

## **MENTAL HEALTH BILL [HL]**

### **EXPLANATORY NOTES**

#### **INTRODUCTION**

1. These explanatory notes relate to the Mental Health Bill [HL] as introduced in the House of Lords on 16th November 2006. They have been prepared by the Department of Health and the Home Office, in consultation with the Welsh Assembly Government, in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill.
2. The notes need to be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a clause or part of a clause does not seem to require any explanation or comment, none is given. The notes on schedules follow the notes on the clauses which introduce them.

#### **LIST OF ABBREVIATIONS USED IN EXPLANATORY NOTES**

3. The following terms are used throughout the explanatory notes:

<b>The 1983 Act</b> - the Mental Health Act 1983
<b>AC</b> – approved clinician
<b>AMHP</b> – approved mental health professional
<b>ASW</b> – approved social worker
<b>CCW</b> – Care Council for Wales
<b>CTO</b> – community treatment order
<b>ECHR</b> – European Convention on Human Rights
<b>ECT</b> – electroconvulsive therapy
<b>GSCC</b> – General Social Care Council
<b>IMCA</b> – Independent Mental Capacity Advocate
<b>LSSA</b> – local social services authority
<b>MCA</b> – Mental Capacity Act 2005
<b>MHRT</b> – Mental Health Review Tribunal
<b>NHSFT</b> – National Health Service foundation trust
<b>NR</b> – nearest relative

<b>PCT</b> – primary care trust
<b>RC</b> – Responsible Clinician
<b>RMO</b> – Responsible Medical Officer
<b>SCT</b> - supervised community treatment
<b>SOAD</b> – Second Opinion Appointed Doctor

## **BACKGROUND AND SUMMARY**

### ***Background***

4. The legislation governing the compulsory treatment of certain people who have a mental disorder is the Mental Health Act 1983 (the 1983 Act). The main purpose of this Bill is to amend that Act but it is also being used to introduce “Bournewood safeguards” (see paragraph 12) through amending the Mental Capacity Act 2005 (MCA).
5. The 1983 Act is largely concerned with the circumstances in which a person with a mental disorder can be detained for treatment for that disorder without his or her consent. It also sets out the processes that must be followed and the safeguards for patients, to ensure that they are not inappropriately detained or treated without their consent. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others.
6. In 1998, the Richardson Committee – an independent expert committee chaired by Professor Geneva Richardson – was set up to review mental health law and to consider what changes were needed. The Richardson Committee presented its report to the Government in July 1999, and the report – *Review of the Mental Health Act: Report of the Expert Committee* – and a Green Paper setting out the Government's proposals for a new Mental Health Act – *Reform of the Mental Health Act 1983, Proposals for Consultation*; Cm 4480 – were published in November 1999.
7. In July 2000, the *NHS Plan* (Cm4818) set out the Government's plans for mental health services, including its plans for reforming mental health legislation.
8. Taking account of views expressed on the Green Paper, in December 2000 the Government published a White Paper – *Reforming the Mental Health Act*; Cm 5016 – which set out a proposed new legal framework for when and how care and treatment should be provided for a person with a mental disorder without his or her consent.
9. In June 2002, the Government published a draft Mental Health Bill for consultation. It was accompanied by a consultation document seeking views about a number of policy areas. Having considered the comments received from the 2002 consultation exercise, the

Government amended the Bill. The amended draft also took account of discussions with stakeholders since 2002.

10. In September 2004, the Government published a revised draft Bill for pre-legislative scrutiny. The Joint Committee on the Draft Mental Health Bill published their report, HL Paper 79-1/HC 95-1, in March 2005. The Government response - *Government response to the report of the Joint Committee on the draft Mental Health Bill 2004*; Cm6624 - was published in July 2005.
11. In March 2006, the Government announced that, having further considered the views expressed about the 2004 draft Bill, it was proposing to amend the 1983 Act rather than replace it.
12. This Bill also amends the MCA. These changes are in response to the 2004 European Court of Human Rights judgment (HLvUK) (the “Bournewood judgment”) involving an autistic man who was kept at Bournewood Hospital by doctors against the wishes of his carers. The European Court of Human Rights found that admission to and retention in hospital of HL under the common law of necessity amounted to a breach of Article 5(1) ECHR (deprivation of liberty) and of Article 5(4) (right to have lawfulness of detention reviewed by a court).
13. A consultation document on the Bournewood judgement was issued for both England and Wales in March 2005 and the consultation period ended in June 2005. The policy proposals in the Bill have been developed in the light of the consultation responses, and further discussions and consideration in the light of those responses.

### ***Summary***

14. The Bill introduces a number of changes to the 1983 Act and the MCA. The following are the main changes to the 1983 Act:
  - **definition of mental disorder:** it changes the way the Act defines mental disorder, so that a single definition applies throughout the Act, and abolishes references to categories of disorder. These amendments complement the changes to the criteria for detention.
  - **criteria for detention:** it introduces a new “appropriate treatment” test which will apply to all the longer-term powers of detention. As a result, it will not be possible for patients to be compulsorily detained or their detention continued unless medical treatment which is appropriate to the patient’s mental disorder and all other circumstances of the case is available to that patient. At the same time, the so-called “treatability test” will be abolished.
  - **professional roles:** it is broadening the group of practitioners who can take on the role of the approved Social Worker (ASW) and Responsible Medical Officer (RMO).
  - **nearest relative (NR):** it gives to patients the right to make an application to displace their NR and enables county courts to displace a NR where there are reasonable grounds

for doing so. The provisions for determining the NR will be amended to include civil partners amongst the list of relatives.

- **supervised community treatment (SCT)**: it introduces SCT for patients following a period of detention in hospital. It is expected that this will allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continue with the medical treatment that they need. Currently some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again – the so-called “revolving door”.
- **Mental Health Review Tribunal (MHRT)**: it introduces an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. It also introduces a single Tribunal for England and one in Wales.
- **abolition of finite restriction orders**: it removes the possibility of restriction orders being made for a limited period, so that they may remain in force for as long as the offender's mental health problem poses a risk of harm to others.

15. The changes to the MCA provide for procedures to authorise the deprivation of liberty of a person resident in a hospital or care home who lacks capacity to consent (“Bournewood safeguards”). The MCA principles of supporting a person to make a decision when possible, and acting at all times in the person’s best interests and in the least restrictive manner, will apply to all decision-making in operating the Bournewood safeguards. The context for the Bournewood policy proposals is the Government commitment in the White Paper *Our Health, Our Care, Our Say* that people with ongoing care needs, whether their needs arise in older age, through illness or disability, should be cared for in ways that promote their independence, well-being and choice. Deprivation of liberty should therefore be avoided where possible and would only be authorised if identified by independent assessment as a necessary and proportionate course of action to protect the person from harm.
16. The Government accepts that there will be some people who will need to be cared for in circumstances that deprive them of liberty because it is necessary to do so, in their best interests in order to protect them from harm. The Government does not consider that deprivation of liberty would be justified in large numbers of cases but recognises that such circumstances may arise, for example for some people with severe autism or dementia.
17. The aim of the Bournewood provisions is to provide legal safeguards for those vulnerable people who are deprived of their liberty, to prevent arbitrary decisions to deprive a person of liberty and to give rights of appeal. The safeguards apply to adults who lack capacity to consent to treatment or care, who are suffering from a disorder of the mind but who are not detained under the 1983 Act.

## **OVERVIEW OF THE STRUCTURE**

18. Part 1 sets out the amendments to the 1983 Act. The commentary follows the order of the clauses in Part 1. Part 2 sets out the amendments to the MCA. Part 3 sets out general provisions such as transitional and consequential amendments.

## **TERRITORIAL EXTENT**

19. The Bill has the same extent as the Acts that it amends. It applies for the most part only to England and Wales.
20. The 1983 Act has provisions for the transfer of patients to and from Scotland, Northern Ireland, the Channel Islands and the Isle of Man. These are amended by the Bill to make it possible to transfer patients subject to non-resident treatment outside England and Wales (currently this will only apply to patients in Scotland) to SCT in England and Wales and vice versa.

### ***Territorial application: Wales***

21. Clause 31 provides for the continuation of the MHRT for Wales, and Schedule 2 to the 1983 Act is amended to provide for the appointment by the Lord Chancellor of a President for that Tribunal.
22. Annex A provides further detail on the provisions of the Bill containing new functions that will transfer, so far as exercisable in relation to Wales, to Welsh Ministers.

## **COMMENTARY**

### **PART 1 – AMENDMENTS TO MENTAL HEALTH ACT 1983**

#### **CHAPTER 1 – CHANGES TO KEY PROVISIONS**

##### **Clause 1: removal of categories of mental disorder**

23. Clause 1 amends the wording of the definition of mental disorder in the 1983 Act from “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disability or disorder of mind” to “any disorder or disability of the mind”.
24. The fact that a person suffers from a mental disorder does not, of itself, mean that any action can or should be taken in respect of them under the 1983 Act. Action can be taken only where particular circumstances or criteria set out in the 1983 Act apply.

25. Examples of clinically recognised mental disorders include mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, eating disorders, autistic spectrum disorders and learning disabilities. Disorders or disabilities of the brain are not mental disorders unless (and only to the extent that) they give rise to a disability or disorder of the mind as well. Nor are beliefs or behaviours which are not the result of any disability or disorder of the mind, even if they appear unwise or cause alarm or distress.
26. The clause also abolishes the four categories of mental disorder used in the 1983 Act at the moment, namely mental illness, mental impairment, psychopathic disorder and severe mental impairment.

**Schedule 1: categories of mental disorder - further amendments etc**

27. *Subsection (4)* of clause 1: Part 1 of Schedule 1 replaces references in the 1983 Act to these four categories of mental disorder with references simply to mental disorder. The effect is to widen the application of the provisions in question to all mental disorders, not just those which fall within one of the four categories (or the particular category or categories to which the provision applies). Practical examples of disorders which would now be covered by those provisions are forms of personality disorder which do not fall within the current definition of psychopathic disorder because they do not result in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. Other examples include certain types of psychological dysfunction arising from brain injury or damage in adulthood. Part 2 of the Schedule makes similar amendments to certain other Acts.

**Clause 2: learning disability**

28. Clause 2 provides that for certain provisions of the 1983 Act a person may not be considered to be suffering from a mental disorder simply as a result of having a learning disability, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.
29. The provisions in question are those which are currently limited to one or more of the four categories of mental disorder which are to be abolished by clause 1. As well as criteria for detention they also include criteria for the use of guardianship in section 7 and guardianship orders in section 37.
30. The reference to association with abnormally aggressive or seriously irresponsible conduct is derived from the current definitions of “mental impairment” and “severe mental impairment” (which are removed by clause 1). Accordingly, where the 1983 Act as it stands now effectively precludes the use of detention or other compulsory measures on the basis of a learning disability which is not associated with abnormally aggressive or seriously irresponsible conduct, the same will be true of the Act as amended.

**Clause 3: changes to exclusions from operation of the 1983 Act**

31. Section 1(3) currently says that the definition of mental disorder shall not be construed as implying that a person may be dealt with under the 1983 Act as suffering from mental

disorder “by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.” Clause 3 substitutes for this a single exclusion stating that dependence on alcohol and drugs is not considered to be a disorder or disability of the mind (ie a mental disorder) for the purposes of section 1(2) of the 1983 Act (the definition of mental disorder).

32. Clinically, neither promiscuity nor “other immoral conduct” by itself is regarded as a mental disorder, so the deletion of that exclusion makes no practical difference. Similarly, sexual orientation (homo-, hetero- and bi-sexuality) alone is not regarded as a mental disorder. However, there are disorders of sexual preference which are recognised clinically as mental disorders. Some of these disorders would probably be considered “sexual deviance” in the terms of the current exclusion (for example paraphilias like fetishism or paedophilia.) The amendment will therefore bring such disorders within the scope of the 1983 Act.
33. The use and misuse of alcohol or drugs are not, by themselves, regarded clinically as a disorder or disability of the mind (although their effects may be). However, dependence on alcohol and drugs is regarded as a mental disorder.
34. The effect of the exclusion is that no action can be taken under the 1983 Act in relation to people simply because they are dependent on alcohol or drugs (including opiates, psycho-stimulants or some solvents), even though in other contexts their dependence would be considered clinically to be a mental disorder.
35. It does not mean that such people are excluded entirely from the scope of the 1983 Act. A person who is dependent on alcohol or drugs may also suffer from another disorder which warrants action under the 1983 Act (including a disorder which arises out of their dependence or use of alcohol and drugs or which is related to it). Nor does it mean that people may never be treated without consent under the 1983 Act for alcohol or drug dependence. Like treatment for any other condition which is not itself a mental disorder, treatment for dependence may be given under the 1983 Act if it forms part of treatment for a condition which is a mental disorder for the purposes of the 1983 Act (see clause 7 for the definition of medical treatment).
- Clause 4: replacement of “treatability” and “care” tests with appropriate treatment test**
36. A person can be detained under the 1983 Act only where certain criteria are met. Different criteria apply to detention for different purposes. Detention of civil patients is dealt with in Part 2 of the 1983 Act. Admission for assessment can be for up to 28 days and cannot be renewed. Admission for treatment is for up to 6 months in the first place, and can be renewed periodically thereafter. The criteria for admission for assessment are in section 2 of the 1983 Act, the criteria for admission for treatment in section 3. Part 3 of the 1983 Act contains various powers for the courts to order the detention in hospital of people involved in criminal proceedings, either while the proceedings are in progress or as an alternative to punishment. It also contains powers for the Secretary of State (in practice the Home Secretary) to transfer prisoners to hospital for treatment. The criteria in each case are set out in the relevant section.

37. Where a patient is detained for treatment under section 3 or under Part 3, the detention must be renewed periodically. Criteria for this renewal are in section 20 of the 1983 Act. Patients detained for assessment under section 2 or for treatment under section 3 and under certain powers in Part 3 may apply to the MHRT for discharge. The criteria the MHRT must use when deciding the application are set out in sections 72-74.
38. Clause 4 introduces a new “appropriate treatment test” into the criteria for detention under section 3, related sections of Part 3 and the corresponding criteria for renewal and discharge. The effect is that these criteria cannot be met unless medical treatment is available to the patient in question which is appropriate taking account of the nature and degree of the patient’s mental disorder and all other circumstances of the case.
39. The test requires that appropriate treatment is actually available for the patient. It is not enough that appropriate treatment exists in theory for the patient’s condition. The words “nature or degree” in the appropriate treatment test are already used in the criteria for detention in the 1983 Act. Case law has established that “nature” refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient’s previous response to receiving treatment for disorder. “Degree” refers to the current manifestation of the patient’s disorder (*R v Mental Health Review Tribunal for the South Thames Region Ex p. Smith* [1999] C.O.D. 148).
40. The appropriate treatment test replaces the so-called “treatability” test. The treatability test requires the relevant decision-maker to determine whether medical treatment “is likely to alleviate or prevent deterioration in the patient’s condition”. Where that test forms part of the criteria for detention under a particular section, it applies at all stages to patients suffering from mental impairment or psychopathic disorder (ie to the initial decision to detain, and both renewal and discharge from detention). However, for patients suffering from mental illness or severe mental impairment it applies only when detention is being renewed under section 20(4) (or 21B) or when the MHRT is considering discharge in accordance with the criteria in section 72(1)(b). In both these cases there is an alternative test – variously known as the “grave incapacity” or “care” test - which may be applied instead. Both the treatability test and this alternative test are abolished by this clause and replaced by the appropriate treatment test. Because of the removal of categories of disorder by clause 1 the appropriate treatment test applies equally to all mental disorders.
41. As an illustration, the effect of clauses 1 and 3 and paragraph 2 of Schedule 1 on the criteria for applications for admission for treatment under section 3 is as follows:



### 3 Admission for treatment

(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as “an application for admission for treatment”) made in accordance with this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that—

- a) he is suffering from ~~mental illness, severe mental impairment, psychopathic disorder or mental impairment~~ and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
- b) ~~in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and~~
- c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
- (d) appropriate medical treatment is available for him.

(3) An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include—

- a) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and (~~d~~ b) of that subsection; and
- b) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

(4) In this Act, references to appropriate medical treatment, in relation to a person’s mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case.

#### **Clause 5: further cases in which appropriate treatment test is to apply**

42. Clause 5 also adds the appropriate treatment test into three other sets of detention criteria in Part 3 of the 1983 Act. They are sections 36 (remand for treatment), 48 (transfer of unsentenced prisoners) and section 51(6) (hospital orders where it is impractical or

inappropriate to bring a detainee before the court). These provisions do not at present apply to patients suffering from psychopathic disorder or mental impairment and so they do not include the so-called treatability test. As a result, the appropriate treatment test will be an additional requirement in these sections, rather than a replacement for an existing test.

**Clause 6: appropriate treatment test in Part 4 of the 1983 Act**

43. Clause 6 makes related amendments to what a registered medical practitioner appointed by the Mental Health Act Commission (a Second Opinion Appointed Doctor or SOAD) must certify when giving a certificate under section 57 (treatment requiring consent and a second opinion) and section 58 (treatment requiring consent or a second opinion) authorising the giving of certain types of medical treatment for mental disorder.
44. Sections 57 and 58 provide procedural safeguards for patients in relation to particular types of treatment.
45. Section 57 provides that certain treatments may not be given to any patient for mental disorder (whether or not they are otherwise subject to the 1983 Act) unless the patient consents, a SOAD and two other people appointed by the Mental Health Act Commission have certified that the patient is capable of giving that consent (and has done so) and the SOAD has additionally certified that the treatment should be given. The treatments in question are any surgical operation for destroying brain tissue or its functioning (sometimes called “psychosurgery”) and, by virtue of regulations under subsection (1)(b), surgical implantation of hormones for the purpose of reducing male sex drive (a procedure which is now effectively redundant).
46. Section 58 provides that patients who are liable to be detained under the 1983 Act may not (in general) be given certain treatments unless they consent and that consent is certified by their RMO (in future responsible clinician (RC)) or a SOAD, or alternatively unless a SOAD certifies that the patient either cannot or will not consent to the treatment, but that it should nonetheless be given. (Clause 27 applies section 58 also to patients who are subject to a community treatment order (CTO) and who have been recalled to hospital subject to certain exceptions. See clause 25 below for an explanation of CTOs.) Section 58 applies to medication once three months have passed since the patient was first given medication while detained – or in future subject to a CTO – under the Act. By virtue of regulations under subsection (1)(b) it also applies to electro-convulsive therapy (ECT), without any initial period.
47. As sections 57 and 58 stand, a SOAD must certify that treatment should be given, “having regard to the likelihood of the treatment alleviating or preventing deterioration of the patient’s condition”. The effect of *subsection (2)* of this clause is to require SOADs instead to certify that it is appropriate for the treatment to be given. *Subsection (3)* adds a new subsection to section 64 which explains what it means for treatment to be appropriate in this context. The wording is consistent with that used in the “appropriate treatment” test to be added to the criteria for detention under the 1983 Act by clauses 4 and 5.

**Clause 7: change in definition of “medical treatment”**

48. Clause 7 amends the definition of medical treatment in section 145(1) to read:

“medical treatment includes nursing, psychological intervention, and specialist mental health habilitation, rehabilitation and care”.

49. Accordingly, the definition covers medical treatment in its normal sense as well as the other forms of treatment mentioned. Practical examples of psychological interventions include cognitive therapy, behaviour therapy and counselling. “Habilitation” and “rehabilitation” are used in practice to describe the use of specialised services provided by professional staff including nurses, psychologists, therapists and social workers which are designed to improve or modify patients’ physical and mental abilities and social functioning. That can, for example, include helping patients learn to eat by themselves or to communicate for the first time, or preparing them for a return to normal community living. The distinction between habilitation and rehabilitation depends in practice on the extent of patients’ existing abilities – “rehabilitation” is appropriate only where the patients are relearning skills or abilities they have had before.

**Summary of effect of amendments in Chapter 1 of Part 1**

Provision	Currently applies to	Will apply in future to	Learning disability provision to apply in future	“Treatability” test applies now	Appropriate treatment test to apply in future
<b>Civil Patients (Part 2 of the Act)</b>					
Admission for assessment for up to 28 days (section 2)	Mental disorder	Mental disorder	x	x	x
Admission for treatment (s3)	MI, MM, PD, SMM	Mental disorder	✓	✓	✓
“Holding power” for patients already in hospital (s5)	Mental disorder	Mental disorder	x	x	x
Guardianship (s7)	MI, MM, PD, SMM	Mental disorder	✓	x	x
<b>Patients concerned in criminal proceedings (Part 3 of the Act)</b>					

*These notes refer to the Mental Health Bill [HL]  
as introduced in the House of Lords on 16th November 2006 [HL Bill 1]*

Provision	Currently applies to	Will apply in future to	Learning disability provision to apply in future	“Treatability” test applies now	Appropriate treatment test to apply in future
Remand to hospital for report (s35)	MI, MM, PD, SMM	Mental disorder	✓	×	✓
Remand to hospital for treatment (s36)	MI, SMM	Mental disorder	✓	×	✓
Hospital order (s37)	MI, MM, PD, SMM	Mental disorder	✓	✓	✓
Hospital order without conviction (s37(3) & 51(5))	MI, SMM	Mental disorder	✓	×	✓
Interim hospital order (s38)	MI, MM, PD, SMM	Mental disorder	✓	×	✓
Hospital and limitation directions (s45A)	PD	Mental disorder	✓	✓	✓
Transfer direction – sentenced prisoner (s47)	MI, MM, PD, SMM	Mental disorder	✓	✓	✓
Transfer direction – other (s48)	MI, SMM	Mental disorder	✓	×	✓

Key: MI = mental illness, MM = mental impairment, PD = psychopathic disorder, SMM = severe mental impairment

## CHAPTER 2 – PROFESSIONAL ROLES

### Overview

50. Chapter 2 provides for roles which are central to the operation of the 1983 Act potentially to be performed by a wider range of professionals than at present. In particular, it replaces the role of the “responsible medical officer” (RMO) with that of the “responsible clinician” (RC) and the “approved social worker” (ASW) with the “approved mental health professional” (AMHP).

51. Under the 1983 Act, the RMO is the registered medical practitioner in charge of the treatment of the patient. As such, the RMO has various designated functions, including deciding when patients can be discharged and allowed out on leave. The identity of the RMO is a question of fact in the circumstances (except in respect of guardianship where the RMO is the person appointed as such by the local social services authority (LSSA)). In practice, RMOs are usually consultant psychiatrists.
52. By contrast, the RC may be any practitioner who has been approved for that purpose (“an approved clinician” (AC) – see below). Approval need not be restricted to medical practitioners, and may be extended to practitioners from other professions, such as nursing, psychology, occupational therapy and social work. RCs will take over most of the functions of RMOs, although some functions currently reserved to RMOs may be taken instead by another AC, not just the RC. RCs will also have certain new functions in relation to SCT (see clause 25 below).
53. Similarly, Chapter 2 replaces the ASW with the AMHP. Under section 114 of the 1983 Act, an LSSA is required to appoint a sufficient number of ASWs to carry out key functions. These include making applications to admit patients for assessment, treatment or guardianship.
54. AMHPs will take on the functions of the ASWs, including the function of making applications for admission and detention in hospital under Part 2 of the 1983 Act. Like RCs, they are also to have certain new functions in relation to SCT (see clause 25 below). As well as social workers a wider group of professionals, for example nurses, occupational therapists and psychologists, will potentially be eligible for approval as AMHPs as long as individuals have the right skills, experience and training.

**Clause 8: amendments to Part 2 of the 1983 Act**

55. Clause 8 makes a number of amendments to Part 2 of the 1983 Act (compulsory admission to hospital and guardianship) to substitute the RC for the RMO. It inserts a definition for the RC, which essentially defines the RC as the AC with overall responsibility for a patient’s case (although there is a slightly different definition in relation to patients subject to guardianship). In other words, all RCs will be taken from a pool of ACs who have been approved as capable of fulfilling the responsibilities of the RC role.
56. Clause 8 also amends section 5(2) and (3) of the 1983 Act so that an AC, in addition to a registered medical practitioner, may hold an inpatient for up to 72 hours from the time a report is furnished to the hospital managers if the AC thinks an application for admission under the Act should be made.

**Clause 9: amendments to Part 3 of the 1983 Act**

57. Clause 9 makes similar amendments to Part 3 of the Act (patients concerned in criminal proceedings etc). It also provides that certain functions currently restricted to registered medical practitioners (who need not be RMOs) will in future be exercisable as well, or

instead, by ACs. For example, it will be possible for an AC as well as any registered medical practitioner to be responsible for the report on the medical condition of a person remanded to hospital for that purpose under section 35. The clause does not, however, change the requirements for courts to have evidence from registered medical practitioners before deciding to impose a hospital order or make other orders or remands under Part 3.

**Clause 10: further amendments to Part 3 of the 1983 Act**

58. Clause 10 makes further similar amendments to Part 3 of the Act (patients concerned in criminal proceedings etc). As well as replacing references to RMOs with RCs, it provides that certain functions restricted to registered medical practitioners may be exercised instead by ACs. For example, under section 50(1), the Secretary of State will be able to return a patient subject to a restricted transfer direction under section 47 to prison, or discharge the patient under supervision, if he or she is notified either by the patient's RC or another AC (rather than only another registered medical practitioner) that the patient no longer needs treatment in hospital or appropriate treatment is no longer available.

**Clause 11: amendments to Part 4 of the 1983 Act**

59. Clause 11 makes similar amendments to Part 4 of the Act (consent to treatment). In particular, it amends sections 57, 58 and 63. Section 57 concerns treatment that requires the patient's consent and a second opinion (such as psychosurgery). Section 58 concerns treatment requiring the patient's consent or a second opinion. Section 63 covers treatment that can be imposed without the patient's consent (such as medication within the first 3 months and nursing care).
60. The clause amends the provisions of Part 4 so that the AC in charge of the treatment in question has the functions previously held by the RMO, for example signing a certificate to say that a patient is capable and willing to consent to the treatment. In the majority of cases the AC in charge of the treatment will be the patient's RC, but where, for example, the RC is not qualified to make decisions about a particular treatment, eg medication if the RC is not a doctor or a nurse prescriber, then an appropriately qualified AC will be in charge of that treatment, with the RC continuing to retain overall responsibility for the patient's case.
61. Sections 57 and 58 are also amended to provide that an AC in charge of the treatment in question cannot be the registered medical practitioner to give the second opinion required by those sections. Similarly, the RC cannot be either of the two other persons that this registered medical practitioner consults. This is to ensure that there is an independent assessment of whether treatment should be given.

**Clause 12: amendments to Part 5 of the 1983 Act**

62. Clause 12 makes similar amendments to Part 5 of the 1983 Act (Mental Health Review Tribunals). For example, it amends sections 67(2) and 76(1) so that an AC as well as a registered medical practitioner can visit and examine the patient for the purposes of a tribunal reference and tribunal application under those provisions.

**Clause 13: amendments to other provisions of the 1983 Act**

63. Clause 13 makes related amendments to other provisions of the 1983 Act. In particular, it inserts into section 145 a definition of an AC. The Secretary of State and Welsh Ministers will have the function of approving persons to be approved clinicians in relation to England and Wales respectively. It is envisaged that this function will be delegated to appropriate NHS bodies. The professions whose members may be approved and the type of skill and experience required will be set out in directions by the Secretary of State and Welsh Ministers.

**Clause 14: amendments of other Acts**

64. Clause 14 makes consequential amendments to the Army Act 1955, the Air Force Act 1955, the Naval Discipline Act 1957, the Criminal Procedure (Insanity) Act 1964 and the Armed Forces Act 2006 to replace the term “responsible medical officer” with the term “responsible clinician”, where it is mentioned in those Acts.

**Clause 15: certain registered medical practitioners to be treated as approved under section 12 of the 1983 Act**

65. Clause 15 amends section 12 of the 1983 Act so that a registered medical practitioner who has been approved as an AC is also approved for the purposes of section 12. Under section 12 of the 1983 Act, at least one of the two doctors recommending detention must be a practitioner who has been approved by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder. It is intended that the competencies a registered medical practitioner will require in order to be approved as an AC will be such that they will have the “special experience in the diagnosis or treatment of mental disorder” required for section 12 approval. ACs who are not registered medical practitioners will not be deemed to be section 12 approved.

**Clause 16: regulations as to approvals in relation to England and Wales**

66. Clause 16 inserts a new section 142A into the 1983 Act which gives the Secretary of State, jointly with Welsh Ministers, the power to set out in regulations the circumstances in which approval in England under section 12 of the Act, and approval as an AC should be considered to mean approval in Wales as well, and vice versa.

**Clause 17: approved mental health professionals**

67. Clause 17 substitutes a new section 114. It replaces the role of ASWs with that of AMHPs. This will mean that a wider group of professionals, such as nurses, occupational therapists and chartered psychologists will be able to carry out the ASW’s functions as long as individuals have the right skills, experience and training, and are approved by an LSSA to do so. A registered medical practitioner is specifically prohibited from being approved to act as an AMHP. This means that there will be a mix of professional perspectives at the point in time when a decision is being made regarding a patient’s detention. This does not prevent all those involved from being employed by the NHS but the skills and training required of AMHPs aim to ensure that they provide an independent social perspective.

68. The definition of an ASW in section 145(1) of the 1983 Act is replaced by the definition of an AMHP in section 114. Unlike with ASWs, there is now no requirement that an AMHP be an officer (employee) of an LSSA.
69. LSSAs will approve AMHPs. In doing so they must be satisfied that the individual has appropriate competence in dealing with persons who are suffering from mental disorder and comply with any directions issued by the Secretary of State if the authority's area is in England, or by Welsh Ministers if the authority's area is in Wales.
70. The directions may contain different criteria for approval for AMHPs in England and Wales. So an AMHP approved by an LSSA in England may only act on behalf of an English LSSA, and an AMHP approved by a Welsh LSSA may only act on behalf of a Welsh LSSA. This means a Welsh LSSA cannot arrange for an English-approved AMHP to act on their behalf and vice versa. However, it does not mean that a Welsh-approved AMHP cannot make an application to admit a patient in England or convey a patient in England and vice versa. It is also possible for an AMHP with the appropriate competencies to be approved in both territories.

**Clause 18: approval of courses etc for approved mental health professionals**

71. Clause 18 inserts a new section 114A into the 1983 Act in relation to the approval of courses for AMHPs. This allows the General Social Care Council (GSCC) and the Care Council for Wales (CCW), which are the statutory bodies set up to regulate the social work profession, to approve courses for the training of English and Welsh AMHPs respectively, regardless of the trainees' profession. To ensure that AMHPs from different professional backgrounds continue to be regulated by their own professional bodies, section 114A(4) states that the functions of an approved mental health professional shall not be considered to be "relevant social work" for the purposes of Part 4 of the Care Standards Act 2000. Part 4 of the Care Standards Act 2000 requires the GSCC and CCW to provide codes of practice for social care workers, which includes "a person who engages in relevant social work". "Relevant social work" is defined as "social work which is required in connection with any health, education or social services provided by any person". Making clear that AMHP functions are not "relevant social work" for the purposes of Part 4 of the Care Standards Act means that the GSCC's and CCW's codes of practice do not apply to AMHPs who are not social workers.

**Clause 19: amendments to section 62 of the Care Standards Act 2000**

72. Although AMHP functions are not to be considered "relevant social work" for the purposes of Part 4 of the Care Standards Act 2000, clause 19 provides that the GSCC's and CCW's codes of practice will continue to apply to social workers when carrying out AMHP functions.

**Clause 20: approved mental health professionals - further amendments and Schedule 2**

73. Clause 20 introduces Schedule 2 which makes further amendments to the 1983 Act in relation to ASWs.



74. ASWs are responsible for assessing whether an application for a patient's admission under the Act should be made. They arrange and co-ordinate the assessment, taking into account all factors to determine if detention in hospital is the best option for a patient or if there is a less restrictive alternative. The Bill allows assessments for admission to be undertaken by an AMHP, who might, for example, be a nurse, occupational therapist or chartered psychologist, as well as a social worker. Paragraph 5 of Schedule 2 amongst other things amends section 13(1) of the 1983 Act so that LSSAs who have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area shall have a duty to arrange for an AMHP to consider the patient's case on their behalf. Where a patient is detained for assessment under section 2, and the LSSA that arranged for an AMHP to consider that admission has reason to think that an application for treatment may be needed under section 3, new subsections (1B) and (1C) of section 13 place a duty on that LSSA to arrange for an AMHP to consider the patient's case on their behalf. The duties under sections 13(1), (1B) and (1C) do not prevent another LSSA from arranging for an AMHP to consider a patient's case. Subsection (5) of section 13, as amended by paragraph (6) of Schedule 2, makes clear that any other LSSA also has the power to do so. The effect of the amendments to section 13 is to provide for LSSAs to continue to have a role in ensuring that there is an adequate AMHP service, whether they choose to run the AMHP service or enter into agreements with other LSSAs and/or NHS organisations.
75. Because AMHPs will no longer always be employed by a LSSA, section 145 is amended to provide in new subsection (1AC) that references to an AMHP in the 1983 Act are generally to be read as ones to an AMHP carrying out their functions on behalf of a LSSA. This is to retain the link between the AMHP and an LSSA even though the AMHP no longer needs to be employed by an LSSA.

### **CHAPTER 3 – PATIENT'S NEAREST RELATIVE**

#### **Clauses 21-24: nearest relative**

76. Sections 26-30 of the 1983 Act provide for the role of the nearest relative (NR) of patients. The 1983 Act provides a list of persons who may act in this role, the person appointed usually being the highest in that list, starting with any spouse or, if there is none, the eldest son or daughter, and so on. The NR has certain rights in connection with the care and treatment of a mentally disordered patient under the 1983 Act, including the right to apply for admission to hospital, the right to block an admission for treatment, the right to discharge a patient from compulsion and the right to certain information about the patient. NRs may not exercise their rights in respect of patients subject to special restrictions under Part 3 of the 1983 Act.
77. Clause 21 introduces a new right for a patient to apply for an order displacing the NR on the same grounds currently in existence for other applicants, and on the additional ground that the NR is unsuitable. The table below summarises possible grounds for applications and who may make them. The provision also amends the basis upon which a court may make such an order. It changes the requirement that the acting NR be, in the court's opinion, a "proper person" to act as the NR to whether the person is, in the court's opinion, a "suitable" person to

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act. Clause 21 also amends section 29 to provide that where the person nominated by the applicant is, in the court’s opinion, not “suitable” or there is no nomination, the court can appoint any other person it thinks is “suitable”.

		Possible grounds for an application				
		29(3)(a) – the patient has no NR	29(3)(b) – the NR is too ill to act	29(3)(c) – the NR unreasonably blocks admission	29(3)(d) – the NR has or is likely to discharge the patient without due regard	29(3)(e) – the NR is unsuitable
Possible applicants	AMHP replacing ASW	Currently provided for	Currently provided for	Currently provided for	Currently provided for	New provision
	Relative	Currently provided for	Currently provided for	Currently provided for	Currently provided for	New provision
	Someone living with the patient	Currently provided for	Currently provided for	Currently provided for	Currently provided for	New provision
	Patient	New provision	New provision	New provision	New provision	New provision

78. In this way, an NR who has in the past subjected a patient to, for example, physical abuse, may, upon application to the court by the patient, be removed from exercising the rights of the NR by order of the court. In the application, the patient can nominate another person to act as the NR. Unless the court finds that person to be unsuitable, or decides not to displace the current NR, the person will be made the acting NR.
79. An application for displacement can also be made by an AMHP or another relative. So long as the court orders the displacement of the current NR, then whomever the applicant nominates will be made the acting NR, unless the court finds that person to be unsuitable.
80. Clause 22 introduces a new right for the patient to apply to discharge - or vary - an order appointing an acting NR. A NR displaced under the new ground will also be able to apply for

such an order, but the NR must first obtain leave of the court. The court can currently appoint an acting NR only for a limited period; clause 22 will allow the court to make an appointment for an indefinite period.

81. This will therefore enable a person who has been made the acting NR to seek to have that order ended. The order displacing the NR - and appointing an acting NR - continues even when the displaced NR ceases to be the first person in the list of relatives. In these circumstances, the patient can apply to have the court order discharged. The new person at the top of the list will then become the NR.
82. An application by the displaced NR for the discharge of the order which displaced him as NR will only be heard if the court first agrees. Spurious or malicious applications can therefore be stopped before the patient is brought into the process.
83. Clause 23 will limit applications to the MHRT from displaced NRs, to those NRs displaced on grounds set out in sections 29(3)(c) or 29(3)(d) (see table above). A person who has been displaced as the NR because he or she is too ill to act, or unsuitable to act, will not have the right to apply to the MHRT. This right will continue to be extended to NRs displaced on other grounds.
84. Clause 24 amends the list in sections 26 and 27 of the Act of those persons who may act in the role of NR of a patient, by giving a civil partner equal status to a husband or wife.

#### **CHAPTER 4 – SUPERVISED COMMUNITY TREATMENT**

##### **Overview**

85. The SCT provisions will allow some patients with a mental disorder to live in the community whilst still subject to powers under the 1983 Act. Patients subject to SCT remain under compulsion and liable to recall to hospital for treatment. Only those patients who have been detained in hospital for treatment will be eligible for SCT. In order for a patient to be placed on SCT, various criteria need to be met. An AMHP also needs to agree that SCT is appropriate. Patients who are on SCT will be made subject to conditions whilst living in the community. Conditions will depend on their individual and family circumstances. Conditions will form part of the patient's CTO which is made by the RC. Patients on SCT may be recalled to hospital for treatment should this become necessary. Afterwards they may then resume living in the community or, if they need to be treated as an in-patient again, their RC may revoke the CTO and the patient remains in hospital for the time being.
86. SCT differs from after-care under supervision, which it will replace, in that it will allow patients who do not need to continue receiving treatment in hospital to be discharged into the community, but with powers of recall to hospital if necessary. It is different from leave under section 17 of the 1983 Act, which remains suitable for a patient as a means to give shorter term leave from hospital, as part of the patient's overall management as a hospital patient.

**Clause 25: community treatment orders, etc**

87. Clause 25 introduces new sections 17A-17G which set out how CTOs are to be made, and how they will work.
88. Under new section 17A, the RC may make a CTO for a patient detained under section 3 or Part 3 (without restrictions) of the 1983 Act, if they are satisfied that the relevant criteria are met, and an AMHP agrees that a CTO is appropriate for that patient. The CTO, and the AMHP's agreement to it, will be in writing.
89. The criteria that the patient must meet - in order to be suitable for SCT - are specified within section 17A(5). The patient must need medical treatment for their mental disorder for their own health or safety, or for the protection of others. It must be possible for the patient to receive the treatment they need without having to be in hospital, provided that the patient is recalled to hospital for treatment should this become necessary. Appropriate medical treatment for the patient must be available whilst living in the community. Patients who are subject to a CTO are referred to in the legislation as community patients.
90. Section 17B requires that CTOs specify conditions to which a community patient will be subject. An example of a condition that may be included is that the patient is to reside at a particular place. The RC and an AMHP must agree the conditions. The RC may vary the conditions, or suspend any of them.
91. The conditions specified under section 17B (with the exception of section 17B(3)(d)) are not in themselves enforceable but, if a patient fails to comply with any condition, the RC may take that into account when considering if it is necessary to use the recall power (section 17B(6)). However, if the criteria for recall are met, the recall power may still be exercised even if the patient is complying with the conditions (section 17B(7)). (A patient cannot be recalled unless the criteria for recall in section 17E are met.)
92. Section 17C specifies the duration of a CTO. A patient's CTO will end either if the period of the CTO runs out and the CTO is not extended, or the patient is discharged from the powers of the 1983 Act. It will also end if the RC revokes the CTO following the patient's recall to hospital under section 17F or, for Part 3 patients, if the CTO they were placed on was time-specific and runs out.
93. Section 17D sets out the effect of a CTO on certain other provisions of the 1983 Act. The application for admission for treatment under which the patient was detained remains in force, but the hospital managers' authority to detain the patient under section 6(2) is suspended whilst the patient remains a community patient. The authority to detain the patient will not expire while it is suspended. However, when a patient's CTO ends, the patient will be discharged absolutely from SCT. Should an application for admission for treatment still remain in force, this will also end.

94. Section 17D(2)(b) provides that where the 1983 Act mentions patients who are “detained” or “liable to be detained”, this does not include community patients. Where it is intended that a provision should apply to community patients, the 1983 Act is being amended to make this clear. In addition, references in other legislation to patients who are detained, or liable to be detained, do not include community patients.
95. Section 17E provides that a community patient may be recalled to hospital if the RC decides that the patient needs to receive treatment for his or her mental disorder in a hospital and that, without this treatment, there would be a risk of harm to the patient’s health or safety, or to other people. The recall notice will trigger the hospital managers’ authority to re-detain the patient (section 17E(6)). A community patient may be recalled even if the patient is in hospital at the time. This could happen, for example, if the patient goes to hospital but then refuses the treatment that the RC considers is needed, and the patient, or someone else, would be at risk if the patient does not receive that treatment.
96. Under section 17E (2), there is also a power to recall a patient to hospital if the patient fails to comply with a condition under section 17B(3)(d) that specifies that patients must make themselves available for examination. This allows the RC to examine a patient to assess whether a patient’s CTO should be renewed and also allows a SOAD to examine the patient in order to meet the certificate requirement in sections 64B and 64E (see below).
97. Section 17F sets out the powers which apply to a patient who is recalled to hospital under section 17E. If the RC decides that the patient meets the 1983 Act’s criteria for detention in hospital (set out in section 3(2)), the RC may, subject to an AMHP’s agreement that it is appropriate, revoke the patient’s CTO under section 17F(4). The RC can only recall a patient for a maximum of 72 hours without revoking the CTO. Therefore, the RC may release a recalled patient from detention at any time within the first 72 hours, provided the CTO has not been otherwise revoked. On release, the patient continues to remain subject to the CTO.
98. Section 17G provides that when a CTO is revoked (so that the patient is no longer a community patient), the authority to detain the patient under section 6(2) applies (unless the patient is a Part 3 patient), exactly as if the patient had never been a community patient. In addition, all the 1983 Act’s provisions apply to the patient as they did when the patient was first admitted to hospital for treatment before the CTO was made (unless the 1983 Act provides otherwise).
99. Clause 25 also inserts new sections 20A and 20B which set out how long CTOs will last, and how they can be extended. A new CTO will initially last for 6 months from the date when the order was made. The order can then be extended for a further 6 months and, following that, it can be extended repeatedly for periods of one year at a time. For an order to be renewed under section 20A, the RC must examine the patient and furnish a report to the hospital managers confirming that the conditions, as set out in section 20A(6), are met. This is essentially the same process as that which applies for the renewal of detention of patients

detained in hospital under section 3. A patient may be recalled to hospital for the purpose of examining the patient to determine whether the CTO should be renewed.

**Clause 26: relationship with leave of absence**

100. Clause 26 makes provision in respect of the relationship of SCT with other powers in the 1983 Act. It amends the provisions in the Act which authorise leave of absence from hospital (section 17). Before granting longer term leave of over 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days), a RC must consider whether SCT is the more appropriate way of managing the patient in the community.

**Clause 27: consent to treatment**

101. Clause 27 replaces section 56 of the 1983 Act which sets out the patients to whom Part 4 of the Act, which deals with consent to treatment, applies. A community patient will not be subject to Part 4 unless recalled to hospital.

102. On recall, a patient may be treated on the basis of the Part 4A certificate if that certificate specifies treatment as being appropriate in these circumstances. If the certificate does not specify any such treatment, then (if it is section 58-type treatment) it cannot be given on recall without the patient's consent, unless or until its administration is permitted under Part 4. However, if a section 58 certificate was in place before the CTO was made, and covers the patient's current treatment needs, there is no need for new section 58 certificate.

103. A section 58 certificate is not required in circumstances where:

- discontinuing the treatment or the plan of treatment at that point would cause serious suffering to the patient as provided for under new section 62A(5)
- the treatment is immediately necessary: immediately necessary treatment can be given under section 62 of the 1983 Act
- in the case of medication regulated by section 58(1)(b) the patient is still within the period described above ie either one month has not elapsed from the time when the CTO was made or the three month period from when treatment was first given to the patient has not elapsed.

104. It is not necessary to meet the certificate requirement before treatment can be given in emergencies to a patient in the community where that patient consents to treatment or, for patients who lack capacity, where an attorney, deputy or the Court of Protection consents to it on the patient's behalf.

**Clause 28: authority to treat**

105. Clause 28 introduces a new Part 4A into the 1983 Act to regulate the treatment of community patients whilst in the community ie when they are not recalled to hospital. Community patients aged 16 or over with capacity can only be treated in the community if they consent to that treatment. New section 64B gives the authority to treat adult patients who have the capacity to consent in the community only.

106. Community patients aged 16 or over who lack the capacity to consent to treatment in the community can be treated in the community if a donee of lasting power of attorney (an “attorney”) or deputy or the Court of Protection consents to treatment on their behalf and there is authority to give treatment under new section 64D (eg where the patient does not object to treatment). If the treatment conflicts with an advance decision or a decision made by an attorney or deputy or the Court of Protection it also cannot be given to the patient.
107. Children aged under 16 can also be made subject to a CTO. As with adults who have capacity, treatment cannot be given to a child in the community who is competent to consent and does not consent to it. New section 64F provides the authority to treat a child who lacks competence in the community. Similar conditions must be met in order to treat a child lacking competence as for an adult who lacks capacity. The only difference is that advanced decisions and decisions made by an attorney or deputy or the Court of Protection will not apply to child patients, because the MCA, from which these concepts derive, does not apply to children aged under 16.
108. In emergencies, force can be used to give treatment to patients who lack capacity or to children who lack competence. New section 64G sets out how and when treatment can be given in these situations. Force can be used to give treatment only if it is immediately necessary, prevents harm to the patient and is a proportionate response to the likelihood of the patient suffering harm and to the seriousness of the harm. In other circumstances force may be used to treat a patient who has not been recalled to hospital if the patient does not object. The factors to be considered by a practitioner in determining whether a patient objects to treatment are outlined in new section 64J.
109. All community patients receiving the type of treatment which falls under section 58 of the 1983 Act must have that treatment certified by a SOAD in accordance with the provisions of Part 4A. For treatment specified in section 58(1)(b), ie medication, a certificate does not have to be in place immediately for a community patient, but must be in place after a certain period. This period is one month from when a patient leaves hospital or three months from when the medication was first given to the patient (whether that medication was given in the community or in hospital), whichever is later. The SOAD must certify in writing that it is appropriate for the treatment to be given.
110. The SOAD may specify within the certificate that certain treatment can be given to the patient only if certain conditions are satisfied: so, for example, the SOAD can specify that a particular antipsychotic and dosage can only be given if the patient has the capacity to consent to it in the community and does consent to it. The SOAD can also specify whether and if so what treatments can be given to the patient on recall to hospital and the circumstances in which the treatment can be given. For example, the SOAD can specify, if appropriate, that an antipsychotic can be given to the patient on recall without the patient’s consent.

*These notes refer to the Mental Health Bill [HL]  
as introduced in the House of Lords on 16th November 2006 [HL Bill 1]*

111. The following table summarises when patients can be treated in the community and the safeguards that are in place for the review of section 58-type treatment:

	Patients 16 and over with capacity to consent AND patients under 16 with competence	Patients 16 and over without capacity to consent	Patients under 16 without competence to consent
<p>SCT patient in the community</p> <p>PART 4A regulates treatment</p>	<ul style="list-style-type: none"> <li>• Patient must consent to treatment</li> <li>• Authority to treat patient under s64B (adults) or s64E(children)</li> <li>• For s58 type treatment there must be a SOAD certificate in place: for medication this must be within a certain period<sup>1</sup></li> <li>• But certificate requirement need not be complied with where treatment is immediately necessary</li> </ul>	<ul style="list-style-type: none"> <li>• Can treat if an attorney or deputy or the Court of Protection consents under s64B</li> <li>• Can treat a patient under s64D provided patient does not object to treatment or it is not necessary to use force (unless the treatment conflicts with decision of an attorney, deputy or Court of Protection or advanced decision)</li> <li>• Can be treated in emergencies with force but only if it is immediately necessary and the use of force is proportionate under s64G</li> <li>• For s58 type treatment there must be a SOAD certificate in place: for medication this must be within a certain period</li> <li>• But it is not necessary to comply with the certificate requirement where treatment is immediately necessary or under section s64G</li> </ul>	<ul style="list-style-type: none"> <li>• Can treat a patient under s64E provided patient does not object to treatment or it is not necessary to use force</li> <li>• Can be treated in emergencies with force but only if it is proportionate under s64F</li> <li>• For s58 type treatment there must be a SOAD certificate in place: for medication, this must be within a certain period</li> <li>• But it is not necessary to comply with the certificate requirement where treatment is immediately necessary or under section s64G</li> </ul>
<p>SCT patient on recall to hospital or where SCT is revoked</p> <p>PART 4 regulates treatment</p>	<p>Section 58 type treatment can be given without consent under s62A where:</p> <ul style="list-style-type: none"> <li>• SOAD certificate is in place certifying that it is appropriate to give the treatment (s62A 3(a))*</li> </ul> <p>or</p> <ul style="list-style-type: none"> <li>• For medication regulated by s58 (1) (b) the patient is still</li> </ul>	<p>Section 58 type treatment can be given without consent under s62A where:</p> <ul style="list-style-type: none"> <li>• SOAD certificate is in place certifying that it is appropriate to give the treatment (s62A 3(a))*</li> </ul> <p>or</p> <ul style="list-style-type: none"> <li>• For medication, regulated by s58 (1) (b), the patient is still within the certain period (s62A3(b))</li> </ul>	<p>Section 58 type treatment can be given without consent under s62A where:</p> <ul style="list-style-type: none"> <li>• SOAD certificate is in place certifying that it is appropriate to give the treatment (s62A3(a))*</li> </ul> <p>or</p> <ul style="list-style-type: none"> <li>• For medication, regulated by s58 (1) (b)the patient is still</li> </ul>

<sup>1</sup> The certain period is one month from when a patient leaves hospital or three months from when the medication was first given to the patient (whether that medication was given in the community or in hospital), whichever is later.



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treatment	<p>within the certain period (s62A 3 (b))</p> <p>or</p> <ul style="list-style-type: none"> <li>• Discontinuing the treatment or plan of treatment would cause serious suffering to the patient under s62A (5)</li> </ul> <p>or</p> <p>Treatment is immediately necessary under s62</p> <p>Or if none of the above is satisfied a new s58 certificate is required to treat the patient.</p> <p>* where an SCT patient's CTO is revoked, relevant treatment can be given if the Part 4A certificate requirement is met, but only pending compliance with s58.</p>	<p>or</p> <ul style="list-style-type: none"> <li>• Discontinuing the treatment or plan of treatment would cause serious suffering to the patient under s62A(5)</li> </ul> <p>or</p> <p>Treatment is immediately necessary under s62</p> <p>Or if none of the above is satisfied a new s58 certificate is required to treat the patient.</p> <p>* where an SCT patient's CTO is revoked, relevant treatment can be given if the Part 4A certificate requirement is met, but only pending compliance with s58.</p>	<p>within the certain period (s62A3(b))</p> <p>or</p> <ul style="list-style-type: none"> <li>• Discontinuing the treatment or plan of treatment would cause serious suffering to the patient under s62A (5)</li> </ul> <p>or</p> <p>Treatment is immediately necessary under s62</p> <p>Or if none of the above is satisfied a new s58 certificate is required to treat the patient.</p> <p>* where an SCT patient's CTO is revoked, relevant treatment can be given if the Part 4A certificate requirement is met, but only pending compliance with s58.</p>
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**Clause 29: repeal of provisions for after-care under supervision**

112. SCT replaces the regime of supervised after-care. The supervised after-care provisions (sections 25A to 25J of the 1983 Act) are repealed by clause 29. Clause 45 provides the power to make transitional provisions by order in connection with the repeal of sections 25A to 25J.

**Schedule 3: SCT and further amendment of the 1983 Act**

113. Schedule 3 sets out the detailed amendments to the 1983 Act which are needed to enable the introduction of SCT. The ones of particular note are described below.
114. In relation to absence without leave, under amended section 18(2A), a community patient who has been recalled to hospital can be taken into custody and returned to the hospital (whether the patient has not arrived there or has absconded). Any AMHP, officer on the staff of the hospital, a constable, or anyone authorised in writing by the RC or hospital managers may exercise this power. A community patient cannot be taken into custody after his or her CTO ceases to be in force, or six months have elapsed since the patient was first absent without leave, whichever is the later. (This mirrors the provisions for detained patients and

those subject to guardianship.) The authority to take such a patient into custody will therefore last until at least six months after the first day of absence.

115. If extension of a community patient's CTO does not take effect before the patient's first day of absence without leave, then the period during which the patient can be taken into custody is not extended by the extension of the order.
116. Sections 21, 21A and 21B are amended to provide certain provisions relating to community patients absent without leave. If a community patient:
- is absent without leave on the day the patient's CTO would have expired, or during the preceding week, the CTO is extended for a week after the patient returns or is returned to hospital.
  - is absent without leave on the day when the 72 hour period for recall is up, the 72-hour period effectively begins again when the patient is taken into custody, or returns voluntarily to the hospital, subject to the time limits as for detained patients.
  - returns or is returned to hospital within 28 days of the first day of his or her absence without leave, the RC has a week after the patient's return to carry out the examination and make his or her report for the extension of the CTO, if the CTO would have otherwise expired.
  - returns, or is returned, to hospital more than 28 days after the patient was first absent without leave, the RC has a week after the patient's return to examine the patient, and, if the RC decides that the patient meets the criteria for SCT, prepare a report for the hospital managers extending the CTO.
117. Section 22 is amended so that community patients, like those detained for treatment, who are imprisoned for more than six months (or for successive periods exceeding six months in total) are no longer subject to the Act upon their release.
118. Community patients can be absolutely discharged from SCT (and therefore liability to recall to hospital), under amended section 23, by the RC, hospital managers of the responsible hospital or by the NR, in the same way as patients can be discharged from detention.
119. Where the NR makes an order for the discharge of a community patient under amended section 24, any registered medical practitioner can visit or examine the patient and access records relating to the patient, just as for detained patients.
120. The restriction on discharge by a NR applies to community patients in the same way as it does to detained patients. The NR must give 72 hours notice in writing to the managers if they wish to make the order and the RC can bar the order for discharge from taking effect, if a report is made that certifies that the patient is likely to act in a dangerous manner if discharged from SCT.

121. An application can be made to the county court to appoint or replace a community patient's NR.
122. A community patient may apply to the MHRT, under amended section 66, when a CTO is made, when it is revoked, when it is extended after six months or a year (as appropriate) and when an order is extended after the patient has been absent without leave for more than 28 days. A NR may also apply to the MHRT if the NR makes a discharge order which is not put into effect because the RC reports that the patient would be likely to act in a dangerous manner if discharged; or if he or she is displaced by a court order as allowed under section 29(1)(c) or (d) of the Act. The hospital managers must refer a patient to the MHRT if a CTO is revoked.
123. Community patients who were under a hospital order before being made subject to a CTO may make an application to the MHRT in the second six months of the patients being subject to the CTO. The power under section 66 to apply to a Tribunal when a CTO is made or revoked cannot be exercised until six months after the date of the hospital order. The NR of such a patient may apply to the MHRT whenever the patient has a right to apply. The Secretary of State can refer a case of a community patient to the MHRT, in the same way as for detained patients.
124. The MHRT must direct the discharge of a community patient under amended section 72(2)(c) if the MHRT is not satisfied as to any of the following:
- the patient needs medical treatment for mental disorder for his or her own health or safety, or for the protection of others
  - it is necessary for the patient's health or safety or the protection of others that he or she should be liable to be recalled to hospital for treatment
  - appropriate medical treatment is available for the patient.

The MHRT has a new power (section 72(3A)) in respect of a patient detained under section 3 of the Act, or subject to a hospital order or direction. The MHRT may recommend that the RC consider if a CTO for the patient should be made, where it does not discharge such a patient. When considering whether to discharge a patient the MHRT need not direct the discharge of a patient just because they think SCT might be appropriate for the patient.

125. The special procedures in section 141 of the 1983 Act to be followed if an MP (or a member of the National Assembly for Wales, Scottish Parliament or Northern Ireland Assembly) is detained on the grounds of mental disorder do not apply to community patients.

## **CHAPTER 5 – MENTAL HEALTH REVIEW TRIBUNALS**

### **Clause 30: references to Mental Health Review Tribunal (MHRT)**

126. The MHRT is an independent judicial body with the power to order the discharge of a patient from detention for assessment and/or treatment and from guardianship under the 1983 Act.

The MHRT reviews a patient's case either on application from the patient or the patient's NR, on referral from the Secretary of State or, if the MHRT has not reviewed the case within a given period, on referral by hospital managers. Under the 1983 Act, section 68 sets out the provisions for when hospital managers must make a referral. Clause 30 amends this section so that it applies to a wider group of patients (those who are still subject to section 2 at the point of referral and patients who are on a CTO).

127. Under the 1983 Act, hospital managers are required to refer a patient's case to the MHRT at six months from the beginning of the detention for treatment or the patient's transfer from guardianship to hospital if the patient has not applied for a tribunal themselves, if an application has not been made on their behalf or if they have not been referred to the MHRT by the Secretary of State. Under clause 30, hospital managers will be required to refer the patient at six months from the day on which the patient was first detained, whether under section 2 for assessment, section 3 for treatment, or the day on which they were detained in hospital following a transfer from guardianship (this is defined as the "applicable day" at section 68(5)). This will make the referral period the same for all patients whether they have first been detained for treatment or for assessment. This six month time period can be reduced by order of the Secretary of State or Welsh Ministers under section 68A. The provision enables the order to include any consequential arrangements that may be required to ensure that patients who are transferred from England to Wales or vice versa between the period of referral in one territory and the other do not miss out on a referral to the MHRT by virtue of the transfer.
128. Clause 30 also removes the requirement that hospital managers are only under a duty to make a subsequent referral to the MHRT upon the renewal of patient's detention. Under the 1983 Act, hospital managers are required to refer patients whose authority for detention has been renewed if three years have passed (or one year for patients aged under 16 years) and the MHRT has not reviewed the case in that time. In practice, it can be up to four years before a patient's case is considered by the MHRT if the patient does not apply, because a renewal only happens once a year, and the referral cannot take place until the detention is next renewed. By removing the link between renewal and subsequent referrals, the only requirement for subsequent referrals is that the MHRT has not considered the patient's case in three years (or one year if the patient is under 16). The order making power at section 68A will also enable the three year and one year period to be reduced. As a further consequence, patients who are absent without leave (AWOL) at the point at which they should be referred to the MHRT (the three year time period has passed) must be referred on their return to hospital.
129. The provision allowing a registered medical practitioner to visit and examine the patient for the purposes of gathering information in preparation for the MHRT is extended to allow ACs to visit and examine, and is extended to cover patients who are on a CTO.
130. Finally the clause amends Schedule 1 to the 1983 Act to ensure that the new provisions continue to apply where appropriate to unrestricted Part 3 patients (ie mentally disordered

offenders not subject to the special restrictions under section 41 of the 1983 Act). Only those Part 3 patients who are transferred from a guardianship order to a hospital order qualify for a referral by the hospital managers after the first six months. Part 3 patients placed on a hospital order will not be entitled to a referral in the first six months of their, as their initial detention has been subject to judicial consideration by the sentencing court and they cannot themselves apply to the MHRT in that period. The referral at three years will extend to all Part 3 patients detained in hospital or on SCT and not subject to restrictions.

**Clause 31: organisation of the MHRT**

131. Clause 31 replaces the existing multiple regional Tribunals with two Tribunals, one for England and one for Wales. In addition, it renames the role of chairman of each of the Tribunals as president. The Tribunal for England and the Tribunal for Wales will each have a president. The term “president” as it is currently used under the 1983 Act to refer to the chair of a Tribunal constituted for particular proceedings will be replaced with “chairman”.

**CHAPTER 6 – CROSS-BORDER PATIENTS**

**Clause 32: cross-border arrangements**

132. The 1983 Act already provides for detained patients to be transferred from England and Wales to Scotland, Northern Ireland, the Channel Islands, and the Isle of Man and vice versa (except Scotland). The removal of patients from Scotland is dealt with under the Mental Health (Care and Treatment)(Scotland) Act 2003, regulations made under that Act and the Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005 (SI 2005/2078) (“the Consequential Provisions Order”).
133. The amendments in Schedule 5 to the Bill provide for community patients to be similarly transferred. It also provides for detained patients to be transferred from Scotland to England and Wales and accordingly repeals the relevant provisions in the Consequential Provisions Order dealing with transfers from Scotland.
134. Transfers are only undertaken when they are in the patient’s interests. For example, a patient may be transferred from Scotland to England when he or she is detained under mental health legislation in Edinburgh but normally lives in London and a transfer would enable friends and family to visit him or her on a more regular basis.
135. No provision is made in respect of the transfer of patients under guardianship in England and Wales as Scotland no longer has the equivalent of mental health guardianship.
136. For patients transferring from Scotland to England and Wales the date of their hospital admission in England or Wales (for detained patients) and their date of arrival at their place of residence (for community patients) will be the date on which an application is deemed to have been made in England and Wales. As soon as practicable after the arrival of a community patient in England and Wales a CTO should be made and it will be deemed to be dated from the day of the patient’s arrival. A community patient transferred from Scotland to England

and Wales will not be detained in hospital following their transfer prior to becoming a community patient in England and Wales. For example if a patient detained under section 3 in hospital in Scotland is transferred to England or Wales on 5th April, they will be treated as if they had been admitted to hospital in England or Wales on 5th April. A community patient transferred from Scotland to England or Wales and arriving at their place of residence in England or Wales on 10th April will have a CTO made in England or Wales and dated 10th April. The dates of 5th April and 10th April will therefore be the start dates under the 1983 Act for each patient. This date is significant because it determines when, for example, a patient's case must be referred by the hospital managers to the MHRT (under section 68 as amended by clause 30).

137. No provision is made in the Bill for the transfer of community patients from Northern Ireland as there is currently no provision for community patients in Northern Ireland. Should this be introduced, provision can be made for transfers by Order in Council.
138. Schedule 5 also amends sections 83 and 85 (which provide for detained patients to be transferred from England and Wales to the Channel Islands and the Isle of Man and vice versa) of the 1983 Act to provide for community patients to be transferred from England and Wales to the Channel Islands and the Isle of Man and vice versa. Similar arrangements to those set out for patients transferring from Scotland will apply to patients transferring to England and Wales from the Channel Islands or the Isle of Man for deeming their date of arrival and the date of the CTO. At present the Channel Islands and the Isle of Man do not have legislation enabling patients to be treated in the community under arrangements similar to SCT so this provision would only have effect when the Channel Islands and the Isle of Man bring in such legislation
139. Schedule 5 also amends section 88 of the 1983 Act, which provides for patients absent from hospitals in England and Wales to be taken into custody and returned to England and Wales, to apply to Scotland and Northern Ireland only. The Channel Islands and the Isle of Man have powers of their own, which they can use to return patients from England and Wales.

## **CHAPTER 7 – RESTRICTED PATIENTS**

### **Clause 33: restriction orders**

140. Clause 33 amends section 41 of the 1983 Act to remove the power of the Crown Court to make restriction orders under section 41 for a limited period. Instead, such orders will remain in force until they are discharged by the Home Secretary or the MHRT. The clause also makes consequential changes to other provisions of the 1983 Act.

### **Clause 34: conditionally discharged patients subject to limitation directions**

141. Clause 34 makes an amendment to section 75(3) of the 1983 Act so that, on the application of a patient who has been conditionally discharged from hospital while subject to hospital and limitation directions, the MHRT may direct that the patient's limitation direction is to cease to have effect, in which case the patient's hospital direction will also cease to have effect, and

the patient will be absolutely discharged. Hospital and limitation directions may be imposed by the Crown Court in accordance with section 45A of the 1983 Act where the court considers it appropriate to direct the prisoner's detention in hospital for medical treatment as well as passing a prison sentence.

## **CHAPTER 8 MISCELLANEOUS**

### **Clause 35: delegation of powers of managers of NHS foundation trusts**

142. Clause 35 amends section 23 of the 1983 Act in relation to the delegation by National Health Service foundation trusts (NHSFTs) of their power to discharge patients from compulsion under the Act.
143. Section 23 gives the managers of hospitals the power to discharge patients who are liable to be detained. (This power is only exercisable with the consent of the Secretary of State (in practice the Home Secretary) in the case of patients subject to special restrictions under Part 3 of the Act.) Paragraph 10 of Schedule 3 extends the managers' powers to include a power to discharge patients subject to CTOs for whom the hospital is responsible. See clause 25 above for an explanation of CTOs.
144. The Act does not set out any specific procedure which hospital managers must follow when considering whether to discharge patients. But managers will generally offer to hold an oral hearing when requested to do so by patients, where patients contest the renewal of their detention by their RMO (in future their RC), or where a NR's discharge order is blocked under section 25 on the grounds that the patient is likely to act in a dangerous manner if discharged. Where renewal is not opposed, the managers may consider the case for the patient's discharge on the papers, without a hearing.
145. Section 145 of the Act provides that the managers of a NHS hospital are normally the body in which the hospital is vested. In practice, this generally means a National Health Service trust, or (in England) a primary care trust (PCT) or an NHSFT. (Clause 36 below adds Local Health Boards (LHBs) in Wales to this list.)
146. These bodies do not have to take discharge decisions themselves. Section 23 allows them to delegate the exercise of their discharge power. NHS trusts may delegate this function to three or more people who are either directors of the trust (including the Chairman) or members of a committee or subcommittee of the trust, provided that the people in question are not employees of the trust. The rules for PCTs are effectively the same. In practice, these trusts usually delegate their function to a combination of non-executive directors and a panel of people specially recruited for the task. This latter group are often known as "associate hospital managers". By contrast, section 23(6) permits NHSFTs to delegate discharge decisions only to non-executive directors of the trust. Accordingly they cannot delegate to associate hospital managers.

147. *Subsection (1)* of this clause amends section 23 of the 1983 Act to give NHSFTs greater flexibility. Specifically, it will allow them to delegate discharge decisions to any three or more people authorised by the board of the trust, provided those persons are neither executive directors nor employees of the trust. The effect is to give NHSFTs powers to delegate their discharge powers similar to those enjoyed by NHS trusts. *Subsection (2)* amends section 32, so that the powers in that section to make regulations (which may include regulations permitting the delegation of hospital managers' functions by NHS bodies) are subject to the revised section 23(6).
148. *Subsection (3)* inserts a new section 142B into the 1983 Act which provides that the constitution of an NHSFT may not permit functions under the 1983 Act to be delegated except in accordance with the Act itself or provision made under it and that paragraph 15(3) of Schedule 7 to the National Health Service Act 2006 ("the 2006 Act") is to have effect subject to that provision. Schedule 7 of the 2006 Act sets out mandatory requirements for the contents of an NHSFT's constitution. In particular, paragraph 15(2) requires the constitution to provide for the powers of the NHSFT to be exercisable by its Board. Paragraph 15(3) then provides that the constitution may allow for the Board to delegate powers to committees of directors or to individual executive directors.
149. The effect of the new section 142B is that an NHSFT's constitution may not permit its functions under the 1983 Act to be delegated to executive directors or committees of directors unless that is permitted by or under the 1983 Act itself. But the constitution may permit delegation to other people where that is allowed by or under the 1983 Act.

**Clause 36: Local Health Boards**

150. Clause 36 adds a reference to LHBs to the definition of "the managers" of hospitals in section 145(1) of the 1983 Act. Hospital managers have a variety of functions under the 1983 Act and the definition of "the managers" identifies the body or people who are the managers of each hospital, depending on who owns or runs it.
151. LHBs are statutory NHS bodies established by the National Assembly for Wales under section 16BA of the National Health Service Act 1977. (From the commencement of the National Health Service (Wales) Act 2006 (NHS Act 2006) the reference to section 16BA of the 1977 Act will be to section 11 of the NHS Act 2006. Additionally, reference to the National Assembly will change to Welsh Ministers as a result of the application of Government of Wales Act 2006.)
152. Most hospitals in Wales are vested in NHS trusts, but in Powys they are vested in the LHB. At present, LHBs are not specifically mentioned in the definition of "the managers". *Subsection (1)* of the amendment accordingly provides that, for the purposes of the 1983 Act, LHBs are the managers of hospitals vested in those Boards.
153. *Subsection (2)* makes an equivalent addition to section 19(3) of the 1983 Act. That subsection allows NHS bodies who are the managers of more than one hospital to move



patients liable to be detained in one of their hospitals to another one. The effect of the amendment will be to make clear that LHBs may also move such patients between their hospitals.

**Clause 37: Welsh Ministers: procedure for instruments**

154. Clause 37 amends the provisions in section 143 of the 1983 Act which make provision in relation to the exercise of regulation, order and rule making powers. In particular it provides the procedure to be applied when such powers are exercised by the Welsh Ministers.

**PART 2 - AMENDMENTS TO MENTAL CAPACITY ACT 2005**

**Clause 38: Mental Capacity Act 2005: deprivation of liberty**

155. Clause 38 inserts new sections 4A, 4B and 16A into the MCA. This makes it lawful to deprive a person of their liberty only if a standard or urgent authorisation is in force or if a consequence of giving effect to an order of the Court of Protection on a personal welfare matter, in accordance with the provisions of the MCA. If there is a question about whether a person may be lawfully deprived of their liberty and the authorisation is to enable life sustaining treatment or treatment believed necessary to prevent a serious deterioration in the person's condition, a person may be detained while a decision is sought from the Court of Protection.
156. New Schedule A1 sets out the detailed procedures and requirements relating to standard and urgent authorisations of deprivation of liberty in hospitals or care homes. These procedures apply to care or treatment funded publicly or privately. The reason that authorisation may only apply to hospitals or care homes is that the Government considers that it would only rarely be justifiable to deprive a person of liberty in their best interests in any other setting. Deprivation of liberty in other settings would only be lawful if it were a consequence of giving effect to an order of the Court of Protection on a personal welfare matter, in accordance with the provisions of the MCA.
157. Deprivation of liberty is defined as having the same meaning as in Article 5(1) of the ECHR. In its judgement in *HLvUK*, the European Court of Human Rights said that the difference between restriction or deprivation of liberty is one of degree or intensity rather than of nature or substance and therefore, in order to determine whether a person is being deprived of liberty, there must be an assessment of the specific factors in each individual case eg the type, duration, effects and manner of implementation of the measure in question and its impact on the person. Guidance on identifying deprivation of liberty will be included in amendments to the MCA Code of Practice to reflect the amendments to the MCA.
158. An authorisation does not entitle the hospital or care home to do anything other than for the purpose of the authorisation. The reason for this provision is that the authorisation procedure is to ensure the lawfulness of deprivation of liberty. It is not directly concerned with the provision of care or treatment to people who lack capacity to consent: this is governed by the

existing provisions of the MCA except where the provisions of mental health legislation apply.

159. Part 3 of the new Schedule sets out the qualifying requirements that must be met before a standard authorisation can be given to detain a person as a resident in a hospital or care home in circumstances which amount to deprivation of their liberty.
160. The person must:
- be aged 18 or over (the age requirement)
  - be suffering from a mental disorder within the meaning of the 1983 Act (the mental health requirement), and
  - lack capacity to decide whether or not they should be a resident in the hospital or care home (the mental capacity requirement) .
161. The deprivation of liberty authorised must also be:
- in the best interests of the person
  - necessary in order to prevent harm to him or her, and
  - a proportionate response to the likelihood of suffering harm and the seriousness of that harm (the best interests requirement).
162. A person must also meet the eligibility requirement which relates to cases where a person is, or might be made, subject to the 1983 Act. Grounds for ineligibility are in new Schedule 1A. In summary, a person is ineligible if they are already subject to the 1983 Act in one of the following circumstances:
- they are actually detained in hospital under the main powers of detention in the 1983 Act (or treated as such).
  - they are on leave of absence from detention or subject to guardianship, SCT or conditional discharge and in connection with that are subject to a measure (such as a requirement to live in a particular place) which would be inconsistent with the authorisation if granted. This means that a person who is subject to the 1983 Act but who is not in hospital could receive the Bournemouth safeguards. This might be necessary for example if a person subject to guardianship who normally lived at home needed respite care in a care home.
  - they are on leave of absence from detention, or subject to SCT or conditional discharge and the authorisation, if given, would be for deprivation of liberty in a hospital for the purposes of treatment for mental disorder. This means that a Bournemouth authorisation cannot be used as an alternative to the procedures for recall in the 1983 Act.

For consistency, the Court of Protection may not make an order which would lead to a person being deprived of their liberty if the person is ineligible under new Schedule 1A.

163. A person is also ineligible if the authorisation would be for deprivation of liberty in a hospital for the purposes of treatment for mental disorder, the person concerned would otherwise meet the criteria for detention under Part 2 of 1983 Act and the person objects to being detained in the hospital or to some or all of the treatment.
164. In deciding whether a person objects consideration must be given to the circumstances including his or her behaviour, wishes, views, beliefs, feelings and values, including those expressed in the past to the extent that they remain relevant. This will inevitably call for a judgment on the part of the relevant decision-maker. The fact that a person cannot (or does not) express a view (or otherwise communicate an objection) does not of itself mean that the person should not be taken to object.
165. The purpose of this provision is to treat people in this situation as if they had capacity to consent but are refusing to be admitted to (or stay in) hospital or are not consenting to the treatment for mental disorder they are to be given there. In such cases, they would either have to be detained under the 1983 Act, or another way of giving treatment would have to be found.
166. A person's objections will not make them ineligible if a donee of Lasting Power of Attorney (an "attorney") or a deputy appointed by the Court of Protection (or the Court of Protection itself) has made a valid decision to consent to the hospitalisation and treatment on their behalf.
167. For consistency, the Court of Protection may not make an order which would lead to a person being deprived of their liberty if the person is ineligible under new Schedule 1A.
168. A person must also meet the no refusals requirement. There are refusals if:
- the authorisation sought is for the purposes of treatment or care covered by a valid and applicable advanced decision by the person (an advance decision being a decision to refuse treatment at a later date, made in anticipation of not having capacity to make the decision at the time in question), or
  - it would conflict with a valid decision by an attorney or a deputy on their behalf (or a relevant decision of the Court of Protection).
169. Again, the purpose of this requirement is to treat people in this position as if they had capacity to refuse consent to the proposed course of action.
170. Part 4 of Schedule A1 sets out the requirements and procedure for requesting and granting a standard authorisation. The managing authority of a hospital or care home must request authorisation from the supervisory body if a person who meets or is likely to meet all of the qualifying requirements is, or is likely to be, detained as a resident in that hospital or care home in circumstances which amount to deprivation of their liberty. The reasons for placing this duty with the managing authority are that it is the hospital or care home which would be

at risk of civil or criminal penalties for depriving a person of liberty without authorisation and also that only the managing authority of the hospital or care home will be in a position in each case to recognise that deprivation of liberty may arise. The managing authority of a hospital or care home must keep written records of requests for authorisation made and the reasons for them. Information required to be given with a request may be specified in regulations.

171. The supervisory body would be:

- in the case of a care home the local authority where the person is ordinarily resident, or where the care home is situated.
- in the case of a hospital the PCT which commissions the care, or Welsh Ministers if the care is commissioned by them.

172. The managing authority means:

- the PCT, Strategic Health Authority, LHB, Special Health Authority, NHS trust or NHSFT in relation to an NHS hospital requesting an authorisation
- the person registered under the Care Standard Act 2000 in respect of an independent hospital requesting an authorisation, or
- the person registered in respect of that home under Part 2 of the Care Standards Act 2000 in relation to a care home requesting an authorisation .

173. An authorisation cannot be given unless relevant assessments have been commissioned by the supervisory body that conclude that all of the qualifying requirements listed in Part 3 of the Schedule are met. Regulations will specify who can carry out assessments, covering the need for more than one assessor, professional skills, training and competence required and independence from decisions about providing or commissioning care to the person and the timeframe within which assessments must be completed. The mental health and best interests assessments must be carried out by different assessors. It is the responsibility of the supervisory body to appoint an assessor who is eligible and who is suitable, having regard to the person to be assessed.

174. The best interests assessment:

- the best interests assessment must take account of any relevant needs assessment or care plan, and to the opinion of the mental health assessor on the impact of the proposed course of action on the person's mental health. In carrying out the best interests assessment, the assessor must consult the managing authority of the hospital or care home.
- the best interests assessor will be required, under paragraph 4(7) of the MCA, to take into account the views of :
  - anyone named by the person as someone to be consulted
  - anyone engaged in caring for the person or interested in his or her welfare
  - any donee of a lasting power of attorney granted by the person, and

- any deputy appointed for the person by the court.
  - the best interests assessor must record the name and address of every interested person consulted as they will be entitled to information about the outcome of the request for authorisation (spouse, civil partner, and close family are defined as interested persons).
  - if the best interests assessment recommends authorisation, the assessor must state the maximum authorisation period which may not be for more than one year.
  - the best interests assessor may recommend conditions to be attached to the authorisation.
  - if the best interests assessor concludes that deprivation of liberty is not in the person's best interests but becomes aware that they are already being deprived of their liberty, they must draw this to the attention of the supervisory body.
175. Assessments must be made as soon as possible after application and regulations may be made to specify the time period for completing the assessment process. If existing equivalent assessments have been carried out within the past year they may be used if the supervisory body are satisfied there is no reason that they may no longer be accurate. If the person is unbefriended, defined in the MCA as having no one to speak for them who is not paid to provide care, an IMCA will be appointed to support and represent them during the assessment process.
176. If any of the assessments conclude that the person does not meet the criteria for an authorisation to be issued the supervisory body must turn down the request for authorisation. The assessment process will be discontinued if any of the assessments reach the conclusion that the person does not meet one of the qualifying requirements. The supervisory body must inform the hospital or care home management, the person concerned, any IMCA appointed and all interested persons consulted by the best interests assessor of the decision and the reasons. This is so that all with an interest are aware that the person may not lawfully be deprived of their liberty.
177. It is the duty of the supervisory body to give the authorisation if all of the assessors recommend it. The supervisory body must:
- set the period of the authorisation which may not be longer than the maximum period identified in the best interests assessment.
  - issue the authorisation in writing, stating the period for which it is valid, the purpose for which it is given, and the reason why each qualifying requirement is met.
  - if appropriate attach conditions to the authorisation, taking account of the recommendations of the best interests assessor.
  - appoint someone to act as the persons representative during the authorisation.
  - provide a copy of authorisation to the managing authority of the care home or hospital, the person who is being deprived of liberty and their representative, any IMCA who has been involved and any other interested person consulted by the best interests assessor and in due course to notify them when a standard authorisation ceases to be in force.
  - keep written records.

178. If an authorisation is granted to deprive a person of their liberty then the managing authority of the hospital or care home must (if acting on that authorisation):
- ensure that any conditions are complied with.
  - take all practicable steps to ensure that the person understands the effect of the authorisation, their right to appeal to the Court of Protection and their right to request a review.
  - give the same information to the person's representative.
  - keep the person's case under consideration and request a review if necessary (see below).

179. If an authorisation is granted, the supervisory body will appoint a person to be the relevant person's representative as soon as practicable (Part 10). They must appoint someone who they consider will:
- maintain contact with the relevant person.
  - support and represent them in matters concerning the authorisation including requesting review or appealing to the Court of Protection on their behalf.

The person concerned and their representative have right of access to the Court of Protection to appeal regarding an authorisation. Any other person with a concern may apply to the Court for permission to be heard.

180. Regulations may be made regarding the selection, appointment, suspension and termination of representatives but only the following can select a person to be appointed as representative:
- the relevant person if they have capacity
  - an attorney or deputy (if it is within the scope of their authority)
  - a best interests assessor
  - the supervisory body.

181. If there is a section 39C IMCA appointed for a person who is the subject of a Bournewood authorisation, for example to represent them until a new appointment is made after the appointment of their representative is ended, all the provisions relating to the relevant person's representative will apply to the section 39C IMCA.

182. If there is both a section 39A IMCA and a representative appointed, the duties and powers of the IMCA do not apply except for the power of challenge. However the IMCA must take the views of the person's representative into account before exercising any power of challenge.

183. Urgent authorisations (Part 5) may be given by the managing authority of a care home or hospital to provide a lawful basis for the deprivation of liberty where it is urgently required

and where the qualifying requirements listed in Part 3 appear to be met, whilst a standard authorisation is being obtained. An urgent authorisation can only last for a maximum of 7 days unless in exceptional circumstances it is extended to 14 days by the supervisory body. An urgent authorisation must be in writing and the managing authority must keep a written record of their reasons for giving an urgent authorisation. The managing authority is required to take all practicable steps (verbally and in writing) to ensure that the person understands the effect of the authorisation and their right to appeal to the Court of Protection and to notify any IMCA when an urgent authorisation is given.

184. The supervisory body may grant a request to extend an urgent authorisation for up to a further 7 days if there are exceptional reasons why it has not been possible to decide on a request for standard authorisation and it is essential that detention continue. This might occur for example if the best interests assessor has not been able to contact someone they are required to consult and considers that they cannot reach a judgement without doing so. An urgent authorisation ceases to be in force at the end of the period specified or earlier if a decision is reached on the application for a standard authorisation. The supervisory body must inform the relevant person and any IMCA involved when an urgent authorisation ceases to be in force.
185. The purpose of Part 6 is to provide a procedure for the authorisation to be suspended if the person becomes ineligible, for reasons other than their own objection, for less than 28 days. This is to allow for short periods of treatment under the 1983 Act.
186. If the person is to move to a different hospital or care home, the new managing authority must request a new authorisation, provided that the new detention would not be under the 1983 Act. The effect of this is that an authorisation will not be transferable to a new facility and a move, which is a significant change in the person's circumstances, will trigger a fresh assessment of whether the deprivation of liberty is in the person's best interests.
187. If the person does not move but the supervisory body changes, for example because of changes in local authority or PCT boundary, the managing authority must apply for a variation of the authorisation, provided that none of the grounds for review are met (Part 7). The new supervisory body must make the variation if it is satisfied that these conditions are met and must notify the relevant person and their representative, managing authority and the former supervisory body. In urgent cases the variation can be made by the managing authority but must be confirmed by the supervisory body.
188. The supervisory body may review (Part 8) a standard authorisation at any time and must do so if requested to by the relevant person, his or her representative or the managing authority of the care home or hospital. The qualifying requirements are reviewable if:
- the person does not meet one or more of the qualifying requirements, or
  - the reason that they meet one of the qualifying requirements is not the reason stated in the authorisation, or

- there has been a change in the relevant person's case and because of that change it would be appropriate to change the authorisation conditions (best interests requirement only).

189. The managing authority is required to request such a review if it appears to it that there has been such a change in the person's circumstances. The relevant person or their representative may request a review at any time.
190. The supervisory body must first decide if any of the qualifying requirements appear to be reviewable. If not there is no further action. If one or more of the age, mental health, mental capacity, objections element of eligibility or no refusals requirements are reviewable, the supervisory body must commission review assessment(s). This may lead to the authorisation being terminated or to a change in the reason recorded that the person meets one of the requirements.
191. If the best interests assessment appears to be reviewable the supervisory body must obtain a best interests review assessment unless the only ground for review is variation of conditions and the change in circumstances is not significant. The best interests review assessment may lead to the authorisation being terminated or to a change in the reason recorded that the person meets the best interests requirement or a change in the conditions attached to the authorisation.
192. When the review is complete, the supervisory body must inform the managing authority of the hospital or care home, the relevant person and their representative.
193. The managing authority may apply for a further authorisation to begin when the existing authorisation expires. If that is the case the full assessment process is repeated.
194. The Secretary of State and Welsh Ministers may make regulations conferring a duty on a body to monitor the operation of the Bournemouth safeguards.
195. It is for the Secretary of State to make regulations under Schedule A1 in relation to English authorisations (where the supervisory body is a PCT or local authority in England) and for Welsh Ministers to make regulations in relation to Welsh authorisations (where the supervisory body is Welsh Ministers or a local authority in Wales) and for the Welsh Ministers to direct a LHB to exercise the functions of a supervisory body (Part 13).

**Clause 39: correction of error**

196. This clause amends section 20(11)(a) of the MCA. It replaces the word "or" with "and". The amendment corrects a drafting error.

**PART 3 - GENERAL**

**Clauses 40-47**

197. This Part sets out general provisions for the Bill. Particular points to note are set out below.



198. Clause 42 allows the Secretary of State to make minor supplementary, incidental or consequential amendments to relevant provisions of other Acts and subordinate legislation by means of an order. This is to ensure that provisions in other Acts and subordinate legislation are consistent with the changes contained in the 1983 Act, as amended by this Bill. Amendments made to primary legislation under the order making power (contained in the Henry VIII part of the power) will be subject to affirmative resolution. This is the usual procedure. Amendments made to secondary legislation under the order making power contained in clause 42 will be subject to negative resolution in both Houses.
199. Clause 44 (commencement) provides that the provisions of the Bill (other than clauses 39 to 41 (and Schedule 9), clause 44 itself and clauses 45 - 47) are to be brought into force on a day appointed for the purpose by the Secretary of State by order. Clause 39, which amends the MCA, will be brought into force on a day appointed by order made by the Lord Chancellor. Clauses 40 (meaning of "1983 Act"), 41 and Schedule 9 (transitional provisions and savings), 44 (commencement), 45 (commencement of section 29), 46 (extent) and 47 (short title) will come into effect on the day the Bill is passed and becomes an Act. Orders made under clause 44 are made by statutory instrument, but are not subject to negative or affirmative resolution procedure.
200. The power in *subsections (4)(b) and (5)* to make transitional provision to modify the application of the Bill once enacted pending the commencement of the provisions of another enactment will be used to make temporary modifications to the amendments being made in Schedule 4 to the Administration of Justice Act 1960, the Courts-Martial (Appeals) Act 1968 and the Criminal Appeal Act 1968. The modifications will be necessary in order to (a) reflect the existing definition of "relevant time" in section 20(5) of the Courts-Martial (Appeals) Act pending its repeal and replacement by a new definition, for which the Armed Forces Act 2006 provides; (b) provide for the retention of the role of the Defence Council under the Courts-Martial (Appeals) Act pending its replacement by that of the Director of Service Prosecutions, for which the Armed Forces Act provides; and (c) provide for the retention of the role of the House of Lords in the Administration of Justice Act, the Criminal Appeal Act and the Courts-Martial (Appeals) Act pending its replacement by the Supreme Court, for which the Constitutional Reform Act 2005 provides.
201. Clause 45 (commencement of section 29) gives the Secretary of State the power to make provision in an order made under clause 44 for transitional arrangements for persons subject to supervised after-care when it ends. The intention is to retain supervised after-care for a brief period after its abolition so that a decision can be made about what should happen to a person who is subject to it at that time. PCTs (LHBs in Wales) will be required to ensure that a registered medical practitioner examines each person subject to supervised after-care within the transitional period with a view to (a) ending the supervised after-care and discharging the person; or (b) recommending that the person be detained in hospital for treatment; or (c) recommending that the person be made subject to guardianship; or (d) making a CTO (subject to the agreement of an approved mental health professional).

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202. Clause 46 (extent) provides that the amendments contained in the Bill will have the same extent as the enactments they amend (subject to *subsection (2)*).
203. It has been agreed with the Office of the Solicitor to the Scottish Executive and the Office of the Solicitor to the Advocate General that the amendments in the Bill which extend to Scotland, in so far as they relate to devolved matters, do not engage the Sewel Convention. Those amendments include the amendment to section 80 (removal of patients to Scotland), contained in paragraph 2 of Schedule 5. As the amendment merely involves a repeal in a devolved area in Scotland, consequential on a change of substance in the same subject area in England and Wales, the Sewel Convention is not engaged.
204. Subsection (2) sets out a handful of qualifications to the general proposition in *subsection (1)*.
205. Paragraph (a) refers to paragraphs 28 and 35 of Schedule 3. Paragraph 28 amends section 128 of the 1983 Act so as to apply the offences provided for by that section to cases involving community patients. But paragraph 35 amends section 146 of the 1983 Act so as to provide that section 128, so far as relating to community patients, does not extend to Scotland. There is already provision in the 1983 Act providing that, in relation to Scotland, the offences under section 128 do not apply in cases involving patients subject to guardianship.
206. Paragraph (b) refers to paragraphs 3 and 4 of Schedule 5. Those paragraphs insert new sections 80ZA, 80B, 80C and 80D, which make provision about the transfer of patients to and from Scotland. There is nothing in any of those sections which needs to form part of the law of Scotland in order for them to operate properly. But section 80 (after which section 80ZA is to be inserted) and section 80A (after which sections 80B to 80D are to be inserted) each extend to Scotland. So it might be arguable that the new sections also extend to Scotland. Paragraphs 3(2) and 4(2) of Schedule 5 remove any such doubt.
207. Paragraph (c) refers to paragraph 12 of Schedule 8. That paragraph amends section 47 of the National Assistance Act 1948 (which makes provision in respect of those in particular need of care and attention) to take account of a change made by the Bill to the Mental Capacity Act 2005. The change will not apply in relation to hospitals outside England and Wales and so it is not likely that the amendment would need, in practice, to have effect in Scotland. On that basis, the amendment does not extend to Scotland.
208. *Subsection (3)* provides that section 42 extends to the United Kingdom so as to ensure that consequential amendments made in reliance on that section can extend to Scotland or Northern Ireland if the provisions being amended also extend there.

## **PUBLIC SECTOR FINANCIAL COST AND PUBLIC SECTOR MANPOWER IMPLICATIONS**

209. The additional public sector costs are estimated to be approximately £22 million in the first full year of implementation: about £10 million for the amendments to the 1983 Act and £12 million for the amendments to the MCA. These costs will rise to about £34 million (£31 million for the 83 Act and £3 million for the MCA) once steady state has been reached after six years.
210. Most of the costs associated with the amendments to the 1983 Act arise from the introduction of SCT, ie the costs associated with supporting people in the community, and from additional tribunals. The costs arising from the amendments to the MCA arise from the provision of safeguards for patients who lack capacity and are deprived of their liberty and who are not under mental health legislation.
211. There are also some pre-implementation costs and there will be additional costs associated with the use of the order-making power to reduce the referral to the MHRT, which will depend on how the power is used. Detailed costings are set out in the Regulatory Impact Assessment.
212. The Bill will involve additional public sector manpower of about 260 in the first full year, falling to about 130 once steady state has been reached after six years. Again, details are contained in the Regulatory Impact Assessment.

## **REGULATORY IMPACT**

213. A Regulatory Impact Assessment has been produced to accompany the Bill and is available on [www.dh.gov.uk](http://www.dh.gov.uk).

## **EUROPEAN CONVENTION ON HUMAN RIGHTS**

214. Section 19 of the Human Rights Act 1998 requires the Minister in charge of a Bill in either House of Parliament to make a statement about the compatibility of the provisions of the Bill with the Convention rights (as defined by section 1 of that Act). The Lord Warner has made the following statement:

“In my view the provisions of the Mental Health Bill [HL] are compatible with the Convention rights.”

215. Special attention has been given to ensure that the Bill is fully compliant with Convention rights because mental health patients are a particularly vulnerable group. Although wherever possible people with mental health problems are treated without compulsion, where this is not

the case, the necessary curtailment of their rights must be within a legislative framework that is compatible with Convention rights with proper safeguards to protect those rights.

216. The Bill raises issues under Article 3 (prohibition of inhuman or degrading treatment), Article 5 (right to liberty and security), Article 8 (right to respect for private and family life), Article 14 (prohibition of discrimination) and Article 3 of Protocol 1 (right to free elections).

#### **Criteria for detention**

217. Clause 4 amends one of the criteria for detention for treatment in the 1983 Act, the treatability test - that for certain categories of mental disorder treatment, treatment must be likely to alleviate or prevent deterioration in the condition. This is to be changed to become a test that appropriate treatment is available to that individual. Unlike the treatability test, this safeguard will apply in respect of any person considered for detention under the Bill, irrespective of the nature of their qualifying disorder. In the Government's view, Article 5 does not include a requirement that the patient be treated, and so it does not consider that Article 5 is engaged.

#### **Patient's nearest relative**

218. Clause 22 of the Bill introduces the ability for the patient to apply to the county court to discharge his or her NR and introduces a new ground on which an application may be made which concerns the suitability of the person to be the NR. It is considered that this is compatible with the patient's Article 8 right to respect for private and family life and remedies the finding of incompatibility against the Government in two cases.

#### **Supervised community treatment**

219. Clauses 25–29 and Schedules 3 and 4 introduce the ability to treat patients who have previously been detained in hospital in the community. The provisions abolish aftercare under supervision and give the power to make transitional arrangements by order. These provisions engage Articles 5, 8 and 14. A person who is made subject to a CTO can be recalled, or have their CTO revoked, only in a manner, and on a basis, that is compatible with these Convention rights and so as to avoid arbitrariness. The reason for recalling a patient to hospital when the patient is subject to a CTO must be related to the patient's need to be treated in hospital and the interests of the patient's health and safety or the safety of others, in order to ensure the patient's ECHR rights are not breached. Patients who are subject to a CTO are given new rights to apply or have their case automatically referred to the Tribunal to meet the requirements of Article 5.

#### **Mental Health Review Tribunals**

220. The Tribunals in England and Wales will continue to be the forum for review of detention. Clause 30 amends the 1983 Act so that all types of civil cases (including guardianship order patients transferred to hospital, but not Part 3 hospital order patients) are to be referred to the Tribunal by the hospital managers at the expiry of 6 months from the applicable date (generally being the date the patient was initially detained under the 1983 Act) unless an application has already been made, for example by the patient or the patient's NR, or the case

has otherwise been referred to the Tribunal. This is compatible with the requirements of Article 5 that detained patients have speedy access to a “court”<sup>2</sup>, to decide the lawfulness of detention, and protects the rights of the patient to be free of arbitrary detention.

### **Restricted patients**

221. Clause 33 will repeal the power for the Crown Court to make a restriction order for a specified period. The effect of the repeal is that restriction orders can no longer be “limited”. They will remain in force until discharged by the Secretary of State or the MHRT. Restriction orders engage Article 5 (deprivation of liberty) and specifically Article 5(4), the requirement for an independent judicial review of deprivation of liberty, with power to order discharge, and bring restrictions to an end. That review will continue to be provided unchanged by the Tribunal. The Government’s view is that the amendment leaves the provision fully compliant with the ECHR.

### **Members of Parliament and members of the devolved assemblies**

222. Section 141 of the 1983 Act provides for the seats of Members of Parliament and the devolved assemblies to be vacated where the members is detained under mental health legislation. At present this applies only where the member is detained on the grounds of mental illness. Schedule 1 extends this to mental disorder generally. This engages Article 3 of Protocol 1 which has been interpreted to include a right to stand for electoral office. The Government’s view is that this interference pursues a legitimate aim, namely the removal of a member in specified circumstances when he or she is suffering from mental disorder, and is proportionate.

### **Amendments to the Mental Capacity Act 2005**

223. Part 2 of the Bill engages the Article 5 right to liberty and security, the Article 8 right to respect for private and family life and the Article 14 prohibition of discrimination Part 2 of the Bill sets out to remedy the finding of incompatibility with the ECHR by the European Court in the case of *HL v United Kingdom*, commonly known as the “Bournewood gap”. There is provision in the Bill to set out a procedure in law and provide relevant safeguards to close the “Bournewood gap”. This is achieved by amending the MCA to permit authorisation of deprivation of liberty if certain qualifying requirements are met. It is the Government’s view that this makes provisions fully compliant with the relevant articles of the ECHR.

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<sup>2</sup> not necessarily a court of the classic kind. In *Benjamin & Wilson v the UK (2003)36 EHRR 1*) the court held it must have necessary judicial procedures, appropriate safeguards, and be independent of the parties and the executive.

*These notes refer to the Mental Health Bill [HL]  
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## **COMMENCEMENT DATE**

224. The commencement clause (clause 44) provides for the Act to be commenced by order of the Secretary of State, with the agreement of Welsh Ministers.

Annex A

## Functions of Welsh Ministers

Clause/Section	Function Description
25 / 17F(2)	Power to prescribe by regulations the circumstances in which and conditions subject to which a recalled patient may be transferred to any hospital.
Schedule 3 / 19A(1)	Power to prescribe by regulations the circumstances in which and conditions subject to which a community patient may be assigned to any hospital.
25 / 20A(4)(b)	Power to prescribe by regulations the form of the report which a RC must furnish to hospital managers, where it appears to that clinician that the conditions in section 20A(6) have been met.
28 / 64H(2)	Power to prescribe by regulations the form of the “Part 4A certificate”
Schedule 3 / 67(1)	Power to refer the case of any community patient to the MHRT.
30 / 68A(1)	Power to shorten by order the time periods set out in sections 68(2) and (6), within which hospital managers must refer patients’ cases to the MHRT.
30 / 68A(2)	Power to include in any order made under section 68A(1) such transitional, consequential, incidental or supplemental provision as the Assembly thinks fit.
Schedule 5 / 80ZA(1)	If it appears that specified conditions are met, power to authorise the transfer of responsibility for a community patient to a hospital in Scotland.
Schedule 5 / 81ZA	If it appears that specified conditions are met, power to authorise the transfer of responsibility for a community patient to a hospital in Northern Ireland.
Schedule 5 / 83ZA(3)	If it appears that specified conditions are met, power to authorise the transfer of responsibility for a community patient to a hospital in the Channel Islands or the Isle of Man as the case may be.

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17 / 114(4) & (5)	Power to give directions to local social services authorities (whose areas are within Wales) in relation to the approval of Approved Mental Health Professionals. The direction may include such matters as the length of approvals, conditions attaching to approvals and the factors to be taken into account in determining whether a person has appropriate competence to act as an AMHP.
17 / 114(6)	Power to vary or revoke directions made under section 114(4).
16 / 142A	Power, exercisable jointly with the Secretary of State, to make regulations as to the territorial extent of approval for s12 doctors and approved clinicians
13 / 145(1)	The function of approving persons to act as ACs for the purposes of the Act.

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Para 21	The function of supervisory body with power to give standard authorisation to deprive persons of liberty
Para 31	Power to prescribe in regulations information required in request for standard authorisations
Para 33	Power to prescribe in regulations the timescales for assessors to carry out assessments for standard authorisations
Para 47	Power to provide in regulations a requirement that eligibility assessors require best interests assessors to provide relevant eligibility information.
Para 77	Power to extend the period of urgent authorisation
Para 95	The function of reviewing standard authorisations
Para 122	Power to include in regulations provision about the selection and eligibility of persons to be appointed as assessors

Para 123	Power to prescribe in regulations as to the number and kind of person that may carry out assessments, including their qualifications, experience and
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	independence. The regulations may also require assessors to hold liability insurance.
Para 130 to 144	Power to make regulations about the selection and appointment of representatives
Para 154	Power to make regulations to enable monitoring and reporting on the operation of provisions, and to direct one or more persons or bodies to monitor and report on the operation of the provisions.
Para 155	Power to make regulations requiring the supervisory body and managing authority to disclose information.
Para 156	Power to direct LHBs to exercise supervisory functions
Para 157	Power to make directions and regulations about the exercise of supervisory functions.
Para 164	Power to determine questions arising as to residence and to make regulations about the determination of residence (as set out in Para 174
Para 175	Power to make regulations about the carrying out of functions where the supervisory body and managing authority are the same body

# MENTAL HEALTH BILL [HL]

## EXPLANATORY NOTES

*These notes refer to the Mental Health Bill [HL]  
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