.

Every effort must be made to give the correct support to people detained under S136, including those under the influence of drugs or alcohol, or displaying aggressive behaviour, thereby helping the police to avoid criminalising people by having to take them into police custody.

Every effort must be made to ensure officers are not delayed in places of safety unnecessarily.

The relevant RMP will attend the relevant place of safety when contacted to provide a S136 assessment.

### **Commitment**

That all possible steps are taken to ensure that the detained person receives appropriate medical and nursing care to alleviate his or her mental disorder and reduce the risk to self and/or others. Where appropriate, aftercare will be provided upon discharge to achieve these aims.

## Appendix 12: Useful Telephone Numbers

<b>Place of Safety</b> – Mental Health Crisis Intervention Team – Crisis line for Adults (GP/Professionals Only – not to be shared with patients or public)	01482 205555
<b>Crisis line for Older People</b>	01482 205520
<b>Mental Health Act Referrals- Adults</b> (Professionals Only – not to be shared with patients or public)	01482 205555
<b>Hull Royal Infirmary</b> – Switchboard	01482 875875
<b>Police Force Duty Inspector</b>	08456060222
<b>Miranda House Switchboard</b>	01482 216624
<b>Emergency Duty Team EY</b>	01482 861103
<b>Police Contact Numbers</b> Police Custody Suite. Cough Road, hull tel 01482 578664 Grimsby tel 01472 264720 ext 4720	

## Appendix 13: Waiting Area (in Agreement with Humberside Police)

Once MHCIT staff are aware that the police are on route to Miranda House with a further detention and the S136 suites remain occupied all action should be taken to provide support in the most appropriate environment.

The Clinical Lead / Coordinator will look at other accommodation while waiting for a 136 suite to be free, this would also include MHCIT contacting other 136 suites etc.

It may be that one of the interview rooms are free and could be utilised as a waiting area. If any risks have been highlighted by the referring officers or there are known risks which makes waiting in an interview room unsafe an alternative place of safety needs to be jointly considered and agreed by Humberside Police and MHCIT; the administration of this task is the role of MHCIT. This alternative may be another S136 suite within the Humberside Police area. This should be considered at point of referral if the 136 suites are in use; Miranda House reception area is not an appropriate place of safety for people detained on a S136.

**The service user must be provided their rights and the detention time starts on arrival to Miranda House. All physical health checks are required to be completed to ensure safety for the detained service user. A minimum of 30 minute checks are required by health staff to ensure safety of the detained individual while remaining in any waiting area at Miranda House.**

MHCIT staff will meet the police in reception and escort them to the waiting area, enquire if refreshments are required and inform the police how to access both the toilets and the MHCIT office. As the interview rooms are situated at Miranda House access to both male and female staff are available 24/7 to help officers from each of the inpatient wards (Avondale and PICU) and MHCIT. This support is available for toilet visits and disturbances.

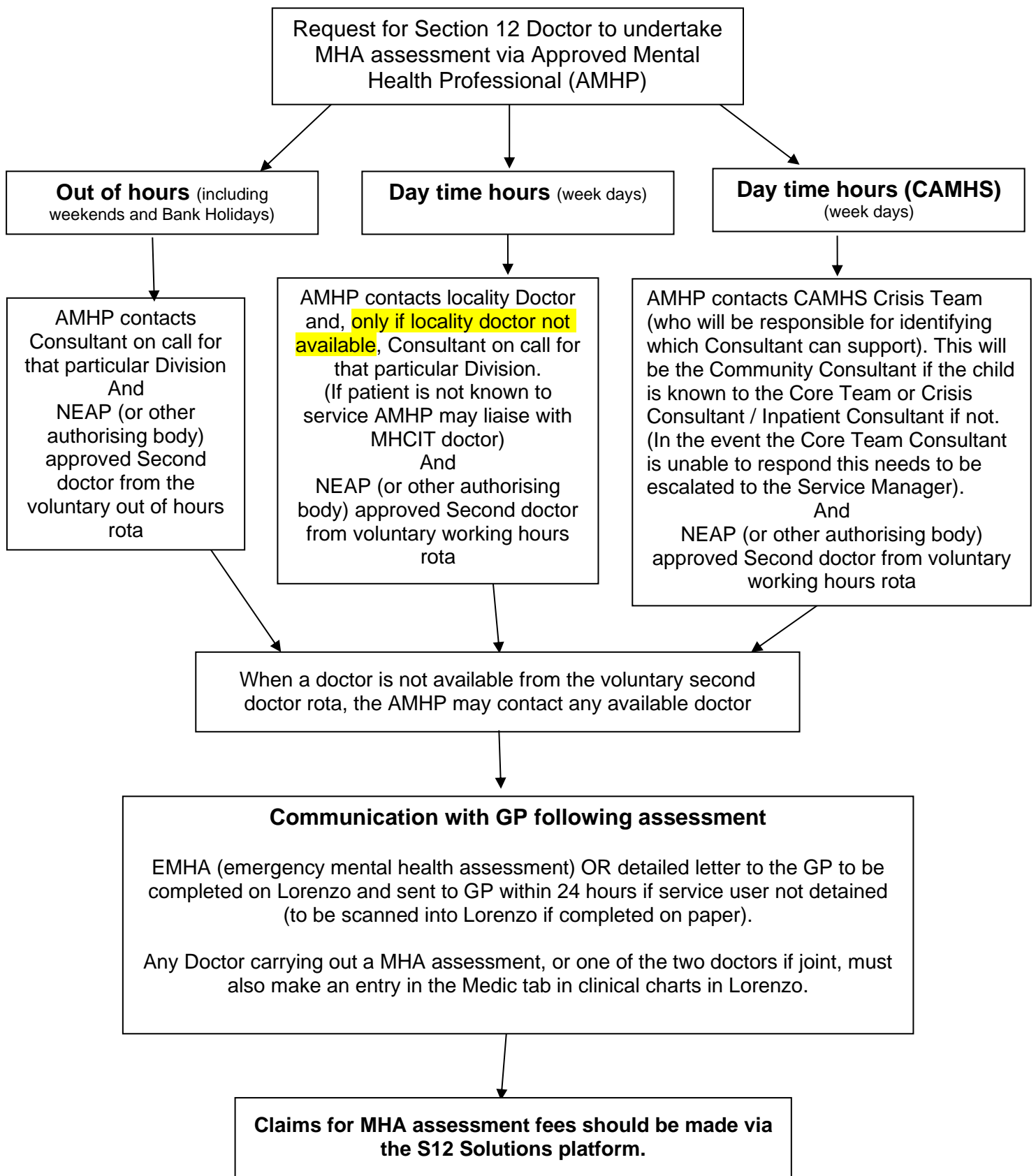
MHCIT to ensure constant updates are provided to the police regarding expected wait and delays. After 30 mins the S136 coordinator has responsibility for reassessing the situation and communicating with the police to update them and offer a rationale for them having to stay with the detained person. After 1 hour the S136 coordinator should have a discussion with the main MHCIT coordinator to consider other options and then the main MHCIT coordinator will have a collaborative discussion with the police. These discussions and agreements must all be documented on 136 paperwork.

If an interview room is free and is used as a waiting area the rooms have an alarm allowing for immediate support to be called in any instance of disturbance. The service user is never left alone and until complete handover **remains the responsibility of Humberside Police within the waiting area, this is not a second S136 room.**

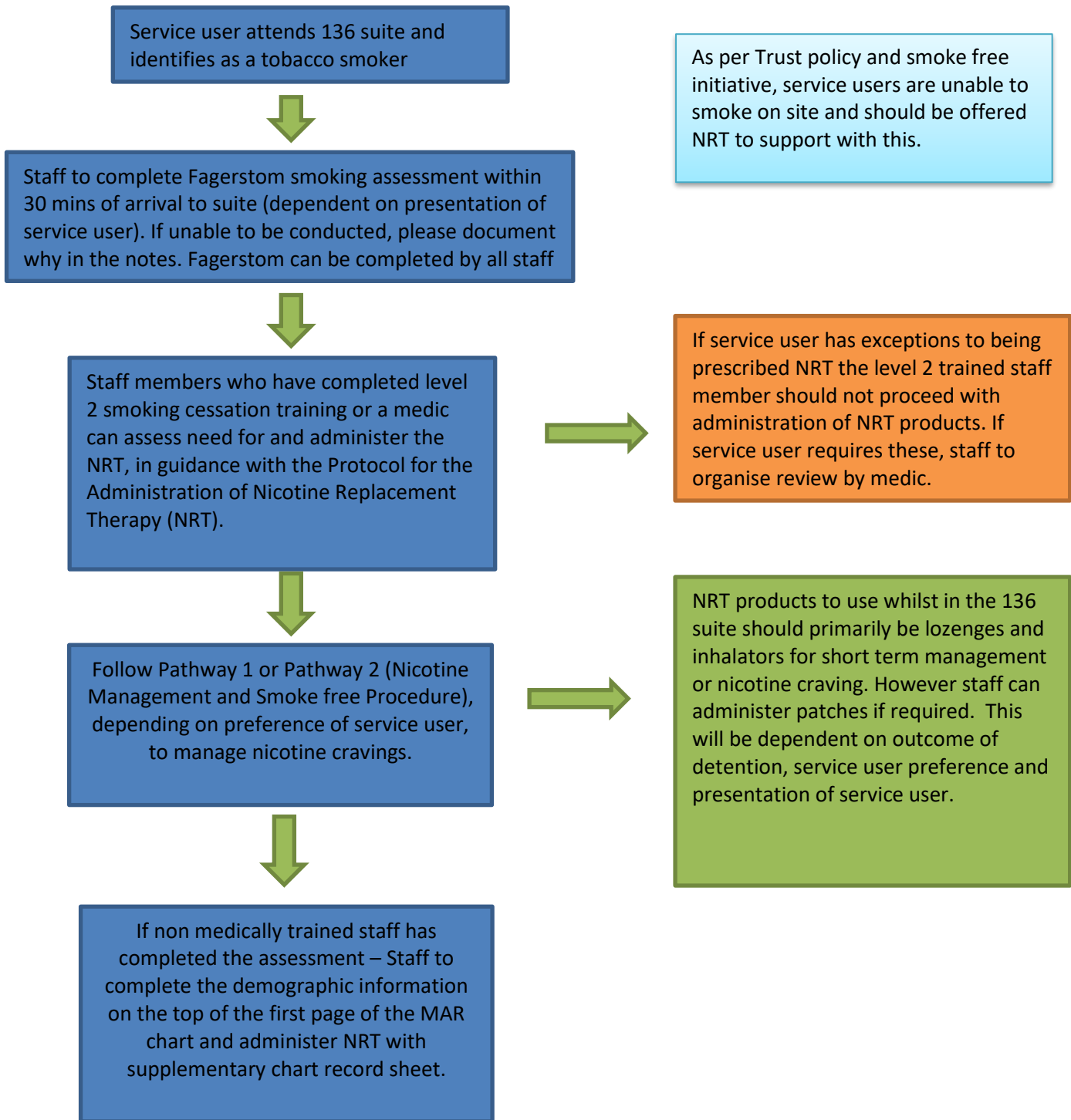
Should a disturbance occur and MHCIT feel the waiting area is no longer safe for the service user to remain, Police to be asked to consider alternative place of safety, rationale for removal to alternative place of safety to be documented within Lorenzo and S136 monitoring form. Disagreements associated with this action require escalation to service manager in hours and on-call manager out of hours. A Datix is to be completed regarding any instance of disturbance within the waiting area.

Once a S136 Suite is vacant the normal S136 process must continue, the monitoring form must record the original arrival time **and if they were escorted to the waiting area** and when the rights were read to the service user.

**Appendix 14: Section 12 Mental Health Act Assessment Request and Follow-up Flowchart  
(from Mental Health Crisis Intervention Team SOP)**

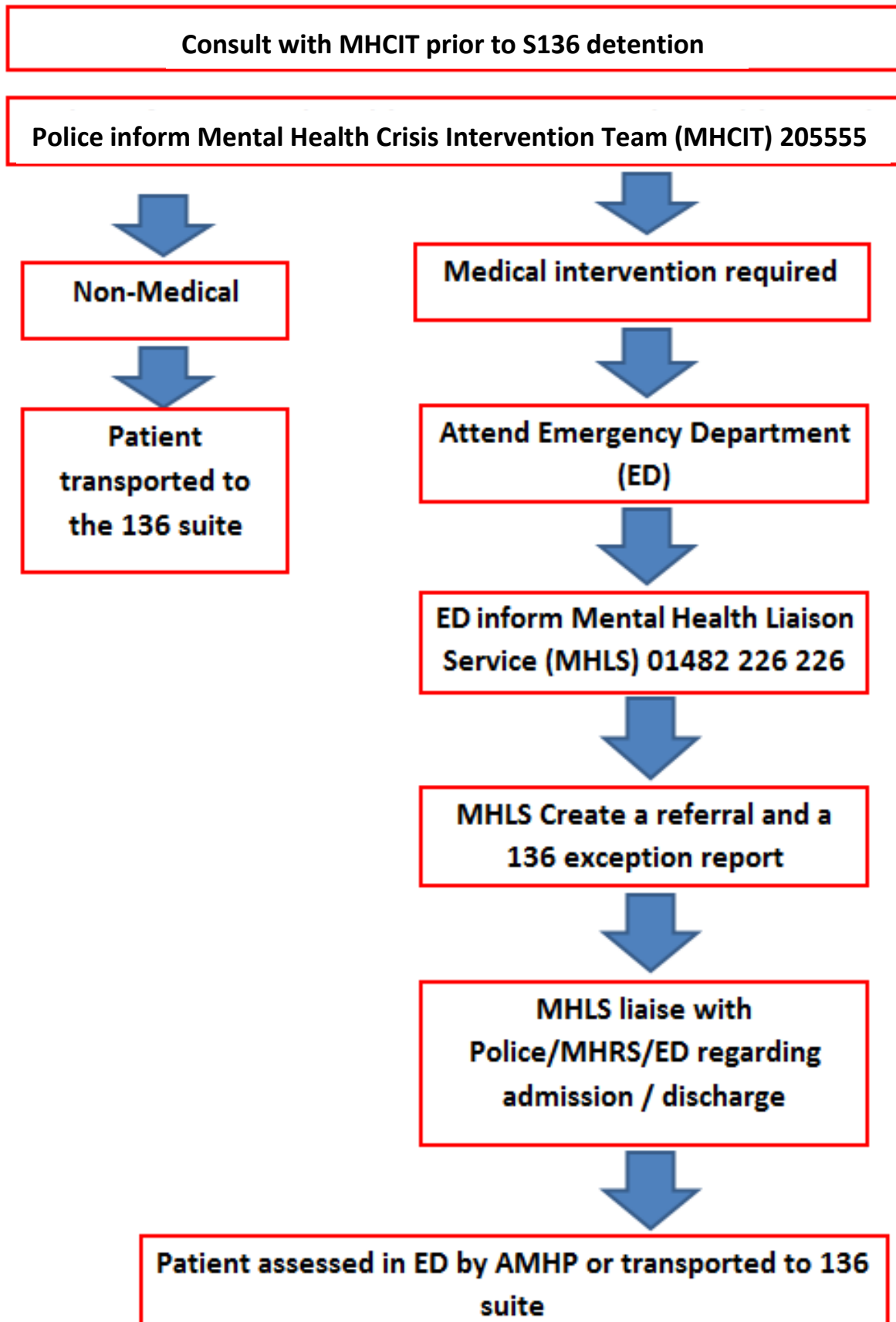


## Appendix 15: Protocol for Smoking Cessation in the 136 Suite



To be used in conjunction with the Trust Smoke Free and Nicotine Replacement Therapy policies.

## Section 136 Pathway



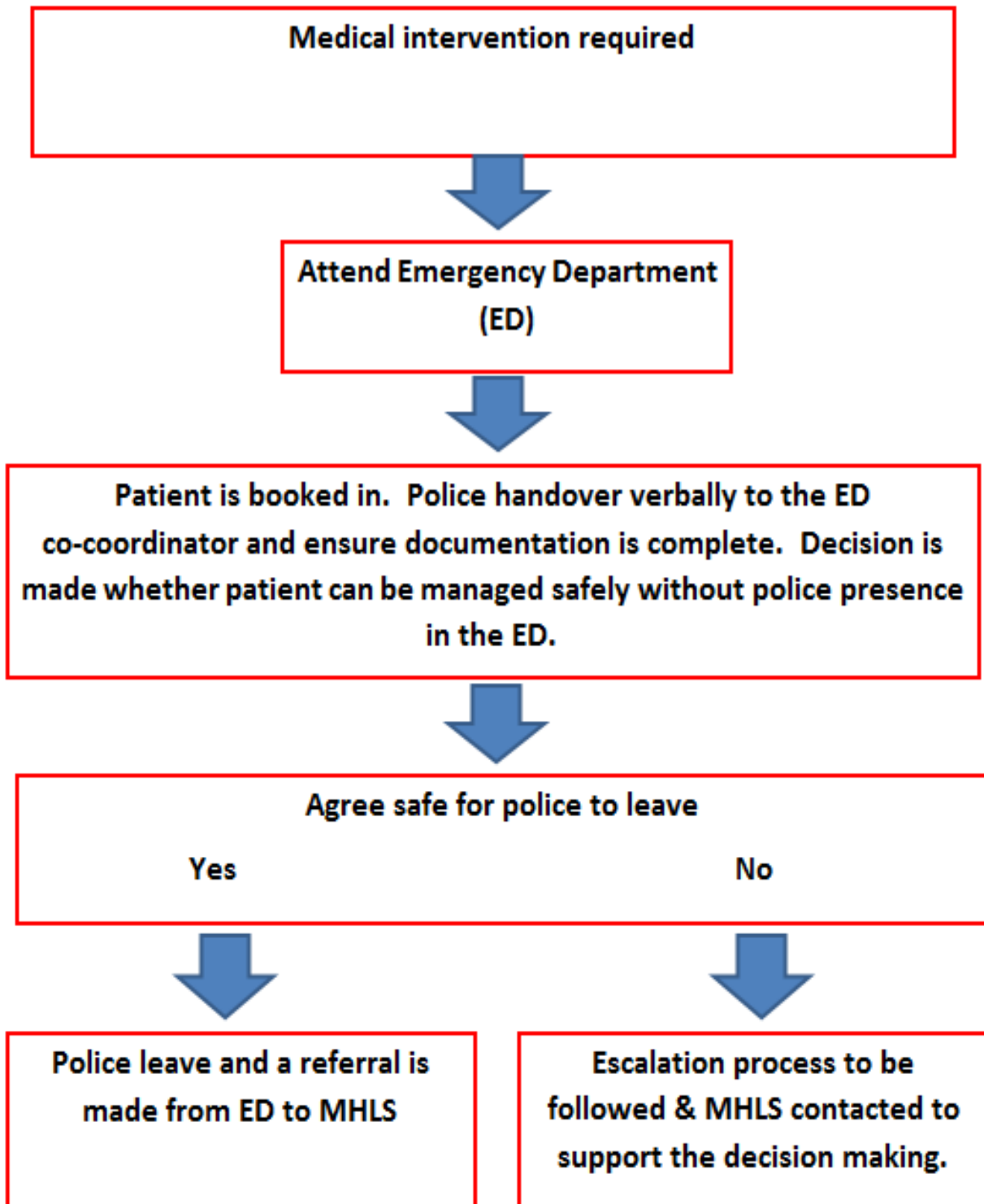
## **Section 136 Pathway in the Emergency Department HRI**

Police may convey a service user who is detained under S136 MHA to the general hospital due to a medical condition being present. On arrival the police will inform the Mental Health Crisis Intervention Team (MHCIT) of their arrival on 01482 205555. This is important as the 24 hours detention clocks will commence at this point if the service user has not been to any other place of safety beforehand.

The coordinator will contact the MHLS on 01482 226226 who will create a referral and S136 exception report. The MHLS will then liaise with the Police / Mental Health Crisis Intervention Team / ED regarding the medical situation with the service user and whether the person may be admitted to a ward or discharged.

MHLS will assist with the service user in ED liaising with MHCIT to ensure the most appropriate support is offered, and where practicable assess their mental health in ED or support transfer to Miranda House.

## Non - Section 136 Pathway





## **Voluntary Service user attending the Emergency department HRI**

Police may convey a voluntary service user they believe is experiencing mental illness to the Emergency Department (ED) at HRI due to a medical condition being present. Police will also ensure they have completed the documentation required to identify any risks involved in leaving the service user unaccompanied.

A decision will jointly be made that the service user can be left in ED and pass responsibility for their care over to the nurse coordinator.

If the staff and police involved are unable to agree, then this will be escalated to the Mental Health Liaison Service (MHLS) at the hospital. This will involve the coordinator contacting the MHLS and requesting they attend to assist in the decision making. The discussion will be recorded and police will remain in the department until a resolution has been found.

**Appendix 18: Voluntary Service User MHLS Handover Form**

**HUMBERSIDE POLICE**

HRI Emergency Department / Webley Voluntary Service user Handover Form

PNC/local checks completed:	
Name of Person	
Date of Birth	
Address	

Any medication taken: Details:	
Any medical treatment issues prior to arrival at hospital: Details	
Has service user taken alcohol or drugs Details:	
Confirmed voluntary attender at hospital:	
Service user searched: Details: <span style="float: right;">FIN</span>	
Reason for Voluntary attendance: Circumstances: Appearance / Behaviour / Communication / Danger / Environment:	
Known to Mental Health Services: Details:	
Any suicidal thoughts or actions? Details:	
Police Supervisor Informed (prior to leaving hospital)	
Member of ED who received the handover:	Officer handing over service user:
Name (print)	Name (print)
Role	Rank <span style="float: right;">FIN</span>
Signature	Signature

Completed form to be retained by the hospital

**Appendix 19: MHCIT Voluntary Service User Handover Form**

**HUMBERSIDE POLICE**

**MHCIT Voluntary Service User Handover Form**

Name of Person	
Date of Birth	
Address	

PNC/local checks completed;
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Any medication taken: Details:
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Any medical treatment issues prior to arrival at Miranda House: Details:
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Has service user taken alcohol or drugs Details:
---

Confirmed voluntary attender at Miranda House:
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Service user searched: Details:	FIN
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Reason for Voluntary attendance: Circumstances: Appearance / Behaviour / Communication / Danger / Environment:
---

Known to Mental Health Services? Details:
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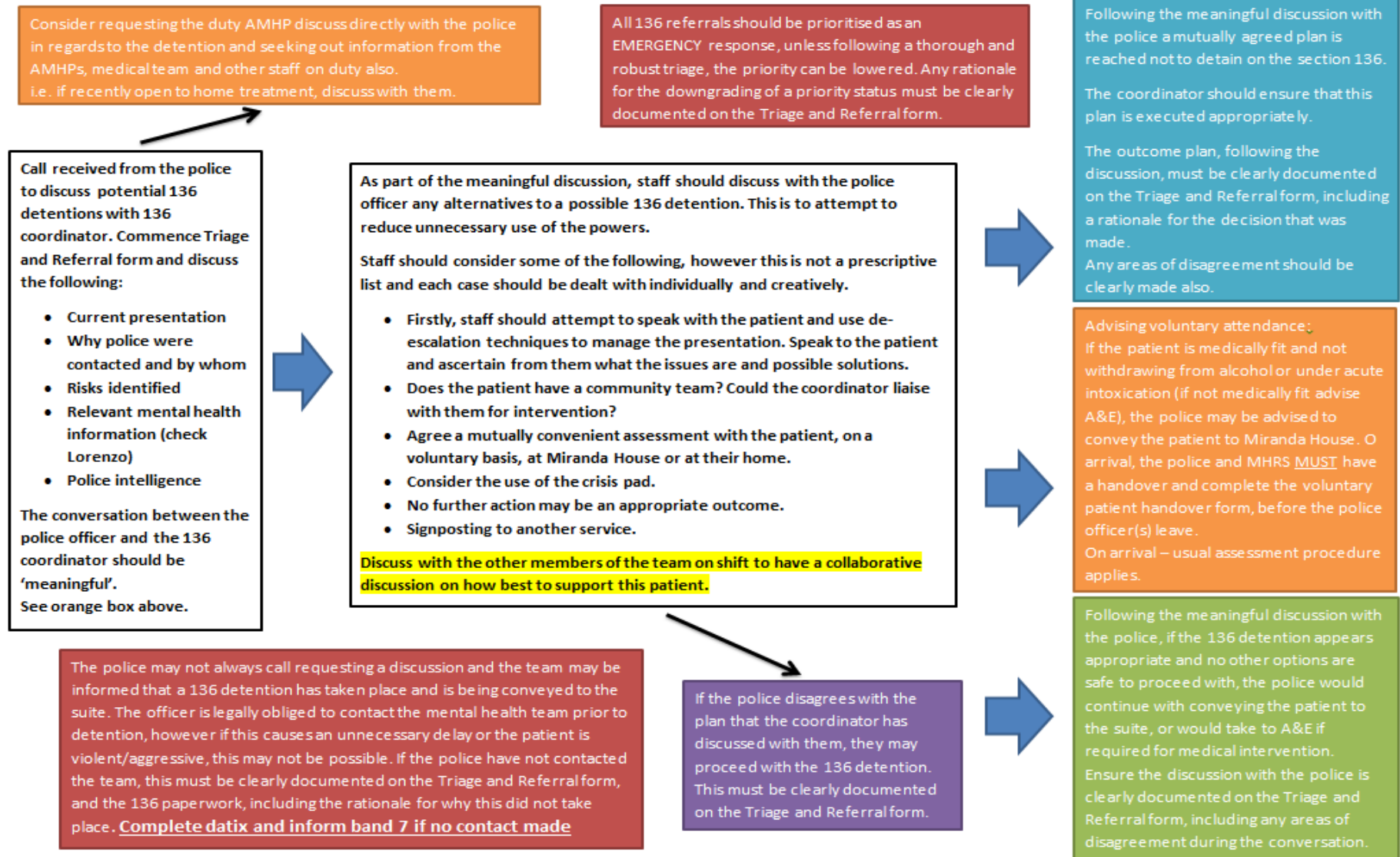
Any suicidal thoughts or actions? Details:
---

Police Supervisor Informed (prior to leaving)
---

Member of MHCIT who received the handover:	Officer handing over service user:
Name (print)	Name (print)
Role	Rank                      FIN
Signature	Signature

Completed form to be retained by the hospital

## Appendix 20: Referral Discussion with police in Regard to Possible 136 Detentions Flowchart



Referral discussion with police in regards to possible 136 detentions – flow chart. Adapted from Humber NHS Trust, 136 policy and should be used in conjunction with policy document. Dec 2018

**Appendix 21 - Police referral and triage form**

**136 triage calls can only be completed by any qualified staff working in MHCIT**

<u>Name:</u> including any previous names/aliases		<u>DOB:</u>	<u>NHS Number</u>
Date and Time of Referral:		Name of Clinician taking referral	
Current location of the patient:			
<u>Patient Address:</u>		Preferred telephone number:	
Postcode:			
Can video link be used to conduct assessment? <b>Y/N</b>	Can voicemail be left: <b>Y/N</b>	Armed Forces: <b>Y/N</b> <i>Current / Ex</i>	
<u>Gender:</u>	<u>Sexuality:</u>	<u>Occupation / Employment Status:</u>	Do they work in a position of trust or with vulnerable people:
<u>Ethnicity:</u>	<u>Marital Status:</u>	<u>Accommodation Status:</u>	<u>Religion:</u>
Spoken Language: Interpreter required: <b>Y/N</b>		<u>Overseas Status:</u> <i>Not Applicable / other</i>	
Name and contact details of officer:  Name:  Collar number:  Tel Number:		<u>Next of Kin / Nearest Relative details:</u> Name: Address:  Tel Number:  Can this person be contacted in an emergency situation? <b>Y/N</b>	
<u>GP details, including practice</u>  Tel Number:		Other professionals/agencies involved (if applicable):_	
<b>Initial screening</b>			
<p><b>Does the officer wish to detain under section 136 MHA Y/N</b> (Only the officer on scene can make the final decision to use section 136 and should not be advised by health staff to use this power)</p> <p><b>Is the patient known to MH services Y/N</b></p> <ul style="list-style-type: none"> <li>Which service:</li> </ul> <p><b>Are they open to a Humber mental health service Y/N</b></p> <ul style="list-style-type: none"> <li>Is it possible to request support from the service to support this situation Y/N</li> </ul> <p><b>Is the patient a frequent attender for 136 or MHA assessment Y/N</b> (See alerts on patient record)</p>			

<b>Discussion with officer at the scene</b>
<b>Current situation and reason for consideration of section 136 use – Police perspective</b>
<b>Evidence of Substance use (significant withdrawal symptoms may need acute hospital care)</b> Historical <i>Yes / No</i> Current <i>Yes / No</i>
<b>Current medical issues requiring immediate attention</b> (Has the patient been seen by a paramedic - if so please request NEWS2 score and any significant findings) <b>Y/N</b>
<b>Discussion with patient</b>
<b>Every effort should be made to speak directly with the patient – has this been achieved Y/N</b> <b>If not, why:</b>
<b>What has led to the current situation?</b>
<b>What are the mental health concerns?</b>
<b>What does the patient think will help?</b>
<b>Protective factors to help maintain safety</b> (explore ways that the patient maintains their safety and positive aspects of their life they wish to preserve):

**Risk Screening – Record relevant historical and current risk**

Please indicate main risk issues identified during discussion below:

- Risk of accidental self-harm Y/N**
- Risk of deliberate self-harm Y/N**
- Risk of suicide Y/N**
- Risk of violence or harm to others Y/N**
- Risk related to physical condition Y/N**
- Risk of abuse or exploitation Y/N**
- Risk of severe neglect Y/N**

**Risk summary (including any other risks identified):**

**Does the risk to the patient, public or other warrant immediate action? Y/N**

**Outcomes-  
should be agreed between clinician, patient and officer**

*Have alternatives been considered to 136 use Y/N*

- *Crisis Pad referral Y/N*
- *Informal assessment at agreed location/time Y/N*
- *Agreed support plan for patient and contact with team Y/N*
- *Engagement with treatment team Y/N*
- *Involvement of carers, family or friends Y/N*
- *Other:*

*If 136 is the preferred option what are the harms and benefits of potential 136 detention? (consider previous 136 assessment outcomes and whether the detention is necessary, legitimate, proportionate and ethical)*

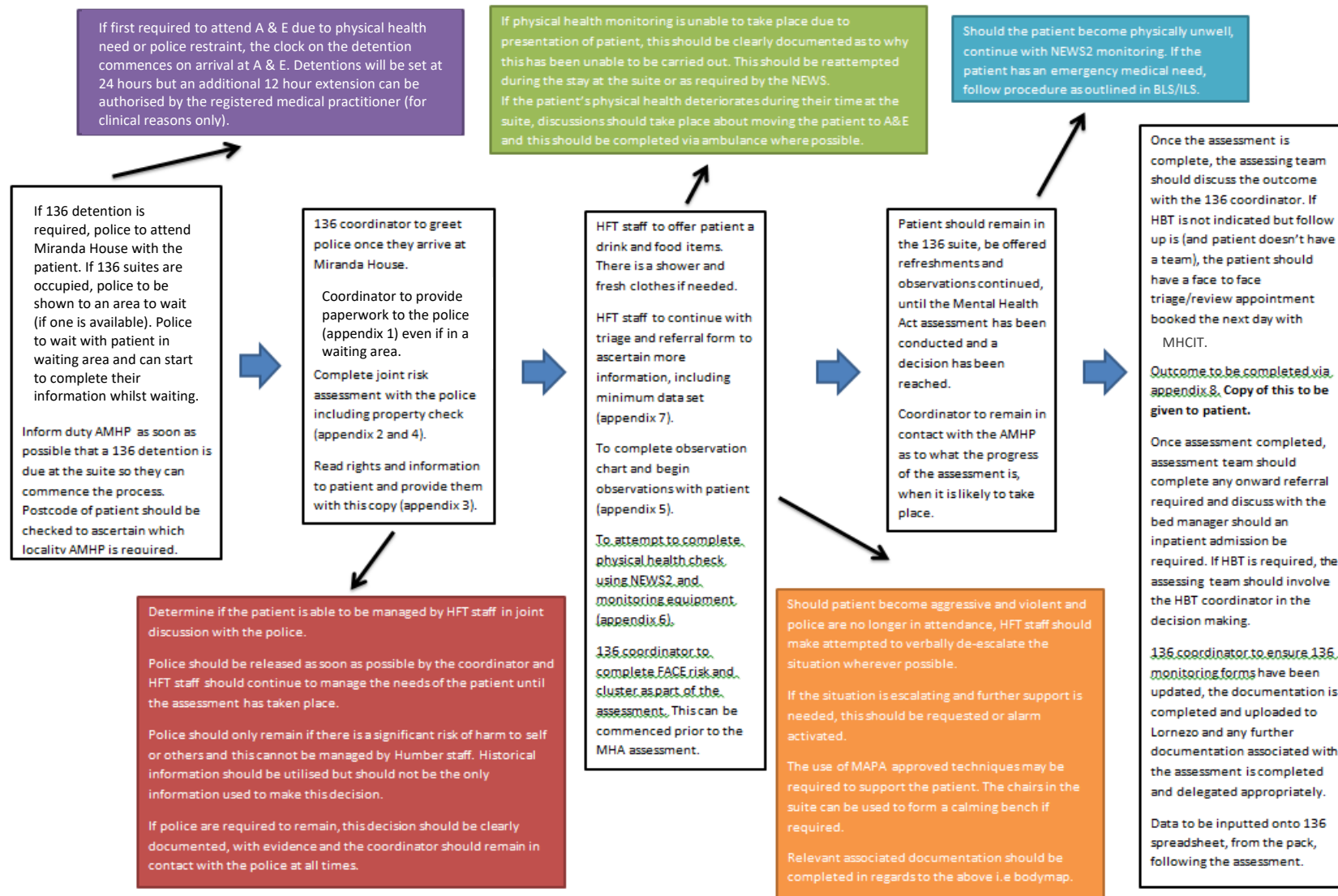
*Is there agreement between the health professional and officer Y/N*

*Details:*

**Plan:**

Name of clinician:	Designation:	Band:
Signature:		Date:

## Appendix 22: Arrival at 136 Suite Flowchart



Arrival at 136 suite - flow chart. Adapted from Humber NHS Trust, 136 suite policy and should be used in conjunction with the policy document. December 2018



## Appendix 23: Equality Impact Assessment (EIA) Toolkit

### For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Policy for the Implementation of Section 136 of the Mental Health Act 1983
2. EIA Reviewer (name, job title, base and contact details): Adrian Elsworth, Assistant Care Group Director
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

<p><b>Main Aims of the Document, Process or Service</b></p> <p>The aim of the policy is to ensure:</p> <ul style="list-style-type: none"> <li>• All agencies that are party to this policy are aware of their roles and responsibilities.</li> <li>• Persons detained under S136 MHA 1983 are treated with respect, without discrimination and are assessed as quickly as possible taking into account the guiding principles listed in the Mental Health Act code of Practice 2015.</li> <li>• Persons with mental health issues detained for criminal offences, are processed with due regard to the law. A mental disorder whilst correctly taken into consideration is not an automatic bar to due criminal process.</li> <li>• All agencies focus on providing the best possible support for the detained person to enable a quick recovery and return to their place in the community.</li> </ul>
<p>Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma</p>

<p>Equality Target Group</p> <ol style="list-style-type: none"> <li>1. Age</li> <li>2. Disability</li> <li>3. Sex</li> <li>4. Marriage/Civil Partnership</li> <li>5. Pregnancy/Maternity</li> <li>6. Race</li> <li>7. Religion/Belief</li> <li>8. Sexual Orientation</li> <li>9. Gender Reassignment</li> </ol>	<p>Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?</p> <p>Equality Impact Score  <b>Low = Little or No evidence or concern (Green)</b>  <b>Medium = some evidence or concern (Amber)</b>  <b>High = significant evidence or concern (Red)</b></p>	<p>How have you arrived at the equality impact score?</p> <ol style="list-style-type: none"> <li>a) who have you consulted with</li> <li>b) what have they said</li> <li>c) what information or data have you used</li> <li>d) where are the gaps in your analysis</li> <li>e) how will your document/process or service promote equality and diversity good practice</li> </ol>
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Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
<b>Age</b>	Including specific ages and age groups:  Older people Young people Children Early years	Low	There is only one section 136 suite therefore there will only be one service user supported at any one time, the environment is suitable for all
<b>Disability</b>	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities:  Sensory Physical Learning Mental Health  (including cancer, HIV, multiple sclerosis)	Low	Estates have ensured the colours and surfaces meet all requirements as laid out in this question. The MHA Code of Practice details the need for non-discriminatory practice and application of the Act as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any special needs or requirements relating to any form of disability.
<b>Sex</b>	Men/Male Women/Female	Low	Suitable for all genders. The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender related preferences, needs or requirements.
<b>Marriage/Civil Partnership</b>		Low	Applicable regardless of partnership status.
<b>Pregnancy/Maternity</b>		High	This environment and work requirements are not suitable for

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
			pregnant staff members therefore they are exempt from this aspect of RRS work
<b>Race</b>	Colour Nationality Ethnic/national origins	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to race or ethnicity.
<b>Religion or Belief</b>	All religions  Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
<b>Sexual Orientation</b>	Lesbian Gay Men Bisexual	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
<b>Gender Reassignment</b>	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender identity related preferences, needs or requirements.

## Summary

Please describe the main points/actions arising from your assessment that supports your decision above.

The standards and principles described within the policy prompt the clinician to have regard to individual holistic needs of the detained person in relation to use of the S136 suite.

It is felt that this policy and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs.

Any audit/monitoring outcomes of related policy would continue to inform any changes to the Equality Impact Assessment in relation to any of the equality target group characteristics and impact of use of S136.

There are statutory requirements and obligations built into existing related legislation (MHA 1983) and its supplementary Code of Practice as well as local systems in place for assurance of the monitoring of compliance with these requirements and reporting through related committees.

EIA Reviewer: Michelle Nolan

Date completed: 29 September 2023

Signature Michelle Nolan

## Appendix 24: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	<b>Policy for the Implementation of Section 136 of the Mental Health Act 1983</b>		
Document Purpose	This policy details the process to be used for the implementation of Section 136 of the Mental Health Act 1983 and related legislation. It applies to all age groups.  Persons detained under S136 MHA 1983 are treated with respect, without discrimination and are assessed as quickly as possible taking into account the guiding principles listed in the Mental Health Act Code of Practice 2015. The purpose of removing a person to a place of safety is to enable the person to be examined by a doctor and interviewed by an Approved Mental Health Professional (AMHP), so that necessary arrangements can be made for the persons care and treatment. The removal should be for no other purpose than that stated above.		
Consultation/ Peer Review:	Date:	Group / Individual	
<i>list in right hand columns consultation groups and dates</i>	16/6/22 (approved)	Mental Health Legislation Steering Group	
	20.09.23	Mental Health Legislation Steering Group	
Approving Committee:	MHLC	Date of Approval:	5 November 2021
Ratified at:	Trust Board	Date of Ratification:	25 November 2021
Training Needs Analysis:	Training requirements include: MAPA ILS/BLS Medication Competencies MHA Training MCA Training	Financial Resource Impact	There are no financial resource impacts
<i>(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)</i>			
Equality Impact Assessment undertaken?	Yes [ <input checked="" type="checkbox"/> ]	No [ <input type="checkbox"/> ]	N/A [ <input type="checkbox"/> ] Rationale:
Publication and Dissemination	Intranet [ <input checked="" type="checkbox"/> ]	Internet [ <input type="checkbox"/> ]	Staff Email [ <input checked="" type="checkbox"/> ]
Master version held by:	Author [ <input type="checkbox"/> ]	HealthAssure [ <input checked="" type="checkbox"/> ]	
Implementation:	<i>Describe implementation plans below - to be delivered by the Author:</i>		
	The Trust has operated a Section 136 HBPOs following its build over 10 years ago and this policy was originally a Standard Operating Procedure introduced April 2016. The changes made within this document have been shared with the MHCIT who manage the detentions within the HBPOs, Implementation of this policy therefore will consist of: <ul style="list-style-type: none"> <li>• Ratified policy to be shared with executive directors for sharing across directorates and with lead authors highlighting the new process</li> <li>• All staff email highlighting informing them of the final ratified version with a link to the full policy</li> <li>• Subcommittees to add approval of policies to their work-plan</li> </ul>		
Monitoring and Compliance:	Monitoring and compliance of the Policy will be evidenced through the process of consultation, approval and ratification of policies.		

<b>Document Change History:</b>			
<i>Version Number / Name of procedural document this supersedes</i>	<i>Type of Change i.e. Review / Legislation</i>	<i>Date</i>	<i>Details of Change and approving group or Executive Lead (if done outside of the formal revision process)</i>
1.00	Review	22/12/10	Ratified as a Protocol
1.01	Review	14/05/12	Reviewed, no changes
1.02	Review	February 2015 July 2015	Reviewed. Minor changes made  Minor changes: amended to include the new code of practice
2.00	Review	February 2017	Following transformation of adult mental health and introduction of regional Policy the current document was updated
2.01	Review	April 2017	Ratified by MH steering group
2.02	Review	September 2017	Converted to a policy
2.03	Amended	December 2017	Amendments from MHLC (09/11/17) including Appendix 14 (Waiting area)
2.04	Review	January 2019	MHLS 136 protocols included Included trust cessation policy NEWS information updated to NEWS 2 in line with trust policy Includes further information on voluntary drop off for informal service user assessments.
2.05	Amended	May 2019	Additional guidance on staff duty of care when Police are restraining a detained person, specifically highlighting when in prone restraint.
2.06	Format review	April 2020	Format of policy updated to ensure contemporary format of policy is available on the Trust intranet.
3	Full review	June 2020	Full review
3.1	Additions made	July 2021	Reviewed in line with actions from SEA 2021-01 and the Right Care Right Person (RCRP) action plan. Also changes to name of MHRS to MHCIT.
3.2	Amendments made	November 2021	Reviewed and amended (minor changes) in relation to changes to 136 process (AMHP responsibilities)
3.3	Amendments made	May 2022	Changes to medical treatment regarding introduction of ePMA (p25/26). Clarified that Grab bag can be used by appropriately trained clinicians (p26 and 32) Approved by director sign off 16-June-2022 (MHL Steering Group)
3.4	Amendments made	April 2023	Document not reviewed, so date of next review not updated. Appendix 14 flow chart updated and approved at Mental Health Legislation Steering Group (April 2023) so updated in this document.
3.5	Amendments made	October 2023	Additional commentary made throughout document to ensure clarity about following the same process for S135(1) as with S136 when person arrives at place of safety. Approved at QPaS (19 October 2023).