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### Title

Nearest Relative – Mental Health Act 1983 (2007)

### Aim / Summary:

Role and function of the Nearest Relative under the Mental Health Act 1983 (2007) including protocol for delegation, displacement and appointment.

### Document Type (Click the relevant box.):

Policy

Guidance

Strategy

Procedure

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# Nearest Relative Guidance

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## 1. Introduction

The Nearest Relative (NR) is a legal term used in the Mental Health Act (MHA) 1983 (amended 2007). The NR provides a significant safeguard, balancing the loss of rights for an individual detained under the MHA. This guidance document seeks to clarify duties and responsibilities of Approved Mental Health Professionals (AMHPs) and provides associated guidance to AMHPs working on behalf of Nottinghamshire County Council. This guidance must be read in conjunction with the more comprehensive guidance given in Jones and advice should be sought wherever necessary.

## 2. Identification of NR

Section 26 MHA provides criteria that informs who an individual's NR is. AMHPs have a duty to identify the NR to enable them to either inform or consult with them.

### 2.1 Usual order of NR hierarchy

The following list provides the NR hierarchy other than those who take precedence (described in 2.2 – 2.6 below) :

1. husband or wife or civil partner (except one permanently separated from the person by agreement or by court order or who has deserted or been deserted by the person)
2. person who qualifies as a relative by living with the person as husband or wife or as if they were civil partners for at least 6 months
3. son or daughter over 18
4. father or mother
5. brother or sister over 18
6. half brother or sister over 18
7. grandparent
8. grandchild over 18
9. uncle or aunt over 18 of the whole blood
10. nephew or niece over 18 of the half-blood (e.g. half-sister of the person's mother)
11. nephew or niece over 18 of the whole blood
12. nephew or niece over 18 of the half-blood (e.g. child of a half-brother of the parent of the person)
13. unrelated carer or person over 18 who has lived with the person for a period of more than 5 years

### 2.2 Determining Precedence among “Relatives”

The general rule is to take whoever comes first on the list of relatives with preference being given to relatives of the whole blood and if there is more than one relative coming within the same category then the eldest takes priority. If a relative “ordinarily resides” with a person or by whom

a person is cared for then they take precedence over all other relatives. An illegitimate child counts as a legitimate child of his/her mother or of the father if he has parental responsibility. Individuals who are under 18 years old cannot be NRs unless they are parents or spouses. Legally adoptive parents count as whole blood parents.

### **2.3 Husband / Wife Identification Issues**

A person living with the person as their husband or wife for six months or more is treated as their husband or wife. This applies to same-sex relationships (see below). This does not apply if the cohabitee is different from the legal spouse and the patient is married but not permanently separated from or deserted by their spouse. The eldest wife of a polygamous marriage is the NR.

### **2.4. Same-Sex Relationships**

Civil Partners recognised in the amended Mental Health Act.

### **2.5 Ordinarily Residing and Caring**

When a person either ordinarily resides with or is cared for by a relative then that person takes precedence. A relative only counts as a carer under this description if the care given is “substantial and sustained”. The caring relative need not reside at the same address so long as the amount of care given is regular.

If a patient has a relative living with them and a relative giving care lives somewhere else, then the eldest gains precedence as the NR.

### **2.6 NRs Who Are Abroad**

Relatives of UK residents (including Channel Islands and Isle of Man) who reside out of the UK are excluded from being NRs. This does not however apply to non-UK resident patients i.e., tourists, migrant workers, newly arrived immigrants. The Act recognises these patients as having NRs that reside outside of the UK. AMHPs will need to inform for Sec 2 therefore, consult with for Sec 3, and Guardianship with NRs living abroad as long as it is practicable to do so or would not cause delay to Sec 3 or Sec 7 Guardianship applications. Likewise, Hospital Managers will have duties to provide information to NRs living abroad for this group of detained patients. NRs who go abroad temporarily for example on holiday or on business remain as NRs.

## **3. Duties and responsibilities of AMHPs**

### **3.1 Consulting the NR prior to assessment**

Every attempt should be made to consult with the NR prior to the assessment to gain a full appreciation of the history of the case. It is of particular importance to establish a holistic appraisal of the person’s mental health needs as well as any social or environmental factors that

may be of concern. Care should be taken to explain the potential outcomes of the MHA assessment and explain the process to avoid misunderstanding (CoP 14.8)

Reasons for lack of contact with the NR beforehand should be recorded.

AMHPs must not assume a NR will agree with a S3 admission on the basis that they agreed with a S2 admission (CV v South London and Maudsley NHS Foundation Trust (2010) EWHC 742.)

### **3.2 Informing the NR of the outcome of assessment**

Regardless of the outcome of assessment, the CoP highlights requirements to inform the NR of the outcome of assessment and should be followed in all cases.

The CoP states the following:

**14.100** - *Having decided whether or not to make an application for admission, AMHPs should inform the patient, giving their reasons. Subject to the normal considerations of patient confidentiality, AMHPs should also give their decision and the reasons for it to:*

- *the patient's NR*
- *the doctors involved in the assessment*
- *the patient's care co-ordinator (if they have one), and the patient's GP, if they were not one of the doctors involved in the assessment.*

**14.101** - *An AMHP should, when informing the NR that they do not intend to make an application, advise the NR of their right to do so instead. If the NR wishes to pursue this, the AMHP should suggest that they consult with the doctors to see if they would be prepared to provide recommendations.*

### **3.3 Objections to Consulting the NR**

There is no scope for patients to choose their NR and from time to time people may consider the NR identified under the Act to be unsuitable. The AMHP should advise the patient of their right to apply to the County Court to displace the NR or, if it would not be reasonable to expect the patient or someone on his/her behalf to make that application, the AMHP may make the application instead (CoP 8.11).

Where a patient expresses an objection to an AMHP consulting with the NR, AMHPs may abstain from doing so only on the grounds that consultation would not be practicable. A High Court case (R (on the application of E) v Bristol CC 2005) stresses that "practicable" should be interpreted in such a way as to give effect to the patient's right to respect for private and family life (Art 8 ECHR) and should take account of the patient's wishes, the likely effect upon his/her health and

wellbeing of consulting the NR and the disadvantages arising from not having the NR's input. "Practicable" should not be equated with "possible" and was more accurately interpreted as "appropriate" in these circumstances.

The decision not to consult with a NR should not be taken lightly. Detailed reasons for not consulting should always be recorded in writing. AMHPs should always anticipate that a decision not to consult may lead to an assessment that lacks valuable information. AMHPs may wish to seek legal assistance on a case-by-case basis.

Consideration should then be given as to whether a request for displacement or invoking the Secretary of States powers should be made. Such an issue should be discussed initially with the Head of Service/Principal AMHP Lead. In addition, where the decision is complicated the AMHP is advised to have access to appropriate professional and legal support where possible to assist them in their decision-making process.

NB: MHA 1983 s.67(1) 'The Secretary of State for Health may, if he thinks fit, at any time refer to a Mental Health Review Tribunal the case of any patient who is liable to be detained or subject to guardianship or SCT under Part II of this Act (CoP 30.39). This is activated by contacting the Dept of Health. Note also that a displaced NR has the powers to apply to a tribunal.

### **3.4 Other Practicable and Unreasonable Delays in Consulting**

It is a statutory requirement that the AMHP consults with the NR about possible admission under Section 3 and reception into Guardianship (see *TW v Enfield Borough Council* [2014] EWCA Civ 362, [2014]). Section 11(4) CoP allows for this process to be waived if it is not reasonably practicable or would cause unreasonable delay. The most likely circumstances when this might happen is when the AMHP cannot obtain enough information to identify the NR or where to do so would require an excessive amount of investigation. One judgment commented that the AMHP "cannot be expected to be a private investigator".

All reasonable attempts to consult however must be made. A High Court judgement (*GP v Derby City Council*, 2012, EWHC 1451) found that given the circumstances 'there was a substantial period from about 4.30 in the afternoon through until midnight in which the consultation process could have been undertaken before the section 3 admission request was signed'. The Judge made several points in his findings, one of which was that it wouldn't have taken a disproportionate amount of time for the AMHP to have gone to the NR's address before making the application. [GP v Derby City Council \(2012\) EWHC 1451 \(Admin\), \(2012\) MHLO 58.pdf](#)

PDF version of this file embedded here:



R (on the application of GP) v Derby City Cc

Should the AMHP be unable to consult with the NR before making an application for admission for treatment after making all reasonable attempts however, then she or he should persist in seeking to contact the NR to inform them of their powers to discharge the patient under section 23. AMHPs should also inform the MHA administrators once they have contacted the NR (CoP 4.59 – 4.63).

### **3.5 Consultation with NR by the AMHP**

It is good practice for the AMHP who is responsible for considering an application to consult directly with the NR. This can be by telephone although preferably it should be face to face.

In exceptional circumstances, it is occasionally essential to ask another professional, preferably another AMHP, to do this. There should still be a full and effective consultation and the AMHP who passes on the consultation remains responsible for it (R v Managers of South Western Hospital ex parte M 1994).

### **3.6 Children Who Are Patients**

People under 18 are children as defined by the **Children Act 1989**. An unmarried child in the care of the local authority under a care order has the local authority as NR. This function will be delegated to a suitable officer. Where a child is not subject to a care order but is the subject of a court order granting residence, special guardianship or parental responsibility, or has a guardian appointed by the court or under a will, AMHPs should seek a legal view on a case-by-case basis.

### **3.7 Where there is no NR**

Consideration should be made for people who have no NR to have one appointed under Section 29a MHA by a Court so that the person has an appointed NR. This is usually a Local Authority officer not working in the person's care team thus preserving an element of independence. Before considering this option AMHPs should consult their Head of Service/ Principal AMHP Lead and relevant legal section. See separate protocol – appendix 2.

### **3.8 Sections Where NR rights do not apply**

- Sections 35 and 36
- Section 38
- Restricted Patients under Part 3 of the Act

## 4. Displacement of NR (Section 29 MHA)

### 4.1 Displacement of NR (CoP 8.6-8.23)

If the NR objects to an application being made for treatment or reception into guardianship, the application cannot proceed at that time. If, because of the urgency of the case and the risks of not taking forward the application immediately, it is thought necessary to proceed with the application, the AMHP will then need to consider applying to the County Court for the NR's displacement (section 29). LSSAs must provide assistance, especially legal assistance, in such cases.

Hospital managers should provide support to detained patients to attend court if they wish, subject to Section 17 leave being granted.

### 4.2 Grounds for application of displacement of NR

An application for an order under this section to a County Court may be made upon any of the following grounds:

- That the patient has no NR within the meaning of this Act, or that it is not reasonably practicable to ascertain whether he has such a relative, or who that relative is;
- That the NR of the patient is incapable of acting as such by reason of mental disorder or other illness; or
- That the NR of the patient unreasonably objects to the making of an application for admission for treatment or a guardianship application, in respect of the patient; or
- That the NR of the patient has exercised without due regard to the welfare of the patient or the interests of the public, his power to discharge the patient from hospital or guardianship under this part of the Act or is likely to do so.
- The NR is otherwise not a suitable person to act as a NR.

### 4.3 Delegating another Person to be NR

- If the NR would find it difficult to undertake the functions defined in the Act, or is reluctant to do so for any reason, it is possible for them to authorise any person – other than the patient or someone excluded under section 25(6) to take on the functions (Ref Guide Section 32.6). AMHPs should consider whether a NR will agree to the delegation of the role to someone else before proceeding to Displacement by County Court (CoP 8.15)
- The authorisation needs to be in writing and can be revoked at any time in writing. A copy should be sent to the Mental Health Trust managers if the person is liable to be detained. The procedure is set out in Mental Health Regs 2008:24. It is now possible to accept the authorisation electronically if this is acceptable to the recipient (Reg 24(8)). It is generally preferable to have a signed letter but if it can be confirmed that it was the NR who sent the electronic authorisation, it would be acceptable. The form is attached as **Appendix 1**.



- The person delegating their rights in regard to a person already subject to compulsory intervention under the Act must inform the hospital managers if that person is detained or under SCT or must inform the Local Authority if they are under Guardianship.
- Note that only the NR who delegates this role can transfer it to another person.

#### **4.4 Applications by persons**

People can also apply for a NR to be displaced. AMHPs, if appropriate, should support and advise the person about how to take forward this course of action. As noted in the CoP 8.12, they may well be deterred by the need to apply to court. The support of an IMHA may be sufficient to reassure such concerns but it may be more appropriate for the AMHP to apply to the Court. The reasons for the application should be carefully considered before taking this step. An application can also be made to the Court to stop the NR being a party to the proceedings if the person has concerns about their own safety.

#### **4.5 Displacement: Action by AMHP**

It is important to recognise that the responsibility for ensuring a rapid process is a shared responsibility between psychiatrists, AMHPs and solicitors. The intention would be to file the application before the Section 2 expires and within 72 hours of the time that the AMHP informs legal services of the need to apply for displacement.

The following procedures should be followed.

- Decide on action to displace NR with relevant members of clinical team (psychiatrists to be alerted to the importance of giving an early warning of the possible need to convert from a Section 2 to 3 so that the necessary action can be taken to arrange for displacement.)
- If in doubt, consult Team Manager or Principal AMHP Lead.
- Notify Legal Services as soon as possible that displacement is likely to require priority.
- Fax written report if available and practicable. The solicitor will inform AMHP which details should be included.
- Arrange to attend at Legal Services to prepare evidence as soon as possible after decision is made that displacement is necessary.
- The application is made before the Judge in closed court, with the AMHP in attendance (the judge may wish to interview the person)

#### **4.6 Outcome**

If the application to displace the NR is successful and the order is granted, the order will appoint either the Corporate Director of Adult Social Care and Health or duly nominated representative to undertake the function of the NR. As noted above, the agreement of the proposed nominee should have been sought by the AMHP although this is not a legal requirement.

Appointment of acting NR is for specific periods or without limit of time where:

- There is no NR
- NR unable to act because of mental disorder or other illness
- NR not suitable

Otherwise, it is for 3 months or for the duration of a guardianship, treatment order or a CTO.

**Appendix 2** contains guidance for Nottinghamshire County Council group managers and team managers who accept delegation of the Nearest Relative role.

## **5. NR request for consideration of a MHA assessment**

### **5.1 Section 13(4)**

Local Authorities must arrange for an AMHP to consider the case of a patient who lives in their area if required to do so by the patient's NR, (CoP 2008 2.16)

Such requests by NRs should be accepted either verbally or in writing. It is unlikely that s/he would know of this specific right. They are more likely to use expressions such as "something terrible will happen if you don't do something" or "s/he should be in hospital". It is therefore necessary for a duty social worker to inform the NRs of this right if they ring with serious concerns about "the person".

Adult Contact duty workers should all be aware of this section. It is acceptable for NR requests to be accepted from GPs, CPNs, OTs and psychiatric medical practitioners. It should then be confirmed with the NR.

The CoP contains a commentary and guidance on the information that can be given to NRs and carers (CoP 2.27).

### **5.2 Initial investigations:**

Once the request has been logged on Mosaic an AMHP should be appointed as soon as "practicable" to investigate the situation further.

Jones underlines the relevance of the wording "to take the patient's case into consideration" – stating that this does not always mean interviewing the person although this would usually be good practice. The consideration as to whether to make an application for admission to hospital is dependent on the Local Authority's knowledge of the person which is the reason why an interview is generally advisable. However, these are examples of where an interview may not be appropriate: -

- Where the person is well known and perhaps has recently been assessed under the MHA. The AMHP role would be to establish whether any change had occurred since that assessment. If not, an interview may not be required.
- If the person is not known, the GP can be contacted. This would be in order to establish whether the person is in fact mentally disordered. The obligation under this section only arises if this is the case. It is important to check that the GP has had meaningful and recent contact with the person. Generally, the person should be assessed.

The AMHP therefore needs to gather all the possible facts before deciding upon whether to interview and/or assess further. This may involve seeking information from other agencies as well as the GP and NR. If the AMHP visits the person this should be in accordance with health and safety considerations.

### **5.3 Action to be taken by AMHP**

If the AMHP believes that an admission to hospital ought to be made or should be considered, then s/he should set up a MHA assessment and decide whether:

- An application for admission under the Act should be made
- Informal admission is appropriate
- Community mental health support should be set up
- Or the person does not require a mental health intervention

If, however the AMHP either decides not to make an application or even interview the person, s/he should write to the NR straight away giving the reasons for this decision. As Jones points out, the reasons do not have to disclose detailed confidential information. Examples given:

- “I took medical advice and was informed that ...is not mentally disordered within the meaning of the Mental Health Act 1983” or
- “... agreed to come into hospital informally”.

Some NRs may decide to make an application him/herself if the required medical recommendation(s) have been made – see guidance below.

AMHPs may wish to remind relatives who are carers that they can obtain support and advice from Carer Support Workers or Third Sector Carer agencies.

### **5.4 Repeated requests from NR where the condition of a person has not changed significantly.**

This happens in rare circumstances. Again, it is useful to remember that “taking into consideration the patient’s case” can be assessed without interview.

However, if the requests were coming in regularly with no change in the situation, then it would be appropriate to hold a multi-disciplinary team meeting. This should include the GP, especially when they know the person and family better than other professionals do. The NR and person should be invited to all or part of this meeting if appropriate. It is important to understand the reasons for the repeated requests as professionals may have missed an important source of concern to the NR. Article 8 of the ECHR should be borne in mind, a right to respect for private and family life. There is subsequent guidance in case law that “regard must be had to the fair balance between the competing interests of the individual and the community, including other concerned third parties, and of the state’s margin of appreciation.” (Jones).

Following the meeting, a clear response and care plan should be written, and copies given to all those concerned.

## **5.5 NR as applicant**

Under Section 11(1) application for admission for assessment and for treatment, and for guardianship can be made by either an AMHP or NR.

The AMHP is usually the right applicant bearing in mind professional training, knowledge and the legislation and local resources, together with the potential adverse effect that an application by the NR might have on the latter’s relationship with the person.

The doctor is obliged, where reasonably practicable, to tell the NR of their rights to apply.

Whilst it does not happen often in our authority and we agree strongly that the AMHP is usually the right applicant, the AMHP cannot prevent the NR from making an application. In fact, the AMHP should give advice re: -

- Their rights and responsibilities which are outlined in <https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/nearest-relative/>
- How to obtain the appropriate form (each team should keep a small supply).
- Local admission procedures and how to convey including health and safety aspects. This includes the NR being aware of and ensuring:
  - That one of the doctors, who made the recommendation, had arranged a bed and an ambulance.
  - That they could ask for the assistance of the police if necessary.

## **5.6 Social reports under Section 14**

When a person is admitted through a NR application (other than an emergency application), the hospital manager will notify the local

authority who “shall as soon as practicable arrange for a social worker to interview the patient and provide the managers with a report on his social circumstances”.

This referral for an interview and report should be allocated and completed as soon as possible. It need not be an AMHP but unless the care co-ordinator is a social worker, it is usually preferable. If not, an AMHP should always be consulted. AMHP training gives relevant experience in the application of the Act and thereby understanding the context of admission. Furthermore, if an application has been refused by an AMHP s/he should write the standard AMHP report pro-forma outlining his/her reasons.

The Social Report should also be written on the standard AMHP report pro-forma. It should of course include an account of the circumstances that led to admission.

- Should you require assistance please contact the Performance, Intelligence and Policy (PIP) Team via: [policy@nottscc.gov.uk](mailto:policy@nottscc.gov.uk)

APPENDIX 1



Date:

Dear [Hospital Managers or Local Authority]

**Delegation of NR rights.**

I, [NR name], of [full address] am the [relationship to person] of [name of person]. I am their NR within the meaning of the Mental Health Act 1983.

I would like to delegate my NR duties for [name of person] To [name of delegate] to delegate to [name] of [full address]. They have agreed to take on the NR duties for [name of person]. In line with my duty.

I have told [name of person] that I am no longer the NR and told them who their NR will be.

The Mental Health Act and Regulation 24 of the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008, gives me the right to delegate my NR rights.

Yours faithfully,

Signed .....NR

Date.....

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

Signed.....Delegate

Date.....



## **Role, duties and expectations of Nottinghamshire County Council group managers and team managers who accept delegation of Nearest Relative role and function as defined in Mental Health Act 1983**

### **Background**

The role of “nearest relative” (NR) defined in the Mental Health Act (MHA) is intended to be an important safeguard to people who have been detained under the Act.

During assessments under the MHA, Approved Mental Health Professionals (AMHPs) have a duty to identify who appears to be the NR according to the criteria in S.26 of the MHA. One of the main functions for AMHPs is to identify the NR, inform or consult with them, and also explain to them their rights under the MHA.

On some occasions no-one meets the criteria under S.26, or an existing NR appears unsuitable and an AMHP will apply to the court to displace them. In both these cases if the court agrees with the application, then an appointment is made to “The Corporate Director, Adult Social Care and Health or duly nominated representative” (DASS). Following this, the role and function of the NR will be delegated to a team manager or group manager.

In addition to the above, an NR may feel unable to fulfil their functions as the NR and wish to delegate their functions to “The Corporate Director, Adult Social Care and Health or duly nominated representative” (DASS). The AMHP will support the NR to do so using the appropriate proforma (Appendix 1).

### **The Rights of the Nearest Relative**

The rights of the NR as described in the MHA are listed below. In practice many of these rights are very rarely used (no.1 particularly). In contrast numbers 2, 3, 6 & 7 are regularly exercised and are important safeguards.

1. To apply for admission to hospital or reception into Guardianship under sections 2, 3, 4 and 7.  
*This right is very rarely used nationally.*
2. Where applications are made by the AMHPs, to be informed of the application (section 2) or consulted (sections 3 and 7).  
*AMHPs are under a duty to do this and may be challenged in court if this is not done.*

3. To notify professionals involved of any objection they have to the making of an application for sections 3 or 7.  
*This will in effect block the making of an application for s.3 or 7 unless the AMHP goes to court to displace the NR for “unreasonably objecting”.*
4. To be informed of rights of discharge under section 23(2)(a) section 2, 3 and 7.  
*All AMHPs should do this directly where possible and will be provided in writing.*
5. To have their wishes considered by AMHPs when considering an application (NB this applies to any relative, not just the NR)  
*The views of the NR should be clearly sought and recorded, and given due weight in consideration of an application*
6. To require the local authority to direct an AMHP to consider the case for admission to hospital and to be informed in writing of the reasons where no application is made  
*These places a duty on the AMHP to consider the case, but not to make an application unless thought appropriate.*
7. To discharge persons from detention in hospital or Guardianship (sections 2, 3 and 7)  
*In the case of hospital detention (this cannot be done in the case of guardianship) the NR is required to give 72 hours' notice to the hospital managers within which period the responsible clinician (RC) may bar the discharge by certifying that in his/her opinion the person, if discharged, would be likely to ‘act in a manner dangerous to other persons or to himself’*
8. To apply to a Mental Health Tribunal (MHT) within 28 days against a notice barring their discharge of the patient detained on a section 3.
9. To appeal against a hospital order (section 37) without restrictions within 6 months of the making of the order and subsequently every year.
10. To appeal against a guardianship order (section 37) made in a court within 12 months of the making of the order and subsequently every year.

## Expectations

In order to fulfil the NR responsibilities as meaningfully as possible there will be an expectation that the appointed NCC team manager or group manager will maintain contact with the person they are NR for-

**Where the person is in the community, not in hospital or care home / nursing home** the expectation would be that the NR contacts them and their treating team (if there is permission to share) every six months to see how they are doing and get a sense of their progress.

**Where the person is in prison-** the expectation would be that the NR contacts them and the prison in reach team (if there is permission to share) every six months to see how they are doing and get a sense of their progress.



**Where the person is detained in hospital (general or psychiatric) or in a care home / nursing home**, NRs will need to keep in much closer contact-

In hospitals, the expectation is contact is made with the person and their treating team (if there is permission to share) every six weeks to ascertain events leading to the hospital admission and the person's view. For those individuals detained on S2 of the Mental Health Act, NRs will need to remember that they may well be asked if they object to a S3 if a further MHA assessment is requested and will need to be ready to give an informed opinion.

In care homes the expectation is that contact is made with the person and their treating team (if there is permission to share) every three months as the person may be "more settled" If this is not the case more frequent visits may be required.

In all situations face-to-face contact would be preferable, if this is not possible, contact should be made via Microsoft Teams or telephone. Face to face contact must occur every six months

Individuals have a right to decline contact from an NCC NR if they wish. In these circumstances the NR should enquire as to whether the person wishes to have contact at regular intervals and if not the reason why. If this is the case the NR to discuss with the AMHP team manager.

All contact with the NR is to be recorded on Mosaic (see information sharing information below).

Every six months a report will be sent to DASS and uploaded on to Mosaic - see attached report.

Every six months a face to face/team meeting will be arranged with the DASS to discuss the person appointed to as NR, this will be organised by the DASS following a reminder e-mail by the NR.

## **Information Sharing**

The nearest relative **does not have an automatic right to information about a detained person from a hospital**. The individual can request information is not shared with their NR and *"in almost all cases the information is not to be shared if the patient objects"* MHA Code of Practice (CoP) 4.35.

**You should make your appointment as NR known and be clear and that you are not acting as the person registered practitioner**, to the key members of an individual's Mental Health support team. In particular, the Care Coordinator, Medic in the CMHT and GP.

**If you are invited to attend a care planning or professionals meeting, please check whether this is with the consent of the person and consider the appropriateness of this as a NR rather than a registered practitioner.**

**NB. Staff fulfilling the NR role do not have permission to access Mosaic or Rio whilst fulfilling the NR role, apart from recording their activity on Mosaic as NR.**

**This is an independent role.**

### **Conflicts of Interest and Disagreements**

Fulfilling the role of NR as an NCC employee creates inherent issues with impartiality. The NR role is an independent safeguard within the MHA, and this is inevitably compromised with both AMHP and NR working for the same organisation. That said, the NR should seek to carry out their role with care and integrity, and the AMHP should not make any assumptions that a colleague will agree with their conclusions about the case.

### **Availability**

The NR role will only be applicable in working hours. If the allocated worker is not at work the role will fall to their manager/service director or out of hours AMHP duty manager/EDT manager. The reports should be accessed together with other case notes to ensure the NR's manager or another manager is as informed as possible to enable them to fulfil their role. Decisions made should be recorded on mosaic with a full rationale.

Whilst in work you may be contacted regarding an MHA assessment, please respond promptly if you receive a message from an AMHP.

**Nearest Relative report**

Copy to be sent to DASS every six months and filed on mosaic

**Basic information**

Mosaic ID number:	<input type="text"/>		
Full name of the person:	<input type="text"/>		
Date of Birth	<input type="text"/>	The person is over 18? Y/N	<input type="checkbox"/>
Current Address and telephone number	<input type="text"/>		
Name, address and telephone number of others with parental responsibility	<input type="text"/>		

**Background information.**

**Important-** Staff fulfilling the NR role do not have permission to access Mosaic, RiO, apart from recording their activity on Mosaic as NR.

Current legal status if known	<input type="text"/>
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Nearest Relative – Mental Health Act 1983 (2007)

<p>Pen picture of the person / background information i.e.</p> <ul style="list-style-type: none"> <li>• Life story</li> <li>• Family</li> <li>• Interests / hobbies</li> <li>• Accommodation</li> <li>• Support network</li> <li>• Mental health-diagnosis-impact on wellbeing /picture of when well and not well-views on treatment.</li> </ul>	<div style="border: 1px solid black; height: 200px; width: 100%;"></div>
<p><b>Person's view</b></p>	
	<div style="border: 1px solid black; height: 100px; width: 100%;"></div>
<p>Date completed</p>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>NR / professional's name, designation and contact details</p>	<p>Name</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div> <p>Address / telephone number</p> <div style="border: 1px solid black; height: 25px; width: 100%;"></div>