Mental Health Bill 2025

Memorandum from the Department of Health and Social Care and Ministry of Justice to the Delegated Powers and Regulatory Reform Committee

A. INTRODUCTION

1. This memorandum has been prepared for the Delegated Powers and Regulatory Reform Committee to assist with its scrutiny of the Mental Health Bill ("the Bill").

2. A version of the Bill was previously published in draft in June 2022 and was subject to detailed scrutiny by a pre-legislative parliamentary committee (the "Joint PLS Committee"). The Joint PLS Committee published its report on the Bill on 19 January 2023 and the Government published its response to that report on 21 March 2024.

3. The Government has now reviewed the Bill, including in light of the Joint PLS Committee report. It has made a number of amendments to the Bill. It has also carefully reviewed the powers to make delegated legislation in the Bill to ensure that all are appropriate and justifiable. In line with existing plans to amend the Bill, one power which permits application of the new 28-day transfer limit to transfers under section 48 with any necessary modifications by regulations has now been replaced with a substantive clause.

4. This memorandum identifies the provisions of the Bill that confer powers to make delegated legislation. In each case it explains why the power is considered appropriate and explains the nature of, the reason for, and the procedure selected.

B. PURPOSE AND EFFECT OF THE BILL

5. The Mental Health Act 1983 (the Act) is the main piece of legislation that covers the assessment, treatment and rights of, and duties associated with, people with a mental health disorder. It provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others. Powers for compulsory admission under the Act are set out in Part 2 and Part 3. Part 2 of the Act deals with patients who are detained in hospital and have no criminal proceedings against them. These are generally referred to as civil patients. Part 3 of the Act is concerned with patients who have been involved in criminal proceedings or are under sentence.

6. The Government seeks to take forward, through the Bill, recommendations for legislative changes made by an Independent Review of the Act ("Independent Review"), which was chaired by Professor Sir Simon Wessely, consultant psychiatrist and professor of psychiatry at King's College London. Sir Simon was commissioned by the then Prime Minister Theresa May to consider the following issues with the current Act:

- the reasons for rising detentions under the Act, which had risen by 40% between 2007 and 2016;
- the disproportionate number of people from black and minority ethnic groups detained under the Act, with black people four times more likely than white people to be detained, and;
- processes that are out of step with a modern mental health care system

7. The Independent Review published its final report, *Modernising the Mental Health Act: Increasing Choice*, *Reducing Compulsion*[1] in December 2018. The Independent Review contained 154 recommendations, covering both legislative reforms and reforms to policy and practice.

8. The Government's Response to the Independent Review was published in its White Paper, *Reforming the Mental Health Act*[2], on 13th January 2021. In the response, the previous Government accepted the majority of the Independent Review's recommendations. The subsequent consultation on the White Paper reported in July 2021, with respondents supportive of the reform proposals.

9. Through this Bill, the Government proposes to take forward the vast majority of the Independent Review's recommendations for legislative change and includes a wide range of changes to shift the balance of power from the system to the patient, putting service users at the centre of decisions about their own care.

10. The Bill has been subject to careful scrutiny by a Joint Parliamentary Committee, chaired by Baroness Buscombe. The Joint PLS Committee, established in July 2022, examined the extent to which the Bill would ensure fewer people were detained against their wishes, promote patient choice, address racial disparities and end the inappropriate long-term detention of people with learning disabilities and autistic people under the Act.

11. The Joint PLS Committee published its report on the Bill on 19 January 2023[3]. It supported the reform of the Act and the intentions behind the Bill and made a number of recommendations. The Government is very grateful to the Joint PLS Committee for its careful consideration.

12. The previous Government responded to that report in March 2024.[4] The Government has now made a number of changes to the Bill, in light of the report and having given further policy consideration. This includes reviewing the Bill, and the planned reforms,

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf
[2] https://www.gov.uk/government/consultations/reforming-the-mental-health-act
[3] https://publications.parliament.uk/pa/jt5803/jtselect/jtmentalhealth/696/report.html
[4] https://www.gov.uk/government/publications/government-response-to-the-joint-committee-on-the-draft-mental-health-bill/government-response-to-the-joint-committee-on-the-draft-mental-health-bill-:~:text=We%20welcome%20the%20committee%27s%20support,when%20it%20is%20absolutely%20necessary.

to be assured that the reformed Act, has the necessary powers to enable clinicians to keep patients and the public safe.

13. The purpose of the Bill is to reform and modernise the Act to provide an effective framework for services to support people experiencing the most serious mental health conditions. These reforms will ensure that patients are more empowered, have more choice and influence over their treatment and receive the dignity and respect they deserve. The measures within the Bill will strengthen patient voice and, together with the non-legislative reforms we are bringing forward to address poor patient experience among people from ethic minority backgrounds. 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 where there is no co-occurring mental health condition that needs treatment under the Act. The planned reforms will not change the fundamental powers and purpose of the Act, which is to detain and treat people when they are so unwell they become a risk to themselves or others. However, when the very serious decision is taken to detain someone, the reforms will ensure 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.

C. DELEGATED POWERS

14. The Bill contains 14 delegated powers. There are two amendments to existing powers to make broader provision, and a new power to issue guidance. There is also an amendment to the existing duty to prepare and revise a Code of Practice under section 118. The Bill also repeals a delegated power. There are four Henry VIII powers, including the power to make consequential amendments. The powers are as follows:

    a. Clauses 1 and 2 - Code of Practice – amendments in relation to duty to prepare, and from time to time revise, a Code of Practice. Clauses 1 and 2 make amendments to the existing duty in the Act on the Secretary of State and Welsh Ministers to prepare a Code of Practice by providing more details as to the existing requirement that the Code of Practice in England contain a statement of principles and extending that requirement to Welsh Ministers in respect of the Code of Practice in Wales. In addition, amendments are made to the section 118 duty by the following clauses of the Bill to expand the scope of the people for whom guidance must be prepared, to include the following persons in respect of their functions:

        i. Para 17 of Schedule 2 to the Bill - for the guidance of nominated persons in relation to their new functions under the Act and for the guidance of health or care professionals within the meaning of paragraph 17 of new Schedule A1 inserted by the Bill in respect of their functions in relation to their new function of witnessing nominated person appointments.

ii. Para 2 of Schedule 3 to the Bill – for the guidance of independent mental health advocates in England, to align with the current position in relation to independent mental health advocates in Wales.

iii. Clause 18(6) – for the guidance of the regulatory authority in relation to their function of appointing "second opinion appointed doctors" in relation to certain treatment.

iv. Clause 42(3) for the guidance of NHS England ("NHSE"), integrated care boards ("ICBs") and Local Health Boards in relation to their new functions under section 130M or 130N regarding advance choice documents.

b. Clause 4 – People with autism or learning disability– duties and power to make regulations regarding a new duty on ICBs to establish registers in respect of people with autism or learning disability who have risk factors for detention under certain provisions of the Act. This is:

i. a duty on the Secretary of State to make regulations specifying the factors the Secretary of State considers increase the probability of a person being detained, ie who have risk factors for detention;

ii. a power for the Secretary of State to make provision regarding the establishment and maintenance of these registers, the information to be included in them, the obtaining and disclosure of that information and the withdrawal of consent; and

iii. a duty on the Secretary of State to make regulations specifying the people that each ICB is responsible for including in its register.

c. Clause 4 – People with autism or learning disability– duty to publish guidance regarding the exercise by certain bodies of functions in respect of persons with autism and learning disability. This is a power for the Secretary of State to issue guidance regarding reviews into the care, treatment, and in certain cases, education, of certain detained patients, guidance regarding the above risk registers and the commissioning functions of certain bodies.

d. Clause 18 – Urgent electro-convulsive therapy etc - Certificates under section 62ZA: powers of appropriate national authority. A power to make regulations regarding the new requirement that a second opinion appointed doctor must provide a certificate before emergency electro-convulsive therapy may be given. The regulations can set a time limit for the certificate and amend the Act by specifying circumstances in which the certificate can be given by the approved clinician, or the second opinion appointed doctor.

e. Clause 20 - Care and treatment plans. A power to make regulations regarding the new duty on appropriate practitioners to prepare care and treatment plans for certain patients. This is a power for the Secretary of State to make regulations setting out the content of a care and treatment plan, and other provision, for example, when such a plan must be prepared by.

f. Clause 30(5)- Repeal of delegated power to reduce periods under section 68 of the Act.

g. Clause 31(2)(b) - References to tribunals for patients concerned in criminal proceedings etc. In the existing power to vary the automatic referral periods at which the Secretary of State must refer a restricted patient to the Tribunal to be considered for discharge, adding power to make provision subject to specified exceptions, and different provision for different cases and areas.

h. Clause 31(3)(a) - References to tribunals for patients concerned in criminal proceedings etc. A new power to vary the periods at which the Secretary of State must refer a conditionally discharged restricted patient (either with or without deprivation of liberty conditions) to the Tribunal for variation of their conditions or absolute discharge.

i. Clause 35(4) and 49 - Transfers from prison etc to hospital: time limits. A power to, by draft affirmative regulations:

    i. Amend the prescribed period for responsible parties to facilitate the removal of a prisoner from prison to hospital for treatment under section 47 or 48 by regulations;

    ii. Alter the list of relevant referring bodies prescribed in new section 47A and 48A; and

    iii. Alter the list of notified authorities prescribed in new section 47A, 48A and 48B.

j. Clause 51 - Power to make consequential provision.

k. Clause 53 - Power to commence provision.

l. Clause 53(6) - Power to make transitional provision.

m. Schedule 3, paragraph 6, inserting section 130CC(4) – Independent Mental Health Advocates. A new power to make regulations setting out "required information" to be provided by a hospital manager or local social services authority to providers of independent mental health advocacy services in relation to patients who qualify for such services.

Clauses 1, 2, 18(6), 42(3), para 17 of Schedule 2 and para 2 of Schedule 3 – Code of Practice

Amendment of existing power conferred on: Secretary of State and Welsh Ministers

Power exercised by: Guidance

Parliamentary procedure: Negative

<u>Context and Purpose</u>

15. Section 118 of the current Act includes a duty on the Secretary of State to prepare, and from time to time, revise, a code of practice in relation to certain specified matters and for the guidance of certain specified people. The Bill amends this duty to bring within the scope of the duty, additional persons in respect of functions that have been newly conferred on them by the Bill.

16. Para 17 of Schedule 2 to the Bill makes provision amending section 118 so that the Code must include guidance for nominated persons in relation to their new functions under the Act. Clause 23 and Schedule 2 to the Bill introduce a new statutory role of nominated person to replace the current nearest relative. This will enable patients to personally select a nominated person to represent them and exercise the statutory functions under the Act, as opposed to having no choice as to who is to represent them as under the current Act.

17. Para 17 of Schedule 2 also amends section 118 to require the code to include guidance for health or care professionals within the meaning of paragraph 17 of new Schedule A1 inserted by the Bill, which sets out provisions relating to the appointment of nominated persons. These include requirements that the instrument appointing a nominated person, or terminating the appointment of a nominated person, must be witnessed The witness must have no reason to think that neither the patient nor the proposed nominated person, lacks capacity or competence to make the appointment, that there is no reason to think that the proposed nominated person is unsuitable to act as such, and that no fraud or undue pressure has been has been used to induce the patient to make, or terminate, the appointment. This new role of witnessing appointments, or terminations of appointments, is conferred on "health or care professionals", as defined by the Bill, or independent mental health advocates.

18. Para 2 of Schedule 3 to the Bill amends section 118 so that the Code is required to include guidance for independent mental health advocates in England. The Code of Practice in Wales is already required to include guidance for independent mental health advocates in Wales by virtue of section 118(1A) of the current Act (by amendments made by the Mental Health (Wales) Measure 2010). Clause 38 and Schedule 3 to the Bill make provision in relation to independent mental health advocates, partly in order to align with existing provisions in the current Act in extending access to independent mental health advocates to voluntary patients and expanding the scope of the help available to them, to align with the current position in relation to independent mental health advocates in Wales.

19. Clause 18(6) of the Bill amends section 118 so that the Code is required to include guidance for the regulatory authority in relation to its functions relating to medical treatment under Part 4. The Bill confers new functions on the regulatory authority in relation to the appointment of "second opinion appointed doctors", who have new functions in relation to certain treatment.

20. Clause 42(3) of the Bill amends section 118 so that the Code is required to include guidance for NHS England, ICBs and Local Health Boards in relation to their new functions in respect of advance choice documents. The Bill introduces new duties on these bodies 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.

Justification for amending the power

21. The Code of Practice provides comprehensive statutory guidance to decision makers under the Act, which they are under a statutory duty to have regard to by virtue of section 118(2D). Where new functions have been conferred on new persons by the Bill, in respect of patients detained under, or at risk of being detained under, the Act, which do not fall within the scope of the existing Code of Practice, it is appropriate for the guidance power to be amended so that the Secretary of State in England, or Welsh ministers in Wales, can provide guidance in respect of those functions. The amendments to section 118 are limited to those necessary as a result of new functions conferred in the Bill, or in order to align with amendments made to section 118 in Wales (in respect of independent mental health advocates), which post-date the Mental Health Act 2007, when the Act was last considered by Parliament.

Justification for taking the procedure

22. The Code of Practice, and alterations to it, are currently required to be laid before Parliament and are subject to the negative Parliamentary scrutiny procedure. The current position under section 118 is confusing because some references to "the Secretary of State" pre-date the transfer of devolved functions to Wales, so should be read, by virtue of the transfer of functions, as meaning the Secretary of State, in relation to England, and the Welsh Ministers, in relation to Wales. And those references to "the Secretary of State", which post-date the transfer of functions (sections 118(2A) to (2D), inserted by the Mental Health Act 2007), should be read only as the Secretary of State in relation to England. The section 118 provisions, which relate to the Parliamentary scrutiny procedure (sections 118(4) and (5)) pre-date the transfer of devolved functions so should be read as applying to both England and Wales (and the respective legislatures). The Bill makes no change in respect of the Parliamentary scrutiny procedure attached to section 118 and the Code of Practice in both England and Wales. But the Bill takes the opportunity to update section 118, both in relation to the functions of the Welsh Ministers post-devolution, and in respect of parliamentary scrutiny of the Welsh Code by Senedd Cymru.

Clause 4 – People in England with autism or learning disability– registers of people at risk of detention

Power in new section 125D(1) and (3) and (4)

Power conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary Procedure: Negative

Context and purpose

23. Clause 4 inserts a new Part 8A into the Act which makes provision in respect of persons with autism or learning disability. The new section 125D requires an ICB to establish and maintain a register of individuals it considers have autism or learning disability who may be at risk of detention under the Act.

24. Section 125D(1)(b) creates a duty on the Secretary of State to make regulations specifying what factors the Secretary of State considers increase the probability of a person being detained which the ICB. The ICB is to include a person on its register who it considers have these risk factors for detention.

25. Section 125D(3) provides the Secretary of State with a general power to make further provision about the register. This is to make provision about the information which must be included in the register, the establishment and maintenance of the register, the obtaining and collecting of personal information for the purposes of the register and disclosing of that information, and a power to make provision about the withdrawal of consent to inclusion in the register.

26. It is intended that regulations will provide a minimum data set which is to be included about individuals on the register, the format of the register, and a power to obtain and disclose information in relation to the register (which will be subject to UK data protection legislation). This will ensure that the registers maintained by the ICBs are consistent and will increase the effectiveness of information sharing across the country, leading to better outcomes for those with autism and learning disability. Regulations will also makes clear the process for withdrawing consent to inclusion and the consequences of that.

27. Section 125D(4) places a duty on the Secretary of State to make regulations specifying the description of people for which each ICB is responsible. The power is limited to providing that the people must be those for whom the ICB has commissioning functions. This is because different ICBs may be responsible for commissioning different services for the same person, so it is necessary to provide which ICB is to include the person its register.

Justification for taking the powers

28. ICBs already maintain registers (as did their predecessor bodies, Clinical Commissioning Groups), but there is no statutory basis which requires them to do so or to do so in a particular way. This has led to ICBs taking divergent approaches to the form and content of these registers.

29. The purpose of taking the power in section 125D(3) is to set down in regulations certain standards which the ICBs are required to comply with (as above). This information will be detailed, and essentially may be a list of things, which is appropriate to be provided for in regulations.

30. For example, it is likely that each register is to include details of the patient's name, whether they are a child, young person (aged 16/17), or an adult, and may also include details of the last review meeting under new sections 125A or 125B (to be inserted by clause 4 of the Bill). The register may also give an indication of the basis on which the "at risk" assessment had been arrived at, as well as details of the patient's clinician or

other health or social care professionals. These details may change and be added to over time – it is a new legislative area, and it may be necessary to include further information in a register to enable commissioners to properly exercise their functions and meet the purposes in section 125E as the policy becomes established. Further NHS England keeps this policy under review – it updated the guidance in January 2023 (which updated previous guidance) and it then reviewed it in December of that year5, and in fact, the guidance has been substantively revised at least 3 times since it was first published in 2015. Thus, setting out this detail in regulations will give sufficient level of flexibility to make any relevant changes depending on how the policy evolves generally, any updates to clinical practice, and any operational policy changes.

31. Further, the Secretary of the State has the power to make regulations such that the ICB may obtain information to ascertain if the clause applies (ie if the person does have learning disability or autism, or may have a risk factor), and obtain information to include in the register. This might be information from patients, their GP, other health and care providers. This will be dependent on what information is to be included in the register and as that is to be set out in regulations, (given it is not static and may change), the provisions regarding the obtaining of this information is also to be provided for in regulations. There is also a power to make regulations such that an ICB may disclose information it has obtained or includes in the register to other bodies, such as LAs, so they can then have regard to it under section 125E, as well as disclosing information to other people who may be involved in the patient's treatment or care. Again, what information is disclosed is dependent on what information is obtained and included in the register.

32. Further, the clause provides that the Secretary of State may make provision regarding withdrawal of consent to the inclusion in the register. It is likely that these regulations will set out how a patient may withdraw consent i.e. the process for that and the consequences of that e.g. how soon afterwards an ICB is to remove them from the register.

33. The primary legislation therefore deals with the overarching principle that registers are to be established, the criteria for inclusion and that consent may be withdrawn; all that is being delegated is the operational detail as to how this works in practice. It is appropriate for this to be dealt with in regulations given these are matters of operational detail and also because the procedure and timings may change as the policy becomes more established and the Department learns from how it works in practice. Taking a delegated power will ensure the law can be amended to reflect best operational practice.

34. In addition to the power, there is also the duty in section 125D(1)(b) to set out in regulations the factors which determine whether an individual is "at risk" of detention. Similar to the power in s 125D(3), the aim of the duty is to ensure that ICBs are as consistent as possible when assessing an individual's eligibility for inclusion on the register. These factors may include (but are not limited to) previous admissions,

[5] https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/ - heading-1

inappropriate housing and increasing and unstable or untreated mental illness. By cross referencing against criteria set out in law, ICBs can make informed assessments about an individual's eligibility for inclusion on the register. The reason for taking a power (as opposed to listing factors out on the face of the draft Bill), is that the risk factors will be regularly updated in line with evolving clinical practice. This will ensure that risk factors are up to date, reflect current clinical concerns on risks and captures all those who would benefit from being included in a register especially given the role of these registers in helping to prevent individuals from being admitted to hospital under the Act (which is particularly detrimental to persons with autism or learning disability). Returning the factors to Parliament at every such instance would be disproportionate. As indicated above, NHS England's guidance was published in January 2023 (which updated previous guidance) and reviewed in December 2023. Making provision in regulations will ensure that the law can keep abreast of evolving policy. This will also assuage concerns that individuals should not be added to, or kept on a register, where new evidence suggests it is no longer appropriate, especially as there is some concern from stakeholders about the paternalistic nature of registers.

35. We also note that this reflects the approach taken in section 77 of the Care Act 2014, which creates a power to make regulations detailing who is to be treated as sight impaired or severely sight impaired for the purposes of the register under that section.

36. As to the duty in section 125D(4) to specify the description of people for which each ICB is responsible (for including in its register), ICBs are responsible for commissioning different services for different people. The rules that determine those for whom an ICB is responsible are a mix of statutory provisions set out in regulations made under the National Health Service Act 2006 (for example, under sections 3(2)(b) and 3A(2)(b))[6] as well as non-legislative rules that are made by NHS England, also under powers in that Act (see in particular rules made under section 14Z317, which determine the group of people for whom each ICB has core responsibility).

37. It is current policy intention that a person is to be included in the register of the ICB which has core responsibility for them, unless they are receiving certain mental health services which another ICB is responsible for commissioning for them, under regulations. Thus, given that the law on which ICB responsibility is largely determined, is set out in rules and regulations, it is sensible to delegate the decision of which ICB is responsible for registering which people, to regulations also. If the Bill were to identify who is to be included in which ICB's register, based on the current commissioning position, but that commissioning position as set out in the rules and regulations, changes in future, the Bill would be out of date. The approach adopted however means that the new law can accommodate future changes. Accordingly, the appropriate way to achieve this is to do so by delegated power.

38. Further, the power is limited such that regulations may provide that an ICB has responsibility for such description of people as are specified in regulations "who must be people in relation to which the integrated care board has commissioning functions." Thus, the Secretary of State does not have power to specify that an ICB has

[6] eg, The National Health Service (Integrated Care Boards: Responsibilities) Regulations 2022 and
[7] https://www.england.nhs.uk/long-read/who-pays/

responsibility to include persons on its register for whom it has no commissioning responsibility.

39. This is entirely appropriate given that the primary legislation sets out that each ICB must establish and maintain a register, and the criteria for inclusion in it. If a person meets the criteria for inclusion, they will be included in a register. All that is being delegated is the decision as to which ICB's register a person is included.

Justification for taking the procedure

40. By virtue of section 143(2) of the Act, regulations made under the power will be subject to the negative parliamentary procedure.

41. The Government considers that this procedure is appropriate and proportionate for regulations of this nature:

    a. the power will relate to finer points of process detail such as the structure of the register and how ICBs are to operate it in practice.

    b. in addition, responsibility for ICB commissioning is also set out in regulations made under this procedure, and these regulations relate to mostly administrative/operational matters: the primary legislation places the duty on ICBs and the criteria for inclusion; the regulations simply provide which ICB is responsible for which persons.

    c. further, there will be no additional obligations which would involve civil or criminal liability.

42. The Government does not consider this to be a controversial area requiring an affirmative procedure. Entry to register will simply enable local areas to help consider how to meet the needs of those with learning disability and autism in the community and does not directly impact on individual's rights – the fact that they are on this register does not mean they will get more or fewer rights. Further, the Government's belief is that such factors have been considered for some time, (albeit are not static) as is apparent in policy guidance referred to above, which sets out the risk factors professionals ought to consider when deciding whether to add individuals to a register.

43. The Government is also of the opinion that because risk factors will be reviewed by those with clinical expertise, as part of NHS England's refresh of the register policy, due diligence and appropriate scrutiny will have been undertaken by those with relevant expertise. Further, an eligible individual will need to provide their consent to be placed on the register so the risk of infringement of individual rights on the basis of this power alone will be minimal.

44. Additionally, the data sharing gateway provided for in section 125D(3)(c) and (d) will be subject to UK data protection legislation. It will also not create additional obligations which would involve civil or criminal liability.

45. Parliament will also have scrutinised the power during the passage of the Bill following introduction and this procedure will afford Parliament appropriate scrutiny of the policy

proposals. Therefore, the Government considers the negative procedure to be appropriate.

Clause 4 – People in England with autism or learning disability - Guidance

Power conferred on: Secretary of State

Power exercised by: Guidance

Parliamentary Procedure: None

Context and purpose

46. Clause 4 (new section 125F) confers a duty on the Secretary of State to publish guidance for a number of persons and public bodies, about the exercise of functions under this new Part 8A. Those bodies will be under a duty to have regard to that guidance.

47. These are functions in respect of persons with autism or learning disability. The guidance will apply to the new duty on the "responsible commissioner" (the relevant NHS commissioning body) to make arrangements for the holding of reviews into the care, treatment and, in respect of children and certain adults with educational, health and care plans (under section 37 of the Children and Families Act 2014), education, of certain detained patients. In addition, the guidance will relate to the new duties in respect of commissioning and registers. Clinicians, Commissioners (ICBs and NHS England) and local authorities will have a duty to have regard to the guidance.

Justification for taking the power

48. The purpose of the guidance is to give practical advice only, to the various bodies to assist them in how they exercise these functions. It is not quasi legislative or legislation in disguise – it is not mandatory, and it will not impose any duties. Bodies to whom guidance is issued will be required to have regard to it. However, having considered it, it will remain open to such a body to depart from the guidance, taking into account the facts of an individual case.

49. In respect of reviews into care, education (where relevant), and treatment of certain detained patients, for example, the legislation provides when these reviews must take place, who receives a review, what the reviews must do and what recommendations they are to make. The clause also provides that a report must be prepared, by when and who it is to be provided to. Thus, the duties are all in the legislation. The guidance however will simply set out granular details and expectations on best practice only, in respect of differing circumstances.

50. Thus, for example, the primary legislation provides that a review must be held within 14 or 28 days of the patient's detention (depending on age/if they have a section 37 Children & Families Act plan) and a further review is to be held 12 months later. However, the guidance in line with the current guidance referred to in paragraph 30 above, will simply suggest that certain and variable circumstances may mean that earlier reviews would be advisable and set out examples of best practice. It is not intended that these earlier reviews must take place on each and every occasion, but

individual circumstances and concerns may mean that a different approach is advisable in a specific situation, and the guidance will assist the public bodies in determining when this might be. Therefore, the guidance will assist in how those bodies exercise their functions, through practical examples based on clinical understanding of persons with autism or learning disability which may adapt over time, and will be based on case examples and individual situations. The guidance will not impose new duties, but will simply provide assistance and give operational detail, on the duties set out in the Bill, based on evolving clinical understanding.

51. In addition, it is anticipated that the guidance will address who should be invited to, or attend, reviews depending on the specific circumstances of the patient or their particular needs. This will not be relevant for all patients, and it would be impossible to set out all of the different circumstances in legislation, but the guidance will give examples of when such situations may arise. For example, where the review concerns a child who attends school, it may be appropriate that the child's headteacher attend the review, however this may depend on details such as the headteacher's knowledge of Special Educational Needs and Disability or their relationship with the child. It may, for example, be more appropriate for the school's Special Educational Needs Co-ordinator or class teacher, who better understands the child's needs, to attend. The guidance will set out factors to be considered when determining this and other similar operational details about how the legislation is to work in practice.

52. In relation to the new duties in respect of commissioning and registers, the guidance will outline matters such as the process ICBs should follow for adding an individual to a register. Matters covered in the guidance will be largely operational – aimed at supporting and assisting commissioners to understand how to fulfil their statutory duty as opposed to imposing further duties on them.

53. The matters which will therefore be dealt with via the guidance will accordingly be targeted and operational in nature. They will be aimed at a number of differing scenarios and circumstances and will seek to address, by way of examples and case studies, the myriad of problems, issues and differing circumstances that may apply in practice, depending on such things like the patient, their age and circumstances. This is to offer assistance to those bodies exercising functions under these provisions, but will not be legislative in nature. It should also be noted, that, as referred to above, policy documents covering these reviews, and registers already exist. The guidance to be issued by the Secretary of State will largely reflect these and will be produced following engagement with NHS England to ensure it reflects the latest position. The Government is requiring bodies to have regard to the guidance to ensure all bodies do so, thereby aiming for consistency of approach in all areas of the country for all patients with autism or learning disability. That said, the guidance itself is not mandatory, it is there to provide assistance only, to offer examples of best practice in a variety of circumstances, and of course bodies may have their own reasons for departing from it.

54. Further, the needs of autistic people or those with a learning disability may also change over time as clinical practice and understanding evolves, and best practice will evolve with this. The guidance will therefore need to be updated regularly. Accordingly, the matters are not appropriate for inclusion in the Bill or in a statutory instrument.

55. By including details in guidance, this will ensure that the advice can be amended quickly to reflect changing circumstances, and practice on the ground, and ensure the content is kept up-to-date, appropriate and relevant to those affected, which would be more difficult if included in the Bill or in a statutory instrument.

56. Further, the Code of Practice prepared under section 118 of the Act is not considered appropriate for the provisions of guidance of this nature. This is because the guidance will be updated frequently and possibly at speed as what is considered best practice changes, for example. The Code of Practice however is subject to Parliamentary procedure which means it cannot be updated so readily to deal with changing needs, circumstances and what is considered best practice. In addition, the Department's view is that the level and type of detail, including lots of case studies, and examples and things to consider in different circumstances, is more appropriate for bespoke guidance rather than the Code of Practice.

Justification for the Procedure

57. Mindful of the Delegated Powers and Regulatory Reform Committee's 12th Report of Session 2021-22[8] published on 24th November 2021, and in particular paragraphs 91 to 100 in Chapter 4 of that Report, it is not considered that a Parliamentary procedure is necessary for guidance issued under this clause.

58. This is because the guidance will supplement the legislative provision and aid policy implementation, for example, by providing examples of best practice. The primary legislation provides details about when a review is to be held, who is eligible, what a review is to do, etc. Thus, by way of example, the primary legislation is clear regarding when a review is to happen. The guidance will however set out issues to consider which might mean an earlier review is advisable depending on the specific circumstances of those who will have such a review. This will not make legislative or quasi legislative provision but rather assist in an already prescriptive landscape and help those subject to the duties determine how best to discharge them in varying circumstances, by reference to examples, case studies, and scenarios and how the duties work in practice.

59. Further, the provision regarding the autism or learning disability register, does contain a regulation making power (clause 4) which gives power to the Secretary of State to make regulations regarding the content of the register, such as the data to be included, information sharing, factors which determine who is eligible to be included on the register. It is considered that Parliamentary scrutiny is appropriate in respect of these provisions. The guidance, on the other hand, will deal with more administrative aspects of the register and accordingly Parliamentary scrutiny is not considered necessary.

Clause 18 -Urgent electro-convulsive therapy etc - Certificates under section 62ZA: powers of appropriate national authority.

[8] Delegated Powers and Regulatory Reform Committee - Reports, special reports and government responses - Committees - UK Parliament

Power conferred on: Secretary of State and Welsh Ministers

Power exercised by: Regulations and Code

Parliamentary Procedure: Negative and affirmative (the affirmative is a Henry VIII power)

Context and purpose

60. The Government proposes a new requirement through the Bill (clause 18 that a second opinion appointed doctor must provide a certificate before urgent electro-convulsive therapy (and the associated medicines) can be given to a patient who has refused electro-convulsive therapy with capacity, either at the time or in an Advance Decision or has a Lasting Power of Attorney/Deputy appointed by the Court of Protection/Court of Protection decision that refuses electro-convulsive therapy. This is intended to be an important safeguard for those refusing electro-convulsive therapy.

61. The duty provides that, in order to proceed with treatment, a second opinion appointed doctor must first provide a certificate within a specified time period. This is based on the Care Quality Commission (CQC) or Health Inspectorate Wales receiving an application from a hospital to appoint a second opinion appointed doctor. This time period would apply from when the CQC or Health Inspectorate Wales receives the application. Through the Bill, the Government proposes a delegated power for the Secretary of State, and in Wales, Welsh Ministers, to make regulations to set this time period, including different deadlines for different types of cases and to provide in regulations that this requirement also applies to certain other forms of treatment under the section.

62. The regulations would also provide for circumstances in which the second opinion appointed doctor requirement can be dispensed with and instead the certificate can be given by the approved clinician in charge of the treatment.

Justification for taking the power

63. The current policy intention in England is to apply a 48 -hour maximum time limit for the certificate. However, the Government wants to keep this maximum time limit under review on the basis that it may need to be reviewed subject to how it works in practice. This may require the extension or reduction of the deadline, and it is therefore necessary to do so by delegated power rather than include the deadline on the face of the draft Bill. In addition, the Government would want flexibility to be able to, for example, vary the deadline for different types of cases and extend this to other forms of treatments that might fall within section 58A (which sets the special rules for electro-convulsive therapy and other treatment).

64. The Welsh Ministers already have separate regulation making powers in respect of section 58A treatment and this power will enable them to set their own deadlines and other relevant matters.

65. The Government would like to set out further detail on the circumstances where it might be appropriate for the second opinion appointed doctor to provide an opinion more quickly than the statutory maximum, for example where a patient has underlying health conditions that put them at increased risk, and that the time limit should be shortened contextually in light of these considerations. This further detail would be set out in the Code of Practice.

66. The Government also intends to use the Code of Practice to provide additional guidance to CQC on how they would be expected to support the provision of this safeguard. Currently the Code of Practice does not formally apply to the CQC or Health Inspectorate Wales. It will therefore be necessary to amend section 118 (i.e. the power pursuant to which the Code of Practice is published) to add in these regulators to the list of those required to have regard to the Code of Practice. But it would only be possible for Government to give guidance to the regulators on the subject of urgent section 58A treatments.

67. The Government also intend to specify in regulations circumstances in which it would be appropriate to dispense with the requirement to obtain a second opinion appointed doctor certificate and instead for the approved clinician in charge of the electro-convulsive therapy to provide the relevant certificate. This is intended to deal with cases which are of such urgency that the delay caused in obtaining the second opinion appointed doctor would place the patient at very serious risk. The precise criteria is something that the Government wishes to test in practice and keep under review, as it should only ever be needed in a very small number of cases. It might be the case that certain cohorts of patients can be identified or that a set of circumstances would be more appropriate. It should be noted that the scope of this power is expressly limited to cases which already require urgent electro-convulsive therapy under the relevant criteria already specified in section 62 of the Act. Therefore the power could only be applied in very limited circumstances.

<u>Justification for the procedure</u>

68. The procedure for the regulations in respect of the timing of the second opinion appointed doctor certificate, exceptions, different cases and transitional etc is negative. This is because the power is closely focused on matters related to the timing of the second opinion appointed doctor certificate and how this would work in practice. These support the statutory provisions in respect of the provision of a second opinion appointed doctor certificate.

69. In contrast the Government recognises that regulations aimed at setting the circumstances in which the second opinion appointed doctor certificate can be dispensed with, is a substantive and important power. In effect, it modifies the statutory requirement of a second opinion appointed doctor certificate and therefore the Government believes that a Henry VIII power is justified so that they can amend the text of the Act so that the whole of the powers in this respect are in one place. It is also subject to the draft affirmative procedure which will ensure appropriate parliamentary oversight over this provision.

Clause 20 Care and treatment plans

Power conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary Procedure: Negative procedure

Context and purpose

70. An appropriate practitioner will, under proposed provisions in the Bill, (clause 20 at new section 130ZA) be under a duty to prepare a care and treatment plan which is a plan for meeting the needs of certain detained patients (both civil patients under Part 2 and Part 3 patients) arising from or connected with their mental disorder, as well patients subject to a community treatment order or guardianship. New section 130ZA(3) of the Act:

    a. Provides that such a plan is a document made in accordance with regulations made by the Secretary of State.

    b. The regulations may also provide other information is to be contained in the plan. The care and treatment plan may include information about persons with whom the patient has a relationship or other connection or to whom the plan is relevant for certain purposes.

    c. It is also proposed, that the Secretary of State may make regulations specifying, when a care and treatment plan must be prepared, reviewed and revised by, and requiring a plan to be revised in specified purposes.

    d. Provision regarding disclosure of information in the care and treatment plan or of other information for the purposes related to the care and treatment plan may also be made.

    e. In addition, the power provides that the regulations may make transitional, consequential, supplemental and incidental provision, as well as different provision for different cases and provisions subject to exceptions.

Justification for taking the power

71. The regulation making power will enable the Secretary of State to make regulations setting out the specific content of a care and treatment plan and specifying when a care and treatment plan must be prepared, reviewed and revised by and requiring that a care and treatment plan is to be revised in certain circumstances. The regulations may make provision subject to specified exceptions, different provision for different cases, and transitional, consequential, incidental or supplemental provision.

72. It is expected that the regulations will require certain information to be included in a care and treatment plan in respect of both Part 2 and Part 3 patients. At this point, this is expected to include:

    a. information about the reasons for a patient's detention,

b. outcomes which the assessment and/or provision of medical treatment for mental disorder during detention are designed to achieve and a care and treatment plan for achieving those outcomes, and

c. information about a patient's wishes and feelings which may impact on their care and treatment.

d. the reasons behind any decision to give the patient compulsory treatment (if applicable) under the Act.

e. the reasons for any use of force for example under the Mental Health Units (Use of Force) Act 2018.

f. details of any services the patient may need on discharge.

g. the outcome of any assessment of the patient's safety and the plan for managing that.

h. details of other persons with a relationship to, or other connection with, the patient or to whom the care and treatment plan is relevant, for certain purposes, for example relatives or those who may be providing care or treatment on discharge. This may also be details of those to be consulted about the care and treatment plan, other than the patient or who have requested a review of the care and treatment plan for example.

i. other information that is important to be aware of during the patient's detention such as whether they wish to fast during certain periods or whether they use sign language or would like an interpreter, for example.

73. In addition, it is expected that regulations will provide that a care and treatment plan must contain, for example, additional information in respect of Part 3 patients, or that certain information need not be included. This information may include information relating to details of the clinical supervisor and the social supervisor (who will be responsible for providing reports to the Ministry of Justice under section 41(6) of the Act), or conditions the patient is subject to, and the reasons for those conditions.

74. Further, it is expected that the regulations may make provision regarding disclosure of the information to be contained in the care and treatment plan or other information for purposes related to the care and treatment plan. This may be to the persons who are to be consulted about the care and treatment plan, or other persons associated with the patient's detention, for example the clinical supervisor. This will ensure that persons who need to know certain information about the patient's care and treatment may receive that information where that would be appropriate and proportionate. The ability to create powers to share data is subject to existing statutory and common law protections relating to the use and sharing of data with the result that any impact on individual rights through use of these powers will necessarily be limited.

75. Care planning is an important aspect of ensuring that relevant mental health patients receive access to timely and high-quality care. The National Institute for Health and Care Excellence has published numerous pieces of guidance on care and treatment planning, which it reviews and updates, to align with the research literature on the

subject. This goes on to inform guidance on care planning and discharge from NHSE and the Department of Health and Social Care at a national level, as well as the guidance developed by Trusts at the local level. It is not expected that what may be considered appropriate to include in a care and treatment plan currently will remain static – some aspects may become obsolete and others may become important and this may happen regularly. Indeed, since the publication of the Act's Code of Practice in 2015, the 'Care Programme Approach' which underpinned care and treatment planning guidance in the Code has been superseded by the Community Mental Health Framework, led by NHSE in 2021. Furthermore, various aspects of NICE and NHSE guidance on care planning has been updated following initial publication, to account for the latest research findings. For example, NICE updated their quality statement on joint care planning in 2019 from the original statement made in 2011[9].

76. By taking a delegated power, the Government aims to ensure that the care and treatment plan requirements can be adjusted to reflect the latest in best practice around care and treatment planning, where appropriate.

77. Furthermore, the information to be included in a care and treatment plan is likely to be very detailed and operational, with the aim of ensuring transparency around clinical decision making, that clinicians properly consider that the detention criteria still stand and to help ensure that patients' wishes play a more central role in their treatment. It is not appropriate to include this level of detail on the face of primary legislation but instead to leave this detail to regulations.

78. In addition, there is provision in Wales regarding the preparation of care and treatment plans for certain patients who receive certain mental health services (see the Mental Health (Wales) Measure 2010. That Measure (section 18), gives power to the Welsh Ministers to make regulations setting out, amongst other things, the form and content of a care and treatment plan and the persons to whom copies of the care and treatment plan are to be provided and there is, accordingly, precedent for taking a delegated power in respect of regulations of this nature.

79. Further, regulations will provide when aspects of the care and treatment plan must be prepared, reviewed and revised by. It is expected that the regulations will provide that certain aspects must be completed earlier than others and that some aspects will need to be reviewed more regularly than others. This is because certain information may not be known at the same time as other information. For example, in respect of Part 3 patients i.e. those in the criminal justice system, it is likely that some information, such as the conditions the patient is subject to on discharge, will not be known until much later than say the reasons for the patient's detention or the medication that is necessary to support their recovery. However, the intention is that that should not delay preparation of the care and treatment plan in respect of information that is known at an earlier point. This means that this will inform when certain aspects of it need to be prepared and reviewed/ revised, and as this is tied to the contents of the plan, and

[9] https://www.nice.org.uk/guidance/qs14/chapter/quality-statement-6-joint-care-planning; https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/; https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/improving-young-people-s-experiences-in-transition-to-and-from-inpatient-mental-health-settings

as the deadlines may change, it is appropriate that the regulations setting out the content of the plan will provide the deadlines for when that content is to be included, revised and reviewed, in the plan.

80. Regulations may also provide for the disclosure of information contained in a care and treatment plan and disclosure of other information for the purposes of functions under this provision. Again, this will be dependent on the content of a plan, but it's likely that those to be consulted on the preparation or review of a plan, may need to be informed of some of its content - for example, why the patient is being detained as that may impact on their responses, and those preparing for the patient's discharge may also need to know about some of the information so they can adequately prepare for that discharge e.g. put in place things to help the patient's transition or arrange services. It is appropriate to leave this detail to regulations given the content of the plan is to be set out in regulations and may change over time, and therefore it is not possible to provide on the face of the primary legislation what information is to be disclosed to whom. Regarding disclosure of other information, this is likely to be about things consultees have said that may be relevant for the patient or others to be aware of, but which is not in a plan, or information to those providing discharge services which they may need to know, but again, it is appropriate to use regulations to set this out because it is dependent on the content of the plan which again may change over time.

81. Regulations may also provide for transitional, consequential, supplemental or incidental provision. This is because it may be necessary to make transitional provision or incidental provision for example, for patients who are already detained, and who may have been detained for differing periods, under different provisions, when these provisions come into force.

Justification for the procedure

82. By virtue of section 143(2) of the Act, regulations made under the power will be subject to the negative parliamentary procedure.

83. The Government considers that this procedure is appropriate and proportionate for regulations of this nature. The regulations will set out the finer details concerning the information which must be included in a care and treatment plan. This is information which is essentially administrative and procedural in nature. Regulations may also provide that information regarding the patient and certain others must also be included in the care and treatment plan, but this must be for purposes set out in the clause and will be in accordance with existing statutory and common law protections and accordingly does not significantly affect any rights of those persons concerned. In addition, the regulations may provide for the disclosure of information in the care and treatment plan, and again the provision will not significantly affect the rights of individuals but will rather enhance rights as it will ensure that those who need to know about a patient's care and treatment may do so. Finally, the power will not create any new obligations, breach of which will lead to civil or criminal liability. It is for all these reasons that it is considered that the negative procedure is appropriate.

Clause 30(5) Repeal of delegated power to reduce periods under section 68

Context, purpose and justification

84. Clause 30(4) of the Bill amends section 68 of the Act, to increase the frequency of automatic referrals to the tribunal by hospital managers in respect of Part 2 patients and unrestricted Part 3 patients. These changes ensure that patients benefit from more regular tribunal reviews during their detention.

85. Clause 30(5) repeals the power conferred on the Secretary of State and Welsh Ministers to reduce the referral periods under section 68. This power has not been previously exercised. It is considered, in light of the increase to the number of automatic referrals and their occurrences at earlier periods in a patient's detention, that this delegated power is now no longer necessary and should therefore be removed.

Clause 31(2)(b) References to tribunals for patients concerned in criminal proceedings etc – change of order-making power to make provision subject to specified exceptions, and different provision for different cases and areas, where an order is made varying the automatic referral period in section 71

Power conferred on:	Secretary of State
Power exercisable by:	Order made by Statutory Instrument
Parliamentary Procedure:	Affirmative Resolution

Context and purpose

86. Restricted patients are offenders suffering with severe mental health conditions who are detained in hospital for treatment and who are subject to special controls by the Secretary of State for Justice, to protect the public from serious harm. Section 71 of the Act provides that a restricted patient detained in hospital currently has an automatic statutory referral to the First Tier Tribunal (Health and Social Care) ('the Tribunal') every three years, for the Tribunal to consider whether or not to discharge the patient. This period is being reduced to every 12 months, so patients can benefit from more frequent automatic reviews of their detention by a judicial body.

87. There is already a power in section 71 to vary, by affirmative order, the length of the prescribed period in section 71. This power is currently subject to the power to make transitional, consequential, incidental or supplemental provision as the Secretary of State thinks fit. This power is being adjusted by clause 30 to include the ability to make provision subject to specified exceptions, and for different provision for different cases and areas.

Justification for taking the Power

88. Detained restricted patients suffering from mental disorder require stringent safeguards to ensure their detention is regularly reviewed. The Act provides a suite of review mechanisms to enable this. Detained restricted patients can apply to the Tribunal after six months and thereafter every 12 months to have their detention reviewed. Where the Secretary of State considers the patient ought to be reviewed by the Tribunal, they can make a discretionary reference. The patient can also contact the Mental Health Casework Section to ask for review of their restriction order at any

time by the Secretary of State. The automatic referral is an additional safeguard supplementary to these measures.

89. Parliament has already determined that the power to change the referral periods is suitable to be delegated. This measure builds on that power by adding flexibility for specified cases. The detained restricted patient cohort is small and has specific needs (as of December 2021, the hospitalised proportion was 4,600). These patients have been convicted of different categories of offence, and also suffer from a wide range of different mental disorders. They are also subject to detention in different NHS Trust areas in both England and Wales, with varying provision available for their detention and treatment. It is considered that the power to tailor the automatic referral period for specific cases (such as for patients lacking capacity, or in the extremely restrictive high-secure estate, who might need more frequent reviews) will give the Secretary of State the flexibility to adjust the time periods to ensure the safeguards provided by the automatic referral provision are at appropriate intervals for different cases. The expanded scope of the power will also allow for adjustments to be piloted in specified areas, where appropriate, to gather data on impacts before bringing any order into force fully. Owing to the devolved nature of the Tribunal system in Wales, it is considered appropriate to be able to retain power to make express provision in Wales, in line with the structure of the Act more generally.

90. The power could also be used to extend the length of the automatic referral period in some very narrow and specific cases. Some categories of patients with neurodevelopmental disorders which cannot be 'cured' find the Tribunal procedure extraordinarily disruptive and stressful, and it is accepted by those responsible for supervising these patients in the community - social supervisors and clinicians - that participation can lead to regression in therapeutic progress in these patients. In cases such as these, with the appropriate scrutiny, the Secretary of State would be able to adjust the automatic referral period in a tailored manner for this category of patient. Any adjustment to the automatic referral period will not impact the other Article 5(4) compliant safeguards in place for review of these patients' detention.

<u>Justification for the procedure</u>

91. The current power to change the automatic referral period for detained patients and incidental, supplementary consequential and transitional provisions in relation to such an order is subject to the draft affirmative Parliamentary process, as it amends primary legislation, affects the rights of detained patients to an Article 5(4) review of their detention, and has implications for Tribunal resources. The power to make provision subject to specified exceptions, and for different provision for different cases and areas is therefore also suitable for that level of scrutiny. The Government's view is that all matters relevant to an order for specific provision under section 71(3) can be adequately considered via parliamentary scrutiny by draft affirmative resolution.

Clause 31(3)(a)- power to vary the periods at which the Secretary of State must refer a conditionally discharged restricted patient, or a conditionally discharged restricted patient subject to conditions which amount to a deprivation of liberty, to the Tribunal for variation of their conditions or absolute discharge under section 75

Power conferred on:	Secretary of State
Power exercisable by:	Order made by Statutory Instrument
Parliamentary Procedure:	Draft Affirmative Resolution

Context and purpose

92. 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, but there are continuing risks to the public that cannot otherwise safely be managed. This is known as conditional discharge. The Government proposes a new measure in the Bill via clause 30 (known as 'supervised discharge') as the result of the decision in Secretary of State for Justice v MM [2018] UKSC 60. The clause enables patients with specialist needs who require conditions which amount to a deprivation of liberty to be imposed to ensure they are safe to be discharged into the community, either by the Secretary of State or the Tribunal.

93. As discussed above section 71 of the Act as amended by the draft Bill provides for an annual automatic statutory referral to the Tribunal by the Secretary of State for restricted patients detained in hospital. For restricted patients who are conditionally discharged, there is currently no automatic statutory referral mechanism; this is being introduced for the first time by clause 29. Clause 29 provides that, for a patient conditionally discharged and not subject to conditions that amount to a deprivation of liberty, they will be automatically referred to the Tribunal two years after discharge, and every four years thereafter. For patients conditionally discharged subject to conditions that amount to a deprivation of liberty, who are subject to a more restrictive regime, they will be referred to the Tribunal 12 months after discharge and every two years thereafter.

94. The power in new subsection 75(2E) mirrors the existing power in section 71(3) in that it enables the Secretary of State to vary the automatic referral period by draft affirmative order, and to make transitional, consequential, incidental or supplemental provision or different provision subject to specified exceptions, and for different provision for different cases and areas (which will allow for piloting, and regulations which apply specifically to different cohorts of patients, e.g., restricted patients or those with a particular mental disorder). This is therefore a Henry VIII power.

Justification for taking the Power

95. These patients are in the community in much less restrictive conditions than patients detained in hospital. As with detained patients, the automatic referral is only one of a suite of safeguards in place in the Act to provide for review of restrictions placed on patients. A conditionally discharged patient can apply to the Tribunal between six months and two years, and thereafter every two years, to have their conditions and discharge reviewed. The Secretary of State can at any time discharge all restrictions on a patient, either by their own volition or on application by the patient, and can at any time refer the patient to the Tribunal to consider conditions or whether to absolutely discharge.

96. As with detained patients, the Secretary of State considers it is necessary to take the power to vary the automatic referral period by order. Parliament has already determined that the power to change the referral periods is suitable to be delegated in the comparable case. This measure is new and will require careful monitoring and assessment of impact on this unique cohort of vulnerable patients. As the new automatic referral periods take effect, changes may be necessary either to the powers as a whole, or particular changes to make provision for specific cohorts of patients. As the Secretary of State for Justice is also the Lord Chancellor and therefore responsible for the resourcing and guardianship of the Tribunal, it is important that flexibility be maintained on the new system of automatic referrals so adjustments can be made as necessary, and in the context of related Tribunal review powers. It is not considered necessary that full primary legislative scrutiny needs to be applied to make adjustments to the referral periods, as Parliament will have already considered and approved the overall automatic referral period policy. It should be noted that the application periods are not subject to any delegated power to vary.

97. As of December 2021, there were 3,140 conditionally discharged patients – who present different risks, suffer from different types of mental disorders, and are subject to supervision by different Local Authorities. Data indicates many patients on conditional discharge will never be suitable for absolute discharge, owing to the enduring nature of many mental disorders and the risk profiles raised by these mental disorders (for example, paedophilia, paraphilia). As with detained patients, it is considered that the power to tailor the automatic referral period for specific cases is necessary, especially in the case of those patients subject to conditions amounting to a deprivation of liberty. These patients on the one hand may benefit from more frequent reviews than currently prescribed owing to the restrictive nature of the regimes they are subject to in the community. However, in addition these patients in particular can find Tribunal reviews highly distressing and potentially clinically regressive. This issue has been addressed at length by the clinical working group of experts formed as the result of the Independent Review recommendation to introduce the measure at clause 29. Concerns for this cohort's clinical stability and wellbeing will inform any decision to adjust automatic review periods after taking time to assess how the new automatic referral periods bed in for this new measure. The power also gives the opportunity to pilot any change on a smaller group to test the effect, where appropriate.

98. As above, any adjustment to the automatic referral period will not impact the other Article 5(4) compliant safeguards in place for review of these patients' conditional discharge.

<u>Justification for the procedure</u>

99. The current power to change the automatic referral period for detained patients and incidental, supplementary consequential and transitional provisions in relation to such an order is subject to the draft affirmative Parliamentary process, as it amends primary legislation, affects the rights of patients, and has implications for Tribunal resources. It is considered this power is therefore also suitable for that level of delegation, and that affirmative scrutiny can facilitate the ventilation of the relevant clinical issues relating to these patients which may form the basis for a change of referral period in an appropriate manner.

Clause 35(4) and clause 49- power to amend the prescribed period for responsible parties to facilitate the removal of prisoners and other detainees from prison and other places of detention to hospital for treatment under section 47 and 48, by regulations

Power conferred on: *Secretary of State*

Power exercisable by: *Regulations made by Secretary of State*

Parliamentary Procedure: *Draft Affirmative Resolution*

Context and purpose

100. Where a person serving a sentence of imprisonment, other detainee in prison or a person detained under the Immigration Act 1971 or section 62 of the Nationality, Immigration and Asylum Act 2000 is suffering from a mental disorder to the degree that requires inpatient treatment, sections 47 and 48 provide for the Secretary of State to transfer them to hospital for treatment. The Independent Review found that while many transfers to hospital do take place in a timely manner, more needs to be done to reduce the transfer times which lead to negative outcomes for these vulnerable people.

101. Clause 35 introduces a 28 -day time limit within which parties involved in these transfers of offenders, remand prisoners or immigration detainees (the 'relevant referring body' and the 'notified authorities') must seek to ensure that the transfer is executed. These powers allow the Secretary of State to amend the time period of 28 days in 47A(4) and 48A(5) by regulations and the powers are therefore Henry VIII powers. Clause 49 provides for draft affirmative procedure for these measures.

Justification for the power

102. Following the consultation held after the White Paper published after the Independent Review, some stakeholders emphasised that 28 days is considered in some cases too long for a prisoner or Immigration Removal Centre (IRC) detainee to wait for treatment. Given this appetite for a shorter time limit in the future, supported by ongoing work by the NHS,([10]) the Government has determined it is appropriate to take a power to enable the Secretary of State to change the time limit in the future. It is expected that any changes to the limit would be for it to be decreased, to further reduce the time taken for a prisoner to access treatment, however it may also be used to increase the time limit where appropriate. This ability to vary the limit is considered important to retain as the new time limit is bedded in, for example, where insufficient beds are available to meet demand over a sustained period of time. The Ministry of Justice and the Department of Health and Social Care are committed to ensuring an equivalence of care for people in prison when compared to people in the community. This power will also allow the Secretary of State to amend the time limit to keep standards in line with practice for civil patients admitted under Part 2. These changes

([10]) See, eg, June 2021 NHS England and NHS Improvement -Transfers and Remissions Guidance.

are suitable for secondary legislation rather than primary, because of the flexibility and potential speed required.

Justification for the procedure

103. The time limit is a cross-cutting measure affecting the Ministry of Justice, the Home Office, the NHS, and private providers of detention services. Both increasing and decreasing the time limit are considered to require an enhanced level of Parliamentary scrutiny. It is also a matter of considerable interest for wider Health and Justice stakeholders. Decreasing the time limit will bring to bear increased pressure and responsibility on Government Departments, as well as creating more resourcing pressures on the NHS. Increasing the time limit will affect the rights of detainees suffering from severe mental health conditions in the system who require transfer for treatment. It is therefore considered appropriate for the draft affirmative procedure to apply to the regulations, so as to ensure that both Houses are given the opportunity to debate any decision to change the time-period. In particular, this would ensure that sufficient scrutiny was allowed for in the event that a decision was made to increase the time limit beyond 28-days which would be a significant step away from the commitment set out in the White Paper.

Clause 35(4) and clause 49 Hospital treatment for prisoners and other detainees: 28-day transfer period - power to alter the relevant referring body and notified authorities by regulations

Power conferred on:	*Secretary of State*
Power exercisable by:	*Regulations made by Statutory Instrument*
Parliamentary Procedure:	*Draft Affirmative Resolution*

Context and purpose*:*

104. The powers allow for the 'relevant referring body' (defined in section 47A(2)(c)) for offenders and 48A(2)(c) for remand prisoners and other detainees) and the 'notified authorities' (defined in section 47A(3),48A(3) and 48B) to be amended via secondary legislation, to be able to add to or remove from the list of these bodies where responsibilities for components of a transfer change. These are Henry VIII powers. Clause 49 provides for draft affirmative procedure for these measures.

Justification for the power

105. Although the ability to change the list of specified bodies is considered to be an administrative matter, the new obligations require close cross-agency and cross-Governmental collaboration to effect the transfers in the prescribed time frames. Breach of the 28-day duty, without exceptional circumstances existing, will result in the responsible body being amenable to judicial review and potential private law challenges. The addition or removal of bodies will have impact on those bodies and on the transfer process more generally.

106. Current drafting of the clauses reflect current responsibilities for commissioning and providing mental health services within prisons, immigration removal centres and

in low-, medium-, high- secure mental health care and psychiatric intensive care units. These responsibilities may transfer to other bodies without the need for further primary legislation. For example, for patients in England, the responsibilities of ICBs may be amended or delegated to a different body without the need for primary legislation. For patients in Wales, Welsh Ministers may take back some responsibilities currently delegated to Local Health Boards. This power will allow for the amendment of these lists to align with these changes, to ensure the obligations in section 47A and 48A fall upon the correct bodies. This will future-proof the definitions of 'relevant referral body' and 'notified authorities' to ensure that they are accurate and align with any changes to responsibility for the commissioning of provision of mental health services changes to the contracting or subcontracting arrangements relating to immigration removal centres, or changes relating to private prisons.

107. As well as the risk above, which makes it appropriate to delegate the power in the event a body's function changes or moves to ensure all relevant parties remain notifiable and accountable, the power is considered to be comparable with other delegated powers Parliament has granted to change applicable bodies, such as the Public Bodies Act 2011, and section 5 of the Freedom of Information Act 2000.

Justification for the procedure

108. Owing to the onerous obligations imposed upon the bodies listed in sections 47A ,48A and 48B, and the cross-cutting nature of the measure, it is considered that any changes should be subject to the draft affirmative process, to enable Parliament to scrutinise the addition or removal of bodies and the reasons for that.

Clause 51 Power to make consequential provision

Power conferred on**:** the Secretary of State

Power exercised by: Regulations

Parliamentary procedure: Negative procedure. This is a Henry VIII power.

Context and Purpose

109. This clause confers a power on the Secretary of State to make consequential provision that is consequential upon this Bill. Such provision may include repealing, revoking, or otherwise amending primary and secondary legislation (including provision contained in legislation passed before the Bill or later in the same session).

Justification for taking the power

110. A power to make consequential provision is a power commonly taken in Bills to deal with any minor and technical changes necessary in consequence of the changes contained in the Bill, to ensure the effect of the existing provision is preserved. The Bill contains such consequential provisions the Government has identified so far on the face of the Bill, but it is only prudent that the Bill includes a power to deal with consequential amendments or modifications that are identified at a later date.

Justification for the procedure

111. The powers conferred by this clause are limited in scope by the fact that any amendments made under the regulation making power must be consequential on provisions in the Bill. They would therefore be limited to amendments which preserve the effect of the existing provision. The negative scrutiny procedure is therefore considered appropriate and proportionate, despite the fact that in respect of consequential amendments to primary legislation, it is a Henry VIII power, given that the power will not be able to be exercised to make substantive amendment.

Clause 53(4)- Commencement

Power conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary Procedure: None

Context and purpose

112. This clause deals with the commencement provisions of the Bill. It provides that other than specified exceptions set out in subsections (1) to (3), the provisions in the draft Bill come into force on such day as the Secretary of State may by regulations appoint. Different days may be appointed for different purposes.

Justification for taking the power

113. Delegating the power provides flexibility to ensure that the provisions in the Bill come into force at suitable dates which cannot yet be predicted. This will ensure an appropriate period of time for preparation for all the bodies affected. For example, Tribunal Procedure Rules will in some cases require adjustment before commencement can occur.

Justification for the procedure

114. Commencement regulations will be made by statutory instrument. However, it is proposed that this should not be subject to parliamentary procedure given that the detail of the provision to be commenced will already have been scrutinised by Parliament during the passage of the Bill following introduction. This is consistent with usual practice.

Clause 53(6) -Transitional arrangements

Power Conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary procedure: None

Context and purpose

115. This is a standard power for the Secretary of State to make transitional or saving provision in connection with the coming into force of any provision in the Bill, and includes a power to make different provision for different purposes. In particular, we expect that these regulations will deal with how the new provisions apply to patients who are already subject to the Act, when the new provisions in the draft Bill are commenced.

Justification for taking the power

116. The new provisions will give increased rights to patients who are detained under the Act such as more choice over treatment decisions. They will also change the criteria which must be met before a patient may be detained under certain sections of the Act. It is prudent to enable provision to be made to allow for a smooth transition between the existing legislative framework and the Bill's new provisions and to ensure clarity about the status of existing arrangements.

117. The Government proposes to make the necessary provision for transitional arrangements by regulations under the delegated power once the necessary consideration has been given to the appropriate transitional arrangements. The Ministry of Justice, which has policy responsibility in respect of Part 3 patients, has taken a different approach in relation to some of its measures regarding detention criteria, by including some transitional arrangements on the face of the Bill. The power at clause 48(7) is additional to, and without prejudice to, the provisions of the Bill which do make such provision (and as referred to in clause 48(9)). The Departments consider that the differential approach is justified because of the different considerations which apply to civil patients (Part 2) and patients in the criminal justice system (Part 3), not least in terms of the far greater number of Part 2 patients subject to the Act and consequent resourcing implications.

Justification for the procedure

118. No parliamentary procedure is proposed for regulations made under this power. This is consistent with commonly accepted practice to have no procedure for such statutory instruments. The regulation-making power applies only to matters concerned with the transition from the current regime to the new one under the Bill, on commencement.

Schedule 3, paragraph 6, inserting new section 130CC (4) Independent Mental Health Advocates (IMHAs) – power to make regulations setting out "required information" to be provided by a hospital manager or local social services authority to providers of advocacy services in relation to patients, who qualify for independent mental health advocate services.

Power Conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary procedure: Negative

Context and Purpose

119. The Bill widens the duty on local social services authorities to make independent mental health advocates (IMHAs) available to voluntary patients as well as to the existing qualifying compulsory patients. It also widens the scope of the help that must be made available to qualifying patients, to include help for patients to make decisions about their care or treatment and help about how to complain about their care or treatment. Paragraph 6 of Schedule 3 to the Bill inserts new section 130CC, which relates to a new duty on "the responsible person" (hospital managers, or the local social services authority in relation to patients under guardianship) to take such steps as are practicable to give providers of advocacy services "the required information" about patients, who qualify for IMHA help. New section 130 CC (4) provides that "the required information" may be prescribed in regulations made by the Secretary of State. The intention is that the information prescribed by the regulations will be the minimum that is necessary for the provider to have sufficient information but no more, in order that they can comply with their new duties under the Act.

Justification for taking the power

120. The purpose of the power is to ensure that providers of advocacy services in England, on whom the Bill places new duties, have the information they need about qualifying patients to enable them to exercise their new functions in the Bill. Whereas in the current Mental Health Act, the duty on advocacy providers is simply to make IMHA help available to qualifying patients, the amendments made by the Bill require providers, on becoming aware of a new compulsory qualifying patient for whom they are responsible, to visit and interview the patient with a view to determining whether the patient wishes to receive help from an IMHA. Currently the patient has to rely on the hospital manager or ward staff being well-informed as to the IMHA role, informing them of this and the patient saying they wish to receive support. The Government considers this has led to low uptake by qualifying compulsory patients of IMHA services. In relation to qualifying informal patients, the Bill requires the responsible person to take such steps as are practicable, as soon as practicable after the patient becomes a qualifying patient, to ensure that the patient understands that help is available from an IMHA and how the patient can obtain that help.

121. It is appropriate for the "required information" to be set out in regulations as it may need to be adjusted in the future. The intention is that the information given will be the minimum needed in order for the provider to be able to make arrangements to visit and interview the qualifying compulsory patients. The Government will engage further with patients, advocacy providers, local authorities and hospital managers to confirm what is the minimum information that will be needed as this is a new model of access to IMHA services. However, the current expectation is that it will cover: (where known) the patient's name, age, NHS number, and home address, and the date on which they became a qualifying patient for IMHA services. Information sharing must be in accordance with existing data protection law in accordance with clause 50 (inserting new section 142C) of the Bill.

Justification for parliamentary procedure

122. The Government considers that this procedure is appropriate and proportionate for regulations of this nature. The regulations will set out a specified list of information that must be provided by the responsible person (as defined in new section 130CC(2)) to the appropriate responsible advocacy service (as set out in new section 130CB) to ensure the required information is the minimum necessary. The purpose of the provision of this information is administrative and procedural in nature, to enable advocacy providers to comply with their statutory duties to provide greater access to help and support for patients..

Department of Health and Social Care

Ministry of Justice

28 October 2024