South Central Ambulance Service NHS
NHS Foundation Trust

Mental Health Policy

DOCUMENT INFORMATION	
Author:	Sue Putman. Clinical Lead, Mental Health and Learning Disability.
Ratifying committee/group:	Patient Safety Group
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Version:	1.1

Contents

1. Introduction

South Central Ambulance Service NHS Foundation Trust (the Trust) is committed to delivering an excellent standard of care to patients with Mental Disorders.
(The term 'Mental Disorder' is used throughout this policy, in line with current NHS protocol and the Mental Health Act 1983 – which defines Mental Disorder as "any disorder or disability of the mind". This includes mental illness and learning disability).

The principles underlying this Policy are in accordance with the Mental Health Act 1983 Code of Practice: (Department of Health [DH] 2015); Mental Capacity Act 2005 Code of Practice (DH, 2007) and the Equality Act 2010.

It is the underlying aim of this policy, and associated procedures, to ensure that patients' rights to dignity and privacy are maintained

2. Scope

This guidance is for all staff working within South Central Ambulance Service NHS Trust who are involved in the care, treatment and support of people who are experiencing a mental disorder, relevant to role.

All NHS Trusts and Local Authorities who care for people who have been detained under the MHA, are required to ensure that practices and procedures are compliant with the associated codes of practice, and all staff receive training relevant to their role within the organisation.

All ambulance clinicians have a duty to be aware of, and act in accordance with, the Code of Practice.

3. Aim

The purpose of this policy is to help ensure that health professionals are able to understand and comply with the law and guidelines relating to the care, treatment and transportation of patients with mental disorders.

This policy must be read and followed by all staff who are working for, or on behalf of, the Trust (on a paid or voluntary basis).

4. Roles and Responsibilities

4.1. Trust Board

The Trust Board has responsibility and accountability for ensuring the provision of the appropriate resources required to implement this policy. The Board, Committee and Meeting structure is at Appendix 1.

4.2 Chief Executive

The Chief Executive has overall responsibility for ensuring that systems for the safe and appropriate use of the Mental Capacity Act 2005 are followed.

4.3 Executive Director

The Executive Director of Patient Care is the board member responsible for the Mental Capacity Act 2005.

4.4 Managers and Supervisors

The Clinical Lead for Mental Health and Learning Disability is responsible for managing the process for the safe and appropriate use of the Mental Capacity Act

2005 within the Trust, and reports through the Executive Director of Patient Care to the Trust Board for this purpose.

The Operations Directors and Area Managers are responsible and accountable for the day to day safe and appropriate use of the Mental Capacity Act 2005 and must ensure that copies of the Mental Capacity Act 2005 Policy and SOPs are available to their staff.

4.5 All Trust Staff

All staff have a responsibility to ensure they are familiar with and understand the policy and any associated procedures; ensuring their application and compliance with legislation when caring for patients.

Clinical staff have a responsibility to maintain their competency and to ensure their familiarity with changes to legislation/therapeutic guidelines as they are adopted by the Trust.

5. Definitions

The Mental Health Act 1983 (MHA) defines Mental Disorder as "any disorder or disability of the mind". This includes mental illness and learning disability.

Patients with a learning disability will only be treated as suffering from a mental disorder for certain purposes of the Act; if it is associated with abnormally aggressive or seriously irresponsible conduct.

Apart from learning disability the Act does not distinguish between different forms of mental disorder and therefore applies to all mental disorders, including all types of personality disorder.

Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind (MHA).

The Mental Capacity Act 2005 (MCA) defines Mental Capacity as "the ability of an individual to make decisions regarding specific elements of their life".

- This includes the ability to make a decision that affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions.
- It also refers to a person's ability to make a decision that may have legal consequences – for them or others. Examples include agreeing to have medical treatment, buying goods or making a will.

6. Abbreviations

Mental Health Act 1983 (MHA).
Mental Capacity Act 2005 (MCA).
Department of Health (DH).

7. Key elements

7.1 Developing Mental Health Care Provision.

The Trust will work with other agencies in order to improve safe, integrated, high quality care for patients with a mental disorder.

The Trust will continue to collaborate with providers and commissioners to establish effective patient pathways related to mental health care.

The Trust will continue to collaborate with providers and commissioners to establish effective feeback from patients and learn from any untowsrd incidents.

7.2 Information sharing.
It is recognised that information sharing plays a key role in safe working practice and there is evidence that patients, public or staff have come to harm when services do not openly share the information they have.

The need to distinguish between the principles of confidentiality and the need to share information must be in accordance with legislation and the guidance provided by the Trust.

All staff will adhere to the Trust Confidentiality policy at all times, seeking advice if needed.

7.3 The Mental Health Act 1983 (MHA).
The Mental Health Act 1983 (as amended by the Mental Health Act 2007) is the law under which a person can be admitted, detained and treated in hospital against their wishes. The Act covers the rights of people while they are detained, how they can be discharged from hospital and what aftercare they can expect to receive. The Act applies in England and Wales.

7.4 Roles and responsibilities under the Mental Health Act.
Approved Mental Health Professional (AMHP).

Local Social Service Authorities (LSSAs) are allowed under legislation to approve a range of registered and professionally qualified mental health professionals to act as an Approved Mental Health Professional (AMHP). Individuals who can act as an AMHP are:

- Registered social workers.
- First level nurses whose field of practice is mental health or learning disabilities.
- Registered occupational therapists.
- Chartered psychologists.

AMHPs are responsible for:

- Making the application for a patient to be detained.
- Organising the safe transportation of the patient when a place has been found.
- Completing an initial risk assessment.

A range of other professional roles are outlined in the Act however, as they do not usually have a direct relationship with the ambulance service, they have not been described here.

7.4.1 The Ambulance Service.
The MHA Code of Practice clearly defines the responsibilities of the ambulance service in the conveyance of patients detained under the MHA. The Code of Practice aims to ensure the individual's right to the maintenance of their dignity and privacy by all health care providers involved in the delivery of care.

The *main* role for the ambulance service under the MHA is to provide transport (and immediate care of any physical/medical needs) for patients who have been detained (i.e. "sectioned"); this permits restraint if required.

Patients should always be transported in the manner which is most likely to preserve their dignity and privacy, consistent with managing any risk to their health and safety or to other people.

This applies in all cases where patients are compulsorily transported under the Act, including:

- Taking patients to hospital to be detained for assessment or treatment.
- Transferring patients between hospitals.
- Returning patients to hospital if they are absent without leave.
- Taking community patients or patients who have been conditionally discharged to hospital on recall.

7.4.2 Detention under the Mental Health Act.
The MHA allows for the detention of patients that have been formally assessed; or for the purposes of the assessment and treatment of the patient's mental health.

Ambulance clincians have no power to detain (ie "section") patients under any circumstances.

Section 2 (admission for assessment) – for up to 28 days.
Application is required by an Approved Mental Health Practitioner (AMHP) or nearest relative, and two medical recommendations are needed. One doctor must be approved under section 12 of the Act and the other should know the patient in his or her professional capacity.

Section 3 (admission for treatment) – For 6 months initially, can be reviewed and extended.
Application and two medical recommendations are required as for section 2. This is undertaken when the patient is already detained under section 2 or the nature and degree of the patient's disorder is known.

Section 4 (admission for assessment in an emergency) – for up to 72 hours.
Application is made by the AMHP and one doctor who has examined the patient for the purpose of the act within the last 24 hours. The person must fit the criteria for detention under section 2 of the Act. Section 4 should only be used in a situation where to delay the detention due to the unavailability of the second doctor presents a significant risk to the patient or others.

Section 135(1) (magistrates powers)
This is a Magistrates order. It can be applied for by an AMHP in the best interests of a person who is thought to be mentally disordered, but who is refusing to allow mental health professionals into their residence for the purposes of a Mental Health Act

assessment. Section 135 magistrates' orders give police officers the right to enter the property for the person to be taken to a locally defined “place of safety”.

Section 135(2) (magistrates powers)
A Police Officer may use powers of entry under section 135(2) of the Act when it is necessary to gain access to premises to retake a person into custody who is already liable to detention, or recall, under the Act.

Section 136 (police authorised powers)
This authorises a police officer to take a person from a public place to a place of safety, usually a hospital, if it appears to a police officer that they are suffering from “mental disorder” and “in immediate need of care or control”. The Mental Health Act Code of Practice states that a police station should be used as a place of safety only on an “exceptional basis”. A person detained under section 136 must be released if they are not detained in a hospital, under the Act, within 72 hours.

7.5 The Mental Capacity Act 2005 (MCA).

The MCA applies to everyone involved in the care, treatment and support of people **aged 16** and over living in England and Wales who are unable to make all or some decisions for themselves. The Trust is required to adhere to legislation and associated guidance which relates to a patient’s mental capacity. The MCA ensures that, as far as possible, all adults can take decisions about their own lives. Other people, (e.g. a family member, or a staff member), must help the individual to make decisions for themselves, as required.

“Mental capacity” refers to the ability of an individual to make a decision *at the time that decision needs to be made*. A person is said to lack capacity, if at that point in time he/she is unable to make a decision for him/herself because of an impairment or disturbance in the functioning of the brain or mind.

Capacity can fluctuate; some individuals may be able to make decisions about their daily lives but may not be able to make decisions about other things. Every effort should be made to assist an individual in making his or her own decisions by using effective communication. Further information about the Mental Capacity Act can be obtained from the SCAS Mental Capacity Policy.

On attendance at any incident where a patient is deemed to lack capacity it is important to remember that this is **not** an automatic trigger to call for police attendance. Police attendance should *only* be requested when a patient is presenting with actual aggressive/violent behaviour, and after all attempts to persuade the patient to travel have failed.

7.6 Interface between the Mental Capacity Act and the Mental Health Act.

The Mental Capacity Act may be used to treat people for a mental or physical disorder when they cannot consent to the treatment because they lack capacity, and where the treatment is in their best interests.

However the Mental Capacity Act cannot be used to *detain* anyone who needs treatment for a mental disorder. If a person is detained under the Mental Health Act, the Mental Capacity Act does not apply to treatment for the person’s mental disorder - which can be given without consent under the Mental Health Act. It also means that attorneys (and deputies) cannot consent to, or refuse, such treatment on the patient’s

behalf. For the same reason, an advance decision to refuse treatment for mental disorder can be over-ridden where necessary.

For most other purposes, the Mental Capacity Act will continue to apply to a patient detained under the Mental Health Act. This means, for example, that an advance decision to refuse treatment for any illness or condition - other than mental disorder - is not affected; nor is any power an attorney has to consent to such treatment. It also means that where a detained patient lacks capacity to consent to treatment (other than treatment for mental disorder) the decision-maker will need to act in accordance with the Mental Capacity Act. For more detail on the interface between the Mental Capacity Act and the Mental Health Act 1983 refer to the Code of Practice.

Professionals may need to consider using the MHA to detain and treat a person who lacks the capacity to consent to treatment, instead of the MCA, if:

- It is not possible to give the care or treatment needed without deprivations of liberty.
- The person needs treatment that cannot be given under the MCA (for example the person has made an advanced decision to refuse essential treatment for the mental illness).
- The person may need to be restrained in a way not allowed under the MCA.
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse parts of it and they have done so or:
- There is some other reason the person might not get treatment and they, or someone else, might suffer as a result.

7.7 Conveyance.

The Mental Health Act Code of Practice (2015) 17.3 states that patients detained under the Mental Health Act: "*should always be conveyed in a manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people."*

The Mental Health Act Code of Practice requires Local Social Services Authorities (defined in S.145 (1) Mental Health Act), the NHS and the local Police Authority to establish a clear policy for the use of the powers to convey a person to hospital under S.6 (1) Mental Health Act.

The Trust will exercise its authority to convey under the Mental Health Act, using the most clinically appropriate vehicle for the presenting circumstances.

The Trust will work with its commissioners, partner agencies and health and social care providers to develop coordinated, multi-agency solutions for the transport of mental health patients.

On attendance at any incident where a patient detained under the MHA is actively resistive to being transported, it is important to remember that this is **not** an automatic trigger to call for police attendance. Police attendance should *only* be requested when a patient is presenting with actual aggressive/violent behaviour. If required, further advice and assistance should be requested from the responsible officer (i.e. the AMHP, following initial detention, or ward staff if Absent Without Leave [AWOL]).

7.8 Section 136 transport.

The transport of people detained under s136 is governed by a National Ambulance Service s136 Protocol (Dec 2013). Brief outline of key points to note:

- Patients should be promptly screened for any underlying medical conditions before being taken to the most appropriate place of safety.
- None of the Emergency Departments (ED) in the Trust's geographic area have agreed to be 'designated' places of safety under the MHA. However, if a patient who has been detained under s136 MHA requires medical treatment - for any reason - they may be taken to the ED and moved to the health based place of safety once treated. The Police Officer must stay with the patient in ED.

A copy of the national protocol is contained in Appendix 4.

HAMPSHIRE. It is important to note that the SCAS response to s136 detentions is different in Hampshire because Hampshire Constabulary has a separate agreement with a Private Provider to transport all s136 detainees. Therefore SCAS will only be involved on an exceptional basis. The principles of the National s136 Protocol govern this arrangement.

7.9 Other MHA Transport.

For all other detentions, the Transport and Conveying process should be followed as outlined in the relevant Joint Working Protocol (Thames Valley and Hampshire).

Guidance on processes to follow when transporting patients who have been detained under the MHA can be found in Appendix 5.

7.10 Restraint (restrictive interventions).

"Restrictive interventions" are defined as *'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently'.* (Positive and Proactive Care: reducing the need for restrictive interventions. DH 2014).

Ambulance staff have limited training in this aspect. Minimal restraint (i.e. reasonable force) can be used in cases where there is no perceived risk of immediate harm to the ambulance crew. If the behaviour of the patient exceeds what the crew can safely manage then assistance must be requested (this does not necessarily have to be police).

When attending a patient and restraint is used by staff it can only be used in accordance with the legal guidance of the Mental Health Act (1983), Mental Capacity Act (2005), Human Rights Act (1998) and actions taken under common law.

Under common law, restraint can be used to prevent harm or injury to others. Actions taken under common law are ones that any reasonable member of the public would also take for self-preservation of themselves and others.

When restraint is used staff must use the least restrictive form of restraint for the least amount of time. Staff must also be able to demonstrate what reasonable steps they took when reaching the decision to use restraint, completing a dynamic risk assessment; recording decisions and actions in the patient's clinical record. Staff should aim to protect the patient's dignity throughout any type of restraint, however it is recognised that this is not always possible.

Whenever any form of forcible restraint has been used this must be recorded in the patient's clinical record and details handed over to staff at the receiving unit.

Ambulance staff should always monitor the physical well-being of a patient who is being forcibly restrained and should be familiar with the signs and symptoms - and management – of Acute Behavioural Disturbance (sometimes referred to as "Excited Delirium"), which may result after prolonged forcible restraint.

8. Training

South Central Ambulance Service NHS Foundation Trust follows the current JRCALC UK Ambulance Services Clinical Practice Guidelines for the management of Mental Health issues and is committed to improving the education, training and development of all staff.

The Trust will provide access to a variety of mental health learning and educational resources, which can be accessed by different means including e-learning. All staff having direct contact with patients will receive, as a minimum, an overview of mental health legislation, mental health conditions (including dementia awareness and the Mental Capacity Act 2005 [MCA]) and providing care in partnership with other organisations). This will be delivered via the Trust Mandatory Training Programme.

The Trust will ensure that teaching staff are suitably qualified to deliver basic mental health education (relevant to role); these will be supported by the Mental Health Subject Matter Expert.

Each Team will have a Mental Health/Dementia Champion who will also support on-going education at an operational level.

The Trust, working with University partners, Police, Mental Health service providers and the Trust Subject Matter Expert, will continue to improve the learning experience of students - both in theory and practice - in relation to the wider Mental Health Agenda. This will include joint training programmes whenever possible.

9. Equality and Diversity

An Equality Impact Assessment has been undertaken on this policy. A copy of the assessment can be found in Appendix 3.

10. Monitoring

This policy will be monitored by review of training records and staff surveys.

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
MHA/MCA training compliance.	Figures and details reported.	Education Department.	Patient Safety Group.	Quarterly.
Staff knowledge review.	Staff survey.	Clinical Lead, Mental Health & Learning Disability	Patient Safety Group.	Annually.

Production of reports on compliance with core outcomes (i.e. response times for s136 detentions).	Monthly reports.	Business Information Team.	Patient Safety Group.	Quarterly.

11. Consultation and Review

This Policy will be reviewed every three years. However, should national guidance or legislation change then the policy may be reviewed earlier.

Stakeholder or Group Title	Consultation Period (From-to)	Comments received (Yes/No)
All managers and staff		
Patient Safety Group		

12. Implementation (including raising awareness)

Education on this policy will be provided by the Education Department, in line with the statutory training plan.

13. References

The Mid Staffordshire NHS Foundation Trust Inquiry.	Robert Francis QC, 2010.
The Mid Staffordshire NHS Foundation Trust Public Inquiry. Final Report.	Robert Francis QC, Feb 2013.
Consent Policy and Procedure (CSPP 21)	SCAS July 2014.
The Mental Health Act 1983.	Dept of Health, 1983 r2007
The Mental Health Act 1983 Code of Practice.	DH, 2015.
The Mental Capacity Act 2005.	DH, 2005
The Mental Capacity Act 2005, Code of Practice.	DH, 2007
Mental Capacity Act Clinical Services Policy and Procedure (CSPP 16).	SCAS Sept 2016.
Confidentiality Policy (Corporate Policy & Procedure No. 8).	SCAS December 2014.
Positive and Proactive Care: reducing the need for restrictive interventions.	DH, 2014

14. Associated documentation

- SCAS Consent Policy and Procedure.
- SCAS Safeguarding Vulnerable Persons Policy and Procedure.
- SCAS Patient Information and Confidentiality Policy.
- SCAS Duty of Candour Policy.
- SCAS Mental Capacity Act 2005 Policy and Procedure.
- SCAS Adverse Incident Reporting policy.
- Joint Working Protocol (Thames Valley).
- Joint Protocol Transport and Conveying (Hampshire).

- National Institute for Health and Care Excellence (NICE) guidelines for Mental Health and behavioural conditions.

Appendix 1: Review Table

Version	Reason for change	Overview of change
V1.1	Transferred into new Trust template.	New headings used in line with Trust template.

15. Appendix 2: Responsibility Matrix – Policies, Procedures and Strategies

Policy Group	Lead Director / Officer	Working Group	Committee	Board Ratification
Strategies	As appropriate	As appropriate	As appropriate	Required
Standing Orders & Standing Financial Instructions	Chief Executive + Director of Finance	Not applicable	Audit Committee	Required
Corporate Policies	Chief Executive +Director of Patient Care	As appropriate	Quality and Safety Committee	Required/ Committee decision
Health and Safety Policies and Procedures	Director of Patient Care	Strategic Health, Safety and Risk Group	Quality and Safety Committee	Health and Safety Policy – Required H&S Appendices – Committee decision
Control of Infection Policy and Procedures	Director of Patient Care	Clinical Review Group	Quality and Safety Committee	Required
Personnel Policies and Procedures	HR Director	Staff Consultation Group	Quality and Safety Committee	Required for new policies. Committee decision for revisions
Financial Policies and Procedures.	Director of Finance	Not applicable	Audit Committee	Required for new Policies. Committee decision for procedural changes.
Operational Policies and Procedures	Director Operations	As appropriate or through Team Meeting	Quality and Safety Committee	Committee decision
Information and IT Policies and Procedures	Director of IT	Information Governance Steering Group	Quality and Safety Committee	Committee decision
Emergency Operational Centre Policies and Procedures	Director Operations	As appropriate	Quality and Safety Committee	Committee decision
Clinical Policies and Procedures	Director of Clinical Services	Clinical Review Group	Quality and Safety Committee	Committee decision

16. Appendix 3: Equality Impact Assessment Form Section One – Screening

Equality Impact Assessment Form Section One – Screening

Name of Function, Policy or Strategy: Mental Health Policy

Officer completing assessment: Sue Putman

Telephone: 07825 680414

1. What is the main purpose of the strategy, function or policy?
The purpose of this policy is to help ensure that health professionals are able to understand and comply with the law and guidelines relating to the care, treatment and transportation of patients with mental disorders.
2. List the main activities of the function or policy? (for strategies list the main policy areas)
The organisational objectives of this policy are to provide an effective framework to assist the Trust in complying with statutory requirements by ensuring that there are arrangements in place for: ✓ Appropriate education for all staff who have direct contact with the patient. ✓ Transport and conveying patients who have been detained under the Mental Health Act 1983. ✓ Effective working relationships with key partners at operational and strategic level.
3. Who will be the main beneficiaries of the strategy/function/policy?
Patients who have been detained under the Mental Health Act 1983 and who require urgent assessment (under s136) and/or transport. All SCAS staff who have direct contact with patients who have been detained under the Mental Health Act 1983. Approved Mental Health Professionals/other healthcare professionals who require transport for a patient who has been detained under the Mental Health Act 1983.
1. Use the table overleaf to indicate the following:- a. Where do you think that the strategy/function/policy could have an adverse impact on any equality group, i.e. it could disadvantage them? b. Where do you think that there could be a positive impact on any of the groups or contribute to promoting equality, equal opportunities or improving relations within equality target groups?

		Positive Impact	Negative Impact	Reasons
GENDER	Women	N/A	N/A	Policy covers all inclusively
	Men	N/A	N/A	
RACE	Asian or Asian British People	N/A	N/A	As above
	Black or Black British People	N/A	N/A	
	Chinese people and other people	N/A	N/A	
	People of Mixed Race	N/A	N/A	
	White/white other	N/A	N/A	
DISABILITY	**Disabled People**	YES	N/A	Will benefit those who have mental illness.
SEXUAL ORIENTATION	**Lesbians, gay men and bisexuals**	N/A	N/A	
AGE	Older People (60+)	N/A	N/A	Policy covers all inclusively
	Younger People (17 to 25) and children	N/A	N/A	
RELIGION/BELIEF	**Faith Groups**	N/A	N/A	As above
	Equal Opportunities and/or improved relations	N/A	N/A	

5. If you have indicated that there is a negative impact, is that impact:		
Yes **No**		
Legal (it is not discriminatory under anti-discriminatory law)		
Intended		
Level of Impact If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.	**High**	**Low**

6(a). Could you minimise or remove any negative impact that is of low significance? Explain how below:
N/A
6(b). Could you improve the strategy, function or policy positive impact? Explain how below:
N/A
7. If there is no evidence that the strategy, function or policy promotes equality, equal opportunities or improves relations – could it be adopted so it does? How?
N/A

Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.
Signed: S. Putman.
Name: Sue Putman
Date: 31/08/2016

17. Appendix 4: National Mental Health Act 1983 *(revised 2007)* [MHA] Section 136 Protocol.

National Ambulance Mental Health Group.

National Mental Health Act 1983 *(revised 2007)* [MHA]
Section 136 Protocol.

Change Control:

Document Number	*V2*
Document	*National MHA Section 136 Protocol*
Version	*(Issued by Document Control Officer)*
Owner	*Association of Ambulance Chief Executives (AACE)*
Distribution list	*England Ambulance Trusts*
Issue Date	*April 1st 2015*
Next Review Date	*By April 1st 2017*
File Reference	*(Issued by Document Control Officer)*
Author	*Mental Health Leads Group (Sue Putman)*

Change History:

Date	Change	Authorised by
December 2013	FINAL version for circulation (v1.5 FINAL)	MH Group Chair & Deputy.
March 2015 V2 released	Review in line with new Code of Practice (2015)	MH Group

Aim:
To ensure that patients detained under Section 136 of the Mental Health Act: "*should always be conveyed in a manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people."* (Mental Health Act [MHA] Code of Practice 2015 para 17.3).

Introduction:
Section 136 of the MHA states:

- **"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 (PoS)".**

- "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".

- "A person removed to PoS under this section may be moved to one or more PoS before the end of the maximum 72 hour period for which they may be detained. **The total period of detention under this section will not exceed 72 hours from the time of arrival at the initial PoS".**

1. Procedure:

1.1 Any Police Officer having detained an individual under s136 of the Mental Health Act 1983 (revised 2007) will contact the Ambulance Trust through a locally agreed route. Where there is an immediate threat to life a 999 call must be made.

1.2 Whenever possible, the following information should be made available at the time of request:
- What is the patient's age?
- Does the patient have any physical disability?
- Is there an obvious need for clinical care?

1.3 The local Ambulance Service Trust will initially respond to the location given. The local Ambulance Service will respond within 30 minutes (dependent on operational demand). The type of response provided will be determined by clinical need. A clinical assessment will be completed to identify any underlying medical/life or limb threatening conditions. It should be noted that on occasion a rapid response vehicle (unable to provide patient conveyance) may be utilised for the initial face to face patient assessment.

1.4 A decision should be made prior to conveyance by the senior ambulance clinician on scene as to whether the patient has a medical need which requires Emergency Department assessment using an agreed assessment criteria – an example of which is demonstrated in ***Appendix 1 and 2***.

1.5 If a decision is made to convey a patient to the designated s136 PoS, the Police should inform the designated PoS and the Approved Mental Health Professional (AMHP) as soon as possible - always prior to the arrival of the patient.

1.6 The Police will remain with the patient during the conveyance.

1.7 Where it is necessary to use a police vehicle because of the risk involved, it may be necessary for the highest qualified member of an ambulance crew to ride in the same vehicle with the patient, with the appropriate equipment to deal with immediate problems. In such cases, the ambulance should follow directly behind to provide any further support that is required. *Mental Health Act 1983 Code of Practice 2015* (*MHA CoP para 17.16*). Where this is necessary the ACPO/AACE guidance should be followed.

1.7.1 Where there are clinical concerns arising from prolonged restraint, an appropriate response will be provided based on clinical need.

1.8 It is generally undesirable and unnecessary to have a person sedated prior to conveyance to hospital. However, there may be occasions where this is deemed necessary and the guidance in the MHA Code of Practice should be followed (*para 17.7*).

2. Escalation:

2.1 When there is dispute within this framework, duty Police Supervisors and on-call Ambulance Trust Managers should be contacted to resolve the difference and ensure an efficient and effective resolution at the time.

2.2 Where concerns remain, these should be raised at the relevant local multi-agency

liaison group.

3. Monitoring.

3.1 A senior professional in each agency will be responsible for the implementation, monitoring and on-going strategic management of this protocol. It is expected that this will be facilitated by local multi-agency liaison groups.

3.2 A formal, two yearly review of this protocol will occur involving those professionals from partner agencies.

3.3 Minor amendments of the protocol may take place from time to time by consultation but without the need to renew the signatures.

Local Police and Ambulance Service employees are responsible for adopting and complying with this protocol in relation to the request for assistance to convey a patient detained under section 136 of the MHA. All agencies will use their best endeavours to work together for the benefit of patients and staff.

PLEASE NOTE the following Appendices are provided as examples only and, if used, can be amended for local implementation.

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1. INITIAL POLICE RISK ASSESSMENT & CALL '999' AMBULANCE

DETENTION UNDER s136 MENTAL HEALTH ACT 1983

S136 'RED FLAGS'? – is a Senior Clinician required?

See overleaf for RED FLAG criteria – utilise BASICS Doctor if necessary (Paramedic / Technician decision only).

2. CONFIRM S136 RED FLAG RISK ASSESSMENT AND CONVEY TO:

1st Resort PoS for	1st Resort PoS	Last Resort PoS
s136 requiring **URGENT** hospital treatment or assessment arising from one or more **RED FLAG** criteria *(see overleaf)* Transferred on, **only** when medically fit for discharge.	NO **RED FLAG** criteria Transferred to ED if **RED FLAG** criteria develop whilst in the PoS	NO **RED FLAG** criteria where they pose: an unmanageably high risk (Inc. assault of PoS or ED staff)
2nd choice PoS?	Identified Alternatives	Exceptional use ONLY
EMERGENCY DEPARTMENT	**PLACE OF SAFETY**	**POLICE STATION**

COMPREHENSIVE HANDOVER BY THE POLICE TO THE NHS

Circumstances of detention, nominal details, risk- based intelligence, other relevant information from FLINTS / PNC

DISCHARGE from s136	**TRANSFER** to PoS	**TRANSFER** to PoS	**DISCHARGE** from s136

REPEAT INFORMATION SHARING UPON TRANSFER

RISK ASSESSMENT OF WHETHER THE POLICE REMAIN

WHEN UNRESOLVED: POLICE REMAIN & DISPUTE REFERRED

Keep reassessing ⟷ *keep reassessing*

i.

S136 RED FLAG CRITERIA (this is not an exhaustive list)

Police Officer / Paramedic triggers for conditions requiring Treatment or Assessment in an Emergency Department

ii.

Dangerous Mechanisms:

Patient has been hit by Taser
Blows to the body (significant potential)
Falls > 4 Feet
Injury from edged weapon or projectile
Throttling / strangulation
Hit by vehicle
Occupant of vehicle in a collision
Ejected from a moving vehicle
Evidence of drug ingestion or overdose

Serious Physical Injuries:

Noisy Breathing
Not rousable to verbal command
Head Injuries:

- Loss of consciousness at any time
- Facial swelling
- Bleeding from nose or ears
- Deep cuts
- Suspected broken bones

Actual (current) Attempt of self-harm:

Actively head banging
Actual use of edged weapon (to self-harm)
Ligature use
Evidence of overdose or poisoning

iii.

Psychiatric Crisis (with self-harm)

Delusions / Hallucinations / Mania

Possible Excited Delirium (agitated patient):

Two or more from:

- Serious physical resistance / abnormal strength
- High body temperature
- Removal of clothing
- Profuse sweating or hot skin
- Behavioural confusion / coherence
- Bizarre behaviour

Senior Clinical Staff where available.
ONLY AT THE REQUEST OF PARAMEDICS / TECHNICIANS – ACCESSED VIA EOC

Where immediate management of RED FLAG conditions necessitates the intervention or skills of a Senior Clinician or where without medical oversight the journey would involve too much risk, ether to the patient, the paramedics or the police officers.

This should include situations where rapid tranquilisation is considered necessary, in accordance with **NICE GUIDELINES 2005**.

Conveyance to the nearest ED:

Should NOT be undertaken in a police vehicle **UNDER ANY CIRCUMSTANCES** where a **RED FLAG** trigger is involved.

This includes remaining in ED until the person is medically fit for discharge to PoS, to Police Station or from s136 detention.

It is the responsibility of the Police to outline to ED the **LEGAL ASPECTS** of detention; it is the responsibility of the Ambulance Service to outline the **MEDICAL ASPECTS**.

When a clinician deems in their opinion a patient requires assessment at hospital this overrides all other situations and the patient MUST be conveyed to hospital

18. Appendix 5: Transport of patients who have been detained under the Mental Health Act 1983. Guidance for staff.

When patient is initially detained:

Patient being transported from:	To:	Requirements:
Home/private address/police station.	Mental Health Unit/ Hospital.	• Section papers – if possible, check to ensure they all have the same patient name and have all been signed. [*This is not a statutory requirement, but is good practice*]. • Completed Authority to Convey Form (provided by the Approved Mental Health Professional [AMHP]). • AMHP is not required to escort the patient.
Public place (including A&E). NOT S136.	Mental Health Unit/ Hospital.	• Section papers – if possible, check to ensure they all have the same patient name and have all been signed. [*This is not a statutory requirement, but is good practice*]. • Completed Authority to Convey Form (provided by the AMHP). • AMHP is not required to escort the patient.
Public place S136.	Mental Health Hospital place of safety (PoS).	• Police Officer who has detained the person is to remain with them. • No papers required by SCAS. • Transport in ambulance vehicle (patient requires initial medical screening to identify any underlying medical conditions).
S136 designated place of safety.	A different S136 designated place of safety (e.g. from police station to health based PoS), Emergency Dept. or Mental Health Unit/Hospital.	• Police Officer (usually the one who has detained the person) is to remain with them. • No papers required by SCAS.
Private place S135 (1).	Mental Health Hospital place of safety.	• **A Constable, AMHP or person authorized by either of them may transfer the person to one or more other places of safety within the 72 hour period.**

If a detained patient absconds on the way to hospital:

- Inform the AMHP.
- Inform EOC/CCC.
- Inform the Police.
- Section papers should be returned to the AMHP.
- Complete Datix.

Photocopies of relevant papers ARE acceptable if the originals are not available.

When patient is already subject to detention:

Patient being transported from:	**To:**	**Requirements:**
Mental Health Unit/Hospital.	General Hospital (planned or emergency).	• Check with MH ward staff. • Section papers and Authority to Convey form are **not** usually required. ○ (Verbal authority given at time of booking transport). • MH ward staff will advise if an escort is required and should provide one if necessary. [*This is not a statutory requirement, but is good practice*].
Mental Health Unit/Hospital.	Mental Health Unit/Hospital.	• Check with MH ward staff. • Section/Transfer papers. • Escort (usually a member of the MH ward staff who knows the patient). [*This is not a statutory requirement, but is good practice*].
Home/private address. Recall from/under: • S17 leave. • Absent Without Leave (AWOL). • Community Treatment Order. • Deprivation of Liberty Safeguards (under Mental Capacity Act 2005).	Mental Health Unit/Hospital.	• **No** section papers or Authority to Convey form required. ○ (Verbal authority given at time of booking transport). • Escort will not normally be provided.
Home/private address. S135 (2) warrant.	Mental Health Unit/Hospital.	• **No** section papers or Authority to Convey form required. • S135 (2) warrant should be available to view. • Escort will not normally be provided.

If the MH ward staff advise the ambulance crew that an escort is not necessary – this is acceptable. Document this clearly in the Patient Clinical Record, including the full name of the member of staff giving this advice. The patient is still lawfully detained and if they abscond:

- Inform MH ward staff (nurse in charge).
- Inform EOC/CCC

- Inform police.
- Complete Datix.

Photocopies of relevant papers ARE acceptable if the originals are not available.

19. Appendix 6 Ratification Checklist

Section 1: To be completed by Author prior to submission for ratification

Policy Title	Mental Health Policy
Author's Name and Job Title	Sue Putman. Clinical Lead, Mental Health & Learning Disability
Review Deadline	
Consultation From – To (dates)	September 2nd 2016 to September 23rd 2016
Comments Received? (Y/N)	
All Comments Incorporated? (Y/N)	
If No, please list comments not included along with reasons	
Equality Impact Assessment completed (date)	August 31st 2016
Name of Accountable Group	Patient Safety Group
Date of Submission for Ratification	

Section 2: To be completed by Accountable Group

Template Policy Used (Y/N)	
All Sections Completed (Y/N)	
Monitoring Section Completed (Y/N)	
Date of Ratification	
Date Policy is Active	
Date Next Review Due	
Signature of Accountable Group Chair (or Deputy)	
Name of Accountable Group Chair (or Deputy)	