Service Evaluation Report: Use of Sections 2 and 3 of the Mental Health Act in BSMHFT

1. Introduction

This report evaluates the application and use of Sections 2 and 3 of the Mental Health Act (MHA) by Section 12 approved Doctors (healthcare professionals) in BSMHFT . It particularly focuses on trends, decision-making challenges, and influencing factors.

Data sources

1.A service evaluation online anonymous survey of all section 12 approved doctors in BSMHFT ,

2.statistical insights, and data available from national datasets for BSMHFT .

2. Understanding Sections 2 and 3

2.1 Criteria for Applications under section 2 and 3 of the Mental health act

- **Section 2:** Applied when a patient requires short-term assessment and treatment (up to 28 days) due to a mental disorder requiring hospital admission for assessment and treatment.
- **Section 3:** Applied for longer-term treatment when the patient's condition is well understood, requiring hospital detention including beyond 28 days.

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.

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

1.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

2.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

3.Appropriate medical treatment is available

2.2 Considerations for Application

- **Nature and Degree of Disorder:** Severity, chronicity, and past treatment responses are evaluated.
- **Protection of Others:** Risk factors, including previous history and likelihood of harm, are considered.
- **Alternatives to Detention:** Informal admission is preferred if the patient has capacity and consents.
- **Legal Conflicts:** Mental Health Act (MHA) versus Mental Capacity Act (MCA) considerations, particularly in fluctuating capacity cases.
- **Section 2 should only be used if**:

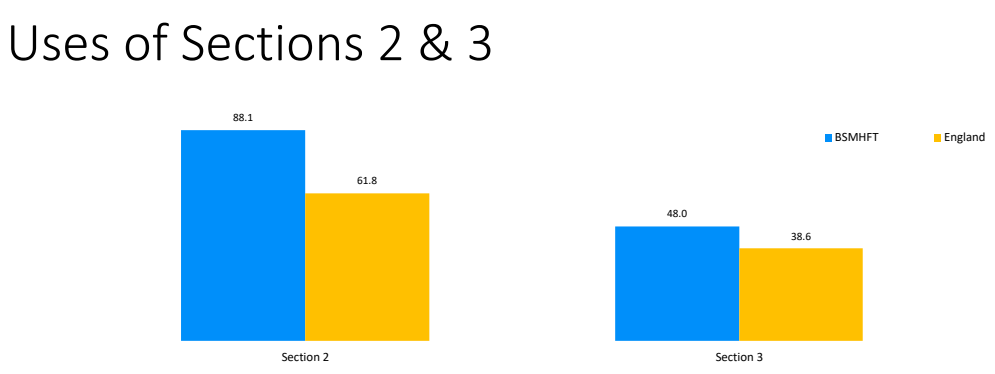
the full extent of the nature and degree of a patient's condition is unclear there is a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission, or there is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis.

- **Section 3 should be used if**:

the patient is already detained under section 2 (detention under section 2 cannot be renewed by a new section 2 application), or the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment as an informal patient are already sufficiently established to make it unnecessary to undertake a new assessment under section 2.

- The rationale for decisions to use section 2 or section 3 should be clearly recorded

3. Statistical Overview and Service Evaluation



Comparing the rate of use of Sections 2 and 3 per 100 000 population between BSMHFT and England.

Note that a renewal of a Section 3 does not count as a 'use' of Section 3 in this comparison.

3.1 Key Factors Influencing Section 2 vs Section 3 Decisions

A variety of factors influence the decision to use Section 2 instead of Section 3, including bed shortages, administrative barriers, and policy constraints. Figure 3 provides a breakdown of these key decision-making influences.

3.2 Reasons for AMHP Resistance to Section 3

AMHPs play a critical role in mental health assessments, and their resistance to Section 3 applications is influenced by several factors, including legal constraints, resource limitations, and lack of consensus among professionals. Figure 4 illustrates the key reasons for this resistance.

3.3 Use of Sections 2 and 3

A comparative analysis of the use of Sections 2 and 3 per 100,000 population between Birmingham and England highlights variations in application rates. Graphical data (Figure 1) illustrates how Birmingham exhibits a higher reliance on Section 2 compared to the national average, indicating potential systemic preferences or constraints.

3.4 Survey Findings (50 Respondents)

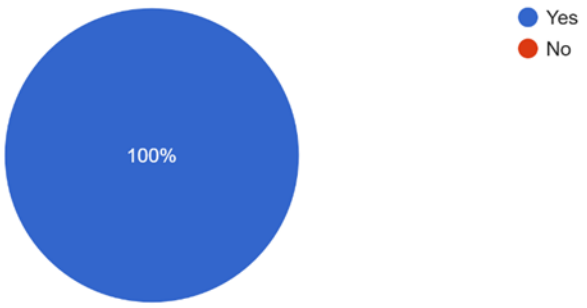
A survey was conducted of All Section 12 approved doctors in BSMHFT asking them

Are you Section 12(2) approved?

- Yes: 100%
- No: 0%

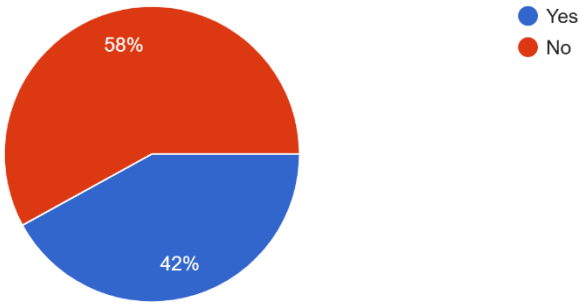
42% of section 12 approved doctors Said they had made section 2 recommendations when section 3 would have been more appropriate in their view

Are you approved under Section 12 (2) of the Mental Health Act?
50 responses



- **Have you recommended Section 2 when Section 3 seemed more appropriate?**
  - Yes: 42%
  - No 58%

In the last 5 years, have you made a Section 2 recommendation, where you felt a Section 3 recommendation would better given more resources?
50 responses



- **Key Reasons for Choosing Section 2 Over Section 3 when you did not want to :**
  - 37% due to AMHP resistance
  - 45% due to lack of beds
  - 18% due to institutional policies i.e section 2 being seen as less restrictive in training and reference resources or similar

4. Challenges in Decision-Making

4.1 Influences on Decision-Making

- **AMHP Preferences:** Many respondents noted resistance from Approved Mental Health Professionals (AMHPs) towards Section 3 applications.
- **Resource Constraints:** The unavailability of beds was a major factor influencing decisions, with practitioners opting for Section 2 due to its lower administrative burden.

- **Policy Restrictions:** Institutional policies, particularly in University Hospitals Birmingham (UHB), discourage direct application of Section 3.
- **Legal and Bureaucratic Hurdles:** Concerns about completing Section 3 paperwork and finding appropriate hospital placements deter its use.

4.2 Notable Comments from Respondents

- **Themes**
- AMHPs often insist on Section 2 due to its less restrictive nature, even when the patient has a clear established mental illness and treatment plan and history are clear . This preference may stem from a belief that Section 2 allows for a more flexible and immediate approach to patient care, minimizing burdens such as need for consent from the nearest relative Additionally, AMHPs may be influenced by concerns over identified bed availability when the mental health act assessment occurs , which can make Section 3 recommendations more difficult to coordinate and Secure . i.e section 3 recommendation requires name of the hospital to be noted .
- However, this reliance on Section 2 can lead to repeated short-term rather than sustained treatment plans, potentially impacting long-term patient outcomes.
- In many cases, the refusal to approve Section 3 was considered by respondents to be linked to social service challenges in arranging aftercare.(section 117)
- Some professionals reported that AMHPs were reluctant to use Section 3 outside of standard hours.
- The absence of identifiable beds often led to Section 2 being preferred to avoid delays.

I've had an AMHP forcefully argue with me that a 'section 2 is least restrictive' even when a patient has an established diagnosis, does not need any period of assessment and had a clear treatment plan

Usually AMHP do not agree with the decision to go for sec 3. It is not that the AMHP suggest sec 2, it is that they are actively against it as much as they can. Unless I have very strong evidence and grounds for section 3 I cannot peruse it. For the AMHP sec 3 comes with 117 meeting aftercare and arranging for that it is a challenge for social services and amhp. Another reason is lack of bed.

AMHPs prefer section 2

Mostly due to AMHP refusing to make application if the recommendations were Section 3 or when we are unable to state where the patient will be admitted.

Amhp and second doctor reluctant to put patient on section 3 when admitted informally, if they have not been on section 2 in the last few weeks

Patient not known to me or not been under 3. Issues with beds

AMPH suggested

No identifiable bed, social worker felt it was a more favourable option for patient

Lack of beds availability

Because UHB policy supports Section 2 to start with and discourages straight Section 3, UHB objects and wants to know the rationale of jumping a hoop.

AMHP was insistent that s2 was used in all cases, despite patient(s) being known to services and not a significant change in their typical presentation when unwell

Suggested as easier option as no specific hospital bed has been identified and to avoid delay in completing paperwork.

I work in secure services and may not reflect the resource issues in the wider trust

Pressure on beds, concerns around patient being stuck in hospital

Patient has not been detained under MHA for the last few years, hence suggestion was to use a S2 instead of S3, although patient was known to MHS/CMHT.

Patient's nearest relative objected to s3 and it was an urgent situation that required detention in hospital.

I was persuaded to do section 3 due to lack of beds. There have been many times when the section 3 has been to section 2 by the AMHPs.

I am aware that this has been an issue with my colleagues. I believe the AMHPs are often reluctant to go for Section 3, even when there is clear history and consistent patter in presentation.

I haven't done this for a long time, but definitely at some point in the last 5 years. There was a push from AMHP to go for Section 2 due to lack of beds and difficulty in finding the medics again to add the hospital name once a bed was found if we went for Section 3. Also difficulty for medics to know what to put on the Section 3 form for hospital name when no idea where bed may be found. Has felt more of a problem in Birmingham than Solihull.

Lack of availability of beds

AMHP did not accept S2 because, according to them, S2 would be the least restrictive option.

AMHPs out of hours have not supported the use of Section 3 even for patients with well established patterns of illness and clear relapse of such, citing less restrictive practice.

Section 3 was indicated but there was no known bed which could have been put on the application

5. Recommendations

1. **Policy Review and Standardization:** Develop clearer guidelines for when Section 3 should be applied to reduce inconsistencies. This responsibility should be undertaken

by BSMHFT and BCC Jointly as lead agencies , ensuring alignment with best practices and resource availability.

2. **Training and Collaboration:** Enhance training sessions for AMHPs and medical professionals to align decision-making practices and ensuring that section 3 is used where appropriate and neither section 2or 3 are considered more or less restrictive
3. **Improve early identification of hospitals where Bed availability will occur so that Doctors can make section 3 recommendations** .
4. **Resource Allocation:** Address bed shortages and administrative bottlenecks that limit Section 3 applications.
5. **Monitoring and Feedback:** Establish an working group to review Section 2 versus Section 3 decisions and identify areas for improvement.
6. **Data-Driven Decision Making:** Utilize real-time statistics and trend analysis to inform policy adjustments and improve Section 3 application rates.

6. Conclusion

This evaluation highlights significant barriers affecting the appropriate use of Sections 2 and 3 of the MHA, particularly due to AMHP resistance, administrative challenges, and resource i.e bed constraints. To address these issues, the report recommends policy standardization led by the BSMHFT and the BCC AMHP service , enhanced training for AMHPs and medical professionals, improved resource allocation to reduce bed shortages, and the establishment of an oversight committee/ working group to monitor decision-making practices. Additionally, leveraging data-driven approaches can help refine future policy adjustments and ensure better long-term patient care outcomes. The graphical insights presented further reinforce the systemic issues at play. Addressing these concerns through structured policy adjustments, increased training, and better resource allocation can lead to improved decision-making in mental health services. Future studies should continue analyzing trends in order to refine recommendations further.

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