Approved Mental Health Professional (AMHP) Service

Operational Policy

London Borough of Waltham Forest

& NELFT

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# Introduction

* 1. Approved Mental Health Processionals (AMHPs) have a range of responsibilities in relation to the Mental Health Act 1983/2007 (MHA). This operational policy is intended to provide detailed guidance regarding the role and remit of the AMHP service in the London Borough of Waltham Forest.

# Scope of Operational Policy

2.1 This Operational Policy and guidelines should not be considered as a substitute for the Mental Health Act itself, nor any associated statutory guidance and regulations.

2.2 In addition to the Mental Health Act, AMHPs should work within the parameters and guidance of the Mental Health Act 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. In particular, the least restrictive principle enshrined in the Mental Health Act Code of Practice (2015). Other related legislation should also be considered at all times in AMHP practice where appropriate, such as the Mental Capacity Act (2005) and the Care Act (2014),

2.3 London Borough of Waltham Forest and NELFT related policies and procedures should also be followed at all times - eg Safeguarding procedures, Serious Incident Reporting, etc.

# 3 AMHP Approval and re-approval process

This policy relates to AMHPs directly employed by the London Borough of Waltham Forest including AMHP’s employed on an agency basis. These procedures address the approval, re-approval, suspension and termination of AMHPs working on behalf of the London Borough of Waltham Forest.

**Legal Context**

**Granting approval p704 (Jones, 22nd Edition)**

3.1 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.”

3.2 The MHA 2007 amended section 114 permits the LSSA to approve registered Social Workers, Nurses, Occupational Therapists and Chartered Psychologists who have completed a recognised AMHP training programme.

3.3 The regulations for approval and re-approval of AMHPs are laid out in Schedule 2 of the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 (Appendix 1)

3.4 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 take into account 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) (Noor the Care Council for Wales.

**Approval Criteria and Procedure**

3.5 In order for a person to be approved by London Borough of Waltham Forest to act on their behalf, the following conditions must be met:

1. Evidence of a valid Professional registration certificate/document must be provided.
2. If previously approved by another Local Authority confirmation from their previous AMHP supervisor that they are competent to practice and were approved by their previous employing authority must be sought.
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.

3.6 Prior to approval in the London Borough of Waltham Forest, the worker will be required to shadow several MHA assessments and take the lead on several assessments as well. The exact number of shadows and leads will be determined on an individual basis by the AMHP manager and will be dependent on a number of factors including the experience of the worker.

3.7 The worker will then have to attend an approval panel which will ideally consist of the AMHP Manager, the Head of Mental Health Service, &/or the Mental Health Act Manager, or a senior manager available who understands the AMHP role and legality.

3.8 At this panel, the worker will discuss the assessments they have lead and must demonstrate that they meet the competence criteria outlined in Schedule 2 of the AMHP approval regulations (see appendix 1)

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

3.10 If an AMHP is already approved by another authority, the London Borough of Waltham Forest AMHP manager must notify that authority that the AMHP has been approved by Waltham Forest

3.11 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. Where an AMHP is practising in Waltham Forest but approved by another area than the Waltham Forest, the AMHP manager should maintain contact with the other authority to ensure there are no practice issues arising. Where this is the case, the approving Local Authority should notify the Waltham Forest AMHP manager.

3.12 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.**

3.13 AMHP’s must be re-approved to practice every 5 years. It is the responsibility of the individual AMHP to inform the AMHP manager when their 5 year period of approval is coming to an end, providing at least 3 months notice. The AMHP manager will then arrange for their re-approval panel.

3.14 Prior to the re-approval panel the AMHP will be required to submit a portfolio which includes 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).
* Copies of AMHP reports for 4 assessments completed in the previous 12 months.

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

3.16 Following successful completion of the panel, the AMHP will have their approval period extended for a further 5 years.

3.17 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 re-approval panel. The AMHP competencies are listed in appendix 1

3.18 Agency AMHPs who are approved for a period of 1 year may be re-approved following submission of 3 AMHP reports and review at the re-approval panel. Agency 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**

3.19 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. At any time, a panel may be convened to consider the current approval of an AMHP working on behalf of London Borough of Waltham Forest.

3.20 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.

3.21 In cases of termination of approval, AMHPs must return their ‘warrant’ card to the AMHP manager.

**Relinquishing AMHP role**

3.22 Where an AMHP wishes to step down from the role and responsibility of being an AMHP, they will be required to put this in writing to the AMHP manager and Head of Service for their consideration giving an explanation for this decision and providing at least 3 months notice where possible.

**Conditions of Approval**

3.23 The continuing approval of an AMHP in the London Borough of Waltham Forest 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 the London Borough of Waltham Forest 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 the London Borough of Waltham Forest of their approval by another authority. AMHPs shall notify the London Borough of Waltham Forest if they are suspended or cease to be registered with the HCPC or other relevant professional register.

**Rota requirements**

3.24 Once an AMHP is approved by the London Borough of Waltham Forest, AMHP’s who are employees of the London Borough of Waltham Forest and agency AMHP’s are required to commit a minimum number of days per month to the AMHP rota. The number of days the AMHP must commit per month is dependent on the substantive role of the employee. This is detailed below –

* Practice Manager and team managers – required to be on the AMHP rota once every 3 weeks minimum.
* Care coordinator/Social Worker – required to be on the AMHP rota once every two weeks minimum.

3.25 For permanent employees, this commitment is linked to the AMHP payment they receive. This payment is current received on a 6 monthly basis.

# 4 Record keeping

4.1 The London Borough of Waltham Forest AMHP service will keep records of the following:

* The names and professional status of all the approved AMHPs.
* The date of the AMHP’s initial approval and subsequent approval dates.
* 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 the London Borough of Waltham Forest to undertake the AMHP training course. At present, this course is provided by the North East London Training Consortium, of which London Borough of Waltham Forest is a partner. The training will be accredited through the London Metropolitan University from 2022/2023.

5.2 Potential candidates must be nominated by their line manager and ideally have at least 2 years post qualifying experience, although each case will be looked at on an individual basis to assess suitability for the AMHP training.

5.3 Potential candidates would be expected to express an interest in the training via their line manager to the AMHP manager. They would then arrange to spend a number of days shadowing the AMHP service to ensure they feel ready to undertake the training.

5.4 If the candidate still wishes to pursue AMHP training after spending a few days shadowing the AMHP service, and their suitability for training has been ascertained by the AMHP manager in agreement with the Head of Service for Mental Health and the candidates own line manager, then the candidate will be expected to complete a pre-AMHP course. This course requires the candidate to provide a written assignment based on a number of observed MHA assessments.

5.5 Once the candidate has successfully passed the pre-AMHP course, they are then able to go through the university enrolment process and enrol for the AMHP course. The AMHP course involves a mixture of academic study weeks and placement weeks with the AMHP service.

# 6 Supervision and Support Arrangements

6.1 All practising AMHPs are required to have regular monthly AMHP focused supervision. If their current supervisor in their substantive post 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. Individual supervision can also be requested at any time by either party.

6.3 In addition, all AMHPs will have access to the monthly AMHP forum, where AMHP practice and reflective discussions can take place. AMHPs will be expected to attend the AMHP forums if possible or provide apologies if unable to do so.

6.4 AMHPs should always have access to debriefing discussions, particularity after complex or challenging assessments. This is facilitated by the AMHP manager or senior AMHP on duty.

6.5 At all times when on duty, AMHPs should be able to contact the AMHP manager or senior duty AMHP with whom they can consult regarding assessments.

# 7 Referral Process to the AMHP Service

7.1 The AMHP Service is operational between the hours of 9.00am to 5.00pm Monday to Friday (excluding bank holidays).

7.2 Referrals to the AMHP service are received from a variety of sources. Any enquiry or referral request for a Mental Health Act Assessment should be made via telephone (0300 555 1246) or in person if possible. An email can be sent to the AMHP@nelft.nhs.uk email address outside of working hours but should always be followed up by a phone call to ensure the referral has been received and to enable the duty AMHP and/or AMHP manager to discuss the referral with the referrer. This discussion will enable the AMHP service to accurately assess the urgency of the referral and make plans for completion of the Mental Health Act assessment.

7.3 Upon receipt, referrals will be triaged and the urgency of each referral assessed on a case by case basis, primarily with regards to immediate risk to self and others. Certain referrals will take precedence as detailed below –

* Referrals for assessments for people in police custody at a police custody suite.
* Referrals for assessments for people detailed under Section 136 either in the Health Based Place of Safety at Goodmayes Hospital or at King George A&E.
* Referrals for young people and particularly vulnerable people in the community.
* Referrals where the risk to self or others appears to be high.
* Referrals for people currently in the community, particularly those living alone without support.
* Referrals for patients detained under Section 2 requesting assessment for Section 3
* Referrals for CTO discharge and renewal.

7.4 When a referral is received, it is the responsibility of the duty AMHP or AMHP manager to gather as much information as possible and complete the assessment request form. All referrals should be screened by the duty AMHP and/or AMHP manager to ascertain its urgency and formulate an action plan. This may mean arranging a Mental Health Act Assessment or preparing a warrant statement. Once a referral is received the AMHP should record this on the patient’s RiO record on a progress note, detailing the plan.

7.5 If a referral is not accepted, the AMHP must inform the referrer why this is and record this on the patient’s RiO record on a progress note.

7.6 The clinical needs of the patient, including assessment and management of risk will continue to be held by the relevant community team even after the referral has been made to the AMHP service for a Mental Health Act Assessment. The referrer should continue to try and engage with the person in question and should notify the AMHP service of any changes in the persons circumstances such as risk issues or change in social circumstances etc.

7.7 Following a referral to the AMHP service arrangements will be made by the to arrange a Mental Health Act Assessment. This may include applying for a s135(1) warrant application and liaison with the Metropolitan Police Service as appropriate. The AMHP service will endeavour to regularly update the referring team regarding the plan to carry out the assessment as well as update the patient’s RiO progress notes.

7.8 It is expected that where possible doctors from the referring team should provide first medical recommendations and/or be available to support with any arranged Mental Health Act Assessments.

7.9 All referral’s received, and outcomes of assessments should be communicated to the business support officer.

Hospital referrals

7.10 Referrals from the inpatient service at Sunflowers Court and any other inpatient unit should be made via telephone. There should be sufficient notice given to the AMHP service for request for Section 3 assessment and CTO discharge meetings. This should ideally be no less than one week. Referrals provided at late notice may not be able to be completed before the Section 2 expires. The inpatient service should also inform the patient and any relatives/carers that the application for a Section 3 or a CTO is being made.

S136 Suites

7.11 Referrals from the Health Based Place of Safety Suite and any other 136 suite should be made via telephone. Information relating to the time that the Section 136 started should be provided at the point of referral. A referral should be made to the AMHP service as soon as is possible to enable time to gather information and arrange any assessment if needed.

Police and custody referrals

7.12 Referrals from custody psychiatric liaison staff should be made via telephone.

Other agencies and Nearest Relative Requests

7.13 Referrals for a Mental Health Act assessment from other agencies (eg GP’s, housing, care homes, etc) and members of the public, should initially be considered by the relevant community mental health team or the Single Point of Access team and then only referred to the AMHP service if it is confirmed that there is a need for a Mental Health Act assessment.

7.14 A nearest relative has the right to request mental health services to consider if detaining their relative under the Mental Health Act is appropriate (S.13). If a Nearest Relative has made a specific request for an assessment to be carried out this should be discussed with the AMHP manager to agree how this will be considered.

7.15 Where the AMHP has considered a patient’s case at the request of the nearest relative and no application has been made, the reasons for this must be provided 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. (Code of Practice, 2015 - CH14.102).

7.16 If a Mental Health Act assessment is required for a Waltham Forest resident at a Court, then the AMHP should first liaise with the relevant Court Mental Health Liaison service.

# 8 Referrals regarding cases with connections to other areas.

8.1 The London Borough of Waltham Forest AMHP Service will primarily conduct Mental Health Act Assessments for patients who reside in the London Borough of Waltham Forest. Usually, assessments will take place within the boundaries of Waltham Forest authority area, although there may be occasions when a person is outside of the borough and requires a Mental Health Act Assessment. If practicable, the London Borough of Waltham Forest will always endeavour to undertake assessments for patients who are the responsibility of Waltham Forest.

8.2 Circumstances where a Waltham Forest patient my need an assessment outside of the borough boundaries could be for example if they have been placed in temporary accommodation in a neighbouring borough or placed in a specialist hospital ward outside of the borough.

8.3 The London Borough of Waltham Forest will undertake assessments on Waltham Forest patients in Goodmayes Hospital, as well as Waltham Forest patients in King George Hospital.

8.4 There may be circumstances when a person who is not ordinarily resident in Waltham Forest requires a Mental Health Act Assessment. For example, when they have been placed in temporary council accommodation in the borough, or in supported accommodation/care home. In these circumstances, the London Borough of Waltham Forest AMHP Service must consider planning for a Mental Health Act assessment to be completed. However, all necessary steps must be taken to contact the borough of origin and if practicable asking them to undertake the assessment. Where a dispute arises about whose responsibility it is to complete an assessment, this must be escalated to the AMHP manager. This underlies principles set out in Section 13 (Mental Health Act, 1983/2007).

8.5 If the London Borough of Waltham Forest AMHP Service agree to carry out an assessment on behalf of another borough, written confirmation must be received from the borough of origin detailing that Waltham Forest are doing the assessment on their behalf and that the borough of origin will retain any Section 117 aftercare responsibilities.

8.6 The borough of origin would also be expected to make contact with the Nearest Relative in the first instance to ascertain if they are going to object (Section 3 assessments only) because if this were to be the case, the borough of origin would be the borough to displace the Nearest Relative if appropriate.

# 9 Section 135 (MHA) Warrant Applications

9.1 There are 2 types of warrants under the provisions of the Mental Health Act:

* 135(1) warrants are to ‘search and remove patients’ from settings in the community - usually their own homes. Applications for s135(1) warrant can only be made by an AMHP. It is the responsibility of the London Borough of Waltham Forest 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 s41, and patients liable for 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.

9.2 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 LBWF in the case of Guardianship).

9.3 In the case of a patients recalled under a CTO, applications for s135(2) warrants can be made by the Care Coordinator or the AMHP service. The decision as to who is best 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.

9.4 For patients subject to s41, 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.

9.5 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 or the AMHP Service. In the cases of detained patients who have absconded 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 LBWF AMHP service can make the s135(2) application if a LBWF 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.

9.6 The AMHP Service is able to provide support and guidance to anyone who is making an application for a Section 135(2) warrant.

9.7 The warrant application process is described in appendix 2.

**Executing Section 135 warrants**

9.8 Once a warrant is obtained from the Magistrates Court a request is made to the police asking for their support to execute the warrant. Once the police provide a time for the warrant execution, the AMHP Service should ensure the team responsible for the patient’s care is made aware and take the necessary steps to arrange the warrant execution (booking of ambulance, arranging access to the property, arranging doctors to attend etc).

9.9 With regard to Section 135(1) warrants, the person being assessed must give their consent for an assessment to take place in their home. They may or may not have the capacity to provide this consent and this is something which must be judged by the attending AMHP and addressed in the AMHP report afterwards. If consent is not given, or it is felt it is not safe to hold the assessment in the person’s home, the warrant does allow for the person to be removed and taken to a place of safety for the assessment to take place.

# 10 Arranging Mental Health Act assessments

10.1 Upon receipt of a referral requesting a Mental Health Act assessment, the AMHP receiving the referral should gather as much information as possible to triage the referral and plan what actions need to be taken next. This may include scheduling an assessment or completing information needed to apply for a Section 135 warrant. The AMHP manager on duty can be consulted if there are any uncertainties on how best to proceed with a referral.

10.2 When arranging a Mental Health Act Assessment, the AMHP should always in the first instance try to arrange for doctors who have acquaintance with the patient to attend any assessment – ideally this will be the doctor in the team the patient is known to.

10.3 Additional independent Section 12 approved doctors can also be booked as required. AMHPs should attempt to use doctors with the appropriate level of skill and expertise in accordance with guidance in the Code of Practice (2015).

10.4 When booking doctors for a Mental Health Act assessment, the AMHP should be aware of any potential conflict of interests. These are listed in appendix 3. Most commonly, conflict of interest arises where one assessing doctor is line manager to the other assessing doctor.

10.5 For planned community assessments, ambulances can be booked via the agreed procedure with the London Ambulance Service/Secured ambulance. Ambulances should be booked with as much notice as possible to ensure availability.

10.6 Consideration needs to be given as to how access to the person being assessed home will be undertaken. If utilising a warrant, a locksmith may be used to help access/secure the property if forced entry is used. Ideally access to the property will be arranged via family members who may have a spare key to the property, or via housing officers.

10.7 The AMHP referral sheet completed by the AMHP’s at the point of referral contains a checklist to support with setting up of assessments. Ideally, all details should also be entered into the patient’s RiO record. The checklist provides prompts for the AMHP to consider when arranging an assessment such as:

* Doctors booked (do they have previous acquaintance)
* Ambulance
* How will property be accessed
* Is care coordinator attending
* ACAT need to attend to support with sourcing a hospital bed if needed
* Is an interpreter needed
* Will there be anyone else at the house – in particular any children.
* Will there be any other hazards at the house
* Contact with the Nearest Relative (see section below)

10.8 Interpreters should always be used if it is thought that understanding and communicating in spoken English may be a problem. Professional interpreters should always be used rather than family/friends of the person being assessed. Only in exceptional circumstances should non-professional interpreters be used and the reasons for this clearly recorded. Ideally face to face interpreters should be booked in advance for an assessment, however, phone interpreters can be used if needed in emergencies. For assessments carried out in hospital, then the ward should be asked to book an interpreter

10.9 If the AMHP service are aware that the person due to be assessed has any pets, then as far as possible, arrangements should be made in advance to ensure the pets are looked after in case the person is admitted to hospital. Ideally, this would involve liaison with family/friends to ask for support to look after the pets. However, if this is not possible then the Waltham Forest Animal Welfare Department can care for the animals until other arrangements are made. Funding should be agreed by the AMHP manager prior to any agreement for Waltham Forest Animal Welfare to look after any pets.

10.10 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.

# 11 Conducting Mental Health Act Assessments

11.1 Mental Health Act Assessments should always be carried out in accordance with the Mental Health Act (1983/2007) and the Mental Health Act Code of Practice (2015) guidance.

11.2 If the person requires admission under the Mental Health Act, it is the doctors responsibility to arrange for a suitable bed (Code of Practice 14.77). 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. However, this responsibility can be delegated to the trust manager (bed manager). In NELFT the bed management is for admission to Goodmayes Hospital is via the ACAT team.

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 this should be communicated to the Home Treatment team via ACAT who should be present at all assessments.

13.4 If there are any differences or disagreements between the doctors attending the Mental Health Act assessment and the AMHP as to the outcome of the assessment, this should in the first instance be discussed amongst the assessing team and if possible, a resolution that all parties agree with be sought. However, if the assessing doctors do not make medical recommendations for detention and the AMHP remains acutely concerned about the patient and of the view that detention is required, then this must be escalated via the AMHP manager in the first instance. It is possible in certain circumstances to ask another doctor for their view at a further Mental Health Act Assessment, but there must be very strong justification for this.

13.5 If the doctors attending a Mental Health Act Assessment do not complete medical recommendations then they should be asked to provide written reasons as to their decision and this should be uploaded to the patients electronic RiO record.

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

13.7 It is the AMHP’s responsibility to convey the detained patients to hospital. However, the AMHP may delegate this to a named person using the appropriate form (Appendix 4). This is usually delegated to the ambulance staff who must agree to accept responsibility to convey. The assessing AMHP must ensure that they receive confirmation that the person has been successfully conveyed.

13.8 AMHPs can request support from police to convey if there are significant risks of absconding or violence to others. However, police may or may not have the resources to support. In cases where a person who is liable to be detained is refusing to be conveyed to hospital, it may be that the AMHP must return with a Section 135(2) warrant and the support of police in order to take the person to hospital.

13.9 AMHPs should be aware of the interface between the Mental Health Act 1983/2007 and the Mental Capacity Act 2005. Further guidance is available in chapter 13 of the Mental Health Act Code of Practice 2015. In all assessments, the AMHP should try as much as possible to assess the person’s capacity to consent to admission to hospital or community treatment.

13.10 The AMHP should consult with the AMHP manager or senior AMHP on duty if there are any uncertainties as to whether the Mental Health Act or Mental Capacity Act/Deprivation of Liberty Safeguards should be used as the appropriate legal framework.

13.11 If an informal admission is planned, the AMHP must be satisfied that the person is able to give valid and informed consent to the admission. This would normally involve a detailed discussion with the person about the purpose of the admission as well as a discussion about what an admission to the hospital would be likely to entail (eg – discussions with doctors, being offered medication, not being able to come and go without asking a nurse to open the doors etc). The capacity assessment should be recorded in the relevant section of the AMHP report.

13.12 Any safeguarding concerns regarding either children or vulnerable adults identified during the assessment must be referred by the AMHP to the appropriate team. Safeguarding concerns, and any actions taken, must be recorded on the AMHP report and in the person’s RiO record. Information should also be shared with the person’s care coordinator and/or community team as well as any ward staff if the person is admitted to hospital.

13.13 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 such cases are outlined in s47 of the Care Act 2014.

13.14 After every Mental Health Act assessment, regardless of outcome – the AMHP must complete an AMHP report. This is the MH1 report which can be found on RiO under the Mental Health Act tab.

# 12 Nearest Relative

12.1 AMHPs are responsible for identifying, and either informing or consulting with the Nearest Relative in cases where the person is subject to assessment and detention under the Mental Health Act 1983/2007.

12.2 AMHPs must be familiar with the hierarchy as outlined within the MHA (S26) and clearly record how the Nearest Relative was identified within the AMHP report. If reasonably practicable, AMHPs should inform or consult with the Nearest Relative prior to the Mental Health Act assessment, as well as letting them know the outcome of the assessment and ensuring they have been informed of their rights.

12.3 Prior to a Section 3 assessment, the Nearest Relative should be consulted with, and a record made as to whether they object to the Section 3 application being made if this is the outcome of the assessment. This is an important statutory duty. AMHP’s should carefully record all attempts to identify and contact a Nearest Relative in the patient’s RiO record as well as the AMHP report completed after the assessment. Where an AMHP is aware of the existence of the Nearest Relative but is not able to consult them, the reasons for this should clearly be recorded on both the AMHP report and on RIO.

12.4 The aim of the consultation with the Nearest Relative will often mean that a full discussion of the case is necessary. This does not require the consent of the person being assessed.

**Objections/Displacement of Nearest Relative**

12.5 If the nearest relative objects to a Section 3 application, then an assessment can still take place, but the Section 3 application cannot be completed. If the Nearest Relative objects to a Section 3 application being made, then the AMHP should carefully record the consultation with the Nearest Relative and the reasons for any objection in as much detail as possible. If time allows, then a meeting should be arranged with the Nearest Relative and any involved professionals to try and explore any concerns the relative has.

12.6 If the objection by the Nearest Relative is deemed unreasonable by the AMHP, then this should be escalated as soon as possible to the AMHP manager and the Mental Health Act Office. If it is felt that the Nearest Relative will need to be displaced (Section 29, MHA 1983/2007) then legal advice will need to be taken from the Local Authority legal department. The AMHP will usually be asked to provide a report outlining the consultation with the Nearest Relative and the reasons why it is felt the objection is unreasonable and on what grounds.

12.7 In these cases, where possible, the AMHP should try to identify any other relative who may be suitable to act as Nearest Relative. If no other relative can be found/or is not felt to be suitable then the Local Authority can be nominated by the court to act as Nearest Relative. This would usually be the Service Manager for Mental Health. The court will ultimately decide on the matter of displacement and appoint an alternative Nearest Relative if appropriate.

12.8 Where a person is detained under s2, once the Court receives and formally accepts the application to displace the Nearest Relative, the s2 is then extended to allow the matter to be considered by the court. The application to displace the Nearest Relative must be attended by the AMHP who took part in the assessment.

**Delegation of Nearest Relative**

12.9 A patient’s Nearest Relative can delegate the role and functions of the Nearest Relative role to another person if they wish to do so. AMHP’s should ensure that they let Nearest Relatives know this information and offer guidance on how this can be done if they wish.

12.10 The person to whom the role and function of the Nearest Relative is being delegated to does not necessarily have to be a relative of the patient, but they do have to agree to take over the functions and role of the Nearest Relative. Request to delegate must be made in writing (Section 32(2)). There is a Nearest Relative delegation form that can be given to Nearest Relatives wishing to delegate their role and function to someone else (Appendix 5) however, this form does not have to be used and the delegation can be in the form of a written letter only. A copy of the form/letter must be stored on the patient record and a copy be provided to the Mental Health Act Office.

# 13 Community Treatment Orders (CTOs)

13.1 The AMHP service will be involved in the making (CTO discharge from hospital), renewing and revoking of Community Treatment Orders. The AMHP service may also become involved when a Responsible Clinician has recalled a patient under a CTO and the patient has failed to attend the hospital as stated on the CTO.

13.2 All referrals for CTO discharge, renewal and revocation should be made to the AMHP service via telephone providing as much notice as possible in all cases.

13.3 The AMHP business support officer will maintain a database of CTO cases and maintain the AMHP diary for planned CTO assessments (particularly CTO renewal assessments).

13.4 All CTO assessments will require the CTO assessment report to be completed.

**Making of a CTO (discharge from hospital on CTO)**

13.5 If a CTO discharge is proposed for a patient in hospital, then the ward should give the AMHP service as much notice as possible before the planned CTO discharge meeting is due to take place (at least one week). This will give the AMHP service time to gather the necessary information.

13.6 The AMHP Service will want to ascertain whether or not the proposal for CTO discharge has been discussed with the community team that will be managing the CTO in the community and consider any proposed discretionary conditions. The AMHPs must consider if any discretionary conditions stipulated are necessary and proportionate and bear in mind that any conditions should not amount to a deprivation of liberty. The ward should also discuss the proposed CTO with the patient and any family/carers prior to the AMHP assessment taking place.

13.7 The AMHP should discuss the proposed CTO with the patient and the care team (inpatient and community) as well as any relatives/carers to make an informed decision about whether or they feel that the CTO is appropriate.

**Renewing a CTO**

13.8 Referrals for CTO renewal should be provided to the AMHP service with plenty of notice (at least 2 weeks). Again, this will give the assessing AMHP time to gather appropriate information and discuss the case with the patient’s care team prior to the assessment taking place. These assessments should be jointly completed with the care coordinator and Responsible Clinician.

**Revoking a CTO**

13.9 The inpatient service should highlight any potential referrals for CTO revocation as soon as they are able. For example, as soon as a patient is received in hospital after being recalled on their CTO. This will enable the AMHP service some time to gather appropriate information as needed, even if the decision to revoke is then not made by the inpatient Responsible Clinician, this is preferable to a late referral with very little time to complete as this may not always be possible.

**CTO recall**

13.10 The AMHP service may be involved in the process of supporting the community team that has recalled a patient to obtain Section 135(2) warrants to return the person to hospital. The AMHP Service will offer support in obtaining the warrant – at a minimum this will be supporting the care coordinator through the process of obtaining the warrant, seeking help from the police and arranging the execution of the warrant. If the AMHP Service has capacity, we will support by attending the court on behalf of the community team and at times attending the recall itself, however this will be dependant on capacity.

# 14 Guardianship

**Introduction**

14.1 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, Chapter 30 of the Mental Health Act Code of Practice (2015) and the Reference Guide to the Mental Health Act 1983 and the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

14.2 Although very rarely used, the Mental Health Act allows applications to be made for people to be placed under Guardianship. The appointed guardian 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**

14.3 As stated in Chapter 30 of the Mental Health Act Code of Practice (2015) “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”.

14.4 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.

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

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

14.7 While the reception of a patient into Guardianship does not affect the continued authority of an attorney or deputy appointed under the Mental Capacity Act (2005) such attorneys and deputies will not be able to take decisions about where a person under Guardianship 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.

**Grounds For Guardianship**

14.8 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.

14.9 Where patients lack capacity to make some or important decisions concerning their own welfare, one potential alternative to guardianship will be to rely solely on the Mental Capacity Act (2005); especially the protection from liability for actions taken in connection with care or treatment provided by section 5 of the Mental Capacity Act (2005). While this is a factor to be taken into account, it will not by itself determine whether guardianship is necessary. AMHPs and doctors need to consider all the circumstances of the particular case. (Chapter 30, (11) Mental Health Act Code of Practice, 2015)

**Powers**

14.10 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.

14.11 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. (Chapter 28, Mental Health Act Code of Practice, 2015).

14.12 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 the person is deprived of their liberty, unless a deprivation of liberty safeguards (DoLS) authorisation is obtained under the Mental Capacity Act 2005.

14.13 A refusal without reasonable cause to permit an authorised person reasonable access is an offence under Section 129 (Mental Health Act 1983/2007). Similarly, it is an offence under Section 127(2) (Mental Health Act 1983/2007) to ill-treat or wilfully neglect a person subject to Guardianship. It should be noted that there is no implied power to force entry to a house where a person under Guardianship is living and if it is felt necessary to do so then a Section 135 warrant would need to be obtained from the Magistrates Court.

**Appendix 1:**

Schedule 2 of the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008.

### 1.    **Key Competence Area 1: Application of Values to the AMHP Role**

Whether the applicant has—

(a)the ability to identify, challenge and, where possible, redress discrimination and inequality in all its forms in relation to AMHP practice;

(b)an understanding of and respect for individuals’ qualities, abilities and diverse backgrounds, and is able to identify and counter any decision which may be based on unlawful discrimination;

(c)the ability to promote the rights, dignity and self determination of patients consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty, and

(d)a sensitivity to individuals’ needs for personal respect, confidentiality, choice, dignity and privacy while exercising the AMHP role.

### 2.    **Key Competence Area 2: Application of Knowledge: The Legal and Policy Framework**

(1) Whether the applicant has—

(a)appropriate knowledge of and ability to apply in practice—

(i)mental health legislation, related codes of practice and national and local policy guidance, and

(ii)relevant parts of other legislation, codes of practice, national and local policy guidance, in particular the Children Act 1989([**1**](https://www.legislation.gov.uk/uksi/2008/1206/schedule/2/made?view=plain#f00006)), the Children Act 2004([**2**](https://www.legislation.gov.uk/uksi/2008/1206/schedule/2/made?view=plain#f00007)), the Human Rights Act 1998([**3**](https://www.legislation.gov.uk/uksi/2008/1206/schedule/2/made?view=plain#f00008)) and the Mental Capacity Act 2005([**4**](https://www.legislation.gov.uk/uksi/2008/1206/schedule/2/made?view=plain#f00009));

(b)a knowledge and understanding of the particular needs of children and young people and their families, and an ability to apply AMHP practice in the context of those particular needs;

(c)an understanding of, and sensitivity to, race and culture in the application of knowledge of mental health legislation;

(d)an explicit awareness of the legal position and accountability of AMHPs in relation to the Act, any employing organisation and the authority on whose behalf they are acting;

(e)the ability to—

(i)evaluate critically local and national policy to inform AMHP practice, and

(ii)base AMHP practice on a critical evaluation of a range of research relevant to evidence-based practice, including that on the impact on persons who experience discrimination because of mental health.

1. In paragraph (1), “relevant” means relevant to the decisions that an AMHP is likely to take when acting as an AMHP.

### 3.    **Key Competence Area 3: Application of Knowledge: Mental Disorder**

Whether the applicant has a critical understanding of, and is able to apply in practice—

(a)a range of models of mental disorder, including the contribution of social, physical and development factors;

(b)the social perspective on mental disorder and mental health needs, in working with patients, their relatives, carers and other professionals;

(c)the implications of mental disorder for patients, their relatives and carers, and

(d)the implications of a range of treatments and interventions for patients, their relatives and carers.

### 4.    **Key Competence Area 4: Application of Skills: Working in Partnership**

Whether the applicant has the ability to—

(a)articulate, and demonstrate in practice, the social perspective on mental disorder and mental health needs;

(b)communicate appropriately with and establish effective relationships with patients, relatives, and carers in undertaking the AMHP role;

(c)articulate the role of the AMHP in the course of contributing to effective inter-agency and inter-professional working;

(d)use networks and community groups to influence collaborative working with a range of individuals, agencies and advocates;

(e)consider the feasibility of and contribute effectively to planning and implementing options for care such as alternatives to compulsory admission, discharge and aftercare;

(f)recognise, assess and manage risk effectively in the context of the AMHP role;

(g)effectively manage difficult situations of anxiety, risk and conflict, and an understanding of how this affects the AMHP and other people concerned with the patient’s care;

(h)discharge the AMHP role in such a way as to empower the patient as much as practicable;

(i)plan, negotiate and manage compulsory admission to hospital or arrangements for supervised community treatment;

(j)manage and co-ordinate effectively the relevant legal and practical processes including the involvement of other professionals as well as patients, relatives and carers, and

(k)balance and manage the competing requirements of confidentiality and effective information sharing to the benefit of the patient and other persons concerned with the patient’s care.

### 5.    **Key Competence Area 5: Application of Skills: Making and Communicating Informed Decisions**

Whether the applicant has the ability to—

(a)assert a social perspective and to make properly informed independent decisions;

(b)obtain, analyse and share appropriate information having due regard to confidentiality in order to manage the decision-making process including decisions about supervised community treatment;

(c)compile and complete statutory documentation, including an application for admission;

(d)provide reasoned and clear verbal and written reports to promote effective, accountable and independent AMHP decision making;

(e)present a case at a legal hearing;

(f)exercise the appropriate use of independence, authority and autonomy and use it to inform their future practice as an AMHP, together with consultation and supervision;

(g)evaluate the outcomes of interventions with patients, carers and others, including the identification of where a need has not been met;

(h)make and communicate decisions that are sensitive to the needs of the individual patient, and

(i)keep appropriate records with an awareness of legal requirements with respect to record keeping and the use and transfer of information.

Appendix 2:

**Warrant Application Process**

Applications for Section 135(1) and 135(2) warrants are heard at 2 Magistrates Courts – Westminster and Uxbridge.

Applications are currently being held over the phone.

1. Once it has been identified that a warrant will be needed – the business support manager should be asked to book a court clot. The business manager has access to the online court diaries and can secure a slot. The business manager will also deal with payment to the court.
2. The appropriate warrant information and warrant forms will need to be completed. With either a Section 135(1) or Section 135(2) application a warrant information must be completed – this details the background of the case and asks for justification as to why a warrant is needed.
3. On the day of the hearing the warrant form and warrant information must be sent to the court 1 hour before the slot.

The email address for Westminster court is - MHwestminster@justice.gov.uk

The email address for Uxbridge court is – Mhthames@justice.gov.uk.

1. The warrant information and warrant form documents must saved/named using the address. EG -

26 Orchard Road Walthamstow E17 4JP. Warrant form

26 Orchard Road Walthamstow E17 4JP. Warrant information.

1. In the email subject line state the time of the slot, the name of the person applying and their contact details. EG -

Warrant application slot at 11.00am. Siobhan Askew 07718 665 028

1. Also attach a copy of your warrant card.
2. The court will then telephone you at the time of application and you will enter a conference call with the Magistrate and the legal advisor. You may be required to provide further oral evidence to justify the need for the warrant. If the warrant is granted, a PDF version of the warrant form will be emailed to you with the signature of the Magistrate.
3. Ensure to save the signed warrant form in the Thorpe Coombe shared drive, and print a copy (ensure not to print on both sides of the paper) for the patient file.
4. Complete the online police risk assessment – <http://www.met.police.uk/partner-services>
5. Email the police attaching the signed warrant, the warrant information and the downloaded PDF of the completed police risk assessment form.

NEMailbox-.MentalHealthTeam@met.police.uk

NEMailbox.OperationsRoom@met.police.uk

NEMailbox-.BCUOperationsRoom@met.police.uk

Appendix 3:

**Potential Conflicts of Interest.**

# The Mental Health (Conflicts of Interest) (England) Regulations 2008

The Secretary of State, in exercise of the powers conferred by section 12A of the Mental Health Act 1983([**1**](https://www.legislation.gov.uk/uksi/2008/1205/made/data.xht?view=snippet&wrap=true#f00001)), makes the following Regulations:

## Citation, commencement and application

**1.**—(1) These Regulations may be cited as the Mental Health (Conflicts of Interest) (England) Regulations 2008 and shall come into force on 3rd November 2008.

(2) These Regulations apply in relation to England only.

## Interpretation

**2.**  In these Regulations—

“the Act” means the Mental Health Act 1983;

“AMHP” means an approved mental health professional;

“application” means an application mentioned in section 11(1) of the Act;

“assessor” means—

(a)

an AMHP, or

(b)

a registered medical practitioner.

## General

**3.**  Regulations 4 to 7 set out the circumstances in which there would be a potential conflict of interest within the meaning of section 12A(1) of the Act such that an AMHP shall not make an application or a registered medical practitioner shall not give a medical recommendation.

## Potential conflict for financial reasons

**4.**—(1) An assessor shall have a potential conflict of interest for financial reasons if the assessor has a financial interest in the outcome of a decision whether or not to make an application or give a medical recommendation.

(2) Where an application for the admission of the patient to a hospital which is a registered establishment is being considered, a registered medical practitioner who is on the staff of that hospital shall have a potential conflict of interest for financial reasons where the other medical recommendation is given by a registered medical practitioner who is also on the staff of that hospital.

## Potential conflict of interest for business reasons

**5.**—(1) When considering making an application or considering giving a medical recommendation in respect of a patient, an assessor shall have a potential conflict of interest for business reasons if both the assessor and the patient or another assessor are closely involved in the same business venture, including being a partner, director, other office-holder or major shareholder of that venture.

(2) Where the patient’s nearest relative is making an application, a registered medical practitioner who is considering giving a medical recommendation in respect of that patient shall have a potential conflict of interest for business reasons if that registered medical practitioner and the nearest relative are both closely involved in the same business venture, including being a partner, director, other office-holder or major shareholder of that venture.

## Potential conflict of interest for professional reasons

**6.**—(1) When considering making an application or considering giving a medical recommendation in respect of a patient, an assessor shall have a potential conflict of interest for professional reasons if the assessor—

(a)directs the work of, or employs, the patient or one of the other assessors making that consideration;

(b)except where paragraph (3) applies, is a member of a team organised to work together for clinical purposes on a routine basis and—

(i)the patient is a member of the same team, or

(ii)the other two assessors are members of the same team.

(2) Where the patient’s nearest relative is making an application, a registered medical practitioner who is considering giving a medical recommendation in respect of that patient shall have a potential conflict of interest for professional reasons if that registered medical practitioner—

(a)directs the work of, or employs, the nearest relative, or

(b)works under the direction of, or is employed by, the patient’s nearest relative.

(3) Paragraph (1)(b) shall not prevent a registered medical practitioner giving a medical recommendation or an AMHP making an application if, in their opinion, it is of urgent necessity for an application to be made and a delay would involve serious risk to the health or safety of the patient or others.

## Potential conflict of interest on the basis of a personal relationship

**7.**—(1) An assessor who is considering making an application or considering giving a medical recommendation in respect of a patient, shall have a potential conflict of interest on the basis of a personal relationship if that assessor is—

(a)related to a relevant person in the first degree;

(b)related to a relevant person in the second degree;

(c)related to a relevant person as a half-sister or half-brother;

(d)the spouse, ex-spouse, civil partner or ex-civil partner of a relevant person, or

(e)living with a relevant person as if they were a spouse or a civil partner.

(2) For the purposes of this regulation—

(a)“relevant person” means another assessor, the patient, or, if the nearest relative is making the application, the nearest relative;

(b)“related in the first degree” means as a parent, sister, brother, son or daughter and includes step relationships;

(c)“related in the second degree” means as an uncle, aunt, grandparent, grandchild, first cousin, nephew, niece, parent-in-law, grandparent-in-law, grandchild-in-law, sister-in-law, brother-in-law, son-in-law or daughter-in-law and includes step relationships;

(d)references to step relationships and in-laws in sub-paragraphs (b) and (c) are to be read in accordance with section 246 of the Civil Partnership Act 2004([**2**](https://www.legislation.gov.uk/uksi/2008/1205/made/data.xht?view=snippet&wrap=true#f00002)).

## **EXPLANATORY NOTE**

*(This note is not part of the Regulations)*

These Regulations set out the circumstances in which there is a potential conflict of interest such that an approved mental health professional cannot make an application mentioned in section 11(1) of the Mental Health Act [1983 (c.20)](http://www.legislation.gov.uk/id/ukpga/1983/20) (“the Act”), or a registered medical practitioner cannot make a medical recommendation for the purposes of such an application.

An approved mental health professional considering making an application mentioned in section 11 of the Act , or a registered medical practitioner considering giving a medical recommendation for the purposes of such an application, will have a potential conflict of interest if the reasons set out in the Regulations apply. These may be financial reasons (regulation 4), business reasons (regulation 5), professional reasons (regulation 6) or because of a personal relationship existing between the assessor and another assessor, or between the assessor and the patient or, where the application is to be made by the patient’s nearest relative, the nearest relative (regulation 7).

There is provision for an approved mental health professional or a registered medical practitioner to make an application or a medical recommendation despite a potential conflict of interest for professional reasons in specified circumstances in cases of urgent necessity where there would otherwise be a delay with a serious risk to the health or safety of the patient or to others (regulation 6).

Appendix 4:

**Authority to delegate conveyance form:**



Delegation of Authority to Convey a Patient to Hospital under the Mental Health Act 1983 as amended by the Mental Health Act 2007

**Full Name of Patient** …………………………………………….

**Name of AMHP** …………………………………..

I am an Approved Mental Health Professional within the meaning of the Mental Health Act 1983 and have made an application, supported by appropriate medical recommendations, for the admission of the above named to: *(name of hospital or registered nursing home):*

…………………………………………………………………………………………………..

I delegate my authority to convey the patient to the above hospital to:

**Name of person accepting responsibility to convey**

……..…………………………………………………………………

**Signature of person accepting responsibility to convey**

……………………………………………………………………….

Reasonable restraint may be used to achieve the objective of conveying the patient to hospital but you should use the least restrictive possible whilst ensuring the patient’s and other person’s safety.

Signed …………………………………………

 **Approved Mental Health Professional/ other (please specify)**

Of London Borough of Waltham Forest

 Jane Atkinson Health and Wellbeing Centre

 714 Forest Road

 Walthamstow E17 3HP

To discuss this delegation to convey arrangements please contact the Duty AMHP on: 0300 555 1246

Date authority issued: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date authority expires: \_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix 5:

**Nearest Relative Delegation form:**



**DELEGATION OF FUNCTIONS OF NEAREST RELATIVE**

My name is [NAME] of [ADDRESS].

To the best of my knowledge and belief I am the nearest relative, within the meaning of section 26 Mental Health Act 1983, of [PATIENT’S NAME] who lives at [PATIENT’S ADDRESS].

I hereby delegate my role as nearest relative to [NAME] of [ADDRESS].

Signed………………………………………

Dated……………………………………….

I, [name of delegatee], of [full address], agree to take on the duties of the nearest relative under the Mental Health Act 1983.

Signed ……………………………………….

Delegatee

Date ……………………………………….