**MENTAL HEALTH ACT ASSESSMENT AMHP REPORT**

**KEY:**

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| **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.**

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| **Orange Shaded areas:** |

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

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| **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:** |  |

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| **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)* |
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| **Service User Group:** | Choose an item. |

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| **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:** |
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| **Current Section:** | Choose an item. | **Date & Time of Expiry:** *(if applicable)* |  |

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| **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) |  |

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| **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) |

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| **Assessing Doctors:** |  |
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| **GP Available?** | Choose an item. |
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| **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:** |  |

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| **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:** |  |

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| **If no doctor available with previous acquaintance, please explain why:** |
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| **Considering all circumstances of the case / Evidence:**  |
| **Personal History/Background:***(Including summary of personal demographics, family composition, relevant childhood factors etc)* |
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| **Psychiatric History:***(Including any diagnoses, current and past treatment, engagement, admission history, formal/informal etc)* |
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| **Contact with services:***(Including Mental Health, Social Care, Substance Misuse Services, third sector – current and historical if relevant)*  |
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| **Social Network:***(wider connections, friends, family, support systems)* |
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| **Housing/Accommodation:***(privately owned/rented, supported accommodation/ residential etc – impact of housing/housing issues)* |
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| **Education/Employment/Occupation:***(Include known information regarding day time activities/hobbies/daily routines)* |
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| **Relevant cultural/religious factors:** |
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| **Physical health:***(Include any known dietary requirements/ allergies / medication etc)* |
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| **Forensic Information:***(Include previous involvement with the police, convictions, prison sentences etc)* |
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| **Substance Use:***(Alcohol, illicit drugs, prescription drugs, involvement with substance misuse services)* |
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| **Finances:***(Including income, benefits, debts)* |
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| **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) |  |  |  |  |

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| **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?)* |
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| **NR Displacement:** *(Is displacement indicated? What action taken?)* |
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| **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.*  |
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| **Duration:** |  |
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| **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?)* |  |

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| **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:** |  |

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| **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):** |[ ]   |

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| **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***:**  |  |

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| **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)* |  |

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| **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** [ ]  |  |

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| **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:** |  |