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| Title of Policy | Inter-Agency Policy for the Assessment of People Detained Under Section 136 of the Mental Health Act | C:\Users\gladwins\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\NWSRXSGC\NELFT logo RGB (3).jpg |
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| Date equality impact assessment carried out: |  |
| Related to other policies | Mental Health Act Overarching Policy |  |
| Version number |  |  |

* Authors must ensure that the title of the policy clearly reflects the content which will enable
* Staff to easily locate the document on the intranet.
* Complete all sections below. The font type must be Arial 11 point throughout the document. Line spacing to be single, paragraphs left justified.
* Authors to ensure gender neutral language is used throughout the policy. e.g. they instead of she/him and partner instead of husband/wife.
* This document must be no more than 12-15 pages long (excluding EQIA, stakeholder list and appendices). Policies larger than this will be returned to the author. If flowcharts or tables are required, please note where these are to be inserted within the body of document and email these separately to policies@nelft.nhs.uk who will insert them.
* When the draft is complete it can be submitted to the policy administrator via email.

Note: Appendices must be emailed separately to policy administrator at policies@nelft.nhs.uk and these will be added as hyperlinks in the final document.

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| **1.** | **‘At a glance’ summary/ key message of policy** |
|  | Section 136 is a police power within the Mental Health Act 1983 that allows any police officer to detain a person in a public place who appears to be mentally disordered and to be in immediate need of care or control and take them to a place of safety for assessment by a doctor an Approved Mental Health Professional. This Policy sets out the powers of the Section and the process that is followed to implement it. Detention under the Mental Health Act 1983 (MHA) is an emergency measure, which needs to be used with care and discretion. The act of detention, in common with other activities under the MHA, is an infringement (however necessary and justified by circumstances) of a person’s independence and normal civil liberties. It is, therefore, necessary that a clear procedure is adhered to by all concerned. As it is a power that requires the co-operation of different agencies the Policy has an emphasis on the separate roles of not only the police but the Trust, Social Services, the ambulance service and others. |

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| **2.** | **Just Culture Statement** |
|  | As part of our Just and Compassionate Culture commitment, we aim to create an engaging place to work, where everyone feels valued, supported and able to be their authentic selves without fear of discrimination based on any protected characteristic.  Developing a Just and Compassionate Culture is about valuing diverse perspectives, and using them to encourage both accountability and development, by promoting a culture based on fairness, respect, honesty and trust, ensuring that we have consistent leadership behaviours and styles across the trust.  We appreciate that things do go wrong and as human beings, mistakes can be made. We strive to empower colleagues to learn when things do not go as expected, rather than feeling blamed and for this learning to be shared across our organisation to deliver positive change for our patients and colleagues.  A Just and compassionate culture is a culture built on trust and transparency and we will focus on a restorative approach to supporting colleagues affected by any interpersonal conflicts, adverse events, errors or incident, whilst holding to account and taking appropriate actions against those who disregard those values or wilfully breach them.  You will be included and appreciated when sharing your voice, for it is a reality that we are all learning while working together. Our professional relationships are built on a foundation of mutual respect, trust and honesty and continuous learning. |

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| **3.** | **Assurance statement** |
|  | The purpose of this Policy is to ensure that use of S136 within the Trust is as far as possible controlled within the legal and good practice framework represented by the MHA and its Code of Practice. The Policy sets out the powers provided by the MHA as amended by the Mental Health Act 2007 and the Policing and Crime Act 2017. It gives guidance on those aspects of Section 136 usage that are left to local practice as agreed between NELFT and its partners, particularly the local police forces, local social services, LAS and BHRUT and Barts Healthcare. It aims to give assurance to services users that S136 will be used correctly in accordance with the law and in response to service user’s needs. |

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| **4.** | **Who should read this document?** |
|  | Within NELFT all staff in Mental Health Services  Outside NELFT, staff in the Metropolitan Police and Essex police , local social services staff , the London Ambulance Service and staff in the Emergency Departments of Barts Health Care NHS Trust and Barking, Havering and Redbridge University NHS Trust.  Approved Mental Health Professionals and other staff as appropriate in local Social Services Departments  Staff in London Ambulance Service (LAS) and Essex Ambulance Service who are Involved in use of Section 136  This policy for Section 136 of the MHA was developed and agreed with the following bodies: -  NELFT, North East London NHS Foundation Trust  London Borough of Redbridge  London Borough of Waltham Forest  London Borough of Barking & Dagenham  London Borough of Havering  Metropolitan Police  British Transport Police  Essex Police  Barking, Havering and Redbridge NHS Foundation Trust  Barts Health NHS Foundation Trust |

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| **5.** | **Aims and objectives** |
|  | i)To provide a local explanation of the power of Section 136 so that all local professionals involved can be fully conversant with its requirements and guidance in the Code of Practice to the MHA 1983  ii)To provide guidance so that use of the power is kept to a minimum  iii)To outline patient’s rights under Section 136 and how these are upheld  iv)To provide a framework for monitoring key aspects of Section 136  v) To define local Places of Safety |

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| **6.** | **Explanation of terms and definitions** |
|  | **MHA –** The Mental Health Act 1983  **MCA –** Mental Capacity Act 2005  **Place of Safety –** a locally agreed and designated place for the reception and safe holding of patients detained under Section 136 or Section 135 of the MHA  **Section 135 –** related power to Section 135 that allows police access to a private address after a warrant has been obtained from a magistrate  **AMHP-** Approved Mental Health Professional with defined powers under the MHA in relation to Section 136  **Section 12 Approved Doctor -** a doctor with *special experience in the diagnosis or treatment of mental disorder* used in the assessment of patients under Section 136  **Definitions**  This Section is defined in the MHA 1983 as follows: -  (*1) If a person appears to a constable 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—*  *(a) remove the person to a place of safety within the meaning of section 135, or*  *(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.*  *(1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than—*  *(a) any house, flat or room where that person, or any other person, is living, or*  *(b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.*  *(1B) For the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force.*  *(1C) Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult—*  *(a) a registered medical practitioner,*  *(b) a registered nurse,*  *(c) an approved mental health professional, or*  *(d) a person of a description specified in regulations made by the Secretary of State.”*  *(2) “.*) *A person removed to or kept at a place of safety under this section may be detained there for a period not exceeding the permitted period of detention 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.*  *(2A) In subsection (2), “the permitted period of detention” means—*  *(a) the period of 24 hours beginning with—*  *(i) in a case where the person is removed to a place of safety, the time when the person arrives at that place?*  *(ii) in a case where the person is kept at a place of safety, the time when the constable decides to keep the person at that place; or*  *(b) where an authorisation is given in relation to the person under section 136B, that period of 24 hours and such further period as is specified in the authorisation.*  *(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the permitted period of detention mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.*  *(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the permitted period of detention mentioned in that subsection.*  *(5) This section is subject to section 136A which makes provision about the removal and taking of persons to a police station, and the keeping of persons at a police station, under this section.* Public Place: where Section 136 can be used It is the police officer’s responsibility to ensure that S.136 is only used to detain a person who is in a place as defined in S.1361A to 1C. In broad terms this means that S.136 cannot be used in any private residence including attached yards, gardens or outhouses.  **Place of Safety:**  Section 135(6) defines a place of safety as a residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1983, a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient. It also allows for a private house or flat to be a place of safety, but it is not envisaged that this will be made use of within NELFT’s area.  S.136(1)b makes clear that a police officer can invoke S.136 when the person is already in a place of safety within the meaning of the section.  Although primarily for patients detained under S.136 it is lawful for a person subject to S.135 to be brought to a place of safety for the assessment to be continued there. |

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| **7** | **Policy/Guideline/ Protocol** |
|  | 7.1 NELFT and its partner agencies strongly support the principle that wherever possible  the local psychiatric inpatient unit, Sunflowers Court( SFC) should be used as the preferred place of safety.   * + A police station **should** never be used for someone under the age of 18 as this is explicitly prohibited by S.136A(1).   + A police station may still be used for an adult in circumstances as specified in regulations. In the NELFT area this is likely to be very rare and to be where the detainee’s level of violence does not allow them to be safely left at a hospital   + Local Emergency Department’s(ED) **should** be used where concern about the detainee’s physical health indicates that immediate medical assessment/intervention is necessary.   + It is also accepted that local EDs act as a back-up and support to the S136 Suite at SFC   The designated places of safety locally are listed in Appendix 1.  7.2 Where Sunflowers Court is used, preference is given to the S136 Suites.  However, it is the hospital as a whole that is the place of safety not the S136 Suite and use could be made of an inpatient ward if necessary.  7.3 Where it appears to either the police or ambulance staff that the person detained has immediate medical needs that take precedence over the need for a psychiatric assessment they should be taken direct to the local ED. Once any immediate medical needs have been addressed the patient can then be assessed under S136 whilst at ED or if necessary, transferred to a psychiatric unit. (S136) (3). Where ED is the place of safety it is again the hospital as a whole which is the ‘place of safety’. This means that where necessary a patient can be moved from ED to an inpatient ward or taken direct to an inpatient ward.  7.4 Where a police station is used as a place of safety speedy assessment is more than  ever essential to ensure that the person spends no longer than necessary in police  custody but is either returned to the community or transferred to hospital. As an alternative the Bleep Holder may negotiate for Police Officers to remain at the  S136 Suite until it is possible to assess the patient’s safety and it is safe for police to  leave.  7.5 Although the Police should try to establish the person’s usual address, any person  detained in NELFT’s catchment area should be taken to one of its places of safety.  The ability to use S136 should not prevent Police from making a routine check on  MERLIN to see if someone is a ‘missing person’. In appropriate cases, it may be  possible to return a person who is lost to their home without needing to detain them  on S.136.  **Police Procedure when initiating use of S136**  7.6 Depriving a person of their liberty is a serious step. The MHA authorises any Police Officer to make a decision about whether someone is in a place coming within the scope of this section and is mentally disordered and in need of immediate care or control.  Before deciding to remove a person to a place of safety a police officer must (S.136(1C) **if it is practicable to do so** consult a registered medical practitioner, registered nurse, AMHP or other person as specified in Regulations. In practice in NELFT preference will be given to consultation with a member of the Street Triage team, an AMHP from the relevant local authority area or the bleep-holder at Sunflowers Court.  The Police Officer must decide whether an ambulance is necessary. If so a 999 ambulance must be called to take the person to the place of safety. In this circumstance, advice will be taken from the ambulance staff as to whether the place of safety should be and ED. Where an ambulance is not thought by police to be necessary, police transport will normally be used.  The person detained may be searched by the police at any time until the completion of the assessment under S136 if it appears to the police that there are reasonable grounds for doing so( see S136C for the full grounds). Where detainees are brought to a psychiatric facility, the police should advise whether the person has been searched. Where they have not been the Bleep Holder will always ask whether the person has been searched and where they have not may ask for a search to be carried out by police before they leave.  If exceptionally a Police Station is used as a place of safety the police will, if a person wishes, in accordance with Section 56 of PACE, inform the person of the detainee’s choice that they have been detained. In addition, the person has a right to consult a solicitor privately at any time. Normal rights under PACE apply as use of S.136 is considered to be an arrest for the purpose of PACE.  Where a decision is made to use the police station as the place of safety, the police will immediately contact the duty AMHP for the relevant Local Authority area. It will be the Police’s responsibility to identify an appropriate doctor to examine the patient. This will normally be a Forensic Medical Examiner (FME).  Where a decision is made to take the person to a hospital as a place of safety, the police must immediately notify the Bleep Holder.  The Bleep Holder must be given as much supporting information as possible before the detained person’s arrival, including:   1. Circumstance of detention and where picked up by Police 2. Person’s name and address 3. Person’s gender and at least approximate age 4. Anticipated arrival time 5. Any language or communication difficulties the person may have 6. Level of Disturbance and potential violence 7. Other concerns (e.g. possible drug/alcohol effects, taser use, C.S spray effects) 8. Whether the person has been searched   **On arrival at the local Place of Safety**  7.7 On arrival at the Place of Safety the 24-hour period commences. The time of arrival must therefore be recorded by police (Met Police S136 form or Essex Police equivalent) and by the Bleep holder on RIO.  7.8 Responsibility for the detention, care and control of the person will be transferred from the police to the Trust. Clinical responsibility rests with the Duty Consultant Psychiatrist and immediate management and care responsibility with the medical and nursing staff on duty.  **Police Handover**  **Sunflowers Court**  7.9 When bringing a person on S136 to SFC , the Police should normally remain for up to a half-hour period until responsibility for the person is safely handed over to the Trust. Where the person’s safety or the safety of other people requires it, the police will remain until both they, the nurse in charge, or the duty doctor agree it is safe for them to leave. Where there is doubt or disagreement about this the police will consult their Supervising Officer for direction about how much longer they can remain. The Supervising Officer will consult with the Bleep Holder /Duty Doctor before any decision for the police to leave is made.  **Local Emergency Departments**  The position is similar at EDs, but it is accepted that it is more difficult for police to hand over due to the lack of a dedicated secure area for S136 patients. This may mean police having to spend longer to control not only difficult to manage patients but those are risk of going AWOL.  7.10 Information should be shared between the Police and Trust in so far as it is available as there is a ‘need to know’ on the part of the Trust/Social Services in order to carry out their responsibilities under S.136. This may include sharing details of known convictions.  7.11 If the patient’s behaviour deteriorates and the level of violence becomes impossible to cope with, police will attend as a matter of urgency. Consideration would then have to be given to arresting the person for breach of the peace or other criminal offence and removing them to a police station. In these circumstances, the patient may be transferred under S136 for the assessment to be continued at the police station. It is possible for a person to be subject to an arrest under PACE and to Section 136 at the same time. (See Richard Jones, MHA Manual, 25th Edition 1-1406).  7.12 Although the patient is cared for at the Hospital as the place of safety it is stressed that they are not admitted as an inpatient whilst being assessed under S136.  7.13 The person’s relative or carer or friend (as appropriate) should be contacted by the bleep holder/psychiatric liaison team as soon as possible, subject to the patient’s consent, and given information as necessary. If the patient lacks capacity to give this consent it may be possible to contact the relative without the patient’s consent, in their best interests. Care should be taken about this and advice sought from a senior/on-call manager as necessary. In some instances it will clearly be essential to make contact e.g. where the patient is being admitted to hospital and relatives need to know, but in others, it may be that the situation should be left so that the patient can recover and make their own decision about whether a relative should be contacted.  **Assessment: general requirements**   * 1. Section 136 requires the patient to be assessed by: - * Section 12 approved Doctor( as specified by the Code of Practice 16.46) * An Approved Mental Health Professional(AHMP)   7.15 The role of the AMHP includes: -   * Interviewing the person; * Providing the person with clear information on their rights, taking account of language, learning disability or cultural issues; * Contacting relatives and friends as appropriate * Considering any possible alternatives to admission to hospital * Considering the need to make any other “necessary” arrangements, particularly if the patient is assessed as not requiring hospital admission. * Considering whether the patient should be transferred to another place of safety.   7.16 The role of the doctor includes: -   * Examining the person * Assessing their mental state * Establishing their capacity and willingness to agree to any proposed treatment * If admission is required, identifying and admitting to a hospital bed. * Considering whether the patient should be transferred to another place of Safety.   7.17 Unless it is absolutely impracticable the patient’s relative(s) should be contacted either to obtain information from them or simply to inform them that the patient is at a Place of Safety under Section 136. This will be subject to the patient’s permission, without which it is not normally possible to contact relatives as it would involve a breach of confidentiality. Where staff are in doubt they should seek advice from a senior/on-call manager. Contact may be by the assessing doctor or AMHP but in practice may be by the bleep-holder/psychiatric liaison team nurse co-ordinating the assessment, particularly if the purpose is primarily to inform the relative of the patient’s whereabouts. Circumstances where it is impossible would include where the patient refuses to provide any names or contact details, or the relative is unable to be contacted.  7.18 Section 136 allows for a period of detention normally up to 24 hours, however the assessment should be completed as quickly as possible and without use of an overnight stay unless essential.  7.19 The doctor who assessed the patient may at any time before the expiry of the period of 24 hours authorise the detention of the person for a further period of 12 hours. This is only possible where it is not practicable to complete the assessment before the end of the 24 hours. See Appendix 8 for a form the doctor must complete for extensions when at Sunflowers Court. If the person is detained at a police station this extension must still be by the assessing doctor but must also be agreed by a senior police officer (superintendent or above).  7.20 Part 4 of the MHA (the Consent to Treatment provisions) does not apply to persons detained under S136. In the absence of valid consent the person cannot be given compulsory treatment, except:   * If they lack capacity to give consent to treatment and may be treated in their best interests in accordance with provisions of the Mental Capacity Act 2005, Section 5. * If it is an emergency and it is immediately necessary to give fast-acting treatment, e.g. a sedative, to prevent the patient harming themselves or another person this may exceptionally be given under common law powers.   7.21 It is unlawful to attempt to extend the period of detention under S136 by use of a Section 5(2) or 5(4).  7.22 If a patient subject to S136 goes missing before the assessment is completed/the 24 hour period is ended they must be regarded as AWOL and as such can be brought back by the hospital staff or police as long as this is within the 24-hour period of detention. The 24 hours starts from when the person arrived at the first place of safety or the time at which they went AWOL if they go AWOL en route.  **Assessment by Doctor and AMHP**  7.23As soon as the bleep holder/psychiatric liaison team has been informed that the police are bringing a patient on S.136 to the hospital they must inform the Duty Doctor.  7.24 The Duty Doctor must:  Carry out an initial screening of the patient as soon as possible.    7.25 Screening by the Duty Doctor should at a minimum include the following:   * Presenting complaint/behaviour * Mental state, including cognitive functioning * As full a physical examination as possible but definitely to include standard observations * Screening assessment to be written up in **core assessment** * If there is evidence of acute organic problems, patient referred to an ED * Risk assessment should be started   1. The bleep holder may involve a community team as appropriate in the assessment e.g. Home Treatment Team. Street Triage, ACAT. This is good practice but should not be seen as removing the need for an assessment by an AMHP, which is a legal; requirement under S136(1C).   7.27 As soon as the bleep holder/psychiatric liaison team nurse has been notified of the S136 arrival they must contact the duty AMHP for the borough in which the person was picked up or out of hours and request their attendance to assess the patient.   * 1. If the AMHP is not immediately available the S12 doctor (consultant or on- call middle grade) must arrange to carry out an assessment without them:      * + If the Assessing S12 Doctor is confident that the patient does not have any symptoms of mental disorder, the S136 is discharged and the patient is free to leave. See the Code of Practice, 16.50:’ *If a doctor assesses the person and concludes that the person is not suffering from a mental disorder then the person must be discharged even if not seen by an AMHP’.*  At this point the AMPH would be informed and their assessment cancelled. The doctor should write to the patent’s GP.   + However also note 16.51 which is equally important: *If the doctor sees the person first and concludes that they have a mental disorder and that compulsory admission to hospital is not necessary, but that 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.*   7.28 Once the formal assessment by the S12 doctor and AMHP is finished, it should be written up in the progress notes including a risk assessment.  7.29 If it is not possible to complete the assessment within the 24 hour period due to factors such as the patient being intoxicated, being very disturbed, it is possible for the assessing doctor to extend the period of detention by 12 hours. This is done by completing the form at Appendix 8 It is not possible to extend the 24 hour period due to delays in finding a bed to admit the patient to.    See Appendix 5 for detailed guidance on Medical Assessments.  **Children and Young People**    7.31 There are inevitably special sensitivities and concerns about the use of the powers of S136 to detain children and young people under 18. Despite this there are no age-limits to the use of the power and in practice children as young as 12 are detained on S.136. In some circumstances the police can invoke the Children Act 1989, Section 46 to remove a person believed to be under 18 to ‘suitable accommodation and keep them there’. This would not have to be a hospital.  7.32 If a child or young person is brought under S.136 to Sunflowers Court they should be taken to the S136 Suite so that handover from the police can take place as normal.  For further information see Appendix 4 , Protocol for management of Under 18s on Section 136  **Documentation:**  7.33 All Police bringing patients on Section 136 to the Trust must complete a Police electronic **S.136 Form**  7.34 The S136 Form is not a statutory form and it is important to realise that a person is detained under S136 from the moment the police make a decision to use the power, not from the moment the S136 Form is completed. However, it is important that the Form is completed as an on-going record of the episode.  7.35 The form will be sent to the MH Legislation Office who use to update RIO and then upload to Care Docs.  7.36 The Trust bleep-holder must complete the S.136 Record on RIO  7.37 Both the Bleep Holder/ Psychiatric Liaison nurse and the Assessing Doctor and AMHP must record the episode on RiO as appropriate. There should be a RiO record even when the patient is discharged without admission or follow-up or when they are immediately transferred to another place of safety. In the event of future contact this record may prove valuable.  **Acute Behavioural Disorder**  7.38 This is the term used by the Independent Police Complaints Commission, and is defined as a period of agitation, ‘excitability and sometimes paranoid thinking’ along with violent or aggressive behaviour and ‘non pain compliance’. This was often not felt to be helpful by A&E staff, who preferred a description of the behaviour giving rise to concern. The condition may be related to illicit drug use or be combined with other symptoms of drug use.  A person in such a condition is of particular concern because of increased risk of cardiac arrest and Positional Asphyxia at any time.   * Police are trained to recognise the symptoms of acute behavioural disorder. They also have an awareness of the signs of positional asphyxia and are trained in how to avoid it.   At any time in the S.136 episode if anyone (police officer, nurse, doctor, ambulance staff) recognise that somebody appears to be in a state of acute behavioural disorder they will:   * Immediately arrange for the person to be taken to the local A&E, by 999 ambulance * Notify the Bleep Holder at the appropriate hospital within the Trust of this.   The ED will:-   * Treat acute behavioural disorder medically if it is confirmed * Make arrangements, if the person is assessed as **not** having acute behavioural disorder, for the transfer of the patient to a psychiatric unit for the S.136 assessment to be completed.   **7.39 Other Medical Emergencies**  Occasionally a person detained by the Police under S136 may need immediate medical assistance, (e.g. following self-harm behaviour, over-dose or for some other physical difficulty). In these circumstances, the police will take the person or arrange for an ambulance to take the person to the nearest A & E department. If the police bring the person to the psychiatric hospital as place of safety, the duty doctor will direct that the person is transferred immediately to A&E.  **CS Spray**  Very exceptionally someone detained on S136 may have been affected by CS Spray. Police can use this almost as a last resort to control a person who may otherwise be a risk to themselves or others. Staff must accept patients even though CS Spray may have been used, however, they are entitled to seek to minimise the risk of cross-contamination as well as needing to reduce unpleasant effects for the patient. Appendix 2 gives some guidance on minimising the effect of CS Spray and managing patients who are subject to it.  **Taser Use**  Tasers are increasingly used by police and this can include occasions when people detained or about to be detained under S.136 are tasered for their own or other’s safety. See Appendix 6 for guidelines on how to deal with a patient who has been tasered.    **Drunkenness/Drug Influence**  7.40 The influence of alcohol or drugs is not in itself a reason for detention under S.136.  7.41 Where intoxication or a drug-induced state is an aspect of a person’s mental state it is possible that they may be detained on a Section 136.  7.42 It is agreed with local Police that as far as possible and allowing for individual judgement, the following template should be used for dealing with drunkenness: - Drunk and IncapableLocal A&E Department **Drunk but also exhibiting symptoms of mental disorder**  **Place of Safety under Section 136**  **Drunk and Disorderly**  **Police Station**  7.43 Where patients are brought to a psychiatric unit and smell strongly of drink/show signs of heavy intoxication, staff may want evidence from the Police of other indications of mental disorder.   * 1. Where patients are heavily intoxicated the Police may be directed to take them to the nearest A&E which is a safer environment for such a patient, Who will be at risk of asphyxiation.   2. Patients who are intoxicated but still accepted for assessment may have   to be allowed to sober up before they can be assessed.  7.46 Use of S136 solely as a response to drunkenness should be documented on RIO and will be raised as a concern with police.  **Transfers from one place of safety to another**  7..47 The Mental Health Act 2007 introduced a power to transfer patients detained under Section 136 from one place of safety to another as long as this is within the 72-hour period. Guidance on this is given in the Code of Practice 16.53 – 16.58. It is necessary for the transfer to be authorised by an AMHP or police officer.  7.48 This power should be used when during the course of the assessment it becomes evident that the patient’s needs are best met within a different facility. Particular examples are;   * transfer to ED of a heavily intoxicated patient * transfer to ED to deal with a medical issue * transfer to a police station where the patient is showing a level of violence or other unmanageable behaviour that cannot be dealt with within a hospital setting * transfers to the patient’s local psychiatric unit if out of the area, when they know the patient and are in a better position to assess. This could include a client known to EWMHS being transferred to a place of safety closer to their home address and to services they may already have contact with.   7.49 A patient who is transferred to ED may either have the assessment under S.136 completed there or may be transferred back to he psychiatric facility when the medical issue is dealt with.  7.50 The power to transfer may be used where a patient has been brought by police to a local unit and it is found that they reside in another area either within the Trust area or outside of it. However there should be an overriding clinical reason why a patient should be assessed close to where they reside, (e.g. such as that they know the patient well). Otherwise the person should be assessed within the place of safety to which they have been brought. Additionally, sometimes a person’s mental state may be too disturbed to allow them to be transferred until a risk assessment indicates they are calm and more suitable for transfer.  7.51 The question of how to transport the patient must be dealt with by the Bleep Holder/Psychiatric Liaison Nurse who must take into account the needs of the patient, the urgency of the situation and the means of transport available. By preference a patient will be transferred by a LAS ambulance.  **Questions about the lawfulness of detentions**  7.52 Any question about the legality of particular uses of S136 should be raised in the first instance with the MH Legislation Office who will seek advice and pursue with police, AMHPs as necessary. A decision that any Section is unlawful will normally be made by the Head of Mental Health Legislation.  7.53 Patients should not be turned away from the hospital nor should the Trust refuse to accept patients because of alleged unlawful use of S.136. Sections should be presumed lawful until it is established otherwise and assessments should be carried out as normal.  7.54 Any instances of alleged unlawful use will be investigated by the Trust, Police, Social Services and action taken and advice given to patients as necessary.    7.55 All instances that are seen to be unlawful will be managed within NELFT by an entry on Datix. In the first instance this will be the responsibility of the bleep-holders to add. Failing that, the MHA Office team, when monitoring S.136 usage will add episodes to Datix. All episodes should be coded as Unlawful Use of the MHA and will be included in reports on MHA use.  7.56 The Police Liaison Group will routinely discuss use of S136, including any instances of questionable legality and any remedial action taken.  **Accepting Patients on S136/ Existing Inpatients**  7.57 Patients on S136 who are brought to a psychiatric unit as a place of safety, should normally be accepted except when there is an urgent condition (e.g. an urgent medical condition needing attention, suspected over-dose, heavy intoxication) requiring the person to be taken immediately to ED.  7.58 The following are not reasons for refusing to accept patients on S.136:   * Person having been drinking (except where heavily intoxicated) * Person from outside catchment area * Alleged unlawful use of S.136   7.59 In the event of the S136 Suites at SFC being in use the fall-back position is :  - the police should be advised of the position and asked to wait with the patient in the back of the ambulance/police vehicle whilst the situation is assessed/dealt with  - where possible one of the patients in the S136 Suite should be discharged or, if this is not possible because the assessment has not been completed, taken to the appropriate ward where the assessment can be completed  - Exceptionally the police may be asked to take the person to a neighbouring place of safety at a psychiatric hospital e.g. Basildon Hospital Mental Health Unit ). If this occurs a Datix should be raised afterwards by the bleep holder.    7.60 If someone on S.136 is unmanageably violent and cannot safely be left, the police must remain (if necessary after authorisation from their supervisor) until either the patient calms down (perhaps as a result of rapid tranquilisation) or a decision is made to remove them to a different unit/police station.  7.61 Section 136 can legitimately be used to detain an existing detained patient who is on section 17 leave or is AWOL. If the patient is in a place that meets the S136 criteria and the other criteria for use of S136 the police may use the power either as the most direct way of returning them to hospital or because they are unaware of their detained status. In this case the situation is somewhat different in that as an existing inpatient with a bed on a specific ward they should be returned directly to that ward. An assessment by a doctor and an AMHP should still take place before the S136 is ended, to fulfil the legal requirements of the power.  **Mental Capacity Act 2005 (MCA)**  7.62 The MCA took effect from April 2007 and provides powers for the care and treatment of people who lack mental capacity.  7.63 ‘Case law[[1]](#footnote-1)’ has established that it is not lawful for police to use the MCA to bring a person to hospital for assessment in circumstances where either S.136 or S.135  should apply. For the Trust to accept such a person for assessment as if under S.136 or S.135 would itself be unlawful.  7.64 If the Trust is presented with a person brought by the police ostensibly under the MCA the following should apply:   * The person will be accepted and ‘hand-over’ from police to hospital staff can take place * If the person appears to be capable of making their own decision about staying for an assessment of their needs and is prepared to stay they will be assessed as an informal patient. * If the person appears to be incapable of such a decision but is nevertheless not objecting to staying or trying to leave they will be assessed under Section 5 of the Mental Capacity Act. * If the person appears to be mentally disordered but, whether or not they have the capacity to make the decision, is clearly refusing to stay and wants to leave, use will be made of an admission Section of the Mental Health Act and common law used if necessary and appropriate in any intervening time before this section can be put in place.   **Ending Section 136**  7.65 Whatever the outcome of the assessment the patient’s relatives should be informed, subject to the patient agreeing. If the patient does not agree it is not normally possible to their relative being contacted as this would involve a breach of confidentiality. If in doubt, advice should be sought from a senior / on-call manager.  7.66 Following assessment, if the person does not require further detention, the S136 ends and the person is free to leave hospital or be informally admitted. Since the patient has not been admitted there is no requirement for a decision to discharge to be made by a consultant psychiatrist. S136 ends automatically once a full assessment has taken place.    7.67 There is no requirement to provide after-care if the person is assessed as not mentally disordered or in need of treatment.  7.68 Where the person does not require admission but has problems relating to their mental health/personal life they should be referred for appropriate follow-up care by the appropriate mental health or other team in the community. This should be documented in the progress notes and noted on the S136 self-audit form.  7.69 When persons are not being admitted to hospital, it is the responsibility of the Trust and in practice the bleep holder, to make any necessary arrangements for their return home. This should take account of their presentation, circumstances and family support. Options include:   1. Hospital transport, taxi or bus/train fare to get them home should be arranged if necessary. 2. A relative collecting them 3. The person making their own way home if this assessed as safe and appropriate   **Process for Implementation**  7.70 This Policy will be posted on the Trust internet site so that all staff are able to access it.  7.71 Ward/Unit and team managers will highlight the key aspects of this policy for their staff.  7.72 Copies of this Policy will be sent to the Chief Executive of the Local Acute Trusts, Directors of Local Social Services, London Ambulance Services, Borough Commanders of Local Police Forces. |

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| **8.** | **External references and supporting documents** |
|  | The NHS Constitution safeguards the enduring principles and values of the NHS; it sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. NHS bodies and local authorities are required by law to take account of this Constitution in their decisions and actions; therefore all policy documents should consider and take into account the NHS Constitution pledges – NHS Constitution [click here](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)  Mental Health Act 1983  Mental Health Act 2007  Policing and Crime Act 2017  Code of Practice to the Mental Health Act 1983  Reference Guide to the Mental Health Act 1983  Mental Health Act Manual, Richard Jones, current edition |

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| **9.** | **Roles and responsibilities** |
|  | 9.1 Chief executive  9.2 Executive Directors (EMT)  9.3 Head of Corporate Affairs  9.4 Clinical Professional Advisory Group (CPAG)  9.5 Integrated Care Directors  9.6 Assistant Directors  9.7 Operational leads  9.8 Staff  9.9 Authors  9.10 Quality and Patient Safety  9.11 Communications |

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| **10.** | **Equality statement** (Mandatory) |
|  | This policy reflects NELFTs determination to ensure that all parts of our community have equality of access to services, and that everyone receives a high standard of service whether they are a service user, carer, or member of staff.  NELFT NHS Trust is aware of its responsibilities under the Equality Act 2010 which recognises our legal obligations to those with a protected characteristic of age, disability, sex, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity & paternity and marriage/civil partnership and same sex marriage.  The intended purpose of the policy is to anticipate and encompass NELFTs commitment to the prevention of discrimination on any illegal or inappropriate basis, and to respond to the needs of individuals based on good communication and best practice.  To reinforce this commitment and promote a culture free from discrimination, NELFT encourages any service user, carer or member of staff who believes they have been subjected to unfair treatment, to express their grievance, complaint or concern without fear of victimisation, and that it will be investigated promptly and acted upon appropriately.  At NELFT, we recognise that some groups of the population are more at risk of discrimination or less able to access services than others, and to this end, we will continue to deliver services in a way that genuinely acknowledges the importance of an inclusive society, one that promotes opportunities and access, and not barriers to individuals.  NELFT NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights Act, the Equality Act 2010, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap, Accessible Information Standards & Sexual Orientation Monitoring Standard (SOMS). |

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| **11.** | **Consent** (Not mandatory but relevant information should be included in all clinical policies) |
|  | Valid consent to treatment is central in all forms of healthcare.  “Consent” is a patient’s agreement for a health professional to provide care. Patients may indicate consent non-verbally, orally or in writing. For the consent to be valid, the patient must:-   * be competent to take the particular decision * have received sufficient information to take it * not be acting under duress.   Please refer to the Consent to examination and treatment policy.  If there is any indication that the patient may lack mental capacity to consent a mental capacity assessment must be carried out. Please refer to NELFT Assessment of mental capacity policy.  Consent and access to treatment for children and young people: please refer to the Consent to examination and treatment policy. |

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| **12.** | **Implementation process** |
|  | Staff will be made aware of any new approved policies/procedures/guidelines via the Trust weekly newsletter. Quality and patient safety team will be responsible for ensuring newly approved documents are sent to the communications team in order for them to insert into the Trust weekly newsletter. A copy of this policy will be placed on the Trust’s intranet.  All senior managers/heads of service/team leaders need to ensure new policies and procedures are placed on team meeting agendas for discussion. There is an expectation that the team leader will develop local systems to ensure their staff are instructed to read all relevant policies and to identify any outstanding training deficits  For specialist advice on the implementation of this policy, contact the Health and Safety team at [Healthandsafety.team@nelft.nhs.uk](mailto:Healthandsafety.team@nelft.nhs.uk) |

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| **13.** | **Monitoring/review of policy** |
|  | The Metropolitan Police, British Transport Police, Barking & Dagenham, Havering, Redbridge and Waltham Forest Social Services and the Trust will undertake regular monitoring of this procedure via a regular Police Liaison Group.  23. NELFT staff will attend any equivalent group i.e. where S.136 issues are considered as part of the agenda, in South or North Essex in order to raise concerns or deal with issues relating to the use of S.136 for EWMHS clients.  23. The Trust will monitor and audit the Section 136 Procedure and submit regular reports to the MHIPAD LT, Police Liaison Group, and other groups in NELFT’s governance structure as necessary. Such reports will include the following at a minimum:-   * Number of Section 136 detentions by Local Authority area * Number of above resulting in (a) use of Section 2 and 3 of the MHA (b) informal admission to hospital (c) no admission to hospital * Time period between the Section 136 detainee’s arrival at the place of Safety and the completion of the assessment * Breakdown of use of Section 136 by ethnic category * Whether the patient was seen by an AMHP as part of the assessment and the timescales for this.   23. |

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| **14.** | **Training** |
|  | 26. Ward/Unit and team managers will regularly brief staff about this policy and ensure that there is a high level of understanding.  26. S.136 will regularly feature in Trust training on the MHA in both introductory and refresher level.  26. Police will regularly include S.136 in required refresher training.  26. Local Social Services Authorities will ensure that S.136 is included in AMHP initial and refresher training.  26. London Ambulance Service will include S.136 in training for affected staff. |

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| **15.** | **Stakeholder Form mandatory – author to seek peer review prior to submitting for approval. Authors to add names of reviewers and tick appropriate** | | | | |
| **Date sent to stakeholder** | | *(enter date here)* | | | |
| **Stakeholder title** | | | **Comments received** | **Returned, no comment** | **Not returned** |
| Equality & Diversity Manager  [Harjit.Bansal@nelft.nhs.uk](mailto:Harjit.Bansal@nelft.nhs.uk) [Mica.McDonald@nelft.nhs.uk](mailto:Mica.McDonald@nelft.nhs.uk)  [Equality&DiversityAdmin@nelft.nhs.uk](mailto:Equality&DiversityAdmin@nelft.nhs.uk) | | |  |  |  |
| Leadership Team – Essex & Kent  [Kayleigh.gardner@nelft.nhs.uk](mailto:Kayleigh.gardner@nelft.nhs.uk)  [Emma.Vidler@nelft.nhs.uk](mailto:Emma.Vidler@nelft.nhs.uk) & [Claire.Allen@nelft.nhs.uk](mailto:Claire.Allen@nelft.nhs.uk) | | |  |  |  |
| Leadership Team – Barking & Dagenham Locality [Sheila.Wright@nelft.nhs.uk](mailto:Sheila.Wright@nelft.nhs.uk) | | |  |  |  |
| Leadership Team – Havering Locality [Lisa.Askew@nelft.nhs.uk](mailto:Lisa.Askew@nelft.nhs.uk) | | | ☐ |  |  |
| Leadership Team – Redbridge Locality [Neha.Patel@nelft.nhs.uk](mailto:Neha.Patel@nelft.nhs.uk) | | |  |  |  |
| Leadership Team - Waltham Forest Locality [Bernadette.Duffy@nelft.nhs.uk](mailto:Bernadette.Duffy@nelft.nhs.uk) | | |  |  |  |
| Leadership Team - Acute & Rehabilitation Directorate  [Lena.Quinn@nelft.nhs.uk](mailto:Lena.Quinn@nelft.nhs.uk) | | |  |  |  |
| Human Resources [Sarah.Thompson@nelft.nhs.uk](mailto:Sarah.Thompson@nelft.nhs.uk) | | |  |  |  |
| Finance Leadership Teams (to include IT) [Michele.Donovan@nelft.nhs.uk](mailto:Michele.Donovan@nelft.nhs.uk) | | |  |  |  |
| Business Development and Transformation,  [Sharon.Shepherd@nelft.nhs.uk](mailto:Sharon.Shepherd@nelft.nhs.uk) | | |  |  |  |
| Compliance – QPS -[Sarah.tuck@nelft.nhs.uk](mailto:Sarah.tuck@nelft.nhs.uk) | | |  |  |  |
| Estates Senior Leadership Team | | |  |  |  |
| Communication team - [Communications@nelft.nhs.uk](mailto:Communications@nelft.nhs.uk) | | |  |  |  |
| Chief Pharmacist Rahul. [Kamaljit.Takhar@nelft.nhs.uk](mailto:Kamaljit.Takhar@nelft.nhs.uk) | | |  |  |  |
| Business Intelligence & Performance  [Umber.gull@nelft.nhs.uk](mailto:Umber.gull@nelft.nhs.uk) / [Joanne.young@nelft.nhs.uk](mailto:Joanne.young@nelft.nhs.uk) / [Jacky.hayter@nelft.nhs.uk](mailto:Jacky.hayter@nelft.nhs.uk) | | |  |  |  |
| Organisational Development [Linda.Hall-Hems@nelft.nhs.uk](mailto:Linda.Hall-Hems@nelft.nhs.uk) | | |  |  |  |
| Procurement - [Procurement@nelft.nhs.uk](mailto:Procurement@nelft.nhs.uk) | | |  |  |  |
| Health Informatics [Sunita.Bhandari@nelft.nhs.uk](mailto:Sunita.Bhandari@nelft.nhs.uk) | | |  |  |  |
| Health & Safety Team - [Chris.Shaw@nelft.nhs.uk](mailto:Chris.Shaw@nelft.nhs.uk) | | |  |  |  |
| Business Support Essex  [Emma.Vidler@nelft.nhs.uk](mailto:Emma.Vidler@nelft.nhs.uk) / [Laura.Ellacott@nelft.nhs.uk](mailto:Laura.Ellacott@nelft.nhs.uk) | | |  |  |  |
| Safeguarding team - [Sarah.williams@nelft.nhs.uk](mailto:Sarah.williams@nelft.nhs.uk) | | |  |  |  |
| Local Counter Fraud Specialist – [Daniel.higgs@nelft.nhs.uk](mailto:Daniel.higgs@nelft.nhs.uk) | | |  |  |  |
| CPAG – [Rebecca.duffy@nelft.nhs.uk](mailto:Rebecca.duffy@nelft.nhs.uk) / [Rosalind.parker@nelft.nhs.uk](mailto:Rosalind.parker@nelft.nhs.uk) | | |  |  |  |
| Just and Compassionate Culture Group – [David.hartie@nelft.nhs.uk](mailto:David.hartie@nelft.nhs.uk) | | |  |  |  |
| Legal Team - [Robert.Keys@nelft.nhs.uk](mailto:Robert.Keys@nelft.nhs.uk) | | |  |  |  |

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| **16.** | | | **INITIAL SCREENING EQUALITY IMPACT ASSESSMENT FORM**  **(All sections of form to be completed by author in conjunction with Equality and Diversity team prior to consultation)** | | |
| **Directorate/Department** | | | | **Nursing and Clinical Effectivenesss** | |
| **Name of Policy/Service/Function** | | | | Inter-Agency Policy for the Assessment of People Detained Under Section 136 of the Mental Health Act | |
| **New or Existing Policy/Service/Function?** | | | | **Existing** | |
| **Name and role of Person completing the EQIA** | | | | **Harjit Bansal, Head of Equality, Diversity and Inclusiveness** | |
| **Date of Assessment** | | | |  | |
| **Policies:**  Equality Act 2010  Accessible Information Standard  Social Inclusion Guidance 2013  Public Services (social Value Act) 2012  Gender Recognition Act | | | | **Yes/No** | **What/Where is the Evidence to suggest this?** |
| **The policy should be reviewed in light of the following:**   * **Will the policy discriminate against or add barriers for a particular group?** * **Will the policy exacerbate existing barriers or difficulties faced by a particular group?** * **Will the policy neither add nor remove difficulties for a particular group?** * **Will the policy:**   + **Reduce discrimination?**   + **Advance equality of opportunity?**   + **Foster inclusion and good relations?**   + **Impact healthcare inequalities** | | | |  |  |
| **1** | **Does the Policy/Service/Function effect one group less or more favourably than another on the basis of:** | | |  |  |
| Race, Ethnic origins (including, gypsies and travellers) and Nationality | | |  | Evidence:  Most BME groups are more likely to be detained under S136 than the White British group. This is particularly true of the Black groups. However, a recent 3 year study in NELFT shows far less disproportionate usage for BME groups than had been expected. This Policy attempts to counteract this. The Policy itself is not discriminatory through practice can be.  **Actions:** |
| Gender (males and females) | | |  | Evidence:  Higher numbers of males on S.136. This is a long-standing and national position and relates to the higher risk profile of males. It is not thought to relate to discriminatory practice  **Actions:** |
| Age | | |  | Evidence:  Over 65 people are exceptional on S136. again this is historic and not felt to be discriminatory  **Actions:** |
| Religion, Belief or Culture | | |  | Evidence:  It should be borne in mind that this links with ethnicity in that some BME groups have different religious beliefs to White British group.  **Actions:** |
| Disability – mental, physical disability and Learning difficulties | | |  | Evidence:  By definition people on S.136 are likely to have a mental disorder or disability. Detainnees with physical disabilities or learning disabilities are in fact rare  **Actions:** |
| Sexual orientation including lesbian, gay and bisexual people | | |  | Evidence:  Not believed to be a factor in S.136 use  **Actions:** |
|  | Married/or in civil partnership | | |  | Evidence:  As above  **Actions:** |
|  | Pregnant/maternity leave | | |  | Evidence:  As above  **Actions:** |
|  | Gender reassignment | | |  | Evidence:  As above  **Actions:** |
|  | **Healthcare Inequalities**  **Does the health inclusion group experience inequalities in health**  **outcomes?**  **Could the work be used to tackle any identified inequalities in access to**  **healthcare or health outcomes?**  **Could the work assist or undermine compliance with the duties to reduce health inequalities?**  **Does any action need to be taken to address any important adverse impact?**  **If yes, what action should be taken?** | | |  | Evidence:  **Actions:** |
| **2** | **Is there any evidence that some groups are affected differently? Is the impact of the policy/Guideline likely to be negative?** | | |  | Evidence:  **Actions:** |
| **3** | **Is there a need for additional consultation e.g. with external organisations, service Users and carers, or other voluntary sector groups?** | | |  | Evidence:  Police. LAS, Social Services, Advocacy/User Group representatives sit on the Police Liaison group where this policy will be discussed and monitored.  **Actions:** |
| **4** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | | |  | Evidence:  **Actions:** |
| **5** | **Can we reduce the impact by taking different actions?** | | |  |  |
| **Assessor’s Name: Date:**  **Name of Director:** | | | | | |
| **6** | | **This section to be agreed and signed by the Equality and Diversity Manager in agreement with the Equality and Diversity Team**  **Recommendation**  Full Equality Impact Assessment required: NO YES | | | |
| **Assessment authorised by:**  **Name:**  **Date:** | | | | | |

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| **17.** | **Appendices** |

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| Appendix 1 | Places of Safety Useful Addresses and contact numbers |
| Appendix 2 | Section 136 Trust Self-Audit Form |
| Appendix 3 | Decontamination of Patients and their clothing from incapacitant Sprays |
| Appendix 4 | Section 136 Assessment Flow Chart |

Appendix 5 Protocol for management of under 18s on Section

Appendix 6 Guidance on Medical assessments

Appendix 7 Taser Use

Appendix 8 Operational Guidelines for use of S.136

Appendix 9 Section 136 Extension of Hours Form

Appendix 10 MEMORANDUM to accompany 136 Briefing

# Appendix 11 SECTION 136 FLOWCHART FOR KENT AND MEDWAY CHYMHS AND YPWS

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| **18.** | **Approval Form** | | | | | | |
| **EMT APPROVAL SHEET** | | | | | | | |
| **Policy title:** | | |  | | | | |
| **Author:** | | |  | | | | |
| **Lead Executive Director approval** | | |  | | | | |
|  | | | | | | | |
| **Meeting** | | **Date of meeting** | | **Chair name and title** | **Signature Chair** | **Approved?**  **Y / N** | **Reason for non-approval** |
| **Governance group:** | |  | |  |  |  |  |
| **Once approved by the EMT Chair/meeting, the assistant to the chair to send signed and dated policy to** [**policies@nelft.nhs**](file://nel.local/dfs/shares/Quality%20Assurance/2.%20Policies/3.%20Policy%20%26%20SOP%20%26%20Notes%20Template/policies@nelft.nhs)**, for final formatting, logging and uploading.** | | | | | | | |

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| **19.** | **Addendum** | | | |
| **Version** | **Author(s)** | **Changes**  **(please identify section, change(s) and page no.)** | **Ratified/ Authorised by** | **Date** |
|  |  |  |  |  |

1. R(Sessay) v South London and Maudsley NHS Foundation Trust(2011) EWHC 2617(QB) [↑](#footnote-ref-1)