BOARD OF DIRECTORS MEETING (Open)

Date: 13 February 2019 **Item Ref:** 15

TITLE OF PAPER	Report on the Performance and Activity of the Associate Mental Health Act Managers (AMHAMs) Quarter 3 2018/19
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	13 February 2019 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 & Mike Haywood
Designation	Head of MH Legislation & Manager MH Legislation Administration
Date of Report	30th January 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 3 2018/19**

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 October 2018 – December 2018.

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 to provide assurance to the Board of Directors that this delegated authority is carried out by the Associate Mental Health Act Managers in accordance with the Legislation and the Mental Health Act Code of Practice, 2015.

This report was received, reviewed and the content agreed on Wednesday 16th January 2019 at the AMHAM Quarter 3 meeting, chaired by Liz Lightbown on behalf of Jayne Brown (Trust Chair).

At the AMHAMs' request, this report is now presented as evidence that the requirements of the Mental Health Act Code of Practice are met in respect of the Board's responsibilities with regard to the appointment, training and work of the AMHAMs, (rather than on their behalf). Please see Appendix 3, paragraph 1

The report is presented under the following headings:

1. Number and Availability of AMHAMs
2. Peer Performance Reviews 2018/2019
3. Peer Support Group Sessions Q3
4. Training and Development
5. Key Themes from Quarterly Meetings
6. AMHAM Activity and MHA data
7. Quality of Reports – Outcome of the Workshop on 6.12.18

Appendix 1 - The Legal Status of the AMHAMs & 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 & the reason(s) for under review.
3.4 Review AMHAM training needs as per Annual Peer Reviews & develop accordingly.

4. Required Action

Board members are informed and assured of the role & performance of the AMHAMs in Q3.

5. Monitoring Arrangements

Via the Board of Directors & 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 3 2018/19

1. Number and Availability of AMHAMs

SHSC has eighteen Associate Mental Health Act Managers of different genders, ages, backgrounds and ethnicity.

The AMHAM Quarter 2 meeting, held on 17th October heard that, following the Q1 report, the Board of Directors had enquired as to whether there were sufficient AMHAMs. The meeting agreed to keep the number under review at the quarterly meetings and it is now a standing item on the agenda.

In 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 Q3, no review took place after the expiry date as a result of AMHAM unavailability.

Notification of the renewal/extension due date is issued from the MHA office at least 7 weeks prior to the current order expiring. Reviews are booked at the same time but late completion can lead to short notice cancelation of a panel, inconveniencing AMHAMs who have committed to attend.

This report now includes data in respect of the RC's response time in addition to the reasons for late review, please see 6.3 – 6.5 below.

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.

2. Peer Performance Reviews 2018/2019

By the end of Q3, 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 Q3, an additional 'Peer Reviewer' was appointed following a request for expressions of interest. This brings the total of Peer Reviewers to 3, who between them will undertake the annual development/appraisal of their peers. The Peer Reviewers' reviews are carried out by the Head of MH Legislation.

3. Peer Support Group Sessions Q3

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 during Q3 18/19, in order that specific training issues might be addressed.

No AMHAMs attended the first session, provided on Thursday 1st November. No extra session was provided in December, owing to the provision of routine training on 6th December; a session is booked for 8th January 2019 in addition to the one to be provided prior to the quarterly meeting on 16th January 2019.

The Peer Support session on 17th October was attended by 7 AMHAMs. It focused on the practicalities of reviews conducted at Forest Lodge, Low Secure Unit.

The AMHAMs questioned whether it was Trust policy that patients cannot remain at Forest Lodge on an informal basis (ie not detained under the MHA). This is not Trust policy; it is a contractual arrangement with NHS England.

In common with all other medium- and low-secure facilities, beds must be occupied by detained patients. There are formal access criteria for admission to Forest Lodge and the appropriateness of continuing detention in secure conditions is subject to continuous monitoring by NHS England.

Some AMHAMS are content to conclude that continued detention remains necessary because it is a criterion for on-going accommodation and treatment at Forest Lodge; others question why informal admission is not possible if the patient needs to stay in hospital and is willing to do so, but could – if accommodated in a non-secure setting - be discharged from detention.

The AMHAMs wished to draw the Board's attention to this matter.

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 were reviewed and incorporated into the training delivered on 6th December. 15 of the 18 AMHAMs attended.

The day comprised:

- A Q&A session provided at AMHAM request by Liz Johnson, the Trust's Head of Equality and Inclusion.
- An update of the role of the AMHAM and criteria for renewal/extension, and
- A session on the Final Report of the Independent Review of the MHA, both provided by HoMHL.
- HR attendance to provide photo ID badges for AMHAMs.
- A workshop with the AMHAMs to refine the AMHAM feedback template (used after hearings) and agree on what an adequate report should contain – reported below.
- A session provided by Dr Sobhi Girgis about the power of recall under CTO.

The AMHAMs agreed some changes to their feedback template, which takes the form of a 'Survey Monkey'. The suggestions will be incorporated for use from Q4.

The training day was well-received. Written feedback was very positive and constructive.

5. Key Themes from the Q2 meeting held on 17 October 2018 (ie within Q3)

The Q2 meeting was attended by 7 AMHAMs.

5.1 Reports sent by post

The meeting heard that the Quality Assurance Committee had raised a question as to whether policy was being breached by not sending AMHAM reports via recorded delivery.

The meeting was informed that it is not policy to send the reports by recorded delivery, and some members noted that to do so may cause problems, as the papers could not be delivered if there was nobody at home.

The reports are sent to the AMHAMs via 1st class post in a tamperproof envelope. One member informed the group that this delivery method is the same as that used by the Mental Health Tribunal. It was agreed to continue to post out the reports in the tamperproof envelopes .

5.2 Review of Remuneration

The AMHAMs requested a review of remuneration. The MHA office on behalf of Liz Lightbown is undertaking the review, including a like-for-like comparison with other trusts.

5.3 Training

There was a request for bespoke training in addition to twice-yearly provision in order to meet different development needs in the group. Monthly Peer Support sessions were reinstated.

5.4 Reviews taking place after expiry date

There was a request for more detail in respect of the reasons why reviews take place after the expiry date. More detail is now provided in the quarterly report, please see 6.2 – 6.5 below.

5.5 Q2 Report to Board

The Q2 report was reviewed, amendments agreed, and approved for the Board of Directors

6. AMHAM Activity and MHA Data: Q3 2018/19

6.1 Number of Hearings – please see Appendix 3 paragraph 2

Table 1: Number of AMHAM Hearings & Reason Q4 17/18 – Q3 18/19

Reason	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
In response to patient application S3 or S37	0	0	1	0
In response to patient application CTO	0	1	0	
RC Renewals S3/S37	15	8	12	9
RC Extension CTO	10	15	10	10
Barring NR	0	0	0	0
At Managers' Discretion	0	0	0	0
Quarterly Total	25	24	23	20
Discharged by AMHAMs	0	0	0	1

Table 2: Applications to the AMHAMs: From Q4 17/18 to Q3 18/19

	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
Total Applications submitted	0	7	7	1
Inpatient applications	-	-	6	0
CTO applications	-	-	1	1
Total not proceeding to hearing	-	6	6	0
Reasons for not proceeding to hearing				
Tribunal pending	-	2	2	-
Discharged by RC before hearing	-	2	4	-
Withdrawn by patient	-	2	0	-
Total	0	6	6	-

The 7 applications in both Q1 and Q2 appear to have been anomalous.

Table 3: AMHAM Hearings: Q4 17/18 - Q3 18/19

Type of Hearing	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
In Response to Inpatient Applications	0	0	1	0
In Response to CTO Applications	0	1	0	1
Following Inpatient Renewal	15	8	12	9
Following CTO Extension	10	15	10	10
Following Barring NR	-	-	-	-
Total	25	24	23	20
Discharged	0	0	0	1

There was a reduction in the number of AMHAMs hearings overall throughout 17/18 and this decrease is continuing.

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

There were no hearings during Q3 which resulted from the Responsible Clinician issuing a Barring Certificate to prevent a nearest relative from discharging the patient.

It is evident that 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 Q3 63 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 Q4 17/18 - Q3 18/19

Type of Review	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
Applications – inpatient	59	70	76	50
Automatic referrals – inpatient	9	5	4	4
Applications – CTO	1	4	3	3
Automatic referrals – CTO – no application	9	8	1	5
Automatic referrals – CTO – revocation	7	3	4	1
Total	85	90	88	63
Discharged	0	5	2	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

Please 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
Q4 17/18	25	16	2	7
Q1 18/19	22	15	2	5
Q2 18/19	22	11	2	9
Q3 18/19	20	16	3	1
Grand Total	89	58	9	22

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 Q3, there were 20 hearings for the renewal or extension of the detention/CTO:

- 16 of the 20 took place before the expiry date.
- 3 of the 20 took place within 7 days of expiry.
- 1 of the 20 took place more than 7 days after expiry.

During Q2, there were 22 hearings for the renewal or extension of the detention/CTO:

- 11 of the 22 took place before the expiry date.
- 2 of the 22 took place within 7 days of expiry.
- 9 of the 22 took place more than 7 days after expiry.

The reasons for the Q2 delays were not available in the last report. They are given below at the request of the Q2 meeting.

6.3 Reasons for AMHAM Hearings Not Taking Place Prior to Expiry

This information is newly included in this report at the request of the Q2 meeting, and therefore includes information in respect of both Q2 & Q3.

Table 6 - Reasons

Reason	Q2	Q3
Hearing not booked prior to expiry – known unavailability of AMHAMs	1	-
Hearing originally booked prior to expiry – unavailability of AMHAMs	2	-
Hearing adjourned	2	2
Hearing not booked prior to expiry – known unavailability of RC	3	-
Hearing originally booked prior to expiry - RC cancelled	2	1
Hearing booked prior to expiry - cancelled – AMHAM sick	1	-
Total	11	3

There has been a marked improvement in Q3. This may be linked to more prompt responses from RC's when requested to furnish renewal/extension paperwork, please see 6.5 below.

One hearing due in Q3 will not take place until Q4 (8.2.19). This is because the patient refused to attend the planned review and will not attend on Thursdays. The date in February is the first date the RC is available that is not a Thursday.

6.4 Number of Hearings Adjourned

Please see Appendix 3 paragraph 5.

Table 7 – Hearings adjourned Q4 17/18 - Q3 18/19

Adjournments and Reason	Q4 17/18	Q1 18/19	Q2 18/19	Q318/19
Total Adjourned	1	1	2	2
Number with reason recorded on report	0	1	2	2
• Patient not present	0	0	0	0
• Relevant staff not present	0	1	0	1
• AMHAM not present	1	0	2*	1**

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 Impact of RC Response to Notification of Renewal/Extension

Please see Appendix 3 paragraph 6.

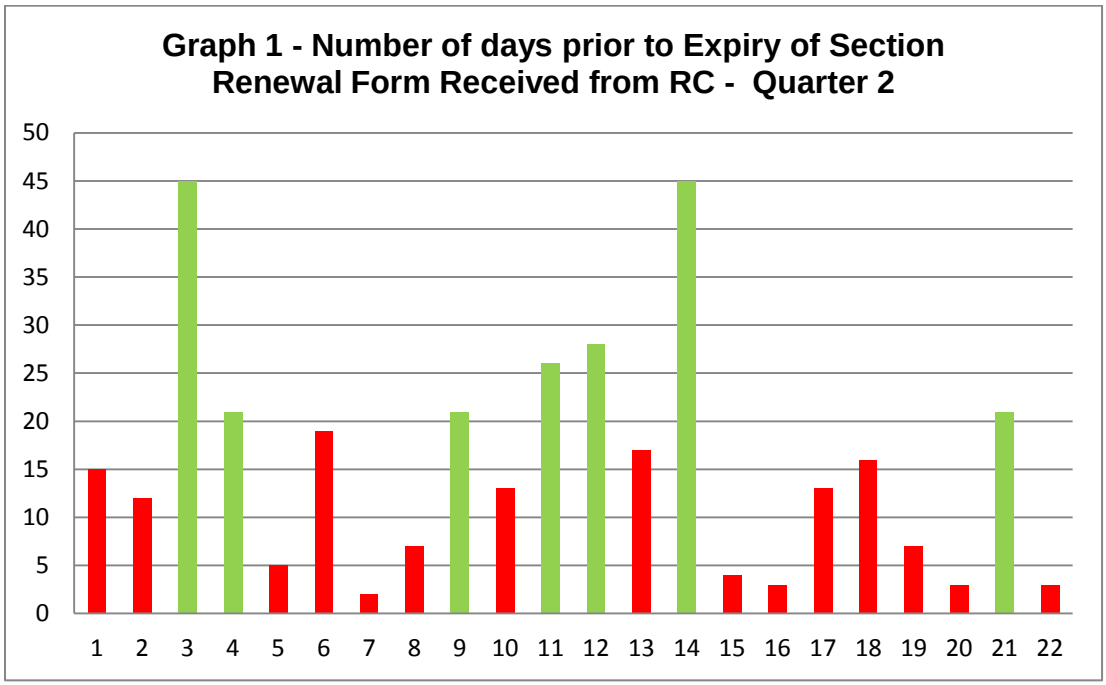
The graphs below show the RCs' response times in Q2 and Q3; the number of days is shown on the vertical axis; the horizontal axis shows individual renewals/extensions.

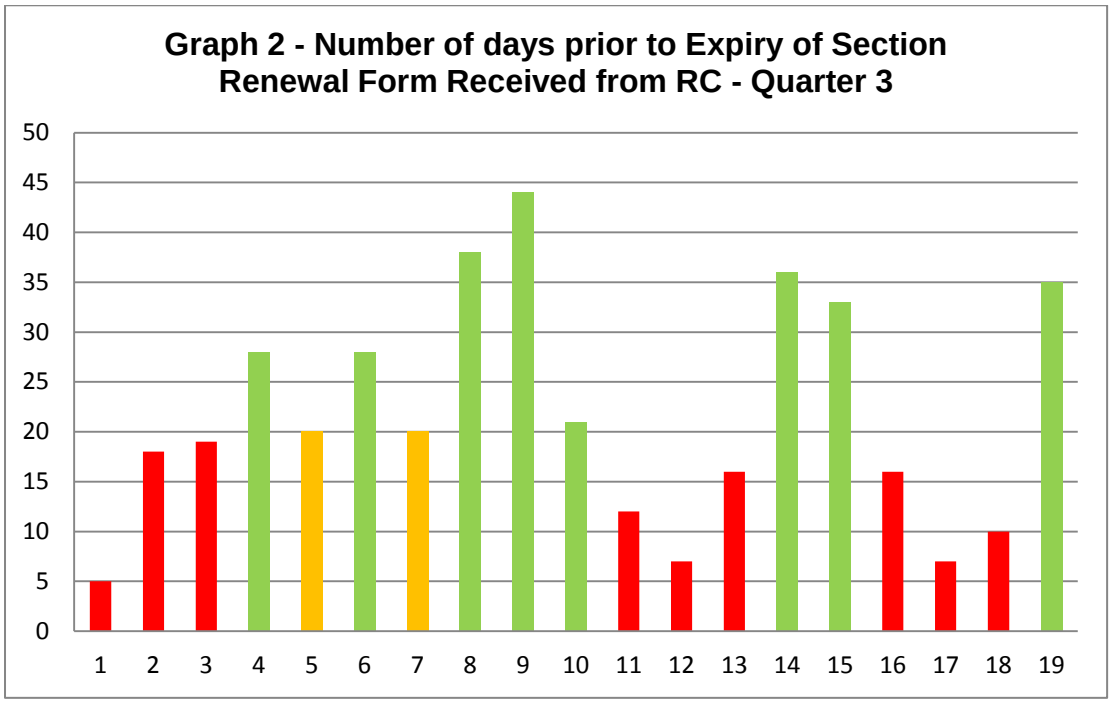
In Q2 32% of renewals were received by the 21 day deadline.

However, there is a significant improvement in Q3 with 42% being received within 21 days. A further 2 (bringing the total to 52%) were received at 20 days.

Hearings taking place more than 7 days after renewal decreased from 9 (out of 22 hearings) in Q2 to 1 (out of 19 hearings) in Q3.

This improvement in response times may be linked to the reduction in hearings taking place after the renewal date, please see table 6.





7. Quality of Reports – Outcome of the Workshop on 6.12.18

7.1 Written Reports

Prior to the hearings managers receive written reports from the professionals involved in the patient's care. Unfortunately, on occasion, this might be on the day of the hearing. Late receipt was discussed by the AMHAMs at the workshop included training day on 6th December. The meetings are currently scheduled for AMHAMs to convene 30 minutes before the time given for other attendees. Those present agreed that it may be necessary to delay the start of the hearing in order to read the reports. It was not felt to be feasible to convene the meeting an hour in advance owing to travelling.

7.2 Type of Report - Medical

If the hearing is because the detention or CTO is to be renewed, then the Responsible Clinician completes the statutory form H5 or CTO7 giving reasons why, in their opinion, the detention or CTO should be renewed. This form constitutes the Responsible Clinician's medical report. This is a statutory form and so cannot be amended or developed locally.

The workshop considered that the statutory form does not allow for much detail to be included in respect of the patient's history or the nature of their mental disorder, such as how their illness manifests when the patient is unwell, and how their presentation alters when they improve. In contrast, such detail is included in a medical report to the Tribunal, which must follow a detailed template: if a tribunal is imminent or has occurred in the previous 28 days, the AMHAMs will be provided with it.

There was a suggestion that the most recent Tribunal report – regardless of its age - could be provided in order to supply a full picture. There was a discussion about whether a less recent report would have the effect of influencing the panel's decision, and it was noted that a previous request for Tribunal reports had been denied by the MHA office.

The source of authority for that decision was uncertain at the workshop however, the Trust Information Manager has confirmed that it would not be permissible in terms of information governance for the AMHAMs to receive a report prepared for a different purpose at a significantly different time.

The RC's oral report must therefore be relied upon for detailed, current information; this can in turn be compromised by an RC's unfamiliarity with the patient.

7.3 Type of Report – Care Co-ordinator or Named Nurse

A narrative report from the care co-ordinator, or - for inpatients – from the named nurse is also required. The workshop agreed that the adequacy of these reports would depend on whether the relevant social and/or nursing information was included. This may include reference to detention/renewal/extension criteria as appropriate to the person's role.

The AMHAMs noted that there are frequent occasions when the staff members attending a review are not those who prepared the reports. In some cases, the attendee has never met the patient.

The difficulty in ensuring that the relevant staff members are on duty given the pressures on wards and teams was acknowledged, but the AMHAMs also reported feeling that there was an attitude that Managers' hearings are not as important as Tribunals.

The workshop suggested some amendments to their feedback 'Survey Monkey', defining the report requirements more objectively. These will be incorporated from Q4.

The Legal Status and Duties of the Associate Mental Health Act Managers

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.

CoP Chapter 38.12 describes the functions of the Hospital Managers.

[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.

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 MHA 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 & 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.

6. 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. Reviews cannot be booked until the renewal has been completed by the RC.