Written evidence submitted by the Approved Mental Health Professional (AMHP) Leads Network (MHB0057)

1. Introduction - The AMHP Leads Network and the role of the AMHP

1.1 The AMHP Leads Network is a self-organised, peer-led, community of interest that provides advice and support to Approved Mental Health Professional (AMHP) Leads and AMHP services across England and Wales. The Network's Steering Group works in partnership with the Black and Minority Ethnic AMHP Forum and the AMHP Research Network, along with representatives from the Department of Health and Social Care, the Association of Directors of Adult Social Services, and Social Work England, amongst others. The Network consists of representation from over 90% of English Local Authorities, several Welsh Authorities, 23 NHS Trust and 16 HEIs. The Network is concerned with all matters relating to AMHP practise and the operational and strategic challenges faced by AMHPs and AMHP services nationwide.

1.2 AMHPs are those professionals tasked with applying the statute and principles of the Mental Health Act for all age groups and all types of mental health condition. AMHPs consider the making of applications to detain under the Act. They also have a duty to consider whether to agree to legal restrictions being placed upon individuals in the community in certain circumstances. At every stage of their work, AMHPs seek to explore and secure viable alternatives to such compulsion by working with family, carers, professionals, non-mental health agencies and the individual themselves.

1.3 In undertaking their role, AMHPs act independently of their approving authority and carry an individual liability for their decision making – a necessary and vital feature of that role. This work is carried out 24 hours a day, 365 days a year. Any amendment to statute represents potentially significant change to the effectiveness of the role and the experience of those subject to the Act.

1.4 AMHP work is recognised as highly stressful, yet remains key to the safeguarding of those who find themselves in mental health crisis, be it in their own homes, police custody, places of safety or hospital environments. Demand for AMHP involvement has increased annually and their work is carried out against of backdrop of challenged resource provision and heightened acuity in the community. AMHPs are highly trained, skilled and experienced in the operation of the relevant legal frameworks in mental health[1]. They pay particular attention to the individual's human rights and least restrictive principles, while also being responsible for organising many of the practical considerations around such arrangements.

1.5 In preparing this submission, the AMHP Leads Network Steering Group, has engaged with the wider network and partners. Individual AMHPs, Lead AMHPs, AMHP Services, and Regional AMHP Forums have also been encouraged to provide their own submissions on specific issues of concern and, as a Steering Group, we support those views being considered alongside those presented here.

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[1] Department of Health & Social Care, 2019, National Workforce Plan for Approved Mental Health Professionals (AMHPs), London

1.6 The AMHP Leads Network welcome the opportunity to continue to support the work of the Select Committee in the developing new mental health legislation in line with the aims of the Mental Health Act Review.

2. The AMHP Leads Network support:

- The aims of the MHA Review in addressing racial disparity in the application of the Act
- The aim of reducing the use of the Act in relation to people with a learning disability or those considered neuro-diverse ("autism" for the purposes of the Bill).
- The aim of reducing compulsory admission
- Extending individual choice, including the introduction of Nominated Persons
- Promoting the involvement of family, carers and loved ones at key points in MHA processes and procedures
- Raising the thresholds for compulsion, including more robust measures around the establishment of Community Treatment Orders

3. The AMHP Leads Network identify the following areas in relation to the Bill that require further development and/or clarification:

- <u>Definitions of Mental Disorder, Psychiatric Disorder, and Relevant Disorder.</u>

3.1 We note the new definitions of the above terms and identify that the distinction between "mental disorder" and "psychiatric disorder" is being made to ensure certain provisions of the Act that will exclude autism and learning disability. We are unsure why the term "relevant disorder" has been created for Part III in that it appears to have the same scope as the term "mental disorder" – it includes psychiatric disorder plus autism and learning disability.

3.2 Is there a specific need to create this new term - if not, we submit that it would be simpler to allow the same term of "mental disorder" to carry through into Part III?

- <u>Definitions of Learning Disability and Autism</u>

3.3 We note that the inclusion of learning disability as a grounds for detention or guardianship is with the additional criteria that it must be associated with *'serious behavioural consequences'.* We believe that this is appropriate and that detention should not ordinarily be the route by which people with learning disability access care and support, and should only be considered in the most serious situations where individuals cannot be supported in another way.

3.4 We note that no such additional criteria exist for the grounds of autism? We find this to be of concern and believe that similar additional criteria should be included to ensure that detention or guardianship are only sought in cases where there are significant risks related to behavioural presentation that cannot be supported by any other means.

- Definitions of medical treatment and appropriate medical treatment.

3.5 We welcome the aim to ensure treatment provided has some therapeutic benefit.

3.6 We have some concerns that there is a risk, in practice, that this definition may allow for the exclusion of particular groups of people, e.g., in cases of complex need and risk, and repeat presentations that are not easy to resolve or treat, such as emotional crisis, personality disorder, complex PTSD.

3.7 The definitions of "mental disorder" and "medical treatment" were amended in the 2007 Act to ensure that there were no longer 'diagnoses of exclusion'. We submit that clear guidance will be required to ensure that busy mental health services seeking to manage their workloads will not utilise this criteria as a tool to reduce the level of service provided to those presenting with such complexity.

- S19 Transfer from Guardianship

3.8 We note that section 19(2)(d) continues to allow for the transfer from guardianship to a hospital for treatment under section 3. While the addition of section 19(2A) makes amendments to the duration of this in line with the amended duration periods, we cannot see anything to represent the exclusion of people with learning disability and autism from these arrangements.

3.9 Is this intentional? We submit that this exclusion should be added to avoid transfer from guardianship to hospital becoming a 'back door' route to a longer term hospital detention?

- New grounds for detention

3.10 We note that the grounds for detention have changed. While we broadly support the tightening of the criteria, we note the addition of a new ground:

> *serious harm may be caused to the health or safety of the patient or of another person unless the patient is so detained;*

3.11 Previously, detention could only be in relation to the person's *own* health or safety or protection of others. This new wording appears to allow for detention on the basis of *another person*'s health**,** which was not previously the case.

3.12 We are concerned this is a ground for detention is unrelated to the individual's own health or treatment need. This could result in individuals being detained purely in relation to the needs of others, for example a carer experiencing burn out, rather than for the individual own clinical need. While impact on the individual's disorder or behaviour on others is always a consideration in the application of the Act, it should not, we feel, be a ground in its own right. This would not fit with the overall aim of reducing detentions and the aim of focussing promoting an individual's choice and autonomy.

3.13 In relation to risk assessment, the criteria of:

given the nature, degree and likelihood of the harm, and how soon it would occur, the patient ought to be so detained

AMHPs are acutely aware that resource pressures, particularly in relation to the availability of doctors, beds and ambulances mean that both assessments and admissions are often subject to long delays. Some consideration and guidance on how AMHPs are expected to evaluate these situations alongside the 'how soon' element of the criteria is required, particularly if there has been a significant delay in securing these resources and the assessed risk has not in fact transpired.

3.14 Is it expected that re-assessments under the Act in these circumstances may well be required and, if so, consideration needs to be given to the impact on the individual and AMHP service provision (this is linked also to the impact of delays in healthcare on AMHP services below).

- Community treatment Order criteria

3.15 We welcome the inclusion of a requirement for inpatient RC and community consultant to liaise in relation to the potential use of CTO. In practice, AMHP teams will require this liaison and agreement to have taken place *before* they are asked to consider agreeing to such an Order; therefore,

3.16 We submit that the criteria in section 17A(b) and (c) should to be switched, so that this more logical assessment process is encouraged and to reduce the demand on AMHP time, as clinicians may conclude amongst themselves that such an Order is not viable.

3.17 We submit that the CTO criteria should also be based on an evidenced history of the individual disengaging from services leading to significant harm and/or established relapse indicators, and not be read so as to allow unevidenced concerns to form the basis of an imposition of restriction in the community (as envisioned prior to the 2008 amendments).

- Nominated Persons (NPs) – Consultation and CTOs

3.18 We welcome efforts to require wider consultation on the establishment of CTOs with the Nominated Person and other relatives and carers.

3.19 In our reading of sections 17AA, 19(3)A, 20(5)(b), 20(6A), 20(8B) we find the Bill confusing and inconsistent. NP Consultation duties move between different professionals (i.e. CTO is RC for application and AMHP for renewal). At some points, the NP has the ability to make an objection, at other times they do not. What is the purpose of the consultation? This needs to be made clear.

3.20 At some points in the scheme there is the option not to consult the NP, where it is felt to be not practicable or involve delay. In other areas there is no option not to consult (e.g.20(5)(b)). What happens if there are significant barriers to consultation? Will the order expire? As CTOs are, by definition, planned pieces of work can 'delay' be relied upon if professionals fail to consult in a timely manner?

4. **As a Network we are significantly concerned about:**

- The practicalities and logistics involved in the functioning of the Nominated Person (NP) arrangements.

4.1 Nominated Persons and the role of the AMHP are fundamental to the operation of the Act. The proposals, as set, out contain many areas of significant concern for the Network. We provide a fuller account of the detail at **Appendix 1.**

- The lack of culturally appropriate advocacy in statute

4.2 The lack of such statutory provision is particularly concerning given a primary driver for legislative change was the need to address racial disparity in detained populations.

- The unintended consequences of changes in the definition of mental disorder, in particular the impact on those described as having an autistic spectrum disorder.

4.3 We identify that the unintended consequences of this change could include:

4.4 Practice changes to medicalise behaviours of communication and distress in people with a learning disability and/or autism in order to fulfil the new definition of mental disorder, and so open up access to section 3 detention.

4.5 The criminalisation of behaviours, distress, and communication styles for people with a learning disability and/or autism in order to resolve unmanageable community situations and maintain safety. This could also potentially increase the use of Part III orders.

4.6 Increases in the use of guardianship – see below

4.7 Increase in the inappropriate use of DoLS or unlawful deprivations, i.e. for those people currently detained in hospital who will no longer be able to remain, plus those people detained on new section 2 applications, who subsequently cannot be placed on section 3.

4.8 The community care market does not currently have available the care, support and accommodation required to support these groups of people. Adequate community resources are needed before this criteria can be introduced.

4.9 The creation of an inequality of entitlement – people with a learning disability and/or autism will now be less likely to qualify for section 117 aftercare as section 3 detention should decrease. The provisions of guardianship do not come with section 117 entitlement, but consideration of extending section 117 to all those subject to guardianship should be made.

4.10 While the impact assessment suggests an increase to section 7 guardianships are not expected, we believe the retention of this power for people with learning disability and/or autism will make it a potential route by which those currently detained may be moved on. Similarly, those not able to be detained and already in the community may be subjected to guardianship to offer professionals at least some kind of legal framework.

4.11 Guardianship orders are not used on a large scale currently and any increase, of even a moderate amount, will likely expose a wide range of process, policy, infrastructure and knowledge deficits that may cause significant resource issues for local authorities, health trusts and individuals.

4.12 Issues relating to MHA administration, access to the MHRT, time scales between application and acceptance and the provision of responsible clinicians are some of those we can predict will become problematic without proper consideration and clarity in the law and guidance.

4.13 We offer the following link as a useful exploration of the issues above in support of our view: Unintended consequences of taking people with learning disabilities and/or autism out of scope of the Mental Health Act 1983 | The Small Places (wordpress.com).

- The lack of 'mirror duties' placed on health providers, police and ambulance trusts to provide resources in support of MHA operations.

4.14 An area of significant concern to the AMHP Leads Network is the lack of 'mirror duty' placed upon agencies who are required to support the functioning of the Act. In particular, the current lack of legal imperative to provide section 12 doctors for Mental Health Act assessment interviews. Such an absence of medical availability greatly impedes the setting up of such assessments and the ability of AMHPs to fulfil their role. Delays of this kind routinely increase the risk to individuals and their families, and to those alone and unsupported in the community.

4.15 The AMHP Leads Network carried out a survey in September 2022 on the impact on AMHP services and delays to patient care as a result of the lack of availability of section 12 doctors. Please see https://padlet.com/AMHP_Leads_Network/kzbkqfs295bveo6y for those findings, which we submit re-enforce the need for serious consideration of including mirror duties in the statute.

4.16 At present, the only such duty in statute is the local authority's responsibility to provide AMHPs to consider applications under the Act (section 13). There are no mirror duties placed upon key partners in health, policing, or elsewhere, to provide the necessary resources to deliver statutory processes, such as the securing and execution of warrants and transportation.

4.16 Please refer to the "National Workforce Plan for Approved Mental Health Professionals" (DHSC, 2019) for a further exploration of the resource issues impacting on undertaking timely MHA assessments.

5. Recommendations to Select Committee in relation to the Mental Health Bill:

5.1 The AMHP Leads Network believe that this Bill represents the best opportunity to correct historic oversights in the previous Act and to reflect changes in the landscape of mental health service provision and the experience of those 'on the ground'. For the benefit of those subject to the Act and those who operate within it, the Bill should not be

allowed to pass without further consideration being given to the issues raised above and the following:

5.2 We believe that the MHA principles should be enshrined into legislation and not left to reside in the Code of practice.

5.3 The Bill should introduce 'mirror duties' for health and ambulance trusts, courts and police, to ensure there are sufficient doctors, beds, transport, access to warrants and police support in the same way that local authorities are expected to provide sufficient numbers of AMHPs

5.4 Similarly, the Bill should promote clarity around the responsibilities of all agencies in supporting individuals, and each other, when there are delays in statutory processes.

5.5 The terminology around guardianship is antiquated and should be removed in order to place the scheme on a par with Community Treatment Orders (for example, for section 7 to be renamed "Community Welfare Orders" or similar, with greater statutory responsibility being placed upon all relevant agencies to support those individuals subject to the same).

5.6 Use of section 7 guardianship should come with automatic entitlement to section 117 aftercare.

5.7 The power to transfer a person under section 5(2) ('doctor's holding power') to a more appropriate mental health facility should be included. This would mirror the power professionals already have at section 136 to transfer between places of safety and would ensure that general hospitals are not expected to look after mentally unwell people without a physical health component.

5.8 Clarify the role of the Social Supervisor in monitoring those subject to Part III ("Supervised Discharge") and introduce clear guidance as to the level of training and expertise required to carry out the role.

5.9 The role of "AMHP Lead" to be given the statutory equivalence of Principle Social Worker in the Mental Health Act. Please see https://padlet.com/AMHP_Leads_Network/kzbkqfs295bveo6y for a Network discussion paper on this topic.

5.10 The development of guidance to AMHP and health service in cross boundary working in the revised Code of Practice. Please see https://padlet.com/AMHP_Leads_Network/kzbkqfs295bveo6y for a recent guide on this subject from the Network.

5.11 Provide clarity as to which professionals can and/or should undertake social circumstances report to the Mental Health Tribunal, in order to ensure a true social perspective on the individual's situation is represented.

Signatories on behalf of the AMHP Leads Network:

Christina Cheney (Chair) **Robert Lewis (Vice Chair)**

16 September 2022

Schedule A1 Section 21, Part 1 and related proposed changes to Mental Health Act 1983

1. Introduction:

1.1. Approved Mental Health Professionals (AMHPs) are central to the operationalisation of the proposed Nominated Persons (NPs) arrangements. The concept of the NP, as with the Nearest Relative (NR) before it, represents a significant procedural safeguard for those under consideration of, or are subject to, the use of the Mental Health Act.

1.2. The AMHP Leads Network welcome the proposal to allow individuals to select their own NP when compared the current Nearest Relative arrangements, in which individuals have no choice as to which family member or significant person is engaged in the legal elements of their care.

1.3. The AMHP Leads Network broadly welcomes the introduction of the 'AMHP nominated NP' as a potential solution to situations where the individual has not previously appointed an NP and would lack the capacity to do so at the point of mental health crisis and possible admission. However, the removal of the 'Interim NP' concept (as described at the Review stage of reform), has weakened the potential effectiveness of this safeguard.

1.4. The AMHP Leads Network welcomes the introduction of the "relevant patient" concept, as it clarifies which individuals might require an AMHP nominated NP and in what circumstances.

1.5. The AMHP Leads Network is significantly concerned, however, that the mechanisms and formalities of the proposed scheme will greatly inhibit, rather than promote, individual choice in this area.

1.6. It is the view of the AMHP Leads Network that, in their present form, the NP proposals are operationally unworkable and that further development is required on this part of the Bill to ensure that the aims of the MHA Review are met and that the resulting Act is both workable and meaningful. It is important to ensure that professionals are not unnecessarily tied up with procedural and logistical matters and that they are able to focus their efforts of safeguarding individuals at times of heightened risk.

1.7. In order to support the Joint Committee's considerations, we present below an overview of the issues and concerns in relation to the proposals set out in the Bill. We also set out a table that provides more detailed questions and issues that will require consideration as the Bill progresses.

2. Summary of main issues and concerns relating to the proposed Nominated Persons arrangements.

2.1. The proposed formalities of appointment are hugely problematic. Signatures from individuals and NP require being witnessed in person. Individuals and nominees also require to have their suitability ascertained and verified by witnesses. No electronic signatures/confirmation appear allowable and, even if these were allowable, they would still represent a major barrier to timely NP appointments.

2.2. The proposals take no account of the geographic distance between the various actors. The logistics and time required to complete nominations lawfully would impact significantly on professional time and would be subject to many 'real world' delays (professional availability, inter-agency arrangements, and so on)

2.3. The proposals significantly risk placing increased demand on already stretched AMHP and other mental health services, as system partners will look to AMHPs in particular to resolve the lack of NP for non-capacitous patients in hospital - along with multiple other unintended consequences of the scheme (disputes over the validity of NP nominations and terminations, and so on). The scheme creates new legal challenges for professionals and works against the intentions of the Review.

2.4. The removal of "Interim NP" from the proposals has left clear gaps in the scheme as originally envisioned by the Review. It is likely that the number of NP appointments be will far fewer than intended and the proposals work against promoting uptake. This scheme, in effect, mirrors that of the Mental Health (Care and Treatment)(Scotland) Act 2003, which led to lower than hoped for numbers of "named persons" being identified due to appointment formalities. Some consideration could be given to the existing scheme (as at section 26) being utilised as the 'fall-back' position in the absence of a patient nominated NP (accepting that this is imperfect, but more likely to secure the procedural safeguard than the proposed scheme).

2.5. The Bill pushes NP appointment to be part of the MHA assessment interview process, which is logistically problematic, clinically inappropriate, and risks additional pressure on both the individual and assessing professionals. It takes no account of how MHA assessments and interviews take place in real time - which may well include police executing warrants to gain entry, the use of restraint, individuals being faced with professionals who are unknown to them, neighbours witnessing such events, and so on.

2.6. The scheme fails to take into account the practical realities of the circumstances individuals and professionals find themselves in. For example, a capacitous person (who had not previously nominated someone) could only realistically nominate someone who was present at the assessment interview, given the need for signatures and documents to be witnessed, roles to be explained, and so on. This is highly unlikely to happen, as often the person will not be aware of the assessment ahead of time, due to concerns over flight risks and risks to self and others. The potential nominee may live hundreds of miles away (or even abroad). This will mean that the individual, if admitted, will need to wait sometime after they arrive in hospital to avail themselves of the safeguards of the NP role. The original "Interim NP" proposals reduced that risk, as it was more akin to the Relevant Person's Representative under the Mental Capacity Act's Deprivation of Liberty Safeguards.

2.7. In a similar scenario, an AMHP could not nominate someone on behalf of the person if that person had the capacity to choose, as the scheme specifically excludes this. In practice such a nomination could be of benefit to the patient if the AMHP were not also bound into the same requirements around the witnessing and validation of nominations (the AMHP Leads Network has made suggestions relating to how such matters could be managed in line with current practices lawfully). It is our submission that the notion of capacity and incapacity with regards to these matters is unhelpful and creates unnecessary obstacles to securing the right NP in a timely manner for the individual.

2.8. Where the person lacks capacity, the proposed NP would need to be present or geographically very close by for the AMHP to complete the process. As the AMHP will be focussed on the welfare of the individual it would be virtually impossible to break away from that person's care to carry out an additional procedure, which is more akin to the witnessing of a mortgage application than a clinical intervention. These procedural requirements risk undoing all of the good intent of the Review and the Bill in this area.

2.9. The Bill gives the AMHP multiple powers normally reserved for the courts around terminating NPs, including those nominated by the person in certain circumstances. This sits uncomfortably with the AMHP role and also the original aims of the MHA Review. It increases the risk of personal legal challenge to AMHPs.

2.10. The power of AMHPs to override NP objections to the use of section 3 on the grounds of "dangerousness" did not appear in the Review or White Paper and we are unclear as to inclusion here. It moves some of the power of a County Court Judge to AMHPs. While there are clear reasons to remove the County Court from situations that could reasonably be managed under the proposed scheme, or an improved version of it, this new power seems to move control further toward professionals rather than the individual.

2.11. It is uncertain how the requirement for AMHPs to notify relevant managers of their appointment of an NP will work in practice.

2.12. There is no indication at this stage of the need for national database of NPs, which would be the preference given the mobility of the population and need for multi-agency access to the latest information. It is assumed that any registers will be organised at a local level. This creates multiple issues with accessing, updating and managing databases, as not all local authorities and health Trusts will have access to the same records systems.

2.13. The proposals as they stand would require a heavily detailed Code of Practice due to reflect the multiple scenarios that arise from, what we view as, an incoherent legislation. It is unlikely that such guidance would cover every eventuality and increase the likelihood of AMHPs being challenged legally (remembering that the AMHP is necessarily independent of their authorities when carrying out duties under the Act and independently liable for their decision making).

2.14. The selection of AMHP nominated NPs would need clear support in any revised Code of Practice to ensure that issues of culture and race are specifically addressed. This awareness would also need to extend to other actors who are required to support these proposals in practice.

2.15. Significant investment is required in educative support for NPs (and patients) as to the nature and power of the roles, as well as logistics of operating such a scheme.

1. Detailed table of questions raised and impacts

Schedule A1 Section 21	**Nominated Person**	**Part 1**	**Appointment of nominated person by a patient**	
Sub-heading	**Effect**	**Summary of detail**	**General questions/comments**	**Impact on AMHP Practice/Workforce and resources**
Rights of patient etc to appoint nominated person Paras 1, 2	A patient may appoint another person to act as NP for the purposes of this Act (1)	2(1) • Age requirement • NP cannot be a disqualified person 2(2) • NP must be 16 or over for 16 years old • NP must be 18 or over for under 16s	• What will be the transition arrangements (will exiting NRs become NPs) for those already in hospital or under community orders? • Will those previously displaced under s.29, either permanently or time limited, be excluded from nomination (this needs to be explicitly set out if this is the case) • The lack of geographical exclusions assumed deliberate	• Lack of clarity risks potentially excluded NRs being able to become NPs, due to current records and court decisions not being accessible. • While geographical location should not be a barrier to nomination, the scheme as a whole creates multiple and near impossible logistical issues. Major risk to supporting the safeguard. • AMHPs and other professionals should be explicitly excluded from being NPs (unless that

			and open, therefore, to appointments on NPs living abroad (see comments on practicalities of NP appointments) • No explicit exclusion of professionals connected to the care of the patient.	appointment relates for a non-working relationship) for the avoidance of confusion.
Appointment formalities Para 3	Requires an instrument in writing, signed by the patient and the NP, in the presence of a health or care professional (not necessarily at the same time).	Valid if (1): a) the person is eligible b) The appointment is made in writing c) Requirements of 2 are complied with (2) The instrument in writing must a) Be signed by the patient in the presence of a health or care professional or IMHA b) Is signed by the NP (also witnessed)	• Due to witnessing requirements, electronic signatures appear excluded, adding logistical complexity for NPs living any distance from the patient (including potentially for those NPs living abroad). • Not reflective of modern living arrangements	• Taken with the 'appointment formalities' the scheme throws up multiple avenues to either frustrate or delay the processes required. • It leaves too much on responsibility on those witnessing (if they even are able to witness due to the potential distances involved). • Witnessing of documents

		containing the statement that i. The NP meets the age requirement ii. NP agrees to act as such c) Witness states: i. The instrument was signed by the patient and the NP in the presence of the witness ii. that neither the patient lacks capacity/competence iii. that the NP lacks capacity/competence iv. there is no reason to think any fraud or undue pressure has been used to induce the patient v. The witness has no reason to think the NP is unsuitable	• Logistical issues likely to hold up and limit the number of NP appointments (working against the purpose of the measure) • Potential confusion over who can sign when and in whose presence. • What does the witness do when they think the person is unsuitable? Can the patient challenge that? Can a different witness be approached, or is the first professional's decision final? • Unclear as to why alternative approaches (Interim NP and RPR) not considered suitable	approach usually seen for mortgage papers and the like, not reflective of social and clinical realities in this area of service provision • A new Code of Practice would almost certainly struggle to answer all the questions raised, leaving uncertainty open to court challenge. • Patients will rightly expect support with resolving issues quickly, which due to the scheme may prove near-impossible for the professional to resolve

			models as both were designed with practical issues in mind.	
Duration of appointment *(by patient)* **Para 4**	Appointment ceases of NP, if:	a) NP dies b) Patient appoints another c) Patient terminates the appointment (para 5) d) NP resigns (para 6) e) County court terminates (section 30B) f) An AMHP appoints another NP	• Fundamental issue with AMHPs being given the power of courts to, in effect, override patient choice once the patient lacks capacity • No clear primacy of appointment – i.e. which party can override another's appointment – the scheme appears potentially cyclical.	• This is a potential for unending appointment and counter-appointment, along with more avenues to challenge decisions in court. • Disputes are highly likely to pull AMHPs and other professionals into trying to resolve issues that have not previously existed in this way. • The thresholds for state operatives to override a patient's choice have lowered – appearing to be the opposite of the intention of the MHA Review.
Termination of	Patient can	Notice must be:	• Unclear as to how	• If a patient indicates that

appointment by patient **Para 5**	terminate their own NP's appointment via written notice	• Signed by the patient in the presence of a health or care professional • Witness signs that the notice was signed in their presence • That there is no reason to think the patient lacks capacity or competence • No reason to think fraud or undue pressure has been used	often a capacitous patient can keep re-nominating (particularly during an admission). Raises the concern as to vexatious use of the right to tie up professionals or frustrate processes (this isn't about mental disorder, but the individual exerting their own power and control) • What if the patient is unable to get a witness? Is there a risk that courts will be overly critical of individuals/services for failing to uphold rights? • What is the duty on individual professionals to witness? Does it	they wish to terminate the NP appointment during the AMHP's considerations at s.13, but the witness arrangements are too logistically difficult, does the AMHP have to rely on "reasonably practical"? Would the AMHP be expected to consider their own power to terminate? Would this then open them to challenge from the NP if they did this without speaking to the NP first? • What does this mean for Art 5 rights, would the AMHP go against a patient's wish over a logistical matter? • What if the AMHP feels that the patient's new preferred choice is "unsuitable" – do they

			need to be on the organisations to provide witnesses?	then choose someone that they know the patient will override at their earliest opportunity? • Cannot be left to the point at which an AMHP becomes involved. • Risk that AMHPs will become the default as health and care workers will say, "you are involved now and you can choose someone", creating more AMHP work. • Again, non-electronic signatures (for any of the parties involved creates significant logistical issues)
Resignation of nominated person **Para 6**	An NP can resign their appointment in writing	Written notice must go to: • The patient And, one of the following: • An AMHP • The patient's RC	• Unlike the requirements at nomination, there is no requirement to check the NP's capacity to	• Too much uncertainty over process. No clear 'owner' of the process or register. • AMHPs should be removed

		For those patients who are: i. liable to be detained in pursuance of an application for admission for assessment or treatment **(THIS APPEARS TO CONFUSE LIKELY WITH LIABLE)** ii. Subject to an application for ss.2 or 3 iii. A community patient • The relevant managers In relation to a patient who is i. Subject to Guardianship in pursuance of a guardianship application **(AGAIN APPEARS TO CONFUSE LIABILITY WITH LIKELY)** ii. Subject to an	make this decision, or whether they are under duress. No witness required • Multiple logistical issues with this provision • It is unclear on which AMHP the notice should go to (if the NP is in one area, does it go there, to where the patient is, and so on)? • Is there to be a centralised register of NPs, locally maintained registers will be hugely time consuming and communication across agencies, localities and regions problematic. • Need clarification over the meaning of "in	from the logistics and MHA Admin offices (or national database) should manage the administration of this. • Non-inpatients. Whoever holds the register of NPs, should be notified. That register holder, should then notify health systems (GPs, MH system). No clarity on who the register keeper is (or by the looks of this, that a register is even a statutory requirement) • How do notices for any new or closing nominations get shared across health and social care records?

		application for guardianship • The relevant local authority. • The notice must be signed by the NP	pursuance". Surely being under s.13 consideration and or liability for detention, cover all bases – does not require an additional measure.	
		Part 2	**Appointment of nominated person by an approved mental health professional**	
Sub-heading	**Effect**	**Summary of detail**	**General questions/comments**	**Impact on AMHP Practice**
Power of approved mental health professional to appoint a nominated person Para. 7	The AMHP may appoint a person to act as an NP. Introduces the "relevant patient" concept.	Where an AMHP reasonably believes that a relevant patient (1): • Lacks capacity/competence to appoint an NP, and • Has not appointed an NP The AMHP **may** appoint an NP "Relevant patient" means a person who is (2):	• It is a "may" not a "must", or even "should" • A capacitous patient being detained highly unlikely to be supported to nominate during the assessment interview (as likely this will require the witnessed signature of the NP who might live hundreds or miles	• The logistics around AMHP work, time scales and the "may" likely to result in few 'real time' nominations from AMHP (see also comments on appointment formalities). Early versions of the scheme were designed to remove these risks, but have not found their way through to the Bill.

		a) Liable to be detained in pursuance of an application for ss.2, 3 b) Subject to an application to detain c) Who an AMHP is considering making an application for ss.2, 3 d) A community patient e) Subject to Guardianship in pursuance of a guardianship application f) Who is subject of a guardianship application g) In relation to whom an AMHP is considering making a guardianship application	away or even abroad) • In the above scenario an AMHP could only nominate if the patient lacked capacity, but would also face the same logistical issues. • Are ss. 135 and 136 excluded deliberately (neither is inherently about considering an application, as per s.13(1), rather they are about securing care and control arrangements – which might include later the consideration of an application) • ***7(2) a, e, g*** *are unclear concepts. Need clarity as to their meaning, as potential measure appears covered*	

			elsewhere – potential repeat of confusion around likely and liable	
Who can be appointed by an approved mental health professional as a nominated person **Para 8**	Sets out the same eligibility around age (as at para 2) and not having been disqualified by a court.		• As above, no geographical requirements. • No bar on professionals being made NP	
Selection of nominated person **Para 9, 10**	Para 9 relates to over 16s Para 10 related to under 16s	Over 16s • If relevant patient has a donee (lasting poa) or deputy (Court of Protection appointment) who is willing to act as NP, the AMHP must appoint them. • Donee or deputy is "competent" if he scope of the authority conferred	• If two LPAs, how do we choose between them? • The practicalities of these arrangements are likely to end up with delays in appointing donees/deputies, as they will still need to be witnessed.	• Will require greater oversight from AMHP services, as assessing AMHPs will often not be available the following day or shift to pursue the appointment and all of the measures that go with it. • Likely impact on duty AMHPs being pulled into unresolved NP situations, rather than focussing on new work.

		on them would extend to decisions of the kind taken by an NP. • Otherwise, AMHP must take into account past and present wishes and feelings, so far as reasonably ascertainable. Under 16s If a person within the following list is willing to act as NP, the AMHP must appoint them • An LA with PR • Any other person with PR • Deputy means as above • Otherwise, AMHP must take into account past and present wishes and		

		feelings, so far as reasonably ascertainable.		
Appointment formalities Para 11	Sets out the requirements to ensure an AMHP NP is valid	The person is eligible to be appointed (as at para8) The NP agrees Appointment is made in writing, signed by the AMHP The AMHP must witness NP signature ("in the presence of the approved mental health professional) Age requirements (as at Para 2) are met	• No requirement to confirm that the AMHP nominated NP has capacity/competence and is suitable in the same way that witnesses to patient nominations does.	• As above, the requirement for the instrument in writing to be witnessed by an AMHP will preclude all but those rare occurrences where AMHP and NP will be together. • Potential to lead to multiple 'call backs' for the AMHP to resolve/fix the lack of NP after admission – significant impacts on work load • Most likely will lead to practice that will conclude that AMHP nominations are impractical, pushing the responsibility onto ward professionals/IMHAs. • Goes against the aims of

				the Review
Notification of appointment Para 12	Sets out the 'must' carry outs for AMHPs	• AMHPs must notify the relevant managers for ss. 2, 3 applications. • AMHPs must notify LA for S.7 applications • Those notified must take steps to then inform the relevant patient of the appointment	• Logistically the AMHP will struggle to notify the relevant Managers for out of area admissions • The method of notification needs to be clear (in order for it to be operationalised, this goes back to who is responsible for the register) • This paragraph also suggests that an AMHP could appoint an NP without the responsibility to directly inform the patient.	
Duration of appointment Para 13	Sets out the circumstances in which an AMHP	a) When the NR dies b) An AMHP appoints a different NP	• This scheme creates the potential for nomination and	• Logistically illiterate • Legally nonsensical

	nominated NP will cease to be such. This includes patients being able to override the AMHP with a new nomination. Ceasing to be a "relevant patient" itself, would end the nomination	c) An AMHP terminates the appointment under para 14 d) The patient terminates to appointment under para 15 e) NP resigns under para 16 f) County Court terminates the appointment g) The patient nominates a different NP h) The person ceases to be a relevant patient.	counter nomination between AMHP and patient. • No limit on the amount of nominations • Would it not be better for the patient to have the opportunity to confirm the AMHP nomination once admitted, rather than start all over again?	• Against the intentions of the Review • Likely to lead to a significant work load for AMHPs, with that being cancelled out the moment the person is no longer liable for detention.
Termination of appointment by approved mental health professional Para 14	Sets out the process and parameters of ending an AMHP nominated NP's involvement	Termination requires written notice to the NP, on the grounds that (2): a) The NP lacks capacity to act as an NP b) NP no a suitable person to act as an NP c) Patient has regained	• Unclear as to notice timescales (when does notice become effective?). When signed, when received?	• Logistically difficult • Scheme works against promoting the rights of the patient, creates disincentives to AMHPs to support the aims. • Does not fit with the aims

		capacity or competence to appoint an NP Where an AMHP terminates the appointment they must (3) a) Notify the relevant managers for ss.2,3 patients b) Notify the LA for s. 7 patients		of the Review.
Termination of appointment by relevant patient Para 15	Provides the process by which patients can terminate the appointment of the NP they have appointed.	Relevant patient must provide the NP with written notice (1) The notice must be (2): a) Signed by the patient in the presence of health or care professional or IMHA b) Contain a statement by the witness that: i. The notice was signed by the patient	• Patients will likely need support with the logistics of this (practically and emotionally). • Potential for conflict over issue of "capacity/competence" – not always easy to determine. What does the witness do if the patient challenges the witness not agreeing to	

		in the presence of the witness ii. Witness has no reason to believe the patient lacks capacity/competence to terminate the appointment iii. Witness has no reason to think any fraud or undue pressure has been used	sign? Relates to point above about patients seeking alternative witnesses.	
Resignation of nominated person **Para 16**	Describes how NP can resign from their appointment	NP may resign by giving written notice to the patient and at least one of the person listed in para 2: a) An AMHP b) The RC (if any) c) The relevant managers for detained patients d) The relevant LA for guardianship patients.	• Is the expectation that the AMHP will – in effect – step in when an NP becomes uncooperative and refuses to engage in the process (i.e. they verbalise that they no longer want to act as such). In effect, forcing the AMHP to carry out the task of removing the NP.	The primary issues here are the lack of NP register provisions/clarity. How in reality communication around these issues are handled – multiple service models, records systems, s.75/MoU/no agreement models hamper information availability.

		The notice must be signed by the NP (3)	• As above, the location of the AMHP is not specified. • Suggests that a centralised NP registration resource is needed.	
Mental Health Act 1983	**Chapter 20**	**Part 1**	**Summary of main changes relating to NP**	
General provisions as to applications Section 11	Right to make an application transferred to NPs (1)		While minimal, NP applications to detain might end up with a 'race' between the patient seeking to terminate the NP's appointment at the same time the NP is trying to detain the individual.	• In general 11(1) is not widely supported across the AMHP Leads Network as it is believed that citizens should not be able to deprive other people of their liberty and authorise enforced treatment upon others in state run institutions.
	11(4) Wording change	11(4A) Consultation for ss.3 and 7 do not apply if: a) Not reasonably practicable, or		

		b) Would involve unreasonable delay		
	11(4B) Wording change	11(4C) Where an NP objects to a ss.3 or 7 objection, the application may be made by an AMHP if they certify that – in their opinion – if not admitted/received the patient would be **"likely to act in a manner that is dangerous to other persons or to the patient"**	• S.11(4C) was not part of the MHA Review recommendations, so unclear as to its origins. • Introduces "dangerousness" into detention criteria via the backdoor. • Makes overriding objection easier for professionals seeking to detain a person.	• Places the AMHP in the role of the County Court (taken with other measures round AMHP NP appointments). It appears that the AMHP has taken on board a number of County Court responsibilities. • This is mirrored in the RC's role with CTOs • We need to be clear on impacts for AMHP (professionally/personally), as places them in a potential more conflictual role with patients and families, where traditionally the courts would be the arbitrator.
Duty of	Remains as before,	Section 11(4) retains the	• Due to the	• Given that NPs will

approved mental health professionals to make applications for admission or guardianship Section 13	with NP replacing NR	"reasons in writing" if no application requirement for AMHPs	practicalities and logistics of both patient and AMHP nominations, it is likely that fewer such NP letters will be required. • However, in considering section 11(4) the patient becomes a "relevant patient" and opens up the potential for AMHPs to appoint an NP (or at least encourage those supporting the patient to nominate) during the period of their involvement.	become part of the suite of procedural safeguards, AMHPs will likely have a positive obligation to show that they have considered NP identification issues and processes. This may only need to be sign posting, but could lead to a greater involvement of the AMHP and, therefore, greater time spent on section 11(4) requests. • Likely to increase 'traffic' into the AMHP service as other parts of the system look to resolve or support NP issues.
Community treatment orders: role of nominated person 17AA	17AA(1) – Confirms that the RC must consult the NR	17AA(4) – Provides the RC with an NP "dangerousness" over-riding power to objections.	• 17AA(2) gives the RC "not reasonably practicable" and "unreasonable delay" get-outs from consultation. Should	• While the confirmation that the RC must consult the NP is welcomed, resolving NP issues is likely to bring the AMHP into situation of greater

			that ever be the case, when these are non-urgent orders and the rest of the NP scheme provides multiple options for ensuring an NP is created who could fulfil the role?	dispute. • As the AMHP will effectively be able to 'displace' an NP (if meeting the criteria to do so), they could find themselves 'ping-ponging' between AMHP and patient nominations/counter nominations.
Sections 26, 27, 28, 29, and 30	All have been completely removed (replaced by Schedule A1)		• No 'fall back' position when deciding who to pick as NP – it is presumed that the new Code of Practice will give greater guidance.	
Power of court to terminate appointment of nominated person 30B	County court retains redefined powers in relation to NPs (2) Applications can be made to terminate NP	30B(3) sets out the grounds: a) NP unreasonably objects to ss 3 or 7 application *(presumably below the dangerousness threshold that an AMHP can disregard*	• Difficult to envision a scenario that, in this scheme, the AMHP cannot resolve before needing to go to court. Is this the intention? • The 'circular'	• Given the powers now conferred on AMHPs to override both patient and NP wishes with regards to who the NP is, this scheme is likely to result in very few approaches to the court and greater pressure

	appointments by: a) the patient b) an AMHP c) "any person engaged in caring for the patient or interests in the patient's welfare"	*the objection)* b) NP, without due regard for the welfare of the patient/public, has exercised the power of discharge c) NP unreasonably objects to making a CTO d) The patient has done anything which is clearly inconsistent with the NP remaining the NP e) NP lacks capacity/competence to act as NP	appointment/counter-appointments as described above are likely to require court. • Would the Court of Protection become involved if the issue is a dispute over the capacity of either the patient or the NP? • "…or interests in the patient's welfare" – this is unqualified and, therefore, potentially open to any person who is interested in a case even if they have no connection (e.g. a member of the public in a high profile case)	on AMHPs to resolve issues and disputes. • This is likely to increase AMHP time spent on conflict resolution and also professionals (RCs) seeking AMHP involvement to 'clear the way' for their preferred treatment option/pathway. • Appears to be against the aims of the review and the stated intention of the Bill to improve patient choice, control and power – it does the opposite. • If the intention is to increase AMHP power, then it requires increase protection and support to the AMHP.
Remands to hospital:	Sets out that the nominated person			• Potential for AMHPs to be engaged to resolve lack of

nominated persons 36A	scheme applies to those remanded under section 35 and 36			NP for those under parts of Part III • We would need an estimates on the use of ss.35 and 36 to calculate how many of these cases may come our way.
Welfare of certain hospital patients Section 116	Removes the duty (at section 116(2)(c)) to arrange visits to adult patients for whom the LA in NP		• Unclear as to transitional arrangements of NR to NP in instances where the LA is currently NR. • By removing the duty to visit such patients risks those adult patients with no external support losing a non-medical interest in their welfare. • Is this picked up by more robust advocacy arrangements?	

Appendix 1

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