BOARD OF DIRECTORS MEETING (Open)

Date: 12 September 2018 **Item Ref:** 13

TITLE OF PAPER	Associate Mental Health Act Managers (AMHAM) Report for Quarter 1 (April - June 2018)
TO BE PRESENTED BY	Liz Lightbown Executive Director of Nursing, Professions and Care Standards
ACTION REQUIRED	Members to receive and Quarterly Report for Information and Assurance

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	September 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 1983 (MHA) Mental capacity Act 2005 (MCA) Human Rights Act 1998 (HRA)
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; Liz Lightbown
Designation	Mental Health Act Manager; Head of Mental Health Legislation
Date of Report	August 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Subject: **Associate Mental Health Act Managers (AMHAMs) Report for Quarter 1: April - June 2018**

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

1. Purpose

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

2. Summary

This report for the Board of Directors describes the performance and activity in respect of the Associate Mental Health Act Managers (AMHAMs) for the period April – June 2018.

The AMHAMs have directly delegated responsibility from the Board of Directors in respect of the Hospital Managers' statutory powers to discharge detained patients from detention under the Mental Health Act 1983. (MHA s23)

This report is to provide assurance to the Board of Directors that this delegated authority is carried out by the Associate Mental Health Act Managers in accordance with the Legislation and the Mental Health Act Code of Practice, 2015.

This report was prepared on behalf of the AMHAMs, and reviewed/approved at the AMHAM Quarter 1 meeting, chaired by Anne Cook, Head of Mental Health Legislation, on behalf of the Trust Chair, on Wednesday 18th July 2018 and is presented under the following headings:

1. Availability of AMHAMs and General Update
2. Peer Support Group
3. Training and Development
4. Themes from Quarterly Meetings
5. AMHAM Activity and MHA data
6. Quality of Reports

Appendix 1 - The Legal Status of the AMHAMs and Hospital Managers' functions and duties with regard to reviewing detention or CTO (Delegated to AMHAMs).

Appendix 2 – Key to MHA sections.

3. Next Steps

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

4. Required Action

Board members are informed and assured of the role and performance of the AMHAMs in Q1.

5. Monitoring Arrangements

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

6. Contact Details

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Associate Mental Health Act Managers (AMHAMs)
Quarter 1: April to June 2018

1. Availability of AMHAMs and General Update

SHSC has 18 Associate Mental Health Act Managers of different genders, ages, backgrounds and ethnicity. Two Associate Managers announced their resignation during Quarter 1. One member announced at the April meeting she would leave the panel owing to the pressure of other commitments; she was thanked by the Trust Chair for her work as an AMHAM. The second Manager gave his resignation at the end of June as he had decided to retire.

Updated contracts for all AMHAMs have been issued since the last report and a policy for AMHAMs has been written. Comments were received from the AMHAMs at the Quarter 4 meeting on 18th April and incorporated into the policy. It was approved by the Policies Governance Group and ratified by the Executive Directors' Group during May 2018.

Updated Terms of Reference for the quarterly meetings were agreed at the Q4 meeting.

2. Peer Support Sessions

Peer Support Sessions for AMHAMs, which last for up to 2 hours, commenced in July 2017, on a monthly basis. This meeting is led by the AMHAMs with the MHA Manager and the Head of Mental Health Legislation in attendance; an AMHAM makes notes.

Owing to low attendance figures, discussed at the Q3 meeting, the AMHAMs elected at the Q4 meeting to continue with peer support sessions on a quarterly basis on the same day as the quarterly meetings.

No notes were produced from the peer support session on 18th April, but the meeting addressed similar themes to previous ones: the circumstances under which it is appropriate to adjourn a hearing and Community Treatment Orders. In addition, there was a discussion about the role of Independent Mental Health Advocates (IMHAs) [1] at AMHAM hearings.

Previously the Peer Support Group raised the issue of the inadequacy of the AMHAM feedback form in highlighting problematic reports etc. The work to make it specific to the problems encountered during hearings has not progressed to date.

3. Training and Development

One of the twice-yearly training days provided for AMHAMs was delivered on 21st June.

[1] All patients who are detained (other than under short-term sections) are entitled by law to an Independent Mental Health Advocate – a specialist advocate with specific training in the Mental Health Act.

The day included an updated presentation about the role and duties of AMHAMs and sessions on Human Rights and Equality, the effects of dementia on a patient's ability to understand and participate in hearings and what makes for a good written decision.

The day was attended by10 AMHAMs.

Feedback was given by all attendees at the time, who reported the training to be useful (particularly regarding decision writing); informative and all agreed it was relevant to their role.

Annual performance reviews are due to take place early in Q1 and Q2 2018/19. Any further training needs emanating from these reviews, plus any topics identified at the quarterly meetings will be addressed at future training. Further training is planned for 6th December 2018, and will continue twice yearly.

4. Themes from the quarterly meeting – Q4 18 April 2018

This meeting was attended by 14 of the AMHAMs.

4.1 AMHAM feedback report from Q4

4.1.1 The relatively low level of patient attendance at inpatient hearings was noted, and the meeting was reminded that it is the duty of the Chair of the panel to offer to see and interview the patient if they do not wish to attend.

4.1.2 There had been 14 hearings during Q3 for those on CTO but no patient had attended. This improved in Q4, with 3 patients having attended their reviews. However it was noted that it was not part of the AMHAMs' remit to check whether the patient wishes to attend, and that electing not to attend might be an expression of the patient's freedom to choose.

It was agreed that staff in attendance should be asked if the patient had been asked if they wished to attend, and whether the patient had had the opportunity to see the reports.

4.1.3 It was reported that Mental Health Tribunals are increasingly undertaking only a paper review of uncontested renewals of CTO, which may mean that an AMHAM review affords the only opportunity to attend a face-to-face review of continuing compulsion, thereby serving to strengthen patient rights.

4.1.4 There was further discussion (following the peer support session) in respect of advocacy attendance at hearings. This led to the inclusion of an advocacy session in the June training.

5. AMHAM Activity – Q1 2018-2019

5.1 Number of Hearings

AMHAM hearings take place 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 (Hearings) and the reason for the hearing being held from Quarter 2 17/18 to Quarter 1 18/19.

Table 1 - Number of Reviews and Reason

Reason	Q2 July 17	Q2 Aug 17	Q2 Sep 17	Q3 Oct 17	Q3 Nov 17	Q3 Dec 17	Q4 Jan 18	Q4 Feb 18	Q4 Mar 18	Q1 Apr 18	Q! May 18	Q1 Jun 18	Q1 Total
In response to patient applications S3 or S37	0	0	0	0	0	0	0	0	0	0	0	0	0
In response to patient applications CTO	0	0	0	0	0	0	0	0	0	0	0	1	1
RC Renewals S3/S37	7	4	7	4	5	5	3	6	6	4	1	3	8
RC Extension CTO	5	4	5	3	6	6	3	5	2	6	6	3	15
Barring NR	0	1	1	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	0
Total	12	8	13	8	11	11	6	11	8	10	7	7	24
Discharged by AMHAMs	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 2: Quarter 1 AMHAM Hearings

Type of Hearing	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
In Response to Inpatient Applications	0	0	0	0
In Response to CTO Applications	0	0	0	1
Inpatient Renewals	18	14	15	8
CTO Renewals	14	15	10	15
Barring NR	2	0	0	0
Total	34	29	25	24
Discharged	0	0	0	0

There was reduction in the number of AMHAMs hearings throughout 17/18 and Quarter 1 of 18/19 sees this decrease continuing = 24.

7 applications were made by patients in Q1 (for inpatient and CTO hearings). Of these: 1 CTO progressed to hearing; 2 were not granted a hearing owing to having applied to the Tribunal; 2 were discharged by the RC; and 2 were withdrawn by the patient.

The 7 applications represent an increase in the rate of patient applications, which may be due to increased input from the IMHA service. The number of patient applications made overall will continue to be recorded.

The number of inpatient hearings dropped from 15 in Q4 to 8 in Q1 (47%). This suggests that patients are being detained for less time as the detention is not reaching the stage of renewal (3/6/12 months).

The number of CTO hearings increased from 10 in Q4 to 15 in Q1 (33%).

There were no hearings during Q1 which resulted from the Responsible Clinician issuing a Barring Certificate to prevent a nearest relative from discharging the patient.

During Q1 there were a total of 90 applications and automatic referrals made to the First Tier Tribunal in respect of section 2, section 3 and CTO; 5 of these resulted in discharge. Compared to previous quarters this is a high number of discharges but this is due to an increase in the number of CTOs discharged by the Tribunal.

Despite the increase in patient applications for a Managers Hearing (AMHAMs), overall patients still 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	Q1 18/19
Applications - inpatient	192*	59	70
Automatic referrals – inpatient		9*	5
Applications – CTO		1	4
Automatic referrals – CTO – no application		9*	8
Automatic referrals – CTO – revocation		7*	3
Total	192	85*	90
Discharged	2	0	5

*Figures amended due to adjournments and restricted patients having been included.

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).

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 and 37. Section 20A provides the authority to extend the Community Treatment Order).

Table 4 below shows the number of hearings which 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 17/18 – Q1 2018/19

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 17	12	8	4	0
August 17	8	4	1	3
September 17	13	8	3	2
October 17	8	6	2	0
November 17	11	7	1	3
December 17	11	8	0	3
January 18	6	3	1	2
February 18	11	7	0	4
March 18	8	6	1	1
April 18	10	5	1	4
May 18	6	4	1	1
June 18	6	6	0	0
Total	110	72	15	23

During Q1, 22 hearings for the renewal of the detention/CTO took place; 68% (15) of the hearings were held before the expiry date and 23% (5) took place following a delay of more than 7 days. The reasons for these delays were due to the adverse weather conditions during February, RCs' availability and the minimum number of AMHAMS not available to form a panel.

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.

5.3 Number of Hearings Adjourned

Table 5 – Hearings adjourned

Adjournments and Reason	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
Total Adjourned	5	2	1	1
Number with reason recorded on report	5	2	0	1
Patient not present	0	1	0	0
Relevant Staff not present	4	1	0	1
Written report inadequate	0	1	0	0
Oral report inadequate	0	0	0	0
Other	5	1	1	0

Please note that more than one reason has been given, where the number of reasons is greater than the number of adjournments.

MHA CoP 38.37 states:
(…) If there is a divergence of views among the professionals about whether the patient meets the clinical grounds for continued detention or CTO, managers' panels should reach an independent judgement based on the evidence that they hear. (..) *In some cases, it might be necessary to consider adjourning to seek further medical or other professional advice.*

In three of the cases above the panel had no choice but to adjourn as one of the panel members failed to attend; the requirement of S23(4) is for the panel to consist of 3 or more members in order to consider discharge.

Two of the hearings where adjourned at the patient's request; one because they wanted a solicitor present and the other because the patient was stated 'several witness statements relevant to the hearing had not arrived'.

When deciding to adjourn the managers must give adequate reasons. They should take into account that the person remains subject to compulsion and therefore adjourning may not be the least restrictive option. Before adjourning because a member of the care team is not present the mangers should review the written reports, question the professional present and only adjourn if the evidence presented is not sufficient to reach a decision.

Adjourning also may cause a prolong delay between the renewal and the hearing which makes the RC account for a decision at a time when the clinical picture may well have been different.

6. Quality of Reports

6.1 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. This form constitutes the Responsible Clinician's report.

A narrative report from the care co-ordinator is also required, and for inpatients a report from the named nurse is also requested.

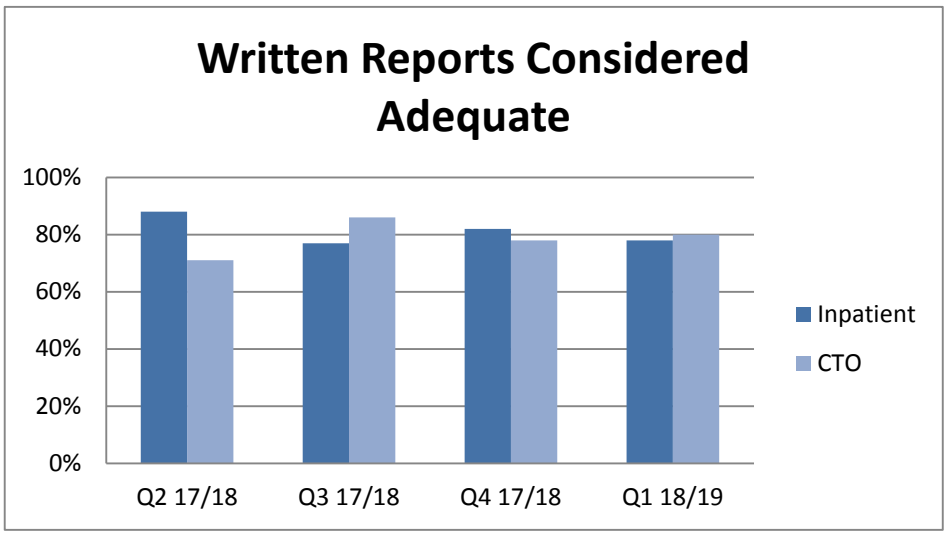
Following every hearing the AMHAMs complete a feedback form commenting on whether in their opinion the reports from the professionals, both written and verbal were adequate.

Chart 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 Q2 17/18 to Q1 18/19



The number of adequate written reports for inpatients slightly decreased in Q1 compared Q4 17/18 but those for CTO slightly increased. The chart shows these variations are in keeping with the trend to date.

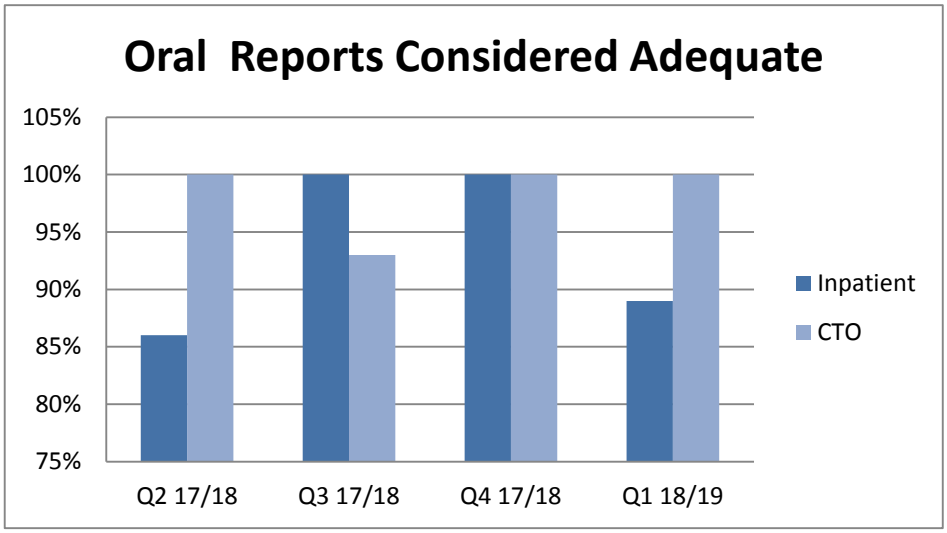
In the event that inadequate reports are presented, the Mental Health Act Manager is informed immediately by the AMHAMs of the reasons why the reports were found to be inadequate. This enables prompt feedback to be given to the report's author and their line manager for discussion in supervision. Despite the increase in inadequate reports, the MHA manager was not informed of these.

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. The MHA Manager was not informed of any particularly good report during Q1

6.2. Oral Reports

The chart below shows a marked variation in the quality of oral reports from inpatient care teams dropping from 100% in Q3 and Q4 to under 90% in Q1. The reason for this variation is difficult to understand; unlike written reports oral reports are there to be questioned in tempore, but may be due to more than one factor e.g. inexperienced staff attending the hearing or managers not being clear in their questioning.

Chart 2 - Oral Reports



Appendix 1

The Legal Status and Duties 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: 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).[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.

[2] 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.

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.

Appendix 2

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