HPFT

MHA Guidance for Discharge, Renewal of Detention and Extension of CTOs under the MHA 1983

Incorporating Standards for Managers Hearings

Mental Health Act 1983 as amended by Mental Health Act 2007

HPFT Policy

Version	7
Executive Lead	Executive Director Quality & Safety
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Target Audience	❖ Anyone working with patients subject to detention or CTO (Community Treatment Orders) under the MHA 1983. ❖ MHA Administration Staff ❖ MHA Managers

Title of document	MHA Guidance for Discharge, Renewal of Detention and Extension of CTOs under the MHA 1983		
Document Type	Policy		
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Version	**Issue Date**	**Review Date**	**Lead Author**
7	18/05/2018	18/05/2021	MHA Quality Manager
Staff need to know about this policy because (complete in 50 words)	All Trust staff dealing with patients subject to the MHA are aware of their responsibilities in respect of patients subject to either detention orders or a CTO and their right of appeal to the MHA Managers		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	If at any time the RC concludes that the criteria which would justify renewing a patient's detention or extending a CTO are not met, they should exercise their power of discharge. They should not wait for the patient's detention or CTO to expire. Responsible Clinicians must personally examine the patient and decide within the two months leading up to the expiry of the patient's detention whether the criteria for renewing detention under Section 20 of the act are met and whether discharge is appropriate. Only Responsible Clinicians may extend the period of a patient's CTO. Responsible Clinicians must examine the patient and decide, during the two months leading up to the day on which the patient's CTO is due to expire, whether the criteria for extending the CTO under section 20A of the Act are met. They must also consult one or more other people who have been professionally concerned with the patient's medical treatment. The RC must obtain the written agreement of an Approved Mental Health Professional (AMHP).		
Summary of significant changes from previous version are:	Updated MHAM Decision forms and Guidance Note for MHA Hospital Managers regarding dangerousness criterion added.		

PART 1 – Preliminary Issues:

1. Summary

This policy details the procedures to be followed when renewing detention or extending Community Treatment Orders (CTO) for patients being treated under the Mental Health Act 1983 within Hertfordshire Partnership University NHS Foundation Trust (HPFT or the Trust). It also provides clear guidelines to Mental Health Act Managers in executing their role within the Trust.

All patients that have their detention orders renewed or CTO extended must have their MHA status reviewed by the MHA Managers (MHAM). All patients subject to a detention order without restrictions or Community Treatment Orders (CTO) can appeal against their section order to the MHA Managers, (MHAM). The MHAM have the right to discharge a patient if they believe a patient does not meet the criteria for on-going compulsion under the MHA.

2. Objectives

The purpose of this document is to ensure a consistently high standard in relation to renewal of detention or extension of CTO. It provides guidance on how the procedures in the MHA for renewing detention or extending a CTO should be applied and highlights the responsibilities of all professionals involved in this process.

This document also ensures that all Trust staff dealing with patients subject to the MHA are aware of their responsibilities in respect of patients subject to either detention orders or a CTO and their right of appeal to the MHA Managers. It outlines the procedures to be followed by staff and MHA Managers in respect of appeal applications and review of renewals by the MHAM. All procedures follow the Guiding Principles as specified in the MHA Code of Practice, see Appendix 1. The standards specified represent the expectations of HPFT in the context of such hearings; they are intended to facilitate compliance with MHA 83 as amended by MHA 2007, Code of Practice 2015 (CoP), the Human Rights Act 1998 (HRA98), the Mental Capacity Act 2005 (MCA 2005) and any relevant professional guidelines.

3. Definitions

Mental Health Act Managers (MHAM) - The MHA Hospital Managers of hospitals have various powers and duties under the Act. In this context, “managers” does not mean the management team of the hospital. For NHS Trusts the Trust itself is defined as the “Managers” for the purpose of the Act. MHA Managers are a subcommittee of the board and have the authority to detain patients under the Act and they have the primary responsibility for seeing that the requirements of the Act are followed.

Mental Health Act Managers’ panel - In the context of “hospital managers’” power to discharge patients, it generally means the three or more individuals appointed by the Trust Board to exercise delegated powers on its behalf and the task of holding “managers hearings” and deciding whether to exercise the power of discharge under S23 from detention or CTO.

4. Duties and Responsibilities

4.1. Duties

The Trust is ensuring through this document that all staff are aware of their role in relation to those subject to the MHA.

Part 2 – What needs to be done and who by

4.2. **Duties within the Organisation**

It is the responsibility of the organisation's operational management to ensure policy distribution, implementation and compliance throughout the organisation.

4.3. **Individual Staff working with patients**

It is the responsibility of individual staff working with patients to ensure that they are aware of all requirements in respect of the MHA.

4.4. **Lead Directors**

The Chief Executive is ultimately responsible for ensuring that the Trust meets its responsibilities with regard to the delivery of services. The lead Director for this policy is the Executive Director, Quality & Safety/Deputy CEO.

4.5. **MHA Managers**

It is the responsibility of the MHA Managers to ensure that they are aware of all requirements in respect of the MHA when reviewing detention orders. They must have completed all training necessary to enable them to carry out the functions of a MHAM.

4.6. **Key Groups with a Policy Role**

The Mental Health Act Quality and Policy Group meeting agree this policy and any changes that need to be added as legislation changes.

5. Renewal of Detention

5.1. Responsible Clinicians must personally examine the patient and decide within the two months leading up to the expiry of the patient's detention whether the criteria for renewing detention under Section 20 of the act are met and whether discharge is appropriate. The In Control Clinician must discuss this decision with the patient.

Where Responsible Clinicians are satisfied that the criteria for renewing the patient's detention are met, they must submit a report to that effect to the hospital managers. It is important that this is completed in time to arrange a MHA Managers to review the renewal before the actual due date of the renewal.

5.2. The Responsible Clinician is required to obtain the written agreement of another professional ('the second professional') that the criteria are met. This second professional must be professionally concerned with the patient's treatment and **must not** belong to the same profession as the Responsible Clinician. The second professional should be identified and recorded before examining the patient for the purposes of renewal. They should ensure they have sufficient information on which to make the decision and be given enough notice to be able to interview or examine the patient if appropriate.

5.3. Unless there are exceptional circumstances the decision of the second professional should be accepted, even if the Responsible Clinician does not agree with it. This should be documented on the patients EPR including the reasons for the disagreement.

5.4. Where the renewal does not happen, due to whatever circumstance and the patient continues to be deprived of their liberty without legal authority the CQC must be informed as soon as is possible as will the Commissioners of the service. Appropriate

steps will need to be taken by the ward staff, ie: use of section 5 or an emergency DOLS application to rectify the situation immediately.

6. Determining who the Second Professional should be

6.1. The Act does not say who the second professional should be. Practice should be based on the principle that the involvement of a second professional is intended to provide an additional safeguard for the patient ensuring that:

- renewal is formally agreed by at least two suitably qualified and competent professionals who are familiar with the patient's case;
- those two professionals are from different disciplines, and so bring different, but complementary, professional perspectives to bear; and
- the two professionals are able to reach their own decisions independently of one another.

Accordingly, second professionals should:

- have sufficient experience and expertise to decide whether the patient's continued detention is necessary and lawful, but need not be approved clinicians (nor be qualified to be one);

- have been actively involved in the planning, management or delivery of the patient's treatment; and

- have had sufficient recent contact with the patient to be able to make an informed judgment about the patient's case.

7. Extending Community Treatment Orders

Only Responsible Clinicians may extend the period of a patient's CTO. Responsible Clinicians must examine the patient and decide, during the two months leading up to the day on which the patient's CTO is due to expire, whether the criteria for extending the CTO under section 20A of the Act are met. They must also consult one or more other people who have been professionally concerned with the patient's medical treatment. Where appropriate consultation with the patient, nearest relative, IMHA and/or other representative, family, carers, local authority, and key service providers should take place during a Care Programme Approach (CPA) meeting before the RC decides whether or not to extend the CTO.

The RC must obtain the written agreement of an Approved Mental Health Professional (AMHP). This does not have to be the same AMHP who originally agreed to the CTO. It may (but need not be) an AMHP who is already involved in the patient's care and treatment.

The AMHP must be given enough notice to interview the patient. The RC, second professional and AMHP should all consider carefully whether or not the criteria for extending the CTO are met and if so whether an extension is appropriate. For example, the longer patients have been on a CTO without the need to exercise the power to recall them to hospital, the more important it will become to question whether that criterion is still satisfied.

All decisions should be taken in line with the least restrictive option and maximum independence principle. Therefore guardianship and discharge should be fully considered.

8. Powers of Discharge

8.1. Section 23 of the Act allows Responsible Clinicians to discharge part 2 patients and unrestricted part 3 patients and all CTO patients by giving an order in writing.

If at any time the RC concludes that the criteria which would justify renewing a patient's detention or extending a CTO are not met, they should exercise their power of discharge. They should not wait for the patient's detention or CTO to expire.

For patients that are discharged from detention or CTO, a Form 23 should be completed and sent to the MHA Office.

8.2. Patients detained for assessment or treatment under part 2 of the Act may be discharged by their nearest relative. The MHAM via the MHA office should ensure that the nearest relative is aware of this power and how to use it, please see the HPFT S131/132/133 Information Policy. Before giving a discharge order, nearest relatives must give the MHAM at least 72 hours' notice in writing of their intention to discharge the patient. The 72 hours begin when the notice requesting discharge is received by an "officer of the Trust" i.e.: a nurse on the ward where the patient is detained or the MHA Office.

8.3. During that period, the patient's RC can block the discharge by issuing a 'barring report' stating that, if discharged, the patient is likely to act in a manner dangerous to themselves or others.

8.4. This question focuses on the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm, not merely on the patient's general need for safety and others' general need for protection.

8.5. The nearest relative's notice and discharge order must both be given in writing, but do not have to be in any specific form. In practice MHAM should treat a discharge order given without prior notice as being both notice of intention to discharge the patient after 72 hours and the actual order to do so. The MHAM expect that all staff are aware of their duties to ensure notices and discharge orders served on the hospital are received and considered without delay by the MHAM or their authorised officers.

Standards for Managers Hearings

9. The Board of the Trust and MHA Managers

9.1. The Board has appointed a sub-committee to undertake the MHA Managers function on their behalf. It is the MHA Managers who collectively detain a patient. The Board retains the ultimate responsibility for the performance of the MHA Managers duties. The main responsibilities which the Act confers on MHA Managers in relation to hearings are incorporated within this document.

9.2. Because HPFT is a Foundation Trust, the MHA Managers for the purposes of MHA '83 are any three or more people appointed by the Trust Board to exercise delegated powers on its behalf, "whether or not they are members of the Trust itself or any of its

committees or sub-committees"[1]HPFT, however, chooses to exercise these powers through a committee.

9.3. Although the MHA Code of Practice 2015 refers to "Hospital Managers", to avoid confusion with operational posts within HPFT this document refers to them as "Mental Health Act Managers" or "MHA Managers", or "MHAM".

9.4. Managers who sit on review panels must not be employees of the Trust[1], in practice they have a wide variety of professional backgrounds. They are recruited independently and the Trust will make every effort to ensure that the pool of managers is representative of the population it serves, although it is not always possible to achieve this in individual panels.

9.5. "The Board is responsible for ensuring that MHA Managers properly understand their role and the working of the Act"[1], which means that HPFT has a duty to provide appropriate training to those appointed as MHA Managers. Managers, in turn, are expected to participate in this training. This will include training on the need to consider the views of patients, and if the patient agrees their nearest relative and/or carer.

9.6. HPFT will ensure adequate training is available with regard to understanding equality issues, and the specific needs of particular groups including, patients from minority cultural or ethnic backgrounds, patients with physical and/or sensory impairments, and patients with learning disabilities and/or autism. This also includes effective communication skills when interacting with patients with specific needs.

9.7. Appointment as a MHA Manager should last for a fixed period; reappointment should not be automatic and should be preceded by a review of continuing suitability, HPFT reviews all MHAM annually.

9.8. The Trust Board has decided that the Chairs of hearings will be either:

- a Non-Executive Director of the Trust; or
- a MHA Manager specifically authorised by the Board to chair hearings

10. Powers and Purpose of MHAM Hearings:

10.1. The MHA Managers have important statutory powers, responsibilities and duties concerning detained patients and these are specifically defined in sections 132, 132A, 133 and 134 of the 1983 Mental Health Act. These powers are delegated for operational purposes to officers employed by the Trust.

10.2. MHA Managers should ensure that all relevant patients, their nearest relative and, if different, carer, are aware that the patient may ask to be discharged by the MHA Managers and the distinction between this and their right to apply for a Tribunal hearing. The appropriate level of support should be available to help the patient understand this right and distinction.

10.3. Section 23 of the MHA gives MHA Managers the power to discharge an unrestricted patient from compulsion. The power may only be exercised if three or more

[1] MHA Code of Practice 2015. Chapter 38.

persons, appointed by the Trust to act in this role, on a review panel agree that the patient should be discharged from compulsion.

10.4. A MHA Managers' review is the process by which the Managers decide whether or not a patient continues to remain liable to compulsion within the terms of the Act.

HPFT MHA Managers:

- may undertake a review at any time at their discretion;
- must undertake a review if the patient's Responsible Clinician (RC) submits a report to renew a detention order or extend a CTO;
- should consider holding a review when they receive a request from a patient (who may be supported by their IMHA, IMCA, attorney, deputy or carer).
- should consider holding a review when the RC makes a report barring an order by the nearest relative to discharge a patient.

In the last two cases, when deciding whether to consider the case, MHAM are entitled to take into account whether the Tribunal has recently considered the case or is due to do so in the near future. Any decision not to consider the case should be documented.
Where a review in respect of the RC's decision to either renew or extend a MHA order is not held before the expiry date this must be documented within the patient's records. This should be considered a very serious matter. The reasons for the review not having taken place and the actions put in place to stop this happening again should be fully documented in the patients EPR. The MHA Quality Manager should also be informed to further address this issue.

10.5. It is the role of the Chair to manage the hearing. This means ensuring that everybody participating in the hearing has the opportunity to be heard without allowing them to stray away from the purpose of the hearing i.e: to ascertain whether there is evidence to support the criteria for on-going detention/CTO or not. The Chair must ensure that an evidence based decision is reached and recorded. The Chair's opinion carries no greater weight than that of the other members of the panel.

11. The Legal Context

11.1 The Act, together with the 2015 Code of Practice, lays upon the MHA Managers a duty to protect the individual's rights whilst under compulsion by providing them with specific information about the details of that compulsion, the right to review and the right to free legal advice for representation at Tribunals; they must facilitate visits, at any reasonable time, by legal representatives. (Delegated powers - see 6.1 above.) Specialist Independent Mental Health Advocacy (IMHA) services are empowered to support detained patients. The Managers, as service providers, have a duty to advise qualifying patients (anyone subject to detention for periods longer than 72 hours or, to CTO) of their right to access these services.

11.2 The circumstances in which the liberty of the individual may be restricted are limited and clearly defined; therefore decisions made under the MHA 83 are of

immense importance. Detention under the MHA deprives people of their liberty within the meaning of the Human Rights Act 1998 (HRA 98) by curtailing many of their rights to self-determination. The Trust is mindful of HRA 98, which specifies the conditions necessary to a lawful detention:

- Article 5.1 states that a person may only be detained "in accordance with a procedure prescribed by law";

- Article 5.4 asserts the right of the detained individual "to take proceedings by which the lawfulness of his detention shall be determined speedily by a court and his release ordered if the detention is not lawful."

These rights are extended to include patients subject to compulsion under a CTO.

11.3 The onus is on the care team to present evidence for why the patient should continue to be subject to the Mental Health Act. The patient has no responsibility to prove entitlement to discharge. This very important fact is at the core of every hearing. It is therefore essential that the professionals preparing reports and speaking make clear recommendations and provide evidence relevant to the criteria to assist the MHA Managers in coming to a decision. The criteria for each form of compulsion are specified on the Decision Form.

11.4 In the absence of clear recommendations to continue detention or CTO and evidence to support those recommendations, i.e.: insufficient to satisfy the MHA Managers that the statutory criteria still apply, the MHA Managers are legally bound to discharge the patient.[2]

11.5 At an appeal or review hearing for compulsion under any relevant section of MHA 83, the question for MHA Managers is "Do the criteria for compulsion still apply?"[3] If the MHA Managers agree with the professionals that they do, then the patient remains detained. At least three Managers must agree to discharge a patient[4] and an HPFT panel consists of three members; as the law does not permit a majority decision of two to one, the decision to discharge must be unanimous. Unless it is a unanimous decision to discharge, the patient will remain liable to compulsion. With regard to upholding the section, although there may be dissenting views it is recommended that only the views of panel members as a whole should be recorded; the panel must be aware that the patient will see the decision form and that a record of dissenting views may lead to false expectations of future clinical needs and/or discharge. For all decisions regard should be had to the principle of the least restrictive option and maximising independence for each patient. Consideration should also be given as to whether the Mental Capacity Act 2005 can be used to treat the patient safely and effectively.

11.6 Managers have discretion to discharge even if the criteria for continuing compulsion are met, but must always consider all the factors involved in the individual case and weigh them against the best outcome for the patient. This ensures a proportionate use of compulsion as required by European case law.

[2] (Mental Health Act 1983 (Remedial) Order 2001 (SI 2001/3712)
[3] (R v London South & Southwest Region MHRT ex parte Moyle [1999])
[4] (R v The Hospital Managers of the Park Royal Centre ex parte Tagoe-Thompson)

If a patient is discharged and lacks capacity to decide where to live, the Managers may request that consideration be given to making an application for a Deprivation of Liberty Safeguard (DoLS) authorisation.

The standard of proof at MHA hearings is the balance of probability; that is, that what is presented in evidence is, in the opinion of the panel, more likely or less likely to be true in fact.

11.7 MHA Managers' hearings are subject to general and public law duties, which means that the conduct of reviews must satisfy the legal requirement to be fair, reasonable and lawful, that is

- The Managers must apply a procedure that is fair and reasonable;
- They must not make irrational decisions (defined as "decisions that no panel, properly directing itself as to the law, could have made on the available information");
- They must not act unlawfully, this means not acting contrary to the Act itself, other relevant legislation such as HRA98 or any applicable equality and anti-discrimination legislation.

11.8 If the hearing is to consider the decision of the RC to bar discharge by the Nearest Relative (NR), then the extra criterion of "dangerousness" has to be considered[5]. If the panel finds that it cannot agree with the RC's argument on this point, the decision will usually be to discharge. MHA Managers however have discretion, in exceptional circumstances, to decide that compulsion should continue even when they do not find that this criterion has been satisfied, assuming that the original criteria for detention are still met[6].
A record of the panels' discussion of the "dangerousness" criterion must be included on the decision form in all cases.

11.9 The criteria for compulsion under Sections 2 (admission for assessment & treatment), 3 (admission for treatment), 37 (Court-ordered admission for treatment) and 17A (Community Treatment Orders) are to be found on the decision form used by the Chair at MHAM meetings to record the conduct of the meeting. The decision form records both the decision of the panel and the reasons for that decision as required by case law. (See Appendices 2a-2e)

11.10 If a patient has made an application to the Tribunal during the first 14 days of detention and has had a Tribunal hearing within the 28 day maximum duration of detention under Section 2 then the requirements of Art. 5.4 HRA98 may be said to be satisfied.

However all efforts should be made to ensure that a MHAM hearing should take place if a patient makes an application to the Managers after missing the deadline for submitting an application to the Tribunal.

11.11 Where patients lack the capacity to instruct a solicitor or even to explain their point of view to an advocate the Mental Health Act Office will refer the patient to the appropriate Independent Mental Health Advocacy Service as a Best Interest

[5] (R v MHRT ex parte Huzzey [1998])
[6] (R (SR) v Huntercombe Maidenhead Hospital [2005] 12 R (Li) v MHRT [2004])

decision made by either the RC, named nurse or care co-ordinator. HPFT is especially concerned that compulsion is rigorously reviewed where the patient is unable to object to its use of his/her own accord.

11.12 Sections 35-45 of the Domestic Violence, Crime & Victims Act 2004 (DVCV 2004) place a number of duties upon MHA Managers. These concern liaison with the victims of crimes committed by unrestricted patients detained under Part 3 of MHA 83, (eg: Sections 37 or 47). In practice, these duties will be delegated to officers of the Trust. Managers should, however, be aware that in rare instances they may have to consider representations from such victims as part of the hearing process. Please see HPFT's "Victim's Policy"

12. Before the Hearing

12.1 On behalf of the MHA Managers, upon receipt of an application from the patient or patient's solicitor or notification of renewal of compulsion by the RC, the MHA Office will arrange hearing dates and request reports from the appropriate professionals.

12.2 The Trust has a Guide to Hearings for patients which is sent to the patient to provide information and advice on the review process. It is essential that the patient, their nearest relative and/or carer are involved in all elements of this process so that they are enabled and supported to participate at all times. Patients are entitled to have a relative, friend, carer or IMHA attend to offer support. A form is sent to the patient to inform them that a review will be taking place and asking them if they wish to attend and if so the names of the people they would also like to invite.

12.3 The MHA office will ask the Managers' Administrator to arrange and confirm a panel for that date and will advise in writing all other attendees (including the NR where the patient does not object) of the location, date and time of the hearing. Consideration will be given to the best location for the hearing to be held based on what is in the patient's best interests and the availability of suitable accommodation for the hearing.

12.4 In the case of an appeal, the date of the hearing should be within five weeks of application, if the hearing is not scheduled within five weeks of application this should be reported to a MHA Quality Manager.

12.5 In the case of a review of renewal, the date of the hearing should be before the actual due date of the renewal. If the review does not take place before the due date of renewal, the reason for this should be reported to a MHA Quality Manager. This will be discussed with the clinical lead and reasons for this will be documented in the patient's record.

12.6 The MHA Office will ensure that the patient's authority for disclosure of his/her medical records to the legal representative is made available to front-line staff by attaching a copy of the letter of authority to the EPR.

12.7 If the services of an interpreter or any other specialist communicator are needed for a Tribunal hearing, it is the responsibility of the ward staff (inpatient) or Care Co-ordinator (CTO patient) to inform the MH Legislation Department so that they

can inform the Tribunal Service to arrange for an independent interpreter to attend the hearing.

12.8 If the services of an interpreter or any other specialist communicator are required for a Managers Hearing this must be booked by the ward (inpatient) or Care Co-ordinator (CTO patient) – see HPFT Accessible Information Policy.

12.9 The MHA Office responsible for administration of the MHA section paperwork will request, receive, copy and collate the reports and prepare all necessary paperwork for the hearing; this should be available at the hearing venue at least 45 minutes before the meeting is to begin.

The patient's legal representative should receive copies of all reports from the MHA Office in good time to consult with the patient and take instruction. This means that all professionals must forward copies of their reports (including CPA records, which are particularly vital to the conduct of CTO hearings) by the date specified by the MHA Office.

12.10 The MHA Office will ensure that copies of all reports are available to a patient through their legal representative or IMHA. If a patient has no independent representation all reports will be delivered directly to the patient in most cases; however, where there is reason to believe that the patient is not capable of reading or understanding the reports without help, or may not be in a fit state of mind to guard his/her own confidentiality then the patient's copies should be discussed with the care coordinator where appropriate. If the patient agrees their nearest relative and/or carer should also receive copies of these reports.

13. Conduct of Hearings

13.1 On arrival at the venue for the hearing, the Chair should check with the MHA Office/Nurse in Charge/Care co-ordinator that the patient is fit to attend the hearing. It may be that medication has been administered recently and the patient is not sufficiently alert to understand the proceedings. In rare instances, the staff may consider the patient's mental state to be unstable to the point where s/he may present a danger to other attendees. If this is the case they **must** alert all parties urgently so that an adjournment can be considered if necessary.

13.2 If the patient is not fit, or is unwilling to attend, the hearing may go ahead without delay, given that the legal representative is present and has taken instruction.

13.3 If the patient is not fit, or is unwilling to attend and the legal representative has been unable to obtain instruction from the patient, the panel should consider an adjournment or postponement of the hearing until the patient is able to/wishes to attend in person and/or has had the benefit of legal advice. Hearings can proceed without legal representation; however there is an added emphasis for the MHA Managers to ensure fairness.

13.4 A review of detention or extension should normally go ahead in the circumstances referred to in 7.3 above due to the automatic referral by the MHAM for a patient that has not appealed their case to the First-Tier Tribunal (Mental Health) in the first applicable period of detention. The patient may appeal to the Managers at any subsequent time; therefore there is no breach of a patient's rights.

13.5 The Trust recognises that hearings of any kind are difficult events for the patient and believes that, acting in accordance with the guiding principles, every effort should be made to reduce the stress of the occasion as much as possible. Some practical ways to achieve this are:

- All attendees should arrive on time for the meeting to avoid keeping the patient waiting;
- The meeting should be as informal as the dignity of its purpose permits;
- If there are no safety implications to doing so (and if the necessary furniture is available), everyone should sit around a table together rather than having the panel separated from the other attendees. This creates a less intimidating and more inclusive environment;
- Allowance must be made for the fact that the patient is obliged to sit still whilst being discussed by others, some of whom are strangers, in quite intimate detail. The patient may need a short break during the hearing;
- A friend or relative may provide important insight and should be welcomed as the patient's supporter – s/he probably feels outnumbered by the professionals and the panel. The Empowerment and Involvement Principle states that "the views of families, carers and others, if appropriate, should be fully considered when taking decisions".
- The patient should be addressed directly even if a legal representative is present; care should be taken to ensure that s/he feels included in the meeting and empowered to voice his/her view. The Respect and Dignity Principle requires that "patients, their families and carers should be treated with respect and dignity and listened to by professionals".

13.6 A panel member who realises that s/he knows the patient in any capacity other than that of MHA Manager must immediately make the fact known; unless another MHA Manager can be found to replace him/her within a reasonable time, the hearing must be postponed until another panel can be convened.

13.7 The panel will take such time as is needed to read all the reports, letters or other written evidence before them; professionals should therefore keep their reports as brief as possible whilst presenting the facts that support their contention. Where a MHA managers hearing is held to review the renewal of detention or extension of CTO, the Section 20, 20A or 21B report should be available. A copy of the record of consultation undertaken by the Responsible Clinician must also be available.

13.8 If there are to be representations from the solicitor, on the subject of matters designated by professionals as "not for disclosure to the patient", the Managers will discuss these in private and give their decision to the legal representative and MDT before the hearing begins. The high threshold for non-disclosure in Tribunal hearings should advise Managers in any such decision: "...that such disclosure would be likely to cause [the patient] or some other person serious harm.

13.9 The panel may agree to a request from the patient for a private interview, but the members must make it plain from the outset that they may not be able to treat as

confidential everything they hear. As an example, accusations of improper conduct against individuals would in fairness require the right of reply.

14. Uncontested Renewals

14.1 Where a patient (with capacity) has stated clearly, that s/he has no intention of contesting a renewal of detention or extension of CTO, does not wish to attend a hearing, does not wish to have legal representation or an IMHA attend a hearing, the panel can conduct a "paper review", however currently HPFT only hold paper reviews for CTO extensions. A patient subject to detention or CTO can request a MHAM Hearing whenever they wish, unlike that of an application to the Tribunal Service.

14.2 A refusal to attend the meeting should not automatically be taken to mean that the patient is not contesting renewal of detention, if there is no legal representation, the Chair or another member of the panel should attempt to speak to the patient and ascertain his/her view of continuing compulsion where this is practicable, this HAS to be subject to a risk assessment.

14.3 If the patient's intention not to contest renewal is clear, the panel should consider a paper exercise. This may take different forms, depending upon the quality and coherence of the body of reports, the detail of the care-plan and any remarks the panel has elicited from the patient. Generally speaking, an HPFT panel will review the reports available, checking for any discrepancies. The care team will be available to answer any questions and expand upon any points highlighted by the panel via telephone, and will then make a decision. The MHA Officer facilitating the meeting will advise if a different procedure is necessary in individual circumstances. It is important to underline that this is not simply a case of "rubber-stamping" the decision of the RC; the Managers may still decide that continuing compulsion is not warranted by the evidence presented.

14.4 MHA Managers should apply as much rigour to considering uncontested cases as to contested ones to ensure that the least restrictive option and maximising independence principle is being applied and those decisions are only being made on the basis of the statutory criteria.

14.5 In deciding whether or not to hold a paper review, the MHA managers should consider if previous reviews during the current period of detention have been 'paper reviews'. In all cases a person should have no more than two paper reviews before a full hearing is held.

15. The Hearing

15.1 The Chair will introduce him/herself and ask everybody present to do the same. The Chair will explain the procedure to the patient and make sure that s/he has understood what will happen. They should also confirm that they are not employed by the Trust. The Chair should ask the patient how they would like to be addressed.

15.2 The Chair will check that the patient and legal representative/IMHA have seen the reports and had a chance to discuss them; s/he will also ask why the patient is seeking discharge **from** detention/compulsion. The professionals will be asked to highlight the key information from their reports in turn, with a verbal update if one is needed. They should bring to the panel's attention any points they consider to be especially important in confirming their opinion that the criteria for continuing

compulsion are met. Please see Appendices 3 and 4 in respect of guidelines for hearings where the NR has requested discharge.

Ideally the author of each report will attend, but when this is not possible the line manager of the author, or someone else from the team who knows the patient, should be thoroughly briefed to present the report.

15.3 At the end of each presentation, the solicitor will be given the opportunity to ask questions from the professional about the evidence provided. The MHA Managers may also put questions to each professional, with the aim of eliciting clear evidence as to whether or not the criteria for compulsion are met. Once the professional's evidence has been given they should be allowed to leave the hearing subject to the MHAM panel's approval, a cogent reason for leaving prior to the end of the hearing would be for other clinical duties, it is desirable that they should remain on site, however if this is not possible that they can be contacted by 'phone.

15.4 The Code of Practice 2015 states that the patient should be given a full opportunity and any necessary help to explain why they should no longer be subject to compulsion. Some patients may need an interpreter, advocate or signer or other assistance and HPFT hearings will accommodate any requirement of this kind. Where practicable the patient's view should usually be sought, where appropriate, at the beginning of the hearing and before the panel's private discussion of the evidence.

15.5 The MHA Managers will take notes about the evidence, both for and against continuing compulsion and are encouraged to use the "decision making process" paper provided. The notes should be used by each Manager to evidence the reasons for either continued compulsion or discharge.

15.6 Once the professionals" reports have been examined to the satisfaction of the panel and the legal representative, the latter will be asked by the Chair to sum up the case for the patient. The panel and solicitor may choose to ask the patient questions designed to address the concerns expressed by the professionals in the event of discharge by the panel.

15.7 The Chair will ask everybody to withdraw while the panel debates the decision, considering all the evidence, including the patient's psychiatric history, and weighing it against the criteria for continuing compulsion. Unless there is a particular reason to the contrary, the panel may at this point release the professionals to their duties.

15.8 The panel will use any notes made during the hearing as a summary of the evidence to assist them in their discussion. Although the MHA Officer, who will have taken notes during the hearing, is present at the discussion to provide legal advice, the decision is for the Managers alone.

15.9 In order to avoid keeping the patient waiting longer than is necessary, it is usual for the panel to recall the attendees and announce their decision verbally before completing the decision form, briefly explaining the reasons for that decision. If the patient does not return for the decision, one of the panel should usually see him/her and explain the reasons for the decision unless ward staff advise against doing so. If there is a legal representative present when the decision is announced, he or she will usually perform this task. If not sometimes it may be

easier, from the patient's point of view, to hear the result from the care co-ordinator or named nurse or other known and trusted person, especially if the decision went against discharge.

15.10 Following the hearing, MHA managers should ensure that the patient is offered the opportunity to discuss the hearing and informed of their rights to be considered for discharge by the Tribunal.

16. After the Hearing

16.1 The Chair of the panel will use the information gained from the reports and verbal evidence to summarise the discussion on the relevant part of the decision form. Any notes taken during the hearing will be shredded following full completion of the decision form.

16.2 The Chair will complete the appropriate decision form, Appendix 2a-e. **It is not sufficient to reiterate the criteria and state that the panel believes them to be met or not met; the written reasons must present the evidence which led to the belief of criteria being met.** The reasons should be written by the Chair in consultation with the other members of the panel and must address the criteria for the particular form of compulsion relevant to the case. The decision form is designed to elicit the evidence for each criterion, but must also answer any specific points raised by the patient's legal representative. Because the panel is communicating a decision that affects a patient's liberty, it is important that the reasons be written legibly. Legal challenge may follow if the reasons are insufficient or cannot be read.

16.3 It is the duty of the MHA Officer to ensure that the stated reasons do address the criteria and that the forms are fully and correctly completed. The MHA Officer will bring any missing elements to the attention of the panel so that amendments may be made in the presence of all its members. The Managers are expected to respect any requests for amendment or clarification by the MHA Officer. If there are any issues that arise, either during the hearing or when writing the decision, a senior member of the MH Legislation Dept should be called.

16.4 In the case of a review of renewal of detention or extension of CTO where this is upheld, the renewal/extension report must be signed and dated by each individual MHA Manager.

16.5 In the interests of patient confidentiality, panel members may not carry away from the hearing any reports, letters or other papers which might identify the patient.

16.6 The MHA Officer will dispose of the panel's papers after the hearing. The MHA office is responsible for copying the decision form and ensuring that copies are sent to the patient, legal representative and NR and available on the EPR so as to make it accessible to the professional team. If relevant a copy of the signed renewal of detention/extension of CTO report should also be attached to the EPR.

17. Training and Awareness

Course	For	Renewal Period	Delivery Mode
MHA Overview	Anyone that	Every 3 years	

	deals with patients subject to the MHA. This includes all clinical in-patient and out-patient staff		

18. Process for monitoring compliance with this document

Key process for which compliance or effectiveness is being monitored	Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	Job title and department of person responsible for leading the monitoring	Frequency of the monitoring activity	Monitoring Committee responsible for receiving the monitoring report/audit results etc.	Committee responsible for ensuring that action plans are completed
Monitoring of tribunal cases	Review time-scales for scheduling	MHA Quality Managers	Monthly	MHA Quality and Policy Group	Who
Quality of reports	Review reports against templates	MHA Quality Managers	Monthly	Practice Governance Annually	

19. Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and support of service users, carers and staff.

Respect means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further

information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

Service user, carer and/or staff access needs (including disability)	This should specifically address how the needs of people with disabilities and differing communication needs are given appropriate adjustments within the service/process/workplace to facilitate better access. Consider issues such as interpreters, location of services, access to physical and sensory impairment etc taking into account how the service/process would cope with any demands. For staffing it should access to the workplace as well as issues such as reasonable adjustments. This should also reflect how potential for inequality is minimised.
Involvement	This should specify the opportunities that are made available within the service/process for service users and carers to be involved in making contributions to the Trust and development of services. This should also reflect how potential for inequality is minimised.
Relationships & Sexual Orientation	How is the service/process taking account of the needs of people in different relationships as well as those in none? This should address issues around sexual orientation (and any barriers for people around their orientation) as well as any relevant issues re: nearest relatives and family carers. For staff this may also include an awareness of the needs of LGB staff in workforce and an understanding of how an open workplace culture improves the experience for staff working in the Trust. This should also reflect how potential for inequality is minimised.
Culture & Ethnicity	What is specifically in place to ensure that ethnic minority service users will receive a cultural appropriate experience from the service/process? This should include issues of language, diet, hygiene and personal care etc. This should also reflect how potential for inequality is minimised.
Spirituality	How are issues of spirituality assured for the service user or carer where necessary? This should focus around the HOPE model for: **H** – Sources of Hope **O** – Needs re: organised religion **P** – Personal belief structure (including non-faith) **E** – Effects on care of practicing spiritual beliefs. (positive and negative) This could include how chaplains and spiritual care visitors are used in the service/process (where applicable) This should also reflect how potential for inequality is minimised.
Age	Does the service/process take account of the needs of different age groups? There should be specific references that identify how any particular groups are favoured for targeted support. This should also reflect how potential for inequality is minimised.

Gender & Gender Reassignment	This should specifically look at how the service/process provides equal treatment for men and women or – where justified – one group is favoured (e.g. single sex accommodation). All services/processes should include detail on how the needs of transgender service users and carers are acknowledged and what support is offered. As well as links to documentation supporting staff in relation to gender. This should also reflect how potential for inequality is minimised.
Advancing equality of opportunity	General information on how the service/process will develop in a way that incorporates equality of opportunity through continual feedback and evaluation of the service/process.

Part 3 – Document Control & Standards Information

20. Version Control

Version	Date of Issue	Author	Status	Comment
V1	October 2008	MHA Dept and MHAM Manager	Superseded	Awaiting comments from Service Users & Carers
V2	October 2008	MHA Dept and MHAM Manager	Superseded	Comments added and EIA completed
V3	October 2008	MHA Dept and MHAM	Superseded	Forms now added and comments re EIA
V4	August 2010	Directorate Manager MH Legislation	Superseded	Archived
V5	21st January 2014	MHA Operational Manager	Superseded	Reviewed in light of paper reviews
V6	24th April 2015	MHA Quality Manager	Superseded	Reviewed following Code of Practice April 2015
V7	18th May 2018	MHA Quality Manager	Current	Policy reviewed and revised

21. Relevant Standards

a) Mental Health Act 1983, as amended Mental Health Act 2007
b) Code of Practice 2008
c) Equality and RESPECT: The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

The 2012 Policy Management System and the Policy Format:
The PMS requires all Policy documents to follow the relevant Template.

- **Policy Template** is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.
- **Operational Policies Template** provides the format to describe our services, how they

work and who can access them.

- **Care Pathways Template** is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.
- **Guidance Template** is a sub-section of the Policy to guide Staff and provide specific details of a particular area. An over-arching Policy can contain several Guidance's which will need to go back to the Approval Group annually.

22. Associated Documents

Mental Health Act Manual, Richard Jones (17th Edition)

23. Supporting References

- Mental Health Act 1983
- Mental Health Act 2007
- Mental Health Act Code of Practice 2015
- Mental Capacity Act 2005
- Mental Capacity Act 2005 Code of Practice
- Care Act 2014
- Human Rights Act 1998

24. Consultation

In the case of the Procedural Document Management System, the following have been consulted so far.

Directorate Manager MHA Legislation	MHA Legal Department
MHA Managers	AMHP Lead
MHA Quality and Policy Group	

Part 4 Appendices

Appendix 1

Guiding Principles – MHA Code of Practice, Chapter 1

It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The MHA Code of Practice stresses that the principles should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

The five overarching principles are:

- *Least restrictive option and maximising independence*
  Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

- *Empowerment and involvement*
  Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

- *Respect and dignity*
  Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

- *Purpose and effectiveness*
  Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

- *Efficiency and equity*
  Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Terminology	How it is to be understood	Exceptions
Must	Reflects legal obligations which it is essential to follow	No exceptions
Should	For those to whom this is statutory guidance see paragraphs II – V For those to whom it is not statutory guidance VI – VII	See paragraphs II – VII. Any exceptions should be documented and recorded including the reason for this. Patients, their families and carers, regulators, commissioners and other professionals may ask to see this
May/could/can	Reflects guidance to be followed wherever possible	Good practice but exceptions permissible

Appendix 2a

Hertfordshire Partnership NHS
University NHS Foundation Trust

MENTAL HEALTH ACT MANAGERS' SECTION 2 DECISION FORM

PLACE: **DATE:**

MENTAL HEALTH ACT ADMINISTRATOR: **TIME:**

Chair of Panel:	**Patient Name:**
2nd Member:	**Solicitor:**
3rd Member:	**Advocate:**
Reason for Meeting:	**Responsible Clinician:**
	Care Co-ordinator:
	Others:

	Yes	No
Patient Request	☐	☐
Barring Order S25(1)	☐	☐

Expiry Date of Section:

DECISION OF MHAM PANEL

a.) The patient should be discharged with immediate effect ☐

b.) The patient should not be discharged ☐

c.) Adjournment ☐

Decision communicated to patient by

Chair ☐ Hospital Staff ☐

Legal Representative ☐ Other (please specify) ☐

_____

DOCUMENT REVIEW	PRESENT	
	Yes	No
1. Responsible Clinician's report	☐	☐
2. Social Circumstance report	☐	☐
3. Nursing report	☐	☐
3. Other reports (write in)	☐	☐
4. Other views heard	☐	☐

CONDITIONS NECESSARY TO CONTINUE DETENTION

RC Barring Discharge by Nearest Relative (Section 25(1))

Where the RC has barred the nearest relative from discharging the Patient under Section 25(1) the following question **must** also be considered in addition to the criteria for the relevant detention order
Salient points of the resulting discussion **must** be recorded as part of the decision.

	Yes	No
Would the patient, if discharged, be likely to act in a manner dangerous to other persons or him or herself?	☐	☐

_____

_____

_____

_____

	Yes	No
a) The patient is suffering from mental disorder of a nature or degree which warrants the detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period;	☐	☐

_____

_____

_____

and

b) He/She ought to be so detained in the interests of his/her own health or safety or with a view to the protection of others. ☐ ☐

_____

_____

_____

REASONS FOR DECISION: Other issues arising or recommendation

SIGNATURE OF PANEL MEMBERS

1. _____

2. _____

3. _____

DATE: _____

Hertfordshire Partnership NHS
University NHS Foundation Trust

MENTAL HEALTH ACT MANAGERS' SECTION 3/37/47 DECISION FORM

PLACE: **DATE:**

MENTAL HEALTH ACT ADMINISTRATOR: **TIME:**

Chair of Panel:	**Patient Name:**
2nd Member:	**Solicitor:**
3rd Member:	**Advocate:**
Reason for Meeting: Yes No Patient Request ☐ ☐ S.20 Renewal ☐ ☐	**Responsible Clinician:** **Care Co-ordinator:** **Nurse:**
Current Section: **Expiry Date:**	**Others:**

DECISION OF MHAM PANEL

a.) The patient should be discharged with immediate effect ☐

b.) The patient should not be discharged ☐

c.) Adjournment ☐

Decision communicated to patient by

Chair ☐ Hospital Staff ☐

Legal Representative ☐ Other (please specify) ☐

_____

DOCUMENT REVIEW	PRESENT	
	Yes	**No**
1. Responsible Clinician's report	☐	☐
2. Social Circumstance report	☐	☐
3. Nursing report	☐	☐
4. Other reports (write in)	☐	☐
5. Other views heard	☐	☐

CONDITIONS NECESSARY TO CONTINUE DETENTION

	Yes	**No**
a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;	☐	☐
_____		
_____		
_____		
and		
b) It is necessary for the health or safety of the patient or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section;	☐	☐
_____		
_____		
_____		
and		
c) Appropriate medical treatment is available.	☐	☐
_____		
_____		
_____		

REASONS FOR DECISION: Other issues arising or recommendation

SIGNATURE OF PANEL MEMBERS

1. _____

2. _____

3. _____

DATE: _____

Appendix 2c

Hertfordshire Partnership NHS
University NHS Foundation Trust

MENTAL HEALTH ACT MANAGERS' CTO DECISION FORM

PLACE: **DATE:**

MENTAL HEALTH ACT ADMINISTRATOR: **TIME:**

Chair of Panel:	**Patient Name:**
2nd Member:	**Solicitor:**
3rd Member:	**Advocate:**
Reason for Meeting:	**Responsible Clinician:**
	Care Co-ordinator:
	Others:
	Date of Original CTO: **Expiry Date:**

	Yes	No
Patient Request	☐	☐
S.20A Renewal	☐	☐

DECISION OF MHAM PANEL

a.) The patient should be discharged with immediate effect ☐

b.) The patient should not be discharged ☐

c.) Adjournment ☐

Decision communicated to patient by

Chair ☐ Hospital Staff ☐

Legal Representative ☐ Other (please specify) ☐

_____

DOCUMENT REVIEW	PRESENT	
	Yes	**No**
6. Responsible Clinician's report	☐	☐
2. Social Circumstance report	☐	☐
3. Other reports (write in)	☐	☐
4. Other views heard	☐	☐

CONDITIONS NECESSARY TO CONTINUE THE COMMUNITY TREATMENT ORDER

	Yes	**No**
a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment;	☐	☐

_____

_____

_____

and

b) It is necessary for his/her health or safety or for the protection of other persons that he/she should receive such treatment ;	☐	☐

_____

_____

_____

and

c) Subject to his/her being liable to be recalled, such treatment can be provided without continuing detention in hospital;	☐	☐

_____

_____

_____

and

d) It is necessary that the responsible clinician should be able to exercise the power under S17E(1) to recall the patient to hospital; ☐ ☐

e) Appropriate medical treatment is available for him/her ☐ ☐

REASONS FOR DECISION: Other issues arising or recommendation

SIGNATURE OF PANEL MEMBERS

1. _____

2. _____

3. _____

DATE: _____

Appendix 2d

Hertfordshire Partnership NHS
University NHS Foundation Trust

MENTAL HEALTH ACT MANAGERS' CTO DECISION FORM WITH BARRING

PLACE: **DATE:**

MENTAL HEALTH ACT ADMINISTRATOR: **TIME:**

Chair of Panel:	**Patient Name:**
2nd Member:	**Solicitor:**
3rd Member:	**Advocate:**
Reason for Meeting:	**Responsible Clinician:**
	Care Co-ordinator:
	Others:
	Date of Original CTO: **Expiry Date:**

	Yes	No
Patient Request	☐	☐
Barring Order S25(1)	☐	☐

DECISION OF MHAM PANEL

- **c.) The patient should be discharged with immediate effect** ☐
- **d.) The patient should not be discharged** ☐
- **c.) Adjournment** ☐

Decision communicated to patient by

Chair	☐	**Hospital Staff**	☐
Legal Representative	☐	**Other (please specify)**	☐

_____

DOCUMENT REVIEW	PRESENT	
	Yes	**No**
1. Responsible Clinician's report	☐	☐
2. Social Circumstance report	☐	☐
3. Other reports (write in)	☐	☐
4. Other views heard	☐	☐

RC Barring Discharge by Nearest Relative (Section 25(1))

Where the RC has barred the nearest relative from discharging the Patient under Section 25(1) the following question **must** also be considered in addition to the criteria for the relevant detention order

Salient points of the resulting discussion **must** be recorded as part of the decision.

	Yes	**No**
Would the patient, if discharged, be likely to act in a manner dangerous to other persons or him or herself?	☐	☐

_____

_____

_____

_____

CONDITIONS NECESSARY TO CONTINUE SUPERVISED COMMUNITY TREATMENT

	Yes	**No**
a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment;	☐	☐

_____

_____

_____

and

b) It is necessary for his/her health or safety or for the protection of other persons that he/she should receive such treatment ;	☐	☐

and

c) Subject to his/her being liable to be recalled, such treatment can be provided without continuing detention in hospital; ☐ ☐

and

d) It is necessary that the responsible clinician should be able to exercise the power under S17E(1) to recall the patient to hospital; ☐ ☐

e) Appropriate medical treatment is available for him/her ☐ ☐

REASONS FOR DECISION: Other issues arising or recommendation

SIGNATURE OF PANEL MEMBERS

1. _____

2. _____

3. _____

DATE: _____

Appendix 2e

Hertfordshire Partnership NHS
University NHS Foundation Trust

MENTAL HEALTH ACT MANAGERS' DECISION FORM

UNCONTESTED CTO PAPER REVIEW

Review Date: _____

Patient Name:	**Renewal date:**
Responsible Clinician: **Author of report:**	**Care Coordinator:** **Author of report:**
Date of last Tribunal Hearing: **Referral:** **Referral, paper review:** **Appeal:**	**Date of last MHA Managers hearing:** **Review with MDT:** **Paper review:** **Appeal:**

DECISION OF MHAM PANEL

Based on the written evidence by the professionals we are satisfied that the patient:

e.) Should be discharged with immediate effect ☐

f.) Should not be discharged ☐

Based on the written evidence by the professionals we cannot make a decision without further information therefore must:

g.) Adjourn ☐

Reason for adjournment and further information required:

This decision will be communicated to patient and professionals by the MHA Office

DOCUMENT REVIEW	PRESENT Yes	No
1. Responsible Clinician's report	☐	☐
2. Social Circumstance report	☐	☐
3. Evidence that patient is not contesting extension	☐	☐
4. Other reports (write in)	☐	☐

CONDITIONS NECESSARY TO CONTINUE SUPERVISED COMMUNITY TREATMENT

a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment; ☐ ☐

_____

_____

and

b) It is necessary for his/her health or safety or for the protection of other persons that he/she should receive such treatment ; ☐ ☐

_____

_____

and

c) Subject to his/her being liable to be recalled, such treatment can be provided without continuing detention in hospital; ☐ ☐

_____

_____

and

d) It is necessary that the responsible clinician should be able to exercise the power under S17E(1) to recall the patient to hospital; ☐ ☐

_____

_____

and

e) Appropriate medical treatment is available for him/her ☐ ☐

_____

_____

Other issues arising or recommendations

NAME AND SIGNATURE OF PANEL MEMBERS

1. _____ _____

2. _____ _____

3. _____ _____

DATE: _____

Decision Making Process

Criteria	Issues to consider	Comments – *for* discharge	Comments – <u>against</u> discharge
Is the patient suffering from a mental disorder of a nature or degree to require medical treatment in a hospital? Is a Learning disability accompanied by abnormally aggressive or seriously irresponsible conduct?	• Specific diagnosis • History of conduct • Nature of incidents resulting in detention • Length of illness • Severity of illness • Recent symptoms; current level of functioning • History of compliance with medication / treatments and response to treatment		
What is the evidence that detention is required for the patient's health or safety? What is the evidence that detention is required for the protection of others?	• History of absconding • Extent of insight • Nature of recent incidents of self-harm and neglect • Extent of vulnerability • History of exploitation by others • Nature of recent incidents of harm to others, harm includes psychological as well as physical		
What is the evidence that appropriate medical treatment is available?	• Proposed treatment; is there an appropriate package of treatment? • Evidence that the patient's mental condition will deteriorate if treatment is not received • Patients attitude to treatment • Alternatives to hospital? • Effect of medication and other forms of treatment		
Have the five guiding principles been considered?	• Purpose – Undesirable effects of Mental Disorder are minimised • Least restrictive option • Respect – Due recognition has been give to race, religion, culture etc • Participation – Patient and Family views have been taken into consideration • Resources for the patient's need are used in most efficient and effective way		
Current Risk Assessment	• Recent incidents		

Decision Making Process – Guidelines for Use

The proforma is intended to help the objectivity of the decision making process and the recording of these decisions

- All managers should complete the form during the hearing and compare notes afterwards.

The top portion of the proforma focuses on the conditions necessary to continue detention.

- The criteria are taken from the Managers' Decision Form
- The issues to consider are examples of the most common areas that will inform decision for each criterion. This is not an exclusive list.
- The evidence boxes can be filled in during the course of the hearing or afterwards from your own notes with specific facts and views. A balance of clear evidence in the left hand column indicates lifting the section.

The '**Five Guiding Principles'** should be considered when making decisions about a course of action under the Act. These should inform decisions, they do not determine them. The principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

There must always be an assumption that the patient has capacity with regard to each specific decision unless proven otherwise.

Decision Making Process – CTO

Criteria	**Issues to consider**	**Comments – *for* discharge**	**Comments – <u>against</u> discharge**
Is the patient suffering from a mental disorder of a nature or degree to require medical treatment? Is a Learning disability accompanied by abnormally aggressive or seriously irresponsible conduct?	• Specific diagnosis • History of conduct • Nature of incidents resulting in detention • Length of illness • Severity of illness • Recent symptoms; current level of functioning • History of compliance with medication / treatments and response to treatment		
What is the evidence that detention is required for the patient's health or safety? What is the evidence that detention is required for the protection of others?	• History of absconding • Extent of insight • Nature of recent incidents of self-harm and neglect • Extent of vulnerability • History of exploitation by others • Nature of recent incidents of harm to others, harm includes psychological as well as physica		
Can the treatment be provided without continued detention in hospital? Is it necessary for the RC to be able to recall the patient?	• Extent of insight • Extent of vulnerability • Attitude and compliance with treatment • Social circumstances on discharge • History of exploitation by others • Nature of recent incidents of harm to others, harm includes psychological as well as physical		
What is the evidence that appropriate medical treatment is available?	• Proposed treatment; is there an appropriate package of treatment? • Evidence that the patient's mental condition will deteriorate if treatment is not received • Effect of medication and other forms of treatment		
Current Risk Assessment	• Recent incidents		

Decision Making Process – Guidelines for Use

The proforma is intended to help the objectivity of the decision making process and the recording of these decisions

- All managers should complete the form during the hearing and compare notes afterwards.

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- The issues to consider are examples of the most common areas that will inform decision for each criterion. This is not an exclusive list.
- The evidence boxes can be filled in during the course of the hearing or afterwards from your own notes with specific facts and views. A balance of clear evidence in the left hand column indicates lifting the section.

The '**Five Guiding Principles'** should be considered when making decisions about a course of action under the Act. These should inform decisions, they do not determine them. The principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

There must always be an assumption that the patient has capacity with regard to each specific decision unless proven otherwise.

Appendix 3

Guidelines for Hearings- Nearest Relative request to discharge.

A detained patient's Nearest Relative (NR) can request discharge from section at any point during a patient's detention, however this can be barred by the Responsible Clinician (RC). If the request is denied the MHAM should consider holding a hearing on receipt of the barring order (Form M2).

If a patient is subject to detention under section 2 there is no right of appeal by the NR to the Tribunal therefore we must hold a review hearing If a request to discharge is barred, this should be held within 7 days of the barring order where practicable. However, in respect of a section 3 patient the NR is entitled to appeal to the Tribunal Service to review the criteria for detention, if the NR does appeal to the tribunal the right to appeal a decision is satisfied, therefore a MHAM hearing does not need to be held. If they do not appeal to the Tribunal steps will be taken by the MHA office to ensure a hearing is held within 7 days from the expiry date of their right to appeal to the Tribunal

Although a MHAM hearing may be generated due to a request by a NR to discharge a patient it is **NOT** a hearing for the NR as they are not the person detained. The purpose of the hearing is to ascertain all the facts and consider all evidence whether this is from the NR or the patient, and/or their representatives.

The conduct of a hearing generated by the barring of a request to discharge a patient will alter only by the facts that there is an additional criterion, "dangerousness" and that the NR may have legal representation. The MHA office will advise the NR that they can have legal representation and will supply a list of accredited solicitors for them to consult with if they require this.

MHAM should be aware that there may be a conflict of interest if both the patient and NR have elected to have the same legal representative. In situations like these the MHAM should advise the legal representative, prior to the hearing, of a concern that there may be a conflict, however if assured that there is no conflict should continue with the hearing. If, during the hearing, there appears to be a conflict of interest the MHAM could adjourn for a short period of time to allow the legal representative to speak to both clients to ascertain their instruction.

Please note that the Law Society have their own code of conduct so should a legal representative believe that there is a conflict of interest they should request an adjournment, where appropriate, if they believe there may be a conflict.

During the course of the hearing all parties should be given an opportunity to speak and both the NR and patient's legal representative should be allowed to question/cross examine the professionals in respect of the evidence given. It is for the Chair of the panel to ensure, at outset, that all are aware of what the order of questioning will be and to control this should boundaries become blurred.

When recording the decision the panel must ensure that adequate evidence is recorded in respect of the "dangerousness" criteria, regardless of whether it supports or refutes the evidence given.

Appendix 4

Guidance Note from Mental Health Legislation Dept For MHA Hospital Managers. July 2016

Dangerousness

An order for discharge by the nearest relative can be barred by the responsible clinician if they certify that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to themselves.

'likely to act' – There are different degrees of likelihood, varying from "more likely than not' to 'may well' happen. It is submitted that 'likely' is to be used in the sense of 'could well happen'

In the context of a person being dangerous to others, the *Butler Committee* equated "dangerousness with a propensity to cause serious physical injury of lasting psychological harm".

There is no requirement for the risk of dangerousness to be an immediate risk, a patient with a history of becoming dangerous some time after ceasing to take medication would therefore be covered.

The dangerousness test could also be satisfied if it was considered that it was likely that the patient, if discharged, would suffer serious harm to his physical and/or mental health through self neglect or the neglect of others.

If the managers override the report certifying dangerousness, this is a strong pointer in favour of discharge, it is not however, an inflexible rule that in every case the managers must discharge it they overturn the finding of dangerousness. MHA Managers must consider whether to exercise their residual power if the grounds for continued detention are satisfied and there is evidence to suggest that the patient's health would be significantly compromised if they were to be discharged.

Our Values

Welcoming Kind Positive Respectful Professional