AMHP Service

Referral Checklist (reviewed 04-07-22)

Referral Checklist

This checklist is designed to enhance referrals for a Mental Health Act Assessment; it is not designed as a barrier. However, the checklist will assist the AMHP service to ensure that a case is appropriate for a statutory intervention. The right-hand column is a tick box for the referrer.

Referral from:

Community Mental Health Teams (CMHT)
Community Mental Health Teams Older Persons (CMHTOP),
Children and Young Persons Services (ChYPs)
Crises Resolution and Home Treatment Teams (CRHT)
Place of Safety Teams (POS)
Psychiatric Liaison Service (PLS)
Early Intervention in Psychosis Service (EIS)
Criminal Justice and Liaison Service (CJLADS)
Private Psychiatric Hospitals
KMPT Inpatient Units

Community Assessments

Service user; name, DOB, RIO number	
Need for an interpreter – if yes which language?	
Has face to face contact been made in the last 24 hours?	
If no face to contact is made, what engagement strategies have been applied?	
Has the risk assessment, CORE assessment been updated in the last 24 hours?	
ChYP need to provide historical and updated information from the last 24 hours including up to date risk information	
Clear verbal handover of Risk • Safeguarding issues • Carer responsibilities • Physical health issues-last time physically examined by a GP if could be impacting on mental health. • Substance misuse • Forensic history • This should also include a check of Patient Archived Data system (PADs) and any paper files.	

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Have you discussed the case with a consultant, if the presentation is chronic has a medical review taken place, if the situation requires a priority intervention when is the team doctor available to attend? If a medical recommendation has been made please refer to the AMHP Service on the date completed. A copy should be emailed to the AMHP Service: amhpstatutorymhaforms@kent.gov.uk Please ensure this is GDPR compliant (needs to be in a sealed envelope and addressed to the AMHP Service). Without access to the medical recommendation the AMHP will be unable to act.	
Has this case gone to high risk forum? If so, what was the outcome?	
Has a referral been made to CRHT or informal admission considered? If not why not?	
Have you discussed the case with Patient Flow Team (Bed Management), so they are alerted to the potential need for a bed? All referrals to the AMHP Service should be discussed with Patient Flow prior to making a referal. Including OOH referrals.	
Where required for treatment of a physical health condition that may be impacting on mental capacity has an admission under the MCA or informal admission been explored?	
Are there details of advanced care plans including family and carers opinions and arrangements for care of pets?	
Contact details for family members?	
Potential issues with the assessment being completed e.g. access, weapons	
Home circumstances; children, vulnerable adults, pets or protection of property etc?	

Referrals for Section 136

Service user; name, DOB, RIO number	
Location (POS or acute hospital site)	
Reason for detention?	
Police officer contact details if on acute hospital site	
Need for an interpreter, if yes which language	

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Fitness to be assessed to be discussed?	
If in a Designated POS the risk assessment, CORE assessment will need to be updated by POS staff.	
Clear verbal handover of the person (as they become known); • Risk • Safeguarding issues • Carer responsibilities • Physical health issues-last time physically examined by a GP if could be impacting on mental health. • Substance misuse • Forensic history	
Discussion with the consultant and their availability to attend an assessment?	
Contact details for family members?	
For client's originating from out of area have you contacted the home team and obtained information? If not, why not?	
Home circumstances; children, vulnerable adults, pets or protection of property etc.	
Accommodation – are there any potential accommodation issues such as homelessness? Have these been explored and attempts made to find solutions?	
Has the case been discussed with the Patient Flow Team? This needs to be done prior to making a referral to the AMHP Service. Including OOH referrals.	

Ward referrals (Excluding CTOs)

Service user; name, DOB, RIO number	
Need for an interpreter?	
Contact details for family members/carers to be on RIO?	
Section 5(2) referral made on day of application with information as to when the consultant will review this section? A consultant can rescind a s5.2 without moving to full MHA Assessment if appropriate.	
If MHA Assessment required when is the consultant available to attend an assessment?	

Section 2 and Section 3 requests to be made by the doctor completing the medical recommendation on the day it is made. All referrals need to be made in a timely manner preferably with a minimum of 7 days' notice (excluding informal to s2 or s3 referrals). This is to allow the AMHP Service to plan in the assessment and fulfil statutory duties.	

Community Treatment Orders (Requests, Extensions and Revokes)

Community Treatment Orders (CTO) may enable patients with an established history of repeated re-admission to hospital remain safely in the community by helping them to engage with treatment conditions and community services. This will support the least restrictive principle, minimise the use of detention in hospital and promote the patient's independence.

Orders are made under Section 17(a) of the Mental Health Act 1983 (as amended 2007) (MHA83)which requires an unrestricted patient detained under Section 3 or Section 37 to be discharged subject to mandatory and if required additional conditions.

This checklist sets out all necessary tasks required to prevent delayed discharges and duplication of work which needs to be completed prior to the CTO meeting.

If the check list requirements are not complete this may result in the referral being declined.

This checklist is for new CTO requests only.

CTO extensions should be referred to the local Social Care Teams.

CTO recalls should be managed by the local team responsible for the service users care. Out of hours the local crises resolution and home treatment team (CRHT) should manage the recall.

CTO revoke referrals should be taken in the same way as other referrals.

Service user name, DOB, RIO number Mosaic number.	
Need for an interpreter – if yes which language?	

Which dialect?	
Has the CTO been discussed with the client? Are they in agreement with the conditions? Note: **It is not a Legal requirement for the patient to agree to either the CTO or the conditions but it is good pactice.** Other than the mandatory are there any additional conditions and does the person have capacity to understand these?	
Is the risk assessment and CORE assessment upto date?	
Has a Care Plan been completed which also lists the CTO condition and contingency plan to prevent recall? **RISK CONTINGENCY PLAN** If the patient is not compliant with any condition of the CTO, the reasons for this needs to be properly investigated. A recall to hospital may be needed if it is no longer safe and appropriate for the patient to remain in the community. Failure to meet a condition should not necessarily result in an automatic recall. Equally even if the patient is fully compliant with all the conditions, recall can still be made if the patient's health deteriorates significantly to an extent necessitating hospital treatment.	
Has a discharge planning meeting taken place with the community team (previously called CPA Meeting)? Date and time. Location.	
Has the CTO been discussed with the community reposnible Clinician? Do they agree that the CTO is appropriate? Do they agree with the CTO conditions? Name Telephone Number Base Email:	

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Is there a named care coordinator. Name. Base. Telephone number Email.	
Is the patient physically well for discharge.	
Has s17 leave been tried. If not why not?	
Contact details for family members? Nearaest relative.	
Address of accommodation to be discharged to? Status of accommodation. Private owned. Patients own home. Local aurthority. If so which local authority. Is funding required? If so has funding been secured. Does the discharge accommodation require any adaptaions or amendments prior to discharge.	
Has a referral to social care been considered? Is there a care packarage to facilitate community living. Has this been agreed? Has funding been agreed? Keys?	

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Start date. Provider. Providers details.	

Referrals from Psychiatric Liaison

Service user; name, DOB, RIO number	
Need for an interpreter, if yes which language?	
Risk assessment, CORE assessment been updated?	
Clear verbal handover of; • Risk • Safeguarding issues • Carer responsibilities • Physical health issues-last time physically examined by a GP if could be impacting on mental health. • Substance misuse • Forensic history	
Has the person been reviewed by a psychiatric consultant, are they available to attend an assessment? Has a medical recommendation been made (this is preferred practice)? If medical recommendation made please refer on date completed.	
Is the person medically clear and fit for interview?	
If on a ward has a medically fit for transfer form been completed?	
Has a referral been made to CRHT or informal admission considered?	
Has the case been discussed with the Patient Flow Team? This needs to be done prior to making a referral to the AMHP Service. Including OOH referrals.	
Where required have specific capacity issues been assessed for treatment or	

informal admission?	
Are there details of advanced care plans including family and carers opinions?	
Contact details for family members?	
Potential risk issues with the assessment being completed?	
Home circumstances; children, vulnerable adults, pets or protection of property etc.	

Referrals from Custody Liaison

Service user; name, DOB, RIO number	
Need for an interpreter, if yes which language?	
Risk assessment, CORE assessment been updated?	
If a serious offence has been alleged why is this case not being manged via the Criminal Justice System?	
Clear verbal handover of; • Risk • Safeguarding issues • Carer responsibilities • Physical health issues-last time physically examined by a GP if could be impacting on mental health. • Substance misuse • Forensic history • Reason for arrest	
Have you discussed the case with a consultant, are they available to attend an assessment? Has a medical recommendation been made (this is preferred practice)?	
Has a referral been made to CRHT or the Home treatment team or informal admission considered?	
Has the case been discussed with the Patient Flow Team? This needs to be done prior to making a referral to the AMHP Service. Including OOH referrals.	

Where required have specific capacity issues been assessed for treatment or informal admission?	
Are there details of advanced care plans including family and carers opinions?	
Contact details for family members?	
Potential risk issues with the assessment being completed?	
Home circumstances; children, vulnerable adults, pets or protection of property etc?	
When PACE clock started?	
Can the assessment be scheduled for somewhere other than custody?	