BOARD OF DIRECTORS MEETING (Open)

Date: 14 November 2018 **Item Ref:** 18

TITLE OF PAPER	**Associate Mental Health Act Managers (AMHAM) Report for Quarter 2 18/19**
TO BE PRESENTED BY	Liz Lightbown Executive Director of Nursing, Professions & Care Standards
ACTION REQUIRED	Members to receive the Report for Information & 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	November 2018 Board Meeting
LINKS TO OTHER KEY REPORTS/ DECISIONS	Mental Health Act Code of Practice 2015
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Objective A1 02: Deliver safe care at all times BAF Risk: A1 02i. "Failure to deliver safe care due to insufficient numbers of appropriately trained staff". BAF Risk No: A1 02ii. "Inability to provide assurance regarding improvement in the safety of patient care". Strategic Objective: A1 03: Provide positive experiences and outcomes for service users. BAF Risk No: A1 03 "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 made where necessary.
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	Anne Cook & Mike Haywood
Designation	Head of MH Legislation & Manager MH Legislation Administration
Date of Report	October 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Subject: **Associate Mental Health Act Managers (AMHAMs) Quarter 2 Report: 2018/19**

Presented by: **Liz Lightbown, Executive Director of Nursing, Professions & Care Standards**

Authors: **Anne Cook, Head of Mental Health Legislation**
Mike Haywood, Manager MH Legislation Administration

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 July to September 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 2 meeting, chaired by Jayne Brown, Trust Chair, on Wednesday 17th October 2018 & 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 & Hospital Managers' functions and duties with regard to reviewing detention or CTO (Delegated to AMHAMs).

Appendix 2 – Key to MHA sections.

3. Next Steps

3.1 To continue to report on the activity of the AMHAMs each quarter
3.2 Keep the numbers of AMHAMs under review
3.3 Keep hearing adjournments & the reason(s) for under review.
3.4 Review AMHAM training needs as per Annual Peer Reviews & develop accordingly.

4. Required Action

Board members are informed and assured of the role & performance of the AMHAMs in Q2.

5. Monitoring Arrangements

Via the Board of Directors & supported by the MH Legislation Team.

6. Contact Details

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Associate Mental Health Act Managers (AMHAMs)
Quarter 2 Report 2018/19

1. Availability of AMHAMs & Peer Performance Reviews

SHSC has eighteen Associate Mental Health Act Managers of differing: genders; ages; backgrounds; and ethnicity. Two Associate Managers announced their resignation during Quarter 1 and one in Q2. One new AMHAM has been appointed during Q2. The number will be kept under review at the quarterly meetings.

In particular, regard will be paid to where review of renewal or extension of detention or Community Treatment Order (CTO) occurs after the date the previous order expired, due to insufficient AMHAM availability. The reasons for unavailability / why, will be recorded.

Although, it must be noted that continued detention/CTO is lawful provided that the Responsible Clinician furnishes the papers on time and a late review does not lead to unlawful practice.

Twelve of the AMHAMS required an annual peer performance review. Two AMHAMs act as the 'Peer Reviewers' & received their annual reviews, conducted by the Head of Mental Health Legislation and MHA Manager. Seven other peer reviews are complete and three are outstanding. Arrangements are in place for completion of the three outstanding reviews by the end of Q3

Of the remaining six, one AMHAM did not attend reviews in the period owing to illness, and five have been in post less than a year.

The MHA Manager, Cath Dixon, retired at the end of September and the AMHAM's thanked her for her extensive knowledge, experience, help and support over many years. Mike Haywood has been appointed as the new Manager for MH Legislation Administration.

2. Peer Support Sessions

Monthly AMHAM Peer Support Sessions which last for up to 90 minutes, commenced in July 2017. This meeting is led by the AMHAMs with the MHA Manager and the Head of Mental Health Legislation in attendance, an AMHAM makes notes.

The AMHAMs elected at the Q4 17/18 meeting to continue with peer support sessions on a quarterly basis on the same day as the quarterly meetings.

The Peer Support session conducted on 18th July prior to the Q1 meeting focused on the management of hearings where the panel members disagree about discharging the patient from detention. For discharge from detention, at least three panel members must agree. Panel membership is always comprised of three AMHAMS therefore the decision to discharge must be unanimous.

A solution was agreed at the Q2 meeting in respect of communicating to the patient that dissenting opinions were discussed and the possibility of discharge

carefully considered, but without identifying whether the final decision was unanimous – please see below at 4.2.

3. Training and Development

Training needs emanating from the AMHAMs' annual peer performance reviews, plus any topics identified at the quarterly peer support groups and the quarterly AMHAM meetings will be collated, reviewed and incorporated at future training. If bespoke training for individuals / smaller groups is required it will be provided. The second bi-annual AMHAM full training day is scheduled for 6th December 2018.

4. Themes from the quarterly meeting for Q1 18 July 2018

Please note that this report captures events which took place in Q2, including the Q1 AMHAM meeting.

The Q1 meeting was attended by ten AMHAMs.

4.1 AMHAM Quarterly Feedback Report for Quarter 1

Laptop computers became available during Q1 to facilitate recording of AMHAM decisions. This allows each member of the panel to contribute to the completion of the documents. The meeting agreed that the completed decision document would be sent to the chair for them to read/amend it before being sent to the patient.

4.2 Dissenting Opinions at Hearings

The Q1 meeting was informed that the Peer Support Group had had a thorough and lengthy discussion in the morning about whether to record that a panel decision is not unanimous.

Opinions were split between those present at both meetings. Some AMHAMs argued strongly that the decision should inform the patient if the outcome was reached unanimously or by majority or minority and that to do so would enhance the reputation of AMHAMs; others were equally strongly in favour of not disclosing that there had been a dissenting opinion or opinions and for presenting the decision as that of the panel as a whole.

There was a view that the decision could be written in a way that demonstrates the care taken by AMHAMs in their consideration of the evidence and in a way that imparts hope to the patient for the future. It was felt that such decisions had the potential to increase attendance at hearings.

The issue had been raised originally because the decision template does not include guidance about how to proceed in the event that there is dissent in the panel. In an attempt to formulate guidance it was agreed to adopt a compromise.

The Head of MH legislation agreed to draft an account of the discussion and the compromise reached and to e-mail this for comments and agreement to those present. The following agreed text was circulated to all AMHAMs on 26.7.18:

The following compromise was agreed for the guidance:

1) Add the following statement to the decision template at the beginning of the conclusion:

The Mental Health Act Code of Practice states at paragraph 38.19: "If three or more members of the panel (who between them make up a majority) are satisfied from the evidence presented to them that the answer to any of the questions [asked by the panel with regard to the criteria for detention] is 'no', the patient should be discharged."

This means that if three managers make up the panel, they all have to agree to discharge from detention; therefore discharge cannot happen if one member of the panel does not agree.

2) AMHAMs will write their decision in a way that indicates clearly that all the evidence has been considered carefully. If there has been a dissenting opinion, this can be articulated in the record but the record will not identify whether the final decision was unanimous.

For example, the decision could include something along the lines of:

"The panel has carefully considered all the evidence it has heard today. We were impressed with the evidence in respect of [record here the issue(s) about which the panel disagrees].

The panel has taken these different views into account in reaching its decision and has taken into consideration the different opinions of the panel members. However, on balance, the panel's decision is .... "

Please note that it is not the intention that AMHAMs use this exact phrase, it is offered as an example.

5. AMHAM Activity: Q2 2018/19

5.1 Number of Hearings

AMHAM hearings take place for one of the following four reasons:

1. The patient has applied for a hearing.
2. The RC has renewed the detention or extended the CTO.
3. The RC has issued a certificate barring the nearest relative (NR) from discharging the detention/CTO.
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 hearings and the reason for the hearing being held from Quarter 3 17/18 to Quarter 2 18/19.

Table 1: Number of AMHAM Hearings & Reason

Reason	Q3 Oct 17	Q3 Nov 17	Q3 Dec 17	Q4 Jan 18	Q4 Feb 18	Q4 Mar 18	Q1 Apr 18	Q1 May 18	Q1 Jun 18	Q2 Jul 18	Q2 Aug 18	Q2 Sep 18
In response to patient application S3 or S37	0	0	0	0	0	0	0	0	0	0	0	1
In response to patient application CTO	0	0	0	0	0	0	0	0	1	0	0	0
RC Renewals S3/S37	4	5	5	3	6	6	4	1	3	4	3	5
RC Extension CTO	3	6	6	3	5	2	6	6	3	6	2	2
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
Monthly Total	8	11	11	6	11	8	10	7	7	10	5	8
Quarterly Total			30			25			24			23
Discharged by AMHAMs	0	0	0	0	0	0	0	0	0	0	0	0

Table 2: Applications to the AMHAMs: From Q3 17/18 to Q2 18/19

From Q3 18/19 the type of application will be recorded

	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19
Total Applications submitted	0	0	7	7
Inpatient applications	-	-	-	6
CTO applications	-	-	-	1
Total not proceeding to hearing	-	-	6	6
Reasons for not proceeding to hearing				
Tribunal pending	-	-	2	2
Discharged by RC before hearing	-	-	2	4
Withdrawn by patient	-	-	2	0
Total	0	0	6	6

The 7 applications in both Q1 and Q2 represent an increase in the rate of patient applications, which may be due to increased input from the IMHA service. It is apparent that

making an application prompts a review of the detention criteria by the patient's RC, and that discharge ensued in 57% of cases. Patients may also be becoming aware of the likelihood of discharge occurring by this means.

Table 3: AMHAM Hearings: From Q3 17/18 to Q2 18/19

	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19
Type of Hearing				
In Response to Inpatient Applications	0	0	0	1
In Response to CTO Applications	0	0	1	0
Following Inpatient Renewal	14	15	8	12
Following CTO Extension	15	10	15	10
Following Barring NR	0	0	0	0
Total	29	25	24	23
Discharged	0	0	0	0

There was a reduction in the number of AMHAMs hearings overall throughout 17/18 and this decrease is continuing. 23 hearings in Q2 represents a 23.4% decrease from Q3 17/18

However, the number of inpatient hearings rose from 8 in Q1 to 12 in Q2 a 50% increase. This indicates that patients remained detained long enough during this period to hit a trigger for renewal (sections 3 and 37 run for 2 consecutive 6-month periods and for 12 month periods thereafter). Nonetheless this does represent a decrease in renewals compared to Q3 and Q4 17/18.

The number of CTO hearings reduced from 15 in Q1 to 10 in Q2, a 33% decrease attributable to fewer patients hitting a trigger for extension during the period.

There were no hearings during Q2 which resulted from the Responsible Clinician issuing a Barring Certificate to prevent a nearest relative from discharging the patient.

Despite the increase in patient applications for a Managers Hearing (AMHAMs) 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.

For comparison, during Q2 88 applications and automatic referrals were made to the First Tier Tribunal in respect of section 2, section 3 and CTO; 2 of these resulted in discharge. Compared to previous quarter the number of discharges has fallen by 60% - please refer to Table 4.

Table 4 - First Tier Mental Health Tribunals

Type of Review	Q2 & Q3 17/18 Combined	Q4 17/18	Q1 18/19	Q2 18/19
Applications - inpatient	192*	59	70	76
Automatic referrals – inpatient		9*	5	4
Applications – CTO		1	4	3
Automatic referrals – CTO – no application		9*	8	1
Automatic referrals – CTO – revocation		7*	3	4
Total	192	85*	90	88
Discharged	2	0	5	2

*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 is evidence 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 AMHAM Hearings Taking Place Prior to Expiry

The MHA CoP 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 5 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 5 – AMHAM Hearings taken place in relation to expiry date Q3 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
Q3 October 17	8	6	2	0
Q3 November 17	11	7	1	3
Q3 December 17	11	8	0	3
Q4 January 18	6	3	1	2
Q4 February 18	11	7	0	4
Q4 March 18	8	6	1	1
Q1 April 18	10	5	1	4
Q1 May 18	6	4	1	1
Q1 June 18	6	6	0	0
Q2 July 18	10	4	1	5
Q2 Aug 18	5	3	0	2
Q2 Sept 18	7	4	1	2
Total	99	63	9	27

During Q2, 22 hearings for the renewal or extension of the detention/CTO took place; 50% (11) of the hearings were held before the expiry date and 41% (9) took place following a delay of more than 7 days.

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. Given that the AMHAMs did not discharge anyone from detention or CTO during this period, it is apparent that no patient's renewal or extension was inappropriate.

5.3 Number of Hearings Adjourned

Table 6 – Hearings adjourned Q3 17/18 TO Q2 18/19

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

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

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.*

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.

In both of the cases adjourned in Q2 the panel had no choice but to adjourn. In one case a panel member failed to attend, and in the other an AMHAM was taken ill during the hearing. The panel must consist of 3 or more members in order to consider discharge (s23(4) MHA), therefore it would be unlawful to proceed with only 2 members.

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.

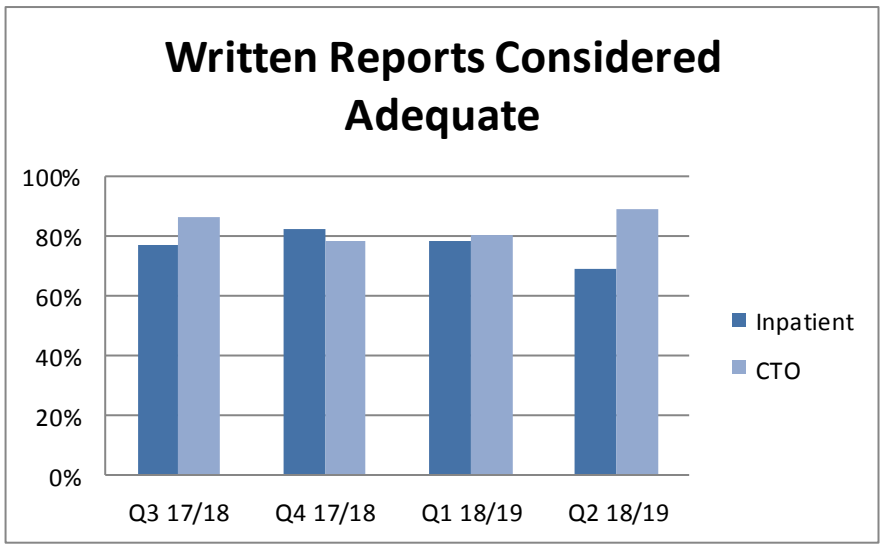
Following every hearing the AMHAMs complete a feedback form commenting on whether in their opinion the reports from the professionals, both written and verbal were adequate.

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 for the AMHAM feedback form, with the aim of standardising as far as possible the panels' expectations of reports (both written and oral) will be pursued on the training day planned for 6th December 2018. 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 Q3 17/18 to Q2 18/19



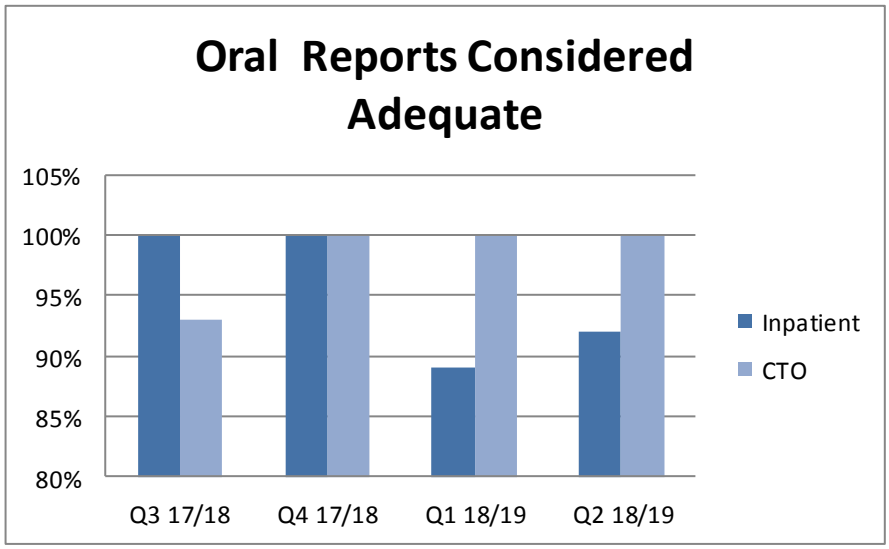
The number of adequately written reports for inpatients decreased in Q2 compared to Q1 whilst for CTO it slightly increased. The chart shows these variations are in keeping with the trend to date.

In the event that inadequate reports are presented, the Mental Health Legislation 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 Q2

6.2. Oral Reports

Chart 2 - Oral Reports



The chart above shows a marked variation in the quality of oral reports from inpatient care teams dropping from 100% in Q3 and Q4 17/18 to under 90% in Q1 18/19 increasing to 92% in Q2. The reason for this variation is difficult to understand. Unlike written reports oral reports, by definition, are delivered in person and panels are able to question the person concerned. The decrease in quality may be the result of more than one factor e.g. inexperienced staff attending the hearing or AMHAMs not being clear in their questioning. This will be further explored.

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).[1]

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.

[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.

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