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| **Document name:** | Section 132, 132A and 133 patients’ rights policy |
| **Document type:** | Mental Health Act |
| **What does this policy replace?** | Update of previous policy |
| **Staff Group to Whom it Applies:** | All mental health staff throughout the Trust |
| **Distribution:** | The whole of the Trust |
| **How to Access:** | Intranet |
| **Issue Date:** | Version 5  November 2022 |
| **Next Review:** | November 2025 |
| **Approved By:** | Executive Management Team on 24 November 2022 |
| **Developed By:** | Assistant Director of Legal Services |
| **Director Leads:** | Director of Nursing, Clinical Governance and Safety  Medical Director |
| **Contact for Advice:** | Mental Health Act administration |

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Duties of Hospital Managers to give information to detained patients and the Nearest Relative under the MHA 1983

# Introduction

Section 132/132A/133 Mental Health Act 1983 (MHA) applies to all patients who are detained or subject to a Community Treatment Order (CTO). It places a duty on the hospital managers to provide certain information to patients and their Nearest Relative (NR), regarding which section of the MHA they are subject to and the effects of that section. The hospital managers are the trust as a body. Under the Mental Health Act, they have the authority to delegate this duty to staff within the trust.

This policy should be read in conjunction with Chapter 4 of the Code of Practice (2015) and Reference Guide to the Mental Health Act 1983 (2015) chapters 9 and 31.

In order to fulfil their statutory duties hospital managers should ensure that:

1. the correct information is given to the patient/nearest relative (with patient consent)
2. the information is given in a suitable manner, in a format or language that the patient understands, at a suitable time and in accordance with the law;
3. the member of staff who is to give the information has received adequate guidance and is aware of the key issues regarding the information to be given.
4. A record is kept of the information given, including how, when and by whom it was given, and an assessment made of how well the information was understood by the recipient.
5. Regular checks are made that the information has been properly given to each patient, and understood by him or her.
6. Informal patients should be informed of their legal position and rights.

# Guidelines

The information must be given to patients as soon as practicable after the commencement of the patient’s detention or CTO and as soon as practicable after a different section of the Act is used to authorise detention or recall under CTO. In practice this will mean that the patient will have to be told immediately if they are detained for 72 hours or less. Informal patients must be informed of their rights on admission.

The information must be given both orally and in writing and in a suitable manner. Where required, interpreters or people with specialist expertise in sign language should be arranged by staff who have responsibility of the patient. The patient must be given a copy of the statutory information leaflet provided by the Department of Health.

The patient must be informed of the advocacy services and legal services that are available to them in regard to their care and treatment.

There is a statutory duty to inform patients detained under specific sections of their right of access to an Independent Mental Health Advocate (IMHA).

Guidance contained in The Code of Practice (2015) is that the following information should be given to the patient:

## Information on detention/CTO, renewal and discharge

The patient must be informed:

* of the provisions of the Act under which they are detained or subject to a CTO and the effect of those provisions
* of the rights (if any) of their nearest relative to discharge them (and what can happen if their responsible clinician does not agree with that decision)
* for community patients, of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their responsible clinician may recall them to hospital, and
* that help is available to them from an IMHA, and how to obtain that help

As part of this, they should be told:

* the reasons for their detention or CTO
* the maximum length of the current period of detention or CTO
* that their detention or CTO may be ended at any time if it is no longer required or the criteria for it are no longer met
* that they will not automatically be discharged when the current period of detention or CTO ends
* that their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends
* the reasons for being recalled, and
* for patients’ subject to a CTO, the reasons for the revocation of a CTO.
* Patients should also be told the essential legal and factual grounds for their detention or CTO. For the patient to be able to adequately and effectively challenge the grounds for their detention or their CTO, should they wish, they should be given the full facts rather than simply the broad reasons. This should be done promptly and clearly. They should be told they may seek legal advice, and assisted to do so if required.
* A copy of the detention or CTO document should be made available to the patient as soon as practicable, unless the hospital managers are of the opinion that this would adversely affect their health.

## Information about recall to hospital

* Where a patient is recalled to hospital from a CTO the responsible clinician should give (or arrange for the patient to be given) oral reasons for the decision before the recall.
* Where a conditionally discharged patient is to be recalled to hospital, a brief verbal explanation of the Secretary of State’s reasons for recall must be provided to the patient at the time of the recall, unless there are exceptional reasons why this is not possible. The patient should also receive a full explanation of the reasons for recall, both orally and in writing, within 72 hours of admission.
  1. **Information on consent to treatment**

Patients must be told what the Act says about treatment for their mental disorder. In particular, they must be told:

* the circumstances (if any) in which they can be treated without their consent – and the circumstances in which they have the right to refuse treatment
* the role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved, and
* (where relevant) the rules on electro-convulsive therapy (ECT) and medication administered as part of ECT

## Information on applications to tribunal

Patients must be informed:

* Of the rights of the responsible clinician and the tribunal to discharge them (and for restricted patients that this is subject to the agreement of the Ministry of Justice).
* Of their right to apply to the tribunal;
* About the role of the tribunal;
* How to apply to the tribunal;
* How to contact a suitably qualified legal representative;
* That free legal aid is available.
* How to contact any other organisation which may be able to help them make an application to the tribunal, e.g. advocacy services.
* It is particularly important that patients on CTO who may not have daily contact with people who could help them make an application to the tribunal are informed and supported in this process.
* CTO patients whose community treatment orders are revoked, and conditionally discharged patients recalled to hospital, should be told that their cases will be referred automatically to the tribunal.

This information should be provided whenever:

* The patient is first detained or discharged onto a CTO
* Whenever their detention or guardianship or CTO is extended
* Whenever their status under the Act changes.

## Information on applications to the hospital managers

Patients must be informed:

* That the responsible clinician and the hospital managers have the authority to discharge them. It should be noted that where a patient appeals against section 2 to both the tribunal and hospital managers’ priority will be given to the tribunal appeal.
* That the hospital managers must consider discharging them when their detention is renewed or their CTO is extended.
* Of their rights to apply to the hospital managers;
* About the role of the hospital managers;
* How to contact a suitably qualified representative.
* That free legal aid may be available
* How to contact any other organisation, which may be able to help them make an application such as advocacy services

## Information about the Care Quality Commission

Patients must be informed:

* About the role of the CQC
* When the Commission is to visit a hospital or unit;
* Of their right to meet visitors appointed by the CQC in private
* Of their right to complain to the CQC and the process for this.
* The patient should also be given information about the Trust’s complaints system.

## Nearest relative procedure and practice

The nearest relative of the patient must be informed as soon as practicable and supplied with copies of any information given in writing to the patient: (subject to the consent of the patient):

* Details of the section
* Renewal/extension of CTO
* Right of appeal to the hospital managers
* Right of appeal to the tribunal
* Transfer from one hospital to another
* Details of discharge from detention or CTO

The Mental Health Act office will be responsible for writing to the nearest relative on admission and discharge. This should not prevent the care team from continuing with communication between themselves and carers.

The remaining duties listed at (g) above are the responsibility of the care team.

## Communication with other people nominated by the patient

Patients can nominate one or more people who they would wish to be involved in, or notified of, decisions relating to their care or treatment. These may include an IMHA, legal representative, carer or other informal supporter or advocate.

## Informal patients

Informal patients must be told:

* Why they have been admitted to the ward and the proposed treatment they will receive.
* Of their right to leave the ward at any time and how to get the ward door unlocked to allow them to enter and leave.
* That treatment cannot be given without their consent, which can be withdrawn at any time.
* That they can be supported by an advocate, family member or friend.
* That the ward will not share details of their admission or treatment with family or friends unless the patient agrees.
* How to contact an advocate.
* The hospital complaints procedure.

# Procedure

At the commencement of a patient’s detention under the MHA or becoming subject to CTO the patient must be given their rights orally and in writing, unless it is not practicable at that time.

The information under section 132/132A must be given to the patient by a registered nurse to ensure that information regarding treatment issues can be answered.

When giving the patient information orally it should be explained as clearly as possible and the patient must be given the opportunity to ask questions to clarify the information they are being given. This may also be helpful in deciding if the patient has understood their rights. It is not acceptable to just read out the information on the information sheets.

The nurse must complete the section 132 recording form on SYSTM 1. All further iteration of rights must be recorded on SYSTM1 – specifically in the patient’s rights recording section.

If the patient wishes to appeal to the hospital managers or tribunal, standardised forms/letters are available from the Mental Health Act office. When completed these forms must be sent to the local MHA office.

In the event that the patient is unable to receive or understand their rights on the application of a section of the Mental Health Act, the professional responsible for giving the patient his/her rights, must formulate a care plan to address this need and has a duty to consider referring the patient to an Independent Mental Health Advocate (IMHA) if appropriate.

The patient should be read their rights on a daily basis until the member of staff feels that the patient understands, or the multidisciplinary team and independent mental health advocate agree that the patient’s cognitive condition will never improve to the level that the patient will understand their rights. This must be recorded on SYSTM 1 section 132 patient’s rights module.

When the patient has been given their rights it must be recorded in the ward diary when they are due to have their rights reiterated.

Where a patient has the need for an interpreter or other augmented communication, a care plan should be raised and appropriate support sought throughout the period of care.

Independent interpreters should always be sought, however in the case of emergencies staff should consult with their manager or the manager on call regarding the appropriateness of using relatives or carers. If this issue occurs it should be fully documented in the patient records.

# Definitions

|  |  |
| --- | --- |
| Code of Practice | The Mental Health Act Code of Practice 2015 |
| Section 132. 132A and 133 | Sections of the mental Health Act 1983 which relates to informing patients about their rights |
| Detained patient | A patient detained in hospital under the MHA. |
| Informal patient | A patient who has agreed to stay in hospital of their own volition. |
| CTO | Community Treatment Order |
| Hospital Managers | Independent people appointed by the hospital, under the MHA, to be responsible for certain aspects of the MHA, review patient’s detention and monitor the use of the MHA. |
| Mental Health Act Office | The department of the hospital responsible for ensuring that the paperwork and practice relating to detention of patients under the MHA. |
| MHA | Mental Health Act 1983. |
| Ministry of Justice | The department of government responsible for approving leave for restricted patients. |
| MoJ | Ministry of Justice |
| Responsible clinician | An approved doctor authorised under the MHA as the doctor responsible for the treatment of a detained patient. |
| Restricted patient | A patient who has been directed to be detained in hospital by a court and who has restrictions placed on them, including their entitlement to leave. |
| Secretary of State for Justice | The government minister responsible for the management of patients detained in hospital by a court. |
| Community Treatment Order | A provision of the Mental Health Act which allows a patient to live outside of the hospital, but can be recalled to hospital if the responsible clinician considers this necessary |
| IMHA | Independent Mental Health Advocate |
| Independent Mental Health  Advocate | An independent person recognised under the Mental Health Act, who is able to support detained patients with their rights. |

# Duties

1. Trust Board is responsible for approving the policy, its dissemination and implementation.
2. The Hospital Managers are responsible for approving the process relating to informing patients of their legal rights under the MHA. They are responsible for monitoring the adherence and effectiveness of the policy and advising when the policy needs reviewing.
3. The Lead Director is responsible for ensuring that the policy has been developed in line with the trust policy for the development, approval and dissemination of policy and procedural documents.
4. General managers, clinical leads and team managers are responsible for ensuring that staff in their area of responsibility are aware of their responsibilities under the policy and that they follow the policy.
5. Medical, nursing and other clinical staff are responsible for ensuring that their actions comply with the policy.
6. Mental Health Act Office staff are responsible for advising on the practice related to the policy insofar as it is governed by the Mental Health Act 1983.

# Principles

This updated policy seeks to operationalise sections 132, 132A and 133 of the MHA and the statutory guidance within the Code of Practice and the guidance. It seeks to ensure that all detained patients are aware of the effects of their detention under the MHA and their rights within that detention.

# Equality impact assessment

The policy has had an equality impact assessment, (appendix 2). There were no groups on whom the policy had a more negative impact than others.

# Dissemination and implementation arrangements

The policy will be disseminated through the trust information channels and through professional groups.

# Monitoring arrangements

The Hospital Managers will monitor the arrangements through the Mental Health Act Committee. They will be supported by the Mental Health Act Office.

# Review and revision arrangements

The policy will be reviewed by the Assistant Director, Legal Services on behalf of the Hospital Managers and accountable director by the review date, or earlier if required. Previous copies will be archived in line with trust procedures.

# References

Mental Health Act 1983

Department of Health (2015) Mental Health Act 1983: Code of Practice, TSO

# Associated Documents

Department of Health (2015) Reference Guide to the Mental Health Act 1983, TSO

Mental Capacity Act (2005)

# Appendix 1

# Section 132 Recording

Record on SYSTM 1

Use section 132 Tab

# Appendix 2

# Equality Impact Assessment

**Date of EIA: 2nd August 2022 Review Date:**

**Completed By: Yvonne French**

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|  | **QUESTIONS** | **ANSWERS AND ACTIONS** |
| **1** | **What is being assessed?**  Prompt: what is the function of this document (new or revised) | **Section 132 Mental Health Act - Patients’ Rights .** |
| **2** | **Description of the document**  Prompt: What is the aim of this document | **The overall aim of the document is to describe the Trust approach to the use of Section 132 Mental Health Act 1983.**  **To provide guidance to clinicians on its application**  **To provided guidance to MHA administrators re the application of Section 132 Mental Health Act 1983 and its legal powers.** |
| **3** | **Lead contact person for the Equality Impact Assessment** | **Yvonne French: – Assistant Director Legal Services** |
| **4** | **Who else is involved in undertaking this Equality Impact Assessment** | **Mental Health Act Administration manager (Trust Wide)**  **Clinical Legislation Manager**  **Equality and involvement manager** |
| **5** | **Sources of information used to identify barriers etc**  Prompts: service delivery equality data – refer to equality dashboards ([BI Reporting - Home (sharepoint.com)](https://swyt.sharepoint.com/sites/BIReporting) satisfaction surveys, complaints, local demographics, national or local research & statistics, anecdotal. Contact [InvolvingPeople@swyt.nhs.uk](mailto:InvolvingPeople@swyt.nhs.uk) for insight  **What does your research tell you about the impact your proposal will have on the following equality groups?** | **Data used was from the quarterly MHA performance report which is presented to the Mental Health Act Committee on a quarterly basis.**  **The data covers the period April 2021 – March 2022.**  **information contained in the quarterly reports regarding its use and any complaints that have been received in the application of Section 132.**  **Some data has been used from the national census 2011 and from the Trust BI reporting.**   * The Trust split of 77.9% female to 22.1% male is reflected approximately across most areas, except for Medical Staff (36%/64%). As in previous years, female staff make up over three quarters of Trust staff * As in previous years, the highest number of Trust staff fall in the age bands 40-49 and 50-59 with over 55% of the total staff being between 40 and 59. Just over 42% of medical staff are between 40 and 49. Support Services have the highest percentage of staff in the 60-69 age bands with 14% (102) being 60 or over * The data shows that 6.1% of our staff consider themselves to have a disability, the same figure as last year. The total number of staff is 266, this is an increase of 11 since last year. * The Trusts staff profile has a larger White British representation than the local demographic of the people that it serves collectively. Trust wide, 90% of the total staff in post are white British which is similar to previous years and equates to an over-representation of 1.3% (last year 1.1%). Mixed race staff are underrepresented by 0.2%, Chinese staff are over-represented by 0.2%, Black staff are over-represented by 1.6% and South Asian staff are under-represented by 3.2%. However, the Trust’s local demographic has large variation in BAME representation and there is a significant under-representation of South Asian staff in Kirklees/Calderdale (exact figures not available due to mixed teams) * The number of staff who have not stated their religious belief (Unknown) has decreased slightly from 2018 (23%) to just below 21% currently. Staff reported as 48% Christianity, 3%Islam, 12% other and 17% Atheism. * There has been a significant increase in the number of staff reporting their religion and sexual orientation. Currently 83% of staff have provided data indicating their sexual orientation, which is a slight improvement on last year’s figures. |
| **5a** | **Disability Groups:**  Prompt: Learning Disabilities or  Difficulties, Physical, Visual, Hearing  disabilities and people with long term  conditions such Diabetes, Cancer,  Stroke, Heart Disease etc. Accessible information standard | **Section 132 is prescribed in law and does not discriminate on grounds of disability.**  **However, because its use can be applied to people who may have a disability it is crucial that all efforts are made to have effective communication with the person when assessing for mental disorder to eliminate any unintentional discrimination.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Disability** | **All Patients**  **2021/22** | **All Patients**  **2022/23** | | Disability NOS | **118** | **37** | | Disability status not given - patient refused | **118** | **50** | | Not disabled | **1473** | **577** | | Not Recorded | **786** | **252** | | Registered disabled | **130** | **57** |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com)**  **Section 132 can only be applied in an in patient setting, hence the inpatient data and not overall data applicable to the Trust activity.** |
|  | **QUESTIONS** | **ANSWERS AND ACTIONS** |
| **5b** | **Gender:**  Prompt: Female & Male issues should be considered | **Section 132 is prescribed in law and does not discriminate on grounds of gender.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Gender** | **All Patients**  **2021/22** | **All Patients**  **2022/23** | | **Male** | **1527** | **581** | | **Female** | **1066** | **389** | | **I** | **1** |  | | **U** | **1** | **3** |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com). All in-patients are subject to section 132 MHA** |
| **5c** | **Age:**  Prompt: Older people & Young People issues should be considered | **The application of the Section 132 is not broken down into age groups and therefore unable to provide any analysis or conclusion.**  **The use of section 132 is statutory for all in-patients. This part of the Act is implemented to ensure that patients are aware of their when receiving care in an in-patient mental health unit or are detained under the Mental Health Act.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Age Band** | **All Patients**  **2021/22** | **All Patients**  **2022/23** | | **Under 16** | **3** |  | | **16-17** | **29** | **1** | | **18-29** | **447** | **184** | | **30-39** | **532** | **180** | | **40-49** | **384** | **165** | | **50-59** | **498** | **135** | | **60-69** | **339** | **126** | | **70-79** | **301** | **124** | | **80-89** | **145** | **50** | | **90+** | **19** | **8** |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com)** |
| **5d** | **Sexual Orientation:**  Prompt: Heterosexual, Bisexual, Gay,  Lesbian groups are included in this  Category | **The reporting of section 132 is not reported against in relation to sexual orientation.**  **This policy does not affect any group unfavourably.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Sexual Orientation** | **All Patients**  **2021/22** | **All Patients**  **2022/23** | | Heterosexual | **1870** | **270** | | Not Recorded | **583** | **202** | | Sexual orientation unknown | **57** | **17** | | Sexual orientation not given - patient refused | **25** | **10** | | Bisexual | **25** | **10** | | Male homosexual | **21** | **7** | | Female homosexual | **16** | **7** |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com).** |
| **5e** | **Religion & Belief:**  Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered | **The use of Section 132 is not broken down in to religion or belief. This policy does not apply the Act in a manner that has bias towards any particular group.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Religion** | **All Patients**  **2021/22** | **All Patients**  **2022/23** | | **Not religious** | **548** | **221** | | **Not Recorded** | **407** | **144** | | **Christian** | **455** | **177** | | **Muslim** | **206** | **81** | | **Declines to disclose religious beliefs** | **227** | **113** | | **Church of England, follower of religion** | **188** | **51** | | **Religion not given - patient refused** | **116** | **38** | | **Patient religion unknown** | **109** | **27** | | **Religion NOS** | **76** | **34** | | **Church of England** | **60** | **17** | | **Religion (Other)** | **54** | **20** | | **Roman Catholic** | **39** | **14** | | **Christian religion** | **24** | **9** | | **Atheist** | **15** | **3** | | **Sikh** | **11** | **5** | | **Agnostic** | **10** | **2** | | **Methodist** | **10** | **4** | | **Spiritualist** | **6** | **3** | | **Nonconformist** | **5** | **1** | | **Pagan** | **5** | **1** | | **Anglican** | **4** |  | | **Buddhist** | **4** |  | | **Religious affiliation** | **4** | **1** | | **Protestant** | **3** |  | | **Apostolic Pentecostalist** | **1** | **1** | | **Elim Pentecostalist** |  |  | | **Baptist** | **1** |  | | **Church in Wales, follower of religion** | **1** |  | | **Eastern Catholic** | **1** | **1** | | **Ethiopian Orthodox Tewahedo** | **1** |  | | **Greek Orthodox** | **1** |  | | **Jewish** | **1** | **2** | | **Mormon** | **1** |  | | **Romanian Orthodox** | **1** |  | | **Russian Orthodox** | **1** | **1** | | **Satanist** | **1** |  |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com)**  We know that White British people make up 87% of our region’s local authority population, more than the England average of 81%. The other main minority groups include Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the UK’s population growth (Policy Exchange, 2014). |
| **5f** | **Marriage and Civil Partnership**  Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status are included in this category | **This policy does not discriminate against any group based on marriage/civil partnership or other habitual status.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Marital Status** | **All Patients**  **2021/22** | **All Inpatients**  **2022/23** | | **Single** | **1344** | **524** | | **Married** | **554** | **204** | | **Not Recorded** | **264** | **81** | | **Widowed** | **202** | **69** | | **Divorced** | **159** | **61** | | **Separated** | **74** | **34** |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com)** |
| **5g** | **Pregnancy and Maternity**  Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered | **The use of the Mental Health Act is applicable to all people regardless of their current health condition. It does not have a bias towards people who are or are not pregnant.** |
| **5h** | **Gender Re-assignment**  Prompt: Transgender issues should be considered | **There is no specific data relating to the application of Section 132, it is however noted that there have been 2 occasions where a service user who has been/or is in the process of gender re assignment has been subject to detention under the Mental Health Act.**  **Due to the nature of detention under the Mental Health Act this has meant that the person concerned has no choice but to be in hospital.**  **Where it has been necessary to admit to a gender specific ward, the service user and staff have been supported in providing agender appropriate accommodation and treatment.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Gender Re-assignment** | **All Patients**  **2021/22** | **All Patients**  **2022/23** | | **No** | 2594 | 971 | | **Gender reassignment patient** | **3** | **2** |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com)** |
| **5I** | **Carers**  Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered | **Section 132 is used on an inpatient ward to ensure that service users are given their rights, data is not collated.**  **It is essential for clinicians to contact carers to inform them of on-going changes to the situation and to give them a copy of the rights leaflet, should the patient agree to it being shared. Carers would be informed of the status of the patient as soon as possible after the event.** |
| **5j** | **Race**  Prompt: Indigenous population and BME Groups such as Black African and Caribbean, Mixed Heritage, South Asian, Chinese, Irish, new Migrant, Asylum & Refugee, Gypsy & Travelling communities.) | **The MHA sections are not broken down into specific groups, although it is reported nationally that there is a higher incidence of people from black, Asian and mixed race groups are disproportionality detained under the Mental Health Act.**  **The Trust Performance and Information department recently took a snap shot of 1 quarter of the admission and detention rate under the Mental Health Act and concluded the that this was consistent with the national picture. The Trust is undertaking significant work to understand the data and draw some conclusions.**   |  |  |  | | --- | --- | --- | | **Applied filters: Service Type is Inpatient** | |  | | **Ethnicity** | **All Patients**  **2021/22** | **All Patients**  **2022/23** | | **Any other Asian background** | 31 | 11 | | **Any other black background** | **14** | **4** | | **Any other Ethnic group** | 36 | 22 | | **Any Other mixed background** | **22** | **8** | | **Any Other White background** | 74 | 28 | | **Bangladeshi** | **1** | **1** | | **Black African** | 41 | 11 | | **Black Caribbean** | **25** | **17** | | **Chinese** | **1** | **1** | | **Indian** | 49 | 22 | | **Not Recorded** | **18** | **2** | | **Not Stated** | 43 | 21 | | **Pakistani** | **150** | **44** | | **White and Asian** | 7 |  | | **White and Black African** | **6** | **2** | | **White and Black Caribbean** | 17 | 13 | | **White British** | **2048** | **758** | | **White Irish** | 12 | 8 |   **Data Gathered on 18/07/2022 from BI Reporting – Home (sharepoint.com)**  The Trust considers services which meet the needs of our diverse population. Specific targeted work to ensure the **diverse population of Kirklees** are served well and the emerging growth of an **Asian population in Wakefield** will be considered in all service development and delivery. Support can be provided via the Trust commissioned service to assist people whose first language is not English. They can provide assistance to the assessor and the person being assessed for detention and also development of care plans to address on-going issues.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | White | Asian | Black | Mixed | Chinese & Other | | England % av. | 85.5 | 5.1 | 3.4 | 2.2 | 1.7 | | **Kirklees** |  |  |  |  |  | | % average | 79.1 | 15.7 | 1.9 | 2.3 | 0.7 | | **Barnsley** |  |  |  |  |  | | % average | 97.9 | 0.7 | 0.5 | 0.7 | 0.2 | | **Calderdale** |  |  |  |  |  | | % average | 89.6 | 7 | 0.9 | 1.3 | 0.6 | | **Wakefield** |  |  |  |  |  | | % average | 95.4 | 2.6 | 0.77 | 0.9 | 0.29 |   There are some identified negative impact on the protected characteristic of race related to language.  The service may be required to offer information in the language appropriate for a specific individual.  Much of this work has already been done but the languages available are not exhaustive. |

**Action Plan**

EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). This rates the quality of the EIA. This means that the team can review the EIA and make recommendations only. The rating and suggested standards are set out below:

* + **Under-developed** – red – **No data**. **No strands** of equality
  + **Developing** – amber – **Some census data plus workforce**. **Two strands** of equality addressed
  + **Achieving** – green – **Some census data plus workforce. Five strands** of equality addressed
  + **Excelling** – purple –**All the data and all the strands** addressed

Potential themes for actions: Geographical location, built environment, timing, costs of the service, make up of your workforce, stereotypes and assumptions, equality monitoring, community relations/cohesion, same sex wards and care, specific issues/barriers.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Who will benefit from this action? (tick all that apply)** | | **Action 1: This is what we are going to do** | **Lead/s** | **By when** | **Update -outcome** | **RAG** |
| **Age** |  | Race, specifically does not impact on the delivery of patient’s rights, however there may be language difficulties that could impact negatively on an individual’s understanding, particularly with regard to information and rights.  All information to be produced in numerous languages and easy-read format. Interpreters to be provided and family and carer involvement to be promoted  The MHA sections are not broken down into specific groups, although it is reported nationally that there is a higher incidence of people from black, Asian and mixed race groups are disproportionality detained under the Mental Health Act | MDT | Ongoing | All rights leaflets are produced in alternative languages and carers are involved in communication with patients.  The Trust Performance and Information department recently took a snap shot of 1 quarter of the admission and detention rate under the Mental Health Act and concluded the that this was consistent with the national picture. The Trust is undertaking significant work to understand the data and draw some conclusions. |  |
| **Disability** |  |
| **Gender reassignment** |  |
| **Marriage and civil partnership** |  |
| **Race** | X |
| **Religion or belief** |  |
| **Sex** |  |
| **Sexual Orientation** |  |
| **Pregnancy maternity** |  |
| **Carers** |  |

**Involvement & Consultation: New or Previous (please include any evidence of activity undertaken in the box below)**

|  |
| --- |
| The Trust ensure that all **training is recorded and monitored**, study leave forms are completed and training outcomes are identified through formal learning needs analyses. From the workforce data in 2020 the Trust sees no adverse barriers to training access for any of its staff regardless of their ethnicity, disability, age, gender or sexuality  **Development of BAME staff** – The Trust supports the BAME network, the development of both ‘Stepping Up’ and “Ready Now”, the NHS Leadership  Academy inclusive leadership programmes; and partnering with Bradford District Care Trust on the ‘Moving Forward’ programme.  **Supporting staff with a disability** – Continuing to focus on improving staff disability experience remains a priority, and the Trust has established a Staff  Disability network across the Trust and are implementing the Workforce Disability Equality Standard (WDES). The Trust encourages all staff to  access Occupational Health and wellbeing services, access health checks and attend Trust wellbeing workshops.  **A representative workforce** that is reflective of its localised need – The Trust considers workforce diversity issues as part of our annual planning process and will continue to support the ‘New Horizons’ project, working with schools and engaging with local communities in the areas of mental health awareness, employability skills and promoting the NHS as an employer of choice, particularly regarding apprenticeships and HCSW opportunities in the Trust. The Trust is continuing with its participation in the Insight programme which seeks to increase Trust Board BAME representation. |

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| **SECTION 7**  **Grading the EIA**  **Name: Aboobaker Bhana**  **Date: 08/10/22**  **Rating: Developing**  EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). The team have reviewed and rated the EIA using the following:   * **Under-developed** – red – **No data**. **No strands** of equality * **Developing** – amber – **Some census data plus workforce**. **Two strands** of equality addressed * **Achieving** – green – **Some census data plus workforce. Five strands** of equality addressed * **Excelling** – purple –**All the data and all the strands** addressed   **Comments:**  **Overall a base line EIA**  **No Data breakdown provided by protected group of patients that have been denied their rights and the reasons of denial.**  **Some impact on carers noted and no inclusion of the carers passport**  **Some specific examples in the involvement section- You Said -we did would have been good to include, e.g. the report of the Discovery stories work undertaken on Bretton Centre**  **Include any complaints or concerns related to one of the equality groups, that led to learning lessons and positive outcomes**  **The new census demographic data for all areas needs to be added as soon as available in the winter of 2022**  **8 Methods of Monitoring progress on Actions**  Assessing and developing the production of multi-lingual information and rights leaflets and the use of interpreters to ensure there is no barrier to language based on patients’ nationality and/or race  P&I in conjunction with Race Equality Working group to look at reasons for apparent disproportionate use of MHA on ethnic minority in-patients |

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| |  | | --- | | 1. **Publishing the Equality Impact Assessment** | |

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| --- | --- |
| |  | | --- | | 1. **Signing off Equality Impact Assessment:**   Service Manager: Yvonne French | |

# Appendix 3

# Version Control Sheet

*This sheet should provide a history of previous versions of the policy and changes made*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment / changes** |
| 1 | June 2010 | Director of Risk and Governance | Original policy | Final version approved by Trust Board |
| 2 | August 2012 | Director of Risk and Governance | Reviewed |  |
| 3 | Dec  2105 | Assistant Director, Legal Services | Reviewed | Updated to reflect changes in the Code of Practice 2015 |
| 4 | February 2019 | Assistant Director  Legal Services | Reviewed | Lead Director change  Removal of paper form, now record on SYSTM 1 |
| 5 | May 2022 | Assistant Director Legal services | DRAFT |  |
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# Appendix 4

# Section 132 Patient’s Rights Guidance Documents

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| --- | --- |
| **Guidance Notes** | |
| Informal Rights |  |
| Section 2 Rights |  |
| Section 3 Rights |  |
| Section 3 Renewal Rights |  |
| Sections 4, 5, 135 & 136 |  |
| Section 17a (CTO) |  |
| Section 35 |  |
| Section 36 |  |
| Section 37/41 |  |
| Section 37 |  |
| Section 38 |  |
| Sections 47/49 & 48/49 |  |
| Section 47 |  |

## Appendix 5

## Checklist for the Review and Approval of Procedural Document

*To be completed and attached to any policy document when submitted to EMT for consideration and approval.*

|  | **Title of document being reviewed:** | **Yes/No/ Unsure** | **Comments** |
| --- | --- | --- | --- |
| **1.** | **Title** |  |  |
|  | Is the title clear and unambiguous? | YES |  |
|  | Is it clear whether the document is a guideline, policy, protocol or standard? | YES |  |
|  | Is it clear in the introduction whether this document replaces or supersedes a previous document? | YES |  |
| **2.** | **Rationale** |  |  |
|  | Are reasons for development of the document stated? | YES |  |
| **3.** | **Development Process** |  |  |
|  | Is the method described in brief? | NO |  |
|  | Are people involved in the development identified? | YES |  |
|  | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | YES |  |
|  | Is there evidence of consultation with stakeholders and users? | NO | Consulted with Practice Governance Coaches and senior staff in the forensic unot. |
| **4.** | **Content** |  |  |
|  | Is the objective of the document clear? | YES |  |
|  | Is the target population clear and unambiguous? | YES |  |
|  | Are the intended outcomes described? | YES |  |
|  | Are the statements clear and unambiguous? | YES |  |
| **5.** | **Evidence Base** |  |  |
|  | Is the type of evidence to support the document identified explicitly? | YES |  |
|  | Are key references cited? | YES |  |
|  | Are the references cited in full? | YES |  |
|  | Are supporting documents referenced? | YES |  |
| **6.** | **Approval** |  |  |
|  | Does the document identify which committee/group will approve it? | YES |  |
|  | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | N/A |  |
| **7.** | **Dissemination and Implementation** |  |  |
|  | Is there an outline/plan to identify how this will be done? | YES |  |
|  | Does the plan include the necessary training/support to ensure compliance? | N/A |  |
| **8.** | **Document Control** |  |  |
|  | Does the document identify where it will be held? | YES |  |
|  | Have archiving arrangements for superseded documents been addressed? | YES |  |
| **9.** | **Process to Monitor Compliance and Effectiveness** |  |  |
|  | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | YES |  |
|  | Is there a plan to review or audit compliance with the document? | YES |  |
| **10.** | **Review Date** |  |  |
|  | Is the review date identified? | YES |  |
|  | Is the frequency of review identified? If so is it acceptable? | NO |  |
| **11.** | **Overall Responsibility for the Document** |  |  |
|  | Is it clear who will be responsible implementation and review of the document? | YES |  |