Approved Mental Health Professional Service

Operating Procedures

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# 1 Introduction

1.1 Approved Mental Health Processionals (AMHPs) have a range of responsibilities in relation to the Mental Health Act 1983 (MHA). These procedures are intended to outline processes and standards in relation to AMHP work carried out on behalf of the London Borough of Barking and Dagenham (LBBD).

# 2 Scope

2.1 These AMHP procedures should not be considered as a substitute for the MHA itself, nor its associated statutory guidance and regulations.

2.2 In addition to the MHA, AMHPs should work within the parameters and guidance of the MHA Code of Practice 2015, The Reference Guide to the Mental Health Act 2015 and The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008.

2.3 Related legislation should also be considered as appropriate, including the Mental Capacity Act 2005 and the Care Act 2014.

2.4 LB of Barking and Dagenham related policies and procedures should also be followed - eg Safeguarding, Serious Incident Reporting, etc.

# 3 Adult Mental Health Professional Approval and Re-approval

**Introduction**

3.1 These procedures support the approval, re-approval, suspension and termination of AMHPs working on behalf of the London Borough of Barking and Dagenham. The policy relates to AMHPs directly employed by the London Borough of Barking and Dagenham, as well as those employed as a locum AMHP.

**Legal Context**

3.2 Section 114, (1) of the MHA states “A Local Social Services Authority (LSSA) may approve a person to act as an approved mental health professional for the purposes of the Act.”

3.3 In 2007 sections 18 and 19 of the MHA amended Section 114 of the MHA to permit the LSSA to approve registered social workers, nurses, occupational therapists and chartered psychologists, who have completed a recognised AMHP training programme.

3.4 The regulations for approval and re-approval of AMHPs are laid out in The Mental Health (Approved Mental Health Professionals) (Approval)(England) Regulations 2008 (Appendix 1)

3.5 Regulation 3 states:

(1) An LSSA may only approve a person to act as an AMHP if it is satisfied that the person has appropriate competence in dealing with persons who are suffering from mental disorder.

(2) In determining whether it is satisfied a person has appropriate competence, the LSSA must consider the following factors—

(a) that the person fulfils at least one of the professional requirements, and

(b) the matters set out in Schedule 2 [the AMHP key competences].

(3) Before an LSSA may approve a person to act as an AMHP who has not been approved, or been treated as approved, before in England and Wales, the person must have completed within the last five years a course approved by the Health and Care Professions Council (HCPC) or the Care Council for Wales.

**Approval Criteria and Procedure**

3.6 In order for a person to be initially approved by LB of Barking and Dagenham to act on their behalf, the following conditions must be met.

1. Evidence of a valid Professional registration certificate/document;
2. If previously approved by another area, confirmation from their previous AMHP supervisor that they are competent to practice and were approved by their previous employing authority;
3. Evidence of completion of a recognised AMHP training programme;
4. Evidence of a minimum of 18 hours AMHP training or relevant courses undertaken within the previous year (April- March).

3.7 Prior to approval, the worker will be required to undertake a minimum of 3 fronted MHA assessments supervised by an AMHP colleague. The worker will complete a local authority report for each assessment, and these will be presented at an approval panel.

3.8 The approval panel will consist of the AMHP Service Manager and or the of Head for Mental Health for LB of Barking and Dagenham and or the Consultant AMHP within LB of Barking and Dagenham.

3.9 At this panel, the worker will present the three reports and provide a briefing on the cases and the decisions made. Workers must demonstrate that they meet the competence criteria outlined in Schedule 2 of the AMHP approval regulations (see appendix 1)

3.10 Upon successful completion of the AMHP warranting panel, the worker will be approved to act as an AMHP for a period of 5 years. Locum AMHPs will be approved for a period of 12months.

3.11 If an AMHP is already approved by another authority, the LB of Barking and Dagenham AMHP manager must notify that authority that the AMHP has been approved by LB of Barking and Dagenham

3.13 An AMHP must only be approved by one local authority. If an AMHP wishes to carry out additional work for another authority, the authority where the AMHP predominately acts should be the main approval authority. If an AMHP is practising in Barking and Dagenham but approved by another area then the B&D AMHP manager should maintain contact with the other authority at least every 3 months to ensure the criteria to act as an AMHP continues.

3.14 If the panel members do not think that the worker meets the necessary standards for approval, further requirements will be outlined with the worker and a date will be agreed for the panel to meet again to consider the approval.

**Re-Approval Process.**

3.15 In cases where AMHPs have been approved for a period of 5 years by LB of Barking and Dagenham, AMHPs will be given three months notice of their re-approval panel.

3.16 Prior to the panel, the AMHP should submit a portfolio with the following:-

* A reflective statement of their AMHP practice, which would include competencies, strengths, and learning since last approval, how AMHP work is incorporated within their other professional roles and responsibilities, training needs and any areas they wish to develop further. (1000 words).
* Evidence of successful completion of open book legal test.
* Copies of reports for 4 assessments carried out in the previous 12 months.

3.17 At the panel, the AMHP will present 2 assessments in detail and provide a briefing of the issues and the decisions that were made.

3.18 Following this panel, the AMHP may have their approval period extended for up to 5 years.

3.19 The panel may decide that the AMHP has not sufficiently demonstrated the AMHP key competencies. In such circumstances, the AMHP will be asked to provide additional evidence for consideration at a further approval panel. The AMHP competencies are listed in appendix 1

3.20 Locum AMHPs who are approved for a period of 1 year may be re-approved following submission of 3 reports and review at an approval panel. Locum AMHPs who are approved for a period of 5 continuous years must be subject to a full approval process as outlined above.

**Suspension, Termination and Appeals**

3.21 At any time, a panel may be convened to consider the current approval of an AMHP working on behalf of LB of Barking and Dagenham.

3.22 If there are concerns about the practice of an AMHP, their approval may be suspended until a panel fully considers if termination or suspension is necessary The reasons for such actions should be made in writing to the AMHP, along with any recommendations for remedial actions.

3.23 The AMHP may appeal any panel decisions in writing to the chair of the approval panel. Any appeal should specifically detail the reasons for appeal.

3.24 In cases of termination of approval, AMHPs must return their ‘warrant’ card.

**Conditions of Approval**

3.25 The continuing approval of an AMHP at LB of Barking and Dagenham is subject to the following conditions:-

* In each year that the AMHP is approved, the AMHP shall complete at least 18 hours of training relevant to their role as an AMHP. For such purposes each year is considered as being from April to March.
* AMHPs shall notify LB of Barking and Dagenham in writing if they agree to act as an AMHP for another authority, and when such agreement ends.
* AMHPs are only permitted to be approved by one authority. Therefore, an AMHP must notify LB of Barking and Dagenham if approved by another authority. This would result in the removal of approval from LB of Barking and Dagenham.
* AMHPs shall notify LB of Barking and Dagenham if they are suspended or cease to be registered with the HCPC or other relevant professional register.

# 4 Records

4.1 LB of Barking and Dagenham AMHP service will keep records of the following:-

* The names and professions of the approved AMHPs.
* The AMHP’s date of initial approval and subsequent approval dates.
* Details of any period of suspension.
* Details of the completion of relevant training.
* Details of any previous approvals as an AMHP within the previous five years.
* The names of other LSSAs for whom the AMHP has agreed to act as an AMHP.
* The date of and reason for the end of approval, if applicable.

# 5 AMHP Training

5.1 Suitably qualified workers who wish to train as AMHPs may be considered by LB of Barking and Dagenham to undertake the AMHP training course. At present, this course is provided by the North East London Training Consortium, of which LB of Barking and Dagenham is a partner.

5.2 Potential candidates must be nominated by their line manager and have 2 years post qualifying experience. Prior to the AMHP course, candidates will be expected to have successfully completed a Pre-AMHP course recognised by a University, or have completed a Master’s degree in the previous 5 years.

5.3 AMHP course candidates must formally make an application to the Consortium and successfully pass an interview panel coordinated by the Consortium.

# 6 Supervision and Support Arrangements

6.1 All practising AMHPs are required to have regular AMHP focused supervision. If their current supervisor is an AMHP, or was an AMHP in the past 5 years, then this should be incorporated into their regular supervision.

6.2 For other AMHPs, AMHP specific group supervision will be provided every 2 months by the AMHP manager. This group supervision will be compulsory and governed by a signed contract. Individual supervision can be requested by either party.

6.3 In addition, all AMHPs will have access to the bi-monthly AMHP forum, where AMHP practice and reflective discussions can take place. AMHPs will be expected to attend at least 2 AMHP forums per year.

6.4 AMHPs will always have access to debriefing discussions, particularity after complex or challenging assessments.

6.5 At all times, AMHPs should have access to a senior AMHP with whom they can consult regarding assessments. The senior AMHP should be of senior practitioner grade, or above. The senior AMHP must be on duty and contactable, by phone if need be, within one hour.

# 7 Referrals

7.1 During working hours the day time AMHP service coordinate all requests for MHA assessments on behalf of LB of Barking and Dagenham. The AMHP service operates Mon to Fri, 9am-5pm (except Bank Holidays).

7.3 Referrals to the AMHP service are expected to come from a variety of sources. Referrals to the AMHP team will, in many cases, require a written AMHP service referral form. This referral form will enable the AMHP service to accurately assess the urgency of the referral and make plans for completion of the MHA assessment.

7.4 It is recognised that referrers will request MHA assessments for a variety of people. This will include persons well known to mental health services and others who are presenting to Barking and Dagenham mental health services for the first time. In cases where the person is well known to services, it is expected that referrers comprehensively complete the AMHP service referral form. In cases where the person is not previously known to mental health services, it is recognised that the initial referral information will be limited.

7.5 As referrals come into the AMHP Service, it is the responsibility of the AMHP, work flow organiser to gather as much information as possible and record this on the referral sheet.

7.6 All referrals received either in writing or via telephone, should be screened by AMHPs on duty to ascertain its urgency. AMHPs on duty should decide an initial response to the referral which may involve action to progress the MHA assessment, or allocation of further work such as s135 court reports, booking doctors, etc.

7.7 If the referral is accepted, AMHP, workflow organiser will ensure the person is loaded on the LAS system.

7.8 AMHP workflow organiser should confirm receipt of the referral to the referrer wither via telephone or via email. If a referral is not accepted, the referrer must be clearly informed of the reasons. This would include any recommendations for the referrer to consider. The referral and reasons for the referral not being accepted should be recorded on the AMHP database and on LAS.

7.9 The referral spreadsheet will be updated by the AMHP workflow organiser on a daily basis.

7.10 Below is further guidance on how other teams and agencies can refer to the AMHP service.

**Community Teams**

7.11 Referrals from community recovery services will need to be put in writing via the AMHP referral form sent to the following email address amhplbbd@lbbd.gov.uk . All email referrals will receive a confirmation via email that it has been received and being dealt with.

7.14 The written referral should include a brief history of the person, current assessment of mental health needs, risks, willingness to accept treatment on an informal basis and contacts of nearest relative and other relevant contacts.

7.15 In emergency situations, a request for an AMHP/MHA assessment can be made via telephone.

7.16 All referrals from community teams will need to have a named person in the community team who will be the main point of contact regarding the case. This contact person should be available if there is a need for further consultation regarding the case. If the contact person is not available they should delegate this role to a colleague in their team.

7.17 The clinical needs of the patient, including assessment and management of any risk issues will continue to be held by the relevant community team. Community teams will need to notify the AMHP service of any changes in the persons needs such as risk issues, change in social circumstances etc.

7.18 Following a referral to the AMHP service, arrangements will be made by the service to arrange a MHA. This will include any s135(1) warrant applications and liaison with the Metropolitan Police Service as appropriate. The AMHP service will regularly update the referring team regarding the plan to carry out the MHA.

7.19 Referrals from Disabilities Services, Housing and Children and Adolescent Mental Health Service (CAMHS) can be made directly to the AMHP service using the above procedure.

7.20 It is expected that doctors from the referring team, should be able to make medical examinations under the MHA.

Home Treatment Team and Inpatients

7.21 Referrals from HTT can be made directly to the AMHP service via emails and telephone. If HTT decided to close the case, discussions should be held regarding which community team will be holding the case until a MHA can be carried out.

Sunflowers Court

7.22 Referrals from the inpatient service at Sunflowers Court can be made via telephone but preferably by completing the AMHP referral form. Wards should give sufficient notice- especially for CTO’s and s2 to s3.

S136 Suites

7.23 S136 Suites can refer directly via telephone but preferably by completing the AMHP referral form and request must be for Barking and Dagenham residents. Patients admitted from other local authorities should be assessed by that local authority- see Assessments on non-Barking and Dagenham residents below.

Police

7.24 Referrals via telephone from the police will be accepted if the person is currently in police custody. Other referrals from the police relating to people in the community should initially be dealt with by the relevant community based teams.

Courts

7.25 Requests for MHA assessments relating to Barking and Dagenham residents attending Courts can be made directly to the AMHP service via telephone or email.

King George and Queens Hosptal

7.26 Referrals can be made directly from A&E, wards and Perinatal Services via telephone or email after the patient had been assessed by the psychiatric liaison team.

Other agencies (inc family referrals)

7.29 Referrals for a MHA from other agencies (eg GP’s, housing, care homes, etc) and members of the public should initially be considered by the relevant community MH team and only referred to the AMHP service if it is confirmed that there is a need for a MHA assessment.

7.30 A nearest relative has the right to request mental health services to consider if detaining their relative under the MHA is appropriate (MHA s13). If a Nearest Relative has made a specific request for a MHA assessment to be carried out on their relative, this should be discussed with the AMHP senior to agree how this will be considered.

7.31 Where the AMHP has considered a patient’s case at the request of the nearest relative, the reasons for not applying for the patient’s admission must be given to the nearest relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the nearest relative to understand the decision while at the same time preserving the patient’s right to confidentiality. (COP 14.102)

7.32 For urgent telephone referrals, the AMHP taking he call should complete an AMHP referral form.

# 9 Referrals regarding cases with connections to other areas.

B&D AMHP service applies PAN London agreement, we are open to treat each case based on relationship established with local authority involved.

9.1 LB of Barking and Dagenham AMHPs will only conduct MHA assessments within the boundaries of Barking and Dagenham authority area.

9.2 If an individual presents within the boundaries of the Barking and Dagenham area and requires a MHA assessment then the B&D AMHP service must consider making arrangements for a MHA assessment to be completed. In all cases consideration, as below, regards to ordinary residence should be followed.

9.3 If the person being assessed is not an ordinarily resident of LBBD, then the assessing AMHP is expected to confirm the area of ordinary residence prior to making the application. If the person is in a placement in LBBD, then confirmation of the ordinary residence status should be confirmed in writing prior to any application being made.

S2 Applications:

9.4 If the person is on a S136, S5(2) or any other holding powers, B&D AMHP Service would be contacted to carry out the assessment. Prior to carrying out the assessment, the AMHP on duty must obtain information regarding the ordinary residence.

9.5 If the person is living in Barking and Dagenham, the B&D AMHP Service will undertake the assessment as per normal.

9.6 If person is ordinary residence in another area, that area should be contacted and confirmed in writing that they agree the person is living in their area and that any further assessments will be undertaken by their AMHP’s.

9.7 This is to prevent:

1. Code of practice 4.35 states “If a patient is already detained under section 2 as the result of an application made by an AMHP, the LSSA on whose behalf that AMHP was acting is responsible for arranging for an AMHP to consider the patient’s case again if the LSSA has reason to believe that an application under section 3 may be necessary. This applies even if the patient has been detained outside that LSSA’s area.”

2. If the person returns to their ordinary residence area which could be anywhere in England, B&D AMHP Service does not have availability for any AMHP to travel long distances to complete the S3 application following an S2.

S3 Applications:

9.8 For all S3 assessments, the same principles apply. The AMHP on duty should check the ordinary residence of the person. If the person is in a contracted bed or spot purchased bed, the responsibly for the S3 assessment lies with the ordinary residence area i.e. the area that placed the person in Hospital.

9.9 If the person is a B&D client, B&D AMHP Service will take on the set up and assessment for a potential S3 application.

9.10 Barking and Dagenham Clients:

LB of Barking and Dagenham who are an inpatient in a hospital in a different local authority area should be assessed by the AMHP Service covering that area.

9.11 However, in cases where a LBBD resident was assessed for S2 by a LBBD AMHP, then the LBBD AMHP Service should assess for S3 or make arrangement for the AMHP Service covering the area of the hospital to assess for S3.

# 10 135 (MHA) Warrant Applications

10.1 There are 2 types of warrants under the provisions of the MHA.

* 135(1) warrants are to ‘search and remove patients’ from settings in the community- commonly their own homes. Applications for s135(1) warrant can only be made by an AMHP and so it is the responsibility of the LBBD AMHP service to make such applications.
* S135(2) warrants relate to patients already ‘liable to be detained’. There are 3 main categories of patients who may require warrants to facilitate their admission, or re-admission, to hospital. The categories are: Patients recalled under Community Treatment Orders (CTOs), Ministry of Justice recalls of patients subject to s37/41, and patients liable to detention in hospital (eg s2, s3). Less commonly s135(2) warrants can be applied for patients subject to Guardianship Orders in order to facilitate their return to the address stipulated in the Guardianship Order.

10.2 Applications for s135(2) warrant can be made by police officers, AMHPs or any other person authorised by the hospital managers. In practice S135(2) applications should be made by the professional who has most detailed knowledge of the persons circumstances. If the applicant is not an AMHP, it is best practice for a letter of authorisation to be issued by the hospital managers (or by LBBD in the case of Guardianship).

10.3 In the case of a patients recalled under a CTO, applications can be made by either NELFT Care Coordinator or the LBBD social worker. The decision as to who should make the application should be made jointly between the 2 services. If there is any uncertainty, then this should be escalated to the relevant team managers at the earliest opportunity.

10.4 For patients subject to s37/41, s135(2) warrant application should be made by the patients allocated Social Supervisor. If the Social Supervisor is not available (eg they are on leave) the manager of the social supervisor should make any necessary arrangements for the application.

10.5 For patients ‘liable to be detained’ in hospital under s2, s3, etc, s135(2) warrants should be made by the relevant team responsible for the persons care. In the cases of detained patients AWOL from the hospital, ward staff should make the s135(2) application. In the cases of patients liable to be detained but not yet admitted (eg patients detained under s2 or s3 in the community), the LBBD AMHP service can make the s135(2) application if a LBBD AMHP was involved in making the s2 or s3 application. In other circumstances, then the application should be made by the professional who has most knowledge of the persons circumstances, similar to patients recalled under CTO.

10.6 All the necessary arrangements for making a s135(2) application remain the responsibility of the applicant. This includes completing any necessary court paperwork. For LBBD applicants, blank S135(2) warrants can be obtained by LBBD AMHP service. Payment for warrants applications made by LBBD staff can also be made via the LBBD AMHP service.

10.7 In all circumstances LBBD AMHP service can provide advice of the process of making warrant applications.

10.8 The MHA warrant application process is described in appendix 6. In summary, to initiate the process a warrant application form should be emailed to the Court LMAC team (Lmac1@hmcts.gsi.gov.uk tel No 0203-126-3040) . The email should specify the date and Court being requested, and the name of the AMHP who will be making the application if this is known. The booking form must include the account details for the fee payment. Once payment is authorised the LMAC team email back a booking confirmation. The AMHP making the application must print this off and bring it with them to the court as proof of payment.

10.9 Applications are currently being heard at Barkingside Magistrates Court in Barkingside. Normal hearing days are Tuesday, Wednesday and Thursday. MHA warrant applications of an emergency nature can be heard on the other days.

10.10 AMHPs must ensure that they bring with them the necessary paperwork (ie the warrant, S135 information sheet, and typed warrant report) and ensure that all the necessary documents are correctly completed to a high standard before attending court.

**Executing s135 warrants**

10.12 As soon as the AMHP service is made aware by police of a time to execute the warrant, an AMHP must notify the treating doctor of the plan and ask if they can attend. Only if they cannot attend should 2 section 12 approved doctors be booked.

10.13 As a s135(1) warrant only authorises the entry by 1 doctor (accompanied by AMHP and police), the person being assessed should be asked if they wish to be assessed by 2 doctors at their home address, or if they would prefer to be assessed at the place of safety by the 2 doctors. In such circumstances, the s135(1) warrant authorises the person to be removed to the place of safety for this assessment.

# 11 Setting Up assessments

11.1 Upon receipt of a referral requesting a MHA assessment, the AMHP should make the necessary arrangements regarding the case. This may involve initiating a response, scheduling an assessment for a later date, requesting additional information, or completion of reports for a s135 warrant application. The senior AMHP on duty should be consulted if there are any uncertainties about how to proceed.

11.2 If the MHA assessment will be completed via a MHA warrant, then a request for police assistance should be made. Requests for police assistance should be made via email to <https://www.met.police.uk/partners/partner-services/>

(needs to be re-confirmed). The email should be in the agreed format and include a completed 435 form and a copy of the MHA warrant.

11.3 The email should indicate the level of urgency (critical, urgent, standard) according to the jointly agreed AMHP/ Police s135 Standard Operating Procedure (appendix 8). The email should also indicate a suitable rendezvous point for the assessing team to meet prior to the MHA assessment.

11.4 In cases where there have been no medical recommendation as yet completed, the relevant NELFT doctor should be booked in the first instance. Addition s12 doctors can be booked as required. AMHPs should attempt to use doctors with the appropriate level of skill and expertise in accordance with guidance in the MHA Code of Practice and MHA- ie learning disability, young people, etc.

11.5 For planned community assessments, ambulances can be booked via the agreed procedure with the London Ambulance Service. (See appendix 9). Ambulances need to be booked prior to 12 noon the day before the ambulance is required. Any booking made via NETS should be printed off and placed alongside the other case papers.

11.6 A locksmith should be booked by the AMHP workflow orgainser, or AMHP in their absence if one is required to assist with entry or securing the property after the assessment. LBBD’s locksmith are use for council’s houses

11.7 For planned assessments in the community, the AMHP checklist should be used to summarise the arrangements made.

# 12 Nearest Relative

12.1 AMHPs are responsible for identifying, and either informing or consulting, the nearest relative in cases where the person is subject to assessment and detention under the MHA.

12.2 AMHPs must be familiar with the hierarchy outlined within the MHA and clearly record how the nearest relative was identified within the AMHP report.

If reasonably practicable, AMHPs should consult with the nearest relative prior to the MHA assessment.

12.3 Consultation prior to making a s3 application is an important statutory duty. Therefore AMHPs will need to use all of the time available (ie if they are on s2, s5(2), s136 etc) and make concerted efforts to consult with the nearest relative and all efforts should be recorded on the AMHP report and Azeus. If an AMHP is aware of the existence of the nearest relative but is not able to consult them, then the senior AMHP on duty should be contacted for advice on how to proceed.

12.4 The aim of the consultation means that a full discussion of the case is necessary and this does not require the consent of the person being assessed. The nearest relative does not necessarily have to agree to an application, and if they are neutral or indifferent then an application can still be made. If the nearest relative objects to a s3 application, then an assessment can still take place, but the s3 application cannot be completed.

12.5 A NR relative rights letter should be sent to the NR when any AMHP application has been made. This letter should also be AIS processed.

12.6 If the NR objects the AMHP should record the consultation, and the reasons for any objection in as much detail as possible. If time allows, then a meeting with the nearest relative, RC and AMHP should be convened to explore any concerns and options to resolve them.

12.7 If the nearest relative objection is deemed unreasonable by the AMHP, then LBBD Legal services should be consulted as soon as possible in relation to a s29 displacement claim.

12.8 To initiate a s29 displacement claim to Court, LBBD legal would normally require a full report from the AMHP (not the AMHP report) , a psychiatric report and copies of relevant statutory paperwork (eg s2 records, s3 medical recommendations). In cases of urgency a short report would suffice.

12.9 The AMHP should, if possible, identify any other relative who may be suitable to act as the person NR. If no other relative is suitable to act as NR, then LBBD can be nominated by the court to act as NR. The person nominated would usually be the Service Manager for Mental Health or alternative senior manager. The court will ultimately decide on the matter of displacement, and appoint an alternative nearest relative if appropriate.

12.10 Where a person is detained under s2, once the Court receives a nearest relative displacement ‘claim’ then the s2 is extended until the matter can fully be considered by the court. AMHPs are expected to attend any court hearing with LBBD legal support.

12.12 The required paperwork would include all the relevant statutory MHA papers (ie medical recommendations and s2 papers if appropriate) and a written AMHP statement. The court form N208 should also be completed –available online.

12.13 NR can delegate to another person to perform the function of the nearest relative. The delegated nearest relative does not necessarily have to be a relative. Delegation should be in writing using the nearest relative delegation form (appendix 10). Copies of the form should be kept on AIS and also emailed to the MHA office.

12.14 Delegation can occur at any time. Confirmation should be made by the AMHP service that both parties have capacity, and consent to, the delegation.

The delegated NR cannot delegate to another person once delegation is in place.

12.15 In cases where there are no identified NR, then the AMHP must refer to the IMHA service -Cambridge House 020 7358 7007

# 13 Assessments

13.1 Assessments should be carried out in accordance with the MHA and COP guidance.

13.2 If the person requires admission under the act, it is the doctors responsibility to arrange a suitable bed. This is especially important with specialist beds such as children and young people aged under 18, older adults, forensic beds, mother and baby unit, etc.

13.3 If the AMHP considers that there is a possibility that support via Home Treatment Team (HTT) may be a suitable alternative to admission, then HTT should be contacted in advance to attend the MHA assessment . The decision to admit the person under the MHA or not would remain with the AMHP

13.4 Assessments should be made with the relevant treating doctor if possible. When booking doctors for a MHA assessment, the AMHP should be aware of any potential conflict of interests listed in appendix 11. Most commonly, conflict of interest arises where one assessing doctor is in a line management relationship with another assessing doctor.

13.5 If there are any differences or disagreements then AMHPs must consult as necessary with the other assessing doctors. If the AMHP is concerned that a person requires detention, but the assessing doctor has not completed a med rec, then the AMHP does have the option of asking another doctor to make a formal MHA assessment. In such cases the senior AMHP on duty should be consulted prior to making arrangements. The MHA Code of Practice advises that doctors should not ask another AMHP to assess in cases where a disagreement arises.

13.6 AMHPs must thoroughly scrutinise any medical recommendations to ensure they met the statutory criteria and are completed correctly.

13.7 It is the AMHP’s responsibility to convey the detained patients to hospital. The AMHP may delegate this to a named person using the appropriate form (Appendix 12). The person delegated to must accept the responsibly to convey, and cannot delegate this to another. The AMHP should leave contact details on the delegation form in cases of difficulties in conveying. The assessing AMHP must ensure that they receive confirmation that the person has been successfully conveyed. The senior AMHP on duty should be consulted prior to any delegation to convey.

13.8 As outlined above in 13- Setting up Assessments, AMHPs can pre book LAS NETS. If the assessment is unplanned from a community setting, a LAS ambulance can be book via 0207 827 4555. AMHPs should request police support to convey if there are significant risks of absconding or violence to others.

13.9 AMHPs should check if the person is subject to a Lasting Power of Attorney or has a Deputy appointed by the Court of Protection. In such cases the guidance in COP (Ch 7) should be followed.

13.10 Interpreters must always be used if it is thought that understanding and communicating in spoken English may be a problem. Professional interpreters should always be used. Only in exceptional circumstances should non professional interpreters be used. In such cases the senior AMHP must be consulted and the reason recorded.

13.11 For MHA assessments carried out in hospital, then the relevant NHS service should be asked to book an interpreter. For community based assessments then the AMHP service can book an interpreter via [www.language-empowerment](http://www.language-empowerment) using purchase order / cost code 10781019.

13.12 AMHPs need to be aware of the interface between the MHA and the MCA. Further guidance is available in the COP –CH 13. AMHPs must assess the capacity of the person to consent to treatment and admission in all cases. This would include cases where the person is detained in hospital or there is a plan to admit informally.

13.13 If an informal admission is planned following a MHA assessment, the AMHP must be satisfied that the person in able to give valid informed consent to the admission. This would normally involve a detailed discussion with the person about the purpose and arrangements relating to the informal admission. The capacity assessment should be recorded in the relevant section of the AMHP report. AMHP should consult with the senior AMHP on duty if there are any uncertainties as to whether the MHA or MCA/DOLs should be used as the appropriate legal framework.

13.14 If a MHA assessment is required for a LBBD resident at a Court, then the AMHP should liaise with the relevant Court MH Liaison service. For planned assessments an ambulance can be booked via NETS. For unplanned assessment a LAS ambulance can be booked via 0207 827 4555. If the assessment is taking place at Barkingside Magistrates Court only, then a secure ambulance can be booked by the AMHP directly on 0800 169 5718.

13.15 Any safeguarding concerns regarding either children or vulnerable adults initially identified during the assessment must be referred by the AMHP to the appropriate team. Safeguarding concerns, and any actions taken, must be recorded on both the outline and full AMHP report.

13.16 The local authority have a duty to ensure that property and any ‘movable property’ is protected when someone is admitted to hospital (or other accommodation provided by the local authority). The responsibilities and powers in relation to this such cases are outlined in s47 of the Care Act 2014.

If pets are present and it is not possible to make other arrangements for them –eg friends or family to look after them, then LBBD Animal Welfare can care for the animals until other arrangements are made. Funding should be agreed by the AMHP senior prior to any agreement for LBBD animal welfare to board any animals. LBBD Animal Welfare service can be contacted on 0208 586 9739. The Animal Welfare booking form (Appendix 11) should also be completed. Any arrangements to board animals via the Animal Welfare service should be reviewed at least on a monthly basis.

13.17 If following a MHA assessment, the doctor decides not to complete a medical recommendation, then the reasons for this should be recorded by the doctor on RiO.

# 14 Community Treatment Orders (CTOs)

14.1 All referrals for CTOs should be sent via email to the AMHP service. The AMHP Business Support Officer then checks to ascertain if the person is case managed by LBBD. If the case manager is an AMHP, then they would be expected to complete the CTO assessment- whether that be for initial order, renewal or revocation. All other cases will be completed by the AMHP service. The flowchart outlining the process is in Appendix 15.

14.2 The AMHP business support officer will maintain a database of CTO cases and maintain the AMHP diary for planned CTO assessment not in the near future.

14.3 CTO assessments should be made jointly with the person’s RC wherever possible. The AMHPs must consider if any additional condition recommended are necessary and bear in mind that any conditions should not amount to a deprivation of liberty. AMHPs should discuss any conditions with both the RC and the person being assessed.

14.4 The AMHP service will not normally be involved in arrangements regarding the recall of the person. This would remain the responsibility of the relevant community team - either NELFT or LB of Barking and Dagenham. If a s135(2) warrant is required to recall the person to hospital please refer to 10- MHA Warrant Applications above.

14.5 Once a person has been recalled to hospital, the RC must make an assessment for revocation. Revocation assessments should be made jointly with the RC wherever possible.

14.6 All CTO assessments will require a standard AMHP assessment report completed.

# 15 Guardianship

**Introduction**

15.1 This guidance is informed by and should be read in conjunction with the 2007 amendments to the Mental Health Act 1983, the Mental Health Act 1983 Code of Practice, (2015 Chapter 30); the Reference Guide to the Mental Health Act 1983 and the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

15.2 The Act allows applications to be made for people to be placed under the Guardianship of a guardian who may be a local social services authority (LSSA) or an individual, such as a relative, who is approved by the LSSA.

**The Purpose Of Guardianship**

15.3 As stated in the MHA Code of Practice, (2015), Chapter 30, “the purpose of guardianship is to enable patients to receive care outside hospital when it cannot be provided without the use of compulsory powers. Such care may or may not include specialist medical treatment for mental disorder”.

15.4 Guardianship provides an authoritative framework for working with a patient, with a minimum of constraint, to achieve as independent a life as possible within the community. Where it is used, it should be part of the patient’s overall care plan.

15.5 Guardianship must not be used to impose restrictions that amount to a deprivation of liberty.

15.6 Guardianship does not give anyone the right to treat the patient without their permission or to consent to treatment on their behalf.

15.7 While the reception of a patient into Guardianship does not affect the continued authority of an attorney or deputy appointed under the MCA, such attorneys and deputies will not be able to take decisions about where a Guardianship patient is to reside, or take any other decisions which conflict with decisions made by the Guardian. The Court of Protection lacks jurisdiction to determine residence where Guardianship has residence requirement.

15.8 The Code of Practice (Ch 30.20), further sets out the planning components of effective Guardianship and emphasises that it must be part of a comprehensive care and treatment plan established on the basis of multi-disciplinary discussions.

**Grounds For Guardianship**

15.9 An application for Guardianship, for a patient aged 16 years of age or older, may be made on the grounds that:

• The patient is suffering from mental disorder of a nature or degree which warrants their reception into Guardianship; and

• It is necessary in the interests of the welfare of the patient or for the protection of other persons, that the patient should be so received.

15.10 Where patients lack capacity to make some or all important decisions concerning their own welfare, one potential alternative to guardianship will be to rely solely on the MCA; especially the protection from liability for actions taken in connection with care or treatment provided by section 5 of the MCA. While this is a factor to be taken into account, it will not by itself determine whether guardianship is necessary or unnecessary. AMHPs and doctors need to consider all the circumstances of the particular case. (Code of Practice 30.11)

**Powers**

15.11 Guardians have three specific powers as follows:

* They have the exclusive right to decide where a patient should live, taking precedence even over an attorney or deputy appointed under the Mental Capacity Act 2005 (MCA). The Court of Protection also lacks jurisdiction to determine a place of residence of a patient whilst that patient is subject to Guardianship and there is a residence requirement in effect
* They can require the patient to attend for treatment, work, training or education at specific times and places (but they cannot use force to take the patient there), and
* They can require that a doctor, approved mental health professional (AMHP) or another relevant person has access to the patient at the place where the patient lives.

15.12 Guardians have the power to decide where patients should live and the power to return them to that place if they leave without permission. This power can also be used to take patients for the first time to the place where they are required to live if they do not or cannot go there by themselves. If patients leave the place they are required to live without the Guardian’s permission, they can be taken into legal custody and brought back there. (Code of Practice Chapter 28)

15.13 The power to require patients to reside in a particular place may not be used to require them to reside in a situation in which they are deprived of their liberty, unless a deprivation of liberty safeguards (DoLS) authorisation is obtained under the Mental Capacity Act 2005.

15.14 A refusal without reasonable cause to permit an authorised person reasonable access is an offence under Section 129 MHA 83. Similarly, it is an offence under Section 127(2) MHA 1983 for anyone to ill-treat or wilfully neglect a person subject to Guardianship.

15.15 It should be noted that there is no implied power to force entry to a house where a person is living but if it is felt necessary to do so then Police assistance should be sought under Section 135 MHA 83.

15.16 Please see Appendix 16 for additional guidance and procedures regarding Guardianship Orders.

# 16 S136

# The Policing and Crime Act 2017

**Change** **in Law around Section 136**

As of Monday 11th December, 2017 the Policing and Crime Act 2017 changes to Section 136 come into effect. These are important changes that alter the way in which S.136 is used. Bleep Holders need to be aware of them and work to the new legal position.

**Reduction in Time Period**

The maximum detention period under S.136 reduces from 72 to 24 hours. This is a big reduction but in fact we have been completing assessments within 24 hours in the overwhelming majority of cases.

It is possible for the doctor conducting the assessment to extend the detention period by a maximum of 12 hours. This can only be because it has not been possible to complete the assessment due to the patient being too disturbed, too intoxicated or for another clinical reason. It is **not** possible to extend the detention period because of delays in the doctor or AMHP arriving, or because the patient has been assessed and is waiting for a bed.

See attached local NELFT form to authorise the extension. This can only be completed by the assessing doctor. Forms should be attached to the S.136 paperwork and sent to the MHA Office, who will scrutinise them.

**Options if the 24/36 hour period is reached and the situation is unresolved**

It should be exceptional that this happens, but the exceptional can happen and staff should be prepared. Options include:

* The patient may agree to stay informally until an assessment is completed or, if it has been completed, until arrangements are made for the patient’s admission or discharge
* An application can be made for a Section 2 if it is absolutely necessary e.g. because a bed cannot be found on an inpatient ward. The patient can be made subject to a S.2 whilst remaining in the Section 136 Suite. Although lawful this is clearly not good practice and should only be for a short period until a suitable inpatient ward can be found. It is essential that the patient is made as comfortable as possible with a 1.1.nurse, bed if staying overnight, Responsible Clinician, Treatment Plan. In such instances Section 2 should be used and the application made out to Sunflowers Court.
* If the patient over-stays the 24/36 hour limit this should be documented on Datix as a breach of the Mental Health Act and the investigating officer should identify measures to prevent this happening in future

**Police Consultation with a Mental Health Professional**

Police will be required to consult with a MH professional before using S.136 ’where practicable’. Police are likely to interpret this as where it is safe and lawful to do so, so in the case of someone who is very disturbed or refusing to remain with police whilst they phone, it will not happen. Where it does happen police may phone e.g. Street Triage, the Bleep Holder, duty doctor , duty AMHP. The main purpose of the discussion will be to help identify whether the person is mentally unwell, whether there are better alternatives to use of S.136, if S.136 is appropriate which is the most suitable Place of Safety. It will give MH professionals some opportunity to influence use of S.136 for the better e.g. to direct someone to go to A&E not Sunflowers Court, or vice versa, or to suggest alternative strategies for a repeat presenter. The requirement to consult does not mean that the police are bound by any advice they receive.

**Change in the Definition of a Public Place**

A public place will become any place that is not a private house or other dwelling place. In other words it will include not just parks, roads, railway stations etc.  as it has always done but hotel or hostel rooms, railway lines, any area of a hospital, office block, shop. This broadens the scope of the power and removes many grey areas. It will remain unlawful for police to detain someone on a S.136 who is in a private dwelling, including an attached garden, shed, or garage. Overall scrutiny of this should be left to the MHA Office as part of their monitoring of the section’s use. S.136 patients should not be refused because it is suspected that the person was in a private dwelling when detained, though concerns can be flagged up with the MHA Office/ MH Law Manager.

**Restrictions on use of a Police Station**

It will be unlawful ever to use a police station as a place of safety for anyone under the age of 18. For adults a police station should only be used if it is absolutely essential because it is not possible to manage the patient safely in a health based place of safety. In fact it is unheard of for patients in NELFT’s area to go to a police station under S.136 but it should not be ruled out. The usual alternative will be to negotiate with police to remain with a patient until they are calmer. If a police station is used for an adult, a health professional must remain with them at all times.

**Power to Search**

There is now a specific power to search under S.136. Police should always search the patient before completing handover, if the search was not conducted before the patient arrived at the place of safety

16.1 Prior to an AMHP assessing a person who is detained under s136, the person should be assessed by a doctor on duty at the place of safety. If the doctor assesses that the person has no mental disorder, the person must be immediately discharged and does not require an AMHP assessment. If the person does have a mental disorder, then the AMHP should discuss with the referrer to agree if the plan is to discharge, admit informally, or assess further under the MHA.

16.2 If further assessment under the MHA is required, the AMHP should ascertain, if the doctor who had initially assessed can make a medical recommendation. If this doctor does not have sufficient experience to make a medical recommendation, then the AMHP should then liaise further with the referrer to facilitate the assessment with another doctor on duty and book a s12 approved doctor as required.

16.3 When a person is detained on a s136, the Metropolitan Police Service complete a s136 yellow form. This form should be completed by healthcare staff based at the place of safety, and not the AMHP.

16.4 s136 cases can be transferred form one place of safety to another. Currently this can be authorised by a police officer, AMHP, or doctor or nurse based at the place of safety. Both places of safety must agree with the transfer.

16.5 The Policing and Crime Act 2017 introduced changes regarding some aspects of s136. This includes changing who can authorise s136 transfers. Only a police officer or an AMHP can authorise the transfer of the person detained under s136. The AMHP does not necessarily have to personally see the detained person, but can only authorise transfers if it is in the person’s best interests to do so. The person in charge of the place of safety would remain responsible for any practical arrangements regarding the transfer, including liaison with the purposed place of safety.

16.6 Whilst the AMHP must be aware of guidance that a person should be seen within 4 hours, there may be occasions where this is either not possible, or it would not be in the persons interests to do so. For example, a person detained during the middle of the night may benefit from an assessment the following day, when the person has rested and arrangements regarding discharge can be more readily considered.

16.7 A full AMHP reports is required for any assessment of people detained under s136. This would include people who are informally admitted, or discharged home following the assessment.

# 17 Short term Holding powers

17.1 S5(2) and S5(4) are short term holding powers for informally admitted patients.

17.2 Persons detained under s5(4) can be held at the hospital for a period up to 6 hours. During this time, the person should be seen by a doctor who has the authority to assess under s5(2)- ie the RC or their delegated deputy. If the doctor competes a s5(2) authority, an AMHP should be called so that necessary arrangements can be made. This may include further review by the RC if the s5(2) was completed by a deputy/duty doctor. If the s5(2) was completed by the RC then arrangements should be made for a full MHA assessment. If a s5(2) is completed out of hours, the on call AMHP should agree with the ward if the assessment must be done immediately- eg in case where urgent treatment under the MHA is required, or if the case can wait until assessment via the daytime AMHP service.

# 18 Safeguarding

18.1 A vulnerable adult at risk is anyone aged 18 and over who:

•has needs for care and support

•is experiencing, or at risk of abuse or neglect

•is unable to protect themselves against significant harm or exploitation

18.2 If during an assessment, the AMHP reveals a Adults Safeguarding concern then the AMHP must complete a Safeguarding Adults concern form and email to the appropriate team.

18.3 Similarly if a AMHP reveals a child protection or a child in need issue, then the AMHP must make a referral to the Children’s Triage Service. The referral can be made online via the LBBD Homepage. The Children’s triage s be contacted on …………tbc………..during office hours or on …………tbc…….. at any other time.

18.4 Both Safeguarding Adults and Safeguarding Children guidance advise that it is the professional who first comes across the safeguarding concern who should make the referral to the relevant team.

# 19 Social Supervision and Restriction Orders

19.1 What is a Restricted person?

A restricted person is someone who has been detained under Part 3 of the Mental Health Act and has been convicted of an offence or found unfit to plea because of mental ill health and subsequently placed in hospital. People in this category can be detained on several different sections of the Mental Health Act; the most commonly used is section 37/41. The section 37 is the hospital order and section 41 is the restriction order.

19.2 What does restriction mean?

It means that the Ministry of Justice (MOJ) make all decisions about restricted people including community leave, transfer or discharge. A doctor cannot make those decisions.

19.3 What is the role of a Social Supervisor?

The term ‘Social Supervisor’ refers to the professional who provides reports to the Ministry of Justice about a restricted person who has been ‘conditionally’ discharged from hospital into the community. A Social Supervisor can be any mental health professional with knowledge of the restricted person. Social Supervisors and their employing organisation must understand and implement the MOJ guidance on ‘conditionally’ discharged patients. They must be adequately trained and supported to undertake this role.

19.4 The person conditionally discharged from the hospital remains subject to Section 37/41 of the Mental Health Act. The Social Supervisor has to report on the person’s wellbeing, progress towards goals, any significant life events, changes in circumstances and any potential risk to the public on a regular basis. A statutory report has to be completed initially within 28 days of the discharge and quarterly thereafter. This report is usually completed jointly with the Supervising/Responsible Clinician.

19.5 The key to the effectiveness of the role is that the Social Supervisor endeavours to establish a good rapport with the person and provides a supportive role alongside the supervision and monitoring required. It would be expected that a Social Supervisor would visit the person once a week initially following discharge and then less frequently, but regularly, when the person becomes more settled in the community. The Social Supervisor should liaise with any services the person receives or uses and visit them at home at least quarterly to ensure they have a rounded picture of the person’s life. In addition it is expected the Social Supervisor would have regular discussions about the restricted person with the Supervising Clinician.

19.6 The Social Supervisor has the power to seek permission from the Ministry of Justice to recall the person back to hospital from the community.

19.7 The Recall Process

The Social Supervisor is responsible for the coordination of the recall process. This includes liaising with other professionals involved in the person’s care and ensuring that this process is completed, i.e. the recalled person is admitted to the specified ward and hospital.

19.8 In preparation for the possibility of recall being needed the community team (including the clinical and social supervisor) should have agreed and recorded a threshold and plan for recall of the person to hospital. However, there must be sufficient flexibility in the plan to respond to unexpected or unforeseen grounds for concern. Social Supervisors should discuss any concerns with the Ministry of Justice immediately, and recognize that the Ministry of Justice may take a different view about the threshold for recall.

19.9 It is not possible to specify all the circumstances in which the Secretary of State may decide to exercise powers under section 42(3) of the Mental Health Act to recall to hospital a conditionally discharged patient, but in considering the recall of a patient he will always have regard to the safety of the public. There will always be an MH Case Work Section officer (MHCS) available within the MOJ to discuss the case, and work with the authority to instigate recall. MHCS staff will not over-react to any concerns expressed, but the lesson of a number of homicides committed by restricted patients is that failure to report concerns in timely fashion has proved fatal. A report to the Ministry of Justice should always be made of situations where:

• There appears to be an actual or potential risk

• Contact with the patient is lost or the patient is unwilling to co-operate with supervision

• The patient is admitted to hospital for any reason

• The patient’s behaviour or condition suggests a need for further in-patient treatment in hospital and / or

• The patient is accused of, charged with or convicted of a serious offence, or an offence similar to the Index Offence and / or

• The patient’s relatives or carers have expressed concern about the patient’s behaviour or condition.

19.10 The is nothing in the MHA that precludes restricted patients being informally admitted. However, in such cases the MOJ Casework team should be notified. If a request for a restricted patient to be assessed for either a s2, s3 or s4, then the MOJ Casework team should be contacted to consider a recall. Similarly, if a person is detained via the MHA and it is later discovered they are a restricted patient the MOJ casework team should be contacted to consider recalling.

19.11 A fax or scanned copy of a MOJ recall notice is sufficient authorisation for detention in hospital.

19.12 The MOJ Casework team can be contacted on 020 3334 3335. Outside office hours the duty officer at the Home Office should be contacted on 020 7035 4848, who will in turn contact a member of the Mental Health Casework Section staff at home. A telephone report should be followed up by a written report as soon as practicable.

19.13 If a s135(2) warrant is required, it would be the responsibility of the social supervisor, or a representative from their team, to make the warrant application and the arrangements to execute.

19.14 Below is a link for the MOJ Guidance for Social Supervisors.

<https://www.google.co.uk/url?url=https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/guidance-for-social-supervisors-0909.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjr3cXxl9rPAhWMIsAKHaR9DKMQFggYMAA&usg=AFQjCNFLyL4UE2j9QGsslnh5bwWUpb3X0Q>

# 20 Advocacy

20.1 People who are subject to certain parts of the MHA have the right for support from an Independent Mental Health Advocate (IMHA). The following categories of people have the right of access to a IMHA:-

* Anyone who has been detained in hospital under a section lasting over 72 hours
* Informal or voluntary patients who are being considered for section 57 treatments (neuro surgery/hormonal implants)
* Under 18 and being considered for electro-convulsive therapy (ECT) or any other treatment to which section 58A applies

For LBBD residents in the community:

* People on Community Treatment Orders (CTO’s)
* People who have been conditionally discharged from hospital
* People on leave of absence (s17)
* People who are subject to a Guardianship Order

20.2 The MHA outlines that the support which IMHAs provide must include helping patients to obtain information about and understand the following:

• their rights under the Act

• the rights which other people (eg the nearest relative – see chapter 5) has in relation to them under the Act

• the particular parts of the Act which apply to them (eg the basis on which they are detained) and which therefore make them eligible for advocacy

• any conditions or restrictions to which they are subject (eg conditions of leave of absence from hospital, conditions of a CTO, or conditions of conditional discharge)

• any medical treatment that they are receiving or might be given

• the reasons for that treatment (or proposed treatment), and

• the legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment.

20.3 The Act enables IMHAs to help patients to exercise their rights, which can include representing them and speaking on their behalf, eg by accompanying them to review meetings or hospital managers’ hearings. IMHAs support patients in a range of other ways to ensure they can participate in the decisions that are made about their care and treatment, including by helping them to make applications to the Tribunal.

20.4 AMHP should always inform any detained person of their rights to access an IMHA. AMHPs should normally refer a person to the IMHA service if they are detained, lack capacity to consent to informal treatment, and do not have the active involvement of a nearest relative.

20.5 Currently (June 2017) IMHA services are provided by Cambridge House. Telephone referrals to the IMHA service can be made via ………

# 21 Lone Working

21.1 AMHP’s should be familiar with LBBD’s Violence and Aggression at Work and Lone Worker Protection Policy available via the LBBD Intranet

21.2 In order to reduce or manage potential risks, AMHPs must always carry with them a working mobile phone issued by LBBD. AMHPs must also be offered a personal panic alarm and record kept if has been accepted or refused.

21.3 AMHPs who are working away from the AMHP office must call in at the end of the day to notify the senior AMHP on duty that they are finished for the day. If the senior AMHP on duty does not receive a call, then they must call the relevant AMHP to ensure their safety. If the senior is not available, then they can delegate this task to a named member of staff.

# 22 Incidents

22.1 All incidents should be notified to the senior AMHP on duty as soon as possible and be reported and investigated in line with LBBD Adult Directorate’s Serious Incident Reporting Policy and Procedure.

22.2 A Serious Incident in the context of this procedure is defined as a situation which may seriously harm staff, people who use the service, or others. It may also involve financial irregularities. It includes serious damage to Council premises which may disrupt the delivery of services and serious breaches of confidentiality.

22.3 A serious incident in Adult Social Care (ASC) requiring investigation is defined as an unexpected or avoidable death, or serious harm caused to a customer, staff or member of the public within ASC funded or commissioned services. Examples include:

• Unexpected or avoidable death

• Serious risk or harm to customers, staff or members of the public, including any incident when a members of staff is assaulted.

• A scenario that prevents or threatens an organisation’s ability to continue to deliver the service(s), e.g. fire in premises, bankruptcy

• Allegations of abuse (physical, sexual or emotional) of a staff member by a colleague, customer or carer

• Customers reported as missing persons who are not found within 24 hours

• A missing person who poses a serious risk to self, others or the organisation which should be reported immediately

• A situation that potentially brings the organisation into disrepute

• Financial irregularities in a provider organisation

• Failure in Information Governance, e.g. the breach, loss or theft of confidential data of customers, carers or staff.

22.4 It is acknowledged that work undertaken by AMHPs can often be within a challenging and hostile atmosphere. When incidents do occur the AMHP involved should be given any necessary support which would include opportunities for de-briefing by the senior AMHP on duty.

# 23 Complaints

23.1 LBBD complaints procedure must be followed. Complaints will initially be considered by the AMHP Senior, who in turn may delegate the complaint investigation and response to the AMHP manager.

# 24 Legal Support

24.1 At present, legal support is made available to AMHPs via the legal services provided by LBBD’s legal team. The Principal Lawyer for Community Teams is currently …………tbc….. and his contact number is

………tbc……………

24.2 Any request for legal support should initially be discussed with the AMHP Service Manager, AMHP Senior or Head of Mental Health Service.

Legal support should be sought in the following circumstances:

* Any case where a s29 nearest relative displacement is being considered.
* Any request for action or information made by a legal representative.
* Any other legal matter that would have the potential of significant adverse outcomes either for customers, staff or LBBD

# 25 AMHP Reports

25.1 All AMHP’s must write an AMHP report following any assessment including assessments resulting in informal admission or no admission. The following documentation must be completed by the AMHP who has undertaken an assessment whether the outcome is to detain under a section, admit informally or to discharge etc:

1. Full AMHP Report on Liquid Logic
2. Nearest Relative Letter (for s2, 3 and 4)

Full AMHP Report:

25.4 The full AMHP Report must be completed within 48 hours however a brief outline of outcome of the assessment should be recorded on LAS and RiO following the assessment

25.5 Once completed, a PDF version should be emailed

* amhplbbd@lbbd.gov.uk
* any other relevant team- eg where safeguarding concerns are present, or if a carers assessment is required.

25.7 When emailing reports, AMHPs must include the name of the person being assessed and the date of the assessment within the email.

25.8 The AMHP Business Support Officer will be responsible for monitoring that all reports are received within the required timescales.

Nearest Relative Letter:

25.9 AMHPs must send a letter to the nearest relative of any person detained under s2, s3 or s7.

# 26 Audits

26.1 On a monthly basis the AMHP Service manager will audit 10 reports. Feedback from these audits will be given to the individual AMHP, and an anonymised summary discussed at the AMHP forum.

26.2 Quarterly reports will be completed on AMHP assessments in addition to a Annual Report.

# 27 Rota

27.1 AMHP rotas should be sent out at least one month prior to commencement. In addition weekly reminders are sent out by the AMHP Service Business Support Officer. AMHPs must ensure that they record their AMHP commitments in their diary. The AMHP Business Support Officer will take into account any booked leave if this is notified to them prior to the rotas being devised.

27.2 If AMHPs are aware they are not able to cover any other their allocated shifts, then they should arrange with an AMHP colleague to cover or swap the shift. Any swap should be notified to the Consultant SW and the AMHP Business Support Officer who then records any changes on the master rota.

27.3 If an AMHP is on sick leave, or other urgent unplanned leave, then the AMHP can request cover via the Consultant AMHP or via AMHP Service Manager

27.4 In the event of additional AMHP support being required to compliment the AMHP rota (eg when AMHPs are off sick, or during periods of exceptional demand), a list will be maintained to ensure even workload

27.5 Whilst on AMHP duty AMHPs must have a functioning LBBD mobile phone at all times. AMHP should regularly check for messages if they are not able to answer calls immediately.

27.6 No more than one full time AMHP should be authorised to take annual leave at time.

# 28 TOIL

28.1 If an AMHP accrues TOIL whilst on duty, they must email the Consultant AMHP and AMHP Service Manager the following working day outlining how much TOIL was accrued and a brief summary of the reasons. The Consultant AMHP or AMHP Service Manager must then reply via email confirming that the TOIL is authorised and CC’s the AMHP line manager. TOIL should be taken back within one month, and no more than 15 hours should be accrued. Any TOIL taken back needs to be agreed by the worker’s line manager in advance.

# 29 Roles and responsibilities

29.1 **AMHP Service Manager**

* Strategic planning and management of AMHP service
* Managing the operation of EDT/OOH service
* Audits
* Supervision, performance management, etc of Consultant AMHPs
* Recruitment
* Policy and Procedures
* Approval
* Annual and quarterly reports
* Chair of AMHP Forum

29.2 **Consultant AMHP**

* Day to day operational management of AMHP service
* Audits
* Approval
* Training
* Annual and quarterly reports
* Deputise AMHP Service Manager to Chair AMHP Forum

29.3 **AMHP Workflow Organiser**

* Rotas
* Maintaining database
* Financial processing, invoices S12 Doctor payments etc
* Occasional screen calls to AMHP service. However, the workflow organiser should not be required to cover the AMHP service alone for extended periods (I e more than 1 hour)