BOARD OF DIRECTORS MEETING (Open)

Date: 14 February 2018 **Item Ref:** 16i

TITLE OF PAPER	Associate Mental Health Act Managers (AMHAM) Report for Quarter 2, July-September and Quarter 3, October-December 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	February 2018 Board Meeting
LINKS TO OTHER KEY REPORTS/ DECISIONS	Mental Health Act Code of Practice, 2015 Related Legislation
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: Quality & Safety Strategic Objective: A1 03: Provide positive experiences and outcomes for service users. BAF Risk No: A103 BAF Description: Failure to comprehensively capture the experience of our service users and take appropriate action.
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Mental Health Act
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.

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Designation	Mental Health Act Manager; Head of Mental Health Legislation
Date of Report	07.02.2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **14 February 2018**

Subject: **Associate Mental Health Act Managers (AMHAM) Report for Quarter 2, July-September and Quarter 3, October-December 2017**

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 July – December 2017 (inclusive). Two quarters' reports are submitted on this occasion owing to the rescheduling of the AMHAMs quarterly meetings.

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. Training and Development
5. Peer Support Group
6. Themes from Quarterly Meetings
7. AMHAM Activity
8. Quality of Reports
9. Key to Sections

3. Next Steps

To continue to report on the activity of and support for the AMHAMs.

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

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Associate Mental Health Act Managers (AMHAM)
Quarter 2, July-September and Quarter 3 Report, October-December 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 Section 23 of the MHA gives the Hospital Managers the power to discharge patients from detention in hospital under most sections of the MHA and from compulsory powers in the community under a Community Treatment Order (CTO).

In practice, this power of discharge is delegated to managers' panels made up of people appointed specifically for the purpose who are not officers or employees of the Trust: the Associate Mental Health Act Managers (AMHAMs). The payment of a fee for serving on a panel does not constitute 'employment'. (MHACoP Chapter 38.6).

An AMHAM panel must be made up of at least 3 people. If more than 3 sit, at least 3 are required to agree the decision to discharge a patient from detention, ie a 3-person panel must be unanimous, see *R (Tagoe-Thompson) v The Hospital Managers of the Park Royal Centre [2003] EWCA Civ 330*, where the judge ruled "… in circumstances in which the members are laymen, may not be directors of the trust and whose expertise may be limited, a finding that the affirmative view of at least three of them is required to override the opinion of the [RC] and authorise release."

The independent status of AMHAMs is confirmed in case law: *South Staffordshire and Shropshire Healthcare NHS Foundation Trust v The Hospital Managers of St George's Hospital* [2016] EWHC 1196 (Admin).

The AMHAMs continue to report the impact of it no longer being feasible for the Mental Health Act Manager to attend the hearings. Support is offered by telephone, if required, from the MHA office, the MHA Manager and the Head of Mental Health Legislation.

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.

If there is a divergence of views among the professionals about whether the patient meets the clinical grounds for continued detention or CTO, AMHAM panels should reach an independent judgement based on the evidence that they hear. In all cases, the hospital managers (via the AMHAMs) have discretion to discharge patients even if the criteria for detention or CTO are met, if there is a less restrictive (safe) alternative.

In respect of s25 barring orders, AMHAMs need to demonstrate in their written decisions that they have considered both the dangerousness issue and whether any exceptional reasons to continue detention exist in its absence

2.1 The least restrictive option and maximising independence - CTO

The guiding principles of the MHA require that regard should be had to the least restrictive option and maximising independence principles. 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 (RC) 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 RCs 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 a patient can exercise choice whether to accept medication (depot injection in this case) on every occasion it offered, and that the knowledge that recall to hospital might ensue reflects the simple reality of the situation, and does not amount to undue or unfair pressure (Administrative Appeals Chamber 12th June 2013).

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)).

3. Availability of AMHAMs

SHSC now has 20 Associate Mental Health Act Managers from a variety of different genders, ages, backgrounds and ethnicity. The increase in numbers is due to the recruitment of 4 new AMHAMs following interviews on 25th September 2017. However during December an AMHAM unfortunately resigned his post due to health reasons; he was thanked for the service he had offered during his time as an AMHAM.

4. Training and Development

Development reviews for the AMHAM have been completed. The Head of Mental Health Legislation and the Mental Health Act Manager produced a training needs analysis, and training was duly delivered on 18th December 2017.

This training was well attended, including 3 of the newly appointed AMHAMs and 3 non-executive directors of the Children's Trust, who fulfil in their Trust the duties delegated to AMHAMs by SHSC.

The day included presentations about the role and duties of AMHAMs; the different criteria for on-going detention or compulsion dependent on the patient's section; the mental capacity Act in relation to AMHAM duties; psychiatric diagnoses; psychiatric medication; and the use of the updated AMHAM decision reporting form.

Feedback was given by some attendees, who reported the training to be useful, informative and relevant to their role.

Further training is planned in June 2018, and twice yearly thereafter.

5. Peer Support Group

The Head of Mental Health Legislation and the Mental Health Act Manager have arranged and booked monthly Peer Support sessions for the AMHAMs. These sessions, which last for up to 2 hours, commenced in July 2017, on Wednesdays. One of the attendees makes notes of the session which are then shared with all AMHAMs.

The number of AMHAMs in attendance has varied been between 5 and 10 for each meeting. Limited attendance may be the result of the set day for the meetings and the impact on attendance of AMHAMs' other commitments. In order to attempt to maximise attendance, the day of the week on which the session is held will vary, starting in January 2018.

The Peer Support Group enables the AMHAMs to discuss items of interest to them outside the formal setting of the quarterly meeting. Often these discussions are based on a case study. These group sessions appear likely to result in greater consistency in AMHAM practice, and to have the potential to further their training and development needs. The main themes covered to date are:

- The circumstances under which it is appropriate to adjourn a hearing.
- The availability of lap top computers in order to facilitate the completion of the decision papers – these are not yet available, but the MHA manager is pursuing this with the IT team.
- Community Treatment Orders, in particular whether the lack of evidence to support their effectiveness ought to influence AMHAM decisions and the robustness of the Responsible Clinicians' arguments for the on-going need for recall.
- The relevance of historical risk.
- The need to develop chairing experience for newer AMHAMs by actively deciding who, on balance of experience and development needs, is best placed to chair.

The Peer Support Group also raised the issue of the inadequacy of the AMHAM feedback form in highlighting problematic reports etc, and agreed to work on it make it specific to the problems encountered during hearings. More specific and focused feedback will in turn enable this report to the Board to be more informative in this respect in future.

6. Themes from the Quarterly meeting – October 2017

This meeting was attended by 4 of the AMHAMs. The Q1 AMHAM report was discussed with the AMHAMs, who did not have any amendments.

6.1 Reports for Hearings. 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. The renewal form itself constitutes the RC's rationale for renewal.

6.1.1 The AMHAMs reported 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 to comment on the circumstances leading to admission. However, it was noted that the pro-forma is the same as is used for Tribunal reports.

6.1.2 The AMHAMs were informed that in regards to social circumstance reports, the author and the author's manager were now being informed of the AMHAMs concerns about inadequate reports and that inadequate reports would be discussed in supervisions.

It was agreed that it would be helpful for staff that write reports and attend hearings to receive a copy of the Quarterly Feedback report, in order that good reports are also acknowledged.

6.2 The AMHAMs were given an update on the reconfiguration of services. They were made aware that this will result in some patients having a change of care-coordinator and/or Responsible Clinician. This may, for a period, impact on the level of knowledge professionals have in respect of some CTO patients

7. AMHAM Activity – Q2 & Q3 2017-2018

7.1 Number of Hearings

Hearings take place, as described above, for one of the following 4 reasons:

- The patient has applied for a hearing.
- The RC has renewed the detention or extended the CTO.
- The RC has issued a certificate barring the nearest relative (NR) from discharging the detention/CTO.
- A hearing at the 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 the hearing being held for period 01 July 2017 to 31 December 2017.

Table 1 - Number of Reviews and Reason

Reason	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
Patient Applications S3 or S37	0	0	0	0	0	1	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	5	2	4	4	2	6	7	4	7	4	5	5
RC Extension CTO	3	3	3	5	8	2	5	4	5	3	6	6
Barring NR	0	0	0	0	0	1	0	1	1	0	0	0
At Managers' Discretion	0	0	0	0	0	0	0	0	0	0	0	0
Total	8	5	7	9	10	10	12	8	13	8	11	11
Discharged by AMHAMs	0	0	0	0	0	0	0	0	0	0	0	0

Table 2 - Combined Totals

Type of Review	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
Applications (inpatient)	0	1	0	0
Applications (CTO)	0	0	0	0
Renewals (inpatient)	11	12	18	14
Renewal (CTO)	9	15	14	15
Barring NR	0	1	2	0
Total	20	29	34	29
Discharged	0	0	0	0

The renewals for sections in hospital relate to MHA section 3 & section 37. There is an initial renewal period of 6 months, followed by a further 6 months and then yearly thereafter.

The number of renewal hearings for inpatients has risen over the last 3 quarters. By definition, this is the result of the number of inpatient stays persisting into further periods of detention, as detailed above.

The reason for the higher number of inpatient renewals in Q2 is not clear, however it may be due to the fact that there was an increase in the number of S37 (Hospital Order) renewals during this time: there were 4 in Q2 compared to 1 in Q1 and 2 in Q3. It is possible that some of the renewals that took place in Q2 were delayed from Q1, but this would not alter the overall increase: the average number for Q1-3 17/18 = 14.6; an increase of 32.72% over Q4 16/17.

Section 37 is put in place by the courts as an alternative to a custodial sentence following the commission of an offence by the patient. It may be reasonable to expect that these will last longer than S3, therefore resulting in more renewals.

Two hearings also took place during Q2 following the Responsible Clinician issuing a Barring Certificate to prevent a nearest relative from discharging the patient. In both cases the AMHAMs were satisfied that the grounds for dangerousness were met and did not allow the discharge.

Notwithstanding the increase of hearings in Q1 compared to Q4 of last year the number of hearings for CTOs have remained almost constant for the first 3 quarters of 17/18.

There have been no applications from inpatients or those subject to CTO seeking discharge by the AMHAMs during Q2 or Q3. No patient was discharged by the AMHAMs

For comparison, during Q2 and Q3 there was a total of 192 applications and automatic referrals made to the First Tier Tribunal in respect of section 2, section 3 and CTO; 2 of these resulted in discharge (1.04%)

The number of applications to the Tribunal gives assurance that patients are being informed of their right to apply to challenge their detention (the right to apply to either or both the Tribunal and the AMHAMs is detailed in the same rights explanation form).

It is not clear why patients opt for the Tribunal over the AMHAMs. Both bodies have broadly similar powers to discharge patients.

However it is only the Tribunal that amounts to a court for the purposes of the rights guaranteed by Article 5(4) of the European Convention on Human Rights.[1]

7.2 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).

Table 3 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

Table 3 - Hearings taken place in relation to expiry date Q2 and Q3 2017/18

Month	Total number of hearings	Hearings before expiry date	Hearings up to 7 days after expiry date	Hearings more than 7 days after expiry date
July	12	8	4	0
August	8	4	1	3
September	13	8	3	2
October	8	6	2	0
November	11	7	1	3
December	11	8	0	3
Grand Total	63	41 (65.07%)	11 (17.46%)	11 (17.46%)

During Q2 &Q3 a total of 63 hearings for the renewal of the detention/CTO were held; of these, 11 hearings took place following a delay of more than 7 days from the expiry date.

Annual leave was the reason for 4 of these delays, and all panels are dependent on AMHAMs' volunteered availability. Nonetheless, almost 2 thirds of hearing did take place before the expiry date

Given that the AMHAMs did not discharge anyone 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 RC's report that provides the authority for the continued detention or CTO.

8. Quality of Reports

8.1 Written Reports

Prior to the hearings managers receive written reports from the professionals involved in the patient's care. Unfortunately, on occasion, this might be on the day of the hearing.

[1] Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

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.

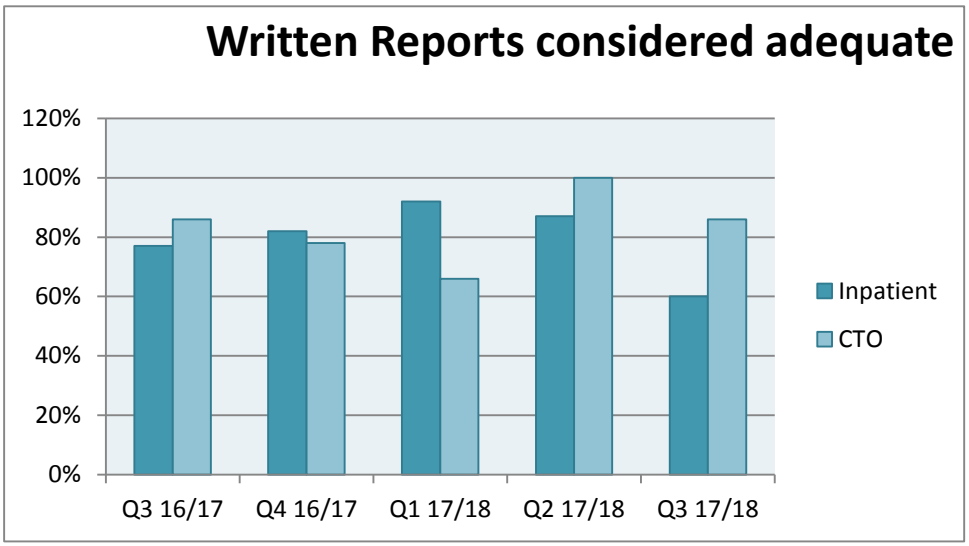
Following every hearing the AMHAMs complete a feedback form commenting on whether in their opinion the reports from the professionals, both written and verbal were adequate. The timeliness of receipt of the reports, relative to the MHA section in question, would be an appropriate criterion to include on the proposed updated feedback form (see above, heading 5).

Chart 1 below shows the percentage of written reports considered to be adequate and Chart 2 shows the percentage of verbal reports considered to be adequate.

The information below is of limited utility, owing to the absence of specific criteria on the current feedback form to address the quality of the reports. Reports do however follow the requirements of the template used by the Mental Health Tribunal.

The development of clear criteria addressing the panels' expectations of reports (both written and oral) for the feedback form will be pursued via the Peer Support Group. This should include a report of any instance when a hearing was adjourned because of lack of adequate written or oral evidence.

Chart 1 - Written Reports for 2017/18



The above chart shows improvement in the written reports for inpatient hearings and a marked improvement for CTO hearings during Q2. However Q3 shows a decline in the quality of reports for both inpatient renewal and CTO. For social circumstance reports this may be due to the reconfiguration of services and care coordinators being asked to write reports for patients new to them. For inpatients this could be due to the acute demand on the inpatient wards.

The Mental Health Act Manager is informed immediately by the AMHAMs of any inadequate reports and the reasons why. This enables prompt feedback to be given to the report's author and their line manager for discussion in supervision.

It should be noted however that the AMHAMs take oral evidence from the staff attending the hearing in order to satisfy themselves of any evidence they believe to be lacking in the written reports.

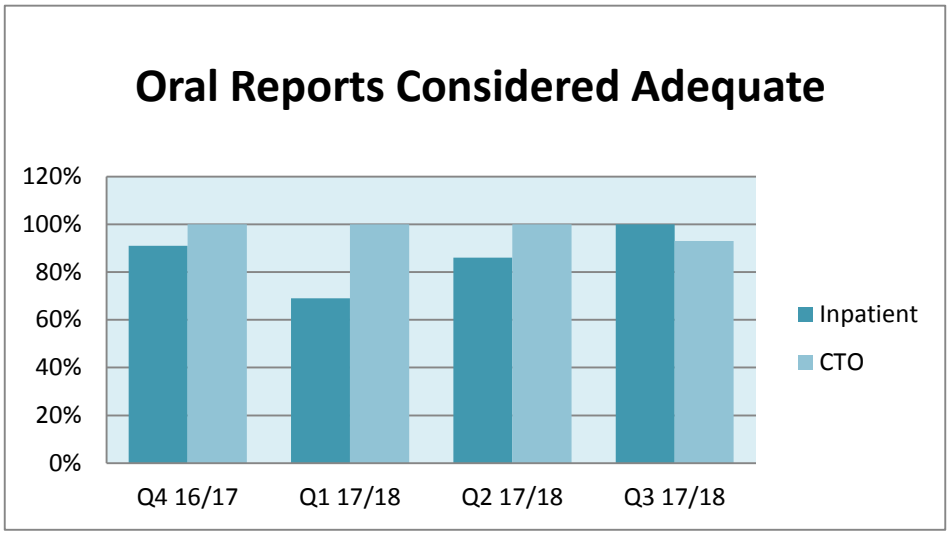
Despite up to 40% of written reports being found inadequate, it is evident from the fact that no patient was discharged as a result of an AMHAM hearing that it was possible to discern sufficient evidence from the combination of written and oral evidence to support on-going detention.

8.2. Oral Reports

Although not all oral reports appear to have been considered adequate for inpatient hearings, the details of why these reports were not adequate have not been recorded.

While Q3 shows a decline in the number of adequate written reports for inpatients, the number of adequate oral reports has improved. This would indicate that the oral reports do address any shortfall in the written information submitted, and allows the AMHAMs to come to a decision.

Chart 2 - Oral Reports



9. Key to Sections NB: This is not an exhaustive list of sections

Section	Purpose	Made By	Length of Time	Can be renewed
2	Admission for assessment or assessment followed by treatment	2 Doctors and 1 Approved Mental Health Professional/Nearest Relative	28 days	No
3	Admission for treatment	2 Doctors and 1 Approved Mental Health Professional/Nearest Relative	Initially up to 6 months	Can be renewed for a further 6 months then yearly – no limit to number of renewals
4	Admission for assessment in cases of emergency	1 Doctor and 1 Approved Mental Health Professional/Nearest Relative	72 hours	No – but if a second medical recommendation is received within the 72 it is then converted to a section 2
5(4)	Nurses Holding power	Nurse	6 hours	No - is used to prevent someone already an inpatient from discharging themselves until a doctor can assess
5(2)	Doctors Holding power	Doctor in Charge of the care or nominated deputy	72 hours	No – completed by the doctor to prevent someone from discharging themselves while waiting for a MHA assessment
25 Barring Order	A patient's legal 'Nearest Relative' (NR - defined at MHA s26) has the power to apply to the hospital managers for the patient's detention under the MHA (the function more usually carried out by the Approved Mental Health Professional or AMHP). There is a corresponding power for the NR to order discharge, which may only be barred by the responsible clinician on the grounds (extra to the criteria for on-going detention) that the patient 'if discharged, would be likely to act in a manner dangerous to other persons or to himself'. The 'dangerousness' criterion does not feature elsewhere in the MHA.			
37	Hospital Order	Magistrates or Crown Court	Initially up to 6 months	Can be renewed for a further 6 months then yearly - no limit to number of renewals
38	Interim Hospital Order	Magistrates or Crown Court	For a period not exceeding 12 weeks	Can be renewed for further periods of not more than 28days up to a total of 12 months
47/49	Transfer of direction from Prison to Hospital with restrictions – sentenced prisoner	Ministry of Justice	No time limit although the restrictions would end when the prison would have ended	
48/48	Urgent transfer of direction from Prison to Hospital with restrictions – other prisoners (usually remanded)	Ministry of Justice	No time limit, but patient should return to criminal justice process ASAP	
CTO	Community Treatment Order	Responsible Clinician and Approved Mental Health Professional	Initially up to 6 months	Can be renewed for a further 6 months then yearly - no limit to number of renewals
Section 136	Place of Safety	Police	72 hours	No but MHA assessment must be carried out within this time