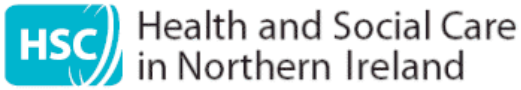

REGIONAL INTERAGENCY PROTOCOL ON THE OPERATION OF PLACE OF SAFETY & CONVEYANCE TO HOSPITAL UNDER THE MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986

October 2015

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1.0 INTRODUCTION

The purpose of this document is to provide a framework for co-operation and joint working between Police Service Northern Ireland (PSNI), Northern Ireland Ambulance Service (NIAS); Health and Social Care Trusts (HSCT) to ensure that people with a mental disorder are managed in a safe, efficient and effective manner when agencies and professional staff are discharging their duties under the Mental Health (NI) Order 1986 (referred to in this document as The Order).

This protocol is based on:

- Mental Health (NI) Order 1986;
- Mental Health (NI) Order 1986 Guide;
- Mental Health (NI) Order 1986 Code of Practice;
- GAIN Network (2011), Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986;
- NPIA (2010), Guidance on Responding to People with Mental Ill Health or Learning Disabilities;
- Police and Criminal Evidence (NI) Order 1989; PACE Codes of Practice (2008);
- Human Rights Act (1998) .

The GAIN (Guidelines and Audit Implementation Network) (2011) Guidelines outline professional roles and responsibilities for staff and agencies. They also describe pathways and key processes for assessment and treatment under The Order. It is not the intention to repeat these here, but rather to identify the potential interfaces

between professionals and organisations and promote improved working relationships across these interfaces.

2.0 INTERFACES

The key interfaces when agencies and practitioners are required to work together to ensure the care and safety of a person with a mental disorder and/or the safety of others are:

- When a warrant is required under Article 129 to gain access to someone in private premises;
- When Police use powers under Article 130[1] to remove someone to a “Place of Safety”;
- When Police and ambulance support is required in the course of an assessment under The Order;
- When conveying someone believed to be suffering from a mental disorder to or between hospitals.

3.0 LEAST RESTRICTIVE OPTION

The Code of Practice for The Order [2] outlines a number of principles which include that people experiencing a mental disorder should: “receive any necessary treatment of care with the least degree of control … consistent with their safety and the safety of others”, and “be discharged from any form of constraint or control to which they are

[1] Mental Health (Northern Ireland) Order 1986

[2] HMSO (1992), pp 3 - 4)

subject under The Order immediately this is no longer necessary". In effect patients should be subject only to the level of restriction appropriate to their individual needs and/or to assure the safety of themselves or others; and only for so long as it is required.

If the person found in a public place is willing to accept assistance then the Officer can offer/provide assistance without having to use any powers.

If the person is compliant; not in need of emergency medical treatment; and the risks are such that they could be safely managed; the person should be returned home and their GP or GP Out of Hours service notified that an urgent home visit for an assessment under The Order is required.

If the person is willing to accept assistance, and in need of medical treatment, they should be taken to the nearest hospital Emergency Department (ED) where their medical needs can be attended to and an emergency, urgent or routine mental health assessment arranged by ED staff as appropriate[3].

In all of these circumstances Police can hand over responsibility for the care and treatment to the relevant health care professional as soon as it is safe to do so, and any on-going Police involvement should be based on an assessment of the risks pertaining to that particular situation.

[3] Appendix 5

4.0 LEGAL CONTEXT

Article 130 of The Order provides the legal basis for Police Officers to act when they find a person in a public place who appears to be suffering from mental disorder. If the individual is in immediate need of care or control Police are empowered to remove that person to a Place of Safety. Police may also detain them for a period of up to 48 hours to facilitate an assessment by a General Practitioner (GP) and an Approved Social Worker (ASW).

Making the decision to use powers under Article 130 does not require the Officer to reach an exact diagnosis, but simply to decide reasonably and in good faith[4] whether or not a person exhibits behaviour suggestive of mental disorder, and appears to be presenting a risk to themselves or others[5].

It is important to note that the decision to remove a person to a place of safety does not automatically engage the power to detain that person at the place of safety. These are two separate powers which need to be separately considered by the officer, and detention does not necessarily follow from the decision to remove a person.

4.1 Criteria for Using Powers under Article 130

- The person must be found in a place to which the public have

[4] Article 133

[5] Appendix 6

access[6];

- It must appear to the Officer that the person is suffering from a Mental Disorder;
- Removal to a Place of Safety must be in the interests of that person or for the protection of others.

All three criteria must be met before a person may be removed.

5.0 CHOOSING A PLACE OF SAFETY

Article 129 (7)[7] defines a Place of Safety as; any hospital designated as such by the managing Health and Social Care Trust; any Police station, or any other suitable place the occupier of which is willing to temporarily receive the person requiring a Place of Safety. The hospitals designated as Places of Safety by their managing Trusts are contained in Appendix 3.

5.1 A Person's Own Home

The person's own home may be a suitable Place of Safety providing there is a responsible person willing to keep the person safely until the GP and ASW can attend.. This particularly applies where the individual's residence is a registered residential care or nursing home, or a supported housing scheme where twenty-four hour care staff are available. A partner, spouse or other caring relative may also be able

[6] If the individual is in private premises Article 129 of the outlines the powers available to Police Officers and health professionals to gain access to that person for the purpose of assessment under The Order.

[7] Mental Health (Northern Ireland) Order 1986

to keep the person safe in a private dwelling until the GP and ASW can attend. This option should be based on; the agreement of the carer; the carer's capacity to keep the patient safe; and the officers assessment of the risks. Considerations to be taken into account include:

- The individual is not in need of immediate medical attention;
- There must be a responsible carer over 18 years who is willing and able to keep the patient safe;
- There has been no threat of violence (particularly towards the carer);
- There is low risk of absconding;
- The carer is not intoxicated or otherwise appears to have limited capacity to undertake the role.

5.2 Hospital

The Emergency Department is the most appropriate place to take an individual if they have sustained injury, are suspected of having taken substances, or have other pressing medical needs.

At present all five Health and Social Care Trusts have identified their hospital Emergency Departments as their designated places of safety. It is incumbent on Trusts to ensure that their Emergency Departments have the knowledge and resources to fulfil the Place of Safety function.

5.3 Police Station

A Police station should only be used when risks are such that they

could not be managed in any other environment, or a serious crime has been committed and it is deemed necessary to keep a person in Police custody until his or her mental health condition has been more clearly determined.

Taking someone to a Police station can wrongly convey the impression that the person has committed a criminal offence. Some Police stations are not well designed for the observation of people who may be at risk of self harm or who are disturbed. Police staff will have received limited training in the management of individuals with a psychiatric disorder.

6.0 POLICE SUPPORT AT THE PLACE OF SAFETY

If Police use their powers to remove under Article 130 they can also detain the person for a period of up to 48 hours so that they can be examined by a doctor and interviewed by an ASW. The decision to detain the person is a separate power and must be justified separately from the decision to remove the person to the place of safety.

Health and Social Care staff do not have powers to detain the individual until after the doctor has made a medical recommendation, and an ASW (or Nearest Relative[8]) has made an application for a compulsory admission. Therefore on arrival at a hospital the Officer should alert staff that the person has been brought in under Article 130, and ensure that the GP and ASW are requested immediately, alongside any triage for medical treatment. The Police should record

[8] Article 32

the time of the request along with the estimated time of arrival of the GP and ASW.

GAIN guidance[9] requires that local protocols be developed to specify the length of time that an officer can reasonably be expected to remain with the patient at the Place of Safety. This is a difficult challenge as there are a number of factors to be considered.

6.1 Emergency Department

Hospital Emergency Departments currently have a 4 hour target to see and treat all patients; therefore in normal circumstances this is the maximum time officers, if they have made a decision to detain the person to facilitate an assessment, should expect to have to remain there. Subsequent to a medical examination an ED doctor may advise that the patient's presentation would not meet the threshold for a compulsory admission and advise diversion into mainstream services. The Police Officer should at that point discontinue the detention on the basis of the medical advice and hand over the patient to HSC staff for treatment. Any need for on-going Police involvement thereafter should be negotiated on the basis of risks associated with normal policing responsibilities.

6.2 General Practitioner/ Medical Practitioner

It is not possible to estimate the response time of GPs as this will be dependent on other clinical pressures and priorities. An **ED doctor**

[9] GAIN 2011 p 380

may make the recommendation in a case of "urgent necessity"[10], but this will be judged in terms of clinical need rather than organisational or work pressures.

Appendix 4 outlines arrangements for GPs carrying out such medical assessments for mentally disordered patients.

6.3 Approved Social Worker

ASW standards require a response within one hour of a referral by a doctor who is considering making a medical recommendation for detention. However an ASW cannot legally make an application before an appropriate doctor has made a medical recommendation.

6.4 Intoxicated Patients

It can be difficult to accurately assess someone's mental state if they are intoxicated. However the fact of the individual having taken alcohol or other substances should not in itself be used to delay the attendance of the GP, mental health staff or other medical treatment. Any decision to delay the attendance of the GP or ASW will necessarily extend the period of detention for the person. Any decision to delay the attendance should be fully justified and recorded.

The need for continued Police support once the patient has been conveyed to the Place of Safety should be assessed and agreed between police and Emergency Department staff. The Risk

[10] Article 6c MHO

Assessment Form (Appendix 2) will assist in this assessment.

6.5 The Criteria for Compulsory Admission is Not Met

If the conclusion of a GP/ASW assessment is that the criteria for compulsory admission have not been met, the patient should be released from custody[11], with HSC staff responsible for providing or arranging treatment or care with the patient's consent.

7.0 USE OF RESTRAINT OR FORCE

An Officer may use reasonable force, if necessary, in the exercise of powers under Article 130[12]. If force and/or restraint have been used, the Officer should inform health care or custody staff upon arrival at the Place of Safety about the type of restraint used and for how long. If CS spray has been used on a person officers must inform the healthcare staff before the person is brought into the ED. Information on the presence of drugs, alcohol and/or weapons, and any other known risks should also be provided.

Where medication/prescription drugs held lawfully by the patient[13] are found during a search, they should be secured and handed over to health care or custody staff immediately upon arrival at the Place of Safety.

[11] DHSSPS SSI (March 2005) p 15 Standard 5.3

[12] Indemnity provided under Article 133 of the Mental Health (Northern Ireland) Order applies to Police Officers as well as Health and Social Care practitioners, "unless the act was done in bad faith or without reasonable care".

[13] As determined by a medicine box having the name of the individual labelled

Officers should not administer medication/prescription drugs to a person with a mental disorder or allow a person with a mental disorder to self-administer their own medication, except under direction from a medical professional, unless it is in an emergency/life-threatening situation.

8.0 POLICE SUPPORT DURING A COMMUNITY ASSESSMENT

When Police use powers under Article 130 then the legal custody considerations will largely determine the transfer of responsibility from Police to HSC personnel. However the requirement for Police involvement in any other circumstances should be based on the specific risks pertaining at the time. Appendix 1 contains a risk assessment that may be used to inform this judgement. Appendix 2 contains a template for recording this assessment if required.

Most requests for an assessment for compulsory admission do not come via Police. In circumstances where the GP and ASW are the first attenders, PSNI support should only be requested when the reason for Police attendance is consistent with their statutory functions (protection of life, prevention of crime, to prevent a breach of the peace), and based on an assessment of the risks associated with the specific circumstance.

Careful consideration should be given to the legal powers which the Police have available to safely manage any assessment conducted in private premises.

The Police have no legal power without warrant to do anything except:

- arrest following an attempted or substantive criminal offence;
- arrest to prevent a breach of the peace or its continuance.

Accordingly, there is no Police power to prevent anything that does not constitute an attempted or substantive criminal offence, or a breach of the peace; and no power to prevent the individual from:

- completely denying access (unless warrant issued);
- moving to a room which can be locked (bathroom/cupboard);
- picking up knives, cutlery or other (improvised) weapons;
- boiling kettles or picking up hot-drinks;
- accessing areas where there are windows/balconies;
- leaving the premises.

There should be no automatic assumption where such an individual leaves premises that Article 130 can automatically be used. The Police Officer must be separately satisfied that the criteria for Article 130 are met.

8.1 Gaining Access to a Person Believed to be Mentally Disordered in Private Premises

If access to a patient in private premises is denied, Article 129 of The Order enables a constable or a member of HSC staff to apply for a warrant to gain access to the person, and if necessary for Police to remove them to a Place of Safety for the purpose of assessment.

It should be noted that warrants granted under Article 129 do not give the ASW access to the private premises, only the constable and the doctor. Therefore if the householder continues to deny access to the ASW the person may need to be removed by Police to a Place of Safety so that the assessment can be completed.

In order to grant a warrant the lay magistrate must have reasonable cause to suspect there is a person on the premises who:

a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control; or
b) being unable to care for himself, is living alone.

Given the nature of the information required the ASW will ordinarily be in a better position to satisfy the lay magistrate and therefore the ASW should normally make the application.

The fact that the Police are present does not in itself ensure that they have the powers to guarantee a safe outcome for all concerned. However the PSNI position is that where there is an anticipated likelihood of resistance, aggression, violence or escape from the person being assessed, the powers afforded by a warrant under Article 129 significantly improve the abilities of the Officers to proactively deliver a safe conclusion without allowing matters to escalate to the point where a service user is arrested and/or that an attending professional or anyone else is injured.

9.0 TRANSPORT TO HOSPITAL

When Police use their powers under Article 130 the mode of transportation to a Place of Safety is ultimately at the discretion of the detaining Police Officer, who remains responsible for the person until the GP/ASW assessment is completed and the ASW can take legal custody of the patient; or until the Officer decides that the use of powers is no longer required. Issues for consideration in reaching a decision about the most appropriate way to transport the patient should include: the well-being and safety of the patient; the safety of Police officers and health and social care staff; the level of threat to the public; and the best use of resources.

Ideally, persons detained under Article 130 should be conveyed to the Place of Safety by ambulance[14] except where the delay in obtaining an ambulance would escalate an already difficult situation. If necessary the Police should accompany the person in the ambulance to the Place of Safety in order that they remain in the lawful custody. Where possible, gender issues should be addressed, ie it is preferable that the accompanying officer(s) should be of the same gender as the detained person.

Where risks are such that a person needs to be conveyed in Police transport, and a requirement for medical supervision is identified, a member of the ambulance crew should accompany the person to the Place of Safety to ensure the immediate availability of personnel trained for medical emergencies and resuscitation. The ambulance

[14] GAIN 2011, p 386

should follow behind to ensure the immediate availability of medical personnel and equipment.

Only in exceptional circumstances should Police transport be used to convey the person to hospital for the purpose of obtaining medical care unrelated to their mental condition (eg visible wounds or suspected fractures). Such circumstances would include:

- where ambulance control have informed Police of a significant delay; or
- where there are life-threatening circumstances to justify the urgent removal of a person to hospital by Police transport.

Ultimately, this decision will rest with the officer at the scene.

Once the medical recommendation has been made and an ASW application for detention has been made, the Order gives the ASW responsibility for making arrangements to have the patient transferred to hospital, along with powers to delegate this task to others. Generally the task is delegated to ambulance staff unless there are pressing reasons for other transport arrangements to be made.

On arrival at the scene the Ambulance Crew will carry out a risk assessment in conjunction with the GP, ASW (and Police if they are present). Any on-going Police involvement to assist with conveyance, including travelling in the ambulance, should be based on the assessment of the particular risks pertaining to that circumstance.

Ambulance crew will make reasonable attempts to assist a patient who may be passively resistant with persuasion, coaxing and/or physical guidance. However where formal, on-going physical restraint is required Police assistance will be sought in taking and conveying the patient to hospital.

Generally 999 calls in relation to mental health problems or suicide attempts are prioritised by Ambulance Control via the AMPDS system according to their status on the continuum from immediately life threatening through to low risk. It is therefore important that the Police Officer, GP or ASW making the request articulates the risks pertaining to a particular situation when requesting an ambulance, including the risk of further deterioration of the patient's mental health; distress to the patient and family members; any risks associated with a protracted wait; and any risk of absconding or harm to the patient or others.

Given that the responsibility for arranging conveyance falls to the ASW, NIAS call handling staff should not "refuse" the request or insist that it is made by a Doctor. However it should be noted that GPs have the facility to bypass the AMPDS system to make a "GP urgent" request for an ambulance within a specific timeframe. It may, on occasion, be appropriate for the GP to use this facility.

10.0 JURISDICTION

If the Doctor and the ASW (or Nearest Relative) agree that the threshold for a compulsory admission has been met it is their responsibility to arrange the admission. It is the responsibility of the Trust where the patient is normally resident to accept that

admission. If the patient is normally resident outside of the Northern Ireland jurisdiction, it is the responsibility of the Trust in whose area the patient was found to provide a bed and arrange subsequent transfer to their home area if appropriate.

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RISK ASSESSMENT MATRIX — Appendix 1

Previous History of Person	Current Circumstances	Police Support
Low Risk		
Person has a history of • violence; • active self-harm; • absconding; • other risk behaviour indicators currently present (other than very mild substance use). ***History is*** • ***Infrequent AND historic*** ***OR*** • ***Irrelevant due to circumstances.***	Person presenting is ***NOT*** • violent • actively self-harming; • stated intention to abscond; • other risk behaviour indicators ***currently present*** (other than very mild substance use).	Police assistance ***will not be*** required.
Medium Risk		
More than infrequent history of violence or more than AOABH, involving weapons, sexual violence, violence towards HSC staff or vulnerable person. **OR** ***LOW RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged.	• Person currently presenting ***some*** behavioural indicators (including substance use). **OR** • Some recent criminal / medical indicators that the individual may be violent OR poses an escape risk OR is a threat to their own or anyone else's safety.	Police assistance ***may be*** required.
High Risk		
Significant history of any of the medium risk indicators. ***MEDIUM RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged	Person currently presenting ***significant*** • behavioural indicators (including substance use) • recent criminal / medical indicators that the individual may be violent OR is a threat to anyone's safety	Police assistance ***will be*** required.

In cases of dispute the joint risk assessment (Appendix 2) will be completed in respect of the person

Appendix 2

JOINT RISK ASSESSMENT TO DETERMINE THE NEED FOR ONGOING POLICE INVOLVEMENT

Patient …… ……. **DOB** ……

Location …… ……**Date** ……/……/……

…….

(Department and name of hospital / home address etc.)

		N	Y	UK
1	Is the person intoxicated?			
2	Does the person need active restraint to prevent harm to self/others?			
3	Does history or person's behaviour suggest a risk of absconding?			
4	Has the person already harmed themselves on this occasion?			
5	Has the person any history of assault on Police or caring staff?			
6	Has the person recently assaulted anyone?			
7	Has the person threatened physical/psychological harm to others?			
8	Has the person expressed but not demonstrated aggressive behaviour?			
9	Is person suspected to have consumed non-prescribed drugs?			
10	Is there evidence/reports of sexually inappropriate behaviour?			

11	Has the person been compliant since their detention/removal by Police to a Place of Safety?			
12	Does the person detained/removed agree with the action(s) taken?			
13	Does the Police Officer believe their continued presence is required at this time?			
14	Has the person required handcuffs or limb restraints? Details ……..			
15	Does the clinician feel the client cannot be managed safely without Police presence?			
16	Please give reasons not covered above why the Police are believed to be required to remain in attendance In the event of a disagreement between staff : Has the above been discussed with the supervising Police Officer? (Please state the name of the supervising officer) What is the outcome at this time?			

Signature of Assessing Practitioner: ……

Signature of Police Officer: ……..

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

Appendix 3

HSC Trust Designated Place of Safety

BELFAST HSC TRUST	• ED, Royal Victoria Hospital, Grosvenor Road, Belfast • ED, Mater Hospital, Crumlin Road, Belfast
NORTHEN HSC TRUST	• ED, Antrim Area Hospital, Bush Road, Antrim • ED, Causeway Hospital, New Bridge Road, Coleraine
WESTERN HSC TRUST	• ED, Altnagelvin Hospital, Glenshane Road, Londonderry • ED, South West Acute Hospital, Enniskillen
SOUTHERN HSC TRUST	• ED, Craigavon Area Hospital, 68 Lurgan Road, Portadown • ED, Daisy Hill Hospital, Hospital Road, Newry
SOUTH EASTERN HSC TRUST	• ED, Ulster Hospital, Upper Newtownards Road, Dundonald • ED, Lagan Valley Hospital, Hillsborough Road, Lisburn

Appendix 4

GPs Carrying out Medical Recommendations for Seriously Mentally Ill Patients (Form 3)

Patient Circumstances	Agreed Position
1. Registered practice patient: • In community (e.g. home address, school within practice area, social services day centre within practice area); • Monday – Friday (core hours 8.00am -6.30pm).	The patients practice should carry out the visit as part of best practice normal patient care. Form 3 to be completed by visiting GP. No circumstances when this would not apply.
2. Registered practice patient : • In a hospital ward detained on a Form 5. Hospital is within the practice area; • Monday – Friday (core hours 8.00am -6.30pm).	The patients practice should carry out the visit as part of best practice normal patient care. Form 3 to be completed by visiting GP. The patient is protected by the Form 5 and the medical recommendation (Form 3) visit can be planned (within 48 hours). The Trust need to be aware of the 48 hour "window". [15]
3. Registered practice patient: • In A&E (hospital within practice area); • Monday – Friday (core hours 8.00am -6.30pm). (Please note a Form 5 cannot be completed for a patient in A&E).	The patients practice should carry out the visit as part of best practice normal patient care. This should be as soon as is reasonably possible. Form 3 to be completed by visiting GP. There may be a circumstance where the patient (or others) is at immediate risk of harm and the GP is unable to attend quickly enough. In this circumstance the practice is not expected to carry out a medical recommendation (Form 3), the Trust can then take action under "urgent necessity".
4. Registered practice patient: • In community (within practice area); • Outside Core Hours (i.e. OOH).	The patient or others are at risk and an alternative arrangement needs to be provided OOH e.g. GP OOH.

[15] Arrangements need to be put in place for weekends especially bank holiday weekends where the 48hour window is more likely to be breached.

5. Registered practice patient: • In a hospital ward in the practice area; • Out of Hours; • Form 5 in operation .	The patient is protected by the Form 5 and the medical recommendation (Form 3) visit can be planned (Within 48 hours). The Trust need to be aware of the 48 hour "window". [16]
6. Registered practice patient: • In A&E(hospital within practice area); • Out of Hours.	The patient or others are at risk and an alternative arrangement needs to be provided OOH e.g. GP OOH. There may be a circumstance where the patient (or others) is at immediate risk of harm and the GP is unable to attend quickly enough. In this circumstance the GP OOH is not expected to carry out a medical recommendation (Form 3), the Trust can then take action under "urgent necessity".
7. Patient not registered: • In practice area : • In the community (core hours 8.00am -6.30pm Mon -Fri).	The contacted practice should carry out the visit as the patient needs care i.e. immediately necessary treatment for the assessment of mental state. Form 3 to be completed by visiting GP.
8. Patient not registered or not registered locally (i.e. outside practice area): • In hospital ward (anytime) (Form 5 in operation); • In A&E (core hours 8.00am 6.30pm Mon -Fri).	A local GP arrangement should be provided e.g. local rota under terms of LES.
9. Patient not registered or not registered locally: • In the community; • Out of hours.	The patient or others are at risk and an alternative arrangement needs to be provided OOH e.g. GP OOH
10. Any Patient: • In a Police Station; • Any time.	Forensic Medical Officer to carry out medical recommendation.

[16] Arrangements need to be put in place for weekends especially bank holiday weekends where the 48hour window is more likely to be breached.

Regional Emergency Department Mental Health and Self Harm Care Pathway

This Pathway should be read in conjunction with NICE Guideline 16 (July 2004) & Nice Pathway for Self Harm Short Term Treatment and Management (November 2011)

Patient Presents at Emergency Department with Mental Health Problems/ Self Harm/Suicidal ideation

Patient Care History Checked Via Trust Information Databases

Step 1:-Triage
Patient Triaged within 15 Minutes In accordance with:-
a) Manchester Triage Standards and b)Mental Health Response Matrix

Step 2:- Assessment
Patient Assessed Using ED Mental Health Risk Assessment Tool

Step 3:- Clinical Formulation
Decisions made regarding patients assessed needs and type of intervention required in line with Mental Health Response Matrix

Guidance Note – Patient who threatens to leave and/or absconds / CTMA before an assessment has been commenced or been completed.

Follow Local Trust CTMA policy

1. Review risk factors and expedite assessment.
2. Consider use of Mental Health Order NI. (1986).
3. If patient has left try contacting them by phone.
4. Inform GP.
5. Consider contacting PSNI.
6. Alert in/out hours Social Services.
7. Contact with next of kin if appropriate .
8. Make a referral to mental health services for outreach support/and/or next day follow-up.

Patient deemed medically unfit for mental health assessment & admitted for medical care.

When patient is medically fit for assessment refer to Mental Health Service at the earliest opportunity. This a*ssessment should be completed prior to discharge.*

Step 4
Patient requires Mental Health Order NI Assessment

Step 4
Patient requires immediate psychiatric assessment

Step 4
Patient assessed as low risk and suitable for CBYL

If Patient Refuses Follow On Care - Refer to GP

Patient referred to Mental Health Services and/or GP and ASW for face to face assessment which should take place within *2 hours or sooner depending on risk factors.*

If medical needs identified during mental health assessment refer back to ED Medical Staff

1. Patient discharged with safety plan
2. Given Next Day CBYL Fixed Appointment Card
3. Given details of services which can provide support prior to mental health assessment including contact details if an emergency assessment is required.
4. As appropriate copy of CBYL Appointment & support plan given to nominated family/carer. Confirm Pt Contact Details and Carer Details (remember consent)

Prior to discharge assessment and action plan reviewed by responsible Emergency Department Practitioner

Police Use of Place of Safety Powers under Article 130(1) & (2) of the Mental Health (NI) Order 1986