Welcome to the session:

AMHP Clinic:
Mental Health Act 2025 (1)

Please be aware this is not a webinar!

Please check your camera & mic are working and you are in a quiet space without distractions.

Please make sure you have the materials to hand; they are attached to your Outlook Calendar or Teams diary entry for today.

If your Wi-Fi isn't great and struggles when your camera is on – Close down any other Windows or Apps that aren't critical to the session.

Now you can sit back and enjoy the music, or go and grab a brew, we'll make a start at 9.30.

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AMHP Clinic:
Mental Health Act 2025 (1)

McGill

Last Updated: *May 2026*

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This is a peer-led adult learning experience; therefore, you will get out of it what you, and your fellow delegates, put into it.

If you can't give this the time it needs, please let your facilitator know and come back another time when you can.

- **Your Expectations of Us:**
  Guide, facilitate, inform and educate (on the tech as well as the content).
- **Our Expectations of You:**
  Take part - both in the room and in the breakout groups. Cameras are not optional; they are a must unless it has been agreed and is for a very good reason.
- **Your Expectation of Fellow Participants:**
  To engage in the room and the group work and be respectful and professional in interactions.

Please don't sabotage the learning for your colleagues, disengaging is disrespectful and impacts on others!

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- ✓ If you can, please have your **cameras on!** You wouldn't come to training with a bag on your head!
- ✓ Googling answers is fine, doing your shopping isn't!
- ✓ Please **listen, engage and ask a question if you have one** – You can shout out, put your hand up or use the chat. Use the **@** to tag one of us directly.
- ✓ **Look after your own health & safety**, as we're not in your house! We have a contact form in case of emergencies (which will be in the chat in 2 ticks).
- ✓ Usual rules apply to confidentiality. If we have any safeguarding or fitness to practice concerns, we will discuss this with you.
- ✓ No smoking on screen – vaping allowed subject to **your** location and organisational rules.
- ✓ **If everything freezes** – breathe, leave, reboot and then come back the way you came in at the start!

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Remember, you never know what someone else might be struggling with at work, at home...in their own heads.

- Be kind to yourselves, each other and us.
- Be curious but respectful, be open to feedback & discussion.
- Be mindful of language and terminology you use.
- We play music in the breaks for a reason. If you would like to know why, please ask. If you would prefer not to listen to music during the break, please turn us down.
- The return time is always displayed on the break slide.

This is intended to be a safe space - if you need a breather, additional support or other self-care – do it!
Just let us know what you need (we have extra rooms / people available if we need them).

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Who's Milo?

Milo is our brown-and-white pup with a purple studded collar and a cheeky grin. He's not just adorable—he's part of our training culture.

Let Milo Out?

When Milo appears near a door, it's your cue to take a break, stretch, or reset.

Why Milo?

- **Symbol of Curiosity & Care**
  Milo reminds us to stay curious, kind, and grounded—especially when things get intense.
- **Spot Milo Challenge**
  You'll find him subtly placed in our 3D plasticine visuals. It's a fun way to stay engaged and take a breather when screen time runs long.

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It's a Resource Pack!!

We will not be using all the slides!

The learning will come from activities and discussion. The pack is there to refer-back to, and to offer further information, links and resources to support today's session.

Rabbit hole warning – wherever you see this icon in the materials there is the opportunity to disappear down a rabbit-hole. *Don't say we didn't warn you!*

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Learning Outcomes

- ✓ An update of the current progress of the Act and any updates available in relation to implementation plans.
- ✓ The ability to explore and reflect upon practice in relation to statutory duties and precedents and consider the impact of the proposals, including Part 3 changes and the nominated person role.
- ✓ Consideration of what would be helpful from the Draft Code from an AMHP and s13 perspective *(we will transcribe this bit and feed it into the DHSC so it does matter).*
- ✓ The opportunity to reflect with colleagues and peers on the proposals and the implications for AMHP practice, including exploring local issues and applying learning and best practice recommendations to these issues.

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Group Discussion:
It's Heerrreee.....Now What?

In small groups:

Based on what you know so far –

- What are the key amendments that you are concerned with?
- What are likely to be the benefits to the amendments?
- What are likely to be the barriers or challenges for implementation?
- What are the priorities locally for mental health reform and do they reflect the new Act?
- Key messages for your wish list for the draft code.....?

Don't forget to nominate someone to feedback *(or agree to do it together, but no tumble-weed (aka awkward silences) when we come back together please!)*

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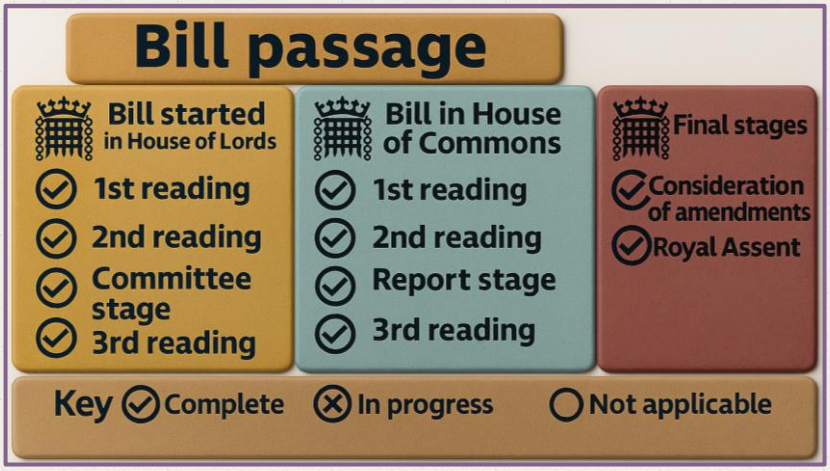
Mental Health Act 2025:
A Quick Recap

Some of the key debates from committee stage:

- Police powers v health powers – ***now removed.***
- Community Treatment Orders (CTO).
- Nominated Person (NP)
- Under 18's.
- Post-discharge advocacy.
- Human Rights in private care *(settled but needs to be confirmed)*.
- Advanced Choice Documents (ACD).
- Statutory Care & Treatment Documents.



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Expected Implementation Timeframes:
Mental Health Act 2025 (speculative headlines)

2025:

- ✓ Royal Assent for the Mental Health Act 2025.
- ✓ Initial planning and communication by DHSC, NHS England, and local authorities.

2026:

- Drafting and consultation on the new Code of Practice - Consultation will involve people with lived experience, carers, professionals, and Parliament.
- Development of secondary legislation.
- Regulations to support new duties (e.g., Care and Treatment Plans, Dynamic Support Registers).
- Early preparatory work Local authorities, NHS Trusts, and ICBs begin reviewing policies, training plans, and systems.

2027:

- Publication of the new Code of Practice (expected late 2026 or early 2027).
- Workforce training
- Some early reforms may be commenced changes that do not require major workforce expansion (e.g., supervised discharge).

2027/28: (First major set of reforms expected)

- Nominated Person replaces Nearest Relative.
- New detention criteria (higher threshold for risk and necessity).
- Advance Choice Documents become available.
- Changes to Care and Treatment Plans and Dynamic Support Registers.
- New rights for people with autism and learning disability (e.g., new criteria for detention, review meetings).
- Ongoing training and system changes.

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Expected Implementation Timeframes:
Mental Health Act 2025 (speculative headlines)

2028–2030:

- Further reforms phased in as workforce and community services expand
- Increased frequency of Mental Health Tribunals (requires more tribunal judges and clinicians).
- Full rollout of new advocacy rights (e.g., for informal patients).
- Expansion of community infrastructure for people with learning disability and autism.
- Ongoing evaluation and feedback to Parliament and stakeholders.

By 2035 (10-year horizon):

- Full implementation of all reforms
- All new duties, rights, and safeguards in force.
- Workforce and community services at required capacity.
- Ongoing monitoring, evaluation, and updates to the Code of Practice as needed.

Watch this space!

- Timelines for each reform will be set by government "commencement orders" after the Code of Practice is finalised and workforce training is complete.
- Until then, the current Mental Health Act 1983 (as amended) remains in force.
- Local pilots and early adopters may trial some reforms before national rollout.

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Quick Overview of Changes (1):
Mental Health Act 2025 (The AMHP Role)

- The statutory core of the AMHP role remains intact, the Mental Health Act reforms do not redesign the AMHP function.

Structurally:

- ✓ The AMHP remains the gatekeeper of compulsory admission
- ✓ The decision-making architecture (AMHP + two doctors) is unchanged
- ✓ The AMHP's independence from the NHS is preserved.

But.....

The reforms subtly reposition AMHPs as:

- Rights guardians, not just process coordinators.
- Ethical decision-makers, not just legal technicians.
- Independent professionals, not just system navigators.

But without:

- Additional statutory power.
- Greater organisational protection.
- Reduced caseload or time pressure.

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Quick Overview of Changes (2):
Principles of the Mental Health Act 2025

1. Choice and Autonomy
Patients should be actively involved in decisions about their care and treatment. Their wishes, feelings, and preferences must be sought and respected wherever possible.

2. Least Restriction
Any restriction on a person's liberty or rights must be the minimum necessary to achieve the intended purpose, consistent with the person's wellbeing and public safety.

3. Therapeutic Benefit:
All interventions must have a clear therapeutic aim and be likely to benefit the patient

4. The Person as an Individual:
Patients must be treated with dignity and respect, recognising their unique attributes, background, and experiences.

How the Principles Will Work in Practice

- ✓ Legal Duty: All professionals (AMHPs, clinicians, hospital managers, etc.) must have regard to these principles when making decisions under the Act.
- ✓ Documentation: Decisions (especially those involving restriction or compulsion) should record how the principles have been considered and applied.
- ✓ Tribunals and Courts: Will expect to see evidence that the principles have been followed in decision-making.

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Quick Overview of Changes (3):
Mental Health Act 2025 (Headlines)

- **Section 2 & 3 Detention:** Will require evidence that "serious harm may be caused to the health or safety of the patient or another person" and that detention is necessary given the nature, degree, and likelihood of harm.
- **Section 3:** Detention for treatment only for "psychiatric disorder" (not autism or learning disability alone), duration of detention – 3 months, 6 months, annual.
- **Section 20:** Renewal of detention must meet new, stricter criteria.
- **Section 17A:** Community Treatment Orders (CTOs) also require demonstration of risk of serious harm.

Renewal Criteria (s20)(Post-2025) criteria are stricter and more specific:

- The patient is suffering from a psychiatric disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital.
- Serious harm may be caused to the health or safety of the patient or another person unless the patient receives medical treatment.
- It is necessary, given the nature, degree, and likelihood of the harm, for the patient to receive medical treatment.
- The necessary treatment cannot be provided unless the patient continues to be detained.
- Appropriate medical treatment is available for the patient.

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Definitions of Mental Disorder:
Mental Health Act 2025

'Mental disorder' means any disorder or disability of the mind.

'Autism' means a lifelong developmental disorder of the mind that affects how people perceive, communicate and interact with others;

'Learning disability' means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence; (and, for some purposes, significant impairment of social functioning).

'Psychiatric disorder' means mental disorder other than autism or learning disability.

(MH Act 2025, s1(2))

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Quick Overview of Changes (4):
Detention Criteria

Section 2: ***(28 days)***

- **Mental disorder** – nature or degree which warrants detention in hospital for at least a limited period, and
- Serious harm may be caused to P or others unless P is detained, and
- Given the nature, degree and likelihood of harm, P ought to be detained.

Section 5:

- **Appears to be suffering - Mental disorder**
- 5(2) – It appears to the RMO/RC that an application ought to be made
- 5(4) – It appears to the nurse that serious harm may be caused unless P is immediately restrained / prevented from leaving the hospital.

Section 3 :

(initial detention reduced to 3 months)

- **Psychiatric disorder** – nature or degree which warrants detention in hospital for treatment, and
- Serious harm may be caused to P or others unless P is detained, and
- It is necessary, given the degree and likelihood of harm, for P to receive medical treatment.
- The necessary treatment cannot be provided unless P is detained under the act .
- Appropriate treatment is available.

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Quick Overview of Changes (5):
Mental Health Act 2025 (Headlines)

Autism & Learning Disability:

- No longer a basis for detention under Section 3 unless accompanied by a psychiatric disorder.
- New duties for care, education, and treatment reviews for people with autism or learning disability detained under the Act.
- Integrated Care Boards (ICBs) must maintain registers of people at risk of detention and commission services to reduce unnecessary admissions.

Nominated Person – Replacing Nearest Relative:

- Patients can appoint a Nominated Person (NP) to exercise rights and be consulted on key decisions (admission, discharge, transfer, CTOs).
- Court can remove or replace an NP if not acting in the patient's best interests.
- AMHPs must consult the NP before making applications for admission or guardianship, unless impracticable or would cause delay.
- NP can object to applications; if so, stricter criteria for proceeding apply.

New Power & Criteria:
The AMHP can override an NP's objection only if they can evidence and certify a risk of dangerous behaviour and must document this decision.

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Quick Overview of Changes (6):
Mental Health Act 2025 (CJS & Part 3 Themes)

Police & Criminal Justice Reforms:

- Police stations and prisons removed as places of safety for people detained under the Act (except in limited circumstances).
- New time limits for transfer of prisoners to hospital (28 days from referral).
- **Deprivation of liberty conditions:** Tribunals and Secretary of State can impose these only if necessary for public protection.

Amendments in Effect 18 Feb 2026.

- **Conditional Discharge** – New power to authorise DoL.
- **Tribunal Access** – New Statutory Timescales.
- **Expansion of Transfer & Removal Powers.**

The Part 3 changes do not radically restructure AMHP practice or forensic social work, but they do materially raise the professional, legal and ethical weight of the role.

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Quick Overview of Changes (8):
Mental Health Act 2025 (Part 3 Themes)

Tribunal Access – New Statutory Timescales
New time periods apply for restricted patients depending on whether:

- They are subject to DoL-level conditions.
- Conditions have ceased.
- They have been recalled.

Key Tribunal access rules from Feb 2026:

- Patients without DoL conditions: 12 months - 2 years window.
- Patients under DoL conditions: 6–12 months for first application, thereafter every 2 years.
- Secretary of State must automatically refer after 12 months, then every 2 years if not reviewed.

Implications for AMHPs, Care Coordinators and RCs:

- Care coordinators and responsible clinicians must track the new cycles.
- Legal literacy essential for ensuring patients' rights to Tribunal access are upheld.
- Expect earlier and more frequent involvement of IMHAs (not yet fully commenced but part of the broader reform direction).

Conditional Discharge:
A Recap.... MM & PJ, 2018

MM [2018] UKSC 60 and PJ [2018] UKSC 66 established that:

❌ The Mental Health Act does NOT allow DoL in the community
❌ Conditional discharge conditions cannot amount to detention
❌ CTO conditions cannot amount to detention

✅ Consent does not make an unlawful DoL lawful.
✅ The reality of the restrictions matter not how "kind" they are.
✅ Risk management must have clear legal authority.
✅ If DoL is required, a lawful framework must be used.

- **Key principle:** Fundamental rights to liberty cannot be overridden by implication or convenience.
- **Impact for Practice:** No "back-door detention" via care plans, CTOs, or conditional discharge – restrictions must be lawful, explicit, proportionate, and properly authorised.

"As the power to deprive a person of his liberty is by definition an interference with his fundamental right to liberty, it engages the principle of legality...Fundamental rights cannot be overridden by general or ambiguous words."

(Lady Hale, MM 2018)

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Quick Overview of Changes (9):
Mental Health Act 2025 (Part 3 Themes)

Conditional Discharge: New Power to Authorise a DoL

What changes: For the first time, it becomes lawful to impose conditions amounting to a deprivation of liberty on restricted patients who are conditionally discharged.

Implications for practice:

- This resolves longstanding post-MM (2018) barriers preventing lawful conditional discharge where community management required DoL-level supervision.
- Expect increased recalls where community packages cannot safely sustain DoL-level conditions (echoed in email feedback that the "new system has no teeth" and recalls will rise).
- Requires close collaboration with probation, secure services, social supervisors (where used), and community MH teams.

Implications for AMHPs & social supervisors:

- Ensure clear rationales for DoL-level conditions linked to "protection from *serious harm*".
- Care plans must specify how DoL will be supervised, including contingency and recall arrangements.
- Multi-agency governance processes will need reviewing to ensure lawful oversight.

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Conditional Discharge:
New Power to Authorise a DoL

Conditional discharge with DoL conditions will be lawful from 18 February 2026

The Act amends sections **42, 71, and 73 MHA 1983** to allow:

- The Secretary of State or The First-tier Tribunal to impose or vary conditional discharge conditions that amount to a deprivation of liberty [dacbeachcroft.com]
- This directly overturns the effect of MM [2018]

Threshold: A community DoL may only be imposed where:

- The decision-maker is satisfied that conditions amounting to a deprivation of liberty are necessary for the protection of another person from serious harm, **and**
- Discharge subject to those conditions is no less beneficial to the patient's mental health than continued hospital detention

Implications for Practice:

- ✓ This is a public-protection test, not a best-interests test.
- ✓ Applies regardless of capacity.
- ✓ Tribunal safeguards strengthened to mirror Article 5 safeguards.
- ✓ Retrospective application: *The provisions apply to patients already detained, and patients already conditionally discharged when the amendments come into force.*

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Conditional Discharge:
What Changed on 18 February 2026?

- **Statutory authority introduced:**
  Conditional discharge may now include conditions amounting to a deprivation of liberty where necessary to protect others from serious harm.

- **Shift in legal scrutiny:**
  Focus moves from whether detention is lawful at all to whether the extent of detention is justified, proportionate, and reviewable.

Pre-18 Feb 2026	Post-18 Feb 2026
Community DoL largely unlawful	Community DoL expressly permitted
AMHPs arguing against detention	AMHPs scrutinising extent of detention
Recall used to solve legal gaps	Recall justified only if threshold breached
Risk aversion exposed	Risk aversion legitimised — requires challenge

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Practical Guidance:
MHA 2005 & Part 3 Patients

For AMHPs:

- Ensure updated understanding of criteria for section 35, 36, 37/41, 48/49 pathways.
- Review risk assessments with explicit reference to serious harm thresholds now central to conditional DoL discharge decisions.
- Ensure family / NP / advocate engagement, especially given increased potential for recall.
- Strengthen cross boundary processes: prisoners being transferred out of area remains a recurrent problem highlighted in practice emails.

For Social Supervisors & Community Teams:

- Prepare for monitoring and evidencing DoL level conditions.
- Review community resources, gaps may force recalls due to unsafe or unachievable conditions.
- Review local protocols for multi agency reviews every 6–12 months depending on patient pathway.

N.B. *Our tips not officially published ones!*

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Group Exercise:
Conditional Discharge & DoL

In your groups, read Aaron's case study, and consider the following questions:

- What is the legal authority for Aaron's restrictions, and how did this change after 18 February 2026?
- What threshold justifies a deprivation of liberty in the community, before and after 18 February 2026?
- How should S2 vs recall be approached in the context of existing DoL and least restrictive principles?
- What factors determine whether Part II detention is required as Aaron deteriorates?

Don't forget to nominate someone to feedback ***(or agree to do it together, but no tumble-weed (aka awkward silences) when we come back together please!)***

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COFFEE BREAK!

It's time to...

- Blink!
- Hydrate.
- Stretch.
- Get yourself another brew.
- Let the dog out.*
- Let the dog back in.*

PLEASE BE BACK FOR 11:XX

*MAKE SURE IT'S YOUR DOG!

DID WE MENTION HOW IMPORTANT BLINKING IS!

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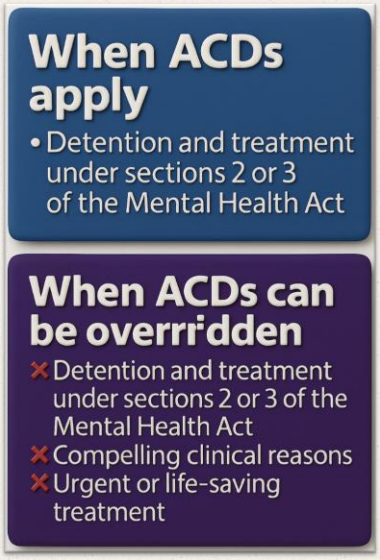
Advance Choice Documents (ACD):
What was the Debate?

- ACDs allow people at risk of detention under the Mental Health Act to record their treatment preferences while they are well.
- Will be a statutory right for patients to create an ACD and for support to create them. Clinicians will be required to inform patients about ACDs and involve them in care planning.
- ACDs will be included in the statutory code of practice, making them a formal part of mental health care. There is broad cross-party support for ACDs as a way to modernise mental health law and reduce racial inequalities.
- Some concerns about implementation challenges, e.g.) digital accessibility and training staff to support patients in creating ACDs.
- Advocacy groups have called for financial considerations to be included in ACDs, as mental health crises often lead to financial difficulties. ***To be clarified in the code.***



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Advance Choice Documents (ACD):
Debates & Outcomes

From the Debates:

- Advance choice documents were discussed as a new right for patients, allowing people to record their wishes, feelings, and decisions about future mental health care and treatment, to be considered if they lose capacity.
- The Minister confirmed that the Bill would require NHS England and Integrated Care Boards (ICBs) to make information and support available to help people create advance choice documents.
- The importance of these documents being respected in decision-making was emphasized, and the Bill includes requirements for clinicians to consider them when making treatment decisions.

Section 130M (Eng) & 130N (Wales):

- NHS England and each ICB (and Local Health Boards in Wales) must make arrangements to:
- Make information about advance choice documents available to people for whom they are responsible.
- Help people create advance choice documents.

Section 130M(3):

An “advance choice document” is a written statement made by a person with capacity specifying their decisions, wishes, or feelings about any relevant matter that may arise if, in the future, they are considered for admission or treatment under the Act and lack capacity or competence at that time.

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Group Exercise:
Advance Choice Documents

In small groups, read the scenarios provided and consider the weight that you would put on the advance choice document in each situation.

- Would you be advocating for the ACD to be followed or overridden?
- Why / why not in each case?

Show your workings out!

Don't forget to nominate someone to feedback ***(or agree to do it together, but no tumble-weed (aka awkward silences) when we come back together please!)***

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Nominated Person:
Mental Health Act 2025

NP can be appointed in advance, at the time of the MHAA or following detention.

If P lacks capacity to make a nomination for NP, the AMHP will appoint one.

Rights of NP to include:

- The right to require an assessment to be made with a view to admitting the patient to hospital **(section 13(4))**.
- The right to apply for compulsory admission or guardianship **(sections 2, 3, 4 and 7).**
- The right to be consulted or informed before an AMHP makes an application for detention under section 3 or guardianship **(section 11(3)-(4)).**
- The right to object to a section 3 admission or guardianship **(section 11(4)).**
- The right to order discharge of the patient **(sections 23 and 25).**
- The right to information given to the detained patient or patient subject to supervised community treatment **(section 132(4)).**
- The right to apply to the Tribunal **(sections 66 and 68(1)).**

PLUS

- **A right to be consulted about statutory care and treatment plans.**
- **A right to be consulted about transfers, renewals and extensions.**
- **The power to object to the use of a CTO.**

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Nominated Person:
Process and Powers

- NP can be selected by a person at any time when they have capacity or competence to do so.
- NP must be aged 16+ (unless person is aged under 16, then NP must be aged 18+).
- The nomination must be witnessed by a health or care professional.
- Witness must confirm: (1) no reason to think the person lacks capacity / competence (2) no reason to think NP is unsuitable, & (3) no undue influence or fraud has been used.
- NP continues to represent the person even if that person subsequently becomes unwell & no longer has the relevant capacity / competence.

Retains all the current powers of the NR.

In addition, new powers:

1) **To be consulted about statutory care & treatment plans.**
2) **To be consulted about transfers between hospitals, and renewals & extensions to the patient's detention or CTO.**
3) **To object to the use of a CTO.**

Can be 'over-ruled' (not displaced) over objecting to section 3 admission, CTO or guardianship, & ordering discharge from detention, CTO, or guardianship.

The RC must, within 72 hours, provide written report that the patient would be likely to act in a manner dangerous to others or themselves.

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The Nominated Person:
Part 3 - Patients

- Currently, some unrestricted patients are given the safeguard of a NR.
- The right to a NP would be extended to all unrestricted patients (including patients remanded for assessment or for treatment, & interim hospital order patients).
- All Part 3 NPs given rights to be consulted about transfers, renewals / extensions, & the patient's care & treatment plan, & can object to a CTO.
- Powers of a Part 3 NP will be more limited (than civil NPs) 'in the interests of justice'.

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The AMHP and Nominated Person

- If the person lacks capacity / competence to nominate, & has not made a nomination, an AMHP may appoint a NP.
- Applies to patients subject to MHA or being considered for detention.
- NP must be aged 16+ (unless person aged under 16, then NP must be aged 18+) or can be a local authority.
- If the person is aged 16+, the AMHP must appoint (1) a 'competent' Donee or deputy (who is willing) or (2) anyone else - considering the person's wishes & feelings.
- If the person aged under 16, the AMHP must give preference to (1) a local authority with PR or (2) anyone else with PR.
- Appointment lasts until, for example, the person gains capacity / competence & nominates, or a new NP is appointed.

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Overruling a Patients Identification:
Nominated Person

If a patient has capacity/competence and has already appointed a nominated person, the AMHP cannot override this.

- If the patient lacks capacity/competence and has not appointed a nominated person, the AMHP may appoint one, taking into account the patient's past and present wishes and feelings.
- For patients under 16, the AMHP must give preference to a local authority or person with parental responsibility, if willing to act.

An AMHP can also terminate the appointment of a nominated person they have appointed (not one appointed by the patient) if:

- The person lacks capacity to exercise the functions of a nominated person,
- The person is otherwise not a suitable person to act as the nominated person, or
- The patient has regained capacity or competence to appoint a nominated person themselves.

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What is Suitable?
Nominated Person

"Suitable" is likely to include considerations such as:

- The person's relationship to the patient.
- Any safeguarding concerns (e.g., risk of abuse, exploitation, or conflict of interest).
- The person's willingness and ability to act in the role.
- Whether the person can understand and carry out the functions of a nominated person.
- Any relevant past or present wishes and feelings of the patient.

- The Code of Practice is expected to provide further guidance on what "suitable" means in context.

- "Suitable" is not defined in law, but AMHPs should consider the person's relationship, safeguarding, willingness, ability, and the patient's wishes when determining suitability.

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NP Objection:
Treatment & Guardianship

- If a nominated person objects to an application for admission for treatment or guardianship by an AMHP:

- The AMHP must consult the NP before making the application (s11 and Schedule A1).

- If the NP objects, the AMHP can only proceed if they certify in writing that, in their opinion, the patient would be likely to act in a manner that is dangerous to other persons or to themselves if not admitted/received into guardianship.

- The "dangerousness override." (Section 11 (4B) – (4C))

  "Dangerousness" is not defined in law but is understood as a likely risk of serious harm (physical injury or death) to self or others, requiring the AMHP to exercise careful, evidence-based professional judgment.

Guess what.....The Code of Practice will provide further guidance

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Termination of the Appointment:
Nominated Person

- County court may make an order terminating the appointment of an NP.
- Application can be made by patient, an AMHP, or any person engaged in caring for the patient or interested in the patient's welfare.

Grounds:

1. NP unreasonably objects to detention, CTO or guardianship.
2. NP exercised discharge powers without due regard to the welfare of the patient or the interests of the public.
3. Patient has done anything which is clearly inconsistent with the NP remaining the patient's NP.
4. NP lacks the capacity or competence to act as a NP.
5. NP is otherwise not a suitable person to act as a NP.

NP can be disqualified from being re-appointed, for the period specified by the court in the order.

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Group Exercise:
NP Suitability & Objection

In your groups, consider the scenarios provided and, in each case, consider:

- Is the identified NP suitable? (or is there someone suitable to be appointed as NP by the AMHP).
- Does the individuals' circumstances warrant override the NPs objection on the basis of dangerousness?
- ***Show your working out!***

Don't forget to nominate someone to feedback ***(or agree to do it together, but no tumble-weed (aka awkward silences) when we come back together please!)***

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Post-Session Reflection Points:

How does what we know inform what we do?

- What is / are your key learning point(s)?
- What else do you need to find out, and how will you find it out?
- How will you use the learning from today in your practice?

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