Birmingham and Solihull Mental Health NHS Foundation Trust

ASSESSMENT FOR ADMISSION UNDER THE MENTAL HEALTH ACT (MHA)

Policy number and category	**C 13**	**Clinical**
Version number and date	**5**	**January 2023**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**January 2023**	
Next anticipated review	**January 2026**	
Executive director	**Medical Director and Director of Operations**	
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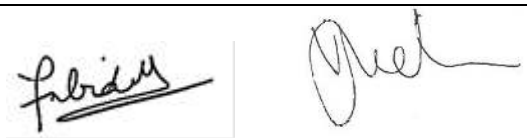
Exec Sign off Signature (electronic)		
Disclosable under Freedom	**Yes**	

POLICY CONTEXT

The Mental Health Act 1983 (MHA) provides for a Mental Health Act assessment to be carried out on individuals to establish whether they may be detained under the Act for assessment and treatment. This policy details the requirements and processes involved in the assessment of individuals under the MHA and is applicable to all professionals and staff from the Trust, Local Authorities, Police and Ambulance Service involved in assessing or providing care and treatment to any persons referred to or in contact with Trust services in all inpatient and community settings.

POLICY REQUIREMENT (see Section 2)

- In deciding whether it is necessary to detain patients, doctors and AMHPs must always consider the alternative ways of providing the treatment or care they need. Decision-makers should always consider whether there are less restrictive alternatives to detention under the MHA.
- In order for a patient to be detained in hospital for assessment or treatment under Part 2 of the MHA, an application for admission to hospital must be made to the managers of the hospital in question.
- The AMHP is responsible for making the application for detention and for co-ordinating the assessment process. An application must be supported by two medical recommendations given in accordance with the MHA. It is the responsibility of the doctor to liaise with bed management to find the bed.
- The Joint Strategic Operational Group (JSOG) will provide the opportunity for formal communication between police, ambulance, local authorities and Trust leads involved in MHA assessments.
- The Mental Health Legislation Committee has overall responsibility to ensure the legal administration of the MHA.

of Information Act 2000	

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1 INTRODUCTION

1.1 Rationale (Why)

The Mental Health Act 1983 (MHA) provides for a Mental Health Act assessment to be carried out on individuals to establish whether they may be detained under the Act for assessment, care and treatment. The Mental Health Act 1983 Code of Practice (the Code) and Reference Guide contain further guidance.

This policy details the requirements and processes involved in the assessment of individuals under the MHA. This guidance should be read in conjunction with the Trust and Joint policies and guidance on MHA, Mental Capacity Act 2005 (MCA), Transfer of Patients, s131 Informal Admission, Multi-Agency MoU for those detained under s135/6 (February 2021) and with the information found in the MHA Code of Practice and Reference Guide, Code of Practice to the MCA 2005, Deprivation of Liberty Safeguards, and Human Rights Act 1998.

The guiding principles as shown at Chapter 1 of the Code of Practice and 1.3 below must be considered when working with the MHA.

1.2 Scope (Where, When, Who)

This document is applicable to all professionals and staff from the Trust, Local Authorities and other partner agencies involved in assessing or providing care and treatment to any persons referred to or in contact with Trust services in all inpatient and community settings.

AMHP (Approved Mental Health Professional) – a social worker or other professional approved by a local social services authority to perform a variety of functions under the MHA including making applications for admission to hospital and guardianship applications.

Section 12 Approved Doctor – a doctor approved by the Secretary of State to carry out certain functions under the MHA.

Medical Director – the Executive Director who has overall responsibility for ensuring that this policy is reviewed and that there are appropriate quality assurance mechanisms in place in relation to the guidance in this policy.

Associate Directors – have the responsibility for responding to and ensuring that the teams implement new guidance.

Each **registered healthcare professional** – accountable for his/her own practice and must be aware of his/her legal and professional responsibilities relating to their competence and work within the Code of Practice of their professional body.

The Head of Mental Health Legislation and Associate Medical Director Mental Health Legislation – responsible for disseminating new guidance as it arises and giving advice to all staff on Mental Health Act and Mental Capacity Act issues. They are also responsible for highlighting practice issues arising within the Trust.

Line managers – responsible for ensuring all staff are conversant with this policy and related policies.

Medical Staff – hold a key role in the processes and actions that are required to be taken in relation to assessment for detention and any issues will be addressed by the Associate Medical director Mental health legislation (MHA).

1.3 Principles (Beliefs)

The underlying principles of this policy are the 5 principles of the Mental Health Act 1983:

1. **Least restrictive option and maximising independence**

   Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

2. **Empowerment and involvement**

   Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

3. **Respect and dignity**

   Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

4. **Purpose and effectiveness**

   Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

5. **Efficiency & equity**

   Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2 POLICY (What)

2.1 In deciding whether it is necessary to detain patients, doctors and AMHPs must always consider the alternative ways of providing the treatment or care they need. Decision-makers should always consider whether there are less restrictive alternatives to detention under the MHA, which may include:

- Informal admission to hospital of a patient based on that person's consent.
- Treatment under the Mental Capacity Act (MCA) if the person lacks capacity to consent to admission and treatment.

- If a deprivation of liberty occurs, or is likely to occur, either the MHA, a DoLS authorisation or a deprivation of liberty order by the Court of Protection must be in place.
- Management in the community; or
- Guardianship

2.2 In considering whether it is necessary for the person to be detained under the MHA, decision-makers must consider whether the person has capacity to consent to or refuse admission and treatment. This should be assessed in accordance with the MCA, which makes clear that a person must be assumed to have capacity unless it is established that they do not.

Professionals must consider available alternatives, having regard to all the relevant circumstances, to identify the least restrictive way of best achieving the proposed assessment or treatment. This will include considering what is the person's best interests (if the person lacks capacity, this will be determined in accordance with the MCA).

2.3 In order for a patient to be detained in hospital for assessment or treatment under Part 2 of the MHA, an application for admission to hospital must be made to the managers of the hospital in question.

2.4 An application for detention may only be made where the grounds in either section 2 or section 3 of the Act are met (See Appendix 2), or section 4 if appropriate. An application may be made by the patient's Nearest Relative, or by Approved Mental Health Professional (AMHP) acting on behalf of the Local Authority (LA).

2.5 Though a Nearest Relative can make an application, it will normally be made by an AMHP. An AMHP is usually a more appropriate applicant than a patient's Nearest Relative, given their professional training and knowledge of the legislation and local resources. This also removes the risk that an application by the Nearest Relative might have an adverse effect on their relationship with the patient.

2.6 When an AMHP is not available / unable to make an application and it is considered that there is urgent need for admission due to serious risk of harm to self or others **and** at least one medical recommendation for admission is available, admission based on the Nearest Relative's application should be facilitated.

2.7 When an AMHP is unable to make an application for detention under the Mental Health Act in cases where there is at least a single medical recommendation for admission, it is the duty of the AMHP to inform the Nearest Relative of their right to make such an application. The doctor involved in making a recommendation may also inform the Nearest Relative of their right to make an application**.**

2.8 A LA is responsible for ensuring that there are sufficient AMHPs available to assess people in their area who may need to be admitted and should have arrangements in place to provide a 24-hour service that can respond to patients' needs. The person does not have to live in the area. The AMHPs' decisions are independent of the LA, and they cannot be instructed to apply for admission.

2.9 In certain cases, LAs must also arrange for an AMHP to consider the case of a patient who is in a hospital outside their area. This applies when the patient concerned is

already detained for assessment on the basis of an application made by an AMHP acting on behalf of the LA in question.

2.10 If that LA has reason to think that an application for admission for treatment may now be needed for the patient, it is that LA (rather than the one for the area in which the hospital is, or where the patient lives) which is under a duty to arrange for an AMHP to consider making the further application.

2.11 LAs must arrange for an AMHP to consider a patient's case on their behalf, if they have reason to believe that an application for admission to hospital may need to be made in respect of a person.

2.12 In addition, LAs must arrange for an AMHP to consider the case of a patient who lives in their area if required to do so by the patient's Nearest Relative. If AMHPs decide not to make an application in these cases, they must give the Nearest Relative their reasons in writing.

2.13 Professionals who are approached directly by a Nearest Relative about the possibility of an application being made should advise the Nearest Relative of their right to require an LA to arrange for an AMHP to consider the patient's case.

2.14 An application must be supported by two medical recommendations given in accordance with the MHA and the medical examination must involve:

- direct personal examination of the patient and their mental state (must be in person not remote / virtual), and
- consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional.

2.15 Doctors must give reasons for the opinions stated in their recommendations. When giving a clinical description of the patient's mental disorder as part of these reasons, doctors should include a description of the patient's symptoms and behaviour, not merely a diagnostic classification.

2.16 When making recommendations for detention under section 3, doctors are required to state that appropriate medical treatment is available for the patient (see chapter 23 of the Code). Preferably, they should know in advance of making the recommendation the name of the hospital to which the patient is to be admitted. If that is not possible, their recommendation may state that appropriate medical treatment will be available if the patient is admitted to one or more specific wards within a hospital.

2.17 Applications for Admission to Hospital must be made on the appropriate forms, accompanied by the necessary medical recommendations and by the AMHP report of the circumstances and decision-making process (see 3.78-3.82).

2.18 Receipt of applications has been delegated to the nurse in charge of the ward to which the patient is being admitted / duty manager / Mental Health Legislation Office staff who may accept the paperwork on behalf of the managers (see Trust MHL Administration Policy MHL05 October 2020). Please see Appendix 3. for full

Procedure and Guidance on Accepting and Communicating Paper and Electronic Forms

2.19 If it appears to the AMHP and doctors that the person being assessed does not have capacity to choose to go to hospital, they must carry out a capacity assessment and record this in accordance with the Trust's Mental Capacity Act Policy. In order to have capacity a service user must be able to:

- Understand the information necessary to make the decision.
- Retain that information long enough to make the decision.
- Weigh up the information in order to make a decision; and
- Communicate that decision.

2.20 If admission does not have to happen immediately and there is chance that the service user will regain capacity before admission is necessary, then the decision could be delayed until the service user regains capacity.

2.21 If the person does not have capacity and the decision must be made, then the AMHP and the doctors must decide if admission is more appropriate under the MCA rather than the MHA.

2.22 It is important to remember that if a service user who does not have capacity to make the decision seems to give consent, then that consent cannot be relied upon as the basis for an informal admission under the MHA but can be taken into consideration as a lack of objection when considering if the MCA can be used.

3 PROCEDURE

3.1 Assessments should, as far as possible, be carried out by the most appropriate AMHP and doctors in the particular circumstances. During working hours this will be the Birmingham or Solihull AMHP service or Trust AMHPs where appropriate and out of hours it will be co-ordinated by the EDT / out of hours team

3.2 Non-Inpatient MHA Assessments

3.3 The Home Treatment team nurse in consultation with a medic / Nearest Relative will put in the request for an MHA Assessment

3.4 In criminal justice settings, including Police Custody, Birmingham Magistrates Court and Birmingham Crown Court, the Liaison & Diversion Team Practitioners can contact the AMHP service to directly request an MHA Assessment. Liaison & Diversion (L&D) are requested to complete a detailed summary of the persons presentation in order for the AMHP/Service to make a decision as to whether a Mental health Act assessment should be convened. It is the responsibility of the individual AMHP to decide whether a Mental Health Act assessment will be convened, and they cannot be instructed to do so but are expected to give clear reasons for their decision where a request for a

mental health act assessment is deemed unnecessary or where further clinical information is required there-by delaying the assessment.

3.5 Where a patient is known to belong to a group for which particular expertise is desirable (e.g., they are aged under 18 or have a learning disability), at least one of the professionals involved in their assessment should have expertise in working with people from that group, wherever possible.

3.6 If this is not possible, at least one of the professionals involved in the person's assessment should consult with one or more professionals who do have relevant expertise at the earliest opportunity and involve them as closely as the circumstances of the case allow.

3.7 The AMHP who assesses the patient for possible detention under the MHA has overall responsibility for co-ordinating the process of assessment. In doing so, they should be sensitive to the patient's age, sex, gender identity, social, cultural or ethnic background, religion or belief, and/or sexual orientation. They should also consider how any disability the patient has may affect the way the assessment needs to be carried out.

3.8 Given the importance of good communication, it is essential that those professionals who assess patients are able to communicate with the patient effectively and reliably to prevent potential misunderstandings. AMHPs should establish, as far as possible, whether patients have particular communication needs or difficulties and take steps to meet these, by arranging for example, a signer or a professional interpreter.

3.9 Doctors and AMHPs undertaking assessments need to apply professional judgement and reach decisions independently of each other, but in a framework of co-operation and mutual support.

3.10 Unless there is good reason for undertaking separate assessments, patients should, where possible, be seen jointly by the AMHP and at least one of the two doctors involved in the assessment.

3.11 While it may not always be feasible for the patient to be examined by both doctors at the same time, they should both discuss/communicate regarding the patient's case with the person considering making an application for the patient's detention.

3.12 Following the Devon Ruling in January 2021, all assessments for both new detentions and renewals must be carried out in person. Please see Guidance in Appendix 4.

3.13 Where exceptional situations are identified, such decisions can still be made by AMHPs using video interviews, provided they are confident that they can sufficiently make a decision in this way and are working within the NHSEi guidance. Where this happens, the reasons for proceeding in this manner should be clearly recorded.

3.14 For our Birmingham AMHPs, any decision to do this has to be agreed by the AMHP lead as an exceptional circumstance and reasons clearly documented.

3.15 The same applies for SMBC and any decision to do this has to be agreed by the AMHP lead and reasons recorded.

3.16 There are no exceptional circumstances for doctors. All assessments must be in person.

3.17 Everyone involved in an assessment should be alert to the need to provide support to colleagues, especially where there is a risk of the patient causing physical harm.

3.18 Coordination during the operating hours may also be assisted through the Triage Team which operates between 10am to 2am. They will also help organise /coordinate the ambulance resources.

3.19 Practitioners and the police should liaise where appropriate to determine whether the level of risk requires assistance from the police.

3.20 **Section 4 of the Mental Health Act**

3.21 The MHA permits an application for detention for assessment to be made under section 4 on the basis of a single medical recommendation, but only in very limited circumstances. An application for detention under section 4 may be made only when:

1. The criteria for detention for assessment under section 2 are met.
2. The patient's detention is required as a matter of urgent necessity, and
3. Obtaining a second medical recommendation would cause undesirable delay.

3.22 An application under section 4 may be made only if the applicant has seen the patient personally within the previous 24 hours.

3.23 Applications can be made by the Nearest Relative when an AMHP is unavailable or unable to make an application. If this is the case, the doctor making the recommendation and BSMHFT Mental Health Legislation staff should assist the Nearest Relative with practical support if needed.

3.24 The duties of AMHPs in respect of applications are the same as for applications under section 2.

3.25 If the application is made by an AMHP, the Nearest Relative should be informed at the same time, or within a reasonable time afterwards, unless the patient requests otherwise (or does not have a Nearest Relative).

3.26 **Inpatient MHA Assessments**

3.27 Inpatients, under the care of BSMHFT, may require MHA assessments if they require further detention from section 2, to section 3 for treatment, or when as Informal patients they have been detained under section 5(2) of the MHA.

3.28 There may also be instances when those detained under sections 48/35/36 may no longer be detainable under these provisions due to court proceedings ending in their case.

3.29 There may also be other exceptional reasons, such as original detention under the MHA of an inpatient may be found to be invalid or unlawful.

3.30 In all the above circumstances inpatients would need an MHA assessment coordinated by the AMHP.

3.31 It is important that when inpatients are to undergo an MHA assessment the AMHP appointed to carry out such an assessment is given sufficient time to carry out such an assessment and, if appropriate, make an application.

3.32 To protect the Human Rights of a patient (the right to liberty) it is necessary that there is sufficient time available to carry out a rigorous MHA assessment with time available to consider all available options and implement the least restrictive alternative whilst the patient is safe in hospital. This procedure is necessary to ensure that sufficient time is available to the AMHP to carry out such a process.

3.33 The full procedure for Admitting from a Police Station in an Emergency to Medium Secure Service (Reaside and Tamarind Centre) can be found in Appendix 5.

3.34 **Section 2 to 3**

3.35 When a Patient is admitted under section 2 of the MHA to any of the BSMHFT wards and remains an inpatient under Section 2 on Day 21, the single email found in Appendix 7 will be sent by the local Mental Health Legislation Administrator with a read receipt request and uploaded to RIO, to:

- **AMHPSecureBSO@birmingham.gov.uk**
- BSMHFT RC for the Patient
- BSMHFT Ward Manager and Deputy Ward Manager where the patient is currently located.
- BSMHFT RC Medical secretary

3.36 Forensic Teams have their own AMHPs attached to their teams – but the email is still to be used as above.

3.37 On receipt of the email, nursing staff on the ward and the RC must contact the AMHP to discuss whether an assessment is required for the patient.

3.38 If the AMHP allocated to coordinate such an assessment is unable to contact the RC by day 24 (or his/her medical secretary/covering consultant) if on leave can email the for the Trust (currently Dr Dinesh Maganty on dinesh.maganty@nhs.net) for further action to be taken with their details and mobile number.

3.39 The Associate Medical Director Mental Health Legislation will liaise with the relevant Clinical Director to ensure that RC/covering RC contacts the AMHP. This will be treated as a clinical incident and investigated.

3.40 **Section 5(2)**

3.41 As soon as a patient is placed on section 5(2). the nurse in charge of the ward will contact the central AMHP centre *within one hour* of such detention. Each call to the team is dealt with by a Senior Practitioner (SPD) who is notified that a patient has been detained under section 5(2), with details of patient and RC, including ward, medical

secretary's telephone number, so that the centre can liaise with all concerned, on an on-going basis.

3.42 Tel no within normal hours: 0121 303 2480. Dedicated telephone line to Emergency Duty Team available to provide a city-wide service outside of normal working hours on 0121 675 4806 including: - Weekdays (Monday to Thursday) – before 8.45 a.m. and after 5:15pm Weekends – after 4.15 p.m. on Friday to 8.45 a.m. on Monday. Available all Bank Holidays. The contact details for the Solihull AMHP manager is 07825 645 535 Mon – Fri 9 -5. Outside of these hours calls need to go to the Solihull Emergency Team 0121 605 6060.

3.43 **Discontinuation of Criminal Proceedings**

3.44 Should an MHA assessment be needed due to potential discontinuation of criminal proceedings it will be the duty of the Police and or CPS to notify the central AMHP centre, as above, as soon as they become aware of this possibility so that a Section 2 or 3 MHA assessment can take place.

3.45 **Role of the AMHP in MHA Assessments**

3.46 The AMHP has overall responsibility for co-ordinating the MHA assessment process.

3.47 For Guidance for AMHPs on what to do when there is no bed available, please see Appendix 10

3.48 The AMHP would initially contact the GP to provide a second medical recommendation; with the second option being the s12 rota held by the Trust Please see Appendix 8 for the s12 rota procedure).

3.49 The Home Treatment team will determine the responsible Local Authority and for BCC ring the AMHP team single number and make the referral, which will be taken by the admin worker. They will take the pertinent details including whether an interpreter is required. For SMBC they will ring the MHT duty number, which will take details and make arrangements for allocation to an AMHP.

3.50 For BCC this will then be transferred to the AMHP team clip board. This will be reviewed by a Senior Practitioner / Delivery (SPD) who will allocate to an AMHP. The allocated practitioner will liaise with the Home Treatment team practitioner to coordinate the MHA assessment. For SMBC, once allocated, the AMHP will liaise with the Home Treatment team practitioner to coordinate the MHA assessment.

3.51 It is expected the assessment in where possible will involve a joint assessment with the AMHP, the medic and the HTT clinician being present as recommended by the Code of Practice. Consideration needs to be given to the presence of family members. The Trust recognises the role of students and training being an integral part of such an assessment and consideration may also be given to their presence.

3.52 The service standards and expectations: the AMHP will respond within 2 hours of the request for an assessment. This does not mean that the assessment will be co-ordinated in this time as the co-ordination of MHA assessments will vary depending on the individual circumstances of each request.

3.53 AMHPs may make an application for detention only if they:

- Have interviewed the patient in a suitable manner.
- Are satisfied that the statutory criteria for detention are met, and
- Are satisfied that, in all the circumstances of the case, detention in hospital is the most appropriate way of providing the care and medical treatment the patient needs.

3.54 At the start of an assessment, the AMHP should identify themselves to the person being assessed, members of the family, carers or friends and the other professionals present.

3.55 The AMHP should ensure that the purpose of the visit, their role and that of the other professionals is explained.

3.56 They should carry documents with them at all times which identify them as AMHPs, and which specify both the local authority which approved them and the local authority on whose behalf they are acting.

3.57 Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act.

3.58 If a patient wants someone else (e.g. a familiar person or an advocate) to be present during the assessment and any subsequent action that may be taken, then ordinarily AMHPs should assist in securing that person's attendance, unless the urgency of the case makes it inappropriate to do so.

3.59 It is not desirable for patients to be interviewed through a closed door or window and this should be considered only where other people are at serious risk. Where direct access to the patient is not possible, but there is no immediate risk of physical danger to the patient or to anyone else, AMHPs should consider applying for a warrant under section 135 of the Act allowing the police to enter the premises.

3.60 Where patients are subject to the short-term effects of alcohol or drugs (whether prescribed or self-administered) which makes interviewing them difficult, the AMHP should either wait until the effects have abated before interviewing the patient or arrange to return later. If it is not realistic to wait because of the patient's disturbed behaviour and the urgency of the case, the assessment will have to be based on whatever information the AMHP can obtain from reliable sources. This should be made clear in the AMHP's record of the assessment.

3.61 **The AMHP and the Nearest Relative**

3.62 When AMHPs make an application for admission under section 2, they must take such steps as are practicable to inform the Nearest Relative and, if different, carer, that the application is to be (or has been) made and of the Nearest Relative's power to discharge the patient.

3.63 Before making an application for admission under section 3, AMHPs must consult the Nearest Relative**.**

3.64 Circumstances in which the Nearest Relative need not be informed or consulted include those where:

- it is not practicable for the AMHP to obtain sufficient information to establish the identity or location of the Nearest Relative, or where to do so would require an excessive amount of investigation involving unreasonable delay, and

- consultation is not possible because of the Nearest Relative's own health or mental incapacity.

3.65 If they do not consult or inform the Nearest Relative, AMHPs should record their reasons. Consultation must not be avoided purely because it is thought that the Nearest Relative might object to the application.

3.66 If the Nearest Relative objects to an application being made for admission for treatment under section 3, the application cannot be made. If it is thought necessary to proceed with the application to ensure the patient's safety or that of others and the Nearest Relative cannot be persuaded to agree, the AMHP will need to consider applying to the county court for the Nearest Relative's displacement under section 29 of the MHA.

3.67 If the AMHP has been unable to identify the Nearest Relative, once the patient is detained and admitted to hospital, it is the responsibility of the Trust clinical team to investigate further and identify who the Nearest Relative is.

3.68 **Medical examination by doctors as part of the assessment**

3.69 An application must be supported by two medical recommendations (other than in cases of section 4) given in accordance with the MHA and the medical examination must involve:

- **Direct personal examination** (not remote) of the patient and their mental state, and
- Consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional.

3.70 Doctors must give reasons for the opinions stated in their recommendations. When giving a clinical description of the patient's mental disorder as part of these reasons, doctors should include a description of the patient's symptoms and behaviour, not merely a diagnostic classification.

3.71 When making recommendations for detention under section 3, doctors are required to state that appropriate medical treatment is available for the patient (see chapter 23 of the Code). Preferably, they should know in advance of making the recommendation the name of the hospital to which the patient is to be admitted. If that is not possible,

their recommendation may state that appropriate medical treatment will be available if the patient is admitted to one or more specific wards within a hospital.

3.72 If direct physical access to the patient is not immediately possible and it is not desirable to postpone the examination in order to negotiate access, consideration should be given to requesting that an AMHP apply for a warrant under section 135 of the MHA.

3.73 Where practicable, at least one of the medical recommendations must be provided by a doctor with previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. It is sufficient for the doctor to have had some previous knowledge of the patient's case.

3.74 It is preferable that a doctor who does not have previous acquaintance with the patient be approved under section 12 of the MHA. The MHA requires that at least one of the doctors must be so approved. The Trust holds a s12 rota for the purpose of MHA Assessments which will be made available to AMHPs.

3.75 **Outcome of Assessment Requires Compulsory Admission.**

3.76 When a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to give or to refuse consent is consenting to admission.

3.77 This should not be regarded as an absolute rule, especially if the reason for considering admission is that the patient presents a clear risk to themselves or others because of their mental disorder.

3.78 Compulsory admission should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people.

3.79 The options available for compulsory admission are section 4, section 2 or section 3.

3.80 The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent).

3.81 Applicants have up to 14 days (depending on when the patient was last examined by a doctor as part of the assessment) in which to decide whether to make the application, starting with the day they personally last saw the patient.

3.82 There may be cases where AMHPs conclude that they should delay taking a final decision in order to see whether the patient's condition changes, or whether successful alternatives to detention can be put in place in the interim

3.83 Applications for detention must be addressed to the managers of the hospital where the patient is to be detained. The application must state a specific hospital. An application cannot, for example, be to BSMHFT without specifying which of our hospitals the patient is to be admitted to.

3.84 The medic will liaise with the bed manager and be responsible for finding a suitable bed as soon as possible and telling the applicant the name of the site at which it is situated.

3.85 Section 140 of the Mental health act 1983 states “it shall be the duty of every clinical commissioning group (CCG) to give notice to every local social services authority for an area wholly or partly comprised within the area of the clinical commissioning group specifying the hospital or hospitals administered by or otherwise available to the clinical commissioning group in which arrangements are from time to time in force for the reception of patients in cases of special urgency”. Please read in conjunction with the s140 MoU (link in the reference list)

3.86 Doctors / AMHPs carrying out Mental Health Act assessments or seeking admission to hospital of informal patients when they are satisfied that s140 is engaged i.e. the patient has special urgency (Patients posing serious and urgent risk of harm to self or others) should:

1. Make a note in the clinical records (RiO) setting out that s140 is engaged and the detailed reasoning behind reaching such a conclusion and the type of bed required.
2. Notify the Bed Manager regarding the engagement of s140 and record the same in RiO.

3.87 It will be the responsibility of the notified bed manager to arrange for a suitable bed.

3.88 Should it become clear that this is not possible within 4 hours, the notified bed manager will notify the Director on call (out of hours) or Associate Director of urgent care (in hours).

3.89 It will be the responsibility of the notified Director to make all reasonable efforts to ensure a bed is available including securing any out of area bed as may be needed.

3.90 It will be the responsibility of the notifying doctor to support sourcing of such a bed by provision of all necessary or available clinical and risk information.

3.91 Should there be a dispute regarding whether s140 is engaged the Director on call can seek a review of the case via the on-call Consultant Psychiatrist (out of hours) or any other suitable Consultant Psychiatrist in hours.

3.92 The reviewing Consultant Psychiatrist’s opinion would determine if s140 is engaged.

3.93 Once an application has been completed, the patient should be transported to hospital as soon as possible, if they are not already in the hospital. However, patients should not be moved until it is known that the hospital has agreed and confirmed accept them.

3.94 An application cannot be used to admit a patient to any hospital other than the one stated in the application.

3.95 A properly completed application supported by the necessary medical recommendations provides the applicant with the authority to transport the patient to hospital even if the patient does not wish to go.

3.96 That authority lasts for 14 days from the date when the patient was last examined by one of the doctors with a view to making a recommendation to support the application.

3.97 It is the responsibility of the AMHP to coordinate the transport and they will contact West Midlands Ambulance Service Control and seek transport where appropriate.

3.98 In exceptional circumstances, if patients are transported to a hospital which has agreed to accept them, but there is no longer a bed available, the bed managers are responsible for finding a suitable alternative for the patient.

3.99 This may involve making a new application to a different hospital. If the application is under section 3, new medical recommendations will be required, unless the original recommendations already state that appropriate medical treatment is available in the proposed new hospital.

3.100 The hospital to which the original application was made should assist in securing new medical recommendations if they are needed. A situation of this sort should be considered a serious failure and should be recorded as an incident.

3.101 The AMHP should provide an outline report for the hospital at the time the patient is first admitted or detained, giving reasons for the application and any practical matters about the patient's circumstances which the hospital should know.

3.102 Where possible, the report should include the name and telephone number of the AMHP or a care co-ordinator / lead clinician / named nurse who can give further information. Local authorities should use a standard form on which AMHPs can make this outline report.

3.103 This report must be sent to the MHL Office of the hospital where the patient is detained no later than one day from the date the patient's detention commences (see contact details in Appendix 9).

3.104 If this report is not received, it is the responsibility of the MHL Administrator to chase this and once received, save and upload to RiO. If there is a delay or problems in receiving this report, the MHLA will escalate to the Head of Mental Health Legislation at no longer than 1 day, who will liaise with the MH Lead at the LA to resolve the issue.

3.105 **Action when the decision is not to apply for admission.**

3.106 There is no obligation on an AMHP or Nearest Relative to make an application for admission just because the statutory criteria are met.

3.107 Where AMHPs decide not to apply for a patient's detention they should record the reasons for their decision on the AMHP report. The AMHP should be given to the HTT (or referring team if not HTT) who will forward to the MHL Office to be uploaded to RiO.

3.108 The decision should be supported, where necessary, by an alternative framework of care or treatment (or both). AMHPs should decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient. That might include, for example, referring the patient to social, health or other services.

3.109 The steps to be taken to put in place any new arrangements for the patient's care and treatment, and any plans for reviewing them, should be recorded in writing and copies made available to all those who need them (subject to the normal considerations of patient confidentiality).

3.110 The patient's care co-ordinator (where they require support under the care programme approach (CPA)) should be fully involved in decisions about meeting the patient's needs.

3.111 Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues where appropriate, e.g. where an application for admission is not immediately necessary but might be in the future. This information will need to be available at short notice at any time of day or night. This should be recorded on RiO, and the patient's care plan updated accordingly.

3.112 More generally, making out-of-hours services aware of situations that are on-going – such as when there is concern for an individual, but no assessment has begun or when a person has absconded before an assessment could start or be completed – assists out-of-hours services in responding accordingly. In this case, a referral to the AMHP team will be made and when the patient becomes available the HTT will contact the AMHP team and update.

3.113 **Communicating the Outcome of the Assessment**

3.114 Having decided whether or not to make an application for admission, AMHPs should inform the patient, giving their reasons. Subject to the normal considerations of patient confidentiality, AMHPs should also give their decision and the reasons for it to:

- The patient's Nearest Relative
- The doctors involved in the assessment.
- The patient's care co-ordinator (if they have one),
- The patient's named nurse, and
- The patient's GP, if they were not one of the doctors involved in the assessment.

3.115 An AMHP should, when informing the Nearest Relative that they do not intend to make an application, advise the Nearest Relative of their right to do so instead. If the Nearest Relative wishes to pursue this, the AMHP should suggest that they consult with the doctors to see if they would be prepared to provide recommendations.

3.116 Where the AMHP has considered a patient's case at the request of the Nearest Relative, the reasons for not applying for the patient's admission must be given to the Nearest Relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the Nearest Relative to understand the decision while at the same time preserving the patient's right to confidentiality.

3.117 **Resolving Disagreements**

3.118 Sometimes there will be differences of opinion between professionals involved in the assessment. There is nothing wrong with disagreements: handled properly these offer

an opportunity to safeguard the interests of the patient by widening the discussion about the best way of meeting their needs.

3.119 Doctors and AMHPs should be ready to consult other professionals, especially care co-ordinators and others involved with the patient's current care and to consult carers and family, while retaining for themselves the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.

3.120 Where there is an unresolved dispute about an application for detention, it is essential that the professionals do not abandon the patient. Instead, they should explore and agree an alternative plan – if necessary, on a temporary basis**.** Under these circumstances the HTT will carry out an assessment of the patient's needs, and the recommendations made by the MHA assessment in the AMHP report for future management will be considered.

3.121 Such a plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing, as should the arrangements for reviewing it. Copies should be made available to all those who need it (subject to the normal considerations of patient confidentiality).

3.122 **Documentation to be completed following assessment.**

3.123 **No admission**

- AMHP Report must be completed whenever an assessment under the MHA has taken place.

3.124 **Informal admission**

- AMHP Report
- Transport documentation.

3.125 **Section 4**

- 1x (A11) medical recommendation
- 1x (A10) AMHP application/Nearest Relative application
- AMHP Report

3.126 **Section 2**

- 1 x (A3) joint medical recommendation
  or
- 2 x (A4) medical recommendation
- 1 x (A2) AMHP application/Nearest Relative application
- AMHP Report

3.127 **Section 3**

- 1 x (A7) joint medical recommendation
  or
- x (A8) medical recommendation
- 1 x (A6) AMHP application/Nearest Relative application
- AMHP Report
- Role of the AMHP leaflet

3.128 **Joint Working between Agencies**

3.129 The JSOG will provide the opportunity for formal communication between police, ambulance, local authorities, and Trust leads involved in MHA assessments. This aims to promote understanding and to provide a forum for clarification of their respective roles and responsibilities and for any issues or difficulties to be addressed.

3.130 Opportunities should also be sought to involve and learn directly from people with experience of being assessed (patients and former patients), their carers, family, and advocates.

3.131 The Mental Health Legislation Committee has overall responsibility to ensure the legal administration of the MHA**.**

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	Have knowledge of and adhere to the policy	
Service, Clinical and Corporate Directors	Responsibility for responding to and ensuring that the teams implement new guidance; Ensure that professionals for which they are responsible are adhering to the policy and its procedures; and take action where non-compliance is identified	
Policy Lead	Ensure the Policy is up to date with Legislation; ensure timely reviews; co-ordinate the review process; make staff aware of the policy	
Executive Director	Has overall responsibility for ensuring that this policy is reviewed and that there are appropriate quality assurance mechanisms in place in relation to the guidance in this policy	
Local Authority	Responsibility for responding to and ensuring that the teams implement new guidance; Ensure that professionals for which they are responsible are adhering to the policy and its procedures; and take action where non-compliance is identified. Report non-compliance to MHLC	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary		
Date policy issued for consultation		Date: June 2024
Number of versions produced for consultation		Version 1
Committees or meetings where this policy was formally discussed		
Comprehensive email consultation with partner agencies and comments incorporated into the revised policy where appropriate.		
JSOG		
Trust Clinical Governance Committee		
Mental Health Legislation Committee		
Where else presented	**Summary of feedback**	**Actions / Response**
PDMG		
TCGC		
MHLC		

6 REFERENCE DOCUMENTS

Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice

Mental Health Legislation - DOLS Code of Practice.pdf - All Documents (sharepoint.com)

Mental Capacity Act 2005

Mental Capacity Act 2005 Code of Practice

Mental Health Legislation - MCA code of practice.pdf - All Documents (sharepoint.com)

Mental Health Act 1983

Mental Health Act 1983 Code of Practice (2015)

Mental Health Legislation - MHA Code of Practice 2015.pdf - All Documents (sharepoint.com)

Reference Guide to the Mental Health Act 1983 (2015)

Mental Health Legislation - Reference Guide.pdf - All Documents (sharepoint.com)

Trust MHL Policies:

Mental health legislation (sharepoint.com)

- Mental Health Act
- Informal Admission
- Mental Capacity Act
- MHL Administration
- s135 / s136 MoU
- s140 MoU

Other Trust Policies:

- Transfer of Patients

7 BIBLIOGRAPHY

None

8 GLOSSARY

Application for detention	An application made by an approved mental health professional, or a Nearest Relative, under Part 2 of the Act for a patient to be detained in a hospital either for assessment or for medical treatment. Applications may be made under section 2 (application for admission for assessment), section 3 (application for admission for medical treatment) or section 4 (emergency application for admission for assessment).
Appropriate medical treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case
Approved Mental Health Professional (AMHP)	social worker or other professional approved by a local authority to carry out a variety of functions under the Act
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to be mean examining or interviewing a patient to decide whether an application for detention or a guardianship application should be made.
Bed Manager	A person a provider has appointed to have responsibility for finding a suitable bed in that organisation
Care Programme Approach (CPA)	A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care coordinator. It is used mainly for adults in England who receive specialist mental healthcare and in some CAMHS services. There are similar systems for supporting other groups of individuals including, children and young people. (children's assessment framework), older adults (single assessment process) and people with learning disabilities (person centred planning)
Criteria for detention	A set of criteria that must be met before a person can be detained, or remain detained, under the Act. The criteria are different in different sections of the Act
Detention for assessment (And detained for assessment)	The detention of a person in order to carry out an assessment. Can normally only last for a maximum of 28 days. Also known as 'section 2 detention'.

Detention for medical treatment (and detained for medical treatment)	The detention of a person in order to give them the medical treatment for mental disorder they need. There are various types of detention for medical treatment in the Act. It most often means detention as a result of an application for detention under section 3 of the Act. But it also includes several types of detention under part 3 of the Act, including hospital directions, hospital orders and interim hospital orders
Guiding principles	The five principles set out in chapter 1 which have to be considered when decisions are made under the Act
Local Authority (LA)	The local authority responsible for care and support services in a particular area of England, which is a local authority for the purpose of the Care Act 2013 (except where otherwise indicated).
Medical recommendation	Normally means a recommendation provided by a doctor in support of an application for detention or a guardianship application
Nearest Relative	A person defined by section 26 of the Act (and in relation to children and young people, sections 27 and 28) who has certain rights and powers under the Act in respect of a patient for whom they are the Nearest Relative
Part 2	The part of the Act which deals with detention, guardianship, and community treatment orders for civil (i.e., non-offender) patients. Some aspects of part 2 also applies to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under part 3 of the Act

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Freq	Reporting Committee
Assessment process	HMHL / HMH LA	Eclipse Monthly meeting	monthly	MHLC

10 APPENDICES

Appendix 1 Equality Impact Assessment
Appendix 2 Criteria for applications
Appendix 3 Procedure and Guidance on Accepting and Communicating Paper and Electronic Forms
Appendix 4 Guidance Following the Devon Judgement
Appendix 5 Procedure for Admitting from Police Stations in an Emergency to the Medium Secure service (Reaside & Tamarind)
Appendix 6 Email Template regarding Section 2 expiry
Appendix 7 Procedure for Availability of Section 12 (2) Approved Doctors
Appendix 8 BSMHFT MHL Administrator contact detail.
Appendix 9 Guidance for AMHPs – What to do when there is no bed available.
Appendix 10 Police custody urgent MHA assessment SOP
Appendix 11 Referral and Mental Health Assessment by Secondary Mental Health Services for a Detained Person in Police Custody (Suite/Station)

Appendix 1

Equality Analysis Screening Form

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

Title of Policy	**Assessment for Admission under the MHA Policy**		
Person Completing this policy	**Louise McLanachan / Dinesh Maganty**	**Role or title**	**Head of MHL Associate MD MHL**
Division	**Corporate**	**Service Area**	**Medical**
Date Started	**June 2024**	**Date completed**	**June 2024**
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
To comply with the MHA statutory requirements and the multiagency working involved to accomplish this.			
Who will benefit from the proposal?			
All staff and service users assessing / being assessed for admission to hospital under the MHA.			
Does the policy affect service users, employees or the wider community? *Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward*			
It affects the community who may become potential service users			
Does the policy significantly affect service delivery, business processes or policy? *How will these reduce inequality?*			
n/a			

Does it involve a significant commitment of resources? ***How will these reduce inequality?***				
no				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
no				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	**x**			As part of the Equality Act – Age is a protected characteristic, this is not monitored in terms of EDI, however, is collated through our recruitment process, dependent on individual being open about their age. It is anticipated that age will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their age
Including children and people over 65				

Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	**x**			Currently we have the Disability and Neuro Diversity Staff Network Group who currently support staff with disability. We also support staff with Reasonable adjustment with the Government 'Access to Work' Grant. Therefore, it is anticipated that disability will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their disability. This is dependent if the individual feel comfortable about being open about their disability especially where this may be a hidden disability or mental health issues. The current WDES is showing the Trust is ranked in the top 10% nationally in Recruitment and Reporting of harassment, bullying and abuse
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	**x**			Currently gender is collated and there is a disparity around gender pay gap overall with an increase from 6.99% to 11.17%. It is anticipated that gender will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. The Trust has now set up a Women's Network who will be meeting on a monthly basis

This can include male and female or someone who has completed the gender reassignment process from one sex to another. Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships	**x**			Although this is a protected characteristic, this is not recorded. It is anticipated that marriage or civil partnership will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their marriage or civil partnership. This is dependent on staff feeling comfortable about being open about their Marriage or Civil Partnership
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters. Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	**x**			Although this is a protected characteristic, this is not recorded. It is anticipated that pregnancy and maternity will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this. However, the Trust will provide necessary support and reasonable adjustment for an employee who is pregnant or on maternity, paternity or adoption leave and this may be pausing the procedure for a temporary time. This is dependent on staff feeling comfortable about being open about their or their partners pregnancy, including miscarriage. We also have started the Women's Network where these matters can be discussed and shared there

This includes women having a baby and women just after they have had a baby. Does your service accommodate the needs of expectant and post-natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation into pregnancy and maternity?				
Race or Ethnicity	**x**			Currently, an average of 66% of all admissions to our inpatient services are detentions under the MHA. MHLC closely monitors MHA data, including the demographics of patients detained under the MHA. The Trust is working towards a Anti Racist organisation. It is anticipated that Race or Ethnicity will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable, and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their heritage or refugee status
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	**x**			Although this is a protected characteristic, we have some recorded data, and this is subject to staff completing this. The Trust will provide necessary support and reasonable adjustment for an employee, and we also have the Spiritual Care Team. It is anticipated that religion or belief will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable, and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their religion or belief

Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	**x**			Although this is a protected characteristic, we have some recorded data, and this is subject to staff completing this. We currently have LGBTQ Staff Network who meet regularly where information is shared. It is anticipated that sexual orientation will not have impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable, and consistent manner irrespective of this
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	**x**			Although this is a protected characteristic, this is not recorded. It is anticipated that Transgender or Gender Reassignment will not have an impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable, and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their being Transgender or undergoing Gender Reassignment There is also a Trans and Non-Binary Policy to support this
This will include people who are in the process of or in a care pathway changing from one gender to another. Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				

Human Rights			**x**	The policy protects the patient's human rights
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**	n/a	
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
EDI Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns				
How will any impact or planned actions be monitored and reviewed?				
Feedback from reporters of concerns, escalating concerns through governance routes. Regular audits and policy updates, communication to managers through Operational Meetings				

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
EDI Communications plan and trust wide promotion in ways accessible to ALL staff without the reliance upon electronic communications
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2

Criteria for applications

14.4 A person can be detained for assessment under **Section 2** only if both the following criteria apply:

- the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period, and
- the person ought to be so detained in the interests of their own health or safety or with a view to the protection of others.

14.5 A person can be detained for treatment under **Section 3** only if all the following criteria apply:

- the person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital.
- it is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section, and
- appropriate medical treatment is available.

Appendix 3

PROCEDURE AND GUIDANCE ON ACCEPTING AND COMMUNICATING PAPER AND ELECTRONIC FORMS

1. Purpose

1.1 The purpose of this protocol is to support the safe and effective service of MHA documentation via both electronic and paper transmission.

1.2 This protocol has been written based on National Guidance published by the Department of Health and Social Care and with the consultation of Approved Mental Health Professionals (AMHP) Managers from Birmingham City Council and Solihull Metropolitan Borough Council.

1.3 An amendment to Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 enables many of the statutory forms under the Mental Health Act 1983 (MHA) to be communicated electronically. This guidance explains the circumstances in which statutory forms and other documents can be sent electronically, best practice for doing so and general principles around the sending, signing, and storing of electronic forms.

1.4 The amended 2008 regulations are in force from 01 December 2020 and apply to England only.

1.5 The DHSC are aware that this guidance conflicts with aspects of the MHA code of practice and the reference guide. Note that this guidance supersedes conflicting guidance in the code of practice and reference guide and the DHSC will endeavour to address these inconsistencies as soon as possible.

1.6 This guidance is not restricted to circumstances related to the COVID19 pandemic, although the pandemic gave rise for the need of more flexibility for clinicians and hospital managers with regards to the use of electronic forms.

2. Receipt of Section Papers

2.1 Paper Forms

2.2 The process for receiving paper forms remains unchanged. In working hours, the original forms will be received by the local Mental Health Legislation Administrator (MHLA) and also in the in the shared MHA inbox bsmhft.mentalhealthact@nhs.net. Out of hours, the forms will be received by the relevant ward nurse and sent to the MHL Office (MHLO) on the above email address the next working day.

2.3 The MHL Administrator will monitor the email box daily as a minimum.

2.4 If the MHLO receives forms via email, the MHLA will upload them to RiO. If received as a hard copy, they will be scanned and uploaded to RiO by the MHLA as per the EDRMS protocol.

2.5 **When the ward emails the section papers to the MHLA, they should state whether they were served in paper or electronic form.**

2.6 Electronic Forms

2.7 The amended 2008 regulations enable statutory forms and other documents under Part 2 of the MHA to be served electronically, but only where the receiving body, authority or person agrees to accept electronic service of these forms.

2.8 There are a couple of exceptions to this:

- Where an Approved Mental Health Professional (AMHP), or a nearest relative wishes to serve an application for detention. In this case, electronic communication to the hospital managers or their officers is always permitted (no agreement needed).

- Where the recipient is a patient. In all such cases, statutory forms, and other notifications for the information of the patient must continue to be served in hard copy.

2.9 When there is a detention under section 2, 3 or 4 being recommended, the AMHP is required to scrutinise the medical recommendations to check that they have been completed correctly: that the medical recommendations correspond, that they are correctly dated and signed, to confirm the Doctor's acquaintance and to check the patient details correspond on all papers. The AMHP should confirm the Doctor's S12 status where applicable. The AMHP is also responsible for ensuring the medical examinations have taken place within the statutory period allowed within 5 five days of each other, and to ensure the application is within the legal timeframe allowed within 14 days of the last medical recommendation.

2.10 In case of statutory forms for detention under section 2, 3, or 4 once the medical recommendation is completed it is the responsibility of the assessing Doctor to ensure the completed medical recommendation is sent securely to:

2.11 For Birmingham patients - the day service inbox AMHPSecureBSO@birmingham.gov.uk / out of hours to AMHPoutofhours@birmingham.gov.uk which is monitored.

2.12 For Solihull patients - During the day – mentalhealthteam@solihull.gov.uk

2.13 Out of hours - EDT (Education & Children's Services) edt@solihull.gov.uk

2.14 It will be the responsibility of the applicant (AMHP/NR) to ensure that all the completed forms are submitted to MHLA in the prescribed form after being appropriately scrutinised by the AMHP and accepted.

2.15 The AMHP is responsible for ensuring all completed detention papers are sent together to the relevant MHLA in box securely using their .gov email account.

2.16 The forms which are to be served and sent electronically should be emailed securely to the receiving ward and cc the MHLA in working hours. The ward staff then complete Form H3 and return all papers to the MHL office.

2.17 Out of hours, the forms will be emailed to the Bed Management email address **bsmhft.possection136@nhs.net** and cc the nurse in charge of the receiving ward where the bed is identified if known and the appropriate MHLA. This must be followed up by a telephone call from the AMHP to bed management informing them they have emailed the forms. The subject line of the email should include:

- The patient's initials.

- A description of the attached i.e., “Section 3 documents” or “Form A8”

2.18 The bed manager will forward the forms to the relevant nurse in charge of the ward of admission if known prior to the patient being admitted.

2.19 Where a form has been sent via email and it does not appear to have been sent to the MHL Administrator, the recipient should forward the form to that address as a matter of urgency.

2.20 In accordance with s.6 MHA an AMHP application is founded on the necessary medical recommendations. As such the AMHP must ensure their application is accompanied by the supporting medical recommendations and are retained and sent to the receiving hospital as a package, whether electronically, in hardcopy, or a mixture of both.

2.21 The MHA Office remains responsible for:

- Uploading forms received electronically to the patients RiO record as soon as practicable.
- Completing administrative scrutiny of documents and arranging for medical scrutiny where applicable
- To monitor and maintain an audit trail for any rectifications, including those under s.15.

2.22 It is important to note the following points:

- MHA assessments must not be conducted remotely, this includes renewals, CTOs, and extensions.
- If you intend to complete a statutory form electronically, you MUST use the electronic version of the form – any forms submitted after 1st February 2021 which are not completed and submitted on the electronic version will NOT be valid or accepted.

2.23 Note that all electronic forms, apart from the discharge order form, should be considered 'served' once they have been successfully sent.

2.24 In the case of a discharge order form sent electronically by the nearest relative to hospital managers, the amendment to the 2008 regulations means that service is considered to have taken place at the beginning of the next business day after which it was sent.

2.25 Electronic forms should be considered equivalent in status to paper forms. One is not more valid than the other. This means that, for example, where forms authorising an individual’s detention are in an electronic format, there should be no question over the validity of these forms simply by virtue of their being electronic, when they are transferred from one hospital to another.

3. Electronic Signatures

3.1 BSMHFT would prefer those signing forms electronically to do so with a scan or photo of a wet ink signature, or an electronically drawn signature and the Local Authority would prefer a copy of a wet signature. However, typed names or initials or other forms of digital signature will be accepted as per the regulations.

3.2 Receipt of an email from an nhs.net or a.gov.uk account will be accepted as proof of identity of the signature. Further clarity may be sought by the MHLA as necessary.

3.3 Electronic signatures on forms have the same meaning as in section 7(2) of the Electronic Communications Act 2000. This states that an electronic signature is 'so much of anything in electronic form as is incorporated into or otherwise logically associated with any electronic communication or electronic data; and purports to be used by the individual creating it to sign'. As such, electronic signatures on electronically submitted statutory forms may be a typed name

or initials, a scan or photo of a wet ink signature, or an electronically drawn signature, among other options meeting the definition specified above

4. Serving the AMHP's application for detention electronically

4.1 As stated in paragraph 14.44 of the code of practice, doctors and AMHPs undertaking assessments for detention need to 'apply professional judgment and reach decisions independently of each other, but in a framework of co-operation and mutual support.' This should not change when forms are submitted electronically, nor where assessments are carried out remotely, as temporarily supported by the NHSE's legal guidance for use during the COVID-19 pandemic.

4.2 Where an AMHP submits an application for detention electronically and then delegates conveyance of the patient, for example to ambulance staff, a paper copy of the form is not needed to indicate that conveyance is lawful so long as the AMHP can provide evidence of a completed application supported by the necessary medical recommendations. In line with paragraph 17.26 of the code of practice, agencies should agree local policies and procedures regarding the nature of authorisation given by AMHPs (and others) when authorising people to transport patients on their behalf.

4.3 This should be the case whether a form is submitted electronically or in hard copy. In accordance with sections 2, 3 and 6 of the MHA, an application for detention submitted by an AMHP must be founded on the necessary medical recommendations. As such, it's the responsibility of the AMHP to support their application with 2 accompanying medical recommendations. It's vital that these statutory documents are retained and sent to the receiving hospital as a package.

5. Where the recipient is the patient

5.1 Statutory forms, such as CTO recall documents, must continue to be served by hardcopy. However, electronic communication can be used in addition if this is the patient's preferred method of receiving information. In circumstances where electronic communication has also been used, staff are expected to clearly document within the patient's notes the date and time the hardcopy of the document was served to the patient.

6. Nearest Relative Applications for Discharge

6.1 The Trust will continue to accept nearest relative applications for discharge. Electronic communication can be used in addition to sending documents via post or hand delivery.

6.2 Please see 2.23 and 2.24 for when a discharge order is deemed served.

7. Scrutiny of Section Papers

7.1 On receipt of section papers, the MHLA will scrutinise for errors in line with s15 procedures and using the scrutiny record in Appendix 1. This will state whether the papers were served electronically or paper.

7.2 Some errors can be corrected under Section 15 of the Mental Health Act; however, other errors cannot be corrected and may invalidate the section making the patient's detention unlawful.

7.3 Any forms received out of hours will be received and scrutinised by the nurse and forwarded to the MHL office for formal MHL scrutiny.

7.4 Any medical recommendations that require amendment (not joint medical recommendations) will be emailed to the Duty Medical Scrutiny Consultant for medical scrutiny.

8. Returning Section Papers for Amendment

8.1 Where rectifications to forms are made, including those under section 15 of the MHA, a transparent audit trail must be maintained that shows who edited the form, when they made the edit and what was added and/or omitted. All electronically completed forms should include the author's (secure) email address, alongside the postal address, in the relevant section of the statutory form so that the author can be easily contacted in case rectifications are required.

8.2 Any rectifications required, including those under s.15 MHA, will continue to require completion as soon as possible, or within 14 days of the patient's admission where applicable.

8.3 Section papers will be emailed to the appropriate professional for amendment if it is within the 14 days.

8.4 The amended version will act as the original section papers.

8.5 Where amendments are made, each set of papers will be named by version to ensure a clear audit trail.

8.6 All email communication surrounding a Mental Health Act assessment and amendment of documents / sections papers pre and post amendment will be retained and held as a record of the amendments made on file.

9. Storage of Section Papers (By Local Authority and NHS)

9.1 The 2008 regulations, as amended, do not specify that the recipient's agreement has to be secured 'prior' to the document being sent, but we nonetheless encourage prior agreement to be sought. This is to avoid confusion and ensure that the form is dealt with in the appropriate way by the recipient. Prior agreement should ideally include a standing agreement, to avoid the need for agreement to be sought every time.

9.2 MHLAs should ensure that storage of section papers and all email communication accompanying the section papers /electronic forms is safely achieved both electronically – upload to RiO and in hard copy – MHA file.

9.3 In line with paragraph 35.5 of the code of practice, which states that those acting on the authority of statutory forms should ensure they are in proper form if concerned about the quality and integrity of an electronically transmitted form, the recipient may request that the form be resent in a revised electronic format or in hard copy, if necessary

9.4 As with hardcopy forms, where documents containing personal data are sent or stored electronically this information should be kept securely, in line with the Data Protection Act 2018 and the General Data Protection Regulation

MHL ADMINISTRATION SCRUTINY RECORD

Patient:		RiO Number:	Section:
Ward:		RC:	Section Date:
Served: (If mixed give details)	paper	electronic	Mixed

SCRUTINY	Checked	Sent for rectification	Not Rectifiable
Is the patient's name and address consistent on all papers?			
Issue / Action /Outcome:			
Have the doctors and AMHP given their full name and address / email address?			
Issue / Action /Outcome:			
Were the medical recommendations signed on or before the date of the application?			
Issue / Action /Outcome:			
Has one doctor had previous acquaintance with the patient?			
Issue / Action /Outcome:			
Is at least one doctor s12 approved?			
Issue / Action /Outcome:			
Are the forms all signed and dated? (Paper – wet; electronic – electronic)			
Issue / Action /Outcome:			
If two separate medical recommendations are used, are there no more than 5 days between the examinations?			
Issue / Action /Outcome:			
If neither doctor had previous acquaintance with the patient, has the AMHP given reasons why they could not obtain a recommendation from a person who does know the patient?			
Issue / Action /Outcome:			
Was the application signed within 14 days of the AMHP seeing the patient?			
Issue / Action /Outcome:			
Was the patient admitted within 14 days of the Examination date on the medical recommendation?			
Issue / Action /Outcome:			
Is the hospital to which the patient is admitted the hospital named on the AMHP application form?			
Issue / Action /Outcome:			
For s3 applications, do the medical recommendations give the name of the hospital at which appropriate treatment is available? **(Joint med recs not rectifiable)**			
Issue / Action /Outcome:			
If so, does this match the hospital to which the patient is admitted?			
Issue / Action /Outcome:			
Any Errors on CTO Documentation			

MHL ADMINISTRATION CHECKS:	YES	No, (give reasons / action taken)
AMHP Report Received:		
Copy sent for medical scrutiny		

Uploaded to RiO		
Scrutinised by:	**Base:**	**Date:**

If you find any other errors, you may make a decision on the document's validity considering the de minis principle (i.e., the error is too trivial to be of any consequence). Please record your findings below

Form:	
Error / query	
De minimis?	
If not de minimis, Action taken:	
Outcome	
Scrutinised By:	
Base:	
Date:	

Note That S15 Rectification does not apply to the following documents:

- Form A3/A7 Joint Medical Recommendation
- S19 Transfer
- S20 Renewals
- Holding Powers
- Guardianship
- Community Treatment Orders

Section papers required for compulsory admission to hospital for patients not involved in criminal proceedings (Part II of the Act)

- **Section 2**

Form A2 1 Application by Approved Mental Health Professional (AMHP) plus Social Worker's assessment report (CR6B)

Form A4 2 Medical Recommendations

OR

Form A3 1 Joint Medical Recommendation

Form H3 1 Acceptance form/Record of Receipt

- **Section 3**

Form A6 1 Application by AMHP plus Social Workers assessment report.

Form A8 2 Medical Recommendations

OR

Form A7 1 Joint Medical Recommendation

Form H3 1 Acceptance Form/Record of Receipt

- **Section 5(2)**

Form H1 1 Report on Hospital Inpatient

- **Section 5(4)**

Form H2 Record of Hospital in-patient.

- **Section 4**

Form A11 1 Medical Recommendation

Form A10 1 AMHP Application

Form H3 1 Acceptance Form/Record of Receipt

A second medical recommendation will convert a Section 4 to a Section 2

APPENDIX 4

Guidance Following the Devon Judgement

Classification: Official
Publication approval reference: PAR241

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH
4 February 2021

To:
• Chief executives of mental health trusts and mental health providers
• COVID-19 leads in mental health trusts
• Regional directors
• Regional mental health leads
• Regional spec comm leads
• Regional learning disability and autism leads
• Regional health and justice lead
• Regional COVID-19 cells
• Regional directors of digital transformation
• Independent sector providers

Dear Colleagues,

In response to a number of helpful queries following the communication on Tuesday 26 January, we are updating the information previously shared, with the intention of providing as much clarity as possible. This information has been agreed with the Department of Health and Social Care (DHSC) and the Association of Directors of Adult Social Services (ADASS).

1) Devon Partnership NHS Trust sought a declaration from the Court as to whether remote assessments could be used to lawfully detain someone under the Mental Health Act (MHA). The Court's ruling was restricted to its interpretation of the phrases "personally seen" in s. 11(5) and "personally examined" in s. 12(1). It concluded that the physical attendance of the person in question (the AMHP and doctors) was required when assessing a person for detention under the MHA.

2) Based on this ruling it is advised that a Court would find a detention following a remote assessment carried out under s. 11(5) and s. 12(1) to be unlawful. I.e. assessments for detention/constraint under s. 2, s. 3, s. 4 or s. 7 (Guardianship) of the MHA.

3) Therefore, we advise that:

   - There are no further remote assessments for detention/constraint under s.11(5) and s. 12(1), i.e., for s. 2, s. 3, s. 4 or s. 7.
   - Anyone who is currently detained in hospital (under s. 2, s. 3, s. 4) or subject to s. 7 as a result of such a remote assessment should be reassessed without using remote technology as soon as possible.

   The NHSEI guidance on conducting remote assessments during the pandemic period has also been redacted and will be updated in due course.
4) The Court did not rule on assessments or examinations made under any other section of the Act beyond s. 11 and s. 12. Therefore, we do not know whether a Court would find remote assessments under any other section lawful. However, in view of the judgement, providers/councils may wish to take a precautionary approach and stop all remote MHA assessments and renewals where the clinician or AMHP is required to 'examine' or 'see' the

individual. This includes assessments and/or renewals under s. 20, s. 20(A) and s. 136, and therefore impacts s .3 renewals, s. 37 renewals, s. 7 (Guardianship) renewals, and CTO extensions. It remains the case that the ruling does not directly apply to Part III of the Act, but for the reasons stated, there are potential implications for s. 37 renewals. Where providers/councils have further concerns, they should seek their own legal advice and decide next steps.

Yours sincerely,

Claire Murdoch CBE

National Director for Mental Health
NHS England and NHS Improvement

Appendix 5

PROCEDURE FOR ADMITTING FROM POLICE STATIONS IN AN EMERGENCY TO THE MEDIUM SECURE INTENSIVE CARE SERVICE (Reaside or Tamarind Centre)

Dinesh Maganty,

Introduction

Under exceptional circumstances patients may be transferred directly from police stations to a medium secure hospital setting.
This procedure has been developed in response to concerns about remand of mentally disordered suspects in custody where there are grave concerns for the safety of the individual and others if the suspect is remanded in custody for even a relatively short period of time and in response to case law in which the ECHR has identified the detention of a severely mentally ill man in police custody as contravening his human rights under Article 3 of the Human Rights Act (RS V UK May 2012).

This could occur when:

1. The patient is unfit to be interviewed, very floridly psychotic and unfit to be detained in custody. Being psychotic in itself will not lead to transfer. Suitable cases may be e.g., where the patient is fully naked in custody in a manic state and eating his own faeces.
2. A risk of harm to self which can be contained by one-to-one observations is not normally a reason for transfer to hospital, but there may be exceptional risks to self that may require transfer to hospital without detention in custody. E.g., patient trying to gauge eyes out with his hand or strong history of self-immolation etc.
3. There may be other exceptional cases which the assessing clinicians and teams believe requires treatment in hospital urgently.

Under the above circumstances patients could be admitted to the Medium Secure Intensive Care Service (MSICS) \ acute wards in Tamarind centre or Reaside clinic.

The initial assessment in all cases will be by the normal protocol by the FME (forensic medical examiner) / Health and Justice Vulnerability service / Liaison and Diversion practitioner.

Subsequently as per already agreed protocol there would be an assessment by the Adults of working age services clinician. In exceptional circumstances where the offence is grave i.e., murder or attempted murder the adults of working age clinician may seek a joint assessment with the forensic service.

This will in all cases involve a joint assessment with the AWA Consultant or a Higher Specialist Trainee/Associate Specialist with concurrent Consultant supervision and

Forensic Consultant or a Higher Specialist Trainee/Associate Specialist with concurrent Consultant supervision.

During working hours

It would be expected that these assessments wherever possible will occur in working hours and would be carried out by the host forensic team with the AWA team.

Should it be obvious in the view of the host team Forensic Consultant during working hours that the patient would require Medium Secure Intensive Care (MSIC) based on information from the FME or the AWA clinician who assessed the case. The host team consultant may pass on the referral to the MSIC team who will then provide the Forensic Consultant or a Higher Specialist Trainee/Associate Specialist with concurrent Consultant supervision for the assessment.

Should the patient be found unfit to be interviewed the PACE clock is likely to be ticking and therefore there is likely to be increased anxiety by the police for a Mental Health Act assessment to be carried out.

The AMHP would generally be from the AWA services / or via the central EDT but the Forensic services AMHP if available could be requested to attend in working hours.

A patient can be admitted to an acute medium secure bed if suitable.

There needs to be availability of a bed and agreement with the Medium Secure Intensive Care Service (MSICS) Consultant if the patient is to be admitted.

In all cases agreement with the bed management team would be necessary for an in working hours admission.

Should the assessing clinical team make a decision that the patient needs to be detained in hospital, a full nursing assessment supporting the admission from the MSICS (if the admission is to be to intensive care) or by the acute ward nurse (for acute ward admissions), including Completion of an assessment summary will be necessary. In Working hours this will be led by the Advanced nurse practitioner for intensive care where possible.

A full medical assessment by the assessing Forensic consultant \Higher specialist trainee including a Level 2 Risk Assessment, and CPA care plan for immediate care needs to be completed.

The on the ward admission due to the grave nature of the risks needs to be done by the assessing nurse and the assessing doctor jointly with the junior doctor. This is to include as a minimum physical health assessment, agreement of observation levels, immediate medication treatment, and a 72-hour care plan.

Forensic Mental Health Services will liaise with the Police and CPS to ascertain whether the suspect is likely to be charged or bailed, in view of the nature of the alleged offences the CPS will almost invariably seek a remand in custody following charge even if initially bailed.

Where it is likely that the suspect will be bailed by the police for further enquiries, Forensic Mental Health Services will consider whether it is appropriate to detain the suspect under section 2 or 3 The Mental Health Act. The person cannot be detained under the Mental Health Act solely because the police are investigating a serious offence.

A Section 48 detention under the Mental Health Act could be considered if the charging decision is made but when the charging decision is not made or when the courts are not open or over the weekend the patient may be detained under Section 2 or 3 of the Mental Health Act 1983 (amended 2007) and could be admitted to Reaside Clinic/Tamarind centre.

A section 3 would be the usual section for detention as a conversion to a Section 48 detention is the most likely course of action once courts and MoJ Senior staff become available and patient is charged.

The AMHP / Advanced Nurse Practitioner for MSICS \ assessing nurse will liaise with the police with regard to transportation. The transport will be provided by the west midland's ambulance service and security for the transport at all times will be provided by the police.

This will be in line with the nationally agreed protocol for transportation of mentally disordered offenders in police station custody.

Immediate ongoing liaison needs to occur with the Crown Prosecution Service and also the detained patient's legal team and the investigating police officer leading the investigation in the case and the Ministry of Justice. This is especially important in cases where the offence is a grave offence or a high-profile offence, such as Homicide.

In such cases there is an established memorandum of understanding for there to be agreement between the Crown Prosecution Service, the investigating police team, the suspects legal team, the treating clinical team at Reaside Clinic/Tamarind centre and the Ministry of Justice for the patient to be charged as soon as practicable.

Forensic Mental Health Services will prepare medical recommendations for the Ministry of Justice Mental Health Case Work Section, to enable the suspect to be transferred under Section 48 of the Mental Health Act, immediately and directly, after his/her first court appearance.

A senior lawyer from the CPS will liaise with the Ministry of Justice and Courts to facilitate the process. The treating forensic consultant will also liaise with the MOJ and the legal teams.

If detained under section 2 or 3 the suspect will remain in hospital and will be interviewed when fit to be interviewed or charged without interview. Once charged they will be produced in court from Hospital.

The Ministry of Justice if satisfied will issue the warrant to transfer the defendant under section 48 on notification by the court that the defendant has been remanded in custody.

The court will email the order immediately after the hearing. This will enable the defendant to be transferred from directly court to hospital. Note that section 128 Magistrates' Court Act 1980 requires the defendant to appear in court for his first remand in custody (further remands can be conducted in absence or via TV link).

Where the defendant is charged with an offence other than murder, the Magistrates' Court will remand the defendant in custody (if appropriate). Accordingly, the section 48 transfer can take effect immediately after the initial Magistrates' Court appearance.

Where the defendant is charged with murder, the decision to remand the defendant in custody must be made by the Crown Court. CPS will liaise with the Magistrates' Court and Crown Court to enable to defendant to be produced for first appearance at the Crown Court and not the Magistrates' Court. The Crown Court Judge will initially sit as a District Judge (Magistrates' Court) under section 66 Courts Act 2003. The Judge will then re-constitute as a Crown Court Judge and remand the defendant in custody (if appropriate). The section 48 transfer will then take effect immediately and directly from the Court.

Out of Hours

It would be expected that these cases wherever possible will be handled in hours by the host Forensic team or by the agreement with the Host team by the Medium secure intensive care team due to the Risks associated.

Out of hours the on call Forensic Consultant with the Duty senior nurse will make the decision regarding admission.

This in all cases would require a nursing assessment from the Intensive Care Service should an intensive care admission be considered.

The admission process and standards will remain unchanged (as detailed above)

A detention under section 3 of the Mental Health Act may have to be utilised should the patient need admission urgently over the weekend with recommendations being completed to be implemented as soon as the patient is charged and courts open and MoJ senior case workers \ CPS senior lawyers become available.

Dinesh Maganty,
Associate Medical director for Mental health legislation.

Appendix 6

Email Template regarding Section 2 expiry.

Dear AMHP and RC

This is a Formal Notification on behalf of the Responsible authority that patient.
Name…
DOB…
Rio No…
RC:
RC: Medical secretary tel. No:

Has now been detained under Section 2 of the Mental Health Act for 20 days.

Over 80% of Section 2 detentions result in conversion to Section 3 detentions. Early and close liaison between the AMHP, RC, nursing team and Nearest Relative/carer is likely to result in better exploration of out of hospital options and the least restrictive outcome for the patient. This protects the patient's Human Rights.

The Responsible Authority requests that the Local authority allocates an AMHP to the case for this Liaison to occur.

The AMHP and RC will each individually liaise with the nearest relative (if available) and also with each other and take all steps necessary to ensure that the patient is either discharged prior to or lawfully remains in hospital once their 28-day detention period under section 2 ends.

The allocated AMHP can contact the RC and the RCs secretary via the email or telephone no. above.

The RC is asked to contact the AMHP service via telephone on 0121 303 2480.

With regards

Mental Health Legislation Administrator on Behalf of the Responsible Authority

Appendix 7

PROCEDURE FOR AVAILABILITY OF SECTION 12 (2) APPROVED DOCTORS FOR MENTAL HEALTH ACT ASSESSMENTS IN BIRMINGHAM AND SOLIHULL MENTAL HEALTH FOUNDATION TRUST AREA

1. Introduction

- The Mental Health Act Code of Practice 2015 requires that "local arrangements should, as far as possible, ensure that assessments are carried out by the most appropriate AMP and doctors in the particular circumstances".

- The procedure as set out below is a jointly agreed procedure between the Birmingham City Council, Solihull Council and Birmingham and Solihull Mental Health NHS Foundation Trust as a jointly agreed arrangement locally (as set out under14.41 of the Mental Health Act Code of Practice 2015).

- The coordination of the Mental Health Act assessment is the responsibility of the AMHP (Approved Mental Health Professional).

- It is necessary that there are two doctors available to carry out a Mental Health Act assessment (under Section 2 and Section 3 of the Mental Health Act).

- Where practical, at least one of the medical recommendations must be provided by a doctor with previous acquaintance of the patient, preferably this should be a doctor who has personally treated the patient. It is sufficient for the doctor to have previous knowledge of the patients' case.

- It is preferable that if a doctor does not have previous acquaintance with the patient, they be approved under Section 12 (2) of the Mental Health Act. The Act requires that at least one of the doctors must be so approved.

- It is the responsibility of the doctors who reach an opinion that the patient needs detention under the Mental Health Act, to take the necessary steps to secure a suitable hospital bed.

- Under Section 140 of the Mental Health Act 1983 Birmingham and Solihull Mental Health NHS Foundation Trust is responsible, on behalf of the CCGs, for reception of patients in cases of special urgency or the provision of appropriate accommodation of these facilities specifically designed.

2. Fees for Consultant and SAS Doctors and New Contract

Consultants on the new contract (after 01 April 2004) Associate Specialist (2008) and speciality doctors undertaking fee paying services are governed by:

a. Consultants Schedules 10 and 11 of the Consultant terms and conditions of service (England 2009)

b. Associate Specialist schedule 11 and 12 of the terms and conditions of service for Associate Specialist (England 2008)
c. Speciality doctors schedule 11 and 12 of the terms and conditions for speciality doctors (England 2008).

Once individual Consultants, Associate Specialists or Speciality Doctors reach an agreement within their contract of employment with Birmingham and Solihull Mental Health Foundation Trust none of the three relevant terms and conditions of service prevent the claiming of Section 12 (2) fees and contain the same principles governing the receipt of additional fees.

An underlying principle of all three contracts is that doctors should not be paid twice for the work they do as work undertaken during programmed activities (PA's) would not attract additional fees.

This principle applies in equal measure when remunerated by on call supplement as part of PA work. **The doctor undertaking fee paying work can keep the fee owed if they are doing the work by means of "time shift" so that their NHS work is unaffected or if the work is by agreement only minimally disruptive to NHS activities**.

Birmingham and Solihull Mental Health Foundation Trust accepts that work done as part of the Section 12 rota would constitute work which is minimally disruptive to NHS activities. Therefore, doctors as part of the rota can claim the fees for Section 12 (2) Mental Health Act related work, i.e. Mental Health Act assessments.

3. Fees will not be chargeable under the following circumstances by Section 12 (2) approved doctors

1. For inpatients where the doctor is involved in the care of the patient on a day-to-day basis.
2. Outpatients where the doctor is involved in the care of the patient.
3. Work undertaken as part of a domiciliary consultation requested by a GP or by another health professional and the request is not by an AMHP for a Mental Health Act assessment.

4. BSMHFT Rota of Section 12 Approved Doctors to provide the Second Doctor for Mental Health Act Assessments

a) The first doctor involved in a Mental Health Act assessment would always be:

The Consultant or another doctor involved in the patient's care on a regular basis or expected to be involved in the patient's care on a regular or ongoing basis or covering for such a doctor on an on-call basis or in providing reciprocal cover.

b) The second doctor necessary to carry out a Mental Health Act assessment under Section 2 or Section 3 of the Mental Health Act 1983, will be determined as follows:

Within Birmingham and Solihull Mental Health Foundation Trust catchment area the AMHP's who assess patients for possible detention under the Act have

overall responsibility for coordinating the process of assessment. Ideally this would be the GP, but they are not always available, especially in core hours.

In this case the ultimate decision therefore on who should be the second doctor carrying out the Mental Health Act assessment will rest with the AMHP coordinating the assessment. In doing so they should be sensitive to the patient's age, sex, gender, identity, social, cultural or ethnic background, religion or belief and/or sexual orientation. The second doctor is chosen by the AMHP to carry out the Mental Health Act assessment, if he does not have previous acquaintance with the patient should be approved under Section 12 of the Act. The 'Act requires at least one of the doctors be so approved.

Where a patient is known to belong to a group for which particular expertise is desirable (example where aged under 18 or have learning disability) it would be expected that this would come from the first doctor (who is directly involved in the care of the patient or would be involved in the care of the patient). Where the first doctor does not have the particular expertise necessary to carry out a Mental Health Act assessment under those circumstances, the AMHP may deviate from the rota and choose another doctor who does have the specific expertise. This would remain at the AMHP's discretion.

5. Practicalities of Working of the Rota during Weekdays, In-hours (9am to 5pm)

- All Section 12(2) approved doctors working for Birmingham & Solihull Foundation Trust who are currently approved would automatically be enrolled on to the Section 12(2) rota.
- It is expected that this would be no more than one day every six months that a Section 12(2) approved doctor would be on this rota.
- It is expected that during this day the doctor would keep themselves free of direct clinical care work, though admin work which can be postponed can be timetabled into that day.
- As with any on call rota it would be the responsibility of the individual doctor on the rota to swap or make alterations to the rota in liaison with colleagues.
- The same responsibilities to be available on this rota would be applicable as any other on call rota on which doctor's work routinely for the Trust.
- This rota would be drawn up annually by the Associate Medical Director MHL and sent out by the PA to the Head of Mental Health Legislation for the Trust. This would be available centrally to all AMHPs.
- The second doctor for police station Mental Health Act assessments would still continue to be the FME where available.

6. Arrangements for Second Doctor for Mental Health Act Assessments Out-of- Hours and Weekends (5pm to 9am weekdays, weekends, bank holidays, etc.)

- The first doctor for any Mental Health Act assessment would be the on-call doctor for the rota covering the relevant part of the city (north or south side).

- The second doctor for police station Mental Health Act assessments would still continue to be the FME where available together with the doctor from the Crisis Resolution and Home Treatment Team.
- In specific cases of alleged serious violent offending (murder, attempted murder) the Mental Health Act assessment may occur jointly between the doctor on the relevant Crisis Resolution and Home Treatment Team rota and the Forensic (secure care) rota for the Trust.
- Under the above circumstances no additional payment can be claimed by the doctors involved in such an assessment (other than the FME as relevant).
- Should a Mental Health Act assessment be coordinated by an AMHP, out-of-hours, in any other circumstance the second doctor undertaking such an assessment at the request of the AMHP would normally come from the BSMHFT rota for which the doctor could claim appropriate fees.
- The out-of-hours rota for Section 12(2) approved doctors for BSMHFT in the above circumstances would involve Higher Specialist trainees/those on Tier 2 rota/Consultants who are not directly covering the location where the Mental Health Act assessment is to take place.
- For the north side of Birmingham this would include those Section 12(2) doctors on the south side rota and also doctors on the secure care, i.e. forensic rota. It would be expected that those Section 12(2) approved doctors on the south rota would provide the second doctor for patients on the north side of the city and similarly those on the north side rota would provide second doctor cover for patients in the south side of the city in the first instance. Should all Section 12(2) approved doctors in the north side of the city and the south side of the city not be able to attend due to on-going commitments whilst on call the higher specialist trainee on the secure care rota would be contacted to provide the second doctor role for a Mental Health Act assessment.
- If all doctors on the out of hours rota are busy (north side, south side and secure services) under those circumstances the AMHP would have to contact other doctors on a list that they hold of Section 12(2) approved doctors. It is expected that this would be a rare occurrence.
- All doctors working for Birmingham & Solihull Mental Health Foundation Trust providing the second doctor role out of hours would be eligible to claim remuneration in line with BMA guidelines for Mental Health Act assessments. It is accepted by the Trust that this would constitute minimal disruption to their normal NHS role and time shifting would be expected.
- Compensatory rest arrangements in line with European working time directives would apply and would be supported by the Trust. Using a second doctor from the rota would remain at the discretion of the AMHP and where specific expertise is necessary the AMHP may choose if available to use a doctor outside of the rota as long as this does not delay the Mental Health Act assessment unduly.

7. Impact Assessment

- The weekday rota of Section 12(2) doctors for BSMHFT would involve no more than one day every six months for Section 12(2) doctors for the Trust and therefore would cause minimal disruption to NHS activities of the doctor. It is also recognised that carrying out Mental Health Act assessments effectively provides a valuable service to patients and the Trust.
- As time shifting arrangements would apply, this would enable more flexible working of doctors.
- Currently payments are routinely made by Birmingham City Council, on behalf of the CCG's, to doctors who act as second doctors and therefore this is unlikely to have any additional financial impact on Birmingham City Council itself.
- The out-of-hours impact of Mental Health Act assessments by doctors on other rotas would impact to a minimal extent on the on-call rota. This will be monitored by way of an audit over three months.

Dr Dinesh Maganty
Associate Medical Director Mental Health Legislation

Appendix 8

Trust Locations and MHL Administrator Contact details.

Mental Health Legislation - Mental Health Legislation (sharepoint.com)

Birmingham City Council

DIRECTORATE FOR PEOPLE

Guidance for AMHP's – What to do when there is no bed available.

The Code of Practice

Paragraph 14.77 of the Mental Health Act (MHA) Code of Practice is unequivocal, in that "if the doctors reach the opinion that the patient needs to be admitted to hospital, it is their responsibility to take the necessary steps to secure a suitable hospital bed**; it is not the responsibility of the applicant**", that is the Approved Mental Health Professional (AMHP). Although many Hospital Trusts have devolved this to a Bed Management Team, the doctor remains responsible for finding a bed.

Paragraph 14.77 of the Mental Health Act (MHA) Code of Practice states that. *We should have regard for the MHA Code of Practice, which must be followed unless there are "cogent reasons" for departure - R(Munjaz) v Ashworth Hospital Authority (2005). Any departures from the CoP could give rise to a legal challenge and reasons for any departure need to be recorded clearly.*

Introduction

This procedure provides guidance to AMHPs on whether an MHA assessment should be undertaken if it is clear that there is no bed space available. It also contains the process to be followed when an assessment has been undertaken and there is no bed available.

Do you need to do a Mental Health Act assessment if there is no bed?

Under the MHA, section 13(1), if the local authority has reason to believe that an application for admission to hospital, or a guardianship application, may need to be made then it has a duty to make arrangements for an AMHP "to consider the patient's case on their behalf".

This is not the same as the local authority having an obligation to immediately initiate an MHA assessment and is not conditional on a Mental Health Trust having an identified bed or not. Any decision to assess would be dependent on a review of risk, which might mean that we don't, in fact, immediately undertake an assessment. Ultimately it is the AMHP's role to **coordinate** the MHA assessment. However, it is not acceptable to refuse to consider undertaking an assessment, following a request under section 13(1), just because there is no bed available.

Starting an MHA assessment without a hospital bed being identified is not uncommon and the AMHP should always engage with the Home Treatment Team (HTT). Remember it is the HTT who has responsibility for a citizen's care until they are admitted into hospital. Therefore, even when a bed has been identified the AMHP will not be expected to return to facilitate admission alone.

What happens after the assessment if there is still no bed?

In situations where there is an indefinite wait for a bed to be identified it is acceptable to leave the premises and return to your base where you can continue to liaise with the Bed Manager/HTT in order to identify a bed. If you do this, you need to record your rationale for doing so in the report and notify any relevant agencies accordingly. This includes letting the HTT know that you are leaving the property and, if needed, letting the police know that a person who is liable for detention has been left at an address alone.

When liaising with the HTT you must formulate an interim care plan with them, which identifies what support the Mental Health Trust will offer to the citizen in the interim period. These discussions **must** be recorded, and a copy of the plan included in your report.

If it is out of hours, you will not be obliged to return to your base and can instead go home. However you will still need to liaise with the HTT and also discuss the situation with the Emergency Duty Team (EDT). If a bed becomes available during the night, the EDT may be in a position to facilitate the admission however they will only be able to do this if they have been given a full handover request.

If there is no bed available and nothing is definite from the Mental Health Trust, or they intend to start looking for a private bed, then you need to consider what will be achieved if you stay. If the response to this is little or nothing, then you are not obligated to remain indefinitely.

Your duty as an AHMP is to assess and organise conveyance. You cannot organise conveyance if there is no bed available and therefore cannot personally make a situation any safer by remaining at the property. In this situation managers will support an AMHP if they decide to leave the premises. However, if you have **any concerns** about this you should first discuss the matter with a manager during daytime hours or with an on-call manager after 17:15 hrs.

Note - be mindful that a section 135 warrant might be required to gain access on your return, and please check the Medical Recommendations to ensure they are still valid.

Does this still apply if the citizen is in an Accident & Emergency Department?

If there is no bed available, or no agreement from partner agencies to convey the person, the AMHP is not required to stay in an Accident & Emergency Department. Whilst AHMPs may be subjected to pressure from hospital staff

to stay, if your presence will not achieve anything there is no obligation to stay.

Before you leave however you should always first advise either a manager or the on-call manager after 17:15.

Your Safety comes First.

Your safety is paramount and if at any point during an assessment you feel that you are at risk you should leave the premises and contact the relevant agencies to ensure that you and others remain safe.

AMHPs are also reminded of their lone-worker app. so must take their work mobile phone on each and every assessment, as well as ensuring that their electronic calendar is up to date so that colleagues know where they are.

Additionally, if you receive a request for an assessment that you are concerned about because of an increased risk to you or others, particularly if you feel that not having a bed space could jeopardise the management of the assessment, you are advised to speak to a manager in the first instance who will discuss a safe and appropriate plan of action with you. If the request is after 17:15 then you should speak to the on-call manager.

Appendix 10

Standard operating procedure/Protocol for people in police custody who require urgent mental healthcare: process, responsibilities, and expectations.

Birmingham and Solihull Mental health Foundation trust

April 2024

1. Scope of this protocol

This protocol applies specifically to people who have been arrested and while in police custody are identified as having acute mental health needs.

This protocol should be read in conjunction with the accompanying flowchart. Numbers in the protocol refer to steps in the flowchart.

Any individual detained in police custody is either under detention under PACE or the Mental Health Act. For those detained in a police custody suite primary healthcare provision is provided by the Police custody healthcare professional commissioned via the Police & Crime Commissioner.

Liaison and Diversion / Health and Justice Vulnerability service commissioned by NHS England provide referral and liaison services in and out of police custody for those with vulnerabilities.

The above two services work in conjunction in making referrals to secondary mental health services for those detained in police custody.

Secondary Mental health services provide secondary mental health care in the community and Inpatient settings.

Custody healthcare professional (PCHCP, commissioned by the Police & Crime Commissioner for the West Midlands) are responsible for supporting the custody officer in making decisions on fitness to be detained, fitness to be interviewed, fitness to be released and in custody risk assessments.

Liaison and Diversion / Health and Justice Vulnerability services and secondary mental health services do not provide this service.

This Protocol includes a STOP for referrals from police station custody to secondary mental health services Provided by BSMHFT.

2. Objective

The overarching principle is that people with an acute mental health need which cannot be supported in custody should be cared for in a healthcare environment wherever possible and should not spend any more time in police custody than is necessary.

3. Abbreviations used.

AMHP	Approved Mental Health Professional
ED	Emergency Department
HBPoS	Health-Based Place of Safety
L&D	Health and Justice Vulnerability service / Liaison and Diversion service
MHA	Mental Health Act, 1983
WMP	West Midlands Police
PACE	Police and Criminal Evidence Act 1984
PHCP	Police Custody Healthcare Practitioner
s12 Doctor	Section 12 Approved Doctor
s136	Section 136 of the Mental Health Act 1983

Reference to flowchart	Expectation	Responsibility	Related document(s)
1.1	Detainee presents with acute mental health need or self-discloses existing mental health condition.	Police custody team	WMP Mental Health in Custody Toolkit, BTP In Custody Process Document
1.2	Referral to PHCP and to L&D team (in service working hours)	Police custody team	Existing L&D / PHCP ways of working
1.3	Physical and mental health assessment (as soon as possible and always within one hour of referral)	PHCP / L&D team	Existing L&D / PHCP ways of working
1.4	PHCP / L&D, where possible jointly, advise on physical and MH presentation and if detainee would benefit from an MHA assessment or referral to HTT.	PHCP / L&D / police custody team	Existing L&D / PHCP ways of working / if BSMHFT referral appropriate referral documents
Reference to flowchart	Expectation	Responsibility	Related document(s)

	If the detainee is intoxicated, existing guidance should be followed; advice from the PHCP about health risks and fitness for assessment is paramount. It should be noted, however, that an individual should not be returned to police custody for a Mental Health Act assessment if they have been conveyed to an Emergency Department for treatment for a physical condition: mental healthcare should be provided within a healthcare setting.		Physical Health Assessment and Treatment Protocol
1.4.1	If the detainee would benefit from mental health inpatient admission and is suitable for informal admission, healthcare professionals should liaise with the responsible trust, following the process set out in the Compact. Go to 1.10	L&D / PHCP	Compact
1.5	Decision to be made whether to use S136 or request an MHA assessment using three questions in structured tool.	Police custody team	
1.6	Question 1. Has the person been arrested for a serious crime and there are ongoing risks to others? A serious crime would include (but is not restricted to) rape, other serious sexual offences, murder, kidnap, false imprisonment and other serious violence offences. “Serious” is likely to include but is not limited to violent offences such as murder, GBH, rape and other serious sexual offences, kidnap, false imprisonment, slavery, people trafficking, drug trafficking, firearms offences, armed robbery, child sex offences. ABH may be included in specific circumstances especially when it involves weapons). In exceptional circumstances Serious crimes may not need management through the criminal justice pathway where there are no significant ongoing risks to others If yes, go to 1.6.1. If no, go to 1.6.2.	Police custody team responsible for conveyance to court	WMP Mental Health in Custody Toolkit, BTP In Custody Process Document, For BSMHFT cases BSMHFT referral documents

1.6.1	In these circumstances, the aim is to manage the person through the criminal justice system in the first instance. The expectation is that the person will appear in court and be remanded into custody.	Police custody team L&D service	

Reference to flowchart	Expectation	Responsibility	Related document(s)
	In case the expected criminal justice process cannot be followed for any reason, the case should be discussed with the on-call forensic psychiatrist and should consider a Mental Health Act assessment through a forensic route.	Forensic mental health services	
1.6.2	Question 2. Is the criminal investigation likely to be ongoing[1]? If the police are not going to take any further action or where there is no ongoing necessity to detain the person in relation to the offence for which they were arrested, go to 1.6.3. If the investigation remains ongoing, go to 1.7.	Police custody team	WMP Mental Health in Custody, Toolkit, BTP In Custody Process Document
1.6.3	Question 2. If no further necessity to detain, PACE no longer applies, and the person cannot continue to be held by the police. The person should be detained under s136 of the Mental Health Act within the police custody suite and arrangements made to transfer them following the s136 protocol.	Police responsible for arranging transfer	s136 pathway

[1] The term 'ongoing' means with an ongoing necessity to detain to secure or preserve evidence relating to the offence for which they are under arrest or to obtain such evidence by questioning the person.

1.7	Question 3. The PHCP should contact the local AMHP service and ask whether an AMHP can co-ordinate a Mental Health Act assessment and they and doctors attend the police custody suite within 3 hours? If the MHA assessment can't take place within three hours, go to 1.7.1. If it can, go to 1.8. The AMHP service may not delay Mental Health Act assessments because they believe that inpatient mental health beds are not available. This approach pre-judges the outcome of the assessment.	AMHP coordinates MHA assessment with two doctors (of which at least one must be s12 approved)	MHA Code of Practice

Reference to flowchart	Expectation	Responsibility	Related document(s)
1.7.1	It is not reasonable or appropriate for someone to remain in police custody for more than three hours when no longer detained under PACE. The person should be detained under s136 of the Mental Health Act within the police custody suite and arrangements made to transfer following the s136 protocol.	Police custody team	s136 pathway / Mental health Act Code of Practice
1.8	The Mental Health Act assessment takes place within the police custody suite. If the person is to be detained under the Mental Health Act and admitted to a mental health inpatient unit, go to[2] 1.9.1. . If the person consents to an informal admission to a mental health inpatient unit, go to 1.9.2. Police custody health care provider should carry out an assessment of mental health needs assessment including a capacity assessment to determine care pathway before referral (for BSMHFT cases BSMHFT referral documents to be completed for referral)	AMHP	

[2] Forensic Psychiatric expertise may be sought by the AMHP in appropriate cases for the Mental health act assessment.

	If the person is not detainable under the Mental Health Act, go to 1.9.3.		
1.9.1	If the person is recommended to be detained under the Mental Health Act, the AMHP should liaise with the responsible trust to identify a bed and arrange admission, following the process set out in the Compact[3]. The PACE clock stops, but the police investigation may remain ongoing. See 1.10.	AMHP	Compact
1.9.2	If the person is suitable for an informal admission to an inpatient unit, the L&D team should support the AMHP to arrange the admission, The PACE clock stops, but the police investigation may remain ongoing. See 1.10.	AMHP, L&D	MHA Code of Practice (16.51)
1.9.3	If the person is not detainable under the Mental Health Act, the L&D team should arrange any other mental health follow-up.	L&D (with advice from AMHP and doctors, as appropriate)	MHA Code of Practice (16.51)
1.10	Regardless of the outcome of the Mental Health Act assessment, the police will make a parallel decision about whether and how to take forward the criminal justice process for the offence for which the person was originally arrested. Fitness to be detained, interviewed and released are decisions for the Police and police health care provider.	Police custody team	WMP Mental Health in Custody, PACE, BTP In Custody
Reference to flowchart	Expectation	Responsibility	Related document(s)
	In some circumstances this decision needs to be made immediately particularly if the offence is serious. If prosecution is to be considered at a later date, the person will be released on bail. The police should liaise proactively with the mental health team caring for the person during this process.		Process Document

[3] 1 clinician who have assessed the patient and will care for the patient will make clinical decisions on admission and level of security.
2.Decision on level of security and admission is a clinical decision not operational. Operational leaders will not be decision makers, whilst ensuring that senior clinicians do carry out an assessment

4. Related documents

Mental Health in Custody Toolkit, As adopted by the WMP from the Metropolitan Police Service, 2021 and the association of chief police officers and National college of policing.

British Transport Police in Custody Document, British Transport Police
Access to Mental Health Inpatient Services ("the Compact"); NHS England, July 2022

Physical Health Assessment and Treatment Protocol (reference and link to be added when available via Custody health care provider)
S136 pathway (reference and link to be added when completed and approved)

Code of practice: Mental Health Act 1983, Department of Health and Social Care, January 2015
Mental Health Act 1983,

Appendix 11

REFERRAL AND MENTAL HEALTH ASSESSMENT BY SECONDARY MENTAL HEALTH SERVICES FOR A DETAINED PERSON IN POLICE CUSTODY(SUITE/STATION)

Pathway and Process for Referral

1. **For detained person subject to PACE.**

a) A referral for secondary mental health care assessments can be made either by the Health and Justice Vulnerability service/ Liaison and Diversion Services or PCHCP.
b) For those detained persons already open to a specific secondary mental health team (home treatment team, CMHT, assertive outreach team, early intervention psychosis team, secure care FIRST team etc.) the referral would be made directly to the team to which the patient is currently open in hours.
c) A referral would be made with a target time of 3 hours of the commencement of the PACE clock enabling sufficient time to be available for appropriate decision making and assessment as necessary.
d) The following documents either directly uploaded to RiO or completed on RiO or sent by email as word documents would be necessary for any referral to be considered. Referrals without sufficient information may be returned seeking further information:
    i. Assessment summary being updated or completed on RiO or equivalent word document.
    ii. Level 1 risk assessment updated or completed on RiO or equivalent word document.
    iii. Fitness to be detained, fitness to be interviewed template from the Forensic Faculty of the Royal College of Physicians completed by the PCHCP (custody healthcare professional).
    iv. Current custody record.
    v. Antecedents, i.e., past convictions with details of outcomes, dates and times.
    vi. Information regarding current reason for detention in custody (information from form MR6 or equivalent).
    vii. Mental capacity assessment for accepting treatment and accepting of admission (if relevant) as assessed under form Mental capacity form 2A and 3A on RiO under mental capacity assessment forms (all Persons in custody assessed as lacking capacity to accept treatment or accept admission would proceed under the Mental Health Act assessment process).
e) Once the above documents are received, the relevant team (consultant/ team manager/senior doctor/clinical lead /senior most clinician on duty at that time) to which the patient is open would make a decision on whether an assessment would occur in custody or post-release and what follow up or further care would be provided.
f) Individuals who have been assessed to lack capacity whether detained under PACE or Section 136 of the Mental Health Act would receive a Mental Health

Act assessment (as assessed under MCA form 2 and 3 on RiO or equivalent).

g) Those unwilling to engage in an assessment or assessed unwilling to cooperate with an assessment or unwilling to accept treatment or care would also require an assessment under the Mental Health Act when considered to require admission or ongoing care based on other collateral information.
h) Advice may be provided by the secondary care mental health service– that a mental health act assessment may be more appropriate this would be determinative.
i) For those persons in police detention under PACE who are not open to any secondary mental health team/service on RiO, the Health and Justice Vulnerability service /Liaison and Diversion service/custody healthcare practitioner can make a referral to an appropriate service based on assessment of need, including home treatment team services. As above, the relevant home treatment team or relevant service would make a decision as to where (in custody or post release in the community) and when an assessment would take place.

2. Those detained in police custody under Section 136 of the Mental Health Act or deemed to require a mental health act assessment.

a) No person can be detained in police custody without lawful basis. Therefore, those detained in police station custody when not detained under PACE would have to be detained under Section 136 of the Mental Health Act.
b) All individuals detained under Section 136 of the Mental Health Act would receive a Mental Health Act assessment jointly via the AMHP and appropriate Section 12 approved doctor from secondary mental health services.
    i. For those patients already open to specific teams in secondary mental health services a Section 12 approved doctor/doctor from the relevant team would participate in such a Mental Health Act assessment in hours. Where this is not possible a Section 12 approved doctor from the Section 12 approved rota for BSMHFT would participate in the Mental Health Act assessment in exceptional cases.
c) For all individuals detained under Section 136 of the Mental Health Act or lacking capacity to accept treatment or care or admission or unwilling to engage in an assessment or unwilling to accept treatment or care a Mental Health Act assessment would occur coordinated by the AMHP from the local authority and either the team doctor (for those patients who are open to a team) or a Section 12 approved doctor from BSMHFT approved rota in hours. The AMHP would request a further independent doctor via the normal process.
d) The following documents as a minimum would be necessary and should be made available to the AMHP for consideration of appropriateness of a Mental Health Act assessment. They would need to be completed/updated as fully as possible with all relevant information. Databases including RiO, relevant available GP medical record systems, Police National Computer System including custody records would need to be accessed jointly by the Health and Justice Vulnerability service/ Liaison and Diversion service and the custody healthcare practitioners for the completion of the below documentation. A Mental Health Act assessment is a restrictive intervention

and to be able to reach a human rights compliant decision a comprehensive medical examination and social care assessment would need to occur as part of the Mental Health Act assessment and therefore the below documentation being available prior to commencement of a Mental Health Act assessment is necessary.

i. A mental capacity assessment to accept care and treatment and to accept admission (completed on RiO MCA form 2, 3 or equivalent word document).
ii. Fitness to be detained, interviewed assessment template of the Forensic Faculty of the Royal College of Physicians being completed by the custody healthcare practitioner.
iii. RiO assessment summary.
iv. RiO level 1 risk assessment.
v. Antecedents (past convictions) as detailed on the Police National Computer, including dates and outcomes.
vi. Current custody record detailing current index allegation and current progress in custody.

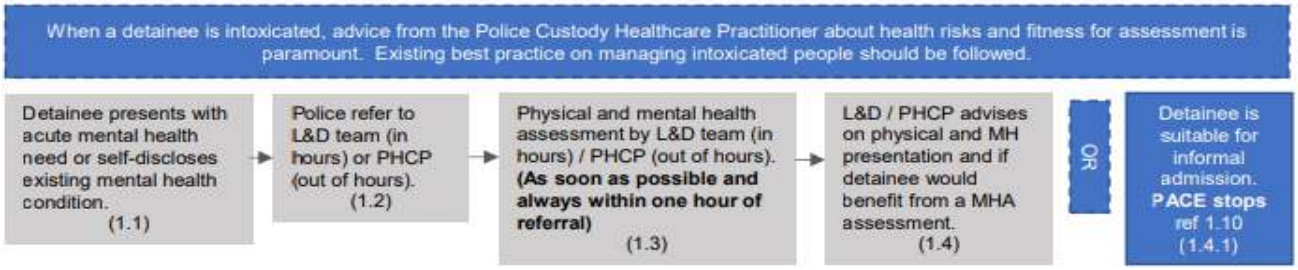
All the above documentation would need to be emailed to the AMHP for consideration of the appropriateness of a Mental Health Act assessment.

e) If the AMHP is in doubt regarding appropriateness of a Mental Health Act assessment (for those not detained under section 136), further discussion and further information may be sought from the referrer (Health and Justice Vulnerability service/ Liaison and Diversion practitioner or Police custody healthcare practitioner).
f) If there is further doubt, a discussion may be had with the Section 12 approved doctor on the Section 12 approved rota of BSMHFT during working hours or the adult consultant on-call for out of hours for BSMHFT by the AMHP. The advice provided by the Section 12 approved doctor/on-call consultant psychiatrist having considered all the above information would be determinative if there is a disagreement between the Health and Justice Vulnerability service/ Liaison and Diversion service / PCHCP and the AMHP service.
g) It would be expected that nearly all Mental Health Act assessments would occur in working hours of the home treatment teams wherever possible so that relevant support can be provided. Therefore, it is essential for individuals detained under PACE that any referral for a Mental Health Act assessment occurs in the early stages of the PACE clock, i.e., within 3 hours.
h) Out of hours Mental Health Act assessments would include for BSMHFT cases a section 12(2) doctor from BSMHFT out of hours Rota. On call adult consultant Psychiatrist can be contacted by the AMHP for this to be facilitated. If deemed necessary by the Adult on call Consultant Psychiatrist (based on a discussion between the Adult On call consultant psychiatrist and Secure care Consultant Psychiatrist and review of the documents set out above in d) i to v) this may also include a second section 12 doctor from the Secure care on call rota .

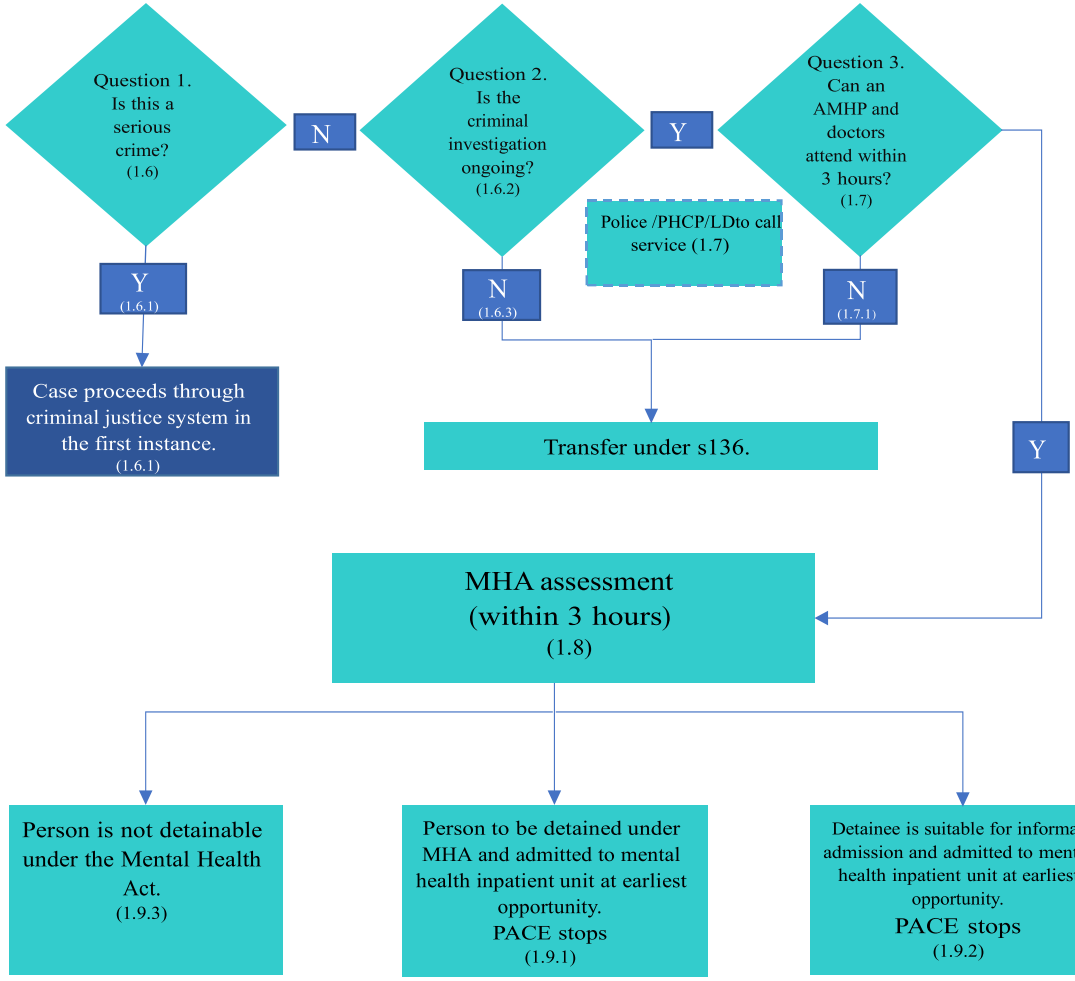
For those detained under Section 136 of the Mental Health Act in police station custody a target time of 3 hours for a Mental Health Act assessment

to occur would be set. For the 3-hour period the person detained in custody would remain detained in custody under Section 136 at the police custody suite.

Flow chart for people in police custody who require urgent mental health care.
This flow chart should be read in conjunction with the accompanying protocol.



Structured tool to support police decision on use of s136 or making a request for MHA assessment. (1.5)



Police decide whether to Bail, charge and bail, charge and remand, no further action (NFA) (1.10)

Glossary

AMHP	Approved Mental Health Professional
ED	Emergency Department
HBPoS	Health Based Place of Safety
L&D HJV service	Health and Justice Vulnerability service/ Liaison and Diversion
MHA	Mental Health Act, 1983
WMP	West midlands Police
PACE	Police and Criminal Evidence Act 1984
PHCP	Police Custody Healthcare Practitioner
s12 Dr	Section 12 Approved Doctor
s136	Section 136 of the Mental Health Act 1983