NHS
Sheffield Health and Social Care
NHS Foundation Trust

Board of Directors' - Open

Date: **12th February 2020** **Item Ref:** 13

TITLE OF PAPER	Report on the Performance and Activity of the Associate Mental Health Act Managers (AMHAMs) Quarter 3 19/20
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	February 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 Mental Health Legislation and Manager Mental Health Legislation Administration
Date of Report	21st January 2020

Proud to care in Sheffield

Summary Report

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
	✓				✓	

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 to December 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 15th January 2020 at the AMHAM Quarter 3 meeting, chaired by Liz Lightbown, Executive Director of Nursing & Professions, on behalf of 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. AMHAM Activity and MHA data
6. 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 Q3.

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 3, 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 Q3, out of a total of 22 renewal hearings, 6 took place after the expiry date:

- 1 as the result of an AMHAM cancelling; unable to find a replacement.
- 1 as the result of transfer from another hospital; the previous hospital had not held the hearing before expiry date.
- 1 (originally booked in Q2) was adjourned at the patient's request in order to secure the attendance of an IMHA and took place in Q3.
- 1 because it was the earliest date the RC was available.
- 1 as a result of the patient not attending for their statutory CTO examination with the RC.
- 1 was listed 3 times, originally before the expiry date. It was postponed initially because the patient did not attend their statutory CTO examination with the RC; the rearranged hearing was then adjourned because an AMHAM failed to attend. The hearing took place 39 days after expiry. The panel did not discharge the patient.

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.

At the end of Q3, SHSC had 19 Associate Mental Health Act Managers of different genders, ages, backgrounds and ethnicity. One is currently inactive for personal reasons.

The Head of Mental Health legislation has clarified the recruitment process for AMHAMs with the new Lead Recruitment Officer.

2. Peer Performance Reviews 2019/20

Dates for Peer Review in this financial year are being arranged for all AMHAMs. Established AMHAMs have an annual review (Peer reviewers are reviewed by the Head of Mental health Legislation) and newly recruited members have a foundation review after attending a minimum of 3 hearings as an observer and before taking an active part on a review panel.

Of the 18 active:

- 14 have received their annual review or their foundation review
- 3 require an annual review
- 1 requires a foundation review (on completion of 3 observation hearings)

In response from suggestions from the AMHAMs at their peer review meeting in July 2019, new appointees now receive a more detailed induction.

Documentation for an 'Administration Induction Pack' covering practical matters such as access to hearing sites, car parking permits, expenses claims etc. has been utilised to good effect during Q3.

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 are reviewed by the HoMHL and incorporated into the regular bi-annual training delivered in June and December.

Training was delivered on 13th December 2019, attended by 13 AMHAMs. The training consisted of:

- A session about correct completion of renewal/extension papers by professionals, presented by the Mental Health Legislation Administration Manager.
- A work-shop on chairing skills and practice led by AMHAMs.
- A session about consent to treatment under Part 4 and Part 4A MHA, presented by the Head of Mental Health Legislation.
- A session about medication in mental health care, presented by a Trust pharmacist.

There was very positive feedback, both written and orally on the day, and suggestions were made for the session to be delivered in June 2020.

4. Key Themes from the Q2 meeting held on 17th October 2019 (ie within Q3 19/20)

The Q2 meeting was attended by 13 AMHAMs. It was chaired by Jayne Brown (Chair of the Board of Directors).

4.1 Quarterly Report to the Board – Q2 2018/19

The Q2 report was reviewed by the members. It was duly approved by the meeting for presentation to the Board.

4.2 Review of Remuneration

There had been a constructive and beneficial meeting between Jayne Brown and three AMHAM representatives on 02.08.19 after the initial decision about remuneration, and a letter summarising the outcome had been sent to all AMHAMs shortly before the Q2 meeting.

Ms Brown apologised for the response taking longer than anticipated.

The outcome of the review was an uplift in travel expenses, and the introduction of the principle that AMHAMs are paid for work done, whether this is more or fewer than 4 hours, to include time spent reading and preparing for hearings, the hearing itself and the extra duties which fall on the Chair afterwards.

As this arrangement might lead to different claims being made for the same hearing more work may be required to finalise the administration of the new approach.

4.3 Potential Conflict of Interest

There are some members of the pool of AMHAMs who are related, and others have taken up the role on the recommendation of an established AMHAM. At the time, in order to ensure that panel members were independent of each other, as well as independent of the Trust, it was the practice that relatives and those who were linked by introduction were not allowed to sit on the same panel. This practice was discussed at the meeting.

It was agreed that it was necessary for a panel to pass the 'perception test', ie that the person subject to the hearing would not perceive any bias resulting from a relationship between panel members.

It was acknowledged that many AMHAMs who sit together know each other very well, sometimes for many years, and that this was not materially different from one member introducing another.

Therefore, the restriction on a member sitting with someone they had introduced to the role was agreed not to be necessary; however members who have a familial connection by blood or marriage will not sit together.

4.4 Future Meetings

Having reviewed the content and conduct of the Peer Support and Quarterly meetings, it was agreed that from the April 2020 meeting, the meetings would be amalgamated into a 2 hour more informal meeting running from 10.00 – 12 noon.

5. AMHAM Activity: Q3 2019/20

5.1 Number of Applications and Hearings – please see Appendix 3 paragraph 2

Table 1: Number of AMHAM Hearings Booked and Reason

Reason	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
In response to patient application S3 or S37	1	0	2	3
In response to patient application CTO	0	0	1	0
RC Renewals S3/S37	9	15	16	11
RC Extension CTO	11	11	13	11
Barring NR	0	0	0	0
At Managers' Discretion	0	0	0	0
Total applications	-	-	3	3
Quarterly Total – Completed Hearings	21	26	29	25
Discharged by AMHAMs	0	0	0	0
Hearings applied for in Q2 to be heard in Q3	-	-	3	0

Table 2: Applications to the AMHAMs

Applications	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
Total Applications submitted	4	8	8	3
Inpatient applications	4	7	7	3
CTO applications	0	1	1	0
Total not proceeding to hearing	3	6	4	1

Reasons for not proceeding to hearing	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
Tribunal pending	1	3	0	0
Discharged by RC before hearing	1	3	1	1
Withdrawn by patient	1	0	2	0
Application considered did not proceed	0	0	1*	0
Total	3	6	4	1

*One hearing was not granted having been considered by the AMHAM, as the patient was very ill and could not recall making an application for discharge.

There is no known reason for the variation in the number of applications, however the increased numbers in year 19/20 indicate that patients are aware of their right to apply for discharge.

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).

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, 83 applications and automatic referrals were made to the First Tier Tribunal in respect of section 2, section 3 and CTO.

Table 3 – Applications and Referrals to the First Tier Tribunal (Mental Health)

Type of Review	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
Applications – inpatient	60	70	68	67
Automatic referrals – inpatient	6	13	14	5
Applications – CTO	4	5	5	5
Automatic referrals – CTO – no application	4	7	8	4
Automatic referrals – CTO – revocation	4	1	4	2
Total	78	96	99	83

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

5.2 AMHAM Renewal/Extension Hearings Taking Place Prior to Expiry

See Appendix 3 paragraph 4

Table 4 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 4 – AMHAM Renewal/Extension Hearings taken place in relation to expiry date:

Quarter	Total number of hearings for renewal or extension	Hearings before expiry date	Hearings up to 7 days after expiry date	Hearings more than 7 days after expiry date
Q1 19/20	26	16	5	5
Q2 19/20	29	19	7	3
Q3 19/20	22	16	0	6
Grand Total	77	51	12	14

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 22 hearings for the renewal of detention or extension of the CTO; 2 applications made towards the end of Q3 will have their hearings in Q4.

- 16 of the 22 took place before the expiry date.
- 0 of the 22 took place within 7 days of expiry.
- 6 of the 22 took place more than 7 days after expiry.

5.3 Reasons for AMHAM Hearings Not Taking Place Prior to Expiry

Table 5

Reason	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
Hearing not booked prior to expiry known unavailability of AMHAMs	0	2	0	0
Hearing originally booked prior to expiry unavailability of AMHAMs (unable to convene a panel)	1	0	1	1
Date up to 7 days after expiry is earliest RC is available	-	5	7	0
Hearing adjourned	1	0	1	1
Hearing not booked prior to expiry known unavailability of RC	0	0	1	0
Hearing originally booked prior to expiry - RC cancelled (RC sick)	2	1	0	0

Reason	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
Hearing originally booked prior to expiry - RC cancelled (Patient did not attend appointment for examination to renew)	-	-	-	2
Hearing booked prior to expiry - AMHAM withdrew	1	2	0	1
Date over 7 days after expiry is earliest RC is available	-	-	-	1
Patient wished to attend hearing but refused to attend on a Thursday (see below)	1	-	0	0
Total	6	10	10	6

One hearing in Q3 was 39 days over the expiry date. The hearing had been listed 3 times as described above at Paragraph 1

None of the patients who had a hearing after the expiry date went on to be discharged at their hearing, therefore there was no negative impact on the patient.

5.4 Number of Hearings Adjourned - See Appendix 3 paragraph 5

Table 6 – Hearings Adjourned

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

One hearing was adjourned in Q3 as the result of an AMHAM not attending.

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.

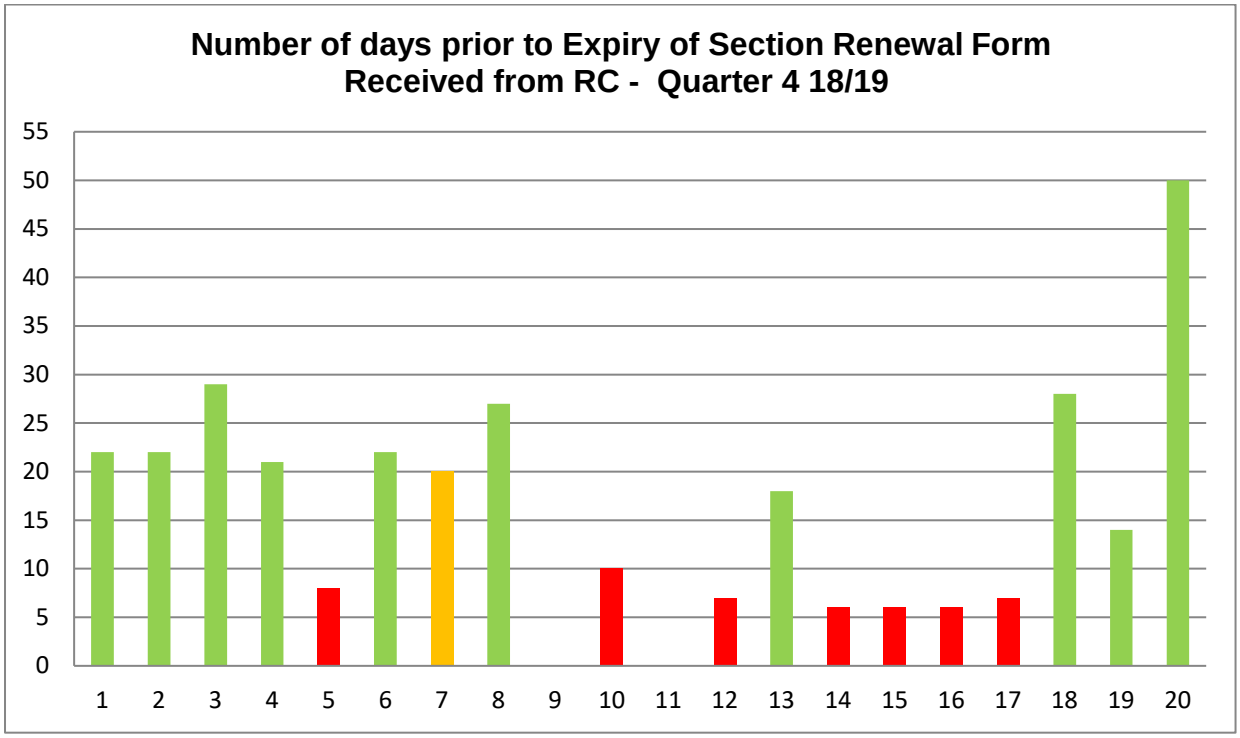
There was no negative impact as a result of these adjournments. Detention continued lawfully until a re-arranged review, and no patient was discharged at a re-arranged review.

5.5 RC Response to Notification of Renewal/Extension

Please see Appendix 3 paragraph 6.

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.


Number of days prior to Expiry of Section Renewal Form Received from RC - Quarter 4 18/19
55
50
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40
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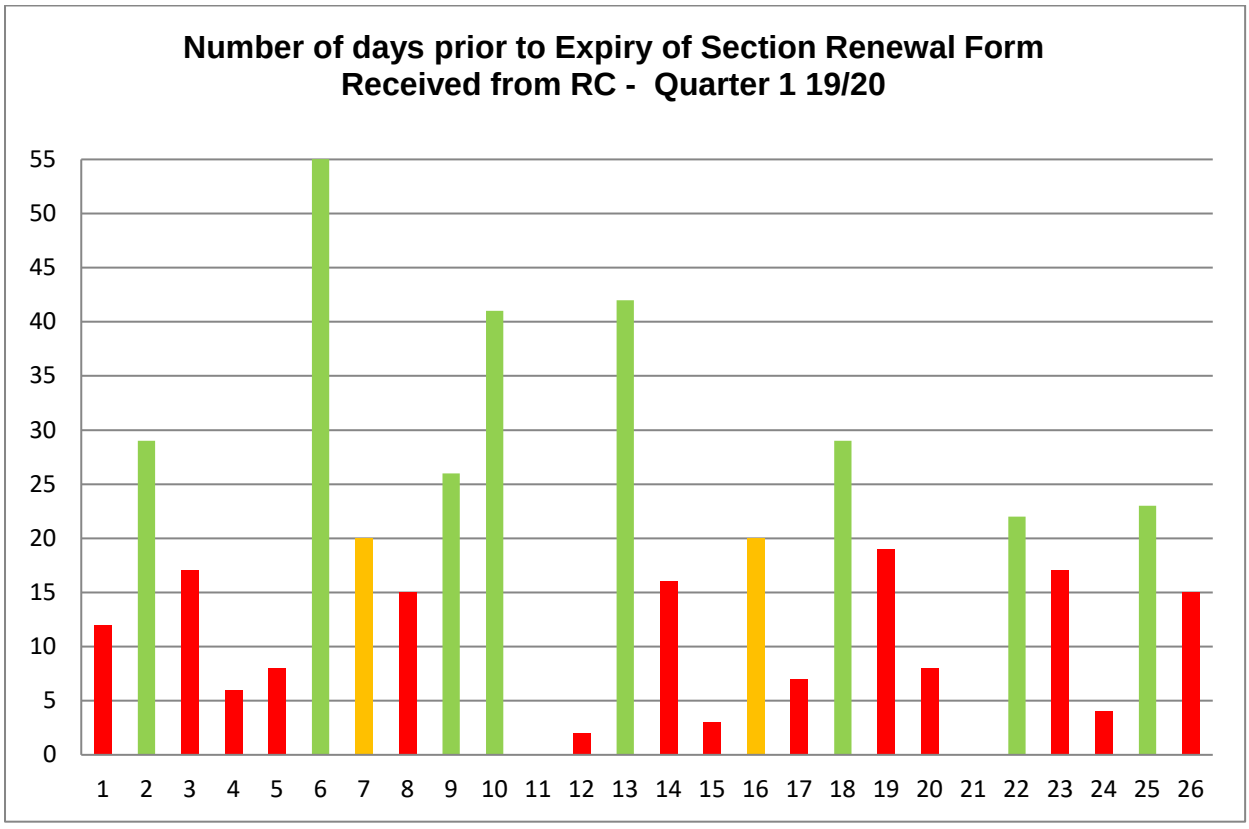
Number of days prior to Expiry of Section Renewal Form Received from RC - Quarter 1 19/20
55
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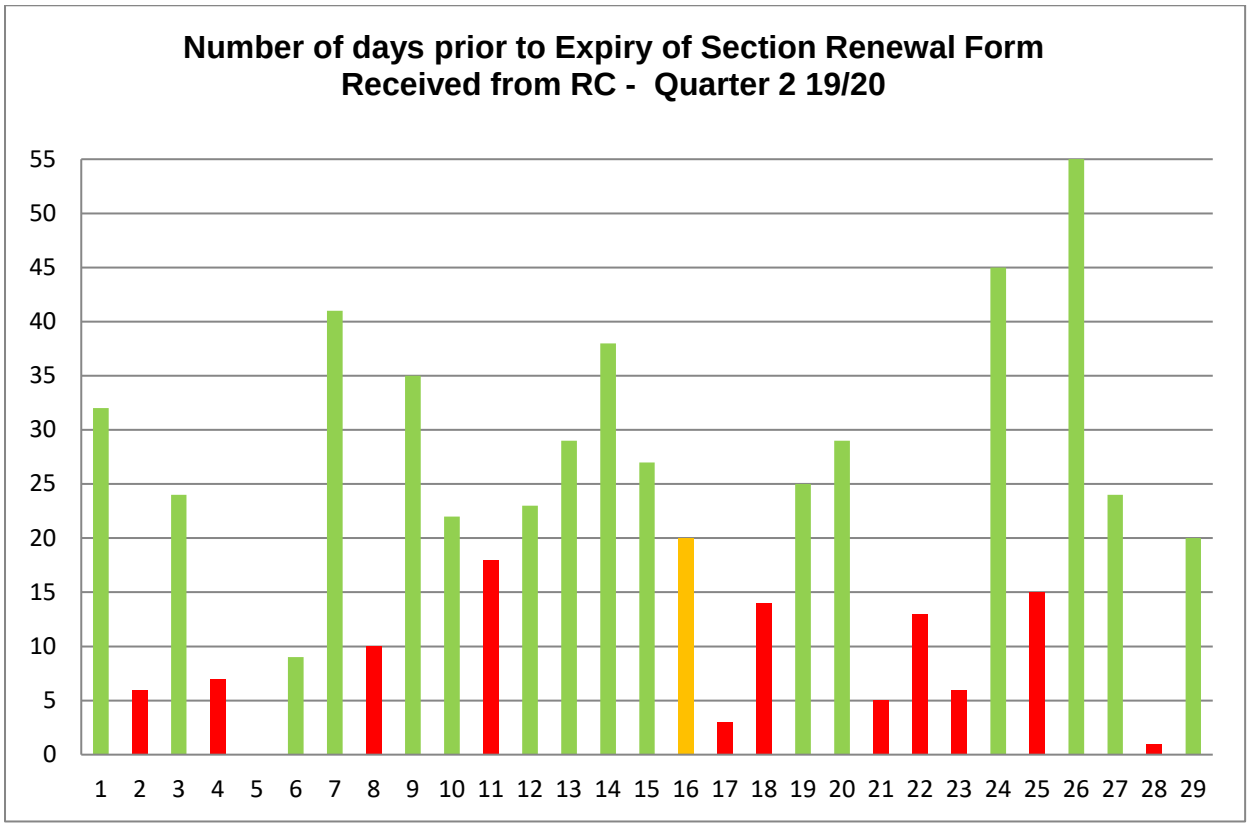

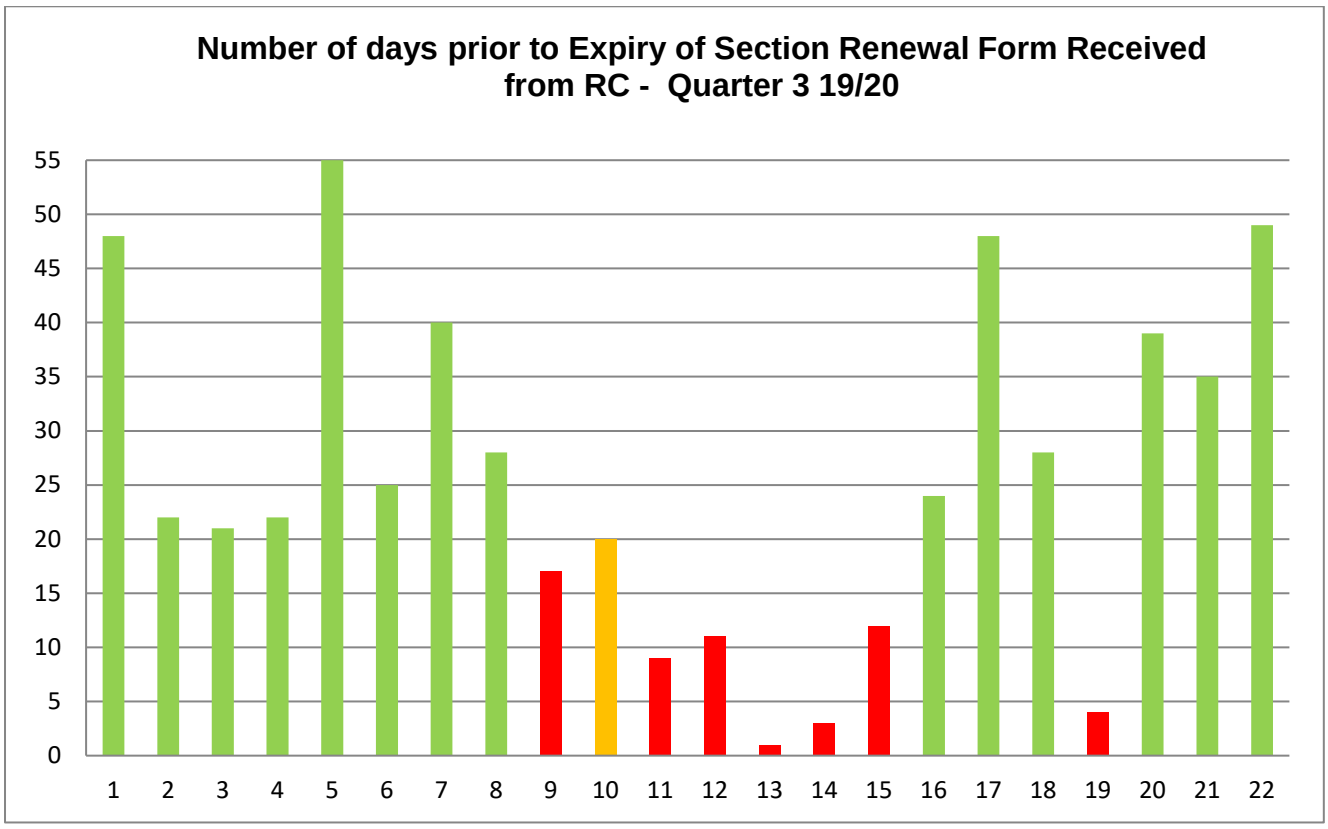

In Q4 18/19, 10 renewal forms out of 20 were provided within the 21 day deadline (50%), and 1 at 20 days (total 20 days or less = 55%). However, there were 2 occasions when the renewal form was received on the day of expiry. These show with no coloured bar on the Q4 graph below, and bring the total missing 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.

In Q2 19/20, 16 of 29 renewal reports (55%) were provided in line with the 21 day deadline; a further report was received at 20 days (58.6% of reports received 20+ days before the deadline). 1 report was not furnished until the day of the hearing and 1 was received the day before the hearing.

In Q3 19/20, 14 of 22 renewal reports (64% - green) were provided in line with the 21 day deadline; a further report (amber) was received at 20 days (68% of reports received 20+ days before the deadline). The remaining 7 reports (32% - red) were received between 1 day and 17 days before the hearing.

6. AMHAM Feedback

The AMHAMs fed back that only one set of written reports and one set of oral reports were inadequate.

91% of inpatients and 46% of CTO patients attended their hearing, reasons for not attending were recorded as follows:

Inpatient
- Not interested

CTO
- Did not want to engage with the process.
- The patient had been asked by her mother and did not wish to attend. Believed that the professionals and ourselves had already made our decision and that we were all in cahoots.
- The patient stated he already knew the outcome.
- The patient was working.

100% of in-patients who did not attend the hearing were invited to speak to a panel member before the hearing.

64% of inpatient hearings and 82% of CTO hearings started on time. Reasons for late starts were recorded as follows:

In-patient
- The RC was late and did not initially attend the meeting, the ward staff went to find her and left the patient waiting on the corridor with the advocate.
- Waiting for the panel to convene and the system was down according to the Drs medical secretary.
- In order for patient to be able to read the reports.
- Manager late.

CTO
- Patient /carers not aware of hearing. Waited for them to be informed and arrive.
- Incomplete panel.

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 Manager's 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.