London's Section 136 Care Pathway

Draft guidance

March 2016

Introduction

This document is aimed primarily at stakeholders involved in the section 136 care pathway, specifically Police, London Ambulance Service, Approved Mental Health Practitioners and Acute and Mental Health Trusts. The section 136 care pathway focusses on all ages and should sit alongside the Health Based Place of Safety specification in order to provide a consistent pathway of care across London.

It has been decided to focus on the section 136 care pathway rather than section 135 as there are fewer section 135 detentions and they tend to be less problematic across London. Unlike s135 cases, where a warrant is required and an approved mental health professional is involved, section 136 can be more unpredictable, with the decision to detain a person relying on the individual police officer's judgement

It is recognised that whilst prevention of mental health crisis is a central goal of mental health services it is outside the scope of the s136 care pathway. The s136 care pathway starts from when the individual is detained until the Mental Health Act assessment is completed and follow up care arranged. However London's crisis care system is responsible for ensuring adequate preventative measures are in place within the local health economy to prevent people being detained under s136. Innovative practices such as street triage, crisis lines and Psychiatric Decision Unit's aim to improve access to crisis care and reduce detentions under section 136; these practices should be explored within London's wider crisis care system.

What is a section 136?

Section 136 is the power that allows a police officer to detain someone whom they believe to be mentally disordered and in need of urgent care and control. The individual must be in a public place, defined as a place to which the public have access, and can be taken to a place of safety to enable a mental health assessment to take place.

Section 136 of the Mental Health Act 1983

1 If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.

2 A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

The maximum duration of detention is 72 hours under section 136 so that the individual can be examined by a registered medial practitioner and interviewed by an approved mental health professional (AMHP), and to make any necessary arrangements for their treatment or care. **This will shortly be changed to 24 hours under new legislation. Information describing London's s136 care pathway is based on 24 hour maximum detainment.**

London's Section 136 Care Pathway

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

1.1 Local arrangements should be in place to ensure there is always a suitable health professional for the police to consult with prior to detaining the person under s136, if there is a care plan in place the instructions in the care plan for managing a mental health crisis should be followed to avoid detention under section 136;

1.2 The Ambulance service or other service transporting the individual will always go to the Health Based Place of Safety closest to where the individual was picked up. However crisis care plans which may include a preferred place of assessment should always be taken into account where feasible;

1.3 If there is no capacity at the local Health Based Place of Safety when Police make initial contact it is that site's responsibility to accommodate the individual through agreed escalation protocols or alternative arrangements, whether the individual is from that area or not. A capacity management tool should be available to support this process (need to include more detail – what does this look like?)

1.4 This role should fall to the Health Based Place of Safety s136 coordinator in liaison with the hospital bed manager. If necessary escalations should be made to the on-call suitability qualified doctor or service manager who should be available through the Trust's switchboard.

2. Transfers

Initial transfer to Health Based Place of Safety or Emergency Department

2.1 The possibility of conveyance by a family member, carer or friend should always be considered first if they are willing and able to do this. An individual should only be transferred by a private vehicle if a health care professional is satisfied that the individual and others will be safe from risk of harm and that this is the most appropriate method of transport. A medical escort should always accompany the vehicle in these situations – and the police?

2.2 If it is not possible or appropriate for the individual to be conveyed by a family member, carer or friend then an ambulance should be used to convey the individual with police support where appropriate. The ambulance should arrive within 30 minutes or 8 minutes if restraint is being used.

2.3 If there is concern that waiting for an ambulance will cause further distress to the individual, the level of risk is considered high or the individual is violent then police transport should be used as a last resort to convey the individual to the Health Based Place of Safety.

2.4 Where conveyance via a police vehicle is necessary because of the risk of violence, a qualified paramedic should accompany the individual in the police vehicle. In any case an ambulance should follow behind to provide additional support that may be required.

2.5 The time of arrival and admission to the Health Based Place of Safety should be clearly recorded; the time of arrival is the start of the 24 hour assessment period under Section 136.

2.6 Individuals detained under a section 136 but requiring physical health care should be transported to an Emergency Department by ambulance with police support. The police must remain with the detainee until s136 papers are transferred or ED staff assess there to be no mental health disorder, remove the 136 and are willing to accept the risk and management of the individual.

Intoxication pathway:

2.7 *The Association of Chief Police Officers and the Independent Police Complaints Commission (2012)* describes drunk and incapable as an individual that has consumed alcohol to the point of being unable to either walk unaided or stand unaided or is unaware of their own actions or unable to fully understand what is said to them.

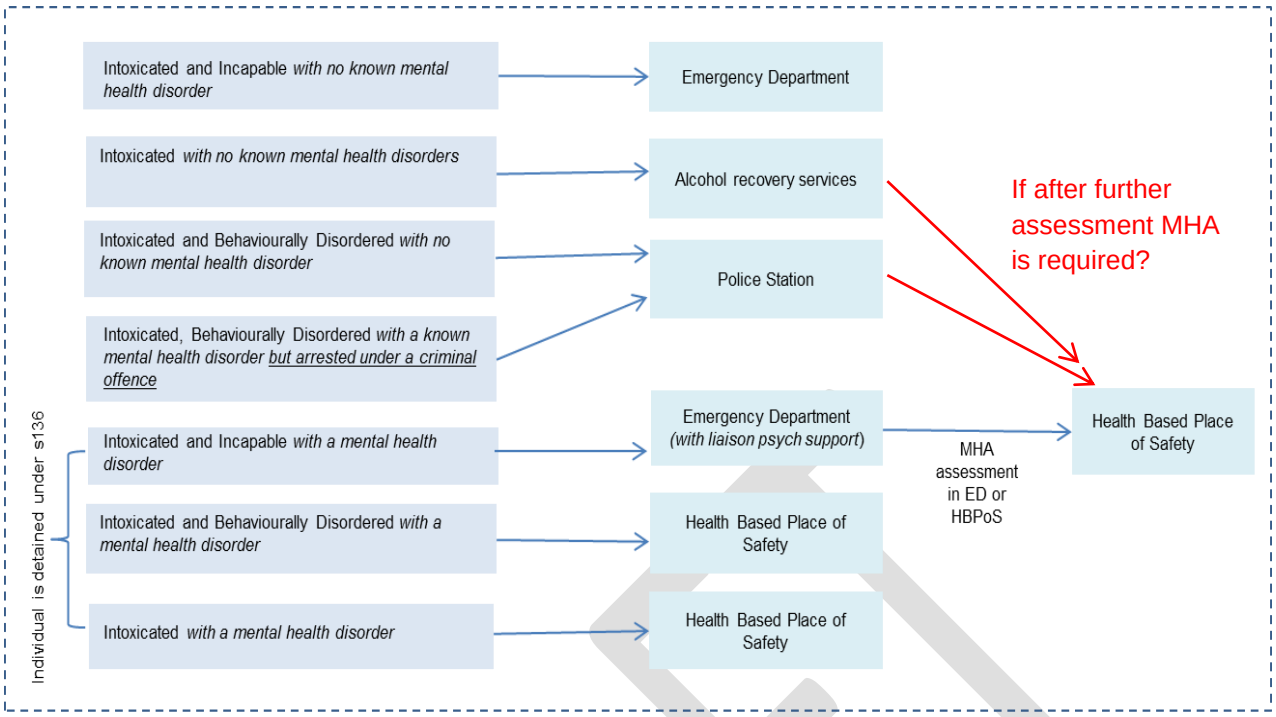
2.8 If someone appears to be drunk and showing any 'aspect' of incapability which is perceived to result from that drunkenness, then that person should be treated as drunk and incapable. A person found to be drunk and incapable should be treated as being in need of medical assistance at an Emergency Department. The same should occur for those who appear intoxicated by drugs.

2.9 A Health Based Place of Safety should not admit an individual that is 'drunk and incapable'. Where this occurs the person is too high a risk to the safety of the individual or staff and access to the Emergency Department should be arranged.

2.10 If the person is not adversely affected by intoxication and is fit for interview, they should be conveyed to the Health Based Place of Safety. The Health Based Place of Safety should not be conducting tests to determine intoxication as a reason for exclusion to the site; this should be based on clinical judgement. It is the clinical decision of the suitability qualified doctor at the Health Based Place of Safety to make the final call on where the individual is seen.

2.11 The following pathway for intoxicated individuals is proposed below; this includes intoxication by both alcohol and drugs. *Case studies will be developed to help define the different elements of the intoxication pathway.*

Intoxication pathway:



Transfers between hospital sites:

2.12 Trust boards are to be accountable for having and monitoring robust and cohesive policies for inter-hospital transfers;

2.13 All transfers should only take place when it is in the individual's best interests; relatives and/or carers are to be properly communicated with and informed where and when the individual is being transferred. The individuals privacy and dignity is to be maintained as far as possible throughout the transfer;

2.14 Unless it is an emergency, all transfers should be agreed by either an AMHP, S12 doctor or another mental health healthcare professional (who is competent to assess whether the transfer would put the person's or others' health or safety at risk) at both the sending and receiving hospitals;

2.15 A request to the Ambulance Service or a private transfer service is not to be made until agreement to transfer has been reached between hospitals with appropriate clinical involvement;

2.16 If the individual is conveyed and accepted into a Health Based Place of Safety and staff believe further treatment is required from the Emergency Department, transporting the individual is the responsibility of the Health Based Place of Safety. This should not be the Police's role unless there is mutual agreement between parties that it is in the best interest of the individual and the Police have capacity to support the transfer.

2.17 If an individual is in an Emergency Department for physical health treatment and a Mental Health Act assessment is required a needs assessment should be established to decide on

timely MHA assessment and the appropriate environment in which to conduct the assessment and provide on-going short term care.

2.18 Transporting individuals between Health Based Places of Safety and Emergency Departments and vice versa is the responsibility of Mental Health Trusts and Acute Trusts respectively, led by the s136 coordinator. This should not be the police's role unless there is mutual agreement between parties that it is in the best interest of the individual and there is capacity to provide support.

(Refer to ***Section 3: Expectations of Staff*** which details the expectation to conduct Mental Health Act assessments in Emergency Departments)

2.19 A person may be transferred before their assessment has begun, while it is in progress, or after it is completed and they are waiting for any necessary arrangements for their care or treatment to be put in place. The maximum period of detention cannot be extended if the person is transferred to another place of safety.

Can an individual be transferred to a HBPoS if the MHA assessment has been completed in the Emergency Department and they need somewhere until further care is arranged (but not wait in the ED)?

2.20 A person should never be moved from one place of safety to another unless it has been confirmed that the new place of safety is willing and able to accept them. The receiving hospital is to inform the sending hospital whether it can accept an individual within the agreed timeframes. An up-to-date Directory of Services should support transfers to alternative services.

2.21 If the individual is out of area and needs to be transferred to their local service the current Health Based Places of Safety is responsible for the individual's transfer. Transport should be arranged by this Trust and not delayed due to other external factors.

2.22 The sending hospital retains clinical responsibility for the individual until handover at the receiving hospital has taken place, handover should take place within 15 minutes of arrival;

2.23 The sending hospital is to ensure the individual is accompanied by an appropriate clinical escort(s) during the transfer, who is ready for transfer when the Ambulance service or private transport service arrives;

2.24 When the Ambulance service or a private transfer service agree to a transfer they are to dispatch or arrive at the hospital within the agreed times;

2.25 If Acute or Mental Health Trusts are unable to accept a transfer on clinical grounds clear reasons for the decision and targeted advice on further care must be provided to the sending hospital. The name of the staff member giving advice should be recorded in the individual's medical notes at the sending hospital;

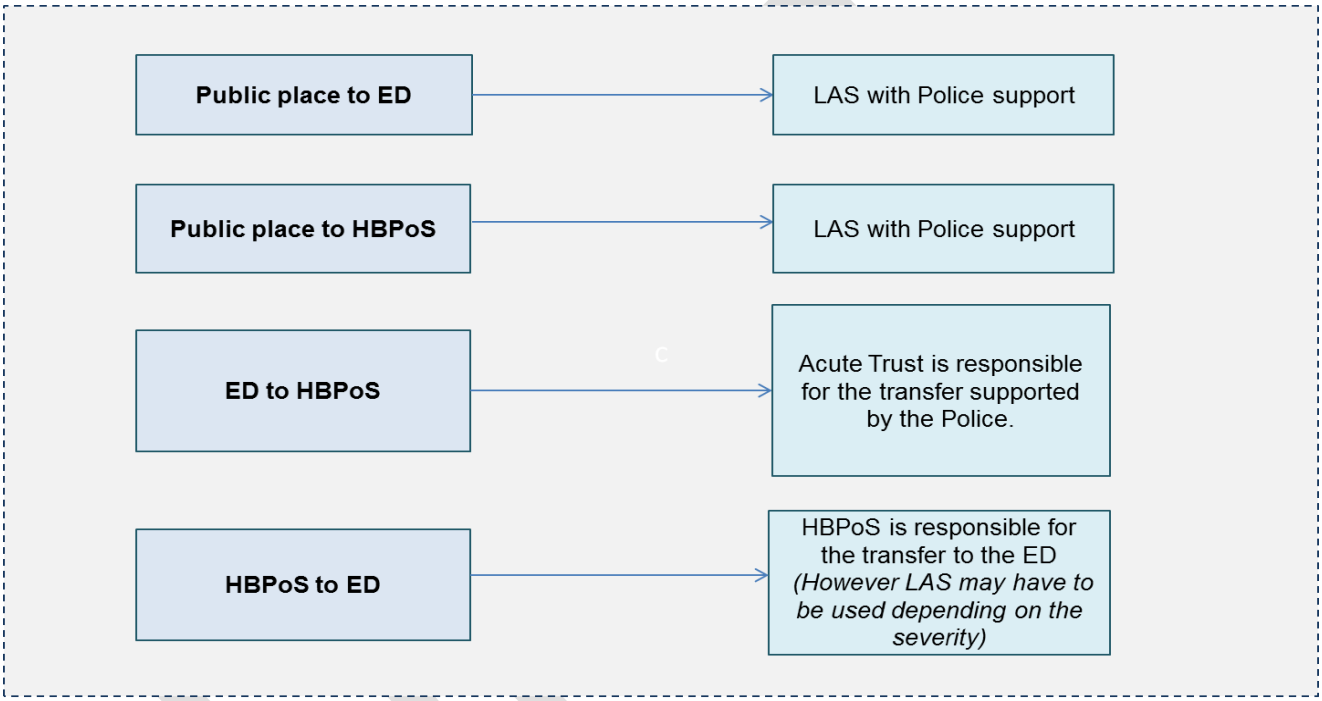
2.26 All transfers are to be carried out with appropriate clinical documentation. On arrival at the receiving hospital, an adequate structured handover to the receiving team is required;

2.27 All hospitals to have an escalation process in place which is instigated where timescales are not met for all transfers;

2.28 For all transfers, on arrival at the receiving hospital the individual must be seen by the receiving specialist team within the agreed timeframe (*refer to Section 4: Assessments in the Health Based Place of Safety specification);*

2.29 All individuals who have received rapid tranquillisation (in an Emergency Department or by the Ambulance Service) or been restrained for an extended period must always be transported in a fully equipped emergency ambulance because of the risk of rapid deterioration of their physical health.

Summary of transfer responsibilities across the s136 care pathway:



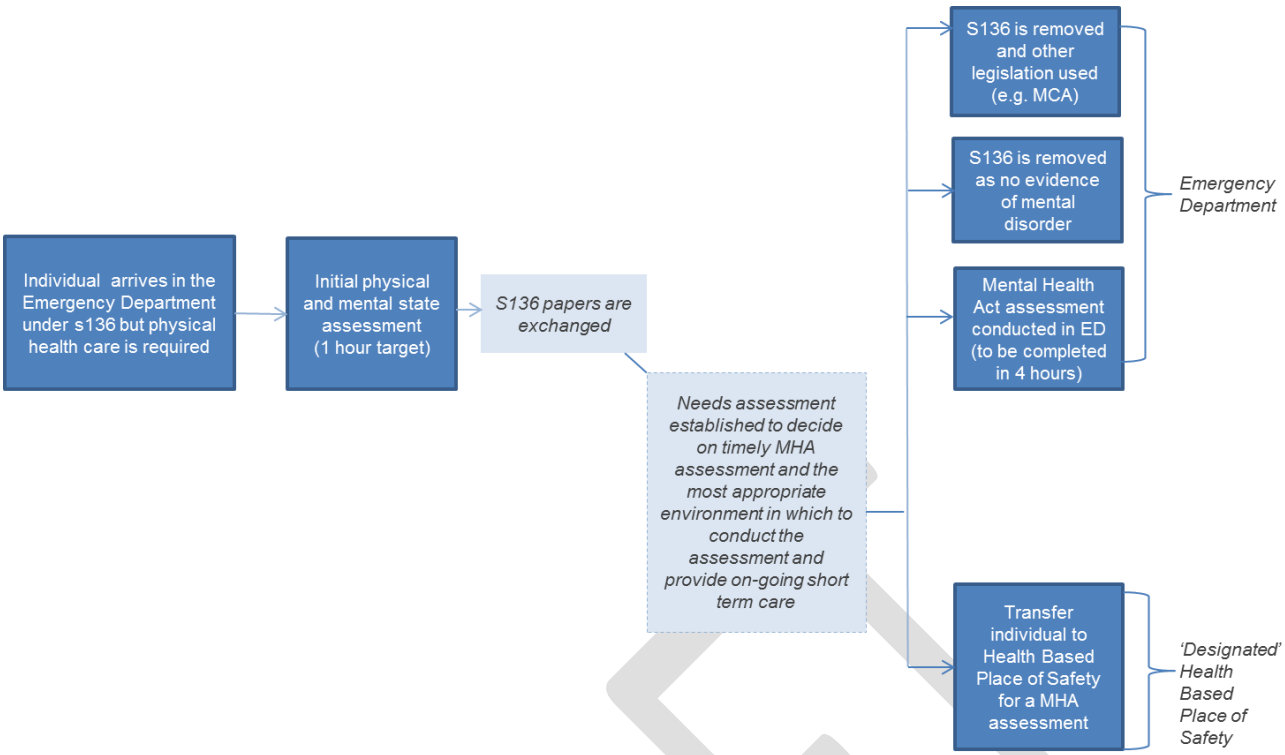
What does 'responsibility' mean – Booking transport, supplying RMN to accompany transfer?

3. Expectations of Staff

Emergency Departments

3.1 If individuals require a prolonged period in the Emergency Department or acute hospital admission, mental health services and the Emergency Department must respond in a timely way to support appropriate assessment and consideration of alternative legislation. This includes liaison psychiatry services seeing individuals within 1 hour of Emergency Department referral and Mental Health Act assessments being completed within 4 hours of the person's presentation to the Emergency Department.

See the proposed pathway below:



S136 is a police power – Are police are required to remain until 'assessment' is completed? If so there should be frequent reviews of police need and judgement calls made whilst the individual is in the healthcare setting.

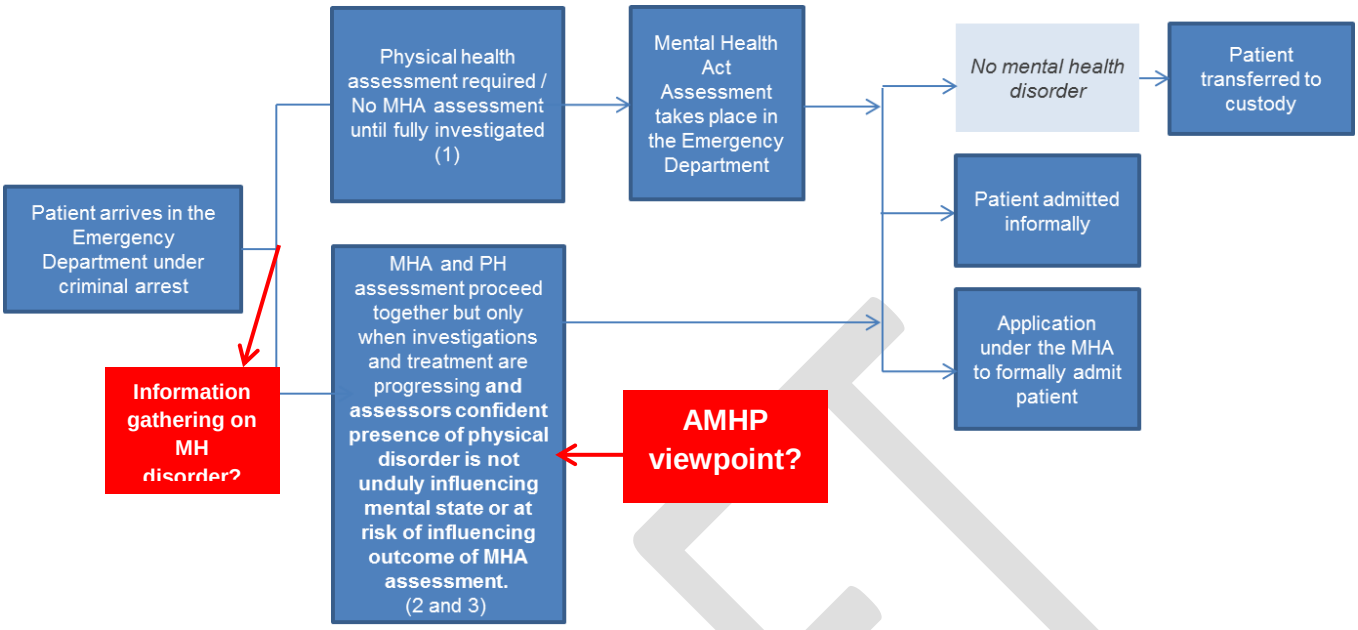
Who is the appropriate person to 'remove' a s136 – should this be a 'designated' person in the Emergency Department so this can be monitored.

3.2 When the detained individual is in an Emergency Department with an active mental health problem (either detained, voluntary with capacity or no capacity and under the Mental Health Capacity Act) and is being treated for their physical health, that individual is the Emergency Department's responsibility with support from medical and psychiatry specialities. The responsibility of that individual remains with the Emergency Department until they leave the Department, either discharged or transferred elsewhere.

3.3 If an individual in the Emergency Department is under criminal arrest, they are still entitled to a mental health assessment. The liaison psychiatry staff will not be expected to determine whether a person is 'fit to be detained in police custody' or 'fit to be interviewed'. However, as with any other patient, liaison psychiatry staff can make an assessment of mental health needs and arrangements for any necessary mental health treatment or aftercare, including whether a person needs Mental Health Act assessment or informal admission to a psychiatric ward. Close liaison with the police officers and ED staff to agree a joint approach is essential.

3.4 Information gained during the Mental Health Act assessment cannot be used in any way by Police in a criminal case. Reasonable consideration should be given where feasible to provide an alternative secure chaperon for the individual being assessed.

See the proposed pathway below:



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

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

3) *Presence of additional unstable pathology with no overt impact on mental state (e.g. musculoskeletal injury, wounds)*

3.5 If an individual is under section 136 in the Emergency Department because physical health care is required but the individual has also committed a crime, the necessary care should continue and Mental Health Act assessment takes place if required.

Health Based Place of Safety

3.6 The Health Based Place of Safety should be provided at a level that allows for around the clock availability and meets the needs of the local population. In exceptional circumstances when the Police make contact with the Health Based Place of Safety and there is no capacity the place of safety is responsible for accommodating the individual through escalation protocols or alternative arrangements, this is for both local and out of area individuals.

Capacity management tools should be available to determine where capacity across London – need to engage further on this.

Acute Trust and Health Based Place of Safety Care Pathways

3.7 Acute and Mental Health Trusts should have local protocols in place that give specific attention to:

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

3.8 The principle components of the care pathways should include:

- Support and buy in from surgical, medical teams and the Emergency Department who understand and respond flexibly to the distinct clinical challenges presented by this populations' needs.
- Optimising available technology for example secure clinical picture transfer systems, shared notes systems and telemedicine facilities.
- Providing clarity and consistency over case ownership with clear agreed shared care arrangements.
- Optimising available clinical advice and triage systems including telephone consultation and advice between Trusts.
- Supporting flexible assessment and treatment arrangements including outreach and fast track care pathways.
- The requirement of direct telephone handovers between the referring and receiving medic on referral to and discharge from acute physical health care providers.
- Clear requirements for transfer of clinical information including specific systems to facilitate transfer (e.g. shared care records, location specific clinical communication templates)
- Referrals and discharge plans that include the name and contact number of clinicians who have responsibility for that individual's care and can be contacted to provide clinical information about the individual from both Mental Health and Acute Trust sites.

Examples of care pathways are include in Appendix 1

Expectations of Local Authority (AMHPs)

3.9 AMHPs to have separate responses for Adults and Children? Currently roles that cover both age groups contribute to the larger waiting times across London.

Appendix 1: Acute and Mental Health Trust Care Pathway Examples

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

Actions:

Referrer (LAS, s136 coordinator or HBPoS medic)

Direct referral to ED + blue light ambulance transfer

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

Actions:

Telephone triage advice from ED, Medical or Surgical registrar:

Referrer to provide medical summary, clinical findings, labs and bed side tests as appropriate / available

Transfer of required clinical information to be agreed during phone call. Name and number point of contact exchanged for referrer and clinician receiving and documented in both notes

Ambulance transfer if agreed to ED, SAU or MAU as appropriate

Liaison psychiatry to provide departmental mental health advice as required.

Presence of additional unstable pathology with no overt impact on mental state (e.g. musculoskeletal injury, wounds)

Actions:

Telephone Triage advice: HBPoS medic to ED Triage nurse or speciality registrar

Access to secure image transfer to support referral assessment

Fast track, in reach or outreach review including assessment appointment time (if next day review deemed appropriate) to be agreed during referral consultation

Risk factors for or presence of undiagnosed or treated stable pathology including chronic disease requiring further medical input (e.g. obesity, hypercholesterolaemia, hypertension, diabetes, COPD, liver disease, CCF)

Actions:

Health Based Place of Safety to arrange assessment and follow up with primary care provider