MENTAL HEALTH BILL [HL]

EXPLANATORY NOTES

What these notes do

These Explanatory Notes relate to the Mental Health Bill [HL] as introduced in the House of Lords on 6 November 2024 (HL Bill 47).

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

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These Explanatory Notes relate to the Mental Health Bill [HL] as introduced in the House of Lords on 6 November 2024.

Overview of the Bill

1 The Mental Health Bill (the Bill) contains a number of amendments to the Mental Health Act 1983 (the Act).

2 The measures in this Bill are generally intended to strengthen the voice of patients subject to the Act. They add statutory weight to patients' rights to be involved in planning for their care, and to inform choices regarding the treatment they receive. The reforms will increase the scrutiny of detention to ensure it is only used when, and as long, as necessary. The Bill also seeks to limit the use of the Act to detain people with a learning disability and autistic people.

3 The Bill is arranged under fourteen headings:

- Code of Practice
- 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
- Discharge: process
- Patients concerned in criminal proceedings or under sentence
- Help and information for patients
- After-care
- Miscellaneous
- General

Policy background

The Mental Health Act 1983 (the Act)

4 The Act provides a legal framework to authorise the detention and compulsory treatment of people who have a mental disorder and are considered at risk of harm to themselves or others. The Act is structured into ten parts.

5 Part 1 of the Act sets out the application of the Act, i.e. "to the reception, care and treatment of mentally disordered patients". Powers for compulsory admission under the Act are set out in Part 2 and Part 3. The majority of the Bill amends these parts of the Act. Part 2 of the Act deals with patients who are liable to be detained in hospital and who are not subject to the Act as a consequence of any involvement with the criminal justice system. These patients are generally referred to as 'civil patients'. Part 3 of the Act is concerned with patients who are involved in criminal proceedings or are under sentence. The majority of people detained under the Mental Health Act are under Part 2, with over two-thirds (70.8%) of people recorded as in detention in hospital on 31st March 2024 being detained under Part 2, and less than a third (29.2%) detained under Part 3.[1] The Ministry of Justice leads on reforms to Part 3 of the Act, and further detail on Part 3 is set out below.

6 The Bill also makes amendments to:

a. Part 4 of the Act, which provides for the treatment of patients detained in hospital, or of community patients who are liable to be so detained;

b. Part 8 of the Act, which contains miscellaneous functions of Local Authorities (i.e. the approval of Approved Mental Health Act Professionals, the provision of after-care, and the right for Local Authority staff to visit patients in certain circumstances), and of the Secretary of State (including the requirement to produce a Code of Practice for the Act, and certain duties of the regulatory authority, the Care Quality Commission in England and in Wales, the Care Inspectorate Wales);

c. Part 9 of the Act, which provides for offences under the Act; and

d. Part 10 of the Act, which contains miscellaneous provisions.

7 The Act was last amended in 2007, amongst other changes these amendments introduced Community Treatment Orders, Independent Mental Health Advocates and amended the detention criteria with the effect that someone cannot be detained for treatment unless *appropriate treatment* is available.

Part 3 of the Act

8 Part 3 of the Act is concerned with the care and treatment of offenders with a 'relevant disorder' (a psychiatric disorder, autism or learning disability which has serious behavioural consequences) who are involved in criminal proceedings or under sentence. There are two categories of Part 3 patients – unrestricted or restricted:

a. Restricted patients are offenders with a relevant disorder who are detained under Part 3 of the Act 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

[1] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures/people-subject-to-the-act-at-year-end

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.

b. 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.

9 Individuals in contact with the criminal justice system may need to be admitted to hospital for assessment or treatment if they exhibit a relevant disorder. 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 Act for as long as this is required by the offender's mental health needs; there is no minimum term to be served for the purpose of punishment.

10 The Court may also add a restriction order under section 41 of the Act, 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. For example, the responsible clinician 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.

11 If a prisoner or other detainee develops mental disorder whilst in custody, in prison or another place of detention, they can be transferred to hospital for treatment under Part 3 of the Act 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.

12 Part 3 of the Act 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 Act 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 Act, when compared to those detained under Part 2. These areas have been set out in relation to specific clauses in the *Commentary on provisions of the Bill* section below.

Timeline to reform

13 The planned reforms to the Act which will be achieved through this Bill respond to the recommendations for legislative change made by an Independent Review of the Act, led by Professor Sir Simon Wessely, a psychiatrist by background, and former President of the Royal College of Psychiatry.

14 The Independent Review published its final report, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion*[2] in December 2018. The Review identified significant problems with the Act and the culture around how it is used by professionals, and made 154 recommendations, covering both legislative reforms and reforms to policy and practice.

15 The Government's response to the Independent Review was published in its White Paper, *Reforming the Mental Health Act*[3], on 13 January 2021. In the response, the Government accepted the majority of the Review's recommendations. The Government publicly consulted on the proposed changes in 2021, and published a draft Bill setting out planned changes to the Mental Health Act in 2022.

16 The draft Bill underwent pre-legislative scrutiny (PLS) by the Joint Committee in 2022, which produced a report and recommendations, to which the previous Government responded in March 2024.

17 The Bill has been revised to incorporate a number of the recommendations of the committee. Further detail is set out below.

Contents of the draft Bill

18 The proposals in the draft Bill were informed by the four key principles developed by the Independent Review and in partnership with people with lived experience of detention:

- **Choice and autonomy** – involving patients in decision making, and considering their past and present wishes and feelings.
- **Least restriction** – minimising restrictions on liberty so far as consistent with patient wellbeing and safety, and public safety
- **Therapeutic benefit** – ensuring patients receive effective and appropriate treatment
- **The person as an individual –** treating patients with dignity and respect, and considering their beliefs, values, past experiences and wider needs.

19 The draft Bill included reforms to:

- Better ensure that detention and compulsory treatment under the Act is only undertaken when 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 Act and provide faster, more frequent reviews and appeals of both detentions and treatment
- Strengthen the voice of patients – with measures that aim to increase the role of the patient in decision making regarding their care and treatment, with the introduction of measures such as the clinical checklist, which are intended to encourage clinicians to support patients to engage in decision making and to give consideration to their wishes and preferences;
- Improve and expand the roles and powers of people who represent and advocate for detained patients – including by allowing patients to choose the person who represents them;

[2] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review
[3] https://www.gov.uk/government/consultations/reforming-the-mental-health-act

- Limit the detention of patients with a learning disability and autistic people under Part 2 of the Act to 28 days for the purpose of assessment of mental disorder. Patients could only be detained for treatment under section 3 if they have a co-occurring mental health condition that requires hospital treatment and meets the detention criteria under the Act. The Bill retains hospital as a sentencing option under the Act, and also retains the facility to transfer patients with these conditions from prison to hospital;

- Introduce duties on commissioners to monitor and improve their understanding of the risk of crisis amongst people with a learning disability and autistic people in the community who they are responsible for commissioning services for; and to ensure an adequate supply of community services to prevent inappropriate detentions in hospital;

- Revise the criteria for the use of Community Treatment Orders (CTOs) in line with changes to the detention criteria, and enhance the professional oversight required for any CTO;

- Remove police stations and prisons as defined places of safety under the Act 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 prisons and other places of detention to hospital for persons in the criminal justice system or immigration detention with severe mental health needs to speed up access to specialist inpatient care and treatment;

- Introduce a new form of supervised community discharge for criminal justice patients who are no longer benefitting from being in hospital but who require conditions amounting to a deprivation of liberty to manage the risks they pose.

Bill measures added since Pre-Legislative Scrutiny:

20 In its response to the Joint Committee in 2024, the previous Government committed to taking forward several of the Joint Committee's recommendations for legislative change. However, a final Bill was not taken forward in the last Parliament. This Bill now takes forward recommendations from the Joint Committee's report. In addition, we have reviewed the Bill, and the planned reforms, to be assured that the reformed Act, has the necessary powers to enable clinicians to keep patients and the public safe. These reforms will not change the core function and powers of the Mental Health Act, which is to detain and treat people when they are so unwell they become a risk to themselves or others. However, they do strive to ensure that when the very serious decision is taken to detain someone – there is a modern framework for the use of these powers, to ensure patients are treated with dignity and respect and that they receive care and treatment which supports recovery. The key changes since the draft Bill are:

- **Detention Criteria – 'how soon'** The Bill takes forward the Committee's recommendation that the proposed requirement for clinicians to consider 'how soon' a harm might occur should be removed from the detention criteria revisions that the Bill seeks to make.

- **Nominated Person:** The Committee supported the Nominated Person provisions but recommended that the Government work with Approved Mental Health Professionals (AMHP) to revise the proposals to address practical concerns. The Bill removes the requirement for the AMHP to see the Nominated Person in person.
- **Advanced Choice Documents:** The Bill has been updated to take on board the Committee's recommendations on Advance Choice Documents. However, rather than create a right for a patient to request an Advance Choice Document, as the Committee recommended, the Bill takes a different approach. The Bill therefore seeks to introduce duties on Integrated Care Boards (ICBs), NHS England and Local Health Boards (Wales) to make arrangements so that people at risk of detention are informed of their ability to make an Advance Choice Document, and (if they accept) supported to make one.
- **Principles:** In line with the Committee's recommendation, the Bill amends section 118, which makes requirements for the Code of Practice, the statutory guidance which sits alongside the Act, to include the language of the four principles from the Independent Review. This will apply to both the Code of Practice for England, and the Code of Practice for Wales.
- **Discharge:** The Bill contains measures for a new requirement for a patient's responsible clinician (or the responsible authority for the patient) to consult with a second professional involved in the patient's care when taking the decision to discharge them from certain powers under the Act.

21 Further detail is set out in the *Commentary on provisions.*

Legal background

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

Territorial extent and application

23 Clause 52 sets out the territorial extent of the Bill, which describes the jurisdictions in which the Bill will form part of the law.

24 The Bill extends and applies to England and Wales only, aside from General clauses 51 to 54, which extend UK-wide. Several clauses, clauses 4, 20, 38 and schedule 3, apply to England only where the Welsh Government has their own respective provisions, or in the case of clause 4, because it implements the policy of NHS England, an England-only body.

25 This Bill seeks to amend the Mental Health Act, which applies to England and Wales. The proposed reforms concern both health, which is primarily a devolved matter in Wales, and also mentally disordered patients in the criminal justice system, which is reserved for England and Wales. Some provisions in the Bill are considered to modify functions of Devolved Welsh Authorities. To the extent that the provisions of the Bill fall within the legislative competence of devolved legislatures, the legislative consent process is engaged.

26 There is a convention that Westminster will not normally legislate with regard to matters that are within the legislative competence of the Scottish Parliament, Senedd Cymru or the Northern Ireland Assembly without the consent of the legislature concerned. It is the view of the UK Government that aspects the Bill relating to health, rather than criminal justice, fall within the legislative competence of the Senedd Cymru. Conversations are ongoing with the Welsh Government to secure legislative consent for these clauses.

27 The table in **Annex A** provides an overview of the territorial extent and application of the Bill's clauses, specifying for which measures the legislative consent motion process is engaged and for which we are not seeking consent to legislate.

Commentary on provisions of the Bill

Principles

Clause 1: Principles to inform decisions

28 Under section 118 the Secretary of State in relation to England and Welsh ministers in relation to Wales are required to prepare a Code of Practice to guide decision-makers listed in section 118(1), which must be consulted on and be presented to Parliament or the Senedd for scrutiny. Section 118 sets out that the Code must include a statement of the principles which the Secretary of State, in relation to England, thinks should inform particular decisions under the Act, and that in preparing the statement of principles the Secretary of State shall, in particular, ensure that a specific list of matters is addressed. The requirement in relation to the statement of principles does not currently apply to Wales.

29 Clause 1 amends section 118 so that the statement of principles must, in particular, include the four principles developed by the Independent Review, in partnership with people with lived experience. These principles are choice and autonomy, least restriction, therapeutic benefit, and the person as an individual. Clause 1 also sets out a number of matters, which must be addressed in the Code, in relation to each of the four principles.

30 The effect of this change is that Secretary of State in relation to England, and Welsh ministers, in relation to Wales, will be required to include the four principles in the statement of principles in the Code of Practice, and that these principles should inform relevant decisions under the Act. Those who under section 118 2D must have regard to the Code, must also have regard for the statement of principles in the Code and therefore will be required to have regard for the four principles when making decisions under the Act.

Clause 2: Application of principles to Wales

31 Clause 2 amends section 118 of the Act to extend to Wales the same requirement to include a statement of principles in the Code, and include in the Code the same principles and ensure the Code addresses the same specific matters in relation to each principle, as is required in relation to the Code in England.

32 The effect of this change is that Welsh Ministers will be required to include the four principles (choice and autonomy, least restriction, therapeutic benefit, and the person as an individual), and ensure the Code addresses the same specified matters in relation to each of the four principles, when preparing the Mental Health Act Code of Practice for Wales. Those who under section 118 2D must have regard to the code, must also have regard to the statement of principles in the code and therefore will be required to have regard for the four principles when making decisions under the Act.

33 The Welsh code is already required to undergo Welsh Parliamentary scrutiny, but the clause also updates the position in relation to the Parliamentary scrutiny procedure in Wales, in relation to the Welsh Code.

Autism and learning disability

Clause 3: Application of 1983 Act: autism and learning disability

34 Currently, people with a learning disability and autistic people can be detained for both assessment and treatment under section 2 of the Act. People with a learning disability may also be detained for treatment under section 3 when their learning disability is associated with abnormally aggressive and seriously irresponsible conduct. This qualification does not apply to autistic people. We have seen that some people with a learning disability and autistic people can be subject to lengthy detentions, which may not provide a therapeutic benefit. Clause 3 and Schedule 1 include new definitions in the Act and make amendments using those definitions throughout the Act. These amendments have the effect of removing, for the purposes of Part 2 of the Act, people with a learning disability and autistic people from the scope of the conditions for which a person can be detained for compulsory treatment under section 3. People with a learning disability and autistic people will only be able to be detained for treatment under Part 2 of the Act if they satisfy the conditions set out in section 3 of the Act, which includes that they have a co-occurring mental disorder which is not learning disability or autism.

35 This change in how the Act applies to patients with a learning disability and autistic people under Part 2 of the Act seeks to ensure that people are only admitted when they have a mental disorder that warrants hospital treatment, which has a reasonable prospect of providing a therapeutic benefit for their mental disorder. The proposed changes also mean that it will no longer be possible to place a person with a learning disability or an autistic person on a CTO unless they have a co-occurring mental health condition that meets the detention criteria. This is supported by the guiding principle of least restriction.

36 The changes to the way the Act applies to people with a learning disability and autistic people detained for assessment or treatment will not apply under Part 3 of the Act (i.e. individuals

accused of, or serving a sentence for committing a crime). For this cohort of people, the only alternative to detention in hospital is detention in prison. Consultation with experts following the publication of the 2021 White Paper found that, on balance, detention in hospital is considered more appropriate in the majority of cases than detention in prison, to ensure that people in this cohort are able to access the specialist support they may need. The Ministry of Justice is satisfied that the current application of the detention criteria to people with a learning disability and autistic people detained under Part 3 of the Act enables professionals to make the right decisions for people in this cohort, including where this requires diversion from criminal justice settings into a hospital setting.

37 Clause 3 amends section 1 of the Act. Subsection (2) modifies the meaning of mental disorder under the Act by including new definitions of "autism", "learning disability" and "psychiatric disorder". Autism and psychiatric disorder were not previously defined in the Act. "Psychiatric disorder" is a new term which covers mental disorder other than learning disability or autism. The definition of "learning disability" is also amended to remove reference to "social functioning", drawing a greater distinction between learning disability and the new definition "autism". Schedule 1 then makes amendments across the Act, to apply these new definitions. The effect of this is that people with a learning disability and autistic people will not be able to be detained for compulsory treatment under section 3 of the Act unless they have a psychiatric disorder, which by the definition, excludes learning disability and autism. They will also no longer be able to be made subject to community treatment orders under section 17A.

38 Subsection (2)(b) inserts a new subsection (2A) in section 1 of the Act which sets out that, for the purposes of the Act, a person's learning disability has "serious behavioural consequences" if it is associated with abnormally aggressive or seriously irresponsible conduct by the person. This currently applies, for the purposes of Part 2, in relation to people with a learning disability in respect of section 3 detention for treatment, section 7 guardianship, section 17A community treatment order, renewals of authority under those provisions and Tribunal discharge criteria from those provisions. Under the changes made by Schedule 1, it will only apply in relation to guardianship. The Bill makes no change to the way the "serious behavioural consequences" threshold applies in respect of people with learning disability under Part 3 of the Act because there is no change to the way the Act applies to them for the purposes of the Part 3 detention criteria.

39 Subsection (2)(c) omits the previous definition of learning disability under subsection (4) of the Act.

40 Subsection (3) inserts definitions of "autism", "learning disability", "psychiatric disorder" and "serious behavioural consequences" into section 145 of the Act.

41 Subsection (4) explains the effect of the Schedule 1 amendments to the Act. Schedule 1 amends section 3 of the Act to prevent individuals from being detained on the basis of their learning disability or autism. It also makes related changes in relation to the application of the Act to autism and learning disability.

42 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. Paragraphs 11(2) to (5) and (10) provide that CTOs are available for these patients, where relevant. Paragraphs 11(6) to (9) provide for renewals of detention for unrestricted hospital order patients. Paragraphs 12 to 15 make consequential changes throughout the treatment provisions of the Act for Part 3 patients. Paragraph 17 clarifies that this definition should apply to discharge assessments by the

Tribunal for patients subject to Part 3 detention, and paragraph 18 and 19 provide for the same application for restricted patients. Paragraphs 20 to 25 make transitory modifications to ensure the new definitions are given effect in the event these provisions are commenced before section 7, which provides for the new discharge criteria.

Clause 4: People with autism or learning disability

43 Clause 4 inserts a new Part 8A into the Act which contains clauses specific to people with a learning disability and autistic people.

44 People with a learning disability and autistic people can be subject to unnecessarily lengthy detentions, which may not meet their needs and provide little or no therapeutic benefit. 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.

45 Care (Education) and Treatment Reviews currently focus on whether a patient with a learning disability or an 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.

46 Care (Education) and Treatment Reviews are part of current NHS England 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 autistic people, often without therapeutic benefit.

47 New section 125A provides for the making of arrangements for ensuring care, education and treatment review meetings take place 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 sections of the Act. By requiring, education and treatment review meetings to be held, the Bill seeks to ensure that the care, treatment and differing support needs of people with a learning disability and autistic people are identified and recommendations as to how to meet these are made so that barriers to progress are challenged and overcome. This measure supports the principle of the person as an individual.

48 Subsection (1) places a duty on the responsible commissioner to make arrangements for ensuring care, education and treatment review meetings in respect of children and adults with an education, health and care plan detained under the Act (subject to the exceptions set out in this clause) take place. This duty applies to patients who the responsible commissioner considers to be autistic or have a learning disability and who give their consent or, where they lack capacity or competence to consent, the responsible commissioner considers that's in their best interests. This includes certain patients detained under Part 3 of the Act. The Secretary of State is to issue guidance to help support the responsible commissioner in exercising their functions, including guidance on factors to consider when determining whether a care (education) and treatment review may be in a patient's best interests.

49 Subsection (2) explains the purpose of a 'care, education and treatment review meeting'. This makes clear a meeting is to consider whether a patient has certain needs and is also to make certain recommendations. The needs and recommendations set out in this clause are designed to ensure that a holistic view is taken of that person's needs and that the most appropriate care and treatment can be provided.

50 Subsections (3) and (4) give further detail on the arrangements referred to under subsection (1). Subsection (3) sets out that the responsible commissioner must 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.

51 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. Secretary of State issued guidance will suggest factors to consider as to whether reviews should happen more frequently in different circumstances.

52 Subsection (5) explains what is meant by 'applicable day', which is the day from when the time for holding a review meeting starts to run. This is determined by when the patient was detained under the Act (not including any emergency period under section 4), or when the responsible commissioner forms the view that the patient is autistic or has a learning disability if that is later.

53 Subsection (6) makes clear that a patient may withdraw consent to the review meeting and to the disclosure of information in accordance with the arrangements under subsection (1). Subsection (7) provides that 'arrangements' under subsection (1) must include provision about how consent may be withdrawn and what is to happen when consent is withdrawn.

54 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 Act (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 in practice, care and treatment review meetings can take place sooner, and at shorter intervals, than set out in the legislation. Again, the provisions also apply to some patients detained under Part 3 of the Act.

55 New section 125C requires that the patient's responsible clinician, the responsible commissioner, integrated care board (ICB) and local authority that receive the report produced following the review must have regard to the recommendations in the report. 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.

56 As part of NHS England's current Dynamic Support Register and Care (Education) and Treatment Review policy and guidance, local health commissioners are required to work with their local partners, including social care and education, to develop and maintain a register of people with a learning disability and autistic people who are at risk of admission to a mental health hospital. This is known as the Dynamic Support Register. The register supports local systems to identify people at risk of admission, review their needs, and mobilise the right support to prevent the person being admitted to a mental health hospital.

57 New section 125D provides a duty on ICBs to establish and maintain a register of people with a learning disability and autistic people, for whom the ICB is responsible, who are at risk of hospital admission under Part 2.

58 Subsection (1) places a duty on ICBs to establish and maintain a register of people for whom the ICB is responsible and who the ICB considers to be autistic or have a learning disability and who have risk factors for detention under Part 2 of the Act.

59 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.

60 Subsection (1)(c) provides that a person must consent to being included in the register (and to the use of their information under the section) or where they lack capacity or competence to do so, the ICB considers that this is in their best interests.

61 Subsection (2) provides that the local authority in which each person included in the register is ordinarily resident must be specified on the register.

62 Subsections (3)(a) and (b) provide a power for the Secretary of State to make regulations specifying the information that an ICB is to include for each individual's entry in a register and the format and content of 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. Subsection (3)(e) provides that regulations may make provision about the withdrawal of consent by a person to their inclusion in the register.

63 Subsection (4) places a duty on the Secretary of State to, by regulations, specify the description of people for which each ICB is 'responsible' for the purposes of 125D. This must identify be people in relation to which the board has commissioning functions.

64 Subsection (5) provides that "risk factors for detention under Part 2 of this Act" mean factors which the Secretary of State considers increase the probability of a person being detained under the Part 2 of the Act. An ICB will consider such risk factors when deciding whether an individual is eligible for inclusion on the register.

65 New section 125E provides that ICBs and local authorities must have regard to certain information and the needs of the local 'at risk' population when carrying out certain commissioning duties (as set out in the clause). These clauses will help ensure the right community provisions are in place for people with a learning disability and autistic people to avoid unnecessary admissions to inpatient settings.

66 Subsection (1) provides that when an ICB is exercising its commissioning functions it must have regard to the information included in its register and any other information it obtains under the clause. Further, an ICB must seek to ensure that the needs of people with a learning disability and autistic people can be met without detaining them under Part 2 of the Act. This clause is meant to ensure that an ICB has a particular focus on the needs of people with a learning disability and autistic people who are at risk of detention under Part 2 of the Act when undertaking its commissioning functions.

67 Similarly, subsection (2) places a similar duty on a local authority to have regard to certain information and the above needs when exercising its market function. 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 autistic people who are or may be at risk of admission.

68 Subsection (3) provides that 'market function' has the same meaning as in section 5(1) of the Care Act 2014.

69 New section 125F provides that the Secretary of State must publish guidance about the exercise of functions in relation to care, (education), and treatment reviews, registers and duties relating to the commissioning of services for Part 8A of the Act. Responsible clinicians, responsible commissioners, ICBs, and local authorities must have regard to this guidance when exercising their functions under this part of the Act.

70 New section 125G is to be used when interpreting the meaning of the following terms of Part 8A of the Act: 'commissioning functions', 'local authority', 'NHS commissioning body', 'responsible clinician', 'responsible commissioner', 'social care provision' and 'special educational provision'.

71 Subsection (2) provides that references to a patient who lacks capacity in this Part has the same meaning as in the Mental Capacity Act 2005. Subsections (3) and (4) explain how ordinary residence is determined for the purpose of this Part.

a. For the purposes of Part 8A, references to ordinary residence, broadly speaking, reflect the new rules for determining ordinary residence of the purposes of section 117 after-care (see clause 44). When it comes to C(E)TRs, the clauses provide that ordinary residence will need to be identified from the point at which the person was admitted to hospital. For the risk register, ordinary residence will need to be determined from the point at which the person was entered on the register and then kept under review.

72 The clauses ensure that the following 'deeming rules' under social care legislation should be applied to the determination of ordinary residence:

a. In relation to those aged under 18, section 105(6) of the Children Act 1989 (as modified), which means that, broadly, any periods should be disregarded when the person was living in certain forms of accommodation, including residential schools, accommodation provided by a local authority and section 117 accommodation.

b. In respect of adults, section 29(1)-(3) of the Care Act 2014, which provide that where a person has needs that can only be met through care home, supported living or shared lives accommodation, and are living in that accommodation, they are treated as ordinarily resident in the area they lived immediately before they moved into this accommodation.

c. In respect of adults, section 39(5) of the Care Act 2014, which provides that a person being provided with accommodation under section 117 of the Mental Health Act 1983 is treated as ordinarily resident in the area of the local authority on which the duty under section 117 is imposed.

73 Some examples of how the ordinary rules would apply are provided below:

a. Where local authority A provides an adult with care home accommodation in another local authority area (local authority B), the person will remain ordinarily resident in the area of local authority A. This means that for the purposes of the C(E)TR and the risk register their ordinary residence will remain in local authority A.

b. Where a child is living at home with their family in the area of local authority A and is moved to a secure children's home in local authority B, their ordinary residence will remain with local authority A for the purposes of the CETR and risk register.

Ordinary residence would remain with local authority A even if the child was detained in hospital and discharged into accommodation provided under section 117 of the MHA, in the area of local authority C.

Grounds for detention and community treatment orders

Clause 5: Grounds for detention

74 Clause 5 amends the criteria for detention under section 2, 3 and 5 of the Act and 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 change the detention criteria to ensure that people can only be detained under these sections if they pose a risk of serious harm either to themselves or to others. This change supports the principle of least restriction, to minimise restrictions on liberty so far as is consistent with ensuring patient wellbeing and safety, and public safety.

75 Apart from aligning the grounds for discharge with the grounds for detention, these changes do not otherwise affect patients who will be detained under Part 3 of the Act, as orders and directions under this Part already have distinct considerations in relation to risks posed by those in the criminal justice system.

76 Clause 5 subsection (2) amends section 2 subsection (2) (admission for assessment) of the Act by introducing risk criteria. The new provisions set out two new tests that must be met to meet the 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". The timeframe in which harm may occur may also be a relevant consideration when considering the detention criteria and further guidance on this will be provided in the Code of Practice.

77 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. The Bill does not define serious harm, further guidance will be provided in the Code of Practice. Secondly, the "nature, degree and likelihood" test introduces a new requirement that the clinician must consider the likelihood that this harm will occur, when deciding to admit the individual under section 2.

78 Subsection (3) (a) amends section 3 (admission for treatment) of the Act. It inserts new wording on risk in alignment with the changes to section 2 described above. Section 3(2)(c) of the Act is amended so that the previous wording, which sets out that an application for admission for treatment may be made in respect of a patient on the grounds that "it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section" in now sets out at subsection (2) (d), "the necessary treatment cannot be provided unless the patient is detained under this Act". The purpose of this change is to clarify that, in cases where a patient satisfies the criteria for detention under section 2 and section 3, a choice can be made about which is the most appropriate section to use.

79 Subsection (4) amends the risk criteria for section 5 (detention for six hours pending application for admission) of the Act, again in alignment with the changes to section 2 of the Act.

80 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 Act, in alignment with the changes to section 3 of the Act so that when a patient's detention is

renewed, the new criteria will apply. This change will also apply to Part 3 unrestricted patients, to whom section 20 applies with the modifications in Schedule 1 Part 1.

81 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 6: Grounds for community treatment orders (CTOs)

82 CTOs, introduced as part of the Act in 2007, provide that people subject to section 3 of the Act, who may otherwise remain detained, may be discharged into the community providing they follow certain conditions. CTOs are intended to maintain ongoing contact with mental health services to provide support and help prevent relapse. In certain circumstances, patients subject to a CTO may be recalled to hospital under the Act.

83 Clause 6 amends the criteria for making a CTO under section 17A of the Act, 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 Act 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,". Subsection (3) substitutes the conditions for renewal of a CTO under section 20A(6) of the Act with the new risk criteria in section 17A(5).

84 The purpose of these changes is to ensure that CTOs are only used when there is a risk of serious harm. This change is intended to help prevent the inappropriate use of CTOs.

85 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 7: Grounds for discharge by tribunal

86 Clause 7 amends sections 72 and 73 of the Act, which concern the powers of the First-tier Tribunal (Mental Health) and the Mental Health Review Tribunal of Wales (together, the Tribunal) to discharge patients. The changes in clause 7 subsection (2) align the grounds for discharge of a patient by the Tribunal with the revised grounds for detention as provided by clause 4. A Tribunal must discharge a patient where the patient no longer satisfies the revised detention criteria relevant to their detention.

87 The new discharge criteria will apply 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 7(3). Subsection (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 Tribunal.

Appropriate medical treatment

Clause 8: Appropriate medical treatment: therapeutic benefit

88 Clause 8 of the Bill inserts a new requirement into the Act, in line with the principle of therapeutic benefit, that when considering whether medical treatment under the Act 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 Act 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 Act, 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 Act. The change will apply to Part 3 patients in the same manner as Part 2.

89 Subsection (2) inserts a new definition of "appropriate medical treatment" into the Act to require that where medical treatment is required under the Act 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. A "reasonable prospect" is one where there is a reasonable possibility that a patient will derive some benefit from the treatment. This does not require the decision maker to conclude that it is more likely than not that the patient will benefit from the treatment. Further guidance on appropriate medical treatment will be provided in the Code of Practice.

90 This new definition applies to the requirement in the criteria for detention under Part 2 section 3, Part 3, and for CTO under section 17A that 'appropriate treatment' must be available to justify detention. This new definition means that in order for someone to be detained or to be subject to a 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.

91 Subsections (3) to (11) of the clause make consequential changes to other provisions of the Act, which make reference to treatment needing to be "appropriate" so that the new definition of "appropriate medical treatment" applies to them.

Clause 9: Discharge of prisoners etc from hospital: treatment condition

92 Sections 50 to 53 of the Act provide for the remission of prisoners or other detainees with severe mental health needs back to their prison or other place of detention (or, where relevant, their release) where no effective treatment for the mental disorder can be given. This test differs slightly from the detention criteria in the rest of the Act 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.

93 Clause 9 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 Act. In practice, this change has no practical or legal effect and is technical in nature.

The responsible clinician

Clause 10: Nomination of the responsible clinician

94 A responsible clinician is an approved clinician (a mental health professional, usually a consultant psychiatrist, approved by, or on behalf of, the Secretary of State for the purposes of the Mental Health Act, with statutory roles and responsibilities). The responsible clinician has the overall responsibility for a patient's case under the Act. Certain decisions, such as renewing a patient's detention or placing a patient on supervised community treatment, can only be taken by the responsible clinician.

95 Clause 10 makes two amendments to section 34 subsection (1) (Interpretation of Part 2) of the Act which contains definitions of certain terms used within the Act. The amendments are 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 responsible clinician 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 responsible clinician.

96 Subsections (3) to (6) then make consequential amendments throughout the Act to apply this extended definition of the responsible clinician.

97 The amendment to the definition of "responsible clinician" to refer to a nomination by the hospital managers seeks simply to clarify the current position in relation to how a responsible clinician is assigned overall responsibility for a patient's care and makes no practical change to the role of a responsible clinician or how they are appointed. This is intended to clarify the distinction between the definition and role of the responsible clinician and the new definition of "community clinician" who will have an increased role in relation to patients on CTOs. The responsible clinician would retain overall responsibility for the patient's case. Further detail on the role of the community clinician can be found at clause 21 (Consultation of the community clinician).

Treatment

98 Part 4 of the Act covers the medical treatment of certain detained patients. It does not apply to those subject to community powers under the Act, such as (for most purposes) patients subject to a CTO who have not been recalled to hospital. Treatment of CTO patients is generally covered under Part 4 A. Part 4 of the Act 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 under section 58A). A number of the clauses that amend Part 4 of the Act include measures to ensure that patients are supported as far as possible to take part in decisions regarding their care and treatment. These measures are informed by the principles of choice and autonomy, the person as an individual and ensuring patients receive therapeutic benefit.

Clause 11: Making treatment decisions

99 Clause 11 amends the Act to insert section 56A. This introduces a duty on the approved 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 4. The duty applies to all treatment given under Part 4 of the Act to any patient, including patients who are consenting, lacking capacity or competence to consent, or withholding consent to treatment.

100 The duty or 'clinical checklist' includes, among other things, the need to consider the patient's past and present wishes and feelings as far as reasonably ascertainable, take 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 alternative forms of medical treatment (see subsection (1)). The intention of this clause is to help ensure that, as far as possible, clinical decisions are tailored to the patient's wishes, preferences, and individual needs (including those expressed in the past, for example in an Advance Choice Document or any other relevant written statement made by the patient when they had the relevant capacity), in line with the guiding principle of choice and autonomy. This is to address the fact that some patients have reported in the past that that their wishes have not been given proper consideration, or that insufficient efforts have been made to establish what it is that they want.

101 Subsection (2) of the duty means that, where the patient lacks the relevant capacity or competence, the clinician must in addition to the matters mentioned in subsection (1)- 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. This is to ensure that, even where a patient is considered to lack capacity or competence to consent to treatment, efforts are still made to personalise their treatment by, for example, looking at their medical history

or past expressions of their wishes and feelings (e.g. those recorded in an Advance Choice Document or any other relevant written statement made by the patient when they had the relevant capacity).

102 Clause 11 also amends other provisions in Part 4 so that, where certification of any treatment is required under the Act, the second opinion appointed doctor or, if applicable, the approved clinician, must confirm in writing whether treatment was given in accordance with the duty under s.56A (sub (3)-(5)) (i.e. the clinical checklist). This is to ensure that the new clinical checklist is followed and that there is written evidence of it having been completed by the approved clinician in charge of the patient's treatment.

Clause 12: Appointment of doctors to provide second opinions

103 Clause 12 amends the Act by inserting new section 56(B) to clarify the role of the regulatory authority (the Care Quality Commission (CQC) in England and in Wales, the Care Inspectorate Wales) in appointing a second opinion appointed doctor, referred to currently in the Act as a 'registered medical practitioner appointed for the purposes of this Part of the Act by the regulatory authority'.

104 The second opinion appointed doctor acts independently, and under the Bill's measures will be responsible for assessing if, for instance, the patient's compulsory treatment has a therapeutic benefit (in line with the new definition of appropriate treatment in clause 8). In addition, they will need to assess if the new duty on clinicians to follow a clinical checklist, which includes (among other things) consideration of the patient's past and present wishes and preferences and an evaluation of available treatment alternatives, has been followed. By making it the responsibility of the second opinion appointed doctor to provide an independent check on whether these new and important safeguards are upheld, we further embed the principles of therapeutic benefit and choice and autonomy in clinical decision making.

Section 58 (medicine) – background)

105 Currently, section 58 of the Act 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 approved clinician or a second opinion appointed doctor must certify that the patient is capable of understanding the nature, purpose and likely effects of the treatment. Alternatively, a second opinion appointed doctor 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 that the patient is not capable of understanding the nature, purpose and likely effects of the treatment.

106 Clauses 13, 14 and 15 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 are organised around whether the patient has or lacks capacity or competence to consent to the treatment in question.

Clause 13: Medicine etc: treatment conflicting with a decision by or on behalf of a patient

107 Clause 13 amends the Act to insert section 57A. This introduces new safeguards for patients who are refusing medical treatment either with capacity or competence at the time, or in a valid and applicable advance decision (which may be expressed as part of someone's Advance Choice Document), 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 that may be specified in regulations made under section 58 subsection (1)(a). The intention of these new safeguards, particularly those that recognise well-established provisions that exist in the Mental Capacity Act 2005, is to strengthen the patient's influence over their care and treatment, thereby further supporting the principle of choice and autonomy.

108 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 second opinion appointed doctor 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)). The intention of this part of the clause is to ensure that the approved clinician gives proper consideration to all other avenues of medical treatment that they consider viable, with a view to finding a medication that the patient is content with (or is likely to be content with, where the patient lacks capacity or competence).

109 Where the clinician in charge of the patient's treatment considers that the 'compelling reason' test is met, a certificate provided by the second opinion appointed doctor 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 8); that the decision to give treatment was made by the approved clinician in line with the new duty to follow a clinical checklist under section 56A; and that in respect of any available alternative treatment 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. It should be noted that, in line with current practice relating to section 58 certificates, the second opinion appointed doctor's certificate may relate to a plan of treatment including one or more forms of treatment or classes or treatment. The exact contents of the certificate will depend on the nature of the patient's refusal and wider circumstances. Subsection (5) further requires that the second opinion appointed doctor must consult two other people who have been professionally concerned with the patient's medical treatment, as part of the certification process. These changes to the second opinion appointed doctor's responsibilities enhance their role in enforcing new safeguards which support the principles of choice and autonomy and therapeutic benefit.

110 This clause requires that the approved clinician secures the second opinion appointed doctor's certification *before* treatment is given. This is a significant change from the current legislation, which allows for the use of compulsory medication for a period of three months before assessment by a second opinion appointed doctor is required. By making it so that the second opinion appointed doctor's certification is necessary before medication can be administered in the face of the patient's refusal or the decision of a donee or deputy or the Court of Protection, the intention is that treating clinicians place more value on finding a medication that is acceptable to the patient. A potential result from this is that we see a reduction in the use of compulsory medical treatment where this is in conflict with a patient's refusal and where there isn't a good rationale for administering compulsory treatment, which we know has a negative impact on patient experience.

Clause 14: Medicine etc: treatment in other circumstances

111 Clause 14 amends section 58 of the Act 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 bringing forward the second opinion appointed doctor's assessment to two months, the use of compulsory medication where the patient lacks capacity/competence to consent, receives independent scrutiny at an earlier point in the patient's treatment course. This helps to ensure that the patient's right to self-determination is being upheld and that the treatment is delivering a therapeutic benefit.

112 Where a patient lacks capacity or competence to consent and the compelling reasons test applies within the first two months of medical treatment, to avoid the second opinion appointed doctor's providing two separate certificates (i.e. one to certify the absence of capacity or competence at two months and one to certify treatment under section 57A), the second opinion appointed doctor is able to provide a single combined certificate covering both issues. This may help to streamline responsibilities on the second opinion appointed doctor's service and minimise administrative burden.

Table 1: Summary of how Clauses 13 and 14 will amend section 58 of the Act 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 14 is that, if the patient is consenting to treatment, after a period of two months an approved clinician or second opinion appointed doctor must certify that: • The patient is validly consenting and • the treatment is appropriate (within the new meaning)
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 13 is that treatment can be given only if there is 'compelling reason' to do so (i.e. there is no alternative medication available or none that the patient accepts) and certification has been provided by a second opinion appointed doctor, which must provide that: • the treatment in question is appropriate; • the decision to give treatment was made by the approved clinician in line with the duties under section 56A; and • in respect of any available alternative treatment/s either the patient has not given valid consent, or 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.
3	Lacks capacity/competence and cannot validly consent to treatment	The effect of clause 14 is that treatment can be given but, after a period of two months, a second opinion appointed doctor must certify that: • the patient lacks the relevant capacity/competence to consent; • the treatment is appropriate.

Clause 15: Electro-convulsive therapy etc

113 This clause amends section 58A (which currently only applies to electro-convulsive therapy) such that it is no longer the role of the second opinion appointed doctor to certify that the decision to administer electro-convulsive therapy 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 by the patient's approved clinician, who will then decide if referral to a second opinion appointed doctor is applicable. This is different to the approach taken under section 57A, where the second opinion appointed doctor is required to certify the presence of valid and applicable advance decision, or decision of an attorney or deputy or the court, before treatment can be given. The main reason for this difference is that, in the case of section 57A, the contents of the advance decision or decision of an attorney or deputy or the court are integral to establishing if a certificate should be issued to permit the use of compulsory treatment, while in the case electro-convulsive therapy the simple presence of an advance decision, or decision of an attorney or deputy or court to refuse electro-convulsive therapy should prevent the use of this treatment.

114 If the approved clinician finds that treatment would not conflict with any of the above, but that the patient lacks capacity to consent, then the second opinion appointed doctor must certify the following before treatment can be given: that the patient lacks capacity to consent; that the treatment is appropriate; and that the decision to give treatment was made in line with section 56A. Compared to the second opinion appointed doctor's current role, under the Bill they will have to apply the new definition of appropriate medical treatment (see clause 7), which puts a greater emphasis on ensuring therapeutic benefit to the patient, and they will need to ascertain if the treating approved clinician has followed the new clinical checklist in coming to their decision to administer electro-convulsive therapy, thereby helping to embed the guiding principle of choice and autonomy.

Clause 16: Review of treatment

115 Clause 16 makes changes to section 61 of the Act to set out the timing at which a report must be provided by the approved clinician to the regulatory authority (in England the CQC, in Wales the Healthcare Inspectorate Wales (HIW)) on the patient's treatment and their condition, where they are not consenting to treatment, so that it is after six months, then six months, then 12 months, within two months of these timeframes. This includes Part 3 patients who have been transferred from guardianship under section 19 regulations, and Part 3 patients who have had a community treatment order revoked after 6 months has passed since their hospital order (new 61(1B). Part 3 CTO-revoked patients within 6 months of their hospital order, and all other Part 3 patients, will retain their existing reporting periods (new

61(1C), bringing all patients into line. This is in line with the current legislation, which requires that a report is provided at the point of each detention renewal, as per section 20, with the exception of the first renewal of section which under the Bill would be at 3 months for relevant cohorts.

116 This clause also gives the regulatory authority the power to require that the approved clinician provides them with a report on the patient's treatment and their condition, where the patient is found to be consenting to treatment falling under section 58A and section 58. If the regulatory authority identifies any concerns, they have the power to require further reports from the approved clinician.

Clause 17: Urgent treatment to alleviate serious suffering

117 Clause 17 removes the power to administer urgent treatment to patients with the relevant capacity or competence on the basis that it is considered immediately necessary to alleviate serious suffering by the patient, as is currently permissible under section 62 of the Act. 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, strengthening the patient's right to self-determination and thereby further embedding 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. This clause otherwise seeks to maintain the ability to administer compulsory medication in urgent circumstances, providing a backstop for exceptional situations.

Clause 18: Urgent electro-convulsive therapy etc

118 This clause inserts new section 62ZA, which introduces additional safeguards for patients where the approved clinician wishes to overrule their refusal of urgent section 58A treatments (currently just electro-convulsive therapy) made 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.

119 Subsection (2) requires that, in order for an approved clinician to administer treatment, a second opinion appointed doctor 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. Current legislation allows urgent electro-convulsive therapy to be administered by the approved clinician without the certification of a second opinion appointed doctor. By requiring the external scrutiny of a second opinion appointed doctor where treatment is being given in the face of a refusal, the patient's autonomy is further protected, and it is better ensured that urgent electro-convulsive therapy is only administered when there is a strong justification for doing so. We recognise that, again, this approach diverges from the changes made under Clause 15. That is because, in this case, the presence of an advance decision does not prevent the use of treatment, and the contents of the advance decision may be important to establishing if a certificate should be issued to permit the use of compulsory treatment.

120 Subsection (6) requires that, before giving a certificate, the second opinion appointed doctor 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 responsible clinician nor the approved clinician in charge of the treatment in question, as well as the patient's nominated person (see clause 23). Consultation with the nurse is to provide a clinical perspective on the patient's condition and the necessity of the treatment in question, which is separate to that of the

approved clinician's. Consultation with the Nominated Person is so that the second opinion appointed doctor can independently gain an understanding of the patient's wishes and feeling, beliefs and values, particularly where the patient is too unwell to engage with the second opinion appointed doctor at the time.

121 Due to the urgent nature of the second opinion appointed doctor's role, subsection (7) states that the request must be made as soon as is reasonably practicable, so that the regulatory authority (in England the CQC, in Wales the Healthcare Inspectorate Wales (HIW)) can, in turn, appoint a second opinion appointed doctor as soon as possible.

122 Clause 18 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 Act to set out the circumstances where the approved clinician can certify the use of urgent electro-convulsive therapy, instead of the second opinion appointed doctor. This is to allow for treatment to go ahead, without the second opinion appointed doctor's approval, in exceptional circumstances. This is because there may be some instances where the second opinion appointed doctor may be unexpectedly prevented from undertaking their role and it is not possible to appoint another second opinion appointed doctor in a safe time period.

123 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 second opinion appointed doctor's certificate of treatment is given within a specified time period. This is to ensure that the second opinion appointed doctor's assessment is undertaken within a safe time period, such that the patient is not put at undue risk. 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. This is because, while currently section 58A applies to electro-convulsive therapy only, if existing regulations are used to insert other treatments under this section, then such treatments may not necessitate the same second opinion appointed doctor certification process as for electro-convulsive therapy. Similarly, it may make sense to only provide for second opinion appointed doctor certification within specific timeframes in particular circumstances.

124 Subsection (7) amends section 119 of the Act to provide that, where a second opinion appointed doctor is required to interview or examine the patient to establish if the administration of urgent electro-convulsive therapy should be certified, they may conduct this function by live video or audio link, if appropriate. This is to ensure that the second opinion appointed doctor's assessment can be conducted within a defined timeframe, avoiding undue risk to the patient in need of urgent electro-convulsive therapy.

Clause 19: Capacity to consent to treatment

125 Under the current Act, 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 19 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 provides clarity by confirming the shared legal concepts between the Act and the Mental Capacity Act 2005 Act (the 2005 Act). It also brings Part 4 in line with Part 4A of the Act, which already adopts this terminology.

126 Subsection (6) provides that references in the 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.

127 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. By cross referencing the 2005 Act, the Bill gives recognition to pre-existing and well-established concepts that seek to provide people with the power to inform their future care and treatment, in case at a later date they are too unwell and lack the capacity to make treatment decisions.

Clause 20: Care and treatment plans

128 The Bill will introduce statutory care and treatment plans with respect to all patients formally detained under the Act, excluding those under short term sections (e.g. section 5(2) which allows detention for 72 hours only). This applies to England only, as there is similar provision already in place in Wales. The main purpose of the new statutory plan is to ensure that all relevant patients have a clear and personalised strategy in place describing what is needed to progress them towards recovery and their timely discharge from the Act.

129 Subsection (1) requires that the appropriate practitioner, as defined in section 34, prepares a care and treatment plan, in respect of all eligible 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 under a CTO, 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 Act, 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.

130 Subsection (3) defines the care and treatment plan as a document containing a plan for meeting the patient's needs, arising from or related to their mental disorder, made in accordance with regulations made by the Secretary of State. The scope of the plan is to include meeting the patient's needs in relation to their care, treatment, leave, and eventual discharge, as well as wider relevant issues such as those relating to the patient's life in the community, for example, their employment and accommodation where this helps meet their needs that arise from or relate to their mental disorder. In addition, the plan may also contain other information, for example, how the patient's communication needs will be met). By setting out what these plans are to contain, the aim is to create a consistent framework that clinicians must follow when preparing a care and treatment plan, thereby helping to ensure that patient's plans are sufficiently comprehensive, while also making them comparable, so they can be more easily quality assured.

131 The plan is also intended to provide evidence about 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 is to ensure greater transparency and scrutiny around clinical decision making, such that detention and the use of

restrictive practice (e.g. compulsory treatment and seclusion) is only used when there is a robust justification. The Independent Review of the Mental Health Act described the new statutory care and treatment plan as the 'cornerstone' of the reforms, delivering on all four of the guiding principles: choice and autonomy; least restriction; therapeutic benefit; and the person as an individual.

132 Pursuant to subsection (4), the regulations may include 'information' about those with whom the patient has a relationship, or other connection, or those to whom the plan is relevant, if this information is for purposes related to meeting the patient's needs, or for the purposes of reviewing or revising the plan or is information contained in a report produced under new section 125A or 125B (as introduced by clause 4). 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 e.g. details of someone who will do this, 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 Act, 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.

133 Subsection (5) introduces requirements around when the plan should be reviewed, such as if the appropriate practitioner is notified that the patient's case is to be considered at a Tribunal hearing, following a care education and treatment review meeting (relevant for patients with a learning disability or autistic patients – see clause 4, or when certain people, including the patient or their Nominated Person - see clause 23, make a reasonable request). By setting out clear trigger points, the aim is that the appropriate practitioner keeps the plan up to date and ensures that it reflects the circumstances of the patient's case.

134 Subsection (6) requires that when the practitioner prepares or reviews the plan that, where practicable 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 nominated person, 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, thereby reflecting the principle of choice and autonomy.

135 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 specifying where a plan is to be prepared, reviewed or revised, when that is to be done.

136 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.

137 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.

138 The clause inserts new section 130ZB, which sets out how patients' plans will be monitored, to ensure that everyone has a care and treatment plan and that these are made in accordance with the legislation to help ensure they are sufficiently comprehensive and up to date.

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 appropriate practitioner in charge of the plan to be requested to review it (subsection (3)).

Community treatment orders

Clause 21: Consultation of the community clinician

139 Clause 21 amends section 17A of the Act 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, and to revoke a CTO after a patient has been so recalled.

140 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.

141 The clause makes a new distinction between a patient's responsible clinician 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 responsible clinician. Clause 21 subsection 7 amends section 34(1) (interpretation of Part 2) of the Act in order to provide a definition of the community clinician as the approved clinician (as defined in section 145 subsection (1) of the Act 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.

142 Subsection (2) amends section 17A(4) of the Act, to require that, where the responsible clinician is not the clinician who will have care for the patient in the community after discharge, then that community clinician must also agree in writing that the CTO criteria are met. This achieves two aims – continuity of care of the patient from the hospital into the community and additional professional oversight.

143 Subsection (3)(a) amends section 17B(2) of the Act so that a CTO may only specify conditions with the agreement of the community clinician, in addition to the AMHP, as is currently required under section 17B(2).

144 Subsection (3)(b) inserts new subsection 17B(5A), which adds a new requirement that a patient's responsible clinician must consult a community clinician who has been involved with the patient's medical treatment in the community, unless the responsible clinician has so been involved, before varying or suspending conditions made as part of a CTO, unless consultation would involve unreasonable delay. The intention is that the opinion of a community clinician is considered in these circumstances by the hospital responsible clinician.

145 Subsection (4) inserts new subsection 17E(2A) in relation to recalls to require that where the responsible clinician is not the community clinician, before a responsible clinician 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 unless consultation would involve unreasonable delay.

146 Subsection (5) inserts new subsection 17F(4A) to require that, after a patient has been recalled to hospital, and before a responsible clinician revokes the CTO to place the patient back on a hospital section, they must first consult the community clinician unless consultation would involve unreasonable delay.

147 Subsection (6) makes amendments to section 20A to require that, when extending a patient's CTO period, the responsible clinician, 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.

148 Subsections (8) and (9) 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 responsible clinician shall specify the conditions to which they are to be subject to the CTO. Subsections (8), (9) and (10) add that that these conditions must be that which the AMHP, as currently, and community clinician have agreed should be specified.

Clause 22: Conditions of community treatment orders

149 The responsible clinician can add, vary or suspend conditions to a person's CTO to require that the person should fulfil particular criteria. This may include, for example, living in a certain place, attending appointments with mental health professionals, or not taking drugs and drinking alcohol. Recall to hospital should not solely be based on whether a person follows these conditions; rather it should be dependent on whether, in the opinion of the responsible clinician, the patient requires medical treatment in hospital for his mental disorder and there would be a risk of serious harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose. However, people on a CTO are often unaware of this and the conditions given to a CTO can therefore be seen as coercive or overly restrictive as not following them can be wrongly understood to be grounds for recall to hospital.

150 Clause 22 makes two amendments in relation to the conditions that a person subject to a CTO may be required to follow.

151 Subsection (1) deletes the words "or appropriate" from the phrase "necessary or appropriate" in section 17B(2), to provide that conditions can only be imposed when they are necessary to serve one or more of the purposes specified.

152 Subsection (2) inserts section 72(3B), which provides a new power for the Tribunal to recommend that the responsible clinician reconsiders whether a particular CTO condition is necessary, in cases where the Tribunal has decided not to discharge a patient from a CTO under section 72(1) of the Act.

Nominated persons

Clause 23: Nominated person

153 Clause 23 introduces a new statutory role to the Act– the nominated person – to replace the nearest relative. The Act currently provides for the role of the nearest relative. It sets out a hierarchical list of 'relatives' and includes a number of rules for identifying the nearest relative 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 nearest relative provisions.

154 The general intention of this reform is that, in place of the nearest relative, a patient would be able to personally select the nominated person to represent them and exercise the relevant statutory functions which the 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.

155 Following the reforms, a nominated person 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 nominated person 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 Act 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 nominated person 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).

156 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 nominated person can be appointed by an AMHP. This nominated person can be in place until the person has the relevant capacity / competence to make their own nomination and does so.

157 The nearest relative currently has a number of important rights and functions under the Act, 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 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 Tribunal (sections 66 and 68(1).

158 The existing nearest relative powers listed in the paragraph above will be transferred to the nominated person role. In addition, the nominated person 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.

159 Currently, if the nearest relative 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 nearest relative. This can prevent the nearest relative 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 interests.

160 As the nominated person will have been identified by the patient as someone they wish to be involved in representing them when detained under the Act, the Bill seeks to provide that the nominated person's use of a power can sometimes be temporarily overruled, but that this does not require the nominated person being removed or displaced altogether, to ensure that where appropriate they continue to have a role in the patient's care and treatment while they are detained.

161 The nominated person 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.

162 The process in which the use of a nominated person power can be overruled is via section 25 of the Act (i.e. the barring order). Currently, under section 23, the nearest relative can order a patient's discharge from detention or from a CTO (where this follows detention under section 3). The nearest relative must give 72 hours' notice in writing to the hospital.

163 The nearest relative's order may be barred if, within the 72 hours, the patient's responsible clinician 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).

164 The barring report prevents the nearest relative from ordering discharge at any time in the six months following the date of the report. This time period has been amended by the Bill to three months in order to align with the updated detention periods set out in these reforms. This is set out under clause 25.

165 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 Tribunal for the patient's discharge instead.

166 All of the above relating to the barring order will apply for the nominated person.

167 Clause 23 introduces Schedule 2 and describes its contents. The Schedule deals with the appointment of a nominated person and transfers existing functions conferred on the nearest relative. The new functions conferred on a nominated person are provided for by clauses 23 to 27.

168 Schedule 2 inserts section 30A and section 30B into the Act.

169 New section 30A introduces new Schedule A1 into the Act which confers the power to appoint a nominated person for a patient for the purposes of this Act and makes provision about the duration of the appointment.

170 New section 30B 'Power of court to terminate appointment of nominated person' replaces section 29, which sets out the procedure for displacement of a nearest relative. It provides that the county court may make an order terminating the appointment of a nominated person. 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.

171 The county court may make an order terminating the appointment of a nominated person. 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.

172 An application for an order under this section may only be made on the grounds that—

a. The nominated person unreasonably objects to the making of an application for admission for treatment, or a guardianship application in respect of the patient;

b. The nominated person 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 Act or is likely to do so;

c. The nominated person unreasonably objects to the making of a CTO in respect of the patient;

d. The patient has done anything which is clearly inconsistent with the nominated person remaining the patient's nominated person. 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 nominated person but lacks capacity to revoke them, and the criteria for displacement are not met;

e. The nominated person lacks the capacity or competence to act as a nominated person; and

f. The nominated person is otherwise not a suitable person to act as a nominated person.

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

174 Schedule A1 concerns the appointment of a nominated person by a patient. A person (the "patient") may appoint a person to act as their nominated person for the purposes of the Act.

175 An individual is eligible to be appointed as a nominated person 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 nominated person).

176 The appointment of a nominated person under Part 1 of Schedule A1 is valid only if the person is eligible to be appointed as a nominated person 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 nominated person in the presence of the witness, that the nominated person meets the age requirement and agrees to act as the nominated person.

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

a. The patient lacks capacity or competence to make the appointment;

b. The nominated person lacks capacity or competence to act as the nominated person;

c. Fraud or undue pressure has been used to induce the patient to make the appointment; and

d. the nominated person is unsuitable to act as a nominated person.

178 The appointment of a nominated person under Schedule A1 Part 1 ceases to have effect if the nominated person dies, the patient appoints a different nominated person, the patient terminates the appointment, the nominated person resigns, or the county court terminates the appointment.

179 The appointment of a nominated person may be terminated by the patient (giving the nominated person 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.

180 A nominated person may resign by giving signed written notice to the patient and either an AMHP, the relevant patient's responsible clinician (if any), the relevant managers (i.e. hospital manager) or the relevant local social services authority (in respect of guardianship).

181 Where an AMHP reasonably believes that a patient lacks capacity or is not competent to appoint a nominated person and has not appointed a person under Schedule A1 Part 1 to act as their nominated person, the AMHP may appoint a nominated person for the patient for the purposes of the Act.

182 A person is eligible to be appointed as a nominated person under Schedule A1 Part 2 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 a nominated person.

183 Where an AMHP is deciding who to appoint as a nominated person 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 nominated person, 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.

184 Where an AMHP is deciding who to appoint as a nominated person for a patient who is aged under 16, the AMHP must give preference to (if the person is willing to act as the nominated person), 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.

185 The appointment of a nominated person by an AMHP is valid only if the person is eligible to be appointed as a nominated person, the person agrees to act as the nominated person, and the appointment is made in writing and signed by the professional. Unlike the appointment process for the nominated person by a patient in which a statement needs to be signed in the presence of a witness (under Schedule A1 Part 1) there is no requirement for the nominated person to sign the instrument in the presence of the AMHP.

186 A nominated person 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 nominated person.

187 Where an AMHP appoints a nominated person, 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.

188 The appointment of a nominated person by an AMHP ceases to have effect if in the case of an individual, they die, an AMHP appoints a different nominated person, an AMHP terminates the appointment, the relevant patient terminates the appointment, the nominated person resigns, the county court terminates the appointment under section 30B, the patient appoints a different nominated person under Schedule A1 Part 1, or the person for whom the nominated person was appointed ceases to be a relevant patient.

189 Where an AMHP has appointed a nominated person for a patient, the AMHP may terminate the appointment by giving the nominated person 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 a nominated person, the person is otherwise not a suitable person to act as the nominated person, or the patient has regained capacity or competence to appoint a nominated person under Schedule A1 Part 1. A nominated person appointed by an AMHP may also resign by giving the patient and either the AMHP, the relevant patient's responsible clinician, the relevant (hospital) managers or the relevant local social services authority, where appropriate, a signed written notice.

190 Under current legislation, certain unrestricted Part 3 patients have been conferred the safeguard of a nearest relative. However, the Act does not currently extend the safeguard of a nearest relative 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. Schedule 2 Part 3 confers the power to appoint a nominated person for these patients.

191 Paragraph 27 addresses this and introduces section 36A (Remands to hospital: Nominated Person) 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 28, new section 30A, new section 30B and schedule A1 are also made applicable to patients subject to an interim hospital order under section 38.

192 Paragraph 29 gives a nominated person for an unrestricted Part 3 patient the following powers:

a. 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

b. The power to object to the use of a CTO.

193 The powers conferred to a nominated person for restricted Part 3 patients have been limited in the interest of public safety and criminal justice. Paragraph 30 limits a nominated person for a restricted patient's powers to the following (whilst nominated persons 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 a nominated person would not alter the outcome, consultation would be inappropriate. Therefore, a nominated person's right to be consulted about transfers will be disapplied. A nominated person should nevertheless be informed about the transfer as soon as is practical.

Clause 24: Applications for admission or guardianship: role of nominated person

194 Clause 24 subsection (2) inserts references to the nominated person into section 11 so that the AMHP should be required to consult the nominated person 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 responsible clinician/appropriate practitioner to consult the nominated person before providing a report for the purposes of renewal of detention or guardianship.

195 The nominated person 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 a nominated person 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. The changes in the Bill allow the AMHP to make use of the barring order on this occasion as AMHPs are professionally fit to judge whether the patient would act in a dangerous manner if they were not admitted or received into guardianship. A.

196 Section 66, which refers to the nearest relative's right to apply to the Tribunal for the patient's discharge, is also being amended to apply to the nominated person and apply where their objection to detention, and guardianship is being overruled.

Clause 25: Discharge of patients: role of nominated person

197 Clause 25 substitutes the word nominated person for nearest relative in section 25 of the Act (restrictions on discharge by nearest relative). The current time limit of six months (i.e. the nearest relative cannot 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 (see clause 28: Detention periods).

Clause 26: Community treatment orders: role of nominated person

198 This clause inserts the new section 17AA 'Community treatment orders: role of nominated person'. Before the responsible clinician makes a CTO, they must consult the patient's nominated person (unless it is not reasonably practicable, or it would involve unreasonable delay). Currently, the nearest relative should be informed of the patient being put on a CTO but there is no requirement to consult with them on the decision, meaning that they currently cannot object to this. Under the reforms, a patient's nominated person may object to the making of a CTO by notifying the responsible clinician.

199 Where the nominated person objects to the making of a CTO by notifying the responsible clinician, the CTO may not be made unless the responsible clinician 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 (i.e. the barring order would apply).

200 Section 66, which refers to the nearest relative's right to apply to the Tribunal, is also amended to cover objections by the nominated person under section 17AA(3) (making a CTO) (subsection(5)).

Clause 27: Transfer of patients: role of nominated person

201 Currently the nearest relative should be informed if the patient needs to be transferred from one hospital to another but there is no requirement to consult with the nearest relative on the decision, meaning that the nearest relative currently cannot object to this. Clause 27 establishes a new right for nominated persons 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 nominated person, unless consultation is not reasonably practicable or would involve unreasonable delay.

Detention periods

Clause 28: Detention periods

202 Clause 28 shortens the period that a patient admitted to hospital 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. This clause is informed by the principle of least restriction and therapeutic benefit.

203 Subsection (2) inserts a new subsection (2A) into section 19 of the Act. 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.

204 Subsection (3) substitutes section 20 subsection (1) and (2) of the Act and also inserts a new section 20(2A). Amended section 20 subsection (1)(a) 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. Amended section 20 subsection (1)(b) retains the six-month initial detention period for guardianship patients.

205 The new section 20 subsection (2) of the Act 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)(a) 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.

206 The new subsection (2A) retains the existing periods of renewal for guardianship. Unlike detention for treatment and CTOs, concerns have not been raised around the renewal periods 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.

207 Clause 28 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.

208 Clause 28 subsection (5) amends Part 1 of Schedule 1 of the Act, which applies the provisions of Part 2 of the Act, 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 (new paragraph 5B of Schedule 1 Part 1) or whose CTO is revoked, and the revocation occurs more than six months after the original hospital order was made (new paragraph 5D of Schedule 1 Part 1). For all other unrestricted Part 3 patients (including those whose CTO is revoked, and the revocation occurs less than six months after the original hospital order was made, via new paragraph 5C to Schedule 1 Part 1) 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 (new paragraph 6 of Schedule 1 Part 1). 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. Paragraph 5(c)(ii) and 6 have the effect of ensuring that renewal periods for transferred guardianship patients run from date of transfer.

209 Clause 28 subsection (6) amends Part 2 of Schedule 1, paragraph 5, which applies certain provisions of Part 2 of the Act with modifications to restricted Part 3 patients.

Periods for applications and references

210 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 for Wales (together the "the Tribunal"), 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 Act.

211 A patient's detention is reviewed by the Tribunal 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 Tribunal within a specified period.

212 The Bill extends the period during which a patient may apply to the Tribunal and extends the existing referral system to increase the frequency and widen the group of patients in respect of whom referrals to the Tribunal must be made ("automatic referrals").

213 These changes are intended to ensure patients have greater access to the Tribunal and those patients who lack the ability or initiative to make an application to the Tribunal can benefit from the safeguard of increased independent judicial scrutiny of their detention by the Tribunal on a more regular basis. This measure is informed by the principle of least restriction.

Clause 29: Periods for tribunal applications

214 Section 66(1) of the Act provides patients detained under Part 2 of the Act, and on certain occasions, their nearest relatives, the right to make an application to the Tribunal to have their detention reviewed. Section 66(2) of the Act sets out the periods for when patients (or their nearest relatives) may make such an application. These periods vary depending on the section of the Act under which a patient is detained.

215 Section 75 of the Act makes provision for the occasions when a referral must be made, or the period an application may be made to the Tribunal, in respect of a restricted patient who has been conditionally discharged.

216 Clause 29 will extend the period in which a patient admitted in pursuance of an application for assessment may apply to the Tribunal to be discharged from detention. Clause 29 also

provides conditionally discharged patients the right to apply to the Tribunal for a review of their detention.

217 Subsection (1)(a) amends section 66(2)(a) of the Act (applications to Tribunals) to extend the period in which a patient detained under section 2 of the Act who is detained in hospital pursuant to an application for assessment, can apply to the Tribunal from 14 days to 21 days, beginning with the day on which the patient is admitted.

218 Subsection (1)(b) amends section 66(2)(b) of the Act, to reduce the period in which a patient who is admitted to a hospital under section 3 of the Act in pursuance of an application for admission for treatment, can apply to the Tribunal, from six months to three months. This change reflects the amendments made by clause 28(3), which shortens the initial detention period for patients admitted for treatment under section 3 from six months to three months.

219 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 Act.

220 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") and who have not been recalled to hospital, have the right to make an application to the Tribunal 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.

221 Subsection (2)(c) inserts a new subsection (2A) after section 75(2) of the Act to provide patients who are conditionally discharged and subject to DoL conditions the right to make an application to the Tribunal 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 30: References to tribunal

222 Section 68 of the Act places a duty on hospital managers to refer patients automatically to the Tribunal in specified circumstances. This section applies to patients who are detained in hospital under Part 2 of the Act, patients detained in hospital under Part 3 of the Act who are not subject to any special restrictions ("unrestricted Part 3 patients"), and patients subject to a community treatment order.

223 Clause 30 amends the Act in relation to automatic referrals by hospital managers for those patients to whom section 68 of the Act applies.

224 Subsection 4(b) amends section 68 subsection (2) of the Act 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 Act. 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 Tribunal.

225 Subsection (4)(c)(i) and (ii) amends section 68 subsection (3) of the Act 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 Tribunal 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 Tribunal.

Section 2 patients

226 Subsection (4)(e) inserts a new subsection (4A) to the Act to bring forward the automatic referral period. 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") whose detention has been extended under section 30B(4), to the Tribunal three months from the day on which the patient was detained under section 2 of the Act.

Section 3 patients

227 Subparagraph (b) of the new subsection (4A) describes the circumstances in which an automatic referral must be made earlier and at more frequent intervals 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 Tribunal, 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 Tribunal, 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 subsequent 12 month period.

Community patients

228 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 Act so that reference to "the 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 Tribunal on the expiry of six months, 12 months and thereafter every subsequent period of 12 months from the date on which the CTO was made.

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

229 Subsection (4)(h) removes section 68 subsection (7) of the Act 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 Tribunal has reviewed their case.

230 Where a patient's CTO is revoked, by virtue of section 17G of the Act (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 Tribunal on the expiry of three months, 12 months and thereafter each subsequent period of 12 months from the date that the CTO was revoked.

231 Section 19 of the Act 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 28 subsection (2) after section 19 subsection (2) of the Act. 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.

232 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 Act (admission for treatment). Consequently, section 68(1)(d) and (e) of the Act 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.

233 Subsection (7) amends Part 1 of Schedule 1, paragraph 10 of the Act, 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 Act 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

234 Subsection 4(g) amends section 68 subsection (6) of the Act 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, to whom section 68 applies, to the Tribunal sooner, where a period of 12 months has elapsed, and the Tribunal has not considered the patient's case. Subsection 4(g) further clarifies that this automatic referral will not be triggered where there is a pending application or reference before the Tribunal in respect of the patient. This referral also safeguards 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 in hospital, or made subject to a CTO for a period longer than 12 months, without having the benefit of a review by the Tribunal.

Consequential changes

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

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

237 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.

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

Clause 31: References to tribunal for patients concerned in criminal proceedings etc

239 Section 71 of the Act currently provides a discretionary power for the Secretary of State to refer a restricted patient's case to the Tribunal at any time. It also requires the Secretary of State to make referrals for restricted patients detained in hospital where the patient's case hasn't been considered by the Tribunal in the preceding three years. There is a delegated power to vary the three year period by order.

240 Section 75 provides for recalled conditionally discharged restricted patients to be referred to the Tribunal within a month of return to hospital, and for conditionally discharged restricted patients to be able to apply to the Tribunal between a year and two years from the discharge, for their detention to be reviewed.

241 Clause 31 amends the current legislative provisions in relation to automatic referrals for mentally disordered offenders subject to special restrictions ("Part 3 restricted patients").

242 Subsection (2)(a) amends section 71(2) of the Act 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 Tribunal, where a period of 12 months has elapsed, and the Tribunal has not considered their case and there is no pending application or reference already before the Tribunal in respect of the patient.

243 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 vary the frequency of automatic referrals for different categories of patients or areas, and make exemptions.

244 Subsection (2)(c) inserts a new section 71 subsections (4A) and (4B) to the Act.

245 The effect of section 71(4A) is to clarify that the Tribunal must exercise the power under section 75 of the Act, when considering the case of a conditionally discharged patient following a discretionary referral by Secretary of State under section 71 subsection (1) of the Act.

246 The new section 71 subsection (4B) extends the Tribunal powers when reviewing the detention of a conditionally discharged patient following a discretionary referral under section 71 subsection (1) to allow the Tribunal 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 Tribunal's power to direct that a restriction order, limitation direction or restriction direction ceases to have effect, thereby discharging the patient from detention.

247 Subsection (3)(a) inserts a new section 75 subsections (2B) to (2I).

248 The new section 75(2B) requires the Secretary of State to refer conditionally discharged patients who are not subject to DoL conditions to the Tribunal 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.

249 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 Tribunal has not considered their case.

250 The new section 75(2D) provides that the new automatic referrals at section 75(2B) and (2C) will not trigger where the Tribunal has already reviewed the patient's detention during the period before the automatic referrals would have been triggered.

251 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 Tribunal. 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).

252 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.

253 The new section 75(2H) ensures that when a referral is made by the Secretary of State it is made to the Tribunal in the area in which the patient is resident.

254 The new section 75(2I) clarifies that when this section refers to the patient's case being considered by the Tribunal it means either by the patient making an application or otherwise.

255 Subsection (3)(b) amends section 75 subsection (3) of the Act to ensure that the Tribunal exercises the powers under section 75 subsection (3) of the Act, when considering the case of a conditionally discharged patient following an automatic referral made under subsection (2B), (2C) or (2E).

256 Subsection (3)(c) inserts a new section 75(4) to extend the power of the Tribunal 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 Tribunal to impose DoL conditions where the relevant threshold is met.

257 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.

258 Subsection (2)(5) is a transitional provision and encompasses all restricted patients as set out in section 79 of the Act. Its effect is to make this section of the Act apply to those patients who became a restricted patient before or after the coming into force of this section of the Act.

Discharge: process

Clause 32: Discharge: process

259 Clause 32 amends section 23 of the Act relating to the discharge of individuals from sections of Part 2 and Part 3 of the Act. This amendment covers section 2, section 3, guardianship under Part 2 of the Act, as well as restricted, unrestricted and guardianship patients under Part 3 of the Act. This amendment also covers patients subject to Community Treatment Orders (CTO).

260 Currently, the responsible clinician in charge of the patient's care and treatment has the power to unilaterally decide to discharge an individual from section 2, section 3 and unrestricted patients subject to a hospital order under Part 3. For patients subject to a restriction under Part 3 of the Act, the decision to discharge (either absolutely or conditionally) remains for the Secretary of State for Justice and/or the Tribunal. Subsection 2A requires that the responsible clinician consults with a person who has been professionally concerned with the patient's medical treatment, and who belongs to a different profession to them, before they discharge (or, in the case of restricted patients, recommend discharge) the individual from detention. The consultee will most likely be a person from the patient's multidisciplinary clinical team, such as an occupational therapist, nurse or psychologist. This amendment seeks to formalise

best practice and is one in a number of other measures that should be taken before an individual can be safely discharged from a hospital bed (as set out in guidance).

261 Subsection 2B requires that the relevant decision maker responsible for discharging an individual from guardianship consults with a second person. Where the responsible clinician is taking the decision to discharge the individual, they must consult with a person who (as above) has been professionally concerned with the patient's medical treatment, and who belongs to a different profession to them. Where it is a member of the responsible local services authority taking the decision to discharge, they must consult with a person who has been professionally concerned with the patient's care and treatment, such as the social worker with oversight of the individual's welfare. Where, in the case of Part 2 guardianship, it is the Nominated Person taking the decision to discharge, they must consult with the responsible local services authority.

262 Subsection 2C requires that, where someone is under a CTO, the responsible clinician must consult with the community clinician, if they are not themselves the community clinician, before they discharge from the CTO. Where it is hospital managers making the decision to discharge an individual from a CTO, they must consult with the community clinician first. This provides additional professional oversight, and the intention is that the community clinician would have knowledge of the patient's engagement with treatment in the community, what benefit is being provided by the CTO, and whether it is suitable for the person to be discharged from this.

Patients concerned in criminal proceedings or under sentence

Clause 33: Conditional discharge subject to deprivation of liberty conditions

263 Clause 33 amends section 42 of the Act, creating a power that allows the Tribunal 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.

264 Restricted patients can be subject to conditions when discharged by the Tribunal 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.

265 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.

266 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 Act. This meant that, if the Tribunal 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 escorted section 17 leave process set out in the Mental Health Casework Section Guidance: Discharge conditions that amount to a deprivation of liberty.

267 Clause 33 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 Tribunal or Secretary of State for Justice is satisfied the conditions are necessary for the protection of others. In making this judgement, the Tribunal 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.

268 Conditional discharge can be affected under the Act by both the Secretary of State for Justice, under section 42, and by the Tribunal, under section 73, where the statutory criteria are met. Clause 33 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 Tribunal'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.

269 Clause 33 subsection (3) amends section 73. New section 73 subsection (5A) allows for conditions amounting to a deprivation of liberty to be imposed where the Tribunal 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 Tribunal. 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.

270 Clause 33 subsection (4) defines deprivation of liberty for the purposes of all the new provisions according to the 2005 Act**.** Clause 33 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 34: Transfers from prison to hospital: conditions

271 Prisoners and other detainees who become acutely mentally unwell in prison or another place of detention, such as an immigration removal centre or youth detention accommodation, can be transferred to hospital for treatment under sections 47 and 48 of the Act. Clause 34 makes two minor changes to how these provisions operate.

272 Part of the detention criteria in the Act 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 (*see the case of R (ASK) v Secretary of State for the Home Department*

[2019] EWCA Civ 1239) held that, in order to exercise the power to make a transfer direction in sections 47 and 48 of the Act, 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.

273 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. Therefore, in order to effectively introduce the new transfer time limit at clause 35, it is necessary to change the threshold as set out in ASK in relation to transfer directions, 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.

274 Clause 34 subsection (2) makes a drafting adjustment to section 47 to clarify this for those serving sentences of imprisonment and clause 34 subsection (3)(a) makes the same adjustment to section 48 to clarify this for all other prisoners and detainees.

275 Clause 34 subsection (3)(b) makes an amendment to section 48(2) of the Act to include an updated list of immigration legislation by which an individual may be detained, ensuring these detainees can also be made subject to a section 48 transfer where they become acutely mentally unwell.

Clause 35: Transfers from Prison to hospital: time limits

276 As set out above in clause 34, sections 47 and 48 of the Act allow the Secretary of State to transfer mentally disordered persons from prisons and other places of detention to hospital for treatment. Clause 35 introduces a statutory 28-day time limit within which agencies must seek to ensure individuals who meet the criteria for detention under the Act are transferred to hospital for treatment.

277 NHS England and HMPPS have already taken steps to encourage health and justice agencies to work towards a 28-day window for transfers from prison and other places of detention to hospital. In 2021, NHS England published good practice guidance on the transfer and remission of adult prisoners and other detainees under the Act which stressed that transfers should not exceed 28 days from the point of initial referral for assessment. Clause 35 adopts an approach consistent with this good practice guidance and goes further by enshrining this time limit in primary legislation to reduce significant delays in individuals accessing treatment.

278 This provision supports the overarching principles of therapeutic benefit and the person as an individual by seeking to reduce the maximum length of time that a patient in prison or another place of detention, such as an immigration removal centre or youth detention accommodation, may have to wait to access inpatient treatment. For example, pending transfer, a patient's mental health may further deteriorate due to them not being able to receive the care they need in a custodial setting. Under clause 35, this new power will seek to ensure that transfers to an appropriate hospital take place more swiftly.

Persons serving sentences of imprisonment transferred under section 47

279 The transfer process is multi-disciplinary, requiring input from numerous health and justice agencies. Clause 35 subsection (2) inserts section 47A into the Act which places the new duty on authorities and bodies involved in a potential transfer, to seek to ensure the transfer takes place within 28 days from the initial referral for a report to admission to hospital, unless there

are exceptional circumstances. For an overview of how the process works, see the NHS England's good practice guidance.[4]

280 If a person serving a sentence of imprisonment exhibits a severe mental health need, the prison or youth detention healthcare team (which could be any of the bodies provided for in 47A(2)(c)) will request an initial medical report to assess if the transfer detention criteria under the Act 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 47A(3)(c)) facilitate the necessary clinical steps needed – two reports from registered medical practitioners and identifying an appropriate bed for the individual.

281 The Secretary of State for Justice and those responsible for running the place of detention in which the individual is being held are responsible for facilitating access to the individual, and organising the physical movement from place of detention to hospital. The Secretary of State for Justice is responsible for issuing the transfer warrant 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).

282 New section 47A(1), (2) and (3) provide for a statutory notice procedure, so that the relevant referring bodies must notify the relevant notified authorities in new 47A(3) and 48B, inserted by clause 35(4). For section 47 transfers, this will be the Secretary of State for Justice, the institution's governor, director or manager (depending on where the person is detained), 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.

283 Section 47A(4) 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 place of detention meaning the patient cannot be safely moved, where hospital provision becomes unavailable owing to a 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 a shortage of hospital accommodation (i.e. beds) or a shortage of hospital staff are not (together or separately) to be counted as exceptional circumstances, unless these shortages have arisen as a result of other exceptional circumstances.

Prisoners and other detainees transferred under Section 48

284 Clause 35 subsection (3) inserts section 48A into the Act which places the new 28-day time limit duties on authorities and bodies involved in a potential transfer for unsentenced prisoners and other detainees to whom section 48 applies.

285 The provision in this clause operates in the same way as that detailed above for new section 47A, by placing responsibilities on the relevant referring bodies responsible for the place of detention in new section 48A(1)(c) to give a statutory notice to the notified authorities in new sections 48A(3) and 48B, requiring all to work together to seek to ensure a transfer within 28 days.

286 As with new section 47A, the duties will only apply to those involved in the transfer of the individual, including those responsible for detaining the individual. Sections 48A(3) and 48B

[4] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0229_ii_Transfer-and-remission-IRC-guidance_080421.pdf

provide that, in prisons and youth detention accommodation, this will be the relevant person (director, governor or manager) of the place in which P is detained. In immigration detention, this will be the relevant manager of the centre, facility or accommodation in which P is detained.

287 Clause 35 subsection (4) inserts new section 48B which sets out the meaning of "detention authority" as referenced in the list of notified authority in sections 47A(3)(b) and 48(3)(b), setting out who the relevant detention authority is, depending on what place of detention the person is held on the day the referral notice is sent.

288 New section 48B(3)(a), read with clause 49, allows the Secretary of State to amend the list of relevant referring bodies and notified authorities provided in sections 47A, 48A and 48B by draft affirmative regulations, to ensure the duty continues to sit with the appropriate bodies if there are changes to commissioning arrangements or responsibilities.

289 New section 48B(3)(b), read with clause 49, allows for the 28-day time limit set out in section 47A and 48A to be amended by draft affirmative regulations.

290 Clause 35 subsection (5) refers to section 49 of the Act in relation to the relevant procedure for the use of the delegated powers inserted by clause 35.

Clause 36: Transfer directions for persons detained in youth detention accommodation

291 Under section 48 of the Act 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 magistrates' court, and civil and immigration detainees, to be transferred to hospital if they are suffering from a mental disorder requiring inpatient care. 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.

292 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. Clause 36 removes the defunct references and ensures all those remanded to youth detention accommodation, including by the Crown Court, can be transferred under section 48 if the criteria is met.

Clause 37: Minor amendment

293 Section 66 of the Act provides specified patients the right to make an application to the Tribunal for a review of their detention on specified occasions. Paragraph 9, of Part 1 of Schedule 1 applies section 66 of the Act, with modifications, to unrestricted Part 3 patients.

294 Clause 37 makes a minor technical amendment to Part 1 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 38: Independent mental health advocates

295 Independent mental health advocates (IMHAs) are specially trained advocates who can support patients detained under the Act to understand their rights under the Act 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 Act. The measures

will also ensure that all compulsory (detained) qualifying 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.

296 Schedule 3 contains amendments to do with IMHAs, which—

a. provide for informal patients in England to qualify for help from IMHAs;

b. impose duties on hospital managers and others to notify providers of advocacy services about qualifying patients, (see paragraph 296 for definition); 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.

297 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.

298 Sections 130A-D of the Act covers 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.

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

300 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 electro-convulsive therapy or any other treatment to which section 58A applies.

301 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.

302 Section 130A of the Act will be amended to extend the right to IMHA services to voluntary patients in England.

303 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 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).

304 New section 130B(2A) of the Act 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.

305 The 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.

306 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 access to IMHA services. This is achieved via a duty on local social services authorities when commissioning IMHA services to ensure that, on becoming aware of a qualifying compulsory patient, providers arrange a visit and determine if the patient wants to use IMHA services or not, and a duty on "the responsible person" (defined as the managers of the hospital or registered establishment, or the local social services authority in relation to patients under guardianship) to provide "required information" about all qualifying patients to the IMHA provider. The "required information" will be prescribed in regulations by the Secretary of State.

307 Section 130CB sets out who is the local social services authority responsible for making arrangements under section 130A(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)).

308 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.

309 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.

310 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 Nominated Person a copy of any information given to the patient in writing.

Clause 39: Information about complaints for detained patients

311 Clause 39 amends section 132 of the Act to place a statutory duty on hospital managers in respect of detained patients to supply complaints information to both the patient and the nominated person. This was previously in the code of practice but will now be a duty under the Act in order to strengthen this safeguard.

312 Hospital managers must provide information both orally and in writing, in line with existing duties to provide information in sections 132 and 132A. Hospital managers must take such steps as are practicable to ensure that patients have understood complaints procedures.

313 New subsection (2A), inserted by clause 39 covers the types of complaints this duty covers. This includes complaints about the carrying out of functions under the Act, and complaints about medical treatment as defined in section 145(1) of the Act. New 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.

314 New subsection (2B) sets out that the duty is triggered as soon as practicable after the patient's detention under a provision of the Act, so will be triggered 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.

315 This duty will not be triggered when a patient is granted leave of absence under section 17.

Clause 40: Information about complaints for community patients

1. Clause 40 amends section 132A of the Act to place a statutory duty on hospital managers in respect of community patients, to supply complaints information to both the patient and the nominated person, in line with the changes made by clause 39 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 41: Information for conditionally discharged patients

316 Clause 41 refers to the new section 132B which requires hospital managers to give complaints information to conditionally discharged restricted patients. Information must 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, orally and in writing, as well as any other steps to ensure the patient understands the information.

317 A copy must also be given to the nominated person within a reasonable timeframe unless the patient otherwise requests.

318 This duty includes restricted patients subject to transfer directions, who can be conditionally discharged under section 74.

Clause 42: Advance Choice Documents

319 Clause 42 inserts new sections 130M and 130N, which create new duties on ICBs, NHS England and Local Health Boards (Wales) in relation to facilitating people to make an Advance Choice Document. An Advance Choice Document can be used by individuals to set out what they want and don't want, while they are well and have capacity or competence to do so, so that the Document can be used by mental health professionals in the event that they are assessed and potentially admitted for care and treatment either informally or formally, and they lack capacity or competence to share these things at the time. Individuals who are most likely to benefit from making an Advance Choice Document are those who may be detained or hospitalised in the future and who have been previously detained under the Act, or have received care and treatment as an informal patient in a mental health hospital. This duty aims to ensure that these individuals are given the opportunity to make an Advance Choice Document while they are in the position to do so – this is normally while they are well and residing in the community, but it may also be for example if the individual is in prison, in a secure children's setting or immigration removal centre.

320 Subsection (3) of section 130M defines an Advance Choice Document as a written statement made by an individual while they have capacity or competence to make the statement, setting out their decisions, wishes and/or feelings about matters that may be relevant to their assessment for admission, and care and treatment as a formal or informal patient, in the event that they lack capacity or competence to make the decision in question. The Document can also include advance decisions under the Mental Capacity Act 2005.Subsections (1)(a) of section 130M and (1)(a) of section 130N place duties on ICBs, NHS England and Local Health Boards (Wales) to make appropriate arrangements so that information about Advance Choice Documents is made available to relevant individuals. Subsections (1)(b) of section 130M and (1)(b) of section 130N place further duties on the same bodies to make appropriate arrangements to support individuals, who wish to receive it, to make an Advance Choice Document. The ICB, NHS England or LHB may decide to implement this duty by providing professional support to individuals or by any other appropriate arrangements.

After-care

Clause 43: Tribunal power to recommend after-care

321 Where a Tribunal does not direct the discharge of a Part 2 patient or community patient during an application or referral to the Tribunal, the Tribunal 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 Act, which also provides the Tribunal with the power to reconvene to reconsider a case in the event that any such recommendation is not complied with.

322 Clause 43 extends the Tribunal's power to make recommendations. Where the Tribunal does not direct the discharge of a patient, it would be able to recommend to the local social services authority and ICB ("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 Act, 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.

323 Subsection (2) amends section 72(3)(a) to give the Tribunal 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.

324 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 Act.

325 The power for the Tribunal 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 Tribunal can challenge the responsible after-care bodies.

Clause 44: After-care services

326 Clause 44 amends section 117 of the Act. Section 117 places a duty on the NHS and local social services authorities to provide after-care to patients who have been detained in hospital for treatment under sections 3, 37, 45A, 47 or 48 of the Act, who then cease to be detained and leave hospital.

327 Subsection (2) applies to decisions to end section 117 after-care taken by the ICBs, or local health boards and local social services authorities. It provides that the provision of section 117 aftercare lasts until the ICB or local health board and local social services authority jointly give notice to the person in writing that they are satisfied that the person is no longer in need of such services.

328 Subsection (3) applies the following 'deeming rules' under social care legislation to the determination of ordinary residence to identify which local authority is responsible for arranging section 117 aftercare to an individual patient:

a. In relation to those aged under 18 in England and in Wales, section 105(6) of the Children Act 1989 (as modified) applies for the purposes of determining the ordinary residence. This means that, broadly, any periods should be disregarded when the child was living in certain forms of accommodation, including residential schools, accommodation provided by a local authority and section 117 accommodation.

b. In respect of adults in England, the deeming rules under section 29(1)-(3) of the Care Act 2014 apply. This provides that where a person has needs that can only be met through care home, supported living or shared lives accommodation, and are living in that accommodation, they are treated as ordinarily resident in the area they lived immediately before they moved into this accommodation.

c. In respect of adults in Wales, the deeming rule under section 194(1)-(3) of the Social Services and Well-being (Wales) Act 2014 apply. This provides that where a person has needs that can only be met through care home accommodation, and are living in that accommodation, they are treated as ordinarily resident in the area they lived immediately before they moved in.

d. In respect of adults in England and Wales, the deeming rule in section 39(5) of the Care Act 2014 applies. This provides that a person being provided with accommodation under section 117 of the Mental Health Act 1983 is treated as ordinarily resident in the area of the local authority on which the duty under section 117 is imposed.

e. In respect of adults in England and Wales, the cross-border provisions of the Care Act 2014 apply. This provides that where a person in England, who has care and support needs and requires residential accommodation to meet those needs, is provided with that accommodation in Wales by a local authority, generally this does not result in a transfer of that authority's responsibility for that person and they are treated as ordinarily resident of the local authority in England. There is similar provision in respect of a person in Wales being provided with accommodation in England.

329 The broad effect of the reforms to subsection (3) are:

330 Where local authority A provides a child or adult with accommodation in another local authority area (local authority B) as part of their s117 responsibilities, the person will remain ordinarily resident in the area of local authority A. This means that if the person is re-detained under section 3 (or another qualifying section), when they cease to be detained and leave hospital, they will be ordinarily resident in the area of local authority A for the purposes of s117 responsibility. (which was the local authority area in which they were ordinarily resident immediately before being detained).

331 Where an adult has been detained under section 3 (or another qualifying section) and, immediately before their detention, they were living in specified accommodation under the Care Act 2014, or Social Services and Well-being (Wales) Act 2014, then the respective

deeming provisions should be used to determine the persons ordinary residence for s117 purposes. This will mean that, when they cease to be detained and leave hospital, they will be ordinarily resident in the area they were living immediately before moving into the specified accommodation.

332 The following sets out a practice example of how the reforms to subsection (3) work for adults in England:

a. Local authority A places an adult into a care home, a supported living, or shared lives accommodation under the Care Act 2014 in local authority B.

b. This adult is then detained under section 3 of the Mental Health Act. Local authority A is responsible for the adult's section 117 after-care.

c. The same adult is placed, by local authority A, upon discharge, into accommodation in local authority C under section 117 of the Mental Health Act. Local authority A is responsible for the adult's section 117 after-care.

d. The patient is then re-detained under section 3 of the Mental Health Act. Local authority A retains ordinary residence by virtue of section 39(4) of the Care Act 2014.

333 The following sets out a practice example of how the reforms to subsection (3) work for adults in Wales

a. Local authority A places an adult into a care home under the Social Services and Well-being (Wales) Act 2014 in local authority B.

b. This adult is then detained under section 3 of the Mental Health Act. Local authority

c. A is responsible for the adult's section 117 after-care.

d. The same adult is placed, by local authority A, upon discharge, into accommodation in local authority C under section 117 of the Mental Health Act. Local authority A is responsible for the adult's section 117 after-care.

e. The patient is then re-detained under section 3 of the Mental Health Act. Local authority A retains ordinary residence by virtue of section 39(4) of the Care Act.

334 The following sets out a practice example of how the reforms to subsection (3) work for children:

a. A child, living with their parents or carers in privately rented accommodation in local authority area A, is detained under section 3 of the Mental Health Act. The Children Act 1989 deeming provisions are not relevant here and so ordinary residence is determined based on its 'usual meaning'.

b. The child is discharged into accommodation in local authority B under section 117 of the Mental Health Act. Local authority A is responsible for s117.

c. The child is then re-detained in local authority B. Local authority A retains s117 responsibility by virtue of section 105 of the Children Act 1989. This is because accommodation under section 117 is to be disregarded under the modified deeming rules. Therefore, they are treated as ordinarily resident in local authority A (which was the local authority area in which they were ordinarily resident immediately before being detained)

335 The following sets out a practice example of how the reforms to subsection (3) work where section 117 after-care does not include accommodation:

a. An adult lives in Local authority A.

b. This adult is detained under section 3 of the Mental Health Act. Local authority A is responsible for the adult's section 117 after-care, which involves community support.

c. The same adult moves of their own choice to Local authority B, whilst still receiving s117 after-care from Local Authority A. The patient is detained again under section 3 of the Mental Health Act and on discharge moves back to local authority B. At this point, local authority B becomes responsible for the adult's section 117 after-care.

Miscellaneous

Clause 45: Tribunal powers in guardianship cases: burden of proof

336 Section 72(4) of the Mental Health Act 2007 (the Act 2007) requires that where an application is made to the appropriate Tribunal by or in respect of a patient who is subject to guardianship, the Tribunal can direct that the patient be discharged if it is satisfied-

a. that the patient is not suffering from a mental disorder; or

b. 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.

337 The effect of this current legislation is that the patient should only be discharged if the patient can prove to the Tribunal that they do not continue to meet the guardianship criteria. The burden of proof is on the patient.

338 Clause 45 reverses the burden of proof so that it rests instead on the local authority responsible for the guardianship to show the Tribunal that the patient continues to meet the guardianship criteria. The effect of the proposed amendment is that the patient should be discharged by the Tribunal unless the local authority can prove that the patient continues to meet the guardianship criteria. This supports the principle of least restriction.

339 Clause 45 amends section 72(4) of the Act 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-

a. the patient is suffering from a mental disorder or;

b. 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 46 Removal of police stations and prisons as places of safety

340 We are removing prison and police cells as "places of safety" under the Act. This is in response to evidence that suggests these settings are not suitable environments for individuals with a severe mental health, in crisis, awaiting assessment and treatment. Alternatives, such as hospitals and other healthcare-based settings, are more appropriate.

341 Before admission to hospital under Part 3 in certain circumstances, a court can order an individual to be detained for a short period of time in a 'place of safety' which currently includes police stations and prisons. This interim provision is used when a bed is not available in a hospital immediately. For civil patients under Part 2, interim detention in a police station as a place of safety is permitted when the police are exercising their powers under sections 135 and 136 of the Act.

342 Clause 46 removes police stations and prisons for Part 3 patients, and police stations for persons to whom section 135 and 136 apply, as a place of safety.

343 Clause 46 subsection (2) removes prisons, and remand centres (which are defunct) from the definition of a place of safety for Part 3 patients. Clause 46 subsection (4)(a) removes police stations from the definition of place of safety in section 135(6) of the Act for the purpose of sections 135 and 136.

344 Clause 46 subsection (3) clarifies that these changes do not apply, in respect of Part 3 patients, to those already detained in a police station or prison when the changes commence.

345 Clause 46 subsection (6) omits section 136A, which relates to the use of police stations as a place of safety.

Clause 47: Remand for a person's own protection etc

346 The Bail Act 1976 provides a general right to bail in criminal proceedings for most unconvicted defendants and for qualifying convicted defendants, the exceptions to which are listed in Schedule 1 to the Act. 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 aged under 18, for their own welfare. Currently, there is nothing to prevent this power being used where the sole concern for refusal of bail is on mental health grounds where, for example, 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 they would otherwise have been bailed were it not for the court's concern for their mental health. The Government considers this provision and this outcome 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.

347 This clause therefore amends the Bail Act 1976 to prevent the remand of an adult defendant for their own protection where the sole concern is their mental health. In such an eventuality, per s.3(6) of the Bail Act 1976, the court may instead impose any bail condition it considers necessary for the defendant's own protection, including a requirement to engage with appropriate mental health support. Courts also have powers under the Act to order that the defendant be remanded into hospital for a report into the defendant's mental condition to be produced, or for treatment, if the conditions for such a remand are met. Under 18s are not included in this provision, as the effect of the Legal Aid, Sentencing, and Punishment of Offenders Act 2012 already precludes the remand of children to custody solely for mental health reasons.

348 Clause 47 subsections (1-4) 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 solely based on concerns about their mental health. Subsection 2 amends the exception to the right to bail as it applies to those accused of indictable-only or either-way offences; subsection 3 makes the same amendment to the exception that applies to those accused of summary only and imprisonable offences; subsection 4 makes the same amendment to the exception as it applies to those accused of summary only but non-imprisonable offences.

349 Clause 47 subsection (5) clarifies that these provisions will only apply to persons before a court after these changes commence.

Clause 48: Removal of interim remand patients to and from Channel Islands or Isle of Man

350 Each separate jurisdiction in the UK has its own mental health legislation. Part 6 of the Act facilitates the transfer of patients between those jurisdictions (England and Wales, Scotland and, Northern Ireland) and between England and Wales on the one hand, and the Crown Dependencies (any of the Channel Islands and the Isle of Man) on the other and provides that when a patient is admitted to hospital in England and Wales, they are to be treated under Part 6 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 Act), 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 of the Crown Dependencies, 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.

351 Clause 48 will remove the exclusions that exist in sections 83, 85 and 91 of the Act 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 48 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.

352 Clause 48 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 6.

353 Clause 48 subsection (3)(a) removes the exclusion for patients in the Crown Dependencies from being transferred 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 6.

354 Clause 48 also inserts Schedule A2 into the Act.

355 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.

356 Different courts in the Crown Dependencies have the power to make remand and interim orders. Schedule A2 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.

357 Schedule A2 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, aside from inherent procedural powers such as adjourning the case to obtain further evidence, and those expressly provided for in the new Schedule (Schedule A2). 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 and the patient is found to not require treatment or their treatment finished and the responsible clinician 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, in line with the prescribed maximum periods, 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 (finding the patient does not require treatment) or treatment is concluded. The modifications prevent the court from terminating a remand (although the court could exercise its discretion not to renew) and 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.

358 Paragraphs 2(1)(a) and (2) allow a court to impose a section 36 on a patient who has previously been transferred from the Crown Dependencies on the equivalent of a section 35, to prevent them from having to be sent back and forth.

359 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 transferred patients will again be subject to the equivalent orders under Crown Dependency legislation and the criminal proceedings may continue as before.

Clause 49: Procedure for certain regulations made by virtue of sections 16 and 31

360 Clause 49 amends section 143(2) of the Act to make provision for the procedure in relation to certain regulations made under the powers in clauses 18 and 35 of the Bill, as set out in the commentary to those clauses.

Clause 50: Data protection

361 Clause 50 creates a new section 142(c), this has the effect that, where there are provisions in the act which provide for data sharing, these are subject to the Data Protection Act 2018.

General

Clause 51: Power to make consequential provisions

362 This clause provides a power which allows the Secretary of State, by regulations, to make provision that is consequential on the provisions in the 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 52: Extent

363 Clause 52 sets out the territorial extent of the Bill, that is the jurisdictions within which the Bill forms part of the law.

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

365 Subsection (2) provides that clauses 51 to 54 of the Bill extend UK wide. This is because the Bill makes amendments to section 143 of the Act, which has UK extent. Clause 49 has UK extent as consequential amendments may need to be made to legislation with UK wide extent.

Clause 53: Commencement

366 This clause makes provision in relation to when the 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 Bill. The clause makes clear, that this transitional and saving provision is additional to transitional provisions made in the Bill itself (and as set out in clause 48(9)).

Clause 54: Short title

367 This clause states the Act's short title as 'the Mental Health Act 2025'.

Financial implications of the Bill

368 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.

369 An Impact Assessment has been prepared for the Bill which outlines the cost implications for bodies and organisations which derive from its proposed measures in England and Wales over a 20-year appraisal period. The Impact Assessment estimates an overall cost of £169 million (2024/25 prices and present value).

370 These reforms are estimated to have an ongoing average annual cost of around £282m (undiscounted, 2024/25 prices). Subject to future funding settlements, 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.

371 In healthcare and social care systems in England, ongoing costs for resourcing the reforms and upfront training costs for existing staff are estimated in the central scenario to total £1.9 billion for the NHS (excluding housing costs for people with a learning disability and autistic people), £78m for the CQC and £396m for Local Authorities (excluding reforms relating to people with a learning disability and autistic people (undiscounted, 2024/25 prices). A further £2.5 billion is required for housing and care costs for the reforms relating to people with a learning disability and autistic people. The increased frequency of referrals to the Tribunal creates costs for Her Majesty's Courts and Tribunals Service (HMCTS) and the Legal Aid Agency, estimated at a total of £287m (undiscounted, 2024/25 prices) in the central scenario for England.

Parliamentary approval for financial costs or for charges imposed

372 The Bill will be introduced in the House of Lords. This section will be completed when the Bill transfers to the House of Commons

Compatibility with the European Convention on Human Rights

373 The Baroness Merron, Parliamentary Under-Secretary of State at the Department of Health and Social Care, has made a statement pursuant to section 19(1)(a) of the Human Rights Act 1998 that, in her view, the Bill is compatible with the European Convention on Human Rights.

374 Issues arising as to the compatibility of the Bill with the Convention rights are dealt with in a separate memorandum.

Duty under Section 20 of the Environmental Act 2021

375 The Baroness Merron, Parliamentary Under-Secretary of State at the Department of Health and Social Care, is of the view that the Bill as introduced into the House of Lords does not contain provision which, if enacted, would be environmental law for the purposes of section 20 of the Environment Act 2021. Accordingly, no statement under that section has been made.

Duty under Section 13C of the European Union (Withdrawal) Act 2018

376 The Baroness Merron, Parliamentary Under-Secretary of State at the Department of Health and Social Care, is of the view that the Bill as introduced into the House of Lords does not contain provision which, if enacted, would affect trade between Northern Ireland and the rest of the United Kingdom. Accordingly, no statement under section 13C of the European Union (Withdrawal) Act 2018 has been made.

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	Yes	Yes	No	No	No	No
Clause 3**	Yes	Yes	In Part	No	No	No	No
Clause 4*	Yes	No	No	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	In Part	No	No	No	No
Clause 8	Yes	Yes	Yes	No	No	No	No
Clause 9	Yes	Yes	No	No	No	No	No
Clause 10**							

Clause 11	Yes	Yes	In Part	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	Yes	Yes	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	No	No	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	In Part	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	In Part	No	No	No	No
Clause 30	Yes	Yes	In Part	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	Yes	No	No	No	No
Clause 34	Yes	Yes	No	No	No	No	No
Clause 35	Yes	Yes	No	No	No	No	No
Clause 36	Yes	Yes	Yes	No	No	No	No
Clause 37	Yes	Yes	No	No	No	No	No
Clause 38*	Yes	Yes	No	No	No	No	No
Clause 39**	Yes	No	No	No	No	No	No
Clause 40	Yes	Yes	In Part	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	Yes	No	No	No	No
Clause 44	Yes	Yes	Yes	No	No	No	No
Clause 45	Yes	Yes	Yes	No	No	No	No
Clause 46**	Yes	Yes	Yes	No	No	No	No
Clause 47	Yes	Yes	In Part	No	No	No	No
Clause 48	Yes	Yes	No	No	No	No	No
Clause 49**							

Clause 50	Yes	Yes	No	No	No	No	No
Clause 51	Yes	Yes	In Part	No	No	No	No
Clause 52	Yes	Yes	No	No	No	No	No
Clause 53	Yes	Yes	No	Yes	No	Yes	No
Clause 54	Yes	Yes	No	Yes	No	Yes	No
Schedule 1**	Yes	Yes	No	Yes	No	Yes	No
Schedule 2**	Yes	Yes	No	Yes	No	Yes	No
Schedule 3*	Yes	Yes	In Part	No	No	No	No
	Yes	Yes	In Part	No	No	No	No
	Yes	No	No	No	No	No	No

* Note: Clauses 4, 20 and 38 and schedule 3 only apply in England and therefore the LCM process is not engaged by these provisions.
** Note: for clauses 3, 7, 10, 23, 28, 29, 39, 46 and 49 and for schedules 1 and 2 we are only seeking an LCM in part, as these clauses contain a mix of reserved and devolved competence.

Subject matter and legislative competence of devolved legislatures

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

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

MENTAL HEALTH BILL [HL]

EXPLANATORY NOTES

These Explanatory Notes relate to the Mental Health Bill [HL] as introduced in the House of Lords on 6 November 2024 (HL Bill 47).

Ordered by the House of Lords to be printed, 6 November 2024

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