**MENTAL HEALTH ACT ASSESSMENT AMHP REPORT**

**KEY:**

|  |
| --- |
| **Blue Shaded areas:** |

**To be completed where possible from initial referral information by Shift Coordinator/ SWA/Admin. Or pulled through automatically from RiO.**

**AMHP to input if additional information available following information gathering or assessment.**

|  |
| --- |
| **Orange Shaded areas:** |

**To be completed by AMHP in all cases.**

|  |  |
| --- | --- |
| **AMHP Details:** |  |
| **Name:** |  |
| **Office Address:** | Kent AMHP Service, 3rd Floor Invicta House, County Hall, Maidstone, Kent. ME14 1XX. |
| **Contact Number:** | 03000 422480 (Mon-Fri 0900-1700) / 03000 419191 (OOH) |
| **Date:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Service User Details:** |  | | |
| **Name:** |  | **RiO No:** |  |
| **Address:** |  | **NHS No:** |  |
| **D.O.B:** |  | **Age:** |  |
| **Ethnicity:** |  | **Gender:** |  |
| **Communication issues:** *(Language? Interpreter required? LD? Sensory impairment?)*  *(To be added at time of referral/pulled through from information already available on the system)* | | | |
|  | | | |
| **Service User Group:** | Choose an item. | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referral:** |  | | | | | |
| **Date & Time referred to AMHP Service:** |  | | | | | |
| **Date & Time allocated to AMHP:** |  | | | | | |
| **Referred by:** *(specific team/person/ contact number)* |  | **s.13(4) NR Request?** | | | | |
| Choose an item. | | | | |
| **1st Medical Recommendation completed?** | Choose an item. | **If yes, where is this held?** | |  | | |
| **Has SU been referred to CRHT?** | Choose an item. | **Has SU recently been discharged from hospital?** | | Choose an item. | **If yes, date of discharge:** |  |
| **Location of Assessment:** | Choose an item. | **Known Access Issues:** | | | | |
|  | | | | |
| **Current Section:** | Choose an item. | **Date & Time of Expiry:**  *(if applicable)* |  | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Composition / Dependents / Safeguarding:** | | | | | | | | |  |
| **Adults:** | | | |  | | | | | |
| **Name:** | | **Contact Details:** | | **D.O.B/**  **Age:** | **What, if any is the impact on the adult?** | | **Safeguarding Concern?** | **Action Taken:** *(Details of alternative care arrangements made, onward referrals/safeguarding alerts)* | **Do they live in the same household?** |
|  | |  | |  |  | | Choose an item. |  | Choose an item. |
|  | |  | |  |  | | Choose an item. |  | Choose an item. |
| (additional rows to be added as required) | | | | | | | | |  |
| **Children/Young People:** | | |  | | | | | |
| **Name:** | **Contact Details:** | | **D.O.B/Age:** | | | **What, if any is the impact on the child/young person?** | **Safeguarding Concern?** | **Action Taken:** *(Details of alternative care arrangements made, onward referrals/safeguarding alerts)* | **Do they live in the same household?** |
|  |  | |  | | |  | Choose an item. |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |  | Choose an item. |
|  | (additional rows to be added as required) | | | | | | | |  |

|  |  |
| --- | --- |
| **Circumstances leading to assessment:** |  |
| ***Include:*** *sources of information, who made referral, was it a s.13(4) request?, when did MH start to deteriorate? What actions have already been taken? What are the reported risks? Police involvement?* | |
| (Initial referral information to be inputted by shift coordinator/SWA at point of referral) | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Assessing Doctors:** | | | | | | |  | | | |
|  | | | | | | | | | | |
| **GP Available?** | | | | | | | Choose an item. | | | |
|  | | | | | | |  | | | |
| **First Doctor:** | | | | | | |
| **Name:** |  | | | | | | **Contact No:** |  | | |
| **s.12 Approved?** | | | Choose an item. | | | | **Previous Acquaintance?** | | | Choose an item. |
| **Specialism?** | | Choose an item. | | | | |  | | | |
| **If Yes** – please state:  *i.e. LD/CAMHS/ED* | | | | |  | | | | | |
| **Joint Assessment with AMHP?** | | | | | | Choose an item. | | | | |
| **Assessment Date:** | | | |  | | | **Assessment Time:** | |  | |
| **Consultation Details:** | | | |  | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Second Doctor:** | | | | | | |  | | | |
| **Name:** |  | | | | | | **Contact No:** |  | | |
| **s.12 Approved?** | | | Choose an item. | | | | **Previous Acquaintance?** | | | Choose an item. |
| **Specialism?** | | Choose an item. | | | | |  | | | |
| **If Yes –** please state:  *i.e. LD/CAMHS/ED* | | | | |  | | | | | |
| **Joint Assessment with AMHP?** | | | | | | Choose an item. | | | | |
| **Assessment Date:** | | | |  | | | **Assessment Time:** | |  | |
| **Consultation Details:** | | | |  | | | | | | |

|  |
| --- |
| **If no doctor available with previous acquaintance, please explain why:** |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Considering all circumstances of the case / Evidence:** | | | | | | |
| **Personal History/Background:** *(Including summary of personal demographics, family composition, relevant childhood factors etc)* | | | | | | |
|  | | | | | | |
| **Psychiatric History:** *(Including any diagnoses, current and past treatment, engagement, admission history, formal/informal etc)* | | | | | | |
|  | | | | | | |
| **Contact with services:** *(Including Mental Health, Social Care, Substance Misuse Services, third sector – current and historical if relevant)* | | | | | | |
|  | | | | | | |
| **Social Network:**  *(wider connections, friends, family, support systems)* | | | | | | |
|  | | | | | | |
| **Housing/Accommodation:**  *(privately owned/rented, supported accommodation/ residential etc – impact of housing/housing issues)* | | | | | | |
|  | | | | | | |
| **Education/Employment/Occupation:**  *(Include known information regarding day time activities/hobbies/daily routines)* | | | | | | |
|  | | | | | | |
| **Relevant cultural/religious factors:** | | | | | | |
|  | | | | | | |
| **Physical health:**  *(Include any known dietary requirements/ allergies / medication etc)* | | | | | | |
|  | | | | | | |
| **Forensic Information:**  *(Include previous involvement with the police, convictions, prison sentences etc)* | | | | | | |
|  | | | | | | |
| **Substance Use:**  *(Alcohol, illicit drugs, prescription drugs, involvement with substance misuse services)* | | | | | | |
|  | | | | | | |
| **Finances:** *(Including income, benefits, debts)* | | | | | | |
|  | | | | | | |
|  | | | | | | |  |
| **Consultation with Others:**  *(Amend as necessary - not all will be relevant/practicable)* | | | | |
| **Role:** | | **Relationship to Service User:** | **Name / Contact Details:** | **Date/Time of Contact:** | | **Details of discussion/views:** *(including whether consent to contact was sought; justification for contacting if no consent)* | |
| **GP** | |  |  |  | |  | |
| **Care Coordinator** | |  |  |  | |  | |
| **Social Worker** | |  |  |  | |  | |
| **Carer** | |  |  |  | |  | |
| **Other Professional** | |  |  |  | |  | |
| **Nurse/Ward Staff** | |  |  |  | |  | |
| **Children’s Services** | |  |  |  | |  | |
| **Family/ Friend** | |  |  |  | |  | |
| (Other) | |  |  |  | |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Nearest Relative:** |  | | | | | | |
| **Name:** |  | | | | | | |  |
| **Relationship to Service User:** |  | | | | | | |
| **Address:** |  | | | | | | |
| **Contact Number(s):** |  | | | | | | |
| **Able to Consult?** | Choose an item. | | | | | | |
| **If ‘No’-why?** |  | | | | | | |
| **Date & Time of Contact:** |  | | **Method of Contact:** |  | | **Duration:** |  |
| **How NR identified:** *(in accordance with s.26 MHA; including whether this is via delegation/displacement)* |  | | | | | | |
| **Views of the NR:** |  | | | | | | |
| **Did the NR object to s.3?** | Choose an item. | | | | | | |
| **NR informed of outcome?** | Choose an item. | **Details:** *(method/who has been requested to complete?)* | | |  | | |
| **NR informed of Rights?** | Choose an item. | **Details:** *(method/who has been requested to complete?)* | | |  | | |
| **NR Delegation:** *(Does the NR wish to delegate?)* | | | | | | | |
|  | | | | | | | |
| **NR Displacement:** *(Is displacement indicated? What action taken?)* | | | | | | | |
|  | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details of interview with Service User:** | | | | |
| **Date & Time of Assessment:** | |  | | |
| **Who was present:** *(Was the service user supported by anyone during interview?)* | |  | | |
| **Location:**  *(specifics to be given to demonstrate how upheld confidentiality, dignity etc.)* | |  | | |
| **Offered to see alone?** *(If not, why – i.e. risks)* | |  | | |
| **Content of interview:**  *(include introductions, how informed of process CoP 14.51. How interviewed in a suitable manner (s.13(2), CoP 14.49). Service User’s views and wishes. Engagement in interview process.* | | | | |
|  | | | | |
| **Duration:** | |  | | |
|  | | | | |
| **MCA:** |  | | |
| **Does the person have capacity to make decisions relating to their care and treatment?** | | |  |
| **Does the person have capacity to consent to or refuse an informal admission?** | | |  |
| **MCA 2 stage Capacity Test:** | Stage 1 – *does the person have an impairment of/ or a disturbance in the functioning of their mind or brain?* | | EVIDENCE: |
|  |
| Stage 2 – *to establish if the person can understand information relevant to that decision, retain* *that information, weigh up that information as part of the decision making process, communicate their decision.* | | EVIDENCE: |
|  |
| **Do they have any Advanced Decisions?** | | |  |
| **Is there an LPA?** | | |  |
| **Are they subject to DoLS?**  *(if so since when?)* | | |  |
| **Can admission under MCA be relied upon?** *(and why?)* | | |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Outcome of MHAA:** | |  | | | | | | |
| **Outcome:** | Choose an item. | | **(Other- detail):** | |  | | | |
| **Admission Details:**  *(if admitted – provide details: ward, hospital, contact number)* |  | | | | | | **Outline Report provided?**  (ss.466) | Choose an item. |
| **Alternative Care Plan:**  *(If not admitted)* |  | | | | | | | |
| **Rationale:** | | | | | | | | |
| *(Needs to be detailed enough to enable reader to understand why specific decisions were made. How was MHA criteria met? Medical Recommendations provided? All the circumstances of the case; views of others and what other documentation has been taken into account. Why hospital is the most appropriate action if it is the outcome? Refer to Guiding Principles where appropriate -* Least Restrictive Option & Maximising Independence; Empowerment & Involvement; Respect & Dignity; Purpose & Effectiveness; Efficiency & Equity) | | | | | | | | |
|  | | | | | | | | |
| **Risks:**  *(Thorough and specific risks to be identified, including whether this is considered a risk to health, safety or with a view to the protection of others. Include historical and present risks)* | |  | | | | | | |
| **Safeguarding Concern?***(specific to the service user)* | | Choose an item. | | **Action Taken:** | |  | | |
| **Service User informed of outcome?** | | Choose an item. | | **If ‘No’ – why?** | |  | | |
| **Service User informed of right of appeal?** | | Choose an item. | | **If ‘No’ – why?** | |  | | |
| **Details of immediate issues:**  *(i.e. Protection of Property / Pets etc.)* | |  | | | | | | |
| **Conveyance:**  *(Arrangements for conveyance. How conveyed? Was this delegated? – reference numbers, contact details etc)* | |  | | | | | | |
| **Who else informed?**  *(GP, CMHT, Family etc….has this been completed or requested by admin?)* | |  | | | | | | |
| **Any other information:** | |  | | | | | | |

|  |  |  |
| --- | --- | --- |
| **Delays to MHA Assessment:**  *(Were there any delays to completing MHA assessment? Tick all that apply)* | | |
| **Reason:** | | **Length of Delay:** |
| **Access to Service User:** |  |  |
| **Police availability:** |  |  |
| **Ambulance availability/arrival:** |  |  |
| **s.12 doctors:** |  |  |
| **Bed availability:** |  |  |
| **Interpreter availability:** |  |  |
| **Warrant application process:** |  |  |
| **Service User unfit for interview:** |  |  |
| **AMHP availability:** |  |  |
| **Other (please specify):** |  |  |

|  |  |  |
| --- | --- | --- |
| **Please tick all of the below that are relevant to this MHA assessment:** | | |
| **Warrant obtained** | **Warrant executed** |  |
| **Community MHA** | **KMPT PoS MHA** | **A&E PoS MHA** |
| **Psychiatric Hospital MHA** | **General Hospital MHA** |  |
| **Adult Service User** | **Child/Young Person Service User** | **Ex-Armed Service Personnel** |
| **Is there a carer?**  *If yes, details***:** |  | |

|  |  |
| --- | --- |
| **Please indicate requests for admin tasks to be completed:** | |
| **NR rights and information letter to be sent?** | Choose an item. |
| **AMHP Report to be sent to:** | **GP  CMHT**  **MH Social Work Team  Other**  **Hospital** |
| **Details:** *(addresses, specific individuals – if not available on RiO)* |  |
| **Children’s Services referral required re s.117 for under 18s?** | Choose an item. |
| **Other admin request:** *(please state)* |  |

|  |  |  |
| --- | --- | --- |
| **Please indicate what onward referrals have been completed (if any):** | | |
| **Children’s services/child safeguarding** | **Adult Safeguarding** | **Carer’s Assessment** |
| **IMHA / IMCA** | **Early Discharge Planning** | **Other *(please specify)*** |
| **Housing** | **Mental Health Social Care Team/ Social Care Assessment** |  |

|  |  |
| --- | --- |
| **Time Spent** |  |
| **Time of MHA Assessment:** |  |
| **Time spent preparing for assessment:**  *(include admin tasks after assessment i.e. onward referrals)* |  |
| **Time spent completing assessment:** *(on site with Service User)* |  |
| **Time spent completing AMHP report:** |  |