AMHP Service

Operational Policy & Practice Guidance

Organisations	Central Bedfordshire Council (CBC) Bedford Borough Council (BBC) Luton Borough Council (LBC) East London Foundation Trust (ELFT)		
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Right Care, Right Person Statement:

Right Care, Right Person (RCRP) (DoH, July 2023) sets out a collective national commitment from the Home Office, Department of Health & Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England to work to end the inappropriate and avoidable involvement of police in responding to incidents involving people.

EDT and the AMHP Service will signpost and respond to contact's taking into consideration the RCRP principles. Meaning, where possible the right person with the rights skills, training and expertise will respond. Staff will use the escalation process in place if they feel this is required. The police have a legal duty to Keep the Kings peace, respond to imminent threat to life and respond where a crime has been committed. All documents will be reviewed and updated in 2025 to include specific details relating to RCRP.

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AMHP Operational Policy

1. AMHP Operational Policy Introduction

1.1 The three Social Services Local Authorities (LSSAs) in Bedfordshire and Luton, Bedford Borough Council (BBC), Central Bedfordshire Council (CBC) and Luton Borough Council (LBC), are committed to working with the East London NHS Foundation Trust (ELFT) to deliver a high quality, well led, responsive, effective and caring service in relation to assessments and other activities carried out by Approved Mental Health Professionals (AMHPs) under the powers contained in the Mental Health Act (MHA 1983, as amended 2007).

1.2 There is an aim that the service not only ensures that the obligations under the Mental Health Act (1983, as amended in 2007), are consistently met but also contributes to the implementation of appropriate and proportionate care and support arrangements for people experiencing mental health crisis in Bedfordshire and Luton.

1.3 The Mental Health Act Code of Practice (CoP) highlights the need for local policies and procedures in respect of sections of the Act and practice guidance to be available to AMHPs. This Operational Policy applies to all AMHPs who operate as part of the Bedfordshire and Luton AMHP service and the Emergency Duty Team (EDT).

2. AMHPs in the Bedfordshire and Luton Multi-Authority Setting

2.1 The purpose of the AMHP service is to provide a safe, responsive, and effective service that is well led and caring as required under the Mental Health Act (1983, as amended 2007).

2.2 It is the responsibility of an authority LSSA to provide the AMHP service and ensure that there are sufficient AMHPs available in their area to provide access to a 24-hour service (CoP 14.35). In Bedfordshire and Luton, this obligation extends equally to all three LSSAs in the county – Luton Borough Council (LBC), Bedford Borough Council (BBC) and Central Bedfordshire Council (CBC).

2.3 Section 13 of the Act places a specific duty on LSSAs to arrange for an AMHP to consider the case of any person who is within their area if they have reason to believe that an application for detention in hospital or a guardianship may need to be made in respect of the person. Section 13(1) states “If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an AMHP to consider the patient’s case on their behalf”. [CoP 14.36]. Section 13(1) applies to all individuals found to be in the geographical of the LSSA including those temporarily there.

2.4 The day to day operational management of the Bedfordshire and Luton AMHP service has been delegated to ELFT through the section 75 Partnership agreements. The daytime AMHP Service is responsible to provide a response to all routine Mental Health Act referrals that fall under part two of the Mental Health Act.

2.5 The operational management of Emergency Duty Team (EDT) is hosted by CBC on behalf of all three Local Authorities. EDT reviews Mental Health Act Assessment requests out of hours to determine if urgent consideration from an AMHP is required.

2.6 The overall legal responsibility for ensuring the training, professional development, approval arrangements and governance of the AMHPs rests with the three LSSAs. In Bedfordshire and

Luton, these responsibilities (in respect of the daytime AMHP service) are discharged by ELFT on behalf of the LSSAs through agreement under s75 of the NHS Act 2006.

2.7 The key responsibilities for the LSSA, where AMHPs undertake Mental Health Act assessments on its behalf, are to:

- Oversee the professional competence of AMHPs, approve, re-approve, remove or suspend AMHPs as necessary according to the AMHP Regulations.
- Ensure that newly-approved AMHPs in the organisation receive a structured induction to the role (development plan), understand their legal and professional responsibilities, and know from where to access information and the relevant statutory (and other) papers needed;
- Ensure that all AMHPs have access to professional supervision in the role;
- Provide a minimum of 18 hours of AMHP refresher training, relevant to the AMHP role, each year (one of which must be a legal update).
- Provide for the health and safety of AMHPs whilst they are undertaking assessments on its behalf.

2.8 Underpinning all activities carried out under the Act are five overarching principles which should always be considered when making decisions in relation to care, support or treatment of patients.

2.9 The five overarching principles are:

- Least restrictive option and maximising independence
- Empowerment and involvement
- Respect and Dignity
- Purpose and effectiveness
- Efficiency and equity

2.10 In addition, all AMHPs are expected to practice within the principles and obligations set out in wider legislation other than the Mental Health Act 1983, including (but not limited to) the Mental Capacity Act 2005, the Equality Act 2010, the Human Rights Act 1998, The Children Act 1989 & 2004, The Children and Families Act 2014, Care Act 2014, Policing and Crime Act 2017. This may also include changes to legislation following Case Law and National and Local Guidance.

3. The Daytime AMHP Service and EDT Operating Hours

3.1 The Daytime AMHP Service – Bedfordshire and Luton operates during usual working hours; Monday to Thursday 09.00-17.00hrs and 09.00- 16.30hrs on Fridays. EDT operates across Luton and Bedfordshire seven days a week Monday to Thursday from 1700hrs - 0900hrs, Friday 1600hrs to Monday 0900hrs and all Bank Holidays.

3.2 The Daytime AMHP Service has a central base within Bedfordshire covering all areas within Luton and Bedfordshire, there are two sites AMHPs can work from. The Daytime AMHP Service has an Operational Manager, AMHP Leads and AMHPs who support the service on a rota basis.

3.3 EDT has one team which operates across all three LSSA's. The team has a Service Manager, one Team Manager, four Senior Practitioners, Core AMHPs and Casual AMHPs who support the service on an ad hoc basis. An EDT On-call Manager system operates at all times so support can be accessed when required.

3.4 For both Services the last referral for same day/night will be accepted one hour before the close of the Service, please refer to the Handover Practice Guidance for further details. Referrals received after this time will be jointly risk assessed regarding the required response. All urgent referrals which cannot wait until the following day will be considered by EDT. Both services are responsible for agreeing a safety/contingency plans with the referrer if it is deemed the assessment can be carried out the following day.

4. AMHP Contact Details:

4.1 AMHPs on duty are not necessarily office based, and are contactable via dedicated numbers:

Daytime AMHP Service Bedfordshire and Luton	
Email address:	elft.amhpservice.bedfordshire-luton@nhs.net
Office Address:	Florence Ball House and Populars
Office Telephone:	01234 315706
	07748106264
	07748123665

EDT– Out of Hours EDT Service	
Email address:	edt@centralbedfordshire.gov.uk
Office Address:	Priory House but team work remotely.
Office Telephone:	0300 300 8123

AMHP Management and Allocation of AMHP Referrals

1. Introduction

1.1 The Approved Mental Health Practitioner (AMHP) Daytime AMHP Service manage all Mental Health Act Assessment (MHAA) requests under Part II of the Mental Health Act (MHA), Emergency Duty Team (EDT) manage MHAA referrals which require an emergency response and that cannot wait until the next working day.

1.2 Under S.13(1) of the MHA (1983) If a Local Social Services Authority 'have reason to think' that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall 'make arrangements for an approved mental health professional to consider' the patient's case on their behalf.

1.3 Within Bedfordshire, the Daytime AMHP Service and EDT are committed to operating within the Mental Health Act (1983) framework in that, when there is evidence to suggest actions under the MHA may be required, the duty falls to the Local Social Services Authority to allocate an AMHP as appropriate. This duty is delegated to East London Foundation Trust (ELFT) for referrals received during business hours.

1.4 This Practice Guidance provides clear and consistent guidance on the management of referrals into the Daytime AMHP Service and EDT and the subsequent allocation of AMHPs to consider the referral further.

2. Management of referrals

2.1 Referrals will be received by both services in line with the referral pathway.

All written referrals are received via the respective team electronic inbox;

- elft.amhpbedford@nhs.net (daytime)
- edt@centralbedfordshire.gov.uk (out of hours)

Once sent the referrer must call the respective team to confirm receipt of their referral (as the email inboxes are not continuously monitored), bearing in mind the hours of operation for each team.

2.2 It is the LSSA duty to respond to all referrals for MHAA. This does not mean, an assessment will be undertaken in every case, but every referral must be reviewed, and appropriate action taken. All referrals must be reviewed by a professional who has delegated responsibility to allocate an AMHP to consider the referral on behalf of the Local Authority.

2.3 ELFT have delegated this duty to the AMHP Operational Manager and the AMHP Leads who have the responsibility of reviewing all referrals and allocating AMHPs accordingly. Should the delegated professionals not be available, a senior AMHP adopts delegated responsibility for reviewing all the referrals and their subsequent allocation. All records relating to this activity is undertaken in line with agreed Practice Guidance.

2.4 EDT have delegated this duty to the EDT On-Call Manager who has the responsibility of reviewing all referrals and allocating AMHPs accordingly. In the event an EDT On-call Manager, EDT Team Manager or the EDT Service Manager is working as the AMHP their line

manager will allocate the MHAA. It will still be the responsibility of the EDT On-call Manager to record referral activity and outcomes on the EDT Manager Record.

2.5 The AMHP Lead and/or EDT On Call Manager will review the referral to ensure it is completed on the correct referral form, if not they will contact the referrer to resolve. Please note the AMHP Lead and/or EDT On Call Manager is determining if an AMHP needs to be allocated for further consideration, it is the AMHPs responsibility to undertake information gathering and a thorough review to determine if a MHAA will be progressed.

2.6 It is the responsibility of the AMHP Lead and/or EDT On Call Manager to record the review outcome section of the referral form. Should the decision be not to progress the referral to an AMHP, it is the responsibility of the AMHP Lead and/or On Call Manager to liaise with the referrer and provide verbal and written feedback. If the decision is to progress the referral, the details of the allocated AMHP will be recorded for audit purposes.

2.7 It is acknowledged that there may be occasions when the referral form cannot be completed, for example, Street Triage referrals or when professionals are with the person. On these occasions the referrer is able to complete a telephone referral and follow this up with a written document as soon as possible. All telephone referrals must be directed to the EDT On-call Manager and/or AMHP Lead to ensure the risks and situation are reviewed and to facilitate allocation of an AMHP. The On-call Manager and/or AMHP Lead will obtain all the relevant information and e-mail the details to the allocated AMHP for further consideration.

2.8 If the AMHPs decision is not to progress with a MHAA they will complete the relevant section in the referral form to evidence the rationale for their decision making. If the AMHP progresses with the MHAA their initial information gathering will be captured within the AMHP report.

2.9 Once allocated, it is the AMHPs responsibility to record all activity on the MHAA referral form and report. Where the person has already and recently been examined by a GP or Responsible Clinician, they are expected to provide a medical recommendation in support of the MHAA. The expectation is that the AMHP to whom the referral has been allocated will carry it through to completion, whether this is admission (informal/formal), alternative care package or no further action (NFA). Should the AMHP conclude the MHAA cannot be completed by them, they should discuss this with their AMHP Lead or the EDT On-call Manager to agree actions required.

2.10 If a MHAA is not progressed, all activity will be recorded on the AMHP referral form. If the referral does not reach the threshold for a MHAA under the MHA (where there is no recorded evidence of either recent GP and/or community team intervention, or where there is evidence to suggest that intervention under less restrictive alternatives such as Crisis Resolution Home Treatment (CRHT) or informal admission could be explored) the AMHP will contact the referrer to offer advice and consultation and agree a joint safety plan.

2.11 As part of the joint working processes with CRHT, where there is a query regarding the suitability for the potential to detain under the MHA, CRHT will be contacted and requested (where feasibly possible) to conduct a joint assessment.

2.12 Should an AMHP identify through their information gathering and/or interview that a vulnerable person (adult of child) has unmet needs they will ensure appropriate actions in

line with relevant legislation are undertaken. It is essential any immediate actions or emergency social care responses are actioned by the allocated AMHP. AMHPs should decide how to pursue any actions required, this will include any referrals to social, health or other services, the code is clear decisions and rationales should be recorded clearly (CoP 14.104). The AMHP must complete the required referral and confirm receipt. Should the referral be completed out of hours follow up actions will be recommended by the EDT Officer/AMHP, all information will be forwarded to the relevant locality team.

2.13 It is the AMHPs responsibility to ensure all information is shared with the relevant Local Authority or team to enable appropriate follow up and aftercare arrangements. This will include information about assessment and outcomes, this needs to be provided in a timely manner (CoP 14.107).

2.14 The AMHP should update the AMHP Lead and/or EDT On-call Manager of the progress of the referral or MHAA and all final outcomes should be confirmed in person or via telephone and e-mail. These updates are essential to enable AMHP Leads and EDT On-call Managers to provide handovers between services and to ensure oversight of advice, guidance and support being provided by the service.

3. EDT Allocation Arrangements.

3.1 When EDT receives referrals, the EDT Officer will forward the referral to the EDT On-call Manager for review. This will be followed up with a telephone call to the EDT On-call Manager at the time the referral is received. The EDT Officer should not review the referral or consider the request until the EDT On-call Manager has considered and made the decision to allocate an AMHP. Should an EDT Officer experience difficulty in contacting the EDT On-call Manager the Escalation Practice Guidance must be implemented immediately.

3.2 Should an EDT Officer receive contact from the person completing the referral prior to a decision being made regarding allocation of an AMHP, the EDT Officer will confirm with the referrer that the allocated AMHP or EDT On-call Manager will return their call. The EDT Officer will contact the EDT On-call Manager to ensure a timely response.

3.3 It is anticipated that the MHAA referrals received by EDT will be reviewed by the EDT On-call Manager in a timely manner. Decisions following a review of the referral should be made within 15 minutes of the EDT On-Call Manager being notified of the referral.

3.4 It is the responsibility of the EDT On-call Manager to record the outcome of the referral and/or allocation of the AMHP on the EDT On-call Manager record and referral form. The EDT On-call Manager will save the referral form and ensure it is forwarded to the AMHP. The AMHP is then responsible for updating this referral form on BOX, detailing their involvement.

3.5 All Out of Hours referrals and MHAA reports must be e-mailed to the Bedford AMHP desk, who will upload referrals and MHAA to RiO on behalf of EDT. The MHAA report should be sent by the AMHP to the ELFT Duty Senior Nurse and/or ELFT worker at weekends and on bank holidays so this information can be uploaded to RIO on their behalf in a timely manner.

4. The AMHP Service Arrangements

4.1 During day time working hours the AMHP Service Administrator and the AMHP Leads are responsible for monitoring the team e-mail inboxes. The AMHP Service Administrator can open a referral on RiO however, AMHP Leads will be responsible for updating RiO.

4.2 Every morning the AMHP Leads or delegated Senior AMHP facilitates a handover meeting. During this meeting the AMHP Lead will allocate an AMHP to consider referrals further. The AMHP Lead will record the outcomes and allocations in the referral form and their Allocation Records.

5. Relating Practice Guidance:

- Escalation Practice guidance
- Referral pathways
- Recording Practice Guidance

6. Appendices:

- Appendix 1 - Allocation of AMHP Assessment flow chart (EDT)
- Appendix 2 – AMHP Allocation sheet (AMHP day services)
- Appendix 3- AMHP Referral Pathway
- Appendix 4- AMHP Referral Form

AMHP Assessment Guidance

1. Introduction

1.1 This Practice Guidance has been developed to ensure EDT (Emergency Duty Team) and Daytime AMHP (Approved Mental Health Professional) Services have a clear and consistent approach for actions being undertaken by AMHPs.

1.2 EDT responds to emergency Mental Health Act Assessments (MHAA) out of hours. It is hosted by Central Bedfordshire Council (CBC) and provides a service to Bedford Borough Council (BBC) and Luton Borough Council (LBC) under Service Level Agreements.

1.3 East London Foundation Trust (ELFT) is responsible for the delivery of Mental Health Adult Social Care services within Bedfordshire and Luton, including the Daytime AMHP Service, as part of a section 75 agreement.

1.4 EDT and the Daytime AMHP Service are committed to promoting a high-quality service for people who access AMHP services in Bedfordshire. This Practice Guidance supports AMHPs in understanding their responsibilities in line with the legal framework and best practice.

2. Legal Framework

2.1 AMHPs are required to adhere to relevant legal frameworks and the MHA Codes of Practice (CoP).

2.2 AMHPs are expected to have a good working knowledge and be able to act in accordance with the legislation relevant to their role. In order to continue practicing as an Approved AMHP there is an expectation they will attend AMHP training including legal updates. AMHPs are expected to ensure their own professional development and remain cited on relevant Case Law which impacts on their role and practice.

2.3 The following legislation is regularly considered and adhered to within the AMHP role;

- Mental Health Act 1983
- Mental Health Act 2007
- Mental Health Act Code of Practice 2015
- Mental Capacity Act 2015
- Human Rights Act 1998
- Autism Act 2009
- Equality Act 2010
- Care Act 2014
- Childrens Act 1989
- Children Act 2007
- Police and Crime 2017.
- Data Protection Act 2018.

3. Role in line with the Mental Health Act

3.1 AMHPs may be allocated to consider referrals for a variety of assessments under the Mental Health Act (MHA) including;

- Mental Health Act Assessments (MHAA) (s.136, s.5(2), s.135, community or ward assessments)
- Community Treatment Order's (CTO's)
- Revocations of Community Treatment Orders
- Guardianships

3.2 The objective of the MHAA is to determine whether criteria for detention are met and whether an application should be made (CoP 14.33).

3.3 The AMHP will ensure when undertaking any functions under the MHA that they understand and can apply the five overarching principles. (CoP 1.1).

3.4 Templates for recording assessments or actions undertaken under the MHA can be found in the ELFT L Drive or Share Point. The following templates are regularly used by AMHPs;

- Mental Health Act Assessment Report.
- Community Treatment Order/revocation Report
- Guardianship Report
- Conveyance Record
- s.12 Doctor Report

4. Out of Area MHAA and Aftercare Responsibilities

4.1 A person who requires a MHAA may ordinarily resides in one local authority area (home authority) but may be present in another local authority area (host authority). Within Bedfordshire and Luton there are not formal arrangements with neighbouring Local Social Services Authority (LSSA), the DASS of Bedfordshire and Luton have requested referrals are considered on an individual basis and if required legal advice should be sought to ensure services are legally compliant with all relevant legislation.

4.2 **In line** with s.39 of the Care Act 2014 even if the person is not ordinarily residence in the LSSA's borough there is a duty to assess under the MHA if they were in the LSSAs area immediately prior to being placed in hospital. AMHPs are required to seek legal consultation in instances where they are being asked to consider referrals/assessments under the MHA for people who are not ordinarily resident. This is particularly pertinent for people who are detained at Yarls Wood Immigration Detention Centre. This also supports further consideration regarding further assessments under the MHA and aftercare arrangements.

4.3 AMHPs acting on behalf of the 'host' authority should contact the home authority (whether AMHP team or other mental health service) to ascertain whether the person is known to their services, and, if so, whether they wish to provide an AMHP to complete the interview. There are no legal grounds to delay assessments whilst LSSA's agree responsibilities, advice from the respective legal departments should be progressed in a timely manner to resolve any queries.

4.4 Where a person has already been detained in hospital under s.2 MHA, responsibility for making arrangements for a further MHAA for an admission for treatment (section 3 MHA) remains with the LSSA that arranged the earlier s.2 admission [CoP 14.37]. However, if an individual is known to a LSSA, other than the host LSSA, and it is clear that the LSSA will have community care responsibilities on the person's discharge from detention then that other LSSA in line with best practice should make reasonable efforts to provide an AMHP to undertake the MHAA. Under s.13(1) if no agreements are reached the host authority is obliged to consider and if appropriate progress the MHAA.

4.5 Where the outcome of the discussion is that the host Local Social Services Authority (LSSA) AMHP undertakes the interview, the home authority should be asked to provide:

- All relevant information it has available to it to support the MHAA process; and
- A named contact for the person responsible for liaison.
- Written confirmation from the home authority that they will undertake any future MHAA for s.3 and be responsible for any assessed s.117 aftercare arrangements.

4.6 Having completed the MHAA, the host LSSA AMHP will forward a copy of their completed report to the home LSSA. Given the likelihood that a detained person will have community care needs when they are discharged from hospital, best practice indicates that the earliest involvement by LSSA with community care responsibility should always be sought.

4.7 Where an AMHP makes a s.2 application of a person from another area the AMHP leads and Operational Manager will be notified as soon as possible to facilitate discussions with the home authority with a view of them managing requests for a consideration under s.3 of the MHA.

4.8 Consideration needs to be given regarding which LSSA should progress with the MHAA in line with best practice, factors to consider include;

- Impact of the Covid pandemic.
- The impact of any time delay regarding the availability of the AMHP in relation to the urgency of the person's need to be interviewed (time delay should be considered in terms of availability and geographical distance)
- The level of knowledge and information which each LSSA has available in relation to the person to be interviewed
- The level of personal knowledge the AMHP has of the person to be interviewed
- The level of knowledge the AMHP has of the service user group from which the person to be interviewed comes

- Knowledge of, or information about, local resources that might provide alternatives to detention under the Act.
- If any post-assessment admission to hospital would be to a hospital within the home LSSA area, every effort should be made by the home LSSA to undertake the interview.

4.9 Aftercare responsibility under s.117 of the Act remains with the LSSA in which the person was resident immediately before being detained in hospital, even if the person does not return to that area on discharge. If no such residence can be established, the duty falls on the LSSA where the person is discharged to from hospital. On occasions there may be disputes (e.g. prisons or immigration centres), any disputes should be escalated for legal advice and guidance to ensure a timely resolution.

5. Setting up the MHAA

5.1 An application must be founded on two medical recommendations given in accordance with the Act (14.31). The AMHP must secure the services of appropriate clinicians, one of which must be s.12 approved.

5.2 AMHPs must be aware of potential conflicts of interest as these can prevent an AMHP from making an application. These conflicts are detailed under The Mental Health (Conflict of Interest) Regulations 2008 and Chapter 39 of the Code of Practice 2015 ("the CoP"). The areas of conflict are defined as financial, business reasons or professional reasons. AMHPs are required to have full understanding of conflict of interests to enable them to arrange the MHAA and be compliant with the CoP.

5.3 The AMHP should also consult with other people who may have been involved with the persons care, including police, local authority, health, GP (CoP 14.69).

5.4 When arranging the MHAA, the AMHP will need to liaise with the Duty Senior Nurse (DSN) to secure a bed, police if support is required for high risks situations or warrants, the local authority for dependents and Housing colleagues for protection of property.

5.5 It is good practice for the referrer of the MHAA to be involved in the MHAA. Experience suggests that this assists with the establishing of rapport and reduction of resistance from the person and more effective assessment of risk and least restrictive alternatives.

5.6 It is the duty of the AMHP co-ordinating the MHAA to gather as much information about the person. This includes; past behaviour, significant life events, history of self-harm or self-neglect violence to others. The AMHP should also consider the context of the place where the MHAA will take place, when the MHAA will take place and who will be present. Where there is no, or limited information known about the person, then AMHPs should proceed with caution and liaise with the AMHP Lead or EDT On-call Manager.

6. Specialisms within the MHAA

6.1 Where a person is known to belong to a group for which particular expertise is desirable, at least one of the professionals involved in the MHAA should have this specialism (CoP 14.30). Alternatively, one of the professionals should have consulted with a professional who has

this professionalism (CoP 14.40). AMHPs should consider specialism areas to ensure MHAA are carried out in accordance with the Act and in line with guidance in the CoP.

Learning Disability and Autistic Spectrum Disorder (Section 20 CoP)

6.2 Although learning disability is defined as a mental disorder, it shares few features with serious mental illness. With this in mind it is believed the vast majority of people with learning disabilities or Autism will never come into contact with the Act. Both learning disability and autism cover a wide spectrum of people with diverse needs which are best met at home or in community settings (CoP 20.5).

6.3 People with Autistic Spectrum Disorder (including Asperger's syndrome) meet the criteria for compulsory measures under the Act without having any other diagnosis of mental disorder (CoP 2.17). Compulsory treatment in hospital is rarely likely to be helpful to a person with Autism who may be very distressed by minor changes to routine and who would find the detention anxiety provoking (CoP 20.20).

6.4 People with a learning disability and no other forms of mental disorder may not be detained for treatment or made subject to guardianship or community treatment unless their learning disability is accompanied by abnormally aggressive or seriously irresponsible conduct (CoP 2.15).

6.5 Under the Equality Act, reasonable adjustments for any person with a learning disability or Autism will need to be made, this will be based on a comprehensive assessment of need (CoP 20.31).

6.6 ELFT have a wide range of Easy Read documents available to support people detained under the Mental Health Act with accessible information needs, these can be found in ELFT's L Drive and EDT's SharePoint file.

6.7 ELFT are committed to the mainstreaming agenda for people who have learning disabilities (Greenlight 2017) and therefore anyone who has a learning disability, who is detained under the MHA, should be supported in the same way as any other individual. Should the person who has a learning disability require reasonable adjustments to be made whilst detained and awaiting the MHAA, the Intensive Support Team can be contacted for advice and guidance on 01234 310538. Information regarding Greenlight accessible information and easy read documents in relation to MHAA can be found in ELFT's L Drive and EDT's SharePoint file.

6.8 When conducting MHAA, the AMHP should give due consideration to the Structure, Positive approaches and expectations, Empathy, Low arousal Links (SPELL) Framework when interviewing people with Autistic Spectrum Disorder. Information regarding the SPELL Principles is available for AMHP's via ELFT's L Drive and EDT's SharePoint file.

Substance Misuse (Cop 2.9-2.13)

6.9 Section 1(3) of the Act states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act. This means that there are no grounds under the Act for detaining a person in hospital (or using other compulsory measures) on the basis of alcohol or drug dependence alone.

Drugs for these purposes may be taken to include solvents and similar substances with a psychoactive effect.

6.10 Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the relevant criteria are met, it is therefore possible to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs.

6.11 Where persons are subject to the short-term effects of alcohol or drugs (whether prescribed or self-administered) which make interviewing them difficult, the AMHP should either wait until the effects have abated before interviewing the person or arrange to return later. If it is not realistic to wait because of the person's disturbed behaviour and the urgency of the case, the MHAA will have to be based on whatever information the AMHP can obtain from reliable sources. This should be made clear in the AMHP's record of the MHAA (CoP 14.56)

Anorexia

6.12 Anorexia is defined as a mental disorder within the MHA, the Care Quality Commission (CQC) have produces clear guidance on support people with Anorexia under the MHA which can be found in Appendix 1.

6.13 When interviewing a person with a diagnosis of anorexia nervosa the AMHP has the same responsibilities and duties as with any other person said to be suffering from a mental disorder. An MHAA is only usually requested in the extreme situation where the person's health is seriously threatened by food refusal. Opportunities for seeking the least restrictive alternative may therefore be limited by the need to treat the self-imposed starvation in order to ensure the proper care of the person.

6.14 Where a person with anorexia nervosa is detained for assessment or treatment, valid consent should always be sought for the medical treatment proposed, following the guidance given in Chapter 23 of the Code of Practice. This Chapter particularly stresses the importance of giving sufficient information to ensure that the person understands in broad terms the nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. (See also paras 20-21 in CQC Guidance.)

6.15 AMHPs have access to Marzipan Guidelines which provide detailed information regarding national standards for supporting people with Eating Disorders. This guidance can be found in the ELFT L Drive and EDT SharePoint File.

Children and Young People (Chapter 19 CoP)

6.16 The MHA defines a child as someone less then 16 years of age and a young person is someone which is 16 or 17 years of age.

6.17 There is no minimum age limit for detention in hospital under the Act. It may be used to detain children or young people who need to be admitted to hospital for assessment and/or treatment of their mental disorder, when they cannot be admitted and/or treated

on an informal basis (see sections 19.49 – 19.70 CoP), and where the criteria for detention under the Act are met.

6.18 The CoP sets out a range of issues which AMHPs will need to consider when assessing a child or young person, including:

- The need to be familiar with other legislation which is relevant for this age group (e.g. Children Acts 1989 & 2004, Family Law Reform Act 1968)
- The best interests of the child or young person
- Keeping the person fully informed in the same way as an adult
- The 'least restrictive' and 'respect' principles.
- The right to privacy and confidentiality.

6.19 It is important to determine who has 'parental responsibility' for the child or young person, it also important to remember that there may be circumstances where the person with parental responsibility is not the parent, i.e. if the child is subject to a care order. For further guidance on parental responsibility see sections 19.6-19.10 CoP.

6.20 Where practitioners conclude that admission to hospital is not the appropriate course of action, consideration must be given to alternative means of care and support that will meet the needs of the child or young person. The appropriate action will usually be to refer the child or young person's case to the relevant local authority's children's services, in accordance with local protocols for interagency working to safeguard and promote the welfare of children and young people.

6.21 In cases where the child or young person has significant needs which mean that the level and type of intervention is likely to amount to a deprivation of liberty, their placement in secure accommodation under section 25 of the Children Act 1989 may be required. This will be a matter for the local authority children's services to consider in the light of the provisions of section 25 of the Children Act 1989, and relevant Children Act 1989 guidance.

6.22 Whilst generally parental consent for children under 16 years can legally override the child's refusal to consent to treatment there is widespread support for the view that in complex and extreme circumstances the endorsement of the Court to compulsory treatment better protects both the child and the professionals involved.

6.23 If a young person lacks capacity, then they may be treated in the same way as an adult, and the Mental Capacity Act can apply unless this would result in a 'deprivation of liberty'. (See section 19.57 CoP). If a young person is capable of consenting and agreeing to treatment, then they do not require any additional consent from a responsible adult. It is however good practice to involve the young person's family in the decision- making process if the young person consents to information being shared.

6.24 Where the young person refuses consent, then the AMHP should not rely upon alternative parental consent but should consider the use of the MHA. If the MHA is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

6.25 Admission of children under 16 years of age, Case Law has now identified the principle of 'Gillick Competence' for children who have sufficient understand and intelligence to enable them to understand fully what is involved in a proposed intervention and will also have the competence to consent to that intervention. This is described as being 'Gillick competent'. Where child's competence to consent should be assessed carefully in relation to each aspect of treatment that is required. Under these circumstances, additional consent from a person with parental responsibility will not be required. However, as with young people it is always good practice to involve the parents if the child consents.

6.26 Where a child who is 'Gillick Competent' refuses to be admitted for treatment, then it may be unwise to rely on alternative parental authority, and the use of the MHA should be considered if they meet the legal requirements. If there is any doubt about this, then referral for a court decision may be required and the AMHP should contact Legal Services for urgent advice.

6.27 Where a child is deemed not to be 'Gillick Competent' it will be acceptable to obtain the consent of the child's parents on their behalf if the issue under consideration is within the Zone of Parental Control (ZPC). (See sections 19.65-19.70 CoP)

6.28 Where a life-threatening emergency arises for a person who is under 18 years of age, and there are issues of refusal of consent from the person or their parent and delays may arise from awaiting a court hearing, then the courts have directed that it will be acceptable to undertake treatment to preserve life or prevent irreversible serious deterioration of the child or young person's condition. (See sections 19.71-19.72 CoP).

6.29 Section 131(A) MHA states that children and young people who are admitted to hospital for treatment of mental disorder should be accommodated in an environment suitable for their age. This means that children and young people should have (CoP 19.90-104):

- appropriate physical facilities
- staff with the right training, skills and knowledge to understand and address their specific needs
- a hospital routine that will allow their personal, social and educational
- development to continue as normally as possible, and
- equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.

6.30 Consideration is also required for other specialist areas including:

- People with Personality Disorder (Section 21 CoP)
- People concerned with criminal proceedings (Section 22 CoP)

Mental Health in Custody

6.31 There is a locally agreed pathway and Practice Guidance for supporting people with a mental disorder in Police and Court Custody which reflect good practice recommendations. These documents can be found in the ELFT L Drive or EDT SharePoint file.

MHAA in Acute Hospital Trust

6.32 There is specific Practice Guidance relating to mental health assessments and MHAA within the Emergency Department. These documents can be found in the ELFT L Drive and EDT SharePoint file.

6.33 Whether the person is in the Emergency Department or on the Acute Hospital Ward, MHAA should not be delayed and opportunities for parallel assessment of physical and mental health should be optimised, if the person is fit for assessment.

6.34 Following the examination/interview under the act, if it is concluded the person is liable to be detained under the Mental Health Act or requires an informal admission the acute hospital retains duty of care and responsibility for the person whilst they are in the department. Appropriate arrangements for support should be made by the acute hospital until arrangements for conveyance are made.

6.35 Should it be assessed the persons level of risk requires a close level of support and observation, the Acute Hospital Trust needs to make arrangements for one-to-one mental health nursing support for the person whilst in the Acute Hospital Ward. This cannot be provided by PLS.

6.36 Under s.137(1) a person who is liable to be detained and conveyed is deemed to be in legal custody. Under s.137(2) The Emergency Department are authorised to keep the person liable to be detained and have the powers, authorities, protection and privileges to do so. If the person who is liable to be detained attempts to leave the police can prevent the person from leaving and ensure they are conveyed to the identified ward. Support can be sought from the security staff or other professionals who can act in the person's best interest to ensure their immediate safety. The Emergency Department are deemed to have legal custody of the person until they have left the department and can keep the person until conveyance has been facilitated.

6.37 If the person has been offered informal admission to a mental health unit but leaves the acute hospital prior to conveyance to the mental health unit a review of the situation and associated risks will be undertaken by the professionals involved. If assessing professionals leave the Emergency Department prior to conveyance they need, wherever possible, to indicate in writing what level of concern / course of action would be appropriate should an anticipated informal admission not take place. If there are concerns regarding the level of risk the person poses to themselves or others, a local search should be done immediately, and the Police will be contacted to report the person as missing. In this scenario if the person is found in the hospital security staff can act by making a best interest decision and via use of the MCA (2005), only where the person has been assessed as lacking capacity for their own safety. Outside this, intervention would only be justified if the criteria in common law or other legal powers are met.

7. Use of Interpreters.

7.1 During the course of undertaking the AMHP role it is a requirement that AMHPs use interpreters where appropriate whether in respect of the people they are interviewing or their Nearest Relative/Carers (NR see section 9).

7.2 ELFT has a contract with The Language Shop for foreign language interpretation services. The use of telephone interpreting should be considered initially, with face to face services requested if this is not practicable. Relevant guidance to telephone interpreting services can be found in Appendix 2.

7.3 Wherever possible pre-booking is recommended for all interpretation requests. However, in an emergency The Language Shop will try to accommodate, but their ability to do so will depend upon the availability of the interpreters. Where The Language Shop are unable to fulfil a booking request, alternative providers may be used. When making a booking, the following information will be required:

- name of the person booking the interpreter, name of the person working with the interpreter, name of the organisation, telephone number and fax number;
- date of appointment, time of briefing and location, time of appointment and location, brief details of the interpreting session and approximate duration;
- full name of person, gender, language, ethnic origin and home address. (This information is required to match up the right interpreter and to make sure the person is not known to interpreter);

7.4 The following ELFT website contains foreign-language translations of explanatory summaries relating to various MHA interventions and can be used for both persons and NRs: https://www.elft.nhs.uk/Professionals/Mental-Health-Act-Leaflets

7.5 EDT will liaise with the ward or DSN to secure the use of interpreters out of hours. For MHAA in the community Language Line is contacted for this service.

7.6 For non-spoken word interpretation, AMHPs should contact the relevant LSSA to find out what services exist locally, to support communication with the person. It is the responsibility of all AMHPs to access the health literacy/accessible communication needs of people at the beginning of assessment under the MHA and take reasonable steps to ensure their needs are supported to ensure the person understands what is being said. For example, SPELL principles should be used when assessing individuals with Autism.

7.7 Where the facilities exist and the AMHP feels that it an appropriate option Typetalk services may be used. Typetalk is the national telephone relay service which enables deaf, hard of hearing, deafened and speech impaired people using the telephone network. It is run by the RNID and funded by BT. RNID Typetalk operates from two call centres and the service is available 24hours a day, 365 days a year. There are additional special functions offered by Typetalk to accommodate people who have lost their hearing but can still speak or conversely people who may not be able to speak but can hear perfectly well. Details of these

services are available on the Typetalk website at www.typetalk.org or by ringing 0800 7311 888.

7.8 Approval to incur expenditure for any of the above should be sought from the appropriate local authority budget holder.

8. Attending the MHAA.

8.1 When undertaking interviews AMHPs must ensure they have all the required documentation, including blank forms for any eventuality, and contact details for doctors, DSN, managers, ambulance and involved professionals.

8.2 As a result of the pandemic it is important all AMHPs have access to the relevant equipment and resources to undertake their role effectively and safely. This will include access to laptops and PPE, AMHPs are also able to access support via the local Business Continuity Plan and risk assessments.

8.3 Section 115 of the MHA, allows an AMHP to enter and inspect any premises (other than a hospital) in the area of their employing authority where a mentally disordered person is believed to be living, if they have reasonable cause to believe that the person is not under proper care. The section requires that the AMHP produce an authenticated document identifying them as an Approved Mental Health Professional if asked.

8.4 Section 115 MHA does not give a right to force entry to a premise although refusal of entry to an AMHP who is acting in accordance with his / her duties could be an offence of Obstruction under Section 129 of the MHA.

8.5 The effect of this section is that it not only allows an AMHP a right to enter premises if they are challenged, but also allows them to enter uninvited into any premises where a mentally disordered person is living. Good practice and common courtesy demands that an AMHP making such an entry should first of all seek to gain access in a conventional manner.

8.6 The Section does not give the AMHP the right to override an owner's refusal to give permission to enter. However, if one of the co-owners gives permission, (for example, the wife of a mentally disordered man), then that permission is sufficient. It should also be noted that whilst it is an offence of Obstruction under section 29 MHA to refuse entry, a prosecution under section 129 MHA will not ultimately provide any access to the premises and can take up to 6 months to process. Accordingly, if access is required more urgently than that, consideration should be given to exercising the AMHPs powers under Section 135 MHA.

8.7 AMHPs may only make an application when they have interviewed in a suitable manner, are satisfied the statutory criteria are met and are satisfied detention in hospital is the most appropriate way of providing care and treatment (14.49 CoP).

8.8 If, in the course of carrying out a MHAA, an AMHP identifies anything that raises a child or adult safeguarding concern or issue, then they should complete a Safeguarding Concern Form and send onto the appropriate ELFT or Local Authority **Safeguarding Team, as follows;**

- CBC Adult Safeguarding Team- 0300 300 8122

- CBC Children Safeguarding- 0300 300 8585
- LBC Adult Safeguarding Team- 01582 547730
- LBC Mash- 01582 547 653
- BBC Adult Safeguarding Team- 01234 276222
- BBC Mash- 01234 718 700
- Local Authority Out of Hours all Authorities- 0300 300 8123
- ELFT Luton and Bedford Safeguarding Lead Adult- 0330 124 1771

8.9 Where risk (to the person and/or others) has increased because of bed availability or conveyance problems then this must be reported to the relevant Department and a Datix/ EDT Escalation Record completed if required.

8.10 AMHPs have a number of support and advice structures available to them during the course of their practice, including: experienced/Senior AMHPs, AMHP Leads, AMHP Operational Manager, EDT On-call Manager, EDT Service Manager, ELFT On-call Manager, CBC Head of Service for Community Assessment Services(who has overall senior responsibility for EDT) and ELFT Director of Social Care.

8.11 The ELFT Mental Health Act Law Office and Manager is also available, during office hours, for some legal and procedural queries on 01582 707601.

9. Legal Access

9.1 LSSA legal advice is available via Local Councils for all AMHPs in each area, AMHPs should liaise with the AMHP Lead or EDT On-call Manager to obtain approval for legal advice. The Local Authorities process for obtaining legal access should be followed in each case.

9.2 Contact can be made with relevant legal team on:

Bedford Borough Council

Adult Social Care (legal)

01234 276066

Adult & Children's Education (legal)

01234 228743

Central Bedfordshire Council

Pathfinder Legal

Child Protection Team: childcareduty.shefford@pathfinderlegal.co.uk

Adult Social Care Team: adultsocialcare@pathfinderlegal.co.uk

Luton Borough Council

Senior Solicitor 01582 547495,

Solicitor 01582 547496

Legal Admin Team - 01582 546549 / 547468.

9.3 Out of hours a shared agreement is in place with all three local Authorities, the advice provided will be brief and should only be used in emergencies. For out of hours magistrate applications contact can be made with the clerk on 020 33343333. For any other legal advice contact can be made with Weightmans on 0800 3029259. Requests for legal access must be approved by the EDT On-call Manager, support will be provided by EDT to ensure the usual processes are followed.

10. Nearest Relative

Nearest Relative (NR) MHAA Requests and applications

10.1 Under the MHA the NR has the right to request a MHAA, via a letter, telephone call or via a health worker. The NR will not usually know the right terminology to use and the onus is on the AMHP to clarify what the nearest relative is requesting. If, in any such case, an AMHP decides not to make an application, s/he must as soon as practicable, inform the NR of the reasons in writing. The AMHP should always inform the NR of their right to make an application.

10.2 The NR has the power to make an application for admission although an "AMHP is usually a more appropriate applicant than a patient's nearest relative, given their professional training and knowledge of the legislation and local resources. This also removes the risk that an application by the nearest relative might have an adverse effect on their relationship with the patient." (CoP 14.30). An NR should not be forced to make an application for admission under the Act because it is not possible for an AMHP to attend a MHAA.

10.3 If the AMHP declines to make an application, the NR should be made aware of his/her right to apply, and the AMHP should suggest that the NR consults with the doctors involved if s/he wishes to consider this option.

10.4 In Appendix 3 a document produced by Mind can be found which explains what a nearest relative is, including what powers and rights they have and how a person can change their nearest relative.

NR Identification

10.5 Section 26 of the MHA defines 'relative' and 'nearest relative' (NR) for the purposes of the Act. Section 26(1) sets out the order in which family members of the person may be considered to be the NR, namely:

- Husband or wife (or civil partner)
- Son or daughter
- Father or mother
- Brother or sister

- Grandparent
- Grandchild
- Uncle or aunt
- Nephew or niece

10.5 Section 26(3) makes it clear that the general rule for determining the person's NR is to take whoever comes first on the list of relatives set out above, with preference being given to relatives of the whole blood, and that if there is more than one relative coming within the same category, the elder/eldest is to take priority regardless of the sex of the relative, subject to preference being given to the relative who either lives with or cares for the person (s26(4).

10.6 Section 26(5) confirms that a family member who might otherwise be regarded as a NR should be disregarded if they are:

- Resident abroad (i.e. outside the UK, including the Channel Islands and Isle of Man) and the person is 'ordinarily resident' in the UK;
- Permanently separated from their husband/wife/civil partner by formal agreement (or estranged from).
- Under 18 years (except when the husband, wife, civil partner, father or mother of the person).

10.7 It is important to remember that the identity of the nearest relative may change with the passage of time, so an assessment of the NR needs to be carried out in every case.

10.8 When interviewing a person who has been residing with a group of people for five years or more in a communal living situation (e.g. as part of a religious community or in a group home), then the group become 'relatives' for the purpose of the Act and the eldest resident of that group would become NR (s26(7)).

10.9 If the person was being "cared for" by one of the 'five year' people, then that person would become the NR under s26(4).

Children looked after by the Local Authority or Guardians

10.10 For children/young people who are subject of care orders, the LSSA should be regarded as the NR in preference to any individual except the person's husband, wife or civil partner (if any) [s27 MHA]. The parents of children who are merely accommodated by the LSSA however retain full NR rights (unless otherwise excluded, for example because they do not have 'parental responsibility' in terms of the Children Act). The guardians of minors would count as the NR (or joint NRs in the case of co-guardians).

10.11 Where an AMHP discovers, when interviewing a person for possible detention or guardianship under the Act (or at any other time), that the person appears to have no nearest relative, the AMHP should advise the person of their right to apply to the County Court for the appointment of a person to act as their nearest relative.

10.12 If the person lacks capacity to decide to apply themselves, the AMHP should consider applying to the County Court on their behalf. Advice of the AMHP Lead and Legal team should be sought before any steps are taken.

The NR's right to be informed or consulted

10.13 Where an application for admission under s2 MHA is being made, the AMHP must take "such steps as are practicable" "before or within a reasonable time after an application has been made" to inform the NR "that the application is to be or has been made" and of the NR's right to make an application for discharge under s23(2).

10.14 Where an AMHP is considering an application for admission under s.3, or an application for guardianship under s.7, they must ordinarily consult the NR (s11(4) MHA). The NR need not be informed or consulted in circumstances where:

- it is not practicable for the AMHP to obtain sufficient information to establish the identity or location of the nearest relative or where to do so would require an excessive amount of investigation involving unreasonable delay;
- and/or consultation is not possible because of the nearest own health or mental incapacity.

10.15 There may also be cases where, although physically possible, it would not be reasonably practicable to inform or consult the NR because the detrimental impact of this on the person would interfere with the person's right to respect for their privacy and family life under article 8 of the European Convention on Human Rights to an extent that would not be justified and proportionate in the particular circumstances of the case.

10.16 Detrimental impact may include cases where people are likely to suffer emotional distress, deterioration in their mental health, physical harm, or financial or other exploitation as a result of the consultation. Consultation with the NR that interferes with the person's Article 8 rights may be justified to protect the person's article 5 right to liberty.

10.17 If you do not consult or inform the NR, the AMHP should always record their reasons.

10.18 When consulting NR's AMHPs should, where possible under CoP 14.64:

- ascertain the nearest relative's views about both the person's needs and the nearest relative's own needs in relation to the person
- inform the nearest relative of the reasons for considering an application for detention and what the effects of such an application would be, and
- inform the nearest relative of their role and rights under the Act.
- [CoP 14.64]

The NR's right to object or discharge

10.19 An application for admission under s.3, or guardianship under s.7, may not be made where the NR has notified the AMHP (or the local authority on whose behalf the AMHP is acting) that they object to the particular application (s11(4) MHA).

10.20 However, if it is thought necessary to proceed with the application to ensure the person's safety or of others and the NR cannot be persuaded to agree, the AMHP should consider applying to the county court for the NR's displacement under section 29 of the Act.

10.21 The NR has the right to order the discharge of a person admitted under s.2 or s.3, or who is received into guardianship under s.7 MHA (s23(2).

10.22 The NR has the right to order the discharge of a person admitted under s.2 or s.3, or who is received into guardianship under s.7 MHA (s23(2).

10.23 In the case of a detained person, the NR must give the hospital managers 72 hours' notice of discharge. In the case of a person received into guardianship no notice is necessary and the person is discharged forthwith.

10.24 Where the NR's order of discharge is barred by the RC under s25 MHA, the NR has the right to appeal this decision to a Mental Health Review Tribunal under s66.

10.25 A person who has been identified as the person's NR is not legally obliged to act as such. He or she can authorise any person (other than the person or a person disqualified under s26(5)) to perform the functions of the NR.

Where the NR is temporarily abroad;

10.26 Where the NR is temporarily outside of the United Kingdom, the Isle of Man or the Channel Islands (e.g. on holiday or business) that person does not cease to be the NR. Good practice would suggest that where possible, especially where an application under s3 MHA is being considered, the AMHP should attempt to contact the NR irrespective of their location. In the event that this is not reasonably practicable, any other relatives contacted should be listed under 'Significant Other'. In these circumstances it is important to demonstrate consultation with other people familiar with the person accessing services.

Where the NR is not contactable:

10.27 It is the responsibility of the acting AMHP at the time of application to pursue the contact of the NR. The AMHP should take all such steps as are reasonably practicable to contact the NR and should record all steps taken in detail both on RIO and in the MHA Assessment Report.

10.28 For s.3 applications resulting from a s.2 the AMHP must continue to try and consult with the Nearest Relative until the s.2 is due to expire. The AMHP must evidence all attempts made to consult with the NR. If the AMHP works for the Daytime AMHP Service the AMHP will be paid to work outside the usual hours of operational for the team in order to

maximise opportunities to consult with the NR. Alternatively, the out of hours EDT will be contacted to consider a handover.

NR Displacement

10.29 There is detailed Practice Guidance in relation to local Displacement processes, this document can be found on the ELFT L Drive or EDT SharePoint file.

11. Conveyance (Section 6 MHA)

11.1 Conveyance may be required for people requiring admission (informal or detained).

11.2 For detained people, a completed application for admission together with medical recommendations gives the applicant or any person authorised by the applicant, the authority to convey the person to hospital under Section 6(1) MHA.

11.3 A person 'authorised' by the applicant can be a police officer or member of the ambulance service or other appropriate professional. The AMHP should ensure that the application form and medical recommendations are always given to the person authorised to transport the person, with instructions for them to be presented to the member of hospital staff.

11.4 The CoP makes it clear that "Patients should always be transported in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people." (CoP section 17.3).

11.5 When deciding on the most appropriate method for transporting a person, factors to be considered include:

- the availability of different transport options;
- the distance to be travelled;
- the wishes and views of the person, including any relevant statement of those views or wishes made in advance;
- the person's age and gender;
- cultural sensitivities;
- any physical disability the person has;
- any risks to the health and safety of the person – including their need for support, supervision and clinical care or monitoring during the journey.
- the nature of the person's mental disorder and their current state of mind;
- the likelihood of the person behaving in a violent or dangerous manner;
- the safety of the people transporting and anyone else accompanying them;
- the likelihood that the person may attempt to abscond and the risk of harm to the person or other people were that to happen;
- the impact that any method of transport will have on the person's relationship with the community to which they will return;

- the effect on the person of who accompanies them (e.g. whether the presence of the AMHP) or one of the doctors involved in the decision to detain them may have a detrimental effect);
- the availability of transport to return those who accompany the person; and
- whether an alternative to transporting the person is available and appropriate e.g. video conferencing for a court appearance.

11.6 The CoP also makes it clear that, where the AMHP is making an application for admission to hospital, they have a professional responsibility to ensure that all the necessary arrangements are made for the person to be transported to hospital and that all relevant agencies should co-operate fully with the AMHP to ensure safe transport to hospital. (CoP section 17.9).

11.7 If the person is likely to be unwilling to be moved, the AMHP will need to provide the people who are to transport the person (including any ambulance staff or police officers involved) with authority to transport the person. This will give them the legal power to transport people against their will, using reasonable force if necessary, and to prevent them absconding en route.

11.8 If the person's behaviour is likely to be violent or dangerous, the police should be asked to assist in accordance with locally agreed arrangements. Where practicable, given the risk involved, the AMHP should try to ensure that an ambulance service (or similar) vehicle is used even where the police are assisting.

11.9 Where it is necessary to use a police vehicle because of the risk involved, it may be necessary for the highest qualified member of an ambulance crew to ride in the same vehicle with the person, with the appropriate equipment to deal with immediate problems. In such cases, the ambulance should follow directly behind to provide any further support that is required.

11.10 Where an MHAA is carried out in an ELFT ward and conveyance is required, the AMHP should first consider whether hospital transport or medical services are appropriate to convey however, where urgency and/or risk is an issue, alternative conveyance arrangements will need to be used.

11.11 When undertaking MHA in community and admission is required, where at all possible (and appropriate) we must use East of England (EoE) ambulance to convey: EoE Ambulance 01234 716120.

11.12 Where the risks are high, Bedfordshire police should be asked to either escort the ambulance or convey where risk indicates. If these agencies are unable to convey then the AMHP should contact the AMHP Lead or EDT On-call Manager to obtain agreement to book secure ambulance service.

11.13 EDT officers out of hours will liaise with the DSN to secure an appropriate cost centre and to seek support in arranging secure transport. If difficulties arise obtaining this support the AMHP will escalate to the ELFT on-call manager for resolution.

11.14 During day service hours the AMHP Lead will make arrangements for a secure ambulance directly. When doing so, the AMHP will need to specify the type of vehicle requested and will also need to provide the appropriate AMHP Service cost code (Bedford or Luton). The AMHP Service Admin needs to be notified in instance where private conveyance has been arranged due to lack of East of England Ambulance availability/ timely response, so this information can be logged.

11.15 AMHP Leads should agree to a person being transported by private vehicle only if they are satisfied that the person and others will be safe from risk of harm and that it is the most appropriate way of transporting the person. In these circumstances there should be a medical escort for the person other than the driver. (CoP section 17.17).

12. Protection of property

12.1 Section 47 of the Care Act 2014 imposes a Duty on Local Authorities to "take reasonable steps" to "prevent or mitigate loss or damage" to moveable property belonging to a person who is admitted to any hospital (regardless of any compulsory detention). The Duty arises even where no member of staff of the authority has been involved in the admission process.

12.2 This Duty applies where a person is admitted to hospital and it appears there is a danger of loss or damage as the person is unable to protect or deal with the property and there are no suitable arrangements in place.

12.3 In order to perform this Duty, the Local Authority may at reasonable times and on reasonable notice enter the premises the person was living prior to being admitted and may deal with this property to prevent loss or damage

12.4 A local authority may not exercise the power to enter premises, and deal with property unless it has either obtained the consent of the adult concerned or where the adult lacks capacity to give consent, the consent of a person authorised under the Mental Capacity Act 2005 to give it on the person's behalf. If there is no such 'alternative adult' then the local authority can exercise the power if it is satisfied that exercising the power would be in the adult's best interests.

12.5 The term 'moveable property' is not defined in the Act but is generally understood to include such items as:

- the personal contents of a house (or other dwelling), including furniture, personal clothing, cash, jewellery and valuables;
- domestic and any other animals owned by the person;
- cars (which have to be taxed and insured if kept on the public highway) and other forms of transport such as bicycles, motorbikes and motorhomes.

12.6 This Duty usually arises where a person is living alone or in lodgings. It could arise where the person lives with other people who might be relatives but to whom s/he is unwilling to hand over responsibilities for possessions or where people may be unwilling to accept responsibility for such property.

12.7 It may be hard to determine who may or may not be a suitable person to accept responsibility for a person's property; if in doubt consult the AMHP Lead or EDT On-call Manager.

Procedures at time of Admission

12.8 If no other suitable arrangements are, or can be made, at the time of the removal of the person, the following detailed procedure must be followed.

- Where possible, the person should be asked which articles of value (including sentimental value) are in the premises. These could include cash, bank pension and rent books, insurance policies, etc. If time and circumstances permit, and these items written down and if appropriate countersigned by the person.
- If there is any question that the person does not understand the meaning of these actions, the signature of an independent witness should be sought. Nevertheless, under no circumstances should valuables be held personally by a member of staff.
- The AMHP, preferably accompanied by the person or another individual, should make a round of the premises checking that all the windows and doors are securely closed and fastened, that all plugs and switches are turned off where relevant, but thought must be given before switching off fridge's and freezers etc.
- Internal doors should, wherever possible, be closed, all lights and fires extinguished, and the key removed when vacating the premises. The whereabouts of other keys should also be checked where possible.

12.9 The AMHP should make all reasonable attempts to identify someone who can take any further actions following admission. Where the person is already involved with a community team, this should be the care co-ordinator. These further actions may include;

- If possible, supplies of electricity, gas and water should be turned off if the premises are likely to be vacated for a substantial period. Special care must be exercised in cold seasons.
- Where there appears to be a health risk, Environmental Health Department should be contracted, and advice sought.

Locksmiths

12.10 If the police enter the person's property without consent under PACE or section 135 MHA 1983, the police have initial responsibility to secure the premises as they forced entry. Police normally have their own locksmith. In exceptional circumstances, where the local authority has had to force entry, they will have their own list of approved locksmiths.

12.11 Where forced entry is anticipated, all efforts should be made to obtain a local authority/housing association locksmith (especially if they own the property), or key holder (if private let). Even where dealing with privately owned property, it is recommended to secure the services of a local authority approved locksmith.

12.12 Where the services of a locksmith are required, the AMHP needs to consult the relevant local authority (either for details of their preferred locksmith or the cost centre code to use to commission a private locksmith).

Pets

12.13 Every effort should be made to enlist the assistance of relatives, friends and neighbours to look after pets where it is appropriate to do so. Failing this RSPCA / PDSA should be contacted. As a last resort pets must be boarded out in approved kennels and charges will be met by relevant local authority.

12.14 Where an arrangement might include a substantial commitment of Council money, the AMHP should ensure that the relevant Local Authority team has been consulted and accepted the liability.

12.15 Once a pet placement has been made, it is the responsibility of the Local Authority to put in place monitoring arrangements. The AMHP may be required to explain the need for and context of pet placement.

12.16 For EDT this approval is sought via the EDT On-call Manager.

12.17 Notification of discharge must be communicated to the local authority by the relevant mental health team.

Cars and Motor Vehicles

12.18 Cars and motor vehicles count as moveable property and are therefore covered by this section of the Act. Where a person's vehicle is parked outside his/her house or in the normal place of parking, the vehicle should be checked that it is locked, the keys taken for safe-keeping and placed with the manager of the ward where the person is admitted or another suitable person. The vehicle should be checked periodically by the allocated team or Local Authority.

12.19 Where a person's car is in a position where it is not safe and cannot be secured where it is, e.g. at a roadside or lay-by, again effort should be made to enlist the person's assistance or that of his/her friends and relatives.

Duration of Storage

12.20 There is no time limit set out on the duty to protect movable property. It is suggested, where a person's stay in hospital is likely to be protracted, that managers will need to make appropriate decisions in consultation with the person and others concerned, so that the authority fulfils its duties while avoiding unnecessary expenditure of public funds.

13. Community Treatment Orders (Section 17(A) MHA)

13.1 Community Treatment Orders (CTOs) are used to enable suitable people to be safely treated in the community rather than under detention in hospital, underpinned by a power to recall the person to hospital if necessary, to provide a quick and responsive way to help prevent relapse and any harm, to the person or to others.

13.2 CTOs may be used only if it would not be possible to achieve the desired objectives for the persons care and treatment without it. The key factor in the decision is whether the person can safely be treated for mental disorder in the community only if the Responsible

Clinician (RC) can exercise the power to recall the person to hospital for treatment if that becomes necessary.

13.3 In making that decision the RC must assess what risk there would be of the persons condition deteriorating after discharge, for example as a result of refusing or neglecting to receive treatment. In assessing that risk the RC must take into consideration: the persons history of mental disorder; and any other relevant factors (such as whether a person has previously had repeated admissions, the persons current mental state, the persons insight and attitude to treatment, and the circumstances into which the person would be discharged).

13.4 It is the AMHPs role to decide whether to agree with the persons RC that the person meets the criteria for community treatment, and (if so) whether CTO is appropriate. The criteria for a CTO are set out in s17A of the Mental Health Act.

13.5 All the criteria must apply. Even if the criterion is met, it does not mean that the person must be discharged under a CTO. In making the decision, the MHA Code of Practice requires the AMHP to consider the wider social context of the person e.g. any support networks the person may have, the potential impact on the rest of the persons family, and employment issues (CoP section 29.22).

13.6 Unlike an admission to hospital it is not a requirement for the AMHP to consult with the Nearest Relative (NR) in respect of an application for CTO. However, the Code of Practice states that the AMHP should consider how the persons social and cultural background may influence the family environment in which they will be living and the support structures potentially available; this will inevitably, therefore, involve consultation with the NR and other carers/family members where they exist.

13.7 The AMHP is required to look wider than the immediate clinical or community mental health setting, therefore anything that provides the personal context/background is always useful e.g. Social Circumstances (or other similar) Report. There are several documents that are required to be sent with the referral form, these include; Form CTO1, Care Plan, Risk Assessment, any previous CTO information.

13.8 Form CTO1 already contains the mandatory conditions so the RC should only focus on clarifying those additional conditions which they think “necessary or appropriate” [s17B(2)]. Conditions should only be regarded as necessary or appropriate for one or more of the following purposes:

a) ensuring that the person receives medical treatment;

b) preventing risk of harm to the person's health or safety;

c) protecting other persons.

13.9 The conditions must not deprive the person of their liberty and should:

- be kept to a minimum number consistent with achieving their purpose;
- restrict the person’s liberty as little as possible while being consistent with their care plan and recovery goal;

- have a clear rationale, linked to one or more of the purposes above, and
- be clearly and precisely expressed, so that the person can readily understand what is expected.

13.10 Common conditions cover matters such as:

- where and when the person is to receive treatment in the community;
- where the person is to live, and
- avoidance of known risk factors or high-risk situations relevant to the person's mental disorder.

13.11 Conditions should also always be kept under review and the CTO amended to reflect any changes in circumstances or risk. Any condition no longer required should be removed (MHA CoP 29.41).

Recall

13.12 The RC has the power to recall the person in several circumstances, including where:

- the person needs to receive treatment for mental disorder in hospital (either as an in-person or as an out-person);
- there would be a risk of harm to the health or safety of the person or to other people if the person were not recalled; or
- if they break either of the mandatory conditions.

13.13 This is a (discretionary) power not an (mandatory) obligation. This means that the RC should consider in each case whether recalling the person to hospital is justified in all the circumstances. CoP makes it clear that the person must always be given the opportunity to comply with the condition before recall is considered (unless there is a risk of harm to their health or safety or to others) and any action should be proportionate to the level of risk.

13.14 The RC has responsibility for coordinating the recall process, unless it has been agreed locally that someone else will do this. In every case the RC must complete a written notice of recall to hospital, which is effective only when served on the person. Within Bedfordshire the RC holds responsibility to recall the individual. See appendix 4.

Revocation of CTO

13.15 Where revocation of CTO is being considered, the AMHP has to consider the same criteria and in the same way as when making decisions about an application for admissions under s.3.

13.16 If the AMHP does not agree that the CTO should be revoked, then the person cannot be detained in hospital after the end of the maximum recall period of 72 hours. The person will therefore remain on a CTO. In such circumstances, it would not be appropriate for the RC to approach another AMHP for an alternative view.

13.17 Where there is a disagreement, the AMHP and RC should consult their respective senior managers for further advice and the Escalation Practice Guidance should be followed.

Practical CTO Suggestions

13.18 If the RC wishes, to include a condition about residence or frequency of attendance at activities, they should be encouraged to try to make it proportionate/flexible. The phrase "unless otherwise agreed with the RC/care co-ordinator" can be considered. This does not mean that AMHPs should unnecessarily delay discharge because of 'dispute' over wording as subsequent amendments can always be made.

13.19 Where the person is already in the community (such as on approved leave), the AMHP should try and secure an indication of whether there is any foreseeable difficulty in meeting the person. Interviewing the person at their home address (prior to 'formal' discharge) is preferable to enable the AMHP to get the best assessment of the person's social circumstances. Where difficulty is anticipated, consideration should be given to arranging for the person to attend hospital so that appropriate assessment/engagement can take place there.

13.20 The person's community care co-ordinator should expect to be asked for input into the AMHP assessment, and ideally attend the final discharge meeting (where the CTO documentation etc should be provided and explained to the person).

13.21 The CTO conditions need to be included word for word in any Care/Support Plan and the AMHP should check to make sure that the person understands and agrees their Plan.

14. Guardianship

14.1 AMHPs will follow the guidance in the tri-borough Guardianship Policy.

15. Aftercare arrangements

15.1 AMHPs should decide how to pursue any actions which their interview indicates are necessary to meet the needs of the person. This will include any referrals to social, health or other services, the code is clear decisions and rationales should be recorded clearly (CoP 14.104).

15.2 Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues, this needs to be provided in a timely manner (CoP 14.107).

15.3 The AMHP must complete the required referral forms for any follow up actions needed.

15.4 Should an AMHP identify through their information gathering and/or assessment that a vulnerable person (adult of child) has unmet needs they will ensure appropriate actions in line with relevant legislation are undertaken. It is essential any immediate actions or emergency social care responses are actioned by the allocated AMHP. It is the AMHPs responsibility to ensure all information is shared with the relevant Local Authority or team to enable appropriate follow up and aftercare arrangements.

15.5 Referrals from AMHPs to CRHT will be accepted as trusted assessments, and the person referred will be accepted onto the CRHT caseload: direct AMHP referrals will not result in a further assessment by CRHT. If following referral, CRHT have concerns about the viability of CRHT care, whether due to poor engagement, levels of risk, or any other factor, the AMHP service will review this in partnership with CRHT.

15.6 CRHT will not be required to complete a new referral to the AMHP service, but will be asked to provide updated information regarding the current situation. Such a review may involve a joint visit to see the patient when this is indicated. The purpose of this review is to take joint responsibility for the person's onward care pathway. Although it is possible that new circumstances, including the response to CRHT, may justify another MHA assessment.

15.7 To assist this situation, AMHPs referring to CRHT are asked, on the AMHP report (including brief reports), to identify the broad purpose of referral to CRHT, and whether, in their view, the situation should be considered for another MHA assessment if CRHT care does not prove viable. [For some referrals viable CRHT care is essential if admission under the MHA is to be avoided, for others CRHT care may beneficial, but disengagement would not justify another MHA assessment]. Other outcomes from a joint review could include informal admission, a decision for both services to monitor the situation for a limited period, or a joint decision that supports discharge from both services (with joint responsibility for liaison with relevant stakeholders).

16. Relating Practice Guidance / Policy

- Escalation Practice Guidance
- AMHP Daily Routine Practice Guidance
- Competencies, Standards and Expectations Practice Guidance
- Guardianship Policy
- Warranting Policy
- MCA Policy
- DoLs Policy
- Multi-agency Emergency Department Practice guidance.
- Multi-agency Mental Health in Custody Practice Guidance.

17. Appendices

- Appendix 1 CQC Guidance - Anorexia
- Appendix 2 Telephone Interpreters
- Appendix 3 MIND Guidance – Nearest Relative
- Appendix 4 Recall Diagram

Section 137/138 Multi-Agency Practice Guidance

1. Introduction / Background

Section 137 of the Mental Health Act (MHA) 1983

1.1 This section states that wherever people are required to be taken, removed or returned to a particular place, or to be detained temporarily in a place of safety, they are deemed to be in legal custody This includes, for example:

- people being conveyed to hospital to be admitted on the basis of an application for admission (whether under s.2 or s.3)
- people under guardianship being taken under Section 18 to the place they are required to reside, because they have not gone there themselves
- people being detained in a hospital (or elsewhere) as a place of safety after being taken from a public place by the police under Section 136.

Section 138 of the Mental Health Act (MHA) 1983

- s.138 of the Mental Health Act states that anyone who was regarded as being in legal custody by virtue of s.137 may, if they escape/abscond, be re-taken by any person who had legal custody of them prior to the escape, or any Police Officer or AMHP or anyone authorised under Section 18.
- No further authority/warrant is required to retake the person if found in a public place.
- Note, however, that this Section does not provide authority for force to be used to enter premises where the person is believed to be. In such circumstances, an application for a warrant under s.135 (2) should be made if considered necessary. Please refer to the Section 135 Multi-Agency Practice Guidance for further information.

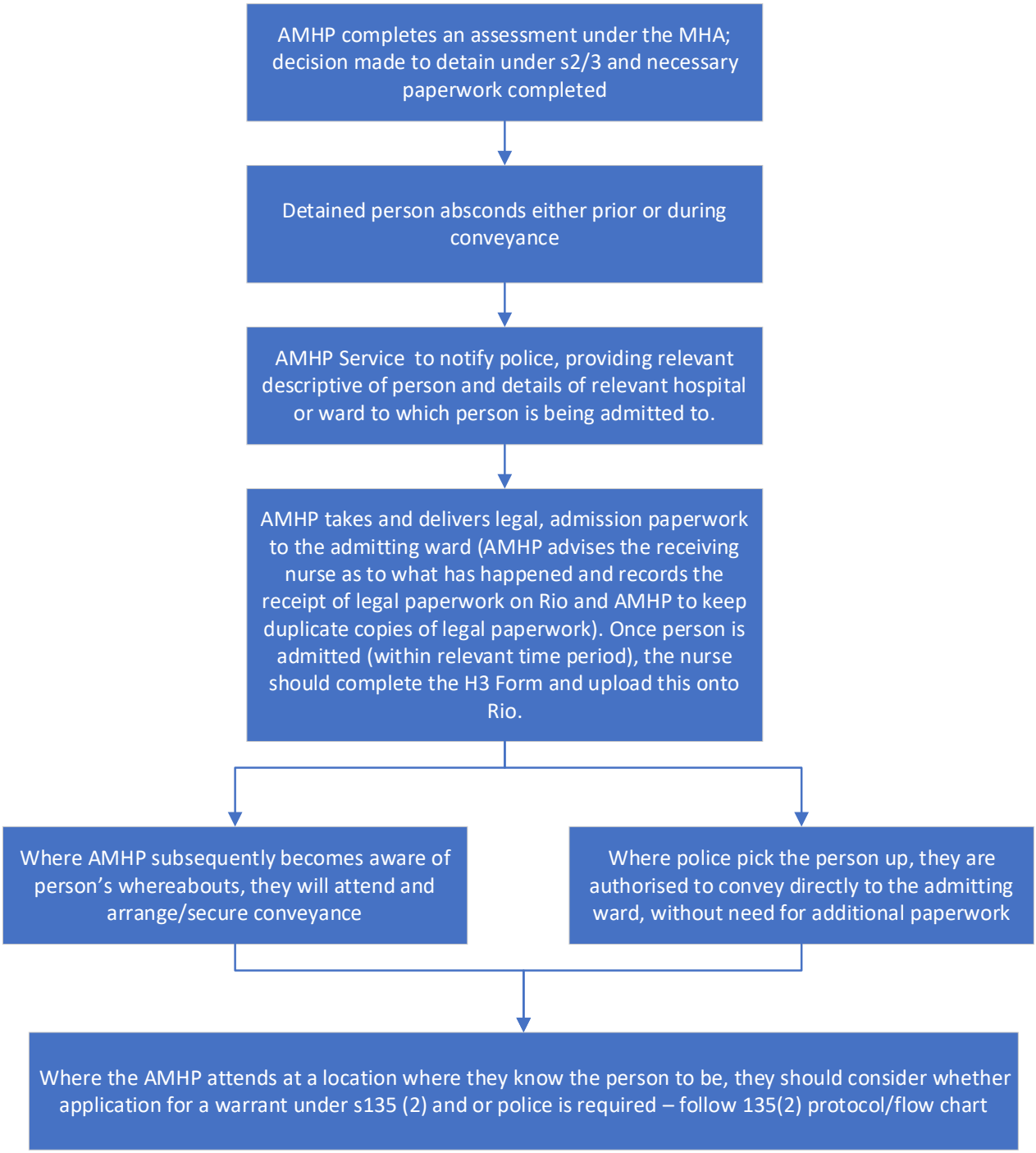
Timescales for Re-taking a Person who has Absconded from Legal Custody

- s.138(1)(a) states that those people who escape from custody (who are not absent without leave) may be retaken (within the relevant time limit).
- s.138 (2) states that those people who are liable to be detained, subject to Guardianship or a Community Treatment Order, who become absent without leave during custody, may be retaken within the time limits set out in section 18 (this does not apply to someone subject to a restriction order who can be retaken at any time).
- s.138 (3) states that people who escape from custody where Sections 135 or 136 have been applied, may only be re-taken within 24-hours of escape. Those people who are already detained at the place of safety under those Sections may only be retaken within the period up to and until the expiry of the 24-hour detention period (or within the extension period if applicable).

1.2 The Reference Guide to the Mental Health Act has a simple table for practitioners to use to work this out (see table below). Key Timescales for retaking the most common situations are set out below:

A patient who, at the time of absconding, was (or is treated as):	May not be returned after:
Being conveyed to hospital on the basis of an application for admission for assessment or treatment under section 2 or 3	14 days starting with the day the patient was last examined by a doctor for the purposes of a medical recommendation in support of the application
Detained on the basis of an application for admission for assessment under section 2	28 days starting with the day the patient was admitted (or treated as admitted) on the basis of the application
Detained on the basis of an application for admission for treatment under section 3	The later of: • six months starting with the day the patient went absent, or • the date on which the authority under which they were detained at the time they went absent is due to expire
Detained in a place of safety under section 135 or 136	The earlier of: • 24 hours from the time the patient absconded, or • the period for which the patient may be detained, i.e. 24 hours' from the start of the patient's detention in the place of safety

s.137/138 Flow Chart



AMHP Standards and Key Performance Indicators (KPI)

1. AMHP Standards and KPIs

1.1 East London NHS Foundation Trust (ELFT) with its partner Local Social Services Authorities (LSSAs) in, Luton Borough Council (LBC), Bedford Borough Council (BBC) and Central Bedfordshire Council (CBC), are committed to offering high quality, safe, effective, well led and responsive AMHP provision via the AMHP Service and Emergency Duty Team (EDT); in relation to mental health act assessments and other activities carried out under the powers contained in the Mental Health Act (MHA, 1983).

1.2 Historically AMHP Services have had no national set of standards or KPIs; from early 2020 the AMHP Service and EDT piloted the national AMHP Standards. This policy aims to integrate locally agreed AMHP standards and KPIs, with the national AMHP Standards. The standards and KPIs set out below have been agreed and developed by ELFT and the local LSSAs – BBC, CBC and LBC and are designed to ensure efficient, responsive, and effective AMHP and EDT service delivery, and consistent levels of service quality.

1.3 In August 2021, Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (BLMK CCG), ELFT, BBC, CBC and LBC jointly agreed their Section 140 (MHA, 1983) policy. This policy further states locally agreed mechanisms for reporting and monitoring of issues in relation to AMHP performance, as detailed in this practice guidance document.

1.4 These standards and KPIs also aim to improve Director of Social Services (DASS) and Director of Mental Health Services understanding of the overall AMHP performance, ensuring a 'direct line of sight' and that reporting structures are in place. Providing further assurance that people receive the best possible outcomes, that reflect legal obligations of the LSSAs (delegated function to ELFT, under section 75 agreement), under the MHA (1983) and associated Code of Practice (CoP, 2015). As well as ELFT and LSSA commitment to providing high quality, safe, responsive, efficient, effective and well led AMHP Services. They are also intended to inform improved training, support and working environments/conditions for AMHPs, and support effective recruitment and retention of the AMHP workforce.

2. AMHP KPIs

No	Indicator	Measure	Frequency of Reporting to DASS & Mental Health Directors (& BLMK CCG, where applicable)
1)	**AMHPs will commence all Section 136 Mental Health Act Assessments (MHAA)s within 3 hours of receiving referral, for people who are fit for assessment, as per CoP (16.47).** *People who are intoxicated due to alcohol or illicit substances or who require medical intervention would not be considered as fit for assessment.*	100% compliance within 3 hours	Monthly

No	Indicator	Measure	Frequency of Reporting to DASS & Mental Health Directors (& BLMK CCG, where applicable)
2)	**A brief outline report will be completed at the time of MHAA for people detained or admitted to hospital** as per CoP (14.93).	100% same day compliance	Monthly
3)	**An audit of all MHA referrals, not resulting in assessment under the MHA will be conducted**	100% compliance within 1 month	Monthly
4)	**All urgent MHA referrals will be assessed within 24 hours,** (people who present a high risk to self/others and who cannot wait to be assessed until the next day)	90% compliance within 24 hours	Monthly
5)	**AMHPs will provide a full MHA report within 7 days of carrying out MHAAs**	90% compliance within 7 days	Monthly
6)	**All non-urgent MHA referrals within 72 hours,** (people whose risks can be safely managed with an appropriate safety plan until MHAA can be arranged, e.g., Section 135 Warrants, complex community MHA required)	90% compliance within 72 hours	Monthly
7)	**A random audit of 20 MHA reports is to be conducted every quarter on a rotation basis by each LSSA**	100% compliance	Quarterly

3. AMHP standards

No.	Standard
1)	**DASS and Director of Mental Health Services responsibility** - The DASS and Director of Mental Health Services will ensure a 'direct line of sight' (supported via the AMHP Lead role) and regular reporting and monitoring regarding AMHP performance.
2)	**AMHP national and regional context -** The locality AMHP Lead, and AMHP Operational Manager is supported by the DASS to be linked into the National AMHP Leads forum and regional AMHP forum. The AMHP Lead and AMHP Operational Manager are responsible for dissemination of national and regional information that will support local best practice. A record of attendance and meeting minutes should be maintained.

3)	**AMHP workforce development -** The AMHP workforce is supported to maintain alignment to the AMHP competencies, has access to appropriate levels of continuous learning and an approved register is in place of approved AMHPs (including suspensions or removal of warrants). Clear routes to AMHP training are in place for all qualifying professionals and agreement is in place to support AMHPs to maintain the requirements of their professional registration. Support to identify and recognise AMHP candidates from a range of professional backgrounds to work on the AMHP rota, whilst maintaining their specialist roles, is in place to avoid organisational and professional isolation. An AMHP workforce plan is in place, which includes detail regarding succession planning and scope to reflect the diversity of the local community within the AMHP workforce and awareness of the specific needs within the local community.
4)	**AMHP professional development and support** – AMHPs have access to managerial, professional, peer and legal support across the 24-hour period, this is provided to support AMHPs in their capacity to make independent AMHP decisions. Ensuring this they have access to individual, peer and professional support to explore their working practices in a safe manner, including the provision of timely de-brief sessions. AMHP supervision is viewed as the cornerstone of quality AMHP practice. AMHPs are provided with the opportunity to carry out a full range of AMHP functions to maintain practice standards, meet the requirements of re-approval warranting and to adhere to the AMHP Key Competencies. AMHPs should have routine opportunities to contribute towards the learning of others, identify their own learning needs and be provided opportunities for personal and professional development. AMHP services should promote a culture of open and honest communication within their services. AMHPs should have routine opportunities to record and share their experience and contribute to on-going service development.
5)	**Data and reporting -** AMHP referral and data management/ reporting systems (RiO Reporting Services and PowerBi/ JADU) are in place to support routine data collection and monitoring to support demand planning, strategic commissioning discussions and improvements to local operational practices. AMHP contingency plans are in place to be able to mobilise additional resources at times of peak demand, through the business continuity plan" BCP". Reporting mechanisms are in place to report issues and delays that have a direct impact upon AMHP practice, as a minimum this will include delays in bed provision, conveyance, s.135 warrant execution, s.12 doctor availability and issues relating to AMHP safety.
6)	**Promotion of wider AMHP role** - AMHP services are integral to mental health and related services, therefore AMHP representation is expected at local and regional level with regards to the development of

	policy and practice guidance in the following areas - prevention, safeguarding, crisis care and multi-agency working. In the promotion of 'localism', AMHP contribution to the functioning of other specialist teams and services is offered in the context of broader (child and adult) safeguarding responsibilities of the local authority. Active interface opportunities are routinely promoted, so routes to access AMHP support is clear to all partners. This also supports AMHPs to promote the rights -based agenda, early intervention, strengths and asset-based approaches and access to social care. System Leadership roles, such as the AMHP Lead, Social Care Lead, Head of Service, Lead for adult Social Care, Social Care Director, should be used to effect wider system change. AMHPs are routinely encouraged to promote the dignity, human and civil rights of those who encounter AMHPs, thus promoting person-centred and preventative approaches to care, equality of access to legal entitlement with the aim to reduce stigma. AMHP services should promote an understanding of social models of mental health, and this should be reflected in AMHPs' recording and reporting systems. AMHP reporting should make clear reference to the principles of the MHA and how the AMHPs have considered these throughout their work with individuals and those connected to them.
7)	**AMHP safety -** Arrangements are in place to ensure AMHP safety and wellbeing through lone working practice guidance and contingencies for AMHPs who have worked past their normal hours (including staff being compensated for their time).
8)	**Co-production** – The principles of co-production are embedded within AMHP service provision and operations. Service user and carer experience and perspective is captured via a variety of methods and used to support the development of AMHP related services. The opportunity for joint learning and identification of ways for service users and carers to engage and influence AMHP practice is a key priority. Thus, emphasising the value of service user and carer experience of the AMHP role as a spur for learning and development. Through working alongside service users and carers AMHPs are supported to explore the impact of social trauma on the experiences of detention and how this shapes the responses of both service user and the AMHP. The production of clear, culturally appropriate, and accessible information about the AMHP role and related professionals should be co-produced.

4. AMHP reporting and monitoring arrangements

4.1 The AMHP Governance Group (AGG) leads, on behalf of all three LSSAs, on the overall governance of the AMHP Service and EDT, AMHP provision. Under the section 75 agreement ELFT have the delegated function to manage the daytime AMHP Service on behalf of all three LSSAs. CBC provide the out of hours AMHP function on behalf of all three LSSAs out of hours.

4.2 It is the responsibility of AMHP Service and EDT to -

- Ensure effective data collection processes are in place to support reporting on AMHP Standards and KPIs.
- Support the analysis and interpretation of data collected to develop on-going service improvements.
- Feedback performance and quality data via the monthly AMHP Operational Group, AGG and Contract Performance Meeting with local commissioners.

4.3 The below table details the areas of AMHP performance that are monitored monthly via the AMHP Operational Group and AGG.

1	AMHP level of response
	Total number of MHAA referrals
	Total number of urgent MHAAs progressed
	Total number of MHAAs not progressed

2	MHAA Referral Source
	CAMH
	CMHT
	GP
	IST
	L&DS
	MHST
	Nearest relative
	PLS
	135
	136 – • Location of detention
	Ward

3	MHAA Outcomes
	Alternative plan- no MHAA arranged
	Community support arranged
	Detained S2
	Detained S3
	Detained S4
	Handed over to the AMHP Service/ EDT (specify)- • Routine/ Urgent MHAA • Unable to assess in a suitable manner- not medically fit (intoxicated) • Unable to assess in a suitable manner- requires medical review/treatment • No s.12 doctor availability • AMHP availability • Handover time
	136 breaches (specify)- • Unable to assess in a suitable manner- Not medically fit (intoxicated) • Unable to assess in a suitable manner- requires medical review/treatment • No s.12 doctor availability • AMHP availability • Handover time
	Informal admission
	No mental disorder
	Not detained
	Referral withdrawn
	S.140 enacted
	S135 warrant- • Declined by Judge • warrant granted & executed • warrant granted & handed over
	S135 location- • HBPOS

	• Own home
	S135 MHAA location – • HBPOS • Own Home

4	MHAA Time delays
	MHAA time delays – • AMHP availability • S12 availability • Information gathering • Difficulty establishing NR • Under the care of CRHT pending bed identification • Bed identification • Conveyance • Not fit to assess in a suitable manner • Serious incident • S135 warrant executed after 24 hours – (specify) • Locksmith/ property access • Ambulance/ conveyance • Police support • AMHP availability • S136 exceeded 24 hours • Police support • Other

Information Recording Practice Guidance

1. Introduction

1.1 EDT and the Daytime AMHP service works collaboratively with a number of partners therefore sharing of information and recording of information is a vital aspect of every professional's role. Good record keeping is an integral part of health and social care practice and is essential to the provision of safe and effective services.

1.2 The principles of good record keeping are well established and should reflect the core values of professional integrity and partnership working. This Practice Guidance should be in read in conjunction with East London Foundation Trusts (ELFT's) the Central Bedfordshire Councils (CBC's) Information and Records Management Policies, these can be found via the organisations intranet sites.

1.3 Good record keeping, whether at an individual, team or organisational level, has many critical functions such as:

- ensures clear accountability
- evidences rationales and supports decision making
- supports the delivery of services
- promotes effective communications between services
- providing evidence of services delivered
- promoting better communication and sharing of information between all professionals and people who access services
- Supports identifying risks
- supports audit, research, allocation of resources and performance monitoring
- Assists when responding to complaints or queries.

1.4 The principles of good record keeping apply to all types of records, regardless of how they are held. These can include:

- handwritten care/case notes
- e-mails
- letters
- reports
- incident and accident reports and statements
- non-disclosable information
- Local Authority and Health recording systems
- EDT On-call Manager Records. Written communication systems within departments, e.g. handover sheets, logs and diaries.

1.5 This document provides clear and consistent guidance on recording within EDT and the Daytime AMHP Service and applies to all paper and electronic records. The Practice Guidance explains what level of practice is expected from all EDT Officers and AMHPs to ensure best practice is achieved.

2. Principles of good record keeping

2.1 It is anticipated all professionals will have a clear understanding of expectations regarding record keeping and expectations in line with their registration and employment. The following principles should be adhered to by all EDT Officers and AMHPs;

- All discussions, advice, guidance or interactions relating to a person and/or family should be recorded on the relevant locality database. If it is not possible for a professional to record on the system the relevant word assessment form will be completed and distributed to the relevant service and/or Local Authority.
- When completing any assessments within a health setting or police custody, the professional must complete a written record in the persons notes to ensure all are clear on the work undertaken and actions agreed.
- If handwritten documents are being completed handwriting must be legible.
- In the case of written records, the person's name and job title should be printed alongside the entry.
- Date and time should be recorded on all records. This should be in real time and chronological order and be completed as close to the actual time as possible.
- Records must be factual and not include unnecessary abbreviations, jargon, meaningless phrases, speculation or opinion and written in black pen.
- Professional judgement to decide what is relevant and what should be recorded should be observed. All practitioners must seek appropriate advice if they require support to make a judgement.
- Professionals should record details of any assessments or reviews undertaken and provide clear evidence of the arrangements you have made for future and ongoing support.
- Records should identify any risks or problems that have arisen and show the action taken to deal with them. This includes rationales for decision making.
- Contingency plans must be clearly recorded.
- Professionals must not alter or destroy any records without being authorised to do so, any mistake should be scored through with a single line only dated and initialled.
- In the unlikely event that you need to alter your own or another professional's records, you must give your name and job title, and sign and date the original record, to ensure records are clear and auditable.
- GDPR guidelines must be followed, all professionals have a responsibility to work with the person or their carer regarding the management of their records.
- The language that is used within records should be easily understood and professional.

- Records should be factual and not include professional's personal views, records should be evidence based.
- Records should be readable when photocopied or scanned.
- Professionals should never falsify records.
- Professionals are responsible for ensuring they appropriate knowledge regarding GDPR requirements.
- Where possible professionals are expected to complete electronic recording using the relevant forms. Advice should be sought from managers if a professional has any concerns regarding how, when or in what format recordings should be completed.
- Any concerns regarding a professional's record keeping should be reported to their line manager at the earliest opportunity. Managers will manage concerns in line with their respective organisations policies and procedures and will be addressed via supervision.

3. Expectations regarding referrals and information.

3.1 Due to the complex and high risk cases which are referred to EDT and the Daytime AMHP Services there is an expectation that all contact is recorded in a consistent manner. This is essential for performance monitoring and collating information regarding advice and guidance offered by the EDT and Daytime AMHP Service.

3.2 All contact made with the services must be recorded on the respective databases, for EDT this should be on the relevant organisations recording system or the EDT Assessment Form and for ELFT this is RiO. Training will be provided to ensure professionals are clear on how to use the recording systems in place. EDT Officers are expected to record all contacts on JADU (EDTs recording system).

3.3 Any information or handover sent to EDT is completed on relevant document. The expectation is the EDT Officer will review the information available to determine if any support will be required from EDT, this is completed in conjunction with a verbal handover of information from the professional involved. The EDT Officer will record the person's name and details on the EDT Electronic White Board to ensure all EDT Officers working or due on shift are aware of the case and possible intervention required.

3.4 When receiving information, handovers or referrals it is essential EDT Officers and AMHPs spend the time considering the information which has been received. This enables the EDT Officer or AMHP to ask relevant questions for clarity purposes when liaising with the referrer.

3.5 If the service concludes further actions or an assessment is required an EDT Officers or AMHP will be allocated for further consideration. It is this EDT Officers or AMHPs responsibility to undertake information gathering and progress arrangements for assessments. This should include the following:

- A review of information available on relevant database.
- Contact with GP to obtain relevant medical history.

- Contact with family, friends or Nearest Relative to obtain additional information and views regarding any actions being proposed. This is in line with the personals wishes, GDPR Regulations and 14.68 of the MHA CoP.
- Contact with other professionals from Health, Police, Local Authority or relevant organisation.

3.6 All conversations undertaken as part of these arrangements will be recorded on the relevant database or recording document. This enables other services to be kept updated of activity and also provides an effective audit trail of support from the EDT or Daytime AMHP Service.

3.7 It is the professionals' responsibility to ensure they are utilising the EDT and AMHP Assessment Practice Guidance, this has the guidance regarding what assessments or templates should be used when recording assessments or actions undertaken.

3.8 Following an assessment or actions being undertaken it is the EDT Officers or AMHPs responsibility to ensure all records are up to date. The EDT Officer or AMHP who managed the referral or support is responsible for ensuring their intervention has been clearly recorded and outcomes distributed.

4. AMHP specific recording.

4.1 The EDT On-call Manager, AMHP Lead or delegated Officer is responsible for reviewing all referrals, the outcome of the referral review should be recorded in the designated section of the referral form. If the referral is not progressed to an AMHP, both verbal and written feedback to the referrer is undertaken and recorded on the referral form.

4.2 If an AMHP is allocated to consider a referral the EDT On-call Manager, AMHP Lead, or delegated Officer will record this as an outcome on the referral form. The AMHP is then responsible for updating the referral form of any actions they undertake in the AMHP section. The AMHP will be responsible for providing both verbal and written feedback to the referrer and will progress with any actions agreed.

4.3 It is the AMHPs responsibility to ensure they have all the required documentation for the Mental Health Act Assessment (MHAA) if this is progressed.

4.4 All AMHPs are required to complete a written record of their involvement, templates of the documents or records which should be completed can be found in the EDT and AMHP Operational Templates folder.

4.5 An assessment of the persons accessible communication needs should have taken place and be documented as part of the assessment. The AMHP is responsible for making any adjustments needed as identified within their assessment.

4.6 If it is concluded an admission following a MHAA is required a copy of a brief MHAA report, AMHP application and the medical recommendations should be given to the admitting ward. All paperwork is now managed electronically therefore documents will have been emailed to the admitting ward. AMHPs are responsible for ensuring they have liaised with the ward to confirm admission arrangements and confirm receipt of the documents needed for the admission.

4.7 For Daytime AMHPs a brief note of attendance and the details of the assessment outcome should be made on the persons progress notes in RIO to ensure that all medical

professionals who may come into contact with the person before submission of the full report are aware of AMHPs involvement.

4.8 The AMHP is required to make every effort to ensure the brief report is uploaded to RiO on their behalf by the receiving team at the point of admission, if this cannot be done at this point the AMHP must upload the brief report to RiO no later than the next working day. EDT will ensure the brief report is e-mailed to the Daytime AMHP Service Desk Administrator to upload on their behalf.

4.9 If an AMHP is admitting a person onto a general ward a H3 form must be provided to the most senior member of ward staff present so that they can complete it by way of accepting the person onto their ward. A H19 form should also be left at the same time, as when an alternative bed becomes available, the ward will then have the necessary paperwork to facilitate transfer. The DSN contact details should be left so that the ward can make direct contact regarding progress of alternative bed identification.

4.10 A full MHAA Report should be completed within seven working days of the date of the assessment; any difficulties in meeting this timeframe must be discussed with the AMHPs line manager or a member of the management team. This is still relevant when there was no admission required. Any concerns regarding an AMHP recording should be addressed via supervision and will be managed in line with each organisations HR Policies.

4.11 It is essential all legal criteria within the MHAA Report is recorded robustly, the AMHP should always use the template for the MHAA. All actions agreed must be recorded within the report including referrals to other mental health teams or other agencies.

4.12 Once the full report has been completed, the AMHP should email a copy to the relevant administrator with clear distribution instructions. As a minimum, a copy should be sent to the:

- admitting ward (where relevant);
- the patient's GP;
- any Responsible Clinician and Care Co-ordinator involved in the persons care;
- any team/agencies to whom a referral has been made as a result of the assessment.

4.13 EDT AMHPs are expected to send a copy of the report to the Daytime AMHP Service Desk Administrator who will ensure the referral is recorded. This will include attaching a copy of the report to RiO.

4.14 There are occasions when AMHPs undertake additional tasks or AMHP activity. This could include; work in preparation for a guardianship application or renewal, consultation to colleagues in other disciplines over a period of time relating to guardianship or other aspects of the MHA or complex case discussions. It is important for AMHPs to keep a written record of all such activity by completing a file note (for the persons file) or by completion of relevant recording documentation. For EDT this activity needs to be recorded on the EDT Assessment Form and JADU.

5. Contingency Planning for Recording

5.1 It is acknowledged on occasions services may experience challenges with its ability to record information. This is including but not exclusive of the following;

- System database failure.
- No access to the internet.
- No access to electronic records or templates.
- No access to physical templates or files.

5.2 EDT and the Daytime AMHP Service will ensure there is both physical and electronic access to the Operational Policies, Practice Guidance and Frameworks. This will enable EDT Officers and AMHPs have access to the guidance and documents needed to undertake their role and to deliver a service.

5.3 Should there be any concerns regarding service delivery, recording ability, an EDT Officer or AMHPs ability to undertake their role the Multi-agency Escalation Practice Guidance should be implemented. This will facilitate appropriate risk assessments, actions and contingency plans to be agreed.

5.4 In the event Business continuity plans are implemented, handwritten documents (when needed) will be completed. Arrangements will be made to record information on the relevant system as soon as practicable afterwards.

6. Related Policies / Practice Guidance;

- EDT and AMHP Assessment Framework
- EDT and AMHP Escalation Practice Guidance
- EDT Daily Routine Practice Guidance
- Handover Practice Guidance
- Management and Allocation of AMHP Referral Practice Guidance

Digitalisation Practice Guidance

1. Introduction.

1.1 In October 2020, The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 were laid before Parliament. The Explanatory Memorandum to the Regulations confirms that they allow for certain statutory forms used for the exercise of powers of admission, detention, assessment and treatment under the Mental Health Act 1983 (MHA) to be served by electronic means.

1.2 This is part of the Government's work to modernise the MHA which has been subject to a recent Independent Review and reflects advances in information technology within the National Health Service ('NHS'). The Memorandum refers to integrated and secure information systems in the NHS, which have potential to help professionals follow the requirements of the MHA in ways that do not use their time unnecessarily, for example by waiting to receive signed paper forms.

1.3 It confirms that the need for these changes has been accelerated because of the current pandemic, and the need to support efforts to control infection by minimising unnecessary face to face contact. Even without these circumstances, the Government sees no continuing need to maintain restrictions on electronic service.

1.4 This guidance has been developed to provide support for The Bedfordshire and Luton AMHP Service and for Emergency Duty Team (EDT) AMHP's undertaking Mental Health Act Assessments (MHAA) in line with the new guidance and amendments.

2. Receipt of Electronic Forms.

2.1 The amended 2008 regulations enable statutory forms and other documents under Part 2 of the MHA to be served electronically, but only where the receiving body, authority or person agrees to accept electronic service of these forms.

2.2 There are however particular exceptions under the regulations to this as follows:

- Where an Approved Mental Health Professional (AMHP), or a nearest relative (NR) wishes to serve an application for detention. In this case, electronic communication to the hospital managers or their officers is always permitted (no agreement needed). Hospital managers are not entitled to reject a validly made application solely on the grounds of it being completed and communicated electronically.
- Where the recipient is a person. In all such cases, statutory forms and other notifications for the information of the person must continue to be served in hard copy. For example, the community treatment order recall form must continue to be served in hard copy and the person should continue to be notified in hard copy if someone is authorised by a nearest relative to act on their behalf under regulation 24 of the 2008 regulations. Electronic communication can, however, be used as an additional means of providing the person with the information, if that is their preference.

3. Service the AMHP's Application Electronically.

3.1 All electronic applications for detention should be considered as served once they have been successfully sent. It is good practice of the AMHP to check with the receiver that all documents have been received and accepted by the ward.

3.2 It is the responsibility of the AMHP to ensure that all supporting statutory documents including the doctors medical recommendations, whether singular or joint are sent along with the completed application. This should be sent via email together within one email.

3.3 Not all forms need to be completed electronically. For example, the AMHP may have paper copies of the medical recommendations and this may be supported by an electronic application. These documents however will be sent together as highlighted in 3.2 in the same email.

3.4 The AMHP should also ensure that a copy of the electronic application is sent with all relevant paperwork (Medical Recommendations) to the relevant Mental Health Law Office.

3.5 All electronically completed forms should include the AMHP's and doctors (secure) email address, alongside the postal address, in the relevant section of the statutory form so that the author can be easily contacted in the event that rectifications are required.

4. When the Person is Detained to a Medical Ward.

4.1 When a person is detained to a medical ward, the application should be served via email electronically at the general hospital in hours.

- For Bedford Hospital please send the completed application to: bhn-tr.safeguardingadultteam@nhs.net
- For Luton and Dunstable Hospital please send the completed application to: Adult.safeguarding@nhs.net

4.2 For out of hours admission, the AMHP will need to contact the bed managers at each site to serve the application to ensure that this is received.

5. Conveyance.

5.1 Where an AMHP submits the application for detention electronically and then delegates conveyance of the person, a paper of copy of the documents are not required to indicate that the conveyance is lawful. The AMHP must provide evidence of a completed application that is supported by the necessary medical recommendations.

5.2 The AMHP can complete the local conveyance form in hard copy or electronically.

6. Remote Mental Health Act Assessments (MHAA).

6.1 During the Coronavirus pandemic on 30th March 2020, NHS England issued NHS England issued a document entitled Legal guidance for mental health, disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic ("the Guidance"). It offered specific advice and guidance on areas which are "posing a particular challenge as a result of the pandemic and where temporary departures from the Code of Practice may be justified in the interests of minimising risk to patients, staff

and the public". The Guidance was revised in May 2020 to include a section, drafted jointly by NHS England and the Secretary of State, headed "Application of digital technology to Mental Health Act assessments" and made particular reference to the use of remote digital assessments.

6.2 Following this the court have now considered whether Mental Act assessments can be carried out remotely - see Devon Partnership NHS Trust v Secretary of State for Health and Social Care.

6.3 The Court has concluded that this requires 'the physical attendance of the person in question on the patient. In light of this, the section dealing with remote assessments in the 'Legal guidance for services supporting people of all ages during the coronavirus pandemic' is being removed, and will be further updated in due course.

6.4 In conclusion all organisations need to ensure that **all Mental Health Act assessments are completed face to face** in line with Section 11(5), Section 13(2) and Section 12 of the Mental Health Act.

7. Related Policies and Practice Guidance

- EDT and AMHP Protocol.