OPEN BOARD OF DIRECTORS
12 April 2017

Open BoD: 12.04.17
Item: **19**

TITLE OF PAPER	Associate Mental Health Act Managers Quarterly Report for Quarter 2, July - September and Quarter 3, October - December 2016
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing, Professions and Care Standards
ACTION REQUIRED	Members to receive and note the quarterly reports

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	April 2017 Board Meeting
LINKS TO OTHER KEY REPORTS/ DECISIONS	▫ Mental Health Act Code of Practice, 2015 ▫ Related Legislation
BAF OBJECTIVE No and TITLE	BAF Risk 1.4 – Compliance with the Mental Health Act
LINKS TO THE NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES ETC	HSE ❑ MH Act ■ Equality ❑ BME ❑ Disability Legislation ❑ NHS Constitution: Staff Rights ❑ Service users' Rights ■ Public's Rights ❑ Principles ❑ Values ❑
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.

Author of Report	Anne Cook and Cath Dixon
Designation	Head of Mental Health Legislation and Mental Health Act Manager
Date of Report	03.03.2017

SUMMARY REPORT

Report to: **Open Board of Directors**

Date: **12 April 2017**

Subject: **Associate Mental Health Act Managers Quarterly Reports Q2, July – September and Q3, October – December 2016**

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

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

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 by for the period July to December 2016. 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. It reports on:

2.1 The legal status of the AMHAMs and their independent role.
2.2 AMHAM availability and increase in the number of hearings.
2.3 Hospital Managers' functions and duties (delegated to AMHAMs).
2.4 AMHAMs' Activity.
2.5 Decision writing.
2.6 Quarterly feedback from AMHAMs.
2.7 Themes from AMHAM Quarterly Meetings.
2.8 AMHAM contracts, training and development.
2.9 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 only.

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

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Associate Mental Health Act Managers Reports for Quarter 2, July – September and Quarter 3, October - December 2016

1. Status 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 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 Ch 37.3)

Section 23 of the MHA gives the Hospital Managers the power to discharge patients from detention in hospital under 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. (MHACoP Ch 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 payment of a fee for serving on a panel does not constitute 'employment'. (MHACoP Ch 38.6).

1.1 Independence – case law

That the AMHAMs are accorded true independent status has been demonstrated recently by case law: *South Staffordshire and Shropshire Healthcare NHS Foundation Trust v The Hospital Managers of St George's Hospital* [2016] EWHC 1196 (Admin).

South Staffordshire and Shropshire Trust sought a judicial review of an AMHAM panel decision to discharge a patient against the advice of the care team and contrary to a recent decision not to discharge the patient made by the Mental Health Tribunal (the Tribunal has the judicial powers of a Court; the AMHAM panel does not).

The High Court found (at paragraph 26 of the ruling) that:

The Trust is seeking judicial review of a decision which it had the power to take but which was taken by a body to which it had delegated that power. If it had taken the decision itself, judicial review would have been impossible (…). In [the judge's] *view the legal position changes given the nature of the delegation in this case, to a body* [the AMHAM panel] *which Parliament intends to be an independent decision-making entity. Section 23(6) of the* [MHA] *ensures the independence of a panel from an NHS foundation trust by the requirement that members cannot be executive directors of its board or employees.*

Consequently, the Panel is, in [the judge's] *view, sufficiently separate from and independent of the Trust to enable the Trust to bring a judicial review challenge to its decision.*

The implication of this ruling is addressed below.

2. 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 increase in the number of hearings; there were 36 hearings in Q3, compared to 19 in Q2 (see below). There are currently 5 expressions of interest in becoming an AMHAM.

2.1 Number of hearings

The increase in volume of hearings is likely to be attributable to the high proportion of detained patients relative to total bed numbers, and (over the longer-term) to the increased proportion of detained patients in older adults' and learning disability services in light of the definition of 'deprivation of liberty' adopted by the Supreme Court in the *'Cheshire West'* case in 2014. This led to the MHA detention of patients who lack capacity to consent to informal admission and whose objection to admission makes them ineligible for deprivation of liberty under the Mental Capacity Act.

2.2 National comparison

The CQC's latest figures show that in England and Wales, 51.44% of mental health inpatients were detained at year end 2014/15, and that 2014/15 saw the highest ever year-on-year rise (10%) to 58,400 detentions (excluding short-term holding powers) (CQC, Monitoring the MHA, 2015/16).

At the time of writing SHSC has 152 beds (excluding beds dedicated to detoxification or designated as a 'place of safety' by MHA s 135-136); 128 of these are occupied by detained patients (84.21%, assuming full occupancy of available beds).

3. Hospital managers' functions and duties with regard to reviewing detention or CTO

3.1 Functions

MHACoP Ch 38.12 describes these functions. 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 (see key to sections, below).

Please note that the MHACoP defines must, should and may. 'Must' reflects 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, exceptions are permitted.

3.2 Duties

The MHACoP also determines the questions the AMHAMs 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.

However, AMHAMs will not normally be qualified to form clinical assessments of their own. They 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.

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

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)

4. AMHAM Activity – Q2 and Q3 2016-2017

4.1 Number of hearings

Review hearings must consist of at least 3 panel members as at least three or more of the panel members must agree if discharge of the detention or Community Treatment Order is to take place. 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.

Table 1 below shows the number of reviews and the reason for them April-December 2016.

	Number of reviews by month								
Purpose of Reviews	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patient Applications S3 or S37	0	0	0	1	0	0	0	0	0
Patient Applications CTO	0	0	0	0	0	0	0	0	0
RC Renewals S3/S37	3	1	3	2	3	4	5	5	3
RC Extension CTO	7	7	5	3	2	4	7	7	9
Barring of NR order	0	0	0	0	0	0	0	0	0
At Managers' discretion	0	0	0	0	0	0	0	0	0
TOTAL	10	8	8	6	5	8	12	12	12
Discharged by AMHAMs	0	0	0	0	0	0	0	0	0

Table 2 below shows the combined total for each quarter

Type of Review	Managers' Hearings during Q1	Managers' Hearings during Q2	Managers' hearing during Q3
Applications (inpatient)	0	1	0
Applications (CTO)	0	0	0
Renewals (inpatient)	7	9	13
Renewal (CTO)	19	10	23
Total	26	20	36

4.2 Analysis of figures

It is apparent that the number of renewals of detention is increasing over the year. MHA s3 and s37 (the sections usually involved) each have initial renewal periods of 6 months, followed by a second period of 6 months, followed by annual renewal thereafter for an unlimited period. Therefore, it is evident that an increasing number of patients remain detained long enough to reach one of these renewal triggers. None has been discharged by the AMHAMs. However this paucity of discharges can also be seen in the practice of the Tribunal, with its equivalent powers.

Although there are many more applications to the Tribunal (242 in the year to date, including statutory automatic referrals made by the Trust when the patient makes no appeal him/herself) there have been only 10 discharges. 6 of these were 'conditional discharges' of patients restricted by the Ministry of Justice under s 37/41 (meaning that they remain liable to be recalled to the s37/41 for further treatment, see key to sections below).

The restricted patients accounted for 20 of the applications, therefore 30% of restricted patients were discharged subject to recall, but only 1.8% of non-restricted detained patients were discharged.

If the Tribunal, with its status as a court, and its panel comprising a legally qualified member, a medically qualified member and a specialist lay-person, represents the 'gold standard' for review of detention or compulsion, then these figures for SHSC suggest that patients are not being denied their right to liberty as a result of the practice of SHSC RCs nor by the practice of the AMHAMs.

It is not clear why patients do not apply to the Managers. The total lack of applications from CTO patients may suggest that the conditions of their orders are not onerous to them, but the number of applications to the Tribunal for discharge from hospital suggests that inpatients do actively seek discharge. Anecdotally, the reluctance to apply to the AMHAMs is reported to be the result of the low likelihood of discharge, but it is evident that the chances of discharge by Tribunal are almost as slim.

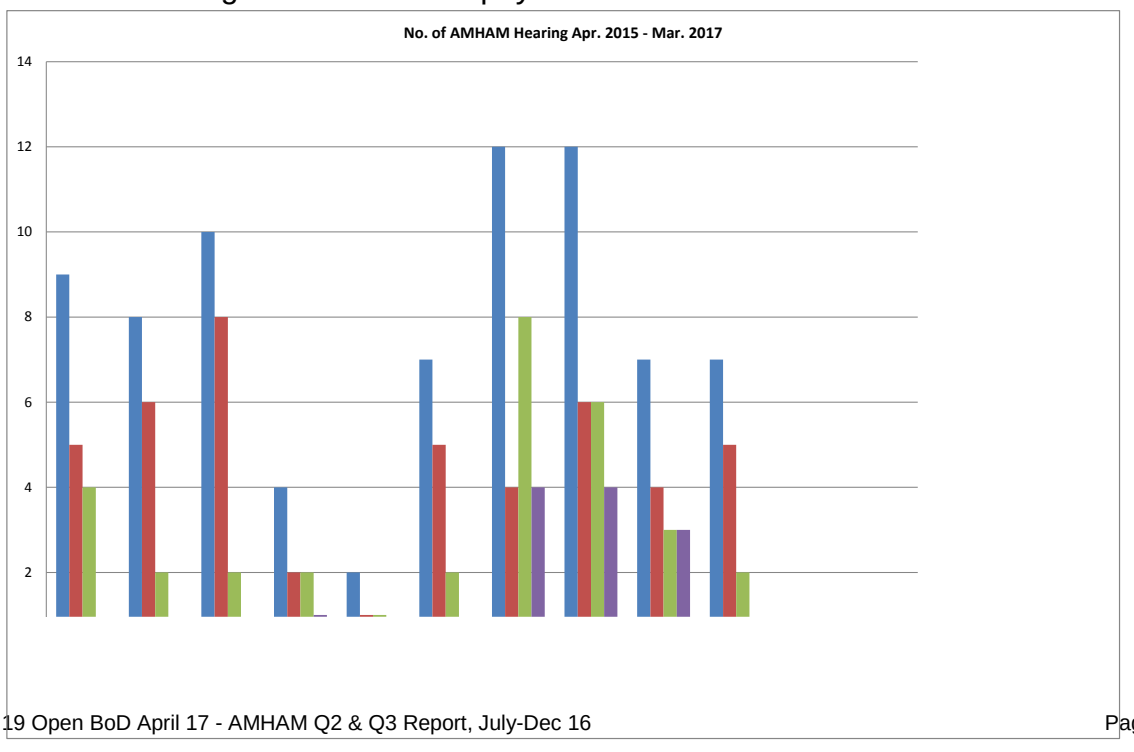
There are currently 63 patients under CTO, 21 (33%) of these are subject to orders made between 2010 and 2014 indicating some long-term use of compulsory powers in the community. It is not possible to say whether these individual patients have not had to return to admission under detention in hospital despite their CTO or because of it, but randomised controlled trials have not confirmed any benefit from CTOs in terms of avoiding such readmission to hospital. (Rugkasa and others 'Recall of patients on CTO over three years in the OCTET CTO cohort' BMC Psychiatry 2016 DOI 10.1186/s12888-016-11204-4).

4.3 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.'

The chart below shows the number of hearings that have taken place prior to the expiry, the number that have taken place up to 7days after expiry date and the number which have taken place over 7 days after expiry

Chart 1- Hearings in relation to expiry dates



Although October, November and December showed an increase in the number of hearings that were carried out after the expiry date, assurance can be given that no patient was detained illegally as although a review before expiry is 'desirable' it is not required by law. It is the responsible clinician's report that provides the authority for the continued detention or CTO.

5. Decision writing

The MHA does not define specific criteria to be used by hospital managers when considering discharge, although the MHACoP does determine the questions and the order in which they are addressed. The essential consideration is whether the grounds for continued detention or CTO under the Act are satisfied. Given that the AMHAMs' decision may be subject to judicial review in contentious cases (as noted above), and the evidence for such a review would be located in the AMHAM decision, it is imperative that decisions are well written.

To aid the AMHAMs to remain focused on the criteria for on-going detention, and to record their reflections on the evidence presented to them fully and appropriately, the Head of Mental Health Legislation and the Mental Health Act Manager are reviewing the written decision form that the Associate Managers must complete for every hearing (a copy of which goes to the patient). In light of the Judicial Review case and the CQC's focus on evidence to support the upholding of patients' rights, an update/training session for the AMHAMs will be arranged once the form has been updated.

6. Quarterly Feed Back Report

Following every hearing, the AMHAMs complete a feedback form which requires the managers to comment whether reports received from the professionals, i.e. Responsible

Clinician, Nurse and Care Coordinator, gave sufficient evidence to help them make a decision. The chart below shows the percentage of written reports that gave sufficient information.

Chart 2 -Written Reports

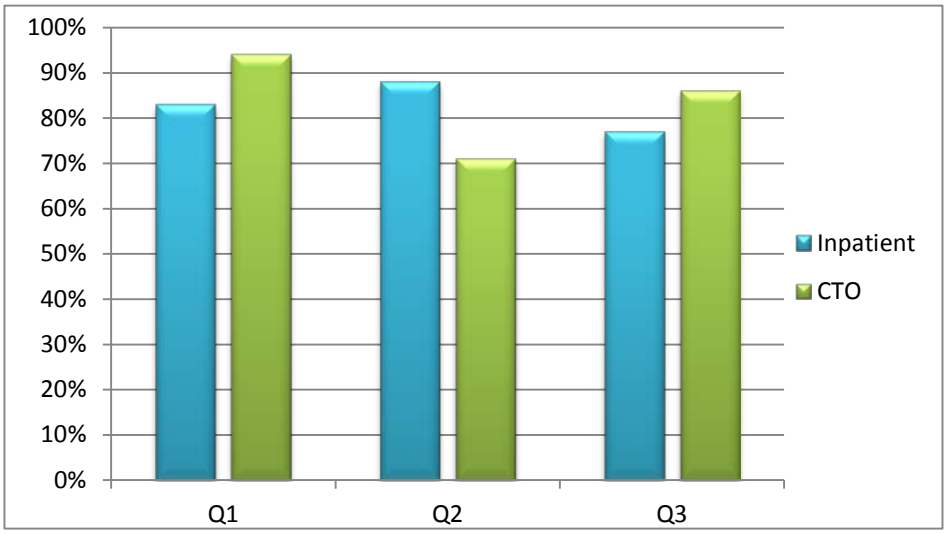
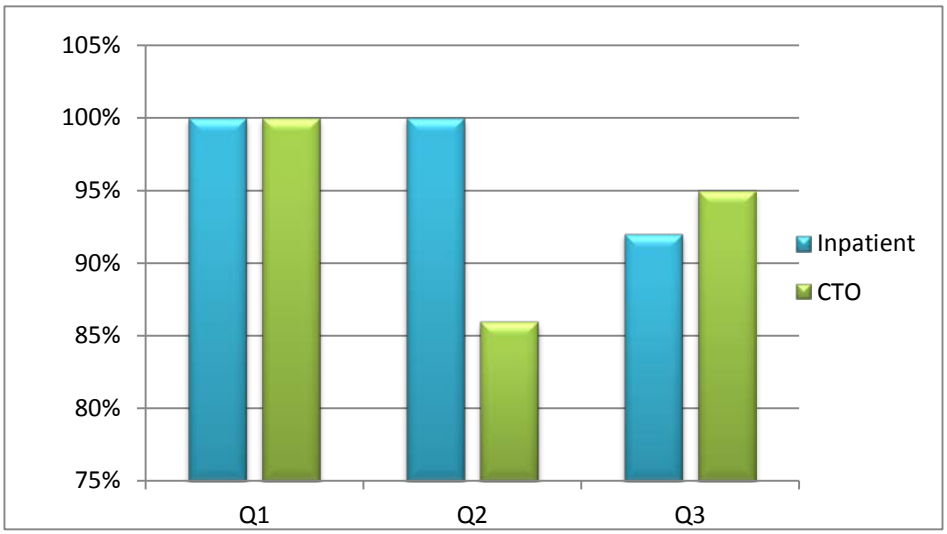


Chart 3 below shows the percentage of oral reports that were adequate. Of the oral reports, all those in Q1 and all the inpatient in Q2 were adequate. No reasons were given why the other reports were considered to be inadequate.

Chart 3 - Oral Reports



Unfortunately, the current feedback form does not identify which specific reports were not adequate. This makes it impossible to feed back to the individual professionals and directorates concerned. In order that appropriate support can be given to those responsible for submitting reports or giving an oral account, changes are being made to the questionnaire completed by the AMHAMs after the hearing that will enable the identification of the individual hearing by Insight number.

An equivalent process for feedback from professionals attending AMHAM reviews will also be produced

7. Themes from the AMHAM quarterly meetings

7.1 Attendance at Review Hearings

Concerns continue to be raised by the AMHAMs regarding lack of attendance at the hearings by inpatients and service users whose detention or compulsion is being reviewed. Inpatients are more inclined to attend the hearings than those on CTO but reasons given on the AMHAM feedback report for non-attendance, on the whole show the person has been informed of the hearing but nonetheless has made the decision not to attend. It might be assumed that the person concerned would attend if they had applied, but as there is no choice with regard to renewal of detention or extension of CTO, and given that it is highly unlikely that the detention/compulsion will end, it may seem to the patient that there is little value in attending

7.2 Community Treatment Orders (CTO)

At a review hearing for the continuation of CTOs one of the questions the panel must consider is:

‘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? (For example, if a patient has been on a CTO for an extended period without the need to exercise the power to recall, it may not be appropriate to continue on a CTO)’.

The AMHAMs expressed concerns that the case for the power of recall being necessary to continue does not always seem well argued. They report that some RCs appear to have difficulty in making clear why power of recall is necessary and that the Managers have to ask a lot of probing questions to discern the reasons.

A meeting was arranged by the Deputy Service Director Community Directorate, Paul Nicholson, with relevant people to discuss this. The meeting took place on 30th January, and an action plan will be produced. As Paul Nicholson will be on leave for the quarterly meeting in March, the action plan will be presented at the June quarterly meeting.This will include the revised feedback form, which will allow the AMHAMs to report specifically when the evidence for maintaining the power of recall is poor. It should be noted however that no CTO orders have been discharged by the AMHAMs, indicating that sufficient evidence for the extension of the order was in fact adduced.

7.3 Support at the Review Hearing

Traditionally the Mental Health Act office has supported the review hearings, giving advice on the MHA and typing up the decision. However due to shortages and changes in staff this has been withdrawn. The AMHAMs would prefer that this be reinstated, agreeing that 'the quality of the advice and additional probing added an extra strand to the quality of the report'. It also contributed to knowledge development for the Managers.

This is to be discussed further with Jayne Brown, Liz Lightbown and Anne Cook, the new Head of Mental Health Legislation. However it is unlikely that hearings will be supported by senior staff in future. Practical solutions to ensuring that the written decision is provided promptly to the patient will be sought, and training sessions to support AMHAMs in areas where they might seek advice will be developed.

8. AMHAM contracts, training and development

Six of the AMHAMs have the status of 'Senior Manager'. Their role is to review performance with other AMHAMs and to establish their training needs. These reviews, which did not occur last year owing to short staffing in the MHA office, began to take place in March and will be completed by the end of May.

Now the Head of Mental Health Legislation is in place, the Honorary Contracts for AMHAMs and appointment and induction procedures will be reviewed. The Mental Health Act Manager is exploring what is necessary for AMHAMs with regard to mandatory training.

9. 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	Up to 28 days	No
3	Admission for treatment	2 Doctors and 1 Approved Mental Health Professional/Nearest Relative	Initially up to 6months	Can be renewed for a further 6 months then yearly – no limit to number of renewals

Section	Purpose	Made By	Length of Time	Can be renewed
4	Admission for assessment in cases of emergency	1 Doctor and 1 Approved Mental Health Professional/Nearest Relative	72hours	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	6hours	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	72hrs	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 6months	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	Purpose	Made By	Length of Time	Can be renewed
Section 136	Place of Safety	Police	72hrs	No but MHA assessment must be carried out within this time

NB this is not an exhaustive list of detention but reflect the ones listed above