Birmingham and Solihull Mental Health NHS Foundation Trust

BIRMINGHAM & SOLIHULL PLACE OF SAFETY POLICY MULTI-AGENCY POLICY FOR THOSE DETAINED UNDER S135/6 OF THE MENTAL HEALTH ACT 1983

Policy number and category	**C16**	**Clinical**
Version number and date	**7**	**October 2023**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**November 2023**	
Next anticipated review	**November 2026**	
Executive director	**Medical Director**	
Policy lead	**Clinical Director for Urgent Care & Urgent Care Manager**	
Policy author *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

This policy will support the provision of multi-agency services to individuals who are likely to be patients under (s135 / 6) of the Mental Health Act 1983. Use of this policy will ensure compliance with relevant legislation, national guidance, and other sources of standards for the NHS, Birmingham City Council and Police. There are aspects of s135 / 6 operations which are unique to particular agencies, and which do not affect the others. These matters will not be outlined here.

Policy requirement (see Section 2)

- To meet the Mental Health Act (MHA) Code of Practice (CoP) requirement to ensure that a jointly agreed local policy is in place governing all aspects of the use of section 135 and section 136 (CoP 16.31)
- All professionals involved in implementation of the powers should understand them and their purpose, the roles and responsibilities of other agencies involved, and follow the local policy (CoP 16.31)
- Partner agencies should decide when relevant information about specific cases can be shared between them for the purposes of safeguarding the person and the protection of others if there is thought to be a risk of harm. (CoP 16.31)

CONTENTS

1. Introduction

1.1 RATIONALE

1.1.1 Local authorities, NHS commissioners, hospitals, police forces and ambulance services should have local partnership arrangements in place to deal with people experiencing mental health crises.

1.1.2 The objective of local partnership arrangements is to ensure that people experiencing mental health crises receive the right medical care from the most appropriate health agencies as soon as possible. The police will often, due to the nature of their role, be the first point of contact for individuals in crisis, but it is crucial that people experiencing mental health crises access appropriate health services at the earliest opportunity (CoP 16.30).

1.2 SCOPE

1.2.1 This policy applies to all incidents where the use of section 136 or 135 is being considered or applied.

1.2.2 It applies to all partnership employees and those working within the partnership agencies as students or other training roles, secondments or under contract, including agency workers, who are in anyway engaged in the section 135 or 136 process.

1.2.3 There are aspects of s135 / 6 operations which are unique to particular agencies, and which do not affect the others. These matters will not be outlined here.

1.3 PRINCIPLES

1.3.1 Care and treatment should always be a means to promote recovery, be of the shortest duration necessary, be the least restrictive option (Ministerial Forward CoP).

1.3.2 The Royal College of Psychiatrists recommends a maximum period within which to conclude Mental Health Act assessments. Whilst the law allows up to 24 hours to do so, assessment should occur and conclude in most cases within 3 hours.

1.3.3 All parties agree, those detained, or requiring an assessment, are a JOINT management responsibility from the point of detention to the point of disposal or admission and it is every organisation's responsibility to ensure support for the other(s), throughout the period of detention (including conveyance) in accordance with the legislation and guidance.

2. The Policy

2.1 All 135 and 136 assessments be completed within 3 hours of arrival at the place of safety (CoP 16.47).

2.2 A hierarchy of approach to assessments. Starting at best practice and working from that to less desirable but other lawful approaches.

2.3 Intoxication (whether through drugs or alcohol) should not be used as a basis for exclusion from places of safety (CoP 16.44) except in circumstances set out in this policy.

2.4 Managers from all partnership agencies will meet quarterly to review, monitor compliance, and address issues relating to the implementation of this policy (CoP16.35).

3. The Procedure

3.1 SECTION 135 (1)

3.1.1 When a person is believed to be suffering from mental disorder and is being ill-treated, neglected, or kept otherwise than under proper control, or is unable to care for themselves consideration can be given to applying for a warrant (CoP 16.3).

3.1.2 The purpose of a section 135(1) warrant is to provide police officers with a power of entry to private premises, for the purposes of removing the person to a place of safety for a mental health assessment or for other arrangements to be made for their treatment or care (CoP 16.3).

3.1.3 The warrant must be applied for by an AMHP (CoP 16.3).

3.1.4 The warrant gives any police officer the right to enter and search the premises, by force if necessary (CoP 16.4).

3.1.5 When acting on the warrant, the officer must be accompanied by an AMHP and a doctor (CoP 16.4).

3.1.6 Following entry under section 135(1), the AMHP and doctor between them should determine whether the person needs to be taken to a place of safety for further assessment or for arrangements to be made for their treatment or care (CoP 16.7).

3.1.7 The AMHP and the doctor may convene a mental health assessment in the person's home if it is safe and appropriate to do so and the person consents to this (CoP 16.8).

3.1.8 Reliance upon section 135 to gain entry in an emergency situation may be inappropriate due to the time it can take to obtain the necessary warrant. The police may use their power of entry under Section 17(1)(e) of the Police and Criminal Evidence Act 1984 (PACE) for the purposes of saving life or limb or preventing serious damage to property: However, this does not confer on the police any power to remove the person to a place of safety or to detain them (CoP 16.13).

3.1.9 The power to detain a person under section 135(1) ceases once an application for further detention has been made under the Act, other arrangements have been made for their treatment or care, or it has been decided that no further action is to be taken in respect of the person (CoP 16.7).

3.2 SECTION 135 (2)

3.2.1 The purpose of a section 135(2) warrant is to provide police officers with a power of entry to private premises for the purposes of removing a patient who is liable to be taken or returned to hospital or any other place or into custody under the Act (CoP 16.14).

3.2.2 Such a warrant may be used, for example to help return a patient who has absconded, or who needs to be transported to hospital, if access to the premises where they are staying has been refused or is likely to be refused (CoP 16.14).

Normally a Section 135(2) warrant will be secured by BSMHFT staff each Hospital / Programme will have its local arrangements (in secure care this will be done by the NHS Employed social worker attached to the team or on call as appropriate).

3.2.3 When a warrant issued under section 135(2) is being used, it is good practice for the police officer to be accompanied by a person with authority from the managers of the relevant hospital (or local authority, if applicable) to detain the patient and to take or return them to where they ought to be (CoP 16.15).

3.2.4 When present, the person with authority will escort the patient or meet them on arrival at the place of safety, in order to ensure continuity of care and to provide information for the hand-over. The police should not normally be needed to transport the person or to escort them for a section 135 warrant but may do so in high-risk situations.

Transportation will be arranged in line with the Mental health act code of practise .where section 135(2) is used the responsibility for Organising transport for the patient to be returned to the Hospital after the police have gained entry and detained the patient rests with the admitting hospital(the Hospital from which the Patient is AWOL) . CTO recall and restricted patients who are recalled are treated as being AWOL from the Hospital where they are due to be admitted to.

Such transport may be the Hospitals own transport/ secure transport provider for BSMHFT. In all circumstances as a minimum a RMN from the Hospital from which the patient is AWOL/HTT will form part of such transport.

The Police May be asked to be part of the transport if the risks posed are considered High and not manageable otherwise especially if force has been needed to gain entry and restraint has been needed to gain control of the patient by the police or the Patient is a restricted patient who has been recalled by the MOJ .

3.3 SECTION 136 PRE DETENTION

3.3.1 A police officer may use section 136 if they encounter the person in a public place, including if they are already on scene, responding to a call, are approached, or otherwise comes into contact with the person (CoP 16.19).

3.3.2 Section 136 is not intended to be used as a way to gain access to mental health services and the person should be encouraged to take a route via primary care services, or to contact local mental health community services. A police officer may, without the use of section 136 powers, decide to escort a person who is voluntarily seeking urgent mental healthcare to an appropriate service (CoP 16.21).

3.3.3 When considering the use of police powers to detain people under the Act, less restrictive alternatives to detention should be considered. Health and/or social care professionals may be able to identify alternative options.

3.3.4 Whenever possible, before using 136 powers, police should seek advice from a mental health professional. Such advice can be obtained from Street Triage between 10.00hrs and 02.00hrs 7 days a week on **07799 459304.** Triage will provide advice to any Officer or Clinician that is with a person appearing to be experiencing a mental health crisis. Outside of these hours, advice can be obtained from Mental Health bed managers on 0121 301 2345.

3.3.5 The purpose of removing a person to a place of safety in these circumstances is only to enable the person to be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made for the person's care and treatment. It should not be used as a substitute for, or affect the use of, other police powers (CoP 16.25).

3.4 SECTION 136 POST DETENTION

3.4.1. Section 136 assessments will be carried out as detailed in Appendix 2 **Descending Heirarchy of 136 Assessments**. The Heirarchy is intended to ensure those detained are assessed as soon as possible, ideally within 3 hours, as required by best practice and the prinicple of least restrictive practice.

3.4.2 The patient should be searched under s32 PACE. Any items which are considered to pose a risk of harm to others may be seized and they should be retained by the Police Officers until handed to the Place of Safety staff (not to ED staff) or to the Custody Officer at the Police Station. NHS staff should note that this search is limited to a physical 'pat-down', to searches of pockets and bags. The individual can only be requested to remove their hat, outer coat and / or gloves – it will not be a strip or intimate search, as defined by PACE.

3.4.3 NHS staff also have the power to search (CoP 8.29), should this become necessary during the period of detention and police officers have left the PoS.

3.4.4 The maximum period a person may be detained under section 136 is 24 hours. In practice, detentions should not need to be this long. The imposition of consecutive periods of detention under section 136 is unlawful. The maximum period begins at the time of arrival at the first place of safety (including if the person needs to be transferred between places of safety). A person is defined as 'arriving' at a Place of Safety when the health professional or custody officer is informed that they are at the location. Making patients wait outside the building does not extend the period of lawful detention.

3.4.5 The registered medical practitioner who is responsible for the examination of a person detained under section 135 or 136 may, at any time before the expiry of the period of 24 hours authorise the detention of the person for a further period not exceeding 12 hours. This may only occur if the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment to be completed (MHA 136B).

3.4.6 If the person is detained at a police station/Custody suite, the assessment Mental health act assessment would be carried out or completed at the station/custody suite within 3 hrs in line with this policy .Transport to a health based place of safety will be considered only if this time is likely to be exceeded and it is safe to do so. The registered medical practitioner employed by the Police may give an authorisation to extend, only if an officer of the rank of superintendent or above approves it.

3.4.7 People detained under section 136 are sometimes far from home. Arrangements should be in place so that the police can take a patient to the nearest available health-based place of safety, which should admit the person even when the person resides in another area (CoP 16.28).

3.4.8 Within Birmingham and Solihull, the following locations may be used as places of safety. In the first instance:
Place of Safety (PoS), Oleaster, B15 2SY. Telephone 0121 301 2345

Should the PoS not be available then detainees should be taken to an A&E department at one of the city's general hospitals. In exceptional circumstances, custody centres can be used as a PoS.

3.4.9 There is nothing that precludes other areas of a psychiatric hospital (such as a ward) being used as a temporary place of safety, provided that it is a suitable place, and it is appropriate to use that place in the individual case (CoP 16.37).

3.4.10 A police station should not be used as a place of safety except in exceptional circumstances, for example it may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff, or other users if the person were to be detained in a healthcare setting (CoP 16.38).

3.4.11 People taken to a health-based place of safety should be transported there by an ambulance or other health transport arranged by the police who should, in the case of section 136, also escort them in order to facilitate hand-over to healthcare staff.

3.4.12 Healthcare staff, including ambulance staff, should take responsibility for the person detained as soon as possible, including preventing the person from absconding before the assessment can be carried out. The police officer should not be expected to remain until the assessment is completed; the officer should be able to leave when the situation is agreed to be safe for the patient and healthcare staff.

3.4.12 A risk assessment tool provided in appendix C informs when police are required to stay at a place of safety and how differences of opinion will be resolved.

3.4.14 Intoxication (whether through drugs or alcohol) should not be used as a basis for exclusion from places of safety, except in circumstances, where there may be too high a risk to the safety of the individual or staff. Health based places of safety should not be conducting tests to determine intoxication as a reason for exclusion (CoP 16.44).

3.4.15 A person who is detained under section 135 or 136 in hospital pending completion of their assessment cannot have their detention extended by use of section 5(2) or section 5(4) (CoP 16.76).

3.4.16 The imposition of consecutive periods of detention under section 136 is unlawful (CoP 16.26).

3.5 ARRIVAL AT PLACE OF SAFETY

3.5.1 Police will remain with the detainee upon arrival at the PoS for at least the duration of the 'handover period'. This period will include completion of the MHA monitoring form (Appendix D), research by the Officers of the individual's background, for sharing of information and for a joint risk assessment.

3.5.2 In the psychiatric setting, the 'handover period' should include a sufficient period for the PoS to co-ordinate their staff and for a Police Officer to provide a comprehensive briefing of relevant information. It should last no more than one hour.

3.5.3 Following acceptance at a Health PoS, the rights of the detainee will be explained by hospital staff. The explanation of these rights should not be delayed where removal is to Accident & Emergency (CoP 16.69).

3.5.4 Police Officers and PoS staff will then undertake a risk assessment to agree on whether the Police Officers may leave the patient with PoS staff or whether they remain until risks reduce or the MHA assessment is concluded (CoP 16.34).

3.5.6 There should be identified objective reasons, based on risks and threats, for Police Officers to remain after arrival in a psychiatric PoS, utilizing the risk assessment tool (Appendix D).

3.5.7 Disputes in the implementation of this policy or risk assessment conclusions will be referred to the Duty Sergeant and the Duty PoS Manager. Where the disagreement CANNOT be resolved through further discussion, or by the involvement of the Duty Inspector or on-call Manager, compromise will be reached in the following way: -

NHS Managers will have the right to insist upon Police support and it will be given, although Police supervising Officers will have the right to insist on the level of that support (e.g., number of Officers, grade of Officers, etc.).

3.5.8 Risk assessments should be regularly subject to joint-review and the Police should be released, recalled or reinforced, where threats occur.

3.5.9 Operational staff will comply with this compromise and may refer the MHA form to the MAG, in the event that they remain dissatisfied.

3.5.10 To maintain confidence in the support arrangements, the MAG will ensure effective communication and feedback to all operational staff regarding difficulties referred to them.

3.5.11 It is desirable for a specialist Consultant Psychiatrist and / or a specialist AMHP to be available to make the assessment if it appears that the detained individual has a learning disability (CoP 16.48).

3.5.12 Where a patient is released from the Place of Safety, either by hospital admission or complete release from detention, PoS staff should ensure they notify any Police Station currently holding someone under s135/6 and begin to consider the possibility of transferring any subsequent patient at the earliest opportunity.

3.5.13 In extremely rare cases, an individual detained under s135/6, may be detained in Police custody. Custody Sergeants who authorise this detention must contact the PoS to notify them as a matter of urgency. The PoS should ensure they record the order in which such notifications were received and that consideration of transferring any subsequent patients under s136 (3) for assessment is made in the order in which those patients were Detained.

3.6 TRANSFER BETWEEN PLACES OF SAFETY

3.6.1 Initial management in an ED and / or Police Station should be for as short a period as possible, and individuals should be transferred to the main PoS as soon as possible.

3.6.2 That stated, a transfer should not occur without the authority of an AMHP, a RMP or another healthcare professional who is competent to assess that the transfer will not put the individual's health at risk (CoP 16.57).

3.6.3 Transfer can only be undertaken by a Police Officer or an AHMP or by someone authorised by either of them to do so. Even where authority is delegated, the Police Officer or AMHP retain responsibility for conveyance (CoP 16.54).

3.6.4 Neither should the transfer occur without the agreement of the receiving PoS that they are able to accept the individual (CoP 16.58).

3.6.5 Transfer of an individual should be undertaken by the Ambulance Service, wherever possible. Alternative methods may be used if it is in the best interest of the patient.

3.7 CONCLUSION OF ASSESSMENT

3.7.1 Where assessment concludes that the individual requires admission to hospital as a detained patient, the Police should remain involved in assisting any necessary conveyance if they have remained involved thus far and are required to do so.

3.7.2 Where it has been agreed that the Police should resume other duties, they should not become re-involved in supporting any conveyance unless the risk assessment has altered. Securing arrangements for admission to hospital remains the responsibility of the AMHP and should be obtained via the Ambulance Service.

3.7.3 Once an individual is subject to an application for compulsory admission under the MHA, they are in legal custody of the AMHP (or the applicant). Where the Ambulance Service or the Police Service are requested to convey, authority to do so must be delegated to them by the AMHP and should be done in writing (See Appendix E).

3.7.4 There is no clearly prescribed process by which to determine which organisation bears responsibility for the repatriation of those individuals who are not subject to formal admission under the MHA. In recognition of the principle that the operation of s136 is a joint responsibility, the following compromise is outlined: -

- The Police service will bear responsibility for the repatriation or the costs of repatriation for all those individuals with whom they have remained involved during the assessment process (including those wholly assessed within an ED); AND those who are not deemed by the assessing RMPs as mentally disordered within the meaning of the MHA.
- The NHS will bear responsibility for the repatriation or the costs of repatriation for all those persons who are deemed by the assessing RMPs to be mentally disordered within the meaning of the MHA but with whom the Police have not remained.

3.7.5 This compromise ensures that Police Officers repatriate and manage all those who pose risks and those in relation to whom the power was used in good faith but without utility.

3.7.6 It ensures that the NHS takes responsibility for those low-risk individuals who are mentally disordered, albeit not subject to hospital admission following their s136 assessment and ensures that their conveyance for repatriation is in the most appropriate way.

3.7.8 This should represent a roughly equitable division of responsibility between agencies. Frequency of conveyance upon conclusions should be monitored.

3.8 SHARING INFORMATION TO MANAGE RISK

3.8.1 The Act creates a number of situations where confidential information about patients is legally authorised to be disclosed, even if the patient does not consent. These include:

- reports to the Tribunal when a patient's case is to be considered.
- reports to the Care Quality Commission (CQC) in relation to patients who have been treated on the basis of a certificate issued by a second opinion appointed doctor (SOAD); and
- reports to the Secretary of State for Justice on restricted patients (CoP 10.7).

3.8.2 In addition, where the Act allows steps to be taken in relation to patients without their consent, it is implicit that confidential patient information may be disclosed only to the extent that it is necessary to take those steps. For example, confidential patient information may be shared to the extent that it is necessary for:

- safely and securely transport a patient to hospital (or anywhere else) under the Act.
- finding and returning a patient who has absconded from legal custody or who is absent without leave; or
- transferring responsibility for a patient who is subject to the Act from one set of people to another (e.g., where a detained patient is to be transferred from one hospital to another, or where responsibility for a patient is to be transferred between England and another jurisdiction) (CoP 10.9).

3.8.2 Although information may be disclosed only in line with the law, professionals and agencies may need to share information to manage any serious risks which certain patients pose to others (CoP 10.15).

3.8.3 Where the issue is the management of the risk of serious harm, the judgement required is normally a balance between the public interest in disclosure, including the need to prevent harm to others, and both the rights of the individual concerned and the public interest in maintaining trust in a confidential service (CoP 10.16).

3.8.4 Whether there is an overriding public interest in disclosing confidential patient information may vary according to the type of information. Even in cases where there is no overriding public interest in disclosing detailed clinical information about a patient's state of health there may, nonetheless, be an overriding public interest in sharing more limited information about the patient's current, and past status under the Act, if that will help ensure properly informed risk management by the relevant authorities (CoP 10.17).

3.8.5 Any decision to disclose confidential information about patients should be fully documented. The relevant facts should be recorded, with the reasons for the decision and the identity of all those involved in the decision-making. Reasons should be given by reference to the grounds on which the disclosure is to be justified (CoP 10.18).

3.9 CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

3.9.1 CAMHS PoS is based at the Oleaster adjacent to the Adult PoS.

3.9.2 The service provides for Children and Young Adults up to their 18th birthday.

3.9.3 There is no minimum age limit for detention in hospital under the Act. It may be used to detain children or young people who need to be admitted to hospital for assessment and/or treatment of their mental disorder, when they cannot be admitted and/or treated on an informal basis.

3.10 INITIAL CONVEYANCE

3.10.1 It will be the responsibility of Police Officers to request an ambulance for conveyance following detention under s136. It will be the responsibility of an AMHP to pre-arrange an ambulance for assessments under s135 (CoP 16.41).

3.10.2. It is the responsibility of the ambulance crews to consider the presentation of the patient detained by the Police. Where paramedics or technicians believe that the patient's presentation is such that it requires medical attention, they should advise that the person needs to be removed to an Emergency Department.

3.10.3 Where it is considered that the safety either of the patient, the ambulance staff or the Police Officers would be at risk during transfer, ambulance crews should give consideration to requesting a pre-hospital Doctor via EOC.

3.10.4 Where a pre-hospital doctor is deployed prior to conveyance, Police Officers and paramedics will act in accordance with the advice given. It should be noted that police officers have no power to restrain for the purpose of medication.

3.10.5 Where Police Officers take a decision to expedite conveyance themselves, this should only be used exceptionally, such as in cases of extreme urgency or where there is an immediate risk of violence. These occasions are expected to be rare (CoP 16.32).

3.11 AWOL UNDER s135/6

3.11.1 Where a patient absents themselves from detention under either s135 or s136, the Police and the AMHP will ensure a co-ordinated approach to recovering the patient. However, it should be noted that AMHPs will only be involved in obtaining a warrant under S135(1), but NOT S135(2).

3.11.2 If an individual escapes detention under s135/6 prior to arrival at the PoS, they may be retaken into custody in the subsequent 24 hours period, commencing at the time of escape. If they absent themselves after arrival at a PoS, they may be retaken with a 24-hour period after their arrival at the first PoS to which they were taken (MHA s138 (3).

3.11.3 There is NO power to force entry to premises in order to secure the re-detention of someone who is missing under the MHA, and this extends to a person AWOL from detention under s135 / 6. Where entry needs to be forced in order to re-detain a patient, this must be done under the terms of a warrant issued under s135(2).

3.11.4 Where a person is re-detained, Police Officers should then recommence the process of this policy from Section 3.4, 'POST DETENTION', calling an ambulance and re-risk assessing the appropriate place to which the patient should be removed. This may or may not be the same location to which they were previously heading to or from which they have absconded.

3.11.5 The fact of the escape should be strongly considered when risk assessment decisions are then made about the appropriate PoS to be used and / or whether the Police remain at that location pending assessment.

3.12 INFORMATION

3.12.1 Parties to this policy will share patient information for the purposes of safeguarding the person detained or where detention is being considered, or for the protection of others, if there is thought to be a risk of harm (CoP 16.31).

3.12.2 Where a hospital is used as a place of safety, the clinician in charge must ensure that the provisions of section 132 (giving of information) are complied with. In addition, access to legal advice should be facilitated whenever it is requested (CoP 16.69).

3,12.3 BSMHFT will be responsible for collecting, analysing, and disseminating the information required for monitoring purposes (CoP 16.64).

3.12.4 MAG will decide the most important data for monitoring purposes, and ensure it is collected in a way that allows it to be analysed so that it is of use to all the parties to the policy (16.64).

3.13 MULTI-AGENCY GROUP (MAG)

3.13.1 Oversight of this policy will be maintained by the establishment of a liaison committee, to be known as MAG. The committee will also take responsibility for examining the processes in place for other multi-agency tasks, such as transport of persons under the Act and policies in respect of patients who go absent without leave.

3.13.2 MAG will meet quarterly as a minimum. Any additional meetings, sub-committees or working parties will be at the discretion of MAG.

3.13.3 There will be at least one representative from each of the parties to this policy, who is able to report on the work of MAG, into a governance structure within their own organisation.

3.13.4 Terms of reference for MAG will be developed at its inaugural meeting and ratified by each organisation.

4. Responsibilities

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
All BSMHFT Staff	All staff members are required to ensure they (and anyone they line manage) abide by the BSMHFT requirements as set out in this policy. Staff are responsible for ensuring appropriate documentation and procedures are adhered to as identified in this policy. Where there is a failure to adhere to this policy by BSMHFT staff or partner agencies, staff are required to escalate this as per the policy.	
External Organisations (e.g., Local Authority, West Midlands Police, etc.)	Staff within external organisations are responsible for ensuring appropriate documentation and procedures are adhered to as identified in this policy. Where there is a failure to adhere to this policy, staff are required to escalate this as per the policy.	
Service, Clinical and Corporate Directors	Responsible for ensuring that all managers and staff are aware of the policy and support its implementation where appropriate. This will be particularly pertinent to Urgent Care.	

Policy Lead	To oversee and communicate any amendments during consultation and inception.	
Executive Director	To ensure that the policy is circulated across all services with a clear briefing and that all processes regarding ratification are completed.	

5. Development and Consultation process

Consultation summary		
Date policy issued for consultation	June 2023	
Number of versions produced for consultation	2	
Committees / meetings where policy formally discussed	**Date(s)**	
Trust CGC	June 2023	
PDMG	11.10.23	
Where received	**Summary of feedback**	**Actions / Response**
PDMG	Policy to reference post-incident support toolkit, as this may be required by staff.	Hyperlink included in Section 6, Reference Documents
PDMG	Confirmation required as to where quarterly reports in Section 9 feed into.	Verbal confirmation provided regarding governance arrangements for reporting outlined within this SOP.
PDMG	Phone numbers listed in section 3.3.4 to be confirmed and to identify who would update the SOP if these numbers are changed.	Confirmed and numbers unlikely to change as have been consistent since services commenced.
PDMG	Section 3.4.3: Searching powers of nurses to be made explicit.	No changes made – this information is available in Section 3.4.2.
PDMG	Section 4 to be updated to reflect all the staff mentioned in the body of the policy.	Additional category of 'External Organisations' added, which will therefore cover all staff mentioned in the policy.
PDMG	EIA to be updated.	Complete.
PDMG	Include Appendix document names into the 'Contents'	Complete.
PDMG	Section 5 to be completed.	Complete.

6. Reference documents

- Mental Health Act
- Mental Health Act Code of Practice
- Mental Capacity Act 2005

- Police and Criminal Evidence Act 1984 (PACE)
- **Post Incident Support toolkit for staff**

7. Bibliography

None

8. Glossary

ABD	Acute Behavioural Disturbance
AHP	Approved Healthcare Professional (defined by PACE)
AMHP	Approved Mental Health Professional (defined by MHA)
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust
BCH	Birmingham Children's Hospital
CAMHS	Child and Adolescent Mental Health Services
CoP	Code of Practice, (either to MHA or PACE, as specified).
D&A	Drugs and Alcohol
DPA	Data Protection Act 1998
ED	Emergency Department
EOC	Emergency Operations Centre
FME	Forensic Medical Examiner (also known as Police Surgeon)
LD	Learning Disability
MAG	Multi Agency Group (who have oversight of this policy)
MHA	Mental Health Act 1983
NoK	Next of Kin
PACE	Police and Criminal Evidence Act 1984
PCT	Primary Care Trust
PoS	Place of Safety
PS	Police Station
RLOC	Reduced Level of Consciousness
RMP	Registered Medical Practitioner
WMAS	West Midlands Ambulance Service
WMP	West Midlands Police

9. Audit and Assurance

8.1 Monitoring will be dealt with by the Multi Agency Group (MAG) and Strategic Liaison Committee. They will have primary but not sole responsible for audits and monitoring in line with the Act.

8.2 It is a requirement of the Code of Practice that a multi-agency group exists. All Signatories to this policy will be a member of MAG (CoP 16.31).

8.3 MAG will meet at least once every quarter.

8.4 MAG will develop its own Terms of Reference, which must include, monitoring the impact of s135 and s136 on individuals who belong to groups with protected characteristics, as defined by the equality act. This does not preclude MAG from monitoring the impact on other groups.

8.5 The Police will ensure provision and Health service provider will ensure collation of Mental Health Act monitoring forms. These will ensure the basis of overseeing the use of s135 / 6 powers in the area. They are legally required and of critical importance (CoP 16.64).

8.6 Completed forms will be sent to the Bed Management Office at Oleaster, who will scan the forms onto the electronic care record.

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Managers from all partnership agencies will meet quarterly (Sec 2)	Urgent Care Manager	Minutes from Multi Agency Group (MAG)	Quarterly	Urgent Care Clinical Governance Committee.
Average duration of detention under 135/6 and percentage of detentions that exceed three hours.	Urgent Care Manager	Monthly Returns submitted to MAG	Quarterly	Urgent Care Clinical Governance Committee
Average time police officers spend with detainees and percentage of occasions the time spent by police exceeds one hour.	Urgent Care Manager	Monthly Returns submitted to MAG	Quarterly	Urgent Care Clinical Governance Committee
Percentage of detentions that ended with no service being imposed or offered to the detainee	Urgent Care Manager	Monthly Returns submitted to MAG	Quarterly	Urgent Care Clinical Governance Committee

10. Appendices

10.1 Appendix 1: Equality Analysis Screening Form

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	MULTI-AGENCY POLICY FOR THOSE DETAINED UNDER S135/6 OF THE MENTAL HEALTH ACT 1983		
Person Completing this proposal	Bethany Solway	**Role or title**	Operational Manager A&UC
Division	Acute & Urgent Care	**Service Area**	Urgent Care
Date Started	June 2023	**Date completed**	June 2023
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy will support the provision of multi-agency services to individuals who are likely to be patients under (s135 / 6) of the Mental Health Act 1983. Use of this policy will ensure compliance with relevant legislation, national guidance, and other sources of standards for the NHS, Birmingham City Council and Police. There are aspects of s135 / 6 operations which are unique to particular agencies, and which do not affect the others. These matters will not be outlined here.			
Who will benefit from the proposal?			
Individuals under s135 or s136 of the Mental Health Act			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
Affects all individuals who are under s135 or s136 of the Mental Health Act and who are utilising a Place of Safety. This policy applies to BSMHFT staff, West Midlands police and potentially other outside agencies.			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
No – this is a review of current policy, so service delivery and processes are already in place.			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			

No – this is a review of current policy, so service delivery and processes are already in place.				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
Applies to all individuals who are under s135 or s136 of the Mental Health Act and who are utilising a Place of Safety. There are known inequalities (gender and ethnicity) in who is detained under s135 or s136 but the process of putting someone on a section happens prior to the enactment of this policy. This policy outlines the process for providing consistent care to all who are on a s135 or s136 regardless of their gender or ethnicity.				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box or leave blank if you feel there is no particular impact.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	X			It is anticipated that age will not have a negative impact in terms of discrimination as this policy ensures that all patients should be treated in a fair, reasonable and consistent manner irrespective of this.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	X			Provision is made in the Place of Safety for those with physical disabilities (e.g., accessible bathroom is available, space is accessible). Section 3.5.11 of this Policy specifies the additional considerations that should be given for those with a learning disability, as per the MHA Code of Practice.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				

Gender			X	Mixed gender staffing is available in the Place of Safety, but same-sex staffing might not always be provided.
This can include male and female or someone who has completed the gender reassignment process from one sex to another. Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	X			No impact. It is anticipated that Marriage or Civil Partnership will not have a negative impact in terms of discrimination as this policy ensures that all patients should be treated in a fair, reasonable, and consistent manner irrespective of this.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters. Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			Section 3.3.4 of this policy states that, before using their powers, Police are encouraged to contact the Street Triage team for mental health input. Team would signpost policing staff to Perinatal and Postnatal mental health teams, if appropriate.
This includes women having a baby and women just after they have had a baby. Does your service accommodate the needs of expectant and post-natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation into pregnancy and maternity?				
Race or Ethnicity	X			Statistically, staff from a BAME background are more likely to be put on a s136. Section 3.3.4 of this policy states that, before using their powers, Police are encouraged to contact the Street Triage team for mental health input. This will help to facilitate any decision to enact s.135/s.136 powers being based solely on the mental health presentation (and risk associated with their mental health). This policy is standardised and so everyone is treated as per the process outlined within.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				

Religion or Belief		X		The legality of s.135 and s.136 under the Mental Health Act means an individual is not free to leave the Place of Safety until an assessment is taken place. Individuals are therefore unable to access a specific prayer room, but individuals would be able to request to speak to the Trust's Spiritual Care Team.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			No impact. It is anticipated that sexual orientation will not have a negative impact in terms of discrimination as this policy ensures that all patients should be treated in a fair, reasonable, and consistent manner irrespective of this.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			This policy is standardised and so everyone is treated as per the process outlined within. Individuals are to be treated and accommodated in line with their identified gender.
This will include people who are in the process of or in a care pathway changing from one gender to another. Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	X			This policy focuses on the restrictive interventions of a s.135 and s.136, as per the Mental Health Act. Basic rights for all individuals are met, in line with the Human Rights Act.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		

What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact
			X	

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?

Mitigating throughout the policy.

How will any impact or planned actions be monitored and reviewed?

Through the MAG group, as outlined in this policy.

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic?

This policy is a Trust-wide policy, which can be accessed by all staff.

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Descending Hierarchy of 136 Assessments

1. At the time of writing this policy, approximately 70% of those detained under section 136 within Birmingham and Solihull, are not subsequently detained under another part of the act. Many are detained for long periods of time. 10 hours is not unusual. 20+ hours is happening all too often. Frequently this is due to either AMHPs or Section 12 Doctors being unavailable. The purpose of the Descending Heirarchy of 136 Assessments, is to ensure legal compliance with the Mental Health Act, while pursuing best and least restrictive practice.
2. Doctors examining patients should, wherever possible, be approved under section 12 of the Act. Where the examination has to be conducted by a doctor who is not approved under section 12, the doctor concerned should record the reasons for that (CoP 16.46).
3. Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment. It is good practice for the doctor and AMHP to attend within three hours; this is in accordance with best practice recommendations made by the Royal College of Psychiatrists (CoP 16.47).
4. The assessment should be undertaken jointly by the doctor and the AMHP (CoP 16.47).
5. In the event a section 12 doctor cannot commence an assessment within 3 hours another doctor will be sought as soon as this is known.
6. When the assessment is being carried out by a doctor other than a section 12 doctor, and that assessment is taking place within an Emergency Department, where possible, a Liaison Psychiatry assessment should be carried out by a nurse in the first instance and the findings of that assessment shared with the Doctor who will be carrying out the s136 assessment.
7. In the event that none of the above approaches are possible within 3 hours, which ever approach is first available, that approach will be used to conduct the s136 assessment.

10.3 Appendix 3: Red Flag Criteria

RED FLAG CRITERIA

RED FLAG CRITERIA ***Police Officer / Paramedic triggers for conditions requiring Treatment or Assessment in an Emergency Department***	
Dangerous Mechanisms: Blows to the body. 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
Attempting self-harm: Head banging. Use of edged weapon (to self-harm) Ligatures History of overdose or poisoning **Psychiatric Crisis** Delusions / Hallucinations / Mania	**Possible Excited Delirium:** 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
BASICS Doctors: **ONLY AT THE REQUEST OF PARAMEDICS / TECHNICIANS – ACCESSED VIA EOC** Where immediate management of RED FLAG conditions necessitates the intervention or skills of a doctor 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**.

10.4 Appendix 4: Risk Assessment Tool, S136(2) MHA

RISK ASSESSMENT TOOL, S136(2) MHA

POLICE SUPPORT WITHIN THE PLACE OF SAFETY		
LOW RISK	**MEDIUM RISK**	**HIGH RISK**
Current / recent indicators of risk	**Current / recent indicators of risk**	**Current / recent indicators of risk**
No currently present behavioural indicators (other than very mild substance use) **AND** no recent criminal / medical indicators that the individual is violent OR poses an escape risk OR is a threat to their own or anyone else's safety. **OR**	Some currently presented behavioural indicators (including substance use) **AND / OR** some recent criminal / medical indicators that the individual may be violent OR is a threat to their own or anyone else's safety. **BUT**	Currently presented behavioural indicators (including significant substance intoxication) **OR** significant recent criminal or medical indicators that an individual is violent OR is an imminent threat to their own or anyone else's safety OR
Previous indicators	**Previous indicators**	**Previous indicators**
Which are few in number AND historic OR irrelevant. **BUT** Excluding violence graver than ABH and not involving weapons, sexual violence or violence towards NHS staff or vulnerable people	Limited in number OR historic OR irrelevant; including violence graver than ABH or involving weapons, sexual violence, violence towards NHS staff or vulnerable people. **OR** LOW RISK patients who have disengaged from treatment and where there are MEDIUM RISKS threats when disengaged.	Neither limited NOR historic NOR irrelevant; including violence graver than ABH or involving weapons, sexual violence, violence towards NHS staff or vulnerable people. **OR** LOW or MEDIUM RISK patients who have disengaged from treatment and where there are MEDIUM RISKS threats when disengaged.

Police support is NOT required	Police support MAY be required	Police support is VITAL

Where there is dispute within this framework, NHS professionals will have the **right to insist** upon Police support where they believe they require it – Police supervisors will have the **right to insist** on what that support should be. **Each agency will accommodate the other, through this compromise.**

Where the Police feel that the NHS have insisted upon support inappropriately or where the NHS feel the Police have provided too much or too little support, this should be referred to the MAG for resolution and feedback should be provided by Managers to ALL professionals involved.

10.5 Appendix 5: Criminal Offences / s136 Mental Health Act

CRIMINAL OFFENCES / s136 MENTAL HEALTH ACT

1. Where an individual is detained by the Police in circumstances where they could either have been arrested for a criminal offence or detained under s136 of the MHA, they should be arrested and removed to a Police Station unless the offence is so trivial as to be safely set aside for the purposes of prioritising a mental health assessment. This might well occur where the offending was very low-level, possibly 'victimless' and / or where the behaviour it is most likely to be related to their mental health condition.

2 It is ultimately up to the discretion of the arresting Officer as to whether to prioritise the offence or s136, where both options exist.

3 For offences which are not trivial, including offences of violence against NHS staff prior to or after arrival at the PoS, an arrest should be made, and a Mental Health Act assessment considered alongside the criminal investigation in Police custody.

4 However, following any arrest for an offence, an ambulance should still be called where the individual is presenting with any of the Red Flag conditions outlined above.

5 They should then be considered for removal to an ED prior to detention in Police custody, subject to any advice given by the Ambulance Service.

6 Where an offence of violence is committed against NHS staff after arrival at the Place of Safety setting, specific and immediate consideration should be given to them being arrested for the offence, removed to a Police Station and their mental health assessment occurring alongside the criminal investigation. Patients who manage to assault NHS staff, by definition, pose an 'unmanageably high risk' and violence towards NHS staff is always unacceptable.

7 There should be NO assumption by Police Officers or anyone else that, because someone was detained under s136 of the MHA at the point where they have offended, they are automatically unable to be prosecuted because of their mental health condition. A thorough criminal investigation of the incident should occur on each occasion, without prejudice or presumption, and Police supervisors should always be directly involved in overseeing this investigation.

8 All incidents of violence or damage towards staff within the Place of Safety staff or property should be referred to the MAG.

11. SIGNATORIES

Birmingham & Solihull ICB		**Date**	
NHS PoS Manager		**Date**	
NHS ED Manager		**Date**	
AMHP Manager		**Date**	
CAMHS Lead		**Date**	
Learning Disabilities		**Date**	
Ambulance Manager		**Date**	
Senior Police Officer		**Date**	