

# Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983

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# Summary and recommendations

Section 136 of the Mental Health Act 1983 allows a police officer to remove a person they think is mentally disordered and 'in immediate need of care or control' from a public place to a place of safety, in the interest of that person or for the protection of others.

The person may be detained for up to 72h so that they can be examined by a registered medical practitioner and interviewed by an approved mental health professional (AMHP), and to make any necessary arrangements for their treatment or care.

## MULTI-AGENCY MENTAL HEALTH ACT GROUP

The multi-agency Mental Health Act group convened and chaired by the Royal College of Psychiatrists, examined best practice with regard to Section 136 and produced this position statement and the following recommendations. The group includes representatives of all the professional and monitoring agencies involved in the Section 136 care pathway in England and Wales.

## RECOMMENDATIONS

- 1 The custody suite should be used in exceptional circumstances only.
- 2 A vehicle supplied by the ambulance provider should be able to attend promptly so that it is used for conveyance unless the person is too disturbed.
- 3 The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3h in all cases where there are not good clinical grounds to delay assessment.
- 4 The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act.
- 5 A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases.
- 6 Commissioners should ensure that there is a multi-agency group meeting to develop, implement and quality assure the agreed policy. This group should review the monitoring data. It should also consider how the need for use of Section 136 might be reduced.

# Standards in relation to care provided under Section 136

There are two Mental Health Act Codes of Practice, one for England (Department of Health, 2008) and one for Wales (Welsh Assembly Government, 2008) that make recommendations about the use of Section 136.

The Royal College of Psychiatrists published more detailed guidance that was developed and agreed by all the professional and monitoring agencies involved in writing the report, which covers England and Wales (Royal College of Psychiatrists, 2011). The report provides an example of a mental health monitoring form to assist in communication and monitoring.

# The Section 136 care pathway

## INITIAL DETENTION AND TRANSFER

The person is detained by a police officer and should be informed that this is under the Mental Health Act. If they have committed a significant offence, such as a violent act, they should be arrested for that offence instead and have a subsequent mental health assessment in the custody suite. Both the arrest and detention can be applied at the same time and then the person should be taken to a custody suite.

The person should be transferred to a place of safety by a vehicle supplied by ambulance provider unless it is not safe to do so. Use of a police vehicle may give the person and others the false impression that they have committed a criminal offence and may be a cause of distress or embarrassment. The ambulance staff should provide emergency medical assessment and treatment and assist the police in determining the most appropriate place of safety. The police should escort the individual, as it is not clear in the Act that the power to convey can be delegated. The police should search the person under the Police and Criminal Evidence Act 1984 unless there are clear grounds for not doing so.

## PLACE OF SAFETY

Usually, the place of safety should be within a mental health unit. Very few individuals will require an alternative place of safety; those who require emergency medical assessment or treatment should be taken to an emergency department and only those too disturbed to be safely accommodated in a healthcare-based place of safety should be taken to a custody suite. Local guidance should stipulate other places of safety that may be considered, when and how they should be used, and ensure that the relevant staff are aware of the policy to avoid problems of acceptance for admission to the place of safety or unnecessary transfers between places of safety.

The person may be detained from arrival at the first place of safety for up to 72h. The person may be transferred from one place of safety to another within that time. For example, if the medical issue has been addressed or their behaviour has settled, they could be transferred to a mental health unit. If that would cause undue delay, it may be better for the assessment to occur in the first place of safety. Decisions to transfer a person between places of safety must always be based on individual circumstances, and not for administrative convenience (Department of Health, 2008).

The place of safety must be designed to assist the assessment process and enable a disturbed person to be safely managed (National Institute for Health and Clinical Excellence, 2005). The facility must be locked, spacious and airy. The person should be able to lie down and have access to snacks, drinks and toilet facilities. There should be good exits from the interview room and the furniture should not be able to cause injury. There should be an alarm system to summon extra staff. Resuscitation equipment and emergency medication should be available.

## STAFFING THE MENTAL HEALTH PLACE OF SAFETY

There should be a minimum of two mental healthcare professionals immediately available to receive the individual from the police. If the unit is staffed by community staff, the local monitoring group must assure itself of their availability and of the required competences, including the ability to safely manage disturbed behaviour without police support. Consideration should be given to having dedicated Section 136 staff who can be assigned to other wards or teams when not required in the mental health place of safety (MHPoS). Extra staff should be available at short notice if required.

In most cases the police should be free to leave within 30min, once the staff are satisfied they can safely manage the person. The handover period also allows the police to complete the necessary paperwork for communication and monitoring purposes.

Mental healthcare staff competences should include physical health assessment, risk assessments, physical restraint and the administration of medication as well as the care and comfort of the person and their carers. Mental healthcare staff will often coordinate contacting the doctor and the AMHP who will carry out the assessment and collect background information. They should provide the detained individual with information about Section 136, both orally and in writing.

If an alternative place of safety is used, staff may attend to offer support to the individual and advice to those responsible for their care. They may assist in the transfer of the individual.

It is helpful for the police to be able to contact the person in charge of the MHPoS for advice prior to detaining the person under Section 136, which may allow alternatives to Section 136 to be used.

Staff should have access to medical staff to provide urgent medical assessment, treatment and assistance with risk management.

## MENTAL HEALTH ASSESSMENT

It is recommended that there is a joint assessment between a doctor and an AMHP. Two doctors should be involved from the outset if the person is likely to require detention.

The AMHP should be expected to commence the assessment within 3h, unless there are clinical grounds for delay, such as the person being unfit to be interviewed. In the future, the aim is for assessments to start within 2h. Should a person be seen by a doctor first (which according to the *Code of Practice for Wales* should only happen on an exceptional basis; Welsh Assembly Government, 2008) and there is no evidence of mental

disorder, the person can no longer be detained and must be immediately released. If the doctor concludes that the person has a mental disorder and that although compulsory admission is not necessary they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP. The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care.

The Code of Practice recommends that the doctor is approved under Section 12(2) of the Mental Health Act for this role. If a more urgent medical assessment is undertaken by a doctor without such a qualification, that should not constitute the formal assessment. The *Code of Practice for Wales* (Welsh Assembly Government, 2008) states that the doctor and the AMHP should have specialist expertise in working with children if the detained person is under 18 years or has recently been transferred to adult services. Specialist expertise in intellectual disability is required by the AMHP and the doctor where the detained patient appears to have an intellectual disability. For England, the *Code of Practice* states that this expertise for both categories is desirable (Department of Health, 2008).

The AMHP and the doctor should have prompt access to interpreting and signing services if required.

The assessment may result in one of four outcomes:

- 1 the individual may be further detained;
- 2 the individual may agree to a voluntary admission;
- 3 the individual may be offered follow-up; or
- 4 the individual may be fully discharged.

After the outcome is agreed, the person should be discharged or transferred to hospital as quickly as possible and the local policy should identify the transport arrangements. Failure to discharge promptly compromises the individual's care and means that the MHPoS may be unable to accept another person requiring admission. Thus, issues of local bed shortages need to be monitored.



# Inter-agency group for policy development and monitoring

It is the responsibility of commissioners to ensure there is a local multi-agency group that meets on a regular basis. Members of the group should include representatives from commissioners of local mental health services, mental health service providers (including a consultant and a staff member of the MHPoS), the emergency department, local Social Services authorities (including those with AMHP expertise; for daytime and night-time services if different arrangements exist out of hours), police, ambulance trust(s) and those providing medical care in custody suites, as well as service user and carer representation. As organisations are not coterminous, more than one representative may be required.

## LOCAL INTER-AGENCY POLICY

The multi-agency group should develop the local inter-agency policy, which should be compliant with the Mental Health Act and associated Code of Practice, national guidance (Association of Chief Police Officers, 2010) and the Human Rights Act 1998.

The group should define the responsibility of the commissioners. The clinical commissioners' responsibilities include: the provision of suitable and sufficient MHPoS, with adequate staffing at all times; a contract with the ambulance provider to ensure they can provide the transport in a timely fashion, wherever appropriate; and sufficient appropriately trained medical staff for the mental health assessment. The Local Authority commissions the AMHP provision. To ensure that the inter-agency group can fulfil that role, members should receive regular reports of trends in the use of Section 136, exceptions to performance requirements and remedial action taken.

The policy should offer guidance on the choice of place of safety and when it is appropriate to transfer the person between places of safety.

The responsibility of the ambulance provider to supply transport to the place of safety and for any subsequent journey should be specified.

There should be agreed timescales for the doctor and for the AMHP to commence their assessment, in line with national guidance (Royal College of Psychiatrists, 2011).

## LOCAL INTER-AGENCY IMPLEMENTATION AND MONITORING

The inter-agency group should review the implementation of the inter-agency policy and update it, as required, using comprehensive data from all places of safety.

One agency should have the task of collating all the information for monitoring purposes. This could be the Mental Health Act Office of the mental health service provider.

The multi-agency group should similarly monitor service provision for Section 135 of the Mental Health Act.

The group should ensure that all relevant staff (including ambulance and emergency department staff) are aware of and receive appropriate training in the policy, so that they understand their role and can fulfil their responsibilities. This should include inter-agency training and ideally should involve service users and carers.

## MONITORING OF THE SERVICE

The following information should be routinely collected:

- sociodemographic characteristics of those detained (age, gender, ethnicity)
- mode of transport to place of safety; if not an ambulance vehicle, the reasons for this
- place of safety used; if not the MHPoS, the reasons for this
- any transfers between places of safety and reasons for this
- time taken for AMHP to commence assessment
- time taken for doctor to commence assessment
- whether doctor was approved under Section 12(2)
- time the police remained at place of safety
- time taken to complete assessment
- outcome of assessment (detained, informal admission, community follow-up or discharge)
- total time the person spent in place of safety, from which delays in transfer following assessment can be determined
- serious untoward incidents.

Data should be collected for each place of safety used – the information from all the places of safety should then be collated and reviewed. The multi-agency group should be able to provide these data at the time of Care Quality Commission or Health Inspectorate Wales visits. The group should be aware of the data submitted nationally to the NHS Information Centre from their service in relation to Section 136. A mental health monitoring form in the Royal College of Psychiatrists' report (2011) also offers suggestions for additional monitoring, including patient and carer surveys.

The multi-agency group should develop action plans to address shortcomings in the service and review progress towards their resolution.

The group should consider what steps could reduce the need for Section 136 use and include any agreed proposals in the overall action plan.

# Key messages for commissioners

- Nearly all individuals detained under Section 136 should be taken to a place of safety in a mental health unit. The main exceptions are those requiring urgent medical assessment and treatment and those too disturbed to be safely managed in a hospital setting.
- There must be adequate provision for the anticipated demand. This should include suitable provision to meet the needs of specific groups; in particular, those under 18 years, the elderly and people with intellectual disabilities. The places of safety that can be used should be set out in the local inter-agency Section 136 policy.
- Individuals who are intoxicated should not be excluded from the MHPoS unless they need acute medical intervention or are too behaviourally disturbed to be safely managed.
- The MHPoS must have staff on hand to receive the individual from the police without delay. There should be sufficient staff to cope with all but the most challenging behaviour, without recourse to ongoing police support.
- The MHPoS staff should have the competences of in-patient staff – to be able to assess and manage risk, including physical health issues, and to give medication if required.
- The local contract with the ambulance provider should specify a timely response within 30 min so that a vehicle provided by the ambulance service will be used, unless it is not safe to do so. This does not have to be a front-line vehicle. The contract should allow for a more rapid response if there is no privacy in the public place to protect the person's dignity.
- There should be sufficient AMHPs for the assessment to begin within 3 h, unless there are good clinical reasons to delay.
- The first doctor to complete the formal mental health assessment should be approved under Section 12(2) of the Mental Health Act. It is recommended (and this should happen in Wales, according to their Code of Practice) that the doctor and AMHP should have specialist expertise when dealing with individuals under 18 years and people with intellectual disabilities.
- There should be a local policy agreed by all the relevant agencies, and services should be commissioned to ensure it can be delivered.
- There should be a local inter-agency monitoring group that meets on a regular basis. The group should review the policy and receive collated

data to ensure the care provided is in line with the Code of Practice, national guidance (Royal College of Psychiatrists, 2011) and the Human Rights Act 1998.

- Training, including multi-agency training, should be provided to ensure all staff have the required competences.

# Key questions in reviewing local service provision against national guidance

- How easy is it for those with a mental health crisis to access help? This includes primary care out-of-hours services and emergency departments as well as crisis teams.
- Is the custody suite used in exceptional cases only? What percentage of those on Section 136 are taken to custody suites and how many of these individuals could be managed elsewhere – i.e. because they are not very disturbed? Is there sufficient capacity in the MHPoS for anticipated demand?
- What percentage are conveyed in a vehicle provided by the ambulance service? In what circumstances is a police vehicle used when it is not required for disturbed behaviour? Does the local contract with the ambulance provider state the appropriate timescale for attending of 30 min, with a faster response if there is no privacy in the public place to protect the person's dignity, and is this standard achieved?
- What is the staffing of the MHPoS? Are staff available as soon as the police arrive? Are there sufficient staff to manage moderately disturbed behaviour safely? Are any exclusion criteria being employed (e.g. age, intellectual disabilities, intoxication) and if so, where do these people go? (This should not be a custody suite.)
- Are the facilities in the MHPoS adequate to ensure safety and comfort of staff, patients and carers? (See National Institute for Health and Clinical Excellence (2005) guidance and Royal College of Psychiatrists' (2011) guidance for details.)
- Are there sufficient AMHPs at all times to ensure that the assessment begins within 3h if the person is clinically fit to be interviewed? In what percentage of cases does this happen?
- Are there sufficient Section 12(2)-approved doctors available to ensure that the assessment begins within 3h and that a second doctor is similarly available if required?
- Is the first doctor to assess the patient always approved under Section 12(2)? In what percentage of cases does this happen?
- In what percentage of cases where the person is under 18 years (and those recently transferred to an adult service) or has intellectual

disability do the AMHP and the doctor have specialist expertise in that area? (Specialist expertise is recommended in Wales and required in England.)

- Are there problems in discharging from the MHPoS due to lack of beds or problems arranging transport for discharge into the community?
- Is the person provided with verbal and written information about their detention under Section 136?
- Is there an agreed inter-agency policy?
- Is there inter-agency monitoring of service provision? How are any identified shortfalls being addressed?
- How are data collated and reviewed by the multi-agency monitoring group? Do they review the data that are being collected nationally by the NHS Information Centre to ensure its accuracy?
- What training do all staff involved with the Section 136 care pathway receive, including the police, ambulance and emergency department staff? Do the police receive multi-agency training on mental health, ideally including patient and carer perspectives? This should include use of the Mental Capacity Act 2005 and the Children Act 2004.

# References

- Association of Chief Police Officers (2010) *Guidance on Responding to People with Mental Ill Health or Learning Disabilities*. National Policing Improvement Agency.
- Department of Health (2008) *Code of Practice: Mental Health Act 1983*. TSO (The Stationery Office).
- 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* (Clinical Guideline CG25). NICE.
- Royal College of Psychiatrists (2011) *Standards on the Use of Section 136 of the Mental Health Act 1983 (England and Wales)* (College Report CR159). Royal College of Psychiatrists.
- Welsh Assembly Government (2008) *Mental Health Act 1983: Code of Practice for Wales*. Welsh Assembly Government.