Policy:

NP 022 - Hospital Managers Review of Detention or Community Treatment Order Under Section 23 Mental Health Act 1983

Executive Director Lead	Executive Medical Director
Policy Owner	Head of Mental Health Legislation
Policy Author	Head of Mental Health Legislation

Document Type	Policy
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Ratified By	Mental Health Legislation Committee
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Summary of policy

A policy to ensure that review of detention or compulsion under detention or CTO pursuant to the Mental Health Act 1983 takes place lawfully and as necessary

Target audience	Trust Board, Associate Mental Health Act Managers, Responsible Clinicians, All staff involved in the care of patients subject to compulsion under the Mental Health Act

Keywords	Managers; detention; review; renewal; s23

Storage & Version Control

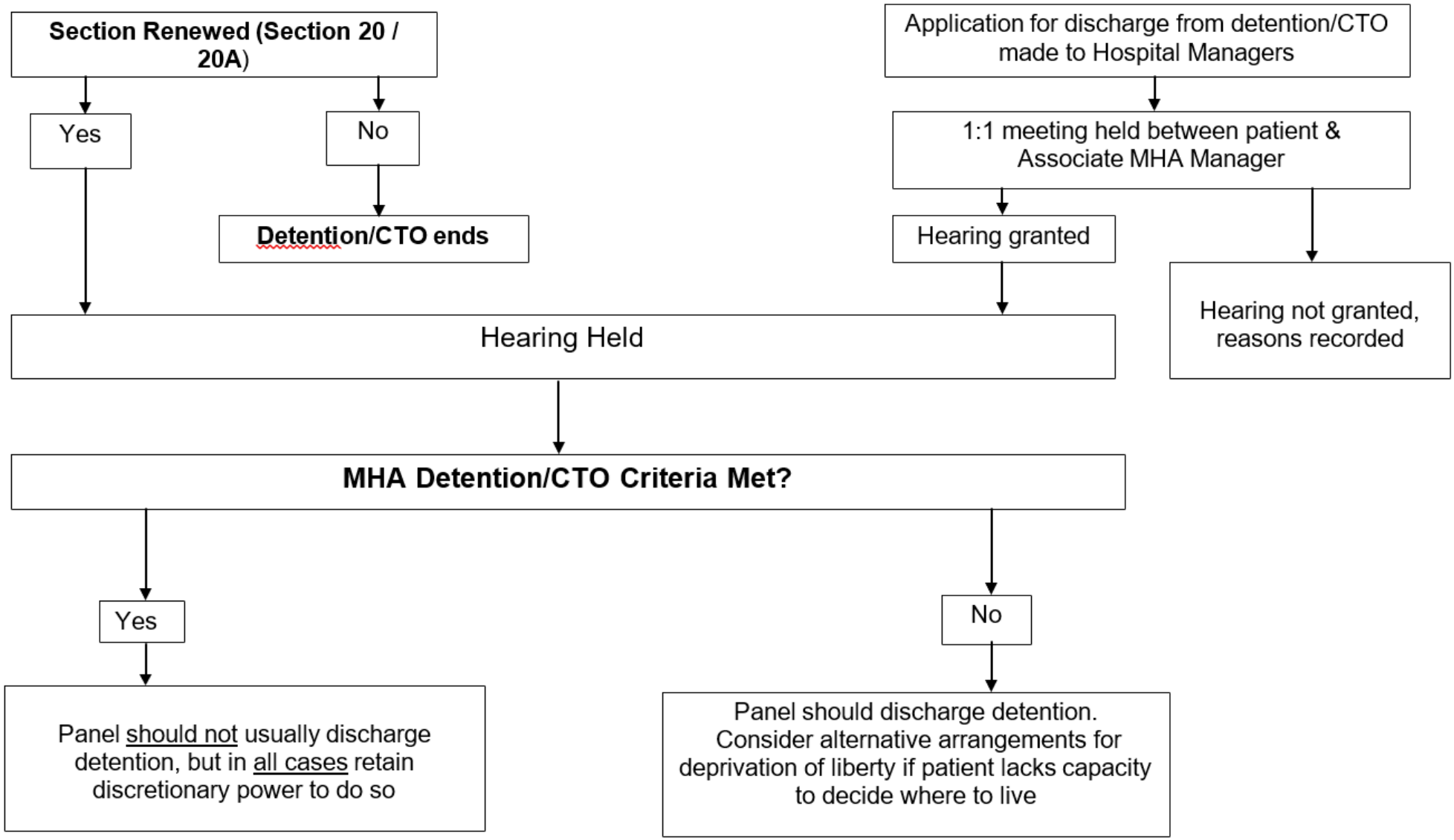
Version 5 of this policy is stored and available through the SHSC intranet/internet.. This version of the policy supersedes the previous version (V4 July 2019). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

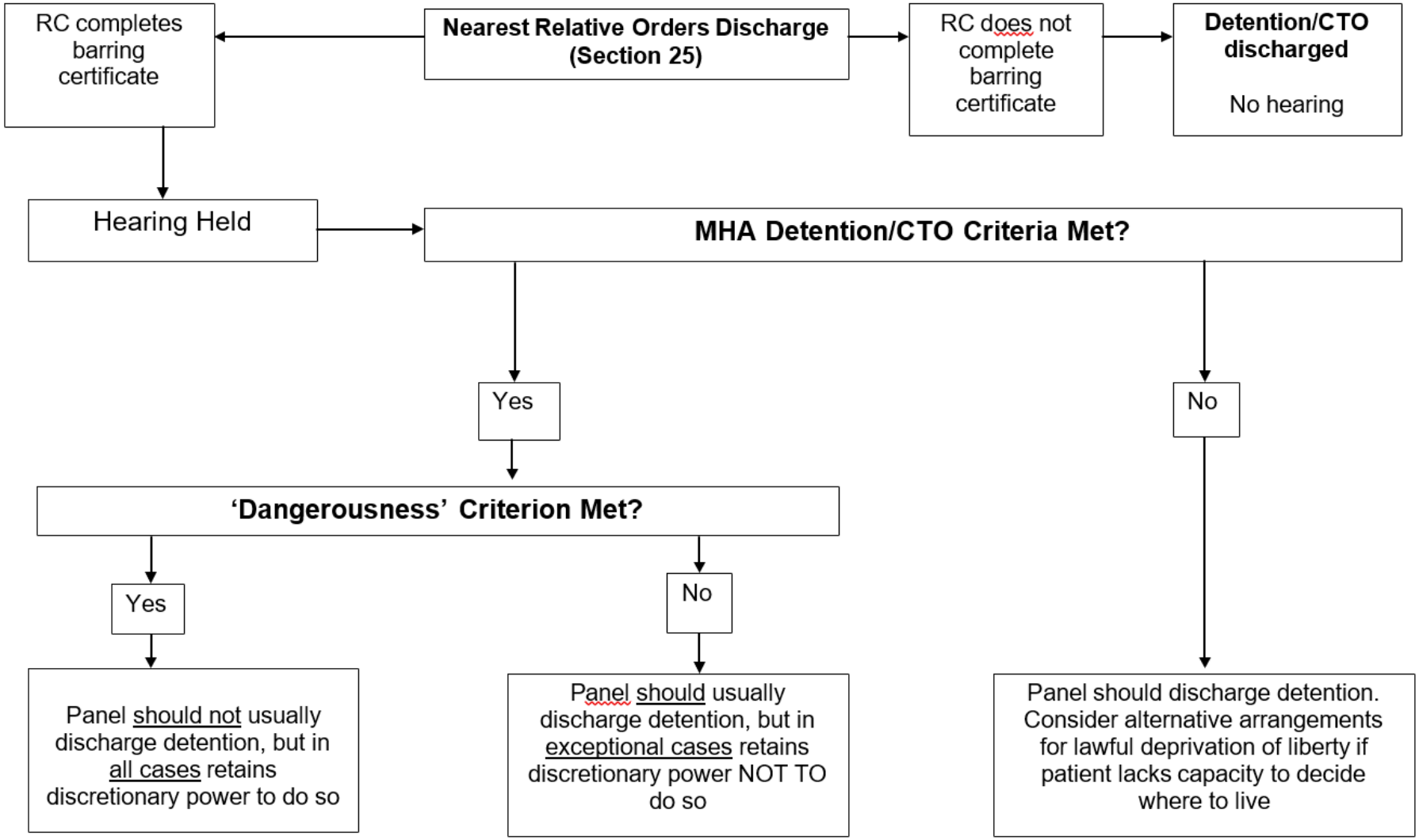
Version No.	Type of Change	Date	Description of change(s)
1.0	New policy	Oct 2008	New policy.
2.0	Reviewed	Feb 2014	Slight amendments to wording.
3.0	Reviewed, ratified and issued.	Aug 2016	General update including MHA Code of Practice, 2015.
4.0	Reviewed	June 2019	Scheduled Review Flow-chart split into 2 charts: renewal of section & applications for discharge; Nearest Relative Order for discharge Updated job titles Addition of standard for RC reports to the hearing No other significant changes
5.0	Review	August 2022	Some terminology changed to assist reader Some definitions reworded to assist reader Governance structure updated to reflect introduction of Mental Health Legislation Operational Group Grammatical and punctual errors corrected Added that policy will be reviewed and revised where necessary in response to any incidents and any lessons learnt

Contents

Flowchart for the Hospital Manager Review of Detention - Section Renewal & Applications



Flowchart for the Hospital Manager Review of Detention - Nearest Relative Order MHA s25



1 Introduction

The Mental Health Act 1983 (as amended) gives the Hospital Managers the power to discharge most detained patients and all patients subject to Community Treatment Orders. These powers of discharge are delegated to the Associate Mental Health Act Managers (AMHAMs).

The Associate Mental Health Act Managers may not discharge restricted patients without the consent of the Secretary of State for Justice. This policy is to ensure the Trust meets its responsibilities in relation to discharge under section 23 Mental Health Act 1983 (MHA).

2 Scope

This policy applies to the Trust Board and the Associate Mental Health Act Managers who have delegated responsibility from the Trust Board.

This policy applies to all staff working in Sheffield Health and Social Care NHS Foundation Trust (including agency and secondees) whose role involves the care and treatment of patients / service users covered under the Mental Health Act.

3 Purpose

Section 23 Mental Health Act 1983 (as amended) does not set out any procedure for reviewing the detention or community treatment order of patients other than to provide that a committee of three or more persons who are not employees of the hospital and who have been authorised by the Trust's Board can exercise the Hospital Managers' power to discharge patients from detention under the MHA. The members of this committee are to be referred to as Associate Mental Health Act Managers (AMHAMs).

The purpose of this policy is to ensure the Trust Board and the AMHAMs are aware of its responsibilities & duties under section 23 Mental Health Act and defines to whom the Trust can delegate this function.

4 Definitions

Mental Health Act: References to the Mental Health Act are to the Mental Health Act 1983 as amended by the Mental Health Act 2007.

The Act: Refers to the Mental Health Act 1983 as amended by the Mental Health Act 2007.

Hospital Managers: Under the Mental Health Act 1983 and for the purposes of s23, the term 'Hospital Managers' does not mean the Management Team of the hospital but the people or body whose hospital it is i.e. the NHS Foundation Trust as a body.

Associate Mental Health Act Managers (AMHAM): Those persons authorised by the Trust Board to carry out the functions of Hospital Managers defined in the Mental Health Act 1983 (as amended) in relation to the review of detention and Community Treatment Orders.

The Managers: Where this term is used in this policy it refers to the Associate Mental Health Act Managers.

Managers' Panel: at least 3 Associate Mental Health Act Managers undertaking a review of detention/CTO. Any decision to discharge from detention/CTO requires 3 members to be in agreement, therefore 3-member panels must be unanimous in a decision to discharge

Patient: The Act uses the term 'patient' to mean a person who is, or appears to be suffering from mental disorder; this includes people subject to Community Treatment Orders.

Responsible Clinician: The Responsible Clinician (RC) is the named person responsible for care and treatment provided under the Mental Health Act. The Responsible Clinician must already be an Approved Clinician.

Community Treatment Order: Community Treatment Order (CTO) is the authorisation for managing patient care and treatment in the community with the power to recall the patients to hospital if necessary.

5 Detail of the policy

This policy is concerned with statutory duties under the Mental Health Act.

6 Duties

The Trust Board, as the body that constitutes the 'Hospital Managers', is responsible for the delegation of the power of discharge under section 23 Mental Health Act 1983 to the Associate Mental Health Act Managers.

Executive Director with responsibility for the Mental Health Act is responsible for the link between the Associate Mental Health Act Managers and the Trust Board.

Mental Health Act Administration Manager has responsibility for ensuring review hearings are coordinated and relevant documents are available for the hearings.

Associate Mental Health Act Managers are responsible for ensuring the reviews are conducted in a way that satisfies the legal requirement of fairness, reasonableness and lawfulness

Responsible Clinicians are responsible for ensuring the renewal of detention or Community Treatment Orders are undertaken in a timely manner to ensure reviews can take place as close to the expiry date of the current detention or CTO as possible.

Mental Health Legislation Operational Group is responsible for monitoring the operation of this policy

7 Procedure

7.1 Principles - Exercise of Power to Discharge

The Hospital Managers must either consider discharge themselves or arrange for their power to be exercised on their behalf by a "manager's panel". A manager's panel may consist of three or more people who are:

- Members of the organisation in charge of the hospital (e.g. the chair or non-executive director of an NHS trust) or Members of a committee or sub-committee which is authorised for the purpose (Associate Mental Health Act Managers - AMHAMs)

In the case of an NHS foundation trust, it is permitted for the AMHAMs to be members of the Trust or any of its committees or sub committees but none of the members of the managers' panel may be employees or officers of the Trust

In delegating this responsibility to the AMHAMs, the Trust must ensure the training needs of the Associate Managers are met.

Section 23 of the MHA does not define the criteria or procedure for reviewing detention/CTOs. In exercising this power, AMHAMs must have regard to the general law and to public duties. The AMHAMs conduct of a review must satisfy the fundamental legal requirements of fairness, reasonableness and lawfulness:

- They must adopt and apply a procedure which is fair and reasonable;
- They must not make an irrational decision, that is, decisions which no other body of hospital managers, properly directing themselves to the law and on the available information, could have made;
- They must not act unlawfully, that is contrary to the provisions of the Act and other legislation and any applicable regulations.

7.2 From which sections can Hospital Managers consider discharge?

Hospital Managers' reviews to consider discharge may be held for patients detained under sections 2, 3, 37, 47 and patients subject to Community Treatment Orders (CTO). They may not discharge patients who are held under the section 5 holding powers, or in a place of safety under section 135 or 136 or subject to interim hospital orders under section 38. Patients who are on restriction orders may request a review but discharge by the Managers could only be with the consent of the Secretary of State for Justice

7.3 Information to patients

Patients must know that they may apply for a Manager's review of detention/CTO and that this is not the same as an application to the First Tier Tribunal for Mental Health.

The patient should be provided with copies of the reports prepared for reviews, unless (in the light of any recommendation made by their authors) panels are of the opinion that disclosing the information would be likely to cause serious harm to the physical or mental health of the patient or any other individual.

The patient's representative, legal or otherwise, such as donee of Lasting Power of Attorney or a Court (of Protection) appointed deputy, the patient's Independent Mental Health Advocate (IMHA) if they have one and - if the patient agrees – their nearest relative or carer should receive copies of these reports.

The patient must receive the decision of a review as soon as practicable, both orally and in writing. Unless the patient objects, the nearest relative should also receive the information and it must be communicated to the relevant professionals.

7.4 When to review detention or CTO

The Responsible Clinician should review the detention or CTO before the current period expires to ensure detention or CTO does not continue without authority, If detention continues without authority this would be an unlawful deprivation of liberty and a breach of the patient's Article 5 (European Convention on Human Rights) right to liberty.

If a section expires without a review taking place (ie it lapses in an unplanned manner) an incident form should be completed to determine why this happened and what actions have been taken to ensure that it would not happen again in the future.

Managers must hold a review when the Responsible Clinician (RC) submits a report under section 20 renewing detention or under section 20A, extending CTO. The review should take place before the date of expiry of the current period of detention or as near to that date as possible. This will be monitored by the Mental Health Act Office.

Managers must hold a review when the Responsible Clinician submits a report barring a patient's discharge by their nearest relative on the ground set out in section 25 MHA. Such a review must consider an additional 'dangerousness' criterion set out below in Criteria for Discharge. If the Managers do not agree with the Responsible Clinician's statement in the section 25 report (i.e. that the patient is likely to act in a dangerous manner if discharged) they should usually discharge the patient.

Patients may request a Manager's review at any other time. The Managers have discretion over when it is appropriate to hold such a review but must satisfy their public law duty of fairness. Following the request for a hearing an Associate Mental Health Act Manager will meet with the patient on one to one basis. When deciding whether a review should take place the managers are entitled to take into account whether the Tribunal has within the last 28 days considered the patient's case or is due to do so in the near future.

The Managers may undertake a review of whether or not a patient should be discharged from detention/CTO at any time at their discretion.

7.5 Conduct of review

Reviews should be conducted so as to ensure the case for discharging or continuing detention is properly considered against the criteria below and in light of all the relevant evidence. The procedure needs to balance informality against the rigours demanded by the importance of the task.

The review should be conducted in the same manner whether the patient contests the detention or not, whether the review is as a result of an application or because of the renewal of the detention of CTO, or whether the patient attends the review or not.

The review panel needs to have sufficient information about the patient's past history of care and treatment and details of any future plans. It is essential the panel are informed of any history of violence and self-harm and any risk assessment which has been conducted.

The panel will receive written reports from the patient's Responsible Clinician, Named Nurse, Care Co-ordinator and any others directly involved in the patient's care.

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

The patient should receive copies of the reports unless The Managers are of the opinion that the information disclosed would be likely to cause serious harm to the physical or mental health of the patient or any other individual.

The patient's nearest relative should be informed of the review, unless the patient objects. If the nearest relative attends the a face-to-face review they should be invited to put their views before the panel.

The patient should be given a full opportunity and any necessary help to explain why he or she wishes to be discharged and, unless it would be considered unsafe, should always be given the opportunity to speak to the panel alone.

7.6 Criteria for discharge

The Act does not define specific criteria to be applied by the Managers when considering the discharge of a patient. The essential factor in considering a review is whether the grounds for admission or continued detention/compulsion under the Act are satisfied. To ensure consistency the panel must consider the following

For section 2:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which warrants the continued detention of the patient in hospital?
- Ought the detention to continue in the interests of the patient's health or safety or for the protection of other people

For all other detained patients:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes treatment in hospital appropriate?
- Is continued detention for medical treatment necessary for the patient's health or safety or for the protection of other people?
- Is appropriate medical treatment available for the patient?
- Consideration should also be given to whether the Mental Capacity Act 2005 can be used to treat the patient safely and effectively

For patients on CTO:

- Is the patient still suffering from mental disorder?

- If so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- If so, is it necessary in the interests of the patient's health or safety or the protection of other people that the patient should receive such treatment?
- Is it still necessary for the Responsible Clinician to be able to exercise the power to recall the patient to hospital, if that is needed?
- Is appropriate medical treatment available for the patient?

In cases where the Responsible Clinician has issued a report barring discharge under section 25, The Managers must also consider the following question:

- Would the patient, if discharged, be likely to act in a manner that is dangerous to other people or to themselves?

If the panel members disagree with the Responsible Clinician and decide that the answer to this question is 'no' then the patient should usually be discharged. However, the Managers have a residual discretion not to discharge in these cases and so should consider whether there are exceptional reasons why the patient should not be discharged.

The panel should be positively satisfied that the above criteria are met before declining to exercise their powers of discharge.

The panel should consider the burden of proof rests with those arguing for the continuation of detention or CTO rather than those arguing for discharge.

In all cases, The Managers have discretion to discharge patients even if the criteria for continuing the detention or CTO are met.

In having regard to the least restrictive option and maximising independence The Managers should always consider whether there are any other reasons why the patient should be discharged

7.7 Communicating the Decision

The Managers decision and their reasons for reaching that decision must be recorded at the end of each review. The decision must be communicated as soon as practicable, both orally and in writing, to the patient, their representative, to the professionals involved and, if the patient consents, to the nearest relative or carer.

The written decision should give clear evidence that all the criteria for detention or CTO have been considered and that regard has been given to the least restrictive option and maximising independence principle. A record to show that the managers have considered using any discretionary powers of discharge should also made.

Unless it would cause undue upset to the patient, at least one member of the panel should offer to see the patient to explain the decision and the reasons for it.

7.8 Venue

The venue for the hearings of patients detained in hospital will usually take place at the hospital the patient is detained at.

For those patients subject to CTO the option of holding the hearings in the Trust's community centres must be considered.

8 Development, Consultation and Approval

This policy was developed by the Mental Health Legislation Operational Group (MHLOG). The policy is based upon the statutory requirements contained within the Mental Health Act 1983 (as amended) along with the Mental Health Act Code of Practice (2015).

The policy has been shared with multi-disciplinary members of the Mental Health Legislation Operation Group for comment.

Some changes to the policy have been made when compared to the previous versions. These changes have been minor changes related to terminology, definitions, and grammar.

9 Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Compliance with policy content	Routine audits	Mental Health Act Office	Ongoing basis	Mental Health Legislation Operational Group	Mental Health Act Administration Manager; Head of Mental Health Legislation	Mental Health Legislation Operational Group; Mental Health Legislation Committee

The policy will be reviewed by August 2025, or sooner should there be any change in legislation, change to national guidance, or in response to any incidents and learning has identified changes to process are needed.

10 Implementation Plan

There are no changes to this policy which requires a specific implementation plan to be produced for those who must adhere to this policy.

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	Policy Governance/Communications	September 2022	

11 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
5.0	September 2022	September 2022	September 2022	

12 Training and Other Resource Implications

Training in relation to the Mental Health Act (as amended) is provided on a rolling basis to Trust staff.

Information within this Policy will be provided as part of the training to new Associate Mental Health Act Managers.

Any staff requiring training or support with the policy can approach either the Mental Health Act Administration Manager, or the Trust's Head of Mental Health Legislation, for this to be arranged and provided.

There are no financial resource implications which arise from this policy.

13 Links to Other Policies, Standards (Associated Documents)

- Mental Health Act 1983 (as amended)
- Mental Health Act 1983 (as amended) Code of Practice (2015)
- Mental Health Act policies

14 Contact Details

Title	***Name***	***Phone***	***Email***
Mental Health Act Office Administration Manager	Mike Haywood	27 18102	mike.haywood@shsc.nhs.uk
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Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Jamie Middleton, 12.8.22	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	No	N/A	N/A
Disability	No	N/A	N/A
Gender Reassignment	No	N/A	N/A
Pregnancy and Maternity	No	N/A	N/A

Race	No	N/A	N/A
Religion or Belief	No	N/A	N/A
Sex	No	N/A	N/A
Sexual Orientation	No	N/A	N/A
Marriage or Civil Partnership	No		

Impact Assessment Completed by: Jamie Middleton, 12.8.22
Name /Date

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	N/A
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Y
5.	Has the policy been discussed and agreed by the local governance groups?	Y
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Y
	Template Compliance	
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
	Policy Content	
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Y
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	Y
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y