Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
SECTION 5 (MHA 1983) – HOLDING POWERS

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1	*23/11/17*	*Holding powers flow chart added as appendix following Mental Health Legislation Committee*
2	*09/08/19*	*Reviewed in response to an action from SEA 2019-12.*
3	*11/07/22*	*Full review. Introduction, and Duties and Responsibilities sections enhanced. Amendments made to Page 5 in relation to use of S5(4) on hospital premises, and other slight amends to highlight the availability of electronic submission of forms. Clarification on pages 7 and 8 that the Approved Clinician could be a Multi Professional Approved Clinician (MPAC). Approved by Mental Health Legislation Steering Group (20 July 2022).*

Contents

1. INTRODUCTION 3
2. SCOPE 4
3. DUTIES AND RESPONSIBILITIES 4
4. PROCEDURES 5
4.1. Powers under Section 5 5
4.2. Section 5(4) 6
4.3. Section 5(2) 8
5. RELEVANT HTFT POLICIES / PROCEDURES / PROTOCOLS / GUIDELINES 10
Appendix 1: Section 5(4) flowchart 11
Appendix 2: Section 5(2) flowchart 12
Appendix 3: Forms required for S5(2) and Section 5(4) Process 13
Appendix 4 – Equality Impact Assessment 14

1. INTRODUCTION

Section 5 of the Mental Health Act 1983 is designed to be used as an emergency holding power to give professionals time to complete a more thorough assessment and to decide whether detention under Section 2 or 3 is necessary.

All nursing staff who are able to invoke Section 5(4) will be suitably qualified, experienced and competent. The doctor/approved clinician with the power to use Section 5(2) will assess the patient as soon as possible and within 6 hours of the S5(4) being made. This must be a fully registered Doctor (FY2 and above).

Any officer who has the responsibility for ensuring that the grounds for admitting the patient are valid and that all relevant admission documentation is in order, will be competent to make such a judgement.

All patients detained under Section 5 will be given appropriate information in relation to their detention and, with the patient's consent, appropriate information will be given to their nearest relatives (as defined by section 26 (1) of the Mental Health Act). No patient will be detained under the Mental Health Act longer than is necessary.

This procedure was developed to provide staff with guidance in the proper application of Section 5(4) and 5(2), as required by the Act and is reflective of the guidance in the 2015 Mental Health Act Code of Practice.

It is essential that all those undertaking the functions under the Mental Health Act 1983 understand the five overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act. The five overarching principles are:

- **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.

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

- **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.

- **Efficiency and 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. Staff must apply all the principles to all decisions.

All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 and Equality Act 2010.

All five principles are of equal importance and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

2. SCOPE

This Standard Operating Procedure relates to the use of Section 5 of the Mental Health Act 1983 – which is an emergency holding power, in respect of a patient of any age who is an inpatient in hospital but not detained under the Mental Health Act.

It applies to all Trust staff, contracted agency staff and supporting agencies that have a responsibility for patients admitted to hospital.

3. DUTIES AND RESPONSIBILITIES

It is the responsibility of all staff who are involved with the emergency detention of an informal patient to be fully conversant with both this document, the Mental Health Act Code of Practice 2015 – chapters 18 and 35.

Division leads ensure dissemination of Mental Health Policy and associated Standard operating procedures

All staff involved in delivery of clinical care must ensure compliance with the requirements of the Mental Health Act code of Practice (2015), associated Trust policies and Standard operating procedures.

Nurse of the Prescribed Class (registered Mental Health Nurse or Learning Disability Nurse) – To personally decide to invoke Section 5(4) in circumstances where criteria are met and it is not possible to obtain the immediate attendance of a doctor/Approved Clinician to use Section 5(2). To complete necessary legal documentation and provide patient with information on their rights in accordance with Section 132.

Responsible Clinician (RC)/Approved Clinician (AC) - To attend the ward urgently when notified by nurse that a Section 5(4) has been used. To assess for and where necessary complete Section 5(2) documentation.

When available, to personally assess in-patients for Section 5(2) or when contactable but not able to attend the ward, to nominate a deputy to implement Section 5(2). Where the nominated deputy uses Section 5(2) the Consultant/Approved Clinician must attend the ward to assess whether an application is required under Section 2 or 3.

Nominated Deputy - Where the Consultant Psychiatrist/Approved Clinician is not contactable / available, the Nominated Deputy should exercise their own judgement when assessing the patient for a Section 5(2). The nominated deputy, in practice, is the junior doctor on call for that unit. In such cases, the doctor invoking the power should make immediate contact with a psychiatrist or an approved clinician to obtain confirmation of their opinion that the patient needs to be detained so that an application can be made. If possible, the doctor should seek such advice before using the power (CoP 18.11).

Approved Mental Health Professional (AMHP) - To coordinate an assessment for the patient's possible detention under Section 2 or 3.

Mental Health Act Administrator - To arrange for the medical/administrative scrutiny and recording of Section 5(2) / 5(4). To provide advice to staff and others about the power.

Mental Health Legislation Manager - To monitor the use of Section 5(2) / 5(4), preparing reports and statistics, and raising concerns as necessary. To provide advice to staff and others on correct use of the power.

Clinical staff - To contact the duty doctor when Section 5(2) may be appropriate. To discuss with the duty doctor the arrangements for an Approved Mental Health Professional to attend to assess for Section 2 or 3. To ensure that patients are given information and informed of their rights

4. PROCEDURES

4.1. Powers under Section 5

Detention under section 5(2) or section 5(4) cannot be renewed, but that does not prevent it being used again on a future occasion if necessary.

Treatment

Detaining patients under section 5 does not confer any power under the Act to treat them without their consent. The rules in part 4 of the Act do not apply to these patients. In other words, they are in exactly the same position as patients who are not detained under the Act in respect of consent to treatment.

If a patient who lacks the capacity to consent requires urgent treatment, this can be given under the Mental Capacity Act 2005 in the patient's best interests, even if the treatment is for mental disorder (MCA 2005 13.32). The legality of treatment if on a Section 5 should always be in discussion with the Consultant. This must be fully documented in the patient's clinical record.

Transfer to other hospitals

Patients cannot be transferred from one hospital to another whilst detained under Section 5; Section 19 does not apply. It is possible to transfer between wards of the same hospital (if the specific ward has not been named on the document), but transfer between different sites of the same Trust is not possible as the power to detain only applies to the original hospital named on the Form H1.

A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA, including that it is in the person's best interests and any restrictions on the person's liberty are permitted by the MCA.

In these situations it must be clearly documented why it is not possible for the AMHP and Doctor to attend the hospital in order to carry out a Mental Health Act Assessment prior to the transfer. It may be that there is a need to act without delay for the safety of the patient, staff and other patients but staff need to justify why this is clinically necessary based on risk of potential harm to self or others.

If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to consider the use of section 5(2) in order to provide authority to detain the patient in that hospital.

In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made to the sending hospital (see chapter 15 CoP 2015). The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.

Leave

Patients detained under Section 5 have been detained in an emergency. It is not legally possible to grant leave to a patient detained under this holding power.

Absence Without Leave

Section 18 of the Mental Health Act enables a patient detained under Section 5 to be retaken by an approved mental health professional (AMHP), an officer on the staff of the hospital or a police officer. The patient cannot be retaken if he/she remains out of custody once the six-hour period (in respect of Section 5(4)) or 72-hour period (in respect of Section 5(2)) has expired.

The AMHP, officer on the staff of the hospital or police officer have the authority to return the patient to the hospital named on the legal document but the holding power under Section 5 does not apply if they are returned to a hospital that is not stated on the original paperwork.

4.2. Section 5(4)

Legal Grounds for Detention

Section 5(4) allows a registered nurse (of the prescribed class) to detain an informal patient, of any age, who is an inpatient receiving treatment for mental disorder for up to six hours. It cannot be used in a general hospital if the patient is not mentally disordered and is receiving treatment for physical illness only.

NB The prescribed class means a registered nurse whose field of practice is mental health nursing or learning disability nursing.

This power may be used only where the nurse considers that:

- the patient is suffering from mental disorder to such a degree that it is necessary for the patient to be **immediately prevented from leaving the hospital** either for the patient's health or safety or the protection of other people, and
- it is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).

Section 5(4) can be used only when the patient is still on the hospital premises (CoP 18.24). If the patient is an inpatient of a hospital which is managed by more than one set of hospital managers the patient can be detained in any part of the hospital that is managed by the hospital managers of the ward where the patient is an inpatient. There is no authority to detain the patient in a part of the hospital that is managed by different hospital managers. So for example section 5(4) could be applied to an informal patient admitted to Avondale if they were in any part of Miranda House.

Paragraph 18.24 of the MHA Code of Practice says the power can "… be used only when the patient is still on the hospital premises". The "hospital premises" can include the grounds and not just inside the buildings AS LONG AS that is the interpretation usually adopted for "the hospital". Where a site is shared (for example Mill View and Castle Hill) there can be issues about which bits are our hospital and which bits are the hospital of another Trust. In short, the "hospital premises" are anywhere you would consider a detained patient (not on any special restrictions) could go without needing leave under s17 MHA.

The holding power lapses upon the arrival of the doctor/approved clinician or at the end of 6 hours, whichever is earlier. Therefore, the doctor/approved clinician should quickly decide whether they should invoke powers as their arrival on the ward ends the power to detain.

NB. The Doctor must be a fully registered Doctor (FY2 an above). The Approved Clinician could be a Multi Professional Approved Clinician (MPAC),

If no doctor or approved clinician able to make a report under section 5(2) has attended within six hours, the patient is no longer detained and may leave if not prepared to stay voluntarily. This should be considered as a serious failing, and should be reported via Datix and investigated by the Mental Health Legislation Team.

It is not lawful to use a Section 5(4) in respect of an informal patient, who is already subject to a Community Treatment Order (CTO).

Action to be taken prior to use of Section 5(4)

The MHA Code 2015 (18.29) states that before using the power, the nurse should assess:

- the likely arrival time of the doctor or approved clinician, as against the likely intention of the patient to leave. It may be possible to persuade the patient to wait until a doctor or approved clinician arrives to discuss the matter further; and
- the consequences of a patient leaving the hospital before the doctor or approved clinician arrives – in other words, the harm that might occur to the patient or others.

If it is not possible to secure the immediate attendance of the doctor/approved clinician or the nominated deputy, the nurse must attempt to encourage the patient to consent to remain in hospital until seen by a doctor/approved clinician, providing they are assumed to have capacity to make this decision. If capacity to consent to remain in hospital is doubted then a capacity assessment should be completed.

If at this point the patient (with capacity to make this decision) is still expressing his /her clear intention to leave the ward (either verbally or by behaviour), the nurse should consider invoking Section 5(4).

The use of Section 5(4) is the personal and professional decision of the nurse; therefore the nurse cannot be instructed to exercise this power by anyone else. Doctors cannot leave instructions to nurses for them to invoke section 5(4) if the patient tries to leave.

Normally assessment should precede action but in extreme circumstances it may be necessary to invoke the power without carrying out the proper assessment. The suddenness of the patient's determination to leave and the urgency with which the patient attempts to do so should alert the nurse to potentially serious consequences if the patient is successful in leaving.

Forms Required

Nursing staff to complete:

- Form H2 - Section 5(4) – record of hospital in-patient. Submit the Form H2 as soon as possible after completion to the Mental Health Legislation Office (with regard to evenings, weekends and bank holidays, the next working day).
- Section 5(4) Audit Form (Z13) upon completion of Form H2 and submit to the Mental Health Legislation Office.
- Administrative Checklist for Section 5(4).
- Section 5(4) / Section 5(2) Termination Form (Z24) - record date and time at which power to detain under MHA Section 5(4) elapsed and record reasons for termination.

Patient's Rights

The patient must be informed immediately of his/her legal position in accordance with Section 132 and given his/her rights both orally **and** in writing (these are not alternatives). The patient must be informed of the consequences of the Section 5(4) and the Section 5(4) Leaflet given to the patient.

This must be recorded in the patient's clinical record.

With the patient's consent the nearest relative is to be given information about the Section 5(4) either by being given or sent a copy of the Section 5(4) Leaflet.

End of Section 5(4)

The holding power begins after the nurse's opinion has been recorded on Form H2 and ends either six hours later or upon the arrival of a doctor/approved clinician who should quickly decide whether he/she should invoke his/her powers under Section 5(2) as his/her arrival on the ward ends the power to detain. Complete Section 5(4)/Section 5(2) Termination Form (Z24).

It is not good practice to simply allow a Section 5(4) to lapse (if not converted to a further section).

4.3. Section 5(2)

Legal grounds for detention

When a patient who has been admitted informally wishes to leave the ward, and the doctor/approved clinician feels that it would be appropriate to assess them for detention under the Mental Health Act 1983 for his/her own safety or for the protection of others, Section 5(2) should be used, pending the assessment.

NB. The doctor must be a fully registered Doctor (FY2 as above). The Approved Clinician could be a Multi Professional Approved Clinician (MPAC),

The power can be used where the doctor or approved clinician in charge of the treatment of a hospital in-patient (or their nominated deputy) concludes that an application for detention under the Act should be made. It authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made. Decision-makers should always consider whether there are less restrictive alternatives to detention under the Act (chapter 14, CoP 2015).

It cannot be used for patients in Accident & Emergency departments, outpatients departments, or those who have been persuaded to come to the ward, but not formally admitted.

It is not lawful to use a Section 5(2) in respect of an informal patient, who is already subject to a Community Treatment Order (CTO).

The power cannot be used to prolong the detention of a patient whose section is about to expire (MHA Manual, Jones 24th edition, page 65).

It is not appropriate to use Section 5(2) "to allow time for further assessment", only when, at the time, the clear intention is to proceed with a MHA assessment for detention under Section 2 or Section 3. Doctors and approved clinicians should use the holding power only after having personally examined the patient.

Sometimes a report under section 5(2) may be made in relation to a patient who is not at the time under the care of a psychiatrist or an approved clinician. In such cases, the doctor invoking the

power should make immediate contact with a psychiatrist or an approved clinician to obtain confirmation of their opinion that the patient needs to be detained so that an application can be made. If possible, the doctor should seek such advice before using the power (CoP 18.11).

The period of detention starts at the moment the doctor's or approved clinician's report is furnished to the hospital managers (e.g. when it is handed to an officer who is authorised by the managers to receive it, or when it is put in the hospital's internal mail system or when it is submitted electronically – see Electronic Forms SOP).

Action to be taken directly after Section 5(2) invoked

As soon as the patient is detained under Section 5(2) an approved mental health professional (AMHP) must be notified via the Mental Health Crisis Intervention Team (MHCIT) as per Trust process.

The Trust/Local Authority make the necessary arrangements to ensure that when Section 5(2) is invoked, the patient is fully assessed by an approved mental health professional and appropriate medical staff for possible detention under the Act.

Examination and assessment for detention under the relevant section of the Act must take place as quickly as possible but within the 72 hour period.

The Nearest Relative must be informed as soon as is practicable (unless the patient objects) about the use of Section 5(2) and given a copy of Section 5(2) Leaflet.

All patients detained under section 5(2) should, within the 72 hour period of detention, be assessed and, if the criteria are met placed on another section of the Act (eg: S2 or S3) or discharged immediately from the detention order if the assessment decision is not to detain the patient further.

Forms Required

Medical Practitioner/Approved Clinician must complete:

- Form H1 - Section 5 (2) report on hospital in-patient – Part 1.

Nursing staff to complete:

- Administrative Checklist for Section 5(2).
- The Nurse in charge of the ward will formally accept the Form H1 on behalf of the Hospital Managers immediately, by the completion and signing (unless submitted electronically) of Form H1 – Part 2.

  NOTE: The patient's detention commences only when the papers have been accepted on behalf of the Hospital Managers, i.e. completion of Form H1.

- The Form H1with Parts 1 and 2 completed must then be scanned (unless served electronically) and emailed to the Mental Health Legislation Office and the original papers will be collected by the Mental Health Legislation Office.
- Section 5(2) Audit Form (Z14) upon completion of Form H1and submit to the Mental Health Legislation Office.
- Upon termination of Section 5(2) please ensure Section 5(4) / Section 5(2) Termination Form (Z24) is completed if further section **not** used - record date and time at which power to detain under MHA Section 5(2) elapsed and record reasons for termination.

Patient's Rights

As soon as possible (but within 24 hours) after the commencement of the patient's detention, having regard to the patient's state of mind and his/her ability to understand the information, the patient must be informed of his/her legal position and rights given **both** orally and in writing (these are not alternatives). Section 5(2) Leaflet is to be used for this purpose.

End of Section 5(2)

Any patient detained under Section 5(2) should be discharged from detention **immediately** if the registered medical practitioner/approved clinician decides that no assessment for further detention needs to be undertaken, **or** an assessment is carried out and a decision is taken by the AMHP not to make an application.

IT IS NOT GOOD PRACTICE TO SIMPLY ALLOW A SECTION 5(2) TO LAPSE.

5. RELEVANT HTFT POLICIES / PROCEDURES / PROTOCOLS / GUIDELINES

Mental Health Act Policy

Electronic Forms SOP

Department of Health: (2015) Mental Health Act Code of Practice. London TSO

Jones R (2016) Mental health act manual. 24th Edition. London. Sweet & Maxwell

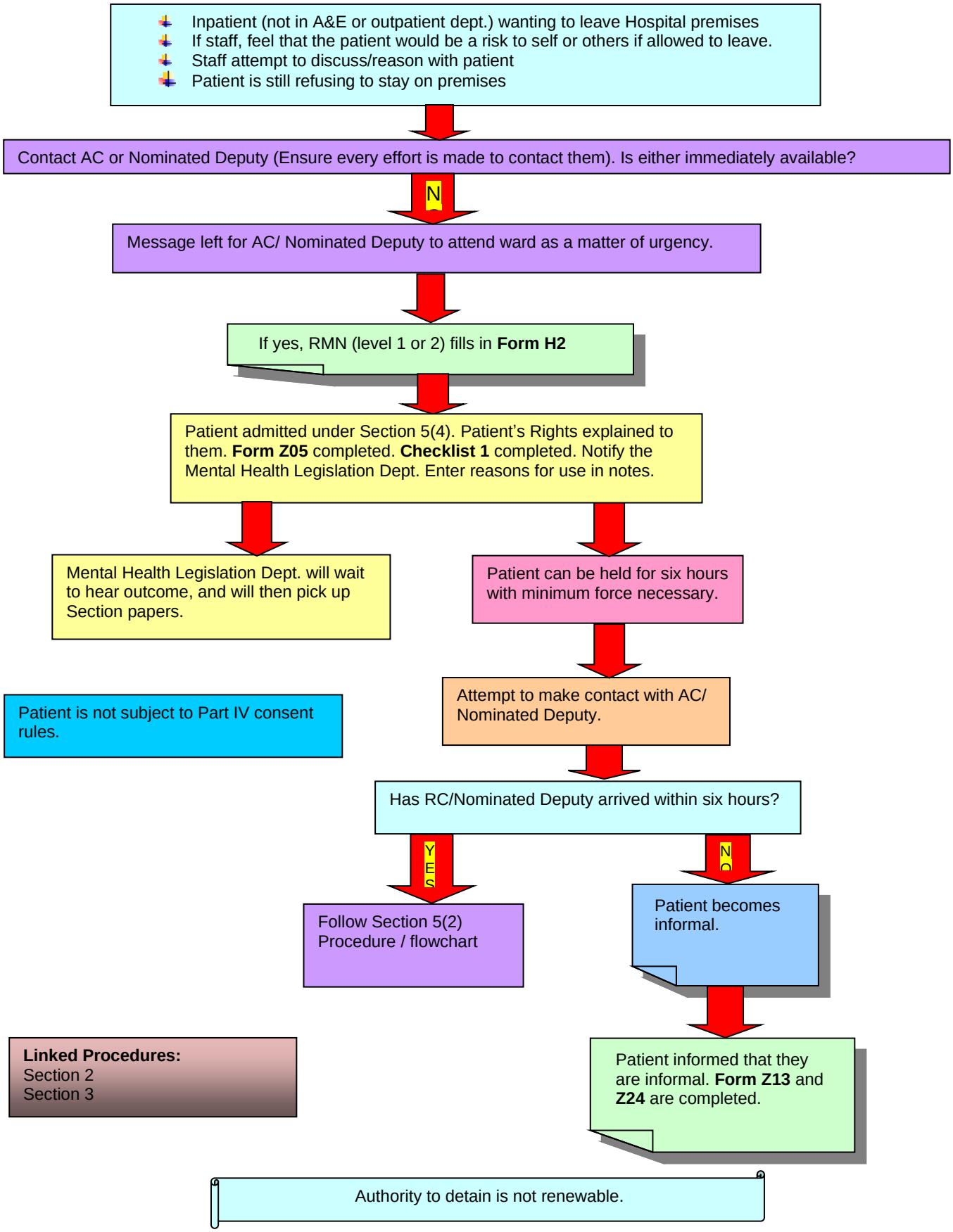
Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007

Nottinghamshire Healthcare NHS Foundation Trust – Mental Health Act 1983 - Section 5 holding powers – Issue 6 January 2017

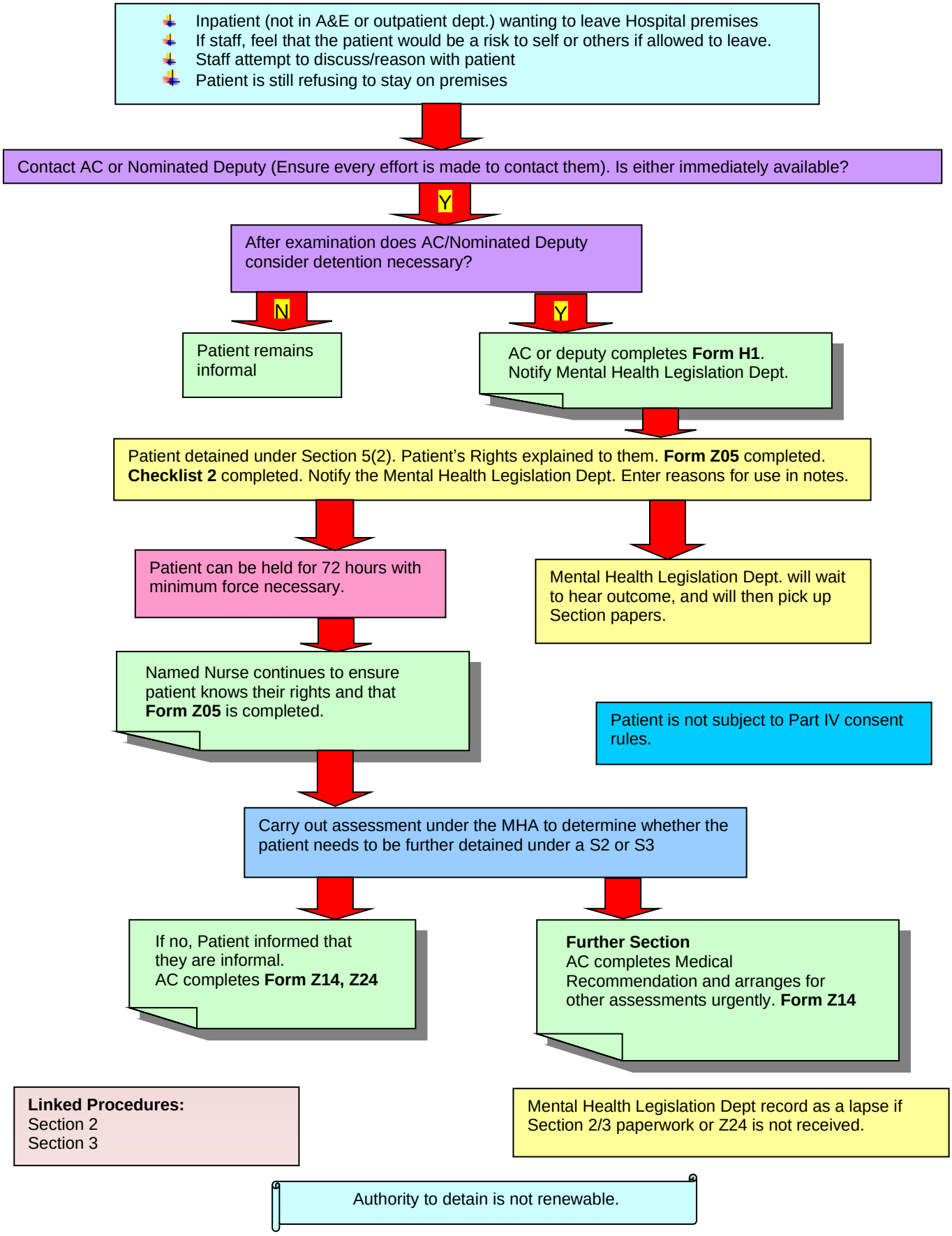
Somerset Partnership NHS Foundation Trust – MHA Section 5(2) and 5(4) Holding Power Policy

Devon Partnership NHS Trust Holding Powers under Section 5(2) & (4)

Appendix 1: Section 5(4) flowchart



Appendix 2: Section 5(2) flowchart



Appendix 3: Forms required for S5(2) and Section 5(4) Process

Z05	Rights form
Z13	Section 5(4) Audit
Z14	Section 5(2) Audit
Z24	Section 5(2) and Section 5(4) Termination form
H1	Section 5(2) Report on hospital inpatient
H2	Section 5(4) Record of hospital inpatient
Checklist 1	Administrative checklist for Section 5(4)
Checklist 2	Administrative checklist for Section 5(2)

Appendix 4 – Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name:** Section 5 of the Mental Health Act 1983 – Holding Powers
2. **EIA Reviewer (name, job title, base and contact details):** Michelle Nolan, Mental Health Act Clinical Manager
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** Standard Operating Procedure

Main Aims of the Document, Process or Service
This procedure was developed to provide staff with guidance in the proper application of Section 5(4) and 5(2), as required by the Act and is reflective of the guidance in the 2015 Mental Health Act Code of Practice.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender Reassignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	Applicable across the lifespan, to all ages who are admitted to our inpatient units (excluding early years).
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (including cancer, HIV, multiple sclerosis)	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the Act as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any special needs or requirements relating to any form of disability.
Sex	Men/Male Women/Female	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender related preferences, needs or requirements.
Marriage/Civil Partnership		Low	Applicable regardless of partnership status.
Pregnancy/ Maternity		Low	There is no procedure in the application of policy that would affect pregnant/antenatal patients.
Race	Colour Nationality Ethnic/national origins	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to race or ethnicity. This procedure is consistent in its approach regardless of race. It is acknowledged however that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Lesbian Gay Men Bisexual	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This procedure is consistent in its approach regardless of the gender the individual wishes to be identified as. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people. Specific guidance is given in relation to gender and trans. As a guiding principal, everyone will be treated as an individual and gender should not be a barrier.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above. The standards and principles described within the procedure prompt the clinician to have regard to individual holistic needs of all people detained under Section 5(4) or 5(2) of the MHA. It is felt that this procedure and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs. Any audit/monitoring outcomes of related policy would continue to inform any changes to the Equality Impact Assessment in relation to any of the equality target group characteristics and impact of use of S5(4) or 5(2). There are statutory requirements and obligations built into existing related legislation (MHA 1983) and its supplementary Code of Practice as well as local systems in place for assurance of the monitoring of compliance with these requirements and reporting through related committees.
EIA Reviewer: Michelle Nolan

Date completed: 14/07/22	Signature M. Nolan