BOARD OF DIRECTORS MEETING (Open)

Date: 8th May 2019 **Item Ref:** 14

TITLE OF PAPER	Report on the Performance and Activity of the Associate Mental Health Act Managers (AMHAMs) Quarter 4 18/19
TO BE PRESENTED BY	Jayne Brown, Chair
ACTION REQUIRED	Members to receive the report for Information and Assurance

OUTCOME	Members are assured the Associate Mental Health Act Managers are undertaking their functions in line with statutory requirements of the Mental Health Act 1983 (MHA) and the MHA Code of Practice 2015 and that patients' rights are thereby protected.
TIMETABLE FOR DECISION	May Board Meeting
LINKS TO OTHER KEY REPORTS/ DECISIONS	Mental Health Act Code of Practice 2015
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Objective A1 02: Deliver safe care at all times BAF Risk: A1 02i. "Failure to deliver safe care due to insufficient numbers of appropriately trained staff". BAF Risk No: A1 02ii. "Inability to provide assurance regarding improvement in the safety of patient care". Strategic Objective: A1 03: Provide positive experiences and outcomes for service users. BAF Risk No: A1 03 "Failure to comprehensively capture the experience of our service users and take appropriate action".
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Mental Health Act 1983 (MHA) Mental Capacity Act 2005 (MCA) Human Rights Act 1998 (HRA)
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	To maintain improvement in the implementation of the MHA and to preserve the rights of those subject to compulsion under its provisions will require on-going monitoring of procedures and practice and recommendations for changes made where necessary.
CONSIDERATION OF LEGAL ISSUES	It is a legal requirement that the Trust complies with the Mental Health Act 1983. The Associate Managers' role is concerned with patients' rights to liberty and security as afforded by the European Convention on Human Rights, Article 5. Their powers to discharge a patient from detention under the Mental Health Act protect patients from unnecessary and/or unlawful detention.

Authors of Report	Anne Cook and Mike Haywood
Designation	Head of MH Legislation and Manager MH Legislation Administration
Date of Report	April 2019

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Subject: **Report on the Performance and Activity of the Associate Mental Health Act Managers (AMHAMs) Quarter 4 18/19**

Authors: **Anne Cook, Head of Mental Health Legislation**
Mike Haywood, Manager MH Legislation Administration

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
				✓	Assurance

2. Summary

This report for the Board of Directors describes the performance and activity in respect of the Associate Mental Health Act Managers (AMHAMs) for the period January – March 2019.

The AMHAMs have directly delegated responsibility from the Board of Directors in respect of the Hospital Managers' statutory powers to discharge detained patients from detention under the Mental Health Act 1983. (MHA s23).

This report is presented as evidence that the requirements of the Mental Health Act and its Code of Practice are met in respect of the Board's responsibilities with regard to the appointment, training and delegated duties of the AMHAMs. Please see Appendix 3, paragraph 1. It was reviewed and the content agreed on Wednesday 17th April 2019 at the AMHAM Quarter 4 meeting, chaired by Jayne Brown (Trust Chair).

The report is presented under the following headings:

1. Number and Availability of AMHAMs
2. Peer Performance Reviews
3. Peer Support Group
4. Training and Development
5. Themes from Quarterly Meetings
6. AMHAM Activity and MHA data
7. AMHAM feedback

Appendix 1 - The Legal Status of the AMHAMs and Hospital Managers' functions and duties with regard to reviewing detention or CTO (Delegated to AMHAMs).

Appendix 2 – Key to MHA sections.

Appendix 3 – AMHAM Duties and the MHA Code of Practice 2015

3. Next Steps

3.1 To continue to report on the performance and activity of the AMHAMs each quarter.
3.2 Keep the numbers of AMHAMs under review.
3.3 Keep hearing adjournments and the reason(s) for under review.
3.4 Review AMHAM training needs as per Annual Peer Reviews and develop accordingly.

4. Required Action

Board members are informed and assured of the role and performance of the AMHAMs in Q4.

5. Monitoring Arrangements

Via the Board of Directors and supported by the MH Legislation Team.

6. Contact Details

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Report on the Performance and Activity of the Associate Mental Health Act Managers (AMHAMs) Quarter 4 18/19

1. Number and Availability of AMHAMs

Particular regard is paid to whether, as a result of AMHAM unavailability, the review of renewal of detention or extension of Community Treatment Order (CTO) occurs after the date the previous order expired: in Q4, out of a total of 20 hearings, 1 hearing took place after the expiry date as a result of inability to convene a panel.

It should be noted, however, that a late review does not amount to unlawful practice. Continued detention/CTO is lawful provided that the Responsible Clinician furnishes the papers prior to the expiry of the current period.

Since the last report, 3 new AMHAMs were interviewed and have accepted positions. The new AMHAMs will observe a minimum of 3 panels before taking an active part. Including these 3 new starters, SHSC has 21 Associate Mental Health Act Managers of different genders, ages, backgrounds and ethnicity. One is currently inactive owing to sickness.

2. Peer Performance Reviews 2018/2019

By the end of Q4, of the 12 AMHAMS who required an annual peer performance review, 11 had been completed. One is postponed owing to sickness and will be arranged as soon as possible.

Of the remaining six, one AMHAM did not attend reviews in the relevant period owing to illness, and five have been in post less than a year. The five most recently appointed AMHAMs have been allocated to a Peer Reviewer for review in 2019/2020

During Q4, the three Peer Reviewers have been working on updating the Peer Review documentation to align it with Trust values and the AMHAM policy. This work is due for completion by the end of Q1 19/20.

3. Peer Support Sessions Q4

In response to the AMHAM's request for more bespoke training than that offered in the routine twice-yearly provision, monthly sessions (2 hours' duration) were reinstated. However, poor attendance continued in Q4, so the monthly sessions therefore will not continue:

- No AMHAMs attended the additional session on 8th January
- 1 AMHAM attended the session on 5th February
- 2 AMHAMs attended on 7th March (one for only the last 30 minutes)

In contrast, attendance is good at the Peer Support sessions provided on the same day as the Quarterly meetings. The session on 16th January was attended by 8 AMHAMs.

3.1 Medical Reports for Hearings

The Peer Support session on 16.1.19 focused on the limited utility of the Responsible Clinician's section renewal/extension document for the purposes of AMHAM hearings. These are narrow in scope, often not containing sufficient information about risk and patient presentation when unwell.

The Peer Support meeting learned from one attendee that the Code of Practice (38.32) requires RCs reports to be provided in a similar format to those provided to the Tribunal:

> The report submitted by the responsible clinician should (…) cover the history of the patient's care and treatment and details of their care plan, including all risk assessments. Where the review is being held because the responsible clinician has made a report under s20, 20A or 21B renewing detention or extending the CTO, panels should also have a copy of the report itself before them. This should be supplemented by a record of the consultation undertaken by the responsible clinician in accordance with those sections before making the report. The written reports should be considered by the panel alongside documentation compiled under the CPA (or its equivalent).

It was agreed that this issue would be taken to the Quarterly meeting in the afternoon, please see 5.4 below.

4. Training and Development

Training needs emanating from the AMHAMs' annual peer performance reviews, plus any topics identified at the quarterly peer support groups and the quarterly AMHAM meetings will reviewed and incorporated into the training to be delivered on 24th June.

5. Key Themes from the Q3 meeting held on 16th January 2019 (ie within Q4 19/20)

The Q3 meeting was attended by 12 AMHAMs. It was chaired by Liz Lightbown (Executive Director for Nursing and Professions).

5.1 Quarterly Report to the Board – Q3 2018/19

The Q3 report was reviewed by the members. It was agreed that - rather than a report from the AMHAMs - it would be more accurate to describe the report as being produced by the officers responsible for Mental Health Legislation in respect of AMHAMs performance of their delegated duties. It was duly amended and approved by the meeting.

The members noted that the AMHAMs might wish to take a matter directly to the Board, and that this would be achieved by direct approach to Jayne Brown, as the Chair of both the AMHAM quarterly meeting and of the Board of Directors.

5.2 Review of Remuneration

Liz Lightbown informed the meeting that she would take forward the request for a review and in the first instance would discuss the matter with the Director of Corporate Affairs and the Director of Finance. The meeting noted that the comparison with other Trusts' rates was not the only matter that ought to be addressed by the review.

AMHAMs wished for the following to be taken into account:

- There has been no review for 13 years - the group was informed by an AMHAM that inflation over that period is 42.6%
- The fact that there has been no review is not satisfied by evidence that Sheffield appears to compare quite well with the other Trusts in terms of current rate – this may not be a like for like comparison
- The extra work involved for the Chair (ie over the 4-hour session remunerated)
- Preparatory work (over the 4-hours)
- The last formal approach resulted only in the introduction of a mileage allowance
- Members' skills, knowledge and experience needs to be acknowledged
- The seriousness of the role needs to be acknowledged: matching to the Agenda for Change banding comes out at around Band 3/4 level which is felt to be quite low for the level of responsibility
- The fact that AMHAMs now write up the reports and have no admin support needs to be acknowledged: several people said that the reports written by other trusts were much less detailed and lengthy than ours
- 1:1 meetings prior to hearings need to be taken into account
- PAYE issues

5.3 Training - Feedback from Training Session

The meeting heard that had been positive written feedback following the recent training and this was reiterated by the meeting, although there were different views about the CTO recall session being delivered by a doctor who is not involved in recall

The meeting was informed that there had been zero attendance at the 2 extra support/bespoke training sessions offered at AMHAM request in Q3. It was agreed that the r 3 sessions planned for Q4 would not be cancelled, but would be reviewed at the April meeting.

5.4 Issue with Medical Reports Raised at the Peer Support Session

The meeting heard about the morning’s Peer Support session in respect of requirement in the Code of Practice that Responsible Clinicians’ reports to AMHAM hearings should be provided in a similar format to those required by the Mental Health Tribunal (please see 3.1 above).

The Quarterly meeting agreed that a request should be made of the Medical and Clinical Directors to ask that Responsible Clinicians adhere to the Code of Practice. This request was duly made and all Responsible Clinicians were e mailed by the medical Director requesting that reports are provided as described in the Code of Practice.

6. AMHAM Activity: Q4 2018/19

6.1 Number of Hearings – please see Appendix 3 paragraph 2

Table 1: Number of AMHAM Hearings and Reason Q1 18/19 – Q4 18/19

Reason	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
In response to patient application S3 or S37	0	1	0	1
In response to patient application CTO	1	0	1	0
RC Renewals S3/S37	8	12	9	9
RC Extension CTO	15	10	10	11
Barring NR	0	0	0	0
At Managers' Discretion	0	0	0	0
Quarterly Total	24	23	20	21
Discharged by AMHAMs	0	0	1	0

Table 2: Applications to the AMHAMs: From Q1 18/19 to Q4 18/19

Applications	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Total Applications submitted	7	7	1	4
Inpatient applications	-	6	0	4
CTO applications	-	1	1	0
Total not proceeding to hearing	6	6	0	3
Reasons for not proceeding to hearing				
Tribunal pending	2	2	-	1
Discharged by RC before hearing	2	4	-	1
Withdrawn by patient	2	0	-	1
Total	6	6	-	3

The 7 applications in both Q1 and Q2 appear to have been anomalous, although there was a marked increase in Q4 over Q3.

Table 3: AMHAM Hearings: Q1 18/19 – Q4 18/19

Hearings	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Type of Hearing				
In Response to Inpatient Applications	0	1	0	1
In Response to CTO Applications	1	0	1	0
Following Inpatient Renewal	8	12	9	9
Following CTO Extension	15	10	10	11
Following Barring NR	-	-	-	-
Total	24	23	20	21
Discharged	0	0	1	0

The number of hearings following in-patient renewal and CTO extension necessarily reflects the number of orders reaching a trigger for renewal during the quarter (sections 3, 37 and CTOs each run for 2 consecutive 6-month periods and for 12 month periods thereafter).

There were no hearings during Q4 which resulted from the Responsible Clinician issuing a Barring Certificate to prevent a nearest relative from discharging the patient.

Patients continue to opt for the Tribunal over the AMHAMs for consideration of discharge from detention/CTO. Both bodies have broadly similar powers to discharge patients although legal representation is more accessible for applications to the tribunal as this is covered by the legal aid scheme. For comparison, during Q4 78 applications and automatic referrals were made to the First Tier Tribunal in respect of section 2, section 3 and CTO; none of these resulted in discharge.

Table 4 - First Tier Mental Health Tribunals Q1 18/19 – Q4 18/19

Type of Review	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Applications – inpatient	70	76	50	60
Automatic referrals – inpatient	5	4	4	6
Applications – CTO	4	3	3	4
Automatic referrals – CTO – no application	8	1	5	4
Automatic referrals – CTO – revocation	3	4	1	4
Total	90	88	63	78
Discharged	5	2	0	0

The number of applications to the Tribunal is evidence that patients are being informed of their right to apply to challenge their detention (the right to apply to either or both the Tribunal and the AMHAMs is detailed in the same rights explanation form). Please see Appendix 3, paragraph 3

6.2 AMHAM Hearings Taking Place Prior to Expiry – See Appendix 3 paragraph 4

Table 5 below shows the number of hearings which have taken place prior to the expiry date, the number that have taken place up to 7 days after expiry date and the number which have taken place over 7 days after expiry.

Table 5 – AMHAM Hearings taken place in relation to expiry date Q4 17/18 – Q3 2018/19

Month	Total number of hearings	Hearings before expiry date	Hearings up to 7 days after expiry date	Hearings more than 7 days after expiry date
Q1 18/19	22	15	2	5
Q2 18/19	22	11	2	9
Q3 18/19	20	16	3	1
Q4 18/19	20	14	2	4
Grand Total	84	56	9	19

Although a review before expiry is 'desirable' it is not required by law, as it is the RC's report that provides the authority for the continued detention or CTO.

During Q4, there were 20 hearings for the renewal or extension of the detention/CTO:

- 14 of the 20 took place before the expiry date
- 2 of the 20 took place within 7 days of expiry
- 4 of the 20 took place more than 7 days after expiry

6.3 Reasons for AMHAM Hearings Not Taking Place Prior to Expiry

Table 6: Reasons across Q2 – Q4

Reason	Q2	Q3	Q4
Hearing not booked prior to expiry known unavailability of AMHAMs	1	-	0
Hearing originally booked prior to expiry unavailability of AMHAMs (unable to convene a panel)	2	-	1
Hearing adjourned	2	2	1
Hearing not booked prior to expiry known unavailability of RC	3	-	0
Hearing originally booked prior to expiry - RC cancelled	2	1	2
Hearing booked prior to expiry - cancelled – AMHAM sick	1	-	1
Patient wished to attend hearing but refused to attend on a Thursday (see below)	-	-	1
Total	11	3	6

1 patient refused to attend hearing on a Thursday. The date was the earliest date available that the RC/CC could accommodate that was not a Thursday (patient refuses to have hearings on a Thursday). This resulted in the hearing taking place 49 days after expiry; the CTO extension was upheld however. The improvement in Q3 and Q4 may be linked to more prompt responses from RC's when requested to furnish renewal/extension paperwork, please see 6.5 below.

6.4 Number of Hearings Adjourned - See Appendix 3 paragraph 5

Table 7 – Hearings adjourned Q1 18/19 – Q4 18/19

Adjournments and Reason	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Total Adjourned	1	2	2	1
Number with reason recorded on report	1	2	2	1
Patient not present	0	0	0	0
Relevant staff not present	1	0	1	1
AMHAM not present	0	2*	1**	0

Please note that where the number of reasons is greater than the number of adjournments more than one reason has been given. Panels must consist of 3 or more members in order to consider discharge (s23(4) MHA). Therefore it is unlawful to proceed with only 2 members.

* Q2 - In one case a panel member failed to attend, and in the other an AMHAM was taken ill during the hearing.

** Q3 - Only 2 AMHAMs were present. This was the result of miscommunication caused by sickness and staffing pressures in the MHA office.

The adjournment in Q4 was because the RC was unable to leave clinic in time to attend the hearing.

There was no negative impact as a result of these adjournments. Detention continued lawfully until a re-arranged review, and no patient was discharged at a re-arranged review.

6.5 Impact of RC Response to Notification of Renewal/Extension

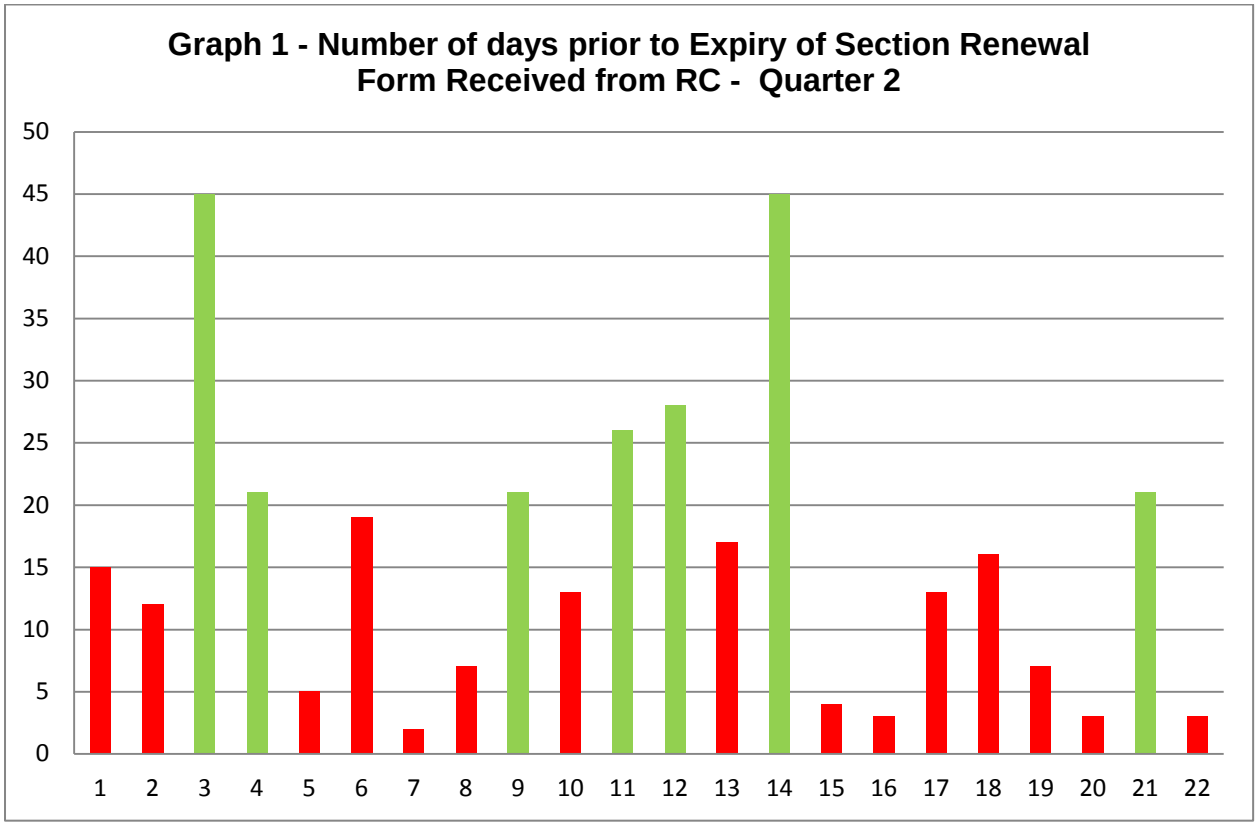
Please see Appendix 3 paragraph 6.

The graphs below shows the RCs' response times Q2 18/19 (when the information was first recorded) to Q4; the number of days is shown on the vertical axis; the horizontal axis shows individual renewals/extensions.

In Q2 32% of renewals were received by the 21 day deadline. There was a significant improvement in Q3 with 42% being received within 21 days.

Hearings taking place after the previous expiry date decreased from 11 out of 22 hearings (50%) in Q2 to 4 out of 20 hearings (20%) in Q3.

In Q4, 10 renewal forms out of 20 were provided within the 21 day deadline (50%), and 1 at 20 days (total 20 days or less = 55%). However, there were 2 occasions when the renewal form was received on the day of expiry. These show with no coloured bar on the Q4 graph below, and bring the total missing the 21-day deadline to 9 of the 20 renewal hearings (45%). 6 of the 20 hearings took place after the previous expiry date (30%).


Graph 1 - Number of days prior to Expiry of Section Renewal Form Received from RC - Quarter 2
50
45
40
35
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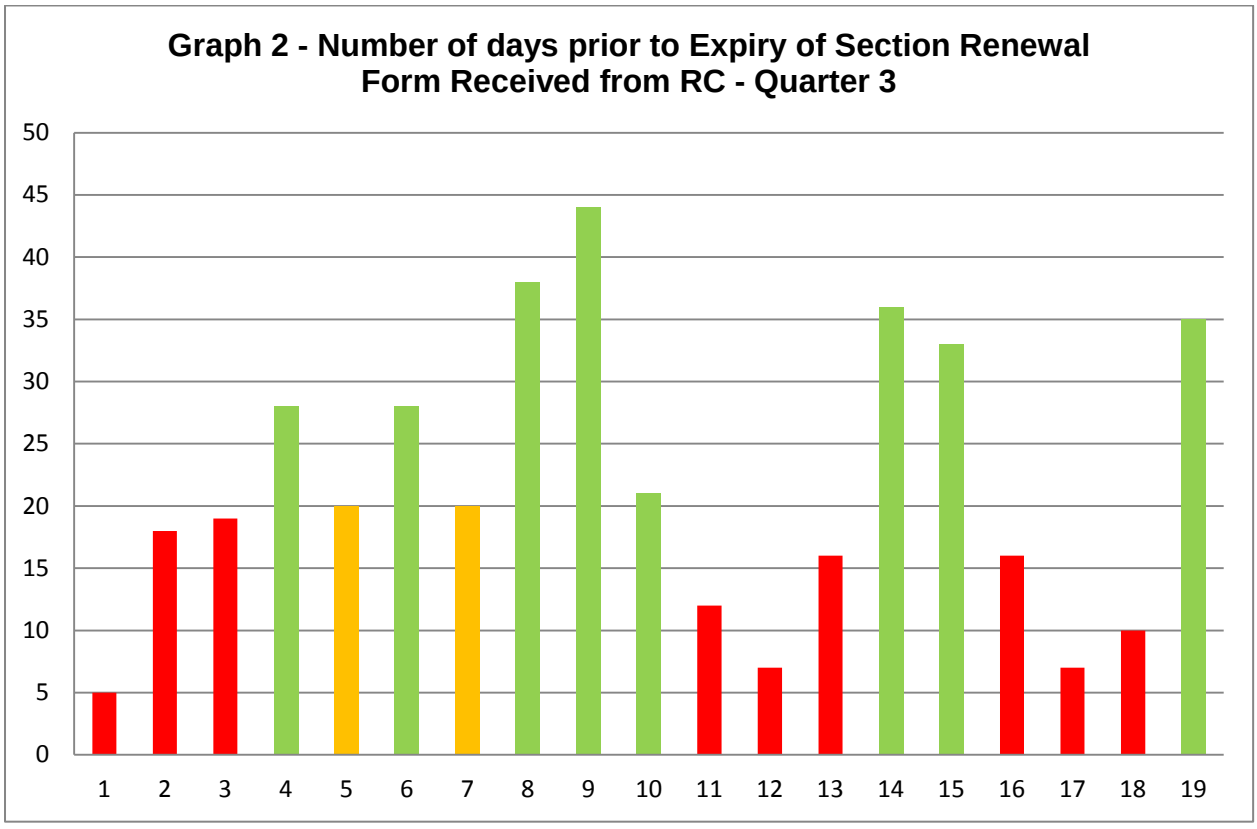
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22


Graph 2 - Number of days prior to Expiry of Section Renewal Form Received from RC - Quarter 3
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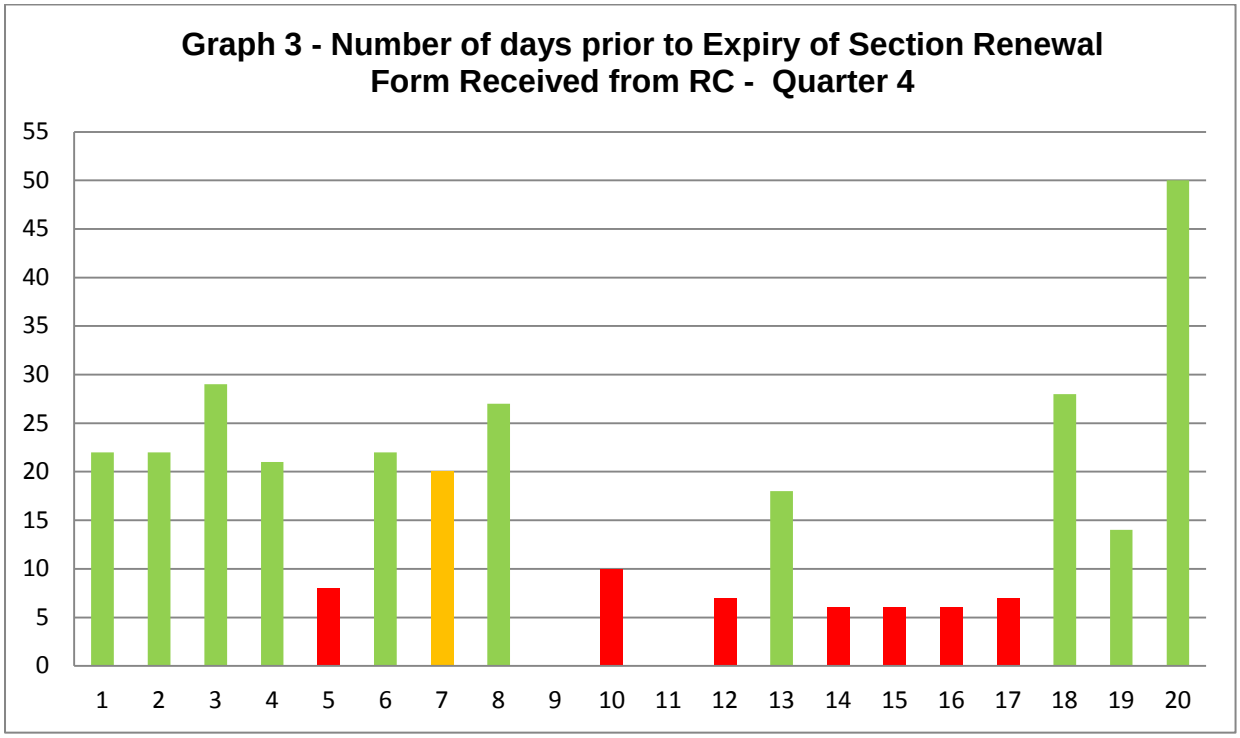
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19



7 AMHAM Feedback

7.1 Reports

From Q4, feedback has been provided via a 'Survey Monkey' which was updated in line with AMHAMs' suggestions from the December 2018 training day. The amendment includes a more specific question in respect of the utility and adequacy of reports.

The AMHAMs fed back that 100% of written reports addressed the necessary information, but in 1 case the oral report was inadequate because there was no one available from the community team with sufficient knowledge of the patient. However, as there were no patients discharged by the AMHAMs, it is evident that sufficient information was available in all cases to warrant on-going detention.

7.2 Independent Mental Health Advocates (IMHA)

All patients with whom the AMHAMs have potential involvement have a right to an IMHA and for an IMHA to attend meetings such as AMHAM reviews. There is a legal duty to explain this right to all detained and CTO patients and adhering to this duty is subject to a weekly audit of inpatient wards for detention, and to a monthly audit of community teams for CTO.

Nonetheless, only 1 hearing included IMHA attendance; the AMHAM feedback noted that "there seems to be no process at present if a patient wishes IMHA to attend for that service to be notified in good time and the service to confirm attendance".

However, services do not necessarily know that a patient has an IMHA. An automatic referral is made for any patient who appears to lack capacity to understand the role of an IMHA, otherwise the arrangement is confidential between the patient and the IMHA and attendance of the IMHA is reliant on the patient arranging it or asking for assistance to do so. The letter to the patient advising them of the date of the hearing includes information about contacting and arranging IMHA attendance.

Appendix 1

The Legal Status of the AMHAMs and Hospital Managers' Functions and Duties with regard to Reviewing Detention or CTO (Delegated to AMHAMs)

In England, NHS Trusts and NHS Foundation Trusts are themselves defined as the 'hospital managers' for the purposes of the MHA. Mental Health Act Code of Practice (2015), Chapter 37.2. (Hereafter: CoP).

Hospital managers have the authority to detain patients under the Mental Health Act 1983 (MHA), and Section 23 of the MHA gives the Hospital Managers the power to discharge patients from detention in hospital under most sections of the MHA and from compulsory powers in the community under a Community Treatment Order (CTO).

In practice, this power of discharge is delegated to managers' panels made up of people appointed specifically for the purpose who are not officers or employees of the Trust: the Associate Mental Health Act Managers (AMHAMs). The payment of a fee for serving on a panel does not constitute 'employment'. (MHACoP Chapter 38.6).

The independent status of AMHAMs is confirmed in case law: *South Staffordshire and Shropshire Healthcare NHS Foundation Trust v The Hospital Managers of St George's Hospital* [2016] EWHC 1196 (Admin).

An AMHAM panel must be made up of at least 3 people. If more than 3 sit, at least 3 are required to agree the decision to discharge a patient from detention, ie a 3-person panel must be unanimous, see *R (Tagoe-Thompson) v The Hospital Managers of the Park Royal Centre [2003] EWCA Civ 330*, where the judge ruled "… in circumstances in which the members are laymen, may not be directors of the trust and whose expertise may be limited, a finding that the affirmative view of at least three of them is required to override the opinion of the [RC] and authorise release."

This is in contrast to the First Tier Tribunal (Mental Health) where a majority decision is sufficient. *South Staffordshire and Shropshire* confirms that 'a panel of Hospital Managers has equal standing when ordering a patient's discharge to that of a tribunal operating under [MHA] s72'. However, because the Hospital Managers (through the AMHAMs) are one of the parties to the hearing, only the Tribunal (as an independent expert body) constitutes a court in satisfaction of Article 5(4) of the European Convention on Human Rights (ECHR).[1]

Hospital Managers' functions and duties with regard to reviewing detention or CTO

The Mental Health Act Code of Practice (CoP) informs all practice under the Act. The CoP defines the terms 'must', 'should' and 'may': 'must' reflect legal requirements and permits no exceptions; 'should' requires that any exceptions should be documented and recorded including the reason, which must be sufficient to withstand judicial scrutiny; 'may' reflects good practice, but exceptions are permitted.

[1] ECHR Article 5(4) - Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

CoP Chapter 38.12 describes the functions of the Hospital Managers.

The hospital managers (via the AMHAMs):

- may undertake a review of whether or not a patient should be discharged at any time at their discretion.

- must undertake a review if the patient's responsible clinician submits a report to them under section 20 of the MHA renewing detention or under section 20A extending the CTO.

- should consider holding a review when they receive a request for discharge from a patient.

- should consider holding a review when the responsible clinician makes a report to them under MHA section 25 barring an order by the nearest relative to discharge a patient. Barring can only occur if the patient 'if discharged, would be likely to act in a manner dangerous to other persons or to himself'. (MHA 1983, s25(1), see also key to sections below).

The CoP determines the questions the AMHAM panel should address in order to satisfy itself that the criteria for detention (or, following a barring order, dangerousness) are met, and the order in which they should be addressed. If three or more members of the panel (panels normally have three members) who between them make up a majority are satisfied by the evidence presented that the answer to any of the prescribed questions is 'no' the patient should be discharged.

If there is a divergence of views among the professionals about whether the patient meets the clinical grounds for continued detention or CTO, AMHAM panels should reach an independent judgement based on the evidence that they hear. In all cases, the hospital managers (via the AMHAMs) have discretion to discharge patients even if the criteria for detention or CTO are met, if there is a less restrictive (safe) alternative.

In respect of s25 barring orders, AMHAMs need to demonstrate in their written decisions that they have considered both the dangerousness issue and whether any exceptional reasons to continue detention exist in its absence.

Other than the order of proceedings laid out in the CoP (as above) there is no formal procedure for AMHAM hearings and no explicit requirement for there to be a hearing at all. The MHA manual states that in circumstances where the patient makes repeated applications to the AMHAMs, or if s/he does not wish to contest the renewal of detention or extension of CTO, or if the application is made immediately after an unsuccessful Tribunal and there has been no change in the patient's circumstances, the review could be limited to consideration of the written reports and an interview with the patient. (Richard Jones, MHA Manual 20th ed, p192).

It is of note that it is the practice of SHSC to hold a full hearing, taking evidence from the RC, care co-ordinator etc. in the event of extension of a CTO. This is in contrast to the practice of some other providers which, in common with the practice of the Tribunal, undertake 'paper' reviews if a capacitous patient does not elect to attend a hearing following renewal.

Appendix 2

Key to Sections NB: This is not an exhaustive list of sections

Section	Purpose	Made By	Length of Time	Can be renewed
2	Admission for assessment or assessment followed by treatment	2 Doctors and 1 Approved Mental Health Professional/Nearest Relative	28 days	No
3	Admission for treatment	2 Doctors and 1 Approved Mental Health Professional/Nearest Relative	Initially up to 6 months	Can be renewed for a further 6 months then yearly – no limit to number of renewals
4	Admission for assessment in cases of emergency	1 Doctor and 1 Approved Mental Health Professional/Nearest Relative	72 hours	No – but if a second medical recommendation is received within the 72 it is then converted to a section 2
5(4)	Nurses Holding power	Nurse	6 hours	No - is used to prevent someone already an inpatient from discharging themselves until a doctor can assess
5(2)	Doctors Holding power	Doctor in Charge of the care or nominated deputy	72 hours	No – completed by the doctor to prevent someone from discharging themselves while waiting for a MHA assessment
25 Barring Order	A patient's legal 'Nearest Relative' (NR - defined at MHA s26) has the power to apply to the hospital managers for the patient's detention under the MHA (the function more usually carried out by the Approved Mental Health Professional or AMHP). There is a corresponding power for the NR to order discharge, which may only be barred by the responsible clinician on the grounds (extra to the criteria for on-going detention) that the patient 'if discharged, would be likely to act in a manner dangerous to other persons or to himself'. The 'dangerousness' criterion does not feature elsewhere in the MHA.			
37	Hospital Order	Magistrates or Crown Court	Initially up to 6 months	Can be renewed for a further 6 months then yearly - no limit to number of renewals
38	Interim Hospital Order	Magistrates or Crown Court	For a period not exceeding 12 weeks	Can be renewed for further periods of not more than 28days up to a total of 12 months
47/49	Transfer of direction from Prison to Hospital with restrictions – sentenced prisoner	Ministry of Justice	No time limit although the restrictions would end when the prison would have ended	
48/48	Urgent transfer of direction from Prison to Hospital with restrictions – other prisoners (usually remanded)	Ministry of Justice	No time limit, but patient should return to criminal justice process ASAP	
CTO	Community Treatment Order	Responsible Clinician and Approved Mental Health Professional	Initially up to 6 months	Can be renewed for a further 6 months then yearly - no limit to number of renewals
Section 136	Place of Safety	Police	72 hours	No but MHA assessment must be carried out within this time

Appendix 3

AMHAM duties and the MHA Code of Practice 2015

1. [The] board (…) of the organisation should ensure that the people appointed properly understand their role and the working of the Act. [It] should ensure that people appointed to a managers' panel receive suitable training to understand the law, work with patients and professionals, to be able to reach sound judgements and properly record their decisions. This should include training or development in understanding risk assessment and risk management reports, and the need to consider the views of patients, and if the patient agrees, their nearest relative, and if different, carer. (MHA Code of Practice 2015 Chapter 38.8)

2. AMHAM hearings take place for one of the following four reasons:

    - The patient has applied for a hearing.
    - The RC has renewed the detention or extended the CTO.
    - The RC has issued a certificate barring the nearest relative (NR) from discharging the detention/CTO
    - A hearing at the Managers discretion.

3. Tribunals: In contrast to the automatic review of detention/CTO undertaken by the AMHAMs, the Tribunal does not consider renewals automatically; renewal brings with it a right to apply to the Tribunal during the new period of detention. The Trust must make automatic referrals in specific circumstances in order to protect patient rights under Human rights legislation.

4. Hearings before Expiry: The MHA CoP 38.14 states 'Before the current period of detention or the CTO ends, it is desirable that a managers' panel considers a report made under section 20 or section 20A and decides whether to exercise its discharge power'. Section 20 MHA provides the authority to renew sections 3 and 37. Section 20A provides the authority to extend the Community Treatment Order.

5. Adjourning Hearings: MHA CoP 38.37 states: (…) If there is a divergence of views among the professionals about whether the patient meets the clinical grounds for continued detention or CTO, managers' panels should reach an independent judgement based on the evidence that they hear. (..) *In some cases, it might be necessary to consider adjourning to seek further medical or other professional advice.*

    When deciding to adjourn the managers must give adequate reasons. They should take into account that the person remains subject to compulsion and therefore to adjourn may not be the least restrictive option. Before adjourning because a member of the care team is not present the mangers should review the written reports, question the professional present and only adjourn if the evidence presented is not sufficient to reach a decision.

Renewal Timetable Notification of the renewal/extension due date is issued from the MHA office to the RC at least 7 weeks prior to the current order expiring, with a request for the return of the completed document at least 21 days prior to expiry. A reminder is issued 3 weeks prior to expiry. The hearing date is booked at the start of the process (7 weeks' notice) but cannot go ahead if the renewal form has not been completed.