

# DRAFT MENTAL HEALTH BILL

## EXPLANATORY NOTES

### What these notes do

These Explanatory Notes relate to the draft Mental Health Bill.

- These Explanatory Notes have been prepared by the Department of Health and Social Care and by the Ministry of Justice in order to assist the reader of the draft Bill. They do not form part of the draft Bill and have not been endorsed by Parliament.
- These Explanatory Notes explain what each part of the draft Bill will mean in practice; provide background information on the development of policy; and provide additional information on how the draft Bill will affect existing legislation in this area.
- These Explanatory Notes are best be read alongside the draft Bill. They are not, and are not intended to be, a comprehensive description of the draft Bill.

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# Overview of the Draft Bill

1. The draft Mental Health Bill (the draft Bill) contains a number of amendments to the Mental Health Act 1983 (MHA). It follows the Government's 2017 and 2019 Manifesto commitments to reform the MHA so that:
  - 'patients suffering from mental health conditions... have greater control over their treatment and receive the dignity and respect they deserve'; and
  - 'it is easier for people with learning disabilities and autism to be discharged from hospital, with improvements in how they are treated in law'.
2. The draft Bill includes reforms to:
  - Better ensure that detentions and treatment made under the MHA are necessary, with revisions to the criteria which must be met in order for a person to be detained, treated, or otherwise made subject to the MHA and provide faster, more frequent reviews and appeals of both detentions and treatment;
  - Strengthen the voice of patients – with reforms adding statutory weight to patients' rights to be involved with planning for their care, and to make choices and refusals regarding the treatment they receive;
  - Improve and expand the roles and powers of people who represent detained patients – in particular by allowing patients to choose the person who represents them;
  - Limit the detention of people with a learning disability and/or autistic people under the MHA to 28 days where there is no co-occurring mental health condition, while retaining hospital as a sentencing option under the MHA for offenders with these conditions, and also retaining the facility to transfer patients with these conditions from prison to hospital;
  - Introduce duties on commissioners to improve understanding of the risk of crisis amongst people with a learning disability and/or autistic people in their local area and ensure an adequate supply of community services to prevent inappropriate detentions;
  - Revise the criteria for the use of Community Treatment Orders (CTOs), and enhancing the professional oversight required for any CTO;
  - Remove police stations and prisons as places of safety under the MHA to ensure people experiencing a mental health crisis or with severe mental health needs are supported in an appropriate setting;

- Introduce a new 28-day time-limit for transfers from prison to hospital for prisoners with severe mental health needs to speed up access to specialist inpatient care and treatment;
  - Introduce a new form of supervised community detention for patients convicted of crimes who are ready for discharge from hospital, but who require a continuing deprivation of their liberty in the community.
3. The draft Bill is arranged under fourteen headings:
- Autism and learning disability
  - Grounds for detention and community treatment orders
  - Appropriate medical treatment
  - The responsible clinician
  - Treatment
  - Community treatment orders
  - Nominated persons
  - Detention periods
  - Periods for applications and references
  - Patients concerned in criminal proceedings or under sentence
  - Help and information for patients
  - After-care
  - Miscellaneous
  - General

## Policy background

4. The MHA is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. It provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others. Powers for compulsory admission under the MHA are set out in Part 2 and Part 3. Part 2 of the MHA deals with patients who are detained in hospital and have no criminal proceedings against them. These patients are generally referred to as 'civil patients'. Part 3 of the MHA is concerned with patients who are involved in criminal proceedings or are under sentence.
5. The draft Bill seeks to take forward recommendations for legislative changes made by an Independent Review of the Mental Health Act, which was chaired by Professor Sir Simon Wessely, consultant psychiatrist and professor of psychiatry at King's College London. Sir Simon Wessely was commissioned by the then Prime Minister Theresa May to consider the following issues with the current MHA:
- the reasons for the rising number of detentions under the MHA, which had increased by 40% between 2007 and 2016;

- the disproportionate number of people from black and minority ethnic groups detained under the Act, with black people four times more likely than white people to be detained, and;
  - processes that are out of step with a modern mental health care system
6. The Independent Review published its final report, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion*<sup>1</sup> in December 2018. The Review contained 154 recommendations, covering both legislative reforms and reforms to policy and practice.
7. The Government's Response to the Independent Review was published in its White Paper, *Reforming the Mental Health Act*<sup>2</sup>, on 13 January 2021. In the response, the Government accepted the majority of the Review's recommendations. The subsequent consultation on the White Paper reported in July 2021. Respondents were overall supportive of the reform proposals.
8. This draft Bill takes forward the vast majority of the Independent Review's recommendations and includes a wide range of changes to shift the balance of power from the system to the patient, putting service users at the centre of decisions about their own care. These changes have been informed by the four principles developed by the Independent Review and in partnership with people with lived experience. They are:
- **Choice and autonomy** – ensuring service users' views and choices are respected
  - **Least restriction** – ensuring the MHA powers are used in the least restrictive way
  - **Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged from the MHA
  - **The person as an individual** – ensuring patients are viewed and treated as individuals
9. These four guiding principles have informed the legislative changes the draft Bill will take forward and are reflected across the measures. They are discussed in relation to specific clauses in the *Commentary on Provisions of the draft Bill* section below.

### *Part 3 of the MHA*

10. Part 3 of the MHA is concerned with the care and treatment of offenders with severe mental health needs who are involved in criminal proceedings or under sentence. There are two types of Part 3 patients – unrestricted or restricted:
- a. Unrestricted patients are defendants or offenders without a restriction order who receive a hospital order or transfer direction. This includes patients who were originally subject to restrictions, but whose restrictions have since ended or been lifted. The Secretary of State for Justice does not have involvement in these cases, unless the patient falls into their ambit in another way, for example multi agency public protection cases.

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<sup>1</sup> <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>

<sup>2</sup> <https://www.gov.uk/government/consultations/reforming-the-mental-health-act>

- b. Restricted patients are offenders with severe mental health needs who are detained under Part 3 of the MHA in hospital for treatment and who are subject to special controls by the Secretary of State for Justice. Restrictions are imposed either by a Court or the Secretary of State, for offenders who present a risk to the public. They can take the form of a restriction order, limitation direction or a restriction direction, depending on the type and status of patient within the criminal justice system. The aim of the restricted patient regime is to protect the public from serious harm while at the same time recognising patients' right to access treatment in an appropriate setting.
11. Individuals in contact with the criminal justice system may need to be admitted to hospital for assessment or treatment if they exhibit a severe mental health need. This could be at the point they enter the criminal justice system. In such situations, the Court may issue an order to divert an offender from punishment in the criminal justice system to ensure they receive the appropriate treatment for their needs. On sentencing, a Court may give a section 45A sentence of imprisonment with a hospital component, or a section 37 hospital order, as an alternative to a custodial sentence. A hospital order authorises detention under the MHA for as long as this is required by the offender's mental health needs; there is no maximum term to be served for the purpose of punishment. This means that Part 3 patients may be detained for considerably longer or shorter periods of time than the prison sentence than they might otherwise have received.
12. The Court may also add a restriction order under section 41 of the MHA, if it considers this to be necessary for the protection of others from serious harm. The patient's management will still be determined by a clinical assessment of the patient's need and the risks arising from it, but the restriction order gives the Secretary of State for Justice responsibility for certain key decisions, rather than the responsible clinician (RC). For example, the RC must ask the Secretary of State for consent to transfer a patient from one hospital to another, or to allow the patient leave in the community, or to discharge the patient from hospital into the community.
13. If a prisoner or other detainee develops a severe mental health need whilst in custody, in prison or another place of detention, they can be transferred to hospital for treatment under Part 3 of the MHA by warrant issued by the Secretary of State Justice. This is known as a transfer direction. These patients can also be made subject to restrictions.
14. Part 3 of the MHA is guided by the principle that those who have been accused or convicted of a criminal offence should be able to access equivalent medical care and treatment to civil patients detained under Part 2. There are, however, some areas where reform to the MHA will differ, due to the nature of the different provisions under Part 3. The need to protect the public from those who have been convicted of serious offences and the need to ensure care and treatment is appropriate for the person it serves must be carefully balanced. In some cases, public safety concerns necessitate a higher degree of restriction and compulsion for patients detained under Part 3 of the MHA, when compared to those detained under Part 2. These areas have been clearly set out in relation to specific clauses in the *Commentary on provisions of the draft Bill* section below.

## Legal background

15. The legal background of the draft Bill is set out in the *Commentary on Provisions of the draft Bill* section of this document.

## Territorial extent and application

16. The draft Bill extends to England and Wales, apart from clauses 44 to 48, which extend UK-wide. The MHA contains measures to do with health and social care which are devolved matters, and to do with the criminal justice system, which is reserved. The draft Bill when introduced will make amendments to the MHA, which apply in England and Wales and so will require a Legislative Consent Motion (LCM). Annex A provides an overview of the territorial extent of the draft Bill's clauses, indicating where an LCM will be required and where it will not.

# Commentary on provisions of the draft Bill

## Autism and learning disability

### Clause 1: Application of 1983 Act: autism and learning disability

17. Currently, people with a learning disability and/or autistic people can be detained for both assessment and treatment under section 2 of the MHA, and for treatment under section 3. People with a learning disability and/or autistic people are often subject to lengthy detentions, which often do not provide a therapeutic benefit. Clause 1 and Schedule 1 intend to make it clearer that for the purposes of Part 2 of the MHA, we do not consider autism or learning disabilities to be conditions for which a person can be subject to compulsory treatment under section 3. People with a learning disability and/or autistic people will only be able to be detained for treatment under Part 2 of the MHA if they satisfy the conditions set out in section 3 of the MHA, which includes that they are suffering from a co-occurring mental disorder which is not learning disability or autism.
18. This change in how the MHA applies to patients with a learning disability and/or autistic people under Part 2 of the MHA seeks to end the practice of patients in this group being detained under the MHA in unsuitable long-stay wards and is supported by the guiding principle of least restriction.
19. The revised detention criteria will not apply to people with a learning disability and/or autistic people detained for assessment or treatment under Part 3 of the MHA (i.e., individuals accused of, or serving a sentence for committing a crime). For this cohort, the only alternative to detention in hospital is detention in prison. Extensive consultation with experts following the publication of the White Paper has shown that detention in hospital may be more appropriate, in the majority of cases, than detention in prison to ensure that this cohort are able to access the specialist support they may need. The Ministry of Justice is satisfied that the current detention criteria of people with a learning disability and/or autistic people detained under Part 3 of the MHA enables professionals to make the right decisions for this cohort, including where this requires diversion from criminal justice settings into a hospital setting.
20. Clause 1 amends section 1 of the MHA. Subsection (2) amends the meaning of mental disorder under the MHA in accordance with subsections (3) to (5). Subsection (3) defines “autism”, “learning disability” and “psychiatric disorder”. Autism and psychiatric disorder were not previously defined in the MHA. “Psychiatric disorder” is a new term which covers mental disorder other than learning disability or autism. These changes, which are set out in full in schedule 1, mean that people with a learning disability and/or autistic people cannot be detained for compulsory treatment under section 3 of the MHA unless they have a psychiatric disorder, which by the definition, excludes learning disability and autism.
21. Subsection (4) inserts a new subsection 2A in section 1 of the MHA which sets out that, for the purposes of the MHA, a person’s learning disability has ‘serious behavioural consequences’ if it is associated with abnormally aggressive or seriously irresponsible conduct by the person. Schedule 1 sets out the provisions of the MHA which the “serious behavioural consequences” threshold applies.

22. Subsection (5) omits the previous definition of learning disability under subsection (4) of the MHA.
23. Subsection (6) inserts definitions of “autism”, “learning disability”, “psychiatric disorder” and “serious behavioural consequences” into section 145 of the MHA.
24. Subsection (7) explains the results of the Schedule 1 amendments to the MHA. Schedule 1 amends section 3 of the MHA to prevent individuals from being detained based on their learning disability and/or autism. It also makes related changes in relation to the application of the MHA to autism and learning disability.
25. These changes do not apply for Part 3 patients, who will continue to be liable to be detained pursuant to the previous threshold. Paragraph 8 of Schedule 1 sets out the new definition of “relevant disorder” which applies for Part 3 patients, including autism and learning disability which has serious behavioural consequences. Paragraph 16(3) (read with paragraph 10(b)) clarifies that this definition should apply to discharge assessments by the Tribunal for patients subject to a hospital order, transfer direction and hospital direction. Paragraph 17 provides for the same application for restricted patients. Paragraphs 20 and 21 make transitory modifications to ensure the definition remains consistent in the event these provisions are commenced before section 5, which provides for the new detention criteria.

## Clause 2: People with autism or learning disability

26. Clause 2 inserts a new Part 8A into the MHA which contains clauses specific to those with a learning disability and/or autistic people.
27. People with a learning disability and/or autistic people are often subject to unnecessarily lengthy detentions, which often do not meet their needs and provide little or no therapeutic benefit. For this reason, NHS England issued guidance regarding the holding of reviews – known as Care (Education) and Treatment Reviews – to focus on reducing unnecessarily long stays in hospital and reducing health inequalities.
28. Care (Education) and Treatment Reviews focus on whether a patient with a learning disability and/or autistic patient is safe and receiving the right care and treatment. They also assess if individuals have any specific needs for social care, special educational provision, or medical treatment. The Care (Education) and Treatment Review panel makes recommendations to overcome barriers related to these key lines of enquiry.
29. Care (Education) and Treatment Reviews are part of current NHS England and NHS Improvement policy; however, it has been found that their recommendations are not always being acted upon and there is often no process of follow-up, contributing to the perpetuated detention of people with a learning disability and/or autistic people, often without therapeutic benefit.
30. New section 125A covers the arrangement of care, education and treatment review meetings for children (i.e., those under 18) and adults with an education, health and care plan under the Children and Families Act 2014 detained under certain provisions of the MHA. By placing care, education and treatment review meetings on a statutory footing, the draft Bill seeks to

ensure that the care, treatment and differing support needs of people with a learning disability and/or autistic people - and their families - are met and that barriers to progress are challenged and overcome. This measure supports the principle of the person as an individual.

31. Subsection (1) places a duty on the responsible commissioner to make arrangements for care, education and treatment review meetings in respect of children and adults with an education, health and care plan detained under the MHA (subject to the exceptions set out in this clause) who they consider to have a learning disability and/or autism. This includes certain patients detained under Part 3 of the MHA.
32. Subsection (2) explains what is meant by the term 'care, education and treatment review meeting'. This clause sets out the types of patient needs which should be reviewed as well as what the recommendations made as part of the review should cover. The needs and recommendations set out in this clause are designed to ensure a holistic view is taken of that person's needs and that the most appropriate care and treatment can be provided.
33. Subsections (3) and (4) give further detail on the arrangements referred to under subsection (1). Subsection (3) sets out that the responsible commissioner needs to make arrangements for a report to be produced following a care, education and treatment review meeting, setting out the needs identified, and recommendations made, and distributed within 14 days to certain bodies (listed in 125A(3)(b)). The bodies identified in 125A(3)(b) play a vital role in the individual's care and treatment and this provision will mean they will receive important information to assist them in this function.
34. Subsection (4) sets out that the arrangements must ensure that care, education and treatment review meetings take place within certain periods. The initial care, education and treatment review meeting must take place within 14 days, starting with the applicable day. Further care, education and treatment review meetings must take place at least once every 12 months (from the date of that first review), during which time the patient continues to be detained. These are maximum timings, meaning that care, education and treatment review meetings can take place sooner, and at shorter intervals, than set out in the legislation.
35. Subsection (5) explains what is meant by 'applicable day', and therefore when the number of days during which the initial care, education and treatment review meeting must take place should start to be counted from, under subsection (4). This sets out that the applicable day is determined by when the patient was detained under the MHA (not including any emergency period under section 4), or when the responsible commissioner forms the view that they are autistic or have a learning disability if that is later.
36. New section 125B covers the arrangement of care and treatment review meetings for adults, (including adults without an education, health and care plan under the Children and Families Act 2014), detained under the MHA (subject to the exceptions set out in this clause). This clause makes similar provisions to that in respect of children and adults with an education, health and care plan set out in 125A, though there are key differences. Subsection (4) sets out that arrangements must ensure that care and treatment review meetings take place within certain periods. The initial care and treatment review meeting must take place within 28 days, starting with the applicable day. As with children, and adults with an education, health and care plan, further care and treatment reviews must take place at least once every 12 months (from the date of the first review), during which the patient continues to be detained. As in 125A(4), these are maximum timings, meaning that care and treatment review meetings can

take place sooner, and at shorter intervals, than set out in the legislation. The provisions set out in the section also apply to some patients detained under Part 3 of the MHA.

37. New section 125C requires that the patient's responsible clinician, the responsible commissioner and the appropriate integrated care board must have regard to the recommendations set out in the report produced following the review. This provision is designed to ensure that recommendations made as part of the review process are given proper weight when making decisions over the individual's care and treatment. This will help to provide the individual with the most appropriate support based on their needs.
38. New section 125D sets out the requirement for Integrated Care Boards (ICBs) to establish and maintain a risk register in their area of individuals with a learning disability and/or autistic people who are at risk of hospital admission and monitor their care and treatment requirements.
39. Subsection (1) places a duty on ICBs to establish and maintain a register of people usually resident in its area who the ICB considers to be autistic or have a learning disability and who are at risk of detention under Part 2 of the MHA. This clause is designed to help ensure that ICBs can monitor individuals at risk of detention and put in place the necessary preventative measures to help keep people out of hospitals. It also creates a duty for the Secretary of State to set out in regulations the factors which make an individual "at risk" for detention. This will ensure consistency in how ICBs make decisions as to which individuals are eligible for placement on the register.
40. Subsection (1)(b) clarifies that even if an individual is considered at risk, they will only be added to the register, and as a result have their information used to inform commissioning decisions with their consent. The new risk register does not include Part 3 patients. The accurate collection and monitoring of any justice-related risk factors is beyond the scope of the ICBs role.
41. Subsection (2) explains that the local authority, in which each person included in the register lives in must be specified on the register.
42. Subsection (3)(a) and (b) provides a power for the Secretary of State to make regulations specifying the information an ICB must include for each individual's entry in a register and the format and content of risk registers. Subsections (3)(c) and (d) also provide a power for the Secretary of State to make regulations pertaining to information-gathering by the ICB for the purposes of determining if an individual is eligible for inclusion on the register and onward disclosure of this information. This power is designed to ensure the register is maintained in a consistent manner across ICBs and to enable information to be collected and shared appropriately.
43. Subsection (4) defines the phrase "risk factors for detention under this Act" to mean factors which the Secretary of State considers increase the probability of a person being detained under the Part 2 of the MHA. An ICB will consider such risk factors when deciding whether an individual is eligible for inclusion on the register.

44. New Section 125E sets out that ICBs and Local Authorities will also need to have regard to risk registers and the needs of the local 'at risk' population when carrying out their commissioning duties. These clauses will help ensure the right community provisions are in place for people with a learning disability and/or autistic people to avoid unnecessary admissions to inpatient settings.
45. Subsection (1) sets out that when an ICB is exercising its commissioning functions it must have regard to the information on the register that covers its area and any other information it obtains whilst ascertaining whether an individual is at risk of detention. Further, an ICB must seek to ensure that the needs of people with a learning disability and/or autistic people can be met without detaining them under Part 2. This clause is meant to ensure that an ICB has a particular focus on the needs of people with a learning disability and/or autistic people who are at risk of detention under Part 2 of the MHA when undertaking its commissioning functions.
46. Subsection (2)(a) sets out that a local authority must have regard to any information disclosed by ICBs in relation to the risk registers under the information-sharing power in section 125D(3)(d) when fulfilling its market functions for commissioning adult social care services. Subsection (2)(b) further provides that local authorities, when exercising their market functions must seek to ensure that the needs of people with autism or a learning disability can be met without detaining them under Part 2 of the MHA. The intention of this clause is to help ensure that the necessary adult social care services are available for people with a learning disability and/or autistic people who are or may be at risk of admission in the local area.
47. Subsection (3) provides the definitions of 'commissioning functions', 'market functions', and 'partner local authority' in the section.
48. New section 125F subsections (1) and (2) explain that the Secretary of State must publish guidance about care, (education), and treatment reviews, risk registers and providing community services for Part 8A of the MHA. Responsible clinicians, responsible commissioners, ICBs, and local authorities must also have regard to this guidance when exercising their functions under this part of the MHA.
49. New Section 125G is to be used when interpreting the meaning of the following terms of Part 8A of the MHA: 'appropriate integrated care board', 'local authority', 'responsible clinician', 'responsible commissioner', 'social care provision' and 'special educational provision'.

## Grounds for detention and community treatment orders

### Clause 3: Grounds for detention

50. Clause 3 amends the criteria for detention under section 2, 3 and 5 of the MHA or the criteria for renewal of detention under section 20. It makes provision as to the level of risk that a patient must pose in order to be detained. This will ensure that people can only be detained if they pose a risk of serious harm either to themselves or to others. This change supports the principle of least restriction. Apart from the discharge provisions, these changes do not affect patients who will be detained under Part 3 of the MHA, as orders and directions under this Part already have distinct considerations in relation to risks posed by those in the criminal justice system.
51. Clause 3 subsection (2) amends section 2 subsection (2) (admission for assessment) of the MHA by introducing new wording on risk. The new provisions set out two new tests that must be met to fulfil the criteria for detention: firstly that “serious harm may be caused to the health or safety of the patient or of another person” and secondly that the decision maker must consider “the nature, degree and likelihood of the harm, and how soon it would occur”.
52. The purpose of these changes is to provide greater clarity as to the level of risk of harm that a person must present in order to be detained. Firstly, the “serious harm” test sets out the severity of the harm a patient must pose in order to fulfil the criteria for detention under section 2. Secondly, the “nature, degree and likelihood” test introduces a new requirement that the clinician must consider the likelihood that this harm will occur and how soon, when deciding to admit the individual under section 2.
53. Subsection (3) (a) amends section 3 (admission for treatment) of the MHA. It inserts new wording on risk in alignment with the changes to section 2 described above.
54. Subsection (4) amends the risk criteria for section 5 (detention for six hours pending application for admission) of the MHA, again in alignment with the changes to section 2 of the MHA.
55. Subsection (5) amends the risk criteria for section 20 (renewal of authority for detention of patient detained in pursuance of application for admission for treatment etc) of the MHA, in alignment with the changes to section 3 of the MHA so that when a patient’s detention is renewed, the new criteria will apply.
56. Subsection (6) has the effect of ensuring that the amended risk criteria will apply when a Part 3 patient, who is already subject to orders or directions, has their detention renewed.

## Clause 4: Grounds for community treatment orders

57. Clause 4 amends the criteria for making a community treatment order (CTO) under section 17A of the MHA, and for renewal of CTOs under section 20A, to align with the new risk criteria for detention. Subsection 2 amends section 17A(5) of the MHA to set the same threshold of risk for CTOs as the new risk criteria for detention: firstly that “serious harm may be caused to the health or safety of the patient or of another person” and secondly that the decision maker must consider “the nature, degree and likelihood of the harm, and how soon it would occur”. Subsection (3) substitutes the conditions for renewal of a CTO under section 20A(6) of the MHA with the new risk criteria in section 17A(5).
58. Subsection (4) has the effect of ensuring that the amended criteria for CTOs in subsection 2 applies to Part 3 patients who are already subject to orders or directions. Subsection (5) has the effect of applying the amended criteria in subsection (3) to Part 3 patients who are already subject to a CTO. when they are considered for renewal of that CTO.

## Clause 5: Grounds for discharge by tribunal

59. Clause 5 amends sections 72 and 73 of the MHA which concern the powers of the First-tier Tribunal (Mental Health) and the Mental Health Review Tribunal of Wales (together, the MHT) to discharge patients. The changes in clause 5 subsection (2) align the grounds for discharge of a patient by the MHT with the revised grounds for detention as provided by clause 3. A MHT must discharge a patient where the patient no longer satisfies the revised detention criteria relevant to their detention.
60. The new discharge criteria will apply automatically to unrestricted Part 3 patients, who are discharged under section 72(1)(b), and to restricted patients, who are discharged under section 73, by virtue of clause 5 subsection (3) and (4). Subsection 5(4) has the effect of ensuring these provisions will apply for Part 3 patients who are already subject to orders or directions, the next time they come before the MHT.

## Appropriate medical treatment

### Clause 6: Appropriate medical treatment: therapeutic benefit

61. Clause 6 of the draft Bill inserts a new requirement into the MHA, in line with the principle of therapeutic benefit, that when considering whether medical treatment under the MHA is “appropriate” for a patient, consideration must be given to whether there is a reasonable prospect that the outcome of the treatment would have a therapeutic benefit for that patient. The existing definition of “medical treatment” in the MHA currently requires any medical treatment for mental disorder to have a therapeutic benefit purpose by virtue of section 145 subsection (4) and the clause moves that definition to the front of the MHA, alongside the new definition of “appropriate medical treatment” so that both definitions, and therefore the need for therapeutic benefit to the patient have a prominent position in the MHA.
62. Subsection (2) inserts a new definition of “appropriate medical treatment” into the MHA to require that where medical treatment is required under the MHA to be “appropriate”, the

treatment must have a reasonable prospect of alleviating, or preventing the worsening of, the patient's mental disorder or one or more of its symptoms or manifestations, to ensure that therapeutic benefit is considered both in relation to the purpose and likely outcome of the treatment.

63. This new definition applies to the requirement in the criteria for detention under section 3 and for CTO under section 17A meaning that in order to be detained or put on CTO, there must be a reasonable prospect of the patient's detention or placing on CTO resulting in a therapeutic benefit to the patient, as well as the purpose of the detention or CTO being for a therapeutic benefit.
64. Subsections (3) to (11) of the clause make consequential changes to other provisions of the MHA, which make reference to treatment needing to be "appropriate" so that the new definition of "appropriate medical treatment" applies to them.

## Clause 7: Discharge of prisoners etc from hospital: treatment condition

65. Sections 50 to 53 of the MHA provide for the remission of, or where relevant, the release of, prisoners and detainees with severe mental health needs back to their place of detention when they no longer require treatment. The provisions allow remission when no effective treatment for the mental disorder can be given. This test differs slightly from the detention criteria in the rest of the MHA and is distinguished because these patients in practice may refuse to engage with treatment or behave in a disruptive manner such that treatment cannot practically be given. These provisions allow for remission in cases where treatment is available as a general concept, but the circumstances mean it cannot be given to the patient.
66. Clause 7 retains the 'can be given' aspect of the test but standardises the type of treatment to 'appropriate medical treatment' for consistency with the rest of the MHA. In practice, this change is not considered to have any practical effect.

## The responsible clinician

### Clause 8: Nomination of the responsible clinician

67. Clause 8 makes two amendments to section 34 subsection (1) (Interpretation of Part 2) of the MHA which contains definitions of certain terms used within the MHA. The amendments are to add the term "relevant hospital" and to amend the term "responsible clinician" (RC) to provide that the RC has been nominated by the managers of the relevant hospital.
68. Subsection (2) therefore makes two additions to section 31(1) – firstly (a), which adds a new term "relevant hospital", to mean either the hospital that a patient is liable to be detained in or, for a patient on a CTO, the hospital which is responsible for them, and secondly (b), which extends the definition of "responsible clinician" to specify that the RC has overall responsibility for a patient's care as now, but with the added provision that this is because the managers of the "relevant hospital" have nominated the RC.
69. Subsections (3) to (6) then make consequential amendments throughout the MHA to apply this

extended definition of the RC.

## Treatment

70. Part IV of the MHA deals with the medical treatment of certain detained patients. It does not apply to those subject to community powers under the MHA, such as (for most purposes) patients subject to a CTO who have not been recalled to hospital. Treatment of CTO patients is generally dealt with under Part IV A. Part IV of the MHA therefore applies to children and young people, as well as adult patients (although sometimes there are different rules that apply to children, for example in respect of Electro-convulsive therapy (ECT) under s.58A). A number of the clauses in Part IV of the MHA include measures to ensure that patients are supported as far as possible to partake in decisions regarding their care and treatment and are therefore informed by the principles of choice and autonomy, the person as an individual and therapeutic benefit.

### Clause 9: Making treatment decisions

71. Clause 9 amends the MHA to insert section 56A. This introduces a duty on the clinician in charge of the patient's treatment to consider certain matters and take a number of steps when deciding whether to give treatment under Part IV. This 'clinical checklist' includes, among other things, considering the patient's wishes and feelings as far as reasonably ascertainable, taking reasonably practicable steps to assist and to encourage the patient to participate in treatment decisions, consult those people close to the patient, and identify and evaluate any available forms of medical treatment (see subsection (2)). The intention of this clause is to help ensure that, as far as possible, clinical decisions are based around the patient's wishes, preferences, and individual needs, supporting the guiding principle of choice and autonomy.

72. The duty applies to all treatment given under Part IV of the MHA to any patient, including patients who are consenting, lacking capacity or competence to consent, or withholding consent to treatment (subs (1)).

73. Subsection (2) means that, where the patient lacks the relevant capacity or competence, the clinician must consider any wishes, feelings, views or beliefs they think the patient might have had, if they had the relevant capacity or competence to consent to treatment.

74. Clause 9 also amends other provisions in Part IV to ensure that where certification of treatment is required under the MHA in order for it to be given, the second opinion appointed doctor (SOAD) or, if applicable, the approved clinician (AC), must confirm in writing whether treatment was given in accordance with the duty under s.56A (sub (3)-(5)).

### Clause 10: Appointment of doctors to provide second opinions

75. Clause 10 amends the MHA by inserting new section 56(B) to clarify the role of the regulatory authority (the Care Quality Commission in England and in Wales, the Care Inspectorate

Wales) in appointing a SOAD, referred to currently in the MHA as a 'registered medical practitioner appointed for the purposes of this Part of the MHA by the regulatory authority'.

76. The SOAD acts independently, and under the draft Bill will be responsible for assessing if, for instance, the patient's compulsory treatment has a therapeutic benefit and that the new duty on clinicians under section 56A to consider a number of matters, including the patient's past and present wishes and preferences and available treatment alternatives, has been applied thus supporting the principles of therapeutic benefit and choice and autonomy.

### Section 58 (medicine) – background

77. Currently, section 58 of the MHA applies to medication for mental disorder when three months have passed from the day on which that treatment was first given to the patient during the existing period of detention. It can also apply to other forms of treatment specified in regulations, although no such regulations have been made. Section 58 requires that, after three months have passed, either an AC or a SOAD must certify that the patient is capable of understanding the nature, purpose and likely effects of the treatment. Alternatively, a SOAD must certify that the patient's treatment is appropriate and that the patient is either capable of understanding the nature, purpose and likely effects of the treatment and is not consenting, or the patient is not capable of understanding the nature, purpose and likely effects of the treatment.
78. Clauses 11, 12 and 13 amend section 58 so that, rather than the need for certification uniformly applying to all patients after a specified time period, there will be three new categories of safeguard (see Table 1). These will be organised around whether the patient has or lacks capacity or competence to consent to the treatment in question.

### Clause 11: Medicine etc: treatment conflicting with a decision by or on behalf of a patient

79. Clause 11 amends the MHA to insert section 57A. This introduces new safeguards for patients who are refusing treatment either with capacity or competence at the time, or in a valid and applicable advance decision, or where treatment is in conflict with a decision made by a donee or deputy or the Court of Protection (see subsection (1)). These safeguards only apply to medical treatment for mental disorder falling in the scope of section 58, and those specified in regulations made under section 58 subsection (1)(a). The intention of these new safeguards is to strengthen the right of the patient to inform their own care and treatment, thereby further supporting the principle of choice and autonomy.
80. Section 57A, subsection (3) sets out that, where section 57A applies, and the urgent circumstances under section 62 are not met, then the patient may not be given any forms of medical treatment unless there is a 'compelling reason' to give the treatment and a SOAD has provided certification. In this context, 'compelling reason' constitutes either that no other

alternative forms of appropriate medical treatment are available for the patient’s mental disorder, or that alternative forms of appropriate medical treatment are available, but the patient has not consented, or they are in conflict with a valid and applicable advance decision, or a decision made by a donee or deputy or the Court of Protection (see subsection (4)).

81. Where the clinician in charge of the patient’s treatment considers that the ‘compelling reason’ test is met, a certificate provided by the SOAD must confirm the following in order for treatment to be given: that the treatment in question is appropriate (under the new definition of “appropriate medical treatment” in clause 6); that the decision to give treatment was made by the AC in line with the duty under section 56A; and that in respect of any available alternative treatment/s either the patient has not given valid consent or that they appear to conflict with a valid and applicable advance decision or a decision made by a donee or deputy or the Court of Protection. Subsection (5) further requires that the SOAD must consult two other people who have been professionally concerned with the patient’s medical treatment, as part of the certification process.

### Clause 12: Medicine etc: treatment in other circumstances

82. Clause 12 amends section 58 of the MHA to shorten the ‘three-month time-period’, after which certification must be provided, to two months. This new time period applies where the patient has capacity or competence in respect of the treatment and consents; or where the patient lacks capacity/competence in respect of the treatment (and there is no conflict with any valid and applicable advance decision, or a decision made by a donee or deputy or by the Court of Protection). By strengthening checks and safeguards this clause embeds the principles of choice and autonomy and the person as an individual.

Table 1: Summary of how Clauses 11, 12 and 13 will amend section 58 of the MHA to create three categories of safeguard.

Category	Patient presentation	Conditions for administering treatment
1	Consenting with capacity/competence at the time	The effect of clause 12 is that, if the patient is consenting to treatment, after a period of two months an AC or SOAD must certify that: <ul style="list-style-type: none"> <li>• The patient is validly consenting and</li> <li>• the treatment is appropriate (within the new meaning)</li> </ul>
2	Refusing treatment with capacity/ competence at the time, or the patient lacks capacity and treatment is in conflict with any valid and applicable advance decision or a decision made by a donee or deputy or by the Court of Protection	The effect of clause 11 is that treatment can be given only if there is ‘compelling reason’ to do so and certification has been provided by a SOAD, which must provide that: <ul style="list-style-type: none"> <li>• the treatment in question is appropriate;</li> <li>• the decision to give treatment was made by the AC in line with the duties under section 56A and</li> <li>• in respect of any available alternative treatment/s either the patient has not given valid consent, or they appear to conflict with a</li> </ul>

		valid and applicable advance decision, or a decision made by a donee or deputy or the Court of Protection.
3	Lacks capacity/competence and cannot validly consent to treatment	The effect of clause 12 is that treatment can be given but, after a period of two months, a SOAD must certify that: <ul style="list-style-type: none"> <li>the patient lacks the relevant capacity/competence to consent;</li> <li>the treatment is appropriate.</li> </ul>

### Clause 13: Electro-convulsive therapy etc

83. This clause amends section 58A such that it is no longer the role of the SOAD to certify that the decision to administer ECT is not in conflict with any valid and applicable advance decision, or a decision of an attorney or deputy or the Court of Protection. Instead, this will need to be established prior to the referral to the SOAD, the SOAD must certify the following before treatment can be given: that the patient lacks capacity to consent; that the treatment is appropriate (in line with the new definition in clause 6); and that the decision to give treatment was made in line with section 56A.

### Clause 14: Review of treatment

84. Clause 14 expands the scope of section 61 of the MHA so that it also applies to patients who are found to be consenting to treatment falling under section 58A and section 58, as opposed to only patients who are not consenting to treatment. A report on the treatment and the patient's condition must be given by the AC in charge of the treatment if so required by the regulatory authority. For patients in receipt of section 58 treatments, an equivalent report must be given to the regulatory authority by the AC when the patient's detention is renewed. The regulatory authority has the power to revoke the certificate if provided by a SOAD.

### Clause 15: Urgent treatment to alleviate serious suffering

85. Clause 15 removes the power to administer urgent treatment to patients with the relevant capacity or competence on the basis that it considered immediately necessary to alleviate serious suffering by the patient, as is currently permissible under section 62 of the MHA. In practice, this change allows patients who have capacity or competence at the time to decide on the degree of suffering they are willing to accept, offering patients greater autonomy over their treatment, supporting the principle of choice and autonomy. This change does not apply to patients who lack the relevant capacity, including those who made an advance decision.

### Clause 16: Urgent electro-convulsive therapy etc

86. This clause inserts new section 62ZA, which introduces additional safeguards for patients who

have refused urgent section 58A treatments with capacity/competence, either at the time or in a valid and applicable advance decision, or where the urgent treatment would conflict with the valid decision of a donee or deputy, or a decision of the Court of Protection.

87. Subsection (2) requires that, in order for an AC to administer treatment, a SOAD must first issue a certificate. According to subsection (4) and subsection (5) the certificate must confirm the following: the patient's capacity/competence and that the decision to give treatment conflicts with their refusal either made at the time or in a valid and applicable advance decision or by a donee or deputy or the Court of Protection; that the decision to give treatment was made by the clinician in charge in accordance with section 56A; and that the relevant urgent criteria in section 62 are met.
88. Subsection (6) requires that, before giving a certificate, the SOAD must, if practicable to do so, consult with a nurse who has been professionally concerned with the patient's medical treatment, who is neither the RC nor the AC in charge of the treatment in question, and the patient's nominated person (see clause 21).
89. Due to the urgent nature of the SOAD's role, subsection (7) states that the request must be made as soon as is reasonably practicable, so that the regulatory authority can, in turn, appoint a SOAD as soon as possible.
90. Clause 16 inserts new section 62ZB which creates regulation making powers that can be exercised by the appropriate national authority (within the meaning given by section 58A(10)). Section 62ZB(1) provides the appropriate national authority with the power to amend the MHA to set out the circumstances where the AC can certify the use of urgent ECT, instead of the SOAD. This is to allow for treatment to go ahead, without the SOAD's approval, in exceptional circumstances.
91. Section 62ZB(2) gives the appropriate national authority the power to impose duties on the following by way of regulations: (a) the managers of hospitals or registered establishments; (b) approved clinicians, or (c) the regulatory authority, for the purpose of ensuring that the SOAD's certificate of treatment is given within a specified time period. Regulations under this section may make provision to specific exceptions, such as applying section 62ZA to certain types of treatment under section 58A but not others, and for different cases, such as where the patient lacks the capacity or competence to consent to the treatment.
92. Subsection (7) amends section 119 of the MHA to provide that, where a SOAD is required to interview or examine the patient to establish if the administration of urgent ECT should be certified, they may conduct this function by live video or audio link, if appropriate, by live video or audio link.

## Clause 17: Capacity to consent to treatment

93. Under the current MHA, the patient's mental capacity or competence to consent to or refuse treatment is expressed by reference to whether the patient is "capable of understanding the

nature, purpose and likely effects” of that treatment. In clinical practice, this is understood to refer to capacity or competence. This position is confirmed in the Code of Practice. Clause 17 amends this wording to references to ‘capacity or competence to consent’. While this amendment is not expected to create a practical change in clinical approaches to assessing capacity or competence, this change confirms the shared legal framework between the MHA and the Mental Capacity Act 2005 Act (the 2005 Act). It also brings Part 4 in line with Part 4A of the MHA, which already adopts this terminology.

94. Subsection (6) provides that references in the draft Bill to “capacity” are applicable to patients who are aged 16 or older, references to “competence” are applicable to patients under the age of 16.
95. Subsection (6) also clarifies that references to an advance decision made by a patient are within the meaning of the 2005 Act. References to “valid and applicable”, in relation to an advance decision, means valid and applicable to the treatment in question in accordance with section 25 of the 2005 Act. References to a “donee” are to a donee of a lasting power of attorney created by the patient, within the meaning of section 9 of the 2005 Act, where the donee is acting within the scope of their authority and in accordance with that Act. References to a “deputy” are to a deputy appointed for the patient by the Court of Protection under section 16 of the 2005 Act, where the deputy is acting within the scope of their authority and in accordance with that Act.

## Clause 18: Care and treatment plans

96. The draft Bill will introduce statutory care and treatment plan with respect to certain patients. This applies to England only, as there is a similar system already in place in Wales.
97. Where appropriate, clinicians will be required to prepare and regularly review a personalised care and treatment plan for certain patients detained under the MHA. This should set out how the patient’s current and future needs, arising from or related to their mental disorder, will be met. The intention is that the plan will also provide evidence of important clinical decisions, such as the reasons behind the individual’s detention, as well as evidence of how the patient and those close to them have been included in care and treatment decisions. This clause supports the principles of choice and autonomy, the person as an individual and therapeutic benefit.
98. Clause 18 amends Part 10 of the MHA and inserts section 130ZA, which covers who is eligible to receive the plan, who is responsible for the plan, the scope of the plan and how it should be prepared, and how often it should be reviewed. The clause also inserts section 130ZB on how the plans will be monitored to ensure that they are of sufficient quality.
99. Subsection (1) requires that the appropriate practitioner (AP), as defined in section 34, prepares a care and treatment plan, in respect of certain patients. Subsection (2) identifies the groups of patients to which the requirement to prepare a care and treatment plan applies, including: those liable to be detained in England excluding under certain provisions, patients who are subject to guardianship where the relevant local authority is England, and patients being treated in the community with a responsible hospital in England. This excludes patients

detained under “short-term” sections (sections 4, 5 subsection (2) or (4),) detention in a place of safety under emergency powers in sections 135 or 136 of the MHA, or where there is a direction for Part 3 patients under section 35 subsection (4), 36 subsection (3), 37 subsection (4), 38 subsection (4) or 45A subsection (5), as these patients are not detained long enough to obtain a benefit from a plan.

100. Subsection (3) provides that the plan is a document containing a plan for meeting the patient’s current and future needs, arising from or related to their mental disorder, made in accordance with regulations made by the Secretary of State. The plan can include both the patient’s care and treatment and also wider issues such as those relating to the patient’s life in the community, like their employment and accommodation where that is to meet a need described above. In addition, the plan may also contain other information: - subsection (3)(b) gives the Secretary of State the power to make regulations regarding any other information to be included the care and treatment plan. Pursuant to subsection (4), the regulations may include ‘information’ about the patient, those with whom the patient has a relationship with, or other connection to, or those to whom the plan is relevant, if this information is for purposes related to meeting the patient’s current or future needs, or for the purposes of reviewing or revising the plan. For example, if the patient has a learning disability, the plan could include how adjustments will be made to communicate information to the patient appropriately, or information relating to the family members the patient wishes to be involved in their care and any updates to their plan (see subsection 4). For patients detained under Part 3 of the MHA, this may also include other information related to the victim(s) of the crime the patient has been accused or convicted of, and any criminal justice involvement such as Multi Agency Public Protection Arrangements to protect members of the public. The overall purpose of the regulation making power is to create a consistent framework that clinicians must follow when they make a patient’s plan, helping to ensure that the relevant patients have a plan which sets out their individual needs and how they will be met so that they can progress towards recovery as quickly as possible.
101. Subsection (5) introduces requirements around when the plan should be reviewed, such as if the patient’s case is to be considered at a MHT hearing, following a care, (where appropriate) education and treatment review meeting (relevant for patients with a learning disability or autistic patients – see clause 2, subsection (2)), or when certain people, including the patient or their NP, make a reasonable request. By setting out clear trigger points, the aim is to ensure that the AP keeps the plan up to date and ensures that it reflects the circumstances of the patient’s case.
102. Subsection (6) requires that when the practitioner prepares or reviews the plan that, where practical and appropriate, they do so in consultation with the patient, and others, such as family members engaged in the welfare of the individual, the patient’s NP, and their independent mental health advocate. The intention is that the plan is prepared in direct collaboration with the patient, or where they are not well enough to engage, those close to them, so that the plan is built around the patient’s wishes, preferences, and individual needs, as far as possible. This aims to reflect the guiding principle of choice and autonomy.
103. Subsection (7) gives the Secretary of State the power to make regulations regarding the circumstances under which a patient’s plan should be revised, and by which point in time the

contents of the plan should be prepared, as well as when it must be reviewed (under subsection (5)) and revised, where applicable.

104. Subsection (8) gives the Secretary of State the power to make regulations regarding the disclosure of information contained in the patient's plan, or information held for the purposes of meeting the requirements associated with the plan. For example, this might include the sharing of information regarding the patient or those who the patient wishes to be involved and consulted on their care, between inpatient and community services, to help facilitate the safe and effective discharge of the patient.
105. Subsection (9) specifies that the provisions made in regulations under section 130ZA may be specific to certain groups of patients, or different cases, or transitional, consequential, incidental or supplemental provision. For example, provisions may be made specifically in relation to restricted patients, who are subject to controls by the Secretary of State for Justice, which do not apply to civil patients.
106. The clause inserts new section 130ZB, which sets out how patients' plans will be monitored. Subsections (1) and (2) impose requirements on the managers of a hospital (within the meaning of section 145) or a registered establishment in England, or a local social services authority, whichever is relevant, to make arrangements to ensure that plans are prepared in accordance with the relevant duties imposed by section 130ZA. If the responsible authority considers that a patient's plan should be reviewed, they should also make arrangements for the AP in charge of the plan to be requested to review it (subsection (3)).

## Community treatment orders

### Clause 19: Consultation of the community clinician

107. Clause 19 amends section 17A of the MHA to require the community clinician responsible for overseeing the patient's care as a community patient, to be involved in decisions regarding the use and operation of CTOs. This covers the decision to make a person subject to a CTO, to vary or suspend conditions made under a CTO, to recall to hospital a patient subject to a CTO, to revoke a CTO after a patient has been so recalled, and to discharge a patient from a CTO.
108. In introducing a further professional opinion and check on whether people really need the support of a CTO and in requiring more evidence that a person otherwise presents a risk, or needs the CTO to support a benefit to their mental health, the principle of least restriction and therapeutic benefit is supported.
109. The clause makes a new distinction between a patient's RC with overall responsibility for them including in hospital, and a community clinician, with the responsibility for the patient in the community, and the clause imposes specific duties on the latter, where the community clinician is not the RC. The community clinician is defined in the amendment to section 34 subsection (1), in clause 19 subsection (8), as the AC (as defined in section 145 subsection (1) of the MHA) overseeing the patient's care as a community patient, or who would oversee the patient's care if they were to become a community patient.
110. Subsection (2) amends section 17A(4) of the MHA, to require that if the patient's RC in

hospital expects that another AC will be responsible for the patient's care in the community after discharge, then that community clinician must also agree in writing that the CTO criteria are met and that the CTO is appropriate. This achieves two aims – continuity of care of the patient from the hospital into the community and additional professional oversight.

111. Subsection (3)(a) amends section 17B(2) of the MHA so that a CTO may only specify conditions with the agreement of the community clinician, in addition to the approved mental health professional, as is currently required under section 17B(2).
112. Subsection (3)(b) inserts new subsection 17B(5A), which adds a new requirement that a patient's RC must consult a community clinician who has been involved with the patient's medical treatment in the community, unless the RC has so been involved, before varying or suspending conditions made as part of a CTO. The intention is that the opinion of a community clinician is considered in these circumstances by the hospital RC.
113. Subsection (4) inserts new subsection 17E(2A) to require that, before a RC recalls a patient under a CTO to hospital to provide medical treatment for medical disorder or to manage a risk of harm to the patient or others, they must first consult the community clinician where practicable.
114. Subsection (5) inserts new subsection 17F(4A) to require that, after a patient has been recalled to hospital, and before a RC revokes the CTO to place the patient back on a hospital section, they must first consult the community clinician where practicable.
115. Subsection (6) makes amendments to section 20A to require that, when extending a patient's CTO period, the RC, if they are not the community clinician, must secure a statement in writing from the community clinician that they are satisfied that the CTO criteria in section 20(A)6 are satisfied.
116. Subsection (7) makes amendments to section 23 in relation to discharge of patients to require that the RC or the hospital managers must consult the community clinician before providing a written order to discharge the patient from the CTO.
117. Subsections (9) and (10) amend section 80C (removal of patients subject to compulsion in the community from Scotland) and section 85ZA (responsibility for community patients transferred from Channel Islands or Isle of Man). Currently, these sections state that as soon as practicable after the patient's arrival at the place where they are to reside in England or Wales, the RC shall specify the conditions to which they are to be subject to the CTO. Subsections (9) and (10) add that that these conditions must be that which the Approved Mental Health Care Professional (AMHP), as currently, and community clinician have agreed should be specified.

## Clause 20: Conditions of community treatment orders

118. Clause 20 makes two amendments in relation to the conditions that a person subject to a CTO may be required to follow.
119. Subsection (1) deletes the words "or appropriate" from the phrase "necessary or appropriate" in section 17B(2), to provide that conditions are only made when they are actually necessary

to serve one or more of the purposes specified.

120. Subsection (2) inserts section 72(3B) and provides a new power for the MHT to recommend that the RC reconsiders whether a particular CTO condition is necessary, in cases where a MHT has decided not to discharge a patient from a CTO.

## Nominated persons

121. Clauses 21, 22 and 23 introduce a new statutory role to the MHA– the nominated person (NP) – to replace the nearest relative (NR). The MHA provides for the role of the NR. It sets out a hierarchical list of ‘relatives’ and includes a number of rules for identifying the NR from this list. The Independent Review highlighted that service users and stakeholders consistently found the current model of family and carer involvement outdated and insufficient. This was found to be particularly true of the current NR provisions.
122. The general intention of this reform is that, in place of the NR, a patient would be able to personally select the NP to represent them and exercise the relevant statutory functions which the draft Bill extends. This supports the policy objective of improving support for detained patients and is linked to the wider policy intention to ensure that the views, experiences and expertise of patients are taken into account more fully and more seriously in their care and treatment, by allowing an individual to express their wishes through someone they know and trust. In doing so, these measures support the principle of choice and autonomy.
123. Following the reforms, an NP can be selected by the patient at any time when they have capacity / competence to do so. Typically, it is envisaged that nominations would be made:
- a. In advance of the detention – this could be done via a document that has been signed by the person, the NP and ‘validated’ by a health or social care professional. This would include for instance when a patient has been admitted to hospital informally.
  - b. At the time of the MHA assessment – the AMHP would be required to check if a valid nomination has been made, and if not (assuming that the person has the relevant capacity/competence), they could explain what the nomination process involves and see if the person wanted to make a nomination.
  - c. Following detention – a patient would be able to nominate someone to be their NP at any time when they have capacity / competence to do so (by following the same process that applies to a nomination in advance of the detention).
124. If someone lacks the relevant capacity / competence to make a nomination at the point of detention or at any other time, and has not previously nominated anyone, a NP can be appointed by an AMHP. This NP can be in place until the person has the relevant capacity / competence to make their own nomination and does so.

### Clause 21: Nominated person

125. Clause 21 introduces Schedule 2 and describes its contents. The Schedule deals with the appointment of a NP and transfers existing functions conferred on the nearest relative. The new functions conferred on a NP are provided for by clauses 22 to 25.

## Clause 22 - Applications for admission or guardianship: role of nominated person

126. The NR currently has a number of important rights and functions under the MHA, including:

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

127. The existing NR powers listed in the paragraph above will be transferred to the NP role. In addition, the NP would be given the following new powers and rights:

- a. A right to be consulted about statutory care and treatment plans.
- b. A right to be consulted about transfers between hospitals, and renewals and extensions to the patient's detention or CTO; and
- c. The power to object to the use of a CTO.

128. Currently, if the NR exercises one of their powers (e.g., the ability to block admission), but the AMHP believes the grounds for this are unreasonable, the only means of overruling them is to remove or displace them as the NR. This can prevent the NR from continuing in their statutory role in supporting the patient while they are detained, even though they may be best equipped to protect and promote the patient's interest.

129. As the NP will have been identified by the patient as someone they wish to be involved in representing them when detained under the MHA, it is important that the NP's use of a power can sometimes be temporarily overruled, as opposed to the NP being removed or displaced, to ensure that where appropriate they continue to have a role in the patient's care and treatment while they are detained.

130. The NP powers to which overruling would apply are the following:

- a. The right to object to section 3 admission or guardianship;
- b. The new right to object to the use of a CTO; and
- c. The right to order discharge of the patient from detention, CTO, or guardianship.

131. The process in which the use of an NP power can be overruled is via section 25 of the MHA (i.e., the barring order). Currently, under section 23, the NR can order a patient's discharge

from detention or from a CTO (where this follows detention under section 3). The NR must give 72 hours' notice in writing to the hospital.

132. The NR's order may be barred if, within the 72 hours, the patient's RC provides a written 'barring' report that they consider that the patient, if so discharged, 'would be likely to act in a manner dangerous to other persons or to himself' (under section 25).
133. The barring report prevents the NR from ordering discharge at any time in the six months following the date of the report. This time period has been amended by the draft Bill to three months in order to align with the updated detention periods set out in these reforms. This is set out under clause 23.
134. Under section 66, if the patient is detained under section 3 or on a CTO following section 3, then the nearest relative may, within 28 days of the barring report being issued, apply to the MHT for the patient's discharge instead.
135. All of the above relating to the barring order will apply for the NP.

#### *Changes in the draft Bill*

136. Clause 22 subsection (2) inserts references to NP into section 11 so that the AMHP should be required to consult the NP before they make an application for admission for treatment or guardianship (unless it is not reasonably practicable, or it would involve unreasonable delay). This also amends section 20, requiring the RC/AP to consult the NP before providing a report for the purposes of renewal of detention or guardianship.
137. The NP can object to the making of an application for admission for treatment or the making of a guardianship application by notifying the AMHP or the local social services authority on whose behalf the professional is acting. Where an NP objects to the making of an application, the application may be made only if it is accompanied by a report certifying that in the opinion of the AMHP, the patient if not admitted for treatment or received into guardianship, would be likely to act in a manner that is dangerous to other persons or to themselves.
138. Section 66, which refers to the NR's right to apply to the MHT for the patient's discharge, is also being amended to apply to the NP and apply where their objection to detention, and guardianship is being overruled.

#### **Clause 23: Discharge of patients: role of nominated person**

139. Clause 23 substitutes the word NP for NR in section 25 of the MHA (restrictions on discharge by nearest relative). The current time limit of six months (i.e., the NR can't make another order for the discharge of the patient during six months within the date of the report) is also changed to three months. This is to reflect the changes in detention periods from six months to three months.

## Clause 24: Community treatment orders: role of nominated person

140. This clause inserts the new section 17AA 'Community treatment orders: role of NP'. Before the RC makes a CTO, they must consult the patient's NP (unless it is not reasonably practicable, or it would involve unreasonable delay). A patient's NP may object to the making of a CTO by notifying the RC.
141. Where the NP objects to the making of a CTO by notifying the responsible clinician, the CTO may not be made unless the RC certifies in writing that it is their opinion that the patient should be discharged and if discharged without a CTO being in force, the patient would be likely to act in a manner that is dangerous to other persons or to themselves.
142. Section 66, which refers to the NR's right to apply to the MHT, is also amended to cover objections by the NP under section 17AA(3) (making a CTO) (subsection(5)).

## Clause 25: Transfer of patients: role of nominated person

143. Clause 25 establishes a new right for NPs is to be consulted about transfers between hospitals. It amends section 19 so that before deciding to transfer a patient between hospitals, the person responsible for taking that decision must consult the patient's NP, unless consultation is not reasonably practicable or would involve unreasonable delay.

## Schedule 2 Part 1 Nominated person: appointment and removal

144. Schedule 2 inserts section 30A and section 30B into the MHA.
145. New section 30A introduces new Schedule A1 which confers the power to appoint an NP for a patient for the purposes of this MHA and makes provision about the duration of the appointment.
146. New section 30B 'Power of court to terminate appointment of NP' replaces section 29, which sets out the procedure for displacement of an NR. It provides that the county court may make an order terminating the appointment of an NP. An order may be made on the application of the patient, an AMHP, or any person engaged in caring for the patient or interested in the patient's welfare.
147. The county court may make an order terminating the appointment of an NP. An order may be made on the application of the patient, an AMHP, or any person engaged in caring for the patient or interested in the patient's welfare.
148. An application for an order under this section may only be made on the grounds that –
- the NP unreasonably objects to the making of an application for admission for treatment, or a guardianship application in respect of the patient..
  - the NP has, without due regard to the welfare of the patient or the interests of the public, exercised the power to discharge the patient under this Part of the MHA or is

likely to do so.

- the NP unreasonably objects to the making of a CTO in respect of the patient
- the patient has done anything which is clearly inconsistent with the NP remaining the patient's NP. This is intended to ensure that the person does not become locked-in with a nomination they wouldn't want. For example, where the patient clearly does not like their NP but lacks capacity to revoke them, and the criteria for displacement are not met.
- the NP lacks the capacity or competence to act as a NP.
- the NP is otherwise not a suitable person to act as a NP.

149. Where an order under this section terminates the appointment of an NP for a patient, the person is disqualified from being re-appointed, for the period specified by the court in the order.

### Schedule A1: Nominated person – Part 1: Appointment of nominated person by a patient

150. Schedule A1 concerns the appointment of an NP by a patient. A person (the "patient") may appoint a person to act as their NP for the purposes of the MHA.

151. An individual is eligible to be appointed as an NP only if the person meets the age requirement of being 16 or over (or 18 or over if the patient is a child under the age of 16), and as long as the person is not disqualified by section 30B(6) (disqualification as a result of court order terminating previous appointment as a NP).

152. The appointment of an NP under this Part of this Schedule is valid only if the person is eligible to be appointed as an NP and the appointment is made by an instrument in writing. This must be signed by the patient in the presence of a health or care professional or independent mental health advocate ("the witness") and contain a statement, signed by the NP in the presence of the witness, that the NP meets the age requirement and agrees to act as the NP.

153. The witness must sign a statement to confirm that the instrument was signed by the patient and the NP in the presence of the witness, and that the witness has no reason to think that:

- the patient lacks capacity or competence to make the appointment
- the NP lacks capacity or competence to act as the NP
- fraud or undue pressure has been used to induce the patient to make the appointment
- the NP is unsuitable to act as an NP.

154. The appointment of an NP under this Part of this Schedule ceases to have effect if the NP dies, the patient appoints a different NP, the patient terminates the appointment, the NP resigns, the county court terminates the appointment, or an AMHP appoints another NP for the patient under Part 2 of this Schedule.

155. The appointment of an NP may be terminated by the patient (giving the NP written notice). The notice must be signed by the witness and contain a statement that the notice was signed by the patient in the presence of the witness, stating that the witness has no reason to think that the patient lacks capacity or competence to terminate the appointment, or that fraud or

undue pressure has been used to induce the patient to terminate the appointment.

156. An NP may resign by giving signed written notice to the patient and either an AMHP, the relevant patient's RC (if any), the relevant managers (i.e. hospital manager) or the relevant local social services authority (in respect of guardianship).

## Part 2 of this Schedule concerns the appointment of nominated person by an AMHP

157. Where an AMHP reasonably believes that a patient lacks capacity or is not competent to appoint an NP and has not appointed a person under Part 1 of this Schedule to act as their NP, the AMHP may appoint an NP for the patient for the purposes of the MHA.

158. A person is eligible to be appointed as an NP under this Part of this Schedule only if the person is an individual who meets the age requirement or is a local authority for the patient and is not disqualified as a result of a court order terminating previous appointment as an NP.

159. Where an AMHP is deciding who to appoint as an NP for a patient who is aged 16 or over, if the patient has a 'competent' donee or deputy who is willing to act as the NP, the AMHP must appoint the donee or deputy. In any other case, the AMHP must, in deciding who to appoint, take into account the patient's past and present wishes and feelings so far as reasonably ascertainable.

160. Where an AMHP is deciding who to appoint as an NP for a patient who is aged under 16, the AMHP must give preference to (if the person is willing to act as the NP), firstly a local authority with parental responsibility for the patient, and secondly, any other person who has parental responsibility for the patient. In any other case, the AMHP must, in deciding who to appoint, consider the patient's past and present wishes and feelings so far as reasonably ascertainable.

161. The appointment of an NP by an AMHP is valid only if the person is eligible to be appointed as an NP, the person agrees to act as the NP, and the appointment is made in writing and signed by the professional.

162. An NP must either be an individual or a local authority (including but not limited to the authority with parental responsibility of the patient). There are no other legal entities that can be the NP.

163. Where an AMHP appoints an NP, the AMHP must notify the patient and the relevant (hospital) managers or social services authority in the case of guardianship, who then must take steps to inform the relevant patient of the appointment.

164. The appointment of an NP by an AMHP ceases to have effect if in the case of an individual, they die, an AMHP appoints a different NP, an AMHP terminates the appointment, the relevant patient terminates the appointment, the NP resigns, the county court terminates the appointment under section 30B, the patient appoints a different NP under Part 1 of this Schedule, or the person for whom the NP was appointed ceases to be a relevant patient.

165. Where an AMHP has appointed an NP for a patient, the AMHP may terminate the appointment by giving the NP and the patient written notice. Notice should also be provided to the relevant (hospital) managers or the relevant social services authority (in the case of guardianship). The appointment may only be terminated by an AMHP on the grounds that the person lacks capacity to exercise the functions of an NP, the person is otherwise not a suitable person to act as the NP, or the patient has regained capacity or competence to appoint an NP under Part 1 of this Schedule. An NP appointed by an AMHP may also resign by giving the patient and either the AMHP, the relevant patient's RC, the relevant (hospital) managers or the relevant local social services authority, where appropriate, a signed written notice.

### Part 3 of this Schedule concerns patients concerned in criminal proceedings etc: functions of the Nominated Person

166. Under current legislation, certain unrestricted Part 3 patients have been conferred the safeguard of an NR. However, the MHA does not currently extend the safeguard of an NR to restricted Part 3 patients, to Part 3 patients remanded to hospital under sections 35 or 36, or to Part 3 patients subject to an interim hospital order under section 38.

167. Paragraph 26 addresses this and introduces section 36A (Remands to hospital: NP) into the Act. Under this paragraph, new section 30A, new section 30B and schedule A1 are made applicable to patients that have been remanded to hospital under section 35 for assessment and section 36 for treatment. Under Paragraph 27, new section 30A, new section 30B and schedule A1 are also made applicable to patients subject to an interim hospital order under section 38. These paragraphs therefore confer the power to appoint an NP to all these patients. Paragraph 28 gives an NP for an unrestricted Part 3 the right to be consulted about transfers between hospitals, renewals and extensions to the patient's detention and patient's care and treatment plan, unless consultation is not reasonably practicable or would involve unreasonable delay; and the power to object to the use of a CTO.

168. The powers conferred to an NP for Part 3 patients have been limited in the interest of public safety and criminal justice. Paragraph 29 limits an NP for a restricted patient's powers to the following (whilst NPs for interim patients only have powers [a] and [b]):

- a. The right to receive information from the hospital about the patient's care and detention, unless the patient objects to this;
- b. The right to be consulted about the patient's statutory care and treatment plan; and
- c. The right to be consulted about transfers between hospitals unless consultation is not reasonably practicable, would involve unreasonable delay, or is inappropriate. In circumstances where the Secretary of State for Justice is exercising their duty under sections 41 and 42 of the Act to protect the public from harm, and consultation with an NP would not alter the outcome, consultation would be inappropriate. Therefore, an NP's right to be consulted about transfers will be disappplied. An NP should nevertheless be informed about the transfer as soon as is practical.

## Detention periods

### Clause 26: Detention periods

169. Clause 26 shortens the period that a patient may be kept in detention for treatment. This change will mean that a patient's initial detention period will expire sooner and if the patient's detention is to continue it must be reviewed and renewed more frequently. The guardianship periods remain unchanged. This clause is informed by the principle of least restriction and therapeutic benefit.
170. Subsection (2) inserts a new subsection (2A) into section 19 of the MHA. The effect of this provision is to treat guardianship patients who are transferred to hospital, for the purpose of section 20, as having been admitted for treatment on the date that they are transferred.
171. Subsection (3) substitutes section 20 subsection (1) and (2) of the MHA and also inserts a new section 20(2A). Subparagraph (a) of the amended section 20 subsection (1) provides that a patient may not be kept in detention for treatment for longer than three months without the authority for the patient's detention being renewed. Subparagraph (b) of the amended section 20 subsection (1) retains the six-month initial detention period for guardianship patients.
172. The new section 20 subsection (2) of the MHA will provide for shorter detention periods where the authority for detention from the expiration of the period referred to in section 20(1)(a) is renewed. Relevantly, the new section 20 subsection (2)(a) provides that the authority for a patient who is detained in hospital for treatment, can be renewed for a further three months. This amendment shortens the subsequent detention period from six months to three months. Section 20 subsection (2)(b) provides that the authority for detention from the expiration of the period referred to in section 20 (2)(b) may only be renewed for a further six months. This shortens the subsequent detention period from one year to six months. Thereafter, section 20 subsection (2)(c) allows for the authority to detain a patient for treatment to be renewed for successive periods of one year.
173. The new subsection (2A) retains the existing periods of renewal for guardianship. The authority to detain a patient under guardianship can be renewed after the initial six months of detention for a further period of six months, and thereafter for successive periods of one year.
174. Clause 26 subsection (4) amends section 21B to insert references to the new section 20 subsection (2A) at sections 21B subsection (5) and (6)(b) so that the section cross refers where appropriate to the new amended detention period provisions.
175. Clause 26 subsection (5) amends Part I of Schedule 1 of the MHA, which applies the provisions of Part 2 of the MHA, with modifications to unrestricted Part 3 patients. The effect of these amendments is to apply the shortened detention periods under section 20 subsection (1) and (2) to unrestricted Part 3 patients who have been transferred from guardianship to hospital or whose CTO is revoked, and the revocation occurs six months after the original hospital order was made. For all other unrestricted Part 3 patients the periods under section 20 subsection (1) and (2) are modified, so that the initial detention period for these cohort of patients remains six months. This is because hospital orders are made by the sentencing court and as such the initial

detention for these patients will have been subject to a robust judicial-led process. Where such patient's detention is to continue the authority for detention can be renewed for a further six months and thereafter yearly.

176. Clause 26 subsection (6) amends Part II of Schedule 1, paragraph 5, which applies certain provisions of Part 2 of the MHA to restricted Part 3 patients. The new section 20 subsection (2A) is not relevant to restricted Part 3 patients and is therefore omitted.

## Periods for applications and references

177. In England, the First-tier Tribunal (Mental Health), which is part of the Health, Education and Social Care Chamber of the First-tier Tribunal and, in Wales, the Mental Health Review Tribunal (together "the MHT"), are independent judicial bodies which have the power to direct the discharge of a patient or recommend the discharge of certain offender patients subject to special restrictions, where it considers that the patient should no longer be detained under the MHA.
178. A patient's detention is reviewed by the MHT on application by or on behalf of the patient, on referral from the Secretary of State (or in Wales by Welsh Ministers) or on referral by hospital managers for certain patients, where a patient's case has not been considered by the MHT within a specified period.
179. The draft Bill proposes amendments to extend the period in which a patient may apply to the MHT and extend the existing referral system to increase the frequency and widen the group of patients in respect of whom, referrals to the MHT must be made ("automatic referrals").
180. These changes are intended to ensure patients have greater access to the MHT and those patients who lack the ability or initiative to make an application to the MHT can benefit from a safeguard of increased independent judicial scrutiny of their detention by the MHT, on a more regular basis. This measure is informed by the principle of least restriction.

### Clause 27: Periods for tribunal applications

181. Clause 27 will extend the period in which a patient admitted in pursuance of an application for assessment may apply to the MHT to be discharged from detention. Clause 27 also provides conditionally discharged patients the right to apply to the MHT for a review of their detention.
182. Subsection (1)(a) amends section 66(2)(a) of the MHA (applications to MHTs) to extend the period in which a patient who is detained in hospital pursuant to an application for assessment, can apply to the MHT from 14 days to 21 days, beginning with the day on which the patient is admitted.
183. Subsection (1)(b) amends section 66(2)(b) of the MHA, to reduce the period in which a patient who is admitted to a hospital in pursuance of an application for admission for treatment, can apply to the MHT, from six months to three months. This change reflects the amendments

made by clause 26(3), which shortens the initial detention period for patients admitted for treatment under section 3 from six months to three months.

184. Subsection (2)(a) amends section 75(1) to clarify that conditionally discharged means a patient who is discharged under section 42(2), 73 or 74 of the MHA.
185. Subsection (2)(b) amends section 75(2) to clarify that conditionally discharged patients, who are not subject to conditions amounting to a deprivation of liberty under the 2005 Act (“DoL conditions”) can make an application to the MHT for a review of their detention between 12 months and two years from the date on which the patient was conditionally discharged or ceased to be subject to DoL conditions, and thereafter every two years.
186. Subsection (2)(c) inserts a new subsection (2A) after section 75(2) of the MHA to provide patients who are conditionally discharged and subject to DoL conditions the right to make an application to the MHT between six months and 12 months from the date on which the patient became subject to the DoL conditions and thereafter every two years.

## Clause 28: References to tribunal

187. Clause 28 amends the MHA in relation to automatic referrals by hospital managers for Part 2 patients and mentally disordered offenders who are not subject to special restrictions (“unrestricted Part 3 patients”).
188. Subsection 4(b) amends section 68 subsection (2) of the MHA so that the duty on hospital managers to make a referral arises on the expiry of the “relevant period”. The “relevant period” is defined by the insertion of a new subsection (4A) to the MHA. The “relevant period” varies depending on the type of patient as set out below. Broadly the intended effect is for automatic referrals to immediately follow the expiry of the period in which a patient could make an application to the MHT.
189. Subsection (4)(c)(i) and (ii) amends section 68 subsection (3) of the MHA so that the duty on a hospital manager to make a referral under the amended section 68 subsection (2) will not arise where a patient has exercised their right to apply as specified by section 68 subsection (3) to the MHT during the “relevant period”. In these circumstances an automatic referral will not be necessary as the patient’s case will have already been considered by the MHT.

### *Section 2 patients*

190. Subsection (4)(e) inserts a new subsection (4A) to the MHA. Subparagraph (a) of the new subsection (4A) requires hospital managers to refer patients who are detained pursuant to an application for admission for assessment (“section 2 patients”) to the MHT three months from the day on which the patient was detained under section 2 of the MHA.

### *Section 3 patients*

191. Subparagraph (b) of the new subsection (4A) describes the circumstances in which an automatic referral must be made in respect of patients who are admitted for treatment under section 3 (“section 3 patients”). A hospital manager must refer a section 3 patient to the MHT, three months from the day on which the patient was first detained under section 3, including

any period in which a patient was detained under section 2 for assessment. Where a section 3 patient's detention is renewed, the hospital managers must make a referral to the MHT, 12 months from the day on which the patient was first detained and thereafter on any subsequent renewal, a referral must be made on the expiry of each 12 months period of detention.

#### *Community patients*

192. Subparagraph (c) of the new subsection (4A) describes the circumstances in which an automatic referral must be made in respect of patients who are subject to a CTO ("community patients"). Subsection 4(f)(ii) amends section 68 subsection (5) of the MHA so that reference to "applicable day" in respect to community patients means the date on which the CTO was made. These provisions provide that a hospital manager is under a duty to refer a community patient to the MHT on the expiry of six months, 12 months and thereafter every subsequent period of 12 months from the date on which the CTO was first made.

#### *Revoked community treatment order patients and patients transferred from guardianship to hospital*

193. Subsection (4)(h) removes section 68 subsection (7) of the MHA so that there is no longer an automatic referral following the revocation of a CTO. In practice, it was found that this automatic referral was an ineffective safeguard, as often the patient is either back in the community subject to a new CTO or they have reverted to a section 3 patient, before the MHT has reviewed their case.
194. Where a patient's CTO is revoked, by virtue of section 17G of the MHA (effect of revoking CTO), the patient is treated as if they have been admitted pursuant to an application for admission for treatment. Subsection (2) amends section 17G(5) to include reference to section 68. This amendment allows the automatic referral periods in the new subsection (4A)(b) to apply afresh from the date on which the CTO is revoked. For such patients, a hospital manager will be under a duty to make a referral to the MHT on the expiry of three months, 12 months and thereafter each subsequent period of 12 months from the date that the CTO was revoked.
195. Section 19 of the MHA governs the regulations that may be prescribed in relation to the transfer of patients. Section 19(2)(d) provides that where a patient is transferred from guardianship to a hospital, they are treated as having been admitted to hospital for treatment from the date that the guardianship application is accepted. Subsection (3) inserts reference to section 68 to the new subsection 19(2A), which is inserted by clause 26 subsection (2) after section 19 subsection (2) of the MHA. The effect of this provision is to treat transferred guardianship patients, for the purpose of section 68, as having been admitted for treatment on the date that they are transferred to hospital. This amendment allows the automatic referrals in the new subsection (4A)(b) to apply to transferred guardianship patients. For such patients, an automatic referral will arise on the expiry of three months, 12 months and thereafter each subsequent period of 12 months from the date of the transfer.
196. As revoked CTO patients and patients transferred from guardianship are treated as patients who are admitted to hospital on the date of the revocation or transfer, such patients would fall within section 68 subsection (1)(b) of the MHA (admission for treatment). Consequently,

section 68(1)(d) and (e) of the MHA is repealed by subsection (4)(a) and section 68 subsection (5)(d) is repealed by subsection (4)(f)(iii) as these provisions are no longer necessary.

197. Subsection (7) amends Part I of Schedule 1, paragraph 10(b) of the MHA, to ensure that Part 3 guardianship order patients who are transferred to hospital and Part 3 CTO patients whose CTO is revoked and a period of more than six months has passed since the courts first made an order under Part 3 of the MHA have the same automatic referral periods as Part 2 patients who have been transferred from guardianship to hospital and Part 2 patients whose CTO has been revoked.

#### *Part 2 patients and unrestricted Part 3 patients*

198. Subsection 4(g) amends section 68 subsection (6) of the MHA to reduce the automatic referral period from three years to 12 months. The effect is to require hospital managers to refer all Part 2 patients and unrestricted Part 3 patients sooner, where a period of 12 months has elapsed, and the MHT has not considered their case. Subsection 4(g) further clarifies that this automatic referral will not be triggered where there is a pending application or reference before the MHT in respect of the patient. This referral also safeguard's patients where there is a change in status during their detention period, for example where a patient is moved from section 3 on to a CTO. This ensures that no Part 2 patient or unrestricted Part 3 patient can be detained for a period longer than 12 months, without having the benefit of a review by the MHT.

#### *Consequential changes*

199. Subsection (4)(d) amends section 68 subsection (4) to refer to the "relevant period" as a consequence of the new section 68 subsection (4A).

200. Subsection (4)(f)(i) amends section 68 subsection (5) to refer to the new section 68 subsection (4A).

201. Subsection (5) repeals the delegated power that the Secretary of State (and in Wales, the Welsh Minister) has to shorten the periods in which an automatic referral may arise. This power is now unnecessary due to the increase in frequency of automatic referrals during a patient's detention.

202. Subsection (6) removes reference to section 68A from section 143 as a consequence of repealing section 68A.

#### **Clause 29: References to tribunal for patients concerned in criminal proceedings etc**

203. Clause 29 amends the current legislative provisions in relation to automatic referrals for mentally disordered offenders subject to special restrictions ("Part 3 restricted patients").

204. Subsection (2)(a) amends section 71(2) of the MHA to reduce the automatic referral period for Part 3 restricted patients from three years to 12 months. The effect is to require the Secretary of State to refer all Part 3 restricted patients detained in hospital to the MHT, where a period of 12 months has elapsed, and the MHT has not considered their case and there is no pending application or reference already before the MHT in respect of the patient
205. Subsection (2)(b) amends subsection 71(3A) to extend the Secretary of State's delegated power to allow where amendments are made to the automatic referral periods under section 71 subsection (2) to make an order that can specify different automatic referral periods for different categories of patients or areas, allow exemptions to automatic referrals for certain patients and make transitional, consequential, incidental or supplemental provisions.
206. Subsection (2)(c) inserts a new section 71 subsections (4A) and (4B) to the MHA.
207. The effect of section 71(4A) is to clarify that the MHT must exercise the power under section 75 of the MHA, when considering the case of a conditionally discharged patient following a discretionary referral by Secretary of State under section 71 subsection (1) of the MHA.
208. The new section 71 subsection (4B) extends the MHT powers when reviewing the detention of a conditionally discharged patient following a discretionary referral under section 71 subsection (1) to allow the MHT the power to vary or impose any conditions to which the patient is subject, including imposing "DoL conditions" where the relevant threshold is met under subsections (4B)(a) and (b). This is in addition to the MHT's power to direct that a restriction order, limitation direction or restriction direction ceases to have effect, thereby discharging the patient from detention.
209. Subsection (3)(a) inserts a new section 75 subsections (2B) to (2I).
210. The new section 75(2B) requires the Secretary of State to refer conditionally discharged patients who are not subject to DoL conditions to the MHT two years from the date that they were conditionally discharged (or ceased to be subject to DoLs conditions), thereafter such patients are required to be referred every four years. The new subsection (2B)(i) clarifies that patients whose DoL conditions are removed will be referred two years from this date. The effect of this provision is to ensure that, whenever a patient changes status, the patient will receive the benefit of the shorter initial referral period that applies in relation to their new status.
211. The new section 75(2C) extends the automatic referrals by the Secretary of State to conditionally discharged patients subject to conditions amounting to a deprivation of liberty ("supervised discharged patients"). The effect is to require the Secretary of State to refer supervised discharged patients 12 months from the date that they became subject to DoL conditions and thereafter each subsequent period of two years, where the MHT has not considered their case.
212. The new section 75(2D) provides that the new automatic referrals at section 75(2B) and (2C) will not trigger where the MHT has already reviewed the patient's detention during the period before the automatic referrals would have been triggered.

213. The new section 75(2E) provides an additional safeguard to ensure that no conditionally discharged patient can be detained for a period of more than four years without their detention being reviewed by the MHT. This automatic referral will only be engaged in the unlikely event that, a patient switches back and forth between being a conditionally discharged patient not subject to DoL conditions and a supervised discharged patient without triggering the new referral periods at subsections (2B) and (2C).
214. The new section 75(2F) provides the Secretary of State the power to vary by order the referral periods as set out under subsections (2B), (2C) and (2E). Where the Secretary of State makes such an order section 75(2G) allows the order to specify different automatic referral periods for different categories of patients, or areas, allows exemptions to automatic referrals for certain patients and includes the power to make transitional, consequential, incidental or supplemental provisions. The effect of this provision is to ensure that automatic referral periods can be adjusted where in practice it would be more appropriate or beneficial for different arrangements to be in place.
215. The new section 75(2H) ensures that when a referral is made by the Secretary of State it is made to the MHT in the area in which the patient is resident.
216. The new section 75(2I) clarifies that when this section refers to the patient's case being considered by the MHT it means either by the patient making an application or otherwise.
217. Subsection (3)(b) amends section 75 subsection (3) of the MHA to ensure that the MHT exercises the powers under section 75 subsection (3) of the MHA, when considering the case of a conditionally discharged patient following an automatic referral made under subsection (2B), (2C) or (2E).
218. Subsection (3)(c) inserts a new section 75(4) to extend the power of the MHT when reviewing the detention of a supervised discharged patient, whether on application by or on behalf of the patient or following an automatic referral under section 75(2B), (2C) or (2E). This power is additional to those set out in section 75 subsection (3) and allows the MHT to impose DoL conditions where the relevant threshold is met.
219. Subsection (4) extends section 143 subsection (3) to apply to the new section 75(2F). This ensures that an order to vary the automatic referrals as specified under new subsections (2B), (2C) or (2E) can only be made if a draft of it has been approved by a resolution of each House of Parliament.
220. Subsection (2)(5) is a transitional provision and encompasses all restricted patients as set out in section 79 of the MHA. Its effect is to make this section of the MHA apply to those patients who became a restricted patient before or after the coming into force of this section of the MHA.

## Patients concerned in criminal proceedings or under sentence

### Clause 30: Conditional discharge subject to deprivation of liberty conditions

221. Clause 30 amends section 42 of the MHA, creating a power that allows the MHT or the Secretary of State for Justice to place conditions that amount to a deprivation of liberty on a patient as part of a conditional discharge.
222. Restricted patients can be subject to conditions when discharged by the MHT or the Secretary of State if they no longer require detention for treatment in hospital, but there are continuing risks that cannot otherwise be safely managed in the community. This is known as conditional discharge.
223. There are a small number of cases where restricted patients have complex needs and pose a high risk of harm to the public through violent or sexual behaviour, which is a result of their mental illness, but are no longer benefiting from the extremely restrictive regime of detention in hospital. Historically, these patients were conditionally discharged into conditions of constant supervision to manage this risk, with their consent. Additional conditions may have also been put in place, such as a requirement for patients to maintain contact with their mental health care team, or to stay away from certain locations, such as the place where the crime which led to their detention in hospital was committed. The conditions sought to carefully balance the need to protect the public with the patient's need for treatment in the least restrictive setting possible.
224. The Supreme Court decision in *MM v Secretary of State for Justice* [2018] UKSC 60 confirmed the position established in lower courts (relevantly, *Secretary of State for Justice v RB* [2011] EWCA Civ 1608; *MM v WL & Anor* [2016] UKUT 37 and on appeal EWCA Civ 194) that a patient with capacity cannot be discharged in this manner under the existing provisions of the MHA. This meant that, if the MHT or Secretary of State considered that a restricted patient could be discharged, but only if they would be subject to continuous supervision and control (for example, to reside at a particular secure care home and not to go out into the community without an escort), this could no longer be set as a condition and the patient could not be discharged. At present, these patients are being managed using the technical recall and long term section 17 leave process set out in the Mental Health Casework Section Guidance: Discharge conditions that amount to a deprivation of liberty.
225. Clause 30 provides for the lawful imposition of these conditions on discharge, which amount to a deprivation of liberty, in the small number of high-risk cases where the patient's mental disorder persists but they are no longer benefitting from hospital detention, and the MHT or Secretary of State for Justice is satisfied the conditions are necessary for the protection of others. In making this judgement, the MHT and Secretary of State for Justice must also satisfy themselves that being conditionally discharged with appropriate monitoring safeguards in place is as beneficial, or more beneficial, for the patient than detention in a hospital. This power supports the principle of least restriction by allowing patients to be discharged from hospital and treated in the community, where otherwise this might have been prevented.
226. Conditional discharge can be effected under the MHA by both the Secretary of State for Justice, under section 42, and by the MHT, under section 73, where the statutory criteria are

met. Clause 30 subsection (2) amends section 42 by enabling the Secretary of State for Justice to impose conditions amounting to a deprivation of liberty when ordering the conditional discharge of a patient under that section, where they are satisfied the conditions are necessary to protect the public from serious harm. This test is slightly different to the MHT's test. Where evidence suggests more benefit to a patient one way or another, the Secretary of State for Justice will already have regard to that under the existing broad discharge test. The different references to 'the public' versus 'another person' are to encompass the hybrid responsibilities of mental health and non-mental health risk the Secretary of State for Justice must have regard to in their role.

227. Clause 30 subsection (3) amends section 73. New section 73 subsection (5A) allows for conditions amounting to a deprivation of liberty to be imposed where the MHT considers they are necessary to protect another person from serious harm if the patient were discharged from hospital, and that being discharged from hospital subject to these conditions must be no less beneficial than remaining in hospital. This ensures where the benefit is equal, the patient can still be discharged. Section 73(4)(b) and (5) allow the Secretary of State for Justice to impose or vary conditions on patients conditionally discharged by the MHT. New section 73(5B) enables the Secretary of State for Justice to be able to add conditions that amount to a deprivation of liberty in these cases where those conditions are necessary for the protection of the public from serious harm.

228. Clause 30 subsection (4) defines deprivation of liberty for the purposes of all the new provisions according to the 2005 Act. Clause 30 subsection (5) allows the new measures to operate retrospectively by providing that deprivation of liberty conditions can be imposed on restricted patients who are already detained, or who are conditionally discharged, at the time the provisions come into force.

## Clause 31: Transfers from prison to hospital

229. Prisoners and other detainees who become acutely mentally unwell in prison or another place of detention such as an Immigration Removal Centre (IRC) can be transferred for treatment under Part 3 of the MHA. Clause 31 introduces a statutory 28-day time limit within which individuals with a severe mental health need must be transferred from prison to hospital for treatment under the MHA.

230. NHS England and NHS Improvement has already taken steps to encourage health and justice agencies to work towards a 28-day transfer window from prison to hospital. On 10 June 2021, NHS England and NHS Improvement published [good practice guidance on the transfer and remission of adult prisoners under the Mental Health Act 1983](#), which stressed that transfers should not exceed 28 days from the point of initial referral for assessment. Clause 31 adopts an approach consistent with this good practice guidance and goes further by enshrining this time limit within law to prevent significant delays in individuals accessing treatment.

231. This provision supports the overarching principle of least restriction by reducing the maximum length of time that a patient in prison or another place of detention such as an IRC may have to wait to access inpatient treatment. For example, pending transfer, a patient might be residing in a particularly restrictive setting within a prison to protect their own safety or

the safety of others, such as a segregation unit. Under clause 31, this new power will have the effect of ensuring that transfers take place more swiftly to an appropriate hospital.

232. Clause 31 subsection (2)(c) and clause 31 subsection (4)(a)(c) amend the detention criteria set out in section 47(1)(c) and section 48(1)(c) of the MHA from “that appropriate medical treatment is available for them” to “that appropriate medical treatment can be given”. This change alters the threshold for part of the detention criteria in transfer cases (see the case of *R (ASK) v Secretary of State for the Home Department* [2019] EWCA Civ 1239). It sets out that the detention criteria which are the precedent to a transfer direction can still be met, even where there is no identified hospital place for the patient.
233. Part of the detention criteria in the MHA provides that appropriate treatment must be ‘available’ for the patient. Owing to the specialised provision and security requirements relating to Part 3 patients, the case of *ASK* held that, in order to exercise the power to make a transfer direction in sections 47 and 48 of the MHA, the detention criteria required, not simply that treatment for the patient’s condition is treatable in the sense of hypothetically available, but that it is available in practice, i.e., that a hospital place has in fact been identified.
234. The requirement to ensure that a hospital place has been identified before the detention criteria is considered to have been met risks denying access to treatment for those who need it by inadvertently suppressing referrals. In order to effectively introduce the new transfer time limit, it is therefore necessary to change the threshold as set out in *ASK* in relation to transfer directions only, so that the statutory detention criteria which are the precedent to a transfer direction can still be met, even where no hospital place has yet been identified for the patient. Clause 31 subsection (2) makes a drafting adjustment to Part 3 to clarify this and therefore enable health and justice agencies to work together throughout the entire 28-day period to find an appropriate bed.
235. Clause 31 subsection (3) inserts section 47A into the draft Bill which places the new duty in 47A(4) on all those authorities and bodies involved in a potential transfer, to ensure the transfer takes place within 28 days from the initial referral for a report. Transfer of a prisoner with severe mental health needs is a multi-disciplinary process. For an overview of how the process works, see the NHS England and NHS Improvement’s [good practice guidance](#).
236. If a prisoner exhibits a severe mental health need, the prison healthcare team (which could be any of the bodies provided for in 47A(2)(c)) will request an initial medical report to see if the transfer detention criteria under the MHA are met. This request is the beginning of the process where various healthcare providers or commissioners (which could be any of the bodies provided for in 47A(3)(c)) facilitate the necessary clinical steps needed – two reports from registered medical practitioners and identifying an appropriate bed for the prisoner.
237. The Secretary of State for Justice or, where the prisoner is held in a private prison, the contracting authority (as reflected in 47A(3)(a) and (b)) are responsible for facilitating access to the prisoner, and the physical movement from prison to hospital. The Secretary of State for Justice is responsible for issuing the transfer warrant under section 47 once they are satisfied the statutory criteria are met and having regard to the public interest and all the circumstances. It may be a transfer does not occur where it is found not to be necessary, the detention criteria are not met or the Secretary of State decides not to issue a warrant, but

where there is potential for a transfer, these authorities are all bound by the duty in section 47A(4).

238. New section 47A (1), (2) and (3) provide for a statutory notice procedure, so that relevant referring bodies in the prisons must notify the Secretary of State for Justice, the private prison provider where relevant, and any of the healthcare authorities who may have a role in relation to the prisoner's transfer (i.e., facilitating the second medical report, or admitting and receiving the prisoner in a hospital) when an initial referral has been made. This will ensure all bodies are aware of the duty and their obligations to take relevant steps to facilitate any resulting transfer.
239. Section 47A(4) and (5) provides that the 28 day limit does not apply where there are exceptional circumstances which make it inappropriate to do the transfer in this period. For example, this could be in cases where there is a riot in a prison meaning the prisoner cannot be safely moved; where hospital provision becomes unavailable owing to fire, flood or other unexpected event, or in clinically exceptional or complex cases where a longer time period is required to properly understand an individual's needs and identify appropriate treatment. Section 47A(5) provides that bed or staff shortages, unless these shortages have arisen as a result of other exceptional circumstances, are not to be counted as exceptional circumstances.
240. New 47A(6)(a) allows the Secretary of State to amend the list of bodies with responsibilities for components of a transfer by regulations, to ensure the duty continues to sit with the appropriate bodies where there are changes to provisioning arrangements or responsibilities.
241. New section 47A(6)(b) allows for the 28-day time limit set out in section 47A to be amended by regulations.
242. Section 48 of the MHA provides for the same transfer powers for remand prisoners, civil prisoners, and people detained in immigration removal centres. Clause 31 (4)(b) amends section 48 by providing for a power by regulations to apply section 47A with any necessary modifications to transfers made under section 48 of the MHA.
243. Clause 31 subsection (5) and clause 44 provide for the affirmative procedure for regulations laid under section 47A(6) or section 48(4).

### Clause 32: Transfer directions for persons detained in youth detention accommodation

244. Under section 48 of the MHA, the Secretary of State has the power to make a transfer direction allowing for individuals on remand in a prison or remand centre or remanded in custody by a magistrate's court, and civil and immigration detainees, to be transferred to hospital if they are suffering from a mental disorder requiring inpatient care.
245. Since 2012, remand centres have not been utilised in the criminal justice system and children arrested for or formally charged with a crime have instead been remanded to youth detention accommodation. Consequentially, where the Crown Court remands children to youth detention accommodation, there is currently no provision for the Secretary of State to make a transfer direction in respect of them under section 48. Clause 32 subsection (1) rectifies this,

and clause 32 subsection (2) makes a consequential amendment to remove a defunct entry referring to this provision in Schedule 8 to the Criminal Justice and Court Services Act 2000.

### Clause 33: Minor amendment

246. Clause 33 makes a minor technical amendment to Part I of Schedule 1, para 9(b), which modifies the application of section 66 for unrestricted Part 3 patients. The effect of the amendment is to clarify that the whole of section 66(2)(d) is omitted for unrestricted Part 3 patients.

## Help and information for patients

### Clause 34: Independent mental health advocates

247. Independent mental health advocates (IMHAs) are specially trained advocates who can support patients detained under the MHA to understand their rights under the MHA and participate in decisions about their care and treatment. They are therefore an important safeguard for patients. The reforms expand the right to access the services provided by an IMHA to voluntary patients in England who are not detained under the MHA. The measures will also ensure that all qualifying patients (both compulsory and voluntary patients) will be offered services through automatic referral to an IMHA provider. The intention of the reforms is to improve uptake of IMHA services so that all those who would benefit from advocacy will be able to access services.

248. Schedule 3 contains amendments to do with IMHAs, which –

- (a) provide for informal patients in England to access services from IMHAs,
- (b) impose duties on hospital managers and others to notify providers of advocacy services about qualifying patients, and
- (c) impose duties on providers of advocacy services to arrange for qualifying patients to be interviewed to find out whether they want to use those services.

249. The amendments will seek to ensure that decisions are made in the context of each person's unique needs, even where they may not be able to engage in decisions themselves and in doing so, supports the principle of the person as an individual.

250. Sections 130A-D in the MHA cover IMHA provision in England and sections 130E-L cover IMHA provision in Wales. For Wales, qualifying patients are split into 'qualifying compulsory' and 'qualifying informal' patients as referred to in section 130F and 130G respectively.

251. The MHA currently provides that, in England, IMHA services are only available to compulsory patients who are liable to be detained under the MHA, including those who are subject to guardianship and community patients.

252. Patients are also currently eligible to access IMHA services if they are being considered for a treatment to which section 57 applies (treatment requiring consent and a second opinion, for example any surgical operation for destroying brain tissue or for destroying the functioning of

- brain tissue) or if they are under 18 being considered for ECT or any other treatment to which section 58A applies.
253. The amendments introduce the concepts of an “English qualifying compulsory patient” and an “English qualifying informal patient” (referred to collectively as English qualifying patients). These mirror the corresponding concepts for Wales.
254. 130A of the MHA will be amended to extend the right to IMHA services to voluntary patients in England.
255. There are some exceptions whereby patients under short term sections are not eligible for IMHA services and no changes to this are made in this draft Bill. These exceptions include those who are subject to sections 4 (admission for assessment in cases of emergency) and 5 (application in respect of patient already in hospital), and sections 135 (warrant to search for and remove patients) and 136 (removal of mentally disordered persons without a warrant).
256. New section 130B(2A) of the MHA sets out a non-exhaustive list of the help that must be provided to informal patients, based on section 130G(1). IMHA services for informal patients should provide help in obtaining information about and understanding what (if any) medical treatment is given to the patient or is proposed or discussed in the patient’s case, why it is given, proposed or discussed, and the authority under which it is or would be given.
257. The draft Bill also expands the help available to both English informal and compulsory patients to reflect arrangements in Wales, whereby help is also provided to patients to become involved in decisions made about their care or treatment, or to complain about their care or treatment. Patients will also be provided with information about other services which may be available to them.
258. New sections 130CB and 130CC concern the introduction of an “opt out” system, facilitated by a set of measures designed to ensure that all qualifying compulsory patients in England have the opportunity to opt-in to IMHA services. This is achieved via a duty on local social services authorities when commissioning IMHA services to ensure that providers arrange a visit and determine if the patient wants to use IMHA services or not, and a duty on the managers of the hospital or registered establishment to refer all patients to the IMHA provider.
259. Section 130CC imposes a duty on “the responsible person” in relation to an English qualifying patient to take such steps as are practicable to inform the appropriate provider of advocacy services of the patient and to give the provider the required information about the patient. If the responsible person notifies the wrong provider of advocacy services, they will remain under a duty to notify the right provider under section 130CC. The responsible person is defined as the managers of the hospital or registered establishment or the responsible local social services authority in relation to the patient, as appropriate.
260. Section 130CB refers to the local social services authority responsible for making arrangements under section 130(1). A local social services authority is responsible for an English qualifying patient if the hospital or registered establishment relevant to the patient is situated in that authority’s area (the relevance to the patient depends on the type of patient or specific section under which the patient is detained – details are set out under section 130CB (1)).

261. Arrangements under section 130A must require a provider of advocacy services, on becoming aware of an English qualifying patient for whom they are responsible, to arrange for an IMHA to visit and interview the patient (if possible) with a view to determining whether the patient has the capacity or is competent to take a decision about whether to receive help from an independent mental health advocate, if so, whether the patient wishes to receive such help, and if not, whether it is nonetheless in the patient's best interests to receive such help.
262. Alongside the opt out system, it will no longer be necessary for hospital managers to provide information about IMHAs to English qualifying compulsory patients (as set out at section 130D). We will substitute the current section 130D 'Duty to give information about independent mental health advocates' with 'Duty to give information to English qualifying informal patients' as informal patients who will not be captured by the opt out system will still need to receive this information.
263. The responsible person (i.e., the managers of the hospital or registered establishment to which the patient is admitted as an inpatient) must take such steps as are practicable to ensure that the patient understands that help is available to them from an IMHA and how to obtain that help. These steps must be taken as soon as practicable after the patient becomes an English qualifying informal patient, and this includes giving the requisite information both orally and in writing. The responsible person must also, except where the patient otherwise requests, take such steps as are practicable to give the person (if any) appearing to be the patient's NP a copy of any information given to the patient in writing.

### Clause 35: Information about complaints for detained patients

264. Clause 35 amends section 132 of the MHA to place a statutory duty on hospital managers in respect of detained patients to supply complaints information to both the patient and the NP. This was previously in the code of practice but will now be a duty under the MHA.
265. Hospital managers must provide information both verbally and in writing, in line with existing duties in sections 132 and 132A. Hospital managers must ensure that patients have understood complaints procedures. Hospital managers will also be under a duty to ensure the patient understands how to exercise their right of complaint and who to complain to.
266. Subsection (2A) covers the types of complaints this duty covers. Subsection (2A)(c) ensures the duty covers information about the patient's right to complain to the Parliamentary and Health Services Ombudsman about the maladministration of complaints about medical treatment.
267. Subsection (2B) sets out that the duty is triggered as soon as practicable after the patient's detention under a provision of the MHA, each time the section under which the patient is detained changes and when the authority to detain under that section is renewed. In respect of Part 3 restricted patients, to whom automatic renewals do not apply, the duty will be triggered every 12 months from the start date of detention.
268. This duty will not be triggered when a patient is granted leave of absence under section 17.

## Clause 36: Information about complaints for community patients

269. Clause 36 amends section 132A of the MHA to place a statutory duty on hospital managers in respect of community patients, to supply complaints information to both the patient and the NP, in line with the changes to section 132 in respect of detained patients. Patients must be provided with complaints information both as soon as practicable after being placed on a CTO and as soon as practicable each time the CTO is renewed.

## Clause 37: Information for conditionally discharged patients

270. Clause 37 refers to the new section 132B which requires hospital managers to give complaints information to conditionally discharged restricted patients. Information should be provided before the patient leaves hospital, or as soon as possible when a patient is conditionally discharged. Patients are to receive complaints information when they are first detained in hospital and again whenever they are conditionally discharged. This duty includes restricted patients subject to transfer directions, who can be conditionally discharged under section 74.

## After-care

### Clause 38: Tribunal power to recommend after-care

271. Where a MHT does not direct the discharge of a Part 2 patient or community patient during an application or referral to the MHT, the MHT is empowered to make certain recommendations regarding the patient's care, with a view towards facilitating the discharge of the patient on a future date. These powers of recommendation are set out in section 72(3) and (3A) of the MHA, which also provides the MHT with the power to reconvene to reconsider a case in the event that any such recommendation is not complied with.

272. Clause 38 extends the MHT's power to make recommendations. Where the MHT does not direct the discharge of a patient, it would be able to recommend to the local social services authority and Clinical Commissioning Group (CCG) ("responsible after-care body") that they make plans for the provision of after-care services for the patient. After-care services in this context means care to which a patient may be entitled to under section 117 of the MHA, which meet a need arising from or related to the person's mental disorder; and reduces the risk of a deterioration of the person's mental condition. This recommendation is made with the view to facilitating a patient's discharge on a future date.

273. Subsection (2) amends section 72(3)(a) to give the MHT a new power (see new subsection 72(3)(a)(iii)), when it does not direct the discharge of a patient, to be able to make a recommendation for the "responsible after-care body" to consider making plans for after-care services to be made available for a patient to facilitate a patient's discharge at a future date.

274. Subsection (3) inserts a new section 72(8), to provide definitions to the terms "after-care services" and "responsible after-care bodies", in both cases specifying that the meaning for

these terms follows the provisions in section 117 of the MHA.

275. The power for the MHT to reconvene under section 72(3)(b) to consider a patient's case again if the recommendations have not been complied with will also apply to this new power. This will ensure that where necessary the MHT can challenge the responsible after-care bodies.

### Clause 39: After-care services

276. Clause 39 amends section 117 of the MHA. Section 117 places a duty on the NHS and local social services authorities to provide after-care to patients detained in hospital for treatment under sections 3, 37, 45A, 47 or 48 of the MHA, who then cease to be detained and leave hospital.

277. Subsection (2) provides that the provision of section 117 after-care lasts until the NHS body and the local authority jointly give notice to the person that they are satisfied that the person is no longer in need of such services.

278. Subsection (3) makes reforms to the identification of which particular NHS body and local authority is responsible for arranging section 117 aftercare to an individual patient, by applying the 'deeming rules' under social care legislation to the determination of ordinary residence. It provides that,

- in relation to those aged under 18 section 105(6) of the Children Act 1989 applies for the purposes of determining the ordinary residence. This means that, for example, any periods should be disregarded when the child was living in accommodation provided by a local authority; and
- in respect of adults, the deeming rules under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014 apply.

## Miscellaneous

### Clause 40: Tribunal powers in guardianship cases: burden of proof

279. Section 72(4) of the MHA 2007 requires that where an application is made to the appropriate MHT by or in respect of a patient who is subject to guardianship, the MHT can direct that the patient be discharged if it is satisfied-

- that the patient is not suffering from a mental disorder; or
- that it is not necessary in the interests of the welfare of the patient, or for the protection of other persons, that the patient should remain under guardianship.

280. The effect of this current legislation is that the patient should only be discharged if the patient can prove to the MHT that they do not continue to meet the guardianship criteria. The burden of proof is on the patient.
281. Clause 40 reverses the burden of proof so that it rests instead on the local authority responsible for the guardianship to show the MHT that the patient continues to meet the guardianship criteria. The effect of the proposed amendment is that the patient should be discharged by the MHT unless the local authority can prove that the patient continues to meet the guardianship criteria. This supports the principle of least restriction.
282. Clause 40 amends section 72(4) of the MHA 2007 to require that where application is made to the appropriate tribunal by or in respect of a patient who is subject to guardianship under section 7 or section 37, the tribunal can direct that the patient be discharged if it is not satisfied that-
- the patient is suffering from a mental disorder or;
  - it is necessary in the interests of the welfare of the patient, or for the protection of other persons, that the patient should remain under guardianship.

#### Clause 41: Removal of police stations and prisons as places of safety

283. The Government committed to removing prison and police cells as places of safety under the MHA as part of the 2021 White Paper. This commitment was made in response to evidence that suggested they were not suitable environments to remand individuals with a severe mental health need awaiting assessment and treatment. Alternatives, such as hospitals and other healthcare-based settings are more appropriate. Before admission to hospital in certain circumstances, a court can order an individual to be detained for a short period of time in a 'place of safety'. This interim provision is used when a bed is not available in a hospital immediately. Clause 41 removes police stations, and prisons for Part 3 patients, as a place of safety.
284. Section 55(1) of the MHA defines places of safety for the purposes of Part 3 of the MHA. Clause 41 subsection (2) removes police stations, prisons, and remand centres (which have been out of use since the Legal Aid, Sentencing and Punishment of Offenders Act 2012) from the definition for adults. For children and young people, the currently utilised definition of place of safety from the Children and Young Person Act 1933 is read via the amendment in clause 41 subsection (2) to exclude police stations. Clause 41 subsection (3) clarifies that these changes do not apply to those already detained in a police station or prison when the changes commence.
285. Clause 41 subsection (4)(a) removes police stations from the definition of place of safety in section 135(6) of the MHA for the purpose of sections 135 and 136. Clause 41 subsection (4)(b) excludes police stations from the meaning of "a suitable place" in section 135(7). As a consequence of this change, clause 41(6) repeals section 136A of the MHA, which makes provision for the use of police stations as a place of safety.
286. Clauses 41 subsection (4)(c), (5), (6) and (7) make consequential amendments to omit subsections of Section 135 and Section 136 of the MHA because of their references to the use of police stations as a place of safety.

## Clause 42: Remand for a person's own protection etc

287. Under the Bail Act 1976, courts are permitted to refuse bail if they are satisfied that a defendant should be kept in custody for their own protection, or if they are a child or young person for their own welfare. Currently, there is nothing to prevent this power being used where the concern is solely on mental health grounds; for example, where a person may be considered a danger to themselves. Evidence suggests that in some cases this power is being used by the courts to remand defendants into custody where the defendant would be bailed were it not for the court's concern for their mental health. The Government considers this provision to be inconsistent with measures within the draft Bill that remove prison as a place of safety. Prison should not be used solely to protect individuals with a severe mental health need and alternative provision, preferably a healthcare setting or support, should be sought.
288. This clause seeks to address this and amends the Bail Act 1976 to prevent the remand of a defendant on own protection or welfare grounds where the sole concern is their mental health. Instead, the person should be considered for detention under the relevant section of the MHA or bailed with an appropriate package of mental health support.
289. Clause 42 subsections (1-5) make the required changes to the relevant paragraphs in Schedule 1 to the Bail Act 1976 in order to remove the ability of the courts to remand an adult for their own protection and for a child or young person for their own welfare solely based on concerns about their mental health. Instead, it directs the courts to consider exercising the existing power to remand the defendant to hospital under section 35 of the MHA 1983 to enable assessment of their mental condition. The changes covered in these subsections relates to defendants accused or convicted of imprisonable offences.
290. Clause 42 subsection (6) relates to defendants accused or convicted of non- imprisonable offences. It again makes the required change to ensure that the courts cannot remand an adult for their own protection or a child or young person for their own welfare solely based on concerns about their mental health. However, for non-imprisonable offences the only option for the courts is to bail with conditions attached aimed at meeting the mental health concern. This is because it is not considered appropriate to introduce a new power to remand in relation to this type of offence.
291. Clause 42 subsection (7) sets out a change to section 35(2) of the MHA. This change is to ensure the section 35 power is available for consideration in all cases where (i) the defendant is accused or convicted of imprisonable offences; and (ii) the court considers the defendant should be remanded for their own protection or welfare for reasons solely on the grounds of concerns about their mental health. In its current form this is not always the case. For instance, without this amendment it would not be available to magistrates for use in the first appearance by a defendant charged with an indictable-only offence. The section 35 power can only be used in these circumstances where the defendant consents to its use.
292. Clause 42 subsection (8) clarifies that these provisions will only apply to persons before a court after these changes commence.

## Clause 43: Removal of interim remand patients to and from Channel Islands or Isle of Man

293. Each separate jurisdiction in the UK has its own mental health legislation. Part VI of the MHA facilitates the transfer of patients between jurisdictions (England and Wales, Scotland, Northern Ireland and the Crown Dependencies, which consists of the Channel Islands and the Isle of Man) and provides that when a patient is admitted to hospital in England and Wales, they are to be treated under Part VI of the Act as if subject to a corresponding domestic application made, order or direction. At the moment, these provisions do not apply to patients with extant criminal proceedings made subject to remand or interim orders (in England and Wales, these are section 35, 36 and 38 of the MHA), as it was considered appropriate to prevent transfer of these patients owing to their ongoing criminal proceedings in the home jurisdiction. For patients with complex needs in the criminal justice system on the Islands, where appropriate secure mental health facilities and provision may not be available, it is considered important to create a quicker and simpler process by which they can be transferred into the correct setting in England and Wales.
294. Clause 43 will remove the exclusions that exist in sections 83 and 85 of the MHA that prevent offenders remanded to hospital or made subject to interim hospital orders from transferring between the Crown Dependencies and England and Wales. The exclusions have had an effect of limiting the powers of courts in the Crown Dependencies from appropriately dealing with offenders suffering from complex mental health needs. Clause 43 will resolve this by providing that remand and interim patients can be transferred into England and Wales from the Crown Dependencies for reports or treatment, whilst being appropriately detained under domestic provision, and then returned for the continuation of their criminal proceedings.
295. Clause 43 subsection (2) removes the exclusion for patients who are subject to an order under section 35, 36 and 38 in section 83, meaning they can be functionally transferred from England and Wales to the Crown Dependencies under Part VI.
296. Clause 43 subsection (3)(a) removes the exclusion for patients in the Crown Dependencies to England and Wales who are subject to the Crown Dependency equivalents of orders under section 35, 36 and 38, meaning they can be functionally transferred from the Crown Dependencies under the legislation of the sending jurisdiction, and received in hospital in England and Wales under Part VI.

## Schedule A2: Interim and remand patients from Channel Islands or Isle of Man: Modifications of this Act

297. Once the patient is admitted to hospital in England and Wales, their Crown Dependency order will cease to have effect under the relevant Crown Dependency legislation. Schedule A2 provides for modifications to sections 35, 36, 38 to enable patients transferred from the Crown Dependencies to be appropriately managed by the domestic courts in England and Wales.
298. Different courts in the Crown Dependencies have the power to make remand and interim orders. The Schedule provides for modifications which mean the patients will be dealt with in England and Wales by the court with functions which most closely corresponds with those of

the court in the Crown Dependency which made the original order, except in the case of a remand for treatment, which can only be managed by the Crown Court.

299. The Schedule also restricts the powers of the court to deal with the patient; as the patient has no extant criminal proceedings in England and Wales, the court is unable to exercise any of its criminal jurisdictional powers in relation to the patient. The court can renew the remand or interim order for prescribed periods in line with the domestic order renewal periods, and it must notify the Secretary of State of any renewals. The court's considerations for renewal are not restricted so the court may take into account all relevant considerations- for example, it may be the case that a patient's report is completed or their treatment finished and the RC considers they no longer need to be detained for treatment, but the patient needs to be returned to the Crown Dependency to participate in their criminal proceedings – in this case, additional remand may be appropriate to continue to detain them and allow the Secretary of State to return them for trial. The court can also recommend to the Secretary of State the patient be returned to the sending Crown Dependency, for example where a report or treatment is concluded. The modifications prevent the court from terminating a remand (although the court could exercise its discretion not to renew) or dealing with the patient in any other manner which it would be able to, were the patient accused of an offence in England and Wales.

300. Paragraph 4 makes it clear that the Secretary of State can transfer one of these patients to the Crown Dependencies if it is appropriate, ensuring patients with extant criminal proceedings can meet the transfer criteria. Once transferred and admitted, the extant remand or interim orders will cease to have effect under section 91(1) and the Crown Dependency legislation will operate to give effect to the original orders and the criminal proceedings may continue as before.

#### Clause 44: Procedure for certain regulations made by virtue of sections 16 and 31

301. Clause 44 amends section 143(2) of the MHA to make provision for the procedure in relation to certain regulations made under the powers in clauses 16 and 31 of the draft Bill, as set out in the commentary to those clauses.

## General

#### Clause 45: Power to make consequential provisions

302. This clause provides a power which allows the Secretary of State, by regulations, to make provision that is consequential on the provisions in the draft Bill. The power may be used to amend, repeal or revoke any provision made by or under primary legislation passed before this Act is passed or later in the same Parliamentary session. Primary legislation includes primary legislation passed in Wales. The regulations are subject to the negative procedure.

## Clause 46: “The 1983” Act: The Mental Health Act 1983

303. This clause is an interpretation provision. Where the term “the 1983 Act” is used in the draft Bill, it refers to the Mental Health Act 1983. In these notes “the 1983 Act” is referred to as the “MHA”.

## Clause 47: Extent

304. Clause 47 sets out the territorial extent of the draft Bill, that is the jurisdictions within which the Bill forms part of the law.

305. Subsection (1) provides that an amendment or repeal made by the draft Bill has the same extent as the provision which it amends or repeals. The majority of the MHA, which the Bill amends, extends to England and Wales.

306. Subsection (2) provides that clauses 45 to 49 of the draft Bill extend UK wide. This is because the draft Bill makes amendments to section 143 of the MHA, which has UK extent. Clause 45 has UK extent as consequential amendments may need to be made to the Armed Forces Act 2006, which has UK extent.

# Commencement

## Clause 48: Commencement

307. This clause makes provision in relation to when the draft Bill comes into force. The clause also contains provision for the Secretary of state to make transitional or saving provision in connection with the coming into force of any provision of the draft Bill. The clause makes clear, that this transitional and saving provision is additional to transitional provisions made in the draft Bill itself (and as set out in clause 48(9)). This is because decisions regarding such transitional arrangements have not yet been made in respect of all provisions, and therefore where the Bill does not make such provision, no inferences should be drawn from that.

## Clause 49: Short title

308. This clause states the Bill’s short title as ‘the Mental Health Act 2022’.

# Financial implications of the draft Bill

309. A money resolution is required for the final version of this Bill. A money resolution is required where a Bill authorises new charges on the public revenue (broadly speaking, new public expenditure). For this Bill the potential increase in public expenditure is attributable to new or expanded functions conferred on public authorities.

310. An Impact Assessment has been prepared for the draft Bill which outlines the cost implications for bodies and organisations which derive from its proposed measures in England over a 14-year appraisal period. In healthcare and social care systems, ongoing costs for resourcing the reforms and upfront training costs for existing staff are estimated in the central scenario to total £436m for health care, £46m for the Care Quality Commission and £446m for Local Authorities (present values, 2022/23 prices). The increased frequency of referrals to the MHT creates costs for Her Majesty's Courts and Tribunals Service (HMCTS) and the Legal Aid Agency, estimated at a total of £171m (present value, 2022/23 prices) in the central scenario.

311. When fully implemented, these reforms are estimated to cost an additional £100m per annum. The full implementation of these reforms is expected to take around ten years largely due to the lead-in time required to train additional clinical and judicial staff.

## Compatibility with the European Convention on Human Rights

312. The Government considers that the draft Bill is compatible with the European Convention on Human Rights. Accordingly, the Secretary of State for Health and Social Care will make a statement under section 19(1)(a) of the Human Rights Act 1998 when the Bill is introduced to Parliament to this effect.

## Annex A - Territorial extent and application in the United Kingdom

Provision	England	Wales		Scotland		Northern Ireland	
	Extends to E & W and applies to England?	Extends to E & W and applies to Wales?	Legislative Consent Motion process engaged?	Extends and applies to Scotland?	Legislative Consent Motion process engaged?	Extends and applies to Northern Ireland?	Legislative Consent Motion process engaged?
Clause 1	Yes	Yes	Yes	No	No	No	No
Clause 2*	Yes	No	No	No	No	No	No
Clause 3	Yes	Yes	Yes	No	No	No	No
Clause 4	Yes	Yes	Yes	No	No	No	No
Clause 5	Yes	Yes	Yes	No	No	No	No
Clause 6	Yes	Yes	Yes	No	No	No	No
Clause 7	Yes	Yes	No	No	No	No	No
Clause 8	Yes	Yes	Yes	No	No	No	No
Clause 9	Yes	Yes	Yes	No	No	No	No
Clause 10	Yes	Yes	Yes	No	No	No	No
Clause 11	Yes	Yes	Yes	No	No	No	No
Clause 12	Yes	Yes	Yes	No	No	No	No
Clause 13	Yes	Yes	Yes	No	No	No	No
Clause 14	Yes	Yes	Yes	No	No	No	No
Clause 15	Yes	Yes	Yes	No	No	No	No
Clause 16	Yes	Yes	Yes	No	No	No	No
Clause 17	Yes	Yes	Yes	No	No	No	No
Clause 18*	Yes	No	No	No	No	No	No
Clause 19	Yes	Yes	Yes	No	No	No	No
Clause 20	Yes	Yes	Yes	No	No	No	No
Clause 21	Yes	Yes	Yes	No	No	No	No
Clause 22	Yes	Yes	Yes	No	No	No	No
Clause 23	Yes	Yes	Yes	No	No	No	No
Clause 24	Yes	Yes	Yes	No	No	No	No
Clause 25	Yes	Yes	Yes	No	No	No	No
Clause 26	Yes	Yes	Yes	No	No	No	No
Clause 27	Yes	Yes	Yes	No	No	No	No
Clause 28	Yes	Yes	Yes	No	No	No	No
Clause 29	Yes	Yes	No	No	No	No	No
Clause 30	Yes	Yes	No	No	No	No	No

Clause 31	Yes	Yes	Yes	No	No	No	No
Clause 32	Yes	Yes	No	No	No	No	No
Clause 33	Yes	Yes	No	No	No	No	No
Clause 34	Yes	Yes	Yes	No	No	No	No
Clause 35	Yes	Yes	Yes	No	No	No	No
Clause 36	Yes	Yes	Yes	No	No	No	No
Clause 37	Yes	Yes	Yes	No	No	No	No
Clause 38	Yes	Yes	Yes	No	No	No	No
Clause 39	Yes	Yes	Yes	No	No	No	No
Clause 40	Yes	Yes	Yes	No	No	No	No
Clause 41	Yes	Yes	Yes	No	No	No	No
Clause 42	Yes	Yes	No	No	No	No	No
Clause 43	Yes	Yes	No	No	No	No	No
Clause 44	Yes	Yes	No	Yes	No	Yes	No
Clause 45	Yes	Yes	No	Yes	No	Yes	No
Clause 46	Yes	Yes	No	Yes	No	Yes	No
Clause 47	Yes	Yes	No	Yes	No	Yes	No
Clause 48	Yes	Yes	No	Yes	No	Yes	No
Clause 49	Yes	Yes	No	Yes	No	Yes	No
<ul style="list-style-type: none"> <li>Note: Although clauses 2 and 18 concern health policy, and are therefore devolved, these policies will only apply in England and therefore an LCM will not be required.</li> </ul>							

## Subject matter and legislative competence of devolved legislatures

294. Many provisions of the draft Bill apply to Wales and are within the legislative competence of the devolved legislature in Wales. None of the draft Bill's provisions are within the legislative competence of the devolved legislatures in Scotland or Northern Ireland.

295. Conversations are ongoing with the Welsh Government and a legislative consent motion shall be sought on formal introduction of the Bill.



# DRAFT MENTAL HEALTH BILL

## EXPLANATORY NOTES

These Explanatory Notes relate to the Mental Health Bill as published in Draft on 27 June 2022.

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