



Home Office

Alternative Place Of Safety The West Sussex Pilot Evaluation 2015

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Foreword

Improving provision for those experiencing a mental health crisis, and reducing inappropriate police involvement in dealing with people who are essentially in need of health care, is a priority for this Government. While there has been a steady and welcome decrease since 2011/12 in the reliance on police cells as places of safety for those detained under section 136 of the Mental Health Act, experiences still vary considerably across the country. Many areas report persistent pressures on health based places of safety meaning that people in need can face significant delays or long journeys before being admitted to a suitable place.

In October 2014, the Home Secretary announced her intention to fund a pilot of an alternative place of safety utilising the expertise of the third sector.

With one of the highest rates of use of police cells in the country, local agencies in Sussex agreed to participate in this pilot in partnership with Richmond Fellowship, a respected national provider of mental health and other recovery services.

The following document provides a description of the service offered, its impact on some of the

recipients of these services and the lessons that were learned by partners during the journey to establish and run this innovative enterprise.

The Home Office would like to thank all those people involved who rose so well to the challenge of forming a new partnership and devising fresh ways of working to address the inevitable complexities and challenges that arose along the way. We are extremely grateful to Richmond Fellowship (particularly the staff and residents at Blatchford House), Sussex Police, Sussex Partnership NHS Foundation Trust, NHS England South East Strategic Clinical Network, West Sussex County Council, NHS Horsham and Mid Sussex Clinical Commissioning Group, the South East Coast Ambulance Trust and the South East Commissioning Support Unit for their support for and commitment to the pilot.

We hope that the experiences and learning set out in this document will act as a model and inspiration for other areas which may be considering how to increase and improve place of safety provision for vulnerable people.

Introduction

The Mental Health Act (MHA) 1983 defines a place of safety as being residential accommodation provided by a local social services authority, or a hospital, an independent hospital or care home for mentally disordered persons, a police station, or any other suitable place where the occupier is willing to temporarily receive the person. This means anywhere can be a Place of Safety under the MHA as long as the occupier is willing to receive the person. There is no legal definition for a “designated” place of safety. However the accompanying Code of Practice¹ requires a joint agreement to indicate which place of safety should be used and in which circumstances.

This pilot was established to test the viability of a section 136 alternative place of safety (APoS) outside of a custody suite or traditional health-based place of safety (HBPoS) and the extent to which police officers could be freed up as a result. The pilot linked together a third sector provider to work with NHS organisations and the police. This paper sets out our findings.

The report follows the experiences of those involved in setting up and managing the new place of safety. It identifies the challenges they faced, how these were overcome and shares important learning for others. In addition it highlights the issues around the merger of disparate organisations where mental health pathways are pre-locked into block contracts and the establishment of an alternative operating framework in Sussex. This consists of new pathways and protocols to improve and promote a person centred-approach for people in crisis who require a combination of psychological, social and medical crisis intervention and support and offers a new solution for providers and commissioners.

South East Strategic Clinical Network provided support to the pilot working group and additional financial support to evaluate the alternative place of safety. South East Commissioning Support Unit undertook the evaluation.

Vision

When people are in crisis they are at their most vulnerable. It is essential that they receive the care and support they need as quickly as possible, in a place they can feel safe, and that they are supported by people who understand their needs.

Dr Paul Lelliott
Deputy Chief Inspector of Hospitals
Lead for Mental Health
Care Quality Commission (2014) A safer place to be

In summary the findings of the pilot have identified the benefits of reviewing the types of places of safety required and broadening the range of clinical and non-clinical interventions that promote resilience, wellbeing, empowerment and care for service users

through using a wider range of providers. The South East Strategic Clinical Network, NHS Horsham and Mid Sussex CCG with Richmond Fellowship and partnering organisations intend to extend the pilot through to the end of March 2016.

¹Department of Health (2015) Code of practice: Mental Health Act 1983

I. Executive Summary

I.1. Background

In December 2014 the Home Office and Department of Health reported their findings and recommendations following a joint review into the operation of sections 135 and 136 of the MHA. The review explored how to improve access to mental health interventions for those detained under the Act and encouraged the NHS to consider and enable innovation in using APoS to a police cell through developing a greater range of places that could be used when needed and relieve pressures on HBPoS, delivering the right care in the right place at the right time.

In the preceding October the Home Secretary announced her intention to fund a pilot of an APoS for people detained in police custody under section 136 of the MHA.

The pilot brought together for the first time a third sector organisation Richmond Fellowship, (based at Blatchford House, a supported accommodation facility for those with low-medium support needs in Horsham, West Sussex) with other agencies to provide a statutory service for those in mental ill health crisis. The pilot ran from March 2015, in parallel with the introduction of street triage in West Sussex (see page 8).

I.2. Aims and Approach

The aim of the pilot was to trial an alternative place of safety to police custody for people aged 18 and over detained under section 136 of the MHA and evaluate whether such an alternative could give people a better experience whilst they await a mental health assessment.

The pilot evaluation aimed to understand how the introduction of an APoS run by a third sector organisation would work in practice and identify any lessons learnt for possible future roll out, adaption of a similar model, or expansion of the scheme in this or other regions. The assessment was not specifically designed to consider the longer term outcomes of those detained or to estimate the “value for money” of the scheme.

The evaluation aimed to understand:

- if a third sector organisation could work in partnership with statutory agencies to provide an effective place of safety as a viable alternative to a custody suite in a police station;
- the number, type and characteristic of detentions manageable by an APoS;
- perceptions of police officers and partner agencies involved in implementing and utilising the scheme;

- shared learning between partnering organisations;
- experiences of those who were detained; and
- any difference in outcomes between a traditional HBPoS, a police custody cell and an APoS.

It drew on:

- feedback from the individuals detained;
- health based places of safety monitoring data collected by Sussex Partnership NHS Foundation Trust;
- APoS monitoring data collected by Richmond Fellowship;
- Sussex Police staff monitoring questionnaires;
- APoS staff feedback questionnaires collected by Richmond Fellowship;
- interviews with staff from Sussex police, Richmond Fellowship, Sussex Partnership Foundation Trust, West Sussex Local Authority; and
- working group feedback.

It was anticipated that approximately 24 people could be diverted from being held in police cells to being detained to the APoS when the HBPoS were full and where they would be offered interventions to reduce distress and resolve crisis.

I.3. Implementation of the Pilot Process

The Home Office provided non-recurrent funding of £25,000 to Richmond Fellowship to support the pilot.

A working group consisting of key partners from: Sussex

Partnership NHS Foundation Trust, West Sussex County Council, the Home Office, South East Coast Ambulance Trust (SECAMB), Sussex Police, South East Strategic Clinical Network was set up to oversee the development of the project. The working group

²Department of Health and Home Office (2014) Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983



agreed a memorandum of understanding which included operational policies and protocols, staff training, and communications.

The priority for the working group was the development of the operational policy. Discussions involved combining expertise and experience; uncovering attitudes, perceptions and misunderstandings, as well as identifying potential issues with the implementation of the APoS. Each of the partners was able to validate the policy from their respective organisation's position and reach consensus that the pilot could achieve its intended objective. In one person's words the "Operational Policy became the heartbeat for the pilot" (Appendix i).

The memorandum of understanding was signed between Sussex Police, Richmond Fellowship and the Chief Executive of the Sussex Partnership NHS Foundation Trust. As the APoS was not intended to provide an alternative to the HBPoS it was agreed that the two health based places of safety should be the first choice and that the APoS would only be used in a situation where the police had detained a person under section 136 and:

- the HBPoS were unable to accept the person due to unavailability or did not meet acceptance criteria;

- the person would otherwise have been held in a police custody suite to await a MHA assessment;
- the police and Richmond Fellowship considered the person could be safely detained at the APoS; and
- that the APoS was prepared to accept the person.

An awareness and education programme was provided to all staff involved. Roles and responsibilities were made explicit and communicated to front-line staff and their on call managers who might have been required to provide guidance and support.

Comprehensive operational policies and procedures were agreed through the working groups over the three month period running up to the start of the pilot and designed to guide staff through the process from the referral to discharge and provide the assurances and safeguards needed by statutory partners.

The APoS was launched by the Home Secretary on 9 March 2015. The service started at Blatchford House in Horsham, Sussex on 13 March, and was available for 60 hours each weekend for 12 weeks until 1st June 2015, between 20.00 on Friday evening to 08.00 on Monday morning.

1.4. Conclusion and Recommendations

The overall number of section 136 detentions in West Sussex during the pilot period reduced as a result of the parallel implementation of a street triage scheme in West Sussex. This led to a much lower number of people presenting to the APoS than anticipated. There were just seven detentions to the APoS and therefore limited quantitative and qualitative data for the pilot evaluation.

Whilst the numbers were low, it was the view of those involved that the APoS was a suitable alternative that functioned effectively and was perceived as a "business as usual" place of safety for police officers and partner agencies directly involved in the pilot as the 12-week period progressed.

Building on the pilot it is recommended that NHS commissioners, namely Clinical Commissioning Groups (CCGs) and their local partners responsible for providing places of safety:

- actively seek to commission third sector organisations to support people detained as an alternative to police custody;
- develop a model of best practice for an APoS as part of a collaborative commissioning approach;
- ensure places of safety have onward pathways in place for those detained so they are offered practical solutions and support such as housing, employment, debt and relationship advice and who have good links into local agencies;
- take a 'values based' approach to build on active engagement of people accessing services in the commissioning cycle and trust the views of those who use the services;
- work with current health based places of safety to deliver similar interventions using a person- and community-centred approach;
- develop a joint strategic approach and design appropriate pathways and interventions for people who are intoxicated, whether or not they are suffering from a mental health crisis;
- utilise the third sector within the wider system of the crisis care concordat to assist with crisis interventions to prevent admissions to custody suites, aid recovery and signpost people on to local more appropriate services; and
- consider and agree the skills and competencies required for an APoS workforce.

Alternative Place of Safety



Figure one: Alternative Place of Safety, Richmond Fellowship

Custody Place of Safety



Figure two: Place of Safety Custody Cell

The evaluation concluded that the APoS provided by a third sector organisation was able to support safely and securely the seven people it received. Of those detained who provided feedback that too was generally positive.

2. Main Report

2.1. National Context

It is well established that the police are often the first to respond to a person in a mental health crisis in a public place and need to be able to secure the right response from other public services to ensure the vulnerable person receives the most appropriate care and support. People being detained under section 136 of the MHA should be taken to an HBPOS and police cells should only ever be used under “exceptional” circumstances.³

In October 2014 the Care Quality Commission (CQC) published findings from a survey of HBPOS for people detained under section 136.⁵ It found that police custody suites were being used because of a lack of HBPOS provision as well as for those who were intoxicated or exhibiting disturbed behaviour that could not be managed in a health setting.

2.2. Local Context

Sussex includes Gatwick airport and a number of coastal towns with busy rail links as well as Beachy Head, a landmark attracting people from all over the country intending to commit suicide, Sussex Police therefore deal with high numbers of people in distress.

There are only five HBPOS in the whole of Sussex and with only one bed each, meaning the county can only accommodate a maximum of five people experiencing a mental health crisis and requiring assessment at any one time. In 2013 1,358 people were detained by Sussex police under section 136 of whom 63% were held in police custody, while only 37% went to an HBPOS. This significant number led to the introduction by Sussex police and Sussex Partnership NHS Foundation Trust of a street triage pilot scheme in Eastbourne in 2013. This pilot brought together a dedicated police officer and nurse to work together to decide on the best option for people suffering a mental health crisis. To build on this and further reduce the reliance on police custody as the back-up option when the two HBPOS in Crawley and Worthing were full or unable to

In December 2014 the Home Office and Department of Health published findings and recommendations following their joint review into the operation of sections 135 and 136 of the MHA. The report looked at how to improve access to mental health interventions for those detained with an emphasis on the NHS and CCGs to develop and co-design innovative solutions. It also set out legislative recommendations to amend the “list of possible places of safety so that anywhere considered suitable and safe can be a place of safety”.⁵ The report recommended that in England (and in Wales, their equivalent), Clinical Commissioning Groups (CCGs) and partner agencies should explore alternative places of safety (APoS) to custody cells for those detained in order to give the police additional options, and relieve pressures on (HBPOS), delivering the right care in the right place at the right time.

take a person, West Sussex was selected to pilot the APoS and the street triage scheme was also extended to cover the West of the county.

Richmond Fellowship, a specialist provider of mental health services in West Sussex, is one of the biggest third sector organisations in England. It offers a wide range of housing, care, employment and community support across more than 120 services. It is a registered charity and a registered provider of social housing. It therefore met the legal definition for a place of safety and registration with the CQC was not required to carry out what would otherwise be deemed a regulated activity (i.e. detention under section 135 or 136).

Blatchford House in Horsham is the location of one of Richmond Fellowship’s supported housing schemes and it was here that a bedroom with en-suite toilet and shower was specially refurbished in line with recommendations for commissioners by the Royal College of Psychiatrists in their 2013 guidance.⁶

³HM Inspectorate of Constabulary, HM Inspectorate of Prisons, the Care Quality Commission and Healthcare Inspectorate Wales 2013 A Criminal Use of Police Cells

⁴Care Quality Commission (2014) A safer place to be

⁵Department of Health and Home Office (2014) Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983

⁶Royal College of Psychiatrists London (2013) Guidance for commissioners: service provision for section 136 of the Mental Health Act 1983

2.3. Description of the pilot service

The design of both the APoS accommodation and procedures needed to ensure the safe management of the detained person whilst waiting for the doctor and Approved Mental Health Professional (AMHP) to attend and conduct the necessary assessments. It needed to be secure and spacious with facilities for the detained person to sleep, eat and wash. Two members of staff, aware of their responsibilities under the MHA were required to accept handover of the detained person from the police as quickly as possible, coordinate the formal assessment process, and offer support and advice.⁷

As the APoS was not intended to provide an alternative to the HBPoS it was therefore agreed that the two health based places of safety should be the first choice and that the APoS would be used in a situation where the police had detained a person under section 136 and;

- HBPoS were unable to accept the person due to unavailability or the person not meeting the acceptance criteria;
- the person would otherwise have been held in a police custody suite to await a MHA assessment;
- the police and Richmond Fellowship considered the person could be safely detained at the APoS; and
- the APoS was prepared to accept the person.

The memorandum of understanding set out the conditions for the APoS to be accessed; this included the roles and responsibilities for each of the partners including a joint information sharing agreement. The operating policy set out the governance arrangements between the partnering organisations. West Sussex County Council, as the local authority who warrant and employ the AMHPs, agreed that section 136 assessments could be undertaken at Blatchford House.

The following standards were agreed:

- there would be two members of staff trained in understanding their roles and responsibilities under section 136 legislation and managing disturbed behaviour by prevention and de-escalation;
- the APoS would be available when required;
- the police would contact the APoS before arriving with the person;
- an ambulance would convey those detained to the APoS;
- the police would be able to leave promptly after handover;
- information would be collected by the APoS to show the length of time a person was detained and the outcome of the

assessment; and

- those detained in the APoS would be asked to give feedback on their experience.

These standards were informed by:

- Royal College of Psychiatrists (2013) Guidance for Commissioners: service provision for Section 136 of the Mental Health Act 1983 (England and Wales);
- Care Quality Commission (2014) A safer place to be; and
- Mental Health Act 1983 Refreshed Code of Practice 2015.

Sussex Police agreed to communicate the pilot to all frontline police officers and ensure that the agreed conditions were met so that the person would be taken to the APoS instead of a police cell. They would assure themselves that the staff at the APoS were able to safely manage the person so the police officers could leave as quickly as possible. The police would be available to return and to provide support if a person's behaviour could not be managed.

Sussex Partnership NHS Foundation Trust agreed to act as the umbrella organisation for the partnering organisations, and to take responsibility for ensuring that the pilot was linked to existing care pathways. Richmond Fellowship accepted the duty of care and had policies in place to keep the person safely detained until he / she had been assessed, or was transferred to an HBPoS, or other suitable arrangements were made for the person's ongoing care or treatment. In preparation for working in the APoS, staff had training in de-escalation, MHA legislation, First Aid, CPR and in the administration of defibrillation. Richmond Fellowship rotas ensured both a male and female member of staff was on duty at the same time. If a person detained appeared to be physically unwell the staff were instructed to call the General Practitioner (GP) out of hours service or an ambulance.

South East Coast Ambulance Service Foundation Trust (SECAmb) as part of the West Sussex Crisis Care Concordat had already agreed to adapt 'NHS Pathways' protocols and increase the priority for calls from the police in respect of section 136 detentions, including commitment to attend within 60 minutes and convey the person to the place of safety.

Sussex Police, Sussex Partnership NHS Foundation Trust, and Richmond Fellowship worked within the framework of the Sussex Section 135 and 136 partnership agreement. The partnership and the Home Office agreed the criteria to evaluate the pilot.

⁷Royal College of Psychiatrists London (2013) Guidance for commissioners: service provision for section 136 of the Mental Health Act 1983

2.4. Criteria for pilot success

The outcome measures for success were agreed as:

- development of an agreed, workable protocol based on good practice standards;
- demonstration of collaboration between partners;
- no incidents in the APoS;
- no complaints received about the APoS;
- police able to leave within 30 minutes;
- police not recalled to APoS;
- positive feedback received from those detained; and
- positive feedback received from staff.

2.5. Methodology

A reporting template, based on that of the HBPoS (Appendix ii), was devised by the pilot working group to evaluate the APoS.

A weekly anonymised data report was provided by Richmond Fellowship to the South East Commissioning Support Unit which included:

- the date, time of admission and length of time detained;
- conveyance and attendance at Accident and Emergency Department;
- assessment of underlying medical issues;

- presenting need; i.e. substance misuse;
- interventions, engagement and support provided;
- reported outcomes at discharge; and
- incidents and complaints log.

Staff feedback forms were designed for the police, the APoS and HBPoS staff to complete about their experience during the pilot (see Appendix iii and iv) and follow up telephone interviews were conducted.

Comparable information was sourced from the HBPoS and the police for detentions during the pilot period, (Appendix v and vi).

2.6. The data

The extension of the street triage pilot in West Sussex and the fact that the two HBPoS were fully staffed and open during the pilot meant that there was less need to use the APoS than originally forecast.

During the operational hours of the pilot 37 people were

detained under Section 136 of the MHA in West Sussex. Of these:

- one person was detained to police custody;
- 29 people were detained to the two HBPoS; and
- seven people were detained to the APoS.

APoS usage

- the Alternative Place of Safety was used seven times during the pilot period
- four men and three women were detained
- the age range for men was 23 – 48
- the age range for women was 42 – 63
- six people were white British and one was any other white background
- the arrival at APoS times ranged from
 - 09.00 - 17.00 – one person
 - 17.00 - 21.00 – one person
 - 21.00 - 00.00 – one person
 - 00.00 - 09.00 – four people
- the duration of detention at APoS ranged from five hours to 24 hours
- nobody was detained over the 72 hour expected maximum



Ethnicity

Previous research literature on section 136, based mainly in London, indicates that its use is associated with social disadvantage, a diagnosis of schizophrenia, male gender, and Black British, African or Caribbean ethnicity. Threatened or actual violence is the most common presenting problem, followed by threats or acts of deliberate self-harm. The picture seems to be different in other areas of the country particularly outside of London and the big cities, with self-harm replacing violence as the most common presenting problem and differing ethnicity profiles. In this pilot:

- of those detained at the HBPOS, 27 were white British one not stated and one was any other white background;
- the person detained in custody was any other white background; and
- at the APoS six out of seven were white British and one was any other white background.

This is consistent with the 2011 Census results which show that in West Sussex, 88.9% of the population are White British (English/Welsh/Scottish/Northern Irish), a higher proportion than for the population of England and Wales (80.5%) and the South East (85.2%). There is little variation in the proportion of White British people across six of the seven districts, however in Crawley the proportion of White British drops to 72.1% of the total population. Overall, 43.6% of the population who are not White British belong to the White Irish, White Gypsy or Irish Traveller or Other White ethnic groups. A further 31.7% are Asian and 11.2% are of Mixed or multiple ethnic groups.

Availability, Accessibility and Presenting Need

The APoS was available when needed throughout the pilot period with the exception of one evening when staff were not available. The service was not required during that period. Four out of seven people arrived overnight between 00.00 and 09.00 hours. The police contacted the APoS before arriving with each person and an ambulance conveyed six of the seven detained to the APoS.

Most of those accepted by the APoS had consumed alcohol. However, no one was excluded because of this and the APoS

considered it safe to accept those whose alcohol levels did not impact on their ability to walk, talk and maintain consciousness. This meant that the five people who had consumed alcohol and as a result of which were excluded by the HBPOS, were admitted and not taken into police custody. It is important to note that the 2014 Review of section 136 recommended that HBPOS should not exclude people on the basis of alcohol consumption.

Six out of seven people detained to the APoS presented with suicide/self-harm.

⁸Bendelow G Warrington C. Section 136 in Sussex Project Report (forthcoming) University of Brighton, Sussex Partnership Foundation Trust and Sussex Police
⁹Department of Health and Home Office (2014) Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983



Steve is 25, homeless, in debt and struggling to keep his job as a warehouse assistant. His alcohol intake has increased significantly over the past week. After an argument in a pub Steve became upset about his situation. Police were called and Steve was detained on a section 136. He has had previously received medication for depression from his general practitioner.



Helen is 33 and has recently lost her job as a receptionist. A victim of domestic violence, Helen was fearful of the consequences and so drank a bottle of wine and went to the railway tracks with the intention to end her life. A member of the public called the police and Helen was detained under section 136. Helen has had no previous involvement with mental health services.

Presenting Risks

- To physical health due to alcohol use
- Vulnerability resulting from homelessness and domestic violence
- Loss of employment
- Debt
- Self-harm

The concept of recovery is not new and for many people it means staying in control of their life despite experiencing a mental health problem. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms¹⁰. The Recovery Model¹¹ is well documented and was adopted as part of the pilot.

The recovery approach requires a different relationship between people in receipt of care and professionals and has

been characterised as a shift from staff who are seen in a position of expertise and 'authority', to someone who is kind and behaves more like a personal coach or trainer: "offering their professional skills and knowledge, while learning from and valuing the person, who is an expert-by-experience".

The interventions provided during the pilot are non-medical and focus on the person's situation. De-escalation and break away interventions (while trained for) were not required as there were no incidents of violence.

APoS Interventions

- establish rapport whilst waiting for a MHA assessment to gain an understanding of the person's situation
- focus on the person's needs and priorities (debt, unemployment, substance misuse, housing, relationships)
- help find solutions to their problems that could be addressed at home
- normalise and validate their situation
- promote self-care and wellbeing
- ensure returning Home Support
- referral for follow-up to mental health community team
- sign-posting to debt advice, benefit support and welfare rights, Richmond Fellowship Outreach and housing support including direct access hostels
- follow-up welfare call
- referral to Domestic Violence service
- alcohol service drop in details provided
- accommodation arranged

¹⁰Recovery at <https://www.sussexrecoverycollege.org.uk/>

¹¹<http://www.mentalhealth.org.uk>

Interventions and outcomes by person during APoS pilot period

APoS Interventions and outcomes							
		Practical Support	Emotional Support	Promoting self-care/ wellbeing	Referral for follow-up	Sign posted to other agency	Outcome
1	Substance misuse	●	●	●	●	●	Assessed by AMHP as fit for formal discharge
2	Suicide attempt & substance misuse		●	●		●	Assessed by AMHP as fit for formal discharge
3	Suicide attempt & substance misuse		●		●	●	Assessed by AMHP as fit for formal discharge Referred to Community Mental Health Team
4	Suicide attempt & substance misuse		●	●	●	●	Assessed by AMHP as fit for formal discharge
5	Suicide attempt	●	●		●	●	Assessed by AMHP as fit for formal discharge
6	Suicide attempt	●				●	Assessed by AMHP as fit for formal discharge
7	Suicide attempt & substance misuse		●	●	●	●	Assessed by AMHP as fit for formal discharge Referred to Community Mental Health Team

None of the seven detentions to APoS required subsequent admission to a mental health unit.

2.7. Perceptions of the APoS

Overall those involved in the pilot were very positive about the APoS and considered it was an effective alternative to police custody and comparable to the HBPOS. They reported collaborative partnership working between the third sector and

statutory agencies. There were some concerns expressed about the levels of security and capacity to contain possibly violent or agitated vulnerable people. However these types of concerns were expressed equally by the HBPOS staff.



2.8. The experience of those detained

Of the seven people detained at the APoS, five had the opportunity to provide feedback via evaluation cards and four did so. All of those who responded said they felt supported and given space to talk by staff at the APoS and that their stay had a

Those detained said...

- “this has been really helpful and made me see my issues I need to address”
- “felt supported and like people cared”
- “very good service”
- “if I had been locked up in a police cell I probably would have killed myself when I got home”.

positive impact on their wellbeing. Three of the four respondents said they believed the emotional and practical support they were given may help them in the future. Three out of four said they felt safe and secure during their time in the APoS. The fourth felt that the environment was “more comforting than a cell” although “didn’t think it was secure. Felt I could get out and windows should have bars”. Three out of four said the APoS environment was comfortable, one person felt it was “uncomfortable / scary”.

All four felt listened to and understood by staff. One said that staff had been “genuinely non-judgmental” and that they were able to talk freely and comfortably. Two of them felt they had a better understanding of what led to their crisis following their stay in the APoS.

Experiences reported of custody, street triage and APoS

Since 2014 qualitative data from the Sussex Street Triage Pilot has been collected by an independent study of the use of section 136 led by Professor Gillian Bendelow of Brighton University. The study was initially funded by the British Academy in collaboration with Sussex Police and Sussex Partnership NHS Foundation Trust and resourced through the National Institute for Health Research, Mental Health Research Network and due to be completed by December 2015. This study was in response to data showing that despite the provision of six section 136 Place of Safety suites in NHS units across East and West Sussex, approximately two thirds of detainees are still taken into police custody and that fewer than half of these detentions result in admissions to mental health units, suggesting there are wide

variations between police interpretations of emotional distress and the subsequent diagnoses of mental health professionals. Using a combination of secondary analysis of existing data and in-depth interviews with police and other emergency services, mental health professionals and members of the public who have been detained under section 136, the study provides an in-depth multi-method analysis of the experience of section 136. In addition it evaluates how the alternatives to section 136 (for example, the introduction of the Street Triage pilot and APoS) are perceived by the various stakeholders. The following quotes are taken from accounts given during interviews by those who have had first-hand experience of the custody suite, the APoS and street triage.

Experiences of custody

- “I still burn with shame whenever I think about it”
- “anyone in this position should never be subjected to the stigma of custody, when there are health based places of safety available”
- “you’re like a criminal, when I’m ill I like to wear clothes to cover myself completely but I had to strip off and wear a padded suit. I was in the police cell crying. When you are in the suite you feel more human, not so degraded”
- “if I was in the street with a broken leg, would you put me in a police cell?”
- “the experience will haunt me forever. I can really tell you if I had been in a prison instead of in hospital I would never be able to recover from the experience, from the shame; it’s difficult enough I was thinking I would be in the newspapers, worrying about my workplace hearing about it”
- “putting me in a cell for hours was not the right way to help me deal with the problems I was having. I needed someone to talk to.”

Experiences of street triage

- “I have nothing but praise, police were every sensitive, the nurse who did the assessment was wonderful, talked to me for ages” and “arranged for me to go home by ambulance. Everyone was so kind.”
- “An officer and a mental health team member visited me at home... they were helpful and friendly. They made me feel at ease.”

Experience of APoS

Angie (not her real name) had taken an overdose and was first taken to Accident and Emergency where she stayed a night with the police before going to the APoS. Angie said staff at the APoS were “wonderful can’t say enough praise about them, so brilliant... the key word here is empathy.”

“I was very glad to have ended up in the APoS, any alternative would have been unbearable”

Angie added “if I had been locked up in a police cell I probably would have killed myself when I got home. I am grateful for the support received at the APoS”.

2.9. The experience of staff

Feedback from Police Officers

The police reported that the pilot went well. The availability of a third place of safety was communicated to constables by personal email. Sergeants and Inspectors were emailed and given a verbal briefing. Call handlers were alerted and advised to ask “have you considered Blatchford House?” when appropriate. Duty inspectors kept an overview and custody sergeants were also briefed.

The police had some initial reservations about the ability of the APoS to provide secure accommodation however

Richmond Fellowship provided the necessary assurances. The police had also been concerned that the APoS would need to call them back for assistance. This was not the case and the APoS supported all seven people without recalling the police. Overall the police considered the APoS was helpful and considered Richmond Fellowship to be an excellent partner, skilled in understanding how to support those in crisis. A police officer interviewed said he would have liked the pilot to have continued and is of the view that the seven people detained to the APoS would have been otherwise taken

to custody. The police consider people who are detained following a mental health crisis to be in a highly emotional state that renders them vulnerable to serious harm and injury and therefore require care and empathy. They added that they present differently from someone who is just drunk. The police felt that the way people were welcomed at the APoS was much less intimidating than an HBPoS and therefore the person less likely to be afraid or aggressive.

Time was saved by police officers not having to travel outside their county looking for a place of safety. Officers were able

to be back “on the streets” in their areas quickly. The custody suite staff were not at risk of putting a vulnerable person into a cell knowing that they should not be there and may not be able to cope with this environment.

Sarah Gates, Police Mental Health Liaison Officer, said “the pilot was definitely a success” and added “that it had opened her eyes to working with a third sector provider who comes in and delivers a whole service and would like to do more in the future. Richmond Fellowship proved to be worthy partners who really knew their business.”

Police quotes

- “it opened my eyes to working with a third sector provider who comes in and delivers a whole service and would like to do more in the future”
- “it is much more daunting to be in a police cell with loud shouting from prisoners; the APoS was much calmer and people sat and talked to him providing him with the attention he needed”
- “if Blatchford hadn’t been available he would have spent the night in a cell”
- “I felt the environment, facilities, appropriate and clean room was better equipped and furnished than other places of safety I have seen”
- “the staff were friendly, welcoming and attentive and I genuinely believe had a positive outcome on the clients mental state”
- “I would be concerned if the person became aggressive or violent and if they could be contained”
- “when I arrived, there were only two members of staff on duty at the time. I feel as though this may be enough if the patient is compliant, however, should the patient’s mood change, two members of staff may find it difficult to deal with”.

Feedback from Approved Mental Health Professionals (AMHPs)

Four AMHPs also completed feedback questionnaires. The majority of feedback was positive. One AMHP expressed concerns that medical facilities were less accessible than at an HBPoS and concerns about privacy and dignity.

AMHP quotes

- “having worked in other formal PoS, the environment and atmosphere of assessment in the APoS was more relaxed, there was no shouting and I imagine it wouldn’t have been as frightening and intimidating as the mental health ward or police station”
- “those working at the APoS were good at reassuring the customer”
- “the staff were all warm, welcoming and went over and above to make sure that the client was supported before, during and after the mental health assessment, including that there was always someone to sit with her and talk/provide reassurance. When we did not detain they arranged alternative accommodation with the client who was of no fixed abode”
- “I just wanted to say how fabulous all the staff were at this new service yesterday. They were helpful and efficient. This is a vast improvement on other places of safety and I feel that it should be expanded throughout the week. One of the best resources I have come across in years”.

Feedback from Richmond Fellowship staff at the APoS

Richmond Fellowship staff reported that there had been good partnership working and strong commitment from all partners. Working group meetings were held on a monthly basis and were well attended. The APoS staff found the police and ambulance staff helpful.

The low number of admissions impacted on staff confidence and morale. Higher throughput would have allowed staff to develop and stretch their new skills. Richmond Fellowship emphasised the need ideally for a dedicated team as they had to rely on a mix of contracted and agency staff which at

times posed a challenge for them as a group. They considered the person centred approach based on the organisation's values was vital to building a rapport and led to not having any incidents of violence or aggression.

Rachel Kundasamy, Locality Manager from Richmond Fellowship when asked about the use of a person centred approach said "We all felt we did these things automatically however it was still good to explore and for staff to develop a greater awareness around how we communicate we care, in what was a very new environment and way of working".

Feedback from the CCG

The CCG acknowledged that due to the small number detained to the APoS meant that it would be challenging to draw definitive conclusions. However it was interested to hear about the triggers to crisis and the type of problems that

people had experienced. There is an opportunity to look at the definition for detention in high level terms from clinical to social and environmental factors and which would require different responses, expertise and interventions.

CCG quotes

- "interested in exploring further how this evolving model can support people in distress as well as those detained, i.e. provide respite with appropriate follow up support"
- "links strongly to local need of group of people who currently use but probably are not best served by services at Accident and Emergency Department, psychiatric inpatient units and use of police custody"
- "opportunities here to strengthen and further develop local partnerships"
- "due to the complex and fine judgements that characterise the pathway, maximising links across all agencies involved will generate better and safer outcomes for people. Evolving the pilot would strengthen this further"
- "discussion will benefit a more detailed analysis and understanding of value for money from the pilot, particularly including wider cost avoidance across acute care, psychiatric services and police custody".

HBPoS staff feedback on HBPoS suite

HBPoS staff also reported concerns around the security of the HBPoS suite. Both the APoS and the HBPoS were therefore reliant on recalling the police if a person became aggressive or violent.

HBPoS staff quotes on HBPoS

- "we do not have the staff resources on the ward to manage difficult behaviour in the section 136 suite.
- "section 136 staffing comes out of ward staffing; we need dedicated Section 136 staff"
- "as no seclusion it has the potential to become unsafe without back up from the police"
- "we do not currently have the ability to manage highly agitated or aggressive patients"
- "not always enough AMHPs available".

2.10. Cost

There is a lack of national data and information showing the cost of a detention in an HBPoS and a police custody suite that would allow an effective comparative cost analysis. Estimated costs of an HBPoS in Sussex are £1200-£2000 a day. A news report by BBC Wales 2013¹² refers to the Centre for Mental Health estimated cost of a detention of £1800 per person. The cost of custody is estimated by Sussex Police to be around £1300 per day. The cost of setting up the pilot APoS in a third sector organisation within a short timescale was £31,000 to refurbish existing accommodation to meet required standards. This compares to reports of set up

costs of HBPoS requiring several hundred thousand pounds.¹³ The total running cost for the APoS was £29,979 over the 12 week period of weekends.

It was not directly the aim of the pilot to evaluate the relative costs of the APoS compared to other provision given its short term nature. However, the limited information available suggests that the cost of setting up an APoS is lower than a new HBPoS and similar to the cost of a 24 hour detention in a police cell. Financial savings of improved quality of care for people detained are hard to measure.

	APoS pilot set up and duration of pilot	APoS cost per day	HBPoS estimated cost per day	Police Custody suite estimated cost per day (2013)
Capital cost	£31,000			
Staff pay	£30,000	£967	£1200 - £2000	£1300
Non pay	£517			

The Revised Code of Practice impact equality assessment¹⁴ reviewed the overall costs and benefits of changes to the MHA Code of Practice¹⁵ and identified that the costs and savings for section 136 are difficult to estimate. It advises that "it is not assumed that police forces would be able to make direct savings by closing custody suites if fewer people were held in custody under section 136 and that further work is required to investigate the cost of providing additional places of safety".

The Independent commission on mental health and policing¹⁶ in 2013 reported that 20% of police time is spent on mental health including section 136 activity. During 2012/13 a total of 24,489 people were detained under a section 136; of these 6028 people to custody and 18,461 to HBPoS. The average length of time estimated in custody for a person detained is ten hours¹⁷ and that there are between six to eight hour waits for the police at HBPoS.¹⁸

Financial savings of improved quality of care for people detained are hard to measure.

¹²<http://www.bbc.co.uk/news/uk-wales>

¹³<http://www.nottinghamshirehealthcare.nhs.uk>

¹⁴https://www.gov.uk/MHA_CoPImpact_EqualityAssessment

¹⁵17 Department of Health (2015) Code of practice: Mental Health Act 1983

¹⁶Independent commission on mental health and policing report (2013)

¹⁷College of Policing (2015) College of Policing Analysis: Estimating demand on the police service

¹⁸HMIC (2013) A criminal use of police cells. The use of police custody as a place of safety for people with mental health needs

3. Lessons Learnt

The evaluation aimed to identify challenges experienced during the pilot in order to capture the lessons learnt.

3.1. Development of the care environment

As it is a legal requirement for the suite to be secure to prevent those detained from leaving before the section 136 is discharged, £31,000 was invested by Richmond Fellowship to refurbish a room to specified standards. Guidance was given by the mental health trust's Director of Nursing Safety who visited the suite and advised on its layout and design. Additional security measures were included as necessary.

The design of the suite was based on that of an HBPOS however visibility in the toilet and washroom facilities was compromised. To address this, the door was removed which allowed access and improved but did not wholly resolve visibility. This may be a recurring issue when considering converting existing premises rather than commissioning bespoke premises.

Lessons Learnt: Development of the care environment

The care environment should:

- be influenced by the views of those who have been detained in relation to the design
- be secure to prevent detainees leaving and to contain any violent behaviour
- be free of ligatures as far as possible and where they exist mitigating actions identified to reduce risks
- have a space that staff can move to and keep safe, in the event of a person becoming aggressive until the Police can attend to assist
- be less clinical with the addition of a TV or music
- be inspected by a Director of Nursing Safety and Standards.

3.2. Assessment of underlying medical conditions

For the purpose of the pilot, fitness to detain was referred to as an 'assessment of underlying medical conditions' to ensure the person had no immediate health-related issues prior to detention to the APoS. SECAmb clinicians would undertake a standard clinical assessment which would define whether conveyance to an Accident and Emergency Department or other health care facility was required.

Anyone taken to the APoS was conveyed by ambulance. Communication with both the ambulance crew and Accident and Emergency Department allowed information regarding any immediate physical health concerns to be shared and an informed decision was made regarding acceptance of the person into the APoS.

In one case the health of one person had been checked by both the ambulance staff and Accident and Emergency Department clinicians on route to the APoS. However, this person's physical state deteriorated whilst in the APoS and the person was therefore taken back to Accident and Emergency for further investigations and treatment.

Additionally a Sussex Partnership Foundation Trust senior nurse practitioner was contacted each time a person was detained at the APoS. If the detainees were known, information was shared regarding risk, relatives and General Practice contact details. The practitioner explained the background history and assisted with working out the best approach. This was identified as a crucial mechanism for getting information to those supporting the person in the APoS.

Lessons Learnt: Assessment of underlying medical conditions

A range of communication methods were developed to increase awareness and understanding for the professionals; these involved the following:

- the APoS is staffed by support workers and they therefore need to know of any physical illnesses/injuries the detained person may have
- police to call an ambulance to convey those detained to an APoS
- the ambulance service will assess underlying medical conditions. People who require emergency treatment for an underlying medical condition or injury should be taken to the Accident and Emergency Department first
- a copy of the Patient Clinical Record was left at the APoS containing details of who to contact in an emergency and allowing APoS staff to make informed decisions to accept a person detained
- people with an underlying medical condition can deteriorate on arrival at the APoS even if they have been cleared by Accident and Emergency Department – this needs to be closely monitored
- police to provide a full risk assessment as part of handover to the APoS.

3.3. Conveyance

Six out of seven people were conveyed to the APoS by ambulance. In one case however police transport was used. This meant an ambulance had subsequently to be called to the APoS to carry out the assessment of underlying medical conditions and led to a delay in the person being accepted by the APoS.

3.4. Multi-agency governance

The working group provided the essential leadership and structure to the pilot. Data collection and documentation did not initially include the AMHP's assessment summary. This was added to the document pack later in the pilot and served as the main record of the person's detention. Information sharing was a crucial component to anticipating the needs of a person and managing any risk as well as assisting individuals to make informed decisions. The operational policy included an information sharing agreement and protocol with all partners. This meant that the APoS could contact a registered mental health

Lessons Learnt: Conveyance

All professionals require a range of communication methods to ensure all professionals understand:

- the reason detainees are to be transported by ambulance is so they can be assessed for underlying physical conditions
- transport arrangements to be made explicit in protocols and operational documents.

professional on call who could advise if a person was known to mental health services and provide information that related to previous admissions, medication, crisis contingency plan, name of the care coordinator and known risks.

The length of time a person is detained can result in multiple handovers, thereby increasing the risk that important information is not relayed. Critical information was shared between Richmond Fellowship staff during the staff handover process to ensure continuity of care.

Lessons Learnt: Multi-agency Information sharing

- hold early discussions with partners (both managers and practitioners) to understand the process
- a specific information sharing agreement covering all parties is essential
- a written agreement is required detailing roles and responsibilities and an escalation process if disputes arise
- the information sharing and support from all professionals enables better care
- time needs to be given to engage multi-agency practitioners/clinicians and communicate their collective roles and responsibilities
- a wider range of communication methods to communicate with all practitioners to ensure understanding of own roles and expectations of others
- key people available out of hours at the beginning of “go live” to trouble shoot and resolve issues not anticipated during the planning stage
- a discharge protocol should include notification of the individual’s General Practitioner and care coordinator where applicable as well as a follow-up call to AMHP
- multiple verbal handovers increases the risk that important information is not relayed
- hold regular staff briefings to update all involved on agreed protocols and process.

3.5. APoS Staff Training

The operational policy was used as a basis for APoS staff training. It included understanding the legal requirements of section 136, the duty of care required by the staff accepting the detainee, the legal requirements to keep the detainee in the place of safety and to alert the local authority of the need for an assessment. APoS staff also undertook the following training / best practice groups:

- service induction;
- section 136 and the law;
- first aid, CPR and defibrillation;
- de-escalation;
- medication proficiency;
- best practice team meeting and debrief and team practice supervision;

- basic therapeutic techniques; and
- suicide awareness and self-harm.

Due to the number of people detained at the APoS with alcohol problems more formal training on recognising and responding to alcohol withdrawal is recommended in future training programmes.

Time was spent with APoS staff part way through pilot to refresh them on the protocols and their individual responsibilities. The low numbers meant that some staff did not experience activity during their shifts and this could have impacted on levels of confidence when responding to professionals. The use of agency staff led to some inconsistency in responding to the police and AMHPs.

Lessons Learnt: APoS Staff Training

- create a policy/agreement covering all aspects of the service and use this as a basis for a staff training plan
- training for staff to be provided by all agencies involved, rather than just their own organisation
- training for staff to include legal requirements of section 136 MHA 1983, the powers associated with section 136 for police officers, the duty of care required by the staff accepting the detainee as well as the legal requirements to keep the detainee securely in a place of safety and to alert the local authority of the need for an assessment
- employ a dedicated staff team to ensure consistency in best practice
- staff must have a system to recall police should their assistance be required
- training to include section 136 and the MHA, CPR and defibrillation, first aid, de-escalation, medication proficiency, service induction, basic therapeutic techniques, suicide and self-harm awareness
- medication proficiency training delivered by a clinical lead
- offer formal training to recognise signs of alcohol withdrawal
- have a process to keep staff up to date with agreed protocols.

3.6. Managing intoxicated people

The perceived needs of an intoxicated person who is considered vulnerable and at immediate risk either to themselves or others can often impact on decisions taken by those involved in the section 136 process. The approach taken by Richmond Fellowship however was to accept people when intoxicated as long as they could walk, talk and show a degree of cognitive ability¹⁹. The staff were trained to:

- recognise someone who has had one too much to drink;
- remain calm and reassuring and avoid saying anything that could provoke or anger;
- protect the person from falling particularly in the toilet area;
- observe whilst asleep and check regularly to ensure the person responds to being stirred;
- look for signs of alcohol poisoning; and
- talk with the person once sober and ask if their drinking is a concern to them. Share information that may help.

This approach mirrors police guidance from 2012.

The Royal College of Psychiatrist guidance for commissioners also supports this and indicates that intoxicated people should not be turned away from a HBPoS “unless they need acute medical intervention or are too behaviourally disturbed to be safely managed”.

The CQC echoes this also in findings from the survey of HBPoS and states that “although in some cases it may be preferable to delay an assessment when someone is intoxicated; this is not a reason on its own to deny someone

entry to a place of safety. The effect of alcohol varies from person to person, and setting an absolute limit is unhelpful and inappropriate”.

The police assessment was that the intoxicated persons accepted by the APoS would not have been accepted by the HBPoS. A 2011 study reported on the attitudes of professionals to the use of section 136 in Gloucestershire and showed that almost three-quarters of those involved thought that there should be an alternative place of safety to the police station, with many also thinking that the Accident and Emergency Department was unsuitable. The findings however indicated difference of opinions between professional groups thus supporting the need for clear guidance for front line staff to follow and ensure the right care for the person detained²⁰.

According to the report by Public Health in 2014²¹, alcohol misuse is a major cause of attendance at Accident and Emergency Departments and hospital admissions and the figure has more than doubled over the last 15 years with 70% of Accident and Emergency Department attendances between midnight and 05.00 on weekend nights likely to be alcohol-related. The need for places of safety will continue whilst appropriate solutions are found.

One individual whilst detained to the APoS experienced symptoms of alcohol withdrawal and needed to be taken back to Accident and Emergency. Direct communication and liaison with Accident and Emergency may have been helpful in this case.

Lessons Learnt: Managing people who are intoxicated

- wider engagement with the local health system to have in place crisis care intoxication pathways and in the future a comprehensive alcohol and misuse and prevention strategy as alcohol was involved in most of those detained
- agree inclusion criteria for people who are intoxicated
- all staff should have alcohol awareness training including signs and symptoms of withdrawals
- all staff should be trained in how to manage people who are intoxicated.

¹⁹<http://www.nhsstaywell.org/helping-a-drunk-person/>

²⁰A frightening experience: detainees' and carers' experiences of being detained under Section 136 of the Mental Health Act (2011) Riley et al

²¹Public Health England (2014) Alcohol Treatment in England 2013-14

3.7. Interventions provided

A reason Richmond Fellowship was selected to provide the APoS was because of the interventions it was able to offer. These included emotional support, social care support, and sign posting to other agencies, self-care promotion and basic therapeutic techniques.

Lessons Learnt: Interventions available

- a person centred and solution focused approach should be used to provide practical non-medical interventions that focus on reducing the person's distress
- work with individuals from the time of arrival
- provide emotional support, social care support, signposting to other agencies, de-escalation techniques, self-care promotion and basic therapeutic techniques
- de-escalation and break away techniques provide alternatives to restraint
- these interventions could be provided in HBPOS.

3.8. Medication provision, storage and administration

The out of hours General Practice service had been involved in the setting up of the APoS. Whilst a General Practitioner was not required to attend the APoS for a person detained and physically unwell or to prescribe medication during the pilot period, they did provide telephone advice.

A clear protocol is needed to set out those 'critical' physical health conditions with links to out of hours General Practitioner service and local pharmacist who could act as a safety net for advice on medication provision and approve administration of physical health medication.

Lessons Learnt: Medication provision, storage and administration

- develop a clear protocol in respect of 'critical' physical health medication i.e. for hypertension and diabetes
- engage local pharmacist to promote joint working, safe practice and provision of medication and to act as an advisory body where staff have concerns
- ensure service level agreement with out of hours General Practitioner service
- protocols agreed for any occasion when staff do need to give medication.

A person centred and solution focused approach should be used to provide practical non-medical interventions that focus on reducing the person's distress.

4. Conclusion

4.1. Summary of key findings

Ensuring the safety of people detained due to a mental health disorder is a multi-agency issue that cannot be addressed by the police alone. The experience of this pilot through galvanising new and improved partnership working demonstrated that better outcomes could be achieved for a number of individuals who would have otherwise ended up in custody. The experience of the pilot demonstrated that professionals could find new and innovative ways of working that successfully challenged the norm.

Both the police and AMHPs reported that the person centred approach operated by Richmond Fellowship helped establish a rapport with the person and so avoided frustration, anxiety and confrontation. "We would explain to the person detained

rather than the police or AMHP what was going to happen. Not rushing was important as the more harassed it was, the more unsafe the person might feel. Police were often advised on arrival that we would be taking our time. This was particularly important for those who were intoxicated".

A joint strategic approach is therefore required as recommended by the Independent Commission on Mental Health and Policing (2013)²² to develop protocols relating to section 136 "so that appropriate pathways can be developed for people who are drunk, as opposed to having a mental health problem". Information on these can be found in specific reports on work alone in NHS Trusts in South West London²³ and Kent and Medway²⁴.

4.2. Summary of key learning points

The table below summarises the five key learning points and solutions identified in the evaluation.

Key learning points	Actions and solutions
<p>1. Collaborative partnerships Integrated thinking and mutual objectives were needed in order to avoid fragmented care and disjointed responses along the pathway.</p> <p>2. Clarity of definition and understanding Agreement on the definition for the APoS was needed to ensure everyone at all levels understood their roles and responsibilities in order to avoid misunderstandings, conflict between agencies and potential risk to those detained, staff and the public.</p>	<p>Strong leadership and multi-agency collaboration A working group included the right people and decision makers committed to taking the pilot forward. They reached consensus on the objective and the definition which in turn informed the development of the operational policy and joint agreements.</p> <p>The group considered the pathway from the individual's perspective and experience rather than by agency or service.</p> <p>Communication through all levels would have benefited from a formal strategy including different communication methods as well as engagement with front line operational practitioners.</p>

²²Independent Commission on Mental Health and Policing (2013)

²³Alcohol and the 136 Suite: Pilot of a Brief Alcohol Intervention at www.swlondonssystem.org/our-work/current-small-grants-2013/alcohol-and-the-136-suite

²⁴<http://www.kmpt.nhs.uk/news/aande-alcohol-pilot-up-and-running-in-medway/7973>

Key learning points

Actions and solutions

3. Guidance for multi-agencies to follow

Locally agreed operational policy and procedures were needed to provide governance assurances. These local arrangements needed to be unambiguous and communicated clearly to avoid confusion and conflict.

Protocols and operational procedures

APoS pilot procedures were prepared in accordance with the Royal College of Psychiatrists. Royal College of Psychiatrists London (2013) Guidance for commissioners: service provision for section 136 of the Mental Health Act 1983.

The standard NHS contract details the operational standards and requirements for all providers of services to the NHS. They include quality, governance, safeguarding, complaints procedure and incident reporting, regulatory requirements and any local agreements, policies and procedures including protocols required to deliver the service commissioned.

An Information Sharing Agreement set out the rules for the sharing of information guided by the data protection act 1998, Caldicott guardians and the partners' policies.

4. Values attitudes and interventions

The values and attitudes of those involved in the pilot are transmitted in how they interact with each other. This was reflected in the ideas about the design of the APoS environment and the type of interventions to be provided. Such values and attitudes can leave a lasting impression and can encourage others to become conscious of their own values.

This does appear to have had an impact on the experience of both the person detained and the staff involved in the section 136 process.

A person centred approach

There was consensus reached that a person centred approach was needed and this informed the decision about the type of organisation required to provide the APoS.

These values and approach also determined the level of support, training and reflection necessary for staff to carry out their role effectively.

5. Supporting those who were intoxicated

People who are intoxicated can be supported in a non-health setting.

NHS advice

Richmond Fellowship staff took an approach with people who are intoxicated as advised by NHS on the staying well website.

Awareness training in recognising signs of alcohol poisoning.

The evaluation is able to conclude that all success measures agreed at the start of the pilot were met as set out below.

	Criteria for success measure	Criteria met Yes/No	Evidence
1	Development of protocol based on good practice standards	Yes	Operational Policy and procedure
2	Demonstration of collaboration between partners and shared learning	Yes	Minutes of working group meetings, memorandum of understanding, staff feedback and lessons learnt report
3	No incidents in the APoS	Yes	Incident and Complaints Log
4	No complaints received about the APoS	Yes	Incident and Complaints Log
5	Police able to leave within 30 minutes	Yes on four of seven occasions	Within 30 minutes for four detentions Within 40 minutes for two detentions Within 50 minutes for one detention
6	Police not recalled to APoS	Yes	Incident and Complaints Log
7	Positive feedback received from those detained	Yes	Feedback cards
8	Positive feedback received from staff	Yes	Feedback questionnaires and telephone interviews

The evaluation also concludes that the APoS was able to support safely and securely seven people aged 18 and over detained there by the police under section 136 during the pilot period and thus avoid the use of custody cells.

It is not always possible to plan for unexpected detentions and the significant reduction in detentions overall during

the pilot period, although welcomed by the partners, was not anticipated. The number of those detained in the APoS under the pilot was small however this evaluation does provide the evidence to support the concept that a third sector provider could safely provide an alternative place of safety to police custody.

The evaluation concludes that the APoS was able to support people safely and securely and avoid the use of custody cells.

5. Recommendations

Providing innovative additional capacity at times of high demand for HBPoS is a challenge. However, commissioning the third sector to provide APoS is certainly worth exploring given the positive response from those who came into contact with this pilot.

There are already a number of charities across the country providing a wide range of services including crisis interventions to people with mental health problems, promoting their independence, recovery, health and wellbeing. People have shared their experience of services when in crisis and have reported a much more positive one of third sector services compared with services provided by the statutory health sector. However the number of services commissioned from the third sector is small in comparison to those provided by the large NHS Trusts. In 2011/12 it was reported as 26%.

People who experience crisis have fed back a similar response in the CQC survey regarding the third sector with strong evidence that they are more than able to provide the person-centred approach with the practical support that people say they want. They are able to assist people in taking control and build resilience to achieve independence.

The evaluation findings recommend that NHS commissioners, namely CCGs and their local partners responsible for providing

places of safety:

- commission third sector organisations to support people detained as an alternative to police custody;
- develop a model of best practice for an APoS as part of a collaborative commissioning approach;
- ensure places of safety have pathways in place for those detained so they are offered practical solutions and support such as housing, employment, debt and relationship advice and who have good links into local agencies;
- take a 'values based' approach to build on active engagement of people accessing services in the commissioning cycle and trust the views of those who use the services;
- work with current HBPoS to deliver similar interventions using a person- and community-centred approach;
- develop a joint strategic approach and design appropriate pathways and interventions for people who are intoxicated and address unnecessary barriers that lead to people being excluded from HBPoS;
- utilise the third sector within the wider system of the crisis concordat to assist with crisis interventions to prevent admissions, aid recovery and signpost people on to local more appropriate services; and
- consider and agree the skills and competencies required for an APoS workforce.

6. Appendices

- 6.1 Appendix i Operational Policy working document and Memorandum of understanding
- 6.2 Appendix ii APoS monitoring data template
- 6.3 Appendix iii APoS staff and police feedback form
- 6.4 Appendix iv HBPoS staff feedback form
- 6.5 Appendix v HBPoS monitoring data template
- 6.6 Appendix vi Police monitoring template

²⁵Rees J, Miller R and Buckingham H (2014) The Public sector commissioning of local mental health services from the third sector pages 9-10

²⁶Care Quality Commission (2015) Right Care Right Now People's experiences of help, care and support during a mental health crisis

²⁷Joint Commissioning Panel for Mental Health (2013) Guidance for implementing values-based commissioning in mental health



Operational Policy
Richmond Fellowship
Alternative Place of Safety
For people detained under Section 136 Mental Health Act
1983

Author: Richmond Fellowship
Title: Locality Manager: – RF West Sussex Services
Date in draft: 18th February 2015

Review Schedule / Date:	Reviewed by:	In partnership with:	Date complete
24th Feb 15	RF	SPFT / WSCC / RF / Sussex Police	24th Feb 15
6th March 15	RF	SPFT / WSCC / RF / Sussex Police	6th March 15

Brief Memorandum of Understanding and Commitment to Working in Partnership

This is a brief Memorandum of Understanding and commitment to working in partnership to deliver a pilot for an Alternative Place of Safety [APoS] for people detained on Section 136 between

- **The Richmond Fellowship**
- **Sussex Partnership NHS Foundation Trust**
- **Sussex police**

The Home Office are providing funding Richmond Fellowship [RF] to partner with Sussex Partnership NHS Foundation Trust and Sussex Police to test the use of an Alternative place of Safety. The length of the pilot will be 12 weeks. If the pilot is successful and the partners express an interest to continue it may be necessary to carry a procurement exercise. Evidence of this proof of the models viability will be used to brief the Home Secretary and Department of Health Ministers and look at setting up further similar projects nationally.

Wherever possible, a health-based place of safety will be the first choice. RF's Alternative Place of Safety will be used in a situation where:

- Police have detained a person under S136 of the Mental Health Act 1983
- Health-based places of safety are unable to accept the person
- The person would otherwise be held in police cells to await a mental health assessment
- The police consider the person suitable to be safely held in the supported accommodation
- The supported accommodation operated by the Richmond Fellowship agrees to accept the person.

Sussex Police are committed to ensuring that where the above conditions are met, the person is taken to RF's APS in preference to a police cell.

Sussex Partnership NH Foundation Trust will act as the umbrella organisation for the Sussex CCGs and Local Authority partners, and take responsibility for ensuring that the pilot is linked to existing care pathways, and that a mental health assessment is carried out in accordance with the Mental Health Act by a Registered Medical Practitioner and an Approved Mental Health Professional as soon as possible and within the allocated length of detention (72 hours). In the context of the pilot they will also provide overall governance in partnership with Richmond Fellowship.

Richmond Fellowship will be providing 1 x unit of accommodation to keep the person safely until they have received a mental health assessment, or are transferred to a health-based place of safety, or other suitable arrangements are made for the person's ongoing care or treatment to return home. Richmond Fellowship will undertake the following:

- Provide a secure and safe alternative to police custody for people detained under s136 of the mental health Act;
- Ensure the alternative is available at agreed times and will take referrals directly from the police

- Work closely with South East Coast Ambulance Service (SECAMB) who may transport individuals to the APS
- Operate the project in line with the pan – Sussex sections 135 and 136 assessment policy, accepting both persons detained under section 136, and where required section 135 (1)
- Ensure governance and accountability structures are adhered to as set out in the Sussex sections 135 and 136 assessment policy.
- Support the reduction of section 136 detentions that would previously be routed to Sussex police custody suites;
- Develop a local operating model during the pilot with Sussex Police, Sussex Partnership NHS Foundation Trust, Sussex Approved Mental Health Professionals [AMHPs] and section 12 Doctors;
- Provide a person-focused, independent service, distinct from the role of other local section 136 health provision;
- Work in partnership with a range of local statutory and voluntary services to provide best support for people detained under section 136;
- Provide advice, support and ongoing referral across a wide range of issues, that will help to support the vulnerable person and ensure their ongoing safety;
- Ensure each service user receives the appropriate response particular to their needs;
- Respect and value the diversity of the community in which the service works, and recognise the needs and concerns of a diverse range of service users ensuring the service is accessible to all;
- Collect data and evidence to demonstrate the impact of the service which will be agreed with the Home Office, Sussex police and Sussex Partnership NHS Foundation Trust;
- The recipient will undertake the necessary steps to ensure the completion of the Alternative grants information form, to be submitted with Annex B (End of Year Financial Monitoring Report - April 2013 to March 2014) in April 2014;
- Be subject to scrutiny by the Home Office and its partners in relation to how the terms and conditions of this grant are being fulfilled.

Risk for service delivery will be shared with Sussex Police and Sussex Partnership NHS Foundation Trust but relate to the parts of the detainees s136 journey which the organisation has control over or involvement with.

All 3 organisations are committed to making Alternative Places of Safety work for the people of Sussex and over the duration of the pilot will work together to develop the model. This MoU also confirms that all 3 named organisations are committed to safely sharing information by jointly agreed means so that the APS service works for individuals. This is based on the principle of respecting the right to dignity and confidentiality whilst operating within the parameters of ensuring safety is achieved.

Signatures

Appendix i Operational Policy working document
and Memorandum of understanding

Signed by :

Name :

Date : 04.02.2015

For and behalf of the **Richmond Fellowship**



Signed by :

Name :

Date : 04.02.2015

For and behalf of **Sussex Partnership NHS Foundation Trust**

Sussex Partnership 
NHS Foundation Trust

Signed by :

Name :

Date : 13.03.2015

For and behalf of **Sussex Police**



Overview:

This document sets out the protocols and operational procedures for those staff members working for Richmond Fellowships' (RF) *Alternative Place of Safety* (APS) for persons detained under section.136/135 of the Mental Health Act 1983.

All protocols have been drafted in-line with the RF *'Model for the Sussex Alternative Place of Safety Pilot'* and by referring to the guidance as presented in the *Clinical Assessment of Persons under Sections 135 and 136 of the Mental Health Act 1983*. Whilst it is accepted that staff working for the APS are not operating within a clinical setting and / or required to provide clinical interventions; the guidance provided within the clinical framework is referenced in respect of admission and assessment under the Mental Health Act 1983 as well as arrangements for the conveyance of persons to other locations.

RF internal policy and procedure may also be referenced throughout the document as will any guidance that relates to the Health & Safety of those working for the APS alongside Information Governance.

The APS has been commissioned by the Home Office as a pilot service and will be operational for 12-weeks (only) from the date of commencement

This document and all associated protocols are therefore designed for the sole use of staff working within the APS (as well as RF management /senior management in an advisory capacity) and may only be used operationally and / or in reference to work undertaken at the following RF site:

section.136/135 Suite:, Horsham, West Sussex This has been agreed as a designated *Place of Safety* by West Sussex County Council (WSCC) in agreement with RF Executive Team.

Governance – Complaints, Incident Reporting and Review:

The protocols and operational procedures as set out in this document are as agreed, and in-line with recommendations from the following statutory partners and who formed part of the working group:

Sussex Foundation Partnership Trust (SPFT) / West Sussex County Council (WSCC)

The Home Office (HO) / South East Coast Ambulance Service (SECAMB)

Sussex Police (SP)

The protocols and operational procedures as set out in this document are as agreed, and in-line with recommendations from the following internal partners:

Richmond Fellowship Executive Team (RF ET / Assistant Director (AD) of Performance and Quality

A partner from each of the associated organisations and those with the appropriate authority to agree changes to the protocols will be consulted at each review to ensure shared risk management, operational transparency and to ensure the expectation of partner agencies is agreed and communicated.

Complaints: Governance will also be provided by RF (*Performance and Quality*) in respect of any operational practices and in the receiving of complaints as raised by those in our 'care' and/or family members as to a person's treatment whilst in the section.136/135 suite.

Any complaint/s will be recorded in-line with RF policy (*Complaints, Comments and Suggestions*) and must all be escalated to the Locality Manager (Rachel Kundasamy) as a level 2 incident (see below).

For the duration of the pilot, it is agreed all complaints will be escalated to the Assistant Director of Performance and Quality and RF senior management in order to ensure transparency in those actions taken. Where resolution is unsatisfactory; the Chief Executive and Commissioners may be notified in accordance with policy.

On entering / leaving the suite, information on how to raise a complaint will be given.

Incident Reporting: The reporting of incidents will be in-line with RF internal procedures *Accident and Incident Policy* with an incident defined as follows:

“An untoward occurrence i.e. a noteworthy event which is not planned desirable or positive in nature and needs to be actively addressed”

For the duration of the pilot, it is agreed all incidents / accident will be treated as a **Level 2** (minimum) as to ensure the Locality Manager is notified and can make a decision as to further escalation to senior management where required.

The policy will be followed in respect of the categorisation of Level 2 and 3 incidents and their escalation criteria

Any incident designated as a Level 3 will be deemed a *Serious Incident* and require the Locality Manger to call for a case review; this may include but not exhaustive of:

- Death of a Service User / Staff / Visitor
- Assault of staff and / or visitors that resulted in a 3-day or more absence from work
- Hostage taking
- Any incident, accident or dangerous occurrence that meets the criteria for the ‘Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR)

A case review will be attended by a representative from each of the statutory partners and RF senior management who have formed the working group. A decision will be reached as to the continuation of the pilot and offer a platform for the revision of protocols and safe working practices and staff team debrief and support. The service will use a specially designed form to record incidents which is located in the service file.

Where an injury of death is incurred to the service user in the care of RF; the *Duty of Candour* policy will be referenced and followed in consultation and agreement with the AD of P&Q and the Director of Operations.

Safeguarding: Where staff have concerns about the welfare of a service user within their care that pertains to abuse, neglect or exploitation; staff will follow RF policy on the *Safeguarding of Adults*. They will ensure that an incident form is completed at a level 2 (escalated) and that they communicate all concerns to the local WSCC board. Where a

crime is suspected, Sussex Police will also be contacted. The necessary 'follow-up' will be under-taken once a service user is discharged from the suite; this will include notification of any 'alert' made to the responsible professional (i.e. psychiatrist, care coordinator)

- Sussex Police – on 101
- Sussex Safeguarding alert raised on tel: (insert here)

Where safeguarding results to Children, staff will adhere to RF *Safeguarding Children Policy* and ensure all steps are taken in the immediacy to ensure a child's welfare. This will include and immediate call to Sussex Police on 999 where they have reason to belief a child has been 'left' without adequate parental / adult supervision as a result of the service users detention. Where staff are satisfied that they child is being care for at the time of detention but concerns remain as to their welfare, staff will follow the policy and ensure the necessary action is taken. Any concerns may be made / reported to:

- Telephone:
- Or email:
- The out of office hours (17.00 – 08./00 weekdays) and 24 hour emergency number on weekends and bank holidays is
- [email](#) :

Review: The review schedule of this document is to commence as follows:

Pre-commencement:

24th Feb 2015: This will be under-taken by the working group with input from AD of Performance and Quality and RF ET

6th March 2015: This will be under-taken by the working group with input from AD of Performance and Quality and RF ET

Post-commencement:

13th April 2015: One month post-start date. All staff providing front-line services and those associated partners from the working group.

13th May 15: Two months post-start date. All staff providing front-line services and those associated partners from the working group.

A review will also take place upon any incident that poses a risk to staff, service user and / or presents an operational failure

Structure and Use:

The protocols and operational procedures are designed for use 'in service' and by:

- Front-line staff providing services directly to persons detained under section136/135
- Management / on-call management / Senior Management providing guidance &support in an advisory capacity

The protocols are designed for use in isolation (for a specific protocol) as well as providing staff with guidance that can 'walk' them through admission to discharge from the APS

The document is designed to be a 'working document' and therefore also contains the appropriate numbers, named contacts and addresses that correspond to each of the protocols where appropriate.

The document is designed for easy and quick access and each protocol is 'isolated' to a section for ease of reference. No protocol is more than 2-sides of A4.

The document is therefore broken-down into 12 sections that underpin each of the following areas:

<p>Admission into service:</p> <p>1.1: Pre-screening 2.1: Arrival & Acceptance</p>	<p>Communication with Family & Friends / Visitors:</p> <p>7.2: Keeping Family / Friends Informed 7.3: Visitors 7.4: Unplanned visits</p>
<p>Informing the AMHP service & assessment procedure:</p> <p>3.2: Informing the AMHP Service 4.2: Assessment Procedures</p>	<p>Escalation Protocol:</p> <p>8.1: Violence / Aggression / Threats 8.2: Medication / Medical Emergency</p>
<p>In-service support:</p> <p>5.2: Observation, privacy and dignity 5.3: Sight & Sound Practice 5.4: Provision of comfort, refreshment and recreation 5.5: Support 5.6: Recording and Communication</p>	<p>Discharge from section 136/135 Suite:</p> <p>9.2: Discharge <i>without</i> acute admission 9.3: Discharge Planning 9.4: Discharge <i>with</i> acute admission 9.5: Discharge Planning 9.6: Conveyance 9.7: Communication & Record Keeping</p>
<p>Medication:</p> <p>6.2: Removal & Storage 6.3: Administration of Medication 6.4: Medication Exceptions 6.5: Out-of-hours prescribing</p>	<p>Monday Discharge & Conveyance:</p> <p>10.2: Process 10.3: Conveyance</p>
<p>Reporting / Evaluation:</p> <p>11.1: In service reporting / recording 11.2: Evaluation and weekly reporting 11.3: Monthly reporting and section 136 attendance</p>	<p>Staff Contingency:</p> <p>12.1: Staff cover & practice 12.2: Handover 12.3: Staff Absence</p>
<p>Special Arrangements:</p> <p>13.1: Use of G24 13.2: Fire</p>	<p>Appendices</p>

1.1: Admission into Service: Pre-presentation screening:

This guidance sets out the steps to be taken for initial police contact and deciding if the person can be considered for the APoS. Where a person is to be considered, it does not automatically commit the service to accepting the person however, where under-taken thoroughly, will inform an appropriate presentation.

1.2: Use of 136 call log: Sussex Police will notify RF before the detained person is presented to the APoS. The staff member taking the call, will refer to the '136 call log' and MUST complete each section of the form. They must ensure they ask each of the questions as stated and may ask for further circumstantial information where they feel it will aid their decision

1.3: Eligibility for Presentation to APoS: Where a 'yes' answer is given to the questions relating to violence or aggression and / or as to a crime being committed, the staff member will say NO to any presentation to the APoS.

Where a 'yes' answer or an inconclusive answer is given in respect of an over-dose / potential over-dose and / or a physical health concern (**including known insulin dependant diabetes**), the staff member will advise on a presentation to A&E, assessment by triage or ambulance crew in attendance and say NO to any presentation at the APoS until such a time as medical clearance has been given.

Where a 'yes' answer is given to substance misuse / alcohol, the staff member will enquire further about the persons ability to communicate, walk and over-all cognition. They will advise that a presentation can only be made where that person is able to demonstrate all three to a reasonable degree with further assessment on arrival at the service.

The staff member will enquire where the person has been picked up from. Where the person has been found in the vicinity of Gatwick but is not deemed to have arrived from abroad; the service can accept. Where the person is confirmed as having arrived from abroad; staff will say NO and advise on detention to A&E and / or custody.

NB: The APoS is for the use by Sussex Police only. Request for use by any other force is to be declined.

1.4: Standard clinical assessment by ambulance staff which would define whether conveyance to A&E or other health care facility was required. In-line with the Crisis Care Concordat, all persons subject to section.136/135 detention will be conveyed to any designated *Place of Safety* by the ambulance service (with Police escort).

In Sussex, the ambulance service is referred to as SECAMB (*Sussex and East Coast Ambulance Service*). The target time for SECAMB to attend the location at which the person has been found is currently 60-minutes.

It has been agreed that for the purpose of this pilot, the ambulance crew responsible for conveying the person to be detained to the APoS, will under-take a SUMC to aid admission and inform the service of any physical health concerns. Those persons who are attended to by SECAMB who do not have a paramedic on board, will be required to 'call-in' the results of the SUMC to the paramedic desk and relay their findings to a senior staff member. The decision will be made as to suitability to come to the APoS within 30-mins.

Staff taking the initial screening call MUST advise the Police officer making the referral that this is a requirement and that on arrival we will ask for the '*Clinical Performance and Outcome Indicator*' (this may also be referred to a 'NUSE').

It is also agreed that where a person has been assessed by 'street triage' teams (a clinically-trained nurse who is tasked with teaming up with the Police to assess and decide upon the need for a s.136) a SUMC may be under-taken by them and this can be recorded on the pre-screening form.

RF staff must make clear to the Police Officer that should they convey the person to the APoS without the SECAMB escort (due to a delay in attendance) and / or where the person has not been subject to a street triage assessment by medically trained staff; this may delay admission to the APoS upon their arrival and where staff have concerns as to the persons physical health; they may re-direct to A&E or a health-based *Place of Safety*.

1.5: If the patient is advised to go to A&E prior to presentation at the APoS, upon being deemed fit for discharge from hospital the nurse, SECAMB or Police Officer will contact the APoS and ensure it remains vacant. A&E should arrange transport with SECAMB. Police will escort. In the event the APoS is occupied, the hospital shall contact a health-based place of safety.

Where it is agreed upon screening that the person may be presented to the APoS, all staff must make the request that on approach to the building, there should be no 'blue-lights' or sirens in use. Prompt for side-entrance use only.

2.1 Admission into Service - Arrival & Acceptance:

2.2: Sharing of Information: Once it is agreed that the person may be transferred to the APoS, staff are authorised to request additional information about the person being conveyed. This is in line with the *Information Sharing Agreement* as agreed with SPFT and contained in **Appendix A**.

Staff will consult the following:

When street triage is operational (13.00 -21.00 Friday, Saturday and Sunday)

Street triage mobile number

Outside of Street Triage, staff will contact CRHT referral-line (09.00-21.00 Monday-Fridays)

CRHT referral number

Outside CRHT working hours, staff will contact the *Senior Nurse Practitioner* (SNP's)

SNP telephone number and ask for the SNP direct line.

Any information received and stored by the service will be treated in accordance to RF *Information Governance Framework* and *Confidentiality and Access to Records Policy*. Both policies are governed by the Data Protection Act 1998.

In sharing information *with* others, this will be governed by RF policy (as above) in respect of grounds for disclosure:

Explicit: In all cases, staff should aim to secure explicit consent for the sharing of information with others

Needs to know basis: Staff will only share information that is deemed to be of benefit to an individuals support and wellbeing.

Public interest: Where it can be demonstrated that the sharing of information will produce a greater and significant benefit to one or more people than the withholding of information.

Risk or harm: Where the sharing of information will prevent or reduce immediate or future harm to the service user and / or other (including child protection)

Those parties with who RF will share information with are inclusive of:

- WSCC – AMPH service
- SPFT
- GP
- Nearest Relative
- Sussex Police

PNC: The staff member will also ensure that a PNC check has been completed and that staff have been made party to the information as to ensure any decision to accept is in-line with the service level risk assessment and where required, any additional controls that may determine / support an acceptance into the APoS can be implemented.

The staff member will also ensure that where known to Police (this may not always be ascertained); details of the nearest relative / friends are made known to the staff.

2.3: Removal of ligatures, other 'high risk' items (listed with *property recording sheet*) and appropriate storage: It will be the responsibility of Sussex Police to search the detained person prior to being conveyed to the APoS. This will involve a search outer clothing, pockets and a general 'pat down' (the law does not allow the Police to strip search someone) in order to remove any ligature risks to include belts, any lighters and medication about their person and / or any other item that is required.

On arrival and admission into the APoS, the handover of property will be recorded on the *Removal of ligatures, high risk items and property recording sheet*.

Where the person has a handbag / bag / rucksack; these may be searched at point of admission and where there are concerns about its contents and / or concerns about concealment.

All items will be stored in a locked facility and counter-signed by the Police officer as part of their handover.

Medication will be stored in a separate lockable facility.

2.4: Standard clinical assessment by ambulance staff which would define whether conveyance to an Accident and Emergency Department or other health care facility was required due to presence of physical health condition or injury. Where the person has been conveyed to the APoS by the ambulance service, the staff member will request a copy of the *Clinical Performance and Outcome Indicator*. This will be kept with the person's records. In the unlikely event the person is conveyed to the APoS by the Police alone; the staff member will be required to contact the 'first doctor' (**see 3.2**) for this to be under-taken.

2.5: Acceptance: Acceptance into the APoS will be a joint decision agreed by both RF staff members on duty. Once the staff member/s are satisfied that the APoS is appropriate for the detained person they will proceed as follows:

- Provide the detained person with their rights both in writing and verbally along with the service FACT sheet
- Ensure the Police *Handover Form* is completed fully inclusive of PNC and nearest relative / family details (if known)
- Ensure the *Removal of Potential Ligatures and High Risk Items* and that the *Property recording sheet* has been completed and counter-signed by the Police Officer
- Commence completing p.1 of the Monitoring Form for Section 136 along with the equality and diversity record.

The time from which acceptance is recorded is the time from which the 72hrs detention under the MHA will commence

2.6: Grounds for refusal / requesting additional support

Where the person arrives and there are notable inconsistencies as to the information gathered during the pre-presentation screening and their *actual* presentation i.e. notable health concerns, high levels of intoxication (absence of functioning – inability to walk or talk or both) and / or acts or threats of aggression / violence – the staff may decline and the person will be taken to A&E or detained to Police Custody

Where upon arrival there are any immediate / presenting concerns about the persons' physical health and there is an absence of a SUMC; the staff member may decline acceptance into the APoS and ask they be taken to A&E or, ask the Police to stay until the first doctor's arrival.

Where there are signs of *agitation on presentation – the Police may be asked to remain for no longer than 60-minutes until the person has ‘settled’ into the s.136 suite as to ensure that any indication of the situation escalating can be responded to immediately.

SECAMB are only permitted to stay a maximum of 15-minutes for a handover period

*Emotional state of excitement or restlessness that for the purposes of admission is underpinned by aggression and / or threats / constant bodily movements

3.1: Informing the AMHP Service& arranging Interpreters:

3.2: Where no SUMC has been under-taken: Where there is an absence of the SUMC but a decision is made to accept the person into the APoS with this pending; the first action of staff following acceptance will be to contact the ‘first doctor’ (Registered Mental Health Practitioner) in order to:

a) notify of admission to the APoS and

b) advise of admission *without* the relevant medical assessment and the need for this to be under-taken urgently.

An out-of-hours rota for the ‘first doctor’ will be provided to the Locality Manager by the lead AMHP and made available for office display on the ‘*Assessment notice board*’.

3.2: Where there is an SUMC: Staff first action will be to contact the AMHP Service as follows on the out-of-hours duty line:

Out-of-hours duty line: 01903 843 239

Staff will advise that they are calling from Richmond Fellowship, Blatchford House APoS.

They will give all relevant details as prompted. It will be the AMHP responsibility to then coordinate the attendance of both the first and second (s.12) doctor (where appropriate) for assessment purposes

***Where the ‘first doctor’ has already been notified due to the absence of a standard clinical assessment by the ambulance staff, staff MUST inform the AMHP service which doctor they have contacted and at what time.*

Staff will request that the AMHP contact the service at their earlier convenience in order to establish an estimated time of arrival.

3.2: Interpreting Services: Where an interpreter is required for the assessment, the staff member should advise the AMHP of this and this will be arranged via the he AMHP service.

Where the service cannot communicate effectively with the person detained due to use of language and / or disability; staff will contact SIS (Sussex Interpreting Service) on: insert phone number

3.4: Communication & Record Keeping: Staff will now continue to up-date the Monitoring Form with the time of contact with the first doctor (where a SUMC was requested) and / or time of first contact with the AMHP service.

All other communication with our statutory partners will be recorded on the '*professionals contact log*'.

Where there has been no communication / up-dates by the AMHP service within 4hrs of notification; the staff will make a second call to the same number

4.1: Assessment Procedure:

This guidance sets out the procedure for assessment under the Mental Health Act 1983. It is to set expectation and most actions will be carried out by those statutory partners attending

4.2: It is best practice for the detained person to be seen by both the 'first doctor' and the AMHP together. However if the first doctor sees the person first due to:

a) RF requesting a SUMC to be carried out

b) simply arriving first for assessment

and concludes that the person is not mentally disordered then a telephone conversation can be had with the AMHP.

The individual can then no longer be detained under s.136 and should be immediately discharged from detention (see Discharge *without* acute admission).

4.3: If the first doctor feels that an inpatient episode is deemed unnecessary but the detained person has a mental disorder they must be seen by an AMHP.

4.4: If the person requires admission and agrees to voluntary/informal admission an AMHP must be involved. If the person declines admission a section 12 approved doctor will be contacted (second doctor) by the AMHP to undertake a full MHA assessment.

4.5: Communication & Recording Keeping: Upon attendance of both the first doctor and AMHP; the times must be recorded on the Monitoring Form.

In the case of **4.2**, staff will request confirmation of the outcome from those attending. They will up-date the Monitoring Form as required as well as the '*professional contact log*'. They will move to follow the procedure for Discharge *without* acute admission.

In the case of **4.3 and 4.4** and where unable to attend together, the first doctor may leave written recommendations for the AMHP. This may include recommendation for detention under s.2 / s.3 of the MHA 1983 and the relevant papers will be held at the service for use by our statutory partners. Any paperwork left by the first doctor, must be given to the AMHP on arrival at the service and copies retained for the persons file.

In all events, all written records inclusive of *observation and contact sheets* for the person detained will be given to our statutory partners for viewing on their arrival

In all events the Monitoring Form will be up-dated with the outcome of all assessments

5: In Service Support:

This guidance sets out the protocols for the provision of support to those detained to the s.136/135 suite.

5.1: Risk

Staff will adhere to the service level risk assessment in the provision of support *however* as to ensure transparent communication with each other they will be required to complete a *individualised risk assessment* that simply 'alerts' staff to any area of the service risk assessment and protocol they feel need to be applied.

An example may be where a person has 'self-harmed' cutting prior to admission and therefore staff have deemed it that the 'lowest' level of risk in respect of food items need to be deployed (i.e. – no knife)

5.2: Observation, privacy and dignity:

The person detained under s.136/135 of the Mental Health Act 1983 is subject to strict observation throughout their time in 'detention'. In line with governance set out by the Standing Nursing & Midwifery Advisory Committee (SNMAC) however:

observation is defined as "regarding the patient attentively, whilst minimizing the extent to which they feel they are under surveillance."

As an organisation that promotes the recovery and independent choice of those we support; RF staff will adhere to this ethos whilst acting at all times to safeguard at person under our duty of care. RF staff will therefore follow the principle of being in '*sight and sound*' of a person at all times as opposed to observation.

The degree to which the practice of '*sight and sound*' will be applied will also be determined by ensuring that where safe to do, a person right to privacy and dignity will be up-held.

5.3: Sight and Sound in Practice:

- One staff member will remain with the person in the suite (in-line with the service risk assessment) at all times where they may engage that person
- Staff will leave the suite where the person wishes to use the toilet. The staff member will be able to have 'sight' of the person via the viewing window and mirror and will make all effort to allow privacy and follow the *Clinical Framework* of allowing 3-minutes for the person to return the suite and 'full-sight'. Staff will advise the person of the need to re-enter the suite at this time.

- Staff will remain in the suite where the person wishes to use the shower but will remain least intrusive and use the mirror as opposed to direct observation
- Where the person wishes to get changed (RF will have clothes available if the clothes of the person have been soiled) staff will leave the suite and use the mirror. If the person moves to the bathroom; the same principles as above will be applied.
- Staff will allow the person to sleep peacefully where required and leave the suite. This will be after 30-minutes as to ensure they are not concerned as to the persons intended actions / welfare. **Staff will not leave where upon the person is risk to self and / or under the influence of alcohol / substances.** The lights may be dimmed to the extent to which the person must still be in sight via the viewing window and mirror. Staff will be silent in re-entering the room every 30 minutes to ascertain sound / movement.
- Where a person becomes aggressive and / or violent – the sight and sound principle will be adhered to via the viewing window only. This will however be undertaken by both staff using both viewing windows as to ensure full sight and sound of the person until a time as statutory support / Police arrive. **Staff will NOT re-enter until the Police have arrived.**

5.4: Provision of comfort, refreshment& recreation:

The service will look to provide an *Alternative Place of Safety* in so far as where as is possible and safe to do so, bedding / pillows / blankets will be provided to each person detained to the suite. The service will also look to (if required, and due to the presentation of someone on arrival) provide a change of clothes / socks that provide adequate warmth and comfort. Towels and wash items will also be provided in the event of showering.

Bedding:

- The beds will be dressed with bottom sheet and pillows only upon arrival of the person
- The person will be provided bedding shortly after their arrival and where there is no early indication of concealment; i.e. suspected concealment of items/ 'hiding' in bathroom area and / or apparent harm to self; they will be provided a duvet. Where there may be concerns about concealment / their intentions and we need to ensure the person movements can be better ascertained; blankets will be given.
- Bedding will be removed in any attempt to strip the bed for use of harm to self or others; i.e. attempting to wrap round staff / use to conceal viewing windows
- Bedding will be removed after each use for infection control and the service will hold 2 sets at all times.

Clothing:

- Where the person is 'soiled' upon arrival and requires a change of clothes and / or is not warm enough. Clothing will be given.
- The service will hold one-set of 'joggers' in each size for male and female and all times. They will not be 'draw-string' or 'hoodies'.

- The service will hold socks / slippers in various sizes
- Where a person strips naked and refused to dress where items provided, the warmth and comfort of that individual will remain paramount and subject to risk assessment, staff will attempt to provide bedding for warmth.
- Any clothing removed from the person that is subject to infection control i.e. covered in human material will be kept in a yellow waste bag. The person will make a decision about the disposal and / or retaining these clothes only upon the outcome of the MHA assessment.

Toiletries:

- A maximum of one large bathroom towel will be given to the person for use only when showering. It will be removed for laundry immediately after.
- A toothbrush and toothpaste (disposable) will be provided only when needed and removed immediately after.
- Travel size body-wash / shampoo will be provided in the bathroom
- Toilet roll will be given as and when required and removed immediately after use

Recreation:

- A selection of books will be kept at the service
- There will be a selection of magazines kept at the service

Refreshments:

- Staff will ensure water is available in the suite at all times in a plastic cup
- The person will be offered a hot drink and / or on request be provided with one. This will be offered in line with the risk assessment i.e. standing times for cooling periods
- Staff will be able to offer the person food. This will be in the form of sandwiches; microwave meals, soups, toast and cereal only. There will be food preparation at the service and all food sources are to have been 'pre-prepared' and required heating only. Cold food sources will be the chosen first option. Cereals and Toast are also provided. Staff will wear disposal gloves in all instances and in line with risk assessments
- Staff will follow a *food order checklist* before giving the food. This will include allergies, cultural and dietary requirements
- Staff will ensure only plastic cutlery and plates are provided
- Where the person being detained is at high risk of self-harm (determined by admission details and risk assessment); food that does not require a knife and fork will be given i.e. sandwiches and soup at a cooled temperature
- No person will be forced to eat. However fluids are to be encouraged (especially in instances of alcohol consumption) and where the person has not taken fluids throughout the time until our statutory partners arrive; this will need to be reported.

Sleep:

- Person who are able to sleep and wish to do must be allowed
- Staff will not disturb the person unless they have immediate concerns for their wellbeing

- Staff will as above, leave the suite and be in sight only from the viewing window after the initial 30-minutes – they will stay in the suite if any concerns about concealment / persons intent to act to harm self (as above)
- Lack of movement over the course of 30-mins may permit the staff member to enter with minimal disruption to ensure 'sight and sound' is established; breathing / movement
- In all cases where substances / alcohol are suspected – the staff member will remain in the suite at all times to ensure their wellbeing but ensure minimal disturbance.

5.5: Support:

It is accepted that a person detained to the suite may wish to engage with staff on a therapeutic level in respect of talking about their difficulties, what led to their detention and / simply need human contact to help contain their symptoms. Staff will be expected to draw upon their experience and using the values that underpin RF and work with those in the service to promote 'recovery'. Staff may do this in a variety of ways to include but not exclusive of:

- Emotional support
- Practical support – the person may inform you of debt, housing problems etc. and staff can be proactive in giving advice, guidance and information
- Supporting the management of visual and auditory hallucinations where safe to do so i.e. in absence of violent command hallucinations
- Promoting and encouraging self-care at all times
- Allowing for 'quiet' and promoting choice where able. No person will be forced to talk / sleep / eat / sit still. Provided their actions are not deemed to cause harm to self or others; this will be respected and upheld

5.6: Record Keeping & Communication:

Staff will be required to record every action / concern / communication with the person being detained.

In addition, staff will be required to write a 'general observation' on the person's wellbeing every 30-mins.

This will be recorded on the '*communication and observation log*'

This record **MUST** be shared with our statutory partners on arrival

6.1: Medication – Persons own medication:

The detained person may arrive at the APoS with medication on their person. This sets out the protocol for storing medication and deals with the permissions required to supervise the medication of any person detained to the suite.

6.2: Removal & Storage:

Upon arrival and acceptance into the APoS all medication will be removed from the person and stored in a locked facility that is used only for medication. Both staff members will count, record and counter sign all medication onto an RF *Medication Recording Sheet*. The record will be kept with the medication. Any 'over-the-counter' medications i.e. aspirin / paracetamol will also be removed and recorded with the same degree of care.

6.3: Administration of medication:

Under no circumstances will staff give the medication that has been removed to the person being detained. Staff can never be 100% as to an over-dose of medication having already been taken and so this is a necessary measure. The identity of the person being detained may also need to be known / established

Staff will therefore need to follow the agreed protocol:

- Staff will advise the AMHP service and / or first doctor that the person has arrived with medication and that this cannot be administered without medical authority
- Upon arrival of the first doctor; staff MUST give the doctor the medication and the RF medication recording sheet to check along with the SUMC (where already undertaken)
- Where upon the doctor confirms that this medication can be given; staff will in the first instance request that this be under-taken by the doctor.
- Where this is not possible due to 'prescribing instructions and / or the doctor recommending that a period of time needs to be extended; staff may proceed to administer the agreed amount at the agreed time. This will be recorded on the medication recording sheet
- Where RF staff are given medical permission to administer; the doctor will advise on the time/s to be given, any side-effects and cautionary indicators that staff need to be aware of. This will be recorded on separate sheet that the doctor will be asked to sign. This will be retained with the medication recording sheet.
- Staff will not force the person to take any medication against their will and failure to take will simply be recorded on the Medication Record and the *communication and observation log*.
-

6.4: Medication Exceptions - Own:

Asthma: Where a service user has presented with an inhaler; this may be given to them upon request. This can still be recorded in the Medication Recording Sheet and should ideally be removed after each use

Insulin: Any person that presents with known insulin dependant diabetes will, in the first instance be re-directed to a health-based place of safety. Where a SUMC has been completed however the persons 'blood sugar' deemed at an acceptable level; the Insulin will be stored in a compartment of the fridge, clearly labelled. It will NOT BE ADMINISTERED by anyone other than a medically trained professional.

This professional, may be the 'first doctor' who can be asked to under-take blood sugar reading on arrival and administer where required. If there is a need to arrange a district nurse for administration at a given time, this can be for those registered with a Horsham GP only:

One-call – Rapid Access: (insert phone number)

If the service user requires a prescription for Insulin; staff will need to alert IC24 (as indicated below in **6.5**) and then arrange administration via One-call or the GP attending

In the event of any concerns as to the person's physical health whilst in the service, staff will follow the escalation procedure (**8.2**)

Where it is apparent that the person detained has insulin dependant diabetes once already accepted into the APoS, please refer to out-of-hours (**6.5**) prescribing and escalation (**8.2**)

Clozaril / Lithium: Any person that presents with Clozaril in their possession will need to have had a SUMC prior to acceptance into the service. They will follow the same procedure as above in **6.3** however on alerting the AMHP service of the admission; they MUST advise of the person being on Clozaril and the need to obtain medical permission to administer. The person must be closely monitored and any signs of infection, especially influenza-like illness (e.g. sore throat, fever) will be immediately called into the AMHP service and the GP out-of-hours service. Any escalation of these symptoms will result in 999 being called.

6.5: Out-of-Hours prescribing and administration: The staff are not expected to leave the service at any time whilst the suite is occupied and therefore any medication deemed to be required will need to be secured via the Sussex Out-of-Hours service IC24.

In the event that medication is prescribed / advised by the first doctor (RMP), IC24 may be contacted for attendance of their GP service and / or to provide the medication required.

IC24: Out-of-Hours are contactable: (insert number here)

Any medication that is supplied is subject to the same protocol as stipulated in **6.2-6.4**

7.1: Communication with Family / Friends and Visitors to suite:

All those in the s.136/135 suite will be permitted contact with close friend or relative and where they have already been informed and this has been recorded as part of the *Police Handover*(if known by Police), staff may also be permitted contact.

RF staff need to inform the person that they need to advise their nearest relative of their admission at the absolute minimum.

7.2: Keeping family / friends informed:

Staff will refer to RF *Confidentiality Policy* and explicitly use the guidance as set out in the *Consent to Communicate form* in order to help support the person to identify what they would and would not like us to share with their identified family member or friend.

Staff should be mindful that as no visits are permitted to the suite and therefore when up-dating family / friends they should be advised of this policy.

Staff will make clear that where possible, their right to privacy will be respected however they will advise that in some circumstances this cannot be promised:

- Their death
- You having a serious injury or illness that means you are taken to hospital
- There is something that could be a serious risk to you

Staff will ensure that the form is written (even where the person may not be able to sign) and record all communication with them in this regard on the *communication and observation log*. Staff will need to make a decision as to the information that they will share with the person identified based on these three guiding principles as well as the grounds for disclosure set out in **2.2**.

7.3: Visitors:

The person is not permitted visits to the service. This decision has been made in-line with the service level risk assessment in order to minimise risks to service user, staff, visitor and other tenants on site.

The service may welcome visitors at the point of discharge in respect of supporting the person home.

7.4: Unplanned Visits:

- Where the friend / family arrive unplanned having been alerted to the admission by the person detained; staff will need to advise the visitor that they are not permitted access and that this is service policy for all admissions. They will be asked to leave
- If they refuse and cause a disturbance on the property, the Police will be called.

8. Escalation Protocol:

8.1: Violence / Aggression / Threat:

All staff are trained in verbal de-escalation and break-away techniques and it is hope no situation will become 'violent'. However, the nature of the service does present a risk and the following must be adhered to in order to self-guard themselves and the person detained:

- Staff will adhere to all controls on the service level risk assessment at all times
- Staff will act on the 'earliest opportunity' to change working practices i.e. where a threat is made or a person starts to change in presentation and is seen to become

aggressive; staff will commence in using the viewing window only. Contact may be minimal i.e. for the provision of water / food where required

- Where this behaviour is seen to escalate (marked by damage to property, violent threats and gestures) the Police will be called without delay
- Where staff become entrapped / subject to assault; 999 will be called by the second staff member in the first instance
- Where an entrapped staff member cannot alert their office-based colleague – the staff member will **press 5** on their phone – this will trigger a Guardian 24 alert which has the special instruction to respond by ‘recording’ and ‘alerting’ emergency services without delay
- Where the person ‘breaks free’ of the suite; staff will lock themselves in the main building and contact the Police

8.2: Medical Concern / Emergency:

In becoming concerned as to the person physical health, staff will contact:

- The out-of-hours GP (via IC24) and ask for their attendance in the case non-medical emergencies. They will give as much information as possible as to the persons presentation, circumstance, medication and symptoms
- Where the staff member becomes concerned about a persons withdrawal from substances (especially alcohol) and the person has limited responsiveness, seizures, breathlessness, severe and persistent vomiting and hot and cold ‘sweats’; the staff will contact 999 and convey to hospital
- Where the staff member is aware of the person has insulin dependant diabetes and the out-of-hours GP is unable to attend in order to administer, the service will call 999 in any situation where the person becomes unwell. The staff will convey to hospital upon arrival.
- Any other medical concern / emergency will be responded to accordingly. This includes a person harming themselves in anyway that required medication attention. Staff trained in first aid are permitted to deal with and alert GP / 999 based on the seriousness of the injury
- Staff are permitted to use CPR (where trained) and a defibrillator (according to awareness training and guidance) if required until such a time as the ambulance arrives
- Staff will ensure that where they convey to hospital; nearest relative informed

Any incident that requires escalation will be recorded as Level 2 escalated (minimum). Where there is serious injury to staff / service user – this must be recorded as Level 3 and called in to the National-Manager-On-call

9.1: Discharge from the s.136/135 suite

9.2: Discharge without acute admission:

The AMHP, first doctor (Registered Medical Practitioner) and second (s.12) doctor (if required for a full Mental Health Act assessment) will advise staff on their recommendations.

Where it is deemed that the person is:

- a) not to have a mental disorder
- b) has a mental disorder but does not require an admission to an acute unit

The person is no longer detainable s.136 and should be immediately discharged from detention *unless* they are considered vulnerable and a recommendation made by the AMHP and doctor after-care need. The AMHP will advise on the time of discharge and the person may continue to be 'detained' on the s.136 until this time; this is providing it is not greater than 72hrs after acceptance into the service.

9.3: Discharge Planning:

In-line with the *Clinical Framework* it is good practice for staff to under-take a 'pre-discharge' risk assessment that considers and 'controls' for the following risks:

- Support on discharge – in all cases, staff will consider family / friend as given on the *Police Handover and / or RF Consent to Share* to support the person home. This may be deemed the preferable option at anytime of day or night and should be ruled out in the first instance. Where the person has chosen to leave the service alone, the staff will inform the family / friend of their discharge
- Time of discharge – consideration need to be given to the vulnerability of the person, the distance to be travelled and the availability of transport. Staff are permitted to allow the person to remain in the suite until the morning where discharge is agreed later than 9pm at night and the person is not local to the county of West Sussex. Where the person is local to Horsham; this is negated and the use of 'Road Runners' taxi-account is permitted
- Travel – this will need to include consideration given to means of transportation, finance and distance to be travelled. Travel warrants for use on public transport may be issued for travel outside of Horsham. The use of 'Road Runners' taxi-account is permitted for transport within the Horsham locality only
- Support after discharge – where possible, the staff will provide the person with information on support after discharge. This may include sign-posting to specialist services. Where local to West Sussex, staff are permitted to take a referral for RF outreach / peer services and may facilitate a follow-up support session either by phone or at an RF office base
- Staff will ensure that where possible and they have the mean to do so; the person if offered a follow-up call at the ETA at their home address
- Staff will complete a simple risk assessment covering these areas
- If the person wishes to leave immediately on being deemed fit to discharge and / or refused any assistance, staff cannot prevent this and the person should be free to go
- The belongings of the person, including any medication will be returned to them and signed for. Where they changed clothes they can be offered back to the person and if they choose for them to be discarded due to them being 'soiled' they will be asked to sign to confirm this decision. Whilst service users chooses to remain in the suite and receive our support; the service will not return 'high risk' items to the person.

9.4: Discharge with acute admission:

The AMHP, first doctor (Registered Medical Practitioner) and second (s.12) doctor (where required if the person will not agree to an informal admission) will have conducted a Mental Health Act assessment and will advise staff on their recommendations

Admission may be informal or agreed under section .2 or 3 of the Mental Health Act.

9.5: Discharge Planning:

- Where an admission is required the doctor will contact the Crisis Team in order to request a bed.
Between 8am – 9pm each day (inclusive of weekends) the bed-referral will be made to the following duty-line: **telephone**;
- Where admission is required outside of these times; the doctor will need to advise the Senior Nurse Practitioner (SNP)
- Where not readily given, staff must request details from the doctor as to who the bed request has been made and secure the contact details.
- Staff will (where safe to do so) continue to provided the person with in service support as highlighted above (**section5.1**)
- Staff will ensure that all belongings and medication is ready to be given to ambulance crew on arrival at the APoS. This will be signed for.
- Staff will ensure copies of all paperwork that relate to the person (*communication and observation logs, medication records, monitoring form, Police Handover, any risk information, risk*) is prepared and given to the ambulance crew on arrival at the APoS

9.6: Conveyance:

- The Crisis Team and AMHP service will arrange for the conveyance of the person to hospital once a bed has been located
- Staff are not required to travel with the person to the hospital.

9.7 Communication & Record Keeping:

Once an outcome / decision has been reach, staff will fully complete the *Monitoring Form* ready for handover and / or to be sent to the GP, Care Coordinator and / or Crisis Team as required.

The discharge planning sheet will be completed.

Once the discharge from the service is complete - all the paperwork will be scanned to the T-drive and filed in a lockable facility ready for the Locality Manager to retrieve and record on the data sheet.

10.1: Monday - Discharge and Conveyance:

The service is operational between 8pm each Friday until 8am each Monday morning.

This protocol relates specifically to the requirements of the service in respect of the need to convey the person in the following 2 circumstances:

- a) The person has not been assessed by 8am on the Monday morning
- b) The person has been assessed and deemed as needing an acute admission but no bed has been located.

10.2: Process:

Where the person has yet to be assessed, there will be a need to convey the person to another health-based place of safety (PoS). This will be done at 09.00 after the arrival and handover the 08.00 staff members; one of whom shall be a Team Leader and / or Locality Manager.

The TL and LM will take responsibility for calling the following health-based PoS to arrange for the persons transfer. They will ask for the ward manager.

- HBPOS – insert phone number
- HBPOS – insert phone number

Where the person has been assessed and deemed as requiring an acute hospital admission, the TL and LM will take responsibility in contacting the Crisis Team and / or SNP in order to ascertain progress made in securing a bed. Where they advise this is unlikely within the next 2hours; the TL / LM will proceed in contacting the above 4 PoS

In the event that staff are unable to speak directly to the health-based PoS, staff may contact the following:

- AMHP service – mobile and out-of-hours telephone numbers

10.3: Conveyance:

Where a bed is secured in the a health-based PoS; the TL / LM will call **the Health Care Professional Line – HCP** and request an ambulance for the purpose of conveying a person detained under s.136 to an alternative location for assessment and / or further detainment.

*On arrival, staff are required to travel with the person to the alternative location. They must ensure they take copies of all paperwork that related to the person as to ensure a through handover.

*Staff will contact the Police for support in conveying where the person has become violent / aggressive during the time at the APoS.

As in line with **9.6**, staff are not required to travel where upon an acute bed is secured via the appropriate means (Crisis Team / SNP)

11 Evaluation & Reporting:

The following will advised on the standards for record keeping and

11.1: In service reporting / recording

The suite of paperwork for each service user will consist of:

- S.136 Call-log
- Police Handover
- Removal of Ligature, high risk items and property sheet
- Monitoring Sheet
- Consent to Communicate
- Individualised Risk Assessment
- Professional contact log
- Observation & contact log
- Food Checklist
- Discharge Planning

Referrals to RF for follow-up care will be made under the 'standard' procedure and signed by staff & service user.

11.2: Evaluation and weekly reporting

The Locality Manager will take responsibility in completing the *throughput & outcome data-sheet* each Monday afternoon for submission to:

HBPoS data collection lead

Pilot evaluation data collection lead

Assistant Director of Business Development RF

Director of Performance & Quality RF

Regional Manager RF

11.3: Monthly reporting and s.136 attendance

The Locality Manager will take responsibility in completing the *Operational data-sheet* by 1st of each month for submission to the above persons. This data will report on:

- Staffing issues
- Incidents & complaints
- Issues on admissions
- Police call out to APoS and reason why
- Compliance with Protocols

12: Staffing Contingency & Handover:

This section will aim to provide guidance in respect of staff cover and contingency as well as handover procedures.

12.1: Staff cover and suite attendance: The service will be covered by 2 staff at all times. There should never be a situation in which the suite is occupied and a staff member is off site. This would result in disciplinary action being taken.

Where an agreement is in place for one (only) staff member to leave immediately upon the arrival of the second shift; they may only leave on the grounds:

*Both staff members have arrived for the next shift

*They have ensured full communication with notes and handover sheet being up-to-date.

*There has been no risk incidents that have a) been escalated to viewing through both windows b) the Police have been called to attend c) any other risks that require all 4 staff during handover

All staff on shift are expected to adhere to the following procedures in line with protocol and service risk assessments:

- The observing staff member will be with the person detained in the suite at all times excluding those times as set out in the protocol and based upon risk assessment
- The observing staff member will be expected to take a break from direct observation every 2 hours minimum and should move outside of the suite for a period of 15-minutes. Their colleague will take-over. If the staff member takes a toilet break and needs to leave the office, their colleague will use the viewing window only as risk assessment dictates no staff member is to be in the suite when their colleague is not office based.
- After 6 hours of observation, the staff members will switch roles. Staff need to communicate this with the service user to ensure they feel supported and safe.
- If it is felt that switching roles is not appropriate in respect of service user need and/or it appears to be triggering a behaviour change; the staff member should dynamically risk assess this situation and where they are alert and able; can made a decision to continue observation with increased breaks moving to 10 minutes in every hour. They should re-assess this situation every hour.
- Staff should stay hydrated and bring adequate provision in respect of food.
- The office-based staff member is responsible for carryout 'checks' on their colleague every 15-minutes. This needs to consider safety, clear exits and wellbeing of staff (do they look tired / concerned).

- Staff will report on the person detained every 30 minutes updating the *observation and contact sheet* for all general activity / concerns / wellbeing and actions.

12.2: Handover: Staff will be allocated 30-minutes period for handover. During this time (where safe to do so), one staff member will observe from the window only as to ensure all parties can be present. During the shift, staff will be required to note down anything of significant importance that they know must be relayed verbally to ensure staff are aware. This may include risks, food allergies, delays in assessment, physical health and any 'incidents' that have occurred. This will be recorded on a *Handover Recording Sheet*

Handover will take the following form:

On arrival – both staff will take 10-minutes to read the information / notes / risk

The 'new' staff will then be introduced to the person detained (one at a time only) – there must always be one person in the office. The staff should also reduced the risk of the person being detained feeling 'overwhelmed'.

The verbal handover will take no more than 15-minutes with all parties outside and one staff member viewing at all times.

The staff coming on the shift will need to sign the handover form to confirm this has been under-taken

12.3: Staff absence: It is accepted that staff may become unwell from time-to-time and the service will try and reduce an impact on operations. In order to achieve this, and in order to ensure the safety of our service users, staff and statutory colleagues, the service has put in the place the following measures:

- All staff are advised to notify the service of illness / absence at the earliest convenience – this will ideally be a minimum of 3-hours notice (it is accepted that in an emergency situation this may not be possible)
- Where a Friday night staff member is unable to attend; the service will not be operational until 08.00 Saturday morning
- Where a Saturday or Sunday staff member is unable to attend, the service will operate an on-call system from 08.00 Saturday for 48 hours. It will be the staff members' responsibility to alert the service on **telephone**; of their impending absence as to ensure cover can be arranged via the on-call
- **The on-call rota will be displayed on the notice board.**
- The on-call is intended to offer a contingency for both day & night and any decision should be made on occupancy of room:
 - On-call used to cover Saturday day staff – night staff calls in unwell – room unoccupied – service is not operational until Sunday at 8am

- On-call used to cover Saturday day staff – night staff calls in unwell – room occupied – staff should follow plan under **10.2** and arrange for the transfer of the service user to a *health-based place of safety* using SECAMB and staff conveying.
- Staff should however go through the SNP in order to arrange this as opposed to going directly to each suite (**insert telephone number and ask** for the SNP direct line).

The same protocol should be in-use for Sunday staff contingency planning

- There the service is out of operation – staff will inform:
 - RF National Manager On-call
 - Sussex Police
 - Each of the 4 health based-places of safety as identified in **10.2**

Special Arrangements

This section aims to outline a strict protocol that is unique to this service in respect of fire and an emergency situation for staff when working in the suite and using Guardian 24 (G24) effectively for safe working and escalation:

13.1: Use of G24: Each of the service phones are linked to Guardian 24 ARC system and staff **MUST** use these phones when on shift at the APoS (no other phone is permitted).

The numbers are

Procedure:

- Staff will allocate themselves a phone
- They will log on to G24 via telephone numbers; at the start of each shift registering for 12.5hrs (speed dial 2)
- The pin number for telephone x is y
- The pin number telephone y is x
- Staff **MUST** advise on the location and nature of the service being the APoS. Staff must advise that any alert should be responded to without delay and the emergency services called. The script will be as follows:
 - Staff name,
 - Service (Richmond Fellowship APoS section.136 suite)
 - Location (address and postcode, Horsham West Sussex)
 - Special arrangements: *This service is 'high risk'. Please ensure any alert received is responded to in line with the escalation protocol and emergency services are sent to the location.*

13.2: Fire: In the event of a fire, special arrangements are in in place to ensure the detention of a person is maintained as far as is safe to do so.

This has been agreed with Richmond Fellowships Health & Safety Officer, in-line with guidance from Performance and Quality via the service level risk assessment. On hearing the alarm:

- One staff member will remain with the service user in the suite
- The office-based staff member will take up-position at the exit to the office where they are still able to observe their colleague and person detained, but can ensure ease of immediate exit if required
- The office-based staff member will alert 999 and request Police attendance advising of the APoS and the need for Police escort
- The office-based staff will also contact Blatchford House front-line on-call

These arrangements have been agreed to ensure the APoS staff can remain fully focused on the person in the suite and not need to act for the purposes of the Blatchford House Service.

These protocols are displayed on the notice board in the office

Appendix A: Information Sharing Agreement with SPFT



INFORMATION SHARING AGREEMENT

1. Scope

- 1.1 This agreement will apply to the sharing of personal information concerning people receiving a service from Sussex Partnership NHS Foundation Trust at:

Langley Green Hospital, Martyrs Avenue, Crawley, West Sussex RH11 7EJ

with the staff of:

Blatchford House Place of Safety Suite, Richmond Fellowship, 52 Kings Road

Horsham, West Sussex RH12 1BX

in respect of: All service users using Blatchford House Place of Safety Suite

- 1.2 The agreement will cover all personal information, whether recorded and stored electronically, on paper, or on tape/DVD/CD etc and whether communicated verbally, in writing or electronically/digitally.
- 1.3 This scope may be restricted by agreement to particular types of information, or that held in certain formats.

2 Purpose of the Agreement

- 2.1 The purpose of this agreement is to provide guidance to staff within Sussex Partnership and in other organisations to enable them to share information concerning people using the services of the organisations; and to ensure that the sharing of information is lawful, properly governed, and based on consent wherever possible.
- 2.2 This agreement therefore sets out how information sharing will take place, and underlines the obligations of all parties to the agreement to adhere to the Data Protection Act, the NHS Code of Confidentiality and the Human Rights Act.

This agreement covers the sharing of personal information about service users for the purposes of providing health and social care and related services to these individuals. As per principle 3 of the Data Protection Act, any data shared shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed. Only information deemed relevant to the individual's care should be shared.

- 2.3 The information to be shared will relate only to individuals who may be detained in the Richmond Fellowship Place of Safety under Section 135 or 136 of the Mental Health Act. This will include:
 - Whether the person is using or has used Sussex Partnership NHS Foundation Trust services
 - Date of the last contact with Sussex Partnership NHS Foundation Trust services
 - Name of Care Coordinator and GP
 - Clinical Diagnosis
 - Risk Alerts – violence
 - Latest recorded details on medication
 - Name and Contact Details of Nearest Relative
 -

3 Duties of all Staff

- 3.1 All staff of the organisations covered by this agreement must ensure that they are familiar with the policies and procedures relating to data protection and confidentiality of their respective organisation, and must comply with them.
- 3.2 All staff must in particular act in accordance with the NHS Code of Confidentiality, and any breaches of confidentiality will be dealt with according to the organisation's policy. This may include disciplinary action or in serious cases, civil or criminal prosecution.

4 Consent

- 4.1 Consent to share their personal information for the purposes set out above will be sought from the individuals to whom this agreement applies.
- 4.2 The existence and nature of this agreement, the purposes of sharing information, and the procedures relating to confidentiality (including the process whereby information may need to be shared without consent) will all be explained to each individual subject to this agreement.
- 4.3 All organisations covered by this agreement must ensure that this explanation has been given to the individual(s) to whom they are providing services.
- 4.4 The consent of each individual will be recorded. In the case of Sussex Partnership, this will be by means of a standard consent form, which will contain options for restricting the sharing of certain personal information with certain individuals or organisations. Detailed explanation of the form and its implications should be given where required and guidance can be supplied in different languages, large print, Braille if needed.
- 4.5 The consent of each individual will be reviewed on a regular basis, and any changes to that consent will be clearly recorded.
- 4.6 An individual may withdraw or change their consent at any time.

5 Method of Storing and Exchanging Information

- 5.1 All personal information will be stored securely and confidentially by the organisations indicated in this agreement. The managers of each organisation will be responsible for ensuring that no access to personal information will be allowed to anyone not authorised to have it.
- 5.2.1 The managers of each organisation will be responsible for ensuring that information will be equally protected while in transit between the organisations or being transmitted by hand, email, post, courier fax or telephone.

6 Alerts of Information Security Failure

- 6.1 If for any reason personal information is shown to have been exchanged inappropriately, or to anyone not entitled to access it, all organisations named in this agreement will undertake a formal investigation, jointly if necessary and appropriate. Any failure by staff to adhere to the relevant policies, procedures or terms of this agreement uncovered by the investigation will be dealt with severely. This may include disciplinary and/or legal action.

7 Onward Transmission

- 7.1 The organisations covered by this agreement will not share any information gained from a signatory to this agreement with another person or organisation not party to this agreement, unless the consent for this has first been secured from the originating organisation and/or the service user.
- 7.2 Any organisation or person that is to receive on-ward transmitted information in this way must first demonstrate their commitment to the principles of data protection, security and confidentiality.

8 Review and Amendment

- 8.1 This agreement will be jointly reviewed by the organisations party to it no later than 3 months from the date of signing as shown below.
- 8.2 Any party to the agreement may request an amendment to the scope or terms of this agreement at any time. This request will be jointly considered in a review of the agreement, and if acceptable to the relevant managers of the respective organisations, will lead to the signing of a redrafted agreement.
- 8.3 No amendment will be acceptable if it would compromise in any way the adherence to the Data Protection Act, the Caldicott Principles, or the NHS Code of Conduct for Confidentiality.
- 8.4 Any changes impacting on the subjects of this agreement will be communicated to them

9 Auditing

- 9.1 The operation of this agreement may be subject to auditing at any time by any of the organisations party to it.

10 Statement of Compliance

Sussex Partnership NHS Foundation Trust

Langley Green Hospital,

Richmond Fellowship

Place of Safety suite, Horsham West Sussex

Appendix i Operational Policy working document
and Memorandum of understanding

On behalf of the above organisations, we (the undersigned) certify that we have read, understood and agree to abide by the conditions set out above in this agreement. Our organisations will abide by these conditions for the use and transfer of all personal information relating to service users.

We understand that knowingly or negligently failing to adhere to these requirements may result in legal action being taken against the organisation and/or its employees, agents or sub-contractors.

We confirm that all those covered by this agreement will be familiarised with its contents and given access to a copy of it whenever required.

For Sussex Partnership NHS Foundation Trust:

Signed
Name of individual
Position in organisation Service Director
Date

For Richmond Fellowship:

Signed
Name of individual
Position in organisation Assistant Director of Business Development
Date

Appendix ii APoS staff and police feedback form

Appendix ii APoS data items Alternative Place of Safety RICHMOND FELLOWSHIP - s136 Admissions					
Name					
Address					
Date of Birth					
Date of Admission	Not accepted codes:	codes	Outcome codes:	RF engagement & Outcome	RF discharge support
Time	1 - Drugs	10	Informal Admission	ES - Emotional Support	WRAP - wellness & recovery plans
Male	2 - Intoxicated	11	Admitted - Section 2	PS - Practical Support i.e. debt	RF - RF referral made for follow-up support
Female	3 - Violence / aggression	12	Admitted - Section 3	MMS - Management of Mental Health Symptoms	SP - Sign-posting
Custody transfer	4 - Physical health issue	13	Discharged - advised to contact GP	SC - Promoting self-care/ welfare	FC - Follow-up welfare call
A&E transfer		14	Discharged - referred to CRHTT	WRAP - wellness & recovery plans	TR - Transport provided
Eligible	Presenting Need	15	Discharged - referred to CMHT / other		
HB PoS full		16	Taken into Police Custody		
Presenting Need	5 - Suicide attempt	17	Transferred to A&E		

Appendix ii APoS monitoring data template

Accepted into 136 (Y/N)		6 - Self-harm	18	Discharged home - no follow up
Not Accepted (code)		7 - Substance Misuse		
Ethnicity Code		8 - Self-neglect		
Outcome Code		9 - Positive symptoms of mental illness (may include delusions / hallucinations / grandiose thoughts)		
Outcome Details				
RF engagement and in-service support				
RF discharge support				
Total time in Suite (Max Target 6 Hours)				
Time Left 136 Suite				
Issues/Notes				

**Alternative Place of Safety
Staff Feedback Form
13 March to 1 June 2015**

Introduction

As you know the Alternative Place of Safety (APoS) is being piloted for 12 weeks at Blatchford House, Horsham. In order to evaluate the pilot we would like your feedback of your recent experience via a short questionnaire or you can just comment.

Please then forward to Deborah.frazer@nhs.net or give us your name and daytime telephone contact number for us to call you

Please read each statement, decide how strongly the statement applies and score 1 to 5 based on the guide below, commenting where appropriate.

How much does each statement apply?		1	Strongly disagree			
		2	Slightly disagree			
		3	Neither agree nor disagree			
		4	Slightly agree			
		5	Strongly agree			
		Mark Your Score				
A	Engagement	1	2	3	4	5
	I was provided with information about the APoS and made aware of the pilot objectives					
	I am aware of my role and responsibilities in relation to the APoS					
	The APoS was available when needed					
	The facilities at the APoS were adequate to ensure safety and comfort of both those detained and the staff					
Comments						
B	Joint working	1	2	3	4	5
	Good information was shared by colleagues about the person detained					
	I felt supported by my colleagues from the police/Ambulance/Richmond Fellowship/AMPH and Doctors					
	Colleagues responded within agreed timescales					
	We were able to reach agreement					
Comments						

Hospital Based Place of Safety
 Staff Feedback Form
 13 March to 1 June 2015

Introduction

As you know the Alternative Place of Safety (APoS) was piloted for 12 weeks at Blatchford House, Horsham. In order to evaluate the pilot we would like your feedback of your recent experience of working in the Section 136 place of safety (PoS) via a short questionnaire or you can just comment.

Please then forward to Deborah.frazer@nhs.net by 29 June 2015

Please read each statement, decide how strongly the statement applies and score 1 to 5 based on the guide below, commenting where appropriate.

How much does each statement apply?		1	Strongly disagree			
		2	Slightly disagree			
		3	Neither agree nor disagree			
		4	Slightly agree			
		5	Strongly agree			
		Mark Your Score				
A	Engagement	1	2	3	4	5
	I know when I am required to cover the PoS					
	I am aware of my role and responsibilities in relation to the PoS					
	The PoS was available when needed					
	The facilities at the APoS were adequate to ensure safety and comfort of both those detained and the staff					
Comments						
B	Joint working	1	2	3	4	5
	Good information was shared by colleagues about the person detained					
	I felt supported by my colleagues from the police/Ambulance/Richmond Fellowship/AMPH and Doctors					
	Colleagues responded within agreed timescales					
	We were able to reach agreement					
Comments						

Appendix v Hospital Based Place of Safety admissions Langley Green and Meadowfield Hospitals - 136 admissions			
Person (anon)			
Place of Safety			Not accepted codes: 1 - Drugs 2 - Intoxicated 3 - Violence / aggression 4 - Physical health issue
Home area			
Date of Detention			
Time			
Male			Presenting Need 5 - Suicide attempt 6 - Self-harm 7 - Substance Misuse 8 - Self-neglect 9 - Positive symptoms of mental illness (may include delusions / hallucinations / grandiose thoughts)
Female			
Aged 0-17			
18-64			
65+			
Custody transfer		Outcome code	Outcome codes: Informal Admission
A&E transfer		10	
Eligible		11	Admitted - Section 2
HB PoS full		12	Admitted - Section 3
Presenting Need		13	Discharged - advised to contact GP
Accepted into 136 (Y/N)		14	Discharged - referred to CRHTT
Not Accepted (code)		15	Discharged - referred to CMHT / other
Ethnicity Code		16	Taken into Police Custody
Outcome Code		17	Transferred to A&E
Outcome Details			
136 Suite Discharge Date			
136 Suite Discharge Time			
Approx. total time in suite (hours)			
			RF engagement & Outcome ES - Emotional Support PS - Practical Support i.e. debt MMS - Management of Mental Health Symtoms SC - Promoting self-care/ welfare WRAP - wellness & recovery plans

Mental Health Monitoring Form

Recording Details:

Police Area

Date of encounter

Time of arrival at incident

Time of Detention

Police Ref Number

Personal Details:

Name

DOB

Gender Male Female Other

Ethnicity White Black
 Mixed Other
 Asian Not known

Any other details disclosed:

1a Initial Police Encounter:

Incident Address/Postcode

Location of Client Public place Private place Missing

In what circumstances did the person come to your attention?
 Encountered in the community Suspect
 Victim/witness of crime Missing person
 Section 135 Warrant

Behavioural issue that triggered concern (select all reasons that apply)
 Harm to self Physical violence
 Harm to others Other aggression
 Unusual behaviour

Is the person suffering from the affects of Drink or Drugs? Yes No

1b. Action taken:

What action was taken by the police?
 S136 Detention Was CJS action taken? Yes No
 S135(i) warrant If 'yes', what was CJS response?
 Informal referral to MHS Arrested
 Community referrals Warning/Caution
 NoK (taken home) FPN

Did you request advice from a Mental Health Professional? Yes No Has Client been detained under S136 previously? Yes No
 If yes did they provide advice? Yes No
 Was client taken to A&E for illness/injury? Yes No No further action taken Yes

Continue the rest of the form only if the client was Detained under Section 135 or 136

2a. Method of Transport and Place of Safety - 1st

Transport	Place of Safety
Transport	Place of Safety
Note: Blatchford House or the Health Based Place Of Safety (HBPOS) should be used in all but the most exceptional circumstances	
Method of Conveyance to POS <input type="checkbox"/> Ambulance <input type="checkbox"/> Police vehicle <input type="checkbox"/> Other health vehicle <input type="checkbox"/> Not requested	Type of Place of Safety <input type="checkbox"/> HBPOS <input type="checkbox"/> Police custody <input type="checkbox"/> Blatchford House <input type="checkbox"/> Other
Time ambulance called <input type="text"/>	Arrived at POS <input type="text"/>
Time ambulance arrived <input type="text"/>	Officers leave POS <input type="text"/>
Did the police escort ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If police custody, why? <input type="checkbox"/> Joint risk assessment - violent <input type="checkbox"/> HBPOS no capacity <input type="checkbox"/> HBPOS refused admission <input type="checkbox"/> Blatchford House no capacity <input type="checkbox"/> Blatchford House refused admission <input type="checkbox"/> Arrested for substantive offence <input type="checkbox"/> Other
If not ambulance, why not? <input type="checkbox"/> Not available in time scale <input type="checkbox"/> Risk assessment - behaviour <input type="checkbox"/> Ambulance refused to take <input type="checkbox"/> Already at POS <input type="checkbox"/> Other	Details: <input type="text"/>
If longer than 30 mins, reason for delay in police leaving POS: <input type="checkbox"/> POS not warned of arrival <input type="checkbox"/> Risk assessment - officers to remain <input type="checkbox"/> Lack of staff	<input type="checkbox"/> Bed/Cell watch <input type="checkbox"/> No delay <input type="checkbox"/> Other Details: <input type="text"/>

2b. Method of Transport and Place of Safety - 2nd (if applicable)	
<p style="text-align: center;">Transport</p> <p>Method of conveyance to POS <input type="checkbox"/> Ambulance <input type="checkbox"/> Police vehicle <input type="checkbox"/> Other health vehicle <input type="checkbox"/> Not requested</p> <p>Time ambulance called _____ Time ambulance arrived _____ Did the police escort ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If not ambulance, why not? <input type="checkbox"/> Not available in time scale <input type="checkbox"/> Risk assessment - behaviour <input type="checkbox"/> Ambulance refused to take <input type="checkbox"/> Already at POS <input type="checkbox"/> Other</p>	<p style="text-align: center;">Place of Safety</p> <p>Note: Blatchford House or the Health Based Place Of Safety (HBPOS) should be used in all but the most exceptional circumstances</p> <p>Type of Place of Safety <input type="checkbox"/> HBPOS <input type="checkbox"/> Police custody <input type="checkbox"/> Blatchford House <input type="checkbox"/> Other</p> <p>Arrived at POS _____ Officers leave POS _____</p> <p>If police custody, why? <input type="checkbox"/> Joint risk assessment - violent <input type="checkbox"/> HBPOS no capacity <input type="checkbox"/> HBPOS refused admission <input type="checkbox"/> Blatchford House no capacity <input type="checkbox"/> Blatchford House refused admission <input type="checkbox"/> Arrested for substantive offence <input type="checkbox"/> Other</p> <p>Details: _____</p>
If longer than 30 mins, reason for delay in Police leaving POS: <input type="checkbox"/> POS not warned of arrival <input type="checkbox"/> Risk assessment - officers to remain <input type="checkbox"/> Lack of staff <input type="checkbox"/> Bed/Cell watch <input type="checkbox"/> No Delay <input type="checkbox"/> Other	

2c. Method of Transport and Place of Safety - 3rd (if applicable)	
<p style="text-align: center;">Transport</p> <p>Method of conveyance to POS <input type="checkbox"/> Ambulance <input type="checkbox"/> Police vehicle <input type="checkbox"/> Other health vehicle <input type="checkbox"/> Not requested</p> <p>Times: Time ambulance called _____ Time ambulance arrived _____ Did the police escort ambulance <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If not ambulance, why not? <input type="checkbox"/> Not available in time scale <input type="checkbox"/> Risk assessment - behaviour <input type="checkbox"/> Ambulance refused to take <input type="checkbox"/> Already at POS <input type="checkbox"/> Other</p>	<p style="text-align: center;">Place of Safety</p> <p>Note: Blatchford House or the Health Based Place Of Safety (HBPOS) should be used in all but the most exceptional circumstances</p> <p>Type of Place of Safety <input type="checkbox"/> HBPOS <input type="checkbox"/> Police custody <input type="checkbox"/> Blatchford House <input type="checkbox"/> Other</p> <p>Times: Arrived at POS _____ Officers leave POS _____</p> <p>If police custody, why? <input type="checkbox"/> Joint risk assessment - violent <input type="checkbox"/> HBPOS no capacity <input type="checkbox"/> HBPOS refused admission <input type="checkbox"/> Blatchford House no capacity <input type="checkbox"/> Blatchford House refused admission <input type="checkbox"/> Arrested for substantive offence <input type="checkbox"/> Other</p> <p>Details: _____</p>
If longer than 30 mins, reason for delay in police leaving POS: <input type="checkbox"/> POS not warned of arrival <input type="checkbox"/> Risk assessment - officers to remain <input type="checkbox"/> Lack of staff <input type="checkbox"/> Bed/Cell watch <input type="checkbox"/> No Delay <input type="checkbox"/> Other	

3. Restraint	
Was physical restraint used during: <input type="checkbox"/> Initial encounter <input type="checkbox"/> Transport <input type="checkbox"/> At the Place of safety	Details: None used Details: None Used Details: None Used

4. Client Outcomes	
Time assessment requested _____ Time assessment started _____ Fitness to Detain _____ Fitness to Detain completed by _____ End time of encounter (leave POS) _____	Client subsequently: <input type="checkbox"/> Admission to hospital <input type="checkbox"/> Referred to community MHS <input type="checkbox"/> Continuation of existing care plan <input type="checkbox"/> Other health/social support services <input type="checkbox"/> No referral
For analyst use: Time from arrest to first POS _____ Time from first POS to police leaving POS _____ Total length of police encounter _____ Total length of client detention _____	Details: _____

Any other details relevant to the encounter: _____ _____ _____
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7. References

7.1. References

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Rees J, Miller R and Buckingham H (2014) The Public sector commissioning of local mental health services from the third sector pages 9-10

Royal College of Psychiatrists London (2013) Guidance for commissioners: service provision for section 136 of the Mental Health Act 1983 Section 136 and Ethnicity at <https://www.sussex.ac.uk/> accessed 23 July 2015

The Independent Commission on Mental Health and Policing (2013)

West Sussex CCGs and signatories (2015) Mental Health Crisis Concordat action plan page 6

7.2. Glossary

Terms, acronyms and abbreviations used:

Accident and Emergency Department, also called an Emergency Department or A&E

A Health Based Place of Safety is usually within a mental health unit

AMHP Approved Mental Health Professional

CCG Clinical Commissioning Group

CQC Care Quality Commission

Custody suite is a designated area within a police station designed to process those who have been detained or arrested or who are there for purposes such as answering bail

GP General Practitioner

Mental health crisis is a situation where there is an immediate life-threatening emergency to the person or

another, or where help is needed fast and urgently however it is not an emergency

Mental Health Crisis Care Concordat is a national agreement between services and agencies setting out how organisations will work together better so that people get the help they need when they are having a mental health crisis

SECAmb South East Coast Ambulance service

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

Third sector organisation is those organisations that are neither public nor private sector

7.3. Document version control

Version	Date	Author	Approver	Reason
Number	Date	Individual	Insert group or n/a	First draft / minor corrections / (insert) detail added etc
0.1	06.07.15	Kim Solly & Deborah Frazer	Pilot Working Group and SECSCN	Additional comments and lessons learnt glossary and references
2.0	13.07.15	Kim Solly & Deborah Frazer	Working Group	Operational Policy removed and amendments to interventions. Introduction, vision and key learning points included
3.0	24.07.15	Kim Solly & Deborah Frazer	Working Group	Operational Policy included. Narrative to accompany cost; change of title and working group members
4.0	31.07.15	Kim Solly & Deborah Frazer	Richard Jolley and Cathryn Masters	Cost to police time
5.0	06.08.15	Kim Solly & Deborah Frazer	Richard Jolley	

7.4. Working Group

Name	Post	Organisation
Laura Bagnall	Mental Health Commissioning Manager	NHS Horsham and Mid Sussex CCG (on behalf of NHS Crawley CCG, NHS Coastal West CCG)
Gillian Bendelow	Professor in Sociology of Health & Medicine	University of Brighton
Matthew England	Clinical Quality Manager	South East Coast Ambulance NHS Trust
Deborah Frazer	Principal Associate	South East Commissioning Support Unit
Sarah Gates	Mental Health Liaison Officer Force Crime & Justice Department	Sussex Police
Thomas Gillespie	Assistant Director of Development	Richmond Fellowship
Daryl Hitchings	AMHP Lead	West Sussex County Council
Tom Insley	Senior Manager Mental Health Commissioning	NHS Horsham & Mid Sussex CCG
Richard Jolley	Health and Policing Lead Public Protection Unit	Home Office
Rachel Kundasamy	Locality Manager West Sussex	Richmond Fellowship
Cathryn Masters	Quality Improvement Lead, Mental Health	South East Strategic Clinical Networks NHS England
Dr Minesh Patel	Chair	NHS Horsham & Mid Sussex CCG
Marian Trendell	Head of Social Care - Specialist Service	Sussex Partnership Foundation Trust
Kim Solly	Associate Partner	South East Commissioning Support Unit
Emma Wadey	Director of Nursing Standards & Safety	Sussex Partnership Foundation Trust