Citation for published version (APA):
Stevens, M., Martineau, S., Manthorpe, J., Steils, N., & Bramley, S. (2020). The availability of section 12 doctors for Mental Health Act assessments - a scoping review of the literature. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-037

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The availability of section 12 doctors for Mental Health Act assessments – a scoping review of the literature

Martin Stevens, Stephen Martineau, Jill Manthorpe, Nicole Steils, Stephanie Bramley

NIHR Policy Research Unit in Health and Social Care Workforce
The Policy Institute, King’s College London
To cite this report

Disclaimer and acknowledgment
This study is funded by the National Institute for Health Research (NIHR) Policy Research Programme (Policy Research Unit in Health and Social Care Workforce: Ref. PR-PRU-1217-21002). The views expressed in this publication are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care. We thank members of the Unit’s advisory group for their comments on this review.
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**Summary**

**Introduction and rationale**

This report presents the findings of a scoping review of the literature on the availability of section 12 doctors for Mental Health Act (MHA) assessments. Over the past two decades, there have been many accounts of difficulties Approved Mental Health Professionals have experienced accessing section 12 doctors to take part in assessments. Sometimes this led to delays in MHA assessments, which can lead to worse outcomes for patients. However, little is known about possible reasons for these difficulties and any approaches being undertaken to lessen them. Consequently, we undertook a scoping review and a focused synthesis of the evidence about reasons or causes underpinning reported problems with accessing section 12 doctors. In addition to identifying messages from and gaps in the literature, the review will inform a new research project asking key informants about their views and experiences.

**Aim and research questions**

The review aimed to identify evidence about factors promoting and inhibiting, and any approaches to improve, the timely availability of section 12 doctors to participate in MHA assessments in England. The review addressed six research questions:

1. What is known about reasons for difficulties in accessing section 12 doctors to undertake MHA assessments?
2. What is known about the variation in these difficulties across England?
3. What approaches have been found to improve access to section 12 doctors to undertake MHA assessments?
4. What is known about how MHA assessments fit with section 12 doctors’ overall workload (including numbers undertaking this work on a private basis)?
5. What is known about the remuneration of section 12 doctors for MHA assessments?
6. What are the gaps in the evidence?

**Methods**

At the request of the Department of Health and Social Care we undertook searches of academic literature databases (n=10). These were supplemented by a search for grey literature, reference harvesting, and personal correspondence. Papers and sources (e.g. information from websites) (n=1494) were screened by title and abstract, 101 were retrieved and read in full, which resulted in 37 papers and other sources being included in the review. A data extraction form was constructed and information relevant to the research questions was recorded and the findings synthesised.

**Results**

The papers included in the review reported 16 research studies, a literature review and a service review involving mixed methods. The other papers (n=5) from peer review journals included two ‘think pieces’, one personal account of practice, an editorial and a commentary on another paper. The 13 sources included from the grey literature search included four blogs, information on four web pages, three local policy documents (which are typically included as grey literature, according to Bickley et al, 2020) and two short reports.
Findings (focused synthesis)
We report the findings by research question, integrating the results of the academic and grey literature searches. It is important to note that we could not find any research directly exploring the views and experiences of section 12 doctors about these topics.

What is known about reasons for difficulties in accessing section 12 doctors to undertake MHA assessments?
We identified four themes from the literature in relation to this question: ‘Managing power relations’; ‘Working relationships between Approved Mental Health Professionals (AMHPs) and section 12 doctors’; ‘Organisational factors’; and ‘Training and approval processes’.

AMHPs are free to make the decision about whether to apply for an individual’s compulsory admission to hospital and can support or disagree with the recommendation of a section 12 doctor. Two papers noted that section 12 doctors may therefore have to engage in negotiation and persuasion, changing the usual power relationships between non-medically qualified staff (AMHPs) and doctors. However, we identified no evidence that this affects whether doctors are motivated to get the formal approval or to practise as a section 12 doctor.

Problems were identified in several papers in relation to doctors leaving soon after they complete their assessment of the patient, since this could leave AMHPs feeling isolated as they stayed with the patient, waiting for transport to a hospital for instance. In other papers, some AMHPs reported they had been left inappropriately responsible for administrative tasks such as securing a hospital bed. Though these factors may lead to difficulties in relations between section 12 doctors and AMHPs/Approved Social Workers (ASWs, the predecessor role to AMHPs) in individual instances, they do not appear to impact on the availability of section 12 doctors.

The ending of some section 75 (National Health Service Act 2006) agreements between local authorities and NHS organisations to run integrated mental health services may have had a negative impact on the timely availability and general availability of section 12 approved psychiatrists or GPs. However, there is no evidence comparing previous times with the present.

Several papers referred to the short training course required to become a section 12 doctor, which is not assessed, and the limited guidance to referees about how to judge the suitability of candidates. Consequently, section 12 work may not be attractive because of the low level of training required, given the importance of prestige in choices about medical careers (Walker et al, 2019). However, we did not find evidence of an overall shortage of section 12 doctors.

What is known about the variation in these difficulties across England?
We found very little recent information about variations across England: no information was found about variations in the numbers of section 12 doctors across England beyond requirements for bodies responsible for approving section 12 doctors to maintain up-to-date lists. There was also no evidence about how to judge how many are required in different contexts.
What approaches have been found to improve access to section 12 doctors to undertake MHA assessments?
The main approach we found to improving access to section 12 doctors was the development of the ‘S12 Solutions app’. The app and website were developed from the perspective of an AMHP involved in the MHA assessment process and it was also intended to help section 12 doctors manage their work. Early evaluations have found that more doctors joined the local networks on the app compared to other localities and that assessments were carried out quicker than expected in the pilot areas (S12 Solutions, 2017b; 2017d Wessex Academic Health Science Network, 2020).

What is known about how MHA assessments fit with section 12 doctors’ overall workload (including numbers undertaking this work on a private basis)?
Several studies mentioned that delays in accessing section 12 doctors could be explained by doctors’ workloads and hours/days of work, which often meant that they were unable to undertake MHA assessments until after 6pm. In addition, Patel et al (2016) found evidence that while some patients were more likely to be admitted to mental health hospitals at the weekend, compulsory admission was less likely. This raises the question of whether the availability of section 12 doctors may vary at weekends compared to weekdays. Another study (Leah, 2019) raised a question about the role of gatekeepers, such as receptionists, in allowing access to doctors to arrange MHA assessments.

What is known about the remuneration of section 12 doctors for MHA assessments?
Section 12 doctors are seemingly well remunerated for this role: for example, in one area the fee is currently £173.37 per assessment (NHS, 2019). However, there is some evidence that increasing remuneration helps in recruiting section 12 doctors (Anonymous NHS manager, 2016; North Cumbria Clinical Commissioning Group, 2019). Different payment agreements concerning when and where section 12 doctors can claim extra money for undertaking MHA assessments mean that it is more remunerative to undertake them outside their contracted hours of work. This may be a reason for the difficulties reported in accessing them during office hours.

What are the gaps in the evidence?
The review identified a wide range of gaps in the evidence:
1. Voice of section 12 doctors – motivations, tensions, power relations
2. Partnership working – Barriers/facilitators/approaches
3. Clarity over definitions, evidence of and reasons for delays
4. The implications of payment arrangements for MHA assessments and their processes; the sums involved
5. The fit of MHA assessments within section 12 doctors’ overall workloads
6. Availability and retention of section 12 doctors
7. Approval and re-approval processes – standardisation and fitness of training to meeting needs and legal safeguards

Discussion and conclusion
The literature reviewed has suggested several possible factors influencing access to section 12 doctors, which will help to guide the next stage of our study and possibly future research. Our study will need to focus on exploring the perspectives of section 12 doctors (which are
almost entirely absent from the literature) about: working with AMHPs; the training required; the impact of becoming section 12 approved on career prospects; managing section 12 work within existing workloads; levels of remuneration; rules about payment; and, processes for claiming pay.

The review has also identified questions in relation to Trust and local authority roles in the organisation of the section 12 doctor service. In addition to covering some of the questions identified for interviews with section 12 doctors, interviews with managers will also need to cover: approaches to establishing the appropriate numbers of section 12 doctors across different areas and the impact of the degree of integration of mental health services and relationships between local authorities and NHS Mental Health Trusts and Clinical Commissioning Groups (CCGs) and their successor organisations such as Integrated Care Systems.

The review suggested the need for further research investigating decision-making about the optimum number of section 12 doctors in different localities. This is complicated by the fact that section 12 doctors can choose how much work they take on, particularly in relation to work undertaken outside their normal roles, which makes it difficult to assess capacity.

The only approach to ameliorating the problem of access to section 12 doctors we found was the development of the S12 Solutions app. While the pilots showed promising results, further, independent evaluation of the impact of the app and its implementation would be valuable.

The main outcome of this literature review has been to identify gaps in the literature and research. Given that almost all the research was qualitative and the lack of research including section 12 doctors’ views and experiences, the review has identified areas for further exploration, within this study and in future research.
Introduction
What is the nature of reports of difficulty in getting hold of doctors to carry out Mental Health Act (MHA) assessments? This report presents the findings of a scoping review of the literature on the timely availability of section 12 doctors for MHA assessments that was undertaken to answer this question at the request of the Department of Health and Social Care. In addition to identifying messages from and gaps in the literature, the review will inform a new research project asking key informants about their views and experiences. Section 12 doctors are practitioners approved by the Secretary of State for Health and Social Care under section 12(2) MHA 1983, where they are described ‘as having special experience in the diagnosis or treatment of mental disorder’. Whenever the MHA 1983 requires the recommendations of two doctors, one of them must be section 12 approved (Hale, 2017). A detailed account of the legal basis for section 12 doctors is given in the Appendix to this report (it also covers relevant provisions in the Coronavirus Act 2020). The next section outlines the specific rationale for conducting the review.

Rationale for the review
There have been several accounts of problems in accessing section 12 doctors. The Independent Review of the Mental Health Act 1983 (2018) heard about such problems and recommended that ‘the factors that affect the timely availability of section 12-approved doctors and AMHPs should be reviewed and addressed’ (p217). The problem was also highlighted in the National Workforce Plan for Approved Mental Health Professionals (Department of Health and Social Care, Social Work England, Skills for Care and Health Education England, 2019).

Approved Mental Health Professionals (AMHPs) in our previous study (Stevens et al, 2018, 2019a/b) reported problems at times in accessing section 12 doctors when discussing difficulties in arranging MHA assessments. Similar comments were expressed in a series of focus groups held by the Care Quality Commission (2018). The availability of section 12 doctors to undertake MHA assessments after section 135 and 136 detentions by the police was considered to be of particular concern by individual practitioners. One study (Hampson 2011) reported that there is often a delay in commencing the assessment and the first doctor does not always have section 12 approval as recommended in the Codes of Practice (for England and Wales). One blog (Mental Health Cop, 2018) highlighted the impact of this on the ability of AMHPs to respond urgently to referrals, commenting on the need sometimes to make 25 phone calls to secure a section 12 doctor.

Such reports are made more significant by the context of increasing numbers of detentions under the MHA 1983. NHS Digital’s statistical report on numbers of mental health patients detained in hospitals in England under the MHA 1983 showed that detentions increased by nearly 50% in the decade to 2015/6, from 43,361 in 2005/6 to 63,622 in 2015/6 (NHS Digital, 2019). Over the past decade there has been a small rise (9,110 in 2009 to 9,295 in 2020) in the overall number of NHS psychiatrists in England (NHS Digital, 2020).

Concerns about accessing section 12 doctors have been raised for almost two decades (Greenberg et al, 2002). The Association of Directors of Adult Social Services (ADASS) and NHS Benchmarking (2018) survey of AMHPs found that waiting for a section 12 doctor was the most common, although only in just over a quarter of instances (28%, 74 occasions),
reason for avoidable delays (not related to decisions about the best course of action for the patient, see below), defined as being of over four hours between the receipt of a referral and the assessment taking place.

There has been some evidence of delays in commencing assessments relating to the availability of section 12 doctors and AMHPs, although, often, no reasons are put forward as to why accessing section 12 doctors is a problem or how it could be addressed. Hudson and Webber’s (2012) survey of AMHPs found a lack of resources was often cited by them, including limited availability of ambulances, police and doctors, this leading to delays and late working by AMHPs. Hampson (2011) mentioned section 12 doctors in her paper about raising standards in relation to section 136 of the MHA 1983. She highlighted six common misconceptions in relation to care under section 136, one of which is that ‘it is not important for the first doctor who does a Mental Health Act assessment to have Section 12 approval’. She argued that, while this is not mandatory (DH, 2015a), there is a danger that a doctor without section 12 approval may ‘wrongly determine that the person does not require further assessment’ (Hampson, 2011: 369). The Royal College of Psychiatrists (RCP, 2011) identified four key standards, which include ensuring that the doctor conducting the first medical assessment for the purposes of the MHA should be section 12 approved; and the AMHP should commence the assessment within three hours unless there are valid reasons to delay the interview.

More recently, Wickersham et al (2020) analysed MHA assessment statistics in one NHS Mental Health Trust in England. They found that over a quarter (29%, n=44) of MHA assessments were held without all professionals attending at the same time, although there did not appear to be a link between this and the ultimate decision about whether to detain the person. Wickersham et al (2020), who interviewed four section 12 doctors and other professionals involved in the assessment process, also found that different members of the assessment team sometimes assess people separately at different times. This meant that there may be a gap in time which could ‘obscure’ the decision-making process, in the words of one section 12 doctor (p651). For example, a recommendation to detain made by the first doctor might be supported by the second doctor, as their opinion could be influenced by the first doctor’s decision. Therefore, they suggested that assessments should not go ahead unless all three assessors can be present at the same time (ibid).

Delays in assessment may negatively impact upon people as their health may decline during the wait for an assessment, thus increasing the likelihood of detention (of course, the converse may happen). As a result of this concern, an AMHP in Stone’s (2018) study suggested that ensuring a short turnaround between referral and assessment might be a possible way to reduce detentions. Such a requirement was also recommended by the Independent Review of the Mental Health Act 1983 (2018): ‘The government should consider introducing a minimum waiting time standard for the commencement of an MHA assessment.’ (p217).

Several participants in Wickersham et al’s (2020) study, which included four section 12 doctors, highlighted the problem of delays caused by doctors not being available to undertake assessments and also felt that this may have had an influence on detention rates, because people deteriorate while waiting. However, they also found that perceptions of risk
were the strongest factor predicting decisions to detain, rather than factors related to aspects of the MHA assessment process, such as delays.

Moreover, in the ADASS and NHS Benchmarking (2018) survey, more assessments (39%, 102 occasions) were reported to have been purposefully delayed because it was in the best interests of the client/adult to delay the assessment, than because of the unavailability of professionals or services. Other causes of delays had earlier been attributed to difficulties about the availability of other professionals as well as section 12 doctors (Quirk et al, 2003).

Facilitating access to section 12 doctors and increasing cooperation between AMHPs and section 12 doctors have been identified as ways to improve the quality of assessments and to relieve the emotional pressure on AMHPs (Dwyer, 2012; Gregor, 2010; Hudson and Webber, 2012; Stevens et al, 2019a).

As indicated above, little is known about the underlying reasons for difficulties in accessing section 12 doctors and any approaches being undertaken to lessen them. Consequently, we undertook a scoping review and a focused synthesis of the evidence about reasons or causes underpinning reported problems with accessing section 12 doctors. The overall aim of the review was to highlight where there is strong evidence and identify gaps in evidence. The review will also inform a planned set of stakeholder interviews to establish the nature of reports about any shortages, difficulty in access and work organisation.

**Aim**
To identify evidence about factors promoting and inhibiting, and any approaches to improving, the timely availability of section 12 doctors to participate in MHA assessments in England.

**Research questions**
1. What is known about reasons for difficulties in accessing section 12 doctors to undertake MHA assessments?
2. What is known about the variation in these difficulties across England?
3. What approaches have been found to improve access to section 12 doctors to undertake MHA assessments?
4. What is known about how MHA assessments fit with section 12 doctors’ overall workload (including numbers undertaking this work on a private basis)?
5. What is known about the remuneration of section 12 doctors for MHA assessments?
6. What are the gaps in the evidence?

**Methods**
While this was not a full systematic review, we followed the guidelines for reviews identified in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Statement, using the extension for scoping reviews (PRISMA-ScR), set out by Tricco et al (2018).

**Information sources**

**Bibliographic databases**
The following bibliographic databases were searched:
Grey literature databases and websites
The following databases and websites were searched for grey literature:

**Databases**
- Social Care Online
- NICE Evidence Search
- Bielefeld Academic Search Engine
- MedNar
- King’s Fund database
- EThOS (UK PhDs)

**Websites and other sources**
- Community Care
- King’s Fund website
- Care Quality Commission website
- NHS Mental Health Trust websites
- Clinical Commissioning Group (CCG) homepages

**Search strategy**
A search strategy was developed using the mnemonic PICo: Population or Problem, phenomenon of Interest and Context. However, initial database searches indicated that a manageable number of hits (n=366) was found using a simplified search term based around variations of ‘section 12 doctors’, given that this was an essential term to use. A similar approach was used to search for grey literature. In addition, papers were identified from reference harvesting and personal correspondence.

**Selection of sources of evidence**
The database search yielded 366 publications (from database searches). After removing duplicates, the abstracts and titles of potential papers were screened and relevant papers were selected for further investigation. Three authors (S.B., N.S. and M.S.) identified relevant sources and screened for relevance by title and abstract. Following this, items which met the study criteria were retrieved and read by all authors to extract evidence relating to the research questions. Searches (see p6) of databases and websites for grey literature produced 33,280 hits, initially. Figure 1 shows a flow diagram of publication identification, screening, eligibility and inclusion in the review.
Eligibility criteria
The scoping review was not intended to undertake critical appraisal of the research as this was not a systematic review of evidence for effectiveness, but rather to identify evidence about access to section 12 doctors, what aspects of remuneration or work organisation might discourage them from doing or staying in that role, and any evidence gaps. Following Bickley et al’s (2020) guidance, ‘unpublished research, governmental reports, policy statements conference proceedings, and theses or dissertations’ (p2) were all deemed to be eligible for inclusion. In addition, we included blogs on some recognised sites (see above). Research using a wide range of different methodological approaches and theoretical perspectives was included, placing the section 12 doctor role within a context of other medical workforce policy and practice developments, as well as reports of personal testimony and the perspectives of patients/service users (see Akther et al, 2019). We focused on evidence about England, but also included relevant information relating to Scotland, where psychiatrists receive accreditation as Approved Medical Practitioners (AMPs) under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003. AMPs must be fully registered medical practitioners who are either members or fellows of the Royal College of Psychiatrists or have four years' continuous experience in the specialty of psychiatry and are sponsored by their local medical director. In addition, the team used its experience and connections to identify other relevant literature.

Data charting process
The aim of the literature review was to identify evidence about the timely availability of section 12 doctors for MHA assessments. However, the searches found no research which had focused on this question directly. A data extraction form was constructed in Microsoft Excel in which all the identified literature was included. Information relevant to the research questions was recorded (e.g. findings, descriptions of practice or theories). Information about the nature of the literature included in the study is shown in Tables 1 and 2 showing:

- Type of literature
- Type of source: Research, NHS Clinical Commissioning Group (CCG) report, etc
- Research methods (where appropriate)

Narrative synthesis
We followed a simplified version of Thomas and Harden’s (2008) thematic synthesis, to identify key themes and concepts from the literature which related to the research questions. This formed the basis of the scoping review.

Given the lack of evidence, we have not produced a table outlining findings from each source.
Results

Selection of sources of evidence

Figure 1 shows a flow diagram of records found, from different sources and numbers excluded at different stages. This process resulted in an inclusion of 37 sources, including 14 academic papers and 13 reports and blogs.

Figure 1.

Records identified:
Database searching = 366
Other* = 9
Grey lit = 33,280

Records excluded
Duplicated D/B searching = 97
Other* = 9
Grey lit not considered = 32064

Records screened
Database = 269
Other* = 9
Grey Lit = 1216

Records excluded (relevance)
Database = 212
Grey Lit = 1179

Full-text papers assessed for eligibility
Database (57)
Other* = 9
Grey Lit (35)

Full-text papers excluded for relevance
Database = 39
Other* = 3
Grey lit = 22

Studies included in qualitative synthesis
Database = 18
Other* = 6
Grey lit = 13

*Other: correspondence and reference harvesting
**Characteristics of sources of evidence**

Tables 1 and 2 show the types of research papers included for analysis from database searching, correspondence and reference harvesting.

### Table 1: Key and summary of literature

<table>
<thead>
<tr>
<th>Source:</th>
<th>N</th>
<th>Type:</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB = Database</td>
<td>18</td>
<td>Res = Research</td>
<td>17</td>
</tr>
<tr>
<td>Oth = Other (correspondence and reference harvesting)</td>
<td>6</td>
<td>TP = ‘Think-piece’, paper presenting a personal analysis and discussion</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>SR = Service Review</td>
<td>1</td>
</tr>
<tr>
<td><strong>Pub:</strong></td>
<td></td>
<td>PA = Personal account and reflection on practice</td>
<td>1</td>
</tr>
<tr>
<td>PRJ = Peer reviewed journal</td>
<td>1</td>
<td>Edit = Editorial</td>
<td>1</td>
</tr>
<tr>
<td>Brief = Briefing paper</td>
<td>21</td>
<td>Comm = Commentary on another paper</td>
<td>1</td>
</tr>
<tr>
<td>Rep = Research report</td>
<td>2</td>
<td>Rev = Literature review</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

**Methods (including 17 research papers, 1 literature review and 1 service review)**

<table>
<thead>
<tr>
<th>N</th>
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<tbody>
<tr>
<td>Lit review</td>
</tr>
<tr>
<td>Mixed</td>
</tr>
<tr>
<td>Qualitative*</td>
</tr>
<tr>
<td>Quantitative</td>
</tr>
<tr>
<td>Survey</td>
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<tr>
<td>Total</td>
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</table>

*Two papers (Stevens et al, 2018; Stevens et al, 2019a) reported on the same qualitative research study.
<table>
<thead>
<tr>
<th>Authors (date)</th>
<th>Source</th>
<th>Year</th>
<th>Pub</th>
<th>Type</th>
<th>Aim of publication</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brown &amp; Humphreys (2003)</td>
<td>DB</td>
<td>2003</td>
<td>PRJ</td>
<td>TP</td>
<td>To reflect on legal definition of s12 doctor approval and consider the requirements for training.</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Care Quality Commission (2018)</td>
<td>DB</td>
<td>2018</td>
<td>Brief</td>
<td>SR</td>
<td>To identify themes that support or challenge the effective running of AMHP services.</td>
<td>Secondary analysis of LA data; site visits to: LAs (n=23); NHS Trusts (n=10); independent MH service providers (n=2). Interviews and Focus Groups with: detained patients (n&gt;60); carers (n=30); Staff (AMHPs &amp; AMHP leads, LA staff) (n&gt;250).</td>
</tr>
<tr>
<td>6. Greenberg et al (2002)</td>
<td>DB</td>
<td>2002</td>
<td>PRJ</td>
<td>Res</td>
<td>This study aimed to examine the use of section 136 MHA in a rural area of England (Devon and Cornwall) and also aimed to examine the correlation between the use of section 136 and social deprivation.</td>
<td>A prospective survey of the use of section 136 in Devon and Cornwall (n=178 cases).</td>
</tr>
<tr>
<td>7. Gregor (2010)</td>
<td>DB</td>
<td>2010</td>
<td>PRJ</td>
<td>Res</td>
<td>To explore some of the unconscious processes that may be at play during statutory mental health work.</td>
<td>Semi-structured interviews with ASWs (n=25). Grounded Theory analysis.</td>
</tr>
<tr>
<td>Authors (date)</td>
<td>Source</td>
<td>Year</td>
<td>Pub</td>
<td>Type</td>
<td>Aim of publication</td>
<td>Methodology</td>
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<tr>
<td>8. Hampson (2011)</td>
<td>DB</td>
<td>2011</td>
<td>PRJ</td>
<td>TP</td>
<td>To highlight problems in implementing s136 MHA and suggest improvements.</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Hudson &amp; Webber (2012)</td>
<td>DB</td>
<td>2012</td>
<td>Rep</td>
<td>Res</td>
<td>To explore the prevalence of stress and burnout among AMHPs and examine whether there are differences between the professional groups that administer the role.</td>
<td>Total population national online survey (n=504) of AMHPs incorporating the General Health Questionnaire and the Maslach Burnout Inventory.</td>
</tr>
<tr>
<td>11. Leah (2019)</td>
<td>DB</td>
<td>2019</td>
<td>PRJ</td>
<td>Res</td>
<td>To investigate the professional role and identities of 10 multi-professional AMHPs.</td>
<td>Three rounds of semi-structured interviews with AMHPs from different professions (n=10). Case study approach using framework analysis.</td>
</tr>
<tr>
<td>12. Morriss (2016)</td>
<td>DB</td>
<td>2016</td>
<td>PRJ</td>
<td>Res</td>
<td>To explore the notion of ‘dirty work’ in relation to AMHPs’ role in decisions to detain after an MHA assessment.</td>
<td>Semi-structured interviews with social worker AMHPs (n=17). Narrative analysis.</td>
</tr>
<tr>
<td>15. Quirk et al (2003)</td>
<td>DB</td>
<td>2003</td>
<td>PRJ</td>
<td>Res</td>
<td>To describe non-clinical and extra-legal influences on professionals’ decisions about compulsory admission to psychiatric hospital.</td>
<td>Participant-observation of MHA assessments, including informal and depth interviews with the practitioners.</td>
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<tr>
<td>Authors (date)</td>
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<td>16. Rigby, &amp; McAlpine (2019)</td>
<td>DB</td>
<td>2019</td>
<td>PRJ</td>
<td>Edit</td>
<td>To analyse the process of s12 approval from a medical educational perspective.</td>
<td>Interviews (n=59) with: nurses, chartered psychologists, and OTs AMHPs and non-AMHPs; managers of AMHP services; people with mental health problems and their families; and other professionals. Survey of local authorities (n=53)</td>
</tr>
<tr>
<td>17. Stevens et al (2018)</td>
<td>DB</td>
<td>2018</td>
<td>Rep</td>
<td>Res</td>
<td>To identify factors encouraging and discouraging the recruitment of mental health and learning disability nurses, chartered psychologists and occupational therapists (OTs) as AMHPs.</td>
<td>Semi-structured interviews (n=52) with health professional AMHPs, non-AMHPs; AMHP managers. Survey of AMHP senior managers. Interviews and open-ended survey questions were analysed thematically.</td>
</tr>
<tr>
<td>18. Stevens et al (2019)</td>
<td>DB</td>
<td>2019</td>
<td>PRJ</td>
<td>Res</td>
<td>The research aimed to identify factors motivating and discouraging health professionals from becoming and working as AMHPs.</td>
<td>Semi-structured interviews (n=52) with health professional AMHPs, non-AMHPs; AMHP managers. Survey of AMHP senior managers. Interviews and open-ended survey questions were analysed thematically.</td>
</tr>
<tr>
<td>19. Stevens et al (2019)</td>
<td>DB</td>
<td>2019</td>
<td>PRJ</td>
<td>Rev</td>
<td>To identify evidence about factors promoting and inhibiting recruitment and retention of social workers to the AMHP role</td>
<td>Systematic thematic synthesis of literature (n=23 papers)</td>
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<td>Authors (date)</td>
<td>Source</td>
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<td>23. Wickersham et al (2020)</td>
<td>Oth</td>
<td>2019</td>
<td>PRJ</td>
<td>Res</td>
<td>To investigate predictors of detention amongst patients assessed under the MHA for compulsory admission. To explore factors that might help or hinder detention minimisation.</td>
<td>Secondary analysis of historical, routinely collected health and social care data. Semi-structured interviews with AMHPs (n=4) and s12 doctors (n=4). Focus group with AMHP leads (n=3)</td>
</tr>
</tbody>
</table>

**Key:**

**Source:**
- DB = Database
- Oth = Other (correspondence and reference harvesting)

**Publications:**
- PRJ = Peer reviewed journal
- Brief = Briefing paper
- Rep = Research report
- Total

**Type:**
- Res = Research
- TP = ‘Think-piece’, paper presenting a personal analysis and discussion
- SR = Service Review
- PA = Personal account and reflection on practice
- Edit = Editorial
- Comm = Commentary on another paper
- Rev = Literature review
Synthesis of results

Table 1 shows that most (17/24) of the items included from the database and ‘other’ searches reported research, although two papers (Stevens et al 2018; 2019) relate to the same research study. One, CQC (2018), reports findings from extensive quantitative and qualitative work with different stakeholders as part of a review of AMHP services and a further paper (Stevens et al, 2019b) reported a review of literature on AMHPs. Of the 16 research studies, eight involved purely qualitative methods and one included mixed methods involving secondary analysis of routinely collected data and interviews. Of the others, six reported single-shot cross-sectional surveys and one involved secondary analysis. The service review involved mixed methods. The other papers from peer review journals included two ‘think pieces’ (Brown and Humphreys, 2003; Hampson, 2011) exploring relevant topics, one personal account of practice (Dwyer, 2012), an editorial (Rigby and McAlpine, 2019) and a commentary on another paper (Zigmond, 2003).

The 13 sources included from the grey literature search included four blogs (Anonymous NHS manager, 2016; Carson, 2018; Chamberlain, 2020; Mental Health Cop, 2018), three of which were from Community Care online magazine; information on four web pages (S12 Solutions, 2017abc; Wesssex Academic Health Science Network (WAHSN), 2020); three policy documents (Camden, 2019; NHS, 2019; North Cumbria, 2019); and two short reports, both about the S12 Solutions app (Manning, 2019; S12 Solutions, 2017d).

As we outline below, one of the main findings of the review is a lack of research that includes direct participation of section 12 doctors, and none of the studies or other papers directly aimed to explore reasons for the difficulties of accessing section 12 doctors to undertake MHA assessments. The findings we use in the paper are broadly tangential to the main aims of these studies; sometimes this report focuses on questions raised, rather than the direct findings. As a result, it was decided not to summarise the findings of each paper included.

Findings (focused synthesis)

We report the findings here by research question, integrating the results of the academic and grey literature searches.

What is known about reasons for difficulties in accessing section 12 doctors to undertake MHA assessments?

We identified four themes from the literature in relation to this question: ‘Managing power relations’; ‘Working relationships between AMHPs and section 12 doctors’; ‘Organisational factors’; and ‘Training and approval processes’.

Managing power relations

Social workers, nurses and occupational therapists who have successfully completed an assessed period of post-qualifying training and have been approved as AMHPs are ultimately responsible for deciding whether to apply for compulsory hospital admission of a person under a section of the MHA 1983 (Stevens et al, 2019a). They are free to make this decision against the recommendation of a section 12 doctor. The ability to make such decisions, against the advice of doctors, has been identified as a challenging part of the AMHP role, given that it goes against usual professional hierarchies (Morriss, 2016; Stevens...
et al, 2019a; Stone, 2018). This was illustrated by an AMHP taking part in Morriss’s (2016) research, who described the advocacy element of their role and noted that AMHPs can challenge the decision-making of section 12 doctors – ‘When somebody is at their weakest it needs to be somebody at their strongest who’s going to challenge the doctors, who’s going to say “no that’s not right”.’ (Morriss, 2016: 714).

Section 12 doctors may therefore have to engage in negotiation and persuasion. For example, in one study an AMHP reflected that a psychiatrist perceived her ‘as the judge’ and the ‘two doctors have got to persuade the AMHP to sort of settle on their side’ (Leah, 2019: p8). Section 12 doctors in Leah’s (2019) study also received legal advice from AMHPs about procedural aspects of the MHA assessment. Leah (2019) suggested that AMHPs enact eight hybrid roles and it may be that each of these roles potentially represents a challenge to traditional hierarchies when section 12 work is being undertaken. Another earlier study noted anecdotally that doctors complain that approved social workers are able to ‘turn down’ medical decisions (Zigmond, 2003: 44).

However, we identified no direct evidence about section 12 doctors’ views about these aspects of MHA work, so we do not know whether they have any bearing on doctors’ willingness to become section 12 approved or to agree to take on the work.

**Working relationships between AMHPs and section 12 doctors**

Difficulties in working between AMHPs/ASWs (Approved Social Workers, the predecessor role to AMHPs) and section 12 doctors were mentioned in four studies as a potential factor affecting timely availability of section 12 doctors. Gregor (2010) interviewed 25 ASWs, many of whom stated they had experienced stress as it could be challenging to co-ordinate a complex assessment involving doctors and other professionals, and also to work in isolation after a doctor has completed their assessment of the patient. Uncertainty about whether and when doctors will arrive to undertake the assessment was mentioned by Dwyer (2012) as adding to the stress experienced by AMHPs in organising MHA assessments.

Doctors leaving after they have finished their assessment was raised in other papers (Karban et al, 2020; Vicary et al, 2019). For example, Vicary et al (2019) mentioned that section 12 doctors often leave after the assessment, which can leave AMHPs in potentially dangerous situations with patients known to have been violent. This was experienced by one AMHP in Vicary et al’s (2019) study as being ‘abandoned’ (p2198). Consequently, some AMHPs thought that these doctors are not as involved in the process as they should be and that they do not spend enough time with patients. Karban et al (2020) also noted that if doctors did stay, they took a different approach to that of the AMHP. One AMHP in their study commented that after a decision to detain had been made then doctors who do remain with the AMHP and patient tend to focus on the illness, rather than the broader implications of the decision.

In an earlier study, ASWs called for ‘consistent support from external resources such as specialist mental health doctors, known as section 12 doctors’ (Gregor, 2010: 440), but no further detail was provided about what type of support in practical terms the ASWs required from section 12 doctors.
One AMHP in Vicary et al’s (2019) study reported that doctors may try to delegate administrative tasks (e.g. updating a patient’s medical record) and securing a hospital bed to the AMHP. This may lead to tension between section 12 doctors and AMHPs/ASWs, which may be detrimental to the process of undertaking MHA assessments. However, it is important to note that the voices of section 12 doctors are currently absent from discussions of their role and working practices and should therefore be examined in the next stage of this project.

Organisational factors
Changes to agreements between local authorities and NHS Primary Care Trusts (at the time; subsequently replaced by CCGs, themselves being replaced by Integrated Care Systems) may have affected the timely availability and general availability of section 12 approved psychiatrists or GPs. Focus groups conducted with Trust staff and carers as part of the CQC’s (2018) review of AMHP services found that delays may be partly because ‘Trust doctors no longer come out with the AMHP to do assessments….and there is lack of multidisciplinary team discussion that has had a negative impact effect on patients’ (ibid: 11). This could be explained by the decisions made by some local authorities and NHS Trusts to withdraw their section 75 (National Health Service Act 2006) agreement (ibid). These agreements set up arrangements to pool resources and delegate certain NHS and local authority health-related functions to other partner(s) if it would lead to an improvement in the way those functions are exercised (Goodman et al, 2011). After local decisions to withdraw section 75 agreements, Trust staff and carers in the focus groups felt that the ‘relationship between the local authority and the trust appeared somewhat strained’ with ‘some staff expressing concern about hostility on both sides that impeded their work’ (CQC, 2018: 11).

Apart from one study, conducted nearly 20 years ago (Quirk et al, 2003), there is little coverage in the literature about where section 12 doctors fit within an organisation and how this impacts on their availability to undertake MHA assessments. Quirk et al (2003) observed 20 MHA assessments conducted by five teams in one inner and one outer London borough. Assessments in one of the inner London teams were conducted via an integrated health and social services duty team, which was typically staffed by a full-time supervisor, three care managers (ASWs), two community psychiatric nurses on weekly rotation and a full-time section 12 doctor. In an outer London team, by contrast, MHA assessments were conducted by a 24-hour crisis service, staffed during office hours by social workers and other crisis team personnel, including doctors, although not necessarily section 12 approved on ‘daily rotation’ (Quirk et al, 2003: 124). Out of office hours, the same staff covered the work on a rota. It is not known whether these approaches are typical or atypical in other Trusts and whether they impact on the availability of section 12 doctors. However, Quirk et al (2003) concluded that team arrangements may have some impact on detention rates, which were the focus of their study.

Training and approval processes
Prestige can be a motivating factor for doctors to choose certain career paths (Walker et al, 2019), suggesting that the value doctors place on becoming section 12 approved may relate to the level of training required, as it does in surgery specialisms, for example (Creed et al, 2010). Rigby and McAlpine (2019) surveyed the 23 providers of section 12 doctor training and approval, although only five providers replied. They found that initial induction training usually takes place over two days and revalidation/refresher training lasts one day (p251).
The induction training was described as mainly ‘lecture-based’ (p252) and there was no mandatory assessment at the end of either training by the five providers who replied (pp251 & 253). Several years previously, Brown and Humphreys (2003) had called for this training’s content to be extended to ensure section 12 doctors have a good understanding of the legislation and how it applies in practice; they argued that courses should include rigorous assessment of learning.

In addition to the short training course, applicants must name two referees in order to become approved, one of whom must be an NHS consultant psychiatrist familiar with the work of section 12 doctors (Rigby & McAlpine, 2019: 252). However, there is no framework for referees to use to make judgements about whether the candidate has the necessary skills and experience to undertake the role. Consequently, there is no knowledge about how such referees assess whether a candidate will be able to conduct MHA assessments correctly.

What is known about the variation in these difficulties across England?
The number of section 12 doctors was reported in some studies (e.g. Ogundipe et al, 2001); however, this evidence is very dated and patchy in terms of its geographical coverage. Guidance from the National Institute for Mental Health in England (2008) observed that there ‘will need to be a close partnership between Local Social Services Authorities (LSSAs) and local NHS partners to ensure that there are sufficient ... Section 12 doctors trained and available in sufficient numbers to meet local needs and this may be an issue to consider in terms of workforce planning and implementation’ (National Institute for Mental Health in England, 2008: 25).

Ogundipe et al (2001) had surveyed section 12 doctors about their interpretation of section 136 of the MHA 1983. Their survey was sent to a randomly selected sample of the 597 doctors on the section 12(2) register in the West Midlands as of 1999. Section 12 doctors included psychiatrists, most of whom were consultant psychiatrists, with the remainder being General Practitioners (GPs) or police surgeons. More recently, Wickersham et al (2020) conducted a service evaluation of one inner London NHS Trust, which served 459,525 people, to examine potential risk factors for detention under the MHA 1983. In this Trust, 99 professionals could act as section 12 doctors, although there was no indication of the adequacy of this number.

An earlier study (Greenberg et al, 2002) found that MHA assessments were delayed more by the wait for ASWs than section 12 doctors in the rural area they studied. They investigated the use of section 136 of the MHA 1983 in an area of rural England and found evidence of long delays when waiting for an ASW (3 hours and 25 minutes) which was far longer than the arrival time of the section 12 doctor (2 hours and 10 minutes). However, Greenberg et al argued that section 136 assessments affected ASWs more than section 12 doctors because they were held outside normal working hours, and because ASWs may have been doing background work before the assessment. Concerns were also raised by Social Services departments because the ‘time taken for mental health assessments was too long because of the unavailability of section 12 doctors’ although delays in arriving to conduct assessments were also experienced by ASWs themselves (Greenberg et al, 2002: 132).
What approaches have been found to improve access to section 12 doctors to undertake MHA assessments?

Little was mentioned in the literature about specific initiatives to improve access to section 12 doctors to undertake MHA Assessments. However, NHS Trusts were advised (National Institute for Mental Health in England, 2008) that they should have a list of section 12 doctors for use by local Social Services Departments and AMHPs. Local authorities were recently encouraged to monitor access to section 12 doctors with a view to monitoring the difficulties that affect the AMHP service (Department of Health and Social Care, Social Work England, Skills for Care and Health Education England, 2019).

S12 Solutions app

Arising from the need for ‘lists’ of current section 12 doctors, the main approach to improving access to AMHPs has been the development of the ‘S12 Solutions app’ (application). This work was funded with support from the NHS Innovation Accelerator Scheme, which was set up to ‘scale high impact, evidence-based innovations across the NHS and wider healthcare system’ (NHS Innovations Accelerator, 2019: 4). The app and website were developed from the perspective of an AMHP involved in the MHA assessment process (S12 Solutions, 2017a), although there was also an ambition to make it easier for section 12 doctors to control their work and to claim fees (Manning, 2019; S12 Solutions, 2017c). It enables AMHPs to contact section 12 doctors, to arrange MHA assessments; approval of involved doctors is checked against the national database on a weekly basis (S12 Solutions, 2017b). The app also allows AMHPs and section 12 doctors to create, complete and submit payment claim forms for MHA assessments. Section 12 doctors can enter their availability on a personal calendar and ‘build a profile containing their location, specialities and languages spoken, and monitor their activity via a dashboard’. Doctors can also use the platform to record the assessments they have attended, to provide supporting evidence for Continuing Professional Development. In addition, the app provides data capture and reporting about the MHA assessment process (S12 Solutions, 2017b).

The S12 Solutions website reported outcomes in two pilot sites, which they evaluated (S12 Solutions, 2017d). The pilots reported that: more doctors joined the local networks; assessments were carried out quicker than expected; the ability to search for specialism improved outcomes for patients; there were fewer out-of-hours assessments (S12 Solutions, 2017b; 2017d). The two pilot sites still use the platform according to S12 Solutions (2017b). North Cumbria Clinical Commissioning Group (CCG) has implemented the S12 Solutions app (North Cumbria Clinical Commissioning Group, 2019: 16), but there is no information as to how it is used, how successful it is, or about any potential barriers to its utilisation within the CCG.

What is known about how MHA assessments fit with section 12 doctors’ overall workload (including numbers undertaking this work on a private basis)?

Several papers (Carson, 2018; CQC, 2018; Leah, 2019; Patel et al, 2016) mentioned that delays in accessing section 12 doctors could be explained by doctors’ workloads and hours/days of work. While there was a rota of section 12 doctors available out-of-hours, AMHPs reported that MHA assessments were often delayed until after 6pm because section 12 doctors were not available until then (CQC, 2018). This was also identified in other local
areas, for example, ‘Leicestershire council says the majority of Mental Health Act assessments occur after 5.00pm, mainly due to the availability of doctors’ (Carson, 2018).

AMHPs in the CQC (2018) study thought that when GPs were involved who knew the patient, this led to a positive outcome and improved the patient’s experience. Furthermore, they believed that not being able to secure a doctor with previous knowledge of the patient may mean that patients are more likely to be admitted to hospital rather than being offered alternatives (ibid). However, these AMHPs also identified limited access to GPs to contribute to MHA assessments, even during the day. Consequently, it was possible that no-one with personal knowledge of the patient would be present at the MHA assessment so running contrary to section 12(2) MHA 1983 (see Appendix).

Indirect evidence about the availability of section 12 doctors was found in studies about admissions to hospitals. For example, Patel et al (2016), in their study of clinical outcomes and mortality associated with weekend admission to psychiatric hospital, found that while some patients were more likely to be admitted to hospital at the weekend, compulsory admission was less likely at the weekend. This raises the question of whether the availability of section 12 doctors may vary at weekends compared to weekdays, which may require further investigation in interviews with section 12 doctors and those organising MHA assessments or documentary analysis.

Gatekeepers may also play a part in managing the timely availability of section 12 doctors. Leah (2019: 9) mentioned that an AMHP had been obstructed in their duty as a ‘GP receptionist refused to access a GP for a requested MHA assessment’ (the reason for this was unknown). The role of any gatekeepers in relation to the timely availability of section 12 doctors should also be examined in future work on this topic.

**What is known about the remuneration of section 12 doctors for MHA assessments?**

Under the NHS Act 2006 (section 236) the government must pay a fee to a medical practitioner who medically examines a person to apply to admit them to hospital for assessment, or for treatment under Part 2 of the MHA 1983 (British Medical Association, 2019). Section 12 doctors are seemingly well remunerated for this role. One study reported that section 12 doctors are paid a fee per assessment for out-of-hours work in addition to their salary. In the Staffordshire area, the fee is currently £173.37 (NHS, 2019), which is a considerably higher fee than the amount paid to AMHPs who receive a standard monthly payment regardless of how many or how few assessments they have undertaken (Stevens et al, 2019a) but appears to be a fairly typical sum (West London Mental Health Trust, 2018) or thereabouts (£176.84, Sheffield Local Medical Committee, 2016).

There is anecdotal evidence that increasing the fee for section 12 doctors helped resolve historic difficulties in accessing section 12 doctors, especially in London. For example an NHS manager commented, in a *Community Care* article that focused mainly on the shortage of AMHPs: ‘The situation literally changed overnight when their [the section 12 doctors’] assessment fee was doubled.’ (Anonymous NHS manager, 2016). Furthermore, North Cumbria CCG’s annual report for 2018/19 (North Cumbria Clinical Commissioning Group, 2019: 16) highlighted success in recruiting and training of section 12 doctors and reviewing
and increasing the remuneration package for section 12 activities, although no further details are provided in its report. Fees were uprated in Sheffield in 2016 (Sheffield LMC 2016).

Different payment agreements concerning when and where section 12 doctors can claim extra money for undertaking MHA assessments mean that it is more remunerative to undertake them outside their contracted hours of work. This may be a reason for the difficulties in accessing these doctors during office hours. Several CCGs in the Staffordshire area addressed the risk of double payments in a policy detailing when section 12 doctors can claim additional payment for undertaking section 12 work during times that are already paid for as part of other activities (NHS, 2019). This was very similar to Camden and Islington NHS Foundation Trust’s (2019) published policy, which states that section 12 doctors cannot claim (additional) payments ‘for section 12 work carried out on patients who are currently under their care as inpatients, outpatients or community patients in the Care Programme Approach in Mental Health (CPA) system either at an enhanced or standard level’ (p3). This also applies where responsibilities are delegated. Furthermore, the Staffordshire policy states that fees cannot be claimed for MHA assessments relating to:

- ‘Patients examined in a mental health trust outpatient clinic or following a GP request for a domiciliary consultation between the hours of 9am – 5pm’
- Mental Health Trust inpatients that present out-of-hours to the on-call Consultant or Specialist Registrar
- Patients under the current caseload of the community mental health team Consultant or a section 12 doctor in the Consultant’s team. This includes: day patients, outpatients and patients on community team caseloads, during weekdays 9am-5pm’ (NHS, 2019: 6).

**What are the gaps in the evidence?**
The review identified a wide range of gaps in the evidence:

- Voices of section 12 doctors – motivations, tensions, power relations
- Partnership working: barriers/facilitators/approaches
- Clarity over definitions, evidence of and reasons for delays
- The implications of payment arrangements for MHA assessments and the sums involved
- The fit of MHA assessments with section 12 doctors’ overall workloads
- Availability and retention of section 12 doctors
- Approval and re-approval processes – standardisation and fitness of training to meeting needs and legal safeguards
Discussion
The discussion is also structured around the research questions and will present a summary of the findings and suggest implications.

What is known about reasons for reported difficulties in accessing section 12 approved doctors to undertake MHA assessments?

Power relations
Several of the references and sources reviewed suggested that AMHPs consider that their role in decision making in MHA assessments may upset the usual hierarchy among non-medically qualified staff and doctors (Morriss, 2016; Stevens et al, 2019a; Zigmond, 2003: 44). It is possible that such concerns may be a factor in some of the difficulties in accessing section 12 doctors and could possibly discourage them from becoming approved or continuing to practise. However, there is no direct evidence about section 12 doctors’ views about these matters, and this should be a major focus of the next stage of this project.

Working relationships between AMHPs and section 12 doctors
Four studies (Dwyer, 2012; Gregor, 2010; Karban et al, 2020 and Vicary et al, 2019) identified points of potential difficulties between AMHPs and section 12 doctors: the difficulties of access; conflicts in approach during assessments; and the fact that doctors tend to leave soon after a decision has been made about whether to detain the person. The research involved was qualitative in method, focused on the AMHP, and there is no indication about whether and how far these factors are experienced more widely. The voice of section 12 doctors is currently absent from discussions of their relationships with AMHPs and working practices; this is needed to help understand the different perspectives involved and to develop approaches to overcome any problematic factors.

Organisational factors
Some questions were raised in the reviewed literature about the impact of the withdrawing of section 75 (National Health Service Act 2006) agreements in some areas on the availability of section 12 doctors. It may therefore be worthwhile investigating how the relationship between local authorities and NHS partners works in practice to facilitate the work of section 12 doctors. This may be something to probe in interviews with section 12 doctors to determine their working practices, working relationships with their employers and the extent that they engage with partnership working. In addition, the lack of guidance and clarity about the number of section 12 approved doctors needed in a locality is a further question to explore with NHS Trust and other NHS bodies, and local authority managers.

Only one study (Quirk et al, 2003) addressed the question of where section 12 doctors ‘fit’ in organisations and how or whether this impacts on their availability to undertake MHA assessments. Location in different teams was found to affect the ease with which AMHPs undertake their work (Stevens et al, 2019a), suggesting this is a question for exploration in relation to section 12 doctors.

Training and approval processes
Rigby and McAlpine (2019) argued that the current level of training required for initial approval and renewal of section 12 doctors and lack of frameworks or criteria for referees were inadequate. They recommended a thorough overhaul, based on evidence of the
knowledge and skills required and, crucially, examined to test and evaluate learning at the end of the training. Such an increase in the level of training and the need to pass assessments may also give the training and role greater status and therefore attract more doctors, given the importance of prestige and its association with length of training (Creed et al., 2010), although the extra work involved and potentially personal financial cost may be off-putting. In addition, the lack of framework for referees to use in their recommendations of candidates for section 12 approval may give the impression of the role as being not very serious or important. Further research would be needed to establish future and present section 12 doctors’ views about training and approval, which will therefore be a topic for the next phase of this study. More extensive research exploring the impact of these factors, in relation to detention rates and other outcomes may also be needed but would likely be outside the focus of this proposed study.

What is known about the variation in these difficulties across England?
There appears to be little evidence, in the literature reviewed, about numbers of section 12 doctors, and little mention of whether numbers are adequate and sufficiently meet demand in different localities. This is despite guidance (produced over a decade ago) stating the need for ‘a close partnership between LSSAs and local NHS partners to ensure that there are sufficient...Section 12 doctors trained and available in sufficient numbers to meet local needs’ (National Institute for Mental Health in England, 2008: 25). This may be a matter to consider in terms of workforce planning and implementation. This suggests the value of investigating how the relationship between local authorities and NHS partners works in practice to facilitate the work of section 12 doctors, particularly in the context of emerging Integrated Care Systems.

Again, there was little evidence in the literature about the impact of location. Some suggestions were made that assessments in rural areas are more difficult to arrange (Greenberg et al., 2002). We will cover the impact of location in our interviews with section 12 doctors, but further work to explore the impact of location on the availability of section 12 doctors and indeed on other aspects of MHA assessments is needed.

What approaches have been found to improve access to section 12 doctors to undertake MHA assessments?
Information about numbers and availability of section 12 doctors was the main intervention identified in the literature, and Trusts have developed their own lists. The development of the S12 Solutions app, which allows AMHPs to identify the availability of local section 12 doctors and to check their experience and suitability for a particular MHA assessment, appears to be a very promising and practical means of overcoming some of the problems in accessing section 12 doctors for MHA assessments. The one independent evaluation of the app was undertaken by the WAHSN (2020) and published after our literature searches had been completed. The evaluation found very promising indications that use of the APP reduced the time taken to organise MHA assessments, enabled AMHPs to involve a wider range of s12 doctors in MHA assessments and improved payment administration for s12 doctors (WAHSN, 2020).
**What is known about how MHA assessments fit with section 12 doctors’ overall workload (including numbers undertaking this work on a private basis)?**

Most of the evidence stemmed from AMHPs’ reports in CQC (2018) and relates to the difficulties of accessing section 12 doctors out-of-office hours or the pattern of compulsory hospital admissions (Patel et al, 2016). There was very little evidence about the reasons for these difficulties, although they suggested that there may be other pressing demands being made on doctors’ time which may take precedence. It will therefore be worth exploring how doctors prioritise their time in relation to the completion of MHA assessments.

Gatekeepers, such as GP receptionists, may play a role managing workloads and therefore affect the ease with which AMHPs can arrange GP involvement in MHA assessments, as was suggested by Leah (2019) (although these may not be section 12 doctors). Again, there was little evidence about the potential role of gatekeepers from section 12 doctors’ or from gatekeepers’ perspectives, suggesting another aspect to be explored in the future study.

**What is known about the remuneration of section 12 doctors for MHA assessments?**

While there was evidence about the fee paid to section 12 doctors being perceived as being generous by AMHPs (Stevens et al, 2019), one CCG had found that increasing the fee attracted more section 12 doctors to the role (North Cumbria Clinical Commissioning Group, 2019). However, the degree to which the overall fee on offer encourages section 12 doctors to become approved and influences the amount they practise in the role is not known.

Some CCGs and Trusts have policies that forbid payments for section 12 doctors for MHA assessments conducted in normal working hours. Such policies, if common, may provide some explanation for the claim by AMHPs that section 12 doctors are not available until the evening. It is possible that section 12 doctors might not be willing to undertake section 12 work during times when they are already being paid as part of other activities (which may be hard to postpone or delegate). They may prefer to wait to do the assessment ‘in their own time’ when they will be able to claim additional payment. However, views of section 12 doctors are entirely absent from the evidence about the impact of remuneration rules and nothing is known about whether section 12 doctors experience any difficulties with making claims for payments or receiving payments.

**Conclusion**

The literature reviewed has suggested several possible factors influencing the difficulty of accessing section 12 doctors that contain aspects to guide the study and possibly future research. Given that the perspectives of section 12 doctors are missing from almost all the literature we reviewed this suggests that our study will need to focus on exploring the perspectives of section 12 doctors about:

- Their views and experiences of MHA assessments in relation to the role of the AMHP as final decision-maker
- The training and approval processes to become a section 12 doctor
- The advantages of becoming section 12 approved in relation to career progression
- How section 12 work is managed in relation to other workloads
Remuneration levels for MHA assessments and the rules on when, and for which patients, fees can be paid. Processes of making claims for and receiving payments.

It will be important to include doctors working full time in this role, as well as those who fit in their role as section 12 doctors with other duties, whether this is in relation to hospital or community work.

The review has also identified questions in relation to Trust and local authority roles in the organisation of the section 12 doctor service. In addition to covering some of the questions identified for interviews with section 12 doctors, interviews with senior managers will also need to cover:

- Approaches to establishing the appropriate numbers of section 12 doctors across different areas
- Impact of the degree of integration of mental health services and relationships between local authorities and NHS Mental Health Trusts and CCGs/ICSs.

Further research investigating what is seen as the required numbers of section 12 doctors would also be valuable. This is complicated by the fact that section 12 doctors can choose how much work they take on, particularly in relation to work undertaken outside their normal roles, which makes it difficult to assess capacity.

The only approach to improving access to section 12 doctors we found was the development of the S12 Solutions app. While a pilot showed promising results, further, independent evaluation of the impact of the app and its implementation would be valuable.

The main outcome of this literature review has been to identify gaps in the literature and research. Given that almost all the research was qualitative and in light of the lack of research including section 12 doctors’ views and experiences, the review has identified areas for further exploration, in this study and in future research.
Appendix: Legal basis of the section 12 doctor role and compulsory admission

This appendix focuses on the legal basis of the section 12 role and the part these doctors play in compulsory admission under Part 2 of the Mental Health Act 1983 (MHA 1983). We do not detail the responsibilities of others involved in MHA assessments, notably those of the Approved Mental Health Professional (AMHP). The MHA 1983, as amended by the Mental Health Act 2007, is concerned with the reception, care and treatment of mentally disordered patients in England and Wales. However, Wales has its own Code of Practice and we focus on the 1983 Act’s application in England.

Legal basis of section 12 doctor role

While the decision to apply for a person’s compulsory hospital admission as part of a MHA assessment is that of the Approved Mental Health Professional (AMHP) or, less commonly, the Nearest Relative (NR), there must be ‘objective medical expertise’ (Winterwerp v The Netherlands, para. 39) confirming the existence of mental disorder, and its seriousness, for such a decision to be legitimate under Article 5 European Convention on Human Rights (Right to liberty and security). In England, the pink forms the AMHP (or NR) fills out for a s.2 (assessment) or s.3 (treatment) detention state that the application for admission is ‘founded’ on two medical recommendations (s.4 emergency detentions only require the recommendation of a single doctor). For their part, recommending doctors give their grounds in corresponding forms as part of the detention procedure (Mental Health Online, 2020).

Whenever the MHA 1983 requires the recommendations of two doctors one of them must be a section 12 doctor (Hale, 2017). This includes applications for admission to hospital under the most common means of detention, s.2 and s.3 (as well as for reception into guardianship under s.7). Where a patient has been admitted on a s.4 emergency basis and the recommending doctor was not section 12 approved, then if the admission is to be converted to a longer-term detention the second recommendation must come from a section 12 doctor.

In the English context, section 12 doctors are those approved by the Secretary of State (or persons with whom the Secretary of State has entered into agreements: s.12ZA or s.12ZB) under s.12(2) MHA 1983, where they are described ‘as having special experience in the diagnosis or treatment of mental disorder’. Rules governing approval (which lasts for periods of five years) are contained in the Instructions with respect to the exercise of an approval function in relation to section 12 doctors 2015 (Secretary of State for Health, 2015). The Schedule to these instructions sets out the professional requirements for approval. While one way of meeting these requirements is to be a member or fellow of the Royal College of Psychiatrists, the Schedule lists five other means, including being a GP with the experience stipulated in the Schedule. A doctor who is an Approved Clinician (one of the roles brought in by the Mental Health Act 2007) is automatically treated as being section 12 approved (s.12(2A) MHA 1983).

In addition to the mandatory provisions relating to section 12 doctors in the 1983 Act, the MHA Code of Practice (DH 2015a) describes those circumstances when it would be preferable for a section 12 doctor to be involved. The Code states that at MHA assessments,
‘[i]t is preferable that a doctor who does not have previous acquaintance with the patient be approved under section 12 of the Act’ (DH, 2015a: para. 14.74), with ‘previous acquaintance’ meaning that the doctor has personally treated the patient or at least has some previous knowledge of the case (DH, 2015a: para. 14.73). The implication of this is that where neither doctor has previous acquaintance, then both should preferably, according to the Code, be section 12 doctors. Also, where a person has been taken to a place of safety under s.135 (warrant to search for and remove patients) or s.136 (mentally disordered people found in public places, judged to need a mental health professional), doctors examining patients should be section 12 approved and where this is not the case the reasons for this should be recorded (DH, 2015a: para. 16.46). When executing a warrant under s.135, the Code states that it may be helpful if the doctor who accompanies the police officer is section 12 approved (DH, 2015a: para. 16.4).

Under the Code of Practice local authorities are responsible for ensuring that ‘sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made’ (DH, 2015a: para. 14.35). There is no corresponding requirement in respect of section 12 doctors, though the Code of Practice states that approving bodies should:

- ‘take active steps to encourage doctors, including GPs and those working in prison health services and police services, to apply for approval, and
- ensure that the up-to-date list of approved doctors and details of their availability are available to all those who may need them, including GPs, providers of hospital and community mental health services and social services. There is now an online national Section 12/Approved Clinician register in England available to providers, AMHPs and others’ (DH, 2015a, para. 14.112).

Note, the Code of Practice for Wales states:
‘Local health boards should consider including an obligation to become approved under section 12 in the terms of employment of prospective consultant psychiatrists who have responsibility for providing a catchment area service. Local health boards should also consider including an obligation to keep such approval up-to-date and to take part in the 24-hour on-call approved doctors’ rota’ (Welsh Government, 2016: para. 14.105).

**Compulsory admission**

Individuals may enter hospital for treatment for mental disorder in just the same way as someone with a physical disorder. Under the MHA 1983, this is informal or voluntary admission: s.131(1) MHA 1983. Compulsory admission under Part 2 MHA 1983, also known as sectioning, civil admission, formal admission or detention, is a procedure that refers to the use of one of three sections in the MHA 1983, requiring the recommendations of two doctors (s.2 and s.3) or one (s.4) and the decision of the AMHP (or NR) to make an application for admission to hospital as the result of a MHA assessment (Hale, 2017).

Focusing here on the recommending doctors’ role at the MHA assessment, each doctor must have ‘personally examined’ the person (s.12(1)). Doctor examinations may be joint, but if they examine separately no more than five days may elapse between the days on
which their examinations take place (s.12(1)). Unless there are good reasons for making separate assessments, individuals should be seen by the AMHP and at least one of the recommending doctors together (DH, 2015a: para. 14.45). Both doctors should discuss the patient’s case with the AMHP (DH, 2015a: para. 14.46). As already noted, one of the doctors must, if practicable, have previous acquaintance with the patient (s.12(2)), and it is preferable that a doctor who does not have previous acquaintance with the patient is section 12 approved (DH, 2015a: para. 14.74).

**Basis for medical recommendation for admission**
The AMHP’s or NR’s decision is taken on the recommendation of a doctor or doctors who themselves must be satisfied of the following:

1. Diagnosis of mental disorder **AND**
2. The disorder is of nature or degree which warrants detention **AND**
3. The ‘necessity requirement’ is met i.e. detention is in the interests of the health or safety of the patient or with a view to the protection of others **AND**, in the case of s.3 admissions for treatment,
4. Appropriate medical treatment is available. (Hale, 2017).

The Code of Practice requires that 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’ (DH, 2015a: para. 14.44). The Code reflects, ‘[s]ometimes 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’ (DH, 2015a: para. 14.109). If a decision is made not to apply for compulsory admission, practitioners must ensure the patient is not abandoned and should explore and agree an alternative plan (DH, 2015a: para. 14.110).

**The three sections**
Hale (2017) describes the three sections in Part 2 of the MHA 1983 allowing for compulsory admission. The descriptions below focus on the role of doctors and the reasons for choice of section (rather than the AMHP or NR role).

**Section 2 MHA 1983**
Admission for assessment. This authorizes detention for up to 28 days and requires recommendations of two doctors, one of whom must be section 12 approved. The Code of Practice (DH, 2015a: para. 14.27) states that s.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.’
A patient detained for assessment may also be compulsorily treated. Indeed, treatment may form part of the assessment (DH, 2015b: para. 8.5).

Section 2 is the most commonly used of the three sections. In 2018/19 there were 37,610 uses in England; 25,963 of these were direct from the community, and the remainder through changes in the status of existing informal patients or from short-term detention (holding powers: s.5(2) or 5(4); place of safety: s.135 or s.136) or from s.4 admissions (NHS Digital, 2019).

Section 3 MHA 1983
Admission for treatment. This authorizes detention for treatment for up to six months and is renewable for a further six months, then annually. It requires recommendations of two doctors, one of whom must be a section 12 doctor. The Code of Practice (DH, 2015a: para. 14.28) states that s.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.’

In 2018/19, the total use of s.3 in England was 23,646, of which 4,151 were made directly from the community, and 11,640 were conversions from s.2 detentions. The remainder were through changes in the status of existing informal patients or from short-term detention (holding powers: s.5(2) or s.5(4); place of safety: s.135 or s.136) or from s.4 admissions or other sections (NHS Digital, 2019).

Section 4 MHA 1983
Emergency admission for assessment. This authorizes detention for assessment for up to 72 hours and requires recommendation of one doctor, who does not have to be section 12 approved: again, an AMHP is responsible for making the application. This means of admission gives no power to impose treatment without consent (s.56(3)(a)) and is only to be used where admission is an ‘urgent necessity’ and complying with the requirements of s.2 would involve ‘undesirable delay’ (s.4(2)), that is, a second or section 12 doctor cannot be found in time (Hale, 2017). Continued detention requires the recommendation of a second doctor and one of the two recommending doctors must be section 12 approved (s.4(4)(b)).

In 2018/19, the total number of s.4 admissions in England was 195, of which 38 were converted to s.2 and 32 were converted to s.3 (NHS Digital, 2019). Note that s.4 is sometimes classified as a short-term detention order rather than one of the three ‘sections’.

Coronavirus Act 2020 and pandemic related guidance
The Coronavirus Act 2020 (passed 25 March 2020) contains provisions which, if brought into force, would make temporary modifications to the MHA 1983. In MHA assessments, AMHPs would only have to obtain the medical recommendation of one doctor (who must be section 12 approved, but who is not required to have previous acquaintance with the person being
assessed) rather than two, if obtaining two would be ‘impractical or would involve undesirable delay’ (Coronavirus Act 2020, Schedule 8, para. 3). Comparable measures were put out to consultation, but not brought in, during the 2009 influenza (‘swine flu’) pandemic (DH, 2009). On 30 September 2020 (as this report was being prepared), the Secretary of State for Health and Social Care told Parliament in respect of these provisions in the 2020 Act, ‘I was not persuaded, even in the peak, that they were necessary, because our mental health services have shown incredible resilience and ingenuity. I have therefore decided that these powers are no longer required in England and will not remain part of the [Coronavirus] Act. We will shortly bring forward the necessary secondary legislation to sunset these provisions’ (Hansard, 2020: vol 681, col 392).

NHS England published Guidance on 19 May 2020, which states that this (and other measures) will only be brought into force if ‘it is deemed nationally that the mental health sector is experiencing extraordinary resource constraints that put patients’ safety at significant risk.’ (NHS England, 2020: 5). Even then, local Trusts will need to apply ‘to NHS England and NHS Improvement regional teams for support to use them when required providing clear justification as to why they are needed’ (NHS England, 2020: 5). The same Guidance (NHS England, 2020) foresees MHA assessments being one of the areas affected by workforce shortages, possibly leading to inadequate access to section 12 doctors and AMHPs. The Guidance suggests there should be additional administrative resource to support local section 12 rotas and strong communication between the management of the section 12 rota and AMHP rota locally (NHS England, 2020). The same document also gives guidance about MHA assessments by video and departing from the Code of Practice during the pandemic. In response to the pandemic, the rules around approval of section 12 doctors were also relaxed, the Guidance stating: ‘Licenses will be extended for 12 months, either from the next expiry date or from the date of application for licence renewal from doctors whose approvals have lapsed in the previous 12 months’ (NHS England, 2020: 8; see also Secretary of State for Health and Social Care, 2020).

The COVID-19 pandemic has affected all face-to-face encounters of professionals with patients, including MHA assessments (Chamberlain, 2020). Despite the need for good communication and the requirements for AMHPs and doctors to ‘personally examine’ the patient in a MHA assessment, video assessments have been considered as a response to increased pressures due to the COVID-19 pandemic, in relation to staffing and the risks associated with face-to-face interactions. This would clearly also impact on the role of the section 12 doctor involved in the assessment (Chamberlain, 2020). While the Guidance stated that video assessments meet MHA requirements, it stressed that ‘only courts can provide a definitive interpretation of the law’ (NHS England, 2020: 21), which passes on the responsibility (and therefore the risk) to AMHPs as the professional responsible for arranging the MHA assessment and for making any application for detention.

NHS England (2020) advised that video assessments may be considered where there is: a high risk of passing on coronavirus, and a significant risk of harm resulting from delays in the MHA assessment and/or subsequent intervention, and minimum quality standards and safeguards are met (p22). Chamberlain (2020) outlined several factors that need to be considered before undertaking an MHA assessment via video: access to appropriate devices (laptops/tablets etc); availability of sufficient broadband connection; support for the interviewee; impact on the interviewee of the use of technology, and ethics and data
security. The impact of these changes would be another subject for research to consider, in terms of patient outcomes and experiences.
References


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