

A safer place to be

Findings from our survey of health-based places of safety for people detained under section 136 of the Mental Health Act

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Foreword

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.

Under section 136 of the Mental Health Act 1983 (MHA), someone who appears to be experiencing a mental health crisis in a public place can be picked up by the police and taken to a place of safety for an assessment of their needs. In all but exceptional circumstances this should be in a healthcare setting.

Last year, we carried out a joint thematic review with Her Majesty's Inspectorate of Prisons and Healthcare Inspectorate Wales. Together we found that, despite clear guidance, police stations were regularly used as a primary or secondary place of safety in the nine force areas we inspected. Police records showed that this was mostly because there were not enough staff or beds at the health-based place of safety, or because the person had consumed alcohol, or was displaying or had a history of violent behaviour.

It is of serious concern that police stations are being used as a default place of safety. We undertook this national survey to look at the availability, accessibility and operation of health-based places of safety.

The results support the findings of the joint thematic review. Mental health trusts in some areas told us that they did not believe there was enough local provision. In addition, many providers' policies had a number of different criteria that could be used to exclude people from their health-based places of safety. It is essential that these issues are resolved, with input from commissioners of healthcare where necessary, to make sure that people who are in crisis are always cared for in an appropriate environment.

However, commissioning and providing sufficient and appropriate health-based places of safety are not the only answer. There is a wide range of services that can respond to people experiencing a mental health crisis. Specialist services, such as liaison psychiatry services, crisis resolution home treatment teams, crisis houses and crisis helplines, can all help to provide an effective response. Effective partnership working, inter-agency training and support can help to reduce the use of section 136 and, as a result, the demand for places of safety. There is emerging evidence from innovative triage schemes that joint working between the police and health staff to provide people in crisis with the right help and support can contribute to reducing the use of section 136 overall. They can also increase the proportion of section 136 detentions that result in further mental health care, including inpatient stays. We welcome this and encourage the further development of the evidence base to evaluate the effectiveness of the triage schemes.

Other providers that we regulate, including primary medical services and specialist mental health services, also have a key role to play in intervening early to prevent a mental health crisis escalating in the first place.

We are reviewing the care pathway for people detained under section 136 as part of a wider thematic review that we are undertaking in 2014/15. This will look at the quality, safety and responsiveness of care provided to people experiencing a mental health crisis by providers registered with CQC and organisations responsible for operating the MHA. We expect to publish our national report in 2015. Delivering this review and the national survey of health-based places of safety are two key commitments we have made in the national Mental Health Crisis Care Concordat for improving outcomes for people experiencing a mental health crisis.

Over the last year we have also been developing a new approach to monitoring, inspecting

and regulating care services. At the heart of this approach is the commitment to tailor our inspections to the issues that matter in each sector. For specialist mental health services, this includes having a consistent focus on core services across all providers where there are known inequalities, or where people are in especially vulnerable circumstances. Health-based places of safety is one of these core services that we will always inspect as part of our comprehensive inspections.

The findings of this survey, and the tools and methods that we are developing as part of the 2014/15 thematic review, will help us to develop our inspection approach. We will judge whether health-based places of safety meet nationally recommended standards of good practice. From October 2014, we will begin to rate whether the quality of care provided to people is safe, effective, caring, responsive and well-led.

We will continue to monitor the wider operation of section 136, both as part of and in addition to our inspection activity, through our responsibility under the MHA to keep the use of the Act under review and check that it is being used properly.

We are grateful to the staff who completed this survey on behalf of their organisations, and hope that all agencies involved in commissioning, providing and operating health-based places of safety will use our recommendations and findings to make improvements.



Dr Paul Elliott
Deputy Chief Inspector of Hospitals
(Lead for Mental Health)

People's experiences of section 136 and places of safety

In 2014/15, CQC is carrying out a thematic review of mental health crisis care in England. As part of this review, from February to April 2014 we asked to hear from people who had experienced a crisis in the last two years, people who had cared for someone going through a crisis, and groups and organisations that work with people who have experienced a crisis. Below is a selection of quotes taken from the responses we received.

"I was taken by the police from a public place (in handcuffs in the back of a police van) to custody and was stripped searched and placed in a cell for over 12 hours. I had a coffee and some water but nothing else. I left custody and went home with my parents, but my mental state became worse again so I ended up in a mental ward as a voluntary patient."

"The A&E staff seemed to have a different understanding [from the police] of whether hospital was a place of safety. There was also a lack of communication between the two services. In the end the police and nurse got into an argument in front of me, which increased my suicidal ideation."

"The 136 suite was not available... so our daughter was taken to the police station until it became free... this happens a lot because of the lack of the right grade of nurse. She then got put in three different hospitals because of the bed situation... we wanted her to stay in [the first location] as it was an all-female ward...we fought, but no! Then on to [a second location], which in her words was like one flew over the cuckoo's nest... so back home to [a third location]... three assessments started... three locations... just not good enough."

"Once the police realise the person is ill, they show amazing compassion and the workers attached to the cells [...] are also very kind and seem to realise that although the person is acting scary, they are, in fact, terrified."

"It would have been better if I could have been taken to a place of safety in a hospital or specially designed crisis house instead of being held in a police cell. Having a crisis makes you feel like you have lost control over everything and being held in a police cell enforces your helplessness and shame and makes you feel like a criminal."

Summary

Background

A mental health crisis can happen to anyone, at any time in someone's life, and in any place. Experiencing a crisis might mean that there is an immediate risk of the person harming themselves, or they might be having a panic attack, a psychotic episode, or severe anxiety. A mental health crisis is an emergency and help is needed urgently.

Depending on the circumstances, different services are responsible for providing help to someone experiencing a mental health crisis. This could include specialist services, such as crisis resolution home treatment teams, crisis houses, helplines and liaison psychiatry services. If the police find someone in a public place who they believe is in crisis, and that there is an immediate risk they may harm themselves or another person, they can use section 136 of the Mental Health Act 1983 (MHA) to detain them and take them to a 'place of safety', where a mental health assessment will be carried out within 72 hours.^{1, 2}

1. Section 136(1) of the Mental Health Act 1983 states: "If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above."

2. A 'place of safety' is defined in section 135(6) of the Mental Health Act 1983 as: "residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948; a hospital as defined by [the Mental Health Act]; a police station; an independent hospital or care home for mentally disordered persons; or any other suitable place the occupier of which is willing temporarily to receive the patient."

A place of safety can be anywhere, but it is most commonly a designated room or suite of rooms in a mental health inpatient service, the emergency department of an acute hospital, or a police station. The MHA Code of Practice states that the preferred option is a health-based place of safety where mental health services are provided.

Police stations should only be used in exceptional circumstances. The reason for detaining someone under section 136 is to enable quick access to mental health care, not because a criminal offence has been committed. While we have heard from many individuals who have told us that the police were very kind and compassionate, police stations can be stressful places, and healthcare can be more difficult to access than in a health-based location. In 2011/12 and 2012/13, people with mental health problems accounted for half of all deaths in or following police custody (seven out of 15 deaths in both years), and over a third in 2013/14 (four out of 11). Of these 18 deaths, five people had been detained under the MHA.³

Despite guidance from the MHA Code of Practice and elsewhere, evidence shows that the use of police stations across the country is far from uncommon; though this is variable. In some areas, difficulty in accessing health-based alternatives is one of the likely reasons for relying on police stations as a place of safety.

3. Figures from annual IPCC reports, available at: www.ipcc.gov.uk/page/deaths-during-or-following-police-contact

About this survey

We carried out this survey to:

1. Establish a baseline and to inform and strengthen CQC's approach to monitoring and regulating place of safety provision in the future.
2. Provide relevant agencies with information on how local provision of health-based places of safety compares with other areas.
3. Fulfil one of CQC's commitments in the Mental Health Crisis Care Concordat to carry out this survey and publish its findings. The survey is part of a wider thematic review that CQC is conducting on the experience and outcomes for people who experience a mental health crisis.

The survey covered 56 NHS trusts and two social enterprises providing specialist mental health services, and was carried out in January and February 2014. In total, we received information about 161 designated health-based places of safety in England.

It is important to note that the survey primarily focused on assessing the provision and operation of health-based places of safety against national standards, rather than the way in which section 136 is used in practice, or the quality of care people received. These aspects of care and practice will inform our judgements about the operation of health-based places of safety, as part of our new inspection approach.

In this context, the survey asked questions about:

- The availability, in practice, of health-based places of safety.
- Accessibility, including any exclusion criteria.
- Staffing and training of those involved in operating places of safety.
- Target times and delays in carrying out MHA assessments after people have been taken to places of safety.
- The role of police and ambulance services.

Key findings

Overall we found that some places of safety are operating effectively, with innovative examples of positive practice and organisational developments. However, there was also evidence that recommended national standards are not being fully met in a range of areas. This is likely to have an impact on people's experience from the point that they are detained by police under section 136, through being transported to hospital and then being transferred into the care of place of safety staff, before they are assessed under the MHA.

There are four key findings that we believe need to be urgently addressed:

1. Too many places of safety are turning people away or requiring people to wait for long periods with the police, because they are already full or because there are staffing problems. This raises questions about provision and capacity. A quarter of providers told us that they did not believe that there was enough local provision. We also found that the use of police stations as a place of safety is directly linked to the provision, or lack of, health-based places of safety.
2. Too many providers operate policies that exclude young people, people who are intoxicated, and people with disturbed behaviour from all of their places of safety. In many cases, this leaves the police with little choice but to take a vulnerable individual in their care to a cell in a police custody suite.
3. Too many commissioners are not adequately fulfilling their responsibilities for maintaining an oversight of the section 136 pathway. This may limit their awareness of key issues that could inform their commissioning decisions.

4. Too many providers are not appropriately monitoring their own service provision. Many places of safety could not give us basic information about the use of their service or how often people were turned away, or excluded, and the reasons for this. In addition, not all providers said they collected all the monitoring data required by the MHA Code of Practice. This makes it difficult for those providers and their commissioners to evaluate if provision is meeting the needs of people in their local area.

Recommendations

Over the next year we would ask all agencies involved in operating section 136 and health-based places of safety to review the findings of this survey, and to take appropriate action where there are shortfalls.

Although our recommendations are directed at specific agencies, many of the issues discussed in this report, and their related recommendations, are connected. Local agreement will be needed on how best to address these, and the decision-making process should ideally take place in a collaborative forum.

We recommend that all providers of health-based places of safety:

1. Draw on the findings of this survey to identify areas where local health-based places of safety do not meet national standards. They should also agree plans to improve any areas of shortfall, in discussion with key partners. This includes:
 - Reviewing local protocols and making sure that there are appropriate arrangements in place for children and young people.
 2. Ensure that a minimum of two healthcare staff are allocated to receive an individual brought to the place of safety by the police, in line with the recommendations of the Royal College of Psychiatrists. Training for staff who work in the place of safety should be reviewed in relation to the Department of Health's guidance on reducing the need for restrictive interventions. Plans should then be developed to address any shortfalls. This should include training for security staff who may be required to intervene with an individual brought to the place of safety.
- Reviewing the exclusion criteria for health-based places of safety in light of the recommendations of the national Mental Health Crisis Care Concordat. This includes making sure that practices reflect the expectations of the Concordat, for example in relation to people who are intoxicated, whose behaviour is disturbed or who have a previous history of offending or violence. Reducing the number of people who are excluded may mean that there needs to be greater flexibility in where is designated a place of safety, or having a greater range of places that can be used when needed.
 - Improving local data collection, reviewing and monitoring of the use of health-based places safety to meet the requirements of national guidance. This should include:
 - The age, gender and ethnicity of people brought to the place of safety.
 - The number of requests received from the police for people to be brought to the place of safety; the number of people referred to the place of safety who are resident out of area; the number of times people were accepted; how often health-based places safety cannot be accessed; and the reasons why this happens each time.
 - The time taken to start MHA assessments, the reasons for delays, transfers between places of safety and the reasons for using alternatives to the designated place of safety.

3. Implement a clear reporting mechanism, if one is not already in place, to make sure that the board, or relevant sub-group, are made aware of key issues relating to the health-based place of safety on a regular basis, and at least quarterly.

We recommended that clinical commissioning groups:

4. Make sure that multi-agency groups exist and meet regularly to oversee the operation of section 136. Commissioners should also attend multi-agency meetings and oversee the review, implementation and quality assurance of agreed policies.
5. Draw on the findings of this survey to review the availability and use of health-based places of safety to identify whether provision meets local needs. This includes reviewing the frequency that people are unable to access the local place(s) of safety, the reasons for this and making sure that there are enough and appropriate places of safety for children and young people. This should be in the context of considering how to make the pathway for people subject to section 136 as effective as possible. This may include commissioning services or specifying interventions that may prevent or reduce the use of section 136.
6. Put in place commissioning specifications that:
 - Drive data quality improvements and require services to provide data and analysis to inform commissioning decisions.
 - Include evidence-based standards for the provision of health-based places of safety.
 - Include health-based places of safety as one component of services that can respond to people in crisis.

7. Make sure that arrangements for transporting people subject to section 136 to hospital by ambulance are appropriate and timely. This may require a needs assessment for specialist ambulance provision for people in mental health crisis. Response times should be in line with the National Mental Health Act Section 136 Protocol for ambulance trusts; that is within 30 minutes or within eight minutes for people who are being actively restrained.
8. Review the local availability of section 12 doctors to undertake MHA assessments. Work with the Department of Health to make sure that there are enough doctors applying for approval locally, so that delays in initiating MHA assessments for people subject to section 136 can be minimised.

We recommend that health and wellbeing boards:

9. Assess local need for health-based places of safety as part of their Joint Strategic Needs Assessments. Where need is not being met, Joint Health and Wellbeing Strategies should address this as a priority. Health and wellbeing boards should also consider how best to meet the needs of people whose circumstances make them more vulnerable and who are currently excluded from designated places of safety.

We recommend that multi-agency section 136 groups:

10. Develop an action plan to address any shortfalls identified through the survey and monitor its implementation. This should include:
 - Agreeing alternative arrangements for people subject to section 136 when the place of safety is occupied.
 - Auditing local data on the operation of places of safety and promote improvements in data quality where required.
11. Engage local commissioners with group meetings, where this is not already happening.

We recommended that local authorities:

12. Review the availability of approved mental health professionals (AMHPs) to undertake MHA assessments. They should also make sure that there is enough capacity, so that delays in initiating MHA assessments for people subject to section 136 can be minimised.

We recommended that NHS England:

13. Considers the use of capacity management systems to include real-time information on the availability of health-based places of safety, in order to help streamline the process for police and ambulances to access a place of safety.

What CQC will do:

- In April 2014, we published an online map showing the location of designated health-based places of safety across England, with details of opening hours, capacity, age groups accepted, and the local areas they are intended to serve. This was refreshed in October, and we will make sure that it is updated regularly in the future.
 - Alongside this report we are publishing the quantitative data collected through the survey to provide relevant agencies with information on how local provision of health-based places of safety compares with other areas. We hope that it will help local services and agencies to make declarations, in line with the Concordat, about how they will improve mental health crisis care and support.⁴
- Under our new approach to the regulation of care services, health-based places of safety is one of our core services that will always be inspected as part of our comprehensive inspections of specialist mental health care providers. We will use the findings of this survey, and of our wider thematic review of crisis care, to further develop our approach to inspecting these services.
 - Our analysis of the survey findings will be included in the data we use to inform future inspections, and will also help us to target areas for improvement. We will expect to see action plans where practice does not meet national standards.

4. Further information is available at:
www.crisiscareconcordat.org.uk

Introduction

In January 2014, we sent out a survey to mental health trusts and social enterprise providers of health-based places of safety. The purpose of this survey was to examine the provision and use of health-based places of safety for people detained under section 136 of the Mental Health Act 1983 (MHA), especially as a means of understanding the availability and accessibility of the places of safety.

Aim and focus of this survey

The Mental Health Crisis Care Concordat was published in February 2014 in response to concerns about the variation in standards of crisis care across the country, including the number of people with mental health needs being detained in police cells in some areas.⁵ The Concordat committed its signatories to working together to improve the system of care and support, so that people in crisis are kept safe and are helped to find the support they need.⁶ Our intention is that the findings of this survey will become a baseline for the Concordat with regard to the care and support provided to people detained under section 136 and taken to a place of safety in a healthcare setting.

5. www.crisiscareconcordat.org.uk

6. Signatories of the Concordat included: Association of Ambulance Chief Executives, Association of Chief Police Officers, Association of Directors of Adult Social Services, Association of Directors of Children's Services, Association of Police and Crime Commissioners, British Transport Police, CQC, College of Emergency Medicine, College of Policing, The College of Social Work, Department of Health, Health Education England, Home Office, Local Government Association, Mind, NHS Confederation, NHS England, Public Health England, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health, Royal College of Psychiatrists.

The Concordat sets out that:

“NHS commissioners are required by the Mental Health Act to commission health-based places of safety for this purpose. These should be provided at a level that allows for around the clock availability, and that meets the needs of the local population. Arrangements should be in place to handle multiple cases.

Police officers should not have to consider using police custody as an alternative just because there is a lack of local mental health provision, or unavailability at certain times of the day or night. To support this aim, it is essential that NHS places of safety are available and equipped to meet the demand in their area.

Police officers responding to people in mental health crisis should expect a response from health and social care services within locally agreed timescales, so that individuals receive the care they need at the earliest opportunity.”

Our survey focused on:

- **The availability of health-based places of safety** – are there places of safety in every local authority, what type of health provider hosts them, are they open around the clock, how often are they used, and does provision appear to be sufficient?
- **The accessibility of health-based places of safety** – are they open to different age groups, people with disabilities, people resident out of area, people detained under section 135, and to people who might be more challenging to manage (for example, people who are intoxicated, or behaving violently)?
- **Staffing and training** – how many staff are available for each detained person in the place of safety, how quickly can they receive people from the police, what training do different staff groups receive, and are security staff ever needed to assist?

- **Mental Health Act assessments following detention** – do places of safety set target times to begin and complete assessments, are these target times met, and if not, what are the reasons?
- **Governance arrangements and multi-agency working** – does each area have an inter-agency policy and a multi-agency group, and which agencies are signed up to these? What arrangements for monitoring and oversight are in place?
- **The role of ambulance and police services** – how are people transported to the place of safety, do police contact the place of safety before their arrival, how far are police expected to assist once they have arrived at the place of safety?

Why we carried out this survey

Contrary to guidance from the MHA Code of Practice and elsewhere that police stations should only be used for people detained under section 136 on an exceptional basis, evidence shows that police stations (more specifically, a cell in a custody suite) are commonly used as health-based places of safety across the

country. Difficulty in accessing health-based alternatives is one of the likely reasons for relying on police stations as a place of safety. CQC and other organisations have raised this issue over a number of years.⁷

We carried out this survey for three reasons:

1. To establish a baseline and to inform and strengthen CQC's approach to monitoring and regulating place of safety provision in the future.
2. Provide relevant agencies with information on how local provision of health-based places of safety compare with other areas.
3. Fulfil one of CQC's commitments in the Mental Health Crisis Care Concordat to carry out this survey and publish its findings. The survey is part of a wider thematic review that CQC is conducting on the experience and outcomes for people who experience a mental health crisis.

7. For example, in CQC's annual Mental Health Act Monitoring reports; *Police Custody as a Place of Safety*, Independent Police Complaints Commission, 2008; *Standards on the Use of Section 136 MHA 1983*, Royal College of Psychiatrists, 2011; and *Responding to People with Mental Ill Health or Learning Disabilities*, Association of Chief Police Officers, 2010.

Case study: A police officer's story⁸

As an operational duty officer, I became involved in an incident whereby my officers were called to a 16-year-old male at a railway station who, they were informed, was intending to throw himself in front of a train after an argument with his girlfriend. The officers located the male and, after ensuring his safety and assessing him, decided to detain him under section 136. They then asked their control room to nominate the nearest place of safety.

Enquiries showed that [location A] was the nearest place of safety, but on contacting them they were told [location A] could not take the individual because they already had two S136 patients to be assessed. Officers then tried [location B] who refused to take the male simply because he was detained out of their area. They instructed the officers to contact [location C]. [Location C] refused to take the male due to his age and instructed the officers to contact [location D]. On contacting [location D] the officers were told to wait as the key personnel were in a meeting and they would be called back. In the meantime, it transpired after further contact with [location B] that they did have space but were simply refusing because of the location involved and the home address of the individual. [Location D] advised that, due to staff shortages, they were unable to assist and the unit was closed for the day.

8. Received during our call for evidence from groups and organisations that work with people who have experienced a mental health crisis, part of our thematic review of mental health crisis care.

All this time officers were waiting with the male at the railway station. A number of other mental health units were contacted but wouldn't assist, therefore officers decided to escalate the issues to me as their duty inspector. The officers told me that they had been advised by a number of the mental health units that there were no managers available to speak to. I managed to speak to one who stated that [location B] cannot refuse on the grounds they stated, and that they would be best suited in this case because they are the dedicated unit in the area to deal with juveniles/minors.

I was directed to the senior practitioner, who was the approved mental health professional (AMHP) coordinator for [the county]. On speaking with him, he stated that it was above his head and needed to refer it higher, which wasn't helpful. The officers were still at the railway station with the male, who now had been in the caged van for over an hour and a half, as this was the only transportation that the officers had available to them. Due to the lack of information about a place of safety, the local ambulances had been redirected to deal with other emergency calls.

In the meantime, arrangements were made to accept the male at [location E] by officers in another location who worked alongside NHS staff. [Location E] was located in the other side of [the county] and, to my knowledge, did not have the facilities that [location B] had available for minors. In addition, the senior practitioner had suggested that this should be a matter for [location B]. I instructed the officers to start making their way to [location B] as I was starting to have concerns for the welfare of the juvenile because of the length of time we had already spent with him, in what I felt were unsuitable surroundings. I was not able to speak with the senior practitioner again as his phone was going to voicemail.

On arrival at [location B] the doors were closed and locked in front of the officers and the patient. The member of staff at the other side of the doors was waiting with a breath kit in their hand but still refused to allow them inside. After another 20 minutes, they were allowed inside but the staff still refused to accept the juvenile, demanding a breath sample from a vulnerable 16-year-old. They had already been informed by the officers that the juvenile wasn't intoxicated, but they chose not to take this information on board initially.

Eventually after another 30 minutes they accepted him into the unit and admitted him on to a ward. This was approximately 4 hours 30 minutes after the officers detained him. My feeling on the incident is that the whole process went against the Concordat and demonstrated an unprofessional and unempathetic approach to the needs of the individual in this matter. On a number of occasions, staff at [location B] have been rude, threatened officers, left vulnerable individuals outside in the cold and abused the rights of individuals by demanding breath tests at the door while still under police care and protection.

The only [police service] resources in the southern half of [the county] were taken up for over four hours with this matter. Other instances that required police support during this time period had to be redirected to other resources. The expectation of the mental health units involved was that it was a police problem to resolve and that we should be responsible for transporting the individual over a large distance, simply because of their reluctance to become involved in their primary role and function of looking after those who are vulnerable and need support.

Background

Section 136

Section 136 of the Mental Health Act 1983 (MHA) allows the police to detain someone that they believe may have a mental disorder, and who may cause harm to themselves or another person, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out.

Section 136 states:

(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it is necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

A 'place of safety' is defined in section 135(6) as:

- residential accommodation provided by a local social services authority under part III of the National Assistance Act 1948;
- a hospital as defined by [the Mental Health Act 1983];
- a police station;
- an independent hospital or care home for mentally disordered persons; or
- any other suitable place the occupier of which is willing temporarily to receive the patient.

Specific guidance about the use of section 136 is provided by the MHA Code of Practice:

- It is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting where mental health services are provided.
- A police station should be used as a place of safety only on an exceptional basis, for example where the person's behaviour would pose an unmanageably high risk to other patients, staff or users of a healthcare setting.
- A police station should not be assumed to be the automatic second choice if the first choice place of safety is not immediately available.

At the time of writing, the Code of Practice is undergoing revision. However, this is likely to follow the direction set by the Concordat and make it clearer that health-based places of safety should be available and able to take people detained under section 136, and that police stations should only ever be used in genuinely exceptional circumstances.

The use of health-based places of safety

The availability and use of places of safety in healthcare settings has been increasing over time. However, the most recent data shows that such places of safety were still only used for two-thirds of people detained under section 136 in 2012/13.

Although we found very good practice in many of the places visited by CQC inspectors and MHA reviewers, we also found problems with capacity, staffing, delays in carrying out assessments, and unclear arrangements for multi-agency working.⁹ In addition, it is not uncommon for health-based places of safety to operate with exclusion criteria, for example excluding people under a certain age, or people believed to be intoxicated.

9. MHA reviewers were formerly known as Mental Health Act Commissioners

National statistics

Although improving, there are still difficulties in getting a full picture of the use of section 136 because of problems with the availability and quality of data.

For a number of years, the main source of national data on section 136 has come from the KP90 data collection. This is an annual data return to the Health and Social Care Information Centre (HSCIC), from which national statistics have been derived. This includes returns from both mental health and acute sector providers that operate health-based places of safety. Figures on the use of section 136 are also collected through the Mental Health Minimum Data Set (MHMDS) for specialist providers of mental health services. In due course, this will replace the KP90 data collection as the data source for this information. However, there can be discrepancies in figures from these two data sources, even taking into account the differences in what each set covers. It is concerning that providers do not reliably complete the MHMDS, and this will become even more important when the KP90 collection is discontinued. Neither of these collections contains information about people who are not taken to NHS services (whether police stations, or any other non health-based location).

Police forces have been collecting data on their use of section 136, including the type of place of safety people are taken to, for the last few years. This source would give the most complete picture of the use of section 136 and the outcomes for people subject to it. Despite efforts to standardise data collection, there are still concerns about accuracy, with variations between police forces in the quality and completeness of data collected. For this reason, most of the collected data has only been published at a national level. For the purpose of this review, the Association of Chief Police Officers (ACPO) provided police force level data to CQC on where people are taken. In future, it is planned that the Home Office will require all police forces to complete a national dataset, and a pilot is currently taking place within several force areas.

HSCIC published relevant data for 2012/13 taken from the KP90 collection and Police Force IT systems (provided by ACPO). The HSCIC report showed that there were 21,814 reported uses of section 136, of which 7,761 (36%) involved the use of a police cell. It was also reported that 580 uses of section 136 were for children and young people under the age of 18, of which 263 (45%) were taken to police stations.¹⁰ Despite the comparatively small numbers of children and young people detained, statistical analysis of this data shows that adults were significantly less likely to be taken to a police station than people under the age of 18.

Methodology

In January 2014, we sent out an online survey to 56 mental health trusts and two social enterprises that were identified as providing health-based places of safety.¹¹ Providers were required to complete the survey and submit it to CQC within six weeks.

We asked for information about the designated health-based places of safety in the area their organisation covered. A designated health-based place of safety was defined as, "one that has been commissioned as a designated place to which people detained under section 135 and/or section 136 of the Mental Health Act can be taken, and is regularly used for that purpose." Where the health-based place of safety was hosted by an acute trust (for example, if it was located in an A&E department), and the relevant information had not already been shared with the mental health provider, we asked that it should be requested from the acute trust.

The survey was split into two parts: the first requested information that was likely to be

10. Police force data for some areas was not available. These figures were estimations and were published as experimental statistics.

11. There are 58 NHS mental health trusts in total. We did not survey the Tavistock and Portman NHS Foundation Trust, or Calderstones Partnership NHS Foundation Trust, as neither provides a health-based place of safety. The former does not provide mental health inpatient services, and the latter provides services for people with learning disabilities only.

held at provider level, and the second asked for information about each health-based place of safety in the area covered by the provider, some of which was likely to be held by the individual places of safety themselves.

We received a 100% response rate from the organisations we surveyed and were told about 161 designated health-based places of safety. In April 2014, we published an online map showing each of their locations.¹² Following the publication of the map, we were told about another designated place of safety in Birmingham Children's Hospital, which brought the total to 162. We refreshed the map in October 2014, and in future, we will be updating this information at least annually.

The place of safety in Birmingham Children's Hospital has been included in a very limited amount of our analysis, as we did not request that they complete a full survey return. In addition, four of the places of safety we were told about opened in the first two months of 2014 (two of which did not complete a full survey return). Where possible we have included these four in our analysis of the survey data, but they have been excluded where the questions asked specifically about events in 2013 or where they did not return data.

12. Available at: www.cqc.org.uk/hbposmap

1. Availability of places of safety

Key findings

- The provision and use of health-based places of safety in 2013 varied considerably. Some were only used a few times a month, whereas others often had their spaces used more than 30 times in a month.
- There was a direct link between provision of health-based places of safety and the use of police cells in 2012/13. The police forces that took the greatest proportion of people to a health-based place of safety also had more than the average number of health-based places of safety within their force boundaries. Those places also tended to have above average capacity.
- A quarter of providers do not believe that their current provision of health-based places of safety is sufficient.
- Over one in 10 places of safety reported that people were not able to access the unit at least once a week because it was already occupied. Fourteen places of safety (10%) reported that people were not able to access the unit quarterly or more frequently because of staffing problems, including one place of safety that said this happened daily or most days.
- Seven places of safety (five per cent) reported that if the unit was already occupied, the person would wait in the vehicle in which they were brought to the place of safety until it became free.

1.1 Geographical coverage

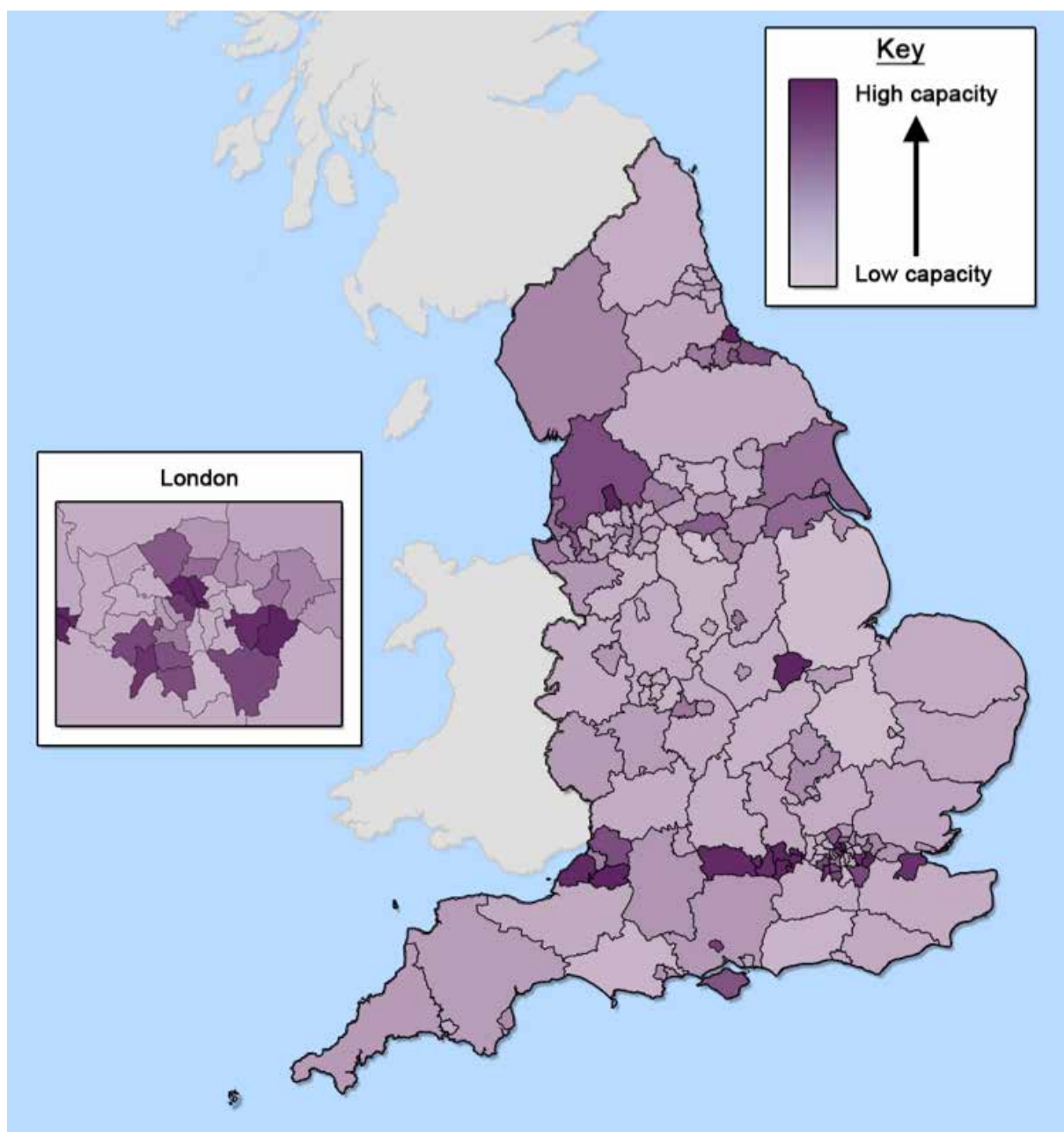
We asked providers which local authorities they served and whether those local authorities were fully or partially served by a health-based place of safety. Of the 152 upper tier local authority (county or municipal borough) areas in England, all but one (Isles of Scilly) were served by at least one health-based place of safety.

As at March 2014, the majority (104) of upper tier local authorities were served by one health-based place of safety. Twenty-one local authorities were served by two, 17 local authorities were served by three, and six local authorities were served by four. Essex was served by six, Hampshire was served by seven, and Lancashire was served by 12 health-based places of safety (**FIGURE 1**).

In Essex, Lancashire and Hampshire the capacity of the health-based places of safety corresponds with these areas also having among the largest populations in England. However, the number of place of safety spaces available does not generally reflect the size of the local authority population in most other areas.

We did find that the number of health-based place of safety spaces available strongly reflects the size of the population served by each police force (which cover much larger geographical areas). The Metropolitan police force serves the largest population by far and, correspondingly, has the most health-based place of safety spaces available (over 34 spaces). Greater Manchester police force also serves a very large population and has 13 health-based place of safety spaces available, whereas Gloucestershire police force serves a comparatively small population and has only two place of safety spaces available.

FIGURE 1: CAPACITY OF PLACES OF SAFETY IN ENGLAND (HIGH TO LOW)



Note: This figure represents the capacity of places of safety per head of population.

The average (median) number of health-based places of safety located in each jurisdiction is three (this is true for nine, or 23%, police forces). Six forces have just one health-based place of safety located in their jurisdiction. Warwickshire Police were the only force to not have a health-based place of safety in their jurisdiction, although the Warwickshire local authority is served by a place of safety in Coventry.

Where local authorities are served by only one designated place of safety, there may be few

alternatives, other than a police station, when more than one person is detained at the same time. This is made worse in areas where the place of safety serves more than one local authority, and where it can only physically accommodate one person. If the data shows that a health-based place of safety is not needed frequently, there should be agreed plans in place with relevant agencies about where people should be taken on the rare occasions when more than one person is detained at the same time.

1.2 Host providers of health-based places of safety

We found that 132 (81%) of the 162 health-based places of safety are located in a mental health hospital. Twenty-three (14%) are based in an A&E department in an acute hospital and seven (4%) are part of an acute hospital's mental health service. Of the 151 local authorities served by a health-based place of safety, 129 are served by places of safety that are only located in mental health services (whether at a mental health hospital or an acute hospital), 12 are served by places of safety that are located in both mental health services and A&E departments, and 10 are served by places of safety that are only located in A&E departments.

The places of safety that are based in A&E departments are clustered in the North West and London regions. Those based in mental health services in acute hospitals are either in the North West or East Midlands.

Standards from the Royal College of Psychiatrists on the use of section 136 suggest that emergency departments should only be used as a place of safety where medical problems need urgent assessment and management.¹³ This is likely to be because of concerns that A&Es do not always have appropriate facilities for people with mental health needs, as in the example below:

"Patients with mental health needs will still be brought to the emergency department by the police. Patients have to wait in a curtained cubicle with no private interview space. [The mental health trust] does not currently provide staff to assist emergency department staff who are not trained to manage patients with mental health needs."

Mental Health Act monitoring visit, April 2013

However, the Crisis Care Concordat has not specified that a health-based place of safety is best suited to any one type of health service and, where there are good facilities, A&E may be entirely appropriate.

Case study: Accident and emergency department, The Royal Liverpool University Hospital, Royal Liverpool and Broadgreen University Hospitals NHS Trust

"The Hospital Mental Health Liaison team, based at the Royal Liverpool University Hospital, has the busiest [A&E] department for mental health presentations in the city of Liverpool. The section 136 facility in the [A&E] department is a secure room with appropriate furniture, CCTV and en-suite toilet.

The jointly locally developed, dedicated pathway and guidance '10-stepped approach to section 136' has emphasis on early response and assessment. This is supported by the local consultant psychiatrists and clinicians. Excellent collaboration by [A&E] medical staff in prioritising the medical assessment, addresses the medical treatment needed. A designated mental health practitioner coordinates the Mental Health Act assessment as a parallel process thereby reducing delays. Dedicated mental health support workers in [A&E] provide reassurance, explain the process, listen and engage the service users throughout the process and have had a significant positive impact on experience of service users during this detention period. A jointly agreed RAG rating risk assessment tool allows appropriate police presence, freeing up police time. In some situations when medical needs have been addressed, then swift transfer to a mental health facility for psychiatric assessment follows."

13. Royal College of Psychiatrists. Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales). CR159. July 2011.

1.3 Use of health-based places of safety

The 162 designated health-based places of safety that were open at the end of March 2014 had a combined physical capacity for at least 208 people to be accommodated at the same time.¹⁴

Guidance for commissioners from the Royal College of Psychiatrists suggests that, ideally, places of safety should be dedicated for that purpose.¹⁵ We found that 86% were. Of those that were not dedicated, 14 were located in an emergency department (60% of the 23 places of safety located in emergency departments), and eight were located in a mental health service.

All but one health-based place of safety told us that they were open 24 hours a day, 365 days a year. The one exception was located in an urgent care centre of a general hospital, and was open from 8am to midnight. We are aware that the police and others have reported instances where places of safety are not available because there are not enough staff or because they are

already operating at full capacity. This means that, occasionally, the stated opening times are theoretical. These issues are addressed in chapter 1.4.

We asked each place of safety to provide a monthly breakdown of the number of times the place of safety had been used for people detained under section 135 or 136 in 2013. Not all places were able to provide monthly data (this is discussed further in chapter 5.5); some were able to provide approximations, and others believed that the data they provided were underestimations.

Data supplied by the 150 places of safety (with a combined physical capacity for at least 190 people) that were able to provide some monthly figures (either actual or approximated), indicates that they were in use more than 23,000 times in 2013.¹⁶ The use of the individual places of safety varied considerably. Some were only used a few times a month, whereas others were often used more than 30 times in a month. The Lambeth Place of Safety Suite in Lambeth Hospital (South London and Maudsley NHS Foundation Trust) was used most frequently. It had capacity for only one person, and on average was in use 70 times per month. At its highest, in May 2013, it was in use 82 times (TABLE 1).

14. Six places of safety responded that there was no limit on the number of people they would accept at any one time (five of which were emergency departments in acute hospitals). This has been counted as one for this purpose.

15. Royal College of Psychiatrists. Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983. PS2/2013. April 2013.

16. Where the place of safety has provided an estimate, for example five to seven times per month, the average of six has been used for each month.

TABLE 1: MONTHLY AVERAGE OF THE NUMBER OF TIMES PLACES OF SAFETY WERE USED IN 2013

Monthly average use in 2013	Places of safety	Place of safety space (capacity)*
Less than 5 people	29	34
5 to 9	43	55
10 to 19	53	42
20 to 29	14	12
30 to 39	5	6
40 to 49	3	0
More than 50	3	1
Total	150	150

*Calculated as average monthly use of place of safety, divided by the number of people who could be accommodated at the same time (the capacity of the place of safety).

The findings from this analysis raise a question about how well health-based places of safety are dispersed to meet local needs, particularly where demand is very high or low. Commissioners may want to use this data to explore the distribution of places of safety within in their local area.

1.4 Sufficient provision

“During the afternoon of 22 April 2013, the police were trying to find a place of safety for someone who required this. The nursing staff advised the police that all three local 136 suites were occupied and the person would need to be taken to the police station.”

Mental Health Act monitoring visit, April 2013

The Concordat expects that health-based places of safety “should be provided at a level that allows for around the clock availability, and that meets the needs of the local population.”

Our analysis of the unpublished police force data for 2012/13 shows that the majority of the 39 English police forces took more detainees to a health-based place of safety than to police stations (64% of police forces). Five forces in particular (West Midlands Police, Metropolitan Police, Lancashire Constabulary, Kent Police, City of London Police) are shown to have taken more than 20 times the number of section 136 detentions to a health-based place of safety than to police stations. Although the City of London Police only detained a comparatively small number, they took 100% of the people they detained under section 136 directly to a health-based place of safety. However, around 28% of police forces took fewer detainees to a health-based place of safety than to police stations.

When taken together, data from ACPO and this survey show that the police forces that took the largest proportions of people detained under section 136 to health-based places of safety in 2012/13, usually have more than the average (median) number of health-based places of safety in their boundaries. Those places of safety also tend to have above average capacity. Police forces that took the lowest proportions of people to health-based places of safety generally have below the average number in their boundaries,

and these places also tend to have below average capacity. At face value, this would suggest that the use of police stations as health-based places of safety is directly linked to the provision of, or lack of, places of safety in healthcare settings.

Just over three quarters (76%) of providers told us that they believed there were currently enough health-based places of safety in their local authority areas. Fourteen providers did not believe that there was enough provision, mostly because demand was higher than the available capacity. Five of the 14 trusts said that provision was not good enough because they covered such a large area. In some cases, this could mean that people have to travel long distances to access a health-based place of safety. Other reasons for insufficient provision, given by one or more providers, included:

- Inadequate staffing.
- Concerns with the place of safety environment.
- The lack of provision for young people.
- The lack of provision for people who were intoxicated, or where there was a risk of violence or absconding.

Most of the 14 trusts said that these issues were being addressed, for example by working with police to reduce the number of section 136 detentions. Some trusts were undertaking work to increase capacity, improve the environment, or reduce the amount of time people spent in the place of safety through faster assessment times. Other trusts said that they were monitoring how often the health-based places of safety were used or were communicating with their commissioners.

We asked individual places of safety to tell us how often they turned people away because it was already occupied. Over a quarter of the places of safety were not able to provide this information. Of those that could, 44% reported that this had not happened at all in 2013, and 20% said that it happened less than every six months. However, more than one in 10 said that it happened once a week. The Hazel Unit in Callington Road Hospital (Avon and Wiltshire

Mental Health Partnership NHS Trust) said that this had happened daily or most days.¹⁷

We also asked if people were turned away because of staffing problems. Although most (78%) reported that this had never happened, one place of safety reported that this was a daily issue (FIGURE 2).

It is concerning that over a quarter of all places of safety could not provide even approximate figures of how often they turned people away. It is also possible that some responses provided are underestimations, as they might depend on whether the police actually turned up at the place of safety or called ahead and were told that it was already in use.

We asked where people would be taken if the place of safety was already in use. Eighty per cent said the person might go to an alternative health-based location (of which just over one in four said this could be an A&E). Eighteen per cent said the person might go to a police station, and five per cent (seven places of safety,

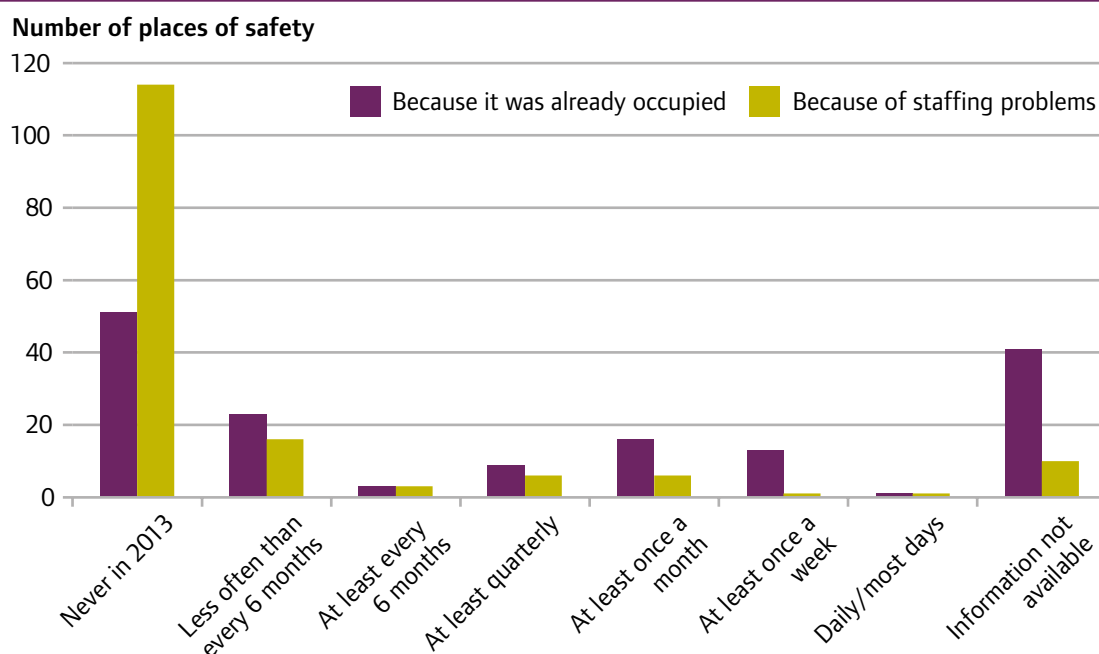
of which six said this was the only option) said the person would wait in the vehicle they were brought to the place of safety in, until it became free. These figures broadly map to police force data. In police force areas where there were higher numbers of people taken to police stations, places of safety said that people tended to be taken to police stations if the place of safety was occupied.

For the 14 places of safety that turned people away once a week or more because it was already occupied, five out of the seven relevant trusts reported that they did not believe that there were enough health-based places of safety in their local area. The remaining two trusts, Kent and Medway NHS and Social Care Partnership Trust and Avon and Wiltshire Mental Health Partnership NHS Trust, said that there was enough provision. However, at the time they submitted their survey return, Avon and Wiltshire had very recently expanded their provision.

For the two places of safety that turned people away daily/most days or at least once a week because of staffing problems, their trusts also said there were not enough health-based places of safety in their local area.

17. The Hazel Unit was able to accommodate only one person at a time in 2013. In February 2014, this unit was replaced by the Mason Unit in Southmead Hospital, which is able to accommodate four people at the same time.

FIGURE 2: FREQUENCY THAT PEOPLE WERE NOT ABLE TO ACCESS THE PLACE OF SAFETY



1.5 In use for another purpose

We asked whether the place of safety had ever had to be used for another purpose during 2013 (for example, for storage, or as a seclusion room, lounge, medication clinic, or waiting area), which prevented them from accepting someone brought to the place of safety. In addition, we

asked if it had ever had to be closed so that it could be used as an additional inpatient bed. Where the information was available, the majority of places of safety said that neither scenario had happened in 2013. It was slightly less likely that a place of safety would be used as an inpatient bed than for any other purpose (TABLE 2).

TABLE 2: PLACES OF SAFETY USED FOR OTHER PURPOSES

Has the place of safety been used for another purpose in 2013?	Used for another purpose (not inpatient bed) Percentage (number) places of safety	Used as inpatient bed Percentage (number) places of safety
Never in 2013	83% (126)	92% (143)
Less often than every 6 months	7% (11)	6% (9)
At least every 6 months	3% (4)	0% (0)
At least quarterly	3% (5)	1% (1)
At least once a month	3% (4)	2% (3)
At least once a week	1% (1)	0% (0)
Daily/most days	0% (0)	0% (0)
Total	100% (151)	100% (156)
Information not available	6	1
Grand Total	157	157

2. Accessibility of places of safety

Key findings

- Sixteen percent of providers said that there was no local provision for people aged 16 to 17 years, and 26% of providers reported that there was no provision for people under 16 years.
- Almost half of the providers that responded said that people who were intoxicated would be excluded from the places of safety in their local area. Over a third reported that disturbed behaviour was a reason for exclusion.
- Despite anecdotal evidence, places of safety reported that people who were resident out of area were rarely excluded in 2013, although 22 places of safety indicated that this information was not available.

2.1 People of different ages

“Staff told us they were concerned there were no facilities for young people under the age of 18 who needed a place of safety... This meant young people were sometimes reviewed by the team in police cells when they required a place of safety, although staff told us that they sought alternatives, such as residential units or the accident and emergency department wherever possible.”

*Mental health service inspection report, March 2014*¹⁸

In our annual report *Monitoring the Mental Health Act 2012/13*, we reported that the police in one area of the South West told us that 41 young people had been detained in police cells over the previous year, the youngest of whom was 11 years old. This is clearly unacceptable practice. The health-based places of safety had not accepted them because the places of safety were connected to adult wards and as a result were not age-appropriate. However, the MHA Code of Practice states that the need to accommodate someone in a safe environment in the short-term should take precedence. It also recognises that there is a clear difference between what a suitable environment is for a child or young person in an emergency situation, and what is a suitable environment on a longer-term basis.

The Concordat has reiterated this position, stating that “unless there are specific arrangements in place with Children and Adolescent Mental Health Services, a local place of safety should be used, and the fact of any

18. Inspection report available at: www.cqc.org.uk/sites/default/files/new_reports/AAAA0746.pdf

such unit being attached to an adult ward should not preclude its use for this purpose.”

The survey asked providers which of the places of safety in their area accepted people of different ages. This was to ascertain whether each age group had at least one place of safety they could go to. Sixteen per cent of providers said that there was no local provision for people aged 16 to 17 years. Twenty-six per cent of providers reported that there was no provision for people under 16 years. All providers said there was some provision for adults aged 18 to 64 and 65 years and over in their local areas.

We also asked individual places of safety to tell us how often people were excluded because of their age. This data may, however, be misleading as police are likely to be aware of which places of safety accept people of different ages, and will approach them accordingly. Inconsistent

recording of instances where people are turned away may also mean that the data in table 3 are underestimations. This issue is discussed further later on in the report.

It is also feasible that recording in some areas is dependent on whether the police actually turned up at the place of safety, or called ahead and were told that the person they had detained could not be accepted.

We compared providers’ age exclusion policies with how often people in the different age groups were excluded. Where providers said people of a certain age were not excluded, this broadly matched places of safety reports on age groups that were not excluded in 2013. Where the two statements did not match, there may have been extenuating circumstances as they had only excluded people once in six months.

TABLE 3: FREQUENCY OF EXCLUSIONS DUE TO AGE

Were people excluded from the place of safety in 2013 due to their age?	Aged under 16	Aged 16 to 17	Aged 65 and over
Never in 2013	84% (103)	83% (108)	96% (129)
Less often than every 6 months	13% (16)	15% (19)	4% (5)
At least every 6 months	2% (3)	2% (2)	0% (0)
At least quarterly	1% (1)	1% (1)	1% (1)
At least once a month	0% (0)	0% (0)	0% (0)
At least once a week	0% (0)	0% (0)	0% (0)
Daily/most days	0% (0)	0% (0)	0% (0)
TOTAL	100% (123)	100% (130)	100% (135)
Information not available	34	27	22
Grand total	157	157	157

Case study: The St Aubyn Centre, North Essex Partnership University NHS Foundation Trust

“As part of our business case for the provision of a purpose built specialist child and adolescent inpatient facility in 2008, we decided that we wanted to provide not only a specialist psychiatric intensive care unit alongside our generic inpatient ward, but also provide to our local community a dedicated section 136 facility for children and young people up to the age of 18. This decision was born out of our concerns and experiences of children being detained and taken to adult facilities with the inherent difficulties this caused both for the young person and their families, but also for the staff trying to care for them in what is a very unsuitable environment.

We believe the provision of a dedicated section 136 facility has improved the experience for the young people presenting in a very distressed state by providing an environment and trained, experienced staff able to meet their needs. The police are also very appreciative of having a place of safety available to them that is designed and staffed accordingly.”

Essex and Birmingham have designated places of safety specifically for young people that are located in a child and adolescent mental health service. While this model may appear to be the ideal, we acknowledge that it may not be possible for every locality to put in place. There may be alternative and appropriate arrangements for this age group.

We recognise that providers may find themselves in a difficult position if, following an assessment under the MHA, a young person needs inpatient care but they are not commissioned to provide beds for that age group.

Local protocols on the use of section 136 and places of safety must clearly state the process

to follow in these scenarios. Where there is not a place of safety specifically for young people, there must be processes for identifying and agreeing the most appropriate place of safety for these individuals that is not a police station. Where providers do not believe that their places of safety are suitable, and that young people are being taken to police stations as a result, they should raise the issue with local commissioners.

In some areas, police forces may also need to work more closely with child and adolescent mental health services to reduce the numbers of section 136 detentions for this age group where possible. We are aware of examples of where such partnership working has had a big impact.

Case study: Section 136 protocol for under 18s, Wiltshire Police and child and adolescent mental health services (CAMHS), Oxford Health NHS Foundation Trust

When officers respond to a young person in significant mental health distress or crisis, the officer contacts CAMHS from the scene by phone to discuss risk and consider alternative options to a section 136 detention. CAMHS professionals are available 24 hours a day, seven days a week for telephone consultation. The officer provides the CAMHS professional with information about the young person, including their presentation, need for medical attention, circumstances of the incident, and concerns regarding safeguarding or welfare.

The CAMHS professional checks the electronic health record system for previous or ongoing contact with CAMHS. If known, the professional may speak directly with the young person and propose a safety plan, and/or speak to the parents or carers. If the distress can be de-escalated by phone, the young person is normally offered an urgent assessment within 24 hours. If concerns remain acute, an emergency assessment can be offered in a safe location within two hours.

If the young person is not known, additional risk may be considered to the above procedure and an urgent mental health assessment may be offered. The options are discussed fully in partnership with the officer at the scene who reserves the right to use a section 136 detention or other police powers that are deemed appropriate. The protocol enables the attending officers to gain a mental health perspective to inform their decision making and consider alternative options. It also makes sure that CAMHS are alerted to mental health concerns at the earliest possible stage and can offer an urgent assessment whether detained or not.

At a time when mental health services are reporting an increase in crisis and emergency presentations in this age group, the data suggests that the collaborative approach between the police and CAMHS is leading to less restrictive and more child-focused outcomes.

2.2 People with disabilities

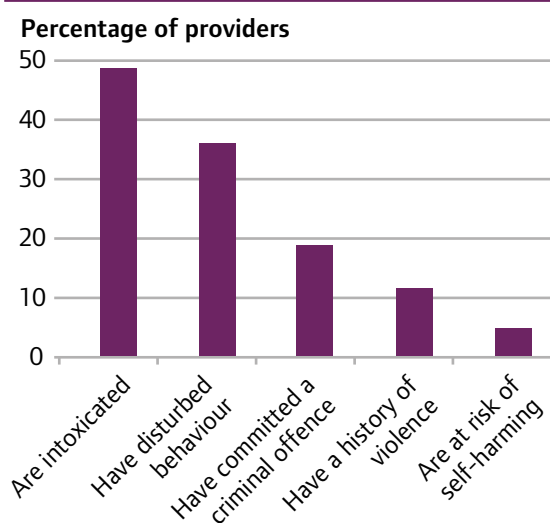
We also asked whether there was provision for people with physical disabilities or people with learning disabilities. All providers except one (Derbyshire Healthcare NHS Foundation Trust) confirmed that there was provision for these groups. This trust, however, said that their two local places of safety had not excluded anyone on that basis in 2013.

5.3 People in challenging circumstances

“The police told us that the current hospital-based place of safety policy, which refuses entry to a person if they have consumed any alcohol, no matter how much (or little) and whether or not it is affecting the person’s behaviour or ‘presentation’. As a result more people are being taken to the police station than is necessary.”
MHA monitoring visit, March 2013

A core principle of the Crisis Care Concordat is that people in crisis who need to be supported in a health-based place of safety will not be excluded. However, we have found evidence, both anecdotal and from our MHA monitoring visits, that people are often excluded on the basis of intoxication, disturbed behaviour, a history of violence, or having committed a criminal offence.

We asked providers whether people would routinely be excluded from their local places of safety in any of these circumstances. Two-thirds of providers reported that some or all of these exclusion criteria were included in either, or both of, the trust policy and inter-agency policy (**FIGURE 3**).

FIGURE 3: REASONS FOR EXCLUSION IN PROVIDER OR INTER-AGENCY POLICIES

Three trusts said that their exclusion criteria were listed in their trust policy only (not the inter-agency policy). All three providers said that they excluded people who were intoxicated; one said they excluded on the basis of disturbed behaviour; and one said that they excluded people who had committed a criminal offence. Having different exclusion criteria for the trust policies and inter-agency policies could create difficulties for the police or other agencies who are not aware of, or who have not signed up to, such a protocol.

We also asked individual places of safety approximately how often people were excluded on the basis of intoxication, disturbed behaviour, having committed a criminal offence, having a history of violence or being at risk of self-harming (TABLE 4).

TABLE 4: FREQUENCY OF EXCLUSIONS DUE TO INTOXICATION, DISTURBED BEHAVIOUR, CRIMINAL OFFENCE, HISTORY OF VIOLENCE OR RISK OF SELF-HARMING

	Intoxication	Disturbed behaviour	Criminal offence	History of violence	Risk of self-harming
Never in 2013	53% (66)	61% (76)	85% (100)	79% (102)	97% (132)
Less often than every 6 months	11% (14)	12% (15)	9% (11)	9% (11)	2% (3)
At least every 6 months	6% (7)	8% (10)	3% (3)	3% (4)	0% (0)
At least quarterly	13% (16)	10% (13)	1% (1)	5% (7)	0% (0)
At least once a month	14% (17)	7% (9)	0% (0)	3% (4)	1% (1)
At least once a week	4% (5)	1% (1)	2% (2)	1% (1)	0% (0)
Daily/most days	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
TOTAL	100% (125)	100% (124)	100% (117)	100% (129)	100% (136)
Information not available	32	33	40	28	21
Grand total	157	157	157	157	157

There were a small number of discrepancies between what the place of safety reported and what the trusts said was in their policies. Generally, where trusts said their policies did not contain certain exclusions, these took place less than once a month. There were a few exceptions: Sussex Partnership NHS Foundation Trust said that their policy did not exclude people with disturbed behaviour from the places of safety in their area, but one place (Pavilion Ward at Mill View Hospital) reported that they excluded people on this basis at least once a week. The same place of safety also said that it excluded people at risk of self-harming at least once a month, although this was also not in their policy.

We are aware that different places of safety may apply the exclusion criteria in different ways. We asked providers to explain their approach for assessing if a person should be excluded. We did not ask where the person would be taken as part of this question, but some providers volunteered this information.

Intoxication

Thirty-one providers explained their approach to assessing intoxication (this figure included three providers that said they did not use this as a reason for excluding people). Of these, 12 providers (40%) said that they would exclude someone if they thought the person was not fit for assessment, and one said it would depend if the person was too intoxicated to be assessed within a reasonable timeframe, usually four hours. Seven providers (23%) said the decision to accept someone would be taken jointly by the clinical staff and the police, and one provider said that police would follow their drunk and incapable procedures.

Some providers had more specific means of testing how intoxicated the person was:

“The place of safety suite will not admit someone who is unable to carry his or her own body weight.”

“Any person admitted to the unit who is believed to be intoxicated is breathalysed. Until breath alcohol falls to below 0.35 units, assessment is delayed. Intoxication alone is not sufficient reason to deny admission, that person must also present as an unmanageably high risk in line with the Mental Health Act Code of Practice paragraph 10.21 or must be in need of urgent medical attention.”

Four providers (13%) said that the person would only be excluded when there were clear medical issues, for example if the person was in danger of asphyxiation or seizure, in which case the person would be taken to A&E. One provider said that the police would contact the crisis team and take the person to A&E. Eight providers (26%) said that the decision to take someone to a health-based place of safety was made depending on the individual circumstances. For example, people who posed a health risk to themselves would be taken to A&E, and those who were disorderly or unruly or a risk to others would be taken to a police station. Five providers (16%) said only that the person would be taken to a police station.

As well as the above example, we have heard anecdotal evidence that a number of places of safety ask people to take a breath test before they are admitted. In some instances, this is conducted on a routine basis, whether or not the person appears to be intoxicated. We are concerned about the use of breathalysers in this way. Healthcare providers have no power to require such testing. 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.

We are aware that health professionals are concerned that section 136 may be being used too much for people who are intoxicated, as they may not prove to have a mental health issue at all once sober. However, where police are concerned about someone's behaviour, and believe that it may relate to a mental disorder, it would be wrong for them not to act on those concerns. This is a challenging issue, and we hope that the future edition of the MHA Code of Practice will be clear about the action to take in these circumstances.

Disturbed behaviour

For cases of disturbed behaviour, 34 providers explained their approach (only 21 said that their policies stated this as a reason to exclude people). The main reason for exclusion was extreme or unmanageable violence, or disturbed behaviour. The decision about whether to exclude someone would be taken on a case-by-case basis. For some trusts, the number of staff available was a factor in the decision:

"The person demonstrates a level of violence and aggression at a level that could not be managed in a [health-based place of safety] which is only staffed by one member of staff."

"Assessment is based on transparent communication between the police and nursing staff and understanding of each other's capacity."

Five providers (15%) said that the decision would also depend on whether the person had been, or was being, restrained by the police. For example, this included the use of physical restraint, handcuffs, Taser or CS spray on the person, or the use of riot equipment by the police.

Six providers (18%) said that the most appropriate place of safety would be determined after a discussion between police and clinical staff or a risk assessment. Fifteen (44%) said the person would generally be taken to a police station. One provider explained the difference between their policy and practice:

"Very disturbed people are theoretically directed to a police station, in practice it is more likely that we would negotiate for police to stay with them."

Criminal offence

Fifteen providers explained their approach to excluding someone because they had committed a criminal offence (10 providers said that this was included in their policies). Almost all indicated that the police would lead the assessment for where the person should be taken.

"We don't exclude for serious criminal offences but if the offence is very serious would not expect the police to bring the person on s136."

Six providers (40%) said that people would not be taken to the health-based place of safety when the offence was significant or substantive. One provider said that all people who had committed criminal offences would be considered for arrest first. Three providers said that people who committed an offence would always be taken to a police station (one trust added that the crisis team would be informed in these cases). Two providers said a risk assessment would determine whether they should be accepted into the health-based place of safety. One provider reported specific criteria for exclusion:

"The person has a current criminal conviction or recent conviction of violence or arson."

One provider reported that the person could be moved between health and police-based places of safety:

"A MHA [assessment] can take place in the health-based place of safety and if the person is not detained then the police are able to consider if the criminal justice route should be pursued."

The Concordat is clear that a person in crisis and in need of detention and assessment should be supported in a health-based place of safety, irrespective whether they are intoxicated, have a history of offending, or because of violence. People who are intoxicated should be managed in either the designated place of safety or A&E if there is a medical need. Only in exceptional circumstances, where the risk to the safety of the individual and staff is too high, could the person be excluded from the place of safety. Police

stations should only be used in exceptional cases of seriously disturbed and aggressive behaviour.

While some providers' practices are already consistent with these recommendations, others will need to review their local policies to make sure that, in these circumstances, people will be cared for in the appropriate environment. Anecdotal evidence suggests that police and health staff often undertake risk assessments separately, with little explanation to each other about how a decision has been made. This suggests that there needs to be a joint approach for assessing risks and/or sharing information so that everyone involved understands the risks an individual may pose.

2.4 People detained under section 135

The definition of a place of safety is provided in section 135, not section 136, of the Mental Health Act. Section 135 allows police to enter premises and to temporarily remove someone who appears to be suffering from a mental disorder to a place of safety. Section 135 is used much less than section 136. In 2012/13, section 135 detentions made up just two per cent of all place of safety orders to hospital.¹⁹

There is no legal difference between a place of safety to be used for people detained under section 135 and a place of safety for people detained under section 136. However, our MHA monitoring visits have found that there are health-based places of safety that do not accept people detained under section 135, leading to them being taken a police station.

None of the providers' policies stated that people detained under section 135 should be excluded. However, a small number of places of safety said that they had excluded people detained under section 135 in 2013. One place of safety said that they excluded people detained under section 135 daily or most days, even though this was not stated in their trust's policy (TABLE 5). Given how

rare section 135 detentions are nationally, this is an unexpected finding and may be a data quality issue.

TABLE 5: PERCENTAGE OF PEOPLE DETAINED UNDER SECTION 135

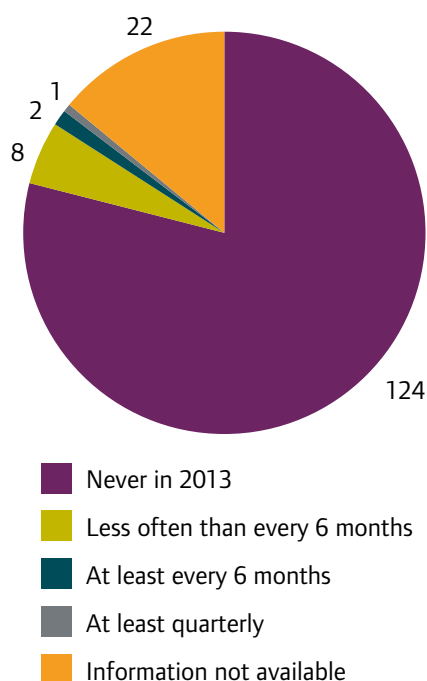
	Detained under section 135
Never in 2013	93% (121)
Less often than every 6 months	5% (6)
At least every 6 months	1% (1)
At least quarterly	1% (1)
At least once a month	0% (0)
At least once a week	0% (0)
Daily/most days	1% (1)
TOTAL	100% (130)
Information not available	27
Grand total	157

2.5 People who are resident out of area

The survey also asked providers whether they excluded people who are resident out of area from their local places of safety. No providers reported that their local policies included this as a reason for exclusion. Most places of safety also reported that this was not an issue, although a small number did occasionally exclude people who lived out of area (FIGURE 4).

19. Health & Social Care Information Centre, Mental Health Act Statistics, England 2013: www.hscic.gov.uk/catalogue/PUB12503

FIGURE 4: FREQUENCY OF EXCLUSIONS OF PEOPLE WHO LIVE OUT OF AREA



However, 22 (14%) places of safety were unable to provide this information. Anecdotal evidence suggests that refusing to take someone who is resident out of area is a problem in some places, but that this is not routinely recorded. We would expect local section 136 multi-agency groups to have agreed arrangements in place for this situation. They should have arrangements for monitoring when this happens and for notifying relevant clinical commissioning groups or local authorities where cross boundary issues impact on the delivery of effective care.

2.6 Alternative places of safety

Where providers reported that no health-based places of safety in their local area accepted people aged 16 to 17 and/or under 16 years old, we asked where these people would generally be taken. Of the 15 providers that had restrictions on young people at all of the places of safety in their area, all but one said they might be taken to an alternative health-based location (seven said this would be an A&E), and seven said they might go to a police station. A police station was the only alternative place of safety for one provider.

We also asked where people would go if they were excluded from all the designated places of safety in the provider's local area for any other reason (the survey did not ask where people would go in each circumstance). Of the 39 providers with exclusions that included intoxication, disturbed behaviour, risk of self-harm, criminal offence or history of violence, 37 said they might be taken to a police station and 30 said they might be taken to an alternative health-based location (almost always A&E).

3. Staffing and training

Key findings

- The majority of staff (91%) allocated to work in places of safety also worked in other teams or wards.
- Forty-three per cent of places of safety had the recommended two or more members of staff allocated to work in the place of safety, and the same proportion had one member of staff. Thirteen per cent had no allocated staff, just under half of which were based in emergency departments.
- In seven places of safety, staffing issues meant that people often had to wait with the police for one hour or more before they were handed over to place of safety staff.
- Almost all places of safety reported that staff had received training on their roles and responsibilities under section 136, although for nearly a third of nursing and medical staff training was 'on the job' rather than before they started work in the place of safety. Five per cent of places of safety indicated that nursing and medical staff were not trained in de-escalation, which is recommended for managing disturbed behaviour.

3.1 Staffing numbers and availability

The Royal College of Psychiatrists Standards suggest that, ideally, psychiatric places of safety should have dedicated staffing. The College's Guidance for commissioners goes further, suggesting that there should be a minimum of two mental healthcare professionals immediately available to receive the individual from the police, and that trusts should consider having dedicated staff who can be assigned other wards or teams when they are not required in the place of safety.

We found that 69 places of safety (43%) had a minimum of two or more members of staff allocated to work in the place of safety at all times of day. Sixty-nine places of safety (43%) had one member of staff as a minimum, and 21 places of safety (13 %) had no staff allocated to work there. Nine of those with no allocated staff were based in A&E departments.

When the capacity of each place of safety was taken into account, 51 places of safety (32%) had two or more members of staff per person that could be accommodated. Seventy-two (45%) had one member of staff per person, and 30 (19%) either had one member of staff for more than one person or no allocated staff.

The survey asked whether the specified number of allocated staff was always available. At most places of safety, staff were always or mostly available. However, the allocated staff were rarely or never available at almost one in 10 places of safety (**TABLE 6**).

TABLE 6: AVAILABILITY OF ALLOCATED STAFF

Specified number of allocated staff available	Percentage (number) of places of safety
Yes – always	76% (121)
Mostly	14% (22)
Occasionally	1% (1)
No – rarely/never	9% (15)
Total	100% (159)

Note: All places of safety answered this question, including those that replied they had no allocated staff.

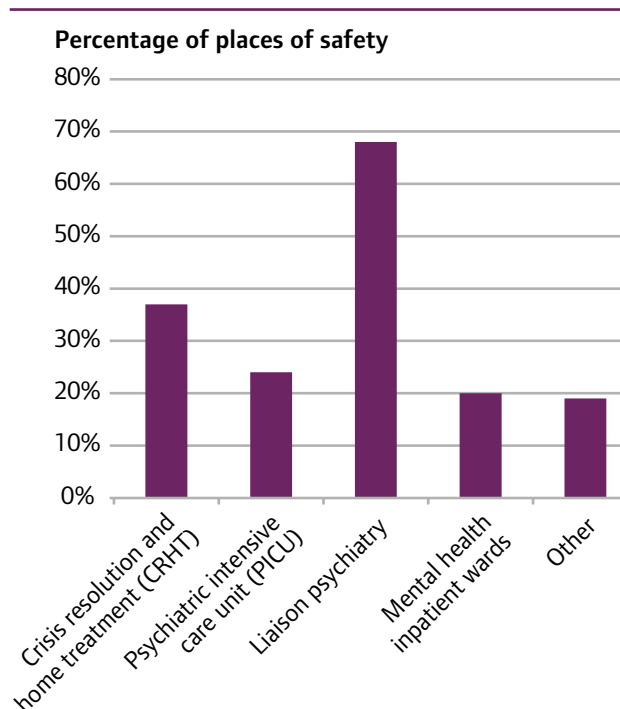
We found that places of safety that had the same, or a higher, number of staff than the number of people who could be accommodated, also tended to respond that those staff were always or mostly available. This is likely to mean a better experience for the detained person. However, the converse was also true: places of safety that had fewer staff tended to respond that those staff were rarely or never available.

In 145 places of safety (91%), staff worked in other teams or wards, including crisis resolution and home treatment teams (CRHT), psychiatric intensive care units (PICU), mental health inpatient wards and liaison psychiatry, as well as in the place of safety (FIGURE 5).

Where respondents chose “Other”, most staff (seven places of safety) were on-call or duty staff (nurses and doctors), AMHPs (five places of safety) or assessment team staff (five places of safety). Three or fewer places of safety mentioned: the police, A&E staff, bank staff, CMHT, child and adolescent mental health services (CAMHS), clinical managers or senior nurses, adult mental health acute care pathway staff, and single point of access service staff. For one place of safety, only police staff the service:

“In [the county], the local protocol determines that the police effectively “staff” the 136 suite until such time that the MHA assessment has been undertaken and a decision reached regarding the admission to hospital (or not).”

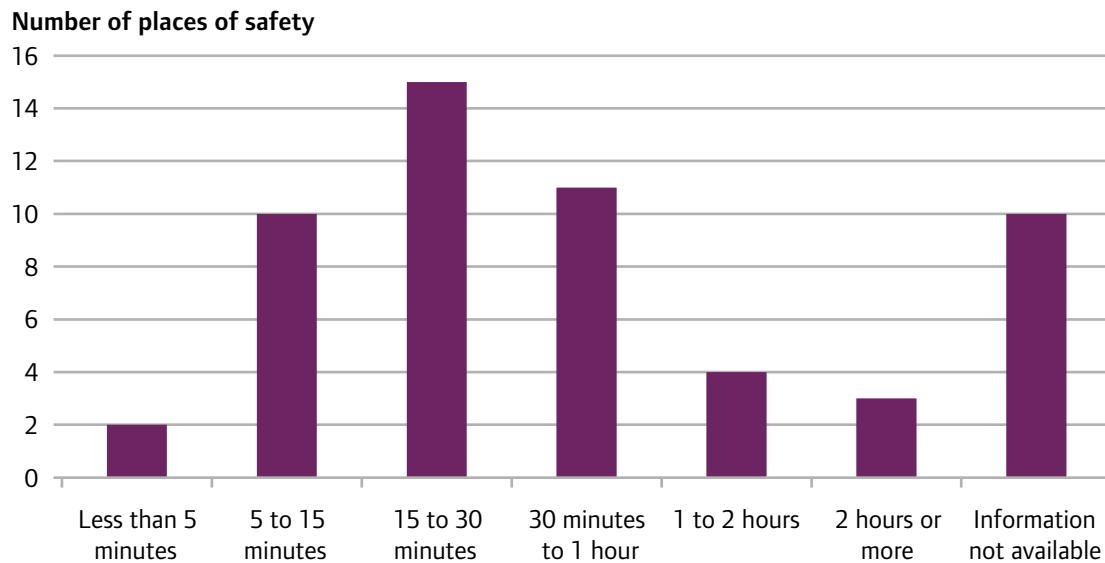
FIGURE 5: OTHER TEAMS/WARDS WORKED IN BY PLACE OF SAFETY STAFF



Note: Percentages do not add up to 100% as more than one option was ticked in some cases.

Almost two-thirds of the places of safety reported that there were rarely or never delays in making sure that there were enough staff (in line with their policies) when the police arrived. Thirty per cent said there were occasional delays, four said delays happened most of the time, and a further four places of safety said that there were always delays.

Where data was available for the 55 places of safety where delays took place occasionally, most of the time or always, almost three-quarters reported that people had to wait with the police on average more than 15 minutes before they could be handed over to staff. Of the eight places of safety that reported there were mostly or always delays in providing staff, four could not say on average how long people had to wait with police (FIGURE 6).

FIGURE 6: LENGTH OF WAIT WITH POLICE BEFORE HANDOVER TO PLACE OF SAFETY STAFF

One place of safety had no allocated staff, and reported that people always had to wait between one and two hours with police. Another place of safety said people mostly had to wait two hours or more before the one allocated member of staff was available for handover to take place.

3.2 Training

In order to gain an understanding about the types and range of training available to staff working in health-based places of safety, the survey asked whether the majority of staff from different staff groups had received training in a number of areas that could be relevant in the place of safety environment (this included AMHPs, for whom local authorities may have provided such training). We recognise that certain aspects of training may be more relevant to some roles than others.

The MHA Code of Practice states that good practice in places of safety depends on a number of factors including:

- “all professionals involved in implementation of the powers should understand them and their purpose, and the roles and responsibilities of other people involved, and should follow the local policy;

- professionals involved in implementation of the powers should receive the necessary training” (paragraph 10.16).

Elsewhere in the MHA Code of Practice, training is suggested in managing disturbed behaviour, including prevention and de-escalation, as a way to minimise such issues (paragraph 15.16). It is also stated that hospitals should have policies on training staff that work in areas where they could be exposed to aggression or violence, or who may need to restrain patients (paragraph 15.36).

Almost all places of safety reported that staff received training on their roles and responsibilities under section 136. However, it is concerning that this was not universal. As might be expected, nursing staff were more likely to be trained in restraint, although doctors and AMHPs had also received this training in some areas. AMHPs were the group least likely to be trained in breakaway and de-escalation, although 70% were trained. The majority of nursing and medical staff had also received training in these areas (**TABLE 7**).

TABLE 7: TRAINING FOR PLACE OF SAFETY STAFF

Training	Nursing	Medical	AMHPs
Roles and responsibilities under section 136			
No	3% (5)	3% (4)	1% (1)
Yes – before starting work	65% (104)	69% (109)	91% (145)
Yes – on the job	31% (50)	29% (46)	8% (13)
Safe assessment and risk management			
No	1% (2)	1% (2)	4% (6)
Yes – before starting work	82% (131)	81% (128)	82% (131)
Yes – on the job	16% (26)	18% (29)	14% (22)
De-escalation			
No	5% (8)	6% (9)	28% (45)
Yes – before starting work	81% (128)	74% (117)	53% (85)
Yes – on the job	14% (23)	21% (33)	18% (29)
Breakaway			
No	6% (9)	9% (15)	30% (47)
Yes – before starting work	80% (127)	72% (115)	51% (81)
Yes – on the job	14% (23)	18% (28)	19% (30)
Unknown	n/a	1% (1)	1% (1)
Control and restraint			
No	18% (28)	70% (111)	86% (136)
Yes – before starting work	67% (107)	26% (42)	9% (14)
Yes – on the job	15% (24)	3% (5)	5% (8)
Unknown	n/a	1% (1)	1% (1)
Mental Capacity Act			
No	6% (10)	1% (1)	1% (1)
Yes – before starting work	69% (109)	77% (123)	92% (146)
Yes – on the job	25% (40)	22% (35)	8% (12)

Our findings suggest that training for staff, and when this is given, varies. We would encourage providers to review training for staff that work in a place of safety in light of Department of Health guidance on reducing restrictive interventions.²⁰ It may also be helpful to make sure that the expected training for different staff groups is clarified as part of the MHA Code of Practice review.

3.3 Involvement of security staff

We have previously been made aware that security staff are also occasionally involved in responding to people brought to health-based places of safety. However, we did not know whether this practice was widespread. We found that security staff are involved, at times, in more than one in five places of safety (35 out of 158). Over half of those (20) were based in A&E departments (over 80% of all places of safety based in A&E), and two were in a mental health service on an acute hospital site (a third of the six places of safety of this type in 2013). Thirteen were in a mental health service on a mental health hospital site (10% of this type of place of safety).

Where security staff were involved, over half of places of safety said that they were involved in responding to someone brought there “some of the time”, and a third said they were involved “rarely”.

Three places of safety based in A&Es said security staff were involved “most of the time”, to prevent people absconding. They were also involved to support staff when the police had left, either to “manage risk” or to deal with people who “may be disturbed and agitated”. Only one place of safety responded that security staff were involved all of the time. Their role was

“to open the suite, remain on site to support staff, [and] to support the safe conveyance of the service user to hospital where appropriate.”

In most cases security staff were involved when a person was deemed to be a risk to themselves or others; either immediately when the police left, or if staff needed additional support later on. Eight places of safety said it was to prevent the person from leaving, and four said security staff would help to transfer people between A&E and a mental health services, or vice versa.

“Security will supervise and monitor patients in the 136 suite to ensure they remain in the department. They will only put hands on patients if there is immediate risk to staff, other patients or property. They support mental health and acute staff if restraint for rapid tranquilisation is needed.”

Twenty-four places of safety (69% places of safety where security staff could be involved) reported that security staff had had training in de-escalation, either before they started working or on the job. Twenty-three places reported that they had received breakaway training. Half said that security staff who could be involved had received training in control and restraint, and a similar proportion said they had received training in safe assessment and risk management practices. Fewer than half (16 places of safety) said that security staff had received training in their roles and responsibilities under section 136. One in five places of safety reported that security staff had been trained in the Mental Capacity Act. Department of Health guidance on reducing the need for restrictive interventions would also apply to security staff, and providers that require the involvement of security staff should take this into account.

20. Department of Health (2014) *Positive and proactive care: reducing the need for restrictive interventions*. April 2014.

4. Mental Health Act assessments

Key findings

- **Almost three-quarters of health-based places of safety were setting target times for starting assessments within the recommended three hour standard, and over half had target times of two hours or less. However, target times were more likely to be missed where they were more ambitious.**
- **Most places of safety (72%) said that delays were most likely to occur outside of working hours.**
- **The most common reasons for delays were that approved mental health professionals (AMHPs) and/or a section 12 approved doctor were not available, or because there were clinical grounds for delaying the assessment.**

4.1 Target times

Legally, the maximum amount of time a person can be detained in a place of safety is 72 hours. During this time, the person should be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made for their care and treatment. The MHA Code of Practice states that assessment by the doctor and AMHP should begin as soon as possible after the person arrives at the place of safety. Royal College of Psychiatrists Standards recommend that joint assessments should begin within three hours, with the expectation that this should become two hours in the future.

We found that the target times for starting assessments varied considerably between places of safety. Over half were already setting target times of two hours or less to begin assessment and, overall, almost three-quarters set target times within three hour standard. Less than 10% of places of safety did not have a specified target time, or their target was only to complete the assessment within the statutory 72 hours. Nearly two-thirds of places of safety had set target times for completing the assessment. Of those, the majority aimed to complete their assessments within six hours.

The target times at one place of safety were different for adults and young people aged 16 to 17. The target times for young people (two hours to begin and four hours to complete) were half the length of the target times for adults (four hours to begin and eight hours to complete). Another place of safety had a target time of two to three hours specifically for people who had been risk assessed as needing urgent assessment. Three places of safety linked their target times to when the person was deemed fit for assessment.

4.2 Delays in assessment

The survey also asked how often assessments took longer than the target times to be started or completed. Delays in assessments occurred daily, or almost daily, at eight places of safety. Twenty-seven places of safety said that they did not meet their target times at least once a week, and a further 37 said they did not meet their target at least once a month. Perhaps unsurprisingly, delays were more common where there were shorter target times in place. The majority of delays were reported in places where the target time to begin assessment was three hours or less, and to complete the assessment was six hours or less. Just six places of safety, where the target time to begin the assessment was three hours or less, reported that there were no delays, or that delays occurred less than every six months.

Where the information was available, most places of safety (72%) reported that delays were more likely outside of working hours. Evidence from police custody records shows that when a custody suite is used as a place of safety, the length of time before starting an assessment can be considerably longer.

We are aware that there are multiple, and often simultaneous, reasons for delays in beginning and completing assessments. This is highlighted by the following MHA monitoring visit:

“Delays had been identified following assessments under section 136, due to staffing, bed availability and resource issues for AMHPs, in particular out-of-hours availability. Delays also occurred when the person was required to be transferred to hospital from a custody suite. We were also informed that delays were also due to section 12 approved doctor availability, which has resulted in heavy reliability on the same section 12 approved doctors out-of-hours. Also, the on-call consultant was reluctant to attend MHA assessments out-of-hours and at weekends, and the current specialist registrar is not section 12 approved, ...this ...resulted in both doctors making medical recommendations under the Act not knowing the patient.”

MHA monitoring visit, June 2013

We asked places of safety to rank from one to seven (or report not applicable) the most common reasons for delays, and these were scored accordingly (**TABLE 8**).

The most common reason for delays was because the AMHPs were not available. We raised this issue in the *MHA Monitoring report for 2012/13*. Although the MHA Code of Practice does not set a required number of AMHPs, it does state that local authorities must provide an around the clock service that can respond to patients' needs.

Where other reasons were listed, these included: other clinical responsibilities/priorities (such as medical staff being on-call for a large site or planned outpatient clinics); access to interpreters; delays in conveyance or transferring people between places of safety; and the taken time to gather information about the person (including contact with the Nearest Relative and carers, or with other involved agencies).

TABLE 8: COMMON REASONS FOR DELAYS

Reason	Total score (higher number = more common reason)	Number of times option ranked as 1 (most common) by places of safety	Number of places of safety which included option in their rankings
AMHP not available	768	52 (35%)	144 (92%)
Clinical grounds for delaying the assessment	730	43 (29%)	136 (87%)
Section 12 approved doctor not available	724	24 (16%)	142 (90%)
Assessment carried out but no bed available	443	8 (5%)	119 (76%)
Doctor who knows the person not available to attend	388	4 (3%)	109 (69%)
AMHP unwilling to initiate assessment until a bed is available	314	8 (5%)	95 (61%)
Other	139	8 (5%)	29 (18%)

5. Governance, reporting and multi-agency working

Key findings

- **Many clinical commissioning groups are not involved with the operation of health-based places of safety, despite guidance from the Royal College of Psychiatrists. They are signatories on less than a third of local section 136 inter-agency policies, and are only represented on just over a third of section 136 multi-agency groups.**
- **Many providers are not collecting monitoring data as recommended by the Royal College of Psychiatrists guidance and the Crisis Care Concordat. Twelve places of safety were only able to provide estimates, very little or no data, or data that was known to be unrepresentative, on the number of times the unit had been used in each month of the last year.**

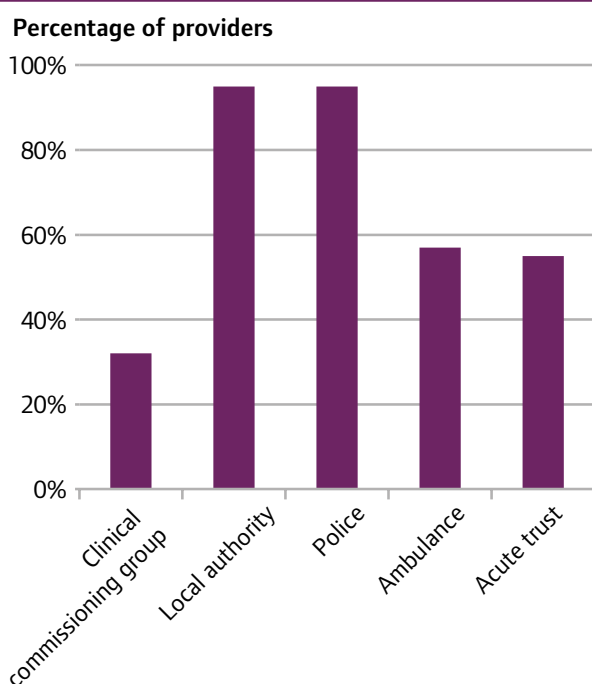
5.1 Inter-agency policies

The MHA Code of Practice states that there should be a jointly agreed local policy in place that governs all aspects of the use of sections 135 and 136. This should be maintained by a multi-agency liaison committee. It also suggests that the signatories to the policy should include local social services authorities, hospitals, NHS commissioners, police forces and ambulance services.

Fifty-four (93%) providers said that there were agreed inter-agency policies in place for the health-based places of safety in their local area. Two trusts reported that some, but not all of the places of safety in their area were covered by inter-agency policies. A further two trusts (East London NHS Foundation Trust and Solent NHS Trust) said that there was no such policy in place. Two-thirds of the policies had been agreed in the last two years (from January 2012). Only one (5 Boroughs Partnership NHS Foundation Trust) had last been agreed over five years ago.

Where there was a policy in place, almost all trusts reported that the local authorities and police had signed up to it. However, only 57% reported that ambulance services were signatories, and less than a third said that the clinical commissioning group (CCG) was signed up. Just over half reported that an acute trust had also signed the policy. Two inter-agency policies did not have an acute trust signatory, even though one of the places of safety in each of the areas they covered was based in an A&E. Only a few trusts reported that there were additional signatories. The majority of these were former primary care trusts and other local providers (FIGURE 7).

FIGURE 7: SIGNATORIES TO THE INTER-AGENCY POLICIES



The Code of Practice (paragraph 10.17) sets out 11 aspects of the operation of places of safety where responsibilities should be defined in the policy. Forty-seven (84%) trusts said that the policy covered all of these aspects. Of the nine trusts that said it did not, the following were omitted:

- Commissioning and providing secure places of safety in healthcare settings (five trusts).

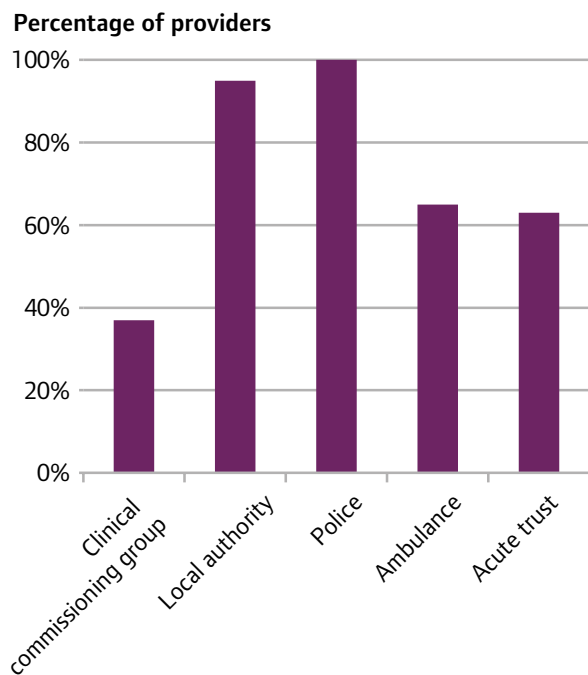
- The release, transport and follow up of people assessed under section 135 or 136, who are not then admitted to hospital or immediately accommodated elsewhere (four trusts).
- Record keeping and monitoring and audit of practice against policy (three trusts, plus one that reported that its monitoring form did not cover all required aspects).
- The safe, timely and appropriate conveyance of the person to and between places of safety (three trusts).

Twenty trusts (38%) reported that no audit of practice against their policy had been completed, or was planned for the future. One trust did not know whether any audit had been carried out. Twenty-three reported that an audit had been completed (of which 13 had taken place in 2013 and five had been in the first two months of 2014). Ten trusts said that an audit was planned to take place in 2014. Three trusts reported that an audit had been completed or planned, but did not provide a date.

“Although our trust has a well-developed and regularly reviewed section 136 policy, which is kept under scrutiny at a multi-agency liaison group, I do not believe that either of the two medical trusts running the A&E departments have local operational policies or even want to have them.”

Multi-agency groups

The MHA Code of Practice suggests that local policies on the operation of section 136 should be maintained by a multi-agency liaison committee. The Royal College of Psychiatrists guidance states that it is the commissioners’ responsibility to make sure that this group exists and meets regularly, and takes on responsibility for developing, implementing and quality assuring the agreed policy. We would also expect providers to make efforts to talk to CCGs where this is not happening.

FIGURE 8: REPRESENTATIVES ON MULTI-AGENCY GROUPS

While only one trust (Barnet, Enfield and Haringey Mental Health NHS Trust) reported that they did not have a multi-agency group, of those that did, the majority (37%) reported that the CCG was not represented on the group (**FIGURE 8**).

Sixteen trusts reported that their multi-agency groups included additional representatives. Although we did not suggest which other representatives might be included, four trusts volunteered that their groups included a service user representative (one also included a carer representative) and a further two included advocacy representatives. This is good practice, and Royal College of Psychiatrists guidance suggests that the group should include both a service user and carer representative. Other representatives came from CAMHS providers, AMHPs, crisis resolution and home treatment teams, SERCO, nursing staff, courts, probation, Crown Prosecution Service, prisons, forensic medical examiner services, medical leads, British Transport Police, and learning disability services.

Less than one in five groups met on a monthly basis. The majority of groups met at least every two or three months, and three trusts told us that their group met at least every six months. Devon Partnership NHS Trust said that the group they were involved in had never met.

The job titles of the groups' chairs varied, although the majority worked for either the mental health trust or the local authority. Some of the more common roles included lead AMHP, head of service, service director, service manager, and director of nursing. Two chairs were from the police: a chief superintendent and a chief inspector. Two of the more unusual chairs were a local security management specialist, and a head of PALS, complaints and legal services.

5.2 Trust board and CCG oversight

We asked what reporting mechanisms were in place to make sure that the trust board and local CCGs were kept informed about key issues discussed by the multi-agency group.

The majority of trusts were able to tell us how key issues were raised with the board. In many cases, this was via a named trust committee (often a Mental Health Act committee or a quality and risk committee), which would in turn escalate issues to the board. In some cases, issues were escalated to the board on an 'as and when' basis, and in others the board received reports on the use of the Mental Health Act, including the use of section 136. Such reports varied in frequency, though were just annual in some cases. Three trusts said that there was no specific reporting mechanism for issues around section 136 and places of safety. However, one did clarify that a process was being put in place for the future, and two trusts did not answer the question.

In a few cases, a member of the trust board was also a member of the multi-agency group meeting, enabling any issues to reach the board directly, as in the example below:

"The Director of Quality and Nursing is Chair of this meeting and is a member of the trust Board – providing a direct route of communication. We also have a Mental Health Act Committee which is a sub-committee of our Quality Committee – both of these include non-executive directors from the trust Board. The Acute Care Forum provides a link with operational services for the reporting and governance of MHA issues."

More providers were able to explain the reporting mechanism to their board than could explain how the CCG were kept informed on key issues. However, the majority were still able to tell us how they reported issues to the CCG. Where there was a reporting mechanism in place, most providers said that this consisted of regular meetings with their commissioners. These were mostly contract meetings, but also included quality review meetings. Some providers said there was also an ad hoc mechanism for reporting key issues or incidents as they arose, either as the only mechanism, or in addition to regular meetings. One provider said that the mechanism they used was the health and wellbeing board meetings. Some trusts also highlighted that commissioners were part of the multi-agency group. Twelve providers either did not answer the question or reported that no such mechanism existed for the CCG.

5.3 Complaints and incident reporting

The survey asked how many complaints and incidents there had been relating to the places of

safety in 2013, and how many of those had been reported to the board. Forty trusts reported that there had been no complaints, and 15 trusts said that there had been no incidents in 2013 (11 of these reported no complaints either) (TABLES 9 AND 10).

TABLE 9: NUMBER OF COMPLAINTS REPORTED TO PROVIDERS IN 2013

Number of complaints	Percentage (number) of providers
0	69% (40)
1	10% (6)
2	2% (1)
3	5% (3)
4	2% (1)
5	3% (2)
6	5% (3)
Unknown	3% (2)
Total	100% (58)

TABLE 10: NUMBER OF INCIDENTS REPORTED IN 2013

Number of incidents	Percentage (number of providers)	
	Overall	Per place of safety space (capacity)
0	26% (15)	26% (15)
Less than 5	17% (10)	38% (22)
5-9	12% (7)	10% (6)
10-19	16% (9)	17% (10)
20-39	10% (6)	2% (1)
40-59	9% (5)	2% (1)
60-79	5% (3)	0% (0)
80+	2% (1)	2% (1)
Unknown	3% (2)	3% (2)
Total	100% (58)	100% (58)

Of the 16 trusts that reported that there had been complaints, 11 said that some or all of these were reported to the board. Of the 41 trusts which reported incidents, 27 said that some or all were reported to the board, although for three they were reported as part of the trust's general incident data.

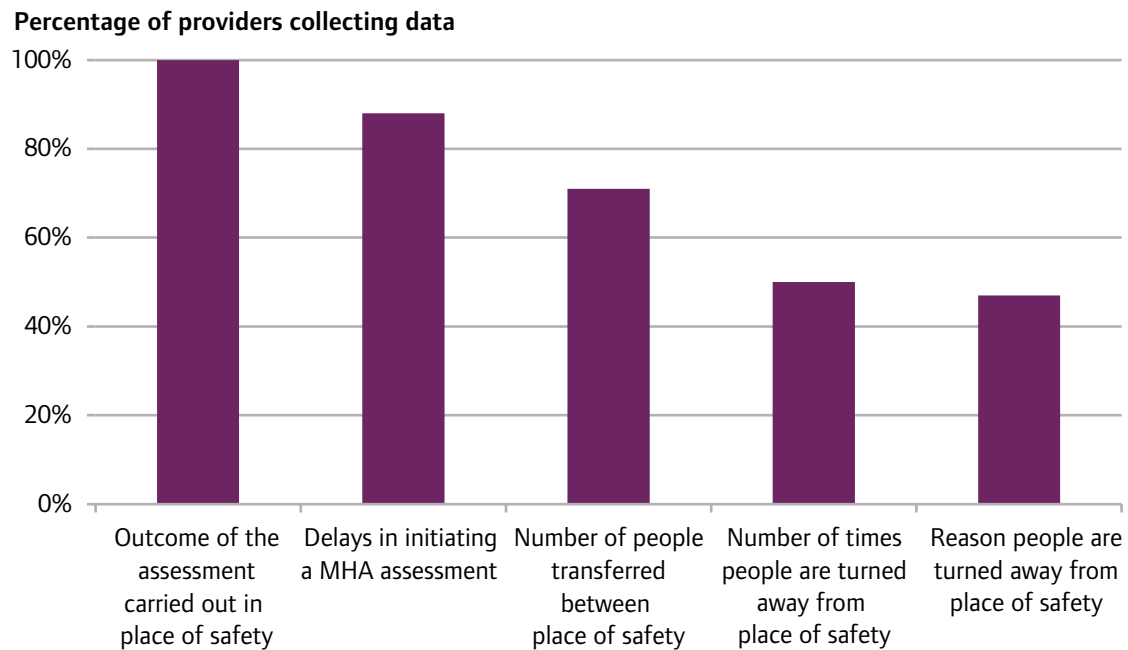
5.4 Monitoring places of safety

All trusts said that some data was routinely collected from all of the places of safety in their area. Most providers said that they collected data on a number of protected characteristics (as defined by the Equality Act 2010). The MHA Code of Practice specifically recommends that providers should monitor the use of section 136 in relation to people from Black and minority ethnic communities, as well as children and young people. In addition, Royal College of Psychiatrists guidance suggests that at least age, gender and ethnicity should be routinely collected (**TABLE 11**).

Of the trusts that collected data that was linked to other protected characteristics, three collected information on marital status, three collected information on religion, and two collected information on sexual orientation. In addition, two trusts collected data on whether the person had responsibilities for children or vulnerable people, and one collected data on country of birth. Other data collected, which were unrelated to protected characteristics, included circumstances of address, employment status, and alcohol and drugs usage.

TABLE 11: PROTECTED CHARACTERISTICS DATA COLLECTED BY PROVIDERS

Protected characteristic collected	Percentage (number) of providers
Age	98% (57)
Gender	98% (57)
Ethnicity	83% (48)
Disability	34% (20)
Other protected characteristic(s)	19% (11)

FIGURE 9: OUTCOMES OF PEOPLE BROUGHT TO THE PLACE OF SAFETY

The survey also asked providers whether information was collected on what happened to people who were brought to the place of safety (**FIGURE 9**).

When we asked places of safety to give us specific data on the number of times (by month) that the place of safety had been used in 2013, 150 were able to provide data, but seven stated that their figures were estimated or unrepresentative. A further seven provided very little or no data. Of those 14 places of safety, seven were based in A&E departments and seven were located in mental health services on a mental health hospital site.

Of the 65 places of safety that reported that they had turned people away because they were already occupied, 29 were also able to provide some specific monthly data about how often this happened.

Royal College of Psychiatrists guidance also recommends that trusts collect data on transfers between places of safety, the time taken to start assessment, and why a place is used if it is not the designated health place of safety. The Concordat also requests that detailed data is collected showing why and how often police cells are used as places of safety. In order to fulfil

these recommendations, we would expect that all providers should be able to provide data on the above, if requested.

5.5 Feedback from people who have been taken to the place of safety

We asked places of safety whether they ever sought feedback about people's experiences of being detained in the place of safety. A quarter (40) reported that they did seek feedback, but three-quarters did not (119). Obtaining feedback from service users and carers is recommended in standards from the Royal College of Psychiatrists. This is also something that we would like to see happening much more frequently.

6. The role of ambulance and police services

Key findings

- **Over a quarter of places of safety identified that people were only brought there by the police, even though national guidance indicates that an ambulance is the preferred form of transport to and between places of safety and that police vehicles should only be used to transport people in exceptional circumstances.**
- **Eighty-five per cent of providers said that they were contacted by the police before the person arrived at the health-based place of safety all or most of the time.**
- **While there is no expectation in national guidance that police should remain at the place of safety until the MHA assessment has been completed, 12% of places of safety reported that police did generally remain for this period, and one in 10 providers reported that this was an expectation in their inter-agency policy.**

6.1 Transport to the place of safety

While there is no requirement for how people should be transported from a public place to a place of safety, the Royal College of Psychiatrists Standards state that “an ambulance... is the preferred form of transport to and between places of safety in most cases.”

The Crisis Care Concordat states that police vehicles should only be used in exceptional circumstances to transport people who are subject to section 136. It also flags a new national protocol for transporting people detained under section 136. This outlines NHS ambulance trusts’ intention to respond within 30 minutes (or within eight minutes for people who are being actively restrained), to carry out an initial assessment, and to arrange transport to a place of safety.

HSCIC estimated data for 2012/13 showed that just over a quarter of people were transported to a health-based place of safety by ambulance, while just under three-quarters were transported by police transport.

We asked places of safety to tell us how people were brought to their location (the options provided were: police, NHS ambulance, independent ambulance, on foot, or other). Over a quarter of places of safety (28%) identified the police as the only way people were brought to them. The majority of places of safety selected multiple options, including both the police and ambulance services. No other means of bringing people to the place of safety were reported.

Where people were brought to places of safety in an ambulance, the majority of these were NHS ambulances. Just five places of safety (3%) said that people might be brought by an independent ambulance service.

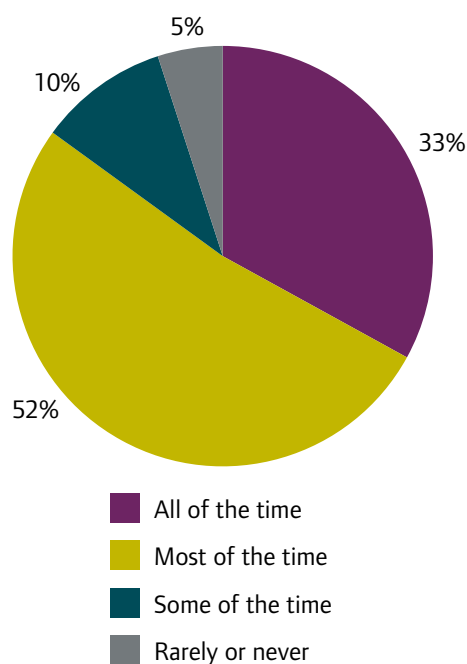
There is still some way to go before the use of police vehicles to transport people detained under section 136 is exceptional. We hope that the new national NHS ambulance protocol will help to address this issue and we look forward to seeing it implemented. The Concordat tasks commissioners with making sure that the transfer arrangements put in place by mental health trusts and acute trusts provide appropriate and prompt transport, and that caged ambulances should not be routinely used for this purpose.

6.2 Police contact following section 136 detention

When the place of safety is a hospital, the MHA Code of Practice requires that the police make contact with the hospital before arriving with the person. This is so that arrangements can be made for the person to be assessed as soon as possible.

Only a third of providers said that the police always contacted the service before they arrived. However, just three trusts said that the police rarely or never contacted the service. It may be relevant that for two of those three trusts, the six places of safety were located in emergency departments in acute hospitals (**FIGURE 10**).

FIGURE 10: POLICE CONTACT BEFORE ARRIVAL AT THE PLACE OF SAFETY



6.3 Expectations of support from the police

Standards from the Royal College of Psychiatrists recommend that police should be able to leave promptly after a handover period at the place of safety, even when the detained person is disturbed. The Royal College of Psychiatrists guidance is more specific and recommends that police should be free to leave within 30 minutes, once staff are satisfied they can safely manage the person.

The Concordat further supports the view that NHS staff should take responsibility for the person as soon as possible, as long as it is agreed that the situation is safe for the person and healthcare staff. It states that the police should not be expected to stay at the place of safety until the person has been assessed.

Where an inter-agency policy existed, all the providers reported that it included details of the support the police would be expected to provide. The survey asked how long the police were expected to stay, as detailed in the policy, and also asked how long they tended to stay at individual places of safety (**TABLE 12**).

TABLE 12: LENGTH OF TIME POLICE STAY AT THE PLACE OF SAFETY

Expectation in inter-agency policy (provider response)/ how long police tend to stay (place of safety response)	Response from provider		Response from place of safety	
	Percentage (number) of providers	Number of places of safety to which this relates	Percentage (number) of places of safety	Number of providers to which this relates
Police leave as soon as the person has been handed over to the place of safety staff	2% (1)	4	8% (13)	9
Police stay past handover only if there is a risk to the person's safety or for the protection of others	81% (47)	121	74% (118)	46
Police stay until MHA assessment has been completed	10% (6)	12	12% (19)	12
Other	7% (4)	21	5% (8)	5
No inter-agency policy	2% (1)	1	n/a	n/a
Information not available	n/a	n/a	1% (1)	1
Total	100% (58)		100% (159)	

In general, most places of safety agreed that police tended to stay according to the arrangements set out in the policy, with a few exceptions.

Where the policy stated that police would stay past handover if there was a risk:

- Eight places of safety (from four providers) responded that the police would generally stay until the MHA assessment had been completed.
- Eight places of safety (seven providers) responded that police would leave as soon as the person had been handed over to staff.
- Two places of safety (one provider) said that police would stay up to one hour maximum if required.

Where the policy stated that police would stay until the MHA assessment had been completed three places of safety (two providers) said that police would generally only stay past the handover if there was a risk to the person's safety, or for the protection of others.

In addition, providers reported that almost 40% of their inter-agency policies stated whether police are expected to assist in physical restraint. In almost all cases, this was to prevent harm or injury to the person or others. Two policies stated that police would assist in restraining the person to stop them leaving the place of safety. One policy also stated that police would help with restraining someone, to enable them to be transferred to another place of safety.

Conclusions

Our survey focused on the availability, in practice, of health-based places of safety and the processes and infrastructure to support this. Overall, our findings suggest that some places of safety are working effectively, with examples of good practice and organisational developments. However, there is also evidence that recommended national standards are not being fully met in a range of areas.

This is likely to have an impact on people's experience from the point they are detained by police under section 136, through being conveyed to hospital, transferred into the care of place of safety staff, and waiting to be assessed under the Mental Health Act. For most, this is likely to be a distressing experience. This can only be made worse when a place of safety cannot be accessed, when a person has a long wait in the back of a police car, or when they have a long wait to be assessed.

There are examples of good practice that other providers can learn from. There are also examples of effective partnership working to make the pathway of care as safe, effective and responsive as it can be for people subject to section 136. However, the survey has highlighted some key areas for improvement.

Availability, capacity and staffing

Analysis of the survey findings has shown that there is a clear link between the availability and capacity of health-based places of safety and whether people are taken there or to police stations. There are also some marked differences in how often places of safety are used, raising questions about how well dispersed some places of safety are.

It is very concerning that around one in 10 places of safety said that people were not able to access the unit at least once a week because it was already occupied. It was also concerning that a

quarter of providers do not think that there are currently enough places of safety. This suggests that provision is not matching need in many areas of England. We urge local commissioners to review local provision where this is the case.

The number of staff allocated to work in places of safety also varies, with over one in 10 having no staff allocated. Where the allocation of staffing is higher, they are more likely to be available to receive someone brought into the place of safety without lengthy delay, even if they work in another team or ward.

Although relatively small in number, it is still unacceptable that some places of safety said that people in need of urgent of mental health care had to wait with the police for an hour or more before being handed over to place of safety staff.

Accessibility

When we published the online map of places of safety in April 2014, we highlighted our significant concerns about the restrictions in place preventing children and young people from accessing health-based places of safety. National data from 2012/13 showed that young people detained under section 136 are more likely to be taken to police stations than adults. We asked providers to prioritise reviewing local protocols where access was restricted for children and young people. We also asked them to make sure that there were appropriate arrangements are in place, not least because this raises important human rights and safeguarding issues. We reiterate our expectations that providers undertake this, and expect that there will be progress made when we next refresh the information for the map.

It is clear that people of all ages are being excluded from health-based places of safety, for a variety of reasons. This is contrary to the requirements of the Mental Health Act Code of Practice and the Crisis Care Concordat. People

who are intoxicated in particular are being excluded, but other groups, including people whose behaviour is disturbed, are also being excluded. National guidance makes it clear that, in most cases, people in these vulnerable circumstances are best managed in a healthcare setting. As a result, it is important that providers make sure that staff who run the place of safety are trained, skilled and equipped to support people in this situation, other than in exceptional circumstances or where assessments indicate that people's physical health is at risk.

Contribution of key agencies

The survey findings raise questions about how professionals from different agencies are able to fulfil their roles and responsibilities as part of the section 136 care pathway. The findings show that, in some areas, the police rather than ambulances are transporting people to the place of safety, and that the police do not always contact the places of safety before they arrive. They also show that, in one in 10 areas, the police are requested or required to stay until the MHA assessment has been completed, rather than leaving promptly when healthcare staff are confident that they can manage the person. Difficulties with the availability of AMHPs and section 12 approved doctors are also two key reasons why there are delays in carrying out MHA assessments. Each of these professionals play a key role in the section 136 process, and interagency discussion, at both operational and strategic levels, is required where there are difficulties.

The findings also suggest that clinical commissioning groups (CCGs) are not engaged enough in some areas. Only a third of local section 136 interagency policies have been signed by CCGs, and only 37% of the section 136 local multi-agency groups have representation from the CCG. This is despite guidance from the Royal College of Psychiatrists that suggests CCGs should be responsible for these groups. There are also implications from the survey for the commissioning of services to better meet the needs of some local populations. Depending on locality, this may require interventions to reduce

the use of section 136 as well as, or instead of, focusing on the places of safety themselves.

Data quality

The survey has highlighted major problems with the availability and robustness of the data collected to monitor the operation of places of safety. Many providers are not collecting the information recommended by the Royal College of Psychiatrists and the Crisis Care Concordat. Without this information, it is hard to see how providers can effectively monitor their operation of places of safety or provide assurance about the care they provide to people subject to section 136. Collecting this information could also inform needs assessments and highlight shortfalls in the commissioning of services.

Our expert advisory group who reviewed the survey analysis, raised questions about the accuracy of some of the reported data, in light of the information that is collected by other agencies. The survey findings only represent the perspective of providers of health-based places of safety. However, we hope that publishing this data will encourage discussion among local partner agencies, and will help develop agreement about the issues that challenge the effective operation of places of safety.

Recommendations

Over the next year we would ask all agencies involved in operating section 136 and health-based places of safety to review the findings of this survey, and to take appropriate action where there are shortfalls.

Although our recommendations are directed at specific agencies, many of the issues discussed in this report, and their related recommendations, are connected. Local agreement will be needed on how best to address these, and the decision-making process should ideally take place in a collaborative forum.

We recommend that all providers of health-based places of safety:

1. Draw on the findings of this survey to identify areas where local health-based places of safety do not meet national standards. They should also agree plans to improve any areas of shortfall, in discussion with key partners. This includes:
 - Reviewing local protocols and making sure that there are appropriate arrangements in place for children and young people.
 - Reviewing the exclusion criteria for health-based places of safety in light of the recommendations of the national Mental Health Crisis Care Concordat. This includes making sure that practices reflect the expectations of the Concordat, for example in relation to people who are intoxicated, whose behaviour is disturbed or who have a previous history of offending or violence. Reducing the number of people who are excluded may mean that there needs to be greater flexibility in where is designated a place of safety, or having a greater range of places that can be used when needed.
 2. Ensure that a minimum of two healthcare staff are allocated to receive an individual brought to the place of safety by the police, in line with the recommendations of the Royal College of Psychiatrists. Training for staff who work in the place of safety should be reviewed in relation to the Department of Health's guidance on reducing the need for restrictive interventions. Plans should then be developed to address any shortfalls. This should include training for security staff who may be required to intervene with an individual brought to the place of safety.
 3. Implement a clear reporting mechanism, if one is not already in place, to make sure that the Board, or relevant sub-group, are made aware of key issues relating to the health-based place of safety on a regular basis, and at least quarterly.
- Improving local data collection, reviewing and monitoring of the use of health-based places safety to meet the requirements of national guidance. This should include:
 - The age, gender and ethnicity of people brought to the place of safety.
 - The number of requests received from the police for people to be brought to the place of safety; the number of people referred to the place of safety who are resident out of area; the number of times people were accepted; how often health-based places safety cannot be accessed; and the reasons for each time this happens.
 - The time taken to start MHA assessments, the reasons for delays, transfers between places of safety and the reasons for using alternatives to the designated place of safety.

We recommended that clinical commissioning groups:

4. Make sure that multi-agency groups exist and meet regularly to oversee the operation of section 136. Commissioners should also attend multi-agency meetings and oversee the review, implementation and quality assurance of agreed policies.
5. Draw on the findings of this survey to review the availability and use of health-based places of safety to identify whether provision meets local needs. This includes reviewing the frequency that people are unable to access the local place(s) of safety, the reasons for this and making sure that there are enough and appropriate places of safety for children and young people. This should be in the context of considering how to make the pathway for people subject to section 136 as effective as possible. This may include commissioning services or specifying interventions that may prevent or reduce the use of section 136.
6. Put in place commissioning specifications that:
 - Drive data quality improvements and require services to provide data and analysis to inform commissioning decisions.
 - Include evidence-based standards for the provision of health-based places of safety.
 - Include health-based places of safety as one component of services which can respond to people in crisis.
7. Make sure that arrangements for transporting people subject to section 136 to hospital by ambulance are appropriate and timely. This may require a needs assessment for specialist ambulance provision for people in mental health crisis. Response times should be in line with the National Mental Health Act Section 136 Protocol for ambulance trusts; that is within 30 minutes, or within eight minutes for people who are being actively restrained.

8. Review the local availability of section 12 doctors to undertake MHA assessments. Work with the Department of Health to make sure that there are enough doctors applying for approval locally, so that delays in initiating MHA assessments for people subject to section 136 can be minimised.

We recommend that health and wellbeing boards:

9. Assess local need for health-based places of safety as part of their Joint Strategic Needs Assessments. Where need is not being met, Joint Health and Wellbeing Strategies should address this as a priority. Health and wellbeing boards should also consider how best to meet the needs of people whose circumstances make them more vulnerable and who are currently excluded from designated places of safety.

We recommend that multi-agency section 136 groups:

10. Develop an action plan to address any shortfalls identified through the survey and monitor its implementation. This should include:
 - Agreeing alternative arrangements for people subject to section 136 when the place of safety is occupied.
 - Auditing local data on the operation of places of safety and promote improvements in data quality where required.
11. Engage local commissioners with group meetings, where this is not already happening.

We recommended that local authorities:

12. Review the availability of approved mental health professionals (AMHPs) to undertake MHA assessments. They should also make sure that there is enough capacity, so that delays in initiating MHA assessments for people subject to section 136 can be minimised.

We recommended that NHS England:

13. Considers the use of capacity management systems to include real-time information on the availability of health-based places of safety, in order to help streamline the process for police and ambulances to access a place of safety.

What CQC will do:

- In April 2014, we published an online map showing the location of designated health-based places of safety across England, with details of opening hours, capacity, age groups accepted, and the local areas they are intended to serve. This was refreshed in October, and we will make sure that it is updated regularly in the future.
- Alongside this report we are publishing the quantitative data collected through the survey to provide relevant agencies with information on how local provision of health-based places of safety compares with other areas. We hope that it will help local services and agencies to make declarations, in line with the Concordat, about how they will improve mental health crisis care and support.²¹
- Under our new approach to the regulation of care services, health-based places of safety is one of our core services that will always be inspected as part of our comprehensive inspections of specialist mental health care providers. We will use the findings of this survey, and of our wider thematic review of crisis care, to further develop our approach to inspecting these services.
- Our analysis of the survey findings will be included in the data we use to inform future inspections, and will also help us to target areas for improvement. We will expect to see action plans where practice does not meet national standards.

21. Further information is available at:
www.crisiscareconcordat.org.uk

Appendix: Mapping of survey findings to national standards

The standards quoted are taken from the following:

- Code of Practice: Mental Health Act 1983 (2008).
- Mental Health Crisis Care Concordat. Improving outcomes for people experiencing mental health crisis. February 2014.
- Royal College of Psychiatrists. Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales). CR159. July 2011.
- Royal College of Psychiatrists. Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983. PS2/2013. April 2013.

Source	Standard	Survey question and finding
Royal College of Psychiatrists Standards	The ideal situation would be to have a dedicated emergency psychiatric facility for those detained under section 136 in close proximity to acute admission wards.	<p>Is this a dedicated place of safety (not intended to be used for any other purpose)?</p> <p>Yes: 86% (138) places of safety</p> <p>No: 14% (22) places of safety</p>
Concordat	[Health-based places of safety] should be provided at a level that allows for around the clock availability, and that meets the needs of the local population.	<p>When is the place of safety open?</p> <p>24 hours a day/365 days a year: 99% (160) places of safety</p> <p>8am to midnight: 1% (1) places of safety</p> <p>Does your trust believe that there is currently sufficient provision of health-based places of safety in the local authority area(s) covered by the Trust?</p> <p>Yes: 76% (44) providers</p> <p>No: 24% (14) providers</p> <p>In 2013, how often has a person not been able to access the health-based place of safety because the assessment room(s) was (were) already occupied?</p> <p>Never in 2013: 44% (51) places of safety</p> <p>Less than every 6 months: 20% (23) places of safety</p> <p>At least every 6 months: 3% (3) places of safety</p> <p>At least quarterly: 8% (9) places of safety</p> <p>At least once a month: 14% (16) places of safety</p> <p>At least once a week: 11% (13) places of safety</p> <p>Daily/most days: 1% (1) places of safety</p>
Concordat	Unless there are specific arrangements in place with child and adolescent mental health services, a local place of safety should be used, and the fact of any such unit being attached to an adult ward should not preclude its use for this purpose.	<p>Which health-based place of safety can the following groups of people use?</p> <p>Under 16s:</p> <p>None: 26% (15) providers</p> <p>At least one place of safety in local area named: 74% (43) providers</p> <p>16 to 17 year olds:</p> <p>None: 16% (9) providers</p> <p>At least one place of safety in local area named: 84% (49) providers</p>

Source	Standard	Survey question and finding
Concordat	Irrespective of other factors, such as intoxication, or a previous history of offending or violence, individuals suffering a mental health crisis and urgently needing to be detained while waiting for a mental health assessment should expect to be supported in a health based place of safety.	<p>What exclusion criteria (if any) for accepting individuals are applied to all health-based places of safety in your trust area?</p> <p>Either or both of the trust policy and inter-agency policy contained the following exclusion criteria:</p> <p>Intoxication: 48% (28) providers</p> <p>Disturbed behaviour: 36% (21) providers</p> <p>Criminal offence: 17% (10) providers</p> <p>History of violence: 10% (6) providers</p> <p>Risk of self-harming: 3% (2) providers</p>
Royal College of Psychiatrists Standards	The psychiatric section 136 facility should ideally have dedicated staffing, or at the very least, a supernumerary post attached to the team responsible for the place of safety.	<p>As a minimum, how many mental healthcare professionals are allocated to work in the place of safety?</p> <p>Two or more: 43% (69) places of safety</p> <p>One: 43% (69) places of safety</p> <p>None: 13% (21) places of safety</p>
Royal College of Psychiatrists Guidance	There should be a minimum of two mental healthcare professionals immediately available to receive the individual from the police [...] Consideration should be given to having dedicated section 136 staff who can be assigned to other wards or teams when not required in the mental health place of safety.	<p>Members of staff per person that can be accommodated in each place of safety:</p> <p>Two or more: 32% (51) places of safety</p> <p>One: 45% (72) places of safety</p> <p>Less than one: 19% (30) places of safety</p> <p>Is this number of staff always available at the opening times specified?</p> <p>Yes – always: 76% (121) places of safety</p> <p>Mostly: 14% (22) places of safety</p> <p>Occasionally: 1% (1) places of safety</p> <p>No – rarely/never: 9% (15) places of safety</p> <p>When police arrive are there ever delays in providing staffing levels in accordance with your policy?</p> <p>Yes – always: 3% (4) places of safety</p> <p>Mostly: 3% (4) places of safety</p> <p>Occasionally: 30% (47) places of safety</p> <p>No – rarely/never: 65% (104) places of safety</p>

Source	Standard	Survey question and finding
MHA Code of Practice	All professionals involved in implementation of the powers should understand them and their purpose, and the roles and responsibilities of other people involved, and should follow the local policy.	Do all or the majority of nursing staff/medical staff/AMHPs working in the place of safety have training in their roles and responsibilities under section 136?
MHA Code of Practice Royal College of Psychiatrists Standards	Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. The local implementation group must ensure that there are adequate approved mental health professionals and doctors approved under section 12 of the Mental Health Act to enable joint assessments to begin within three hours currently, with an expectation that in the longer term the target will become two hours.	<p>What is your local target time for starting a MHA assessment for people brought to the place of safety?</p> <p>Two hours or less: 54% (86) places of safety Three hours or less: 72% (115) places of safety Longer than three hours: 19% (30) places of safety No target time/statutory 72 hours: 9% (14) places of safety</p> <p>In 2013, how often have the MHA assessments for people brought to the place of safety taken longer than your target time to be started or completed?</p> <p>Never in 2013: 11% (12) places of safety Less often than every 6 months: 2% (2) places of safety At least every 6 months: 4% (4) places of safety At least quarterly: 21% (24) places of safety At least once a month: 32% (37) places of safety At least once a week: 24% (27) places of safety Daily/most days: 7% (8) places of safety</p> <p>The majority of delays were reported in places where the target time to begin assessment was three hours or less. Six places of safety where the target time to begin the assessment was three hours or less reported that there were no delays, or delays occurred less often than every six months.</p>

Source	Standard	Survey question and finding
MHA Code of Practice	Local social service authorities (LSSAs) are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, LSSAs must have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.	<p>What are the reasons for delays in either carrying out or completing MHA assessments?</p> <p>'AMHP not available' named as the most common reason by 35% (52) places of safety. Ninety-two percent (144) places of safety included this in their rankings of different possible reasons for delays.</p>
MHA Code of Practice	LSSAs, hospitals, NHS commissioners, police forces and ambulance services should ensure that they have a clear and jointly agreed policy for use of the powers under sections 135 and 136, as well as the operation of agreed places of safety within their localities.	<p>Is the operation of the health-based place(s) of safety within your trust area subject to an agreed inter-agency policy?</p> <p>Yes: 93% (54) providers</p> <p>Some, but not all, of the places of safety in the trust area have an agreed inter-agency policy: 3% (2) providers</p> <p>No: 3% (2) providers</p> <p>Who are the signatories to the inter-agency policy?</p> <p>Clinical commissioning group: 32% (18) providers</p> <p>Local authority: 95% (53) providers</p> <p>Police: 95% (53) providers</p> <p>Ambulance: 57% (32) providers</p> <p>Acute trust: 55% (31) providers</p>
MHA Code of Practice	The policy should define responsibilities for: [11 aspects of the operation of places of safety where responsibilities should be defined in the policy] – see paragraph 10.17	<p>Does the inter-agency policy include all of the areas set out in paragraph 10.17 of the Code of Practice for the Mental Health Act 1983?</p> <p>Yes: 84% (47) providers</p> <p>No: 16% (9) providers</p>
MHA Code of Practice	Such policies may be best maintained by the establishment of a liaison committee.	<p>Do you have a multi-agency group that includes active representatives from the following:</p> <p>Clinical commissioning group: 37% (21) providers</p> <p>Local authority: 95% (54) providers</p>
Royal College of Psychiatrists Guidance	It is the responsibility of commissioners to ensure there is a local multiagency group that meets on a regular basis.	<p>Police: 100% (57) providers</p> <p>Ambulance: 65% (37) providers</p> <p>Acute trust: 63% (36) providers</p> <p>One trust reported that they did not have a multi-agency group.</p>

Source	Standard	Survey question and finding
MHA Code of Practice	The locally agreed policy should include arrangements for the use of section 136 (in particular) to be monitored effectively so that a check can be made of how, in what circumstances and with what outcome it is being used, including its use in relation to people from Black and minority ethnic communities and children and young people.	If data is routinely collected [from each health-based place of safety], does this include: Age: 98% (57) providers Gender: 98% (57) providers Ethnicity: 83% (48) providers Disability: 34% (20) providers Other protected characteristic(s): 19% (11) providers
Royal College of Psychiatrists Guidance	The following information should be routinely collected: sociodemographic characteristics of those detained (age, gender, ethnicity)	
Concordat	Commissioners and providers should make sure there is accurate and detailed data showing why and how often police cells are used as places of safety.	Do you also collect information on: How many times people are turned away from the place of safety: 50% (29) providers The reason people are turned away from the place of safety: 47% (27) providers The number of people who are transferred between places of safety: 71% (41) providers The outcome of the assessment carried out in the place of safety: 100% (58) providers Delays in initiating a MHA assessment for people brought to the place of safety: 88% (51) providers
Royal College of Psychiatrists Guidance	The following information should be routinely collected: <ul style="list-style-type: none"> Place of safety used; if not the MHPoS, the reasons for this. Any transfers between places of safety and reasons for this. Outcome of assessment (detained, informal admission, community. Follow-up or discharge). Time taken for AMHP to commence assessment. Time taken for doctor to commence assessment. 	In 2013, how many times has the place of safety been used for people detained under s135/136? Able to provide some data (including estimates and data known to be unrepresentative: 96% (150) places of safety Provide estimates or unrepresentative data: 5% (7) places of safety No/very little data provided: 5% (7) places of safety If the data is available, please specify how many people per month and/or in 2013 were not able to access the place of safety because the assessment room(s) was (were) already occupied?

Source	Standard	Survey question and finding
		<p>Forty-one places of safety were unable to provide an estimate and selected 'Information not available'. Fifty-one places of safety reported that this had never happened in 2013. Of the 65 places of safety that reported this had happened in 2013:</p> <p>43% (29) places of safety were able to provide data. 57% (37) places of safety did not provide data.</p>
Concordat	Police vehicles should not be used [to convey people detained under section 136 from the community to a health-based place of safety] unless in exceptional circumstances, such as in cases of extreme urgency, or where there is a risk of violence.	<p>How are people brought to this place of safety?</p> <p>Police: 97% (154) places of safety NHS ambulance: 72% (115) places of safety Independent ambulance: 3% (5) places of safety On foot: 6% (10) places of safety</p>
MHA Code of Practice	Where the place of safety is a hospital, the police should make immediate contact with both the hospital and the LSSA (or the people arranging AMHP services on its behalf), and this contact should take place prior to the person's arrival at the place of safety. This will allow arrangements to be made for the person to be interviewed and examined as soon as possible.	<p>In your trust area, do police tend to contact the service prior to the person's arrival at the place of safety?</p> <p>All of the time: 33% (19) providers Most of the time: 52% (30) providers Some of the time: 10% (6) providers Rarely or never: 5% (3) providers</p>

Source	Standard	Survey question and finding		
Royal College of Psychiatrists Standards	Staffing levels should be sufficient 24 hours a day to ensure that the police can leave promptly after a handover period, even when the patient is disturbed. There should be no expectation that the police will remain until the assessment is completed, as currently happens in some places.		If the [inter-agency] policy includes details about support from police, what are the expectations?	How long do the police generally stay after they have handed the person over to staff working in the place of safety?
			% (number) of providers	% (number) of places of safety
Concordat	NHS staff, including ambulance staff, should take responsibility for the person as soon as possible, thereby allowing the officer to leave, so long as the situation is agreed to be safe for the patient and healthcare staff. There should not be an expectation that the police will remain until the assessment is completed.	Police leave as soon as the person has been handed over to the place of safety staff	2% (1) provider	8% (13) providers
		Police stay past handover only if there is a risk to the person's safety or for the protection of others	81% (47) providers	74% (118) providers
		Police stay until MHA assessment has been completed	10% (6) providers	12% (19) providers
		Other	7% (4) providers	5% (8) providers

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