BOARD OF DIRECTORS MEETING (Open)

Date: 09 May 2018 **Item Ref:** 09

TITLE OF PAPER	**Associate Mental Health Act Managers (AMHAM) Report for Quarter 4 2017/18: January to March 2018**
TO BE PRESENTED BY	Giz Sangha, Deputy Chief Nurse on behalf of 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	May 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** **BAF & DESCRIPTION**	Quality & Safety A1 03: Provide positive experiences and outcomes for service users. A103 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.

Authors of Report	Cath Dixon; Anne Cook
Designation	Mental Health Act Manager; Head of Mental Health Legislation
Date of Report	10.04.2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **09 May 2018**

Subject: **Associate Mental Health Act Managers (AMHAM) Report for Quarter 4: January-March 2018**

Presented by: **Giz Sangha, Deputy Chief Nurse 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 for the period January – March 2018 (inclusive). This report was prepared on behalf of the AMHAMs, and reviewed and approved by the AMHAM Quarter 4 meeting, Chaired by the Trust Chair, on Wednesday 18th April 2018.

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 and MHA data
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

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 4: January to March 2018

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: CoP).

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).

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).

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."

This is in contrast to the First Tier Tribunal (Mental Health) where a majority decision is sufficient. *South Staffordshire and Shropshire* confirms that 'a panel of Hospital Managers has equal standing when ordering a patient's discharge to that of a tribunal operating under [MHA] s72'. However, because the Hospital Managers (through the AMHAMs) are one of the parties to the hearing, only the Tribunal (as an independent expert body) constitutes a court in satisfaction of Article 5(4) of the European Convention on Human Rights (ECHR).[1]

[1] ECHR Article 5(4) - 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.

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.

Other than the order of proceedings laid out in the CoP (as above) there is no formal procedure for AMHAM hearings and no explicit requirement for there to be a hearing at all. The MHA manual states that in circumstances where the patient makes repeated applications to the AMHAMs, or if s/he does not wish to contest the renewal of detention or extension of CTO, or if the application is made immediately after an unsuccessful Tribunal and there has been no change in the patient's circumstances, the review could be limited to

consideration of the written reports and an interview with the patient. (Richard Jones, MHA Manual 20th ed, p192).

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, in common with the practice of the Tribunal, undertake 'paper' reviews if a capacitous patient does not elect to attend a hearing following renewal.

Lap-top computers will be provided to AMHAM panels in order to mitigate the effects of the loss of the 'clerking' function previously provided by the MHA Manager.

3. Availability of AMHAMs

SHSC 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. Although availability to undertake hearings was not compromised, the pool of active AMHAMs was adversely affected for the early part of Q4 as a result of delays in the HR process in issuing contracts to the new starters. Without contracts in place it is not possible for the new AMHAMs to observe the requisite hearings prior to taking a place on the panel. The contracts were issued in February.

4. Training and Development

Development reviews for the AMHAM were completed early in 2017/18. 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.

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 at the time, who reported the training to be useful, informative and relevant to their role. This positive feedback was reiterated at the Quarterly meeting of AMHAMs, which took place on 21st February 2018 (postponed from 17th January on account of bad weather)

Annual performance reviews are due to take place early in 2018/19. Training needs emanating from these reviews, plus any topics identified at the Quarterly meetings will be addressed. Further training is planned on 21st June 2018, and will continue twice yearly.

5. Peer Support Group

These sessions, which last for up to 2 hours, commenced in July 2017, on a monthly basis. One of the attendees makes notes of the session which are then shared with all AMHAMs.

The number of AMHAMs in attendance has remained low, with only one person attending in March, despite an attempt to maximise attendance by varying the day of the week on which the session is booked. At the Quarterly meeting in February, the AMHAMs were asked to express their preferences for the frequency of the Peer Support sessions, particularly whether it would be more beneficial to hold them only quarterly on the same date as the Quarterly meeting.

The Peer Support Group is intended to enable the AMHAMs to discuss items of interest to them outside the formal setting of the quarterly meeting. Topics in Q4 included similar issues to previous meetings, in particular:

- The circumstances under which it is appropriate to adjourn a hearing
- Community Treatment Orders in respect of whether evidence of their efficacy/inefficacy is relevant to the AMHAMs' role in reviewing the extension of a CTO, and whether they might breach a patient's human rights under the ECHR.

With regard to the latter, opinions vary between AMHAMs: one perspective is that, as meta-analyses of the evidence shows that CTOs make little difference overall to readmission rates, the AMHAMs should take this into account when hearing evidence supporting extension of the order.

The converse perspective is that CTOs are a lawful option in the MHA and the role of the AMHAMs is simply to satisfy themselves that the criteria for the CTO and the need for the RC to retain the power of recall are met for the individual in question, regardless of the statistics for the broader population.

With regard to human rights considerations, Hospital Managers are held to have 'equal standing when ordering a patient's discharge to that of a tribunal (…)'.[2]

Case law has determined that the tribunal's powers are confined to what is allowed under the MHA and that that does not include consideration of issues related to the ECHR.[3]

The equal standing between Hospital Managers and the tribunal in respect of powers of discharge would suggest that the Hospital Managers' powers (delegated to the AMHAMs) are likewise confined to what is allowed under the Act, therefore not extending to consideration of the ECHR.

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. This work has not progressed to date.

6. Themes from the Quarterly meeting – 21 February 2018

This meeting was attended by 9 of the AMHAMs including two of the newly appointed AMHAMs, who were welcomed to the meeting. Owing to the postponement of the meeting because of bad weather, the combined Q2 & Q3 AMHAM reports had been circulated by e mail, and comments/amendments received were incorporated. The report had been presented to Board prior the week before this meeting was held.

6.1 Readmission rates. Emergency readmission rates (within the first month after discharge from the ward) were presented in response to an earlier request. The figures showed that Sheffield's rates compared favourably to the national figures, and it was suggested that it could be inferred from this that patients were discharge at the

[2] *South Staffordshire and Shropshire Healthcare NHS Foundation Trust v The Hospital Managers of St George's Hospital* [2016] EWHC 1196 (Admin)

[3] *Secretary of State for Justice v MM; Welsh Ministers v PJ* [2017] EWCA Civ 194: *Djaba v West London MH Trust* [2017] EWCA Civ 436).

appropriate time. This was countered by evidence from one AMHAM of an individual case involving potentially inappropriate discharge, which (it was stated) was not untypical.

There was a discussion about the relevance of the readmission data to AMHAMs' practice. It was agreed that the overall picture of readmission, and of recall and revocation of CTO would be of interest to the meeting, but the details of individual cases were not relevant to AMHAM practice. The readmission and recall/revocation rate will be included in this report going forward and they are given below.

6.2 The Q3 AMHAM feedback report to the Quarterly meeting

6.2.2 Out of 14 hearings for those on CTO no patient had attended. All these hearings were brought about automatically due to the uncontested renewal of the CTO and had not been applied for by the patient.

6.2.3 One patient was reported to have been unable to communicate orally owing to the effects of his dementia. In response to a query about available practical aids to communication, it was established after the meeting that the ward employed a range of means to maximise the potential for communication and involvement. However, in this individual's case it was agreed that extent of the cognitive deficit was such that the patient was unable to understand the nature of the proceedings and that this would not have been overcome by the use of communication aids.

7. AMHAM Activity – Q4 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 April 2017 to 31 March 18.

Table 1 - Number of Reviews and Reason

Reason	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Patient Applications S3 or S37	0	0	1	0	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	4	2	6	7	4	7	4	5	5	3	6	6
RC Extension CTO	5	8	2	5	4	5	3	6	6	3	5	2
Barring NR	0	0	1	0	1	1	0	0	0	0	0	0
At Managers' Discretion	0	0	0	0	0	0	0	0	0	0	0	0
Total	9	10	10	12	8	13	8	11	11	6	11	8
Discharged by AMHAMs	0	0	0	0	0	0	0	0	0	0	0	0

Table 2 - Combined Totals – AMHAM reviews

Type of Review	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Applications (inpatient)	1	0	0	0
Applications (CTO)	0	0	0	0
Renewals (inpatient)	12	18	14	15
Renewal (CTO)	15	14	15	10
Barring NR	1	2	0	0
Total	29	34	29	25
Discharged	0	0	0	0

The number of AMHAM renewal hearings during Q4 is the lowest for the year 17/18. This appears to be largely due to the reduction of hearings for CTO renewals. The number of CTO renewal hearings show a reduction of 33% compared to Q3. The number of renewals for inpatient remains comparable with Q1-Q3.

There have been no applications from inpatients or those subject to CTO seeking discharge by the AMHAMs during Q4. No patient was discharged by the AMHAMs

There were no hearings during Q4 which resulted from the Responsible Clinician issuing a Barring Certificate to prevent a nearest relative from discharging the patient.

For comparison, during Q4 there was a total of 98 applications and automatic referrals made to the First Tier Tribunal in respect of section 2, section 3 and CTO; none of these resulted in discharge by the Tribunal.

It is not clear why patients opt for the Tribunal over the AMHAMs for consideration of discharge from detention/CTO. Both bodies have broadly similar powers to discharge patients although legal representation is more accessible for applications to the tribunal as this is covered by the legal aid scheme.

Table 3 - First Tier Tribunals Mental Health for Comparison

Type of Review	Q2 & Q3 17/18 Combined	Q4 17/18
Applications - inpatient	192	59
Automatic referrals - inpatient		21
Applications - CTO		1
Automatic referrals – CTO – no application		11
Automatic referrals – CTO – revocation		6
Total	192	98
Discharged	2	0

The renewals considered by the AMHAMs for sections in hospital relate to MHA sections 3 & section 37. There is an initial renewal period of 6 months, followed by a further 6 months and then yearly thereafter. The Tribunal does not consider renewals automatically; renewal brings with it a right to apply to the Tribunal during the new period of detention.

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).

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 4 - Hearings taken place in relation to expiry date Q2 – Q4 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
January	6	3	1	2
February	11	7	0	4
March	8	6	1	1
Total	88	57	13	18

During Q4 a total of 25 hearings for the renewal of the detention/CTO were held; of these, 7 hearings took place following a delay of more than 7 days from the expiry date.

The reason for these delays was due to both the RCs availability and the minimum number of AMHAMs available to form a panel. Nonetheless, almost 65% 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.

Emergency readmission

Table 5

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Number of Discharges	119	130	122	124
Number of re-admissions within 28 days	7	3	5	18
Percentage	5.88	2.31	4.10	14.52

The significant increase for Q4 is as yet unexplained. Prior to this, Sheffield's readmission rates (based on the available data) appeared to be below the national average see table 6 below:

Table 6 - Benchmarking Trends

	2014-15	2015-16	2016-17
Number of people re-admitted within 30 days of discharge	36	32	41
Sheffield readmission rate – adult acute wards	5%	5%	8%
National readmission rate – adult acute wards	9%	8%	9%

Community Treatment Orders

Table 7: Table of Community Treatment Orders

CTO	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
New CTO	15	10	17	10
Recalls	8	11	10	9
*Revocation	6	7	6	6
Discharge from CTO	7	6	8	7

*Revocation is when a person on CTO has been recalled to hospital and the CTO is then revoked placing the patient back under section 3/37. Not all recalls end with revocation: some are discharged back into the community within the 72hrs; occasionally the patient will consent to staying in hospital on an informal basis.

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.

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.

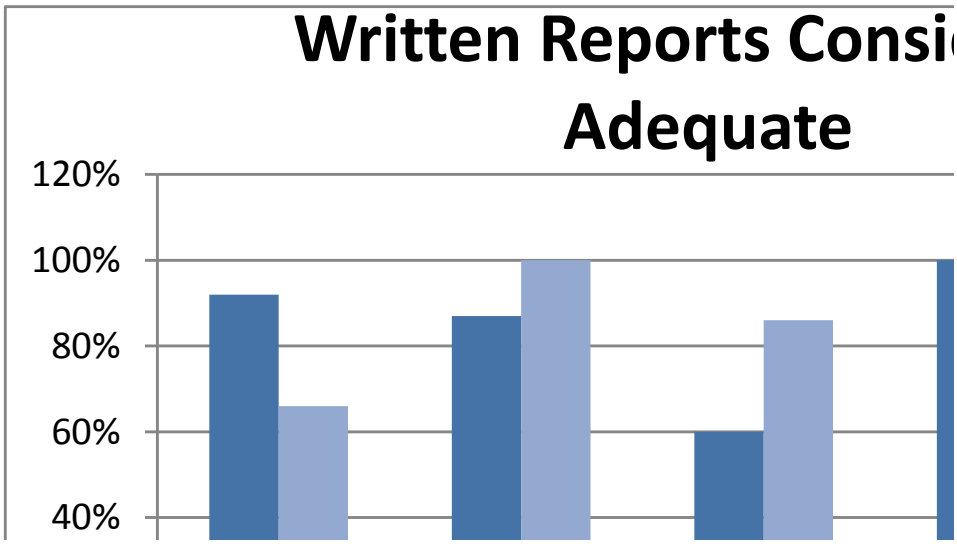
Following every hearing the AMHAMs complete a feedback form commenting on whether in their opinion the reports from the professionals, both written and verbal were adequate. The timeliness of receipt of the reports, relative to the MHA section in question, would be an appropriate criterion to include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



Q4 shows a marked improvement in the written reports for both inpatients and CTO. All reports presented were considered to be adequate.

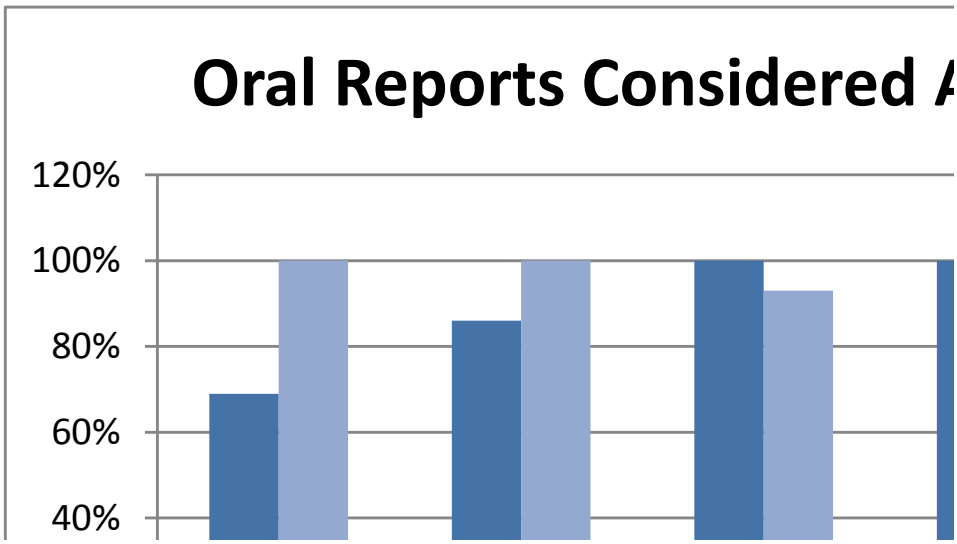
In the event that inadequate reports are presented, the Mental Health Act Manager is informed immediately by the AMHAMs of the reasons why the reports were found to be inadequate. This enables prompt feedback to be given to the report's author and their line manager for discussion in supervision.

The AMHAMs have also been asked to inform the MHA Manager of any report they thought to be particularly good.This is then fed back to the report writer and their manager.

8.2. Oral Reports

An improvement was also made in the oral reports given to the AMHAMs; 100% were considered to be adequate for both inpatient and CTO hearings.

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