AHM hearings policy (Ref tbc) - Appendix A

Sussex Partnership NHS
NHS Foundation Trust

Associate Hospital Managers'

Hearings Protocol and Resource Pack

Version	Version date	Review date	Author
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Contents

1	Duties and Functions of Hospital Managers	Click to return to contents page

(See also Code of Practice, chapters 30 and 31)

Under the Mental Health Act, the term “Hospital Managers” describes the body that is in charge of a hospital, for example a NHS trust. Hospital Managers are responsible for detaining and treating people under the Mental Health Act; for making sure the law is used properly and for ensuring that patients who are detained and treated under the Act are fully informed of their rights. For the most part, Hospital Managers do not have to perform their functions personally, but may delegate them to officers (i.e. members of staff) and, in some cases, to other people.

The Hospital Managers may delegate their power of discharge from detaining section to panels made up of people appointed specifically for the purpose, who are not officers or employees of the organisation concerned. These people are called Associate Hospital Managers.

The Role of the Associate Hospital Manager

Sussex Partnership NHS Foundation Trust ("the Trust") currently has a team of 17 Associate Hospital Managers. These independent volunteers are recruited and trained specifically by Sussex Partnership to carry out the following key duties:

- To sit as members of a panel to consider appeals from patients who are detained under the Mental Health Act, or who are subject to a Community Treatment Order.

- To review, as a member of a panel, when a patient already detained or on a Community Treatment Order has had their section renewed or extended.
- To review, as a member of a panel, an application from the nearest relative of a detained patient that the patient be discharged.

The Trust retains the responsibility for the performance of all Hospital Managers’ functions exercised on its behalf and must ensure that the people undertaking delegated duties and functions on their behalf are competent to do so.

To this end, Associate Hospital Managers are required to complete a full induction programme prior to commencing their duties and, on an ongoing basis, to attend quarterly practice development sessions and contribute fully to regular reviews. Attendance at AHM Forums will be discussed with individual AHMs as part of the Review and Reappointment process.

The Trust has appointed a Mental Health Act Committee as a sub-group of the Trust Board to monitor and review the way the functions under the Act are exercised on its behalf. This Committee meets quarterly and includes a number of Associate Hospital Managers as its members.

2	Responsibilities of the hearing clerk	Click to return to contents page

Hospital Managers' hearings are clerked by a Mental Health Act Co-ordinator whose responsibilities are outlined below.

During the Covid-19 pandemic all types of hearings are held on a secure virtual platform (Go to Meeting). AHMs are to be provided with a secure nhs.net email account to enable reports to be emailed to them securely.

2.1 Virtual hearings

Preparation in advance
Set up the virtual hearing and circulate the meeting link to all attendees.

Establish whether the patient wishes to attend, whether the patient wishes a relative or friend to attend and the patient has invited them to the hearing.

If an observer wishes to attend obtain the consent of the patient and the Chair of the Hospital Managers panel.

Ensure all reports are received and emailed to the AHM panel to their nhs.net email account.

Complete the Hospital Managers Review of Detention form - Part 1.

Ensure feedbacks are prepped and ready for AHMs, patient and professionals, as applicable.

Preparation on the day

Ensure the Hospital Managers Review of Detention form - Part 1 is ready for review, along with any other required forms, such as completed H5 renewal or CTO7 extension forms.

Ensure the MHA office mobile is fully charged and switched on to enable the AHMs to contact the clerk by phone if needed.

Pre Hearing
Open the meeting link to access the hearing.

Ensure all AHMs log in to the meeting link as scheduled. Where an AHM does not log-in, attempts should be made to contact the AHM.

For all hearings the clerks will share and go through the housekeeping rules to support an effective and efficient hearing. This is standard practice

Ensure AHMS are aware and have noted the instructions within the Welcome and Housekeeping slides should they get disconnected - this instruction applies to everyone in attendance.

Display and go through the current H5/CTO7 statutory form(s) and the Hospital Managers decision form - Part 1 with the panel.

The Hearing
The attendees will log on at the specified time (noted in the email correspondence sent) and if the AHMS require further time for discussion, the attendees will be informed and put into a virtual waiting area.

For all hearings the clerks will share and go through the housekeeping rules to support an effective and efficient hearing. This is standard practice.

Ensure professionals are aware and have noted the instructions within the Welcome and Housekeeping slides should they get disconnected - this instruction applies to everyone in attendance.

Once the hearing starts, the clerk will not be actively involved, but will remain online in case of any queries. If any issues arise during the hearing on which the panel consider they require advice, the Chair should indicate this to the clerk.

Decision making / after the hearing
When all the evidence has been heard, the attendees, including the patient, will be asked to leave the virtual hearing and return at an agreed time to hear the verbal decision. If the patient is willing and able they will return to the virtual hearing room with their legal representative and primary nurse/care co-ordinator to hear the decision.

While the Hospital Managers are deliberating, they may seek advice from the clerk.

It is not the role of the clerk to make the decision for the panel, but the clerk has a responsibility to ensure that the panel has given full reasons for its decision.

The Hospital Managers Review of Detention form - Part 2 will be displayed on screen by the clerk, who will type the decision based on verbal information provided by the panel. The Clerk will confirm the panel were in attendance by virtual link and agree for their electronic signature/printed name to be added as confirmation of agreement of the typed decision.

Where the decision is made to discharge the section, the clerk will also display on screen the Section 23(4) discharge form and complete/sign it on behalf of the AHM panel. The Clerk will confirm the panel were in attendance by virtual link and agree for their electronic signature/printed name to be added as confirmation of agreement of the decision to discharge.

Support the completion of the AHM feedback form. Send this to the Information and Quality Manager.

If the clerk has any concerns regarding the decision/process they must advise their line manager as a matter of urgency.

At the end of the process, the clerk will ensure that the following paperwork is completed:

- Hospital Managers Review of Detention - Part 2
- Section 23 (4) form signed if the patient is to be discharged. The Clerk will confirm and agree for the AHMs electronic signature/printed name to be added to this form

Associate Hospital Managers should ensure that all reports and additional paperwork emailed to them for the hearing are deleted from their nhs.net inbox and recycle bin and any notes taken are destroyed accordingly.

The clerk will send a copy of the Hospital Managers Review of Detention Parts 1 and 2 to the patient, solicitor and Nearest relative (with patient consent). An electronic version will be uploaded to Carenotes (MHA tab), and the clinical team alerted.

2.2 Paper review

A paper review hearing will be held as a virtual hearing.

All the above provisions and supports will apply, save for the absence of attendance by the patient and clinical team.

In addition to the documentation outlined above the clerk will provide the AHM panel with the following:

- Capacity assessment statement confirming the patient has capacity to make this decision (completed by the RC).
- Signed statement from the patient confirming they wish the hearing to go ahead as a paper review.
- Telephone contact details of the relevant clinicians/professionals should the panel request further information during the review.

2.3 Face to face hearings

Preparation in advance

The Clerk should:
Establish whether the patient wishes to attend, whether the patient wishes a relative or friend to attend and the patient has invited them to the hearing.

Complete the Hospital Managers Review of Detention form - Part 1 and make available to the Chair along with any other required forms, such as section papers, completed H5 renewal or CTO7 extension forms and access to Carenotes if required.

Set up the hearing room and make arrangements for refreshments.

If additional people are observing the hearing, obtain the consent of the patient and the Chair of the Hospital Managers panel.

Ensure all reports are received and on arrival, provide copies of report to the panel.

Ensure feedback forms are prepped and ready for AHMS, patient and professionals, as applicable.

Preparation – as panel members start to arrive at the hearing

Panel members should arrive 1 hour before the start of the hearing to allow for reading and discussion of reports and to formulate questions.

Where the hearing is for a CTO patient, the panel members should arrive 30 minutes before the start of the hearing to allow for reading and discussion of reports and to formulate questions.

If panel members have not arrived by half an hour before the start time, the clerk will contact them to check they are on their way. The clerk will also check that other attendees have arrived and are ready for the start of the hearing.

The clerk must make available, if required, the information below:

- Section 23(4) discharge forms
- Hospital Managers hearing protocol and resource pack (digital format)
- Medication information (link in Appendix E of Protocol & Resource pack)
- Code of Practice to the Mental Health Act 1983

The Hearing

When the panel is ready, the clerk directs attendees into the room and to their seats. The clerk will balance the need for the patient to be supported by their legal representative/IMHA against the need for the patient to receive nursing support during the hearing. It is usual for the patient to be seated between the nurse and legal representative. The clerk will discuss any risk issues with the attending nurse and solicitor in advance of the hearing, appraise the Chair of any issues identified and agree the final seating arrangements with the Chair.

The clerk does not sit in with the panel during the hearing, but will be working nearby. If any issues arise during the hearing on which the panel consider they require advice, the Chair should adjourn the hearing, ask those attending the hearing to leave temporarily and seek advice from the clerk. Contact details for the clerk will be provided so can easily be contacted.

Decision making / After the hearing

When all the evidence has been heard, the attendees, including the patient, will leave the room. The clerk will ask a representative to be available to hear the decision. If the patient is willing and able they will return to the hearing room with their legal representative and primary nurse to hear the decision. Alternatively, the Chair will offer to visit the ward to advise the patient of the decision (with the patient agreement, and taking into account any risk concerns).

While the Hospital Managers are deliberating, they may seek advice from the clerk.

It is not the role of the clerk to make the decision for the panel, but the clerk has a responsibility to ensure that the panel has given full reasons for its decision.

If the clerk has any concerns regarding the decision/process they must advise their line manager as a matter of urgency.

The decision may be handwritten or typed by the clerk or Associate Hospital Manager (if the clerk has access to a laptop/PC/printer).

At the end of the process, the clerk will ensure that the following paperwork is completed:

- Hospital Managers Review of Detention - Part 2

- Section 23 (4) form signed if the patient is to be discharged.
- Support the completion of the AHM feedback form. Send this to the Mental Health Law Information and Quality Manager

Associate Hospital Managers should pass all reports and notes to the clerk for shredding.

The clerk will send a copy of the written decision and recommendations to the patient, solicitor, professional staff and Nearest relative, if the patient consented to them being invited to the hearing

3	Types of hearing	Click to return to contents page

3.1 Appeal

A patient detained under Sections 2, 3, 37 or a Community Treatment Order may appeal against their detention to the Hospital Managers. Where the Hospital Managers panel consider the patient no longer meets the criteria for detention they can discharge the section.

Patients detained under restricted sections, for example Sections 37/41, may also appeal against their detention to the Hospital Managers, however for these patients the Hospital Managers do not have the power of discharge.

3.2 Renewal/ Extension

Where a responsible clinician renews the detention of a patient subject to Sections 3 or 37, or extends a Community Treatment Order, the Hospital Managers are required to review the detention.

3.3 Barring order

Where a nearest relative has exercised their power of discharge and the responsible clinician has completed a "barring order" preventing that discharge from taking place, the Hospital Managers have a duty to review the detention. See also "Barring order - criteria".

4	Observations at AHM hearings	Click to return to contents page

Clinical/social worker observers

A request may be made for a student or new member of staff to observe a hearing for the purposes of their training and development.

In this instance the observer will be required to remain for the duration of the hearing but will not take part in the hearing or be required to give any evidence - they will be observing quietly from the "side".

In advance of the hearing the clerk will obtain the consent of the patient (and legal representative) and on the day of the hearing advise the Chair of the panel of the observation request and the view of the patient/legal representative.

The Chair of the panel, in consultation with panel colleagues, will determine whether they consent to the observation being permitted.

The observer will need to be aware that the final decision will be made by the Chair of the panel on the day.

AHM observation

As part of an AHM's Review and Reappointment process, a member of the Mental Health Law Senior team will observe the AHM during a hearing.

The member of staff undertaking the observation is not in attendance to support the hearing or provide guidance. The clerk support should be used in the usual way.

The presence of the observer is not subject to the consent of the Associate Hospital Manager panel members.

If the patient is in attendance at the hearing they will be asked if they consent to the observer being present. If the patient does not consent the observation will not go ahead.

Also see the AHM Review protocol.

5	Guidelines for Conducting a Hospital Managers' hearing	Click to return to contents page

This section describes the roles and duties of Hospital Managers (Directors of the Trust) and Associate Hospital Managers in reviewing a patient's detention under the Mental Health Act 1983 (MHA).

5.1 Purpose of a Hearing

The purpose of a hearing is to determine whether a patient's continued detention is justified , i.e. whether the ground for continued detention or continued CTO under MHA 1983 are satisfied. Specifically:

For patients detained for assessment under sections 2 or 4 of the Act:

a) is the patient still suffering from mental disorder?
b) if so, is the disorder of a nature or degree which warrants the continued detention of the patient in hospital?
c) ought the detention to continue in the interests of the patient's health or safety or for the protection of other people?

For other detained patients:

a) is the patient still suffering from mental disorder?
b) if so, is the disorder of a nature or degree which makes treatment in a hospital appropriate?
c) is continued detention for medical treatment necessary for the patient's health or safety or for the protection of other people?
d) is appropriate medical treatment available for the patient?

For patients on CTO:

a) is the patient still suffering from mental disorder?
b) if so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
c) if so, is it necessary in the interests of the patient's health or safety or the protection of other people that the patient should receive such treatment?
d) is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed?
e) is appropriate medical treatment available for the patient?

(Code of Practice 31.15 – 31.17)

If the panel is considering discharging the patient from detention, it should consider the following:

- Will the patient reside in an appropriate environment following discharge?
- Will the patient be able to care for him or herself?
- If not, will the patient receive the necessary care from others?
- If discharged, will the patient be at risk of exploitation?
- What are the concerns of others if the patient is discharged?

The hearing must be fair and this fairness is best achieved by having the patient accompanied or represented either by a friend/relative, lay advocate, a member of the legal profession or an Independent Mental Health Advocate. It should be based on written reports and verbal evidence, although it is reasonable to take into account the patient's history.

If the patient is not legally represented and there is no IMHA support, it is reasonable for the panel to ask the clinical team the reasons for this.

It is desirable that at least one member of the panel is of the same sex as the patient and, where possible, that at least one panel member is of the same ethnic origin.

With the patient's permission, the nearest relative will be invited to attend the hearing and/or submit any written information they wish to put before the panel.

5.2 Before the Hearing

Virtual hearings

Maintaining patient confidentiality is important. All persons involved in a virtual hearing, including the AHM panel, are responsible for ensuring they are located in a room that ensures the hearing cannot be overheard and their screen cannot be overlooked by others.

The panel should access their nhs.net email account and read the reports sent to them by the MHA office.

At the specified time they should access the virtual hearing room using the meeting link provided.

If there are difficulties accessing the meeting room link they should contact the relevant MHA office (preferably) by telephone or email.

Face to face hearings

The panel should arrive and report to the unit reception desk at the agreed time (1 hour before a s.3/37 appeal/renewal and 30 minutes before a CTO appeal/extension hearing. This allows the panel time to read the reports that will be provided to them by the clerk.

Attending at the specified time will allow the panel to

- discuss key points from the reports.
- discuss and agree whether to uphold any requests from a report author to "not disclose" a report to the patient. This information must be submitted by the report author on a separate page clearly marked "**Not for Disclosure**" and outline why it is believed that disclosing the information would be detrimental to the patient or others. The legal representative should be given both the report and the confidential attachment. However, it is for the panel to decide whether or not the information should be disclosed to the patient or other named party.

  The panel decision and the reasons for this should be recorded on the "AHM hearing - Not for Disclosure" form.
- scrutinise other documentation provided by the clerk (such as renewal/extension forms)
- review the criteria relating to the hearing,
- agree specific questions to be asked
- check the patient has been given opportunity to read the reports prior to the hearing.
- ensure the reports have been distributed to all other relevant parties.
- ensure that all parties to the hearing are available and will be in attendance.
- review any requests for observers to attend.

- resolve any other pre-hearing issues with the clerk.

5.3 Conducting the hearing

The conduct of the hearing is managed throughout by the Chair. The proceedings are confidential to those present.

Every effort should be made to achieve a proper balance between informality and the gravity of the situation. A hearing can be an ordeal for patients, who should be put at ease as much as possible. All participants should be welcomed and introduced and undue delay should be avoided.

Every help should be given to the patient (or their representative) to explain the nature of the hearing and help them explain why they wish to be discharged.

If it appears that the patient is not actually requesting discharge, he/she should be encouraged to explain what outcome they want from the hearing, for example extended s17 leave, transfer from one ward to another or change in Responsible Clinician, etc.

Interviewing all in the presence of each other has the benefit of natural justice, allows a frank exchange and challenge of views and may – if undertaken correctly – have therapeutic advantages and is in compliance with the Human Rights Act.

If the panel agrees to speaking to any professional involved in the case or the patient's nearest relative before or after the hearing, then the panel must ensure that the patient's legal representative and the Mental Health Act Co-ordinator are also present.

Requests for private meetings should only be made in exceptional circumstances and where there is a genuine belief that the information to be discussed would cause great distress and/or deterioration in the patient's mental condition. However, it is considered acceptable for discussion to take place with the professionals without the patient present prior to the hearing to decide on matters of process relating to the hearing as opposed to specific details of the case itself.

If the circumstances warrant it, the panel may decide to adjourn the hearing. An explanation must then be given to all participants, the reasons for the adjournment documented and, where possible, a specific date provided for reconvening. If possible, and where appropriate, the same panel members are to be used to ensure continuity.

5.4 Questioning Patients, Professional Opinions/Recommendations

The importance of the following should be noted:

- Impartiality, ie weighing patients' views against staff opinion;
- The need to distinguish between hearsay/opinion and fact;
- Consideration of conflicting opinions of professionals, with a view to reaching, if possible, a balanced judgement;
- Using active and positive questioning but avoiding an adversarial style.
- The need for accuracy and evidence, for example the statement "This patient is a fire risk" should be examined in terms of how many episodes have occurred, when, how, why and the future prognosis in the matter;

5.5 The Criteria for Continued Detention

In deciding whether to discharge the patient from detention, the panel must judge whether the criteria for detention continue to be satisfied. The criteria are;

a) Admission for Assessment (section 2)

An application made for admission for assessment for up to a maximum of 28 days may be made in respect of a patient on the grounds that;

- He is suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; **and**
- He ought to be so detained in the interest of his own health or safety or with a view to the protection of other persons.

Section 2 is not renewable. If it is considered necessary to detain a patient beyond 28 days then the patient would normally be assessed for detention under s3 (admission for treatment).

b) Admission for Treatment (section 3)

An application for admission for treatment, for up to a maximum of 6 months in the first instance, may be made in respect of a patient on the grounds that;

- He is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and it is necessary for the health or safety of the patient or for the protection other persons that he should receive such treatment and it cannot be provided unless he is detained under this section and appropriate medical treatment is available for him.

Section 3 is renewed for a further six months period and annually thereafter.

c) The Grounds of Continued Detention (section 20) – Renewal of s.3

If it appears to the RC that the above grounds are satisfied he/she must furnish a report to the Hospital Managers (form H5) stating that in his/her opinion it is necessary to continue to detain the patient for his/her own health or safety or for the protection of others.

The criteria for continued detention are the same as those for detention under the original s3.

d) Hospital Order (section 37)

Either the Crown Court or magistrates court can impose a hospital order. It is usually given after conviction. The effect is largely the same as an admission under s3, as are the criteria for continued detention under s37.

The court directs the admission of the offender to a named hospital for an initial period of up to six months. The grounds for detention are;

- The offender is suffering from mental disorder and that either

i) The mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him, or

ii) In the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and

Once in hospital the order runs like a s3 in all respects except that of relative/patient appeals for discharge to the Mental Health Tribunal, which can only be made during the **second six months** of detention and during each subsequent renewal period thereafter. However, a patient under s.37 can apply to the Hospital Managers for their case to be reviewed as often as he/she likes.

Renewal of section 37 is as section 3.

e) Community Treatment Order (section 17A)

This section enables an application for a CTO to be made by the patient's Responsible Clinician, with the agreement of an Approved Mental Health Professional. The patient must already be subject to detention under Section 3 or is subject to an order under Part III without restrictions.

The criteria for continuation of the CTO:

- The patient must be suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
- It must be necessary for his health or safety or for the protection of other persons that he should receive such treatment;
- Subject to his being liable to be recalled, such treatment can be provided without his continuing to be detained in a hospital;
- It is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospital;
- Appropriate medical treatment must be available.

Section 17A (Community Treatment Order) is extended by the responsible clinician for a further six months period and annually thereafter by the completion of Form CTO7.

f) Barring Order (section 25)

If a Responsible Clinician opposes the request by a Nearest Relative for a patient's discharge from section, he or she does so by certifying that the patient, if discharged, would be likely to act in a manner dangerous to himself or others.

When considering a barring order the Hospital Managers must also set out that they have considered the fourth question above in relation to dangerousness. In the case of Hussey it was made clear that even when the Hospital Managers decide that the first three questions can be answered in the affirmative, if they are not persuaded by the barring report relating to dangerousness then this would mean in almost all circumstances that the Hospital Managers should discharge the patient. However, where the Hospital Managers override the Responsible Clinician's decision on dangerousness, they must consider whether to exercise their residual discretion not to order discharge where the grounds for continued detention are satisfied and there is evidence to suggest that the patient's health would be **significantly** compromised if he / she were to be discharged.

5.6 The Process and Criteria for reaching a decision

The panel should reach a decision on its own, although the Mental Health Act Co-ordinator will be in attendance and will provide advice and assistance on the law. It is entirely for the panel to reach a decision regarding the patient's continuing detention.

The panel's decision must be **unanimous**. Should this prove initially not to be possible, the Chair must ensure that the evidence concerning the specific difficulty is carefully re-examined and, if necessary and where possible, witnesses recalled either to amplify or explain the relevant parts of their evidence.

If after further discussion there is still disagreement which cannot be resolved, the hearing should be adjourned and a further hearing convened with a new panel as quickly as possible.

If the panel agrees that more information needs to be provided to enable it to reach a decision, then it should consider adjourning and specify on the Hearing Decision form what information is to be provided for the reconvened hearing.

The panel will need to reach a decision on the following questions;

- Is the patient suffering from a mental disorder of a nature **or** degree which makes it appropriate for him/her to receive treatment as a hospital in-patient?

- Is it necessary for either the health or safety of the patient that he/she receive treatment as a hospital in-patient?

- Is it necessary for the protection of other persons that he/she receive treatment as a hospital in-patient?

- Is the patient's detention as a hospital in-patient the only appropriate and available way of ensuring that he/she receives their treatment? Is it the less restrictive option?

- Is appropriate medical treatment available for the patient?

- Would the patient be willing to remain in hospital as an informal in-patient if the section was discharged?

- Would the patient continue to take their medication if they were discharged from section and became an informal patient?

- What arrangements have been made, or are being made, for the patient's aftercare if they were to be discharged? If none have been made, why is this the case? Where possible aftercare arrangements must be made before a hearing. The presence or absence of suitable aftercare arrangements may affect whether or not the patient may safely be discharged.

The decision, and the reasons for it, should be relayed verbally to the patient, usually by the Chair of the panel, immediately following the decision. The outcome of the appeal must be recorded on the Hospital Managers - Review of detention form, a copy of which is sent to the patient, the nearest relative (if informed of the appeal), legal representative and care team. The original Hospital Managers - Review of detention form will be uploaded to Carenotes by the clerk.

If the patient is not discharged they should be reminded of their right to enter further appeals to the Hospital Managers, and where appropriate, to the First Tier Tribunal (Mental Health).

Matters of concern should be recorded on the Associate Hospital Managers' Feedback form and passed to the Mental Health Act Co-ordinator.

6	Questions to consider during hearings	Click to return to contents page

Section 2

- Is there a mental disorder?
- What is its nature or degree?
- What is the purpose of the assessment?
- What has happened and is to happen during assessment?
- Does assessment need to be in hospital?
- If in hospital, does it need to be under the MHA?

Sections 3 and 37

- Is there still a mental disorder and what is it?
- If there is a disorder what now is its nature or degree?
- What is the medical treatment?* What has already been achieved and what is still to be achieved?
- Is the treatment actually in hospital? Why can't the treatment be provided as an informal patient or in the community?

  *- "medical treatment" includes nursing care, psychological intervention, habilitation, rehabilitation and care.

Sections 2, 3 and 37

- What is the health 'benefit' of detention?
- Does this 'benefit' outweigh any negative health effects?
- Is the patient's own safety an issue? What exactly has happened or might happen?
- Is the protection of others an issue? What exactly has happened or might happen?
- Would discharge from section result in the patient continuing to be deprived of their liberty but without the benefits of a legal framework in place, ie de facto detained?

Section 17A (Community Treatment Order)

- Is there still a mental disorder and what is it?
- What is the health "benefit" of remaining subject to the CTO?
- Is the patient's own safety an issue? What exactly has happened or might happen?
- Is the protection of others an issue? What exactly has happened or might happen?
- Can the treatment continue to be provided in the community without the continuing need for detention in hospital?
- Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, and if so why?
- Is appropriate medical treatment available for the patient?

Key points to consider

- Consider whether your question is directly relevant to the whether the patient meets the criteria for continued detention.

  For example if the reports refer to the patient suffering abuse, it may not be relevant or appropriate to ask questions about the abuse. Where there are concerns about ongoing vulnerability if the patient were to be discharged from section, phrase the question carefully and be mindful of the impact of the question on the patient (if they are present in the hearing).

- Be careful not to disclose information contained in a "not for disclosure" report that the panel have agreed to withhold.

- It is appropriate to question the appropriateness of treatment, and the patient's compliance and progress in the context of whether continued detention is necessary.

  However your role is not to challenge the appropriateness of the diagnosis or medication, even where you may have medical/clinical knowledge/qualifications.

7	Responsibilities of the Panel Chair	Click to return to contents page

This section sets out the key duties of the Associate Hospital Manager chairing the hearing panel.

7.1 Prior to commencement of the hearing

The Chair should:

- Check that all Associate Hospital Managers have all the required reports..
- If any reports are marked “Not for Disclosure”, decide whether or not to uphold the request, completing the “Not For Disclosure” paperwork as appropriate with support from the Mental Health Act Co-ordinator clerking the hearing.
- Check whether there is any conflict of interest between panel members and any other parties to the hearing.
- Ensure a pre-hearing discussion takes place, which should include the division of question topics amongst all three panel members.
- Check with the Mental Health Act Co-ordinator whether the patient requires access to any necessary aid, for example an interpreting service.

7.2 Conduct of the hearing

The Chair should:

- Manage the process of the hearing.
- Ensure a good balance between informality and the gravity of the task.
- Introduce panel members to all parties and ask the parties to introduce themselves.
- Inform the patient that the Managers are independent of the Trust.
- Ensure that questions and responses remain focussed on the criteria relevant to the hearing.
- Give the patient ample opportunity to explain why they wish to be discharged.
- Ensure the patient is aware that they may remain or leave at any time

7.3 Fairness and Procedure

The Chair should ensure that the following is observed:

- That the legal representative and clerk are also present if the panel agrees to speak to any professional, Nearest Relative or other attendee in private.
- The patient/relative can be excluded, but only in exceptional circumstances, where it is demonstrated that the information would adversely affect the health or welfare of the patient or others. Where a decision is made to exclude someone from the hearing this should be recorded on the Hospital Managers - Exclusion from hearing form.
- It is acceptable to meet with a professional without the patient present, where it is necessary to decide on matters of process rather than specific details of the case.
- The patient should be offered the opportunity to speak to the panel alone with their legal representative. The Mental Health Act Co-ordinator must remain present throughout this discussion.

7.4 Obtaining and assessing the evidence

The Chair must ensure the following:

- The panel is impartial.
- The panel uses active and positive questioning.
- The panel distinguishes between hearsay / opinion and hard fact.
- Vague statements are clarified and examined.
- The risk of self harm or harm to others is quantified.
- Conflicting professional opinions or considered with a view to reaching balanced judgments.
- The variability of a patient's mood and behaviour is taken into account.
- The patient's wishes are taken into account.

7.5 At the end of the hearing

The Chair should:

- Inform all parties that the panel will discuss the evidence presented and make its decision in private (with the Mental Health Act Co-ordinator present).
- Request that the patient (if they attended the hearing), legal representative and a representative of the Trust return to hear the verbal decision.
- For virtual paper review hearings the clerk will type up and distribute the decision to the patient and others and ensure the clinical team are notified of the decision

7.6 Reaching the decision and completing the decision form

The Chair should:

- Seek the views of both non-chairing panel members as to whether or not the criteria are met in the patient's case, bearing in mind that the decision must be unanimous.
- Ensure that the reasons given on the decision form accurately reflects the decision of all three panel members. For this reason, all three panel members must remain until all documentation is completed.

7.7 Communicating the decision

The Chair should:

- The decision should be shared with the patient, and at least one member of the hospital staff.
- In cases where the patient does not wish to return to hear the decision, and where the patient consents, visit the patient on the ward to communicate the decision to the patient (face to face hearings only).
- If the patient does not attend the hearing and does not wish to return to the hearing room/virtual hearing room for the decision, the decision can be given to them by a member of their clinical team.
- If the patient is not discharged, remind them of their right to lodge a further appeal (if applicable and to be checked with the clerk).

8	Writing Decisions	Click to return to contents page

The Code of Practice advises that, following a review of detention by the Hospital Managers, "*the decision ….. and the reasons for it should be recorded"* and that decision should be communicated immediately both orally and in writing to the patient. This section has been prepared to assist with what should be considered before writing such decisions.

8.1 Principles

- The panel should use a structured approach to making its decision.
- All panel members should have an equal say in what is found to be "fact".
- Panels should agree the basis for their decision based on a clear identification of the issues.
- Areas of agreement and disagreement between parties should be identified on such issues as the existence of mental disorder, its nature or degree and whether the patient could receive appropriate treatment without detention.
- Evaluation of witnesses and their statements should consider the nature and quality of their evidence and whether second or even third hand accounts are included. Consider their credibility. Identify conflicts within accounts. Which evidence is preferred and why?
- The standard of proof in these cases is the balance of probability.
- Apply the law – statutory criteria / discretionary power / recommendations.
- Formulate the decision, taking each aspect of the criteria in turn.
- Record the decision reflecting the process followed.

8.2 Reasons

In simple terms, people will not feel that they have been fairly treated if it is not apparent to them why one part has "won" and the other "lost". They need to know what the panel has decided and why. Providing reasons also concentrates the minds of those on the panel about what has really been discovered. The issues are serious because they lead to decisions about a person's liberty.

8.3 Written Reasons

The written reasons for the decision must be recorded on the Hospital Managers Review of Detention form - Part 2.

Reasons need to be based on the relevant evidence – what has been accepted or rejected and, particularly if there is a conflict, why this is the case. Statements about undisputed issues can be relatively brief with more room for emphasis on what is disputed. For example, a patient will often agree that he / she is ill but assurances about levels of co-operation may be more contentious.

Written reasons should be in a style which is clear, intelligible and structured and avoiding the use of jargon.

In writing a decision, the following suggests some statements which may prove useful:

- Record whether or not the patient attended the hearing:
  "The patient attended throughout the hearing".

- Describe the history of illness and the current episode:

"She was detained following deterioration in her mental state at her home address, having been discharged from hospital just two months previously. She had been acting aggressively towards neighbours and shouting in the street at various times of the day and night".

- Consider evidence about nature or degree:
  "The patient suffers from chronic treatment resistant paranoid schizophrenia exacerbated by periods of substance misuse. It was evident to the panel during the hearing that she is still experiencing symptoms. She described a young female voice which tells her to harm herself. This was corroborated by Dr Stevens and the nurse who reported that they had heard her arguing with this voice".
- Compliance with treatment:
  "The patient was described as generally compliant with medication on the ward but the panel accepted Dr Stevens' evidence that there had been insufficient time to stabilise her condition and that in her current mental state her co-operation fluctuated and she could not be relied upon to take medication if she were not detained in hospital".
- History of co-operation with treatment on a voluntary basis:
  "The social worker described occasions in the community when considerable persuasion had been required to achieve compliance and that this had not always succeeded".
- Insight:
  "Whilst the patient accepts that she has an illness, the panel were not convinced that she is fully aware of the seriousness of her current situation".
- Capacity:
  "The patient states a willingness to remain in hospital and take medication / accept treatment. The capacity test undertaken by Dr Stevens shows that she lacks capacity to make those decisions. Having considered the evidence it is apparent that it would not be possible to treat the patient without de facto detention should she be discharged from section".
- If not accepting assurances, why not?
  "Although the patient said that she would do all the care team asked of her, following the evidence from the social worker of non-compliance, the panel was concerned that the voice would remain more powerful and that without the security of the section she would soon revert back to former ways and become uncooperative in the community".
- Nature or effectiveness of treatment:
  "The panel considers that the treatment proposed reflects the in-patient treatment plans of previous admissions. This treatment plan was successful in the past and the care team is confident that it will be again and they wish to discharge her into the community as soon as she is stabilised sufficiently".
- Aftercare and home / community circumstances:
  "A care plan is available which indicates an appropriate level of support available outside hospital, but work is needed on her flat to make it safe for occupation at the current time".
- Health or safety of patient or others:
  "While there is no evidence that the patient is a genuine risk to others, the panel was concerned for her own safety in her current state and especially concerning the demands of the voices she admits to hearing".
- Recommendations:
  "The panel would like to see the patient being offered an opportunity to make an accompanied visit to her flat to collect some of her belongings, which she clearly feels are important to her recovery".

Appendix A	A brief guide to the Mental Health Act	Click to return to contents page

A mental disorder – any disorder or disability of the mind.

Section 2
Detention allowing a patient's mental state to be assessed for up to 28 days. Not renewable, but patient can be placed on section 3 (below). Treatment for mental disorder can be administered without the patient's consent but see Section 58A (below).

Section 3
Detention allowing a patient to receive treatment for mental disorder in hospital. Treatment for mental disorder can be administered without the patient's consent for the first 3 months under section 63 (below) but see section 58A (below). Initial duration is 6 months, but can be renewed by the patient's Responsible Clinician (RC) for a further 6 months, and annually thereafter.

Section 4
An emergency provision allowing a patient who meets the criteria for section 2 to be admitted quickly where there is evidence that delay would cause a significant risk of harm and/or serious harm to property and/or the need for physical restraint of the patient. The patient is admitted to hospital on the basis of one medical recommendation and 72 hours is allowed for a second medical recommendation to be completed which converts the section 4 to a section 2.

Section 5(2)
"The doctor's holding power". Authorises the doctor or approved clinician (AC) in charge of an informal in-patient's treatment to detain them for up to 72 hours for assessment for section 2 or 3.

Section 5(4)
"The nurse's holding power". Authorises a nurse of the prescribed class to lawfully prevent an informal in-patient from leaving the hospital for a period of up to 6 hours or until a doctor / AC in charge of the patient's treatment with the power to use section 5(2) arrives.

Section 37
An order by the court under part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment.

Section 17
Only the Responsible Clinician (or in their absence the acting Responsible Clinician) can authorise a detained patient to be absent from hospital. A patient can be given accompanied, unaccompanied, overnight or escorted leave (under section 17(3)) which puts the detained patient in the custody of the escort. A patient can also be given longer term trial leave if their RC is considering discharging them into a community setting.

Section 17A – A community treatment order (CTO), which allows certain patients to be discharged from detention while remaining liable to recall to hospital for further medical treatment if necessary.

Section 20
Authorises the RC to renew the detention of a patient if they are subject to either section 3 provided they meet the necessary criteria. The hospital managers are required to hold a review whenever a RC renews a patient's detention.

Section 23
Gives the RC, hospital managers or nearest relative the authority to discharge a detained patient from section.

Section 58
Section 58 requires the patient's consent **or** a second opinion from a Second Opinion Appointed Doctor (see below) to continue medication beyond three months from the first administration of medication under detention (see also section 63, below).

Second Opinion Appointed Doctor ("SOAD")
An independent doctor appointed by the Care Quality Commission (CQC) to assess the capacity of a detained patient and approve and authorise their treatment plan in certain circumstances where required.

Section 58A
The administration of electroconvulsive therapy (ECT) **at any time** under detention requires the patient's consent (if they have capacity) and a SOAD certificate. If the patient lacks the requisite capacity, a SOAD must be requested to authorise the treatment, but the SOAD may only authorise ECT where the treatment is appropriate and does not conflict with an advance decision or terms of a Lasting Power of Attorney.

Section 62
Allows for treatment to be administered in an emergency without the patient's consent where the legal criteria are satisfied. It can be used to administer ECT in an emergency or to give medication beyond the first three months of detention.

Section 63
Provides authority for certain detained patients (including sections 2 and 3 but not 4, 5 and 136) to receive certain forms of medical treatment for mental disorder (not coming within s58 and s58A, see below) without their consent for 3 months from the first administration of medical treatment to them.

Section 64
As per Section 62, but for patients subject to a Community Treatment Order (see below).

Section 132 / 132A
Requires the hospital managers to ensure that detained/community patients are informed of their rights both orally and in writing. It also requires the hospital managers to advise the patient's nearest relative of their rights, unless the patient objects to them being contacted. In practice this duty is delegated to ward staff to fulfil in accordance with Trust Policy.

Section 135(1)
Allows a magistrate to issue a warrant to authorise an Approved Mental Health Professional (AMHP) to gain access to a property, with the aid of the police, for the purpose of assessing a person who they believe to be suffering from a mental disorder and is at risk of neglect or unable to care for themselves.

Section 135(2)
Allows a magistrate to issue a warrant to the police, based on information provided by hospital staff, for the purpose of returning to hospital a detained patient who is absent without leave (AWOL). The warrant gives the police authority to enter the premises along with a member of the hospital staff (usually a qualified nurse) and physically remove the patient and return them to hospital.

Section 136
Provides legal authority for a police officer to remove a person from a public place to a place of safety if they believe that person to be suffering from a mental disorder and to be in need of care and control.

Section 117

Places a legal obligation on Health and Social Services to provide after-care free of charge for patients who are detained under Section 3 (amongst others). Where the Tribunal or hospital managers are holding a hearing to consider discharging a patient, discussion of possible after-care arrangements needs to have taken place in advance so that the decision makers can consider the available options.

Barring order

Patients detained for assessment or treatment under part 2 of the Act may be discharged by their nearest relative. Before giving a discharge order, the nearest relative must give the hospital managers at least 72 hours' notice in writing of their intention to discharge the patient. During that period, the responsible clinician 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. When a barring report is completed a Hospital Managers hearing must be convened to review the detention. See "Types of hearing" chapter for process and criteria to be applied by the panel.

Appendix B	AHM hearing forms	Click to return to contents page

	Double click on the pdf icon to open the file.
Hospital Managers Review of detention - Part 1	Hospital Managers - Review of Detention '
Hospital Managers Review of detention - Part 2	Hospital Managers - Review of Detention '
AHM hearing - Not for Disclosure	Hospital Managers - Review of Detention '
AHM hearing - Exclusion from hearing	AHM Hearing - Exclusion From Hearir
Section 23 - discharge form	Hospital Managers - Section 23 v2.2.pdf
AHM feedback form - full hearing	AHM Hearing - Full Hearing Feedback Fo
AHM feedback form - paper review	AHM Hearing - Paper Review Feedback For

Appendix C	The Mental Health Tribunal	Click to return to contents page

See also Code of Practice, chapter 32 and First-tier Tribunal (Mental Health) web page.

First–tier Tribunal (Mental Health)

The First–tier Tribunal (Mental Health) hears applications and references for people detained under the Mental Health Act 1983 (as amended by the Mental Health Act 2007). Tribunal judiciary and members are appointed by the Lord Chancellor. Its jurisdiction covers the whole of England. There are two Regional Tribunal Judges, currently based in London and Preston. There is a separate Mental Health Tribunal for Wales, which is administered and based in Cardiff and a separate Mental Health Tribunal for Scotland.

What does the First-tier Tribunal (Mental Health) do?

The Tribunal is an independent judicial body that operates under the provisions of the Mental Health Act 1983 (as amended by the Mental Health Act 2007). Its main purpose is to review the cases of patients detained under the Mental Health Act and to direct the discharge of any patients where the statutory criteria for discharge have been satisfied.

In some cases, it also has the discretion to discharge patients who do not meet the statutory criteria. These cases usually involve making a balanced judgement on a number of serious issues such as:

- the freedom of the individual,
- the protection of the public and
- the best interests of the patient.

Tribunal hearings are normally held in private and take place in the hospital or community unit where the patient is detained. During the Covid-19 pandemic hearings are held virtually.

The Tribunal's powers are:

- to discharge a detained patient from hospital immediately or after a short further period of detention;
- to recommend leave of absence;
- to recommend a CTO;
- to recommend transfer to another hospital.

Unlike the Hospital Managers, the Tribunal may reconvene and rehear a case if there is failure to comply with their recommendations.

Members of the Tribunal

Tribunal Judges are appointed by the Lord Chancellor. Non legal members are appointed by the Secretary of State for Health or the Secretary of State for Wales. Regional Tribunal Judges determine which members should sit at a particular hearing. Each Tribunal Panel must consist of a Judge and two members – one of which must be a medical specialist.

Role of the Tribunal Members

The Legal Member

The tribunal judge's role is to preside (i.e. take the chair) at Tribunal hearings. His or her responsibilities also include making sure that the proceedings are conducted fairly, that the legal requirements of the Mental Health Act are properly observed and advising on any questions of law which may arise. He or she is also responsible, in consultation with other members of the Tribunal,

for drafting the reasons for the decision, and for signing the record of the decision. The tribunal judges are required to have "such legal experience, as the Lord Chancellor considers suitable". They are normally senior practitioners, but in "restricted patient" cases, must be Circuit Judges, or one of a small number of Recorders, who are also Queen´s Counsel.

The Tribunal Member (Medical)

The tribunal member (medical) has a dual role to perform. The Tribunal Rules also require them to carry out an examination of the patient before the hearing and to take any steps that they consider necessary to form an opinion of the patient´s mental condition. At the hearing, they, together with the other members, have the judicial responsibility of deciding whether or not the patient should continue to be detained. If the member´s opinion of the patient differs significantly from other medical witnesses then this should be made known at the beginning of the hearing. This is because it would be unfair and contrary to a basic principle of natural justice if the Tribunal members were to take notice of information that had not been shared with all the other parties at the hearing. The tribunal member (medical) is invariably a consultant psychiatrist of several years' standing. He or she will be able to advise the other members of the Tribunal on any medical matters.

The Tribunal Member

The member provides balance to the Tribunal as a representative of the community outside the legal and medical professions. Most of them will have a background of practical experience of working in the health and welfare fields in the NHS, voluntary organisations or private health sector.

The Regional Tribunal Judges

There are two Regional Tribunal Judges currently based in London and Preston. The Regional Tribunal Judges responsibilities include:

- Appointing members to particular hearings, ensuring that all the statutory requirements are complied with
- Making judicial decisions and giving such directions as are necessary to ensure the speedy and just determination of every case
- Organising training for members
- Overseeing the members' appraisal and mentoring scheme; and handling complaints about a Member's conduct under the supervision of the Chamber President.

Tribunal Administration

The Tribunal is administered by the Tribunals Service, and the Tribunal administration is undertaken by the Secretariat offices based in Leicester. The Welsh Assembly has similar responsibilities for Tribunals in Wales and administration is carried out at the Secretariat office in Cardiff. All the Secretariat staff are civil servants and are completely independent of the hospital authorities.

The Regional Tribunal Judges and the Secretariat work closely together to make sure that the whole Tribunal process is closely managed. It is important to point out that the Tribunal operates completely independently of all Government Departments.

When can a patient apply to the Tribunal for a hearing?

Patients detained under section 2 of the Mental Health Act (MHA) who wish to appeal to the Tribunal **must do so within 14 days of the start of their detention**. If, between making the appeal and the hearing, the patient is transferred to a section 3, the Tribunal will still hear the original appeal and it will not affect the patient's right to appeal under section 3.

Patients detained under section 3 of the MHA can only appeal to the Tribunal **once in any 6 month period.**

Patients detained under section 37 can only apply to the Tribunal **after the initial 6 months period has elapsed**. Thereafter, their rights of appeal are the same as for section 3 patients.

Does a patient have to apply to the Tribunal in order for a hearing to take place?
Some patients will automatically be referred to the Tribunal even though they did not make an application. In particular, these include:

- Patients detained under section 3 who have not had their detention reviewed by the Tribunal in the first 6 months of detention.
- Patients who have had their detention renewed and have not had a Tribunal hearing in the last 3 years (if aged 18 years or over) or the last 1 year (if aged less than 18 years)
- Patients whose Community Treatment Orders are revoked.

How soon after receiving the application, will a hearing take place?
For patients detained **under section 2** the hearing must take place within 7 days of receipt of the application by the Tribunals office in Leicester.

For non restricted patients the hearing will normally take place within 8 weeks.

For restricted patients the hearing will normally take place within 16 weeks.

Who will be present at the hearing?
The Tribunal Panel is composed of a Judge and two members, one of which will be a medical specialist. The Tribunal Judge will chair the proceedings.

The patient, their hospital doctor and social worker will also be at the hearing. If the patient or their representative has provided full details of the patients nearest relative, then they too will be invited to attend the hearing.

Can the patient appeal against a Tribunal Decision?
The Tribunals Courts and Enforcement Act implemented on November 3rd 2008 gives the parties a right to challenge any decision made on or after this date, providing criteria set out in Part 5 of the Act is satisfied.

Providing pre–hearing medical reports
The Mental Health Act 1983 places a statutory responsibility on the Responsible Authority to provide the Tribunal with a statement for restricted and non – restricted cases (other than section 2) within 3 weeks of receipt of the Tribunal's request.

Section 2 reports, together with copies of the section papers, should be made available to the Tribunal members and patient's representative at least half an hour before the hearing is due to commence. Patients not represented, must also have sufficient opportunity to read the reports before the hearing begins.

In a restricted case, if the opinion of the Responsible Clinician or Approved Mental Health Professional changes from what was in the original Tribunal report(s), it is vital that this is communicated in writing, prior to the hearing, to the Tribunal office and the Ministry of Justice to allow the Secretary of State the opportunity to prepare a supplementary report.

Those responsible for completion of reports are made aware of the statutory timescales and requirements as to the content of Tribunal reports. Social circumstances reports should always contain a post-discharge care plan, if only in skeleton form.

The Human Rights Act leaves Trusts and hospitals vulnerable to challenge where the statutory time scales as to the provision of reports are not met, particularly where the hearing is delayed or adjourned for late or non–receipt of reports. The Regional Tribunal Judge may direct Senior Managers to appear before the Tribunal to explain why reports are late.

Non-disclosure reports
Any document/report not for disclosure to the patient should be annotated clearly and a written explanation attached as to the reasons for requesting non–disclosure.

The Tribunal will consider carefully the request for non–disclosure and all the issues involved before deciding whether to override the wishes of the author of the report. The Tribunal will only agree to non–disclosure where there are compelling reasons to do so, and where they are convinced that "disclosure would be likely to cause that person or some other person serious harm". The Tribunal may give direction that the reports be made available to the patient's representative.

The Mental Health Act 1983 (as amended by the Mental Health Act 2007) places a statutory responsibility on the Responsible Authority to provide the Tribunal with a statement for restricted and non – restricted cases (other than section 2) within 3 weeks of receipt of the Tribunal's request.

Appendix D	Glossary of commonly used terms	Click to return to contents page

AC	Approved Clinician
AHM	Associate Hospital Manager
AMHP	Approved Mental Health Professional
AWOL	Absent Without Leave
CQC	Care Quality Commission
CTO	Community Treatment Order (also known as SCT or Supervised Community Treatment)
DHSC	Department of Health & Social Care
ECT	Electro Convulsive Therapy
Form T2	A statutory Mental Health Act form completed by the Responsible Clinician if the patient has capacity and is consenting to treatment
Forms T3 to T6	A statutory Mental Health Act form completed by the SOAD if the patient lacks capacity to consent **or** if the patient has capacity and is refusing to consent to treatment.
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
MCA	Mental Capacity Act 2005
MHA	Mental Health Act
MHT	Mental Health Tribunal
PMVA	Prevention and Management of Violence and Aggression (approved control and restraint techniques used by a team of trained staff)
RC	Responsible Clinician (Consultant Psychiatrist)
Section 12	Refers to recognition by the Department of Health that a doctor has special experience in the diagnosis or treatment of medical disorder and is thus authorised by the SHA to make recommendations for detention under the MHA.
SOAD	Second Opinion Appointed Doctor from the Care Quality Commission

Appendix E	Key clinical terms explained	Click to return to contents page

Source: the website of the Royal College of Psychiatrists: www.rcpsych.ac.uk

Royal College of Psychiatrists

Problems and Disorders

Support Care and Treatment

Young People's mental health

Appendix F	Associate Hospital Managers' Forum	Click to return to contents page

Associate Hospital Managers are required to attend Associate Hospital Managers' Forum in order to keep their learning up to date and to enable them to contribute fully as a member of a large and active team.

Forum is held quarterly over an afternoon, usually in a central location, and includes a formal practice development session, as well as informal discussion groups, which are facilitated by the Mental Health Act Services team.

Practice development sessions arranged to date have included:

- An introduction to dementia services
- Risk assessment and management
- Community Treatment Orders
- Legal updates
- The role of the Approved Mental Health Professional

We ask Associate Hospital Managers for ideas for both formal and informal sessions on a regular basis.

Forum is arranged by Alison Naylor, Mental Health Law Information and Quality Manager and you are welcome to contact her with any ideas, suggestions or questions.

Appendix G	Mental Health Act Committee	Click to return to contents page

The Mental Health Act Committee has responsibility on behalf of the Trust Board for overseeing the systems and procedures for the implementation of the Mental Health Act and for monitoring performance and activity around the use of the Mental Health Act.

The Committee meets quarterly and includes as its members:

- Non-Executive Director (Chair)
- Chief Nursing Officer
- Consultant Psychiatrist/Associate Medical Director
- Associate Director of Nursing
- Operational Service Directors or nominated Deputy Operational Services Directors (one from each Clinical Delivery Service)
- Head of Legal Services
- Director of Quality Assurance
- Deputy Director of Social Work
- Lead AMHPs
- Associate Hospital Managers
- Sussex Police Representative
- Mental Health Law Information and Quality Manager
- Practice Development Manager – Mental Health Law
- Mental Health Act Services Manager
- Expert by Experience- People Participation

Hospital Managers who wish to attend as observers are very welcome.

The key duties of the Mental Health Act Committee are as follows:

- To ensure that the Trust's statutory responsibilities under the Mental Health Act 1983 as amended by the Mental Health Act 2007 are met.
- To have responsibility for ensuring strong and effective governance of the Mental Health Act 1983 is in place, reporting to the Board on any areas / activities that may lead to serious concern.
- To produce a quarterly update for the Board.
- To ensure the Trust's policies and procedures relating to the Mental Health Act and the Mental Capacity Act are appropriate and fit for purpose.
- To review issues raised through Care Quality Commission visits to services, their Annual statement of compliance and receive reports on implementation of recommendations.
- To review governance frameworks in place to support Associate Hospital Managers in conducting hearings/reviews and efficiently and effectively discharging their roles.
- To ensure appropriate training programmes are in place for Trust staff and Associate Hospital Managers.
- To ratify policies as necessary.
- To receive reports from the committee subgroup, the Mental Health Act Monitoring Group, on activities relating to the operational implementation of the Mental Health Act.

Minutes from the Mental Health Act Committee, as well as reports relating to Associate Hospital Manager feedback received, the use of the Mental Health Act and Care Quality Commission visits, are circulated to Associate Hospital Managers after the Committee.

Appendix H	Care Quality Commission	Click to return to contents page

The Care Quality Commission (CQC) began operating on 1st April 2009 as the independent regulator of health and adult social care in England. It replaced three earlier commissions:

- The Healthcare Commission
- The Commission for Social Care Inspection
- The Mental Health Act Commission

The CQC is funded via a combination of registration fee income and government grant in aid.

Registration with the CQC is our licence to operate. On 1st October 2010, Sussex Partnership was registered as a service provider without conditions. Our service must, by law, demonstrate on an ongoing basis that we are meeting the CQC's Essential Standards of Quality and Safety. These standards are:

- Respecting and involving the people who use our services
- Consent to care and treatment
- The care and welfare of the people who use our services
- Meeting nutritional needs
- Co-operating with other providers
- Safeguarding vulnerable people who use our services
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of our premises
- Safety and suitability of equipment
- Requirements relating to workers
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaint
- Records

The Care Quality Commission makes regular visits to inspect care in hospitals, care homes, people's own homes, dentists and other services, and publishes its findings on its website www.cqc.org.uk and in its inspection reports.

All inspections are unannounced, unless there is a good reason for them to let the service know beforehand that they will be visiting. During the visits, inspectors:

- Ask people about their experiences of receiving care
- Talk to care staff
- Check that the right systems and processes are in place.
- Look for evidence that the service isn't meeting the above standards.

Inspectors judge whether or not services are meeting government standards. If the service is not meeting the standards, the inspector will decide whether there is a minor, moderate, or major impact on people who use it, and they may decide to take enforcement action.

In addition to visits that monitor our compliance with the above standards, the Care Quality Commission also carries out regular unannounced inspections of how the Mental Health Act is used within our services, to ensure that its powers are being used properly.

Mental Health Act Commissioners come from a variety of professional backgrounds, from doctors to lawyers, and are wholly independent of the service they are inspecting. They can visit patients

detained in hospital and meet with them in private to find out about their experiences. Where requested, they can also meet patients who are on a community treatment order.

The key duties of the Commissioners are to:

- Meet with detained patients and listen to their issues
- Raise problems with Ward Managers
- Help patients to write letters or complain
- Check legal paperwork
- Write and publish reports following visits

Within a week of each visit, Sussex Partnership receives a full written report from the CQC, to which we have to respond with details of actions we are taking to rectify any issues.

See www.cqc.org.uk for details of a typical ward visit by a CQC Mental Health Act Commissioner.

A report detailing the CQC visits undertaken within each quarter, as well as the key issues raised, is produced for Mental Health Act Committee and is circulated to Associate Hospital Managers following this meeting.

Sussex Partnership is currently rated “Good” by the CQC, with a rating of “Outstanding” for care provision.

Appendix I	Trust services and locations	Click to return to contents page

Below is a description of the service types that are offered across the Trust.

For a full list of Trust units, locations and contact details please click here.

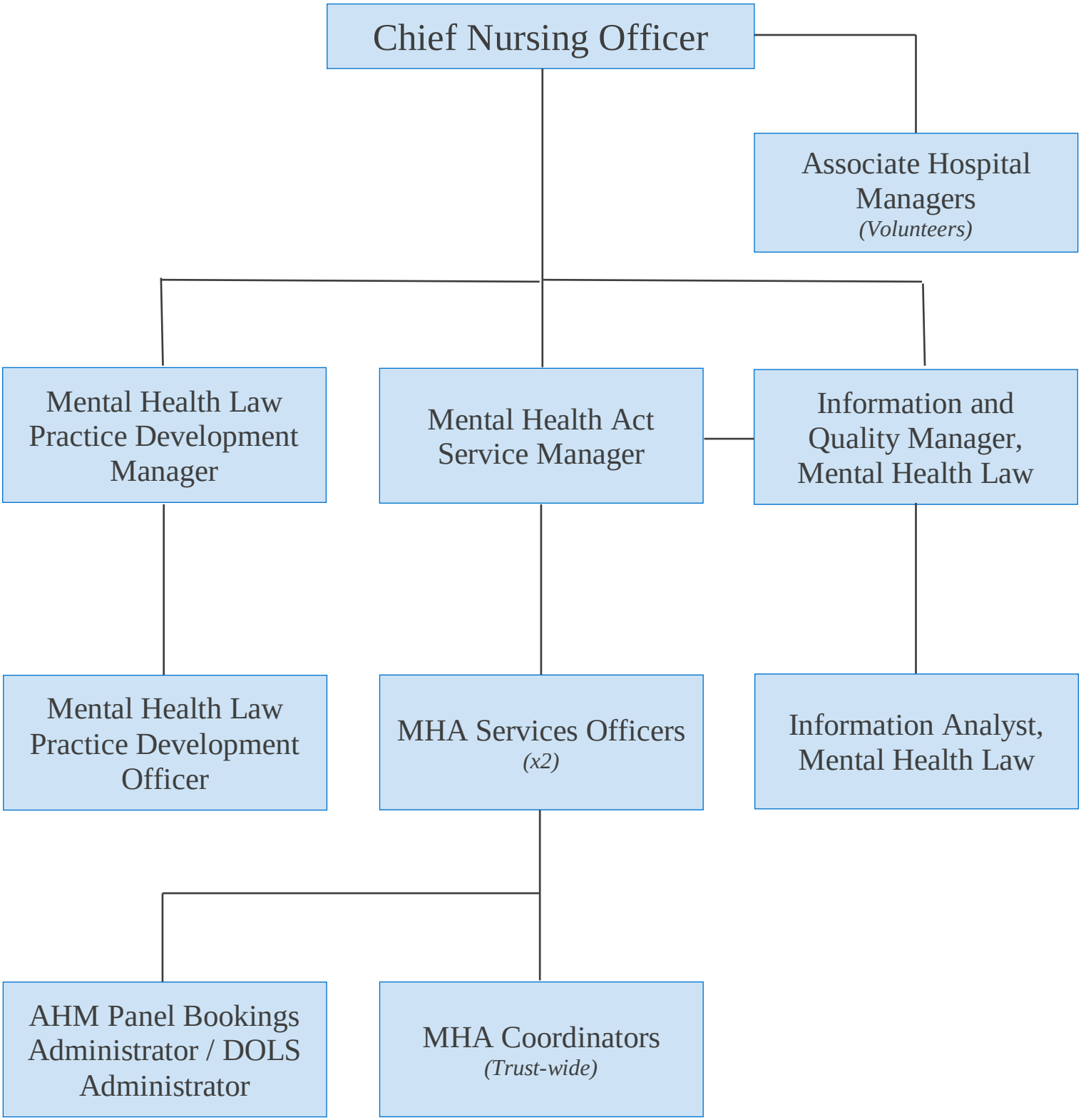
Access and Treatment for Adults	Our assessment and treatment centres (ATCs) are mainly located in bigger towns. They are the entry point into specialist mental health services. Patients are assessed to decide the most appropriate care for them. This may be a specific therapy or longer-term care where a 'care coordinator' will support the patient through their recovery journey.
Adopted Children and Adolescent Mental Health Service	The adopted children and adolescent mental health service (also known as AdCAMHS) is a specialist service in East Sussex with partnership working between Sussex Partnership NHS Foundation Trust and East Sussex County Council's Post Adoption Support Team. They provide consultation, assessment and treatment for adopted children, young people and their adoptive families who are struggling emotionally. The aim is to try and understand the nature of the difficulties, particularly in relation to being adopted, offering a tailor made package of expertise and therapy to help to address the mental health needs of the adopted child and enable their family to work through this together to improve relationships.
Adult Community Mental Health Teams	Community services cover all treatment and care not based in a hospital. This could take place in the patient's home or at a local assessment and treatment centre (ATC).
Assertive Outreach Teams	Assertive outreach teams (AOT) are made up of mental health staff from different professional backgrounds. They work with patients who have complex needs or need encouragement and support to get involved in treatment.
CAMHS/CHYPS	Children and adolescent mental health services (CAMHS) and Childrens and Young Peoples Services (CHYPS) are made up of specialist teams offering assessment and treatment to children and young people up to age 18 who have emotional, behavioural or mental health problems.
Community Forensic Outreach Team	This specialist service supports people with complex mental health problems who may have become involved in the criminal justice system.
Crisis Resolution & Home Treatment Team	Crisis resolution and home treatment teams (CRHTs) are designed to provide safe and effective care in the patient's home when they are experiencing a mental health crisis and

	would otherwise need to be admitted to hospital.
Dementia and Later Life Services	This service provides high quality care where the patient has healthcare needs related to dementia, or if the patient is an older adult with specialist needs as a result of complex mental health problems.
Dementia Assessment Service / Memory Assessment Service	Provides an early detection, diagnosis, treatment and care for patients who have problems associated with dementia.
Early Intervention Service	Provision of community-based support to people aged 14 to 65 years old who are experiencing their first episode of psychosis. Early intervention means getting help quickly for unusual distressing experiences in order to start recovery as soon as possible and to reduce the chances of problems coming back.
Family Eating Disorder Service (Pan Sussex)	FEDS work with children, young people and their families to treat eating disorders. They look at physical health as well as mental health and working with the patient and their family will put together a treatment plan to help get the patient back on track.
Health in Mind	Health in Mind is a free NHS service for anyone in East Sussex experiencing emotional or psychological difficulties such as stress, anxiety and depression.
Lindridge	Lindridge Care Community in Hove offers long and short term specialist health care for patients with complex physical health and end of life care needs, as well as people with dementia, within a beautifully appointed, home-from-home environment.
Neurodevelopmental Services	The Neurodevelopmental Service provides diagnostic assessments of neurodevelopmental conditions in adults. This includes autism spectrum conditions, ADHD and Tourette Syndrome. There are allocated services for two geographical areas: East Sussex and Brighton and Hove, and West Sussex. The services differ slightly in each area.
Partnership Domicilary Care Agency (East Sussex)	The PDCA aims to provide a safe, high quality individualised support service in the community for adults with learning disabilities who have complex and high risk emotional/behavioural difficulties which place themselves or others at risk of harm.
Perinatal Services	Our community-based service supports mothers who are experiencing, or who have previously experienced, severe

	mental health difficulties during pregnancy or up to a year after birth. They provide support to women and their families across East Sussex, West Sussex, Brighton & Hove and East Surrey.
Police & Court Liaison and Diversion Service	This specialist service supports people with complex mental health problems who may have become involved in the criminal justice system.
Primary Mental Health Work Service	The Primary Mental Health Work service (PMHW) offers brief, evidence based support for young people and their families through group work, direct one to one work and psychoeducational sessions. Their aim is to support young people with moderate mental health difficulties to access resources and skills to reduce the need for longer term, more intensive interventions. They also provide training to professionals on a variety of topics around mental health and working with young people and families with mental health difficulties.
Psychiatric Liaison	Psychiatric liaison services provide mental health assessment and treatment for people who are inpatients in general hospitals or for those who may go to an A&E department and are in need of a mental health assessment.
Rehabilitation & Recovery	Inpatient recovery units offering intensive rehabilitation using psychological, psychosocial, physical and medical approaches.
Specialist Older Adults Mental Health Services	Specialist support and treatment people to older adults experiencing moderate to severe mental health problems. Support with both health and social care needs is also provided to people who have a diagnosis of Dementia with complex and challenging needs.
Street Triage	This involves a qualified mental health nurse working alongside the local police force out on call to make sure that people who need mental health treatment receive it as quickly as possible. An immediate assessment is carried out to determine whether the person should be held under Section 136 of the Mental Health Act and if not, whether any follow up is needed from mental health, social or substance misuse services.
Thinking Well	Thinking Well is a dedicated service for people with a diagnosis of personality disorder in East Sussex.

	The service is delivered by Sussex Partnership NHS Foundation Trust in partnership with Southdown. The service is a group based programme offering a range of community, creative, psychoeducational and evidence-based psychological therapy groups to help people develop skills to self-manage their condition, reduce crises and build a more positive sense of identity.

Appendix J	Mental Health Law Services team structure	Click to return to contents page



Appendix K		Mental Health Law Services team contacts	Click to return to contents page

Hospital Managers Bookings: hospitalmanagersbookingteam@sussexpartnership.nhs.uk

Eastbourne office Dept of Psychiatry, Eastbourne DGH, Kings Drive, Eastbourne, East Sussex, BN21 2UD Tel: 01323 438216 / 417400 x 3569 / 438215 Office mobile: 07738758175	*Supports:* Inpatient Units: Department of Psychiatry (Eastbourne), Beechwood, Uckfield, Secure Units (Hellingly and Chichester) and Eastbourne DGH Community teams: Eastbourne, Lewes and Wealden
Mental Health Act Co-ordinators: Louise Fairweather, Matthew Peters	
Langley Green office Langley Green Hospital, Martyrs Avenue, Crawley, West Sussex RH11 7EJ Tel: 01293 590427/590426 Office mobile: 07738758181	*Supports:* Inpatient Units: Langley Green Hospital, Iris Ward(Horsham Hosp), Chalkhill Community teams: Crawley, Horsham, Mid-Sussex, Reigate, Redhill and Oxted
Mental Health Act Co-ordinators: Kayleigh Hather, Molly Timlett	
Worthing office Swandean, Arundel Road, Worthing, West Sussex BN13 3EF Tel: 01903 843255 Office mobile: 07738758176	*Supports:* Inpatient Units: Meadowfield Hospital, The Burrowes, Salvington Lodge Shepherd House, Oaklands Centre, Connolly House, Harold Kidd Unit, Selden Centre Community teams: Worthing and Adur
Mental Health Act Co-ordinators: Paloma Murillo, Naomi Philpott, Louise Robards, Matthew West	

Brighton & Hove office Mill View Hospital, Nevill Avenue, Hove East Sussex, BN3 7HZ Tel: 01273 621984 ext 2432 / 2614 / 2428 Office mobile: 07738758174	*Supports:* Inpatient Units: Mill View and Nevill Hospitals and Rutland Gardens Community teams: Brighton & Hove
Mental Health Act Co-ordinators: John Duffy, Nicola Malton, Mark Sefton, Jodi Singh, Emma White, Bez Zawde,	
Hastings office St Anne's Centre, The Ridge, St Leonards on Sea, East Sussex, TN37 7PT Tel: 01424 758901 / 755255 x 2507 Office mobile: 07738758172	*Supports:* Inpatient Units: Woodlands, Amberstone, St Anne's Centre and Conquest Hospital Community teams: Hastings, Bexhill and Rother
Mental Health Act Co-ordinators: Gary Porter, Andrea Stevens	

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