BOARD OF DIRECTORS MEETING (Open)

Date: 11th September 2019 **Item Ref:** 19

TITLE OF PAPER	Report on the Performance and Activity of the Associate Mental Health Act Managers (AMHAMs) Quarter 1 19/20
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing & Professions on behalf of 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	September 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 standards 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	23rd August 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 1 19/20**

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 April - June 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 July 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. Training and Development
4. Themes from the Quarterly Meeting
5. Response to Issues Raised at the Quarterly Meeting
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 Q1.

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 1 19/20

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 Q1, out of a total of 26 hearings, 2 hearings took place after the expiry date as a result of inability to convene a panel and 1 further hearing which did have a full panel was postponed at the last minute owing to family bereavement of a panel member.

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.

SHSC has 19 Associate Mental Health Act Managers of different genders, ages, backgrounds and ethnicity. One is currently inactive owing to sickness. Since the last report, 2 AMHAMs have resigned their positions and 2 new expressions of interest have been received. The new applicants will be interviewed early in Q2.

2. Peer Performance Reviews 2019/20

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 was presented at the AMHAMs' training day on 24.6.19 for comment and finalisation for use in 2019/20.

Dates for Peer Review in this financial year are being arranged for all AMHAMs.

3. 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 were reviewed and incorporated into the training delivered on 24th June.

Sessions were delivered on the following topics:

- AMHAM Reviews and Learning Disability, presented by Dr Zara Clarke (Clinical Psychologist Learning Disability Services)
- Mental Health Act s132 & 132A (the duty of managers of hospitals to give Information to detained patients and community patients) presented by Anne Cook (Head of MH Legislation)
- Peer Review and Self-Assessment, a workshop presented by AMHAMs Anne Hilton, Robert Gunstone and Tony Mays (Peer Reviewers)
- Attendance and Role of Independent Mental Health Advocates, presented by Staff from Sheffield Advocacy Hub

The day was attended by 14 of the 20 AMHAMs and was well received, with positive feedback being given on the day both orally and in writing.

The document developed for undertaking peer reviews received extensive feedback and critique from the workshop. It was agreed to proceed with reviews using the document, but to review it in line with comments received from the workshop plus feedback about its use in actual reviews.

The current practice of having a peer review after approximately a year in post was reviewed to ensure support and practical objectives early in an AMHAM's appointment. It was agreed that new AMHAMs should be allocated to a reviewer on appointment and have a 'foundation' review after their observation hearings.

It was also agreed to use the Peer Support session prior to the Q1 meeting in July 2019 to start work on the development of an induction pack for new starters. The time-scale for completion will be agreed at that meeting.

4. Key Themes from the Q4 meeting held on 17th April 2019 (ie within Q1 19/20)

The Q1 meeting was attended by 14 AMHAMs. It was chaired by Liz Lightbown (Executive Director for Nursing and Professions).

4.1 Quarterly Report to the Board – Q4 2018/19

The Q4 report was reviewed by the members. It was duly amended and approved by the meeting for presentation to the Board.

4.2 Independent Mental Health Advocate (IMHA) Attendance at hearings

The meeting heard that only 1 hearing in Q4 had included IMHA attendance; the AMHAM feedback report for the quarter had 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".

As a result, the Head of MH legislation was asked to explore the low uptake of IMHA representation at hearings. Please see below at 5.1.

4.3 Review of Remuneration

Liz Lightbown informed the Q4 meeting that the request for a review of remuneration would be taken forward and that updated figures had been obtained from other Trusts for comparison & that the first stage of the review was to put forward the proposal /request to a meeting of the Executive Directors Group, which took place in April, Q1.

This was followed by a meeting between the Executive Director of Nursing & Professions and the Chair of the AMHAM Meeting / Board of Directors and the remuneration review was duly considered by the Remuneration Committee in June 2019 (Q1) when the review was concluded. Please see below at 5.2.

There was some concern from AMHAMs that the request was going from meeting to meeting but not making progress towards a conclusion.

4.4 Discontinuation of the Monthly Peer Support Meetings

The meeting was informed that poor attendance at the reinstated monthly meetings had continued in Q4 with a total of 3 AMHAMs attending in the 3 month period. For this reason, the monthly sessions were discontinued. Quarterly Peer Support sessions on the same day as the Quarterly meetings, as these are well attended.

5. Response to Issues Raised at the Quarterly Meeting

5.1 Independent Mental Health Advocate (IMHA) Attendance at hearings

As requested from the Q4 April meeting, the Head of MH Legislation made enquiries into the uptake of IMHA services in respect of representation at AMHAM hearings.

All detained patients are provided with information about their right to an IMHA and how to contact the service. This is included on all relevant patient rights leaflets and recording of the oral explanation of these rights and the issuing of the written information is included in weekly audits (detention) and monthly audits (CTO). In addition, information about IMHA services is provided when patients are advised of the AMHAM hearing; updated leaflets have been supplied to the MHA office by the Advocacy Hub.

The manager of the Advocacy Hub, Peter Brown, provided the following response when asked his views about IMHA attendance:

> *IMHAs routinely advise clients of their right to request a Managers' Hearing and if the person wants their IMHA to attend, we do our best to facilitate this. On some occasions, this is more problematic but it is not a common request.*
>
> *Complications arise when the person does not have capacity to instruct the IMHA, as our role is strictly to support the person to understand the process and put across their views rather than to take on any quasi-legal representative role. As such, where the person is unable to give that instruction the IMHA isn't really able to participate in a meaningful way and this is where we would question the value, especially if it is a one-off piece of work such as a renewal – it's different if the work is on-going and the advocate is involved in a non-instructed capacity in a range of issues, as the IMHA may have more questions to ask on the person's behalf.*
>
> *I am sure it would cause us some difficulties in practice if there were a significant number of new, short-notice referrals. Our contract does not allow us to maintain staff 'on call' as it were, only to have the number to meet the current demand (which means there is always a time lag when demand increases). However that should not stop appropriate referrals being made as we regularly review our capacity.*
>
> *My only concern is where the hearing is for a one-off renewal where we don't already have involvement, especially for CTOs as in our experience the majority of people in this position don't engage with us when we try to contact them. We would welcome proactive inclusion of information about rights to IMHA, and could supply leaflets if these would be helpful.*

The service provided a session on the AMHAM training day in June to discuss the different approaches to on-going work with patients and 'one-off' attendance, as described above.

Mr Brown was able to inform the attendees that previous difficulties in disclosing the involvement of an IMHA caused by the stringent confidentiality requirements of Citizens' Advice (which made even the fact of contact with a patient confidential) had been overcome, and that there is no longer a barrier to an IMHA informing a ward or community team of their involvement, subject to the patient agreeing or (if lacking capacity) in their best interests.

However, this does not help in respect of the effect of patient choice. A patient may elect not to inform their IMHA of an AMHAM hearing, or may refuse the offer of support at a hearing; on some occasions, even when there has been long-term work with a patient, they do not inform their IMHA until afterwards. If the MHA Office were to inform the advocacy service of all hearings this would be a breach of confidentiality. These factors militate against there being a system for securing IMHA attendance.

However, Mr Brown reported greatly improved rates of IMHA involvement, with 70 – 75% of detained patients having been referred or self-referred (compared to approximately 22 – 30% in 2016). The wards achieve 100% referral rates, as required by the Code of Practice, for those who do not appear to understand their rights under the MHA. In addition, updated leaflets have been provided to the MHA office detailing the right to an IMHA, and one of these is included in every letter of invitation to the patient. Nonetheless, it remains the case the most vulnerable patients are the most likely to be unrepresented.

Mr Brown reiterated that he had no concerns for any area in the Trust that patients were not being referred, and it was noted that patients who request a hearing often have a very good understanding for themselves of what is involved, have mental capacity to manage the process and are less likely to need the support of an IMHA.

In the case of automatic reviews of renewal or extension of detention/CTO, IMHA attendance is more problematic. At the time there were approximately 90 people waiting for an advocate (not only IMHAs) and priority is determined by a carefully scored triage system.

Some referrals are life-and-death urgent (such as an Independent Mental Capacity Advocate for serious medical treatment), others are routine. It was acknowledged that this causes difficulties for the service in accommodating short-notice requests for one-off work, such as attending an AMHAM hearing.

5.2 Review of Remuneration

The review was concluded during Q1. It found that remuneration in SHSC compared favourably to that paid by other Trusts, with SHSC remunerating more generously than all other comparable local providers. Mileage paid however is lower than that paid by the Trusts which pay travel expenses.

On behalf of the Board of Directors, on 12.6.19 Jayne Brown made the following recommendations to the Remuneration and Nominations Committee:

a) There should be no increase in hourly rate as current rates compare favourably. However if/when a hearing exceeds 4 hours the excess time taken will be paid at the hourly rate of £15 or part thereof.

b) There should be an increase in the mileage rate to 45p per mile to bring SHSC in line with other organisations.

c) There should be an annual review undertaken by the Remuneration and Nominations Committee each June.

The Remuneration and Nominations Committee agreed and approved each of the recommendations. The AMHAMs who attended training on 24.6.19 were provided with a letter informing them of the outcome, and the remaining AMHAMs were provided with a copy by e mail on 25.6.19.

6 AMHAM Activity: Q1 2019/20

6.1 Number of Hearings – please see Appendix 3 paragraph 2

Table 1: Number of AMHAM Hearings and Reason

Reason	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
In response to patient application S3 or S37	1	0	1	0
In response to patient application CTO	0	1	0	0
RC Renewals S3/S37	12	9	9	15
RC Extension CTO	10	10	11	11
Barring NR	0	0	0	0
At Managers' Discretion	0	0	0	0
Quarterly Total	23	20	21	26
Discharged by AMHAMs	0	1	0	0

Table 2: Applications to the AMHAMs

Applications	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Total Applications submitted	7	1	4	8
Inpatient applications	6	0	4	7
CTO applications	1	1	0	1
Total not proceeding to hearing	6	0	3	6*
Reasons for not proceeding to hearing				
Tribunal pending	2	-	1	3
Discharged by RC before hearing	4	-	1	3
Withdrawn by patient	0	-	1	0
Total	6	-	3	

*one application was made close to the renewal date, therefore the application is to be heard combined with the renewal review.

There is no known reason for the variation in the number of applications

Table 3: AMHAM Hearings:

Hearings	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Type of Hearing				
In Response to Inpatient Applications	1	0	1	0
In Response to CTO Applications	0	1	0	0*
Following Inpatient Renewal	12	9	9	15
Following CTO Extension	10	10	11	11
Following Barring NR	-	-	-	
Total	23	20	21	26
Discharged	0	1	0	0

*this CTO application is the one combined with the renewal hearing as above

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 Q1 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 Q1 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 – Applications and Referrals to the First Tier Tribunal (Mental Health):

Type of Review	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Applications – inpatient	76	50	60	70
Automatic referrals – inpatient	4	4	6	13
Applications – CTO	3	3	4	5
Automatic referrals – CTO – no application	1	5	4	7
Automatic referrals – CTO – revocation	4	1	4	1
Total	88	63	78	96

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:

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
Q2 18/19	22	11	2	9
Q3 18/19	20	16	3	1
Q4 18/19	20	14	2	4
Q1 19/20	26	16	5	5
Grand Total	88	57	12	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 Q1, there were 26 hearings for the renewal or extension of the detention/CTO:

- 16 of the 26 took place before the expiry date
- 5 of the 26 took place within 7 days of expiry
- 5 of the 26 took place more than 7 days after expiry

6.3 Reasons for AMHAM Hearings Not Taking Place Prior to Expiry

Table 6

Reason	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Hearing not booked prior to expiry known unavailability of AMHAMs	1	-	0	2
Hearing originally booked prior to expiry unavailability of AMHAMs (unable to convene a panel)	2	-	1	0
Date up to 7 days after expiry is earliest RC is available	-	-	-	5
Hearing adjourned	2	2	1	0
Hearing not booked prior to expiry known unavailability of RC	3	-	0	0
Hearing originally booked prior to expiry - RC cancelled (RC sick)	2	1	2	1
Hearing booked prior to expiry - AMHAM withdrew	1	-	1	2
Patient wished to attend hearing but refused to attend on a Thursday (see below)	-	-	1	-
Total	11	3	6	10

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.

6.4 Number of Hearings Adjourned - See Appendix 3 paragraph 5

Table 7 – Hearings adjourned

Adjournments and Reason	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Total Adjourned	2	2	1	0
Number with reason recorded on report	2	2	1	-
Patient not present	0	0	0	-
Relevant staff not present	0	1	1	-
AMHAM not present	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.

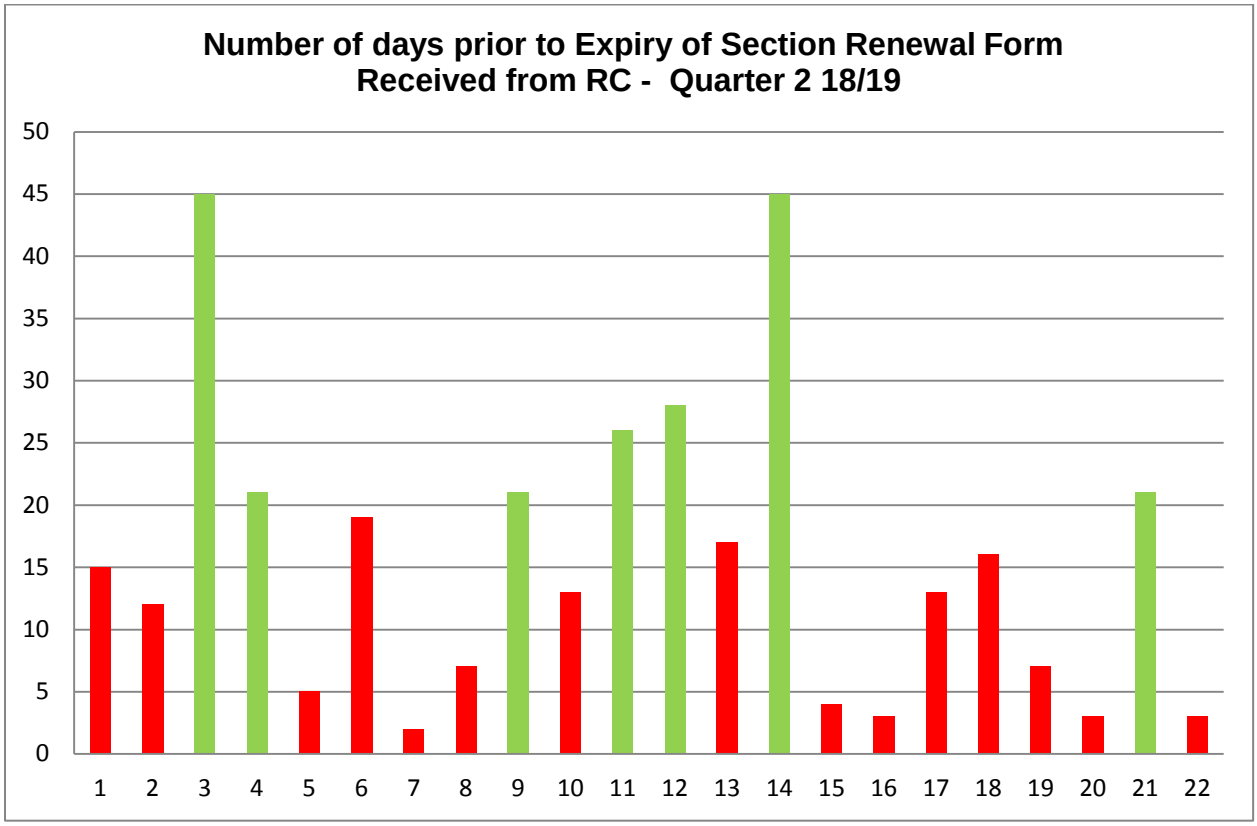
* Q2 - In one case a panel member failed to attend, and in the other an AMHAM was taken ill during the hearing.

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

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 RC Response to Notification of Renewal/Extension

Please see Appendix 3 paragraph 6.


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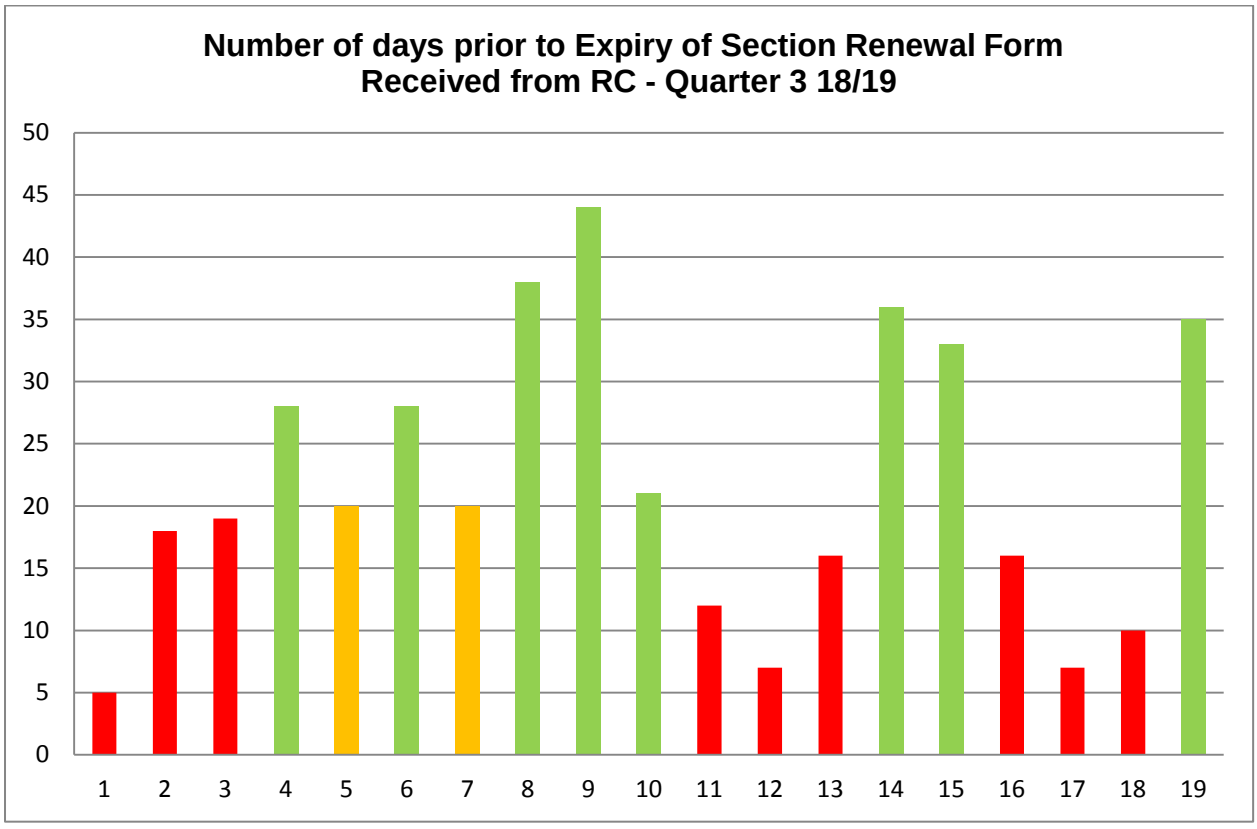
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22


Number of days prior to Expiry of Section Renewal Form Received from RC - Quarter 3 18/19
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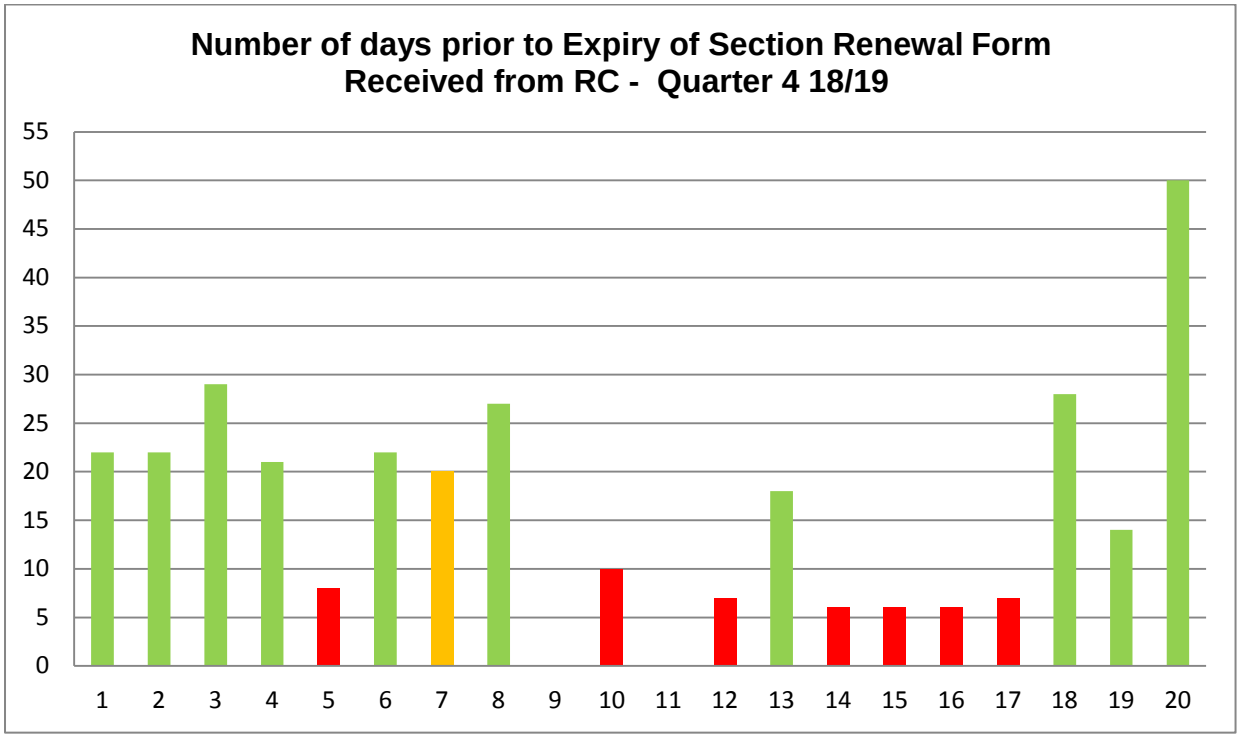

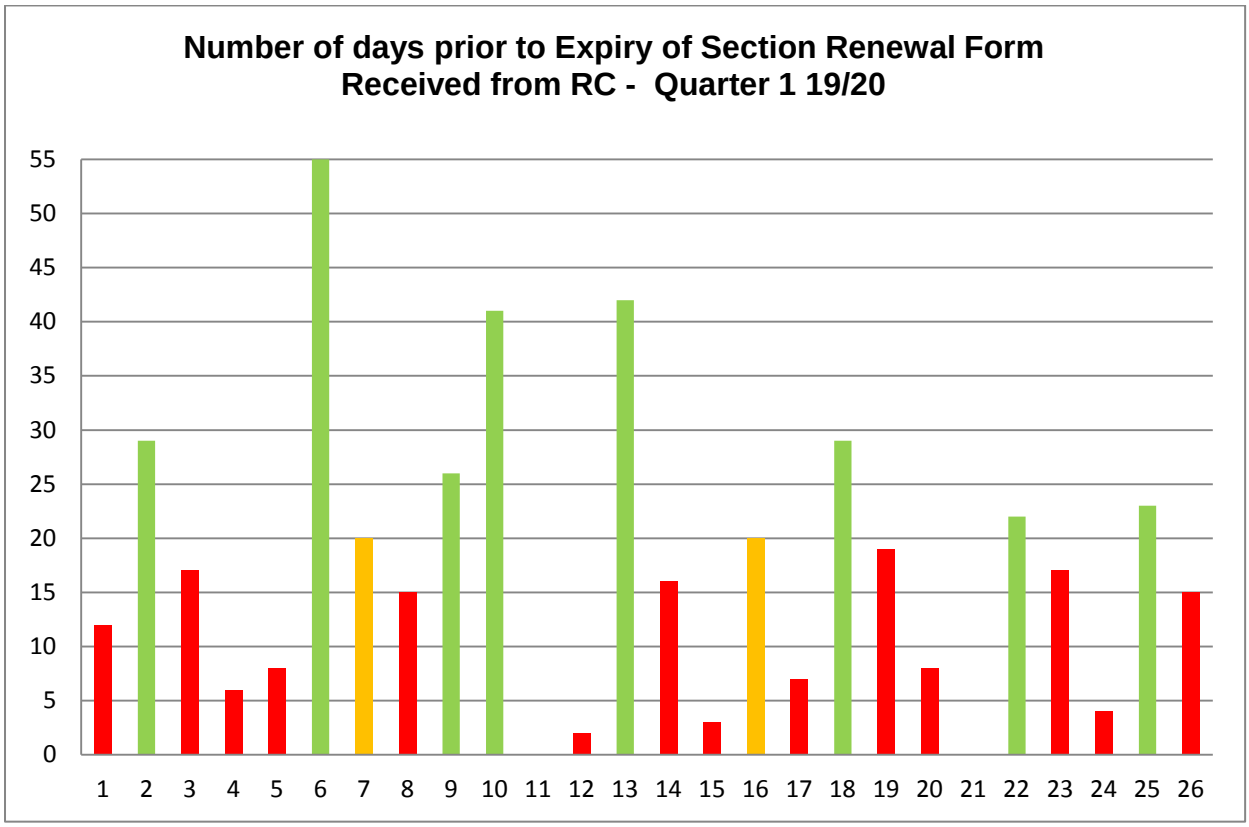

The graphs above show the number of days on the vertical axis; the horizontal axis shows individual renewals/extensions.

Green indicates renewal reports received 21 or more days prior to expiry of the current order; amber indicates reports received at 20 days; red on the graph indicates reports received less than 21 days prior to expiry; a blank indicates that reports were provided on the day of the hearing.

In Q2 18/19 (when this information was first gathered) 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 18/19.

In Q4 18/19, 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%).

In Q1 19/20, 8 reports (30.7% - green) were received with 21 or more days left before expiry, and a further 2 (7.6% amber) were received at 20 days.

14 reports (53.8% – red) were received less than 20 days prior to expiry. 2 reports (7.6%) were not furnished until the day of the hearing.

7 AMHAM Feedback

7.1 Reports

The AMHAMs fed back that 93% for Inpatient and 100% CTO written reports addressed the necessary information, 100% for both inpatient and CTO recorded that the oral report was satisfactory.

It was recorded that 60% of Inpatients attended the hearing. The reasons given for patients not attending included:

- Patients attending for part of the meeting only
- Patients declining to attend, changing their mind or expressing that they were not interested
- Too unwell to attend
- Unable to understand the process and concern from staff that it would be upsetting

38% of patients subject to CTO attended the hearing. The reasons given for patients not attending all amounted to patients, having been made aware of the hearing, declining to attend or expressing that they were not interested.

38% of patients who did not attend the hearing were invited to speak to a panel member the hearing. The reasons for not meeting are listed as:

- The managers were advised the patient did not have the cognitive capacity to understand questions in general
- The patient did not wish to speak to a manager
- Patient had a meeting at the same time
- Patient spoke to chair of panel before and after meeting
- Hostile response when attempts made to discuss meeting with the patient

It was recorded that an IMHA attended 20% hearings for inpatients; however no CTO hearings included IMHA attendance.

60% of inpatient hearings and 100% of CTO hearings started on time. The reasons given why the hearings did not start on time included:

- Patient not ready
- The patient and staff from the ward were late. The RC and Doctor were on time
- Waiting for the doctor to arrive
- The hearing started a few minutes late as this was a complex case which required multiple disciplinary 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.