The Regulation and Quality Improvement Authority

Guidance for the completion of Guardianship Forms (Forms 13-20) under the Mental Health (NI) Order 1986

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

Contents

Definitions

Part II Medical Practitioner	Consultant Psychiatrist appointed by RQIA for the purposes of Part II of the Mental Health (Northern Ireland) Order 1986 (MHO)
Responsible Medical Officer (RMO)	The Consultant Psychiatrist (usually a Part II doctor) in charge of the patient's assessment or treatment
Responsible Board	The Health and Social Care Trust in whose area the person who is to be received into guardianship resides.
Guardian	The Responsible Authority, i.e. the Health and Social Care Trust in whose area the person who is to be received into guardianship resides. While the Trust will be named as the guardian, a professional officer must be nominated to carry out its duties as guardian. This role will be usually delegated to a social worker employed by the Trust, but may be delegated to another Health and Social Care Professional whom the Trust deems suitable. **Or** Any other person, including the applicant (i.e. the approved social worker or nearest relative). However this person must provide a written statement that he/ she is willing to act as guardian and must be accepted as suitable by the Health and Social Care Trust to which the application is made.
Approved Social Worker (ASW)	A social worker who has undertaken specific training to assume duties in accordance with The Mental Health (Northern Ireland) Order 1986
Nearest Relative	Nearest relative is a specific legal term defined in Article 32 of the Mental Health (Northern Ireland) Order 1986 and the role is one of the major safeguards for the rights of someone who is or may be subject to compulsion under the Order.

The Regulation and Quality Improvement Authority

Who We Are

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care services in Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive continuous improvements in the quality of services, through a programme of inspections and reviews.

The Mental Health and Learning Disability team (MHLD) undertakes a range of responsibilities for people with mental ill health and those with a learning disability under the Mental Health (Northern Ireland) Order 1986 as amended by the Health and Social Care Reform Act (Northern Ireland) 2009. These include:

- preventing ill treatment, remedying any deficiency in care or treatment
- terminating improper detention in a hospital or guardianship by monitoring the appropriateness of all applications forms received from HSC Trusts
- preventing or redressing loss or damage to a patient's property.

The MHLD team talks directly to patients about their experiences. This informs the wider programme of announced and unannounced inspections.

RQIA takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research, in any review of services provided. We highlight areas of good practice and make recommendations for improvements. Inspection report can be viewed on our website at http://www.rqia.org.uk/what_we_do/mental_health_and_learning_disability.cfm

Monitoring of Guardianship by the Mental Health and Learning Disability Directorate

Guardianship was introduced by the Mental Health (Northern Ireland) Order 1986 (MHO) with the aim of providing a framework in which people with a mental disorder could live as safely and independently as possible in the community and as a less restrictive alternative to detention in hospital. Guardianship refers to two separate community-based legal provisions contained in Part II and Part III of the MHO:

- Part II contains provision for a person to be "received into guardianship".
- Part III contains provision for a court to make a "Guardianship Order". This can only be used for persons with a mental disorder who are concerned in criminal proceedings

The purpose of guardianship is to ensure that people with a mental disorder, who meet certain criteria, receive the care and protection they require where this cannot be provided without the use of compulsory powers. It is primarily concerned with the welfare of the individual rather than their medical treatment. Guardianship provides a less restrictive means of offering assistance to a person than detention in hospital and should be considered as an alternative to such an admission. It also enables a relative or social worker to help a mentally disordered person to manage in his/her own home or in other accommodation in the community, where the alternative would be detention in hospital.

RQIA has a responsibility to make inquiry into any case where it appears that there may be improper reception into guardianship. When a patient is accepted into guardianship in accordance with the relevant articles of the MHO, RQIA must receive copies of the statutory forms (also called prescribed forms). When received, these forms are screened to ensure that they have been completed correctly by authorised personnel and within the relevant time limits.

Standards and General Principles

This document provides guidance and clarity for those completing prescribed forms relating to guardianship in terms of the information that must be recorded and the manner in which the forms should be completed.

Supporting guidance and clarity for those completing prescribed forms can be found in the following documents:

- The Mental Health (Northern Ireland) Order, 1986
- The Mental Health (Northern Ireland) Order, 1986, A Guide
- The Mental Health (Northern Ireland) Order, 1986, Code of Practice
- The GAIN Guidelines (October 2011) on the use of the Mental Health (Northern Ireland) Order, 1986.
- http://www.gain-ni.org/flowcharts/downloads/guardianship_under_the_mho_1986_a_model_for_operation.pdf

The role and responsibility of the approved social worker is described at Sections 3.11 – 3.13 of the Code of Practice.

The general principles that should be applied to ensure the validity of the documentation include:

- All parts must be completed legibly
- All parts must be completed fully
- Full names of patients and all practitioners involved - **NO** use of abbreviations or initials is permitted
- Full names and addresses of Trusts and Hospital – **NO** use of abbreviations is permitted
- Addresses must include postcodes
- Doctors status should be clearly indicated where required
- Forms must be signed, dated (and timed where required) within the timescales required in the MHO
- The information recorded must contain sufficient detail to ensure the legal validity for guardianship

Provisions for Amendments of Errors and Omissions

It is a requirement of the legislation that prescribed forms are forwarded to RQIA by the Health and Social Care Trust. It is important that completed prescribed forms are forwarded to RQIA immediately after they have been completed. These forms should be received electronically by RQIA no later than **four** days following completion.

Article 21 contains provisions which allow guardianship applications and supporting recommendations to be rectified within 14 days of the application being **accepted** by the Trust. Although an insufficient recommendation may normally be substituted by a fresh one, new medical recommendations may

not be substituted where the application has been invalidated under Article 18(7) because the two doctors do not agree as to the form of the patient's mental disorder.

Faults which may be capable of amendment by the person by whom it was signed, under this Article include the leaving of blank spaces on the Form which should have been filled in (**other than the signature**), or failure to delete one or more alternatives in places where only one can be correct. The patient's forenames and surname should agree in all places where they appear in the application, the supporting medical and approved social worker recommendations and medical and social reports. If dates do not conform to time limits they should be checked with the person who signed them. If it is found that interviews and examinations actually did take place within the specified time limits then the error may be corrected. If the time limits have not been complied with, the application is invalid unless the error is capable of being rectified by the substitution of new Forms.

A document with errors of this sort will be returned to the person who signed it for amendment. The amended document will be scrutinised again by the Trusts medical records department prior to its return to RQIA. This process must be completed within 14 days of the application being **accepted** by the Trust. RQIA must be informed of any alterations made and sent a copy of any substitution furnished. (Article 21)

Please note that RQIA cannot accept forms which are illegible, incomplete or include errors/omissions.

Form 13

FORM 13
Mental Health
(Northern Ireland)
Order 1986
Article 18

GUARDIANSHIP APPLICATION BY NEAREST RELATIVE

[Before completing this form please read the notes overleaf]

PART 1

(To be completed by the nearest relative)

(name and address of responsible Authority) To

Insert FULL LEGAL name and address of the Health and Social Care Trust. No abbreviations or initials to be used.

(full name and address of applicant) I

Make sure the applicants FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the applicants address is written in FULL and includes postcode.

hereby apply for the reception of

(full name and address of patient)

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

(full name and address of proposed guardian) Into the guardianship of

Make sure the proposed guardians FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the proposed guardians address is written in FULL and includes postcode.

in accorda
1986.

Delete (a) or (b)

Delete the phase that does not apply (a) or (b)

(a) To the best of my knowledge and belief I am the patient's nearest relative within the meaning of the Order. I am the patient's

(state relationship)

i.e. Father, Mother, Brother, Sister, Husband, Wife etc..

OR

(b) I have been authorised by a county court to exercise the functions Under the Order of the patient's nearest relative. A copy of the court order is attached to this application.

Delete (i) or (ii)

(date) (i) The patient's date of birth is

Delete the phase that does not apply (i) or (ii)

OR

(ii) I believe the patient is aged 16 years or over

(date) I last saw the patient on

This date is not more than 14 days before the form is signed

Please turn over

This application is founded on and accompanied by two medical recommendations and a recommendation by an approved social worker in the prescribed form.

If neither of the medical practitioners knew the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did know the patient:-

_____

_____

_____

_____

_____

_____

Explanation should be written clearly and give reasons as to why a recommendation was not from a medical practitioner who knew the patient

Signed _____ Date _____

The date of signing must be within 14 days of the applicant last having seen patient and after recommendation forms on which application founded. It should therefore be completed after Form 17 and the Form 15 (or two Form 16's)

PART II

(To be completed by the *proposed guardian)

(full name and address of proposed guardian) I _____

_____

_____

Make sure the proposed guardians FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the proposed guardians address is written in FULL and includes postcode.

am willing to act as the guardian of

(name of patient) _____

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

Signed _____ Date _____

To be signed and dated by proposed guardian. The person who signs MUST have seen the patient no more than 14 days before the application was made and after recommendation forms on which application founded. It should therefore be completed after Form 17 and the Form 15 (or two Form 16's)

*(Complete only if proposed guardian is not the responsible authority)

Notes

Information Required	Guidance
Full name and Address of responsible authority	The form must be addressed to the correct responsible authority eg. Northern Health and Social Care Trust, The Cottage, 5 Greenmount Avenue, Ballymena, BT43 6DA. The use of abbreviations will **not** be accepted.
Full Name and Address of Applicant	The **FULL** name and address of the applicant should be given, i.e. **ALL** forenames and surname, number of house, street, town and postcode. The use abbreviations or initials will **not** be accepted. ***Note*** *The applicant must either be the nearest relative as defined by Article 32 of the Order, or be the person appointed by the county court under Article 36 to exercise the functions of the nearest relative.*
Full Name and Address of Patient	The **FULL LEGAL** name and address of patient should be given, i.e. **ALL** forenames, surname, and house number, street, town and postcode. Ensure this name and address is consistent with **ALL** other forms completed. The use of abbreviations or initials will **not** be accepted.
Full Name and Address of proposed Guardian.	The **FULL** name and address of proposed guardian should be given. If the guardian is the responsible authority, the name and address of the responsibility authority should be used i.e. **FULL** name and address of Health and Social Care Trust. The use of abbreviations or initials will **not**

	be accepted.
Nearest Relative	Option (**a**) or (**b**), regarding the nearest relative should be deleted and the relationship stated i.e. Father, Mother, Brother, Sister etc..
Date of Birth	Option (**i**) or (**ii**) should be deleted in relation to the patient's age.
Last saw Patient on (date)	Enter date when the applicant last saw the patient. The date **must** not be more than 14 days before the form is signed
Reason why medical recommendation could not be given by someone who knew patient	An explanation should **only** be given if neither of the doctors who completed the medical recommendation knew the patient.
Signature and Date	The form **must** be signed and dated. The date **must** be within 14 days of the applicant last having seen the patient.
Part II of Form	Part II of the form **only** needs to be completed if the proposed guardian is **not** the responsible authority, i.e. a relative or other person.
Note: As per Article 19 the application (Form 13) must be founded on and accompanied by two medical recommendations (Form 15, **OR TWO** Form 16's) and an approved social worker recommendation (Form 17) (Article 18([3]). It should therefore be completed **after** Form 17 and the Form 15 (or two Form 16's).	

Form 14

GUARDIANSHIP APPLICATION BY APPROVED SOCIAL WORKER

Form 14
Mental Health (Northern Ireland) Order 1986
Article 18

PART I

(name and address of responsible authority)

Insert FULL LEGAL name and address of the Health and Social Care Trust. No abbreviations or initials to be used.

(full name and address of applicant)

I,

Make sure the applicants FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the applicants address is written in FULL and includes postcode.

hereby apply for the reception of

(full name and address of patient)

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

into the guardianship of

(full name and address of proposed guardian)

Make sure the proposed guardians FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the proposed guardians address is written in FULL and includes postcode.

in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

(name of HSC Trust) I am an officer of

Full name of Health and Social Care Trust – no abbreviations or initials

appointed to act as an approved social worker for the purposes of the Order. I did not give the recommendation under Article 18(3)(b) of the Order on which this application is founded.

The following section should be completed if nearest relative consulted.

Delete either (a) or (b) AND either (c) or (d) as appropriate.

Delete either (a) or (b) and either (c) or (d) as appropriate

(a) I have consulted

(name and address)

Make sure the nearest relatives FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the nearest relatives address is written in FULL and includes postcode.

who, to the best of my knowledge and belief , is the patient's nearest relative within the meaning of the Order.

OR

Please turn over

(*Delete the phrase which does not apply)

who is *the patient's nearest relative
*authorised to exercise the functions of the patient's r
relative
before making this application.

Delete the phase that does not apply

The following section must be completed in all cases.

I last saw the patient on

I have interviewed the patient and I am satisfied that guardianship is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

Delete (i) or (ii)

Delete the phase that does not apply (i) or (ii)

(i) The patient's date of birth is _____

(ii) I believe the patient is aged 16 years or over.

This application is founded on and accompanied by two medical recommendations and a recommendation by an approved social worker in the prescribed form.

If neither of the medical practitioners knew the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did know the patient.

_____

_____

_____

_____

_____

_____

Explanation should be written clearly and give reasons as to why a recommendation was not from a medical practitioner who knew the patient

Signed: _____ Date: _____

The date of signing must be within 14 days of the applicant last having seen patient and after recommendation forms on which application founded. It should therefore be completed after Form 17 and the Form 15 (or two Form 16's

This application cannot be made by the person who gave the recommendation under Article 18[3b] i.e. the person who signs the form 17 cannot be the same person who signs the Form 14 (Article 19[4])

Please turn over

PART II
(To be completed by the *proposed guardian)

(full name and address of proposed guardian)

I,

Make sure the proposed guardians FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the proposed guardians address is written in FULL and includes postcode.

*(Complete only if proposed guardian is not the responsible authority)

am willing to act as the guardian of

(name of patient)

FULL LEGAL name of Patient

in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

Signed: _____ Date: _____

To be signed and dated by proposed guardian. The person who signs MUST have seen the patient no more than 14 days before the application was made and after recommendation forms on which application founded. It should therefore be completed after Form 17 and the Form 15 (or two Form 16's.

Notes

Information Required	Guidance
Name and address of responsible Authority	The form must be addressed to the correct responsible authority e.g. Northern Health and Social Care Trust, The Cottage, 5 Greenmount Avenue, Ballymena, BT43 6DA.
Full name and address of applicant	The full name, i.e. all forenames and surname should be given. Full office address, including postcode. The use of initials and abbreviations will **not** be accepted. **Note** the applicant must be an approved social worker.
Full name and address of patient	The **FULL** name and address of the patient should be given, i.e. forenames, surname, and house number, street and town and postcode Ensure this name and address is consistent with **ALL** other forms completed. The use of initials and abbreviations will **not** be accepted.
Full name and address of proposed Guardian	The **FULL** name and address of the proposed guardian should be given. If the Guardian is the responsible authority, the name and address of the Trust is to be used. The use of initials and abbreviations will **not** be accepted.
Full name of Trust	Enter **FULL** name of the Trust, eg Northern Health and Social Care Trust. The use of initials and abbreviations will **not** be accepted.

Note: The section below should be completed as follows if the nearest relative is consulted. If it has not been possible to consult the nearest relative, it should be deleted. The person consulted must either be the nearest relative as defined by Article 32 of the Order, or be the person appointed under Article 36 by the county court to exercise the functions of the nearest relative.	
Nearest Relative consulted	Delete either (**a**) or (**b**) in relation to the nearest relative. Name and address of the nearest relative should be given, including postcode. <u>The use of abbreviations will **not** be accepted.</u> Delete either (**c**) or (**d**) in relation to whether or not the nearest relative objects to the application. If the nearest relative objects to the application, a second Approved Social Worker should be consulted - **FULL** name and office address should be given. <u>The use of abbreviations will **not** be accepted.</u>
Name of Health and Social Care Trust	Enter name of Trust, i.e. Northern Health and Social Care Trust. <u>The use of abbreviations will **not** be accepted.</u>
Note: The section below should be completed as follows if the nearest relative has **not** been consulted. Otherwise it should be deleted.	
Nearest Relative consulted	If the nearest relative has not been consulted, (**i**) or (**ii**) or (**iii**) should be deleted as appropriate.
Full name and Address of Nearest Relative	Enter name and address of nearest relative if (**iii**) applies having made the appropriate deletion at (**iii**). Delete whichever phrase does not apply. <u>The use of abbreviations will **not** be accepted.</u>
Date Applicant last saw patient	Date applicant last saw patient. Date **must not** be more than **14** days before the Form is signed.
Patients Age	(**i**) or (**ii**) in relation to patient's age should

	be deleted, as appropriate.
Explanation	If neither of the doctors who completed the medical recommendation knew the patient, an explanation should be given.
Signature and Date	Form **must** be signed and dated. The date of signing **must** be within 14 days of applicant last having seen the patient.
Part II of Form	Part II **only** needs to be completed if the proposed guardian is not the Trust, i.e. a relative or other person.
Note: As per Article 19 the application (Form 14) **must** be founded on and accompanied by two medical recommendations (Form 15, **OR TWO** Form 16s) and an approved social worker recommendation (Form 17) (Article 18([3]). It should therefore be completed after Form 17 and the Form 15 (or two Form 16's).	

Form 15

JOINT MEDICAL RECOMMENDATION FOR RECEPTION INTO GUARDIANSHIP

Form 15
Mental Health
(Northern Ireland)
Order 1986
Articles 18 and 20

(full names and professional addresses of both medical practitioners)

We,

Make sure the Medical practitioners FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the Medical Practitioners address is written in FULL and includes postcode.

Make sure the Medical Practitioners FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the Medical Practitioners address is written in FULL and includes postcode.

, medical practitioners, recommend that

(full name and address of patient)

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

be received into guardianship in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

(name of first medical practitioner)

I, FULL LEGAL name of Part II doctor

(date) last examined this patient on

Each doctor must have personally examined the patient not more than two days before signing the Form. The two medical examinations must be within seven days of each other.

I am a medical practitioner appointed by the Mental Health Commission for the purposes of Part II of the Order.

(name of second medical practitioner)

I, FULL LEGAL name of medical practitioner

(date) last examined this patient on

Each doctor must have personally examined the patient not more than two days before signing the Form. The two medical examinations must be within seven days of each other.

*(Delete if not applicable)

*I am this patient's medical practitioner.

OR

Delete the phase that does not apply

*I had previous acquaintance with this patient before I conducted that examination.

In our opinion this patient is suffering from

**(Delete if not applicable)

**mental illness
**severe mental handicap

Delete the phase that does not apply

of a nature or degree which warrants his / her reception into guardianship under Article 18 of the Mental Health (Northern Ireland) Order 1986.

Please turn over

This opinion is based on the following grounds:

[Give a clinical description of the patient's mental condition.]

_____

_____

_____

_____

_____

_____

Signed: _____ Date: _____

Signed: _____ Date: _____

The Form must be signed and dated by both doctors. Each doctor must have personally examined the patient not more than two days before signing the Form.

This should be BEFORE Forms 13 or 14 (Article18 [3]).

Notes

Information Required	Guidance
Full name and Address of both Medical Practitioners	The **FULL** name and professional address of both medical practitioners should be given, i.e. **ALL** forenames, surname and address of the hospital or practice, including postcode as appropriate. The use of initials and abbreviations will **not** be accepted.
Note: One doctor **must** be a Part II doctor, preferably the consultant psychiatrist in charge of the patient's assessment and treatment. The other doctor, if practicable, should be the patient's general practitioner or a doctor who knows the patient. Close relatives, business partners and others specified in Schedule 1 to the Order are **not** permitted to give the medical recommendation. The sequence of the Form suggests that the Part II doctor's name and details are entered first.	
Full name and Address of Patient	The **FULL** name and address of patient should be given, i.e. **ALL** forenames and surname, and number of house, street and town, including postcode. Ensure this name and address is consistent with **ALL** other forms completed. The use of initials and abbreviations will **not** be accepted.
Full name and Address of Part II Doctor	The name of the first doctor (consistent with the above) should be given. They **MUST** be a current Part II doctor (ie a consultant psychiatrist appointed by the RQIA for the purposes of Part II of the Order) and preferably should be the consultant psychiatrist in charge of the patient's treatment.
Date Part II doctor examined Patient	Enter the date when the Part II doctor last examined the patient. The date of examination **MUST** not be more than two days before the date on which Part II doctor signs the Form.
Full name and Address of Second Medical Practitioner	Enter name (consistent with above) of the second doctor.

Date second medical practitioner examined Patient	Enter the date of the second examination. The date of examination **MUST** not be more than two days before the second doctor signs the Form. The two medical examinations must be within seven days of each other.
Second medical Practitioners status	Delete option(s) regarding the second doctor's status. In some circumstances both options may be deleted, i.e. where the doctor is not the patient's general practitioner and did not have a previous acquaintance with the patient. The applicant is required to explain why a doctor who did know the patient was not available.
Disorder specified	Delete whichever option is not applicable. **Note :** As the two forms of mental disorder are not necessarily mutually exclusive, it is possible for the medical recommendation to state that the patient is suffering from both mental illness and severe mental handicap. The doctors should agree on the form of mental disorder specified.
Clinical Description	A clinical description must be given and provide detail on the type of illness, behaviour, etc.
Signatures and Dates	The Form **must** be signed and dated by both doctors. Each doctor must have personally examined the patient not more than two days before signing the Form. This should be BEFORE Forms 13 and 14 (Article18 [3]).
Note: The medical recommendation should be forwarded to the applicant on completion. Each doctor must examine the patient within 2 days prior to signing the recommendation and, where the doctors examine the patient separately, the 2 examinations must not be more than 7 days apart. This means that the earlier of the 2 recommendations can never take place more than 14 days before the application is sent to the board.	

Form 16

MEDICAL RECOMMENDATION FOR RECEPTION INTO GUARDIANSHIP

Form 16
Mental Health
(Northern Ireland)
Order 1986
Articles 18 and 20

(full name and professional address of medical practitioner)

I, _____

Make sure the Medical Practitioners FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the Medical Practitioners address is written in FULL and includes postcode.

, a medical practitioner, recommend that

(full name and address of patient)

_____

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

be received into guardianship in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

(date) I last examined this patient on _____

Date Patient Examined by Medical Practitioner.

The dates of examinations must not be more that 7 days between them.

Delete either (a) or (b)

(a) I am a medical practitioner appointed by the Mental Health Commission for the purposes of Part II of the Order.

Delete either (a) or (b) if not applicable

*(Delete if not applicable)

(b) *I am this patient's medical practitioner.

OR

*I had previous acquaintance with this patient before I conducted that examination.

Delete if not applicable

**(Delete if not applicable)

In my opinion this patient is suffering from
**mental illness
**severe mental handicap
of a nature or degree which warrants his / her reception into guardianship under Article 18 of the Mental Health (Northern Ireland) Order 1986.
This opinion is based on the following grounds:

[Give a clinical description of the patient's mental condition.]

_____

_____

A clinical description must be given and provide detail on the type of illness, behaviour, etc.

_____

_____

_____

Signed: _____ Date: _____

Forms must be signed and dated. The date of signing must not be more than two days apart from second form 16.

This should be BEFORE Forms 13 and 14 (Article18 [3]).

Notes

Information Required	Guidance
Full name and professional address of medical practitioner	The **FULL** name and professional address of the doctor should be given, i.e. **ALL** forenames, surname and **FULL** address of hospital or surgery, including postcode. The use of initials or abbreviations will **not** be accepted.
Full name and address of patient	The **FULL LEGAL** name and address of the patient should be given, i.e. all forenames, Surname, and number of house, street and town, including postcode. Ensure this name and address is consistent with **ALL** other forms completed. The use of initials or abbreviations will **not** be accepted.
Date doctor last examined the patient	Enter the date when the doctor last examined the patient. The date **MUST** not be more than two days before the Form is signed. Where the medical practitioners have seem the patient separately, i.e. two Form 16s. There MUST not be more than 7 days between the days each examination took place.
Medical Practitioner status	Check the status of the doctor(s). One doctor **MUST** be a Part II doctor, preferably the consultant psychiatrist in charge of the patient's treatment; the other doctor, if practicable, should be the patient's general practitioner or a doctor who has had a previous acquaintance with the patient. If (a) applies, both parts of (b) should be deleted; if the first part of (b) applies, (a) and the second part of (b) should be deleted;

	if the second part of (b) applies, (a) and the first part of (b) should be deleted. **Note:** In some circumstances both options at (b) should be deleted, i.e. where the second doctor is not the patient's general practitioner and did not have a previous acquaintance with the patient. The applicant is required to explain why a doctor who did know the patient was not available.
Disorder specified	Delete whichever option is not applicable. **Note :** As the two forms of mental disorder are not necessarily mutually exclusive, it is possible for either of the medical recommendations to state that the patient is suffering from both mental illness and severe mental handicap. However, unless both medical recommendations agree in specifying at least one form of mental disorder in common, a guardianship application will be of no effect.
Clinical description	A clinical description must be given and provide detail on the type of illness, behaviour, etc.
Signatories and Dates	Forms **must** be signed and dated. The date of signing must not be more than two days before the date on which the doctors carried out their respective examinations. This should be BEFORE Forms 13 and 14 (Article18 [3]).
Note: A separate Form 16 should be completed by each of the two doctors. The medical recommendations should be forwarded to the applicant on completion. Each doctor must examine the patient within 2 days prior to signing the recommendation and, where the doctors examine the patient separately, the 2 examinations must not be more than 7 days apart. This means that the earlier of the 2 recommendations can never take place more than 14 days before the application is sent to the board.	

Form 17

RECOMMENDATION BY AN APPROVED SOCIAL WORKER FOR RECEPTION INTO GUARDIANSHIP

Form 17
Mental Health
(Northern Ireland)
Order 1986
Article 18

(full name and office address of approved social worker)

Make sure the ASWs FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the ASWs address is written in FULL and includes postcode.

recommend that

(full name and address of patient)

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

be received into guardianship in accordance with Part II of the Mental Health (Northern Ireland) Order 1986.

(name of HSC Trust) I am an officer of

Full name of Health and Social Care Trust

appointed to act as an approved social worker for the purposes of the Order.

In my opinion it is necessary in the interests of the welfare of the patient that he / she should be received into guardianship. My reasons for this opinion are as follows:

(Give reasons for opinion.)

A clear outline of the welfare grounds to support the application and reception into guardianship must be recorded here

Delete either (a) or (b) AND either (c) or (d) as appropriate

(a) I am not related to the patient.

Delete either (a) or (b) if not applicable

OR

(b) I am related to the patient, being his / her

(state relationship)

i.e. Father, Mother, Brother, Sister, Husband, Wife etc..

AND

(c) I have no pecuniary interest in the reception of the patient into guardianship.

OR

(d) I have a pecuniary interest in the reception of the patient into guardianship. The nature and extent of that interest is (state nature and extent of interest).

Delete either (c) or (d) if not applicable

Nature and extent of pecuniary interest must be stated here.

_____

_____

_____

_____

_____

Signed: _____ Date: _____

The form must be signed and dated by approved social worker. The form should be signed after forms 15 (or two 16's) and before a form 14 or Form 13.

Notes

Information Required	Guidance
Full Name and Address of Approved Social Worker	The Form **must** be completed by an approved social worker. **FULL** name, i.e. all forenames and surname, and office address, including postcode. The use of initials and abbreviations will **not** be accepted.
Full Name and Address of Patient	The **FULL LEGAL** name and address of the patient should be given, i.e. **ALL** forenames, surname, and number of house, street and town, including postcode. Ensure this name and address is consistent with **ALL** other forms completed.
Name of Health and Social Care Trust	The name of the Trust should be shown, e.g. Northern Health and Social Care Trust.
Reasons that the Welfare Grounds are met.	The reasons for the opinion that the welfare ground is met must be given. The reasons must be clearly stated and legible.
Related to Patient	Delete either (**a**) or (**b**) regarding whether or not the applicant is related to the patient. If (**a**) is deleted, the relationship to the patient should be stated. Delete either **(c)** or **(d)** in relation to a pecuniary interest, and state the nature and extent of the pecuniary interest under **(d)**, if appropriate.
Signature and Date	Form **must** be signed and dated. The Order does not specify when Form 17 should be signed. However, The Mental Health (Northern Ireland) Order, 1986, A Guide states that "it is essential that this is done before the date of the application (Form 13 or Form 14), and within - at most – two weeks prior to that date" It is suggested that, in keeping with the

	medical recommendations, the ASW making the recommendation should have **personally interviewed** the patient not more than two days before the recommendation is signed.
Note: The approved social worker's recommendation should be forwarded to the applicant on completion. It should be accompanied by a social report setting out the background to the case and the management strategies which have culminated in the application for guardianship. The report should also indicate which of the powers of guardianship are considered necessary for securing the welfare of the patient.	

Form 18

REPORT BY RESPONSIBLE MEDICAL OFFICER FOR RENEWAL OF AUTHORITY FOR GUARDIANSHIP

Form 18
Mental Health (Northern Ireland) Order 1986
Article 23(2)(a)

(full name and office address of approved social worker)

To

Make sure the ASWs FULL LEGAL name is used here. No abbreviations or initials to be used. Ensure the ASWs address is written in FULL and includes the postcode

(full name and professional address of responsible medical officer)

I,

Make sure the Medical Practitioners FULL LEGAL name is used here. No abbreviations or initials to be used. Ensure the Medical Practitioners address is written in FULL and includes the postcode

(full name and address of patient)

am the responsible medical officer for

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

Delete (a) or (b)

(date) (a) I examined this patient on

Date patient last examined by medical practitioner

OR

(b) I have obtained the attached report from another medical practitioner

Delete as appropriate (a) or (b).

(name and professional address of medical practitioner)

Make sure the Medical Practitioners FULL LEGAL name is used here. No abbreviations or initials to be used. Ensure the Medical Practitioners s address is written in FULL and includes the postcode

on the condition of this patient.

I am of the opinion that he / she is suffering from

(delete if not applicable)

mental illness
severe mental handicap

Delete if not applicable

of a nature of degree which warrants his / her continuing to be subject to guardianship.

This opinion is based on the following grounds:

(Give a clinical description of the patient's mental condition.)

_____

_____

A clinical description must be given, providing detail on the type of illness, behaviour etc.

_____

_____

_____

_____

_____

Signed : _____ Date: _____

The form must be signed and dated by medical practitioner

Notes

Information Required	Guidance
Full name and address of Social Worker	Check for **FULL** name, i.e. **ALL** forenames and surname, and office address of Social Worker. This must be an approved social worker appointed under Article 115 of the Order. The use of initials or abbreviations will **not** be accepted.
Full name and address of Medical Practitioner	The **FULL** name, i.e. **ALL** forenames and surname, and professional (hospital) address of doctor must be given. The use of initials or abbreviations will **not** be accepted. Form must be completed by the patient's responsible medical officer as defined by Article 2(2) (b).
Full name and address of patient	The **FULL LEGAL** name and address of patient should be given - **ALL** forenames, surname, and number of house, street and town, including postcode. Ensure this name and address is consistent with **ALL** other forms completed. The use of initials or abbreviations will **not** be accepted.
Date last examined patient	Delete either **(a)** or **(b)** in relation to examining the patient. If **(a)** applies enter the date of the examination. If **(b)** applies, enter the name and professional (Hospital) address of the second doctor.
Disorder specified	Delete whichever option is not applicable. The doctor must either examine the patient in person or obtain a report on the

	condition of the patient from another doctor. The Mental Health (Northern Ireland) Order, 1986 Guide suggests that "this is most likely to be the patient's own general practitioner". **Note:** The RMO must provide a report (Form 18), within two months **before** the expiry of the authority for guardianship. The RMO may complete Form 18 on the basis of a report received from another doctor. As the two forms of mental disorder are not mutually exclusive, it is possible for either of the medical reports to state that the patient is suffering from both mental illness and severe mental handicap. However, both medical reports should agree in specifying at least one form of mental disorder in common. The completed medical report(s) should be forwarded to the ASW as soon as practicable.
Clinical Description	A clinical description of the patient's mental condition should be given, i.e. type of illness, symptoms, behaviour, etc.
Signature and dates	The form **must** be signed and dated. **Note:** While the Order does not specify when Form 18 should be signed it is suggested that, in line with other recommendations, it should be signed not more than two days after the examination of the patient, whichever is appropriate. The procedure for renewal remains the same regardless of the duration of the authority sought. All Forms and reports associated with the renewal must be received at Trust Headquarters **at least** five working days before the expiry of the authority for guardianship.

Form 19

REPORT BY APPROVED SOCIAL WORKER FOR RENEWAL OF AUTHORITY FOR GUARDIANSHIP

Form 19
Mental Health
(Northern Ireland)
Order 1986
Article 23(2)(b)

(name and address of responsible authority)

Insert FULL LEGAL name and address of the Health and Social Care Trust. No abbreviations!

(full name and office address of approved social worker)

I,

Make sure the ASWs FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the ASWs address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTANT

(name of HSC Trust)

am an officer of

Full name of Health and Social Care Trust

appointed to act as an approved social worker for the purposes of the Mental Health (Northern Ireland) Order 1986.

I have received from

(name of responsible medical officer)

Make sure the Medical Practitioners FULL LEGAL name is use here. No abbreviations or initials to be used.

(* delete whichever does not apply)

the attached report / reports on

(full name and address of patient)

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the patients address is written in FULL and includes postcode. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

(* delete whichever does not apply)

I have considered *that report / those reports and am of the opinion that it is necessary in the interests of the welfare of the patient that he / she should continue to be subject to guardianship.
My reasons for this opinion are as follows:

(Give reasons for opinion.)

ASW must provide evidence that guardianship is in the interests of the welfare of the patient

Signed: _____ Date: _____

The form must be signed and dated by the ASW

Notes

Information Required	Guidance
Full name and address of responsible authority	Form must be addressed to correct responsible authority E.g. Northern Health and Social Care Trust, The Cottage, 5 Greenmount Avenue, Ballymena, BT43 6DA.
Full name and address of Approved Social Worker	The full name, i.e. all forenames and surname, and office address of social worker should be given. **Must** be an approved social worker.
Name of Health and Social Care Trust	The name of the Trust should be given, eg. Northern Health and Social Care Trust.
Full name of medical practitioner	The name of the responsible medical officer should be given.
Report/Reports	Delete singular/plural, as required.
Full name and address of patient	The full name and address of patient should be given, i.e. all forenames, surname, and number of house, street and town, including postcode. Ensure this name and address is consistent with **ALL** other forms completed.
Welfare evidence	The reasons for the opinion that the welfare ground is met must be given.
Signature and date	Form **must** be signed and dated. **Note:** While the Order does not specify when Form 19 should be signed, good practice would suggest that it is completed within two days of receipt of the medical report(s). The ASW should have been made aware that renewal is being considered and should have reviewed the case, interviewing the patient and making contact with the nearest relative, or significant others, where possible, not more than 14 days before the date on which the form is signed.

Note:
This report should be an update to the original applicants' report and should outline any significant changes. It should indicate how the powers of Guardianship have minimised identified risks and ensured the welfare of the patient. Consideration of the consequences should guardianship not be renewed should also be documented.

The procedure for renewal remains the same regardless of the duration of the authority sought.

All forms and reports associated with the renewal should be received at Trust Headquarters **at least** five working days before the expiry of the authority for guardianship.

Form 20

ASSIGNMENT OF FUNCTIONS BY NEAREST RELATIVE

FORM 20
Mental Health (Northern Ireland) Order 1986
Article

1 (name and address of responsible authority)

To _____

Insert FULL LEGAL name and address of the Health and Social Care Trust. No abbreviations to be used.

2 (full name and address of nearest relative

Make sure the nearest relatives FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the nearest relatives address is written in FULL and includes postcode.

am the nearest relative of

3 (full name of patient)

Make sure the patients FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure that the NAME and ADDRESS is CONSISTENT with ALL other forms

4 (*Delete the phrase which does not apply)

*detain

*under guardianship of

5 (name and address of hospital/ full name and address of guardian)

Make sure the guardians FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the guardians address is written in FULL and includes postcode.

6 (full name and address of assignee)

I hereby give notice that I have assigned my functions as nearest relative to

Make sure the assignees FULL LEGAL name is use here. No abbreviations or initials to be used. Ensure the assignees address is written in FULL and includes postcode.

Signed _____ Date _____

The form must be signed and dated by nearest relative

Notes

Information Required	Guidance
Full name of responsible authority	The Form must be addressed to the correct responsible authority, e.g. Northern Health and Social Care Trust, The Cottage, 5 Greenmount Avenue, Ballymena, BT43 6DA.
Full name and address of nearest relative	The full name and address of the nearest relative should be given, i.e. all forenames and surname, number of house, street and town (postcode if possible). **Note:** The applicant must either be the nearest relative as defined by Article 32 of the Order, or be the person appointed by the county court under Article 36 to exercise the functions of the nearest relative.
Full name and address of patient	The full name of the patient should be given, i.e. all forenames and surname. Ensure this name is consistent with **ALL** other forms completed.
Status of patient	Delete the phrase which does not apply.
Full name and address of hospital/full name and address of guardian	Where the patient is subject to guardianship the full name and address of the guardian should be given. Where the Trust is guardian, enter the full name, i.e. all forenames and surname and full office address, including postcode if possible of the professional nominated as guardian.
Full name and address of assignee	The full name and address of the person who is to assume the functions of nearest relative should be given, i.e. all forenames and surname, number of house, street and town (postcode if possible).
Signature and Date by nearest relative	Form **must** be signed and dated by nearest relative.
Signature and Date by assignee	Form **must** be signed and dated by the person who is to assume the functions of nearest relative.

Contact information

Address: Mental Health and Learning Disability Team
Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

E-mail: mhld.forms@rqia.org.uk

Telephone: 028 9051 7500 (Monday to Friday 10am – 4pm)