BOARD OF DIRECTORS MEETING (Open)

Date: Wednesday 12 July 2017 **Item Ref:** 16 ii

TITLE OF PAPER	Associate Mental Health Act Managers Quarterly Report for Quarter 4 2016/17, January to March 2017
TO BE PRESENTED BY	Giz Sangha, Deputy Chief Nurse/ Acting Clinical Director Acute & Inpatient Care, on behalf of 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	July 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	▫ BAF Risk 1.4 – Compliance with the Mental Health Act ▫ 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	10.5.2017

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **12 July 2017**

Subject: **Associate Mental Health Act Managers Quarterly Report for Quarter 4 2016/17, January to March 2017**

Presented by: **Giz Sangha, on behalf of 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 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. 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 and
4 National comparisons
5 AMHAM Activity
6 Written reports
7 Support at review hearings
8 Training and development
9 Peer support group
10 Additional themes from Quarterly meeting
11 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. 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

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
27181992
cath.dixon@shsc.nhs.uk

Associate Mental Health Act Managers Quarterly Report for Quarter 4 2016/17, January to March 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, and 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).

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 Chapter 38.6).

2. Hospital Managers' functions and duties with regard to reviewing detention or CTO

MHACoP Chapter 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.

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 makeup 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.

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)

Hospital Managers panel must be made up of at least 3 people and to discharge someone from detention case law has made clear that a '*Panel of three hospital managers must be unanimous in order to discharge patient'.*

In R (Tagoe-Thompson) v The Hospital Managers of the Park Royal Centre [2003] EWCA Civ 330. Lord Justice Pill in his reasoning stated 'The RMO has a central place in the operation of the Act. "It is not in the least surprising that, 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 RMO and authorise release."

This is in contrast to Mental Health Tribunals were the majority vote is utilised

2.1 <u>The least restrictive option and maximising independence</u>

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.

It would appear that ensuring adherence to medication by means of CTO is supported by the MHACoP (29.16).

CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual. Such evidence may include:

- A clear link between non concordance with medication and relapse sufficient to have a significant impact on wellbeing requiring treatment in hospital.

- Clear evidence that there is a positive response to medication without an undue burden of side effects.

- Evidence that the CTO will promote recovery, and

- Evidence that recall may be necessary (rather than informal admission or reassessment under the Act).

The MHACoP (29.45) goes on to describe the reasons that would support the power to recall the patient from CTO:

> The recall power is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed. The need for recall might arise as a result of relapse, or by a change in the patient's circumstances giving rise to increased risk.

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).

3. <u>Availability of AMHAMs</u>

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 were 20 hearings in Q4; compared to 36 in Q3.

The numbers for Q4 reflect a return to those of the first 2 quarters of the year: Q1 had 26; Q2 had 20 (see below). There are currently 5 expressions of interest in becoming an AMHAM.

4. National Comparison

The total number of detentions under the MHA has continued to rise, increasing by 9% to 63,62 compared to 58,399 detentions in 2014/15 This compares with an increase of 10% between 2013/14 and 2014/15, and is the highest number since 2005/06 (when there were 43,361 detentions). This represents a rise of just under a half over the period. (NHS Digital)

Within the Trust for the year 2016/17, the use of detention continued to rise. Detention was used in Q1 – Q4 on 70; 64; 92; and 85 times, respectively. This will translate into more renewal hearings for the AMHAMs, if detention persists to hit the renewal triggers, and may result in more applications to the AMHAMs for discharge.

Following the CQC's recent 'Appreciative Enquiry' into the use of the MHA and the practice of Approved Mental Health Professionals, it has become apparent that there is a need to formalise scrutiny and governance in order to understand Sheffield's position relative to other providers, their local populations and their bed-stock.

5. AMHAM Activity – Q4 2016-2017

5.1 Number of Hearings

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

5.1.1 The patient has applied for a hearing.

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

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

5.1.4 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 April 2016 to 31 March 2017

Table 1 - Number of Reviews

Total No. of Reviews	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Patient Applications S3 or S37	0	0	0	1	0	0	0	0	0	0	0	0
Patient Applications CTO	0	0	0	0	0	0	0	0	0	0	0	0
RC Renewals S3/S37	3	1	3	2	3	4	5	5	3	5	2	4
RC Extension CTO	7	7	5	3	2	4	7	7	9	3	3	3
Barring NR	0	0	0	0	0	0	0	0	0	0	0	0
At Managers' discretion	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	10	8	8	6	5	8	12	12	12	8	5	7
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 Q1	Managers' Hearings during Q2	Managers' hearing during Q3	Managers' hearing during Q4
Applications (inpatient)	0	1	0	0
Applications (CTO)	0	0	0	0
Renewals (inpatient)	7	9	13	11
Renewal (CTO)	19	10	23	9
Total	26	20	36	20

At the 31 March 2017 118 people were detained in hospital and 62 were subject to Community Treatment Orders.

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.

The first 3 quarters of the year showed increases which would seem to evidence that a growing number of patients were being detained long enough to reach a renewal trigger. However Q4 shows a slight decrease in this trend. Although the numbers are small it represents a 15% decrease in the number of hearings for inpatients.

The renewals of CTOs show a much larger decrease. There are 60% fewer hearings for CTO in Q4 than Q3. The reason for this is unclear but could be seen to offer assurance that those subject to CTO are reviewed by the clinical ream appropriately and people do not remain subject to compulsion longer than is appropriate. However Q2 also showed a large decrease from the previous quarter which 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.

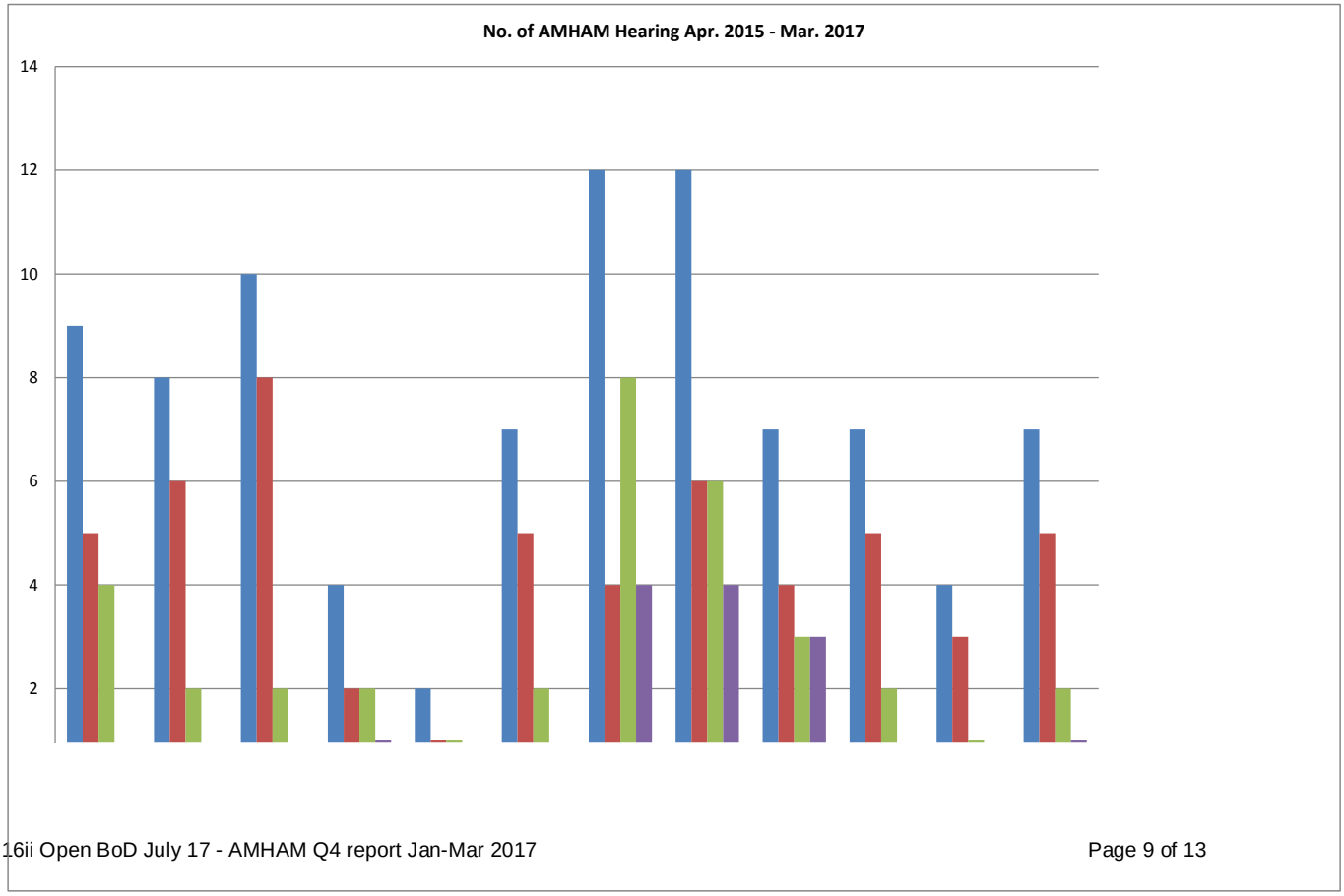
A patient can apply for a hospital managers hearing at any time during the detention/compulsion period and the number of times they apply is not limited – unlike the Mental Health Tribunal when there is only one application per each detention period. However no applications to the hospital managers were received during this quarter. This is in contrast to the applications to the Tribunal which during Q4 totalled 77. This gives assurance that patients are being informed of their right to application to challenge their detention, albeit they choose the Tribunal.

5.2 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 Q4, 13 reviews took place prior to the expiry date Five reviews took place within the 7 days after expiry date and one was 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.

6. 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 coordinator 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

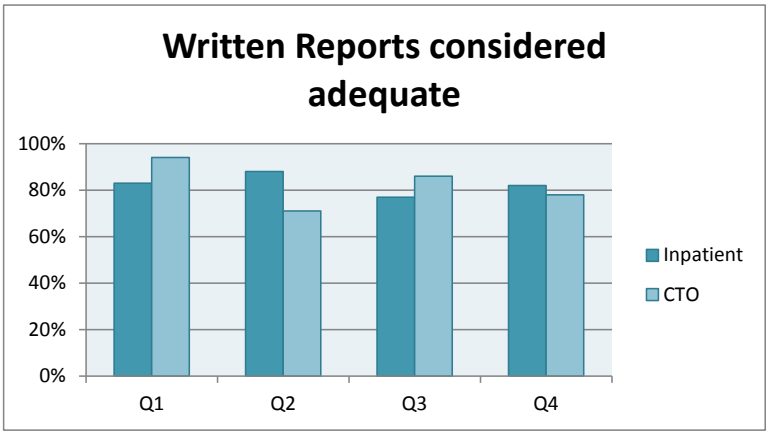
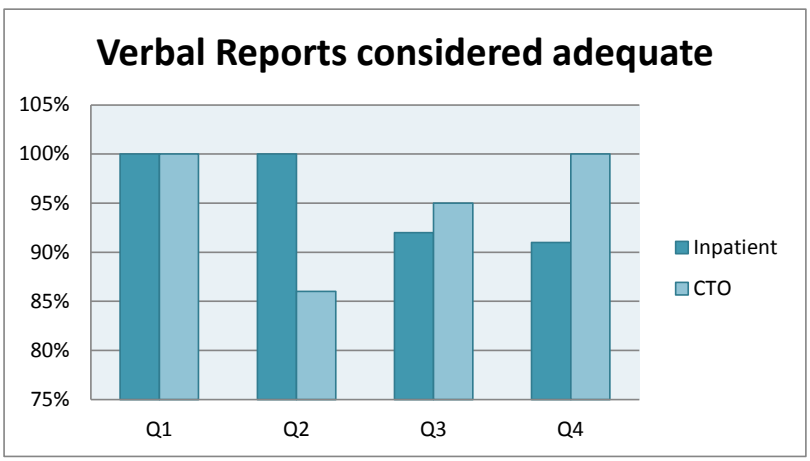


Chart 3 - Verbal Reports



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 the last 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. He will report back to the AMHAM meeting in June of actions taken to improve practice.

7. Support at Review Hearings

It was explained in the Q3 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 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.

8. Training and Development

Development reviews for the AMHAM have commenced and it is hoped these will be completed by the end of May. Once these are completed a training needs analysis (TNA) will be produced and this will inform the training needs of the AMHAMs for the year.

The decision report that the AMHAM complete following a hearing is being reviewed. A draft form has been sent to the AMHAMs asking for comments by 1 June 2017. Once this is finalised, training will be given on the new format.

9. Peer Support Group

The Head of Mental Health Legislation and the Mental Health Act Manager are exploring the possibility of setting up a regular Peer Support group meeting for the AMHAMs. This will enable the AMHAMs to discuss items of interest to them without the formal setting of the quarterly meeting.

10. Additional themes from the Quarterly meeting

The Q3 report to the Board was discussed. Concerns continue to be raised regarding the lack of MHA legal support at the hearings with most AMHAMs preferring that this be reinstated. Assurance has been given to the AMHAMs that MHA advice is available on the telephone from both the MHA Manager and the Head of MH Legislation. Further discussion will take place with Liz Lightbown, Anne Cook and Cath Dixon regarding the most efficient and cost effective way to facilitate this.

The AMHAMs discussed the number of hearings that started late and what would be the most efficient way to prevent this. For the period 1 January to 31 March 2017 9% of inpatient hearings started early and only 55% started on time compared to hearing for CTO where 11% started early and 89% began on time.

It was agreed that the MHA office will remind the wards on the day of the hearing that there is a hearing and time of the hearing. The MHA office will also ensure that a list of useful phone numbers is available for the AMHAMs at each hearing.

Although the AMHAMs and the Mental Health Tribunal both have the power to discharge patients from detention or CTO the AMHAMs sense that they are not viewed with the same respect as the Tribunals. It was agreed the AMHAMs would attend a future inpatient forum to explain their role, what their powers are and what they expect from written and verbal reports to enable them to make a decision.

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	28day	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
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	

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	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