BOARD OF DIRECTORS MEETING (Open)

Date: 8 November 2017 **Item Ref:** 18i

TITLE OF PAPER	Associate Mental Health Act Managers (AMHAM) Quarter 1 Report, April to June 2017
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing, Professions and Care Standards
ACTION REQUIRED	Members to receive and note the quarterly report
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	November 2017 Board Meeting
LINKS TO OTHER KEY REPORTS/ DECISIONS	▫ Mental Health Act Code of Practice, 2015 ▫ Related Legislation
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	▫ Strategic Objectives: A1 Quality and Safety, A2 02 People ▫ Mental Health Act
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 where necessary. If financial implications come to light, individual business cases will be submitted for consideration
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	Cath Dixon and Anne Cook
Designation	Mental Health Act Manager and Head of Mental Health Legislation
Date of Report	25.10.2017

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **8 November 2017**

Subject: **Associate Mental Health Act Managers Quarter 1 Report, April - June 17**

Presented by: **Liz Lightbown, Executive Director of Nursing, Professions and Care Standards**

Authors: **Cath Dixon, Mental Health Act Manager**
Anne Cook, Head of Mental Health Legislation

1. Purpose

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

2. Summary

This report for the Board of Directors describes status, functions and duties of the Associate Mental Health Act Managers (AMHAMs), and the work undertaken for the period April to June 2017. The AMHAMs have delegated responsibility from the Board, in respect of the delegation of the statutory powers to discharge detained patients from detention under the Mental Health Act 1983, s23. This report is to provide assurance to Members that the Associate Managers carry out this role in accordance with the Legislation and the Mental Health Act Code of Practice, 2015. The report is presented under the following headings:

1. The Legal Status of the AMHAMs.
2. Hospital Managers' functions and duties with regard to reviewing detention or CTO (Delegated to AMHAMs).
3. Availability of AMHAMs.
4. AMHAM Activity.
5. Written Reports.
6. Support at Review Hearings.
7. Training and Development.
8. Peer Support Group.
9. Additional Themes from Quarterly Meetings.
10. Key to Sections.

3. Next Steps

To combine the Quarterly reports concerning the MHA Committee and the AMHAMs, and to commence reporting on the Trust's use of Mental Health Legislation more broadly, including the Mental Capacity Act 2005 and its Deprivation of Liberty Safeguards.

4. Required Action

This report is for information and assurance.

5. Monitoring Arrangements

The minutes of Associate Mental Health Act Managers Group quarterly meetings are reported to the Mental Health Act Committee.

6. Contact Details

For further information, please contact:

Anne Cook
Head of Mental Health Legislation
0114 271 6051
anne.cook@shsc.nhs.uk

Cath Dixon, Mental Health Act Manager
0114 271 8102
cath.dixon@shsc.nhs.uk

Associate Mental Health Act Managers (AMHAM)
Quarter 1 Report, April – June 2017

1. The Legal Status of the 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: MHACoP).

Hospital managers have the authority to detain patients under the Mental Health Act 1983 (MHA), and have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the MHA allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in, exercising, their statutory rights. (MHACoP Chapter 37.3).

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, but in order to demonstrate independence from the hospital managers with authority to detain, it may only be delegated to managers' panels made up of people appointed specifically for the purpose who are not officers or employees of the Trust, see MHACoP Chapter 37.7.

It is the people who sit on these discharge panels who are referred to as the Associate Mental Health Act Managers (AMHAMs). The independent status of the 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). The payment of a fee for serving on a panel does not constitute 'employment'. (MHACoP Chapter 38.6).

An AMHAM panel must be made up of at least 3 people, at least 3 of whom 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 Mental Health Tribunals where the majority vote is utilised.

2. 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.

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. 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 addition, case law has determined that AMHAMs must consider whether or not they are persuaded by the RC's barring report when reviewing a patient's detention following a barred order from the nearest relative. If the AMHAMs are 'not so persuaded, they will have reached the position that the nearest relative would have been entitled to an order for discharge [but for the RC's] erroneous conclusion as to the danger presented by the patient.' (*R v Riverside MH Trust ex p. Huzzey* (1998) 43 BMLR).

Nonetheless, AMHAMs retain a residual discretion not to order discharge if they are unconvinced by the 'dangerousness' criterion, but the continuing detention must be for 'exceptional reasons'. (CoP para 38.22)

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, however they will not normally be qualified to form clinical assessments of their own and should give full weight to all the evidence in relation to the patient's care.

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 addition, AMHAMs are governed by general law duties, and should apply fair and reasonable procedures; not make irrational decisions; and act lawfully. (MHACoP Ch38.15-38.25)

2.1 The least restrictive option and maximising independence

The guiding principles of the MHA require that regard should be had to the least restrictive option and maximising independence principles. In some cases, it might be necessary to consider adjourning to seek further medical or other professional advice; in all cases the AMHAM panel need to give careful consideration to the implications of discharge from detention or CTO for the patient's subsequent care. (MHACoP Chapter 38.37 – 38.38)

AMHAMs have, on occasion, expressed concern that a patient might continue to take medication only because recall from the CTO might ensue. This leads to concern about valid consent to the treatment, and whether the power of recall in these circumstances amounts to coercion.

This in turn gives rise to concern that adherence to a medication regime might not, of itself, provide sufficient justification for the Responsible Clinician to argue the case for continuing power of recall and whether the AMHAM panel should therefore discharge the CTO.

However, it would appear that ensuring adherence to medication by means of CTO is supported by the CoP (29.16) where guidance is given about what the evidence for medication adherence and the consequent risks of not taking it should look like. It is therefore incumbent on Responsible Clinicians to ensure that the link between medication adherence and relapse, and relapse and risk are articulated to the AMHAM panel.

Where evidence for this link can be demonstrated, acquiescence to the medication regime by a patient who has capacity has not been found to amount to coercion. Judge Jacobs, sitting in the UK Upper Tribunal, dismissed a patient's appeal. He ruled that the initial Tribunal had not erred in law in its conclusion that:

> [T]he Patient (at present) consents to his treatment and that he does have a choice, and that he exercises that choice at the time of administration of the depot injection. Should the Patient refuse that injection, as is his right, the Tribunal feels that he is aware of the consequences that may follow. [ie recall of CTO]. The Tribunal unanimously agree this is **not** undue or unfair pressure but the reality of the situation. (Administrative Appeals Chamber 12th June 2013).

At the newly convened AMHAM Peer Support Groups (see also heading 9 below) AMHAMS have raised concerns about whether to adjourn if a CTO patient does not attend to make his/her own statement at an automatic review of extension (renewal of the order), as opposed to an appeal for discharge brought by the patient. CTOs have the potential to be renewed after 2 consecutive 6-month periods and annually thereafter.

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 undertake 'paper' reviews when the patient does not wish to attend. This is analogous to the practice of the Tribunal, where the Rules allow for a decision to be made by without a hearing for a CTO patient who has capacity to decide on attending and elects not to. The patient's decision not to attend has to be conveyed to the Tribunal in writing (Tribunal Rule 35(3)(a)-(b)).

The presumption would appear to be against adjournment in these circumstances, if the AMHAM panel is satisfied that the patient was aware of the extension and the consequent automatic hearing.

3. Availability of AMHAMs

SHSC currently has 18 Associate Mental Health Act Managers from a variety of different backgrounds and ethnicity, but will this year be recruiting more members to ensure there are always sufficient members with availability to accommodate the number of hearings;
There are currently 5 expressions of interest in becoming an AMHAM, and interviews are booked for Monday 25th September.

4. AMHAM Activity – Q1 2017-2018

4.1 Number of Hearings

Hearings take place, as described above, for one of the following reasons:

4.1.1 The patient has applied for a hearing.

4.1.2 The Responsible Clinician (RC) has renewed the detention or extended the CTO.

4.1.3 The RC has issued a certificate barring the nearest relative (NR) from discharging the detention/CTO.

4.1.4 A hearing at the Managers discretion.

The hearings are held at the hospital where the person is an inpatient or if the person is subject to a community treatment order at the community health centre where the care team is based.

Table 1 below shows the number of reviews and the reason for them for period July 2016 to 30 June 2017.

Table 1 - Number of Reviews

Total No. of Reviews	July 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17
Patient Applications S3 or S37	1	0	0	0	0	0	0	0	0	0	0	1
Patient Applications CTO	0	0	0	0	0	0	0	0	0	0	0	0
RC Renewals S3/S37	2	3	4	5	5	3	5	2	4	4	2	6
RC Extension CTO	3	2	4	7	7	9	3	3	3	5	8	2
Barring NR	0	0	0	0	0	0	0	0	0	0	0	1
At Managers' discretion	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	6	5	8	12	12	12	8	5	7	9	10	10
Discharged by AMHAMs	0	0	0	0	0	0	0	0	0	0	0	0

Table 2 - Combined Total for each quarter 2016/17

Type of Review	Managers' Hearings during Q2 16/17	Managers' Hearings during Q3 16/17	Managers' Hearings during Q4 16/17	Managers' Hearings during Q1 17/18
Applications (inpatient)	1	0	0	1
Applications (CTO)	0	0	0	0
Renewals (inpatient)	9	13	11	12
Renewal (CTO)	10	23	9	15
Barring NR	0	0	0	1
Total	20	36	20	29

The renewals for sections in hospital relate to MHA section 3 & section 37, with the initial renewal period of 6 months followed by 6 months then yearly thereafter.

Renewals for sections in hospital remains fairly constant with a total of 12 renewal for Q1 2017/18 compared with 11 & 13 in Q4 & Q3 2016/17 respectively.

In contrast hearings for those subject to CTO fluctuate considerably. Q4 of last year showed 60% fewer hearing for CTOs than in Q3. However Q1 of the current year shows an increase of 66%. It is unclear why these hearings see-saw like this. It may be indicative of fewer hearings at the 6-month period but more hearings at the 12-month period. The use of CTO is reviewed on a monthly basis by the Mental Health Act Committee.

A patient can apply for a hospital managers hearing at any time during the detention/ compulsion period and the number of times they apply is not limited, unlike the Mental Health Tribunal when there is only one application per each detention period. There was one application seeking discharge by the AMHAMs during Q1, in contrast to 72 applications seeking discharge by the Mental Health Tribunal. The patient was not discharged from detention by the AMHAMs. However assurance can be given that the low rate of discharge by AMHAMs is in-keeping with the practice of the Tribunal, which discharged only 3 patients. The rate of applications to the Tribunal gives assurance that patients are being informed of their right to application to challenge their detention, albeit they choose the Tribunal over the AMHAMs.

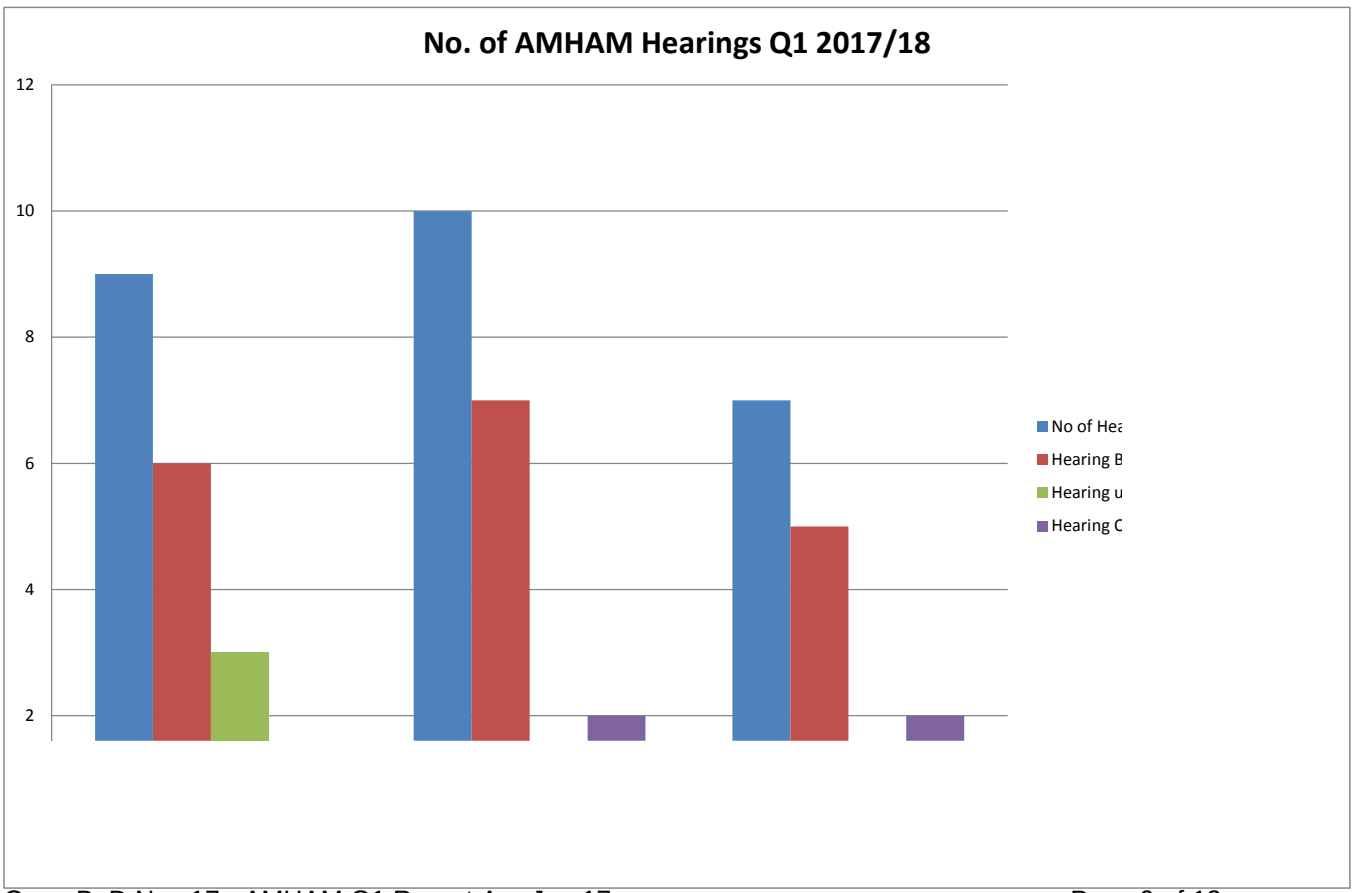
A hearing also took place following the Responsible Clinician issuing a Barring Certificate to prevent a nearest relative from discharging the patient. The managers were satisfied that the grounds for dangerousness were met and did not allow the discharge.

4.2 Hearings Taking Place Prior to Expiry

MHACoP 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).

The Chart 1 below shows the number of hearings that 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

Chart 1 - Hearings taken place in relation to expiry date



For Q1, 18 reviews took place prior to the expiry date. Four reviews took place within the 7 days after expiry date and 4 were delayed for more than 7 days. However, as the Managers did not discharge any one from detention during this period, assurance can be given that no patient was detained illegally. Although a review before expiry is 'desirable' it is not required by law, as it is the responsible clinician's report that provides the authority for the continued detention or CTO.

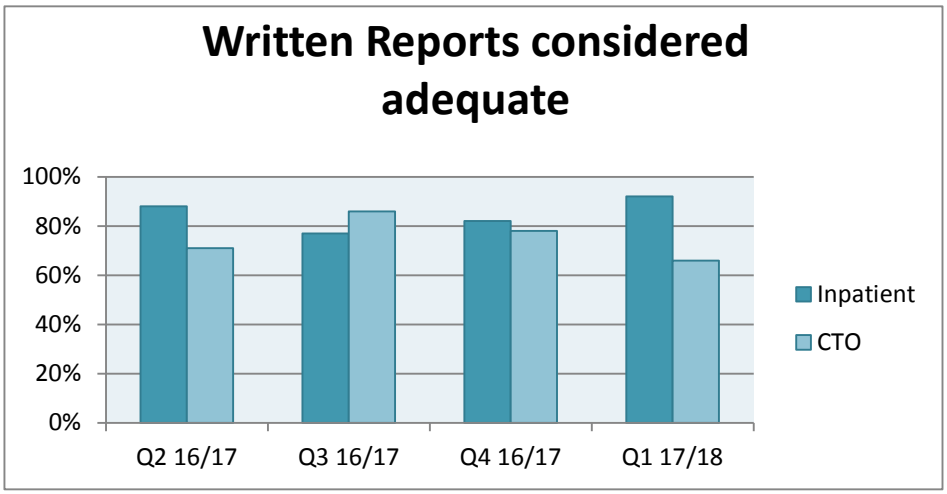
5. Written Reports

Prior to the hearings managers receive written reports from the professionals involved in the patient's care. 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. A report from the care co-ordinator is also required and for inpatients a report from the named nurse is also requested.

Following every hearing the AMHAMs complete a feedback form commenting on whether in their opinion the reports from the professionals, both written and verbal were adequate.

Chart 2 below shows the percentage of written reports considered to be adequate and Chart 3 shows the percentage of verbal reports considered to be adequate.

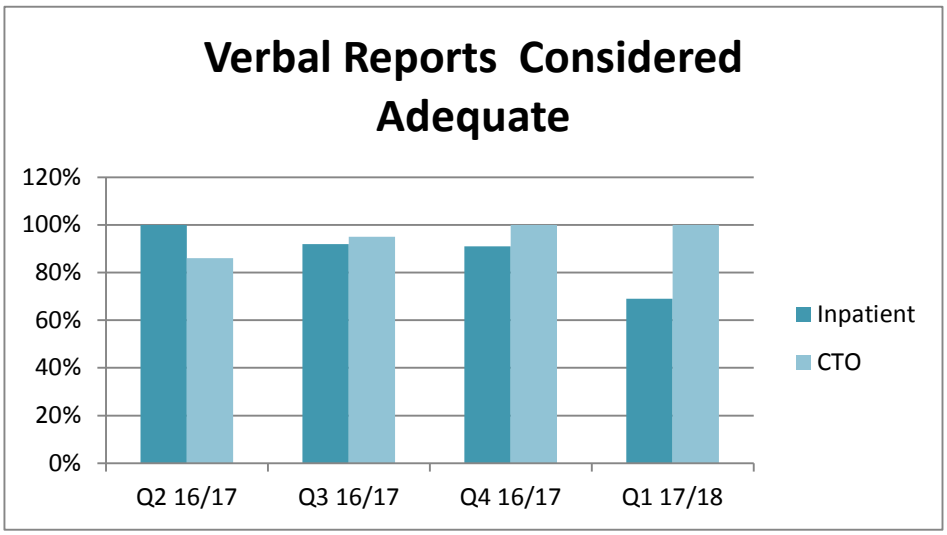
Chart 2 - Written Reports



Although the feedback report shows how many reports the managers have not been satisfied with, it does not show who the author of the report was, therefore making constructive feedback difficult. Therefore, it was agreed at a previous AMHAMs quarterly meeting that the Mental Health Act Manager would be informed immediately of any inadequate reports. This will then be fed back to the report writer and their manager. The AMHAMs have been asked to identify examples of good and bad reports. This is to enable Rhodri Hannan, Assistant Service Director Inpatient Directorate, to raise the issue at the Directorate Senior Management Team meeting

It should be noted however that the Responsible Clinician or other medic always attends the hearings and along with other members of the care team e.g nurse and care co-ordinator should be able to address any shortfalls in the written reports that the managers need answering.

Chart 3 - Verbal Reports



6. Support at Review Hearings

It was explained in the Q3 16/17 report to the Board how traditionally the MHA office has supported the Review hearings by attending the hearings, giving advice on the MHA and typing up the decision, but this had been withdrawn due to resource constraints. Practical solutions, such as access to IT equipment, are still being developed but in the interim the AMHAMs have been given assurance that the Mental Health Act Manager or the Head of Mental Health Legislation are available by phone to give MHA advice should the AMHAMs require this. Also the MHA team when arranging panels will, wherever possible, ensure at least one person on the panel has a good knowledge of the MHA, is confident and is capable of chairing the hearings and writing the decision.

7. Training and Development

Development reviews for the AMHAM have been completed. The Head of Mental Health Legislation and the Mental Health Act Manager will produce a training needs analysis (TNA) and this will inform the training needs of the AMHAMs for the year.

The decision report that the AMHAM complete following a hearing has been reviewed and agreed by the AMHAMs. The new form and associated guidance and checklist for ensuring that all necessary information is included in the decision are now complete, and will be in use from September.

8. Peer Support Group

The Head of Mental Health Legislation and the Mental Health Act Manager have booked monthly Peer Support sessions for the AMHAMs, which will commence in July 2017.The 2 hour sessions will enable the AMHAMs to discuss items of interest to them outside the formal setting of the quarterly meeting. These discussions appear likely to result in greater consistency in AMHAM practice, and to have the potential to further their training and development needs.

9. Additional themes from the Quarterly meeting – June 2017

The Q4 AMHAM report was discussed with the AMHAMs, who did not have any amendments.

The AMHAMs discussed the fact that they do not receive a separate detailed medical report if the hearing is in response the renewal process. However, they do hear evidence from the RC.

They acknowledged that nursing reports had improved since the introduction of the pro-forma but felt the pro-forma did not give the care coordinator the chance to say what the patient is like when unwell or the circumstances leading to admission. However the pro-forma is the same as is used for Tribunal reports.

10. Key to 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	

Section	Purpose	Made By	Length of Time	Can be renewed
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

NB: This is not an exhaustive list of detention, but reflects the ones listed above.